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Bracknell Forest Council

A Review of the Council's Role in Regulated Adult Social Care Services

by a working group of the Adult Social Care and Housing Overview and Scrutiny Panel

September 2014

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Acknowledgements

The Working Group would like to express its thanks and appreciation to the following officers of Bracknell Forest Council for their co-operation and time:-

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All those who have participated in the review have been thanked for their contribution and have received copies of this report.

1. Foreword

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Councillor John Harrison
(Lead Working Group Member)

2. Executive Summary

2.1 The tragic abuse of vulnerable adults at Winterbourne View[1] raised the question nationally as to the role of local authorities when a care home fails to care for its residents properly.

2.2 Owing to the importance of care governance and managing safeguarding in regulated Adult Social Care services, the Council's Adult Social Care and Housing Overview and Scrutiny Panel formed a working group to review the Council's role in these areas. Regulated services are those which are registered with the Care Quality Commission (CQC), which is the regulatory body, and are mostly those provided at residential care homes, nursing homes or domiciliary care.

2.3 During the course of the review the Working Group gathered information and evidence from many sources in order to appraise the Council's role with regard to care governance and managing safeguarding in regulated Adult Social Care services. These sources included research in areas such as the Health and Social Care Information Centre, CQC inspection criteria and its reports of inspections of local care and nursing homes, and discussions with Council officers who provided pertinent background information, data and knowledge. Members also had regard to relevant documents including the Social Care Institute for Excellence's definition of excellence in Adult Social Care services, the operation of the Deprivation of Liberty Safeguards (DOLS), and CQC strategies for raising care quality standards and setting out its approach to the regulation and inspection of services.

2.4 This report describes the work of the Working Group between autumn 2013 and spring / summer 2014 and sets out its findings. The report is organised in the following sections and Members hope that it will be well received and look forward to receiving responses to their recommendations:

Part 1 Lead Member's Foreword.

Part 2 Executive Summary.

Part 3 Background information in respect of regulated Adult Social Care services and a summary of how the review was undertaken.

Part 4 A summary of the information and evidence gathered by the Working Group.

Part 5 Conclusions reached following the review.

Part 6 Recommendations to the Council's Executive.

2.5 The Working Group comprised:

Councillors Harrison (Lead Member), Mrs McCracken, Mrs Temperton and Thompson.

[1] Link to CQC report: http://www.cqc.org.uk/sites/default/files/old_reports/1-116865865_Castlebeck_Care_Teesdale_Limited_1-138702193_Winterbourne_View_20110715v2.pdf

3. Background

3.1 Bracknell Forest Council funds the social care of approximately 2,000 adults and has related duties regarding governance of their care and safeguarding. The Council's statutory duties relating to safeguarding vulnerable adults apply to every adult in Bracknell Forest. This support is crucial to the everyday lives of these adults and their families and in recognition of the importance of this, the Adult Social Care and Housing Overview and Scrutiny Panel added this topic to its work programme for 2013/14 and as a result established a working group to undertake this review of the Council's role in regulated Adult Social Care services. The new vision and direction of the Care Quality Commission (CQC) set out in its Strategy for 2013-2016, *Raising standards, putting people first* which proposes significant changes to the regulation of health and social care services was a further reason for this review. When scoping the review (scoping document attached at Appendix 1), the Working Group acknowledged that part of its remit was to demonstrate understanding and knowledge of the care governance and safeguarding processes, to establish whether these were sufficiently robust and to identify any possible improvements.

3.2 Care governance is a system of monitoring all matters of service quality and taking appropriate remedial steps when services fall below the required standards. Adult safeguarding can be defined as the process of protecting adults with care and support needs from abuse or neglect. It is mainly aimed at people who may be in vulnerable circumstances and at risk of abuse or neglect by others. Local authorities have the lead responsibility for adult safeguarding in their geographic area and work jointly with local service partners to identify those adults at risk and take action to protect them. With exceptions such as reablement, most care aims to manage ongoing conditions, rather than improve or cure them.

3.3 The National Audit Office (NAO) [2] found that in 2011, 9% of adults in England had care needs that limited or prevented them from performing activities of daily living such as washing, taking medicine, paperwork, cooking and shopping without support. Social care meets these needs by providing personal care and practical support for adults with physical disabilities, learning disabilities, old age, or physical or mental illnesses, and also support for their carers. Needs can arise as a result of disability from birth, physical injury, mental health problems, health conditions such as dementia, discharge from hospital following treatment, or ill-health of an informal carer. Care needs may be short-lived, long-term or permanent.

3.4 Adults are cared for in two main ways: either informally by family, friends or neighbours without payment, or formally through services they or their local authority pay for. The latter consists of homecare which assists with personal tasks in an adult's own home, or with shopping and leisure activities; day care that gives opportunities to socialise away from home and respite for informal carers; and care / nursing homes which offer 24-hour support in a residential setting. Some voluntary organisations provide free formal services. Most care is provided informally. The Government's objectives are to enhance adults' quality of life, delay and reduce the need for care, ensure positive care experiences and safeguard adults from harm.

[2] NAO report re: Adult social care in England: overview 13.03.14 at: http://www.nao.org.uk/wp-content/uploads/2015/03/Adult-social-care-in-England-overview.pdf

3.5 Adults' care needs are rising and those with long-term and multiple health conditions and disabilities are living longer which is increasing pressure on the care system and posing a significant public service challenge. The number of adults aged 85 or over, the age group most likely to need care, is increasing more rapidly than the population as a whole. Over two-thirds of adults receiving care through local authorities are aged 65 and over. Similar numbers of younger people aged 18 to 64 have a physical disability, learning disabilities or mental health problems. The majority of users in each group receive non-residential care in their own home or community. However, the proportion supported in care homes is much higher for older adults and adults with learning disabilities.

3.6 Local authorities use a common framework of four bands to determine eligibility for individual packages of services: critical, substantial, moderate or low needs. People who do not request or qualify for local authority funded care can buy care directly from care providers.

3.7 The Working Group's research has identified that adult social care services are provided by 152 unitary and upper-tier local authorities in England; 5.4 million unpaid informal carers as at 2011; and 1.5 million people working in the sector, of which 74% provide care directly to people in 2012. Self-funders are estimated to spend £10bn on their care and support in 2010-11.

3.8 Nationally, social care provides vital support to 1.6 million vulnerable adults. £19bn was spent on adult social care managed by local authorities in 2012-13, of this local authorities paid for 77%, people receiving care contributed 13% and 10% was funded mainly by the National Health Service (NHS).

3.9 Estimates of the value of informal care range up to nearly £100bn per year. The number of informal carers has increased by 11% between 2001 and 2011, from 4.9 million to 5.4 million, a faster rate of increase than population growth in all regions except London. Carers are also providing care more intensively: in 2011, 36% of carers provided 20 hours of care or more per week, an increase from 31% in 2001. Over 1 in 5 carers are now aged 65 or over and this proportion is increasing.

3.10 Central government sets national policy, local authorities' statutory duties and the amount of central funding for authorities, the majority of which is not ring-fenced. Local authorities set local policies and priorities and decide how to spend central government and locally raised funding across local care services. They choose how to best meet local needs and commission Adult Social Care services. Current policy aims to personalise care services, adapting them to a person's particular needs and wishes.

3.11 Since the 1990s, local authorities have moved away from being the exclusive care service provider to commissioning most care services from a range of independent providers in the private and voluntary sectors and provide little care themselves. In 2012-13, local authorities commissioned 74% (by value) of their services from independent providers.

3.12 Local authorities have a duty to work with the police, local NHS bodies and other partners to safeguard vulnerable adults from abuse and neglect which remains a risk throughout the sector. In 2012-13, 109,000 safeguarding referrals were recorded by authorities nationally, a 13% increase over 2010-11. This increase may reflect increased awareness of abuse or may reflect

overstretched resources and pressure within the system. In 2012-13, 29% of referrals of alleged abuse were carried out by family members, friends or neighbours, and 36% were carried out by social care or health workers.

3.13 Local authorities hold providers to account for care quality and user outcomes. They monitor outcomes and challenge providers if planned outcomes are not met. Measurement is challenging and local authorities monitoring focuses on identifying unacceptable standards of care. Authorities have practical difficulties in monitoring outcomes, for example for users placed outside the Borough, or with cognitive impairments.

3.14 The CQC regulates and inspects adult social care providers against minimum standards of quality and safety nationally. It found that, of the providers inspected between October 2010 and March 2012, 72% met all essential standards of care. However, 27% (3,241 locations) required an action plan for improvement. The CQC had serious concerns in 1% of cases (116 locations) and used its powers to safeguard users from harm or hold the provider to account. It publishes an annual summary of care services in its 'state of care' report. However, it does not make a single assessment of quality across all providers in a local area or of the performance of local authority social care departments.

4. Investigation, Information Gathering and Analysis

Introductory Briefing and Discussion

4.1 The Chief Officer: Adults and Joint Commissioning gave an introductory briefing to the Working Group in respect of the Council's role and responsibilities in relation to regulated Adult Social Care services, with particular regard to care governance and safeguarding.

