

Registering the right support

CQC's policy on registration and variations to registration for providers supporting people with learning disabilities

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Background

Since the BBC Panorama programme in 2011, which exposed the abuse of people at Winterbourne View hospital, there has been increased scrutiny of how the health and social care needs of people with learning disabilities are being met. The first response to this was the Department of Health report, *Transforming care: A national response to Winterbourne View Hospital*.¹ This was accompanied by the Winterbourne View Concordat that many organisations, including the Care Quality Commission (CQC), signed up to.² Through this, signatories committed to taking action to transform the provision of health and social care for people with learning disabilities and/or autism who display behaviour that challenges, including those who have a mental health condition. This was particularly in reference to those who are cared for in specialist hospitals.

This programme of work has added momentum to previous strategies and reports, such as *Valuing People: A New Strategy for Learning Disability for the 21st Century*, and the Mansell reports, which have long recognised that long-term institutional care is not a successful approach to supporting people with learning disabilities and described what good quality care looks like for people with learning disability.^{3,4,5} There is limited evidence that hospital placements are effective, particularly in the longer term. The Transforming Care programme* has also shown that care in institutional settings is rarely person-centred, can lead to abusive practices, and hospital placements may be far from people's families, friends, and communities. Specialist hospital placements can also be far from the commissioning case managers who are responsible for reviewing the placements. This can lead to a lack of effective monitoring, and may mean the person does not progress or even deteriorates without intervention to promote discharge.⁶

In October 2015, NHS England, the Association of Directors of Adult Social Services (ADASS), and the Local Government Association (LGA) published *Building the Right Support*.⁷ This is a national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. They also published an accompanying service model for commissioners of health and care services.⁸ These documents look at the impact of closing hospital beds for people with learning disabilities and the services that need to be in place in the community to support them. The principles set out here for commissioning good services, including quality of life, keeping people safe, and choice and control, are consistent with both the fundamental standards set out in regulations and CQC's overall framework of quality.

We support this work as a partner organisation of both the original Winterbourne View Concordat and the Transforming Care Delivery Board. It provides a clear picture of what good quality care models should look like. As NHS England and local commissioners are planning to reduce inpatient provision and develop community services, we will support this by making sure that applications from providers to register or change their registration are in line with this plan and the model because they are aimed at delivered quality care. We will also consider the extent to which

* www.england.nhs.uk/learningdisabilities/care

applicants for registration and variations to their registration for services for people with learning disabilities have considered and applied this model when determining whether or not to grant the applications.

We have already committed to taking a firmer approach to the registration and variations of registration for providers who support people with learning disabilities, for example in *A Fresh Start for Registration* and our report *The state of health and adult social care in England 2014/15*.^{9,10} This policy statement sets out our position and clarifies the factors that will make it more likely for applications to register or vary registration to be refused.

The Department of Health's 2012 report *Transforming Care* states that:

“...the norm should always be that children, young people and adults live in their own homes with the support they need for independent living within a safe environment. Evidence shows that community-based housing enables greater independence, inclusion and choice, and that challenging behaviour lessens with the right support. People with challenging behaviour benefit from personalised care, not large congregate settings. Best practice is for children, young people and adults to live in small local community-based settings.”¹¹

As *Building the Right Support* says:

“Over the last few years hundreds of people from hospital have been supported to leave hospital – but others are admitted in their place, often to inappropriate care settings, so the number of inpatients remains steady. We have not made enough progress when it comes to changing some of the fundamentals of care and support.

...Just like the rest of the population, people with a learning disability and/or autism must and will still be able to access inpatient hospital support if they need it. What we expect however is that the need for these services will reduce significantly. The limited number of beds still needed should be of higher quality and closer to people's homes.”¹²

As the quality regulator, we are committed to promoting the registration of services that reflect these longstanding principles on what constitutes good quality care for people with learning disability or autism.

Scope and purpose

The purpose of this policy statement is to ensure that we have a consistent approach to registration and that we make our expectations clear to registration applicants. Registration managers and inspectors will use this statement to guide their assessments of providers of services for people with learning disabilities, and to decide whether to grant or refuse registration applications, or applications to make variations to registration.

