WOKINGHAM
BOROUGH COUNCIL

Health and Wellbeing

Care Governance Protocol

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Version 1	29/03/2011	Care Governance Protocol for Adult Social Care Services
Version 2	27/09/2016	Updated and new appendices added.
Version 3	07/07/2021	Reviewed and revised.
Version 4	09/08/2021	Updated to include Serious Concerns process references.
Version 5	17/10/2021	Appeals process updated.
Version 6	06/09/2022	Serious Concerns process updated.
Version 7	27/04/2023	Clarity on placing customers in flagged services.

Contents

Introduction

1. It is the responsibility of Wokingham Borough Council (WBC) to work with providers of Adult Social Care to ensure all services provided are safe and meet the needs of customers. When the term safe is used in this protocol, it means safe from harm or the risk of harm. Harm of course can be physical, psychological, or emotional and in the wider context may constitute organisational abuse.

2. Some of the services the council provides through its Local Authority Trading Company (LATC) Optalis, or commissions from other providers are regulated by the Care Quality Commission (CQC). Providers will have a planned review by CQC to measure compliance against the regulations at least once every two years. In addition, the CQC will undertake responsive reviews where there is a sufficient concern. There is a key emphasis on the new regime for Providers to monitor their own self-compliance. CQC – Health and Social Care Regulation (Regulated Activities) aim to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve.

3. CQC monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and publish what they find, including performance ratings to help people choose their own care. To get to the heart of people's experiences of care and support, the focus of CQC inspections targets the quality and safety of services.

4. It is important to note that any CQC inspection operates as a snapshot. As such CQC places an expectation on the Local Authority to continuously monitor, act on, and uphold its standards. The Local Authority therefore liaises closely in this respect with CQC.

5. For note, CQC only inspect services that carry out a regulated activity; services such as day care or supported living without personal care are out of scope. There has also more recently, been concern expressed through the media about the number of whistle blowers resulting in independent inquiries concerning the quality-of-care provision, a situation exasperated by the impending impact and continuation of cuts to the public funding of care services.

6. When considering if a service is safe and adequately meets the customer's needs, this needs to be considered laterally. It is not just about the quality of frontline care or support, but also about care providers giving fair terms and conditions in their contracts to customers or customers having their tenancy rights upheld, as well as ensuring a customer's wellbeing is maintained. Breaches of any of these elements could result in Care Governance engagement.

7. This protocol covers all provision for Adult Social Care in Wokingham regardless of service or provider type, including self-funders and that provision commissioned by Adults Social Care for services outside the Borough.

Principles and Purpose

8. This protocol will be used to assist with ensuring that adult social care is safe and delivers quality outcomes in line with the vision and priorities of the Council and needs of customers. Care Governance aims to work alongside providers and services to support and facilitate improvement.

9. The protocol will naturally, have more influence on those services the Council specifically commissions but aims to influence regardless of funding stream. It establishes and clarifies the systems and processes which will:

    - ensure relevant information is obtained, collated, and disseminated regarding service or provider concerns.
    - ensure appropriate checks are undertaken prior to commissioning new services and to proactively monitor and promote best practice.
    - identify services that are of concern and provide a framework within which to drive improvement or ensure appropriate management action is taken to address concerns where these are identified and not resolved.

10. Information gained through Care Governance will be used to inform strategic and operational commissioning decisions, as well as in ensuring the Council meets its safeguarding responsibilities.

Sources of Information

11. There is information from a range of sources that will provide intelligence regarding the quality and safety of services:

    - CQC reports published on the CQC website. Inspection reports outline areas of non-compliance following inspection. Where CQC have safeguarding concerns, it notifies WBC. WBC monitors CQC Inspection outcomes and close links are in place with CQC. Where it is apparent that providers or services are not sufficiently meeting regulatory outcomes, this will be escalated via the Care Governance operational group to the Care Governance Board for a decision about what level of action is required.
    - Cautions, alerts or references from other Local Authorities where they have concerns about quality-of-care provision or safeguarding and they will notify WBC.
    - Safeguarding concerns made via the Adult Safeguarding Hub (ASH). Where these involve any provider service, they will be copied to the QA Team for inclusion on the log. This will be monitored by the QA Specialists and Care Governance Operational Group for raising via Care Governance Board if there are concerns about indicators of organisational abuse and the need to trigger a large-scale enquiry in the context of concerns about organisational abuse.
    - Deprivation of Liberty Safeguards (DoLS) applications, assessments and authorisations may identify practice concerns, and whilst the issues for

the individual will be resolved by the relevant operational professionals, intelligence will be escalated to the Care Quality Team for Care Governance purposes or raised with the ASH if a safeguarding concern.

- Statutory Reviews occur at least annually. These may identify areas of concern. Whilst case management activity will resolve the issue for the individual, the intelligence will be shared with the Care Governance framework. Reviews should involve a visit to the service and a discussion with the customer and any interested parties, so that a judgement can be made about the current level of needs and whether the service is adequately meeting need. Any quality issues or safeguarding concerns arising from reviews should be raised by the reviewing officer, via a *Care Quality Referral* for quality issues or a safeguarding concern for concerns of abuse or neglect. See serial 14 for further information. Additionally, when a provider or service is placed on the Cautions list, a review of placements will be prioritised if not recently undertaken, or if new information suggests that review needs to revisited using a different lens.
- Complaints, MP enquiries and Member enquiries – there are separate procedures for responding to these. Those processes will be used for responding to the individual concerns and issues, however, where a complaint or enquiry is made that indicates a quality issue with service delivery, the receiving staff member will raise a QR1 to ensure the information is collated on the Care Governance log.
- Financial checks – are undertaken prior to issuing contracts to providers. These measure financial robustness and providers receive a financial rating of green, amber or red. Amber or red ratings indicate a risk to the security of the placement and/or indicated a concern has been identified.
- Insurance Checks - services are required to have a range of Insurance in place, depending on the nature of the service provided. Services without adequate insurance place people who use those services at risk.
- Performance Information - a range of information is gathered in relation to a service's performance. Some of this information is formally collected and some information is received from a range of informal sources.
- Policies and Procedures - whilst being no guarantee on quality, policies and procedures give an indication of a provider's intent and may highlight areas of poor practice that could occur if they are followed.
- Feedback from Individuals - any individual in contact with a service may raise concerns about its quality. This might be a person receiving a service, their family, carers or friends, a member of staff or a professional visiting the service. Such information will be received through a range of routes depending on the source. Central logging allows trends and patterns to be noted which can result in a different form of action or response being required and initiated.