4.2 The Working Group was advised that regulated Adult Social Care services were those services that were registered with the Care Quality Commission (CQC) which was the regulatory and inspection body. Regulated services were mostly those provided at residential care homes, nursing homes or domiciliary care. Day services and domiciliary care which provided services such as cooking, ironing or financial advice without personal care were not regulated. Few domiciliary services and providers were not registered and the majority commissioned by the Council were registered and regulated. The CQC inspected services and determined whether they were compliant with regulations. Currently there were no inspection ratings and services were classed as either compliant or non-compliant. However, the commentary in inspection reports gave indications as to the quality of services provided. Inspection reports could include recommendations for improvement and in the case of serious non-compliance, the Inspector would require an action plan to achieve compliance. Following an inspection, a draft inspection report would be shared with the inspected service which would have an opportunity to comment thereon before the report was finalised and published. In the case of non-compliance, it was usual for the inspected service to challenge the draft report and attempt to demonstrate compliance and the CQC would give the provider an opportunity to do so. The CQC was the only body with compliance enforcement powers and in the event that a home failed to achieve compliance, the CQC could enforce the matter by withdrawing registration resulting in the closure of the home. There were some nationally expressed concerns that the CQC was not taking sufficient enforcement against poor quality care providers and was referring issues to the relevant local authority to solve. Councils had no powers to respond and withdrawal of their contracts was the strongest action which they could take in response to non-compliance. However, it was in the interests of all concerned to assist poor providers to improve and become compliant as this avoided the difficulties and upheaval associated with the local authority's resulting obligation to re-home affected elderly and frail people. Residents should not be transferred to another care home without good reason as it was likely to be a traumatic experience for them and possibly against their will.

4.3 In addition to the CQC, the Fire Service and Environmental Health also regulated care homes in their relevant areas and would notify Adult Social Care of any concerns.

4.4 The Council operated a care governance approach which was overseen by a Care Governance Board chaired by the Chief Officer: Adults and Joint Commissioning. Care governance in Bracknell Forest consisted of monitoring all matters of service quality such as dignity, respect, care quality, safeguarding, engagement, and food quality and choice, and of taking appropriate action when services fell short of the required standards. These were areas that were also considered by the CQC whose inspection criteria were included in its care

home and homecare quality leaflets which were shared with the Working Group. The reports of CQC inspections were available on its website. Any services commissioned by the Council were subject to care governance and the Board considered information regarding care service concerns, including those relating to non-regulated services, from many sources such as the CQC, other local authorities, complaints, whistle blowing and safeguarding alerts. Services would not be commissioned from poor providers and in the event of concerns, representatives of relevant organisations such as the CQC and the Fire Service would assist the Council to work with providers to improve services, the majority of which found the support helpful. It was necessary for poor providers to acknowledge their shortcomings in order to improve and in recent years the Council had withdrawn services from one care home only, and ceased commissioning from a few domiciliary care providers. The new architecture of the NHS included quality surveillance groups where concerns regarding provider quality in NHS funded services were shared. The groups sought to ensure that service provision was of a high quality and that the best arrangements were in place and a related piece of work had commenced the month prior to the meeting.

4.5 The Adult Social Care, Health and Housing Department had undertaken a project following the discovery of a pattern of serious abuse at Winterbourne View, an independent assessment and treatment unit for adults with learning disabilities, complex needs and challenging behaviour, near Bristol. This involved an approach to establish whether monitoring of out of Borough care facilities for former residents of Bracknell Forest was sufficiently robust. The project found that the host council should not be relied on entirely to safeguard people with learning disabilities placed in a home in its locality and that the home council making the placement should develop a relationship with the host authority and have some involvement in the welfare of the people cared for at the home. The learning from this work was being incorporated into a robust Quality Assurance Framework for all Adult Social Care services. An example was cited where a domiciliary care self-funder in a neighbouring county had died after the agency providing her care closed and the relevant local authority had not intervened. The Working Group was advised that such matters depended upon the particular circumstances and that local authorities could arrange care for self-funders in the event that they were unable to do so for themselves. Should a local care provider close, Bracknell Forest would wish to be assured that there were no resulting risks and would expect to be informed of the details by the CQC.

4.6 Bracknell Forest had safeguarding responsibilities for all care homes, domiciliary care agencies and hospitals within the local authority boundary irrespective of whether the services provided were privately funded or commissioned by the Council. Although the Council would investigate and respond to safeguarding alerts from private and uncommissioned services to protect frail and vulnerable people, it did not inspect their safeguarding arrangements. The CQC may notify the Council of safeguarding issues and anyone could raise a safeguarding alert.

4.7 The Council funded the support of approximately 2,000 adults. Apart from intermediate care services, which for example supported people to recovery following a surgical procedure, the majority of people receiving support had longer term conditions such as dementia or learning disabilities and their support services were regulated (other than Day Services). Reviews of the needs of people receiving support were undertaken on at least an annual basis

to ascertain whether their needs were being met or changes to their care plans were required. People involved in reviews varied according to the particular circumstances and could include carers, family members, district nurses, health services etc. Reviews would be undertaken more frequently in the event of complex or changing needs or safeguarding alerts.

4.8 There were different price rates for residential care and for nursing care. Some of the best care homes in the Borough could be twice the rate the Council paid and therefore too costly for the Council to fund care placements. People could have a choice of care homes and in the event that the one they selected to meet their needs was more costly than the Council's rate, a third party could pay the difference.

4.9 There were sufficient care homes / places locally to meet demand and services were generally of good quality with the exception of one home which consistently caused quality concerns. It was felt that the registered care unit manager had a crucial role in the quality of care provision and in the case of large companies owning numerous care homes, the manager may have limited autonomy and responsibility to actively pursue improvements.

4.10 Under the Deprivation of Liberty Safeguards (DOLS), which formed part of the Mental Capacity Act 2005, it was occasionally necessary to deprive someone without the mental capacity to make decisions of their liberties in their own best interests, in order for them to receive the correct care or treatment. People deemed to have mental capacity were free to make decisions whether or not these were considered to be unwise. The definition of what constituted deprivation of liberty was vague and open to interpretation. The Act and DOLS had resulted from the Bournewood Community and Mental Health NHS Trust judgment concerning the unlawful detention in a psychiatric hospital of an adult with autism and learning disabilities whose carers were prevented from visiting him, and they were without legal recourse to challenge this. Two assessors were required to independently decide whether a person had the mental capacity to make decisions when a home or hospital was seeking authorisation for a deprivation of liberty. The Council's responsibilities under DOLS applied in care homes, when it could be necessary to restrict someone's movements to prevent them from wandering into danger, and also in hospitals although Harts Leap Independent Hospital was the only hospital in the Borough. Whilst Broadmoor Hospital was located in Bracknell Forest, it was operated by the West London Mental Health NHS Trust and social work was provided through the London Borough of Ealing which dealt with safeguarding alerts, although it sought support from this Council when issues were particularly complex. Alerts concerning Broadmoor Hospital were reported to Bracknell Forest's Safeguarding Board.

4.11 The Council provided some support services directly to adults through the Bridgewell Centre and Forestcare. The Bridgewell Centre provided 19 beds for intermediate care in a residential setting with 24 hour staffing. Support included nursing staff, GP visits, access to out of hours district nursing and GP services, rehabilitation assistants and therapists to provide short term rehabilitation following, for example, a surgical procedure in hospital, to re-able people to return home and lead more fulfilling and rewarding lives. Forestcare assisted people to stay safe and keep their independence in their own homes through a 24 hours a day, 365 days a year service offering telephone lifelines, care calls, monitored intruder alarm packages, monitored smoke and carbon monoxide packages, and key safe and key holder services.

Care Quality Commission (CQC) Inspection Criteria and Reports

4.12 The Working Group considered and discussed the inspection criteria utilised by the CQC and viewed a selection of CQC inspection reports of the best and worst performing care homes and domiciliary agencies providing care in Bracknell Forest for evaluation and comparison purposes.

4.13 The Working Group noted that the CQC was the regulator of health and social care in England and replaced the former Social Services Inspectorate and the Commission for Social Care Inspection as one combined body for the regulation and inspection of social care. All providers of regulated health and social care services had a legal responsibility to ensure that they met essential standards of quality and safety that everyone who used those services had a right to expect. The CQC regulated against the essential standards which were described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the CQC (Registration) Regulations 2009.

4.14 CQC carried out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards were being met. It undertook inspections of other services less often. All the inspections were unannounced unless there was a good reason to give advance notice of the inspection to the provider. The inspections fell into the following three categories:

Responsive inspection - carried out at any time in relation to identified concerns.

Routine (or scheduled) inspection - planned and could occur at any time.

Themed inspection - targeted to look at specific standards, sectors or types of care.

