CITY OF WOLVERHAMPTON COUNCIL

Adults Scrutiny Panel

20 February 2024

Time 6.00 pm **Public Meeting?** YES **Type of meeting** Scrutiny

Venue Committee Room 3 - 3rd Floor - Civic Centre

Membership

Chair Cllr Val Evans (Lab)
Vice-chair Cllr Christopher Haynes (Con)

Labour

Cllr Qaiser Azeem
Cllr Jenny Cockayne
Cllr Sally Green
Cllr Dr Michael Hardacre
Cllr Linda Leach
Cllr Rohit Mistry
Cllr Rita Potter
Cllr Paul Sweet
Cllr Iqra Tahir

Conservative

Cllr Bob Maddox
Cllr Udey Singh

Quorum for this meeting is three Councillors.

Information for the Public

If you have any queries about this meeting, please contact the Scrutiny Team:

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

1 **Welcome and Introductions**
[The Chair to welcome everyone to the meeting.]

2 **Meeting procedures to be followed**
[The Chair will explain how the meeting will proceed.]

BUSINESS ITEMS

3 **Apologies**

4 **Declarations of Interest**

5 **Minutes of previous meeting (20 November 2023)** (Pages 3 - 12)
[To approve the minutes of the meeting held on 20 November 2023 as a correct record].

6 **Minutes of previous meeting (5 December 2023)** (Pages 13 - 16)
[To approve the minutes of the meeting held on 5 December 2023 as a correct record].

DISCUSSION ITEMS

7 **Wolverhampton Adult Social Care Provider Care and Support Review 2024 - 2025** (Pages 17 - 38)
[Andrew Wolverson, Deputy Director, Adult Social Care, to present report]

8 **Quality Assurance Framework and Suspension Policy 2024 – 2034** (Pages 39 - 264)
[Andrew Wolverson, Deputy Director Adults Services, to present report]

9 **Adults Scrutiny Panel Draft work programme 2023 - 2024** (Pages 265 - 268)
[Earl Piggott-Smith, Scrutiny Officer, to present report]

Adults Scrutiny Panel

Minutes - 20 November 2023

Agenda Item No: 5

Attendance

Members of the Adults Scrutiny Panel

Cllr Qaiser Azeem
Cllr Jenny Cockayne
Cllr Val Evans (Chair)
Cllr Christopher Haynes (Vice-Chair)
Cllr Linda Leach
Cllr Bob Maddox
Cllr Rohit Mistry
Cllr Rita Potter
Cllr Paul Sweet
Cllr Iqra Tahir

Employees

Courtney Abbott	Quality and Improvement Advanced Practitioner for Children and Adults
Sandra Ashton-Jones	Head of Mental Health
Lesley Johnson	Carer Support Manager
Earl Piggott-Smith	Scrutiny Officer
Jennifer Rogers	Principal Social Worker
Andrew Wolverson	Deputy Director of Commissioning and Transformation of Children's Services

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Part 1 – items open to the press and public

Item No. *Title*

1 **Welcome and Introductions**

Cllr Val Evans, Chair, welcomed everyone to the meeting and advised it was being live streamed to the press and public. A recording of the meeting would be available for viewing on the Council's website at a future date.

2 **Meeting procedures to be followed**

Cllr Evans explained the protocol to be followed during the meeting for asking questions.

3 **Apologies**

Apologies were received from the following:

Cllr Dr Michael Hardacre
Cllr Linda Leach

Becky Wilkinson Director of Adult Services

4 **Declarations of Interest**

No declarations of interest recorded.

5 **Minutes of previous meeting (17 October 2023) (to follow)**

Minutes of Meeting 17 October 2023 approved as correct record.

6 **Adult Social Worker and Workforce Health Check Surveys 2022 - update on actions**

The Chair invited Courtney Abbott, Quality and Improvement Advanced Practitioner, to present the report on the findings of the Adult Service's social work and wider workforce health check for 2022 report actions.

The report was prepared in response to a request at the time from the panel who wanted a mid-year update of progress against actions. The Quality and Improvement Advanced Practitioner briefed the panel on the progress of actions from the health check survey 2022.

A copy of the presentation is attached.

The Quality and Improvement Advanced Practitioner commented that the progress on some of the actions, implementing a trauma informed practice may take some time to see the impact of the changes.

The Quality and Improvement Advanced Practitioner advised the panel that work is in progress to analyse the findings of 2023 survey, which recently closed. The findings of the latest survey will be presented to the panel in March 2023. The survey findings will be presented to the Social Workers in September 2024 and the wider workforce in October 2024.

The Quality and Improvement Advanced Practitioner invited the panel to comment and provide challenge on the proposed future actions to improve practice conditions for, and the health of, social work and the wider workforce.

The Chair thanked the presenter for the report and presentation. The panel were invited to comment and ask questions.

A panel member welcomed the work to improve social worker retention rates and manage case workloads. The panel member queried the issue of support for people with complex care needs who may find it difficult to manage changes in the person providing their care and or the social worker and wanted further details about what would be done in this situation.

Jenny Rogers, Principal Social Worker, commented on the importance of relationship-based practice and that in respect of care organisations providers there is a similar expectation that where possible the same person should be used to provide care.

The Principal Social Worker acknowledged the national staffing challenges affecting the care sector and the impact of turnover rates and reassured the panel that the aim is to keep staff changes to a minimum.

Sandra Ashton-Jones, Head of Adult Services, advised the panel that as regards changes in a social worker then the service aims to arrange a 'warm handoff' where the current social worker introduces the person who will be taking over their case to help reduce possible disruption in their care arrangements.

A panel member queried what meaningful support would be offered to a care worker or social worker who reports to their manager that they are feeling stressed and struggling with their case load.

The Principal Social Worker commented on the importance of regular supervision in identifying this early as an issue and added that it should not reach the situation where someone reports they are feeling overwhelmed. The Principal Social Worker highlighted the reference in the report about this issue of burnout and the action being taken in response, for example, trauma informed supervision. There is a recognition at the organisational level of the stressful and challenging nature of social work practice.

The Principal Social Worker commented on the range of employee assistance support available, which includes counselling and support cafes. In addition, workers are encouraged to access the range of other practical and personal support, for example, taking lunch breaks, yoga sessions and booking admin time, to help create reflective spaces.

A panel member queried the plans for and the cost of rebranding the position of Wolverhampton as an employer of choice service to support the recruitment and retention of social workers and care workers and asked if this work would be done in-house or involve the use of external consultants and details of costings.

The Principal Social Worker advised the panel that the rebranding work has largely being done in house and that some support has being provided by external specialists. The use of external specialist has been done through the Council's procurement process.

A panel member suggested that while welcoming the high levels of satisfaction among social workers in the survey responses that it would be helpful to also include negative comments from social workers who would not recommend CWC as an employer. The information would provide learning opportunity and help to improve future practice. A panel member suggested that negative comments should be included in the next annual report to the panel in March 2024.

The Principal Social Worker agreed to include the negative comments in the next annual report and suggested adding a reference in the action plan response to specific comments as part of the improvement plan for the service.

A panel member queried the take up rates among social workers of face-to-face training sessions since 2021.

The Principal Social Worker advised the panel that during the Covid 19 pandemic training was mainly delivered online and the since then more face to face training has been offered and the numbers have increased but not yet returned to the same levels during this period. A possible reason for this is that online learning is more cost effective as it does not involve travel.

The Principal Social Worker accepted the necessity for face-to-face training and commented that people gain value from in person meetings and reassured the panel that there are plans to support this.

The Principal Social Worker agreed to provide details about the take up rates for face to face compared to online training sessions.

A panel member queried the statistics relating to the differences in response between social workers and social care workers to questions about opportunities for reflection within supervision sessions and for them to be observed during practice and asked for an explanation.

The Principal Social Worker agreed to investigate the matter and provide a more detailed response in a future report to the panel. The Principal Social Worker and accepted the need for the number of practice observations of social work practice to increase. The Principal Social Worker commented that observations are important and have been incorporated into social work practice week to improve the situation.

Andrew Wolverson, Deputy Director of Commissioning and Transformation of Childrens Services added that the findings should be treated with some caution as based on what people self-report.

Sandra Ashton-Jones, Head of Adult Services, added that social workers work in very complex or challenging situation, and they will sometimes visit a person with a colleague or manager to support them, but this would not be classed as a formal observation. There is a specific template for managers to complete and give formal feedback to social workers. The Head of Adult Services reassured the panel that there are other informal observations of social work practice.

The Chair suggested social workers should be invited to attend the panel meeting to respond directly to questions about issues arising from the 2023 Adult Social Worker and Workforce Health Check Survey.

The Head of Adult Services agreed to follow up the request and see if any social workers would accept the invite to attend the meeting.

The Chair thanked the presenters for the report and presenters.

Resolved:

1. The Principal Social Worker to note the comments of the panel about the actions from the findings of the Adult Social Work and Workforce Health Check 2022.

2. The Head of Adult Services to invite Social Workers to attend the panel meeting on 19 March 2024 when the 2023 Adult Social Work and Workforce Health Check 2023 report is presented.

7 **Care Quality Commission (CQC) Assurance Preparation**

The Chair invited Andrew Wolverson, Deputy Director of Commissioning and Transformation of Children's Services, to present report.

The Deputy Director gave a presentation about the preparation for the new adult services inspection regime introduced nationally. The inspection will be undertaken by the Care Quality Commission.

The Deputy Director advised the panel that the local authority has specific duties under the Care Act (2014) and there is now a duty announced in April 2023 to be independently reviewed in terms of how it is delivering against a core set of functions. At the end of the inspection a rating will be published outcome/rating (Inadequate, Requires Improvement, Good or Outstanding) as with Ofsted ratings against the core functions.

The Deputy Director commented on the progress of the Strategic Improvement Plan and advised the panel that the document will provide evidence actions against areas of development identified in the Self-Assessment.

A copy of the presentation is attached.

The panel were invited to comment on the report and presentation.

A panel member queried the impact on the assessment of not meeting one of nine listed categories and commented on those services which the Council delivers either jointly is reliant on partner organisation and the need to make clear which parts of the system are not working and give assurance that such issues are being addressed as a partnership.

The Deputy Director referred to care home provision where the majority of which is delivered by the private sector. The Council works with owners to try and influence and improve the quality of care provided. The Deputy Director commented separately on the work being done to support privately owned residential care home where there may not have the same dedicated roles compared to a larger care home organisation.

The Deputy Director commented that the care home sector is experiencing a high turnover of managers and several homes previously rated as ‘good’ are now being rated as either ‘requires improvement or in a recent example, as ‘inadequate’.

The Deputy Director commented on the impact of Covid 19 on care home providers and that the Council is supporting them with a focus on making sure Wolverhampton residents have access to the best care.

The Deputy Director reassured the panel that the Council has very good systems in place to monitor and this has been successful in helping a care provider improve their establishment home rating from ‘inadequate’ to ‘good’ in short period of time.

A panel suggested that it would be helpful to invite a representative of Occupational Therapy Service to a future meeting. The Deputy Director agreed to bring a report to a future meeting. The Deputy Director commented that there is a national shortage of Occupational Therapists and the longest waiting times are for people wanting to access this service.

The Deputy Director suggested that a report could also include work being done address the issue, for example, the introduction of an online self-assessment form and alternative shorter form when a person needs something specific such as a grab rail rather than a full care assessment. The Deputy Director stressed the important role of Occupational Therapist is assessing current and future care and support needs of a person.

The panel discussed the occupational therapy offer provided by RWHT hospital discharge team and the strong performance of the team, particularly during the previous winter pressures period. The Deputy Director highlighted the small numbers of people whose hospital discharge was delayed because they did not have the care package ready.

The Chair thanked the presenter for the presentation.

Resolved:

1. The panel agreed to note the presentation.

2. The Deputy Director of Commissioning and Transformation of Children's Services to present a future report on the performance of the Occupational Therapy service to the panel.

8 **Our Commitment to All Age Carers Update on Progress**

The Chair invited Sandra Ashton Jones, Head of Adult Services, to present the report.

The Head of Adult Services introduced Lesley Johnson, Carer & Community Support Manager, to answer specific questions on the work and performance of the care and support team referenced in the presentation.

The Head of Adult Services advised the panel that the presentation would provide an update on progress on the Council's commitment to all age carers strategy launched in December 2022 that was considered earlier in the year. At the time the panel requested an update on progress of work done against the objectives in the strategy be presented to a future meeting.

The Head of Adult Services advised the panel that a carer is defined as someone who supports a person such as a family member or friend in an unpaid capacity.

In the most recent census, 24,000 people in Wolverhampton identified themselves as a carer and the locality teams are currently working with between 5000 to 7000 carers in the city and that includes carers under the age of 18 and parent carers.

The Head of Adult Services gave a summary of the presentation. A copy of the presentation is attached.

The panel thanked the presenter for the report.

The Chair invited the panel to comment on the presentation.

A panel thanked the presenter for the comprehensive report and queried the number of unpaid carers in Wolverhampton. The Head of Adult Services advised the panel that 84,000 people have identified themselves as carers this compares to 27,000 reported in the 2021 Census. The Head of Adult Services added that a finding from the census was that there has been a significant increase in the number of hours unpaid care provided.

A panel member queried the low take up of the offer of £100 one off payment in 2023/2024 to support carers with the increase in the cost of living.

At present 250 carers have received the offer which is equivalent to about 1 per cent of people who identified themselves as a carer.

The Head of Adult Services advised that the offer is promoted during the carer's conversation as part of the assessment and in addition carers have been given extra financial help through the Household Support Fund. The funding has been used by carers to purchase laptops and driving lessons. The Head of Adult Service acknowledged the low take up of the offer and reassured the panel of the efforts will continue to increase the numbers.

A panel member expressed the concern that based on the current rate of progress it was unlikely that all 24,000 carers would take up the offer of the one-off payment by the end of March 2024.

The Head of Adult Services advised the panel that the service is working with between 5,000 to 7,000 people and commented that some people may not identify themselves as carers and this is the group the service is trying to reach and provide with support.

Lesley Johnson, Carer and Community Support Manager, commented that the funding was awarded late in the financial year and reassured the panel that with every conversation with a carer they are offered the £100 payment and the work will continue as there is awareness of the financial pressures facing carers during the winter months.

A panel member queried the five broad priorities and the listed activities and whether some of them should be 'business as usual' work and wanted to better understand the rationale for their inclusion.

The Deputy Director commented that five priorities have been developed as part of co-production work with carers and professionals and accepted that some of them would considered to be part of the Council's daily work. The Deputy Director added that the inclusion of these priorities in the strategy is to show that action has been taken by the Council to respond to issues raised by carers, against which the Council will be reporting progress.

A panel member queried if plans for future events to support carers would include all WV Active sites including Aldersley Leisure Stadium. The Carer & Community Support Manager confirmed that all WV Active sites will be involved in the promotion to carers who will be offered a free year's membership for WV Active that can be used at any of their sites.

A panel member expressed concern about the willingness of GP surgeries to actively work with the Council to help identify unpaid carers and to promote the offer of support available to them as suggested in the presentation. There was also concern that without clear guidance nationally from Government to get involved in identifying unpaid carers and promoting the support offered, that this will not be seen as a priority for some GP practices without the offer a financial incentive. The importance of sharing best practice in promoting the offer to carers was highlighted.

The Head of Adult Services advised the panel that GP practices have been financially incentivised and get a payment of £100 per carer that they identify, and some GP practice have been very active and making regular referrals to the carers support team.

In addition, the service continues to raise awareness about the support offered to carers.

The Carer and Community Support Manager advised the panel that the service works continually with GP practices and highlighted the importance of the language used when approaching a carer and using the opportunities for example, when someone collects prescriptions from the surgery to have a conversation and to follow up on actions.

A panel member highlighted the experiences of examples when no receptionist is available who could help identify carers or the service is busy as a challenge.

The Head of Adult Services advised the panel about the use of carer information leaflets in GP practice to promote the offer to carers and highlighted the work of the Carers Team in raising awareness across Wolverhampton and in all the primary care networks. The Head of Adult Services acknowledged the challenges people may face when trying to speak to a GP.

The Deputy Director commented that in addition to using GP systems to identify carers, that the Carers Card (to identify the person as an unpaid carer) is also used to promote the offer and signpost people to help. The Deputy Director highlighted the importance of everyone in the GP in helping to identify carers, particular young carers and to respond appropriately.

A panel member queried how representative of different communities is the estimated population of 5000 – 7000 unpaid carers. The Head of Adult Services advised the panel that the service collects this information, and a dashboard is being developed to provide better demographic information. The Head of Adult Services reassured the panel that an analysis of the data shows that the figures of known unpaid carers accurately reflects the profile of different communities in the population. The Head of Adult Services offered to provide the results of the analysis.

The Chair thanked the presenters for the presentation.

Resolved:

The Head of Adult Services to note the comments of the panel and provide information as requested.

9 **Adults Scrutiny Panel - draft work programme 2023-2024**

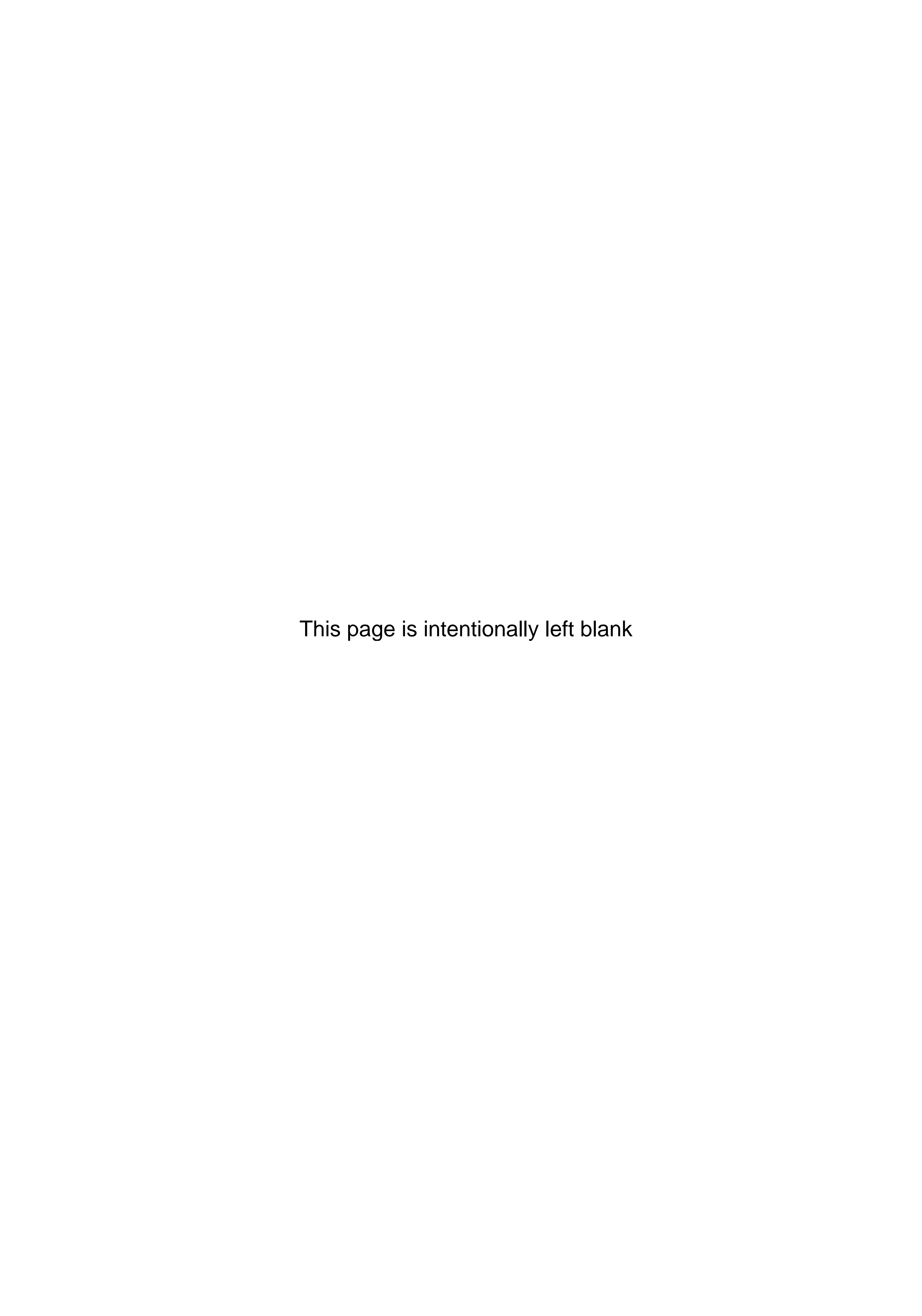
The Chair invited Earl Piggott-Smith, Scrutiny Officer, to present the report.

The Scrutiny Officer commented on the agenda for future meetings and invited members to suggest new topics or questions for report authors to ensure issues of interest are covered.

The Chair thanked the presenter for the report.

Resolved:

The panel agreed to note the report.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Adults Scrutiny Panel

Minutes - 5 December 2023

Attendance

Members of the Adults Scrutiny Panel

Cllr Qaiser Azeem
Cllr Val Evans (Chair)
Cllr Bob Maddox
Cllr Rohit Mistry
Cllr Paul Sweet
Cllr Iqra Tahir

Employees

Lindsey Cowan	Corporate Analytics Manager
Emma Curran	Portfolio Manager
James Barlow	Finance Business Partner
Earl Piggott-Smith	Scrutiny Officer
Becky Wilkinson	Director of Adult Social Services

Part 1 – items open to the press and public

Item No. *Title*

1 **Welcome and Introductions**

Cllr Val Evans, Chair, welcomed everyone to the meeting and advised it was being live streamed to the press and public. A recording of the meeting would be available for viewing on the Council's website at a future date.

2 **Meeting procedures to be followed**

Cllr Evans explained the protocol to be followed during the meeting for asking questions

3 **Apologies and Notification of Substitutions**

Apologies were received from the following:

Cllr Dr Michael Hardacre
Cllr Christopher Haynes
Cllr Udey Singh
Cllr Rita Potter
Cllr Linda Leach
Cllr jenny Cockayne

Cllr Jasbir Jaspal – Cabinet Member for Adults and Wellbeing

4 **Declarations of Interest**
No declarations of interest recorded.

5 **Minutes of the meeting held on 17 October 2023**
The draft minutes of the meeting held on 17 October 2023 were approved as correct record and signed by the Chair.

6 **Budget and Performance Update**
The Chair invited Becky Wilkinson, Director of Adult Services, to introduce the report.

The Director invited James Barlow, Finance Business Partner, to introduce the slides on the budget report. A copy of the presentation is attached.

The Director invited panel members to comment on the Draft budget 2024-2025 and MTFS presentation slides.

A panel member queried the issue of costs for out of area placements for children services and highlighted concerns about the huge discrepancies in the level of charges. The panel member commented on previous discussions about charges for external children's residential accommodations and plans to work with other local authorities to avoid competition for places leading to increased costs. The panel member queried if this was a similar situation facing adult social care placements.

The Director acknowledged the pressures on care costs for adult social placements but the issue for the Council concern cases involving adults with learning and physical disabilities where more people tend to be placed out of city. The Director added that the cost pressures are due the lack of suitable placements rather than the cost of the care package.

The Director commented that the Council is working on the issue and reassured the panel that the cost pressures are not as acute as compared to the situation in children services for out of area residential care placements.

The Director presented the Our City Our Plan Performance slides and progress against six performance indicators. A copy of the presentation is attached.

The Director commented that Adult Social Care is showing strong performance overall and work is being planned in areas where improvements are needed.

The Chair thanked the Director for the presentation. The panel were invited to comment on the presentation.

A panel member queried what checks were in place to ensure the quality of care provided by external agencies to residents.

The Director reassured the panel that checks are done by the Quality Assurance Team on the care provided and the service also do unannounced inspections. The Council works closely with health colleagues to support this, for example, infection control procedures. The Director added that concerns or alerts about the quality of care can either be raised with CQC or with the Council.

The Director commented that that an updated Quality Assurance Framework is scheduled to be presented to the panel on 20.2.24 which details the work being done with partners to improve the quality of care provided.

There is an expectation that there will be further improvements because of the past investment in the sector. The Director acknowledged that the current assurance framework does need further improvement.

A panel member queried the method used to randomly select service users to take part in the survey and expressed concern about the low response rate.

Lindsey Cowan, Corporate Analytics Manager, advised the panel that the analysis is based on a random sample of service users.

The aim is to achieve a response rate of 20 per cent to be statistically significant. To date 1700 survey forms have been issued.

The Chair thanked the presenters for the report.

Resolved:

The panel comments on the Draft Budget 2024-2025 and Medium-Term Financial Strategy and Our City Our Plan Performance report to be noted.

7 **Transforming Adults Service Programme Annual Report 2022-2023**

The Chair invited Emma Curran, Portfolio Manager, to present report.

The Portfolio Manager advised the panel that the presentation would cover the background to the Transforming Adults Service Programme (TASP) Annual Report 2022-2023 and the main headlines, key achievements, and future priorities.

The Portfolio Manager advised the panel that a priority for the forthcoming year will be to continue the test and learn approach and to look for opportunities to use the success from TASP to support projects across adult social care. The Portfolio Manager added the aim will also be to ensure lessons learned from setbacks are being applied well and initiating the expected changes in the design and delivery of future projects.

The Portfolio Manager advised the panel that in the new year that there will be a focus on checking that the vision of the TASP resonates with residents.

The Portfolio Manager invited panel members to comment on the report and the presentation.

A panel member asked for further details about the achievement highlighted in the annual report about Wolverhampton being selected by Government to be one of six local authorities involved in the trailblazer programme for social care charging reform and asked for an update.

The Director confirmed that Wolverhampton had been approached to be one of six local authorities to take part in the work that the DHSS were doing on social care charging reforms. The project was focused on finding the fair cost of what the Council should be spending on social care, however there were significant costs to implementing the reforms and the work was paused at the start of the year.

The Director added that currently not sure what the future of programme will be.

The Chair thanked the presenters for the report.

Resolved:

1. The panel comments on the content of the Transforming Adult Services Programme Annual report and presentation to be noted.

2. The panel note the achievements and successes for this reporting year and the priorities for 2023 – 2024.

8 **Adults Scrutiny Panel - Draft Work Programme 2023 2024**

The Chair invited Earl Piggott-Smith, Scrutiny Officer, to present report. The Scrutiny Office advised the panel of future items scheduled on the work programme. The panel were invited to suggest changes to the work programme.

Resolved:

The Panel agreed to note the report.

The Chair formally recorded her thanks and appreciation on behalf of the panel for the work done by Becky Wilkinson in supporting the work of the panel. The panel wished her the best in her new role.

Wolverhampton Adult Social Care - Provider Care and Support Review 2024/25
Adults Scrutiny Panel
20 February 2024
wolverhampton.gov.uk
CITY OF WOLVERHAMPTON COUNCIL

Purpose

Action Required:

Adults Scrutiny Panel are asked to endorse Option 3 – this is the preferred option that will support the Council to provide market stability in the care sector whilst also being financially prudent.

Adults Scrutiny Panel is asked to consider:

- The cost drivers affecting the Adult Social Care market in Wolverhampton
- Provider engagement and feedback
- The current market risks for sufficiency and sustainability
- The cost impact and that new rates will create an ongoing expectation in the external market

Background and Context

Care fees must balance the **Council's legal duties**:

- Legal duty under section 5 of the Care Act 2014 to promote the effective and efficient operation of Adult Social Care markets.
- Legal duty of setting a balanced budget

All adult social care providers will be impacted by the increase to the National Living Wage (NLW) and Consumer Price Index (CPI) inflation.

The Council is not obliged to offer price increases for either contracted provision or spot purchase arrangements, however under our duty for sustaining the market fee increases are routinely applied on an annual basis.

In future the Council will incorporate indexation clauses to contracted care and support as a mechanism to adjust prices. Linked indices will need to be considered for each service type procured. This will eliminate the need for contracted care to be uplifted outside of contract terms and will allow the market to plan for throughout the contract period.

Scope of the 2024/25 Review

The following care and support services are in scope for the 2024/25 provider review:

- Home Care, Reablement and Home-Based Respite
- Direct Payments – Agency Rate, Employed Personal Assistant Rate, Self-Employed Personal Assistant Rate
- Individual Service Funds
- Extra Care
- Residential and Nursing
- Supported Living
- Day Care

Other care contracts are out of scope for the 2024/25 review (i.e. advocacy, equipment, healthwatch etc)

Note: although not a care type itself, consideration must be given to the treatment of top ups and joint funded packages with health

Drivers to Inform Options

National Cost Drivers:

- From April 2024, the National Living Wage (NLW) for people aged 23 and over will increase from £10.42 per hour to £11.44 per hour – a 9.79% increase.
- Consumer Price Index (CPI) inflation has reduced in the last few months (currently 3.9%) and is forecast to reduce to the governments 2% target within the next four months
- Assumption is that 70% of provider costs are payroll related and subject to any increase in the NLW and the remaining 30% are subjected to general inflation (CPI) – this will result in a composite percentage impact

Provider Feedback (outside of the known impact for NLW and CPI)

- 55% of all providers cited utility (energy) costs as a significant pressure. 100% of care homes identified this.
- 32% of all providers stated recruitment and retention as a key cost pressure with 18% also citing agency costs
- 27% of all providers highlighted the need to retain pay differentials when the NLW increases
- 27% of all providers identified insurance costs, rising to 67% for care home providers

Other Factors

- Benchmarking data suggests that fee levels are broadly in line with comparators across all in scope service types
- CQC quality rates have previously been used to influence preferred options, however increasing costs do not directly improve quality and therefore a more targeted approach is being proposed that has a cost impact but is not passed through to providers in cash terms

Other Considerations

Contracted services via Procurement

- Service types = home care, community activities for adults with complex needs, supported living (Burton Crescent), disabilities supported living framework (multiple providers), supported living (Firsbrook), supported living forensic framework (multiple providers), shared lives, accommodation for young adults (Fir Tree)
- The need to ensure compliance with procurement regulations – regulation 72 where the contract value cannot be exceeded by more than 50%
- Exercises have been completed to determine the position against each contract given historical and forecasted uplifts – contracts are compliant against reg 72 but the use of contract extensions may be problematic dependent on the rate at which care costs continue to be increased.
- Rates are tendered and have historically been uplifted annually. There are currently no contractual clauses for indexation

Non-procured services with standard rates

- Services types = Direct Payments (DPs) and Individual Service Funds (ISFs)
- DP personal assistant rates (employed and self-employed) are only impacted by the NLW and not CPI
- These services are not procured and therefore are exempt from procurement regulations

Negotiated rates

- Service types = residential and nursing
- The Council has “standard” rates which sets the expected market price
- Rates are negotiated on a case-by-case basis - different options need to be considered

Other Considerations

Jointly funded packages and placements

- Packages and placements that are commissioned and contracted by the Council are to be uplifted by a percentage the Council has implemented. Health are/will be engaged on the proposed rate.
- Joint packages/placements where health pay providers directly should be uplifted in line with Council funded care and support. Any disparity between the Council uplift and any uplift given by health will be subject to the provider challenging the increase. Note: historically the Council has applied a higher uplift than health

Top-ups

- Top-ups are only agreed at the start of a placement and cannot be introduced later
- The provider has the ability to increase the top-up without the agreement of the Council and the Council will not assist with the payment of any top-up or any increase
- The review options exclude top-ups and therefore they will not be uplifted

System Constraints

- The corporate social care system that processes and facilitates financial information (currently CareFirst) through to Agresso for payment means that:
    - Hourly rates must be divisible by 4
    - Weekly rates must be divisible by 7

Options Considered

Option No.	Description
1	Do Nothing • Do not apply an increase to current fee rates paid to externally commissioned care providers
2	Baseline position applied to all options: • NLW increase from £10.42 to £11.44 per hour – 9.79% increase • Apply CPI inflation • Composite rate based on a 70:30 ratio (70% payroll costs, 30% non-payroll costs)
3	Option 2 with the exception of DP personal assistant rates (employed and self-employed) • Personal assistant rates are not subject to the impact of inflation and therefore are to be uplifted solely in line with the increase to the NLW
4	Option 3 with the exception of residential and nursing • Care home fees are negotiated rates on a case-by-case basis. Further potential options have been explored.

Residential and Nursing Options

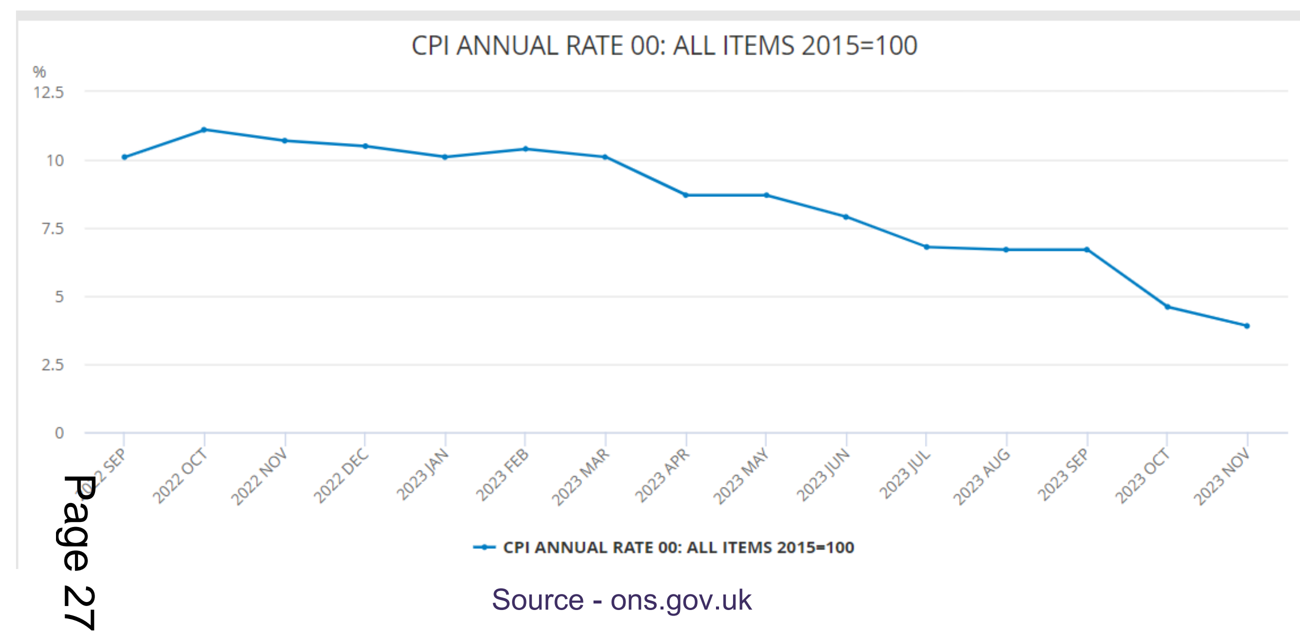
Baseline option is to increase placements below or at the local authority rate – composite rate applied on the basis of 70% payroll costs (NLW impact) and 30% non-payroll costs (CPI impact). Further options applied over and above include uplifting:

Option No.	Description
4a	**Uplift placements that started on or before the autumn statement, all other placements are not uplifted** - assumes that providers will know the increase to the NLW and rate of inflation, and will immediately factor this into placement costs that will be negotiated
4b	**All placements with the exception of complex needs** – complex placements are not automatically uplifted due to the range of needs and funding arrangements. Provider requests would be considered on a case by case basis subject to sufficient evidence being provided of an increase in costs.

Options Analysis

	Option	Benefits	Disbenefits
1	Do Nothing	• No cost impact	• Doesn't fulfil the Council's legal duty to sustain the external care market
2	NLW + CPI applied to all care and support	• Meets base cost impacts in 2023/24 • Recognises all providers face same / similar challenges • Aligns to regional intentions	• Doesn't account for nuances between care types (i.e care homes being negotiated) and potential options to be more targeted, or that not all care is impacted by both the NLW and inflation
3	NLW + CPI to all provision except DP PA rates – uplifted by NLW only	• Meets base cost impacts in 2023/24 • Recognises all providers face same / similar challenges • Recognises that personal assistant rates are solely impacted by the NLW and not inflation • Aligns to regional intentions	• Doesn't account for nuances between care types (i.e care homes being negotiated) and potential options to be more targeted
4a	Option 3 except care homes – uplifted if started after the Autumn Statement	• Potential cost saving in comparison to options 2 & 3 • Mitigates where providers have increased placement costs ahead of April 2024 assuming that future known impacts are already built into prices	• The Council is unable to confirm the assumption that providers have already factored in known cost pressures • Likely that providers do not build in costs but rather wait until uplifts are applied, leading to a risk of not sustaining the care home market and provider challenge.
4b	Option 3 except care homes – complex placements not uplifted	• Potential cost saving in comparison to options 2 & 3 • Approach would allow providers to challenge and costs to be negotiated based on individuals needs. This would have a potential cost saving compared to options 2 and 3	• Cost analysis shows the saving would be minimal and that the likelihood of provider challenge is high given the known cost impacts • Provider requests would be resource intensive to review and on the basis of fairness would likely to be approved

Consumer Price Index (CPI) Inflation



Source - ons.gov.uk

- The 2023/24 care and support provider review factored in inflation at 10.5% given the known position at the time and the forecast of it remaining high
- In the last 12 months, inflation has significantly reduced and there are forecasts for the government's target of 2% to be reached in by April 2024
- This presents options for the rate at which the Council incorporates inflation into the care and support provider review

Inflation options for consideration:

- Apply inflation as at the latest published rate – 4% in December 2023
- Apply inflation at 2% on the basis that it is forecasted to reach this level within the next four months
- Apply inflation at the rate published on 14 February 2024 – due to the internal approval timelines this would be too late to account for in both the fee review and feeding into the Council's budget so should be discounted

Financial Impact – Option 3 (Preferred Option)

Service Type	2023/24 Rate £ph / £pw / £per session	2024/25 Rate £ph / £pw / £per session	2024/25 % Uplift
Home Care	18.84	20.28	7.45%
Reablement	20.12	21.64	
Home Based Respite	18.00	19.36	
Direct Payments – Agency	18.00	19.36	7.45%
Direct Payments – Employed PA	12.80	14.08	9.79%
Direct Payments – Self-Employed PA	15.68	17.24	
Individual Service Funds	Dependent on Care Type	Dependent on Care Type	7.45%
Residential Older People	551.18	592.27	7.45%
Residential Dementia	592.55	636.72	
Nursing Older People	620.76	667.03	
Nursing Dementia	667.10	716.87	
Supported Living	18.00	19.36	7.45%
Day Care – sessional rate	34.32	36.88	7.45%
Day Care – hourly rate	18.00	19.36	

Financial Impact of the Preferred Option

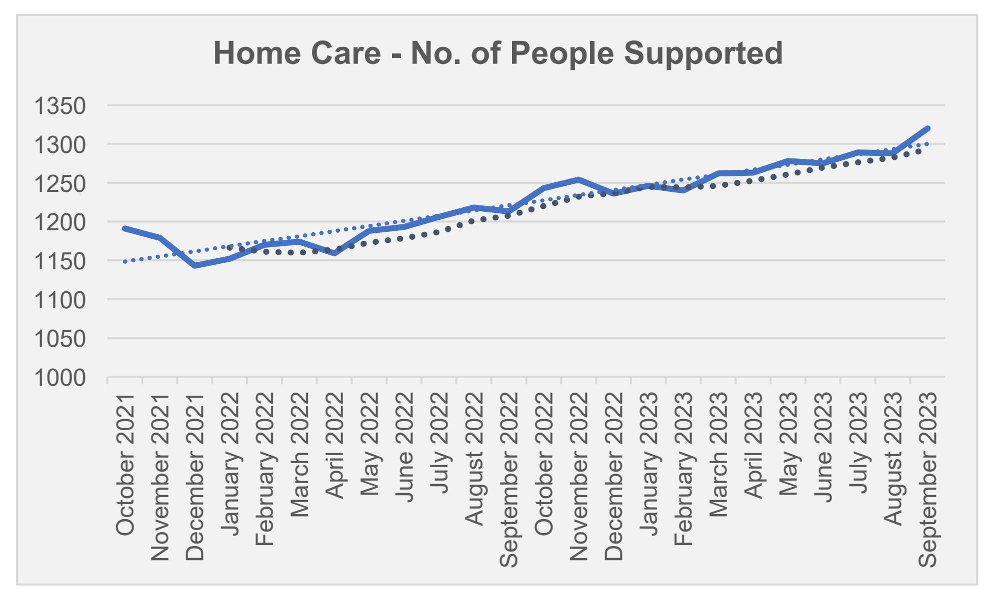
Area	Current Forecast 23-24 £000	Net Demographic growth 24-25 £000	Fee review cost 24-25 £000
OP Care Purchasing	29,750	1,341	2,645
LD Care Purchasing	34,728	729	2,742
MH Care Purchasing	6,695	295	530
PD Care Purchasing	7,784	537	672
	78,957	2,902	6,589

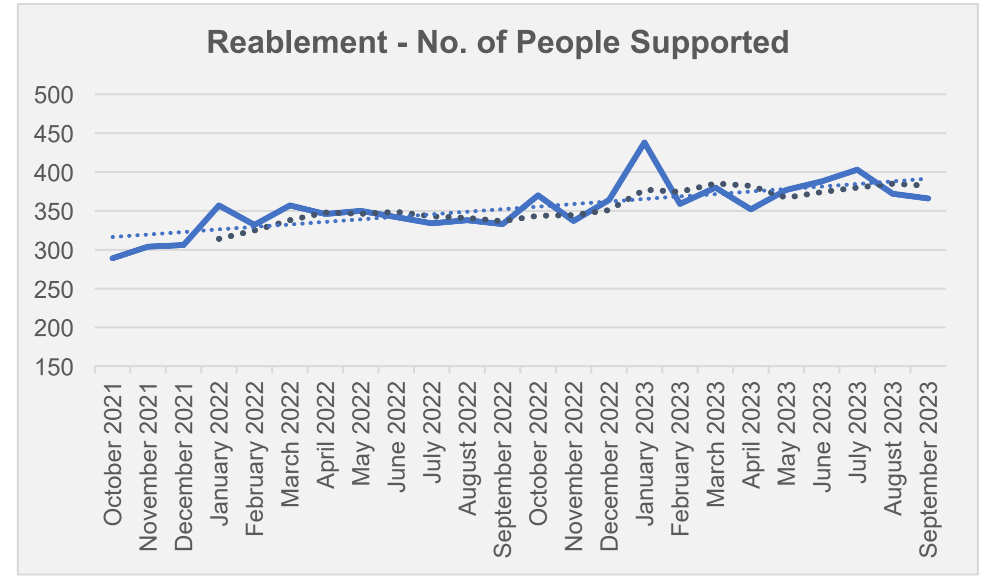
- The assumed cost of demographic growth for 2024-2025 is a £2.9 million increase on the current forecast
- This consists of increases to expenditure (£4.1 million) and income (£1.2 million).
- The cost of the Fee Review is estimated at £6.6 million based on the current forecast.
- As detailed above the Fee Review includes an assumption of 2% for inflation. If the Jan 24 inflation figure of 4% was used, this would cost an additional £420,000
- Taking into account the Q3 position the overall cost to the Council is estimated at £8.9 million.

