COMMITTEE	Care Scrutiny Committee
DATE	30 September 2021
TITLE	The Quality Assurance Service within the Safeguarding Unit
CABINET MEMBER	Councillor Dafydd Meurig
PURPOSE	To provide an overview of the work of the Quality Assurance Service within the Adults, Health and Wellbeing Department

1 PURPOSE OF THE REPORT

1.1 The purpose of this report is to offer an overview of the work of the Quality Assurance Unit within the Adults, Health and Well-being Department of Gwynedd Council. It is intended to focus on the demand and the impact of the work in the context of providing care services for vulnerable residents in the County.

2 INTRODUCTION / BACKGROUND INFORMATION

2.1 The purpose of the Quality Assurance team is to assist residents who require care to *"live my life as I wish".* The team has a key role in ensuring that the care that is commissioned and provided for them is of a good quality and enables residents to do so in a safe way.

2.2 The Team monitors and supports internal and external providers to ensure that the care is in line with the needs of the individuals within residential homes, supported housing, day care provision and domiciliary care. The Team's responsibilities also include monitoring nursing homes jointly with colleagues from the Health Board.

3 OVERVIEW

3.1 The Team was established at the end of 2016. Prior to that, there was a fundamental weakness in the Council's ability to monitor the quality of care for adults consistently and effectively. The monitoring work which happened was entirely responsive as opposed to being pro-active and preventative.

3.2 Currently, the Team has 3.5 Quality Assurance Officers. One of these officers has been seconded from the Department's Business Service in order to assist with the Quality Assurance work, with the Department funding it from temporary

funds. There is no funding for this post in the Safeguarding Unit's basic budget. This officer is on flexible retirement at present and will retire in December. This will leave the team with three officers (approximately 2.6 FTE).

3.3 Quality Assurance is a process which monitors the quality of care services against specific standards. Within the Adults Department, this must include the standards that are set out in a variety of regulations, guidelines and legislations at a national level. These guidelines and the statutory requirements are set by Welsh Government and they are monitored and enforced by Care Inspectorate Wales (CIW). These responsibilities cannot be ignored or neglected and there could be significant implications for providers if they fail to deliver on these measures. This could include the loss of registration and the right to work in the care field.

3.4 All providers commissioned by the Adults Department within the County must be monitored. This includes:

- 11 Internal Care Homes
- 2 Learning Disabilities Homes
- 14 Private Care Homes
- 8 Nursing Homes
- 9 Supported Housing Providers
- All Domiciliary Care Providers
- Day Care Services

3.5 The Team's ethos is to support providers to improve and maintain quality. While the majority of monitoring visits are unannounced, we also welcome contact from providers who express a concern about any aspect of the service and who ask for support to address this.

3.6 Generally, there has been no face-to-face monitoring during the Covid-19 period. During the first lockdown, a procedure of daily contact was established with the providers. This contact was crucial as the Council attempted to ensure that the providers had adequate stocks of PPE, that there were adequate numbers of staff available to maintain services and that the tests were carried out in a timely manner. Officers also supported in terms of contact with Public Health Wales, Environmental Health Officers and Care Inspectorate Wales in order to ensure that the providers were dealing with only a minimum number of calls. One very important factor from this contact was enquiring about the welfare of the manager and care staff. It was an opportunity for managers to discuss their concerns about the situation and this was of great assistance in building a relationship based on trust with the officers. We continue to see the benefits of this close relationship which developed during the first lockdown.

While there is a clear understanding of the quality assurance staff's work to monitor and maintain standards, a strong element of partnership trust has developed between the Council and the providers. We are eager to maintain and build on this as we move to a new era in terms of the arrangements and provision of care services.

3.7 As the restrictions have now been relaxed partly and visits to care homes and other services are permitted, quality assurance officers have restarted face-to-face monitoring in the services since June 2021. The team has already seen nearly all providers in an initial visit to explain what our intentions are; to ask what information could be provided via e-mail and to discuss whether there are any problems/concerns that had not been raised or addressed already. A monitoring visit schedule is being prepared based on this initial information with priority given to services where some problems or difficulties have become obvious.

3.8 Towards the end of 2020, several safeguarding reports were received claiming that suitable care was not being provided within five homes in the County. In response to this, face-to-face monitoring was undertaken and three care homes and two nursing homes within the county were placed under the Escalating Concerns procedure.