4.15 There were 16 essential standards that related most directly to the quality and safety of care and these were grouped into five key areas. When CQC inspected it may check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. For this reason CQC often checked various standards at different times. The five key areas were:

- Treating people with respect and involving them in their care
- Providing care, treatment and support that meets people's needs
- Caring for people safely and protecting them from harm
- Staffing
- Management

4.16 The 16 essential standards described in regulations were:

- Respecting and involving people who use services - Outcome 1 (Regulation 17)
- Consent to care and treatment - Outcome 2 (Regulation 18)
- Care and welfare of people who use services - Outcome 4 (Regulation 9)
- Meeting Nutritional Needs - Outcome 5 (Regulation 14)
- Co-operating with other providers - Outcome 6 (Regulation 24)
- Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)

- Cleanliness and infection control - Outcome 8 (Regulation 12)
- Management of medicines - Outcome 9 (Regulation 13)
- Safety and suitability of premises - Outcome 10 (Regulation 15)
- Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
- Requirements relating to workers - Outcome 12 (Regulation 21)
- Staffing - Outcome 13 (Regulation 22)
- Supporting Staff - Outcome 14 (Regulation 23)
- Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
- Complaints - Outcome 17 (Regulation 19)
- Records - Outcome 21 (Regulation 20)

4.17 CQC inspections involved visits to the provider, observation of how people were cared for, and discussions with people who used the service, their carers and staff. It may also review information gathered in respect of the provider, inspect the service's records and check whether the correct systems and processes were in place.

4.18 The CQC focused on whether the provider was meeting the standards and was guided by whether people were experiencing the outcomes they should be able to expect when the standards were being met. These outcomes indicated the impact care had on the health, safety and welfare of people who used the service, and the experience they had whilst receiving it.

4.19 A regulatory judgement for each essential standard or part of the standard inspected was made by the CQC. The judgements were based on the ongoing review and analysis of the information gathered by the CQC regarding the provider and the evidence collected during the inspection. The CQC reached one of the following judgements for each essential standard inspected:


(Green Tick)

Met this standard This judgement indicated that the standard was being met in that the provider was compliant with the regulation. If CQC found that standards were met, it took no regulatory action but may make comments that may be useful to the provider and to the public about minor improvements that could be made.


(Grey Cross)

Action needed This meant that the standard was not being met in that the provider was non-compliant with the regulation. CQC may have set a compliance action requiring the provider to produce a report setting out how and by when changes would be made to ensure compliance with the standard. CQC monitored the implementation of action plans in these reports and, if necessary, took further action. In the event that a more serious breach of a regulation was identified, CQC would ensure action was taken to rectify it and would report on this when it was complete.


(Red Cross)

Enforcement action taken If the breach of the regulation was more serious, or there had been several or continual breaches, CQC had a range of actions it took using the criminal and / or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers included issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or manager's

registration or prosecuting a manager or provider. These enforcement powers were set out in law and enabled swift and targeted action to be taken where services were failing people.

4.20 Inspectors judged if any action was required by the provider of the service to improve the standard of care being provided. Where providers were non-compliant with the regulations, CQC took enforcement action against them. If it required a service to take action, or if it took enforcement action, it re-inspected before its next routine inspection was due. This could result in several re-inspections of a service in one year. CQC may also re-inspect a service if new concerns emerged before the next routine inspection. In between inspections CQC continually monitored information it acquired in respect of providers from sources including the public, the provider, other organisations and care workers.

4.21 Where the CQC found non-compliance with a regulation (or part of a regulation), it stated which part of the regulation had been breached. Only where there was non-compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, would its report include a judgement about the level of impact on people who used the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact as defined below:

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved rapidly.

Moderate impact - people who used the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who used the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needed to be resolved promptly.

4.22 The CQC decided the most appropriate action to take to ensure that the necessary changes were made and it always followed up matters to check whether action had been taken to meet the standards. In the case of non-compliance causing a major impact, it was possible for the CQC to take enforcement action and issue statutory notices. De-regulating and closing a provider were possible although this was a rare occurrence. One care home in the Borough had recently closed voluntarily following the receipt of a judgement requiring improvement in several areas and enforcement action in respect of standards of staffing. In the event that a care home known by the Council to be poor was being selected by an individual or their carer, officers would discuss the matter with the family of the person concerned to assist them to make a better selection. Care homes sought to protect their reputation and therefore their business.

4.23 When CQC had previously announced that it would inspect very good providers only once every four years, there had been some contention over this inspection regime as matters could change rapidly following, for example, a change in care home manager. A move to inspecting on an annual basis was then pursued. Following the abuse of people with learning disabilities and challenging behaviour discovered at Winterbourne View, the CQC decided to

inspect all similar providers in the country. Inspection teams were multi-disciplined and varied according to the nature of the provider being inspected and could include a health assessor, specialist in learning disabilities, advocate, professional adviser and team leader. Hospitals required a larger team of inspectors. Inspections usually focused on safeguarding, dignity, health and safety, and staff. A poor command of English by staff was identified as a potential hindrance to communication and care and would be considered by inspectors under the categories of involving people in their care and the suitability of staff. When commissioning and using services, the Council undertook a series of checks including recruitment practices before placing an agency on its providers list to ensure that it met the expected standards. Following the initial checks regular contract monitoring would take place to ensure that standards and needs were being met and that people were satisfied with their care. Feedback was received from people receiving care or their carers and if a problem with a care provider was raised the matter would be taken up with the relevant agency and possibly result in a change, such as care visits from a different staff member. Unfortunately, some people were reluctant to raise complaints as they had a perception that complaints would lead to repercussions such as loss of care or bullying. Care home providers in the Borough were generally of a high standard as Bracknell Forest benefited from numerous small private providers which tended to provide better and more personal care than larger national organisations. The closure of a large care home would present a difficulty for a local authority as it would become responsible for the care of the people accommodated there and would need to identify alternative placements for them.

4.24 Issues were referred to the Care Governance Board which would decide on the appropriate action to be taken in response. When a problem at a particular care home was raised the care of all residents would be reviewed and monthly welfare checks would be undertaken until the home reached the required standards with support form the Council. During this time the care home would be amber flagged and no new placements would be made at the home until it improved or they would be made advisedly depending upon the shortcomings in care and the circumstances of the individual. In the event that the home did not make the necessary improvements or did not recognise a failing, the Council would share information with other local authorities, interested organisations and families in addition to moving people whose care it funded to an alternative care home. Whilst people could initially be resistant to a move, they tended to be content in their new surroundings when they had settled in. Some care homes registered with particular specialisms such as catering for bed sores or mental / physical frailty. As people's condition deteriorated it was possible that their home could no longer meet their needs and alternative care would need to be identified. The Council would advise self-funders in respect of care and could assess their needs, arrange their care and undertake a financial assessment or direct them to an organisation to carry out these services, possibly for a fee.

4.25 Care homes were required to report certain occurrences such as falls, safeguarding issues or medicine incidents and advise what response had been undertaken to prevent a re-occurrence. All safeguarding alerts were reported to the Council and the CQC and care homes' record keeping was checked.

4.26 In terms of paying for care, a financial assessment would be made. People would not be required to sell their home to pay for their care if it would result in someone else becoming homeless. Renting out a home to cover the cost of

care was a possibility which would enable the property to be retained. Alternatively, a deferred payment could be made where the Council covered the cost of care and was reimbursed from the proceeds of selling the home after the person had died. The Care Act would introduce future changes including limiting the amount to be spent on a person's care, excluding accommodation or food, to a maximum of £72,000. The Council maintained a care account and paid for the care of people who were unable to fund care themselves. Taking out an insurance policy to cover the cost of care was an alternative option allowing people to select their preferred care home without concerns that their funds would expire.

4.27 The Working Group was advised that the Government had announced that a system of special measures designed to improve failing hospitals in England, introduced following the report into significant failings at the Mid Staffordshire Hospital NHS Foundation Trust, was to be extended to care homes and homecare agencies in 2015. The system would cover 25,000 services and could lead to the closure of those that failed to improve. In the hospital sector, special measures involved:

- closer scrutiny by regulators
- management changes
- "buddying" schemes with successful trusts
- an improvement director being parachuted in to oversee any necessary changes

4.28 At the time of the meeting the CQC was consulting in respect of a proposed new inspection regime associated with the Government's announcement. The future regularity of inspections was likely to depend on the risk profile of a service provider with a greater perceived risk resulting in more frequent inspections. Although the details of the regime for care homes and homecare agencies remained under development, it was likely to involve less external support and instead rely on shorter deadlines to prompt providers into action. The underlying ratings regime would be rolled out in the social care system from autumn 2014 and the first failing services would be placed in special measures from April 2015. The scoring, based on a system first used in schools, gave health and care services a rating of outstanding, good, requires improvement or inadequate. It was intended that openness in respect of failings would lead to increased accountability in the health and care sector. The Working Group decided to look into this proposed new regime further and its findings are set out in paragraph 4.68 onwards.

4.29 Review of CQC inspection reports indicated that the care provided by care homes and domiciliary agencies operating in Bracknell Forest was generally of a high standard and there had been no need for any enforcement action to be taken. However, a small number of inspection reports had included 'action needed' judgements, mostly found to be of minor impact. These reports were not entirely negative and contained some positive comments indicating that the providers were good in some areas despite needing to improve in others. As inspection judgements were subjective and the opinions of a small number of individuals, it was difficult to ascertain the true quality of a care provider and people could be content living in a home which was judged to require some improvement. Inspection report summaries of a selection of providers requiring improvement (two care homes and two home care providers) together with summaries of a selection of compliant inspection reports (two care homes and

two home care providers) were shared with the Working Group and are attached at Appendix 2.