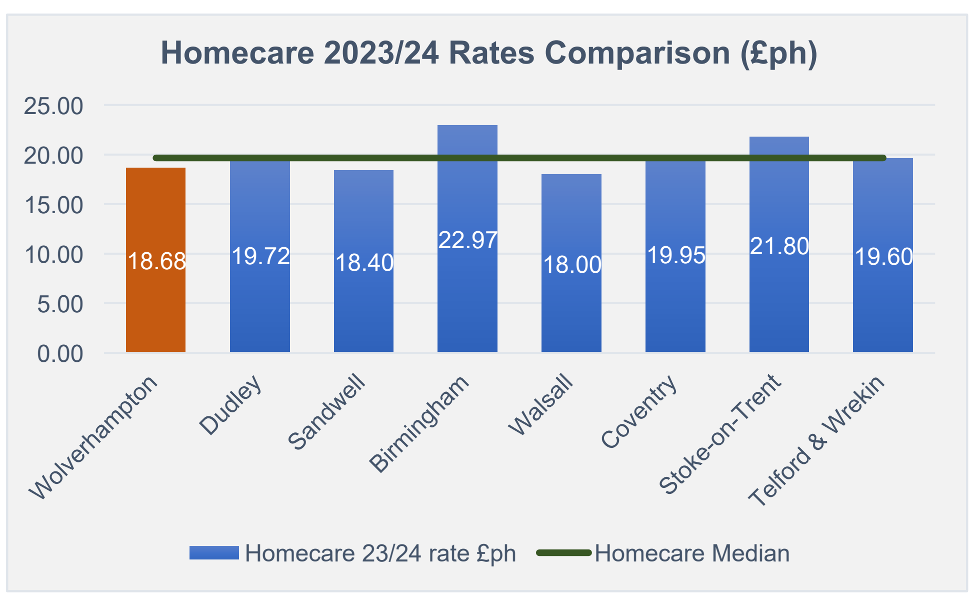
- The budget will also include growth to cover various items identified as not having budgets in 2024-2025, these total £213,000 and include the One Wolverhampton contribution of £100,000.
- The Discharge grant will be available at the same level as in 2023-2024 (£2.1 million), however the increase on this grant and the MSIF are required to fund the growth detailed above and will therefore not be available to fund additional expenditure in 2024-2025.

Appendices – Demand and Benchmarking Data

Homecare, Reablement and Home-Based Respite

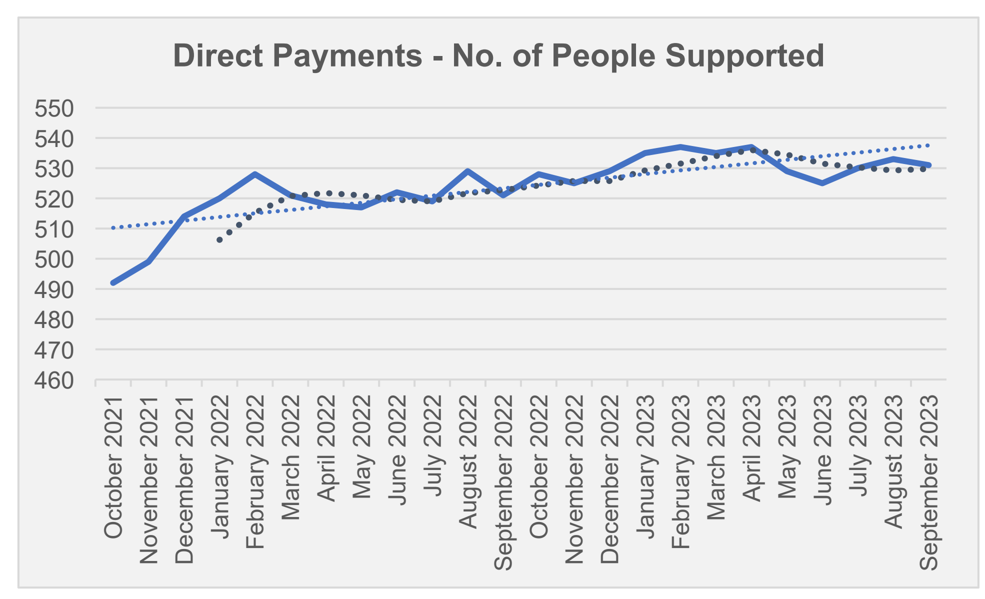


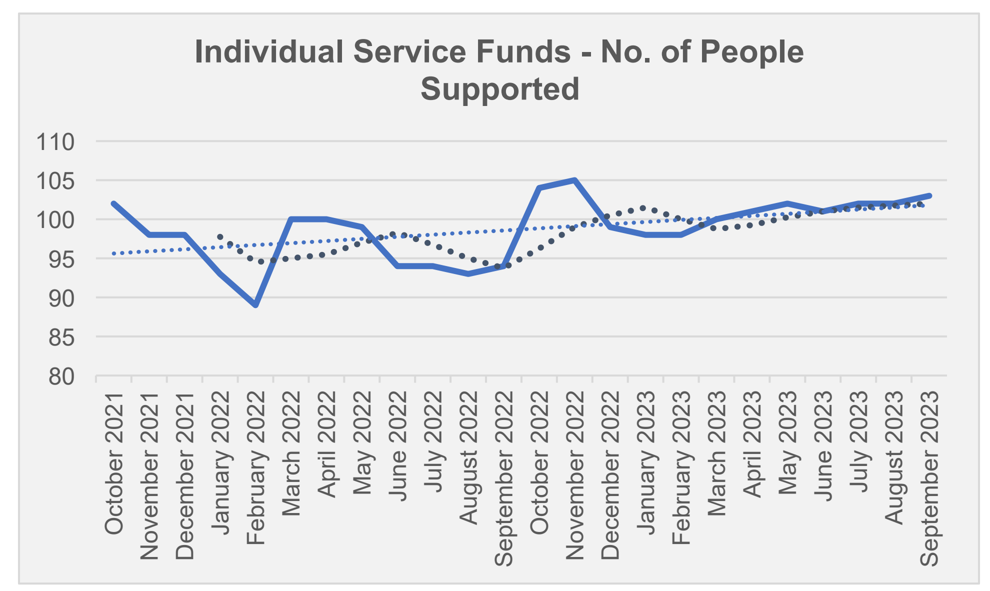


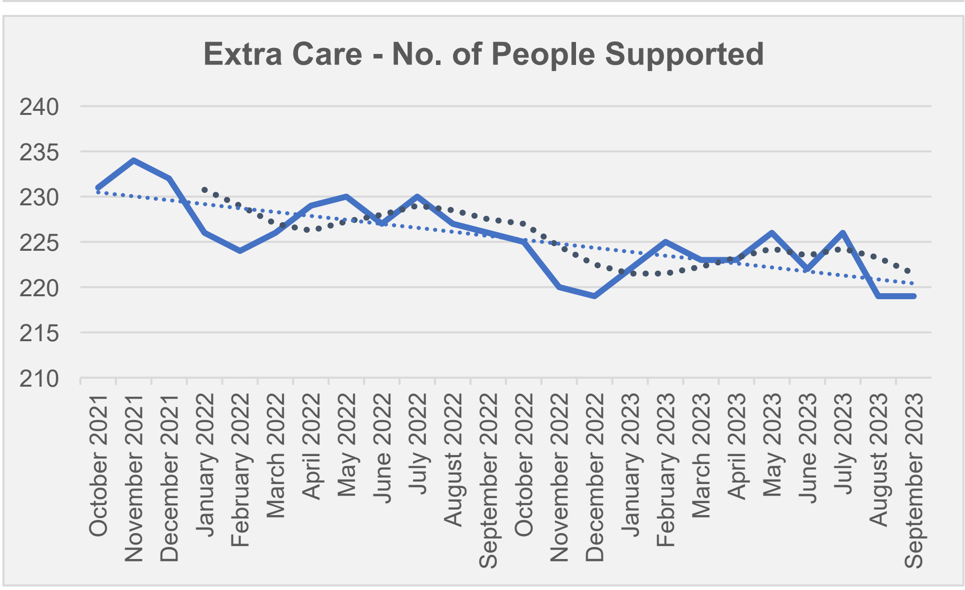


- Current rates are tendered and specific to individual providers
  - Homecare £18.36ph to £18.84 ph
  - Reablement £19.60ph to £20.16ph
  - Home-based respite £17.64ph to £18.00ph
- Note: home-based respite historically linked to the supported living rate
- Historically uplifted as a composite rate of NLW and CPI Inflation on a 70:30 ratio for payroll and non-payroll costs respectively

Direct Payments, Individual Service Funds & Extra Care

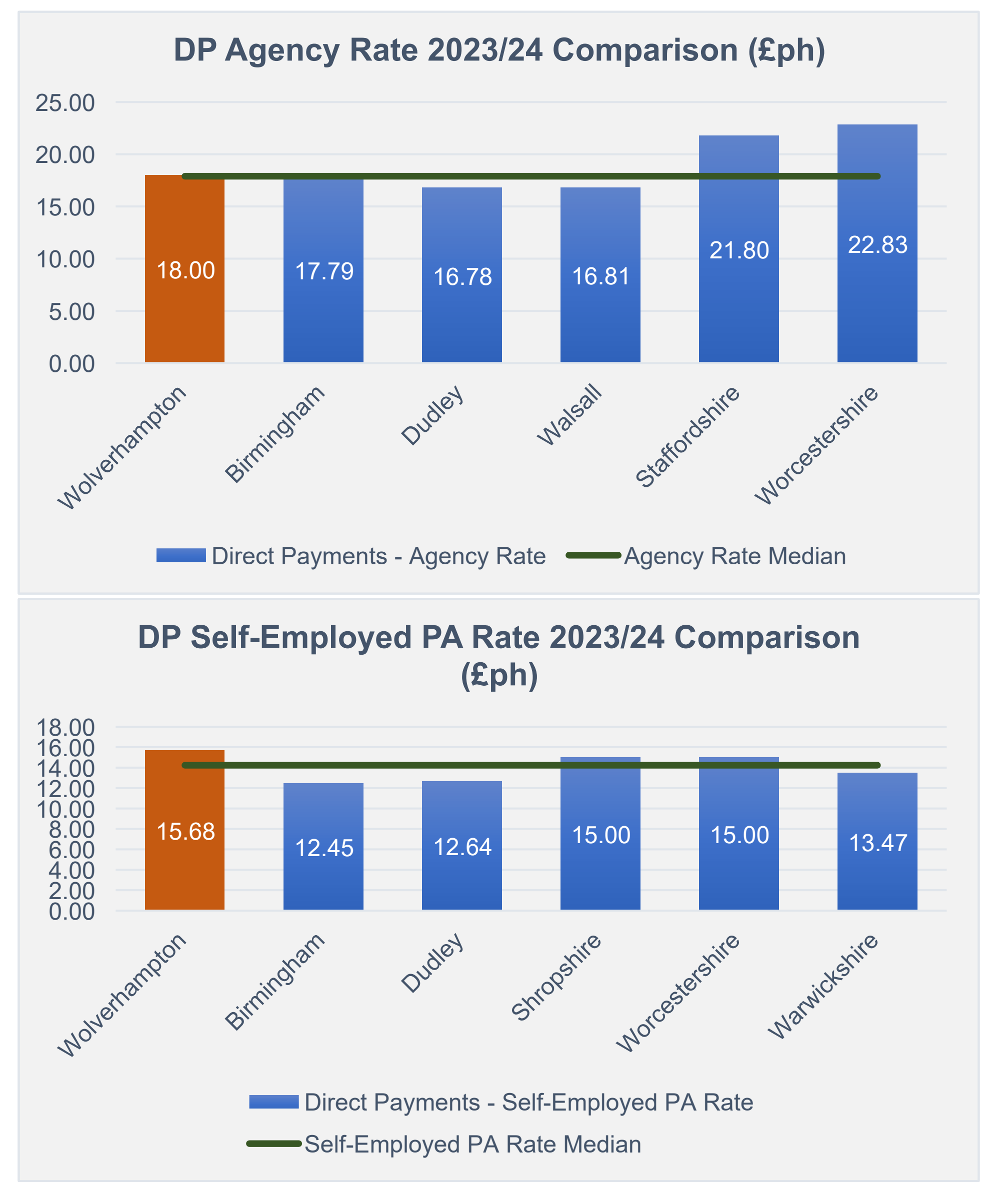


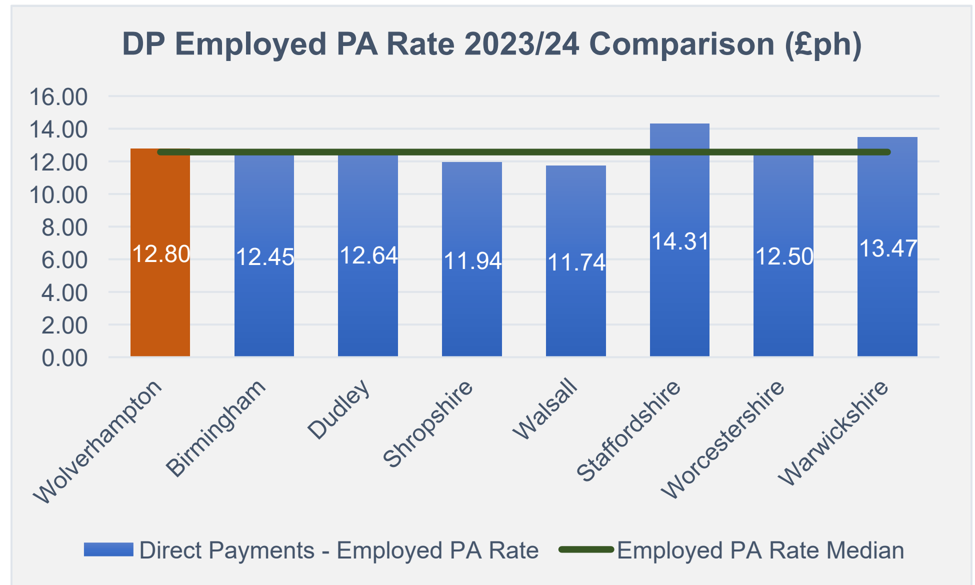




- Current Rates:
  - DP Agency Rate £18.00 ph
  - DP Employed PA Rate £12.80 ph
  - DP Self-Employed PA Rate £15.68ph
  - ISF rate £18.00 ph
- Note: DP agency and ISF rate historically linked to the supported living rate
- DP PA's can be paid different rates – would be better to standardise wage
- Previously uplifted as a composite rate of NLW and CPI Inflation on a 70:30 ratio for payroll and non-payroll costs respectively although PA rates should be payroll only

Direct Payments Benchmarking





- Current Rates:
  - DP Agency Rate £18.00 ph
  - DP Employed PA Rate £12.80 ph
  - DP Self-Employed PA Rate £15.68ph
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- Note: DP agency and ISF rate historically linked to the supported living rate
- DP PA’s can be paid different rates – would be better to standardise wage
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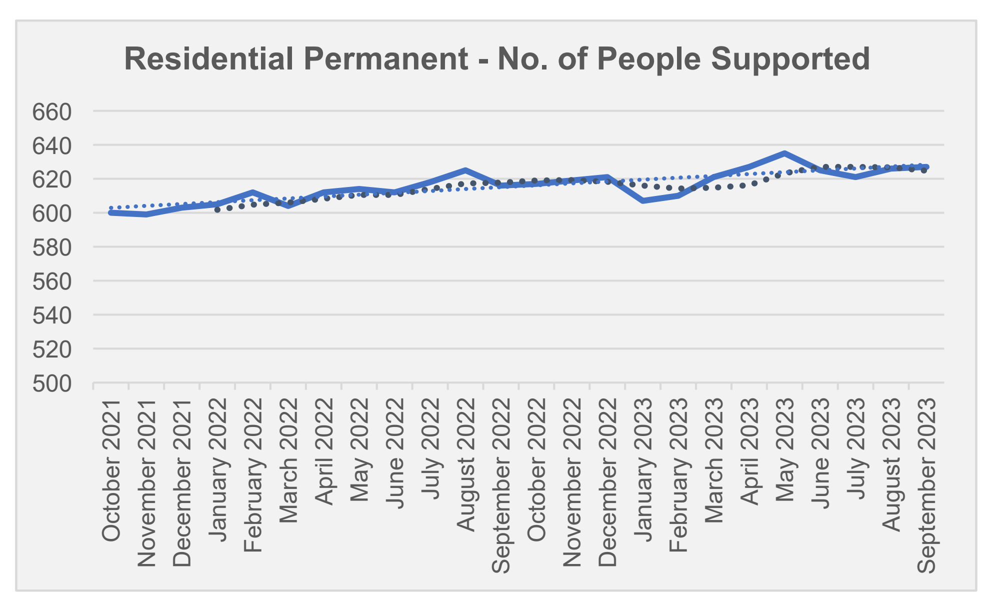
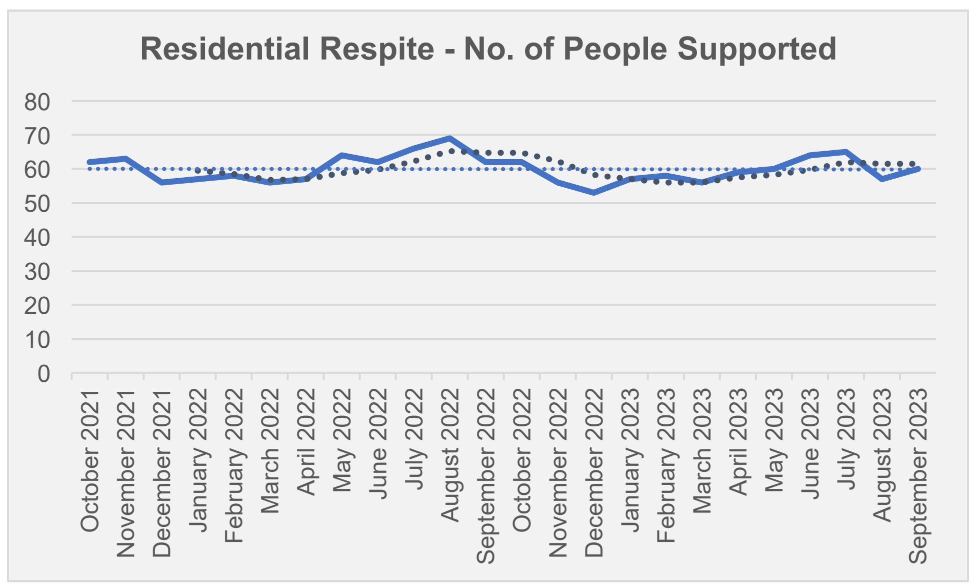
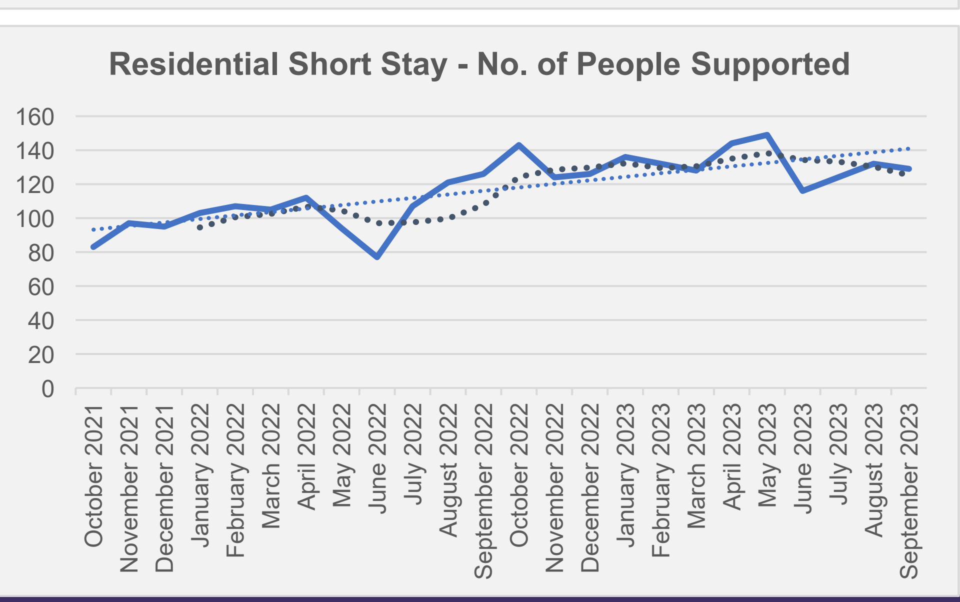
Residential - Demand

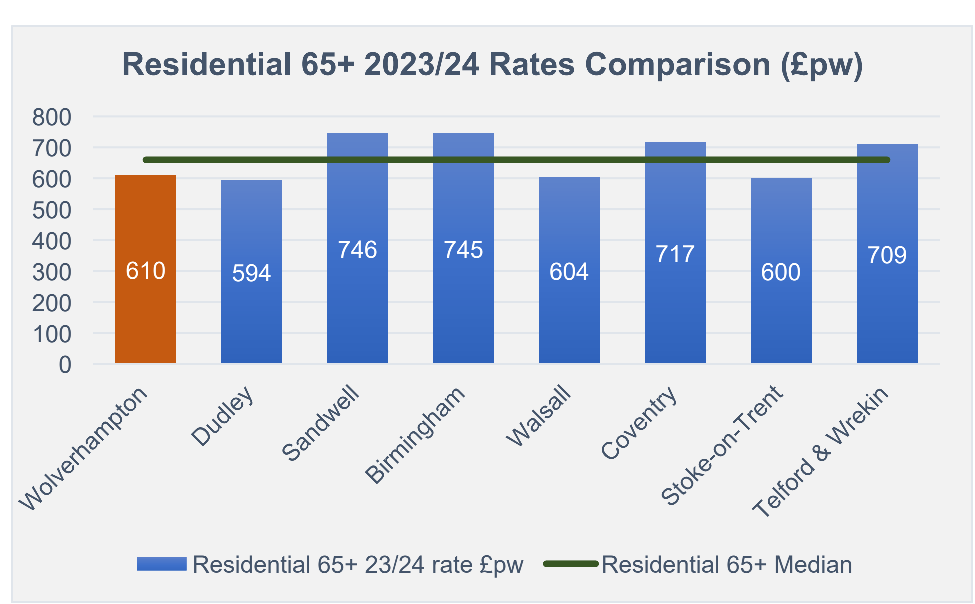


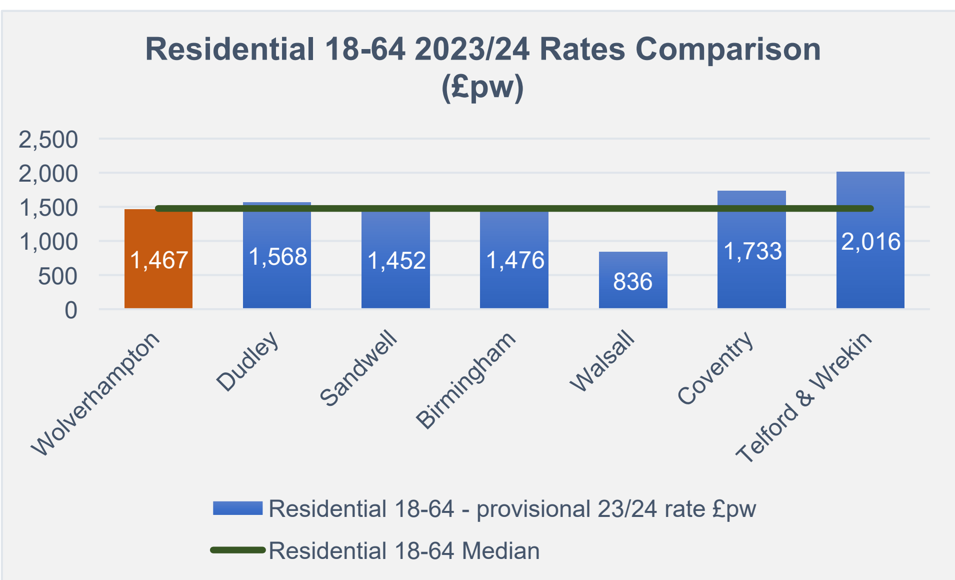




- Non-contracted, rates are negotiated unless provider agrees to pay LA rate
- LA rates 2023/24:
  - Residential OP - £551.18
  - Residential OP Dementia - £592.55
  - Residential Under 65s – individually negotiated
- Previously uplifted as a composite rate of NLW and CPI Inflation on a 70:30 ratio for payroll and non-payroll costs

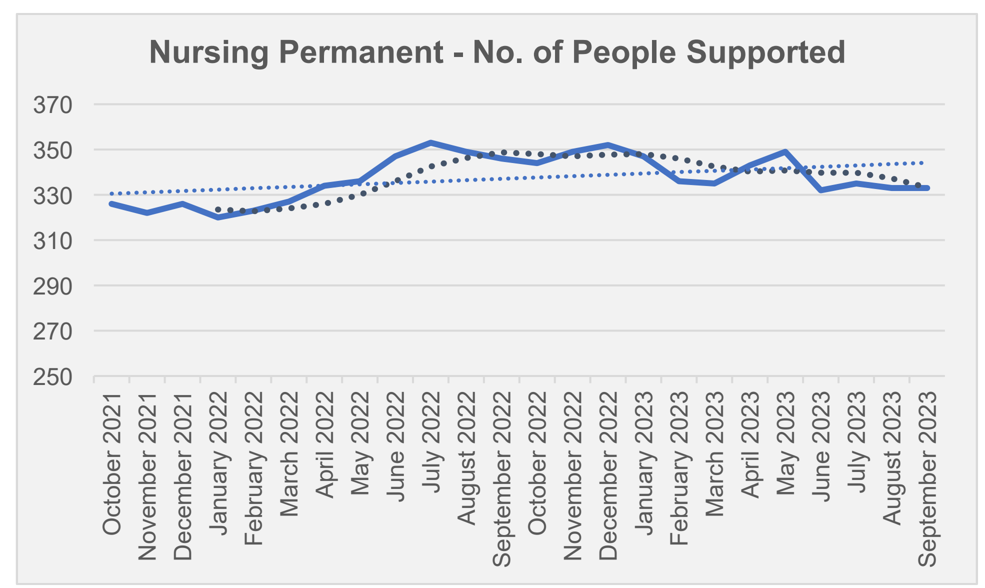
Residential - Benchmarking

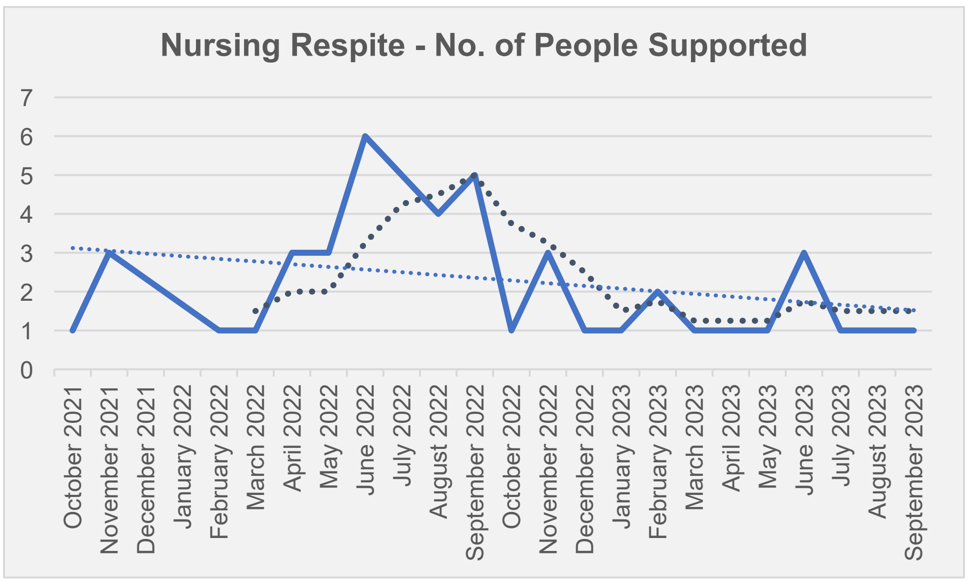


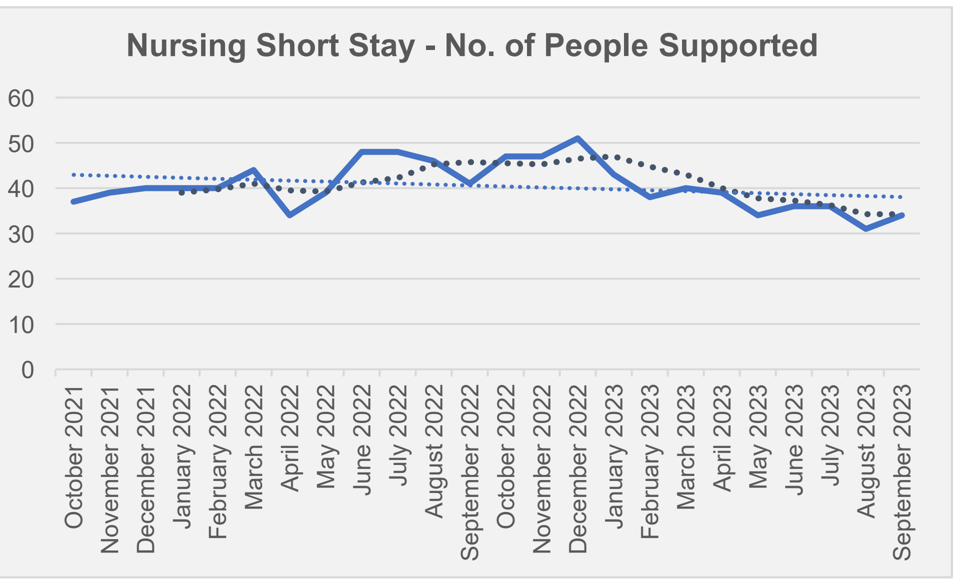


- Benchmarking data taken from regional MSIF summary produced by WMADASS
- Rural counties excluded from the data set on the assumption that they are not comparable
- Rates shown are provisional average costs

Nursing - Demand

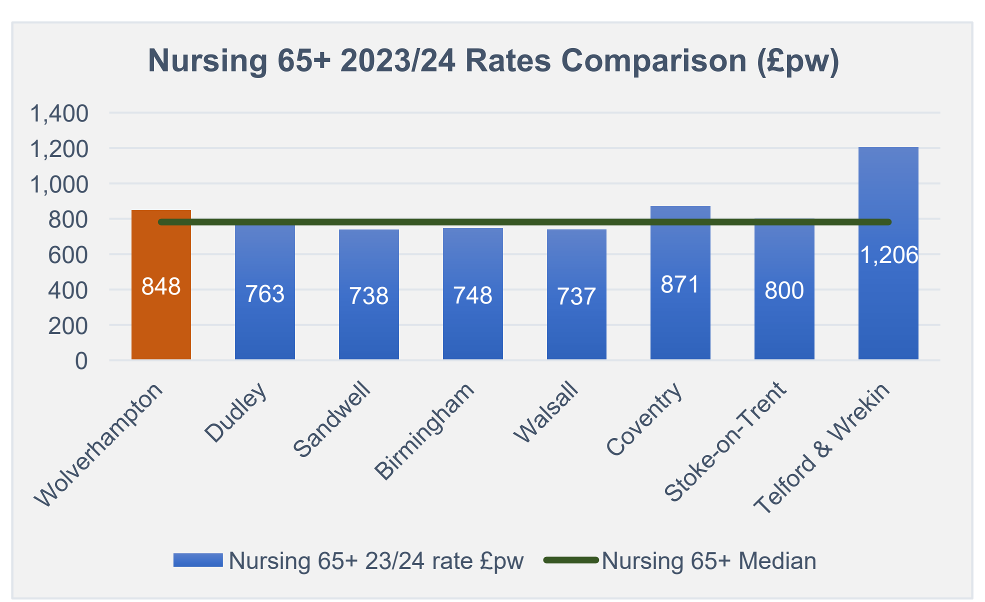


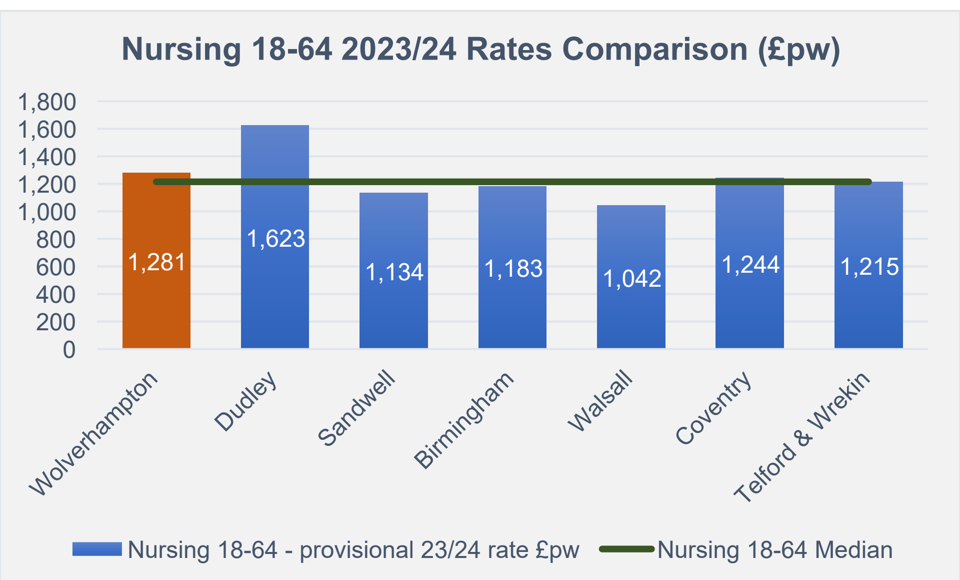




- Non-contracted, rates are negotiated unless provider agrees to pay LA rate
- LA rates 2023/24:
  - Nursing OP - £620.76
  - Nursing OP Dementia - £667.10
  - Nursing Under 65s – individually negotiated
- Previously uplifted as a composite rate of NLW and CPI Inflation on a 70:30 ratio for payroll and non-payroll costs

Nursing - Benchmarking





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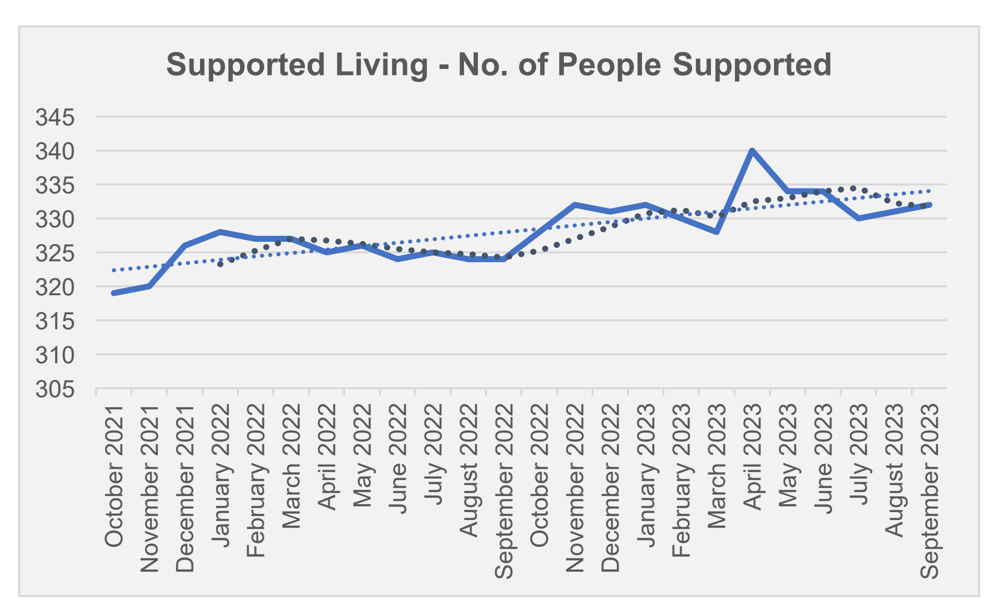
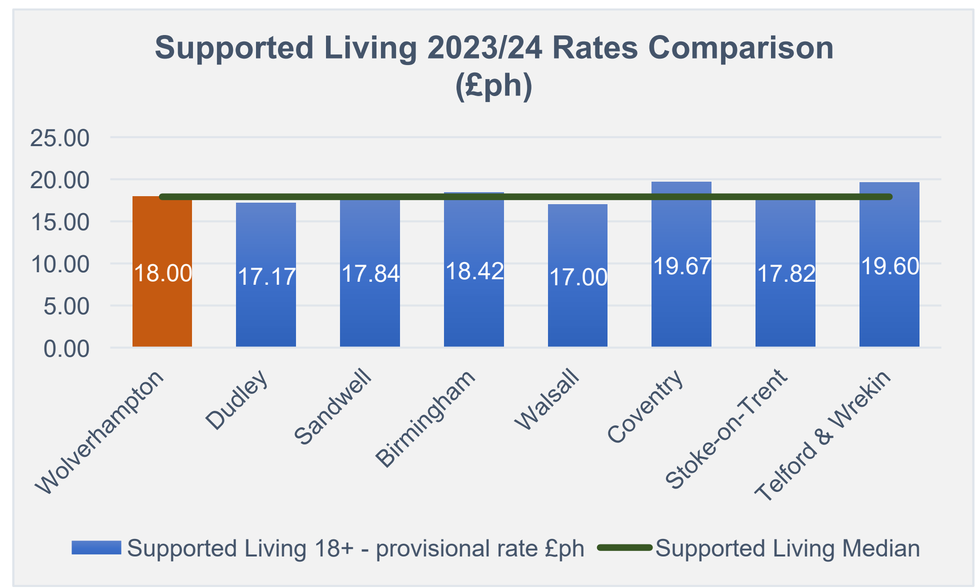
- Rates shown are provisional average costs

Supported Living





- Current Rate £18.00 per hour
- Historically uplifted as a composite rate of NLW and CPI Inflation on a 70:30 ratio for payroll and non-payroll costs respectively

CITY OF WOLVERHAMPTON COUNCIL

Quality Assurance Framework and Suspension Policy

Scrutiny

February 20 2024

Presenter:

Andrew Wolverson
Deputy Director of Commissioning & Transformation

Tracy Lockwood
Adults Quality Assurance Lead (Consultant)

Recommendations for action

The Scrutiny Panel is recommended to:

1. Comment on the Quality Assurance and Suspension Policy to be used as the Adult Social Care's quality assurance compliance system for:

   I. Providers with accommodation and/or established business offices in the City of Wolverhampton but are not currently commissioned to carry out services, must comply with assessment and monitoring requests within the policy and the provider failure procedure.