Obtaining, Collating and Disseminating Information

12. The Care Quality Team will be the central point for obtaining, collating, and disseminating information about providers and services. Through use of the Care Governance log, this ensures a consistent and thorough approach across all services.

13. Any issues or concerns identified by staff across the organisation will be passed to the Care Quality Team, via a *Care Quality Referral* (Appendix 1) for a quality issue or via a copy of the safeguarding concern where one has been raised. There must be no assumptions that they already have information, and all staff should take responsibility for sharing that information. Notifying the Care Quality Team does not take away responsibility for the operational staff member to address and resolve the issue for the individual(s) concerned.

14. In addition to this, the Care Quality Team will pro-actively obtain and collate certain information about services.

15. The Care Quality Team will also disseminate information about providers and services of concern to assist safe and informed decision-making with placements for Adult Social Care. To do this, they will:

    - maintain a 'Cautions List' of providers or services where there are concerns which pose a high enough risk that it impacts on Local Authority commissioning (see below for details about how and why a provider would be added to the Cautions List).

    - disseminate the Cautions List after each Care Governance Board meeting and following any change to it. This will be sent to the Care Governance Board, Operational Managers within WBC for them to cascade to their staff as they see fit. The information given for each provider/service will be the name and outline details of the areas of concern and plans in place to address them. If staff require further details, they should discuss the matter with their Line Manager or contact the Care Quality Team.

    - disseminate the Cautions List following any changes, to agreed colleagues from the CQC, Health and other Authorities in Berkshire. Where it is known that placements are made by commissioners further afield, they will also be notified of any change in cautions list status.

16. It has been agreed that information about the existence of the Cautions List will be made public, rather than the Cautions List itself. People will then contact the Care Quality Team if they want to enquire specifically as to whether a provider is on the list.

17. When considering purchasing or arranging a service, all staff must consult the

Cautions List so that any potential concerns about a service or provider are taken into consideration. This may mean that a provider or service cannot be used, depending on their status. No placements or services should be arranged to agreed without ensuring this is checked first.

18. It is the responsibility of senior managers to disseminate the cautions list to their staff to ensure placements are not arranged that contradict the cautions list.

Identification of Services that are of Concern and Action.

19. There is a continual stream of information about services. The structure of the Care Governance Framework via use of Care Quality Referrals, safeguarding alerts and centralising of all intelligence, in conjunction with use of an Operational Group (consisting of key operational stakeholders) and a Board (consisting of key members of Senior Management) will ensure nominated decision-makers are informed in a timely manner of all concerns that indicate quality concerns or possible organisational abuse concerns about a provider or service. This will enable timely escalation of issues, or decision-making.

Care Quality Team Activity

20. Care Quality Specialists will undertake both proactive and reactive audits and interventions with Providers. They will also work with Providers using self-assessment tools where this is proportionate.

21. The Care Quality Specialists will only undertake Quality Assurance visits where WBC is the hosting Authority for the service or provider. In relation to out of Borough placements, the team will engage with the hosting Authority to inform decision-making via Care Governance Board.

22. Following any proactive or reactive Quality Assurance visit, an evidence-based report will be produced. For a proactive visit (template at Appendix 2), this will be produced within ten working days of the visit. For a reactive visit (template at Appendix 3), it will be produced within 5 working days.

23. For reactive visits (or a proactive visit where areas of unexpected concern have emerged), a formal debrief meeting will be held pending production of the written report, on the same or following day to the visit to identify whether any immediate actions are required – whether that be about safeguarding individuals, or whether it be about an urgent Cautions List status being required. This meeting will take place with the QA Manager, but the ASH Manager may be asked to participate where this is needed. Input from Head of Adult Safeguarding and Care Governance will be sought on an ‘as needed’ basis.

24. For a proactive visit, the draft written report and action plan will be submitted to the Care Quality Manager for review within the above timescales for approval. Should the Provider wish to query or discuss any comment made in the written report they should do this with the relevant Care Quality Specialist in the first instance. It is hoped these occasions will be minimal, as discussions will have taken place as part of the quality audit. However, following this discussion should there remain disagreement about any points made this can be raised with the Care Quality Manager. Where the proactive

visit has identified serious concerns, a decision will need to be made as to whether an AMBER or RED flag is required and any decision on this will need to be signed off outside of the routine Care Governance Board schedule, for ratification at the following meeting. The process for this is covered later in this protocol.

25. Decisions about Cautions List status do sometimes have to be made immediately, depending on levels of risk. As a Cautions List status is a significant one for any business, there is an Appeals Process available, where this decision is enacted, and this is also covered later in this report.

26. Following the issue of a final report, the report will be sent to Head of Adult Safeguarding & Care Governance for sign off – with the report then being fed into the Care Governance Operational Group and framework for discussion, action, monitoring and decision-making via the Board. Once signed off at Head of Service level, the report will also be uploaded to Atamis.

27. Any required actions identified by the Provider will be followed up by the nominated lead and where appropriate be monitored and measured via the Serious Concerns process. Any recommended actions identified, but where a Serious Concerns process is not triggered, will be reviewed at the next proactive (or reactive if triggered earlier) QA visit.

Proactive Quality Assurance

28. In respect of proactive work, the Care Quality team will use a risk matrix tool to apply a set of criteria to each commissioned service and to generate a score, which will determine a priority level of standard, moderate or high. The criteria will include (subject to change); CQC/Ofsted status, WBC cautions list status and status of any action plan, intelligence around quality and safeguarding, any provider self-assessment score, capacity of the service, number of WBC funded placements, type of service, vulnerability profile of customers, financial stability, location of the service and annual contract value. The risk matrix can be found at Appendix 4.