Spot Contracts and Individual Purchase Orders

4.30 Contracts specified the standard and level of care services to be provided. Individual "spot purchase" arrangements supported by individual purchase orders within an overall contract were utilised in favour of block contracts. The Working Group received and considered examples of a spot contract regarding Residential Care Services and an individual purchase order in respect of the provision of domiciliary Adult Social Care services.

4.31 The Chief Officer: Adults and Joint Commissioning advised that spot contracts included quality standards and reporting requirements. The contracts supported good care by setting out what was required. The needs of each person entering a care home were assessed and recommendations were formed to meet their needs. The resulting care plans were monitored. Prior to the Council selecting a care home from which to purchase services, it would undertake some monitoring checks similar to those forming part of CQC inspections. Making observations at a home was an effective method of judging the quality of care provided. Ascertaining that people were safe, happy and well cared for was important.

4.32 Individual purchase orders specified the tasks to be undertaken, the days of the week care was required, the frequency of visits, arrival and departure times, length of visits, and the total weekly amount of hours and the related cost.

4.33 Contract monitoring was undertaken and included checking that safe recruitment processes were in place and that time for travelling between homes to provide domiciliary care was allowed for. Although the introduction of the Electronic Time Monitoring System (ETMS) would facilitate monitoring of attendance of domiciliary care providers and the length of time devoted to care at each call, it would not give an indication of the quality of care provided and it was hoped that people would give feedback of this nature.

Quality Assurance Framework (QAF)

4.34 The Head of Adult Safeguarding and Practice Development introduced the draft QAF and explained that it consisted of three sections, namely, the Outline of Proposals, the Standard Self-Assessment for providers and the service Validation Guidelines. The QAF was described as a set of principles, structures and processes that defined quality, its measurement and how it would be improved. The primary purpose of the QAF was to raise the quality of Adult Social Care services as experienced by the people in receipt of them. All care services, irrespective of whether they were provided by the Council or external providers or were subject to CQC registration, would be covered by the QAF, including services provided at day centres funded by grants from the Council. The draft QAF would be the subject of consultation with providers in due course.

4.35 The QAF was composed of the following four elements:

- Providers would self-assess themselves against a set of expectations for Adult Social Care services annually;

- The results of the self-assessments would feed into wider Service Development Plans which would be monitored throughout the year;

- The Council would collate information in respect of services' performance from a number of sources in order to focus when and where self-assessments required checking. This information would be brought together into a single 'service performance dashboard' that would be updated throughout the year; and

- The Council would then validate the self-assessments and agree the Service Development Plans, grading the services in accordance with its findings.

4.36 There would be a standard QAF and a lighter touch QAF with 2 levels of self-assessment, respectively. The former would apply principally to CQC registered services whilst the latter would mainly relate to unregistered services with some flexibility between the two.

4.37 In order to monitor the quality of unregistered services, a minimum amount of information would be required, including the Self-Assessment and Service Development Plan. Monitoring remained the responsibility of the budget holder.

4.38 There would be exceptions among CQC registered services in terms of the requirement to complete a self-assessment such as out of Borough services which were monitored by the home local authority and those which only occasionally supported people funded by this Council.

4.39 Reaching a consensus regarding what constituted a good service was key to developing the QAF and defining statements had been produced. The expectations of services, referred to as basic, additional or mandatory, as contained in the Self-Assessment would be based on these statements. These expectations would be aligned with CQC requirements allowing providers to transfer the evidence between CQC inspections and the Self-Assessment avoiding double monitoring.

4.40 The QAF was designed to facilitate continuous improvement and registered services would be required to reach an acceptable standard by meeting all the mandatory expectations, the majority of basic expectations, and be anticipated to aspire towards meeting the remainder of the expectations within the following 6 months. Services liable to the lighter touch framework would only be expected to meet all mandatory expectations and meet, or be working towards, all other basic expectations.

4.41 The Service Department Plans were anticipated to be tools that the providers use for themselves to self-monitor progress against development objectives. It was anticipated that services would report on progress against the agreed Department Plan targets (quarterly in relation to registered services and 6 monthly in relation to non-registered services). Although a standard template had been developed, providers were at liberty to prepare their own format for approval.

4.42 It was intended that there would be a number of different sources of information / evidence collected in order to generate a performance dashboard in relation to each contracted service within the standard regime. This would include a standard approach to collecting feedback from people in receipt of services and

assessment of the impact of the services. The dashboard would assist to inform the frequency, timing and focus of the validation visits by officers. The information captured within the dashboard was intended to be as follows:

- Results of Provider Quality Self-Assessment
- Provider Service Department Plan
- Provider Complaints Log
- Provider Staffing Data
- Provider Electronic Call Monitoring Data
- Individuals and Circle of Support feedback results
- Impact measures
- Results of CQC inspections
- Feedback from health and social care practitioners
- Care Governance intelligence on safeguarding alerts, incidents etc.

4.43 Specific proposals had been developed to obtain information regarding feedback from carers and people being supported in addition to information in respect of the impact of the service provided, which would be collected through the standard assessment and review processes for individuals. This included complaints and any issues would be raised with people receiving support or their carers.

4.44 Lighter touch services would submit a return biennially that contained similar information which would be used to inform contract monitoring meetings, make judgements around where a validation of the service was required and / or inform judgements in respect of future funding.

4.45 Every effort would be made to reduce administrative burdens by ensuring wherever possible that the information required would be collected, collated and analysed electronically, making use of Council systems where possible or the intelligent application of commonly accessible software packages where not.

4.46 Under the standard regime, the results of Self-Assessment would be validated by the Council. It would not be possible to validate all domains simultaneously and providers would be notified of which domains the Council would require evidence for each visit and would be provided with guidance on the types of evidence expected. The current contract review for registered services would be replaced by validation visits and there would be a joint focus on validating providers' Self-Assessments and working with them to ensure acceptable standards across the board. This would result in a grading for the service against each domain of 'poor', 'acceptable', 'good' or 'excellent' and an updated Service Development Pan leading to follow-up meetings or other contacts as necessary. All services would be expected to achieve a grading of 'acceptable' in order to continue working with the Council.

4.47 Validation visits for contracted and registered services would take place at least once per year or more frequently based on risk assessment undertaken utilising the performance information collected. Although grant funded services and those falling under the lighter touch regime would normally receive unplanned visits and the norm would be a desk top validation exercise, the relevant head of service would continue to hold liaison meetings with the organisation.

4.48 The overriding principal of the QAF framework was to work with providers to improve standards and not use the process in a punitive manner. Detailed examples of the evidence required to support the Self-Assessment would be

made available to providers in addition to links to on-line information and advice concerning best practice.

4.49 The Standard Self-Assessment consisted of the following 6 CQC service outcome areas:

- Involvement and information
- Personalised care, treatment and support
- Safeguarding and safety
- Suitability of staffing
- Quality and management
- Suitability of management

4.50 The service outcome areas were divided into domains with a quality service statement and the basic, mandatory and additional standards attached to them. The Self-Assessment enabled providers to determine how they compared with good services in these key areas.

4.51 When Self-Assessments had been completed they would be submitted to the Council which would analyse the results and require evidence to support them. This was not a new process for providers as the majority were required to prepare similar returns for the CQC and some did for their own quality measurement purposes. The CQC published essential standards to assist providers to prepare for inspections and some prepared in advance and maintained papers as evidence for inspections. This was not always the case with smaller companies as they lacked back office staffing capacity for this purpose. Providers would not be requested to collect more evidence than would be required for CQC inspections. Those providers which did not require CQC registration and were therefore not inspected by the CQC were expected to have a quality ethos in place and the QAF process would assist them to improve by identifying weaknesses and raising standards.

4.52 The Validation Guidelines explained the planned and unplanned validation visits that contracted and grant funded services would receive. For CQC registered services, the relationship between the Council's validation visit and CQC inspections needed to be established and built on a matching process between CQC outcome areas and the Self-Assessment domains. Whilst focusing the validation on different areas from those covered by CQC inspections would offer broader quality assessment, a poor CQC inspection result would raise the risk score for that service, indicate an area(s) where the Council should concentrate its validation and possibly prompt an unplanned visit.

4.53 It was impossible for the Council to validate the entire Self-Assessment in one visit. Where planned visits were concerned, it was proposed that evidence would be checked against all mandatory expectations at each visit together with 4 or 5 other domains according to the type of service. The intention was to validate the entire Self-Assessment framework within 4 years and once the higher priority domains had been validated attention would be directed towards the remaining domains. Criteria had been established to determine which domains should be validated. Contract monitoring staff were to be allowed the flexibility to validate domains other then those set out in guidelines provided that the reason for the variation was recorded. The focus of the quarter's validation visits would be set during the first month of the quarter, and providers would be given advance notice of the areas of focus and notified of the requirement to submit the Self-Assessment and Service Development Plan at the beginning of

the relevant quarter. Providers would also be notified of any documents to be submitted before the visit and reminded of the need to seek in advance the permission of staff or people being supported in the event that they were interviewed or their files were randomly inspected during the visit. Where a contract included a number of residential settings, a decision would need to be made as to which service was visited depending on the domains to be validated. When Self-Assessments were submitted in advance of visits they would be checked and any queries dealt with rapidly, particularly where there was an indication that a mandatory expectation had not been met. Results of validation visits would normally be communicated within 48 hours of the visit unless there was a judgement that a serious risk was being posed to people receiving care.