   II. Providers who are commissioned by ASC but do not have accommodation and/or business offices in the City of Wolverhampton, must comply with the suspension stipulations and processes.

2. Comment on the proposed policy to supersede the Policy on Suspension of New Business with Social Care Services (12/10/2015) and Care Provider Failure Procedures (March 2017) for Adult Social Care providers.

   I. Children's Social Care is exempt and will be reviewed in the future for possible implementation across commissioned providers.

Key Information for Scrutiny: QA Comparison

Current system:

1. 10 Quality Assurance & Contract Officers carrying out quality assurance duties was in place pre-2022 but there are now 4 quality officers
2. Assessments, and monitoring queries were not published as a policy
3. Monitoring visits, particularly for care homes, was a regular occurrence due to size of the teams
4. The suspension policy was only legally aligned to the Home Care Framework and no other contract or Ts & Cs for spot purchases, which could have led to a Provider legal challenge
5. Quality complaints, concerns and issues does not follow official processes relating to the council's complaints policy
6. Poor relationship management with providers post-covid

New system:

6. 1 x annual self-assessment based on business and policy related questions
7. 4 x quarterly self-assessments based on quality service area specific questions
8. A Quality Assurance & Suspension Board, headed up by the DASS
9. Digital based in-line with the national digital drive strategy through Microsoft Forms in preparation for CMLS
10. Desktop monitoring vs premises monitoring, though premises will be monitored based on high levels of quality risk
11. Scoring mechanism for each self-assessment to assess self-assessment returns and guidance for Officers that are new to quality assurance tasks
12. Collaborative approach through engagement and feedback

Purpose of a Quality Assurance Framework

A. **Accountability** for our Providers but also for the Council through evidence-based monitoring and a quality board

B. **Culture change** with between Parties by building relationships with our Providers through partnership and cooperation

C. Monitoring will be **fair**, as **objective** as possible using data and intelligence as our guide - self-assessments, scoring mechanisms

D. **Supporting** and **guidance** on quality assurance through best practice recommendations and prevention methods

E. **Understanding** and **transparency** of triggers that may lead to a Provider Failure and supporting them to increase quality of service

F. Reduce unnecessary **monitoring visits** that take up significant capacity, ensuring visits only occur as a targeted exercise when there is a serious concern or build-up of various concerns that cannot be monitored through a desktop exercise

G. **Pro-active** when there is a suspension in place to ensure it is lifted as soon as possible during reviews and rectifications

H. **Identifying risk** sooner through automated RAG and scoring mechanism leading to **Prevention** in escalating risk and provider failure (insolvency)

I. **Streamlined** and real time data updates enabling a more accurate analysis from Council systems as well as from the market from self-assessments and contractual outcomes and data outputs, in-line with local and national digital goals

Key Lines of Enquiry Themes – Care Home (example)

A ***safe*** service and living environment:

1. Safeguarding
2. Health and safety
3. Policies and procedures
4. Leadership and staffing
5. Recruitment
6. Medication
7. Accidents and incidences

Services that are ***effective*** in producing its desired outcomes for individuals:

8. Training
9. Food and nutrition
10. Access to NHS Commissioned Services
11. Physical environment

Are services ***caring*** and supportive to its cohort:

12. Care and support
13. Activities

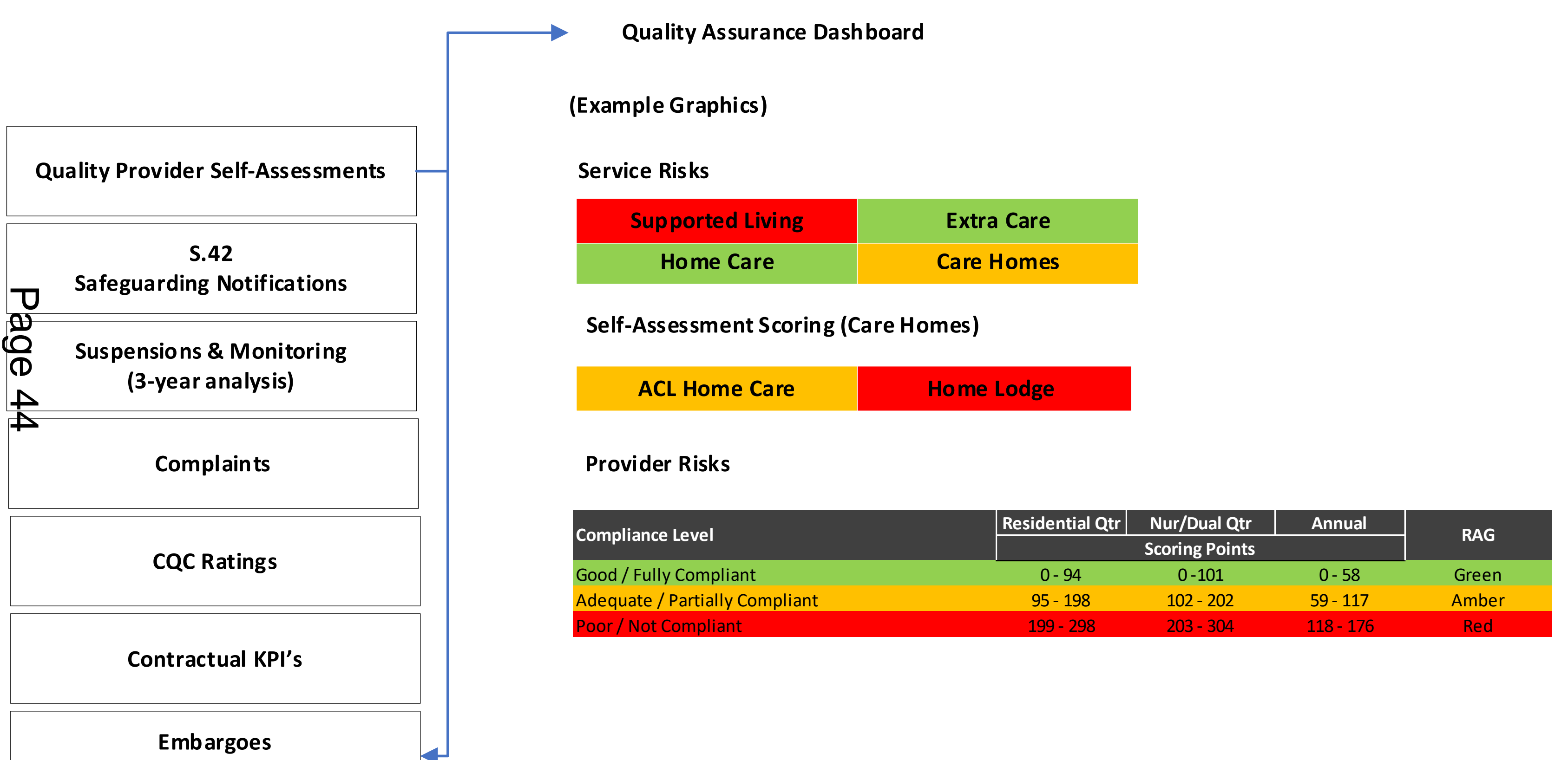
Are services ***responsive*** to the needs of its individuals, specialist cohort and enables a voice to all:

14. Care planning and risk assessments
15. End of life
16. Complaints and compliments

Ensuring a ***well-led*** service includes checks and balances are in place through assurance checks and scheduling and auditing tools:

17. Quality assurance and auditing

Quality Assurance Dashboard



Compliance Level	Residential Qtr	Nur/Dual Qtr	Annual	RAG
	Scoring Points			
Good / Fully Compliant	0 - 94	0 -101	0 - 58	Green
Adequate / Partially Compliant	95 - 198	102 - 202	59 - 117	Amber
Poor / Not Compliant	199 - 298	203 - 304	118 - 176	Red

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CITY OF WOLVERHAMPTON COUNCIL

Adult Social Care Quality Assurance Framework and Suspensions 2024 - 2034

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Document Control

Document Ref:		**Date Created:**	9th February 2024
Version:		**Date Modified:**	
Revision due			
Author:	Tracy Lockwood, Quality Assurance Lead	**Sign & Date:**	
Contributor (Self-Assessments)	Tracey Jones, Quality Nurse Advisor, Wolverhampton Place, ICB		
Commissioning Lead:	Andrew Wolverson, Deputy Director of Commissioning and Transformation		
Director Signatory:	Becky Wilkinson, Director of Adult Social Care	**Sign & Date:**	
Equality Impact Assessment (EIA):	Date undertaken:		
	Issues (if any)		

Change History

Version	Date	Description	Lead Name
1.0	20/10/2023	Initial draft	Tracy Lockwood, QAF Lead
1.1	01/12/2023	Second draft	
1.2	07/01/23	Third draft	
1.3	09/02/24	Fourth draft	

Review Date: January 2025

Contents

Glossary 4
1.0 Provider Quality Assurance Framework 4
Principles 5
Purpose 6
Strategic Aims 7
Applicable To 8
Responsibilities 8
2.0 Adult Commissioning Team (ACT) 9
Legislation 10
Partnership and Intelligence 12
Adult Social Care Quality Assurance Expectations 13
General, Business and Leadership 15
Key Lines of Enquiry – Residential / Accommodation 15
Home Care and Community Care 16
Monitoring Visits and Feedback 16
Supporting our Social Care Providers 17
3.0 Provider Failure Procedures (See Appendix 1 for Action Plan) 17
Unplanned Business / Service Failure or Closure 20
Rapid Unplanned Business / Service Failure or Closure 22
Programmed Failure and/or Closure of a Service or Business 24
Provider Failure Checklist 26
Provider Financial Sustainability 27
Initial Notification 28
Outcome of Review 28
4.0 Provider Suspension Stipulations 29
Principles 29
Scope of Policy 30
Stakeholder Map 31
Reasons for Suspension 32
Suspension Route 34
Types of Suspensions 35
Full Suspension 35

DRAFT

Partial Suspension 36
Emergency Suspension 37
Suspension Arrangements 38
Mutually Agreed Suspensions 38
Imposed Suspensions 39
Termination of New Contractual Relationships 40
Personal Budgets 41
5.0 Quality Suspension Process 41
Quality Assurance & Suspension Board 42
Commissioning Processes 43
Suspension Reviews 45
Reporting 46
Continued Suspension 46
Conditions 46
Completed Suspension 46
Challenge and Appeals 47
6.0 Definitions 48
Appendix 1: Provider Failure Action Checklist 50
Appendix 2: Memorandum of Understanding 55

DRAFT

Glossary

QAF	Quality Assurance Framework
CWC	The City of Wolverhampton Council
ASC	Adult Social Care
ACT	Adult Commissioning Team
PH	Public Health
ICB	Integrated Care Board
CQC	Care Quality Commission
KLOE	Key Lines of Enquiry
KPI	Key Performance Indicator
PST	Personalised Support Team
EMARF	Electronic Multi Agency Referral Form
RWT	The Royal Wolverhampton NHS Trust
LA	Local Authority
MASM	Multi Agency Safeguarding Meetings
CHC	Continuing Healthcare

1.0 Provider Quality Assurance Framework

1.1 A Quality Assurance Framework (QAF) is in place to evidence if services are providing quality services in line with the Care Act and the City of Wolverhampton's Adult Social Care Commissioning Team's compliance expectation outlined in this policy. This provides effectiveness and impact in securing safety whilst mitigating risk for people living in Wolverhampton.

1.2 The Council is responsible for assessing, planning and commissioning Adult Social Care (ASC) services to meet the needs of all within their area who are entitled to public funding, and those who are self-funding and carers, utilising our services to:

I. Organise procurement, commissioning and contract monitoring arrangements with providers in line with the Department of Health and Social Care guidance on effective commissioning for outcomes.
II. Require improvements in outputs and outcomes to be delivered as necessary and as specified in contracts with ASC providers.
III. Provide monitoring and improvement information to ASC providers.
IV. Support a market that delivers a wide range of sustainable high-quality care and support services that will be available to the community.

1.3 All future contracts will include stipulations for providers to adhere to the Quality Assurance and Suspension Policy. All placements and packages purchased without a

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contract or framework, will also be expected to adhere to this policy, depending on location of accommodation or main premises.

Principles

1.4 The Council's aim to build a robust, fair and cooperative quality assurance framework, is not only based on particular schedules, points in time to audit and inspect, or based on contract monitoring stipulations, but also to ensure that council officers, service managers and their staff are assessing and monitoring quality on a daily basis.

1.5 Adult Social Care quality assurance principles in the table below, when working with our marketplace are based on mutual goals that all parties must meet and follow:

Individual Voices	Individuals accessing services are the most important voices when understanding quality of their care. This includes their families, friends and representatives as well. That is why it is necessary to gain feedback and recommendations from those at the heart of these services.
Cooperation	Providing an objective and welcoming environment, where providers can be transparent and feel supported that their quality concerns, while ensuring 'individuals' are safe and in good quality services.
Leadership	Leading by example in our approach to delivering quality services, setting achievable and realistic outcomes, while providing professionalism.
Culture	A person-centred and strength-based approach, that is fair, equal, respectful and proactive.
Workforce	A workforce that is sustainable and professional with appropriate skills and qualifications. Sufficient training, supervision and assessment of induction programmes that include updated recommendations from regulatory bodies and educational organisations.
Participation	All providers are to participate in quality assurance activities: • All commissioned services • Non-commissioned services within Wolverhampton city borders This includes self-assessments, desktop exercises including requesting further evidence and monitoring visits
Outcome-based	Improving performance, mitigating risk and measuring impact is necessary to understand if commissioning and quality interventions are creating and enabling better quality.

Community Partners	The Council must not work in isolation, that's why our relationships with other authorities, the third sector and our market are so important in building pathways and partnerships.

Purpose

1.6 The social care market is not isolated from the impacts of global changes and crisis's, this includes the authorities that monitor the businesses supplying services. Changes in procurement legislation, a global pandemic and conflicts impacting the economical parameters over the past several years, requires changes in ways of working with our partners with the city and surrounding boroughs.

1.7 The new assurance approach in relationships with our service providers and the mechanisms to measure risk ensure a more robust and concise system, enabling the following outcomes:

A. **Accountability** for our Providers but also for the Council through evidence-based monitoring and a quality board

B. **Culture change** with between Parties by building relationships with our Providers through partnership and cooperation

C. Monitoring will be **fair**, as **objective** as possible using data and intelligence as our guide (i.e., self-assessments, scoring mechanisms)

D. **Supporting** and **guidance** on quality assurance through best practice recommendations and prevention methods

E. **Understanding** and **transparency** of triggers that may lead to a Provider Failure and supporting them to increase quality of service

F. Reduce unnecessary **monitoring visits** that take up significant capacity, ensuring visits only occur as a targeted exercise when there is a serious concern or build-up of various concerns that cannot be monitored through a desktop exercise

G. **Pro-active** when there is a suspension in place to ensure it is lifted as soon as possible during reviews and rectifications

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H. **Identifying risk** sooner through automated RAG and scoring mechanism leading to **Prevention** in escalating risk and provider failure (insolvency)

I. **Streamlined** and real time data updates enabling a more accurate analysis from Council systems as well as from the market from self-assessments and contractual outcomes and data outputs, in-line with local and national digital goals

Strategic Aims

1.8 City of Wolverhampton Council's 'Our City: Our Plan 2023/2024'[1] outlines a new approach to working with partners and local communities using a 'place-based' approach that uses a co-operative initiative to create resilience and sustainability. The plan sets out 6 priorities shaped by local people:

1) Strong families where children grow up well and achieve their full potential
2) Fulfilled lives for all with quality care for those that need it
3) Healthy, inclusive communities
4) Good homes in well-connected neighbourhoods
5) More local people into good jobs and training
6) Thriving economy in all parts of the city

1.9 The QAF enables the council and our providers, to work together with transparency and through collaboration. The aim is to identify concerns and issues to support the services to mitigate risk, ensure safety and prevent a provider having a 'suspension' in place.

1.10 Three cross cutting principles within the plan in clause 1.5 include climate consciousness, fairness and equality and for infrastructure to be driven by digitalisation. Digitalisation will include reporting and provider submissions through contract and quality monitoring forms and/or software platforms. All planning for new digitalised systems will include partner and provider support and engagement. Wolverhampton's digital strategy (2022) can be found at https://digitalwolves.co.uk/pdf/Digital-Wolverhampton-Strategy-March-2022.pdf

[1] City of Wolverhampton Council. *Our City: Our Plan 2023/2024*. Available at: https://www.wolverhampton.gov.uk/sites/default/files/2023-03/Our%20Council%20Plan%202019-2024%20%28Mar%2023%29.pdf

DRAFT

Applicable To

1.11 City of Wolverhampton Council employees in Adult Social Care and supporting departments.

1.12 Partner organisations and regulatory authorities including Integrated Care Board (ICB) and Care Quality Commission (CQC).

1.13 Providers that have a premises in the City of Wolverhampton, where the Council is the host authority, will be expected to complete self-assessments pertaining to their service area, will be expected to comply with the provider failure procedure and suspension process. Where the provider does not have a premises in the city borders, the Quality Assurance Framework's self-assessments and provider failure procedure is not applicable, but the suspension process does apply.

1.14 Providers that are hosted by another local authority, will be requested by the Adults Commissioning Team for quality assurance data and information from the relevant authority commissioning team where there is current ongoing packages and placements in place. As well as any provider under a new contract or framework commissioned after the publishing of the policy and any purchasing of a placement that is not aligned or attached to a contract or framework

1.15 Information and data can be shared with other regulatory authorities, officials and the Integrated Care Board (NHS).

Responsibilities

1.16 The Director of Adult Social Care has overall responsibility for ensuring that this policy is managed appropriately in accordance with these agreed standards, with delegated authority given to the Deputy Director of Commissioning and Transformation.

1.17 The Head of Commissioning is responsible for:

I. Directing and reviewing this standard.
II. Publishing and promoting the adoption of this standard.
III. Ensuring compliance with published standards, procedures, working practices and technology changes.

1.18 All City of Wolverhampton Council ASC and Public Health (PH) staff, internal and external Providers of social care services, and external agencies (sub-commissioned

DRAFT

services) working with those Providers are responsible for familiarising themselves with and ensuring that they comply with this standard.

2.0 Adult Commissioning Team (ACT)

2.1 The core duties of the ACT across the council are to contract manage and monitor adult social care services commissioned to providers based on the QAF, individual contracts and frameworks. Each Commissioning Officer and Quality & Contract Officer will oversee their service area while utilising this framework to ensure quality standards and compliance and follow the suspension process, as and when required.

2.2 One of the Council's core services is ensuring the wellbeing of children, young people, and adults, however in this policy the focus is on adult social care services. The ACT can provide guidance and recommendations on quality and safety to providers who work with Wolverhampton individuals that are funded by social care and public health or self-funded, however, this cannot be provided for business- and growth-related concerns.

2.3 There should be a differentiation of quality assurance assessments from contract key performance indicators submissions. However, the Commissioners may request to discuss any queries during contract monitoring meetings that could also include contractual discussions.

2.4 Complaints about the service from a commissioned or non-commissioned provider that resides in the City of Wolverhampton, should always be addressed with the Provider first through their 'complaints process'. Providers will be monitored on their complaints process and number of complaints through the quality monitoring process. If a professional, individual accessing a service, family member or general public do not agree with the final outcome of a complaint of a provider, post appeal, can then make a complaint to the Council through our 'Customer Feedback' webpage - https://www.wolverhampton.gov.uk/contact-us/customer-feedback.

2.5 The ACT work to drive up the quality of services within the City of Wolverhampton and ensure that there is a wide range of high-quality providers within Wolverhampton's demographics, whose services will ensure individuals are able to maintain a good quality life. The ACT monitors, reviews and supports the Wolverhampton's third-party sector, as well, ensuring that those who receive services are safe.

DRAFT

2.6 A key priority for improvement is safeguarding adults at risk of abuse and neglect. Wolverhampton has adopted the West Midlands regional adults safeguarding policy and procedures[2]. The Council seeks to identify issues before they become safeguarding matters and work with providers to improve standards before there is a serious incident. This is achieved through an effective quality assurance programme.

2.7 The objectives of the Senior Commissioning Officer, Commissioning Officer and Quality & Contract Officers are:

I. To support safe commissioning of social care services of Wolverhampton,
II. To be quality centred with an effective and innovative market base,
III. To monitor and respond to intelligence that may indicate that there is a problem with service delivery (i.e., service growth/decrease, quality and contract monitoring submissions, CQC reports, whistleblowers, complaints, safeguarding alerts, information from other agencies/Local Authorities),
    - this includes carrying out reviews and monitoring the progress of improvement and action plans,
IV. To offer challenge, support, information and guidance to services to improve the quality of services being delivered across Wolverhampton and consistently deliver effective outcomes which meet needs of people.

Legislation

2.8 The City of Wolverhampton Adult Commissioning Team are guided by the following institutions and policies that help shape safety of services provided to our individuals, equality to ensure good services are available to those in need and the most up to date technology and programmes.

[2] Warwickshire County Council. *Adult Safeguarding: Multi-agency policy & procedures for the protection of adults with care & support needs in the West Midlands.* Available at: https://www.safeguardingwarwickshire.co.uk/images/downloads/West-Midlands-Policy-and-Procedure/WM_Adult_Safeguarding_PP_v20_Nov_2019.pdf

DRAFT

2.9 Care Act 2014[3] includes the following Parts and Schedules that all providers and local authorities must adhere to:

Part 1 – Care and support
2 – Care standards
3 – Health
4 – Health and social care
5 - General

Schedule 1 – Cross border placements
2 – Safeguarding Adults Board
3 – Discharge of hospital patients with care and support needs
4 – Direct payments: after care under the Mental Health Act 1983
5 – Health Education England
6 – Local Education and Training Boards
7 – The Health Research Authority
8 – Research ethics committees: amendments

2.10 The Council has a number of duties and requirements under the Care Act 2014 to "promote individual well-being" and "promoting diversity and quality in provision of services". This includes a duty relating to "suitability of living arrangements" 1: 2: (h) and "has a variety of high quality services to choose from" 5:1(b).

2.11 City of Wolverhampton Council also has a duty under (s18) to meet the adult's assessed care and support needs (provided qualifying conditions are met).

2.12 The regulations that govern home care and residential social care for adults are set down in the Health and Social Care Act 2008 and associated Regulations, including;

- The Health and Social Care Act 2008[4] (Regulated Activities) Regulations 2014
- Care Quality Commission (Registration) Regulations 2009[5]

2.13 Statutory duties for public health were conferred on local authorities by the Health and Social Care Act 2012. Local authorities are, since 1 April 2013, responsible for improving the health of their local population and for public health services including most sexual health services and services aimed at reducing drug and alcohol misuse.

2.14 Care Quality Commission are the independent regulator of health and social care across England. All providers offering health and care services must be registered and inspected according to the regulator's fundamental standards[6]:

[3] UK Government. *Care Act 2014*. Available at: https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
[4] The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Available at: https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents
[5] The Care Quality Commission (Registration) Regulations 2009. Available at: https://www.legislation.gov.uk/uksi/2009/3112/contents/made
[6] Care Quality Commission. *The fundamental standards*. Available at: https://www.cqc.org.uk/about-us/fundamental-standards

DRAFT

- Person-centred care
- Dignity & respect
- Consent
- Safety
- Safeguarding from abuse
- Food and drink
- Premises and equipment
- Complaints
- Good governance
- Staffing
- Fit and proper staff
- Duty of candour
- Display of ratings

2.15 National Institute for Health and Care Excellence set out priority areas for quality improvement[7] and is an important source for services to utilise guidance around treating and managing specific conditions and diseases, technological appraisals and diagnostics.

Partnership and Intelligence

2.16 Collating intelligence and information will support the commissioning and quality assurance teams to early identify risk levels to enable early intervention and mitigation. Professionals, whistleblowers, individuals, families and the public are able to inform the council of any provider quality issues and complaints after the Provider complaints process has been exhausted via the Adults Commissioning Team's generic email address peoplequalityassurance.&compliance@wolverhampton.gov.uk.

2.17 Intelligence and information support the councils monitoring of services through:

- Gaining a holistic view of quality stipulations so we can recognise and learn from good practice and identify areas that require improvement,
- Being open and transparent across the partnership about risk and areas in need of improvement,
- Identifying priorities for the commissioning and quality teams and partners to feed into social care strategies,
- Evidencing continuous improvement over time, how long this takes and what is required to be successful.

2.18 Information sharing meetings between ICB, CQC, the Royal Wolverhampton NHS Trust (RWT) and the Council takes place at meetings and through email. Meetings are set

[7] NICE. *How to use quality standards.* Available at: https://www.nice.org.uk/standards-and-indicators/how-to-use-quality-standards

weekly, fortnightly or monthly, depending on levels of concerns on quality or urgent issues.

2.19 Joint visits can be carried out with partnering authorities and organisations who can provide specialist skills in nursing (ICB) and infection control and district nursing (RWT). This also includes Environmental Health, Housing, Fire Service, etc.

2.20 Safeguarding enquires will be carried out by the council's social work team and managed by a Multi Agency Safeguarding Meetings (MASM) if required. The Commissioning Officer in the FCT may be requested to contribute to the enquiry.

2.21 Quality monitoring of our services is outlined in clauses 2.24 to 2.29. Expectations, with all contract monitoring outlined in each individual contract service area.

2.22 ASC dashboards include brokering services, operations assessments, commissioning (spend and service area information) and quality assurance (self-assessments, CQC ratings, concerns and issues and risk) to enable council teams to access 'real time' data of their services.

2.23 NHS Tracker listing care home voids, that was created during the covid era to ensure commissioners to have intelligence on bed voids and purchasing opportunities.

Adult Social Care Quality Assurance Expectations

2.24 The Council expects that all providers have in place effective quality assurance and monitoring in compliance with their own regulatory and governance requirements. The Council will therefore seek assurance from providers through evidencing that they can demonstrate:

- ✓ Individuals are safe
- ✓ Services are innovative and effective
- ✓ Good practice is always adhered to

This will be enabled through quality assurance self-assessments of individual care services within the borders of Wolverhampton will be required to complete whether they are commissioned by the Local Authority or not.

2.25 Commissioning Officers and Quality & Contract Officers will monitor and assess regularly as standard practice, following the methodology in table below, to ensure

accuracy and objectivity in their daily tasks to ascertain risk levels and prevent provider failure:

Monitoring and assessing	Evidence and intelligence
	Consider and evaluate evidence against quality standards
	Review quality and identify anything that falls short, any strengths and weaknesses
Knowledge and improvement	Outline actions to address strengths, weaknesses and concerns
	Inform services of recommended actions to meet standards
	Follow up to ensure actions and mobilisation, its impact and outcomes

2.26 Clauses 2.33 to 2.39 include the social care quality assurance themes that providers will be requested to answer through a list of overarching quality assurance queries through annual reviews (business related, all services) and quarterly assessments (service specific, some services do not apply) based on CQC's KLOE (key lines of enquiry) themes through a self-assessment document or software platform. Quality assurance queries will vary depending on service type, particularly residential and accommodation services and those carried out in the individual's home and/or community. Officers may then request evidence to the answers through documentation or pictures. Where significant or serious risk has been identified, a premises monitoring visit (if applicable) may occur with other authorities included as a joint visit (i.e., ICB or RWT).

2.27 Quality performance outcomes will be used as a guidance to best practice, however, if improvements to outcomes are not achieved over a reasonable period of time, this could lead to targeted monitoring, or suspension.

2.28 Any quality or performance KPIs listed in your current service contract/s that are duplicated or similar to the new quality questionnaires listed in this policy, will be omitted from your contract monitoring submission request.

2.29 Quality expectations may be revised based on changes to legislation, demography, individual's needs, demand and crisis situations.

DRAFT

General, Business and Leadership

2.30 General information regarding the business information including registration details, service type, accommodation type and latest CQC ratings. Information requests will vary depending on service type and whether the business is CQC rated.

2.31 A request for relevant insurance policies, GDPR guidance and health and safety company and any action plans.

2.32 Management and leadership structure, retention and stability.

Key Lines of Enquiry – Residential / Accommodation

2.33 Clauses 2.33 to 2.38 relates to those services that are residential (i.e., nursing and residential care homes), supported living and sheltered housing.

2.34 A safe service and living environment:

1. Safeguarding
2. Health and safety
3. Policies and procedures
4. Leadership and staffing
5. Recruitment
6. Medication
7. Accidents and incidences

2.35 Services that are effective in producing its desired outcomes for individuals:

8. Training
9. Food and nutrition
10. Access to NHS Commissioned Services
11. Physical environment

2.36 Are services caring and supportive to its cohort:

12. Care and support
13. Activities

2.37 Are services responsive to the needs of its individuals, specialist cohort and enables a voice to all:

DRAFT

14. Care planning and risk assessments
15. End of life (not applicable to Supported Living Accommodation)
16. Complaints and compliments

2.38 Ensuring a well-led service includes checks and balances are in place through assurance checks and scheduling and auditing tools:

17. Quality assurance and auditing

Home Care and Community Care

2.39 The eleven themes below relate to those services that are carried out in the individual's home environment or a community setting where the individual does not reside (i.e., home care, reablement, day opportunities, advocacy, prevention, etc).

1. Safeguarding
2. Policies and procedures
3. Leadership and staffing
4. Recruitment
5. Medication
6. Accidents and incidences
7. Training
8. Care and support
9. Care planning and risk assessment
10. Complaints and compliments
11. Quality assurance and auditing

Monitoring Visits and Feedback

2.40 All services will receive written feedback from the Adults Commissioning Team after annual and quarterly quality assurance self-assessments and/or on premises monitoring visits. Unannounced monitoring visit for care homes, supported living and sheltered housing will take place when there is a high risk of quality and safeguarding concerns.

2.41 Services that are carried out in the individual's home or community where there is no accommodation required, will be required to complete desktop self-assessments only and will only require an office monitoring visit in the case of a serious concern of data protection and record keeping.

Supporting our Social Care Providers

2.42 The Adult Commissioning Team are at hand to provide guidance and to aid and support improvements and change to rectify quality issues, particularly in times of crisis to help prevent provider service failure and business closure while ensuring an acceptable level of service and safety. The commissioning team must not provide financial and business advice to managers or proprietors. Officers within the authority must be objective when assessing the quality of their services and not interfere with the free market.

2.43 As part of a quality improvement initiative, Providers are encouraged to develop their own action plans and rectification schedules that should be shared with the Council that may not part of the official suspension process, however, lack of completion of rectification in a timely and reasonable manner could lead to an escalation of quality concerns.

2.44 Where a suspension of a provider on the grounds of quality contribute to a financial failure of the business, the Council will not accept liability and shall have no obligation to contract with a provider if that provider is unable or unwilling to offer an acceptable quality of service. Where the imposition or impact of suspension be such that the provider threatens or is forced into closure, Provider Failure Procedures in section 7 will apply.

2.45 The Provider Failure Procedures will also apply where the Council takes a decision to offer service users a move away from a specific service, and this leads to the provider making a decision to withdraw from the market.

3.0 Provider Failure Procedures (See Appendix 1 for Action Plan)

3.1 Where care Providers exit the market in a way that adversely impacts on their ability to manage the closure of the service in a planned way, these procedures aim to give the Council and Providers clear guidelines on how any failures can be mitigated and managed to minimise the risk to people who use our services.

3.2 Where there are concerns about a Provider’s sustainability in the market, the Head of Commissioning and Senior Commissioning Officer for their specific service area, will set up a Service Failure Working Group and will be responsible in leading to:

DRAFT

1. Identify where a provider is displaying signs of failing and agree the approach as a support and guidance on improvements.
2. Review the progress and take actions if targets are unmet or unsatisfactory.
3. Agree on a deadline in each case, where support is withdrawn, and the Council makes the decision to relocate residents/users of the service if it's a care home or accommodation based or move to another service if home care or a community package.

This group may will include stakeholders listed in clause 4.11 below, as well bring other CWC services into these conversations to provide guidance and support, including Legal Services.

3.3 For all the closure situations addressed in this section the Council has various responsibilities and legislative measures to adhere to regarding their duty of care to individuals in receipt of care across Wolverhampton. That each Provider has a 'business continuity' plan in place to ensure the continued provision of their service to individuals in case of a crisis, financial failure or force majeure. This includes all social care Providers within Wolverhampton borders as a 'host' authority, whether or not they are currently commissioned by the local authority.

3.4 Section 48 Temporary Duty on Local Authority of the Care Act place a requirement on local authorities to ensure there is continuity of care in the event of care provider business failure. The City of Wolverhampton Council is required to meet needs regardless of:

a) whether the relevant adult is ordinarily resident in its area,
b) whether the authority has carried out a needs assessment, a carer's assessment or a financial assessment,
c) whether any of the needs meet the eligibility criteria.

The Care Act 2014 imposes legal responsibilities for Local Authorities to oversee the financial stability and ensure that the needs of people continue to be met if their care provider becomes unable to carry on providing care because of business failure.

3.5 If the individual is not ordinarily a resident in Wolverhampton, the Council is still required to meet the needs, and we must do the following:

DRAFT

a) meet the needs of the individual which are being met under arrangement made by another local authority, co-operate with that authority,
b) must meet all or part of the cost of which was paid for by another local authority by means of direct payments, co-operate with that local authority,
c) may recover from the other local authority the cost it incurs in meeting those needs of the individual or carer[8]

3.6 The Council has a duty under the Civil Contingencies Act 2004 to have appropriate emergency plans in place to prevent, reduce, control and/or mitigate the effects of emergencies in the local area. The local authority has a duty of care for individuals within the borough to ensure they are cared for during an emergency incident and in the recovery phase from an incident and has a responsibility to identify vulnerable individuals and premises during an emergency to ensure they are given additional consideration and care.

3.7 The Council has a responsibility for ALL residents within the City that are moved to another service regardless of whether they are funded by the Council or not. All Care Homes that Wolverhampton Council places residents in are required under their contractual terms to have fit for purpose business continuity plans in place. The Council has the right to request and scrutinise plans as they see fit.

3.8 The business or service will be expected to use their continuity plans to manage any emergency that arises. If the continuity plans fail to deal with an emergency situation, then the Council may need to step in to assist as the duty of care for residents still remains with an emphasis on:

1. Contingency planning
2. Identifying needs and suitability when moving
3. Timelines for moving
4. Settling in a new environment

3.9 The Council recognises that the best way to mitigate business failure is to prevent this from happening through early dialogue with Providers. A number of measures can be taken to delay or eliminate the closure prior to any final closure:

[8] Care Act2014. *Section 48: Temporary duty on local authority.* Available at: https://www.legislation.gov.uk/ukpga/2014/23/section/48/enacted

- Provider must give sufficient notice to the Council and engage in an early dialogue.
- Understanding financial viability
- Suspension history and number of safeguarding referrals and concerns

All the above would need to be outlined in an action plan and risk assessed by the identified project lead within Commissioning. These procedures provide a framework, which outlines the management responsibilities in relation to the unplanned closure of a social care service or business.

Unplanned Business / Service Failure or Closure

3.10 Whether or not there is a robust action plan produced by the Provider during an unplanned failure leading to closure, there is still likely to be an interim period in a serious emergency where all individuals will be moved to another service is being established. During this interim period the local authority will work with heath partners and other agencies to ensure the safe transition period of the individuals. This plan outlines the arrangements to responding to this type of incident.

3.11 The following situations may arise which could lead to the failure, unplanned closure or temporary closure of a care home in Wolverhampton. During such cases, the Provider will have contingency plans already in place to mitigate risk and must always inform the Director of Adult Social Care, Deputy Director of Transformation of Commissioning and the Head of Commissiong, as well as the CQC Lead. The following failures include:

A. Business Continuity Failure – this includes a failure that affects the entire business such as loss of staff, loss of heating, water, electricity, etc.
B. Major Incident – fire or flood a failure that affects the entire business and where emergency services must be contacted in the first instance.
C. Failure of Facilities – when one specific service area fails and may not require a full closure of moving of individuals.

3.12 Understanding and mitigating risks of all individuals affected:

RISK	MITIGATION

1. An emergency relocation of vulnerable individuals will produce an unacceptable and dangerous risk to individuals.	All Parties must ensure that relocation is done in a safe manner through planning and understand the individual’s health and social care needs.
2. Individual’s health condition(s) may deteriorate due to the shock of an unplanned move.	A swift move that provides extra care on relocation to provide any rehabilitation and reablement requirements, or nursing services on hand that may support deterioration and shock.
3. Poor emergency plan which has not considered individual preference.	At point of relocation has been established as must, the social care team discusses choice of new placements and planning move with the individual and their families.
4. Potential lack of suitable beds available with other local providers.	Agree short-term placements until a permanent location can be established.
5. Financial risks to securing alternative provision.	Contingency budget planning within the authority and negotiation with new Providers.
6. Lack of communication leading to actions taking place without the Council’s knowledge	Council to ensure that early engagement takes place and officers are part of the planning process.
7. Potential negative media coverage may lead to increased alarm and anxiety.	Provider and Council work together to agree on communications plan and content.
8. Reputational risks of Provider and purchasing local authority.	Ensuring a robust plan is actioned and reviewed daily.

DRAFT

Rapid Unplanned Business / Service Failure or Closure

3.13 A business or service could have to close at short notice following a CQC compliance inspection which identifies that residents are at risk, or the service is in breach of the regulations. Alternatively, a business or service could have to close at short notice because of circumstances that consider the business either no longer financially viable to support individuals or because there has been a breach in Health and Safety that could put residents at risk leading to a temporary closure.

3.14 If a business or service closure is unavoidable, the registered or service manager, local authority and health commissioners must try to manage the pace of the closure in order to reduce the risk to the wellbeing of its individuals. It would be expected that although the service will have a rapid closure that there will be sufficient time to put measures in place to ensure individuals in receipt of service are relocated temporarily in a new home or service until rectifications to the service has taken place or that a permanent new residence or service is established. This will need a co-ordinated response between the Local Authority, ICB (if applicable) other Local Authorities and the Care Provider. This plan outlines the arrangements in place to respond to this type of event.

3.15 The following situation may arise which could lead to the rapid failure/closure or temporary failure/closure of a business or service in Wolverhampton:

- Bankruptcy of the service provider,
- CQC inspection may result in a 28-day closure notice,
- Breach of safety law resulting in enforcement action, including a prohibition,
- Notice, such as the HSE, Environmental Health or Fire Service.