29. The priority level (standard, moderate or high) will determine the frequency of proactive quality assurance visits. The aim will be that every Provider will be quality assured at least once every 18 months. The Care Quality Manager will review this monthly with the Care Quality Specialists to inform movement up and down this schedule. A suite of KPIs will be used to measure performance of the team.

30. Prior to the visit providers will be telephoned and sent an email to confirm details and the purpose of the visit.

31. QA Specialists may routinely request that information is made available to them by the providers prior to the visit. Whilst not exhaustive, this may include any of the following:

    - Organisational Chart
    - Staff training Matrix
    - Staff rotas
    - Current Service Development Plan/Action Plan/Business Plan/Business Continuity Plan – as appropriate.
    - Statement of Purpose – as appropriate
    - Breakdown of current customers
    - Leadership and Management
    - List of policies/procedures, including review dates.

- Dates and types of quality audits that have been completed over previous 6 months - both internal and external
- Date of last regulatory inspection and outcome
- Number of complaints, comments and compliments received in the last 12 months.
- Customer experience
- Publicity material about the service offered to potential customers.

32. A draft written report and action plan will be submitted to the Care Quality Manager for review, within ten working days of the visit, using the proactive visit template.

33. If the visit has *not* identified any serious concerns, the Care Quality Manager will sign off the report and action plan.

34. Where areas of serious concern *have* been identified, the optional risk summary section at the end of the proactive report template will be used to formulate this.

35. In these circumstances, a debrief meeting will be held on the day or day following the visit (see serial 23) to agree any immediate actions required, and if appropriate to discuss an interim cautions status pending formal ratification via the next Care Governance Board.

36. Any decision to impose a cautions status, will be notified verbally to the Provider by the Care Quality Manager or a delegated individual, and then confirmed in writing.

37. Where the proactive visit has triggered a cautions list status, a Serious Concerns meeting will be scheduled; see serials 54-59.

Reactive Quality Assurance

38. In respect of reactive work, this will be informed by dynamic information gathered via the Care Governance log but may also be influenced by a one-off significant event. This may inform a Provider being moved up or down the priority list but may also trigger a reactive Care Quality visit, or Serious Concerns Enquiry as recommended by the Care Governance Operational Group or directed by the Care Governance Board. Reactive visits may be announced or unannounced.

39. Wherein indicators of Organisational Abuse are believed to be present, reactive Quality Assurance visits may be undertaken jointly with safeguarding specialists from the Adult Safeguarding Hub (ASH), solely by the ASH or may be supported by staff from other operational teams within Adult Social Care – depending on the presenting issues and the knowledge and skills mix required.

40. For avoidance of doubt, the Care & Support Statutory Guidance (updated 21 April 2021) defines organisational abuse as:

    - "*Including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation".*

41. SCIE (2020) lists examples of Organisational Abuse as including (but not limited to):
    - Discouraging visits or the involvement of relatives or friends

- Run-down or overcrowded establishment
- Authoritarian management or rigid regimes
- Lack of leadership and supervision
- Insufficient staff or high turnover resulting in poor quality care.
- Abusive and disrespectful attitudes towards people using the service.
- Inappropriate use of restraints
- Lack of respect for dignity and privacy
- Failure to manage residents with abusive behaviour.
- Not providing adequate food and drink, or assistance with eating
- Not offering choice or promoting independence
- Misuse of medication
- Failure to provide care with dentures, spectacles, or hearing aids.
- Not taking account of individuals' cultural, religious, or ethnic needs
- Failure to respond to abuse appropriately.
- Interference with personal correspondence or communication
- Failure to respond to complaints.

42. There is a need for careful judgement in considering whether something may be indicative of potential organisational abuse. It is important to consider; the type of incident(s), the nature of the incident(s), the degree of the incident(s) and any themes, patterns, or prevalence. This is not always a straight-forward decision, as the indicators can range from a one-off serious incident being reported, from whistle-blowing concerns, or from an accumulation of reports of poor practice, each of which may not be overly concerning in isolation.

43. Wherein it is considered this threshold may be met, in the interests of transparency and collaboration, it will be made clear to the provider that the framework is now being used in the context of concerns regarding organisational abuse.

44. Triggers for this may include, but are not limited to:

    - A risk that serious abuse, involving death or serious harm of an individual or individuals will occur or has occurred.
    - It is suspected that a number of adults at risk have been abused or neglected by; the same perpetrator, by a group or perpetrators, or in the same setting or service.
    - There is clear evidence from an individual safeguarding enquiry that other services users are at risk of serious harm or exploitation.
    - An anonymous alert or whistle blower identifies there may be systemic concerns or highlights that several service users may be affected.
    - Cumulative safeguarding concerns, where several concerns are received at the same time, or over a period, naming individual adults at risk in the care setting. This may require a flexible approach depending on the nature and pattern of the alerts raised and whether there are any wider concerns about the service or setting.
    - Evidence that, despite monitoring and/or CQC rating, there continues to be insufficient evidence and assurance of improvements within the service.
    - Despite monitoring, support and actions, service users are being placed at risk of abuse or neglect as per organisational abuse criteria. This may include a poor CQC inspection resulting in requirements, enforcement, or urgent enforcement action.
    - A decision to escalate made at the Care Governance Board meeting or because of information received from the Adult Safeguarding Hub or Care

Quality Team.

45. Wherein these reactive visits are undertaken jointly, the QA Specialist will focus on the overarching infrastructure, policies and procedures and governance mechanisms, whilst the Adult Social Care staff will focus on exploring how those issues are impacting on individual customers and on discussions with customers and other involved parties (families, friends, advocates as appropriate) to inform the overall assurance. Where individual issues are identified because of this, a decision will need to be made about whether this requires a safeguarding concern and intervention for that individual, or whether issues not meeting that threshold require follow up via case management frameworks.

