Thurrock Coalition

In conjunction with

Healthwatch Thurrock

Care Quality in Thurrock

Consultation on the Care Quality Commission's Proposals for a new approach to inspecting Social Care Services

Introduction

Thurrock Coalition

Thurrock Coalition offers advice and support for disabled and older residents of Thurrock and their carers. We are a wide network of individuals and groups aiming to inform people about their rights and entitlements and to improve the quality and choice of services that might assist them. Our main role is to engage, consult and listen to the views of Citizens of Thurrock.

Healthwatch Thurrock

Healthwatch Thurrock is all about local voices being able to influence the delivery and design of local services. Not just people who use them, but anyone who might need to in future.

Background to the consultation event

Thurrock Coalition and Healthwatch Thurrock were invited by Service Managers at Thurrock Council to run several consultation events around the Care Quality Commission's (CQC) proposals for a new approach to inspecting Social Care Services. To this end, we ran 3 workshop style opportunities for people and organisations/providers to have their say and input into the consultation. A total of 45 individuals and organisations attended across the 3 workshops.

The "Care Quality in Thurrock" event was held in order engage Citizens of Thurrock, people who use services, service providers (from residential care, extra care domiciliary care and supported living settings) along with Third Sector groups in order to explore, discuss and emphasise the important factors, evidence, information and lived experience indicators that should inform any new CQC inspection criteria.

Note that for the purposes of the consultation, the following are deemed to be Social Care Services:

- Care home services with nursing
- Care home services without nursing
- Specialist college services
- Domiciliary care services
- Extra Care housing services
- Shared Lives (where people with care needs are looked after in the homes of other residents in their community)
- Supported living services
- Hospice services
- Hospice services at home.

Recommendations and Next Steps

a) This report will serve to inform the content and implementation of the CQC proposals for the new approach to inspection of social care services.
b) This report will serve to inform inspections of locally commissioned Social Care Services by Thurrock Council.
c) Thurrock Coalition and Healthwatch Thurrock will continue to support and strengthen the partnership between local government and the people of Thurrock.

Findings

Attendees were asked to address a series of questions that formed the basis of the consultation. There were 5 main questions that were addressed at each workshop. The consultation was set up so that each participant and breakout group were asked to imagine that they were an Inspector of a Social Care Service, and then to discuss what types of evidence they would look for to determine whether or not a service is:

a) Safe
b) Effective
c) Caring

d) Responsive (to people's needs)
e) Well-led

The feedback from each group was gathered and collated (and appears verbatim in the appendix to this report).

- **Evidence to demonstrate that a Social Care Service is Safe**

In terms of whether a social care service setting is safe, participants across all 3 workshops highlighted the importance of having sight of quantitative evidence relating to the number of deaths in low-risk settings, and ensuring that any events relating to health and safety are reported, logged and action taken to ensure that future incidents do not occur.

Furthermore participants discussed the need for information to be gathered and thus evidence kept around the numbers of avoidable infections, mortality rates and avoidable morbidity. Of paramount importance within the workshops was the need to ascertain patient views of the social care service setting and how the care is delivered on a day-to-day basis.

It was suggested that evidence around service accessibility should be sought by any inspectors, which should be person-centred in nature and focus upon the integration of individuals (including a personalised, holistic assessment of needs) once they arrive and discharge processes and procedures when leaving a service..

Evidence should also be sought relating to staffing (e.g. sickness, retention, turnover, rotas, hours, personnel files, frequency of staff supervision, competency reviews, DBS and Enhanced DBS checks and adequate staffing levels to ensure effective care), this could be monitored via staff and individual surveys.

Clear, open and transparent safeguarding policies, procedures and practice were highlighted as a vital indicator of qualitative evidence for ensuring safety. The participants stated that this could be evidenced through, not only seeing the policies and strategies but also requesting sight of practical examples (and up to date training and qualification certificates) of how situations were dealt with, action taken as well as talking generally to staff and individuals about their awareness of safeguarding, what to look for and how to report any concerns that may arise.

As a corollary to this, evidence of implementation of confidentiality policies and procedures at both strategic and operational levels, for staff and managers alike should be available upon request, as well as up to date risk assessments. However, a balance between flexibility, personalisation, choice and control on one hand and safeguarding, and risk assessments on the other would need to be struck. Evidence of the balance could be sought from quantitative and qualitative sources.