3.16 Understanding and mitigating risks of all individuals affected:

RISK	MITIGATION
1. The moving of vulnerable individuals over a short period of time is a dangerous and unacceptable risk which the rapid home failure/closure presents.	Commissioning and Provider management team working closely with Personalised Support Team (PST) and social work teams to match placements with individuals' specific needs.

2. Individual's health condition(s) may deteriorate due to the stress of a potential move.	A swift move that provides specialist care on relocation to provide any rehabilitation and reablement requirements, or nursing services on hand that may support deterioration and shock. Planning with our Health partners to ensure continuity of care.
3. Poor emergency plan which has not considered individual's preference.	At point of relocation has been established as must, the social care team discusses choice of new placements and planning move with the individual and their families. Where there isn't a support system outside of the home for the individual, independent advocacy must be considered.
4. Potential lack of suitable beds or packages with another home care service available with other local providers.	Agree short-term placements until a permanent location or service can be established.
5. Financial risks to securing alternative provision.	Contingency budget planning within the authority and negotiation with new Providers.
6. Lack of communication leading to actions taking place without the Council's knowledge.	Council to ensure that early engagement takes place and officers are part of the planning process.
7. Potential negative media coverage may lead to increased distress and anxiety.	Provider and Council work together to agree on communications plan and content.
8. Failure/Closure of an establishment which operates numerous services, or the failure/closure of more than one establishment at the same or similar time.	Inform other LA's that maybe affected by failure/closure.

DRAFT

9. The Landlord, where applicable, may change and / or a change of property use may be enforced.	Immediate engagement with new Provider to understand future service and business intentions.

Programmed Failure and/or Closure of a Service or Business

3.17 A service or business may have to close under a structured and programmed closure because of circumstances that deem it to be no longer financially viable to support individuals or a business decision is taken by the owner to close for a range of professional or personal reasons.

3.18 Where closure relates to financial concerns, the Provider will most likely appoint an Administrator for the responsibility of managing the closure particulars and its assets while the service or business is being sold. The individuals may stay with the service or may change due to changes in registration and/or fees. The Council will be involved in the process, however, as the business is private, it is the businesses responsibility to ensure any individuals are relocated or change to the new service except for council funded residents. This may change if the relocation or service change exercise fails, where the Council will then step in to ensure all individuals are safely relocated or the service is reallocated as the host authority and responsibility under the care act. All circumstances must be coordinated between the Provider, Council and in cases of a nursing home closure, the ICB.

3.19 Understanding and mitigating risks of all residents affected:

RISK	MITIGATION
1. Moving individuals to a new home and their belongings or service may pose an increased risk to their well-being, so all measures should be taken to ensure any closure is dealt with in a planned and systematic way.	All Parties working together to ensure each individual's specific condition/s are considered and needs are met during transition. This must also include family, friends, and representatives during this process. Where there isn't a support system outside of the home for the individual, independent advocacy must be considered.

DRAFT

2. Further financial deterioration of the administration process if local authorities stop placing individuals in the affected businesses facilities. This is not in any stakeholders' interests, as further deterioration will make negotiations more difficult and lengthier, increasing the uncertainty for individuals, families and staff.	Provider and Council ensure that the services continue to offer the same levels of care for each individual's needs and renegotiate fees, if applicable. If registration changes, then the Provider and Council work together to ensure moving of individuals and belongings to appropriate accommodations or services.
3. There may be risk of heightened anxiety amongst public, staff and trade unions over the uncertainty of the services future.	Planned communications between the Provider and Council in a public forum, whilst keeping individuals, families, representatives, staff and unions updated on all new occurrences and planned timelines.
4. The Council has no responsibility in regard to the staff or union/company issues which remain a private sector concern. However, the Council must ensure that individuals, families and representatives are reassured that social welfare of vulnerable people will remain our highest priority.	The Council work with the Provider to ensure regular communications and updates.
5. There is likely to be an inaccurate perception that a service or business is going into administration will result in the service being closed and people relocated or reallocated.	Parties to reassure individuals, families, representatives and the public regarding planning and any significant changes.
6. There is a financial risk that the administrator will increase fees which would put an increased financial pressure on commissioners and self-funders.	Council to start financial arrangements at beginning of process with the aim of renegotiations, if applicable.

DRAFT

7. The service staff may be aware of their employers' difficulty and are therefore likely to be concerned about their jobs.	Provider communication updates with staffing whilst keeping the Authority in the loop regarding staff levels.
8. The primary risk of a programmed failure/closure situation is staff migration together with the inability to replace, consequently reaching critical staffing levels.	See mitigation #7.

Provider Failure Checklist

3.20 Quality of care and financial sustainability is crucial to the market. When a business financial position deteriorates, the quality of care it provides tends to be reduced. Poor care can be a sign of financial problems which can lead to lower levels of training for staff and consequently to lower levels of care quality.

3.21 The Adults Commissioning Team will take the lead to analyse the financial sustainability on an on-going basis. A cooperative approach working as a partner with our Providers will encourage and enable transparency regarding financial stability whilst allowing the Council to provide guidance regarding increase in quality of services and understanding contracts and frameworks for their service area. This, in turn, will increase likelihood of good performance and overall stability across services.

3.22 There are various causes of business failure, which include:

- ✓ Financial,
- ✓ Regulatory, including safeguarding,
- ✓ Operational, mismanagement,
- ✓ Unforeseeable circumstances that prevent the provider fulfilling the contract or unexpected circumstances,
- ✓ Strategic exits from the market to reshape business objectives.

3.23 Commissioners will watch for signs of business failure that do not tend to happen in isolation but appear through various issues within the business. Some examples include:

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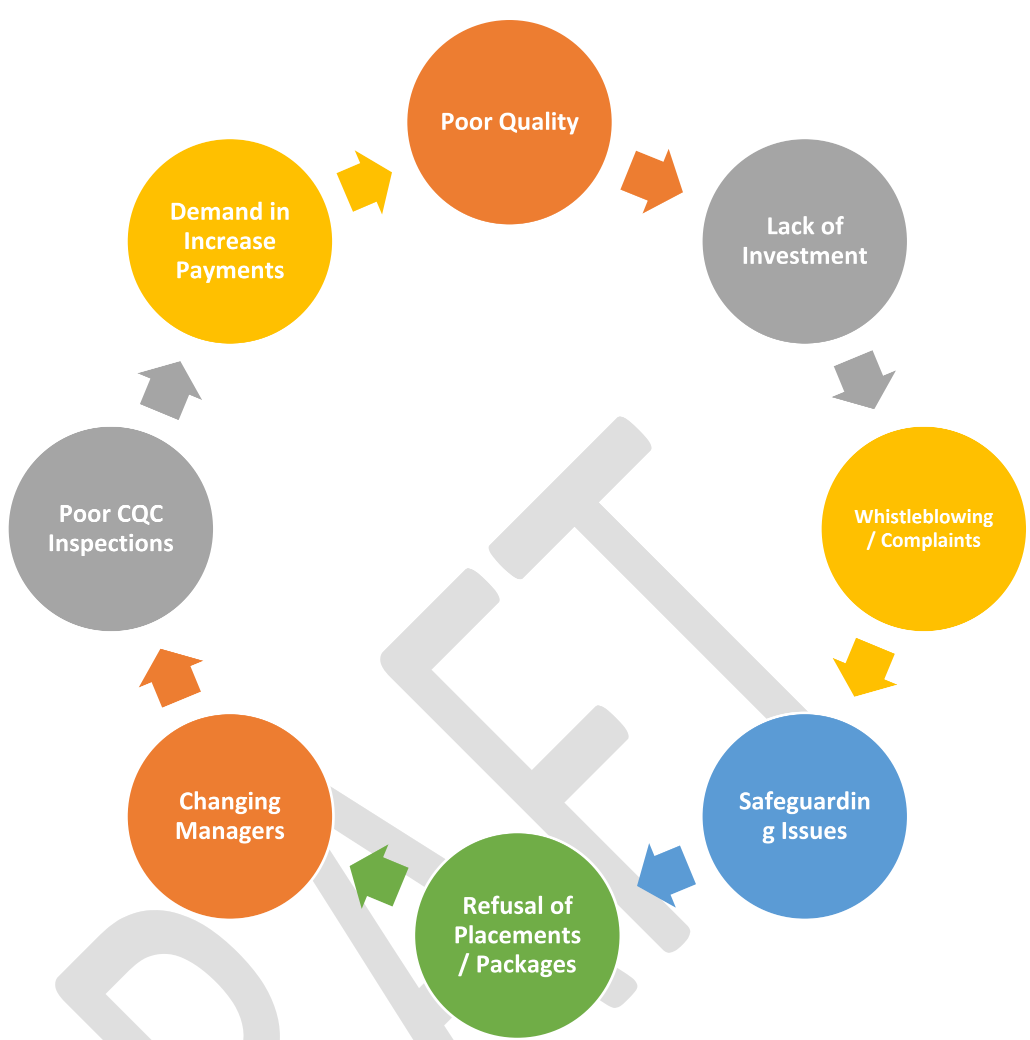

3.24 When these signs appear, it is within the Council's and Providers interest to work in partnership to mitigate further deterioration through transparency, communication, action planning (see Appendix 1 for action checklist), and breathing space for rectification, development and transformation, if the business is deemed salvageable.

Provider Financial Sustainability

3.25 If a social care Provider declares or the Council identifies that they are having financial difficulty under no circumstances should any financial assistance be made to the provider without the prior approval of the Section 151 Officer in conjunction with Legal Services. Nor should any Officer enter an agreement that is or may be classed as a loan at nil interest.

This procedure should be read in conjunction with the Financial Procedure Rules contained within the Council's Constitution.

3.26 This duty applies temporarily until the local authority is satisfied that each person's needs will be met by a new provider or in a different way. The local authority may make a charge for arranging care and support in these situations.

Read the whole factsheet here: https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets#factsheet-10-market-oversight-and-provider-failure

Initial Notification

3.27 The Head of Commissioning from the Adults Commissioning Team will notify the following Officers, immediately, with details of the Provider, provision type, commissioning particulars including spend, number of packages/placements, any contractual arrangements and safeguarding and quality concerns:

- Director of Adult Social Care
- Deputy Director of Commissioning and Transformation
- Head of Operations (Adult Social Care)
    - Who will notify the Section 151 Officer
- Head of Procurement
- Head of Legal Services
- Head of PST

3.28 The Head of Commissioning will assess current risk of the Providers business viability and a timetable of likelihood of business failure. And will also be the first point of contact with the Provider and person of responsibility within the council. The Head of Commissioning will set up a meeting with the Provider to discuss the financial position and include leads in Operations and Procurement, with each lead requesting various bits of information from the Provider through the commissioning Lead.

3.29 The Commissioner will communicate to the Provider that it is their responsibility to seek alternative funds to support their cash-flow and that under no circumstances should the Provider be offered financial assistance by Council Officers without the prior approval of the Section 151 Officers in conjunction with Legal.

Outcome of Review

3.30 The Commissioner will lead in developing a report on any meetings with the Provider with evidence and documentation and will ensure that the Provider has evidenced they have explored all options to raise funds to mitigate failure/closure and detail current

DRAFT

financial position of the service or business and reasons for current position. This report must be developed in conjunction with Operations, Legal and Procurement and must consider likelihood of failure.

3.31 The report is then submitted to the Director of Adult Social Care, Section 151 Officer, Legal Lead and Deputy Director of Commissioning and Transformation, as well as to the Quality Assurance and Suspension Board as information.

3.32 If the Leads agree that that the Provider has explored all options for raising funds and financial assistance is still required to ensure the safety and wellbeing of individuals in receipt of care, then proposals should be drawn up by the Head of Commissioning with the Operations Lead. Options such as making payments in advance for services could be explored with the exception of a loan at nil interest.

3.33 Any options must be presented to the Section 151 Officer, DASS and Legal Lead for approval and any payment must be made to provider with written approval from the Section 151 Officer. Legal (if considered necessary) shall draw up documentation detailing the arrangements to be signed by both the Provider and Legal Representative for the Council before any payment is made.

Any payments made must be in line with Financial Procedures Rules contained within the Council's Constitution.

3.34 The Head of Commissioning will hold regular meetings with the Provider to monitor progress and will update officers on progress and any concerns. If at any point of this process it becomes evident that the Provider is at risk of failure the Provider Failure Procedures will be activated

4.0 Provider Suspension Stipulations

Principles

4.1 City of Wolverhampton Council is committed to ensuring that our individuals receive social care services that are the best quality, is innovative and costed fairly, while meeting regulatory guidance measures, regardless of the setting. The Council will act to promote good practice and to protect our individuals against inadequate or substandard care for social care funded eligible and self-funder individuals.

DRAFT

4.2 As a Council, we are committed to encouraging new businesses across social care and aim to work collaboratively and in partnership with our providers to ensure services are quality assured and contractually compliant.

4.3 'Provider suspension' means that the Council will not agree to fund new placements or may agree to move individuals to other services, if deemed appropriate, and within the service area's contract. Particularly if the service is rated 'inadequate' by the regulating authority.

4.4 The Council recognises that a suspension of new business, places providers at a commercial and reputational risk through the suspension process, however the Council's main priority will always be the safety of vulnerable individuals.

4.5 The Council will therefore take decisions to impose or remove suspensions by the Director of Adult Social Care or above or when delegated authority is granted to the Deputy Director of Transformation and Commissioning. The decision will be taken on the basis that suspension (or lifting of suspension) is a proportionate response to the concerns identified and in the best interests of present and potential individuals.

4.6 Service risk levels will have varied trigger points that could lead to a suspension based on level of risk, number of complaints and issues, vulnerability of the resident cohort and impact of the suspension on the individuals, i.e., suspension where a termination of contract is required could be phased or staggered due to moving of individuals, services, and dwelling.

Scope of Policy

4.7 This policy applies to all contracted providers of Adult Social Care. It includes residential care, home care, supported living, extra care and all other contracted services and grant-funded activities across all ages. The policy also applies to 'in-house' services provided by the Council.

4.8 For services within Wolverhampton borders that are not commissioned currently by the Council and quality issues and concerns have been report and identified, or where the provider is unwilling to cooperate with a quality assurance assessment or monitoring visit, the Council may wish to embargo the service.

4.9 The policy will apply to individual care services. In exceptional cases, where there is evidence that the provider or group (parent company) operates multiple care services

and that there are systemic issues across the organisation(s), the policy can be applied at the level of the service provider (i.e., to all services owned and operated by the provider or group).

4.10 This policy deals only with issues arising from quality of care, safety, and competency; as well as issues arising from other aspects of delivery, for example failure to meet key performance indicators, are dealt with in the individual service contracts and/or framework.

Stakeholder Map

4.11 The following list details all the key stakeholders who need to be considered and involved whenever this plan is activated:

Director of Adult Social Care for their service areas will make the strategic decisions for the Council in response to the event, focusing on strategy, reputation, finance and legal.

Deputy Director of Commissioning and Transformation within Adults or Children's social are service areas can be delegated to make Service Director level decisions outlined in the quality assurance and suspension policy.

Head of Commissioning (Adults) will take a strategic overview in terms of market development and have the main responsibility for supporting the Senior Commissioning Officer, Commissioning Officer and Quality & Contract Officer and the review team. The Head of Commissioning also has the responsibility to ensure that all current information is communicated to external and internal partners including Procurement, Operations and Legal Services. The Head of Commissioning also convenes and chairs the Quality Escalation Meetings and have overall responsibility for the management of the suspension process and the development of any Action Plan agreed with the service, escalating concerns where appropriate.

Senior Social Work Manager (Adult) Multi Agency Safeguarding Hub will chair and co-ordinate a Multi Agency Safeguarding Meetings (MASM), as and when needed. The participants of this meeting will consider and make recommendations on actions arising from adult services safeguarding concerns and investigations.

Operational (Social Services) teams will have responsibility for individual Care Management and Assessment. Operational teams have a significant role to play in

DRAFT

reporting concerns and/or changes in service quality, including improvements, to the Adults Commissioning Team. Operational team members may also be asked to undertake adult services safeguarding investigations.

Providers and their management team have a responsibility to work co-operatively with council staff, the Regulator (where applicable) and other partners in order to improve the service to a good level.

Procurement identifies how the service is contracted and what the terms of the contract are.

Integrated Care Board (ICB) Commissioner will review those users of services who are Continuing Healthcare (CHC) funded.

ICB Quality Nurse Advisors (QNA) will work with services, particularly those residential services with nursing, to improve clinical standards within the services to an acceptable level. QNAs will take the lead in carrying out investigations into breaches of clinical standards, for example 'root cause analysis' of G3 and above pressure areas and STEIS reviews.

Matron – Planned Care Adult Community and District Nurses with the Royal Wolverhampton NHS Trust (RWT) will work with all health and social care services across Wolverhampton providing nursing care to those services that do not have a registered nurse in situ.

Senior Infection Prevention Nurses with the RWT is a specific Public Health funded roles working directly with care homes, supported living, and home care services, supporting good infection prevention practice, managing incidences through education and auditing. **This named role may change based on future funding provisions.*

DRAFT

Reasons for Suspension

4.12 Suspension of new business will be considered in cases where the service in question:

- Is unable to provide a safe, good quality standard of care for its individuals,
- Is or is likely to put individuals at risk by failing to maintain a safe, good quality care service,

- Is, or is at the risk of, putting individuals at risk because the service is unable to meet the needs of its individuals including for specialised support where appropriate,
- Is rated as 'high' risk using the Quality Assurance Dashboard risk register scoring mechanism, for failure to complete 'quality assurance self-assessments' and/or no significant improvement of their quality of service for at least 12-months,
- Is the subject of enforcement action by the Regulator,
- Has multiple safeguarding issues or a significant allegation which leads to a serious criminal investigation,
- The service had not responded appropriately or co-operated with an enquiry then consideration would be given to suspend the service,
- Home Care ONLY - Is in receipt of a 'Notice' or 'Notices' as defined by clauses 21.4 to 21.8 under Termination of Default of the Framework Agreement for the Provision of Home Care Wolverhampton 2019.

4.13 New business will be suspended in all cases where the service in question:

- Is of overall 'inadequate' quality in the judgement of the Regulator (CQC etc),
- Is placed in 'special measures' by the Regulator or is the subject of a Regulatory Management Review Meeting (MRM) where the recommendation is that 'special measures' are appropriate,

unless and by exception the Director of Adult Social Care and/or Deputy Director decides that there are compelling reasons not to suspend.

4.14 Suspension may be continued, once it is approved, where the service:

- Has been required or requested to make improvements have not been met, quality assurance KPI's continue to be non-compliant, there has been an increase in service complaints and/or issues, and where an action plan from the provider has been requested and has yet to complete any action plan,
- Requires time to demonstrate that any improvements are sustainable,
- Requires time to embed new staff, leadership, structures or working practices,
- Refuses to make changes to improve the service,
- Is ineffective at making or sustaining improvements,
- Where an inspection or review by the Regulator results in the service being placed in 'Special Measures'.

DRAFT

4.15 Suspension may also be continued where concerns arise from any source, including safeguarding referrals, monitoring and/or quality assurance activity and other Local Authority suspensions.

Suspension Route

4.16 The decision to recommend suspension of new business can arise through one of the following routes:

a) Safeguarding Adults
b) Information from the relevant Regulatory body
c) Adults Commissioning Team
d) Public Health (PH) Governance arrangements
e) Mutual arrangements with/information from other Authorities and partner organisations

4.17 A recommendation under (a) and (b) above will be made either by a Multi Agency Safeguarding Meeting (MASM) which is chaired by the Senior Social Worker from MASH.

4.18 A recommendation for an emergency suspension under (a) and (b) above may be made directly to any appropriate the Director of Adult Social Care by a Deputy Director, Head of Service, Senior Commissioning Officer, Commissioning Officer, and Senior Social Worker.

4.19 A recommendation under (c) and (d) above may arise through a Quality Escalation Meeting, or as a result of the outcome of a formal inspection by a regulatory body (for example, the Care Quality Commission, or their equivalents for services in Scotland, Wales and Northern Ireland).

4.20 Where a service is placed in 'special measures', the Council will fully suspend business with the service or continue with any existing suspension until such time as 'special measures' are removed unless and by exception the Director of Adult Social Care and/or Deputy Director of Transformation and Commissioning, decides that there are compelling reasons not to suspend (i.e., if a service has been independently reviewed by the Wolverhampton team and found to be acceptable). The Director and/or Deputy Director may also decide to move towards termination of existing contractual relationships.

DRAFT

4.21 Commissioning Officers may also recommend suspension under (d) and Public Health (PH) governance officers under (e) as a result of evidence obtained during monitoring, or in the event that a service has failed to make improvements under an action plan, leaving the individuals at risk.

4.22 Another LA or partner organisation may make a decision to suspend new business or terminate contractual relationships with a care service that they have lead responsibility for (f). The Council will support that decision and will also suspend business with the service as appropriate unless and by exception the Director of Adult Social Care or Deputy Director of Transformation and Commissioning decides that there are compelling reasons not to suspend (as above).

Types of Suspensions

Full Suspension

4.23 A full suspension is where the Council decides not to contract any new business with a particular service or provider. Full suspensions are designed to support services with a 'breathing space' to rectify issues they cannot evidence safe and good quality of care and where they may receive assistance from the Council and others (including the ICB and RWT as appropriate) to become safe, competent and compliant.

4.24 Any decision to impose a full suspension will be monitored regularly by the Families Commissioning Team for their service areas and reviewed monthly during the Quality Assurance & Suspension Board from the date of decision. The decision will be taken by the Director of Adult Social Care and/or Deputy Director of Transformation and Commissioning during the mentioned board meeting, following recommendation by the teams or structures.

4.25 If a full suspension is in place for longer than 3 months with very few improvements being made, the Director/s may decide to extend the suspension with the aim that if all improvements have not been made within 12 months of total time of suspension, a termination of new contractual relationships could be recommended. The Quality Assurance & Suspension Board may, alternatively, mandate additional support or monitoring activity.

4.26 A full suspension may be lifted when the Director/s are satisfied that the service has made improvements such that the Council can be confident that the service is safe,

competent and compliant and likely to remain so. The Director/s will take into account recommendations and evidence provided.

4.27 The Director/s, where a decision to suspend was the result of either:

- A decision by a partner agency or other LA, or
- As a result of an ‘inadequate’ rating by the Regulator, or
- As a result of ‘special measures or enforcement action by the Regulator,

in exceptional circumstances, lift a full suspension before the Regulator or partner agency alters their assessment of the service’s quality or reduce to a partial suspension as appropriate, if there is compelling evidence to do so.

4.28 The decision to lift a full suspension may include the imposition of conditions, including, where appropriate, those of a ‘partial lift’ where continuing restrictions are placed on new business.

Partial Suspension

4.29 A ‘partial suspension’ is a decision to restrict new business by limiting the number of new placements/packages within a specific time period or limiting the total number of individual placements.

4.30 Suspension can be recommended through any of the suspension routes. The decision to impose, agree or lift a partial suspension must be taken to the Quality Assurance & Suspension Board.

4.31 Partial suspension may also be appropriate in restricting new business to part of the service (i.e., one unit or specialism) but not to another.

4.32 Partial suspensions are usually used following improvements to a service that is in full suspension. In this case it is typically used to test admission assessments and readiness, ability to meet individual’s needs and the sustainability of improvements made within an action plan.

4.33 Example of partial suspension:

I. The service is limited to X new placements in each calendar month for the next X weeks or months.
II. The service is limited to X number of new admissions to a total of Y individuals.

DRAFT

III. The service is limited admission of individuals other than those diagnosed with dementia, or with needs assessed as ‘with nursing’.

IV. A service with both residential and nursing units may have their ‘with nursing’ unit(s) suspended, but not their ‘residential’ unit(s) or vice versa.

4.34 Any decision to impose a partial suspension will be monitored regularly by the Adults Commissioning Team for their service areas and reviewed monthly during the Quality Assurance & Suspension Board from the date of decision. When conditions are met, i.e., if a service is limited to X new placements, the decision to suspend the service will not be reviewed until X new individuals have been admitted.

4.35 The outcome of a partial suspension review can be:

I. To fully lift the suspension and remove all restrictions on new contracting.

II. To extend the time period and/or restrictions of the partial suspension (with or without variation, depending on the evidence).

III. To re-impose a full suspension of new business (if the evidence shows that individuals remain at risk or experience poor quality of service).

Emergency Suspension

4.36 Emergency suspension is a type of imposed suspension used pending investigation of allegations of abuse where individuals are alleged to be at risk of, or have suffered, serious harm including those where it is appropriate to involve the Police, or where there are clear and immediate doubts about the ability of a service to continue to operate, i.e., where there is evidence that the proprietor of the service is experiencing financial difficulties impacting on the safety of individuals.

4.37 Emergency suspensions can be approved on a time-limited basis or pending a specific outcome, i.e., the conclusion of a Police investigation or the production of evidence that the proprietor can meet financial obligations.

4.38 Emergency suspension must not be used where the normal processes of full or partial suspension would safeguard individuals from abuse; there must be evidence that individuals are at immediate risk, that the concerns are sufficiently serious to require an instant, precautionary response, and that emergency suspension is a proportionate, appropriate response.

DRAFT

4.39 Emergency suspensions can be approved on a 'without prejudice' basis and should be signed off by the Directors/s within 24-48 hours.

4.40 A Director/s may approve an emergency suspension without reference to other colleagues. The decision must be notified to any other appropriate Director by the Adults Commissioning Team's Head of Service and/or Senior Commissioning Officer and to other colleagues and partner organisations.

4.41 The approval of an emergency suspension will be reviewed within 4 weeks. The review will involve the Quality Assurance & Suspension Board. The review will recommend either:

- Impose a suspension, either full or partial, or
- Agree a 'mutually agreed' suspension, either full or partial, or a lift the suspension.

4.42 Further decisions regarding suspensions for services following an emergency suspension will be taken in accordance with the relevant section of this policy.

Suspension Arrangements

<u>Mutually Agreed Suspensions</u>

4.43 Social Care service providers may elect to request a 'mutually agreed suspension'. Mutually agreed suspension is typically a response to a care quality issue/s that the service has recognised and is working towards resolving, i.e., lack of a registered or service manager or staffing levels to meet new admissions or packages.

4.44 Agreement of a mutually agreed suspension implies a positive management response to difficulties that a service is experiencing.

4.45 A 'mutually agreed suspension':

I. Applies to all placements, not just those funded by the Council,
II. Is 'owned' jointly by both the Council and the service provider. Once agreed, a suspension cannot be lifted without the agreement of both parties,
III. Can be full or partial,
IV. Must be recorded in a 'Memorandum of Understanding' see Appendix 2.

DRAFT

4.46 The decision to accept a mutually agreed suspension is taken by the Deputy Director of Transformation and Commissioning and reported to the Quality Assurance & Suspension Board for comments. The Deputy Director may impose conditions or specify a set of circumstances in which the suspension can be lifted or varied (for example from a full to a partial).

4.47 Mutually agreed suspensions are notified to other LAs and partner organisations in the same way as imposed suspensions.

4.48 Where a suspension is mutually agreed, the service itself will be responsible for informing individuals and other relevant parties (i.e., representatives, relatives) as appropriate.

4.49 There is no requirement for the Council to seek mutually agreed suspension before considering whether an imposed suspension is appropriate.

Imposed Suspensions

4.50 An 'imposed suspension' is where the Council takes an independent decision to cease to commission new business with the provider. This decision is not 'owned' by the service or provider.

4.51 Typically, the decision to impose a suspension is taken when the service does not give confidence that a mutually agreed suspension is a sufficiently robust response to identified concerns. This may be due to the service not accepting the Council's findings or evidence, does not agree with the officers' amendments and additions to an action plan, or is unable or unwilling to propose a mutually agreed suspension.

4.52 Suspension may also be imposed if, in the opinion of the Director/s or Board, the provider or service does not have the management structure, and/or the capacity necessary to deliver sustainable improvement/s to the service.

4.53 An 'imposed suspension' relates only to new council funded placements or new business activity. Existing placements are not affected. The right of other partner agencies, individuals funding their own care or other local authorities to use the service is not affected. The Council may, at its discretion, also choose to exempt planned respite or short-term emergency care for existing individuals. This will be considered on a case-by-case basis.

4.54 Where a suspension is imposed, CWC and other LA's will be informed on a weekly basis. Providers will be requested to officially inform individuals, their families or representatives with the communications signed-off by the Council within 48-hours of suspension. This also applies to lifting, or partial lifting of suspensions. If a suspension is politically sensitive or under exceptional circumstances, the Council will draft communications and send to relevant persons, partners and organisations.

Termination of New Contractual Relationships

4.55 Termination of new contractual relationships will be considered where the Council feels that after a time of suspension of 12 months or more, and improvements have not been achieved from an action plan and all other reasonable efforts to support the service to improve to an acceptable quality level have been exhausted.

4.56 Termination of a contract will require the involvement of Procurement and Legal Services to ensure that it is done according to the correct contract clauses.

4.57 This means that the Council will no longer agree to new placements or any new contractual relationship with the service (or, exceptionally, the provider) for a minimum of 3 years.

4.58 The Council shall consider a 'termination of new contractual relationships' with the service in the event that:

- a service spends more than 12 consecutive months in suspension, or
- a service spends more than 18 calendar months in any three-year period in full suspension, or
- a full suspension is re-imposed following a partial lift of suspension, or
- a service is fully suspended more than three times in a rolling three-year cycle.

4.59 The Council may also, at its discretion, consider terminating new contractual relationships with all services operated by the provider or group where there is evidence that problems are systemic (i.e., in the case of a provider or group with multiple services, evidence that more than one service is unsafe).

4.60 The decision to terminate new contractual relationships will be taken at Director level during a Quality Assurance & Suspension Board meeting.

DRAFT

4.61 In the event of a termination of new contractual relationships, where the proprietors establish a different legal entity but with the same, or similar, management, board or partnership make-up, the Council reserves the right to consider whether any change in legal makeup or status also constitutes a change in provider. Therefore, if a company owned by Miss A, Mrs B and Mr C. become subject to a 'termination of contractual relationships' and decide to re-register as a different legal entity, the Council would look at the individuals behind the company and apply the sanction if the directors continued in post.

4.62 The decision to terminate new business will be shared with partner agencies, other LAs and existing individuals, including relatives and representatives.

Personal Budgets

4.63 Nothing in this policy should be taken as applicable to arrangements made by individuals under personal budget arrangements, which include Direct Payments and Individual Service Funds. The Council and its partner organisation would strongly advise individuals not buy services from services (or providers) which are in suspension, but personal budgets are a matter for individual choice. The Council or its agents will continue to administer personal budgets and to respect individual's wishes if they wish to purchase or retain the services of a suspended organisation.

4.64 The Council (Operational Teams) or its agents will inform individuals if a service that they purchase through a personal budget arrangement is placed in suspension and/or if the Council terminates new or existing contractual relationships with a provider.

5.0 Quality Suspension Process

5.1 This suspension policy relates to quality assurance compliance only. Individual contracts and frameworks are managed and monitored through separate performance KPI's. The Adults Commissioning Team assess and manage provider quality and contractual compliance through various tools and partner meetings. Safeguarding's will be considered during this assessment as well as quality and concerns are raised via a variety of sources including, but not limited to:

a) Social Services Operational Teams
b) Other health professionals
c) Whistleblowers

DRAFT

d) Service Managers
e) Service Staff
f) Individuals, families, and representatives

5.2 FCT manage and facilitate the provider quality escalation and suspension process, drawing in professional guidance and accountability by Council internal stakeholders and other authorities within Wolverhampton borders and the western Midlands region.

Quality Assurance & Suspension Board

5.3 A significant revision to the previous Policy on Suspension of New Business with Social Care Services (2015), includes a quality and suspension board, led by the Director of Adult Social Care (Chair) and includes the Deputy Director of Transformation & Commissioning (co-Chair) and core participants including:

- Heads of Social Care
- Senior Commissioning Officers

As well as guest participants and teams as and when requested pertaining to each escalated case:

- Commissioning Officers
- Quality and Contract Officers
- Social Workers
- Procurement
- Legal

5.4 The board provides accountability and scrutiny to any suspension recommendation and decision along with robustness to the adherence of the processes included in this policy. The board is accountable to the Adult Leadership Team, Corporate Leadership Team, CEO of the City of Wolverhampton and Portfolio Holders and Councillors.

5.5 The board has agreed ‘terms of references’ on how the board conducts new cases, reviews of cases, decision mechanisms and quorum stipulations. The board meets with a standardised agenda and records minutes, actions and decisions.

5.6 A Quality Escalation Brief is submitted for each individual case and presented by the Senior Commissioning Officer, outlining areas for concern, evidence with chronology and

DRAFT

recommendations. Based on the case content, the board will discuss the recommendation and make a decision on the following outcomes:

a) Ongoing monitoring – where risk is present, but does not mitigate suspension at that time but warrant increased monitoring and queries
b) Improvement plan - where suspension is not warranted but improvements have been identified
c) Suspension – type and arrangement
d) Continued suspension
e) Lifting of suspension
f) Termination of contract

All briefs are to be kept in a central commissioning folder for future audits and reviews. These could be used for future evidence and consideration to exclude providers from future tender exercises, or to be added to the Central Government Debarment list. Debarment list

5.7 A suspensions list with reason will be sent to relevant internal and external stakeholders, including other local authorities and will be published on the City of Wolverhampton website for individuals who are self-funders. Services that are not directly commissioned by the Council may also be 'Embargoed', if deemed appropriate by the regulatory bodies or the board.

Commissioning Processes

5.8 Individual concerns raised by commissioners are considered on a case-by-case basis. Raising an individual concern may not automatically lead to monitoring activity in all cases. Examples of concerns include:

1) 'emergency' (for example, specific allegations of abuse or complaints), and/or
2) systemic' (for example, where the service cannot demonstrate that the staff and leadership team are adequately qualified, trained and experienced in order to meet individuals' identified needs, and/or
3) 'operational' (for example where an action plan has been in place for more than three months, the service has not shown adequate improvement and remains of inadequate quality).

5.9 The Quality and Contract Officer will analyse and collate all provider data and evidence and alert the relevant service area Commissioning Officer of a 'service of concern',

which may lead to an 'Escalation Meeting' with the Senior Commissioning Officer who may deem that a case is serious enough to submit to the board. with a 'Quality Escalation Brief'.

5.10 The Commissioning Officer may request additional information to the 'brief' from Operations, Procurement, etc, before submitting 7-days prior to the next board meeting.

5.11 Where an emergency suspension is required and there is no immediate board meeting scheduled, the commissioning officers can step outside of the Quality Assurance & Suspension Board process and submit a Provider Escalation Brief to the Chair and co-Chair via email to provide input and sign-off on recommendation.

5.12 Where ongoing monitoring only is agreed, the Commissioning Officer may be requested to provide updates on the case at a future meeting with timelines.

5.13 If an improvement plan without suspension is required, the Commissioning Officer will request a 'quality monitoring meeting' with the provider to discuss concerns and an 'improvement plan' with agreed timelines between Parties.

5.14 If a new suspension has been agreed at the board or through an emergency suspension, the Commissioning Officer develops an official letter to the provider outlining the following:

1) Quality concerns, issues and events
2) Evidence with chronology – i.e., monitoring visit report, safeguarding investigation details and outcome, etc
3) Suspension terms and conditions
4) Request for an 'action plan' to rectify listed issues within 2 weeks from date of 'official letter'
    a. 'action plan' template will be included with 'official letter' via email
5) Commissioning Officer and Quality & Contract Officer review and agree or amend and return 'action plan' within 7 days

5.15 Any quality issues and events that take place post initial action plan will be reported with an updated 'brief' with recommendations, to the board at the next meeting. This may lead to a full suspension, if the initial suspension was 'partial' or a 'mutually agreed' suspension.

DRAFT

5.16 If a ‘full’ suspension is agreed by the board to be ‘partially’ lifted due to rectification of various tasks in the action plan, the Commissioning Officer will outline the revised suspension terms in an ‘official letter’ with recommendations timelines for completion of actions. The Quality & Contract Officer then notifies the council’s placements and operations team of the suspension terms. Any online suspension notifications are also updated for public viewing.

5.17 If a suspension has been fully lifted, the provider will already have been in discussion with the commissioner on this potential option and an ‘official letter’ will follow stating the suspension has been fully lifted from the date of the letter. All notifications will be carried out as stated in clause 9.16.

5.18 Where a suspension is not applied, but issues have been identified that require rectifying, the Commissioning Officer notifies the provider in an official letter outlining these concerns and may request a monitoring visit in person on premises or desktop questionnaire.

5.19 Any communications to the provider regarding a new suspension, change of suspension or lifting, the individuals and their families must also be informed by letter from the Adults Commissioning Team.

Suspension Reviews

5.20 The Commissioning Officer with the Quality & Contract Officer will officially review in a meeting with the provider any ‘action plan’ within 8 weeks of suspension. A review will include a quality monitoring meeting, premises monitoring visit as well as additional information request. Evidence for any rectifications will be requested with stipulated timelines for submission via email or agreed at a meeting or during a monitoring visit.

5.21 For safeguarding and protection issues, the Operational team may request to review period to 8 weeks.

5.22 These timetables are flexible and can be extended to take account of partner organisations’ policies, for example the NHS ‘Serious Incident’ protocol stipulates a 45 day time limit to complete their investigation.

DRAFT

Reporting

5.23 Results of commissioning activity is to be fed back to the Senior Social Work Manager as well as the Quality Assurance & Suspension Board during their monthly meetings.

5.24 Safeguarding and protection issues to be reviewed by the Multi Agency Safeguarding Meetings chaired by the MASH Manager.

5.25 Urgent or emergency updates on deterioration of the quality of a service, will be reported across all council departments along with partnering authorities and other local authorities by the Families Commissioning Team.

Continued Suspension

5.26 Where no quality improvements have been made within 3 months, the Commissioning Officer, may request through the Quality Assurance & Suspension Board governance process, for a further 3 months suspension period, to allow time for the provider to make the necessary improvements to the service. The officers can offer support and provide guidance to services during this time, within a reasonable capacity.

5.27 Where improvement is made, the officers can recommend a full or partial lift of suspension during the next board meeting.

5.28 Where full suspensions are partially lifted, the officers will review the service within 8 weeks of official lifting. If improvements are sustained, the officers may recommend full lifting of the suspension.

Conditions

5.29 The service may have conditions imposed upon it during a suspension, such as notifying the commissioning team if a new resident (howsoever funded) is admitted to the service, or if the provider ownership or manager changes, or if there are significant changes in the service's operational management or processes.

Completed Suspension

5.30 Following the full lift of a suspension, services will remain under review with the Senior Commissioning Officer and will at least have one follow up visit and/or meeting to ensure that improvements are sustained within 12 months of the decision to lift the suspension.

DRAFT

5.31 Follow up visits will be unannounced and may include partnership authorities (ICB, RWT and other LA) and may be at any time or on any day.

Challenge and Appeals

5.32 The following decisions below, can be challenged by the service or provider by an appeal in writing to the Director of Adult Social Care:

- approve a request to suspend (either fully or partially),
- extend a period of suspension,
- move to a partial (as opposed to a full) lift of suspension,
- terms and conditions attached to a partial lift of suspension.

5.33 Challenges or appeals must be made within 28 days of official notification of the decision to suspend.

5.34 The decision to suspend new business will stand during the process of appeal to ensure the safety of Wolverhampton individuals.

5.35 An appeals investigation must be carried out by a Director from another Council department that has not been a part of the original decision process.

5.36 An 'appeal' may be upheld on the following grounds:

I. Inaccuracy on issues and evidence – a challenge to the issues and evidence that formed the basis of the request to suspend at any of the decision-making stages of approval, and/or

II. Failure to follow due process – evidence that the steps in this policy were not properly adhered to by the Council, and/or

III. Bias or improper conflict of interest – evidence that the process was adversely or materially:

   a. influenced by any person including officers of the Council who were unreasonably prejudiced against the proprietor or service,
   b. influenced by any person who may reasonably be thought to have a 'conflict of interest' and failed to disclose such a conflict of interest or having declared a conflict of interest failed to withdraw from the decision making in respect of the service.