46. Where there are significant concerns about a setting or service, that warrant a RED flag on Care Governance, it will be common to request reviews of all customers placed in that setting, including an assessment of those whom are self-funders to ensure their needs are being appropriately met and there are no indicators of abuse or neglect specific to them.

47. As in proactive visits, WBC may request that information and documents are made available prior to the visit taking place.

48. The templates that will be used for capturing information from proactive and reactive Quality Assurance visits are different and can be found at Appendices 2 and 3.

49. Following a reactive visit, a debrief will be held jointly by the QA Manager, ASH Manager and Head of Service. This will determine whether any urgent actions need to be taken and consider whether any cautions list status needs to be discussed with the Chair of Care Governance Board for immediate implementation and subject to ratification at the next Board. The full report will be generated within 5 working days.

50. Any required actions identified by the Provider will be followed up by the nominated lead and where appropriate be monitored and measured via the Provider Concerns process.

Provider Self-Assessment

51. Self-assessment can help to create a learning culture by encouraging participants to ask; "How well are we doing?" and "How can we improve?" and is therefore a key tool in the drive for continuous improvement.

52. WBC may at times ask any Provider to complete a self-assessment using the toolkit at Appendix 5. However, this will more routinely be used with those Providers risk assessed as being ‘standard risk’ (see serial 21). The template includes both an audit tool and guidance notes, that have been designed to increase Provider’s involvement in the process of assessing strengths, identifying areas where improvement is required and in identifying discrepancies around performance and contributing to constructive evaluation of services. The self-assessment tool may also be used to gather information prior to a Quality Assurance visit or for other strategic reasons. Use of this tool will be reserved for enabling consideration of advice/guidance/signposting that the Provider may benefit from and for informing Local Authority decision-making about risk and strategic considerations, rather than to assign ratings of any kind to the Provider.

Serious Concerns

53. In the event of any service or setting receiving an AMBER or RED cautions status, the Serious Concerns process will be initiated to enable collaborative working, momentum, and evidence-based decision-making.

54. Following generating the report and sharing it with the Provider, a Serious Concerns Meeting with be scheduled at the earliest opportunity.

55. This meeting will usually be held at WBC Shute End Offices, although may be held remotely if circumstances require. Invites will be extended to key stakeholders, including Provider, CCG, CQC, Care Home Support Team, other commissioners, Strategic Commissioning and Adult Social Care. The meeting will provide an opportunity to discuss the concerns and for the Provider to present their action plan and intended course of action.

56. The agenda and note taking template for this meeting can be seen at Appendix 6. The schedule for a review visit will be agreed at the conclusion of this meeting.

57. Following each review visit, a further Serious Concerns meeting may be convened. The decision around whether a further Serious Concerns meeting is required will sit with the Head of Safeguarding. At each meeting, progress will be shared, issues discussed and the risk matrix informing the Care Governance decision reviewed and updated. This provides a forum for multidisciplinary discussion and a forum for challenge by/of any agency where required.

58. This framework continues until the actions are completed and the level of risk assessed supports removal of the cautions status. A provider would move from RED to AMBER as progress is made and immediate safety issues are resolved, whilst removal of the AMBER flag will require evidence of systemic changes to ensure sustainable progress has been achieved.

59. The process is intended to be as collaborative and supportive as possible, with a culture of early identification and prevention. A transparent and honest approach is vital, to ensure clear understanding of accountability of individual organisations, including in relation to Duty of Candor.

Link with Adult Safeguarding

60. Care Governance does not replace the Adult Safeguarding framework; it runs alongside it where required. Where there is any safeguarding concern, the Pan Berkshire Adult Safeguarding protocol should be followed. However, should the safeguarding concern indicate that there is, or may be, a concern about provider practice, the Care Quality Team should be copied into any correspondence and will work alongside the staff member leading the Safeguarding where this is required to ensure that any thematic issues or thresholds for organisational abuse are identified. This will also inform the work of the Care Governance Operational Group

Responsibilities and Decision Making

61. All WBC staff have a responsibility to identify quality issues and to respond appropriately to safeguarding issues as they arise. If they identify either type of issue,

they should discuss the matter as it arises with the provider in the first instance. In the context of safeguarding, that worker remains responsible for ensuring immediate safety is addressed. In terms of quality issues identified, they remain responsible for ensuring the individual issue is addressed.

62. They should also discuss with the Line Manager or Supervisor and must raise a *Care Quality Referral* for a quality issue so that it is recorded and considered by the Care Quality Team, or a safeguarding alert if the threshold for safeguarding is met. The *Adult Safeguarding Threshold Document* will assist with decision-making in this respect. This can be found at Appendix 7.

63. The relevant Head of Service has overall responsibility for decision-making in this respect for issues associated with service provision within their area of responsibility and for ensuring individual issues are followed up. It should be noted that the Care Governance framework is there to deal with themes and overall quality and governance, not for managing concerns about individuals.

64. Providers will be asked to use the *Care Quality Referral* form to report any incidents to the Care Quality Team, wherein they *do not meet the threshold for safeguarding* but are never-the-less CQC notifiable incidents in accordance with the Care Quality Commission (Registration) Regulations 2009. Providers may choose to share other quality issues with WBC in the same way and this is encouraged as it supports most collaborative working.

65. The Care Governance Operational Group will be responsible for monitoring the Care Governance log, where all quality issues, safeguarding concerns and any other intelligence will be recorded. They will be responsible for monitoring the intelligence generated from proactive and reactive QA visits. This group will be responsible for making recommendations to the Care Governance Board for the Board to make decisions. The Operational Group will be responsible for delegating actions and following up to ensure they are completed. The Operational Group will sit every six weeks and be chaired by the Care Quality Manager (or ASH Manager in their absence), and will consist of:

    - Care Quality Manager
    - ASH Manager
    - Care Quality Specialist(s)
    - Senior Social Worker(s) ASH
    - Care Home Support Team
    - Operational Commissioning Manager
    - Intelligent Purchasing
    - Adults Commissioning representative
    - Review Team Manager
    - Older People's Mental Health Team
    - HLT Manager

- CCG Quality Team
- CMHT by invitation

66. Terms of Reference for the Operational Group, a template for presenting information to the group, a Record of Decisions document, Action Log and template for presenting recommendations for Care Governance Board can be found at Appendix 8.