We have a comprehensive assessment process in place to make sure that applications are only granted when we are satisfied that applicants are meeting, and are likely to continue to meet, the regulations and other requirements. To do this, providers are required to demonstrate how their model of support is built on evidence-based care, for example, National Institute for Health and Care Excellence (NICE) guidelines, and that it is in line with national policy, for example, Department of Health, Association of Directors of Adult Social Services (ADASS) and NHS England guidance. We expect providers of services for people with learning disabilities to refer to *Building the Right Support* and the accompanying service model when designing or redesigning service delivery.

This policy statement applies to three key areas of registration:

1. Applying to provide regulated activity in specialist hospital provision, such as an assessment and treatment unit for people with learning disabilities.
2. Applying to provide regulated activity in other services specifically for people with learning disabilities.
3. Applying to vary the provider's conditions of registration by adding or removing a location, or increasing the number of places provided at a location.

This policy statement refers specifically to providers of services for people with learning disabilities. However, we recognise that some providers support people with a wide range of needs or disabilities, which may include people with learning disabilities, and the number of people with learning disabilities and/or autism they support may change over time. As a result, we can apply this policy statement to any provider who could provide a service to a person with learning disabilities, even if they are not supporting people with learning disabilities at the time of their application. We expect to see the underpinning values of enablement, person-centred care, choice, control, increasing independence, and rights in all services.

We will also take a consistent approach across registration and inspection. If we find on inspection that a provider's service does not meet the aims of *Building the Right Support*, and the accompanying service model for quality, we will take this into account in our judgements and ratings of the service. Where we find breaches of fundamental standards, we will use this to support enforcement action.

Although this statement sets out our policy on applications by providers of services for people with learning disabilities, we have not provided detailed checklists about what is and is not required or permitted. We aim to support innovation by providers

and the new models of health and social care that are being developed where they will provide good quality care for people. Prescribed checklists of requirements would not support innovation or be consistent with our new approach. The aim of this statement is to guide, not to replace, the judgements of our experienced registration managers and inspectors.

Opening a new specialist assessment and treatment unit or hospital

Applications to register from new providers or applications by existing providers to vary their registration in relation to regulated activity in new hospital services (new locations) for people with learning disabilities

Building the Right Support sets out plans to close hospital services and strengthen support in the community. NHS England estimate that this would lead to a 35 to 50% reduction in inpatient provision for people with learning disabilities by the end of 2018. As a result, CQC have a responsibility to make sure that providers of new inpatient services are only registered when a clear need is identified. Any new hospital services must have been requested by/agreed with local commissioning partnerships, and should be designed to support the delivery of the plans laid out in *Building the Right Support* because they are designed to deliver quality services.[‡]

Building the Right Support has also tasked local commissioning partnerships with designing local Market Position Statements. The aim of these is to detail the needs of people with learning disabilities in each area and what services are required to meet these needs. When reviewing new applications for new hospital services for people with learning disabilities, we expect to see a clear statement in the local Market Position Statement about why this is needed. We will also need to see written correspondence between the local Transforming Care Commissioning Partnership and the provider confirming they have been asked to provide this service. For regional provision, applicants must have written confirmation of the request to provide hospital services from NHS England to the provider.

Applicants will need to demonstrate that they understand the model for commissioning learning disability services, set out alongside *Building the Right Support*, and how this will be applied to the service they intend to provide. They will need to show evidence of this in their applications and during the assessment. Evidence includes having effective systems for discharging people to avoid long-term hospital placements, supporting people to increase independence and be part of the community, and involving people and their families in their care. This is not an exhaustive list and providers are expected to have carefully considered *Building the Right Support* and the model for commissioning learning disability services when designing their service and submitting their application.

The case studies below provide examples of an acceptable application and an application where we would have concerns.

[‡] This is because the vast majority of hospital places are paid for either by NHS commissioners or local authority commissioners or both jointly (e.g. see Learning Disability Census 2014 (HSCIC) which provides data on the type of organisation paying for care). The role of private fee paying patients is exceptional and as a result it is vital that new services can demonstrate sustainable demand from local commissioning partnerships.

Example of an acceptable application

Provider A applied to vary their registration to add a new location at or from which to provide the regulated activity of 'assessment or medical treatment for persons detained under the Mental Health Act 1983'. The application was for a new specialist learning disability hospital for four people.