4.54 Unplanned validation visits tended to focus on the specific issues that prompted the visit unless they were scheduled planned visits brought forward. The following were the initial reasons that an unplanned visit might be required:

- A validation visit indicated that some basic expectations had not been met and there was sufficient doubt that they would be met. In these circumstances a further return visit would be required.
- It had not been possible to validate all new claims to meet the additional standards requiring a further validation visit.
- A safeguarding alert that potentially implicated the provider had been received.
- Someone had raised a serious concern regarding the service provided by the provider.
- The Service Development Plan had resulted in a ranking of red.
- The quarterly performance indicator dashboard risk score had reached a certain level.
- In relation to a grant-funded service, the volume targets were 25% below the level agreed at the commencement of the funding period.

4.55 The proposed standard agenda for the conduct of the validation visit would consist of:

- Consideration of the Service Development Plan
- Validation of Evidence for Mandatory Expectations
- Validation of Evidence for Specified Domains
- Issues raised by the provider
- Issues raised by the Council
- Agreement on the next steps to be taken

4.56 The validation process would involve a range of the following:

- Inspection of policy and procedure documents (hopefully in advance of the visit).
- Inspection of written evidence such as minutes of meetings, support plans etc.

- Inspection of personal files including staff files at random subject to the receipt of written permission.
- Discussion with the manager or principal provider representative focusing on examples of as to how the expectations were met or explanation of the documents supplied.
- Interviews with staff and people receiving care services or their informal carers. A separate arrangement would be required for domiciliary care services.
- Observation.

4.57 Validation visits and their preparation were likely to be more time consuming than current visits. However, this was balanced against fewer future visits than currently.

4.58 The following information was provided in response to the Working Group's questions and comments:

a) As there were fewer checks and balances in respect of services received by people who self-funded their care, it was important to collect their views also.

b) In terms of meeting expectations of personalised care, care home residents should be provided with the maximum reasonable degree of choice over the service they receive and the limitations of choices should be explained to them. Council officers would have a dialogue with providers and seek feedback from people receiving care to balance the reasonableness of what was sought and what could be provided under the circumstances.

c) Care homes provided accessible and clear information as to the procedure for raising a complaint. It was important that residents felt sufficiently confident to make a complaint.

d) In order to avoid situations such as care home staff putting residents to bed unnecessarily early in order to take an unscheduled break after, staffing rotas were inspected and feedback from residents, professionals and visitors examined at the point of review. Out of hours visits were possible if considered necessary.

e) Although most providers sought to impart a good service, it was possible for standards to decline and for services to fail to meet changing standards and expectations, such as a greater emphasis on customers' quality of life. Registered managers were considered to be key to this and the Council worked in partnership with them to achieve improvements in reflection of its duty to people in need of care.

f) The Council's QAF process was more open, transparent and supportive than the CQC inspection procedure. Whilst some duplication of the CQC's approach was unavoidable, the Council sought to validate additional areas.

g) There were 15 residential / nursing homes in the Borough and up to 15 providers of domiciliary care, some of which catered for people outside Bracknell Forest, in addition to a number of providers grant-funded by the Council. Bracknell Forest was amenable to working with partners in

Berkshire where they operated at an equivalent standard and were agreeable to taking a unified approach to commissioning. The Council would take action to ensure that its commissioned services were compliant with essential standards and work with providers to assist them to operate at levels above those standards.

h) Care providers were expected to match training with customers' needs in broader terms than meeting standards for regulated services, for example communicating with people who were hard of hearing, and the Council would judge them against this and offer constructive feedback to secure improvements.

i) Reporting of incidents such as falls was expected and zero returns could raise suspicion of a poor or negligent reporting process.

j) The reference in the Self-Assessment to having a plan in place for emergency evacuation of the premises that was practiced regularly required re-wording to reflect the difficulties it posed and safe alternatives such as use of fire doors.

k) At the time of the drafting of the QAF the Thames Valley Police were consulting on a review of missing persons' guidance and the outcome would inform the process to be followed in the event of the unexpected absence of a person receiving care. The stage at which the Council should be informed of such an incident and a safeguarding alert issued would depend on factors including the individual's mental capacity, needs and care plan. There were some contractual requirements as to events that required Council notification, such as a death. The need for the adoption and implementation of a missing person's procedure, including maintaining up to date family contact details and reporting the matter to the police, was highlighted.

l) Members suggested that the Validation Guidelines should be expanded to include a section explaining how benchmarks were identified.

m) The Council commissioned an independent advocacy service which was available to advise people and assist them with raising concerns or solving conflicts. Other methods of raising concerns were via annual reviews, CQC inspections, family or friends, General Practitioners (GPs), nurses and Healthwatch.

n) There was a requirement for a care home to advise the CQC of a change of registered manager. The Council generally became aware of the change through contracts if the premises provided contracted services. The QAF could be expanded to include a requirement for it to be notified of a change of manager at a learning disabilities facility further to the care failings at Winterbourne View.

o) An unplanned validation visit should be a proportionate response to the quarterly performance indicator dashboard showing a high risk score.

p) The QAF would apply to services commissioned directly for carers and should reflect this.

q) The majority of people wished to remain in their own home for a long as possible in preference to moving into a care home and good quality domiciliary care played a part in achieving this.

r) The Working Group felt that the QAF was a very useful tool which confirmed that the Council was contracting good quality providers. Members would be interested to learn of the outcomes of the associated consultation exercise. Families often selected care homes based on location and visiting ease rather than quality and the QAF was a means to encourage them to reconsider their choice. A leaflet providing information regarding the service aspects that the Council measured performance against would be useful.

National Carers' Survey

4.59 The outcomes of the most recent national carers' survey which was undertaken in October 2012 were shared with the Working Group as background information as many people with informal carers were in receipt of regulated Adult Social Care services. The survey was carried out biennially and the questions were prescribed as it was a national survey. The business case for the survey from the Department of Health (DoH) stated that the survey was being undertaken due to a need to explore whether or not services received by carers were assisting them in their carers' role and their life outside caring. The results were to be utilised to populate the following outcome measures in the Adult Social Care Outcomes Framework:

- 1D – Carers reporting quality of life.
- 3B – Overall satisfaction of carers with Adult Social Care services.
- 3C – The proportion of carers who report that they have been included or consulted in discussion about the person they care for.
- 3D – The proportion of people who use services and carers who find it easy to find information concerning services.

4.60 Of the 719 eligible carers in receipt of the survey, 388 responded, giving a response rate of 54%. The survey results indicated that approximately a quarter of carers were aged 55 to 64 years and almost half of all carers were over the age of 65 years. 76% were not in employment, with 45% in retirement and 19% unemployed due to their caring responsibilities. 35% of carers were male and the remaining 65% were female. 1 in every 5 carers surveyed had been caring for someone for over 20 years whilst another 20% had been carers for 5 to 10 years. Many respondents indicated that they had made use of the available information and advice to assist them in their caring role, with 32% utilising support groups / talking in confidence. 70% of carers cared for people over 65 years and the remaining 30% cared for people over the age of 85. 68% of carers cared for someone with a physical disability, frailty or sensory impairment and 42% stated that they provided care for over 100 hours per week.

4.61 In terms of carers' quality of life, 64% advised that they were in a position to pursue some activities they enjoyed but not to a sufficient degree. 59% responded that they had insufficient control over their daily lives and approximately 70% felt that they were able to look after themselves. 9 out of 10 carers had no concerns relating to personal safety. Although 45% of carers felt that they had adequate social contact, 43% replied that this was lacking. 1 in 4 carers advised that they did not receive enough encouragement and support.

4.62 With regard to carers' perceptions of their involvement and consultation around support and services for their cared for, 62% felt that they were usually or always involved in such discussions whilst 22% said that they were unaware of being involved during the previous 12 months.

4.63 Although 26% of carers indicated that they had not received any information regarding their caring role from Adult Social Care during the prior 12 months, 94% of those who had found it useful. When trying to find information, 77% advised that they found it 'very' or 'fairly' easy to locate. Further analysis of responses showed that the carers who experienced most difficulty in finding information were caring for someone with a mental health issue or an autistic spectrum condition. Concerns regarding obtaining and receiving information were that Council departments did not communicate with one another or pass on information resulting in carers needing to repeat their details. It was difficult for carers to discover what support they were entitled to, and new information for carers including a directory of contact telephone numbers was not provided. It was acknowledged that GPs had a role in advising carers of their support entitlements and work was constantly undertaken to raise GPs awareness.