67. Decisions about Cautions List status will be made via Care Governance Board. The Board will also sit every six weeks (one week after the Operational Group) and will be chaired by Assistant Director, Adult Social Care. In the absence of the Director, it will be chaired by Head of Adult Safeguarding & Care Governance. The Board membership will be:

    - Assistant Director, Adult Social Care
    - Head of Adult Safeguarding & Care Governance
    - Either of QA Manager / ASH Manager
    - Head of Brokerage & Support
    - Head of Prevention & Support Services
    - Assistant Director, Integrated Mental Health
    - Designated Head of Safeguarding, Clinical Commissioning Group
    - Lead Specialist for Placements, Strategy & Commissioning
    - Category Manager, Adults Commissioning

68. The Terms of Reference for the Care Governance Board can be found at Appendix 9.

69. The Care Quality Manager is responsible for the operational management of the Care Governance protocol, working under the Head of Adult Safeguarding & Care Governance. Both roles are responsible for promoting proactive and preventative measures in relation to Care Governance issues.

70. The Care Quality Team will maintain the Care Governance Log, Cautions List, Radar List and Closed Log. Relevant details will be updated chronologically on each, by provider or service, so that a brief capture of key information is instantly available. Additionally, each provider or service will have an electronic file where full information is held.

71. It should be noted, that whilst most decisions of significance will be made within the operational and Board functions outlined above, in the event of an urgent decision being required, this can be escalated to the Head of Adult Safeguarding and Care Governance who can make an interim decision in consultation with the Assistant Director, ASC pending the next formal meeting of these forums.

The Cautions List

72. The purpose of the Cautions List is to officially record providers and services about

which there are concerns which pose a high enough risk to customers, that it impacts on their health and well-being and impacts on Local Authority commissioning. It is also to ensure that improvement plans are in place and monitored to safeguard customers.

73. Any Provider or Service on the Cautions List will be supported to improve and will be given advice and information to enable recommended or required actions to be completed using the resources available at the time. WBC may undertake a range of interventions to support improvement, or working with partner organisations, support to decommission a service provision. It is important to generate and maintain a good relationship with the provider.

74. When considering decisions to place a provider or service on the Cautions List, the Care Governance Board needs to consider whether to place a single service on the Cautions List or the provider as a whole. This will be made depending on how widespread the concerns are across the provider's services.

75. The service/provider must be advised that they are added to the Cautions List before this occurs and it is distributed; only in extreme cases should this not happen i.e., where it needs to be immediate, and contact is not possible. A provider should be told verbally that they are placed on the Cautions List or that their status has changed, wherever possible. In addition, a formal letter will be sent reiterating the reasons and actions required plus outline that the provider can appeal.

76. If a Provider is placed on the Cautions List, they should already be in liaison with WBC and therefore be aware of any concerns and actions that are required. If not already known, full information must be given to them at the time they are made aware of their placement on the Cautions List.

77. When a provider or service is placed on the Cautions List by the Care Governance Board, they are given either a 'red' or 'amber' flag.

    - **Red flagged service/provider** – services or providers flagged as red are considered at that time to pose a level of risk too high to commission any new services. A service will be flagged as red if it is considered that current practice would not adequately or safely be able to meet any customer's needs and urgent reviews of current WBC placements will be undertaken. **Placement with a service or provider flagged as red can only be made in very exceptional circumstances and with the agreement of both the relevant Head of Service and Head of Adult Safeguarding & Care Quality. If there is disagreement or uncertainty, the final decision will sit with the Assistant Director for ASC.**

    - **Amber flagged service/provider** – services or providers flagged as amber are considered to pose a level of risk that means an assessment of the risk to the customer should be undertaken, before commissioning a new service, i.e. 'place with caution'. A service will be flagged as amber if it is considered that current practice would not adequately or safely be able to meet some new customers' needs. **A robust risk assessment must take place in respect of any proposed placements with an amber service or provider, setting out how identified risks have been sufficiently mitigated. This risk assessment and**

placement must be agreed at either Service Manager or Head of Service level.

78. All services/providers on the Cautions List are required to have a robust and clear action plan in place which will be closely and regularly monitored via the Provider Concerns process. The action plan will make it clear what improvements are required with the aim that these are achieved as soon as possible. Existing placements will need to be reviewed and closely monitored (Adult Social Care Operational Managers have a responsibility arrange this on direction from the relevant Head of Service (or their nominated representative). The Head of Service will determine the timeframe under which this needs to happen.

79. Movements from existing placements may be made, but only when deemed absolutely necessary based on risk assessment. This is a decision that will be made via the Care Governance Board.

80. Where the level of risk changes during the monitoring process, the flag status will be amended in line with the definitions above and as determined by the completed risk matrix. These decisions will be made in Care Governance Board. An interim decision can be made outside of Board with agreement by Head of Adult Safeguarding & Care Governance and the Assistant Director, Adult Social Care. Where risk becomes lower than that defined for a red or amber flag, the service or provider will be removed from the Cautions List and may be placed on the Radar list with review dates identified to check sustained improvement.

Radar List

81. In addition to a Cautions List, there will also be a Radar List in place. The purpose of the Radar List is to ensure that:

    - services or providers that have come off the Cautions List following an extensive or prolonged action plan are proportionately monitored to ensure improvements are maintained.
    - concerns that are not of a high enough risk to warrant inclusion on the Cautions List are monitored and addressed and:
    - where information is received which indicates a potential concern, action is taken to investigate and determine if care governance needs to be involved.

82. The Radar List is a tool to ensure all services or providers that fall into the above categories have the appropriate action taken and do not 'fall off the radar'. The Radar List is therefore not communicated outside of the Care Governance Board. Only the Cautions list is distributed outside of the Care Governance Board.

83. Transfer from the Radar List to either the Closed Log or the Cautions List can only be made by following recommendation by the Operational Group and decision at the Care Governance Board.