The provider's application detailed agreement from the local clinical commissioning group (CCG) and the local commissioning partnership to register this service in the area, as there were no existing learning disability assessment and treatment inpatient services locally. This was in line with their local Market Position Statement.

The application also described how the provider had access to learning disability nurses, psychiatry, occupational therapists, speech and language therapists, and behaviour analysts. They described their model of positive behaviour support as being based on functional assessments. Intervention plans involved supporting patients to meet these functions in alternative ways.

The location was a converted house in an ordinary street. The property had been made secure for people who were at risk from leaving the premises, but the security features had been carefully thought through and looked 'ordinary' to passers-by.

We reviewed the provider's current ratings for other locations and these were good. The provider had a good record of effectively discharging people between six and 18 months after admission. Their other locations were generally larger than this one. The provider commented that they were reviewing their model of provision in line with the current policy and guidance.

This example would meet the low risk indicators described in this policy and as a result it is likely that the application would be granted.

Example of an application where we would have concerns

Provider B applied to vary their registration to add a new location at or from which to provide the regulated activity of 'assessment or medical treatment for persons detained under the Mental Health Act 1983'. This was for a new specialist hospital for people with learning disabilities.

The hospital was a 24 bed unit in secluded grounds. It was distinctly separated from the community in a rural area.

The provider was asked at the application interview where referrals would come from. The provider said that they would accept referrals from the county the hospital was in and neighbouring counties. They were asked if they would accept referrals from anywhere else and the provider confirmed that they would accept these referrals if beds were available.

We contacted local commissioners from this county and neighbouring counties and found no interest in having a specialist hospital in this area had been expressed. There was also no evidence that this was part of the plans from the local commissioning partnership.

The provider stated that they promoted discharge and had positive behaviour support practices in place across all of its services, but their policies focused on the use of restraint, seclusion, and other restrictive practices. Information from the Mental Health and Learning Disabilities National Minimum Data Set showed that the average length of stay in the provider's other hospitals was significantly above the national average. The provider also had two other locations which were rated as requires improvement.

This application is unlikely to be granted and the following fundamental standards¹³ may be referred to:

- Regulation 9 (3) (a) – Assessments should take into account specific issues that are common in certain groups of people and can result in poor outcomes for them if not addressed. These include diseases or conditions such as continence support needs and dementia in older people, and diabetes in certain ethnic groups. [For the purpose of this statement the assessment would need to take into account the evidence that people with learning disabilities in long-term hospital placements are more likely to experience abuse and the risks associated with institutionalisation].
- Regulation 9 (3) (b) – Providers should use nationally recognised evidence-based guidance when designing, delivering and reviewing care.
- Regulation 12 (1) – Providers should consult nationally recognised guidance about delivering safe care and treatment and implement this as appropriate.
- Regulation 15 (1) (f) - When planning the location of premises, providers must take into account the anticipated needs of the people who will use the service and they should ensure easy access to other relevant facilities and the local community.

Factors which indicate higher risk and the applicant is less likely to be able to satisfy CQC about their compliance

- If the hospital is a large institution, where person-centred care will be difficult to achieve.
- If the provider has not been able to provide evidence that this service is needed in this area or that the application is wanted by the local Transforming Care Partnership, (for example, no written expressed intent by commissioners to place people here).
- If the hospital site is secluded, geographically isolated, or creates barriers to involvement in local communities.
- If the provider has not demonstrated how they will promote independence and discharge, including their policies and approach being reactive and not proactive or indicating a reliance on restrictive practices to supporting people's behavioural needs above proactive approaches such as positive behaviour support.

Factors which indicate lower risk and the applicant is more likely to be able to satisfy CQC about their compliance

- If the hospital is small and the provider can demonstrate how it will promote person-centred care.
- If the provider has submitted evidence that NHS England or the local Transforming Care Partnerships have requested this service to be established in this area.
- If the hospital has easy access to local communities.
- If the provider clearly demonstrates how they promote independence and support discharge.

Opening a new care home or location for supported living

Applications to register from new providers or applications to vary their registration to add new locations (not hospitals) specifically for people with learning disabilities

Building the Right Support, and the model for commissioning learning disability services, aim to reduce the need for hospital services by improving the quality and availability of services in the community. As a result, the model applies to all services. We will review all new and variation applications for the provision of regulated activities in new learning disability services, including care homes and supported living, to ensure that the provider has taken account of this model in designing their services.