5.37 Appeals will not be upheld if they rely on the grounds that:

DRAFT

I. the decision to impose a suspension of new business will directly or indirectly harm the viability of the service or provider, or damage the reputation of the service or provider, and/or

II. The CQC or other regulatory body or other non-regulatory inspection or monitoring visit or review has inspected or reviewed the service and reached a different overall conclusion or rating, and/or

III. The proprietor's or service's opinion on the interpretation of the available evidence is more favourable to the service than the collective view of the Quality Assurance & Suspension Board.

5.38 Appeals will be acknowledged by the Commissioning Officer within 5 working days and a response within 21 working days from when the Council receives the appeal.

5.39 Appeals will be reviewed at the next Board meeting, where the Commissioning Officer submits an 'Appeal Suspension Brief' to include provider challenge with reasons and evidence. If the appeal outlines various complexity of evidence that is out of the ordinary, then more time may be needed to do a thorough investigation. The appellant will be advised if more time is needed and when they can expect to receive a response from the Council.

5.40 Where an appeal is upheld by the Board, the Council will ensure that this is acknowledged in its correspondence with partner organisations, individuals, relatives, and representatives, etc.

5.41 Where an appeal fails, the appellant may make a complaint under the ASC complaint's process.

6.0 Definitions

6.1 Adult Social Care (ASC) includes residential care homes with and without nursing, supported living accommodation, home (domiciliary) care, extra-care providers, funded projects, day opportunities, very sheltered housing and other providers supplying a health and wellbeing service to Wolverhampton residents.

6.2 The City of Wolverhampton Council is also a signatory to "Multi-agency Policy and Procedures for the Protection of adults with care and support needs in the West

DRAFT

Midlands[9]". The Policy and Procedures were implemented April 2015 and reflect the changes in the Care Act 2014. It confirms the establishment of a statutory Adult Safeguarding Board.

6.3 The ratings established by 'The Fundamental Standards in Adult Social Care' replace the 'Essential Standards of Quality and Safety[10]' published by the Care Quality Commission. These are based on the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

6.4 'Practice Guidance' means any document issued by Wolverhampton City Council, the Care Quality Commission, other partner organisations (for example, the ICB, the Health and Safety Executive) or relevant industry bodies (for example the Royal Pharmaceutical Society, Skills for Care or the Nursing and Midwifery Council) to interpret the 'Fundamental Standards' and guide ASC providers in the practical delivery of the service, or evidence based guidance where the 'Fundamental Standards ' do not offer a practice standard in a particular area.

6.5 'Good quality' means compliance with the applicable regulatory standards and such other requirements, minimum quality standards and practice guidance as the Council shall from time to time specify.

6.6 'The Contract' means the contract between the Council and the care service provider.

6.7 'Provider' means the legal entity responsible for service provision. It includes the group of companies where a holding company has, for example, incorporated each service as an individual legal entity and registered each legal entity separately.

DRAFT

[9] Policy and procedures for professionals. Available at: https://www.wolverhampton.gov.uk/health-and-social-care/adult-social-care/protecting-adults-abuse/policy-and-procedures-professionals
[10] The fundamental standards. Available at: https://www.cqc.org.uk/about-us/fundamental-standards

Appendix 1: Provider Failure Action Checklist

In the event of any failure/closure of a Provider in Wolverhampton, the following Action Checklist should be followed.

	ACTIONS	RESPONSIBLITY
Identify Commissioning Lead and Team	▪ Establish a Commissioning Lead who will co-ordinate, the relocation of individuals of the service. ▪ Identify resource requirements and, if necessary, bringing in new resources. ▪ Establish the use of existing social care teams or an identified dedicated team. ▪ Identify safeguarding officer and Mental Capacity Act/ Best Interest Assessor/ Independent Mental Capacity Advocate (IMCA) Involvement. ▪ Joint working with ICB on health-related issues. ▪ Determine a meeting schedule. ▪ Determine any additional members that need to be present.	Commissioning Lead
Initial Response and Tasks	Arrange to meet with Provider senior managers and agree a closure date whenever possible. Confirm the final closure date. Provider to provide an up to-date list of individuals accessing the services, family and representative including funding source (CHC/Self/Other).	Commissioning Lead Provider Allocated Manager Provider Allocated Manager, CWC Social Care Team

DRAFT

	A letter to be sent to all individuals accessing the service, family and representative by CWC Social Care Team explaining the position. Where there are individuals of the service from another local authority, the Commissioning Lead will ensure that they are informed of the impending closure. Engage with the CWC Care Management Team, other LA, etc, and work with the Provider to ensure that these workers have open and free access to the service during the relocation or reallocation period. Establish realistic timescales and allocate tasks. Establish what support is available to enable individuals to visit alternative homes and users of the service to another Care Provider. Arrange to meet with Provider and agree a closure date and timelines of relocation or reallocation of individuals whenever possible.	CWC Social Care Team Commissioning Lead CWC Social Care Team, Commissioning Lead and Provider Allocated Manager Commissioning Lead CWC Social Care Team Commissioning Lead, CWC Social Care Team and Provider Allocated Manager
Individual Service Users	Identify individuals who have complex needs who may need to be prioritised and Mental Capacity Act/ Best Interest Assessor/Independent Mental Capacity Advocate (IMCA) involvement. Are there any individuals of the service who may wish to relocate or be reallocated, earlier rather than late. Obtain contact details of the individual's main relative/carer and GP (where necessary). Ensure that there is full consultation and involvement in the relocation or reallocation process. Allocate support staff/key workers to individuals and their families.	Provider Allocated Manager and CWC Social Care Team

DRAFT

	Ensure that every individual of the service has access to a professional key worker who is qualified to undertake their assessment and care planning. Agree and develop a care plan for every individual of the service, in conjunction with them. Establish the extent of involvement with the individuals of the service of their family, friends and/or carers and work with them to ensure the best outcome for them. Agree with the individuals of the service the degree that family, friends or carers are involved in identifying an alternative home or community service and associated arrangements. Stress the importance of protecting friendship groups in the decision making. Ensure that self-funding individuals are offered the support of a Social Worker and all of the above considerations - though they are free to decline support. Obtain the individuals of the service consent to transfer of information and records. Review care plans as their quality will vary considerably, particularly where failure/closure has been enforced because of care practices.	
Operations / Human Resources / Legal Services / Business Intelligence Team	Identify those individuals of the service funded through CWC. Identify individuals of the service funded by other LA's. Identify self–funders and Health funded individuals of the service. Establish level of legal fees to be paid.	Operations Team CHC Team and Provider Allocated Manager Operations Team

DRAFT

	Calculate overall cost of relocation or reallocation of services. CQC advice on the use of care staff in Independent Homes. Establish immediate use of buildings, if large numbers of individuals cannot be relocated or reallocated to another service. Provide an up-to-date list of vacancies through PST for care homes and a list of home care Providers with capacity. Neither the Council nor the ICB will assume responsibility for the Provider during a period of administration, where it remains a private sector business under the administrator. Should the situation deteriorate to such a level where the Provider is transferred to receivership, financial advice will be established to support any takeover. Any and all costs associated with CWC or ICB support will be recharged, on a cost recovery basis, to the administrator. Seek HR / CQC advice on the retention of Provider staff through the use of short-term or casual contracts with CWC recruitment agency if temporary accommodation has to be delivered by the Council.	Operations Team CQC Lead CWC Social Care Team and Housing PST Operations Team, Legal Services, ICB and Provider CWC HR, CQC Lead and Provider
Relocation / Reallocation of Service	In the unlikely event that a full relocation or reallocation to a service is necessary: CWC Social Care Team has a duty to undertake individual assessments/re-assessments, including Mental Capacity Act (MCA) assessments where appropriate and refer for a IMCA service. ICB also has a duty to undertake assessments. This process is likely to be extensive and complex and may also give rise to reconsideration of health and joint funding with the Council. Identify the types of staff that would be required to undertake these	Care Management and Assessment team. (CMA)

DRAFT

	assessments and should the need arise on a large scale then this work will need to be prioritised. Where possible every effort should be made to fulfil personal requests such as home location or keeping groups of friends together; however it must be recognised that this may not always be possible. And consider relocation storage of belongings, items of furniture etc.	
Communications	CWC will prepare and maintain a local stakeholder briefing summarising the response strategy which will be circulated to elected members, MP's, GPs, Commissioners and the Provider Managers. CWC, in conjunction with the ICB, will prepare and distribute via the Provider Manager, a letter of reassurance to all individuals, their families, carers and representatives, which will include assurances about our planning, response strategy, commitment to continuity of care and a contact point should they have further questions or concerns. All agencies/departments will refer all media enquiries to the Communications Team. CWC will adopt a reactive stance to the media, in that we will not issue any press release but will respond to direct enquiries on a case-by-case basis. This may be reviewed, directly by the Director of Adult Social Care, if information circulated by local media becomes excessively derogatory. If requested, this plan may be summarised to the media in the form of our response strategy, however, will only be released in full under a Freedom of Information request. CWC will work closely with any agencies/partners to ensure that any information is shared with providers, individuals, families. Representatives and staff.	CWC Communications Team

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Appendix 2: Memorandum of Understanding

Between

(Insert name of provider)

And

City of Wolverhampton Council

In re: (Name of Service)

MUTUALLY AGREED SUSPENSION OF NEW BUSINESS

1. Purpose
   i. To establish the way the parties to the Memorandum of Understanding (hereafter referred to as the "Memorandum") will work together to improve the quality of service and/or safety of residents/service users at (insert name of service).
   ii. To clarify the roles and responsibilities of the parties to the Memorandum.
   iii. The parties are (insert name of provider) ("the provider") operating (insert name of service) ("the service") and City of Wolverhampton Council ("the Council").

2. Background
   i. The Council is committed to ensuring that its citizens experience the best quality social care, regardless of the setting.
   ii. The Council recognises that social care is a partnership with others and welcomes co-operation with service providers to improve the quality and safety of the services that it purchases.
   iii. The provider has recognised that the quality and/or safety of the service is in need of improvement. In order to give a 'breathing space' to allow for progress to be made against an agreed action plan, this document records that a suspension of new business has been proposed by the proprietor and agreed to by the Council.

3. Mutually Agreed Suspension
   i. A 'Mutually Agreed Suspension' is an agreement between the Council and the proprietor that no new service user will be admitted into the service, no matter what the funding source or referral route.
   ii. This agreement applies to all service users,
   OR
   The service agrees restrictions on making new admissions as specified below.

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iii. The agreement requires the consent of both parties to terminate. The agreement shall not be considered terminated or varied by either party without the express written agreement of the other party.
iv. The provider agrees that the council can share details of this agreement with its partner agencies, including but not limited to other local authorities, the Clinical Commissioning Group, the Care Quality Commission and the Royal Wolverhampton Trust.
v. The suspension does not affect those people funded by Wolverhampton that already use the Service, or those people who are scheduled to receive respite as part of an agreed care package (delete as appropriate).

4. Reasons for Decision
   i. The reasons for this decision are:

(State reasons)

5. Next Steps
   i. An Action Plan agreed with you will be monitored by (insert name), a member of the Quality Assurance and Compliance (QA&C) team who will also offer advice and guidance about how to achieve the necessary improvements. The action plan is attached as Annex A. (delete as appropriate)
   ii. The Action plan is a 'living document' which may be reviewed, revised, completed or expanded as further evidence becomes available. The action plan is a report by exception; the absence of a particular action does not imply that there are no other issues that the service may need to consider or address. The service manager must continue to take responsibility for all aspects of the service, not only those which are being monitored or on which a QA&C team member has given advice.
   iii. To monitor progress, we will gather information and data from different people and sources including:
      a. People who use the Service and those who are important to or support the individual (e.g., relative, advocate)
      b. The Manager and staff of the Service
      c. Other Local Authorities and other partner agencies
      d. Colleagues in care management and assessment teams
      e. The Care Quality Commission
      f. The Quality Nurse Advisor (if applicable)
      g. Documents used in the Service including policies, procedures, care plans and daily records
   i.v The service will receive an initial quality monitoring visit within 6 weeks of the date of this agreement. Further follow up visits will take place periodically. Visits may be unannounced.

6. Lifting the Suspension/Terminating the Agreement
   i. The proprietor should notify the council when the service has made substantial progress towards completion of the agreed action plan. Substantial progress means that the service has achieved a safe, competent and compliant level of quality in its delivery, and is confident of maintaining it. This may include the completion of any 'serious incident' or 'safeguarding' investigation, disciplinary action and/or 'root cause analyses.

ii. If the council concurs, it will seek agreement with the proprietor to lift or vary the agreement to suspend.
iii. A suspension can be partially or fully lifted; a partial lift is used when there is evidence of some improvement but not all actions have been completed and/or we are testing the sustainability of the improvements.
iv. Any partial lift will be time limited and reviewed as part of the on-going monitoring of the Service.
v. If the service does not make adequate progress within 12 months, the council will consider its options via a Commissioning and Quality Conference; options will include extending the action plan, extending the period of suspension, moving to terminate all new business with the service (and with the provider) and in exceptional circumstances terminating all new and existing business with the service and/or provider.
vi. This memorandum may be terminated by either party on 2 months' notice following full consultation with the other. In the event that the mutually agreed suspension is terminated by either party withdrawing its agreement to the memorandum, the council reserves the right to consider an imposed suspension of new business on the service.

7. Status of the Memorandum
   i. The memorandum is an operational document, entered into voluntarily by the parties concerned. The council and the proprietor have by signing the memorandum agreed to use all reasonable endeavours to comply with the terms and spirit of the memorandum.

Signed

Director of Adult Social Care
City of Wolverhampton

(/ /)

And

(Name of Signatory)
(Position)
For and on behalf of: (Name of Provider)

(/ /)

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Care Home Annual Quality Assurance Provider Review

The Provider self-assessment is in relation to the City of Wolverhampton Council's *Quality Assurance & Suspension Policy 2024 - 2034* annual reviews (business related). Each Provider completes this review through the online link sent from your service area Commissioning Officer and Quality Assurance & Contract Officer. Each self-assessment will be scored according to a quality compliance scoring mechanism. After each self-assessment submission, the service may be required to produce evidence through documentation and photographs, as and when requested.

All data and information provided by the service is held in the strictest of confidence and will be shared with the Integrated Care Board (ICB). PROTECT and RESTRICTED information should only be further shared where there is a legitimate need - i.e., Care Quality Commission (CQC).

* Required

Business Information

General business information and leadership details

1. Name of Care Home *

2. Name of Parent Company. If not applicable, state N/A. *

3. Care First ID (as found on Community Care Order Schedule). If you are not a commissioned provider, please state N/A. *

4. CQC Registration Service Number. *

5. Name of nominated individual. *

6. Name of Registered Manager. *

7. Number of registered beds. *

8. Number of beds occupied on date of self-assessment. *

9. Number of Council funded placements. If you do not have funded Council beds, please state N/A. *

10. Number of Continuing Healthcare funded beds. If you do not have CHC funded beds, please state N/A. *

11. Current CQC rating. *

12. Date of last CQC inspection. *

13. Is the CQC rating displayed within the home for visitors to view. *

14. List actions that have come from the last CQC inspection. If not applicable, please state N/A. *

15. Are there any improvement actions in place from your quality assurance or management team. If there are no actions required, please state N/A. *

16. Is your service/business registered with the ICO - Information Commissioner's Officer. *

- ◯ Yes
- ◯ No

17. Does your business have Public Liability insurance up to £10m. *

- ◯ Yes
- ◯ No
- ◯ Partial

0. Does your business have Employers Liability insurance up to £5m. *

- Yes
- No
- Partial

1. Does the home display the insurance policies for visitors to view. *

- Yes
- No
- Partial

2. Which Health and Safety company does the home use. *
3. Are there any current health and safety action plans in place.

Please list below, if Yes. If No, state N/A. *

Safeguarding

4. Does your home have access to and is following the latest Council Adult Safeguarding Enquiry Procedures. *

- Yes
- No
- Partial

5. Does the home report safeguarding issues when necessary to the Counci's EMARF (the Electronic Multi Agency Referral Form). *

- Yes
- No
- Partial

6. Are safeguarding incidents recorded within the home. *

- Yes
- No
- Partial

7. If recorded, how is this done. If not recorded, please state why. *

8. Is there a whistleblowing procedure in place and is it accessible to staff. *

Health & Safety

18. Is there a Fire Risk Assessment. *

- ◯ Yes
- ◯ No
- ◯ Partial

19. Hs the Fire Risk Assessment been reviewed within the last 12-months or sooner if there have been significant changes to the home. *

- ◯ Yes
- ◯ No
- ◯ Partial

20. Have findings from the Fire Risk Assessment been implemented. *

- ◯
- ◯
- ◯

Yes

No

Partial

30. Do you have the following up-to-date policies and are they readily available for staff. *

- [ ] Moving and Handling
- [ ] Health and Safety
- [ ] Food Hygiene
- [ ] Human Resources
- [ ] Recruitment and Appraisals
- [ ] Medication
- [ ] Equality and Diversity
- [ ] Modern Slavery
- [ ] Quality Assurance
- [ ] Training
- [ ] Money Handling
- [ ] Gifts and Hospitality
- [ ] Data Protection and GDPR
- [ ] Whistleblowing and Complaints
- [ ] Infection Prevention and Control
- [ ] Business Continuity
- [ ] First Aid
- [ ] Supervision
- [ ] Advocacy

- [ ] Confidentiality
- [ ] Death of a Resident
- [ ] Challenging Behaviours
- [ ] MCA and DoLS
- [ ] Missing Persons and Wandering
- [ ] Nutrition and Hydration
- [ ] Oral and Dental
- [ ] Person-centred and Strength-based Care
- [ ] Tissue Viability (pressure relief)
- [ ] Record Keeping
- [ ] Medical Emergency Response

31. Have policies been reviewed within the home's established timelines and refer to current legislation. *

- ◯ Yes
- ◯ No
- ◯ Partial

32. Is your Business Continuity Plan reviewed annually to reflect changes in the service. *

- ◯ Yes
- ◯ No
- ◯ Partial

Leadership & Staffing

33. What is the management structure for the home, including on call rota. *

34. What is the home's staffing structure. *

35. Do all staff have annual appraisals. *

- Yes
- No
- Partial

21. Is there a probationary period for new staff. *

- Yes
- No
- Partial

22. How long does probationary period last for new staff. *

- 3 months
- 6 months
- 12 months
- Mixture
- Other

23. Are references required for all agency staff. *

- Yes
- No
- Partial

24. Is there a PIN on file for Nurses with revalidation due date. *

- ◯ Yes
- ◯ No
- ◯ Partial

25. Are there regular staff meetings in the home. *

- ◯ Yes
- ◯ No
- ◯ Partial

26. How often does staff meetings occur. *

- ◯ Weekly
- ◯ Fortnightly
- ◯ Monthly
- ◯ Quarterly
- ◯ Mixture
- ◯ None

42. How many permanent staff left in the last 12-months. List job roles.
If none, state N/A. *

Recruitment

43. Is there an application form on file for all roles in the home. *

- ◯ Yes
- ◯ No
- ◯ Partial

44. Are interview questions and answers recorded and kept on file. *

- ◯ Yes
- ◯ No
- ◯ Partial

45. Is an employment contract provided for all new permanent staff (this will include appointment offer, employment agreement and job specification). *

- ◯ Yes
- ◯ No
- ◯ Partial

36. Has a DBS check been undertaken for all home staff. *

- Yes
- No
- Partial

37. Are all agency staff checked for DBS compliance. *

- Yes
- No
- Partial

38. Has those with a DBS disclosure been reviewed and risk assessed. *

- Yes
- No
- Not applicable, no disclosures

46. Has a declaration of criminal convictions been completed on all home staff. *

- Yes
- No
- Partial

47. Has a health declaration and fitness to work been completed on all staff. *

- Yes
- No
- Partial

48. Is there a recent photograph on file for all staff. *

- Yes
- No
- Partial

49. Has staff gaps in employment history been explored or explained. *

- Yes
- No
- Partial

50. Is there a list on file of staff qualifications. *

- Yes
- No
- Partial

51. Is your home a licenced sponsor organisation for international recruits. *

- Yes
- No

Medication

39. Are there clear processes for handling controlled drugs in place. *

- ◯ Yes
- ◯ No
- ◯ Partial

40. Are there clear procedures in place should an individual repeatedly refuse medication. *

- ◯ Yes
- ◯ No
- ◯ Partial

41. Is there a covert medication policy in place where applicable. *

- ◯ Y e s
- ◯ N o

Accidents & Incidences

58. Is the staff aware of the Serious Incidents Reporting Framework (applicable to CHC funded placements). *

- Yes
- No
- Partial

Training

59. Does the home have a training matrix or equivalent monitoring system in place for all staff. *

- ◯ Yes
- ◯ No
- ◯ Partial

60. Is the training matrix or equivalent monitoring system able to identify the status of staff training. *

- ◯ Yes
- ◯ No
- ◯ Partial

61. How is staff training carried out. *

Access to NHS Commissioned Services

42. Is the home successfully accessing NHS Commissioned services. *

- ○ Yes
- ○ No
- ○ Partial

43. Where the service highlighted concerns with access to the NHS, has this been reported appropriately. Please explain. If no issues, please state N/A. *

Complaints & Compliments

62. Is the procedure on how to complain and compliment the service communicated to everyone. *

- ◯ Yes
- ◯ No
- ◯ Partial

63. Does the service make available the contact details for the Local Government and Social Care Ombudsman (LGSCO) when an individual is unsatisfied with the way a complaint has been handled. *

- ◯ Yes
- ◯ No
- ◯ Partial

64. Is there a record made of all concerns / comments / compliments and the action taken. *

- ◯ Yes
- ◯ No
- ◯ Partial

65. Does the service identify and act upon trends from received complaints. *

- Yes
- No
- Partial

66. Are compliments shared with staff, residents and other visits to the home. *

- Yes
- No
- Partial

Quality Assurance & Auditing

67. Is there a Quality Assurance matrix or monitoring system in place for the home. If so, please explain the type and details. *

68. Does internal Quality Assurance audits take place and how often. *

69. Are individuals (service users) data and information in a secure and dedicated office or system. Please explain. *

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Microsoft Forms

Nursing & Dual Registered Care Home Quarterly Joint Quality Assurance Self-Assessment

The purpose of a Joint Quality Assurance Self-Assessment is to identify quality compliance, risk, improvements and offer support where possible for the benefit of the service and people in receipt of care. The assessment based on CQC's KLOE (key lines of enquiry) themes, also provides reassurances to the city of Wolverhampton Council and Integrated Care Board as to the quality of the service being provided. Each self-assessment will be scored according to a quality compliance scoring mechanism. After each self-assessment submission, the service may be required to produce evidence through documentation and photographs, as and when requested.

Officers may request evidence for specific queries listed. Submissions may also lead to an unannounced monitoring visits of your premises as part of the quality assurance process.

Dual registered care homes will complete the Nursing Care Home Quarterly Joint Quality Assurance Self-Assessment and not the Residential form.

* Required

Business Information

General business information and leadership details

1. Name of Care Home *

2. Name of Parent Company. If not applicable, state N/A. *

3. Care First ID (as found on Community Care Order Schedule). If you are not a commissioned provider, please state N/A. *

4. CQC Registration Service Number. *

5. Name of nominated individual. *

6. Name of Registered Manager. *

7. Number of registered beds. *

8. Number of beds currently occupied. *

9. Number of Council funded placements. If you do not have funded Council beds, please state N/A. *

10. Number of Continuing Healthcare beds. *

11. Number of Self-funder beds. *

Safeguarding

12. Does your service analyse safeguarding issues, trends and themes and take steps to prevent further instances through 'lessons learned' and 'in-house action plans' (separate from any 'mutually-agreed' or imposed suspension with CWC).

13. How are lessons learnt from safeguarding investigations shared with staff.

14. How is the process of 'duty of candour' followed in the home and can this be evidenced if asked. *

15. Are staff able to articulate or demonstrate know how to report safeguarding concerns to the Local Authority. *

Health & Safety

16. Is there an appropriate Personal Emergency Evacuation Plan (PEEP) for current residents. *

○ Yes

○ No

○ Partial

17. Do you perform fire evacuation drills and training to reflect changes in circumstances. *

○ Yes

○ No

○ Partial

18. How often does the drills and training occur.

19. Is there an arrangement in place to ensure fixed and moveable equipment is adequately maintained. *

○ Yes

○ No

○ Partial

20. Is there an equipment maintenance schedule with checks completed on premises (i.e. PAT, LOLER, etc). *

○ Yes

○ No

○ Partial

Leadership & Staffing

21. Is there a CQC Registered Manager in place. *

- ◯ Yes
- ◯ No

22. If 'Yes' how long. Choose 'Not applicable' if you answer 'No' to question 21. *

- ◯ 6 months of less
- ◯ 7 to 12 months
- ◯ 13 to 24 months
- ◯ 2 plus years
- ◯ Not applicable

23. If 'No' to question 21, how long have you been recruiting for this post. If 'Yes' to question 21, choose 'Not applicable'. *

- ◯ 3 months or less
- ◯ 4 to 6 months
- ◯ 7 to 12 months
- ◯ More than a year
- ◯ Not applicable

24. Does your Registered Manager have management (i.e., Level 5, nursing, management diploma, degree or work experience equivalent, etc). *

- ◯ Yes
- ◯ No
- ◯ Partial

25. Does your Deputy Manager have management qualifications (i.e., Level 5, nursing, management diploma, degree or work experience equivalent, etc). *

- Yes
- No
- Partial

26. What is the care staffing ratio per residents. Please list per service type (i.e. nursing, complex, dementia, etc). List for day, afternoon and night shift. *

27. Does the home utilise a dependency tool for staffing, which tool and how frequently is this reviewed. *

28. List all current vacancies and roles. *

29. What is your agency staffing percentage in relation to overall roles across the service on average, for the last 12-months. *

- 0% agency staff
- 1 to 10% agency staff
- 11 to 30% agency staff
- 31 to 50% agency staff
- 51% plus agency staff

30. Have all care staff completed a 'Care Certificate' as part of their induction training.

Skills for Care. Care certificate. Available at: https://www.skillsforcare.org.uk/Developing-your-workforce/Care-Certificate/Care-Certificate.aspx
*

- ◯ Yes
- ◯ No
- ◯ Partial

31. Is management and care staff having monthly supervisions. *

- ◯ Yes
- ◯ No
- ◯ Partial

32. Do supervisions provide the opportunity for care staff to have one-to-one conversations with their line manager. *

- ◯ Yes
- ◯ No
- ◯ Partial

33. Are supervision records signed off by both the supervisor and supervisee. *

- ◯ Yes
- ◯ No

34. Does actions take place when identified in supervisions. *

- ◯ Yes
- ◯ No
- ◯ Partial

35. What is your currently agency ratio against permanent staff. *

- 0%
- 1 - 10%
- 11 - 20%
- 21 - 35%
- 36 - 50%
- 50% plus

36. How many permanent staff left in the last quarter. List the roles. If not applicable, please state N/A. *

Recruitment

37. Are your nurses registered with a membership of any professional body in their file, i.e., NMC. *

- ◯ Yes
- ◯ No
- ◯ Partial

38. Is there evidence on file of staff qualifications. *

- ◯ Yes
- ◯ No
- ◯ Partial

39. Has those staff with foreign passports been checked with confirmed evidence on file for 'right to work' in the UK. *

- ◯ Yes
- ◯ No
- ◯ Partial

40. How many International recruits do you currently employ - numerical response required - this should be a "people count" rather than whole time equivalent. Differentiate between the 3 main role types - "care worker", "non-care worker" and "Registered Nurse". *

Medication

41. Are risk assessments put in place where people self-administer their medication. *

- Yes
- No
- Partial

42. Is medication stored securely. *

- Yes
- No
- Partial

43. Is there person identifiable information on the MAR sheets. *

- Yes
- No
- Partial

44. Does the MAR sheets give adequate explanation if or when medication has not been given. This should include appropriate use of the key or coding. *

- Yes
- No
- Partial

45. Are MAR sheets clear to read. *

- Yes
- No
- Partial

46. Are handwritten additions on the MAR sheets checked and counter signed. *

- ◯ Yes
- ◯ No
- ◯ Partial

47. Does the MAR sheets adequately provide instruction on how prescriptions should be administered. *

- ◯ Yes
- ◯ No
- ◯ Partial

48. Where applicable, are PRN (when required) protocols in place, sufficiently detailed and the reason for each PRN administration clearly documented. *

- ◯ Yes
- ◯ No
- ◯ Partial

49. If medication dosage is variable, is the dosage recorded. *

- ◯ Yes
- ◯ No
- ◯ Partial

50. Are regular medication fridge temperature checks carried out and are they within guidelines. Is there a clear checklist schedule for the fridge/s. *

- ◯ Yes
- ◯ No
- ◯ Partial

51. Are regular medication room temperature checks carried out and are they within guidelines. *

- ◯ Yes
- ◯ No
- ◯ Partial

52. Is there a protocol in place should the medication room or fridge temperature not be within acceptable ranges. *

- ◯ Yes
- ◯ No
- ◯ Partial

53. Is there a process to ensure prescriptions are up to date and reviewed as needs/conditions change. *

- ◯ Yes
- ◯ No

54. Is excess medication stock disposed of correctly. *

- ◯ Yes
- ◯ No

55. Is there a system or process in place to manage medication stock control. *

- ◯ Yes
- ◯ No

56. If covert medication is being given, is there relevant medical professional input in the decision-making process and consideration to DoLS. *

- ◯ Yes
- ◯ No

57. Is there adequate provision for the prescribing, dispensing or administration of medication. *

- ◯ Yes
- ◯ No
- ◯ Partial

58. Is the date of opening recorded on medication where appropriate. *

- ◯ Yes
- ◯ No
- ◯ Partial

59. Number of medication errors in the last quarter. *

60. Number of medication errors that led to a serious incident. *

Accidents & Incidences

61. Are accidents/incidences documented appropriately. *

- ◯ Yes
- ◯ No
- ◯ Partial

62. Do records clearly state actions taken and preventative action to be taken to avoid further occurrences. *

- ◯ Yes
- ◯ No
- ◯ Partial

63. Have incidences been referred/reported as necessary - i.e., relative. *

- ◯ Yes
- ◯ No
- ◯ Partial

64. Is the duty of candour process followed.

- ◯ Yes
- ◯ No

65. Does the Provider assess any trends and do they develop action plans where required. *

- ◯ Yes
- ◯ No
- ◯ Partial

Training

EFFECTIVE - KEY LINE OF ENQUIRY

66. Does the service offer continuous staff development and mentoring. *

- ◯ Yes
- ◯ No
- ◯ Partial

67. Is manual handling training offered to all new care staff and refreshers offered when required. *

- ◯ Yes
- ◯ No
- ◯ Partial

68. Does the manual handling training include single care equipment. *

- ◯ Yes
- ◯ No

69. Is medication training offered to all new care staff and refreshers offered when required. *

- ◯ Yes
- ◯ No
- ◯ Partial

70. Is safeguarding training offered to all new staff and refreshers offered when required. *

- ◯ Yes
- ◯ No
- ◯ Partial

71. Is there regular mental capacity act and DoLS training for all staff and refreshers offered when required. *

- Yes
- No
- Partial

72. Is specialism training offered (appropriate to the service) to all new care staff and refreshers offered when required. *

- Yes
- No
- Partial

73. Is behaviours that challenge training offered to all new care staff and refreshers offered when required. . *

- Yes
- No
- Partial

74. Is nutritional screening training offered to all new care staff and refreshers offered when required. *

- Yes
- No
- Partial

75. Is pressure care training offered to all new care staff and refreshers offered when required. *

- Yes
- No
- Partial

76. Is infection prevention and control offered to all new care staff and refreshers offered when required. *

- ◯ Yes
- ◯ No
- ◯ Partial

Food & Nutrition

77. Is a choice of menu available to individuals. *

- Yes
- No
- Partial

78. If there is a menu, is it available in different formats - i.e., pictural, written. *

- Yes
- No
- Partial

79. Are individual's special dietary needs catered for. *

- Yes
- No
- Partial

80. Is the information regarding specialist diet or IDDSI requirements available for staff. *

- Yes
- No
- Partial

81. Where are thickeners stored in the home. *

82. Where monitoring is required, are individuals at risk of choking regularly assessed during meal times. *

- ◯ Yes
- ◯ No
- ◯ Partial

83. Depending on need, are individuals supported to eat and drink independently, with assistance or using appropriate assistive aids. *

- ◯ Yes
- ◯ No
- ◯ Partial

84. Where required are people prompted to drink. *

- ◯ Yes
- ◯ No
- ◯ Partial

85. Are drinks made freely available to all individuals. *

- ◯ Yes
- ◯ No
- ◯ Partial

86. Is there fluid goals or evidence of a process/strategy to ensure individuals receive adequate fluids. *

- ◯ Yes
- ◯ No
- ◯ Partial

87. Is fluid intake totalled during each shift. *

- Yes
- No
- Partial

88. Is it clear from food recordings how much food is consumed by each individual. *

- Yes
- No
- Partial

89. Is individual's food and fluid intake in line with dietary needs. *

- Yes
- No
- Partial

90. Does actions take place for individuals when low fluid and food intake is monitored such as contacting professionals or other appropriate steps. *

- Yes
- No
- Partial

91. Does the service follow advice from professionals such as GP, SALT, and dietician as and when required per individual's specified needs. *

- Yes
- No
- Partial

92. Are kitchen staff trained in the different consistency of foods. *

- ◯ Yes
- ◯ No
- ◯ Partial

93. How are menu's planned and how frequently are they reviewed or changed. *

Access to NHS Commissioned Services

94. Is the home successfully accessing NHS Commissioned services. *

- ○ Yes
- ○ No
- ○ Partial

95. Where the service highlighted concerns with access to the NHS, has this been reported appropriately. Please explain. *

Physical Environment

96. Are the communal lounge/s clean, in good repair, fit for purpose and free from hazards. *

- ◯ Yes
- ◯ No
- ◯ Partial

97. Are individual's rooms clean, in good state of repair, fit for purpose, person-centred and free from hazards. *

- ◯ Yes
- ◯ No
- ◯ Partial

98. Are bathrooms and toilets clean, in a good state of repair, fir for purpose and free from hazards. *

- ◯ Yes
- ◯ No
- ◯ Partial

99. Is the kitchen clean, in a good state of repair, fit for purpose and free from hazards. *

- ◯ Yes
- ◯ No
- ◯ Partial

100. Is the laundry room clean, in a good state of repair, fit for purpose and free from hazards. *

- ◯ Yes
- ◯ No
- ◯ Partial

101. Is there appropriate hand hygiene equipment around the home. *

- ◯ Yes
- ◯ No
- ◯ Partial

102. Does the laundry operate a dirty and clean flow. *

- ◯ Yes
- ◯ No
- ◯ Partial

103. Is there a sluice room and is it used appropriately. *

- ◯ Yes
- ◯ No
- ◯ Partial

104. Is the service free of any key infection control risks not already identified in the previous questions that require escalation or further advice or guidance. *

- ◯ Yes
- ◯ No
- ◯ Partial

105. Is the home in a good state of repair. *

- ◯ Yes
- ◯ No
- ◯ Partial

106. Is waste stored correctly as guidance - i.e., large clinical waste bins locked. *

- ◯ Yes
- ◯ No
- ◯ Partial

107. Do residents have access to an outside space or garden. What activities are the outside space used for. *

Care & Support

108. Is the privacy and dignity of people maintained. *

- ◯ Yes
- ◯ No
- ◯ Partial

109. Are staff seen to treat people with respect and communicate appropriately. *

- ◯ Yes
- ◯ No
- ◯ Partial

110. Are staff using correct PPE. *

- ◯ Yes
- ◯ No
- ◯ Partial

111. Does the service utilise Assistive Technology (AT) to support people to maintain and increase choice, independence and safety. *

- ◯ Yes
- ◯ No
- ◯ Partial

112. Are staff safely and professionally conducting manual handling. *

- ◯ Yes
- ◯ No
- ◯ Partial

113. Is there access to call bells throughout the home. *

- Yes
- No
- Partial

114. If an individual displayed a behaviour that is challenging, is this managed appropriately. *

- Yes
- No
- Partial

115. While maintaining personal choice are people dressed appropriately. *

- Yes
- No
- Partial

116. Are individuals repositioned as and when required as per their care and support plan. *

- Yes
- No
- Partial

117. Are there adequate care plans and risk assessments to cover clinical care. *

- Yes
- No
- Partial

118. Is equipment (i.e., slings) individual to the person. *

- Yes
- No
- Partial

119. Are individuals hygiene being supported. *

- Yes
- No
- Partial

120. Are sling assessments in place and being carried out by a trained and competent professional. *

- Yes
- No
- Partial

121. Are staff using the correct moving and handling equipment and slings. *

- Yes
- No
- Partial

122. Is the service taking appropriate steps to manage and/or improve pressure areas. *

- Yes
- No
- Partial

123. Is the service delivering wound assessment, evaluation and management. *

- ◯ Yes
- ◯ No
- ◯ Partial

124. Is the service taking appropriate steps to manage and/or improve clinical conditions. *

- ◯ Yes
- ◯ No
- ◯ Partial

125. Where there is an assessed need, is the service appropriately monitoring and managing continence care. *

- ◯ Yes
- ◯ No
- ◯ Partial

Activities

126. Does the service offer a range of social and physical activities for people inside the service. *

- Yes
- No
- Partial

127. Does the service offer a range of social and physical activities for individuals outside of the home. *

- Yes
- No
- Partial

128. Are activities in both a group and 1:1 basis. *

- Yes
- No
- Partial

129. List activities for those individuals bed bound or who prefer to stay in their room. *

130. Are individuals involved in planning activities and are they person-centred to reflect individual interests. *

- Yes
- No
- Partial

131. Does the home document participation in activities. *

- ◯ Yes
- ◯ No
- ◯ Partial

132. Is there a dedicated activities coordinator for the home. How many hours per week do they work. How many days are covered. *

Care Planning & Risk Assessment

133. Are individual's records stored confidentially and securely. *

- ◯ Yes
- ◯ No
- ◯ Partial

134. Are individual's care plans person-centred through the inclusion of preferences and/or routines. *

- ◯ Yes
- ◯ No
- ◯ Partial

135. Are there risk assessments in place for identified risks. *

- ◯ Yes
- ◯ No
- ◯ Partial

136. Have control measures been put in place for the assessed risk(s). *

- ◯ Yes
- ◯ No
- ◯ Partial

137. Are care plans and associated documentation accurate, consistent and legible. *

- ◯ Yes
- ◯ No
- ◯ Partial

138. Are there contact details of the relevant professionals, Next of Kin and relatives, etc. *

- ◯ Yes
- ◯ No
- ◯ Partial

139. Are person-centred daily records kept regarding the persons health and wellbeing. *

- ◯ Yes
- ◯ No
- ◯ Partial

140. Is information communicated to staff at shift change. *

- ◯ Yes
- ◯ No
- ◯ Partial

141. Does the service assess capacity where appropriate. *

- ◯ Yes
- ◯ No
- ◯ Partial

142. If an assessment is required, is it decision specific. *

- ◯ Yes
- ◯ No
- ◯ Partial

143. Where consent to care cannot be ascertained, has the Best Interest Decision taken place. *

- ◯ Yes
- ◯ No
- ◯ Partial

144. Where applicable, are outcomes recorded, reviewed and progress evidenced. *

- ◯ Yes
- ◯ No
- ◯ Partial

145. Are care plans written by a nurse. *

- ◯ Yes
- ◯ No
- ◯ Partial

146. Has the individuals care plan been developed with the individual or with family, friends and representatives. *

- ◯ Yes
- ◯ No
- ◯ Partial

End of Life - to be completed by homes that offer this service ONLY.

147. Is the service undertaking advanced care planning.

- ◯ Yes
- ◯ No
- ◯ Partial

148. Are DNA / CPRs / RESPECT / FREED being used appropriately and follow the guidance outlined by teh Resuscitation Council.