Closed Log

84. Services will be moved the Closed Log when it is assessed they are no longer required to be placed on either the Cautions List or Radar List. They can be moved back to either list from the Closed Log if this is felt necessary in light of new information.

Appeals

85. If a provider wishes to have more information about the decision to place them on the Cautions List, they may request this, and it should be provided as a matter of urgency in written form. Providers may also make an official written appeal against their placement on the Cautions List. There is a two-stage process to appeals, which is outlined below.

86. Stage 1 – providers should make a written submission outlining the reason they disagree with the decision. In this they should state factual inaccuracies in relation to the information used to make a judgement in relation to the level of risk plus anything else they feel is relevant. This should be sent to the Care Quality Manager either by email or formal letter and will be passed to the Chair of the Care Governance Board. The Chair must write and advise of their decision on the appeal within 10 working days, unless there are extenuating circumstance meaning longer is required.

87. Stage 2 – if following Stage 1 the provider remains unhappy, they should write to advise why this is the case and give any additional information that is relevant to their appeal. This should be sent to the Care Quality Manager either by email or formal letter and will be passed to the Director of Adult Social Care, who must write and advice of their decision within 21 working days, unless there are extenuation circumstance meaning that longer is required.

88. A provider will remain on the Cautions Lists during the appeal unless agreed otherwise. This is because there should be robust evidence in place of the necessary level of risk before they are placed ion the Cautions List in the first place. However, appeal letters should be looked at on the day of receipt and if the information from the provider indicates that the risk might not be at the level currently assessed, a further review of risk should be undertaken without delay. Where this is of benefit a meeting will be held with a provider in relation to their appeal.

Appendices

Appendix 1. Care Quality Referral Form

CARE QUALITY ALERT FORM

Date & time care issue identified:	Raised by (if not the person completing this form):

NOTE: PLEASE ONLY COMPLETE THIS FORM FOR A QUALITY CONCERN, ISSUE OR OMISSION OF ERROR

SECTION 1. DETAIL OF PERSON COMPLETING THE FORM	
Name	
Contact Details Email: Tel:	
ROLE:	
SECTION 2. PROVIDERS DETAILS	
Provider and Service Name:	
Provider Address & Contact Details: *Please provide a point of contact in the service – if known.*	
SECTION 3. SUMMARY OF THE QUALITY ISSUE IDENTIFIED	
Please provide as much information as possible regarding the identified concern.	
Section 4. OTHER INTERESTED PARTIES	
Who has been informed about this issue? Please record dates and times. (WBC/QA/Another professional/police/service provider)	

Section 6. DOES THIS ISSUE ALSO RELATE TO A SPECIFIC INDIVIDUAL	
If this Quality Assurance issue being raised relates to specific individual/s please record here.	
Surname:	
Forenames:	
Mosaic or NHS number if known:	
Title:	
Date of Birth:	
Address:	
Section 7. IS THE ISSUE RESOLVED?	
YES: [ ]	*Rationale:*
NO: [ ]	*What further actions are to be taken and by who? What is the timescale for this?*

NOW SEND THIS FORM TO THE CARE QUALITY TEAM: carequality@wokingham.gov.uk Please take care to send the form securely if containing personal information.

OFFICIAL USE ONLY
Logged by: **Date:**
Any other actions taken:

Appendix 2. Proactive Quality Assurance Report

<table>
<tr><th colspan="5">Quality Assurance Review Report</th></tr>
<tr><td>Provider Organisation Name</td><td colspan="4"></td></tr>
<tr><td>Service Name</td><td colspan="4"></td></tr>
<tr><td>Service Manager</td><td colspan="4"></td></tr>
<tr><td>Date of Review/Visit</td><td colspan="4"></td></tr>
<tr><td>Care Quality Specialists</td><td colspan="4"></td></tr>
<tr><td rowspan="5">Type of Service & Customer Group
(tick all that apply)</td><td rowspan="5"></td><td colspan="2">Service Type</td><td colspan="2">Customer group</td></tr>
<tr><td rowspan="4">Children ☐

Adults ☐</td><td>Residential ☐</td><td>PD ☐</td><td>Autism ☐</td></tr>
<tr><td>Supported Living ☐</td><td>LD ☐</td><td>Older People ☐</td></tr>
<tr><td>Non stat Prevention ☐</td><td>MH ☐</td><td>Other (specify) ☐</td></tr>
<tr><td>Domiciliary care ☐</td><td>Sensory Impairment ☐</td><td>Substance Misuse</td></tr>
<tr><td>Capacity of Service</td><td></td><td>No. of WBC Funded Customers</td><td colspan="2"></td></tr>
<tr><td>Member of Regulatory Body
(e.g. - CQC/Ofsted)</td><td></td><td>Date of last regulatory body inspection</td><td colspan="2"></td></tr>
<tr><td>Is this a scheduled visit?</td><td></td><td>Reason for Review</td><td colspan="2"></td></tr>
</table>

PURPOSE OF THE QUALITY ASSURANCE REVIEW **QA Review**
Concern xx RECOMMENDATIONS: ACTIONS:

XXX RECOMMENDATIONS: ACTIONS:
XXX RECOMMENDATIONS: ACTIONS:
XXX RECOMMENDATIONS: ACTIONS:

ACTION PLAN				
Service Provider:	Registered Manager:	Date of Visit:	QA Specialist	
Action	How Provider has met Action Provider to complete this section	Responsible Individual Provider to complete with details of individual responsible for action	Priority (Timescale for action) High - 1 month Medium – 2- 3 months Low – 3- 6 months	Progress Green – Met Amber – Partially Met Red – Not Met
Concern XX				
1.				
2.				
3.				
4.				
5.				
Concern XX				
1.				
2.				
3.				
4.				
5.				
6.				
Concern XX				
1.			HIGH	
2.				

3.				
1.				
2.				