Providers will need to demonstrate in their applications how they will support people to increase their independence and be part of the community, avoid and respond to crisis situations, and involve people and their families or representatives in their care. This is not an exhaustive list and providers may include other examples to demonstrate how they have carefully considered *Building the Right Support* and the model for commissioning learning disability services when designing their service and submitting their application.

The case studies below provide examples of an acceptable application and an application where we would have concerns.

Example of an acceptable application

Provider C applied to CQC to vary their registration to add a new location at or from which to provide the regulated activity of 'accommodation for persons who require nursing or personal care'. This was a new specialist learning disability residential home for up to six residents.

Information in the application showed that the provider aimed to support residents to increase independence and promote discharge to supported living settings. Their team training included positive behaviour support, and they described effective approaches to supporting people at times of crisis. The service is located near community facilities and the provider was able to describe how people will be supported to be part of the local community. The design of the building had been carefully considered to fit in with the local area and look and feel like any other home in the street.

Before the inspection, the provider was asked to give us information about where residents would come from. They were able to demonstrate that they had four referrals from one of the local authority already, which was in line with local Market Position Statements. They were also able to show how their service reflected the local autism strategy, and provided evidence of positive engagement with family carers.

This application would meet the low risk indicators described in this policy statement, and as a result registration is likely to be granted.

Example of an application where we would have concerns

Provider D applied to CQC to vary their registration to add a new location at or from which to provide the regulated activity of 'accommodation for persons who require nursing or personal care'. This was a new specialist learning disability residential home for up to 20 residents. The home was described as being divided into three self-contained units, with some shared communal areas.

On inspection, it was difficult to see how the separation into smaller units would be achieved. There were conjoining doors and already plans for permanent shared staffing arrangements. The communal areas within each unit were very limited, with most communal space being shared by all three units.

Information in the application stated that the provider aimed to support patients to increase independence and promote discharge to supported living settings. However, their processes for doing this were unclear. The service was located near community facilities and the provider described how people would be supported to be part of the local community. However, on inspection of the service during a site visit, the site looked and felt distinctly like a secure place of residence. The layout of the building and grounds would clearly restrict the residents' engagement with the local community and it felt as though the people who would live there were being hidden away.

This application is unlikely to be granted and the following fundamental standards¹⁴ may be referred to:

- Regulation 9(1) –Providers must do everything reasonably practicable to make sure that people who use the service receive person centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be.
- Regulation 9 (3) (b) – Providers should use nationally recognised evidence-based guidance when designing, delivering and reviewing care.
- Regulation 10 (2) (b) – People must be supported to be involved in their community as much or as little as they wish. Providers must actively work with people who wish to maintain their involvement in their local community as soon as they begin to use a service. The provider must make sure that people are not left unnecessarily isolated.
- Regulation 12 (1) – Providers should consult nationally recognised guidance about delivering safe care and treatment and implement this as appropriate.
- Regulation 15 (1) (f) – When planning the location of premises, providers must take into account the anticipated needs of the people who will use the service and they should ensure easy access to other relevant facilities and the local community.

Factors which indicate higher risk and the applicant is less likely to be able to satisfy CQC about their compliance

- If the provider is setting up services where the number of people supported will make person-centred care difficult to achieve. This will vary depending on the needs of the people that are likely to use the service, but current Department of Health policy recommends small services.¹⁵
- If the services planned are secluded, geographically isolated, or create barriers to involvement in local communities.
- If the provider has not been able to demonstrate how they will promote enablement, independence, choice, and inclusion.
- If the provider has not demonstrated understanding of the Mental Capacity Act 2005.
- If the provider cannot describe their effective service systems and staff training plans to prevent and respond to crisis situations, such as the use of positive behaviour support and safe use of restrictive interventions.

Factors which indicate low risk and the applicant is more likely to be able to satisfy CQC about their compliance

- If the provider is planning small scale service delivery, for example, in the individual home of the person receiving support (in the case of supported living, where the regulated activity being provided is personal care, not personal care with accommodation), or a small shared home, and demonstrates how they will promote person-centred care.

- If the provider can demonstrate how they promote easy access and inclusion to local communities.
- If the provider clearly demonstrates how they promote enablement, independence, choice, and inclusion.
- If the provider has effective systems and staff training plans in place to prevent and respond to crisis situations, such as training in positive behaviour support, safe use of restrictive interventions, on call processes, and learning from incidents.