- ◯ Yes
- ◯ No
- ◯ Partial

149. Are staff in the service adequately trained to deliver end of life care.

- ◯ Yes
- ◯ No
- ◯ Partial

150. Does the service have the relevant equipment to meet the needs of people who are at end of life.

- ◯ Yes
- ◯ No
- ◯ Partial

151. Is the service engaging with the relevant GP / Health Professional to ensure people who are at end of life have the required medication / care.

- ◯ Yes
- ◯ No
- ◯ Partial

Complaints & Compliments

152. Have complaints been resolved, following the services complaints procedure and been thoroughly investigated. *

- ◯ Yes
- ◯ No
- ◯ Partial

153. Is the outcome communicated to the complainant and other interested parties. *

- ◯ Yes
- ◯ No
- ◯ Partial

154. How many complaints have you received in the last quarter. Please outline number and complainant type (i.e., individual, family, professional, etc). *

155. How many complaints have been upheld in the last quarter. Please outline number and complainant type (i.e., individual, family, professional, etc). *

Quality Assurance & Auditing

156. When did your last internal Quality Assurance audit take place in the home. *

157. When was your last medication audit. What was the results. *

158. Are there care file, daily notes and daily charts audits conducted and identified issues rectified. *

- Yes
- No
- Partial

159. Are call bell responsiveness being checked. *

- Yes
- No
- Partial

160. Are appropriate specialism audits conducted - i.e., personnel, recruitment files, IPC, weights/MUST, dining experience, health and safety, etc. *

- Yes
- No
- Partial

161. Are there financial audits relating to individual's personal allowance conducted. *

- Yes
- No
- Partial

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Provider:

Care Homes Annual Quality Assurance Self-Assessment

No.	Quality Question	TEXT / DATA: Good Response or Fully Compliant (0 Points)	Adequate Response or Partially Compliant (1 Point)	Poor Response or Not Compliant (2 Points)	MULTIPLE CHOICE SCORING MATRIX: Fully Compliant or Good Response (0 Points)	Partially Compliant or Adequate Response (1 Point)	Not Compliant or Poor Response (2 Points)	ANALYSIS OF EVIDENCE PROVIDED (if requested) *Calculations are based on initial aswer to QA query. This can be changed if evidence sought has not provided the current evidence.	SCORING MECHANISM Columns E to J list scoring according to query type and Provider answer. Populate the number outlined in row 4, correlating to the answer from the Provider in each relevant cell. Text answers will be score allocated based on the Providers answer and the Officers perception of the answer to the question. This could change based on evidence gathered from the Provider.	SCORING GUIDANCE Officers may be require specific evidence and data from Provider to score accurately (i.e., total data for scoring averages and percentages, comparison over previous quarters/years, comparison on 'good' rated Provider data against assessed Provider data).	ICB Comments
	Business Information										
1	Name of Care Home										
2	Name of Parent Company. If not applicable, state N/A.										
3	Care First ID (as found on Community Care Order Schedule). If you are not a commissioned provider, please state N/A.										
4	CQC Registration Service Number (if applicable).										
5	Name of nominated individual.										
6	Name of Registered Manager.										
7	Number of registered beds.										
8	Number of beds occupied on date of self-assessment.								0 = 95% beds filled; 1 = 75-94% filled; 2 = less than 74% filled	Increase in bed voids leads to decrease in business viability.	
9	Number of Council funded placements. If you do not have funded Council beds, please state N/A.								0 = 0-20% beds occupied; 1 = 21-50% occupied; 2 = 51% or more occupied	Increase in Council beds leads to increase in liability if there is a provider failure.	
10	Number of Continuing Healthcare funded beds. If you do not have CHC funded beds, please state N/A.										
11	Current CQC rating.										
12	Date of last CQC inspection.										
13	Is the CQC rating displayed within the home for visitors to view.								0 = Yes; 2 = No	Encouraging transparency.	
14	List actions that have come from the last CQC inspection. If not applicable, please state N/A.								0 = no current actions; 2 = actions ongoing	Current actions and rectifications are a risk.	
15	Are there any improvement actions in place from your quality assurance or management team. If there are no actions required, please state N/A.								0 = no current actions; 2 = actions ongoing	Current actions and rectifications are a risk.	
16	Is your service/business registered with the ICO - Information Commissioner's Officer. Yes No								0 = Yes; 2 = No	Those not registered are at risk of a fine. This is now a legal business requirement.	
17	Does your business have Public Liability insurance up to £10m. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Recommended liability amount via Procurement.	
18	Does your business have Employers Liability insurance up to £5m Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Recommended liability amount via Procurement.	
19	Does the home display the insurance policies for visitors to view. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Encouraging transparency.	
20	Which Health and Safety company does the home use.										
21	Are there any current health and safety action plans in place. Please list below, if Yes. If No, state N/A.								0 = no current actions; 2 = actions ongoing	Current actions and rectifications are a risk.	
	Safeguarding										
22	Does your home have access to and is following the latest Council Adult Safeguarding Enquiry Procedures. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All care homes should be aware of the Council's safeguarding procedures to report on EMARF as a statutory requirement.	
23	Does the home report safeguarding issues when necessary to the Counci's EMARF (the Electronic Multi Agency Referral Form). Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All care homes should be aware of the Council's safeguarding procedures to report on EMARF as a statutory requirement.	
24	Are safeguarding incidents recorded within the home. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All care homes should be logging, monitoring and carrying out trend analysis of safeguarding incidences.	
25	If recorded, how is this done. If not recorded, please state why.								0 = Good; 1 = Adequate; 2 = Poor	A digitial platform recording via a matrix or database for safeguarding and quality issues is best practice. Hardcopy recording is acceptable, but no recommended.	
26	Is there a whistleblowing procedure in place and is it accessible to staff.								0 = Good; 1 = Adequate; 2 = Poor	Required	
	Health & Safety										
27	Is there a Fire Risk Assessment. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Required	
28	Has the Fire Risk Assessment been reviewed within the last 12-months or sooner if there have been significant changes to the home. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	New assessments should be carried out after significant changes to the home or number of service users changes. The more current the assessment, the less risk.	
29	Have findings from the Fire Risk Assessment been implemented. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Any findings of risk should be rectified ASAP.	
	Policies & Procedures										
30	Do you have the following up-to-date policies and are they readily available for staff. *Multiple answers.*										
	Moving and Handling								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Health and Safety								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Food Hygiene								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Human Resources								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Recruitment and Appraisals								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Medication								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Equality and Diversity								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Modern Slavery								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Recommended	
	Quality Assurance								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Training								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Money Handling								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Gifts and Hospitality								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Data Protection and GDPR								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Whistleblowing and Complaints								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Infection Prevention and Control								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Business Continuity								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	First Aid								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Supervision								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Advocacy								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Recommended	

No.	Question	Scoring	Guidance
	Confidentiality	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	Death of a Resident	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	Challenging Behaviours	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	MCA and DoLS	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	Missing Persons and Wandering	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	Nutrition and Hydration	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	Oral and Dental	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	Person-centred and Strength-based Care	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	Tissue Viability (pressure relief)	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	Record Keeping	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	Medical Emergency Response	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
31	Have policies been reviewed within the home's established timelines and refer to current legislation. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Policies should be reviewed within 3-months of review date recommendation and align to new legislation and regulations.
32	Is your Business Continuity Plan reviewed annually to reflect changes in the service. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Policies should be reviewed within 3-months of review date recommendation and align to new legislation and regulations.
	Leadership & Staffing		
33	What is the management structure for the home, including on call rota.	0 = Good; 1 = Adequate; 2 = Poor	Business should have hierarchal structure, differentiating management and supervisory duties.
34	What is the home's staffing structure.	0 = Good; 1 = Adequate; 2 = Poor	Each department should have a structure with line management duties.
35	Do all staff have annual appraisals. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Annual appraisals are essential.
36	Is there a probationary period for new staff. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Probationary periods should be 3 months for management and 1 month for other staff.
37	How long does probationary period last for new staff. 3 months 6 months 12 months Mixture Other	0 = 12 months, Mixture, 6 months (Fully); 1 = 3 months (Partially); 2 = Other (Not Compliant)	The longer the probationary period, the better quality of staffing skills and retaining staff, particuarly management.
38	Are references required for all agency staff. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	References are essential for all agency staff through their agency.
39	Is there a PIN on file for Nurses with revalidation due date. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Nurses must have up to date PIN to practice in the UK as a registered nurse.
40	Are there regular staff meetings in the home. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Best practice include weekly staff meetings with care staff. With daily shift handover meetings. Non-care staff, at least monthly.
41	How often does staff meetings occur. Weekly Fortnighly Monthly Quarterly Mixture None	0 = Weekly, Fortnightly, Mixture (Fully); 1 = Monthly (Partially); 2 = Quarterly (Not Compliant)	Best practice include weekly staff meetings with care staff. With daily shift handover meetings. Non-care staff, at least monthly.
42	How many permanent staff left in the last 12-months. List job roles. If none, state N/A.	0 = Good; 1 = Adequate; 2 = Poor	5% or less of overall staff (0 = Good); 6 - 20% of overall staff (1 = Adequate); 21% plus of overall staff (2 = Poor)
	Recruitment		
43	Is there an application form on file for all roles in the home. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Best practice should include standard application questions to get the best candidates with the most relevant qualifications and experience.
44	Are interview questions and answers recorded and kept on file. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All questions and answers to interviews should be kept on file.
45	Is an employment contract provided for all new permanent staff (this will include appointment offer, employment agreement and job specification). Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All permanent staff should have an employment contract with appointment offer, agreement and specification.
46	Has a DBS check been undertaken for all home staff. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All care home staff must have an up-to-date DBS check. This includes bank staff as well.
47	Are all agency staff checked for DBS compliance. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All agency staff must have an up-to-date DBS check.
48	Has those with a DBS disclosure been reviewed and risk assessed. Yes No Not applicable, no disclosures	0 = Not applicable, no disclosures, Yes (Fully); 2 = No (Not Compliant)	Any disclosures must be reviewed and risk assessed.
49	Has a declaration of criminal convictions been completed on all home staff. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Any criminal convictions must be completed by staff.
50	Has a health declaration and fitness to work been completed on all staff. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Health declarations must be completed at point of new appointment after return to work after 7-days in a row sickness absence.
51	Is there a recent photograph on file for all staff. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	It is recommended that all staff have a recent picture of themselves on their HR record.
52	Has staff gaps in employment history been explored or explained. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Staff gaps during the recruitment process, should be explored and explained as best practice.

53	Is there a list on file of staff qualifications. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Qualifications should be recorded with evidence of certificates, diplomas and degrees.
54	Is your home a licenced sponsor organisation for international recruits. Yes No									
	Medication									
55	Are there clear processes for handling controlled drugs in place. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	There should be clear processes in place for handling controlled drugs as outlined in *NICE Guidelines Managing medicines in care homes Social care guideline [SC1]Published: 14 March 2014 - https://www.nice.org.uk/guidance/sc1*
56	Are there clear procedures in place should an individual repeatedly refuse medication. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Procedures and processes should be included in their Medication Policy. The policy must be up-to-date and reviewed annually.
57	Is there a covert medication policy in place where applicable. Yes No								0 = Yes (Fully); 2 = No (Not Compliant)	Each care home should have a 'covert medication policy' that is up-to-date and reviewed annually.
	Accidents and Incidences									
58	Is the staff aware of the Serious Incidents Reporting Framework (applicable to CHC funded placements). Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Staff should have access to and be aware of the Serious Incidents Reporting Famework.
	Training									
59	Does the home have a training matrix or equivalent monitoring system in place for all staff. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Each home should have a training matrix that is either a digital platform or spreadsheet/document that is regularly monitored.
60	Is the training matrix or equivalent monitoring system able to identify the status of staff training. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	The matrix or monitoring system should have dates of training completed as well as upcoming refresher courses.
61	How is staff training carried out.								0 = Good; 1 = Adequate; 2 = Poor	Training should be carried out by an inhouse trainer, line manager, trainer or reputable external training provider for care homes.
	Access to NHS Commissioned Services									
62	Is the home successfully accessing NHS Commissioned services. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All care homes must have timely access to NHS commissioned services. If they do not, the Commissioner should work with the Provider and Primary Care Network NHS Officer to rectify.
63	Where the service highlighted concerns with access to the NHS, has this been reported appropriately. Please explain. If no issues, please state N/A.								0 = Good; 1 = Adequate; 2 = Poor	Issues must be highlighted and reported in a timely manner. This should not be left for weeks on end.
	Complaints & Compliments									
64	Is the procedure on how to complain and compliment the service communicated to everyone. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	A complaints and compliments procedure must be made accessible by all service users, visitors and professionals. When requesting evidence, this should be available at reception.
65	Does the service make available the contact details for the Local Government and Social Care Ombudsman (LGSCO) when an individual is unsatisfied with the way a complaint has been handled. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	This should be included in the homes complaints policy.
66	Is there a record made of all concerns / comments / compliments and the action taken. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	A log whether it's a spreadsheet, database, or form should be kept on file with actions and dates.
67	Does the service identify and act upon trends from received complaints. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Trends shuld be monitored and acted upon as staffing lessons learned.
68	Are compliments shared with staff, residents and other visits to the home. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Compliments should be shared either on display, newsletter, etc.
	Quality Assurance & Auditing									
69	Is there a Quality Assurance matrix or monitoring system in place for the home. If so, please explain the type and details.								0 = Good; 1 = Adequate; 2 = Poor	This could be via spreadsheets, database or headquarters regular quality assurance monitoring with a breakdown of issues and concerns and timely rectifications.
70	Does internal Quality Assurance audits take place and how often.								0 = Good; 1 = Adequate; 2 = Poor	Medication checks take place end of each shift. Refrigerators take place daily, rehabilitation pool checks are every 24-hours. Comprehensive Quality Assurance checks should take place inhouse monthly, or quarterly audits from head office or external specialist provider.
71	Are individuals (service users) data and information in a secure and dedicated office or system. Please explain.								0 = Good; 1 = Adequate; 2 = Poor	Office and filing cabinet must be locked. Computerised must be accessible to relevant staff only.
TOTALS		0	0	0	0	0	0			
	GRAND TOTAL	**0**								

No.	Provider: **Nursing or Dual Care Homes Quarterly Quality Assurance Self-Assessment** Quality Question	TEXT / DATA Good Response or Fully Compliant (0 Points)	Adequate Response or Partially Compliant (1 Point)	Poor Response or Not Compliant (2 Points)	MULTIPLE CHOICE SCORING MATRIX Fully Compliant or Good Response (0 Points)	Partially Compliant or Adequate Response (1 Point)	Not Compliant or Poor Response (2 Points)	ANALYSIS OF EVIDENCE PROVIDED (if requested) *Calculations are based on initial aswer to QA query. This can be changed if evidence sought has not provided the current evidence.	SCORING MECHANISM Columns D to I list scoring according to query type and Provider answer. Populate the number outlined in row 4, correlating to the answer from the Provider in each relevant cell. Text answers will be score allocated based on the Providers answer and the Officers perception of the answer to the question. This could change based on evidence gathered from the Provider.	SCORING GUIDANCE Officers may be require specific evidence and data from Provider to score accurately (i.e., total data for scoring averages and percentages, comparison over previous quarters/years, comparison on 'good' rated Provider data against assessed Provider data).	ICB Comments
	Business Information										
1	Name of Care Home.										
2	Name of Parent Company. If not applicable, state N/A.										
3	Care First ID (as found on Community Care Order Schedule). If you are not a commissioned provider, please state N/A.										
4	CQC Registration Service Number.										
5	Name of nominated individual.										
6	Name of Registered Manager.										
7	Number of registered beds.										
8	Number of beds currently occupied.								0 = 95% beds filled; 1 = 75-94% filled; 2 = less than 74% filled	Increase in bed voids leads to decrease in business viability.	
9	Number of Council funded placements. If you do not have funded Council beds, please state N/A.								0 = 0-20% beds occupied; 1 = 21-50% occupied; 2 = 51% or more occupied	Increase in Council beds leads to increase in funding liability if there is a provider failure.	
10	Number of Continuing Healthcare beds.										
11	Number of Self-funder beds.								0 = 49% or more; 1 = 21-50%; 2 = 0-20% funded	Decrease in Council funding liability.	
	Safeguarding										
12	Does your service analyse safeguarding issues, trends and themes and take steps to prevent further instances through 'lessons learned' and 'in-house action plans' (separate from any 'mutually-agreed' or imposed suspension with CWC).								0 = Good; 1 = Adequate; 2 = Poor	Analysis of trends and recitifications ensures likelihood of quality assurance compliance.	
13	How are lessons learnt from safeguarding investigations shared with staff.								0 = Good; 1 = Adequate; 2 = Poor	It is pertinent to ensure lessons learnt are shared with staff to improve quality.	
14	How is the process of 'duty of candour' followed in the home and can this be evidenced if asked.								0 = Good; 1 = Adequate; 2 = Poor	Proves transparency with service users and lessons learnt.	
15	Are staff able to articulate or demonstrate know how to report safeguarding concerns to the Local Authority.								0 = Good; 1 = Adequate; 2 = Poor	All staff should be aware of what a safeguarding issue is and how to report to the Council.	
	Health & Safety										
16	Is there an appropriate Personal Emergency Evacuation Plan (PEEP) for current residents. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	PEEP plans should be updated when new residents are admitted, during hospital admissions and changes to accommodation structure and teams.	
17	Do you perform fire evacuation drills and training to reflect changes in circumstances. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Fill evacution drills and training are required to reflect any changes within the home structure, team or service users as and when required as a safety component.	
18	How often does the drills and training occur.								0 = Good; 1 = Adequate; 2 = Poor	Regular drills and training are required. Recommend at least quarterly.	
19	Is there an arrangement in place to ensure fixed and moveable equipment is adequately maintained. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All equipment must be maintaned and fixed according to maintenance schedule and recorded.	
20	Is there an equipment maintenance schedule with checks completed on premises (i.e. PAT, LOLER, etc). Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	There should be a maintenance schedule and checks on premises. If held within the business HQ, the Managers must have immediate access to this and are able to provide to commissioners when requested.	
	Leadership & Staffing										
21	Is there a permanent CQC Registered Manager in place. Yes No								0 = Yes (Fully); 2 = No (Not Compliant)	Providers are required to have a permanent CQC registered manager in place or in the process of recruitment.	
22	If 'Yes' how long. Choose 'Not applicable' if you answer 'No' to question 21. 6 months of less 7 to 12 months 13 to 24 months 2 plus years Not applicable								0 = Not applicable, 2 years plus (Fully); 1 = 13 to 24 months (Partially); 2 = 6 months or less (Not Compliant)	The premise is that the longer a registered manager is in their role, the better led the service in regards to quality, delivery and maintenance.	
23	If 'No' to question 21, how long have you been recruiting for this post. If 'Yes' to question 21, choose 'Not applicable'. 3 months or less 4 to 6 months 7 to 12 months More than a year Not applicable								0 = Not applicable (Fully); 1 = 0 to 6 months (Partially) 2 = 7 months to more than a year (Non Compliant);	The longer it takes to recruit for a registered manager, the likelihood of reputational issues, low salary, staffing instability and business viability.	
24	Does your Registered Manager have management qualifications (i.e., Level 5, management diploma, degree or work experience equivalent, etc). Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	It is encouraged that a registered manager has a management qualification or health and social care qualification or relevant work experience in a similar service for a significant period of time (3 years plus is encouraged).	
25	Does your Deputy Manager have management qualifications (i.e., Level 5, management diploma, degree or work experience equivalent, etc). Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	This is not essential but encouraged that the deputy also has a management or health and social care qualification or several years work experience in a similar service.	
26	What is the care staffing ratio per residents. Please list per service type (i.e. complex, dementia, etc). List for day, afternoon and night shift.								0 = Good; 1 = Adequate; 2 = Poor	Providers must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs and therefore meet the requirements of Section 2 of these regulations (the fundamental standards). There is no set matrix for this, so providers and commissioners must discuss what is adequate per service area and needs of the SU. https://www.cqc.org.uk/guidance-providers/regulations/regulation-18-staffing	
27	Does the home utilise a dependency tool for staffing, which tool and how frequently is this reviewed.								0 = Good; 1 = Adequate; 2 = Poor	It is recommended that homes each have a tool to ascertian staffing level or a matrix.	
28	List all current vacancies and roles.								0 = Good; 1 = Adequate; 2 = Poor	The higher the vacancies and the need for agency staff, the more risk.	
29	What is your agency staffing percentage in relation to overall roles across the service on average, for the last 12-months. 0% agency staff 1 to 10% agency staff 11 to 30% agency staff 31 to 50% agency staff 51% plus agency staff								0 = 1 to 10% (Fully); 1 = 11 to 30% (Partially); 2 = 31 to 50%, 51% plus agency staff (Not Compliant)	The higher the vacancies and the need for agency staff, the more risk.	
30	Have all care staff completed a 'Care Certificate' as part of their induction training. Skills for Care. Care certificate. Available at: https://www.skillsforcare.org.uk/Developing-your-workforce/Care-Certificate/Care-Certificate.aspx Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	It is recommended that homes have at least the 5 day Skills for Care certificate as part of their induction training or an in-house training programme that is similar.	

No.	Question	Scoring	Guidance
31	Is management and care staff having monthly supervisions. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Supervisions whether individually or by groups is pertinent for staff continual professional development.
32	Do supervisions provide the opportunity for care staff to have one-to-one conversations with their line manager. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	One-to-one supervisions are recommended, however, this may not be possible with larger and busy teams.
33	Are supervision records signed off by both the supervisor and supervisee. Yes No	0 = Yes (Fully); 2 = No (Not Compliant)	This is required to ensure transparency and for future appraisals.
34	Does actions take place when identified in supervisions. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Any actions from supervisions, should be followed through, monitored and recorded.
35	What is your currently agency ratio against permanent staff. 0% 1 - 10% 11 - 20% 21 - 35% 36 - 50% 50% plus	0 = 1 - 10% (Fully); 1 = 11 - 20% (Partially); 2 = 21 - 35%, 36 - 50%, 50% plus (Not Compliant)	The higher the ratio of agency staff, the more risk to teams in capturing quality issues, recording and understanding processes.
36	How many permanent staff left in the last quarter. List the roles. If not applicable, please state N/A.	0 = Good; 1 = Adequate; 2 = Poor	Where there is high levels of staff leaving, could be a symptom of service issues and quality risks.
	Recruitment		
37	Are your nurses registered with a membership of any professional body in their file, i.e., NMC.	0 = Good; 2 = Poor	Registered nurses are recommend to be affiliated to a professional body.
38	Is there evidence on file of staff qualifications. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All staff qualifications should be provided and kept on file, particularly management and registered nurses.
39	Has those staff with foreign passports been checked with confirmed evidence on file for 'right to work' in the UK. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Staff who are not British, must prove eligibility to work in the UK and must be kept on file.
40	How many International recruits do you currently employ - numerical response required - this should be a "people count" rather than whole time equivalent. Differentiate between the 3 main role types - "care worker", "non-care worker" and "Registered Nurse".		
	Medication		
41	Are risk assessments put in place where people self-administer their medication. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All service users that self-administer their medication, should be risk assessed and monitored that they are taking them during each shift.
42	Is medication stored securely. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All medications must be stored securely in a medications room or refrigerator (if required).
43	Is there person identifiable information on the MAR sheet. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All service users information should be clear and concise on each MAR sheet.
44	Does the MAR sheet give adequate explanation if or when medication has not been given. This should include appropriate use of the key or coding. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All information regarding medication administration or not, should be provided clearly and concisely on each MAR sheet.
45	Are MAR sheet clear to read. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	MAR sheet information should be easily able to read for each staff member and shift change.
46	Are handwritten additions on the MAR sheets checked and counter signed. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Any changes and additions for MAR sheets should be audited regularly during a shift or auditing schedule. If it's a controlled drug, this will need to be signed off by a registered nurse or Dr.
47	Does the MAR sheet adequately provide instruction on how prescriptions should be administered. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Medication instructions must follow GP or Nurse Practitioner guidance and must be listed on the service user's MAR sheet.
48	Where applicable, are PRN (when required) protocols in place, sufficiently detailed and the reason for each PRN administration clearly documented. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Pro re nata' indicates authorising nurses to administer medications according to Patient's requests and nurses discretion. This is unscheduled medication administration either alone or in addition to routine/regular prescriptions. A protocol and process should be available in each home and for commissioners to review.
49	If medication dosage is variable, is the dosage recorded. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All medication guidance and administering should be recorded on a MAR sheet as well as the service users medication summary.
50	Are regular medication fridge temperature checks carried out and are they within guidelines. Is there a clear checklist schedule for the fridge/s. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Each home should have a refrigeration checklist schedule, monitored by staff and recorded to ensure accuracy depending on medications that are kept in cooler settings.
51	Are regular medication room temperature checks carried out and are they within guidelines. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Each medication room temperature should be checked and follow guidelines stipulated for the medication kept in cooler settings.
52	Is there a protocol in place should the medication room or fridge temperature not be within acceptable ranges. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	A protocol and process must be available to staff when there is an issue with temperature ranges that could effect the medications efficacy.
53	Is there a process to ensure prescriptions are up to date and reviewed as needs/conditions change. Yes No	0 = Yes (Fully); 2 = No (Not Compliant)	There should be a process and schedule to ensure medications are stocked adequately or when there are changes of need/condition there is adequate time to inform the GP Surgery to update prescription and access from pharmacy.
54	Is excess medication stock disposed of correctly. Yes No	0 = Yes (Fully); 2 = No (Not Compliant)	All excess medication stock must be disposed of correctly as per the home's medication policy.
55	Is there a system or process in place to manage medication stock control. Yes No	0 = Yes (Fully); 2 = No (Not Compliant)	Each home should have a medication stock control matrix or schedule and this should be monitored regularly, with a pill count after each shift and allocated audit schedule.
56	If covert medication is being given, is there relevant medical professional input in the decision-making process and consideration to DoLS.	0 = Yes (Fully); 2 = No (Not Compliant)	Each home should have a covert medication policy or it should be included in their medication policy. This should be guided by the affiliated surgery to the home and

	Yes No								0 = Yes (Fully); 2 = No (Not Compliant)	medication policy. This should be guided by the affiliated surgery to the home and included in their MCA/DoLS assessment.
57	Is there adequate provision for the prescribing, dispensing or administration of medication. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	There should be an affiliated GP surgery for each home or service users with easy access to a pharmacy to collect or deliver medications and staff on duty to administer during each shift.
58	Is the date of opening recorded on medication where appropriate. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Medications stored and administered must be in-date and recorded on a medication schedule.
59	Number of medication errors in the last quarter.								0 = Good; 1 = Adequate; 2 = Poor	Medication errors should be kept at a minimum and listed for lessons learnt. See NICE guidelines for managing medicines in care homes - https://nice.org.uk/guidance/sc1
60	Number of medication errors leading to a serious incident in the last quarter.								0 = Good; 1 = Adequate; 2 = Poor	Serious incidences from medication errors must be recorded and should be considered whether this is a safeguarding event.
	Accidents & Incidences									
61	Are accidents/incidents documented appropriately. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All accidents and incidents must be documented for staff to review and learn lessons from.
62	Do records clearly state actions taken and preventative action to be taken to avoid further occurrences. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Actions and lessons learned is a preventative measure.
63	Have incidences been referred/reported as necessary - i.e., relative. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Any accidents and incidences must be notified to the service users next of kin or representative and a recording of doing this.
64	Is the duty of candour process followed. Yes No								0 = Yes (Fully); 2 = No (Not Compliant)	The should be a 'duty of candour' process that is followed by staff.
65	Does the Provider assess any trends and do they develop action plans where required. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Action plans and trends should be carried out and recorded when things go wrong to ensure credibility and accountability.
	Training									
66	Does the service offer continuous staff development and mentoring. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Continued professional development and mentoring should be carried out by senior staff to junior staff or new starters to enable good quality practice.
67	Is manual handling training offered to all new care staff and refreshers offered when required. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Every home must provide manual handling training as part of their induction training and refresher training every year or when new equipment is mobilised in-house or an external provider.
68	Does the manual handling training include single care equipment. Yes No								0 = Yes (Fully); 2 = No (Not Compliant)	Though single care equipment is not manditory, it is recommended when there is capacity issues. Single care equipment is being implemented across various LA's across the country.
69	Is medication training offered to all new care staff and refreshers offered when required. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All new care staff must be offered a mediation training course during induction, access to the medication policy and covert medication policy and provide at least an annual refresher course.
70	Is safeguarding training offered to all new staff and refreshers offered when required. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All new care staff must be offered a safeguarding training course during induction, access to the council's safeguarding policy and provide at least an annual refresher course.
71	Is there regular mental capacity act and DoLS training for all staff and refreshers offered when required. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All new care staff must be offered an MCA/DoLS course during induction, access to the council's MCA/DoLS policy and provide at least an annual refresher course.
72	Is specialism training offered (appropriate to the service) to all new care staff and refreshers offered when required. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All new care staff must be offered specialist training during induction and provide at least an annual refresher course.
73	Is behaviours that challenge training offered to all new care staff and refreshers offered when required. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All new care staff must be offered 'behaviours that are challenging' during induction and provide at least an annual refresher course.
74	Is nutritional screening training offered to all new care staff and refreshers offered when required. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All new care staff must be offered nutritional screening training during induction and provide at least an annual refresher course.
75	Is pressure care training offered to all new care staff and refreshers offered when required. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All new care staff must be offered pressure care training during induction and provide at least an annual refresher course.
76	Is infection prevention and control offered to all new care staff and refreshers offered when required. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All new care staff must be offered infection prevention and control training during induction and provide at least an annual refresher course.
	Food & Nutrition									
77	Is a choice of menu available to individuals. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Service users should be offered a choice of food at meal time and take into consideration, service users preferred choices, meat and vegetarian options.
78	If there is a menu, is it available in different formats - i.e., pictural, written. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	A pictural menu and a written menu should be offered for those with a learning disability, aquired brain injury, dementia, etc.
79	Are individual's special dietary needs catered for. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Special dietary needs should be catered for according to their nutrition screening, any medical condition, religious requirement, etc.
80	Is the information regarding specialist diet or IDDSI requirements available for staff. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Specialist dietary or IDDSI (food textures and drink thickness for those with dysphagia) requirements must be available to all care staff and kitchen staff based on assessed need.
81	Where are thickeners stored in the home.								0 = Good; 1 = Adequate; 2 = Poor	Best practice is to store resident's labelled container of thickener safely and securely, in a similar manner to medicines.
82	Where monitoring is required, are individuals at risk of choking regularly assessed during meal times. Yes								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Individualised risk assessment and care planning is required to ensure that vulnerable people are identified and protected and should be clearly documented

No.	Question	Scoring	Guidance
	No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	details of consistency of fluids, texture the resident can manage and feeding strategies (head and body positioning).
83	Depending on need, are individuals supported to eat and drink independently, with assistance or using appropriate assistive aids. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Individuals should be supported with positioning, time between bites and swallowing and texture modification or any aids applicable to their level of dysphagia.
84	Where required are people prompted to drink. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Those with dementia often forget to drink, therefore, it is important that drink levels are monitored and measured by staff and recorded during each shift to ensure hydration.
85	Are drinks made freely available to all individuals. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Individuals with demential or cognitive impairments should be provided with drinks throughout the day and night and topped up to ensure hydration.
86	Is there fluid goals or evidence of a process/strategy to ensure individuals receive adequate fluids. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Fluid goals should be recorded on the resident's nutrition screening and monitored during each shift.
87	Is fluid intake totalled during each shift. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Fluid intake should be recorded and calculated at the end of each shift for those applicable.
88	Is it clear from food recordings how much food is consumed by each individual. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Food consumption should be recorded after each meal, specifically for those with required within their nutrition assessment.
89	Is individual's food and fluid intake in line with dietary needs. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Food and fluid intake must be in line with their nutrition assessment.
90	Does actions take place for individuals when low fluid and food intake is monitored such as contacting professionals or other appropriate steps. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Actions to be recorded and monitored when there is any changes to food and fluid intake. Relevant professionals to be contacted and advised of such changes.
91	Does the service follow advice from professionals such as GP, SALT, and dietician as and when required per individual's specified needs. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Specialist and medical advice for each individual must be applied and reviewed with professionals regularly or when changes to the individuals habits are identified.
92	Are kitchen staff trained in the different consistency of foods. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Where individuals are required to have thickeners, staff must be trained and advised on consistency and when this is required.
93	How are menu's planned and how frequently are they reviewed or changed.	0 = Good; 1 = Adequate; 2 = Poor	Menu's should be planned according to dietary requirements and individuals consulted on preference through their care and support plan.
	Access to NHS Commissioned Services		
94	Is the home successfully accessing NHS Commissioned services. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	If providers are unable to access NHS services, their GP or Primary Care Network representative should be informed as well as their Commissioning Officer.
95	Where the service highlighted concerns with access to the NHS, has this been reported appropriately. Please explain.		
	Physical Environment		
96	Are the communal lounge/s clean, in good repair, fit for purpose and free from hazards. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Ask for a picture of rooms and cleaning schedules if you require evidence.
97	Are individual's rooms clean, in good state of repair, fit for purpose, person-centred and free from hazards. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Ask for a picture of rooms and cleaning schedules if you require evidence.
98	Are bathrooms and toilets clean, in a good state of repair, fir for purpose and free from hazards. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Ask for a picture of rooms and cleaning schedules if you require evidence.
99	Is the kitchen clean, in a good state of repair, fit for purpose and free from hazards. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Ask for a picture of rooms and cleaning schedules if you require evidence.
100	Is the laundry room clean, in a good state of repair, fit for purpose and free from hazards. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Ask for a picture of rooms and cleaning schedules if you require evidence.
101	Is there appropriate hand hygiene equipment around the home. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Ask for pictures of hygiene equipment around the home and location.
102	Does the laundry operate a dirty and clean flow. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Ask for schedule for evidence.
103	Is there a sluice room and is it used appropriately. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Request picture and location for evidence, if required.
104	Is the service free of any key infection control risks not already identified in the previous questions that require escalation or further advice or guidance. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Ask for infection control and prevention risk checklist and sign-off.
105	Is the home in a good state of repair. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Ask for pictures of the home in specific locations for evidence.
106	Is waste stored correctly as guidance - i.e., large clinical waste bins locked. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Ask for pictures of clinical waste bins and waste contract, if required.
107	Do residents have access to an outside space or garden. What activities are the outside space used for.	0 = Good; 1 = Adequate; 2 = Poor	Ask for pictures of outside space to ensure they are safe and tidy.

No.	Question						Scoring	Guidance
	Care & Support							
108	Is the privacy and dignity of people maintained. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Evidence request can be through completed 'service user satisfaction survey', complaints and staff training.
109	Are staff seen to treat people with respect and communicate appropriately. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Evidence request can be through completed 'service user satisfaction survey', complaints and staff training.
110	Are staff using correct PPE. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Request PPE and infection control and prevention policy. Request feedback from RWT infection prevention team.
111	Does the service utilise Assistive Technology (AT) to support people to maintain and increase choice, independence and safety. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Request evidence of AT systems in use across the home.
112	Are staff safely and professionally conducting manual handling. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Request evidence of manual handling assessments and manual handling policy is up to date. Access staff manual handling training and refreshers schedule.
113	Is there access to call bells throughout the home. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Each room should have a call bell next to their bed that is accessible for each individual. Request spot pictures of individuals call bells for evidence.
114	If an individual displayed a behaviour that is challenging, is this managed appropriately. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Access challenging behaviour policy, staff training and refreshers and any risk assessments that include challenging behaviour risk.
115	While maintaining personal choice are people dressed appropriately. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Assessors can request a picture of a council service user as evidence, however, the service user must agree to this.
116	Are individuals repositioned as and when required as per their care and support plan. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Request evidence of pressure sore risk assessment and repositioning recording evidence as and when required.
117	Are there adequate care plans and risk assessments to cover clinical care. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Any clinical care must be recorded and updated and reviewed regularly by the registered nurse on premises and allocated GP. Request care plans, MAR chart and medication risk assessment.
118	Is equipment (i.e., slings) individual to the person. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Each individual must have their own sling to ensure infection prevention.
119	Are individuals hygiene being supported. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Request hygiene charts as a spot check and laundry schedule.
120	Are sling assessments in place and being carried out by a trained and competent professional. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Request spot checks on sling assessments and training schedules with refreshers.
121	Are staff using the correct moving and handling equipment and slings. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Moving and handling equipment and slings must have usage manuals and up to date manual handling training with clean and robust slings.
122	Is the service taking appropriate steps to manage and/or improve pressure areas. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Individuals assessed with pressure sores must have up to date pressure ulcer risk assessment and trained staff to deliver care and/or an on premises nurse and/or district nurse, depending on grade. See Pressure ulcers https://www.nice.org.uk/guidance/qs89/chapter/quality-statement-1-pressure-ulcer-risk-assessment-in-hospitals-and-care-homes-with-nursingQuality standard [QS89]Published: 11 June 2015 -
123	Is the service delivering wound assessment, evaluation and management. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	This could be in-house or provided by the District Nursing service. If delivering onsite, the home should have pressure sore training, policy and monitoring assessment.
124	Is the service taking appropriate steps to manage and/or improve clinical conditions. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	This should include any improvements and deterioration of conditions such as pressure sore, weight loss, cognitive impairment, etc.
125	Where there is an assessed need, is the service appropriately monitoring and managing continence care. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Request evidence of pad changes and monitoring for individual service users.
	Activities							
126	Does the service offer a range of social and physical activities for people inside the service. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Request activities schedule and attendance for evidence.
127	Does the service offer a range of social and physical activities for individuals outside of the home. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Request activities schedule and attendance for evidence.
128	Are activities in both a group and 1:1 basis. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Request activities schedule and attendance for evidence.
129	List activities for those individuals bed bound or who prefer to stay in their room.						0 = Good; 1 = Adequate; 2 = Poor	Request 1:1 activities list and participants.
130	Are individuals involved in planning activities and are they person-centred to reflect individual interests. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Service users should be consulted about what indoor and outdoor activities are offered as a group on 1:1. Request activities schedules.
131	Does the home document participation in activities. Yes No Partial						0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Request evidence of documentation and schedules.