To be completed to confirm that all actions have been agreed.	
On behalf of Wokingham Borough Council	On behalf of Provider:
Name:	Name:
Signature:	Signature:
Designation: WBC Care Quality Specialist	Designation:
Date:	Date:

If issues identified during this visit have reached the threshold to trigger a Serious Concerns Process (RED or AMVBER status under Care Governance), please complete the Risk Summary below, including a summary of evidence supporting each risk area, and any immediate actions that have been taken.

RISK SUMMARY

Risk

	Severity			
	1	2	3	4
Probability				

1	2	3	4	5
2	3	4	5	6
3	4	5	6	7
4	5	6	7	8

Probability

1. may have occurred but is unlikely to reoccur
2. has occurred and is likely to reoccur, but is not currently occurring
3. has occurred or is occurring and is likely to reoccur *or* has not yet occurred but risk of occurrence is high
4. is occurring and there are no (or limited) protective factors

Severity

1. Standard – no harm has been caused and impact of any future harm would be low
2. Moderate - some harm, but there is no significant or lasting impact for the individual
3. High - has caused or carries risk of significant harm, including to health, pain, injury, psychological harm, permanent harm, or death
4. Critical - immediate safety is of significant concern

Summary of Concerns to be addressed						
Serial	**Identified Risk**	**Evidence Base**	**Severity**	**Probability**	**Risk**	**Actions already taken**

Summary of Concerns to be addressed						
Serial	**Identified Risk**	**Evidence Base**	**Severity**	**Probability**	**Risk**	**Actions already taken**

Summary of Other Recommendations	

Appendix 3 Reactive Quality Assurance Report

Adult Safeguarding & Care Governance Serious Concerns Enquiry				
Provider Organisation Name				
Service Name				
Service Manager				
Date of First Visit				
Date of Second Visit (where a first visit was used for emergency review)				
Lead Professional				
Others Involved				
Type of Service & Customer Group **(tick all that apply)**		**Service Type**	**Customer group**	
	Adults ☐	Residential ☐	PD ☐	Autism ☐
		Supported Living ☐	LD ☐	Older People ☐
		Nursing ☐	MH ☐	Other (specify) ☐
		Domiciliary care ☐	Sensory Impairment ☐	
Capacity of Service		**No. of WBC Funded Customers**		
Member of Regulatory Body *(e.g. - CQC/Ofsted)*		**Details of other commissioners (authority and # customers)** **Include # of self funders.**		
Date of last regulatory body		**Overall Rating From Last**		

inspection		**inspection** *(incl. any details of any concerns)*	
Details of information/concerns leading to visit and enquiry			

Previous Safeguarding History
(Including other services/institutions owned by the Provider)
Previous and Current evidence of breaching regulations or contracts
(CQC, Contracts and Commissioning)

Police – past or current concerns

Terms of Reference for Enquiry	
Serial	**These TORs are to be agreed by ASH Manager, QA Manager and Head of Service in advance of the visit. Additional rows can be added if required.**
1	
2	
3	
4	
5	

Findings	
	Findings (including any evidence collected or observed)
rial 1 (add detail of what you looked at, who you spoke to, observations you made).	

Findings	
	Findings **(including any evidence collected or observed)**
Serial 2 (add detail of what you looked at, who you spoke to, observations you made).	
Serial 3 (add detail of what you looked at, who you spoke to, observations you made).	
Serial 4 (add detail of what you looked at, who you spoke to, observations you made).	

Findings	
	Findings **(including any evidence collected or observed)**
Serial 5 (add detail of what you looked at, who you spoke to, observations you made).	

Feedback from Customers	
	Findings **(including any evidence collected or observed)**

Feedback from staff	
	Findings **(including any evidence collected or observed)**

Feedback from families (where appropriate)	
	Findings (including any evidence collected or observed)

Feedback from other commissioners	
	Findings (including any evidence collected or observed)

Feedback from Health	
	Findings (including any evidence collected or observed)
Continuing Health Care (CHC) and Funded Nursing Care (FNC) feedback – status of placements and history of concerns/complaints.	
NHS - history and pattern of clinical referrals (for example, A&E attendances, GP views).	

Input from Integrated Care Home Service (if appropriate).	
Input from; DNs, TVNs, OTs, CPNs and SALT	

Feedback from Other Partners	
	Findings (including any evidence collected or observed)
Berkshire Fire & Rescue Service (if appropriate).	

Feedback from frontline Health & Social Care staff	
	Findings (including any evidence collected or observed)

Environmental Factors

Visual Inspection of the Premises *(Dependant on the type of service being provided)*	**Answer (including any evidence collected or observed)**
Is the décor of the premises are of a reasonable standard? - *Is there a maintenance plan*	Yes ☐ No ☐ Comment:
Is the furniture of a reasonable standard? *(Furniture replacement plan)*	Yes ☐ No ☐ Comment:
Is the cleanliness of a reasonable standard? Who is responsible for cleaning the premises and how often does this happen?	Yes ☐ No ☐ Comment:
Is the smell of the service pleasant?	Yes ☐ No ☐ Comment:
Do the kitchen and laundry facilities appear clean and clutter free?	Yes ☐ No ☐ Comment: Kitchen area not observed
Are staff friendly and welcoming?	Yes ☐ No ☐ Comment:
Are there any communal areas? Are they adequate? - Clean & tidy - Can it accommodate the individual and collective needs of the customers	Yes ☐ No ☐ Comment:
Are thermostatic mixing valves fitted to water supplies?	