New applications for registration

Application to change regulated activity to provide registered care home services or supported living services

As well as the development of new hospitals and care homes, we have seen a rise in new applications from existing registered providers to change the regulated activity they provide at a location. Examples include applications to change the regulated activity providers are delivering at a location, for example, to change the location's service type from hospital services to care home services. We have also seen a number of applications to change the activity currently delivered from 'accommodation for persons who require nursing or personal care' (registered care homes) to 'personal care' in people's own homes (usually via supported living services). Some of these changes may have been in response to the Transforming Care delivery programme.

This section outlines suggested areas that providers should be able to address during the application and inspection process. This will support registration inspectors to identify whether the application takes account of *Building the Right Support*. If we are not satisfied that these questions are adequately addressed, we will consider whether the applicant meets the requirements and we may refuse the provider's application for registration. This would mean the provider could continue providing the regulated activity they are currently registered for.

When a provider applies to **register for the activity of 'accommodation for persons who require nursing or personal care', at locations which are or were formerly used as hospitals**, the following questions should be addressed:

- Will the environment and location resemble a clinical environment or a home?
- What will be done differently at the location, reflecting the change in regulated activity?
- Will the support and care for those living there feel different and, if so, how?
- If people are currently detained under the Mental Health Act as inpatients, will their Mental Health Act status change, and if so, how?
[If a person is detained who no longer requires detention and should be discharged, it is **not** appropriate that this should be achieved by a change in service registration.]
- Can the provider demonstrate a comprehensive understanding of the Mental Capacity Act?
- How will the provider make sure that the culture of the location changes from a hospital to a care home?
- How will staff be supported to manage this change? For example, additional training and consultation.
- Have there been any previous concerns about the safety and quality of the location, including failure to submit mandatory data?

- Have people using the service and their representatives or carers been engaged in discussions or plans to change the regulated activity provided at the service, and how?

If the evidence shows that the same people will be receiving the same care in the same place from the same staff with the same training and qualifications run by the same provider according to the same policies, there is no clear justification for applying to register to carry on a new regulated activity. The fundamental principle is that changes in the regulated activities being delivered should make a difference to the people receiving services.

The case studies below provide examples of an acceptable application and an application where we would have concerns.

Example of an acceptable application

Provider E applied to use its location to carry on the regulated activity of 'accommodation for persons who require nursing or personal care' instead of the activity of 'assessment or medical treatment for persons detained under the Mental Health Act'.

At the time the provider had only two detained patients resident both of whom were due to remain detained because of their clinical needs but were being transferred to other hospitals closer to their own homes and families.

The provider gave evidence of planning approvals for redevelopments to the site and premises which would substantially change the look and feel, for example, removal of some previous permanent security measures.

The provider had also employed a new senior specialist in Positive Behaviour Support who had reviewed and amended the provider's previous policies and, although most of the previous staff would remain, the provider could evidence that a programme of new training was part way through.

There was evidence of cultural change in the service consistent with a change in regulated activity. The provider had recently appointed a self-advocate with learning disability to the management board responsible for running that location and had engaged with local community, self-advocacy and family groups in re-designing the site and people with learning disability were also involved in delivering some of the training to staff. The provider could provide evidence they were working with local/neighbouring commissioners to develop this facility to meet locally identified needs

This application would meet the low risk indicators described in this policy statement, and as a result registration is likely to be granted.

Example of an application where we would have concerns

CQC received an application for registration from Provider F to enable it to use its location to carry on the regulated activity of 'accommodation for persons who require nursing or personal care' instead of the activity of 'assessment or medical treatment for persons detained under the Mental Health Act'.

The provider gave details of how their statement of purpose had changed. They also described how they would be reducing nursing and psychiatry time at this venue. However, there were no plans to transfer the existing patients to another hospital. All patients were planned to be discharged from their Mental Health Act sections and continue residing there under Deprivation of Liberty Safeguards.

There were no plans to redevelop, redesign or refurbish the building beyond some minor cosmetic redecoration. There was no evidence of culture change being supported for the teams, for example through new training or changes to policies and procedures. During inspection there was evidence that the care provided would remain institutional in feel.