Some discussion also took place around seeing evidence of the values and motives of Providers, and in particular the culture of a service as an indication of how safe people feel. Some questions that were raised include: Is it a welcoming, clean and well-maintained setting, are people greeted upon arrival, do the individual rooms feel personalised and "lived-in"? Is there a log of people signing in and out of the building

(including visitors and staff)? Is the building well-lit and is it easy for people to find their way around the buildings, with good signage? Is there a balance between safety and security of individuals (e.g. fire doors etc.) Are people able to have freedom of the communal areas, but limited access into the building from outside?

Visual checks of the service premises should be cross-referenced to risk assessments. Is the service person-centred across all aspects of service delivery and is there evidence of interactions between staff and individuals, demonstrating dignity and respect as well as naturalistic conversation, engagement and discussions? Do individuals appear happy and well-presented when asked about their lived experience of the service, do individuals have a voice and is there provision for Advocacy support? Are people given opportunities to learn new skills/hobbles and participate in social activities and the local community? What evidence is there that any cultural needs of residents are recognised and respected?

Participants took the view that they would want to see input of patient and user-led groups and representatives, including Healthwatch Thurrock, Thurrock Coalition and the local Patient Participation Group as evidence of the personalisation agenda and including individuals as “Experts By Experience” as valued members of inspection teams.

The issue of older people and the need to create dementia friendly environments, as well as build greater awareness of the needs of individuals with sensory impairments was raised as specific factors that inspectors should look for and recommend for all social care service settings regulated by the Care Quality Commission.

Medication was an overarching issue that arose across all 3 workshops, relating to each of the 5 key questions. In particular the way in which it is managed, monitored, logged and administered will impact upon the care and safety of all individuals concerned. Are important details such as allergies and preferred communication methods accurately recorded in Care Plans? - The suggestion to use a system similar to the Hospital Passport was put forward in this regard.

The ratio of individuals to local G.P.s was also raised, specifically in terms of ensuring the safety of individuals and the responsiveness of the service. Participants also suggested a need to request and see evidence of IMCA/DoLS policies and restraint procedures and practices, including incident logging and reasons for use.

One group highlighted the importance of health and safety considerations of the service as regards food preparation and hygiene, the internal fixtures and fittings of the premises as well as transport; is the insurance, MOT and road tax up to date for each vehicle used by the service when individuals are accessing the community, social events, planned outings etc?

- **Evidence to demonstrate that a Social Care Service is Effective**

The issue of the impact of publicity and social media (both positive and negative) was raised, particularly in publicising the results of inspections and adapting accordingly. In instances where there is a system of time-keeping participants wanted to see evidence of effective and honest time recording for care and providing

a service to people for the time for which they have been assessed as needing, treating people as individuals and not just a number.

The participants discussed the principle of effectiveness in social care service settings with all groups focussing upon the need for equality and diversity policies, reflecting dignity, respect, understanding peoples' needs, coupled with transparent complaints and compliments procedures and whistle-blowing policies, allowing the organisations concerned to respond to breaches and to implement changes with individual user input throughout. It was felt that implementing a customer satisfaction survey every 2 years, involving people, family members, carers and staff, would also improve effectiveness of the service.

People also emphasised the importance of the practical, personal care and support provided to individuals accurately and effectively mirroring the contents of the care plan and for the care plan to be outcome-based and be regularly reviewed in partnership with individuals and staff in a multi-disciplinary setting.

Evidence should also be sought in the form of monitoring visits and reports of relevant bodies and organisations, including: NHS England, Quality Surveillance groups and Healthwatch Thurrock. Furthermore, appropriate information sharing around evidence of effectiveness should be better shared between agencies to avoid duplication.

- **Evidence to demonstrate that a Social Care Service is Caring**

Participants said that they would want to see personalisation, choice and control in practice, as evidence of a caring service. For example, care plans should be kept up to date, and reviewed frequently to ensure all eligible needs are being met. Samples of anonymised care plans could be provided to inspection teams (with consent) to inform the exercise. Moreover, flexibility should be central to any caring service, so that people can maintain their independence wherever possible, meaning for example, people being able to request assistance with personal care (e.g. toileting) without being told to wait 90 minutes for their next care call. Interviews and surveys with individuals would provide an indication of how caring a service is (or is not) and would then inform the safety, effectiveness, responsiveness and leadership of the service.

Views of whether or not a service is caring should be not only be sought from individuals, but also from family members, carers and relatives. Participants discussed the importance of family input, as they will often pick up on evidence and practice of how the service is run through frequent visits, conversations with their relative as well as other people who use the service. Evidence of family input into care plans, practices and forums (where requested by the individual or where the individual lacks the requisite capacity) should therefore also be sought.