4.64 In terms of overall satisfaction with the services and support provided by Adult Social Care, 50% of respondents were extremely satisfied, 29% were fairly satisfied, 13% were neither satisfied nor dissatisfied, 4% were fairly dissatisfied and 4% were extremely dissatisfied. Compared with the results of the last carers' survey, undertaken in 2009/10, levels of satisfaction had reduced slightly in some areas. All carers who responded to the survey received an analysis of the results, fresh contact information and were invited to have follow up discussions regarding their support needs if they wished. Although the results of the survey indicated that most carers were content with the services and support they received overall, there was some scope for improvement and the following actions had been identified and set in motion to deliver improved service and support for carers and their cared for:

- Help carers to gain more control over their daily life by assisting them to do more things that they valued and enjoyed and by supporting them when they felt they were lacking in control.

- Understand the reasons why some carers felt they could not look after themselves well enough.

- Explore whether anything could be done to assist carers who felt that they did not have sufficient social contact with others.

- Identify whether improvements could be made to the support and encouragement given to carers.

- Aim to get carers more involved in discussions regarding their cared for person and ensure that they were aware of any communication taking place.

4.65 Having discussed the survey results, the Working Group welcomed the action points and suggested that a holistic assessment of both carers and their cared for together may be a beneficial way forward. Members noted that there were groups and charities, often specialising in certain conditions such as dementia or stroke that could support carers and increase their opportunities for social

interaction. It was felt that communication was key to supporting carers and directing them to available services.

Research Findings

Health and Social Care Information Centre (HSCIC)

4.66 By way of background information the Working Group had regard to figures provided by the HSCIC, a national organisation collecting Adult Social Care data, concerning Adult Social Care outcomes for Bracknell Forest in 2013/14. This is set out at Appendix 3 and indicates good outcomes in the areas of: social care related quality of life; service users with control over their daily life; people receiving self-directed support; adults with learning disabilities in stable accommodation; adults in contact with mental health services who are in stable accommodation; older people at home 91 days after leaving hospital into reablement; delayed transfers of care, particularly attributable to social services; client satisfaction with care and support; service users who find it easy to get information; people who use services and feel safe; and people who say the services they use make them feel safe and secure.

4.67 Less favourable outcomes in Bracknell Forest were in the areas of: people receiving direct payments; adults with learning disabilities in employment; adults in contact with mental health services who are in paid employment; older people receiving reablement services after leaving hospital; and service users with as much social contact as they would like.

CQC Strategy for 2013-2016, *Raising standards, putting people first*

4.68 The above Strategy was of interest and relevance to the Working Group as it set out the new vision and direction of the CQC proposing significant changes to the way in which health and social care services would be regulated in the future.

4.69 The Strategy stated that people had a right to expect safe, effective, compassionate and high quality care and as the regulator of health and social care in England, CQC played a vital role in ensuring that care services met those expectations. The strategy set out what CQC aimed to achieve by 2016. In developing the strategy CQC had looked closely at how it carried out its role, listening to what people who used health and social care services, providers of those services and others told it about what mattered to them. CQC would ensure that its judgements were completely independent of the health and social care system and that it always viewed services from the point of view of people who used care services.

4.70 CQC would continue to monitor, inspect and regulate services to ensure they met fundamental standards of quality and safety and publish its findings, including performance ratings, to help people choose care. The CQC would set a clear bar below which no provider must fall and publish clear ratings of services which would encourage and drive improvement.

4.71 Changes would involve appointing Chief Inspectors of Hospitals, and of Social Care and Support, and possibly a chief inspector for primary and integrated care. Inspections would ask the following five questions of services:

- Are they safe?

- Are they effective?
- Are they caring?
- Are they well led?
- Are they responsive to people's needs?

4.72 New fundamental standards that focused on those five areas, working with the public, people who used services, providers, professionals and partners would be developed. CQC would ensure inspectors specialised in particular areas of care and lead teams that included clinical and other experts, and people who were experts by experience.

4.73 National teams with specialist expertise to carry out in-depth reviews of hospitals, particularly those with significant or long-standing problems and trusts applying to be foundation trusts, would be introduced in NHS hospitals. A clear programme for failing trusts that ensured immediate action was taken to protect people would also be introduced.

4.74 CQC would predict, identify and respond more quickly to services that were failing, or likely to fail, by using information and evidence in a more focused and open way, including listening better to people's views and experiences of care. It would also improve its understanding of how well different care services worked together by listening to people's experiences of care when they moved between different care services. CQC aimed to work more closely with its partners in the health and social care system to improve the quality and safety of care and enhance work co-ordination. Publishing fuller and clearer information for the public, including ratings of services, would be pursued. The introduction of a more thorough test for organisations applying to provide care services, including ensuring that named directors, managers and leaders committed to meeting CQC standards and were tested on their ability to do so, would be introduced.

4.75 The protection of people whose rights were restricted under the Mental Health Act would be strengthened.

4.76 Efforts would be made to build a high performing organisation that was well run and well led, had an open culture that supported its staff, and was focused on delivering its purpose.

4.77 The changes would come into effect in NHS hospitals and mental health trusts first as there was an urgent need for more effective inspection and regulation of these services. The approach would be extended and adapted to other sectors in 2014 and 2015.

4.78 CQC would continue to carry out its programme of unannounced inspection and enforcement across the sectors it regulated and would also continue to publish inspection reports, national reviews, and other information about the quality and safety of services. It would continue to involve people who used services and their families and carers in its work.

4.79 CQC would maintain its focus on human rights, equality and diversity. In developing its plans, CQC would take into account the transformation of the health and social care system, which strengthened the importance of existing and new organisations working together efficiently and effectively. The strategy reflected the Secretary of State's initial response to the Francis Report into the

failings at Mid Staffordshire NHS Foundation Trust, which set out important new responsibilities for CQC.

Safeguarding Serious Case Review

4.80 The Working Group concluded its review by having regard to the report of a prominent serious case review involving a former care and nursing home in West Sussex which had been registered with the CQC to accommodate a large number of people in the categories of old age and dementia. The report gave an insight in to the implications, impact and consequences of serious failings in an adult social care setting.

4.81 Before the home closed there were a number of safeguarding alerts and investigations, and a team of health and social care staff were deployed within the home to mitigate the poor quality of care, leadership and management evident there. Following an anonymous alert there was sustained police involvement in safeguarding investigations and in the pursuit of possible criminal offences, however, insufficient evidence was found to pursue criminal charges. An inquest found that five people had died from natural causes attributed to by neglect and that several other people had died as a result of natural causes without evidence that their poor care was directly causative of their deaths. It also found that the poor care caused distress and discomfort to residents and relatives.

4.82 This case review was commissioned by the local Safeguarding Board and focused on safeguarding in line with its terms of reference. The findings and recommendations resulting from the case review were presented in response to the questions raised by relatives which focused on areas of the service such as quality of care, safety, support, trust, confidence, care governance, financial security and accountability.

4.83 Since the closure of the home and the inquest, the DoH and the CQC have published a number of consultation documents, some of which are a direct follow on from the Francis Report into care at The Mid Staffordshire Hospital NHS Foundation Trust and seek to extend actions identified in the Francis Report into the wider sphere of service providers beyond the NHS.

4.84 As a regulated service, the home was subject to a regulatory framework, specific requirements in line with that framework and inspection by the CQC. The CQC undertook an internal review of its involvement which concurred with the findings of the case review that this was inadequate at the care home. This analysis of the CQC's responses to events at the home identified key lessons for the CQC and outlined its actions taken or planned.

4.85 The case review identified that a sign of a good service was how it addressed problems and shortcomings, and found that the care issues at the care home were mostly an avoidance of positive action to rectify problems and a series of ineffectual action plans that were not acted on.

5. Conclusions

From its investigations, the Working Group concludes that:

5.1 Bracknell Forest Council fulfils its duty of care to people in need of care and robustly undertakes its care governance and safeguarding roles in regulated Adult Social Care services seeking to identify and eradicate poor care whilst supporting providers to improve the quality and safety of their services.

5.2 There are sufficient care homes / places locally to meet demand and review of CQC inspection reports indicates that the care provided by care homes and domiciliary agencies in Bracknell Forest is generally of a high standard and there has been no need for any enforcement action to be taken. Although a small number of inspection reports included 'action needed' judgements, these were mostly found to be of minor impact.

5.3 The majority of people wish to remain in their own home for as long as possible in preference to moving into a care home and good quality domiciliary care plays a part in achieving this.

5.4 The National Audit Office's finding that 90% of recipients of local authority arranged Adult Social Care services expressed satisfaction with the care and support they receive, amongst 64% of whom were very or extremely satisfied, with minimal variation between local authorities, indicates that good quality care is provided locally, and nationally.

5.5 Adult Social Care service outcome data collected by the Health and Social Care Information Centre confirms that Bracknell Forest performs well against the majority of outcome measures and compares favourably with most other Berkshire unitary authorities.

5.6 The Quality Assurance Framework is welcomed as a means of improving the quality of Adult Social Care services.

5.7 The reference in the Self-Assessment to having a plan in place for emergency evacuation of care / nursing home premises that is practiced regularly is considered to be impractical owing to the condition of residents and requires reconsideration and re-wording if this is permissible within regulations.