This application is likely to be refused and the following fundamental standards¹⁶ may be referred to:

- Regulation 9(1) – Providers must do everything reasonably practicable to make sure that people who use the service receive person centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be.
- Regulation 9 (3) (b) – A person's care and treatment must be designed to make sure it meets all their needs. There may be times when a person's needs and preferences can't be met. In these instances, providers must explain the impact of this to them and explore alternatives so that the person can make informed decisions about their care and treatment.
- Regulation 9 (3) (b) – Providers should use nationally recognised evidence-based guidance when designing, delivering and reviewing care.
- Regulation 10 (2) (b) – People who use services must be offered support to maintain their autonomy and independence in line with their needs and stated preferences. When offering support, staff should respect people's expressed wishes to act independently but also identify and mitigate risks in order to support their continued independence as safely as possible.
- Regulation 12 (1) – Providers should consult nationally recognised guidance about delivering safe care and treatment and implement this as appropriate.

In 2015, we published [guidance](#) on regulated activities for providers of supported living.¹⁷ **All providers seeking to register to provide personal care as part of supported living services should refer to this guidance.** Registration inspectors and managers will take this guidance into account in assessing applications to **register for personal care to be provided to people in premises that are currently being, or were formerly used as care homes.** In these cases, the following questions should be addressed:

- Are the personal care and accommodation arrangements provided under separate agreements? If accommodation and personal care are being provided together as a single package under one agreement, the regulated activity should remain as ‘accommodation for persons who require nursing or personal care’.
- Does the supported person have a genuine choice about who provides their personal care?
- Do the arrangements meet the Reach Standards, and the Real Tenancy test^{18,19}?
- Does the person have exclusive possession of at least part of the accommodation? This means their own private space over which they decide who can enter and when they can enter (that is, they have control over their own front door) and they have unrestricted access to every part of their home, apart from any co-tenants’ private space?
- Are there parts of the home the person cannot access because they are staff areas, and are items (such as files and office equipment) that are not the person’s belongings stored there?
- Has the person chosen to live there and who they live with?
- Does the environment feel like the person’s own home?
- Can the provider demonstrate a comprehensive understanding of the Mental Capacity Act?
- What will be done differently to ensure the culture changes from residential care to supported living?
- Will the support and care for those living there feel different and, if so, how?
- How will staff be supported to manage this change, for example, will there be additional training and staff consultation?
- Have the tenants/residents and their representatives or families been involved in discussions about changing the regulated activity, and how?
- Is the home part of a cluster of congregated care that could promote seclusion or limit inclusion?

The case studies below provide examples of an acceptable application and an application where we would have concerns.

Example of an acceptable application

Provider G applied to CQC to has applied to register for the activity of 'personal care' to be provided to people in premises that are currently used as a care home, as it plans to run a supported living service from this address.

This was a very small setting based in a residential house on a residential street with four bedrooms. There were two existing residents and two new residents whom it was planned would be moving in within the next few months. All the residents knew each other from school and were friends who had chosen to live together. The house had previously contained an office to which the residents did not have free access but this had been removed recently.

All residents had copies of easy read tenancy agreements. In one case, there was a plan for the tenancy to be signed by a relative.

The organisations providing the personal care and the housing are linked organisations but managed separately and covered under separate agreements with the residents. The personal care provider has known and worked with the current and planned residents for an extended period of time. The provider was able to demonstrate that those living there could change personal care provider. There was clear evidence that those who were due to move in shortly had made a real choice of that particular personal care provider but could have lived there in the same house with their friends had they chosen a different provider of personal care. The discussions with these individuals were part of the prompt for the provider to decide to apply to vary the registration.

The provider had a good regulatory track record in CQC inspections and there were no concerns in the last inspection which related to the safety of the premises.

This application would meet the low risk indicators described in this policy statement, and as a result registration is likely to be granted.

Example of an application where we would have concerns

Provider H has applied to register for the activity of 'personal care' to be provided to people in premises that are currently used as a care home, as it plans to run a supported living service from this address. The supported living service would be overseen by a registered manager in the regional office.

There would no longer be the presence of a registered manager in this setting as there currently is, and the supported living service provided in that premises would now be directly managed by a senior support worker.

The home environment would remain the same. There were no plans to redevelop, redesign, or refurbish. The kitchen would remain a largely staff only area and there would continue to be an office at the property where staff complete notes, team meetings occur, and confidential records are held, relating to both housing and personal care. The residents have no access to the office space.