- **Evidence to demonstrate that a Social Care Service is Responsive to peoples' needs.**

Continuous professional development (CPD) for staff and management was seen as vital by participants across all workshops, particularly in terms of anticipatory training and good practice as well as responding to changes to relevant legislation (e.g. equality, human rights, health and social care) policy and individual care needs, evolving alongside any changes in demographic within the various care settings. New staff should be mentored by experienced colleagues and have opportunities to shadow various tasks, such as manual handling and double handed care. All staff should receive training in the theory and practical application of the Social Model of Disability, including equality and diversity awareness. Logs should be kept of all staff training and staff should be prepared to demonstrate practical knowledge if asked by inspection teams. Reflective practice documentation could be used to inform such evidence.

There also followed some discussion about requesting details of a service interacting with and referrals to outside agencies, for example, in the Third Sector for advice, information, guidance and signposting on a range of issues such as welfare benefits, transport, leisure, community access and activities in the wider communities in which the service is based. Furthermore, inspectors could request evidence from the service to demonstrate that external advice agencies are frequently invited in to provide details of what they offer.

- **Evidence to demonstrate that a Social Care Service is Well-Led**

Participants stated they would look for evidence of staff retention, good morale and low staff turnover and clear lines of accountability – all resulting in delivery of higher quality and consistency of service. Participants felt that evidence of frequent meetings and forums alongside individuals, with meaningful, open dialogue resulting in feedback and positive change for individuals. There should also be regular team meetings, supervision with staff, and plans to avoid disruption to management and contingency plans for when disruption does occur.

Participants also recognised a need to see evidence of managers with a social care background as well as demonstrating good performance in management of people and organisations. The management structures (and any changes to it) would need to be clear and transparent with information boards prominently displaying all staff team members easily accessible to individuals. It was also felt that members of the management team should make themselves accessible and contactable by individuals so that any issues, complaints, compliments can be raised, discussed and acted upon.

The management organisation should have plans in place in the event of company liquidation/administration and contingencies in place for handover of care to any new or replacement organisation.

Periodic Internal or Peer-led spot check inspections were suggested as a potential method to maintain good quality services, working alongside Local Authority staff in Performance Management, contract compliance and quality assurance.

The need for input of patient and user-led groups and representatives in financial and budgetary consultations and decisions that might have an effect upon the service was also highlighted.

Conclusion

Over the course of the 3 workshops, people who use services, service providers and a number of Third Sector groups used the opportunity to discuss, debate and elaborate on the types of evidence that should be sought when inspecting social care services settings to determine whether or not such settings are safe, effective, caring, responsive to peoples needs and well-led. The feedback was largely consistent across the consultation groups and workshops. Several important, overarching themes emerged including: Inspection teams, consisting of Experts by Experience talking with individuals and staff to determine:

i) The practical applications of person-centred care planning and implementation, looking for the presence and encouragement of user-led forums and groups for each service.

ii) Integration of individuals (including a personalised, holistic assessment of needs) once they arrive as well as discharge processes and procedures for when an individual leaves a service.

iii) Lighting, signage (including sensory awareness and dementia friendly initiatives), and the overall culture of the service, including open and transparent complaints, compliments and whistle-blowing procedures.

iv) The strategic and operational application and implementation of safeguarding policies, risk assessments, balanced with personalisation, flexibility, choice and control for each and every individual.

v) The importance of visible management, training, supervision and competency, good staff morale, staff retention (low turnover), frequently maintained continuous professional development, honest time-keeping, flexible care calls and effective responses to inspections, publicity and finally, implementation of any recommendations following an inspection.

vi) The importance of medication, particularly how it is managed, monitored and administered, as this will impact upon the care and safety of all individuals concerned.

It is hoped that the influence of this report will be three-fold:

a) To inform the content and implementation of the CQC proposals for the new approach to inspection of social care services.

b) To serve to inform inspections of locally commissioned social care services by Thurrock Council.

c) To provide further opportunities for Thurrock Coalition and Healthwatch Thurrock to continue to support and strengthen the partnership between local government and the people of Thurrock.