3.9 Owing to the monitoring work, an embargo on new placements was imposed on the five homes, and two now have a conditional embargo in terms of the number of new residents who may be admitted.

3.10 It is the Quality Assurance team which leads on the Escalating Concerns procedure on internal and external Adults Services on behalf of the Department and the Council. The process involves co-ordinating multi-agency meetings and decisions, producing risk assessments, corrective/developmental action plans and co-ordinating the monitoring during the process.

3.11 If any provision under-performs and that an embargo on admissions or placements is in place, it has a significant impact on the area teams in terms of their ability to place or use that service. It also has a significant effect on the individuals and their families as it is not always possible to place people within their preferred area or receive a specific service in their community in a timely manner. An embargo can also have a significant financial impact on business owners and it is not always possible for them to overcome these in every case. Naturally, the aim is to avoid reaching this point but if the situation arises, it is crucial that we deal with cases of escalating concerns in a timely manner and working with partners is key for continued quality assurance. The role of the Quality Assurance team and their ability to act effectively is central to achieving this.

3.12 Receiving the opinion of residents/service users is a key part of monitoring and we will also seek the opinion of families and staff when we monitor. We will try to have an opportunity to discuss with residents while on a monitoring visit or questionnaires will be sent out. This will allow individuals (residents, families and staff) to give anonymous observations if they so wish.

3.13 Owing to the number of services to be monitored and the current work-load, it is not possible for officers within the team to monitor every provider. The service has had to prioritise and, at present, there is no capacity within the team to monitor the domiciliary care and day care provision with any activity in these fields limited to emergency or responsive work only. This is not a satisfactory situation, particularly given the significant pressure on these services at present and the significant demand for more domiciliary care and the increase in respite care and day care services.

3.14 In recent years, the work-load has also meant that many providers could go for a period of up to two years between monitoring visits. Ideally, we should be aiming at an arrangement similar to that of Conwy Council who monitor every provision every six months. This would reduce risks of services failing significantly and of course reduce the likelihood of safeguarding concerns involving individuals receiving care.

3.15 It is likely that members will remember press reports about the awful situation in Winterbourne View where residents with Learning Disabilities were physically and emotionally abused. In her review of Winterbourne View Hospital (2012), Margaret Flynn notes that the authorities did not have an overview of the provision and that what was commissioned by the Health Board was not monitored in terms of the quality of care or in terms of their ability to satisfy the needs of residents. The work of the Quality Assurance team needs to ensure that the Council and its partners has the necessary current information in order to have a full overview of adults care services provision in Gwynedd.

4 MOVING FORWARD

4.1 The Department's vision for the future is based on being able to support and monitor provisions consistently, regularly and in a timely manner.

4.2 It must be ensured that we are in a position to monitor all provisions that are commissioned by the Department, as well as any other provision within the County.

4.3 Care Inspectorate Wales reviews the performance of local authorities as they deliver their function in the field of Social Services. Though they regulate us on our statutory duties, our Quality Assurance work intertwines in order to ensure quality within registered provisions. CIW considers that a robust quality assurance provision is an important part of local authorities' ability to be proactive in ensuring standards and safeguarding adults that are being supported.

4.4 A review form has been created for Social Workers, Occupational Therapists and other officers to complete when reviewing cases. This feedback is of assistance in identifying concerns sooner and then support the providers to introduce and maintain improvements.

4.5 Placing our loved-ones in care/nursing homes is a very difficult decision and it is essential that we as an Authority endeavour to ensure that individuals receive suitable and safe care. Reference has already been made to Winterbourne View, but that example shows the potential impact of not monitoring on the residents and their families.

4.6 Provisions need to be prevented from going into the Escalating Concerns procedure in order to avoid increasing pressures on services. One nursing home and two care homes have closed in the County over the past two years. It is essential to support the providers in order to ensure that there is a choice of local provision available for the residents of Gwynedd.

4.7 The information presented verbally at the Committee will reinforce this report in order to facilitate the Committee's consideration of the ability of the Quality Assurance team and the Adults, Health and Well-being Department to fulfil their duties effectively and in doing so safeguard and protect the interests of the residents of Gwynedd.