The residents have been given easy read tenancy agreements. Only two of the five residents can understand these. The provider has reviewed the tenancies with all residents' care managers and there are plans for the majority of tenancies to be signed by relatives with legal power of attorney or court deputies.

The tenancies are with the organisation that is providing personal care, although under separate agreements. The residents and their families have concerns that if they wanted to change support they would have to move out. Provider H could not provide evidence of how the persons living there would be able to arrange for an alternative provider of personal care without affecting their arrangements to live at the home.

This application is likely to be refused as the provider cannot provide evidence that they are not intending to continue to provide the activity of 'accommodation for persons who require nursing or personal care'. The following fundamental standards²⁰ may also be referred to:

- Regulation 9 (1) – Providers must do everything reasonably practicable to make sure that people who use the service receive person centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be.
- Regulation 12 (1) – Providers should consult nationally recognised guidance about delivering safe care and treatment and implement this as appropriate.

Adding beds or places

CQC also receives applications from providers to vary their conditions by increasing or reducing the number of places that may be provided in premises that are care homes. Applications to increase the number of places will receive additional scrutiny from registration. The following questions should be answered:

- If the home will be caring for a larger number of people, how does this fit in with Department of Health policy on small settings ²¹
- How will they maintain appropriate staffing for these needs?
- Has the provider considered how the increase in size may impact on the service needs, and how will these needs be adequately met?
- How will the provider make sure that care remains person-centred with the additional places?
- Will plans for the additional places reduce room size, or increase the number of double rooms?
- How will the plans make sure that people can maintain and increase their independence?

Conclusion

This policy statement provides guidance on handling new applicants for registration and applications to vary registration from providers of services for people with learning disabilities, and should be used with immediate effect. The policy statement complements, and does not replace, existing registration guidance. Generic risk indicators, such as the provider's regulatory track record, for example providing services that are rated as requiring improvement or inadequate, or there being a lack of a registered manager, will continue to apply to the applications described here.

Registration is one part of how we regulate health and adult social care services. The guidance in this document may also be applied to our inspection processes to make sure that providers continue to meet requirements after registration. It will also be used to make sure that providers' existing services are being delivered with reference to *Building the Right Support* and other key national policy and good practice guidance referenced in this statement.

Appendix: Links to Joint NHS England, Local Government Association and ADASS model for commissioning learning disability services

Underpinning the model for commissioning learning disability services are nine core principles, which will be considered during registration applications:

1. A good and meaningful life
2. Care and support is person-centred, planned, proactive and coordinated
3. Choice and control regarding how health and care needs are met
4. Support for family and paid carers
5. Choice regarding where I live and who I live with
6. Access to care and support from mainstream services
7. Access to specialist health and social care support
8. Appropriate support if needed when in contact with Criminal Justice Services
9. Access to high quality hospital admissions if required, for the shortest possible time.

While not all of these principles may be related to registration, we expect providers to detail how the provider's model of support applies to these principles.

The following points are from the model for commissioning learning disability services.²² These will be taken into consideration when we are reviewing applications to register or change registration:

- Quality of life – people should be treated with dignity and respect. Care and support should be personalised, enabling the person to achieve their hopes, goals and aspirations; it should be about maximising the person's quality of life regardless of the nature of their behaviours that challenge. There should be a focus on supporting people to live in their own homes within the community, supported by local services.
- Support and interventions should always be provided in the least restrictive way. Where an individual needs to be restrained in any way – either for their own protection or the protection of others, restrictive interventions should be for the shortest time possible and using the least restrictive means possible, in line with Positive and Proactive Care.
- Local authorities should develop Market Position Statements with an explicit focus on this group.
- People should be offered a choice of housing, including small-scale supported living.
- Everyone who is admitted to a hospital setting for assessment and treatment should expect this to be integrated into their broader care and support pathway, with hospitals working closely with community mental health, learning

disability/autism and other services, including those providing intensive community and/or forensic support.

- When people are admitted for assessment and treatment in a hospital setting they should expect support to focus on proactively encouraging independence and recovery. Services should seek to minimise patients' length of stay and any admissions should be supported by a clear rationale of planned assessment and treatment with measurable outcomes.

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