Appendix

Verbatim Feedback from the 3 Workshops held in February 2014. Organised in line with the "5 Key Questions":

Thurrock Coalition and Healthwatch Thurrock
Care Quality In Thurrock –
Verbatim Feedback from Thurrock Diversity Network

Safe
Lighting, colour schemes Low surfaces – no sharp corners Dementia friendly Safety – doors and security Adequate staff And trained staff with qualifications Safety Medicines Restraint DoLS Council allocation policy Companies' own marketing Accident reporting Management reporting Health and safety Physical environment Cleanliness Pressure sores Medicine management – psychotropic Staff training records Client reviews Trip – advisor NHS direct comments
Effective
Dementia friendly areas – protocols Training Person focussed – conversations Extra care Records up to date Honest time recording eg 1 hour = 1 hour (not 30 minutes) Checked / used Support Plans Kept up to date Service user money management

Staff turnover Staff ratio / rotas / overtime Staff training and supervision Accident practice (change and evidence) Frequency of medical review Ask the customer do they feel safe? Ask the family
Caring
Ask and listen – tailor-made Experience Staff culture – don't assume they know. Shouldn't be afraid to ask Capacity – speaking to families Equality across impairment types Rooms – do they "live" there Personalised / person centred care "evidence" Ask the families of residents / service user Ability of staff to communicate / English spoken? Feeding / meal time regime Clear standards Safeguarding policy Staff know management philosophy Complaints process Links with GP – community nurses Dom care – consistency of carer – back-up plans for sickness Adequate food and water and assistance? Degree of interest / involvement Respect / dignity with persons care Ask them
Responsive?
Listening Catering for the wishes of the person Personal care = paramount – not waiting for the next booking time slot Linking with GP and community nurses Whistle blower End of life plans / where Awareness of lasting power of attorney Mental capacity act awareness Best interest decision DoLS No prior warning for inspections? Participation in activities Time management regime for Dom care Time to assist for tablet needs Flexibility assured timing and person Vetting terms regimental / structure Feedback from customer and family
Well-led
Managers – need experience with management not just Staffing levels

Sickness
Team leaders – managers – people – structure / name /face
Care
Landlord
Local?
On-site
KPIs
Leaving the residents to care for each other
Community concern in the home for safety of fellow residents
Approach, Evidence (deployment)
Industry?
Care home?
Care plans
Risk management process
Financial wellbeing
Collapse plan / recovery plan in the event of closure (handover plans)
Activities
Ambulance calls
Personal affect (or waken in room)
Lead from top – setting example
Staff approval and development plan
Commend and amend, values / behaviour
Effective 2 way communicating with family
Direct feedback
Welcoming / homely
Presentation of staff / knowledge / training
Safe guarding / how well are they are treated security
Staff shift patterns (workforce)
Complaints procedure (accident reports)
(The right of choice) group activity's day outs etc.
Counselling
Notice board with information
Lighting
Floor surface
Staffing
Personal
Supervision

Thurrock Coalition and Healthwatch Thurrock

Care Quality in Thurrock – Verbatim Feedback from People who use Services

Safe
Checking the management paperwork Health and safety paperwork – fire alarms etc. Check staff rota – hours – is there enough staff Care plans – reviews Check house vehicle paperwork e.g. m.o.t insurance is ok Check medication is being administered correctly Make sure furniture and fittings are safe Make sure I am being supported properly e.g. – food that I like, personal care Food safety Staff DBS checks, staff qualifications How to make a complaint if I need to Make sure there is a system in place for visitors when they arrive Check staff and ask them questions about their jobs Dignity and respect Person-centred staff culture Health and safety – statutes – followed and observed Interaction – engaging Welcoming Layout of the building – ability to ask for assistance where required Confidentiality Signing in Bright and light – and clear directions Info board – who the staff are? Complaints procedure Food – diet Adequate staff Clean house Doors locked, safety, fire doors Happy? Learning Getting the right food and water The right staff Room choice colour? Activities Asked about my life Care plan, risk assessment Sickness Infections Safeguarding Whistle-blowing
Caring
Am I being looked after properly? Do the residents feel they are being supported in their everyday life? Have or do residents have a voice do they need an advocate? Are residents engaged in the local community – e.g. college, pubs, restaurants? Recognising the cultural needs of residents If I need to go to hospital would I be supported?

Dignity and respect Hygiene Notes – up to date – care plans Medicines – e.g. recording allergies Communication methods Out of hours – access to relevant info / notes on site Whistle-blower – policy, clear reporting structure, action is taken as a result CPD training Summary to similar to hospital PPT Meds Hygiene Communication Out of bounds Training
Effective
Continuity of service Several doctors covering the res. Care setting Feedback – and how it's monitored / implemented User groups – are they encouraged? Interacting with the staff Are the needs met? Physical / emotional Flexible routines – care calls MDT meetings – acting on need / reg with the involvement of the person Effective reviews Inspector
Responsive
Dignity Respect Equality Transparency Understanding needs – individual is the expert How quickly a response occurs? Consistent service Speak to the families Capacity issues People's needs Listen Support Guide Dignity , Respect Consistent service Management, Care
Well-led
Low Staff turnover Managers – training – care and management Visibility of managers Individual voices on financial / budgetary decisions My life Help with well being