No.	Question	Scoring	Guidance
132	Is there a dedicated activities coordinator for the home. How many hours per week do they work. How many days are covered.	0 = Good; 1 = Adequate; 2 = Poor	There should be a dedicated activities coordinator or a role that a care worker on manager takes on as part of their regular duties. Activities should be reviewed regularly with service users.
	Care Planning & Risk Assessment		
133	Are individual's records stored confidentially and securely. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	This should be kept securely on digital systems that have secure software and of offices with cabinets that are locked or office doors locked.
134	Are individual's care plans person-centred through the inclusion of preferences and/or routines. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Service Users should be included in care and support planning. This should be identified by the provider. Or their representative.
135	Are there risk assessments in place for identified risks. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Risk assessments should be clear, concise and up dated regularly to record any changes in risk.
136	Have control measures been put in place for the assessed risk(s). Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Risk assessments should include mitigation and actions for each risk identified.
137	Are care plans and associated documentation accurate, consistent and legible. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All care plans that are written or typed should be easy to follow, clear and concise in regards to need, risk and mitigation.
138	Are there contact details of the relevant professionals, Next of Kin and relatives, etc. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	This should be included in the Service Users personal information documentation.
139	Are person-centred daily records kept regarding the persons health and wellbeing. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Person-centred daily records are updated during each shift and should be requested to evidence.
140	Is information communicated to staff at shift change. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Request details on shift handover procedures and information sharing.
141	Does the service assess capacity where appropriate. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Management should assess staffing capacity and prove that they deploy as and when needed.
142	If an assessment is required, is it decision specific. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Assessments should outline any actions and mitigations required based on assessment outcomes to ensure safety and that level of needs are met on a daily basis.
143	Where consent to care cannot be ascertained, has the Best Interest Decision taken place. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Request evidence of Best Interest Decision evidence as well as who is the representative.
144	Where applicable, are outcomes recorded, reviewed and progress evidenced. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Outcomes should be listed for all care and support plans with progress or lack of.
145	Are care plans written by a nurse. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Care plans do not necessarily have to be completed by a nurse, but should be signed off if a nursing placement.
146	Has the individuals care plan been developed with the individual or with family, friends and representatives. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All care and support plans should be developed with the Service User, family if they are the official guardian or client welfare representative.
	End of Life (Not all Providers may offer this service)		
147	Is the service undertaking advanced care planning. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	End of Life care advanced planning must be completed, signed off and regularly revised by a registered or palliative nurse and GP within the end of life service. Advanced care planning policy should be requested by the provider. See link for further information: https://www.nice.org.uk/guidance/ng142/resources/end-of-life-care-for-adults-service-delivery-pdf-66141776457925
148	Are DNA / CPRs / RESPECT / FREED being used appropriately and follow the guidance outlined by the Resuscitation Council. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Request End of Life policy and procedures. Request an example that is current or recent.
149	Are staff in the service adequately trained to deliver end of life care. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Request End of Life training applicable to staff delivering this specialist care. Ensure training is up to date and part of induction training and refreshers are provided.
150	Does the service have the relevant equipment to meet the needs of people who are at end of life. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Request manual handeling equipment schedule, clinical equipment used for individuals and that PAT has occurred and up to date. Specialist equipment should be in line with the guidance from the Resusitation Council.
151	Is the service engaging with the relevant GP / Health Professional to ensure people who are at end of life have the required medication / care. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	There should be regular assessments and reviews carried out for care and medications for those on End of Life. Request assessments and details of the GP and Health Professional.
	Complaints & Compliments		
152	Have complaints been resolved, following the services complaints procedure and been thoroughly investigated. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Request the latest Adults Complaints Team report and any actions from complaints listed in your Trends and Actions Log.
153	Is the outcome communicated to the complainant and other interested parties. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All complaints processing must adhere to the providers complaints policy and each complaint reviewed with final sign-off, with outcome, with Adults Complaints Team and Adults Commissioning Team.
154	How many complaints have you received in the last quarter. Please outline number and complainant type (i.e., individual, family, professional, etc).	0 = Good; 1 = Adequate; 2 = Poor	Complaint numbers should be assessed based on complaints 'upheld'.
155	How many complaints have been upheld in the last quarter. Please outline number and complainant type (i.e., individual, family, professional, etc).	0 = Good; 1 = Adequate; 2 = Poor	Upheld complaints should be minimal and may have to be agreed on appropriate numbers with the Head of Commissioning and the Adults Complaints Team Manager.
	Quality Assurance & Auditing		
156	When did the last Quality Assurance audit take place in the home.	0 = Good; 1 = Adequate; 2 = Poor	Quality Assurance audits should take place at least quarterly.

157	When was your last medication audit. What was the results.								0 = Good; 1 = Adequate; 2 = Poor	Medication audits should occur daily.
158	Are there care file, daily notes and daily charts audits conducted and identified issues rectified. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Daily notes charts should be audited weekly, care files audited monthly.
159	Are call bell responsiveness being checked. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Call bell checks should be carried out hourly and at the end of each shift.
160	Are appropriate specialism audits conducted - i.e., personnel, recruitment files, IPC, weights/MUST, dining experience, health and safety, etc. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	HR files should be checked annually. IPC should be schecked weekly. Weights, MUST, dining and regular health audits should be carried out weekly. Health and Safety should be carried out monthly.
161	Are there financial audits relating to individual's personal allowance conducted. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Personal allowance audits should be carried out monthly.
TOTALS		0	0	0	0	0	0			
	GRAND TOTAL	**0**								

Compliance Level	Residential Qtr	Nur/Dual Qtr	Annual	RAG
	Scoring Points			
Good / Fully Compliant	0 - 94	0 -101	0 - 58	Green
Adequate / Partially Compliant	95 - 198	102 - 202	59 - 117	Amber
Poor / Not Compliant	199 - 298	203 - 304	118 - 176	Red

QUALITY ASSURANCE DASHBOARD SCORING

Criteria Type	Percentage (%) of Overall Criteria Value	Scoring Mechanism									QTR Scoring Example Provider X (Res)	%	Annual Scoring Example Provider X (Res)	%	Average SA Scoring (annual and last quarter return)	% Scoring Mechanism	% of Criteria Scoring	Notes
		Nursing/Dual Qtr Categories & Scoring			Residential Qtr Categories & Scoring			Annual Categories and Scoring										
Quality Assurance Self-Assessments	30	Good / Fully Compliant	Adequate / Partially Compliant	Poor / Not Compliant	Good / Fully Compliant	Adequate / Partially Compliant	Poor / Not Compliant	Good / Fully Compliant	Adequate / Partially Compliant	Poor / Not Compliant	100	34%	60	34%	80	0.33823978		
		0 -101	102 - 202	203 - 304	0 - 94	95 - 198	199 - 298	0 - 58	59 - 117	118 - 176								
Suspensions / Termination of Contract / Monitoring	20	Ongoing Monitoring	Partial Suspension	Full Suspension	Termination of Contract						10					50%	50%	
		5	10	15	20													
CQC Rating	10	Outstanding	Good (rating within last 3 months)	Good (rating within last 3 years)	Good (rating over 3 years ago)	Requires Improvement	Inadequate (automatic suspension)	No Rating			2					20%	20%	
		0	0	2	4	6	8	10										
S.42's over 2-years (scoring once according to each area (2 x 'risk reduced' = 3)	10	No Safeguarding Issues in past 2-years	Risk Removed	Currently Investigating	Risk Reduced	Risk Remains					4					40%		1 risk removed, 2 risk reduced
		0	1	2	3	4												
Complaints Upheld	10	No Complaints in Past 12-months	Complaints Recorded, But No Complaints Upheld in Past 12-months	Complaints Recorded, and One or More Complaints Upheld in Past 12-months							5					50%		
		0	5	10														
Embargoes	10	Providers that Refuse to Comply With QA Assessments (in hosted CWC, not commissioned)									0					0%		
		10																
Contractual Obligations	10	Provider Has Contract/Framework and Completes Contractual Performance Schedule/s	Provider Has Contract/Framework and Partially Complete Contractual Performance Schedule/s	Provider is Commissioned by Spot Only							5					50%		
		0	5	10														
TOTAL	100%										126							

Self-Assessment Care Home Schedule *(List date of return in the allocated green cell)*

PROVIDER	ANNUAL RETURN 2024-25		QTR 2 2024-25			QTR 3 2024-25			QTR 4 2024-25			NOTES
	May	June	July	August	September	October	November	December	January	February	March	
Arbour Lodge												
Aldergrove Manor												
Anville Court												
Apple Tree												
Ashley Court												
Aspen Lodge Residential Care Home												
Atholl House Nursing Home												
Belvidere Court												
Bentley Court												
Bethrey House												
Bradley Resource Centre												
Charnwood												
Coachmans Cottage												
Coton Grange												
Coton House												
Duke Street Bungalows												
East Park Court												
Engelberg												
Ernest Bold Resource Centre												
Eversleigh Care Centre												
Foxland Grange (previously Sunrise of Tettenhall)												
Glenthorne House												
Goldthorn Lodge												
Hampton Court EMI Nursing Home (? parent company)												
Harper House												
Highcroft Hall												
Hilton House												
Inshore Support Limited - 110 Wellington												
Inshore Support Limited - 112 Wellington												
Inspirations												
Knoll House Nursing Home												
Langdale and Keswick (Parkfields / Jaffray)												
Langdale and Keswick (Parkfields) / Jaffrey Care Society												
Lavender Court												
Lime Tree Court												
Mancroft												
Maplebrook Care Home												
Meadowcroft												
Mill House												
Mountfield House												
Newbridge House												
Newcross Care Home												
Orchard House Nursing Home												
Park Road CCT												
Parkdale												
Parkfield House / Transitions Care												
Pear Tree Lane												
Penn House												
Primrose Nursing Home												
Redhouse												
Royal Park Care Home												
Stourbridge												
The Cedar Grange												
The Coach House												

The Croft Residential Home												
The Leylands												
Trinity Court Nursing Home												
Victoria Court												
Walton House												
Wanderers House												
Waterside House												
Welbeck House												
Wellesley House												
Wentworth Lodge												
Woodfields Residential Carehome												
Woodlands Quaker Care Home												
Wrottesley Park House Care Home												
Wulfrun Rose												

Residential Care Home Quarterly Quality Assurance Self-Assessment

The purpose of a Quality Assurance Self-Assessment is to identify quality compliance, risk, improvements and offer support where possible for the benefit of the service and people in receipt of care. The assessment based on CQC's KLOE (key lines of enquiry) themes, also provides reassurances to the city of Wolverhampton Council as to the quality of the service being provided. Each self-assessment will be scored according to a quality compliance scoring mechanism. After each self-assessment submission, the service may be required to produce evidence through documentation and photographs, as and when requested.

Officers may request evidence for specific queries listed. Submissions may also lead to an unannounced monitoring visit of your premises as part of the quality assurance process.

* Required

Business Information

General business information and leadership details

1. Name of Care Home. *

2. Name of Parent Company. If not applicable, state N/A. *

3. Care First ID (as found on Community Care Order Schedule). If you are not a commissioned provider, please state N/A.

4. CQC Registration Service Number.

5. Name of nominated individual. *

6. Name of Registered Manager. *

7. Number of registered beds. *

8. Number of beds currently occupied. *

9. Number of Council funded placements. If you do not have funded Council beds, please state N/A. *

10. Number of Self-funder beds. *

Safeguarding

11. Does your service analyse safeguarding issues, trends and themes and take steps to prevent further instances through 'lessons learned' and 'in-house action plans' (separate from any 'mutually-agreed' or imposed suspension with CWC). *

12. How are lessons learnt from safeguarding investigations shared with staff. *

13. How is the process of 'duty of candour' followed in the home and can this be evidenced if asked. *

14. Are staff able to articulate or demonstrate know how to report safeguarding concerns to the Local Authority. *

Health & Safety

15. Is there an appropriate Personal Emergency Evacuation Plan (PEEP) for current residents. *

- ◯ Yes
- ◯ No
- ◯ Partial

16. Do you perform fire evacuation drills and training to reflect changes in circumstances. *

- ◯ Yes
- ◯ No
- ◯ Partial

17. How often does the drills and training occur. *

18. Is there an arrangement in place to ensure fixed and moveable equipment is adequately maintained. *

- ◯ Yes
- ◯ No
- ◯ Partial

19. Is there an equipment maintenance schedule with checks completed on premises (i.e. PAT, LOLER, etc). *

- ◯ Yes
- ◯ No
- ◯ Partial

Leadership & Staffing

20. Is there a permanent CQC Registered Manager in place. *

- ◯ Yes
- ◯ No

21. If 'Yes' how long. Choose 'Not applicable' if you answer 'No' to question 20. *

- ◯ 6 months of less
- ◯ 7 to 12 months
- ◯ 13 to 24 months
- ◯ 2 plus years
- ◯ Not applicable

22. If 'No' to question 20, how long have you been recruiting for this post. If 'Yes' to question 20, choose 'Not applicable'. *

- ◯ 3 months or less
- ◯ 4 to 6 months
- ◯ 7 to 12 months
- ◯ More than a year
- ◯ Not applicable

23. Does your Registered Manager have management qualifications (i.e., Level 5, management diploma, degree or work experience equivalent, etc). *

- ◯ Yes
- ◯ No
- ◯ Partial

24. Does your Deputy Manager have management qualifications (i.e., Level 5, management diploma, degree or work experience equivalent, etc). *

- ◯ Yes
- ◯ No
- ◯ Partial

25. What is the care staffing ratio per residents. Please list per service type (i.e. complex, dementia, etc). List for day, afternoon and night shift. *

26. Does the home utilise a dependency tool for staffing, which tool and how frequently is this reviewed. *

27. List all current vacancies and roles. *

28. What is your agency staffing percentage in relation to overall roles across the service on average, for the last 12-months. *

- 0% agency staff
- 1 to 10% agency staff
- 11 to 30% agency staff
- 31 to 50% agency staff
- 51% plus agency staff

29. Have all care staff completed a 'Care Certificate' as part of their induction training.

Skills for Care. Care certificate. Available at: https://www.skillsforcare.org.uk/Developing-your-workforce/Care-Certificate/Care-Certificate.aspx
*

- ◯ Yes
- ◯ No
- ◯ Partial

30. Is management and care staff having monthly supervisions. *

- ◯ Yes
- ◯ No
- ◯ Partial

31. Do supervisions provide the opportunity for care staff to have on-to-one conversations with their line manager. *

- ◯ Yes
- ◯ No
- ◯ Partial

32. Are supervision records signed off by both the supervisor and supervisee. *

- ◯ Yes
- ◯ No

33. Does actions take place when identified in supervisions. *

- ◯ Yes
- ◯ No
- ◯ Partial

34. What is your currently agency ratio against permanent staff. *

- ◯ 0%
- ◯ 1 - 10%
- ◯ 11 - 20%
- ◯ 21 - 35%
- ◯ 36 - 50%
- ◯ 50% plus

35. How many permanent staff left in the last quarter. List the roles. If not applicable, please state N/A. *

Recruitment

36. Is there evidence on file of staff qualifications. *

- ◯ Yes
- ◯ No
- ◯ Partial

37. Has those staff with foreign passports been checked with confirmed evidence on file for 'right to work' in the UK. *

- ◯ Yes
- ◯ No
- ◯ Partial

38. How many International recruits do you currently employ - numerical response required - this should be a "people count" rather than whole time equivalent. Differentiate between the 3 main role types - "care worker", "non-care worker" and "Manager". *

Medication

39. Are risk assessments put in place where people self-administer their medication. *

◯ Yes

◯ No

◯ Partial

40. Is medication stored securely. *

◯ Yes

◯ No

◯ Partial

41. Is there person identifiable information on the MAR sheet. *

◯ Yes

◯ No

◯ Partial

42. Does the MAR sheet give adequate explanation if or when medication has not been given. This should include appropriate use of the key or coding. *

- ◯ Yes
- ◯ No
- ◯ Partial

43. Are MAR sheet clear to read. *

- ◯ Yes
- ◯ No
- ◯ Partial

44. Are handwritten additions on the MAR sheets checked and counter signed. *

- ◯ Yes
- ◯ No
- ◯ Partial

45. Does the MAR sheet adequately provide instruction on how prescriptions should be administered. *

- ◯ Yes
- ◯ No
- ◯ Partial

46. Where applicable, are PRN (when required) protocols in place, sufficiently detailed and the reason for each PRN administration clearly documented. *

- ◯ Yes
- ◯ No
- ◯ Partial

47. If medication dosage is variable, is the dosage recorded. *

- ◯ Yes
- ◯ No
- ◯ Partial

48. Are regular medication fridge temperature checks carried out and are they within guidelines. Is there a clear checklist schedule for the fridge/s. *

- ◯ Yes
- ◯ No
- ◯ Partial

49. Are regular medication room temperature checks carried out and are they within guidelines. *

- ◯ Yes
- ◯ No
- ◯ Partial

50. Is there a protocol in place should the medication room or fridge temperature not be within acceptable ranges. *

- ◯ Yes
- ◯ No
- ◯ Partial

51. Is there a process to ensure prescriptions are up to date and reviewed as needs/conditions change. *

- Yes
- No

52. Is excess medication stock disposed of correctly. *

- Yes
- No

53. Is there a system or process in place to manage medication stock control. *

- Yes
- No

54. If covert medication is being given, is there relevant medical professional input in the decision-making process and consideration to DoLS. *

- Yes
- No

55. Is there adequate provision for the prescribing, dispensing or administration of medication. *

- ◯ Yes
- ◯ No
- ◯ Partial

56. Is the date of opening recorded on medication where appropriate. *

- ◯ Yes
- ◯ No
- ◯ Partial

57. Number of medication errors in the last quarter. *

58. Number of medication errors leading to a serious incident in the last quarter. *

Accidents & Incidences

59. Are accidents/incidents documented appropriately. *

- ◯ Yes
- ◯ No
- ◯ Partial

60. Do records clearly state actions taken and preventative action to be taken to avoid further occurrences. *

- ◯ Yes
- ◯ No
- ◯ Partial

61. Have incidences been referred/reported as necessary - i.e., relative. *

- ◯ Yes
- ◯ No
- ◯ Partial

62. Is the duty of candour process followed. *

- ◯ Yes
- ◯ No

63. Does the Provider assess any trends and do they develop action plans where required. *

- ◯ Yes
- ◯ No
- ◯ Partial

Training

64. Does the service offer continuous staff development and mentoring. *

- ◯ Yes
- ◯ No
- ◯ Partial

65. Is manual handling training offered to all new care staff and refreshers offered when required. *

- ◯ Yes
- ◯ No
- ◯ Partial

66. Does the manual handling training include single care equipment. *

- ◯ Yes
- ◯ No

67. Is medication training offered to all new care staff and refreshers offered when required. *

- Yes
- No
- Partial

68. Is safeguarding offered to all new staff and refreshers offered when required. *

- Yes
- No
- Partial

69. Is there regular mental capacity act and DoLS training for all staff and refreshers offered when required. *

- Yes
- No
- Partial

70. Is specialism training offered (appropriate to the service) to all new care staff and refreshers offered when required. *

- Yes
- No
- Partial

71. Is behaviours that challenge training offered to all new care staff and refreshers offered when required. *

- Yes
- No
- Partial

72. Is nutritional screening training offered to all new care staff and refreshers offered when required. *

- Yes
- No
- Partial

73. Is pressure care training offered to all new care staff and refreshers offered when required. *

- ◯ Yes
- ◯ No
- ◯ Partial

74. Is infection prevention and control offered to all new care staff and refreshers offered when required. *

- ◯ Yes
- ◯ No
- ◯ Partial

Food & Nutrition

75. Is a choice of menu available to individuals. *

- ◯ Yes
- ◯ No
- ◯ Partial

76. If there is a menu, is it available in different formats - i.e., pictural, written. *

- ◯ Yes
- ◯ No
- ◯ Partial

77. Are individual's special dietary needs catered for. *

- ◯ Yes
- ◯ No
- ◯ Partial

78. Is the information regarding specialist diet or IDDSI requirements available for staff. *

- ○ Yes
- ○ No
- ○ Partial

79. Where are thickeners stored in the home. *

80. Where monitoring is required, are individuals at risk of choking regularly assessed during meal times. *

- ○ Yes
- ○ No
- ○ Partial

81. Depending on need, are individuals supported to eat and drink independently, with assistance or using appropriate assistive aids. *

- ◯ Yes
- ◯ No
- ◯ Partial

82. Where required are people prompted to drink. *

- ◯ Yes
- ◯ No
- ◯ Partial

83. Are drinks made freely available to all individuals. *

- ◯ Yes
- ◯ No
- ◯ Partial

84. Is there fluid goals or evidence of a process/strategy to ensure individuals receive adequate fluids. *

- Yes
- No
- Partial

85. Is fluid intake totalled during each shift. *

- Yes
- No
- Partial

86. Is it clear from food recordings how much food is consumed by each individual. *

- Yes
- No
- Partial

87. Is individual's food and fluid intake in line with dietary needs. *

- ◯ Yes
- ◯ No
- ◯ Partial

88. Does actions take place for individuals when low fluid and food intake is monitored such as contacting professionals or other appropriate steps. *

- ◯ Yes
- ◯ No
- ◯ Partial

89. Does the service follow advice from professionals such as GP, SALT, and dietician as and when required per individual's specified needs. *

- ◯ Yes
- ◯ No
- ◯ Partial

90. Are kitchen staff trained in the different consistency of foods. *

- ◯ Yes
- ◯ No
- ◯ Partial

91. How are menu's planned and how frequently are they reviewed or changed. *

Access to NHS Commissioned Services

92. Is the home successfully accessing NHS Commissioned services. *

- Yes
- No
- Partial

93. Where the service highlighted concerns with access to the NHS, has this been reported appropriately. Please explain. *

Physical Environment

94. Are the communal lounge/s clean, in good repair, fit for purpose and free from hazards. *

◯ Yes

◯ No

◯ Partial

95. Are individual's rooms clean, in good state of repair, fit for purpose, person-centred and free from hazards. *

◯ Yes

◯ No

◯ Partial

96. Are bathrooms and toilets clean, in a good state of repair, fir for purpose and free from hazards. *

◯ Yes

◯ No

◯ Partial

97. Is the kitchen clean, in a good state of repair, fit for purpose and free from hazards. *

- ◯ Yes
- ◯ No
- ◯ Partial

98. Is the laundry room clean, in a good state of repair, fit for purpose and free from hazards. *

- ◯ Yes
- ◯ No
- ◯ Partial

99. Is there appropriate hand hygiene equipment around the home. *

- ◯ Yes
- ◯ No
- ◯ Partial

100. Does the laundry operate a dirty and clean flow. *

- ◯ Yes
- ◯ No
- ◯ Partial

101. Is there a sluice room and is it used appropriately. *

- ◯ Yes
- ◯ No
- ◯ Partial

102. Is the service free of any key infection control risks not already identified in the previous questions that require escalation or further advice or guidance. *

- ◯ Yes
- ◯ No
- ◯ Partial

103. Is the home in a good state of repair. *

- Yes
- No
- Partial

104. Is waste stored correctly as guidance - i.e., large clinical waste bins locked. *

- Yes
- No
- Partial

105. Do residents have access to an outside space or garden. What activities are the outside space used for. *

Care & Support

106. Is the privacy and dignity of people maintained. *

- ◯ Yes
- ◯ No
- ◯ Partial

107. Are staff seen to treat people with respect and communicate appropriately. *

- ◯ Yes
- ◯ No
- ◯ Partial

108. Are staff using correct PPE. *

- ◯ Yes
- ◯ No
- ◯ Partial

109. Does the service utilise Assistive Technology (AT) to support people to maintain and increase choice, independence and safety. *

- ◯ Yes
- ◯ No
- ◯ Partial

110. Are staff safely and professionally conducting manual handling. *

- ◯ Yes
- ◯ No
- ◯ Partial

111. Is there access to call bells throughout the home. *

- ◯ Yes
- ◯ No
- ◯ Partial

112. If an individual displayed a behaviour that is challenging, is this managed appropriately. *

- ◯ Yes
- ◯ No
- ◯ Partial

113. While maintaining personal choice are people dressed appropriately. *

- ◯ Yes
- ◯ No
- ◯ Partial

114. Are individuals repositioned as and when required as per their care and support plan. *

- ◯ Yes
- ◯ No
- ◯ Partial

115. Are there adequate care plans and risk assessments to cover clinical care. *

- ◯ Yes
- ◯ No
- ◯ Partial

116. Is equipment (i.e., slings) individual to the person. *

- ◯ Yes
- ◯ No
- ◯ Partial

117. Are individuals hygiene being supported. *

- ◯ Yes
- ◯ No
- ◯ Partial

118. Are sling assessments in place and being carried out by a trained and competent professional. *

- Yes
- No
- Partial

119. Are staff using the correct moving and handling equipment and slings. *

- Yes
- No
- Partial

120. Is the service taking appropriate steps to manage and/or improve pressure areas. *

- Yes
- No
- Partial

121. Is the service delivering wound assessment, evaluation and management. *

- ◯ Yes
- ◯ No
- ◯ Partial

122. Is the service taking appropriate steps to manage and/or improve clinical conditions. *

- ◯ Yes
- ◯ No
- ◯ Partial

123. Where there is an assessed need, is the service appropriately monitoring and managing continence care. *

- ◯ Yes
- ◯ No
- ◯ Partial

Activities

124. Does the service offer a range of social and physical activities for people inside the service. *

- ◯ Yes
- ◯ No
- ◯ Partial

125. Does the service offer a range of social and physical activities for individuals outside of the home. *

- ◯ Yes
- ◯ No
- ◯ Partial

126. Are activities in both a group and 1:1 basis. *

- ◯ Yes
- ◯ No
- ◯ Partial

127. List activities for those individuals bed bound or who prefer to stay in their room. *

128. Are individuals involved in planning activities and are they person-centred to reflect individual interests. *

- Yes
- No
- Partial

129. Does the home document participation in activities. *

- Yes
- No
- Partial

130. Is there a dedicated activities coordinator for the home. How many hours per week do they work. How many days are covered. *

Care Planning & Risk Assessment

131. Are individual's records stored confidentially and securely. *

◯ Yes

◯ No

◯ Partial

132. Are individual's care plans person-centred through the inclusion of preferences and/or routines. *

◯ Yes

◯ No

◯ Partial

133. Are there risk assessments in place for identified risks. *

◯ Yes

◯ No

◯ Partial

134. Have control measures been put in place for the assessed risk(s). *

- ◯ Yes
- ◯ No
- ◯ Partial

135. Are care plans and associated documentation accurate, consistent and legible. *

- ◯ Yes
- ◯ No
- ◯ Partial

136. Are there contact details of the relevant professionals, Next of Kin and relatives, etc. *

- ◯ Yes
- ◯ No
- ◯ Partial

137. Are person-centred daily records kept regarding the persons health and wellbeing. *

- Yes
- No
- Partial

138. Is information communicated to staff at shift change. *

- Yes
- No
- Partial

139. Does the service assess capacity where appropriate. *

- Yes
- No
- Partial

140. If an assessment is required, is it decision specific. *

- Yes
- No
- Partial

141. Where consent to care cannot be ascertained, has the Best Interest Decision taken place. *

- Yes
- No
- Partial

142. Where applicable, are outcomes recorded, reviewed and progress evidenced. *

- Yes
- No
- Partial

143. Has the individuals care plan been developed with the individual or with family, friends and representatives. *

- ◯ Yes
- ◯ No
- ◯ Partial

End of Life - to be completed by homes that offer this service ONLY.

144. Is the service undertaking advanced care planning.

- ◯ Yes
- ◯ No
- ◯ Partial

145. Are DNA / CPRs / RESPECT / FREED being used appropriately and follow the guidance outlined by teh Resuscitation Council.

- ◯ Yes
- ◯ No
- ◯ Partial

146. Are staff in the service adequately trained to deliver end of life care.

- ◯ Yes
- ◯ No
- ◯ Partial

147. Does the service have the relevant equipment to meet the needs of people who are at end of life.

- ◯ Yes
- ◯ No
- ◯ Partial

148. Is the service engaging with the relevant GP / Health Professional to ensure people who are at end of life have the required medication / care.

- ◯ Yes
- ◯ No
- ◯ Partial

Complaints & Compliments

149. Have complaints been resolved, following the services complaints procedure and been thoroughly investigated. *

◯ Yes

◯ No

◯ Partial

150. Is the outcome communicated to the complainant and other interested parties. *

◯ Yes

◯ No

◯ Partial

151. How many complaints have you received in the last quarter. Please outline number and complainant type (i.e., individual, family, professional, etc). *

152. How many complaints have been upheld in the last quarter. Please outline number and complainant type (i.e., individual, family, professional, etc). *

Quality Assurance & Auditing

153. When did your last internal Quality Assurance audit take place in the home. *

154. When was your last medication audit. What was the results. *

155. Are there care file, daily notes and daily charts audits conducted and identified issues rectified. *

- Yes
- No
- Partial

156. Are call bell responsiveness being checked. *

- Yes
- No
- Partial

157. Are appropriate specialism audits conducted - i.e., personnel, recruitment files, IPC, weights/MUST, dining experience, health and safety, etc. *

- Yes
- No
- Partial

158. Are there financial audits relating to individual's personal allowance conducted. *

- Yes
- No
- Partial

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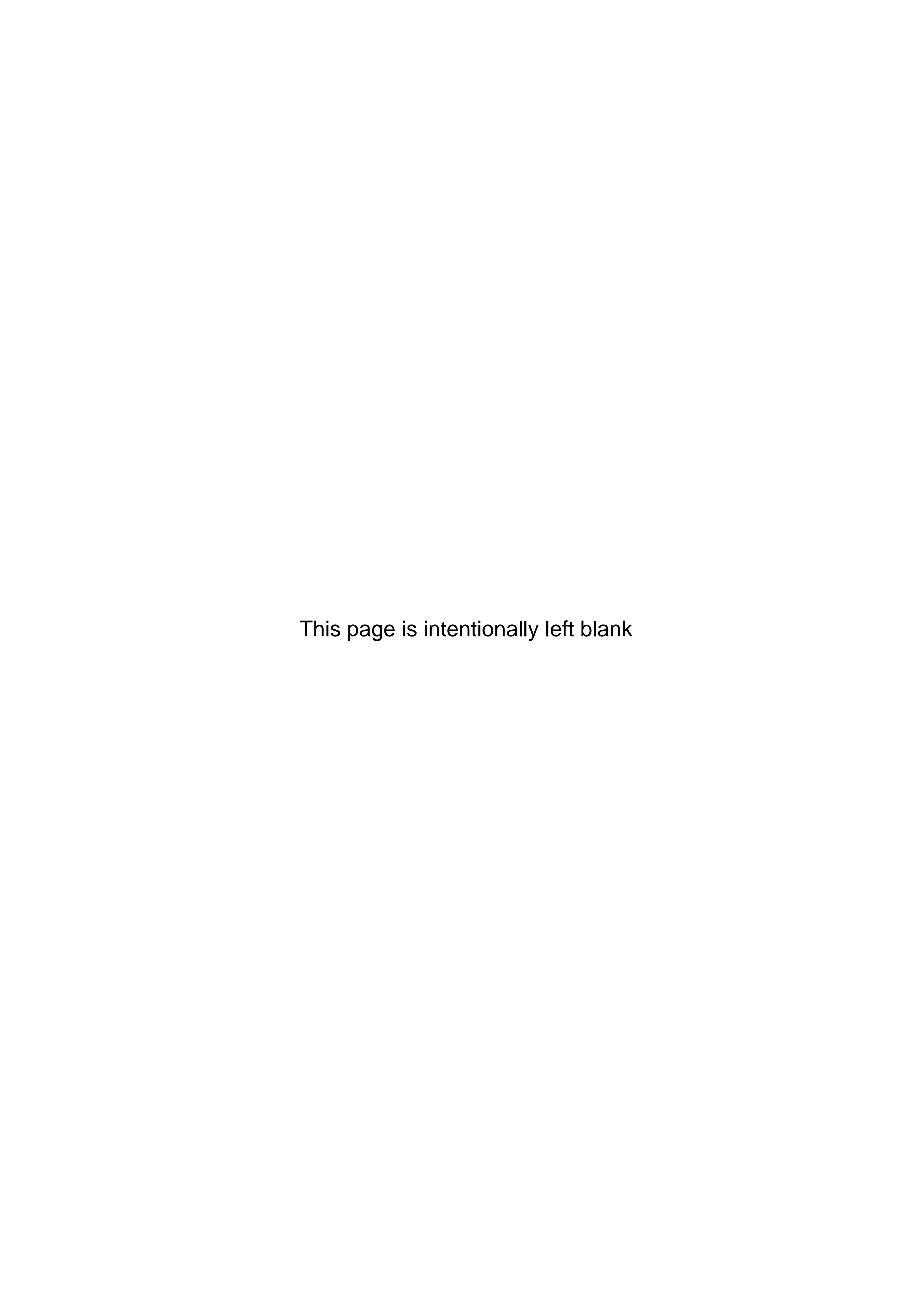
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Provider:

Care Homes Annual Quality Assurance Self-Assessment

No.	Quality Question	TEXT / DATA: Good Response or Fully Compliant (0 Points)	TEXT / DATA: Adequate Response or Partially Compliant (1 Point)	TEXT / DATA: Poor Response or Not Compliant (2 Points)	MULTIPLE CHOICE SCORING MATRIX: Fully Compliant or Good Response (0 Points)	MULTIPLE CHOICE SCORING MATRIX: Partially Compliant or Adequate Response (1 Point)	MULTIPLE CHOICE SCORING MATRIX: Not Compliant or Poor Response (2 Points)	ANALYSIS OF EVIDENCE PROVIDED (if requested): *Calculations are based on initial aswer to QA query. This can be changed if evidence sought has not provided the current evidence.	SCORING MECHANISM: Columns E to J list scoring according to query type and Provider answer. Populate the number outlined in row 4, correlating to the answer from the Provider in each relevant cell. Text answers will be score allocated based on the Providers answer and the Officers perception of the answer to the question. This could change based on evidence gathered from the Provider.	SCORING GUIDANCE: Officers may be require specific evidence and data from Provider to score accurately (i.e., total data for scoring averages and percentages, comparison over previous quarters/years, comparison on 'good' rated Provider data against assessed Provider data).	ICB COMMENTS
	Business Information										
1	Name of Care Home										
2	Name of Parent Company. If not applicable, state N/A.										
3	Care First ID (as found on Community Care Order Schedule). If you are not a commissioned provider, please state N/A.										
4	CQC Registration Service Number (if applicable).										
5	Name of nominated individual.										
6	Name of Registered Manager.										
7	Number of registered beds.										
8	Number of beds occupied on date of self-assessment.								0 = 95% beds filled; 1 = 75-94% filled; 2 = less than 74% filled	Increase in bed voids leads to decrease in business viability.	
9	Number of Council funded placements. If you do not have funded Council beds, please state N/A.								0 = 0-20% beds occupied; 1 = 21-50% occupied; 2 = 51% or more occupied	Increase in Council beds leads to increase in liability if there is a provider failure.	
10	Number of Continuing Healthcare funded beds. If you do not have CHC funded beds, please state N/A.										
11	Current CQC rating.										
12	Date of last CQC inspection.										
13	Is the CQC rating displayed within the home for visitors to view.								0 = Yes; 2 = No	Encouraging transparency.	
14	List actions that have come from the last CQC inspection. If not applicable, please state N/A.								0 = no current actions; 2 = actions ongoing	Current actions and rectifications are a risk.	
15	Are there any improvement actions in place from your quality assurance or management team. If there are no actions required, please state N/A.								0 = no current actions; 2 = actions ongoing	Current actions and rectifications are a risk.	
16	Is your service/business registered with the ICO - Information Commissioner's Officer. Yes No								0 = Yes; 2 = No	Those not registered are at risk of a fine. This is now a legal business requirement.	
17	Does your business have Public Liability insurance up to £10m. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Recommended liability amount via Procurement.	
18	Does your business have Employers Liability insurance up to £5m Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Recommended liability amount via Procurement.	
19	Does the home display the insurance policies for visitors to view. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Encouraging transparency.	
20	Which Health and Safety company does the home use.										
21	Are there any current health and safety action plans in place. Please list below, if Yes. If No, state N/A.								0 = no current actions; 2 = actions ongoing	Current actions and rectifications are a risk.	
	Safeguarding										
22	Does your home have access to and is following the latest Council Adult Safeguarding Enquiry Procedures. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All care homes should be aware of the Council's safeguarding procedures to report on EMARF as a statutory requirement.	
23	Does the home report safeguarding issues when necessary to the Counci's EMARF (the Electronic Multi Agency Referral Form). Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All care homes should be aware of the Council's safeguarding procedures to report on EMARF as a statutory requirement.	
24	Are safeguarding incidents recorded within the home. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All care homes should be logging, monitoring and carrying out trend analysis of safeguarding incidences.	
25	If recorded, how is this done. If not recorded, please state why.								0 = Good; 1 = Adequate; 2 = Poor	A digitial platform recording via a matrix or database for safeguarding and quality issues is best practice. Hardcopy recording is acceptable, but no recommended.	
26	Is there a whistleblowing procedure in place and is it accessible to staff.								0 = Good; 1 = Adequate; 2 = Poor	Required	
	Health & Safety										
27	Is there a Fire Risk Assessment. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Required	
28	Has the Fire Risk Assessment been reviewed within the last 12-months or sooner if there have been significant changes to the home. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	New assessments should be carried out after significant changes to the home or number of service users changes. The more current the assessment, the less risk.	
29	Have findings from the Fire Risk Assessment been implemented. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Any findings of risk should be rectified ASAP.	
	Policies & Procedures										
30	Do you have the following up-to-date policies and are they readily available for staff. *Multiple answers.*										
	Moving and Handling								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Health and Safety								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Food Hygiene								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Human Resources								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Recruitment and Appraisals								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Medication								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Equality and Diversity								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Modern Slavery								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Recommended	
	Quality Assurance								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Training								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Money Handling								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Gifts and Hospitality								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Data Protection and GDPR								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Whistleblowing and Complaints								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Infection Prevention and Control								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	
	Business Continuity								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential	

No.	Question	Scoring	Guidance
	First Aid	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	Supervision	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	Advocacy	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Recommended
	Confidentiality	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	Death of a Resident	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	Challenging Behaviours	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	MCA and DoLS	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	Missing Persons and Wandering	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	Nutrition and Hydration	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	Oral and Dental	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	Person-centred and Strength-based Care	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	Tissue Viability (pressure relief)	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	Record Keeping	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
	Medical Emergency Response	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Essential
31	Have policies been reviewed within the home's established timelines and refer to current legislation. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Policies should be reviewed within 3-months of review date recommendation and align to new legislation and regulations.
32	Is your Business Continuity Plan reviewed annually to reflect changes in the service. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Policies should be reviewed within 3-months of review date recommendation and align to new legislation and regulations.
	Leadership & Staffing		
33	What is the management structure for the home, including on call rota.	0 = Good; 1 = Adequate; 2 = Poor	Business should have hierarchal structure, differentiating management and supervisory duties.
34	What is the home's staffing structure.	0 = Good; 1 = Adequate; 2 = Poor	Each department should have a structure with line management duties.
35	Do all staff have annual appraisals. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Annual appraisals are essential.
36	Is there a probationary period for new staff. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Probationary periods should be 3 months for management and 1 month for other staff.
37	How long does probationary period last for new staff. 3 months 6 months 12 months Mixture Other	0 = 12 months, Mixture, 6 months (Fully); 1 = 3 months (Partially); 2 = Other (Not Compliant)	The longer the probationary period, the better quality of staffing skills and retaining staff, particualry management.
38	Are references required for all agency staff. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	References are essential for all agency staff through their agency.
39	Is there a PIN on file for Nurses with revalidation due date. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Nurses must have up to date PIN to practice in the UK as a registered nurse.
40	Are there regular staff meetings in the home. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Best practice include weekly staff meetings with care staff. With daily shift handover meetings. Non-care staff, at least monthly.
41	How often does staff meetings occur. Weekly Fortnighly Monthly Quarterly Mixture None	0 = Weekly, Fortnightly, Mixture (Fully); 1 = Monthly (Partially); 2 = Quarterly (Not Compliant)	Best practice include weekly staff meetings with care staff. With daily shift handover meetings. Non-care staff, at least monthly.
42	How many permanent staff left in the last 12-months. List job roles. If none, state N/A.	0 = Good; 1 = Adequate; 2 = Poor	5% or less of overall staff (0 = Good); 6 - 20% of overall staff (1 = Adequate); 21% plus of overall staff (2 = Poor)
	Recruitment		
43	Is there an application form on file for all roles in the home. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Best practice should include standard application questions to get the best candidates with the most relevant qualifications and experience.
44	Are interview questions and answers recorded and kept on file. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All questions and answers to interviews should be kept on file.
45	Is an employment contract provided for all new permanent staff (this will include appointment offer, employment agreement and job specification). Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All permanent staff should have an employment contract with appointment offer, agreement and specification.
46	Has a DBS check been undertaken for all home staff. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All care home staff must have an up-to-date DBS check. This includes bank staff as well.
47	Are all agency staff checked for DBS compliance. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All agency staff must have an up-to-date DBS check.
48	Has those with a DBS disclosure been reviewed and risk assessed. Yes No Not applicable, no disclosures	0 = Not applicable, no disclosures, Yes (Fully); 2 = No (Not Compliant)	Any disclosures must be reviewed and risk assessed.
49	Has a declaration of criminal convictions been completed on all home staff. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Any criminal convictions must be completed by staff.
50	Has a health declaration and fitness to work been completed on all staff. Yes No Partial	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Health declarations must be completed at point of new appointment after return to work after 7-days in a row sickness absence.
51	Is there a recent photograph on file for all staff. Yes	0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	It is recommended that all staff have a recent picture of themselves on

