CQC 'Our next phase of regulation' consultation questions:

1a Do you think our set of principles will enable the development of new models of care and complex providers?
[Strongly agree/ **Agree**/ Neither agree or disagree/ Disagree/ Strongly disagree]

1b Please tell us the reasons for your answer.
The principles clearly reflect the way forward for ordinary accommodation services for people with a learning disability/Autism in the development of new service.

Further guidance and advice will be welcomed by services, i.e., the Managers, and Board Level Leadership, as this can only enhance the support for all those in the services.

2a Do you agree with our proposal that we should have only two assessment frameworks: one for health care and one for adult social care (with sector-specific material where necessary)?
[Strongly agree/ Agree/ **Neither agree or disagree**/ Disagree/ Strongly disagree]

2b Please tell us the reasons for your answer.

The format being more condensed and informative will provide a more focused tool for our services to use. However we require clarification on how some of our specialist brain injury rehabilitation services will be covered by these new criteria. We will continue to have conversations with INPA (Independent Neurorehabilitation Providers Alliance) and CARF (Commission on the Accreditation of Rehabilitation Facilities) to advocate for a separate registration category given the complexity of this type of service.

3a What do you think about our proposed changes to the key lines of enquiry, prompts and ratings characteristics?

Additional guidance which takes into consideration the requirements of the MCA can only improve the services. CQC rate all of our registered services, so the ratings characteristics do not affect The Trust.

3b What impact do you think these changes will have (for example the impact of moving the key line of enquiry on consent and the Mental Capacity Act from the effective to the responsive key question)?

Using the MCA example, we cannot see that making the change from 'effective' to 'responsive' should make a significant difference to the care and support being provided. We would always look at the service user assessment of need, outcomes and experience, as well as what the knowledge and actions of the staff is and how the manager ensures that practice meets the outcomes for the service user and service and documentation to evidence all of this. These can be clearly demonstrated whether in 'effective' or 'responsive'.

4 We have revised our guidance Registering the right support to help make sure that services for people with learning disabilities and/or autism are developed in line with national policy (including the national plan, Building the right support). Please tell us what you think about this.

We attended the event on 7th February co-organised by CQC and VODG to gather provider feedback on the consultation and proposals. Many of our concerns were shared by others within the sector.
The proposals provide a clear message that services/organisations will need to "comply with". The information contained within case studies will also support applications and will provide invaluable supporting information for registration purposes. It is right that new services and existing services need to

reflect what people want, national policy and recognised best practice and as an organisation we want to ensure that we provide the best possible care and support to those who we provide a service to.

Whilst the guidance recognises that there are commissioners who continue to purchase services that are outside of the national policy, in our experience is unfair to say that this is always due to a lack of appropriate local services. Our services have often been in response to commissioner's requests and continue to receive regular referrals, when there are local services that reflect the national policy and this guidance. CQC should recognise the climate in which providers are operating – there is increasing difficulty in getting commissioners to fund placements in smaller units and it is extremely worrying that CQC have not specifically sought the views of commissioners for this consultation.

We are concerned about CQC's proposed 'cap' of six beds in new units and that this is being framed as the model for 'good' care in future. We fear that this will be retroactively applied to existing services and current larger services will no longer be seen as fit for purpose. Future planning becomes much more challenging – at what stage will CQC offer advice/support to providers opening new services, i.e. could services be on the verge of opening only to find they will not be granted registration? A formal system of support from CQC should be embedded in the planning system. The proposed 'cap' is impractical given existing pressures on the sector including the rise in the minimum wage and cuts to local authority social care budgets. The loss of economies of scale (including safe staffing ratios and the possibility of floating staff) present in larger units will cause providers to fold or commissioners to sent people to unsuitable placements, e.g. elder care rather than LD focused.

Individual choice seems to be ignored – many people we support actively choose to live in a 'campus style' or rural setting and this model is popular also with families. There is an assumption on the part of CQC that people in services will be contributing to/engaging with their local community independently and should not be reliant on staff, and that properties should not have lockable offices that residents are not permitted to enter. This all displays a lack of familiarity on CQC's part of the extent of the needs of people supported in this type of service and bears little relationship to how care homes operate.

The two questions below relate to NHS Trusts.

5 What should we consider in strengthening our relationship management, and in our new CQC Insight approach?

6 What do you think of our proposed new approach for the provider information request for NHS trusts?