Thurrock Coalition and Healthwatch Thurrock

Care Quality in Thurrock – Verbatim Feedback from Service Providers

Safe
Fire risk assessment completed by a competent contractor. Fire register, evacuation plans Visual checks that are cross referenced to residents risk assessment – fire alarm, escape routes, emergency lighting signage Waste management – duty of care Do residents feel safe – regular meetings, feel able to voice their concerns Audits – medication, fire, electrical, gas landlord checks, legionella and risk assessment, loller – 6 monthly Staff training in H&S, feedback reflective practice documentation Basic food hygiene Staffing levels – rota, recruitment / vetting process, supervision SOVA how to report to whom, when or where Monitoring of accidents Open and welcoming Security of who is living there Appearance, body language and behaviour Staff rota, Staff files Health and safety Training needs Updated policies and procedures Policies and procedures Training Accountability Records – accurate Compliance Co-production External agencies Premises – fire drills / alarms, H&S, accessible Communication & Feedback Environment Whistle blowing Safeguarding Accident / procedures Reviews Spot checks Sup / appeals (DBS) staff check and Manager's enhanced check (DBS) are they registered? Risk assessments / risk management plan reviewed updated Medication meeting standard Staff training Audits Return's booking in meds Staff competency Manual handling Electrical goods PAC tested

Infection control Care plans up dated reviewed to meet the need of the customer Staff training Staff sickness Respect customer's dignity, diversity, religion Is choice being offered (e.g. daily life and meals) Person centred approach Evidence of activities - Community access / activity planner Interviewed staff which is customer led Clean environment / odour free Are customers well presented Policies / procedures in place Finance MCA2 / best decision SE + SAT / CQC notification Specialise skills for specialised services
Effective
Customer satisfaction survey – bi annually – family, professional, service users, staff etc. Service users meetings – minutes, user friendly formats Concerns, compliments and complaints – monitoring, written responses Social worker reviews – outcomes based Quality monitoring by LA Outcome 16s Mystery shopping Evidence base documentation – care plans Performance management of staff – appraisal, supervision, training Visual supervisions Recruitment – effective / retention Statement of purpose Complaints and compliments Sign in book Staff / customer turnover and retention Financial security Quality assurance Feedback Spot checks Reviews – own voice Word of mouth Reputation Contracts Compliance Quality and assurance Reablement in practice Consistency Case management
Caring
Individualised care plan – "perso- centred" Evidence of activities – cross referencing and asking service users – signage, sensory equipment Risk assessments

Empathy – interactions, choice, dignity, respect
Observation of staff
Pre admission assessment? – Able to meet the needs?
Presentation of service users
Meal planning – menu, weight charts, diet / fluid monitoring
Medication reviews – continuity of treatment
Pain management – medication review
Environmental factors
Monitoring of accidents
Adequate / bespoke equipment
None institutionalisation
Effective communication – other professionals, families
Life history / ethnicity
End of life plans – advanced care planning
Engaging with the service user
Effective communication
Physical positioning
Health care checks
Health action plans
Individualism
Body language
Duty of care
Staff
Training
Attitude
Personalization / individuality – outcome based
Dignity
Respect
Listening
Recording
Feedback
Lead by example
Non complacency
Relationships
Professionalism
Time management
Empathy
Understanding
Reflection

Responsive

Identifying triggers – referral to dietician, GP, salts, falls team, physio, OT
Changes to care plans which reflect changing needs
Reviews – monthly reviews or more often if necessary
Communication
Staffing levels
Responding to legislative changes – human rights, advocacy
Responsive to action plans – H&S, care plan audit, infection control, residents meetings, CQC report, surveys
Complaints and concerns resolved
Personalisation

Care plans person centred Quality assurance – evidence of change Customer satisfaction surveys
Well-led
Well qualified manager, staff – experienced, trained, approachable, monitoring, walking the floor Supervision – aligned to job role Appraisals – annual Recruitment / retention policy Induction Staff meeting – agenda, minutes Training Quality monitoring – LA, CQC, HSE, fire, safeguarding Communication – with service users, families, professionals Documentation / evidence Customer care Open and transparent – referral to other services Listening skills Dealing with complaints / concerns Management by walking about (don't hide in the office) Lead by example General staff awareness Structure Compliance, Procedures, Polices and Examples Knowledge - Shared practice Working with people Support, Appreciation, Recognition Non judgemental Adaptability Flexibility Shared experience Praise, Listen Keep Paper trails - Accountability Be willing to change Encourage participation