5.8 The Care Quality Commission's new regulation and inspection regime is considered beneficial as it seeks to ensure that services meet expectations of safe, effective, compassionate and high quality care whilst tackling poor performing services in a robust, open and transparent manner.

5.9 As there are fewer checks and balances in respect of services received by people who self-fund their care, it is important to collect their views in addition to those of people in receipt of local authority funded Adult Social Care services to ensure that they are well cared for and safe.

5.10 There is a need for the adoption and implementation of a missing person's procedure, including maintaining up to date family contact details and reporting related matters to the police, in order to safeguard vulnerable adults.

5.11 It may be helpful for providers if Validation Guidelines included a section explaining how benchmarks are identified and giving information regarding the service aspects that the Council measures performance against.

5.12 Care homes should consistently provide accessible and clear information as to the procedure for raising a complaint or a safeguarding alert. It is important that residents and their families feel sufficiently confident to make a complaint or an alert.

5.13 As the National Audit Office reports that carers express less satisfaction than Adult Social Care users with local authority care services and the results of the most recent Bracknell Forest carers' survey show that levels of satisfaction have reduced slightly in several areas compared with the previous survey, the action points arising from the survey are welcomed.

6. Recommendations

It is recommended to the Executive Member for Adult Services, Health and Housing that:

6.1 The reference in the Self-Assessment to having a plan in place for emergency evacuation of care / nursing home premises that is practiced regularly be reconsidered and re-worded to introduce a more practical emergency response procedure if this is permissible within regulations.

6.2 The Quality Assurance Framework be expanded to include collection of the views of people who self-fund their care.

6.3 A missing person's procedure, including the necessity to maintain up to date contact details and to report matters to the police, be adopted and implemented in order to safeguard vulnerable adults.

6.4 Validation Guidelines be expanded to include a section explaining how performance benchmarks are identified and giving information regarding the service aspects that the Council measures performance against.

7. Glossary

Council	Bracknell Forest Council
CQC	Care Quality Commission
DoH	Department of Health
DOLS	Deprivation of Liberty Safeguards
ETMS	Electronic Time Monitoring System
GP	General Practitioner
HSCIC	Health and Social Care Information Centre
NAO	National Audit Office
NHS	National Health Service
O&S	Overview and Scrutiny
QAF	Quality Assurance Framework

APPENDIX 1

BRACKNELL FOREST COUNCIL

ADULT SOCIAL CARE AND HOUSING OVERVIEW AND SCRUTINY PANEL

WORK PROGRAMME 2013 – 2014

Terms of Reference for:

THE COUNCIL'S ROLE IN REGULATED ADULT SOCIAL CARE SERVICES

Purpose of this Working Group / anticipated value of its work:

1.	To review the Council's role with regard to care governance and managing safeguarding in regulated Adult Social Care services.

Key Objectives:

1.	To identify and define regulated Adult Social Care services.
2.	To establish the Council's role in care governance and managing safeguarding in relation to regulated Adult Social Care services.
3.	To establish whether the Council is satisfactorily carrying out its role in care governance and managing safeguarding in relation to regulated Adult Social Care services.
4.	To identify any areas for possible improvement in the Council's performance in relation to care governance and managing safeguarding in regulated Adult Social Care services.

Scope of the work:

1.	The Council's role in care governance and managing safeguarding in regulated Adult Social Care services.
2.	Care governance arrangements in regulated Adult Social Care services.
3.	Adult safeguarding arrangements in regulated Adult Social Care services.

Not included in the scope:

1.	Care governance and managing safeguarding in non-regulated Adult Social Care services.

Terms of Reference prepared by:	Andrea Carr
Terms of Reference agreed by:	The Council's Role in Regulated Adult Social Care Services Overview & Scrutiny Working Group
Working Group Structure:	Councillors Harrison, Mrs McCracken, Mrs Temperton and Thompson
Working Group Lead Member:	Councillor Harrison
Portfolio Holder:	Councillor Birch
Departmental Link Officer:	Zoë Johnstone

BACKGROUND:

1. The review of the Council's role with regard to care governance and managing safeguarding in regulated Adult Social Care services is included in the agreed 2013/14 work programme for the Adult Social Care and Housing Overview and Scrutiny Panel. The new vision and direction of the Care Quality Commission set out in its Strategy for 2013-2016, *Raising standards, putting people first* and its related consultation, *A new start*, which proposed radical changes to the way in which health and social care services are regulated, was one reason that this topic was selected for review.

SPECIFIC QUESTIONS FOR THE PANEL TO ADDRESS:

1. What is the Council's role with regard to care governance and manage safeguarding in regulated Adult Social Care services?
2. Does the Council adequately fulfil its roles in care governance and safeguarding in regulated Adult Social Care services?
3. Are there any areas for improvement in the way in which the Council fulfils its care management and safeguarding roles in regulated Adult Social Care services?

INFORMATION GATHERING:

Witnesses to be invited / met

Name	Organisation/Position	Reason for Inviting / Meeting
Zoë Johnstone	Chief Officer: Adults and Joint Commissioning	To provide information on regulated Adult Social Care services.
Chairman / Representative	Care Governance Board	To provide information on care governance in regulated Adult Social Care services.
Alex Bayliss, Head of Adult Safeguarding	Safeguarding Adults Partnership Board and Forum	To provide information on safeguarding in regulated Adult Social Care services.

Site Visits

Location	Purpose of visit
No need for site visits has been identified.	-

Key Documents / Background Data / Research

1. Care Quality Commission (CQC) inspection reports
2. Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and Care Quality Commission (Registration) Regulations 2009[3]
3. A definition of excellence for regulated adult social care services in England - A report for the CQC by the Social Care Institute for Excellence
4. A fresh start for the regulation and inspection of adult social care - CQC report
5. Raising standards, putting people first CQC Strategy for 2013 to 2016 and Guide
6. CQC leaflets – What standards you have a right to expect from the regulation of your care home and What standards you have a right to expect from the regulation of agencies that provide care in your own home
7. 'Safeguarding Adults in the Context of Personalisation' – the report of a review by a Working Group of the Adult Social Care and Housing Overview and Scrutiny Panel

[3] CQC inspections are regulated under these Regulations

TIMESCALE

Starting: Autumn 2013 Ending: Summer 2014

OUTPUTS TO BE PRODUCED

1. Report of the review with findings and recommendations.

REPORTING ARRANGEMENTS

Body	Date
Report to the Adult Social Care and Housing Overview and Scrutiny Panel.	September 2014

MONITORING / FEEDBACK ARRANGEMENTS

Body	Details	Date
Reporting to the Adult Social Care, and Housing Overview and Scrutiny Panel by the Executive Member.	Oral or written report	January 2015

APPENDIX 2

A Selection of Summaries of CQC Inspection Reports Including 'Action Needed' Judgements

No.	Unmet Essential Standard	CQC Judgement	Summary of Inspectors' Comments
1.	- Cleanliness and infection control	The provider was not meeting this standard. People were not always cared for in a clean, hygienic environment. We have judged that this has a minor impact on people who use the service, and have told the provider to take action.	People were treated respectfully and in ways that ensured their dignity. At the time of our inspection, there were 10 people living at the care home who needed care and support because of mental health and physical conditions. We spoke with three people who told us they were happy living at the home and the staff treated them well. One relative told us the care provided at the home was "second to none". They said their relatives had been at the home for several years and they had "nothing but praise for the staff. They told us the staff were respectful and kind and their relative was well looked after. Another relative said "the staff do a difficult job but they do it very well". We spoke to two members of staff who had good knowledge about the measures to take to protect people from infection. We looked in three staff files and found that they had undertaken training in food hygiene and infection control. However, on the day of our visit there were two staff providing all care and support for ten people in addition to cooking all the meals. This may have made implementing infection control measures difficult. People's bedrooms and the kitchen were clean and tidy but in some parts of the home there were signs that appropriate deep cleaning had not occurred. These areas had not been picked up because the provider did not have a programme of audit to detect areas which required cleaning.
	- Assessing and monitoring the quality of service provision	The provider was not meeting this standard. The provider did not have an effective system to regularly assess and monitor the quality of service that people receive. We have judged that this has a minor impact on people who use the service, and have told the provider to take action.	
	- Notification of other incidents	The provider was not meeting this standard. The registered person had not notified the CQC when two people received painful injuries following falls. We have told the provider to take action.	
	- Records	The provider was not meeting this standard. People were not protected from the risks of unsafe or inappropriate care and treatment because accurate records were not maintained. We have judged that this	

		has a minor impact on people who use the service, and have told the provider to take action.	
2.	- Caring for people safely & protecting them from harm	The provider was not meeting this standard. People were not protected from the risk of infection because appropriate guidance and record-keeping was not always followed. We have judged that this has a minor impact on people who use the service, and have told the provider to take action.	We spoke with five people who use this care home and a relative of someone who uses the service. Some of the people who use the service were not able to verbally communicate with us due to their health issues. We observed care and support provided to people to inform us of the standard of care and support people experienced. We observed staff asked people for permission before supporting them to attend to personal needs. Where people were unable to verbally consent, care workers explained other factors they used to understand people's preferences, such as gestures and expressions. One care worker told us "We know our residents and adapt to them." Staff understood people's capacity to make decisions and when it was appropriate to make best interest decisions. People's care needs were assessed and care provision was planned to meet them. Staff were aware of people's health conditions and assessed risks to ensure people were cared for safely. One relative told us "I am happy with everything here. Staff are always on top of things and people have lots to do." We observed staff were aware when people required support to maintain a healthy diet. People we spoke with confirmed they had sufficient amounts of food and could ask for changes to the planned menu to meet their preferences. Appropriate records ensured staff were aware of the actions to take to maintain people's dietary health. We found the home to be clean. One relative told us "It's a clean and happy home." However, we found cleaning logs were not completed in accordance with the service's cleaning schedules. One toilet did not contain tissue and another was lacking in paper towels. This meant people were not protected from the risk of infection. Staff told us the manager was supportive. We saw training schedules were up to date, and staff told us they felt suitably trained to care for people safely. Staff attended supervision and appraisal meetings that provided opportunities to discuss training, development needs and opportunities.