	No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	their HR record.
52	Has staff gaps in employment history been explored or explained. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Staff gaps during the recruitment process, should be explored and explained as best practice.
53	Is there a list on file of staff qualifications. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Qualifications should be recorded with evidence of certificates, diplomas and degrees.
54	Is your home a licenced sponsor organisation for international recruits. Yes No									
	Medication									
55	Are there clear processes for handling controlled drugs in place. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	There should be clear processes in place for handling controlled drugs as outlined in *NICE Guidelines Managing medicines in care homes Social care guideline [SC1]Published: 14 March 2014 - https://www.nice.org.uk/guidance/sc1*
56	Are there clear procedures in place should an individual repeatedly refuse medication. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Procedures and processes should be included in their Medication Policy. The policy must be up-to-date and reviewed annually.
57	Is there a covert medication policy in place where applicable. Yes No								0 = Yes (Fully); 2 = No (Not Compliant)	Each care home should have a 'covert medication policy' that is up-to-date and reviewed annually.
	Accidents and Incidences									
58	Is the staff aware of the Serious Incidents Reporting Framework (applicable to CHC funded placements). Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Staff should have access to and be aware of the Serious Incidents Reporting Famework.
	Training									
59	Does the home have a training matrix or equivalent monitoring system in place for all staff. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Each home should have a training matrix that is either a digital platform or spreadsheet/document that is regularly monitored.
60	Is the training matrix or equivalent monitoring system able to identify the status of staff training. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	The matrix or monitoring system should have dates of training completed as well as upcoming refresher courses.
61	How is staff training carried out.								0 = Good; 1 = Adequate; 2 = Poor	Training should be carried out by an inhouse trainer, line manager, trainer or reputable external training provider for care homes.
	Access to NHS Commissioned Services									
62	Is the home successfully accessing NHS Commissioned services. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	All care homes must have timely access to NHS commissioned services. If they do not, the Commissioner should work with the Provider and Primary Care Network NHS Officer to rectify.
63	Where the service highlighted concerns with access to the NHS, has this been reported appropriately. Please explain. If no issues, please state N/A.								0 = Good; 1 = Adequate; 2 = Poor	Issues must be highlighted and reported in a timely manner. This should not be left for weeks on end.
	Complaints & Compliments									
64	Is the procedure on how to complain and compliment the service communicated to everyone. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	A complaints and compliments procedure must be made accessible by all service users, visitors and professionals. When requesting evidence, this should be available at reception.
65	Does the service make available the contact details for the Local Government and Social Care Ombudsman (LGSCO) when an individual is unsatisfied with the way a complaint has been handled. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	This should be included in the homes complaints policy.
66	Is there a record made of all concerns / comments / compliments and the action taken. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	A log whether it's a spreadsheet, database, or form should be kept on file with actions and dates.
67	Does the service identify and act upon trends from received complaints. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Trends shuld be monitored and acted upon as staffing lessons learned.
68	Are compliments shared with staff, residents and other visits to the home. Yes No Partial								0 = Yes (Fully); 1 = Partial (Partially); 2 = No (Not Compliant)	Compliments should be shared either on display, newsletter, etc.
	Quality Assurance & Auditing									
69	Is there a Quality Assurance matrix or monitoring system in place for the home. If so, please explain the type and details.								0 = Good; 1 = Adequate; 2 = Poor	This could be via spreadsheets, database or headquarters regular quality assurance monitoring with a breakdown of issues and concerns and timely rectifications.
70	Does internal Quality Assurance audits take place and how often.								0 = Good; 1 = Adequate; 2 = Poor	Medication checks take place end of each shift. Refrigerators take place daily, rehabilitation pool checks are every 24-hours. Comprehensive Quality Assurance checks should take place inhouse monthly, or quarterly audits from head office or external specialist provider.
71	Are individuals (service users) data and information in a secure and dedicated office or system. Please explain.								0 = Good; 1 = Adequate; 2 = Poor	Office and filing cabinet must be locked. Computerised must be accessible to relevant staff only.
TOTALS		0	0	0	0	0	0			
	GRAND TOTAL	**0**								

Provider:

Residential Care Homes Quarterly Quality Assurance Self-Assessment

No.	Quality Question	SCORING GUIDANCE Officers may be require specific evidence and data from Provider to score accurately (i.e., total data for scoring averages and percentages, comparison over previous quarters/years, comparison on 'good' rated Provider data against assessed Provider data).	ICB COMMENTS
	Business Information		
1	Name of Care Home.		
2	Name of Parent Company. If not applicable, state N/A.		
3	Care First ID (as found on Community Care Order Schedule). If you are not a commissioned provider, please state N/A.		
4	CQC Registration Service Number.		
5	Name of nominated individual.		
6	Name of Registered Manager.		
7	Number of registered beds.		
8	Number of beds currently occupied.	Personal allowance audits should be carried out monthly.	
9	Number of Council funded placements. If you do not have funded Council beds, please state N/A.	Increase in Council beds leads to increase in funding liability if there is a provider failure.	
10	Number of Self-funder beds.	Decrease in Council funding liability.	
	Safeguarding		
11	Does your service analyse safeguarding issues, trends and themes and take steps to prevent further instances through 'lessons learned' and 'in-house action plans' (separate from any 'mutually-agreed' or imposed suspension with CWC).	Analysis of trends and recitifications ensures likelihood of quality assurance compliance.	
12	How are lessons learnt from safeguarding investigations shared with staff.	It is pertinent to ensure lessons learnt are shared with staff to improve quality.	
13	How is the process of 'duty of candour' followed in the home and can this be evidenced if asked.	Proves transparency with service users and lessons learnt.	
14	Are staff able to articulate or demonstrate know how to report safeguarding concerns to the Local Authority.	All staff should be aware of what a safeguarding issue is and how to report to the Council.	
	Health & Safety		
15	Is there an appropriate Personal Emergency Evacuation Plan (PEEP) for current residents. Yes No Partial	PEEP plans should be updated when new residents are admitted, during hospital admissions and changes to accommodation structure and teams.	
16	Do you perform fire evacuation drills and training to reflect changes in circumstances. Yes No Partial	Fill evacution drills and training are required to reflect any changes within the home structure, team or service users as and when required as a safety component.	
17	How often does the drills and training occur.	Regular drills and training are required. Recommend at least quarterly.	
18	Is there an arrangement in place to ensure fixed and moveable equipment is adequately maintained. Yes No Partial	All equipment must be maintaned and fixed according to maintenance schedule and recorded.	

19	Is there an equipment maintenance schedule with checks completed on premises (i.e. PAT, LOLER, etc). Yes No Partial	There should be a maintenance schedule and checks on premises. If held within the business HQ, the Managers must have immediate access to this and are able to provide to commissioners when requested.	
	Leadership & Staffing		
20	Is there a permanent CQC Registered Manager in place. Yes No	Providers are required to have a permanent CQC registered manager in place or in the process of recruitment.	
21	If 'Yes' how long. Choose 'Not applicable' if you answer 'No' to question 20. 6 months of less 7 to 12 months 13 to 24 months 2 plus years Not applicable	The premise is that the longer a registered manager is in their role, the better led the service in regards to quality, delivery and maintenance.	
22	If 'No' to question 20, how long have you been recruiting for this post. If 'Yes' to question 20, choose 'Not applicable'. 3 months or less 4 to 6 months 7 to 12 months More than a year Not applicable	The longer it takes to recruit for a registered manager, the likelihood of reputational issues, low salary, staffing instability and business viability.	
23	Does your Registered Manager have management qualifications (i.e., Level 5, management diploma, degree or work experience equivalent, etc). Yes No Partial	It is encouraged that a registered manager has a management qualification or health and social care qualification or relevant work experience in a similar service for a significant period of time (3 years plus is encouraged).	
24	Does your Deputy Manager have management qualifications (i.e., Level 5, management diploma, degree or work experience equivalent, etc). Yes No Partial	This is not essential but encouraged that the deputy also has a management or health and social care qualification or several years work experience in a similar service.	
25	What is the care staffing ratio per residents. Please list per service type (i.e. complex, dementia, etc). List for day, afternoon and night shift.	Providers must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs and therefore meet the requirements of Section 2 of these regulations (the fundamental standards). There is no set matrix for this, so providers and commissioners must discuss what is adequate per service area and needs of the SU. https://www.cqc.org.uk/guidance-providers/regulations/regulation-18-staffing	
26	Does the home utilise a dependency tool for staffing, which tool and how frequently is this reviewed.	It is recommended that homes each have a tool to ascertian staffing level or a matrix.	
27	List all current vacancies and roles.	The higher the vacancies and the need for agency staff, the more risk.	
28	What is your agency staffing percentage in relation to overall roles across the service on average, for the last 12-months. 0% agency staff 1 to 10% agency staff 11 to 30% agency staff	The higher the vacancies and the need for agency staff, the more risk.	

	31 to 50% agency staff 51% plus agency staff		
29	Have all care staff completed a 'Care Certificate' as part of their induction training. Skills for Care. Care certificate. Available at: https://www.skillsforcare.org.uk/Developing-your-workforce/Care-Certificate/Care-Certificate.aspx Yes No Partial	It is recommended that homes have at least the 5 day Skills for Care certificate as part of their induction training or an in-house training programme that is similar.	
30	Is management and care staff having monthly supervisions. Yes No Partial	Supervisions whether individually or by groups is pertinent for staff continual professional development.	
31	Do supervisions provide the opportunity for care staff to have on-to-one conversations with their line manager. Yes No Partial	One-to-one supervisions are recommended, however, this may not be possible with larger and busy teams.	
32	Are supervision records signed off by both the supervisor and supervisee. Yes No	This is required to ensure transparency and for future appraisals.	
33	Does actions take place when identified in supervisions. Yes No Partial	Any actions from supervisions, should be followed through, monitored and recorded.	
34	What is your currently agency ratio against permanent staff. 0% 1 - 10% 11 - 20% 21 - 35% 36 - 50% 50% plus	The higher the ratio of agency staff, the more risk to teams in capturing quality issues, recording and understanding processes.	
35	How many permanent staff left in the last quarter. List the roles. If not applicable, please state N/A.	Where there is high levels of staff leaving, could be a symptom of service issues and quality risks.	
	Recruitment		
36	Is there evidence on file of staff qualifications. Yes No Partial	All staff qualifications should be provided and kept on file, particularly management and registered nurses.	
37	Has those staff with foreign passports been checked with confirmed evidence on file for 'right to work' in the UK. Yes No Partial	Staff who are not British, must prove eligibility to work in the UK and must be kept on file.	
38	How many International recruits do you currently employ - numerical response required - this should be a "people count" rather than whole time equivalent. Differentiate between the 3 main role types - "care worker", "non-care worker" and "Manager".		
	Medication		
39	Are risk assessments put in place where people self-administer their medication. Yes No Partial	All service users that self-administer their medication, should be risk assessed and monitored that they are taking them during each shift.	
40	Is medication stored securely. Yes	All medications must be stored securely in a medications	

	No Partial	room or refrigerator (if required).	
41	Is there person identifiable information on the MAR sheet. Yes No Partial	All service users information should be clear and concise on each MAR sheet.	
42	Does the MAR sheet give adequate explanation if or when medication has not been given. This should include appropriate use of the key or coding. Yes No Partial	All information regarding medication administration or not, should be provided clearly and concisely on each MAR sheet.	
43	Are MAR sheet clear to read. Yes No Partial	MAR sheet information should be easily able to read for each staff member and shift change.	
44	Are handwritten additions on the MAR sheets checked and counter signed. Yes No Partial	Any changes and additions for MAR sheets should be audited regularly during a shift or auditing schedule. If it's a controlled drug, this will need to be signed off by a registered nurse or Dr.	
45	Does the MAR sheet adequately provide instruction on how prescriptions should be administered. Yes No Partial	Medication instructions must follow GP or Nurse Practitioner guidance and must be listed on the service user's MAR sheet.	
46	Where applicable, are PRN (when required) protocols in place, sufficiently detailed and the reason for each PRN administration clearly documented. Yes No Partial	Pro re nata' indicates authorising nurses to administer medications according to Patient's requests and nurses discretion. This is unscheduled medication administration either alone or in addition to routine/regular prescriptions. A protocol and process should be available in each home and for commissioners to review.	
47	If medication dosage is variable, is the dosage recorded. Yes No Partial	All medication guidance and administering should be recorded on a MAR sheet as well as the service users medication summary.	
48	Are regular medication fridge temperature checks carried out and are they within guidelines. Is there a clear checklist schedule for the fridge/s. Yes No Partial	Each home should have a refrigeration checklist schedule, monitored by staff and recorded to ensure accuracy depending on medications that are kept in cooler settings.	
49	Are regular medication room temperature checks carried out and are they within guidelines. Yes No Partial	Each medication room temperature should be checked and follow guidelines stipulated for the medication kept in cooler settings.	
50	Is there a protocol in place should the medication room or fridge temperature not be within acceptable ranges. Yes No Partial	A protocol and process must be available to staff when there is an issue with temperature ranges that could effect the medications efficacy.	
51	Is there a process to ensure prescriptions are up to date and reviewed as needs/conditions change. Yes	There should be a process and schedule to ensure medications are stocked adequately or when there are	

	No	changes of need/condition there is adequate time to inform the GP Surgery to update prescription and access from pharmacy.
52	Is excess medication stock disposed of correctly. Yes No	All excess medication stock must be disposed of correctly as per the home's medication policy.
53	Is there a system or process in place to manage medication stock control. Yes No	Each home should have a medication stock control matrix or schedule and this should be monitored regularly, with a pill count after each shift and allocated audit schedule.
54	If covert medication is being given, is there relevant medical professional input in the decision-making process and consideration to DoLS. Yes No	Each home should have a covert medication policy or it should be included in their medication policy. This should be guided by the affiliated surgery to the home and included in their MCA/DoLS assessment.
55	Is there adequate provision for the prescribing, dispensing or administration of medication. Yes No Partial	There should be an affiliated GP surgery for each home or service users with easy access to a pharmacy to collect or deliver medications and staff on duty to administer during each shift.
56	Is the date of opening recorded on medication where appropriate. Yes No Partial	Medications stored and administered must be in-date and recorded on a medication schedule.
57	Number of medication errors in the last quarter.	Medication errors should be kept at a minimum and listed for lessons learnt. See NICE guidelines for managing medicines in care homes - https://nice.org.uk/guidance/sc1
58	Number of medication errors leading to a serious incident in the last quarter.	Serious incidences from medication errors must be recorded and should be considered whether this is a safeguarding event.
	Accidents & Incidences	
59	Are accidents/incidents documented appropriately. Yes No Partial	All accidents and incidents must be documented for staff to review and learn lessons from.
60	Do records clearly state actions taken and preventative action to be taken to avoid further occurrences. Yes No Partial	Actions and lessons learned is a preventative measure.
61	Have incidences been referred/reported as necessary - i.e., relative. Yes No Partial	Any accidents and incidences must be notified to the service users next of kin or representative and a recording of doing this.
62	Is the duty of candour process followed. Yes No	The should be a 'duty of candour' process that is followed by staff.
63	Does the Provider assess any trends and do they develop action plans where required. Yes No Partial	Action plans and trends should be carried out and recorded when things go wrong to ensure credibility and accountability.
	Training	

No.	Question	Guidance
64	Does the service offer continuous staff development and mentoring. Yes No Partial	Continued professional development and mentoring should be carried out by senior staff to junior staff or new starters to enable good quality practice.
65	Is manual handling training offered to all new care staff and refreshers offered when required. Yes No Partial	Every home must provide manual handling training as part of their induction training and refresher training every year or when new equipment is mobilised in-house or an external provider.
66	Does the manual handling training include single care equipment. Yes No	Though single care equipment is not manditory, it is recommended when there is capacity issues. Single care equipment is being implemented across various LA's across
67	Is medication training offered to all new care staff and refreshers offered when required. Yes No Partial	All new care staff must be offered a mediation training course during induction, access to the medication policy and covert medication policy and provide at least an annual refresher course.
68	Is safeguarding offered to all new staff and refreshers offered when required. Yes No Partial	All new care staff must be offered a safeguarding training course during induction, access to the council's safeguarding policy and provide at least an annual refresher course.
69	Is there regular mental capacity act and DoLS training for all staff and refreshers offered when required. Yes No Partial	All new care staff must be offered an MCA/DoLS course during induction, access to the council's MCA/DoLS policy and provide at least an annual refresher course.
70	Is specialism training offered (appropriate to the service) to all new care staff and refreshers offered when required. Yes No Partial	All new care staff must be offered specialist training during induction and provide at least an annual refresher course.
71	Is behaviours that challenge training offered to all new care staff and refreshers offered when required. Yes No Partial	All new care staff must be offered 'behaviours that are challenging' during induction and provide at least an annual refresher course.
72	Is nutritional screening training offered to all new care staff and refreshers offered when required. Yes No Partial	All new care staff must be offered nutritional screening training during induction and provide at least an annual refresher course.
73	Is pressure care training offered to all new care staff and refreshers offered when required. Yes No Partial	All new care staff must be offered pressure care training during induction and provide at least an annual refresher course.
74	Is infection prevention and control offered to all new care staff and refreshers offered when required. Yes No Partial	All new care staff must be offered infection prevention and control training during induction and provide at least an annual refresher course.
	Food & Nutrition	
75	Is a choice of menu available to individuals. Yes No Partial	Service users should be offered a choice of food at meal time and take into consideration, service users preferred choices, meat and vegetarian options.
76	If there is a menu, is it available in different formats - i.e., pictural, written.	A pictural menu and a written menu should be offered for

	Yes No Partial	A pictural menu and a written menu should be offered for those with a learning disability, aquired brain injury, dementia, etc.
77	Are individual's special dietary needs catered for. Yes No Partial	Special dietary needs should be catered for according to their nutrition screening, any medical condition, religious requirement, etc.
78	Is the information regarding specialist diet or IDDSI requirements available for staff. Yes No Partial	Specialist dietary or IDDSI (food textures and drink thickness for those with dysphagia) requirements must be available to all care staff and kitchen staff based on assessed need.
79	Where are thickeners stored in the home.	Best practice is to store resident's labelled container of thickener safely and securely, in a similar manner to medicines.
80	Where monitoring is required, are individuals at risk of choking regularly assessed during meal times. Yes No Partial	Individualised risk assessment and care planning is required to ensure that vulnerable people are identified and protected and should be clearly documented details of consistency of fluids, texture the resident can manage and feeding strategies (head and body positioning).
81	Depending on need, are individuals supported to eat and drink independently, with assistance or using appropriate assistive aids. Yes No Partial	Individuals should be supported with positioning, time between bites and swallowing and texture modification or any aids applicable to their level of dysphagia.
82	Where required are people prompted to drink. Yes No Partial	Those with dementia often forget to drink, therefore, it is important that drink levels are monitored and measured by staff and recorded during each shift to ensure hydration.
83	Are drinks made freely available to all individuals. Yes No Partial	Individuals with demential or cognitive impairments should be provided with drinks throughout the day and night and topped up to ensure hydration.
84	Is there fluid goals or evidence of a process/strategy to ensure individuals receive adequate fluids. Yes No Partial	Fluid goals should be recorded on the resident's nutrition screening and monitored during each shift.
85	Is fluid intake totalled during each shift. Yes No Partial	Fluid intake should be recorded and calculated at the end of each shift for those applicable.
86	Is it clear from food recordings how much food is consumed by each individual. Yes No Partial	Food consumption should be recorded after each meal, specifically for those with required within their nutrition assessment.
87	Is individual's food and fluid intake in line with dietary needs. Yes No Partial	Food and fluid intake must be in line with their nutrition assessment.

88	Does actions take place for individuals when low fluid and food intake is monitored such as contacting professionals or other appropriate steps. Yes No Partial	Actions to be recorded and monitored when there is any changes to food and fluid intake. Relevant professionals to be contacted and advised of such changes.	
89	Does the service follow advice from professionals such as GP, SALT, and dietician as and when required per individual's specified needs. Yes No Partial	Specialist and medical advice for each individual must be applied and reviewed with professionals regularly or when changes to the individuals habits are identified.	
90	Are kitchen staff trained in the different consistency of foods. Yes No Partial	Where individuals are required to have thickeners, staff must be trained and advised on consistency and when this is required.	
91	How are menu's planned and how frequently are they reviewed or changed.	Menu's should be planned according to dietary requirements and individuals consulted on preference through their care and support plan.	
	Access to NHS Commissioned Services		
92	Is the home successfully accessing NHS Commissioned services. Yes No Partial	If providers are unable to access NHS services, their GP or Primary Care Network representative should be informed as well as their Commissioning Officer.	
93	Where the service highlighted concerns with access to the NHS, has this been reported appropriately. Please explain.		
	Physical Environment		
94	Are the communal lounge/s clean, in good repair, fit for purpose and free from hazards. Yes No Partial	Ask for a picture of rooms and cleaning schedules if you require evidence.	
95	Are individual's rooms clean, in good state of repair, fit for purpose, person-centred and free from hazards. Yes No Partial	Ask for a picture of rooms and cleaning schedules if you require evidence.	
96	Are bathrooms and toilets clean, in a good state of repair, for for purpose and free from hazards. Yes No Partial	Ask for a picture of rooms and cleaning schedules if you require evidence.	
97	Is the kitchen clean, in a good state of repair, fit for purpose and free from hazards. Yes No Partial	Ask for a picture of rooms and cleaning schedules if you require evidence.	
98	Is the laundry room clean, in a good state of repair, fit for purpose and free from hazards. Yes No Partial	Ask for a picture of rooms and cleaning schedules if you require evidence.	
99	Is there appropriate hand hygiene equipment around the home. Yes No Partial	Ask for pictures of hygiene equipment around the home and location.	
100	Does the laundry operate a dirty and clean flow.		

	Yes No Partial	Ask for schedule for evidence.	
101	Is there a sluice room and is it used appropriately. Yes No Partial	Request picture and location for evidence, if required.	
102	Is the service free of any key infection control risks not already identified in the previous questions that require escalation or further advice or guidance. Yes No Partial	Ask for infection control and prevention risk checklist and sign-off.	
103	Is the home in a good state of repair. Yes No Partial	Ask for pictures of the home in specific locations for evidence.	
104	Is waste stored correctly as guidance - i.e., large clinical waste bins locked. Yes No Partial	Ask for pictures of clinical waste bins and waste contract, if required.	
105	Do residents have access to an outside space or garden. What activities are the outside space used for.	Ask for pictures of outside space to ensure they are safe and tidy.	
	Care & Support		
106	Is the privacy and dignity of people maintained. Yes No Partial	Evidence request can be through completed 'service user satisfaction survey', complaints and staff training.	
107	Are staff seen to treat people with respect and communicate appropriately. Yes No Partial	Evidence request can be through completed 'service user satisfaction survey', complaints and staff training.	
108	Are staff using correct PPE. Yes No Partial	Request PPE and infection control and prevention policy. Request feedback from RWT infection prevention team.	
109	Does the service utilise Assistive Technology (AT) to support people to maintain and increase choice, independence and safety. Yes No Partial	Request evidence of AT systems in use across the home.	
110	Are staff safely and professionally conducting manual handling. Yes No Partial	Request evidence of manual handling assessments and manual handling policy is up to date. Access staff manual handling training and refreshers schedule.	
111	Is there access to call bells throughout the home. Yes No Partial	Each room should have a call bell next to their bed that is accessible for each individual. Request spot pictures of individuals call bells for evidence.	
112	If an individual displayed a behaviour that is challenging, is this managed appropriately. Yes	Access challenging behaviour policy, staff training and refreshers and any risk assessments that include challenging	

	No Partial	refreshers and any risk assessments that include challenging behaviour risk.
113	While maintaining personal choice are people dressed appropriately. Yes No Partial	Assessors can request a picture of a council service user as evidence, however, the service user must agree to this.
114	Are individuals repositioned as and when required as per their care and support plan. Yes No Partial	Request evidence of pressure sore risk assessment and repositioning recording evidence as and when required.
115	Are there adequate care plans and risk assessments to cover clinical care. Yes No Partial	Any clinical care must be recorded and updated and reviewed regularly by the registered nurse on premises and allocated GP. Request care plans, MAR chart and medication risk assessment.
116	Is equipment (i.e., slings) individual to the person. Yes No Partial	Each individual must have their own sling to ensure infection prevention.
117	Are individuals hygiene being supported. Yes No Partial	Request hygiene charts as a spot check and laundry schedule.
118	Are sling assessments in place and being carried out by a trained and competent professional. Yes No Partial	Request spot checks on sling assessments and training schedules with refreshers.
119	Are staff using the correct moving and handling equipment and slings. Yes No Partial	Moving and handling equipment and slings must have usage manuals and up to date manual handling training with clean and robust slings.
120	Is the service taking appropriate steps to manage and/or improve pressure areas. Yes No Partial	Individuals assessed with pressure sores must have up to date pressure ulcer risk assessment and trained staff to deliver care and/or an on premises nurse and/or district nurse, depending on grade. See Pressure ulcers https://www.nice.org.uk/guidance/qs89/chapter/quality-statement-1-pressure-ulcer-risk-assessment-in-hospitals-and-care-homes-with-nursingQuality standard [QS89]Published: 11 June 2015 -
121	Is the service delivering wound assessment, evaluation and management. Yes No Partial	This could be in-house or provided by the District Nursing service. If delivering onsite, the home should have pressure sore training, policy and monitoring assessment.
122	Is the service taking appropriate steps to manage and/or improve clinical conditions. Yes No Partial	This should include any improvements and deterioration of conditions such as pressure sore, weight loss, cognitive impairment, etc.
123	Where there is an assessed need, is the service appropriately monitoring and managing continence care.	

	Yes No Partial	Request evidence of pad changes and monitoring for individual service users.	
	Activities		
124	Does the service offer a range of social and physical activities for people inside the service. Yes No Partial	Request activities schedule and attendance for evidence.	
125	Does the service offer a range of social and physical activities for individuals outside of the home. Yes No Partial	Request activities schedule and attendance for evidence.	
126	Are activities in both a group and 1:1 basis. Yes No Partial	Request activities schedule and attendance for evidence.	
127	List activities for those individuals bed bound or who prefer to stay in their room.	Request 1:1 activities list and participants.	
128	Are individuals involved in planning activities and are they person-centred to reflect individual interests. Yes No Partial	Service users should be consulted about what indoor and outdoor activities are offered as a group on 1:1. Request activities schedules.	
129	Does the home document participation in activities. Yes No Partial	Request evidence of documentation and schedules.	
130	Is there a dedicated activities coordinator for the home. How many hours per week do they work. How many days are covered.	There should be a dedicated activities coordinator or a role that a care worker on manager takes on as part of their regular duties. Activities should be reviewed regularly with service users.	
	Care Planning & Risk Assessment		
131	Are individual's records stored confidentially and securely. Yes No Partial	This should be kept securely on digital systems that have secure software and of offices with cabinets that are locked or office doors locked.	
132	Are individual's care plans person-centred through the inclusion of preferences and/or routines. Yes No Partial	Service Users should be included in care and support planning. This should be identified by the provider. Or their representative.	
133	Are there risk assessments in place for identified risks. Yes No Partial	Risk assessments should be clear, concise and up dated regularly to record any changes in risk.	
134	Have control measures been put in place for the assessed risk(s). Yes No Partial	Risk assessments should include mitigation and actions for each risk identified.	
135	Are care plans and associated documentation accurate, consistent and legible. Yes No Partial	All care plans that are written or typed should be easy to follow, clear and concise in regards to need, risk and mitigation.	

136	Are there contact details of the relevant professionals, Next of Kin and relatives, etc. Yes No Partial	This should be included in the Service Users personal information documentation.
137	Are person-centred daily records kept regarding the persons health and wellbeing. Yes No Partial	Person-centred daily records are updated during each shift and should be requested to evidence.
138	Is information communicated to staff at shift change. Yes No Partial	Request details on shift handover procedures and information sharing.
139	Does the service assess capacity where appropriate. Yes No Partial	Management should assess staffing capacity and prove that they deploy as and when needed.
140	If an assessment is required, is it decision specific. Yes No Partial	Assessments should outline any actions and mitigations required based on assessment outcomes to ensure safety and that level of needs are met on a daily basis.
141	Where consent to care cannot be ascertained, has the Best Interest Decision taken place. Yes No Partial	Request evidence of Best Interest Decision evidence as well as who is the representative.
142	Where applicable, are outcomes recorded, reviewed and progress evidenced. Yes No Partial	Outcomes should be listed for all care and support plans with progress or lack of.
143	Has the individuals care plan been developed with the individual or with family, friends and representatives. Yes No Partial	All care and support plans should be developed with the Service User, family if they are the official guardian or client welfare representative.
	End of Life (Not all Providers may offer this service)	
144	Is the service undertaking advanced care planning. Yes No Partial	End of Life care advanced planning must be completed, signed off and regularly revised by a registered or palliative nurse and GP within the end of life service. Advanced care planning policy should be requested by the provider. See link for further information: https://www.nice.org.uk/guidance/ng142/resources/end-of-life-care-for-adults-service-delivery-pdf-66141776457925
145	Are DNA / CPRs / RESPECT / FREED being used appropriately and follow the guidance outlined by teh Resuscitation Council. Yes No Partial	Request End of Life policy and procedures. Request an example that is current or recent.
146	Are staff in the service adequately trained to deliver end of life care. Yes No	Request End of Life training applicable to staff delivering this specialist care. Ensure training is up to date and part of induction training and refreshers are provided.

	Partial	induction training and refreshers are provided.
147	Does the service have the relevant equipment to meet the needs of people who are at end of life. Yes No Partial	Request manual handeling equipment schedule, clinical equipment used for individuals and that PAT has occurred and up to date. Specialist equipment should be in line with the guidance from the Resusitation Council.
148	Is the service engaging with the relevant GP / Health Professional to ensure people who are at end of life have the required medication / care. Yes No Partial	There should be regular assessments and reviews carried out for care and medications for those on End of Life. Request assessments and details of the GP and Health Professional.
	Complaints & Compliments	
149	Have complaints been resolved, following the services complaints procedure and been thoroughly investigated. Yes No Partial	Request the latest Adults Complaints Team report and any actions from complaints listed in your Trends and Actions Log.
150	Is the outcome communicated to the complainant and other interested parties. Yes No Partial	All complaints processing must adhere to the providers complaints policy and each complaint reviewed with final sign-off, with outcome, with Adults Complaints Team and Adults Commissioning Team.
151	How many complaints have you received in the last quarter. Please outline number and complainant type (i.e., individual, family, professional, etc).	Complaint numbers should be assessed based on complaints 'upheld'.
152	How many complaints have been upheld in the last quarter. Please outline number and complainant type (i.e., individual, family, professional, etc).	Upheld complaints should be minimal and may have to be agreed on appropriate numbers with the Head of Commissioning and the Adults Complaints Team Manager.
	Quality Assurance & Auditing	
153	When did your last internal Quality Assurance audit take place in the home.	Quality Assurance audits should take place at least quarterly.
154	When was your last medication audit. What was the results.	Medication audits should occur daily.
155	Are there care file, daily notes and daily charts audits conducted and identified issues rectified. Yes No Partial	Daily notes charts should be audited weekly, care files audited monthly.
156	Are call bell responsiveness being checked. Yes No Partial	Call bell checks should be carried out hourly and at the end of each shift.
157	Are appropriate specialism audits conducted - i.e., personnel, recruitment files, IPC, weights/MUST, dining experience, health and safety, etc. Yes No Partial	HR files should be checked annually. IPC should be schecked weekly. Weights, MUST, dining and regular health audits should be carried out weekly. Health and Safety should be carried out monthly.
158	Are there financial audits relating to individual's personal allowance conducted. Yes No Partial	Personal allowance audits should be carried out monthly.
TOTALS		
	GRAND TOTAL	

Compliance Level	Residential Qtr	Nur/Dual Qtr	Annual	RAG
	Scoring Points			
Good / Fully Compliant	0 - 94	0 -101	0 - 58	Green
Adequate / Partially Compliant	95 - 198	102 - 202	59 - 117	Amber
Poor / Not Compliant	199 - 298	203 - 304	118 - 176	Red

QUALITY ASSURANCE DASHBOARD SCORING

Criteria Type	Percentage (%) of Overall Criteria Value	Scoring Mechanism									QTR Scoring Example Provider X (Res)	%	Annual Scoring Example Provider X (Res)	%	Average SA Scoring (annual and last quarter return)	% Scoring Mechanism	% of Criteria Scoring	Notes
		Nursing/Dual Qtr Categories & Scoring			Residential Qtr Categories & Scoring			Annual Categories and Scoring										
Quality Assurance Self-Assessments	30	Good / Fully Compliant	Adequate / Partially Compliant	Poor / Not Compliant	Good / Fully Compliant	Adequate / Partially Compliant	Poor / Not Compliant	Good / Fully Compliant	Adequate / Partially Compliant	Poor / Not Compliant	100	34%	60	34%	80	0.33823978		
		0 -101	102 - 202	203 - 304	0 - 94	95 - 198	199 - 298	0 - 58	59 - 117	118 - 176								
Suspensions / Termination of Contract / Monitoring	20	Ongoing Monitoring	Partial Suspension	Full Suspension	Termination of Contract						10					50%	50%	
		5	10	15	20													
CQC Rating	10	Outstanding	Good (rating within last 3 months)	Good (rating within last 3 years)	Good (rating over 3 years ago)	Requires Improvement	Inadequate (automatic suspension)	No Rating			2					20%	20%	
		0	0	2	4	6	8	10										
S.42's over 2-years (scoring once according to each area (2 x 'risk reduced' = 3)	10	No Safeguarding Issues in past 2-years	Risk Removed	Currently Investigating	Risk Reduced	Risk Remains					4					40%		1 risk removed, 2 risk reduced
		0	1	2	3	4												
Complaints Upheld	10	No Complaints in Past 12-months	Complaints Recorded, But No Complaints Upheld in Past 12-months	Complaints Recorded, and One or More Complaints Upheld in Past 12-months							5					50%		
		0	5	10														
Embargoes	10	Providers that Refuse to Comply With QA Assessments (in hosted CWC, not commissioned)									0					0%		
		10																
Contractual Obligations	10	Provider Has Contract/Framework and Completes Contractual Performance Schedule/s	Provider Has Contract/Framework and Partially Complete Contractual Performance Schedule/s	Provider is Commissioned by Spot Only							5					50%		
		0	5	10														
TOTAL	**100%**										126							

Self-Assessment Care Home Schedule *(List date of return in the allocated green cell)*

PROVIDER	ANNUAL RETURN 2024-25		QTR 2 2024-25			QTR 3 2024-25			QTR 4 2024-25			NOTES
	May	June	July	August	September	October	November	December	January	February	March	
Arbour Lodge												
Aldergrove Manor												
Anville Court												
Apple Tree												
Ashley Court												
Aspen Lodge Residential Care Home												
Atholl House Nursing Home												
Belvidere Court												
Bentley Court												
Bethrey House												
Bradley Resource Centre												
Charnwood												
Coachmans Cottage												
Coton Grange												
Coton House												
Duke Street Bungalows												
East Park Court												
Engelberg												
Ernest Bold Resource Centre												
Eversleigh Care Centre												
Foxland Grange (previously Sunrise of Tettenhall)												
Glenthorne House												
Goldthorn Lodge												
Hampton Court EMI Nursing Home (? parent company)												
Harper House												
Highcroft Hall												
Hilton House												
Inshore Support Limited - 110 Wellington												
Inshore Support Limited - 112 Wellington												
Inspirations												
Knoll House Nursing Home												
Langdale and Keswick (Parkfields / Jaffray)												
Langdale and Keswick (Parkfields) / Jaffrey Care Society												
Lavender Court												
Lime Tree Court												
Mancroft												
Maplebrook Care Home												
Meadowcroft												
Mill House												
Mountfield House												
Newbridge House												
Newcross Care Home												
Orchard House Nursing Home												
Park Road CCT												
Parkdale												
Parkfield House / Transitions Care												
Pear Tree Lane												
Penn House												
Primrose Nursing Home												
Redhouse												
Royal Park Care Home												
Stourbridge												
The Cedar Grange												
The Coach House												

The Croft Residential Home												
The Leylands												
Trinity Court Nursing Home												
Victoria Court												
Walton House												
Wanderers House												
Waterside House												
Welbeck House												
Wellesley House												
Wentworth Lodge												
Woodfields Residential Carehome												
Woodlands Quaker Care Home												
Wrottesley Park House Care Home												
Wulfrun Rose												

Adults Scrutiny Panel - Draft Work Programme 2023 - 2024

Chair: Councillor Val Evans
Vice Chair: Councillor Christopher Haynes
Scrutiny Support: Earl Piggott-Smith

Remit, Function and Measures

- Ensuring the health and care reform agenda is delivered for people in Wolverhampton
- Protecting vulnerable people at risk of harm and exploitation
- Services for older and vulnerable adults
- Local safeguarding arrangements for adults
- Support the Health and Social Care system to respond to and recover from Covid-19
- Maximise independence for people with care and support needs
- Work as a system to make sure that people get the right support at the right time
- % of older people (aged 65 and older) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
- % of adults with learning disabilities in paid employment
- % of social care users supported to remain in their own homes
- % of adults who use services who say social care services help them to feel safe and secure
- % of adults in receipt of long-term services who are in control of their own lives

Item	Description	SEB Lead	Officer Report/Author Lead	Date of Meeting	Publication Date	Status
4 July Meeting Postponed	N/A	N/A	N/A	4 July 2023	26 June 2023	**Agenda Sent** ***Postponed***
Post Covid Position – update briefing	Update on current position	Becky Wilkinson	Becky Wilkinson	17 October 2023	9 October 2023	**Completed**

Principal Social Worker Annual Report	This is an annual report that is presented to the panel for discussion and comment on the work of the Principal Social Worker in promoting and improving the quality of social work practice and outline the key priorities for 2023-2024.	Becky Wilkinson	Jennifer Rogers	17 October 2023	9 October 2023	**Completed**
Adult Social Care Winter Planning 2023-24	Request from Director to add this item to the agenda.	Becky Wilkinson and Health Partners	Becky Wilkinson and Sian Thomas, Paul Tulley and Rachel Murphy	17 October 2023	9 October 2023	**Completed**
CQC Assurance Preparation	Presentation on CQC readiness and assurance for comment	Becky Wilkinson	Meena Dulai	20 November 2023	10 November 2023	**Completed**
Our Commitment to All Age Carers Update on Progress	Request from the panel to provide an update on progress. Carers to be invited to present	Becky Wilkinson	Sandra Ashton Jones	20 November 2023	10 November 2023	**Completed**
Adult Social Worker and Workforce Health Check Surveys	This is an annual report that presented to the	Becky Wilkinson	Courtney Abbott	20 November 2023	10 November 2023	**Completed**

2022 - update on actions	panel for discussion and comment.					
Budget and Performance Update	Request from Director to add this item to the agenda.	Becky Wilkinson	James Amphlett, Lindsey Cowan James Barlow	5 December 2023	27 November 2023	Completed
Transforming Adults Service Programme Annual Report 2022-2023	Requested from the Directorate.	Becky Wilkinson	Emma Deakin	5 December 2023	27 November 2023	Completed
Wolverhampton Adult Social Care Provider Care and Support Review 2024 - 2025	This is an annual report that presented to the panel for discussion and comment.	Andrew Wolverson	Andrew Wolverson	20 February 2024	12 February 2024	Programmed
Quality Assurance Framework and Suspension Policy 2024 – 2034	Requested from the Directorate.	Andrew Wolverson	Andrew Wolverson	20 February 2024	12 February 2024	Programmed
Adult Services Social Work and Wider Workforce Health Check Survey.	This is an annual report that presented to the panel for discussion and comment.	tbc	Courtney Abbott	19 March 2024	11 March 2024	Programmed

Adult Social Care Position Statement – Review of the Year	CQC Quality Transformation	tbc	Andrew Wolverson	19 March 2024	11 March 2024	Programmed

Chair and Vice Chair to meet with CQC Inspectors – date tbc – Andrew Wolverson - https://www.cqc.org.uk/local-systems/local-authorities/introducing-assessments (Assessing how local authorities meet their Care Act duties is a new responsibility for CQC)