3.	- Supporting workers - Assessing and monitoring the quality of service provision	The provider was not meeting this standard. A system of staff supervision and appraisal was in place to support workers. However, staff did not always receive appropriate training and professional development to enable them to deliver care and treatment to people safely and to an appropriate standard. We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. The provider was not meeting this standard. The provider had an effective system to regularly assess and monitor the quality of service that people receive. However, the provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others. We have judged that this has a minor impact on people who use the service, and have told the provider to take action.	People who use the support service we spoke with were complimentary about the care they received. They told us that staff listened to them and supported them with their daily activities and tasks. Care was planned with the involvement of the people who use the service and their relatives. Support plans reflected their individual needs. We found people were provided with appropriate care to meet their needs. A system of staff supervision and appraisal was in place to support workers. However, staff did not always receive appropriate training and professional development to enable them to deliver care and treatment to people safely and to an appropriate standard. There were systems for monitoring the quality and safety of services provided to people. These included collecting feedback from people using the service, their relatives and staff. Spot checks by management were in place to monitor the quality and safety of services provided to people in their own homes. The provider had acted on feedback received to improve the service. There was no system for monitoring and learning from incidents relating to the welfare and safety of people who use the service. There were processes in place for recording, investigating and resolving complaints from people who use the service and their relatives. The provider had written information on their complaints procedure, including a version in a format appropriate for people's needs. These had been made available to people who use the service and their relatives. People we spoke with were aware of who they would speak to if they had any complaints or concerns. People's records and other records relevant to the management of the service were accurate and fit for purpose. People's care documentation was stored securely in the office and accessible only by care workers and management.
4.	- Requirements relating to workers	The provider was not meeting this standard. People were cared for, or supported by, suitably qualified, skilled and experienced staff. However, staff were employed without the relevant pre-employment checks required by the regulation. We have	We spoke with eight people who use the service and two relatives. Nearly all of the people we spoke with stated they were happy with the service provided. One relative told us, "X has a care plan and the carers do what they are supposed to do. I am very pleased with them and so is X." However two people felt their care was compromised by having different carer workers. We discussed these concerns with the registered manager. Staff told us they regularly read people's care plans

		judged that this has a minor impact on people who use the service, and have told the provider to take action.	and discussed care with people to ensure they provided care as they wished. Care plans reflected the person's care needs. The provider did not complete all relevant checks before staff began work. We did not see written explanations of gaps in employment history. Some of the files reviewed did not contain a medical questionnaire. Where staff had worked previously in a health and social care setting, their conduct or reason for leaving was not always checked. People we spoke with told us they felt safe with staff and had no concerns. Staff attended regular safeguarding training. Staff were able to describe the possible signs of abuse and knew who to contact if they had concerns. We saw measures to assess and monitor the service were in place. There were spot checks by management to monitor the quality and safety of services provided to people. There were processes in place for recording, investigating and resolving complaints from people who use the service and their relatives.

A Selection of Summaries of Compliant CQC Inspection Reports

No.	Summary of Inspectors' Comments
5.	People we spoke with told us they were very happy living at this nursing home and were well looked after. One person said, "I am really happy here, everything is wonderful". Another person said, "I am very happy living here, the staff are lovely". Care plans showed that people were involved in making decisions about how they wished to be cared for and were asked for their consent before the staff delivered any care or treatment. The staff demonstrated different communication techniques to ensure people understood what was being proposed to them. The care given by staff reflected what was documented in people's care plans, and care plans were regularly reviewed and updated. We saw that the premises and environment were safe and clean. Both individual and communal areas were comfortable and adapted to people's needs and wishes. We observed health and safety information, and the staff we spoke with could explain how to reduce the risk of infection. During our visit we saw staff approach the duties they needed to undertake with confidence and competence. Staff were well supported and there was a comprehensive training and education schedule in place to ensure staff were able to meet the needs of people using the service. This home had various methods that were used to ensure the quality of the care was assessed. Meetings, reviews and senior management audits were in place and records were available.

6.	During our visit we saw that people were being treated with dignity and respect and people's independence was encouraged. People we spoke to and visiting relatives told us that they were happy with the care provided. One visitor said, "the staff are excellent" and another visitor told us that the staff provided exceptional care and they felt very welcomed into the home. One person told us that the staff did things at their pace and were very patient. We saw that people experienced safe and effective care based on detailed care plans. There were risk assessments that met individual needs and provided guidance to staff to minimise potential risks. We saw that good nutritional care was provided in a way that met people's needs and preferences. People were protected from abuse as they were supported by a staff team who had appropriate knowledge and training on safeguarding adults. People we spoke to told us that if they had any concerns they would speak up about it. Staff we spoke to and records we reviewed, demonstrated that staff were trained and competent to carry out their roles. They felt very supported by their manager and the organisation and were very happy to work at the care home. The provider had effective systems in place to monitor and assess the quality of the service. The provider regularly collected the views of families, people who used the service and other practitioners and they were very positive about the service.
7.	We spoke with five people who used the service and/or their primary carer, relative or advocate. The majority were complimentary about the service. They told us staff usually arrived on time and stayed for the required length of time. They told us the care provided centred on their needs and wishes, and staff were caring, kind and respectful. People who used the service told us they had been fully involved in planning their care and had been given the opportunity to say how they wished to be cared for. People said they had received a copy of their care plan and had agreed its content. People told us they were asked what they needed and were actively encouraged to be fully involved in their care plan and reviews. Every attempt was made to provide the service in a way that met the expressed needs of the individual. Care plans were centred on the person and care was tailored to meet the needs of the individual. People we spoke with told us staff were always polite and courteous and their dignity, privacy and choice were always respected. They told us office staff were always quick to respond to queries and requests and made them feel like their enquiry was important to the agency. The majority of people said if there was a need to change the time of a visit, or if different staff were visiting them, office staff informed them of the alternative arrangements.
8.	We were not able to speak to people who use the service because they had complex needs and were not able to fully understand our questions. To help us understand their experiences we spoke with the relatives of five of the 17 people who were receiving a service at the time of our inspection. We found people's privacy, dignity and independence were respected. Relatives we spoke with told us they felt their relative's needs were being met and their care was delivered in the way it had been planned. Comments received from relatives were all complimentary and included: "the staff are very respectful and are very friendly with my relative, that's why it works." Systems were in place to identify the possibility of abuse and relatives of the people using the service told us they felt their relatives were safe with the staff. People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained. We found staff were supported to deliver care and treatment safely and to an appropriate standard. Relatives of people using the service said the staff had the skills they needed when providing care to their relatives. Comments received from relatives about the care staff were all positive and included: "I can't fault them, they are absolutely brilliant", "they do their job and do it very well" and "what is important is creating a good relationship. I think they do that very well."

APPENDIX 3

HEALTH AND SOCIAL CARE INFORMATION CENTRE

Adult Social Care Outcomes for Bracknell Forest 2013/14 (provisional data)

Social care related quality of life	18.8 points out of 24
Service users with control over their daily life	75.9%
People receiving self-directed support	55.6%
People receiving direct payments	11.5%
Carer-reported quality of life	No Data
Adults with learning disabilities in employment	17.4%
Adults in contact with mental health services who are in paid employment	13.0%
Adults with learning disabilities in stable accommodation	87.4%
Adults in contact with mental health services who are in stable accommodation	78.2%
Service users with as much social contact as they would like	41.5%
Carers with as much social contact as they would like	No Data
Permanent admissions to care homes: people aged 18 to 64	No Data
Permanent admissions to care homes: people aged 65 and over	623.3 per 100,000 people
Older people at home 91 days after leaving hospital into reablement	80.8%
Older people receiving reablement services after leaving hospital	3.7%
Delayed transfers of care	5.7 per 100,000 people
Delayed transfers of care attributable to social services	2.1 per 100,000 people
Client satisfaction with care and support	64.8%
Carer satisfaction with social services	No Data
Carers included or consulted in decisions	No Data
Service users who find it easy to get information	76.5%
Carers who find it easy to get information	No Data
People who use services and feel safe	63.4%
People who say the services they use make them feel safe and secure	83.8%

For further information on the work of Overview and Scrutiny in Bracknell Forest, please visit our website on:
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