Summary of any additional Positive Feedback not included above	
Source	**Comments or observations**

RISK SUMMARY

Risk

	Severity 1	2	3	4
Probability				
1	2	3	4	5
2	3	4	5	6
3	4	5	6	7
4	5	6	7	8

Probability

5. may have occurred but is unlikely to reoccur

6. has occurred and is likely to reoccur, but is not currently occurring
7. has occurred or is occurring and is likely to reoccur *or* has not yet occurred but risk of occurrence is high
8. is occurring and there are no (or limited) protective factors

Severity

5. Standard – no harm has been caused and impact of any future harm would be low
6. Moderate - some harm, but there is no significant or lasting impact for the individual
7. High - has caused or carries risk of significant harm, including to health, pain, injury, psychological harm, permanent harm, or death
8. Critical - immediate safety is of significant concern

Summary of Concerns to be addressed						
Serial	**Identified Risk**	**Evidence Base**	**Severity**	**Probability**	**Risk**	**Actions already taken**

Summary of Concerns to be addressed						
Serial	**Identified Risk**	**Evidence Base**	**Severity**	**Probability**	**Risk**	**Actions already taken**

Summary of Other Recommendations	

Appendix 4. Proactive QA Risk Matrix Example

Proactive QA Risk Matrix Example

Provider	Service Name	Contract Number	Service Type	Type of Contract	Care Governance Status	Ofsted/CQC Rating	Location	Financial Stability of Provider	URN	WBC Placements	Vulnerability Profile of Customer Placed at Placement	Annual Contract Value	Maximum Capacity

WOKINGHAM BOROUGH COUNCIL

Appendix 5. Provider Self-Assessment Toolkit.

Wokingham Borough Council Quality Assurance Framework
Provider Self-Assessment Toolkit: Introduction
Under national and local government policies, Wokingham Borough Council must comply with a range of duties to shape the local care and support market to deliver high quality services and improved outcomes for its residents. A range of services are commissioned by the Council with external suppliers to meet the needs of adults and children.
Wokingham Borough Council will manage the contracts with these suppliers, ensuring the quality of services and identifying areas of improvement by use of a Quality Assurance Framework. The framework sets out the contract monitoring approach and describes the steps the Council will take to ensure the care and support services commissioned are reviewed and monitored, through an equitable and transparent process.

The overarching principles of the quality assurance framework are:

- The delivery of outcomes for service customers and WBC residents are at the forefront of service provision;
- Providers are responsible for ensuring they deliver good quality care and services;
- The Council has a duty to provide assurance of and drive up the overall quality of care and service provision in the services it commissions;
- The Council aspires only to do business with good quality providers;
- The Council will measure the overall quality of provision by taking into account a range of opinions to provide a balanced view;
- Quality will be measured against contractual terms and conditions, standards and the delivery of outcomes; and
- The quality assurance framework mechanism is transparent and clear

Purpose of a Self-Assessment Toolkit

The provider self-assessment toolkit is an important component of a quality assurance framework. It is a key tool in the drive for continuous improvement, which is the challenge facing all organisations in the public or private sectors. Pressure on resources, increased expectations from customers and stakeholders, technological advances and the increasing availability of comparative information mean that organisations are required to deliver more and better services to meet customer needs and maintain customer satisfaction. Self-assessment can help to create a learning culture by encouraging participants to ask "How well are we doing?" and "How can we improve?"

Self-assessment uses the knowledge that already exists within an organisation. It does not require specialist knowledge to be brought in. The skills and knowledge that are acquired during the self-assessment, stay with the organisation after the process is complete.

The toolkit has been designed to increase provider organisations involvement in the process of assessing strengths, areas in need of improvement, identify discrepancies of performance and to allow a more constructive evaluation of services. Use of the toolkit should assist in the development of a supportive and positive relationship between commissioners and support providers, that will help to deliver continued improvement in quality, with innovative and cost effective outcomes that promote the wellbeing of people who need care and support and their carer's.

Where appropriate, organisations will be supported to improve and provided with advice and information to enable this to happen, using the resources available at the time.

When will the Toolkit be used?

The toolkit will form one part of the Council's assessment of the quality of services commissioned by Wokingham Borough Council. Completion of the toolkit may be requested in the following circumstances:

- As part of a scheduled desktop quality assurance assessment
- To gather information prior to a quality assurance visit
- In response to a referral to the Care Quality Team following concerns with an aspect of the service
- For large *strategic services it may be requested on an annual basis

*strategic in this context means, an important service for WBC, this may be due to the number of customers, customer group, value of contract, provider organisation etc.

What will the Toolkit be used for?

Completed provider self-assessment toolkits will be stored on the Care Quality Team dedicated drive. Completed questionnaires will not be public documents, access to these folders is restricted to members of the team. However, the information contained within a completed questionnaire, may be shared with management teams and/or the Care Governance Board if it is felt to be appropriate.

A summary of the findings from completed questionnaires may be used to:

- Evidence the current position of providers we commission;
- Identify areas where the Council could provide or facilitate provider training;
- Identify areas where the Council could signpost providers to "best practice" ideas and/or share ideas between provider organisations; and
- Identify areas where the Council could signpost providers to independent training resources

On receipt of the completed self-assessment, the Care Quality Team will moderate the provider self-assessment rating for each standard based on the evidence provided and notify the provider of the final rating within 2 weeks. We reserve the right to request copies of any policy/procedure or document as part of the moderation process. The WBC rating will form part of the overall risk assessment score for the service, which in turn will help determine the frequency and nature of quality assurance undertaken by the Council under the published Quality Assurance Framework.

WOKINGHAM BOROUGH COUNCIL

Wokingham Borough Council			
Care Quality Provider Self-Assessment Toolkit			
Provider Organisation Name			
Service Name			
Name of Service Manager **How Long in Post?**			
Name of Person Completing the Toolkit **Job Title**			
Date Toolkit Completed			
Type of Service & Customer Group **(tick all that apply)**	Children	Service Type	Category

Maximum Capacity of Service **of which:** **Number of WBC Funded Customers; and** **Number of other Local Authority Funded Customers; and** **Number of Self-Funding Customers**	
Member of Regulatory Body and Registration Number, if applicable **(***for example - CQC/Ofsted)*	-
Overall Rating From Last Inspection, if applicable	
Any specific areas of concerns raised *(any requires improvement or Performance Improvement Plans)*	
At the time of completing this toolkit, how	

many members of non-nursing staff are employed at the service to provide care and support to customers?	Out of the above number, show how many staff have as their highest level of health and social care qualification: Care Certificate - NVQ Level 1 - NVQ Level 2 - NVQ Level 3 - Other i.e. Diplomas show level and no's of staff
As a percentage, how many care and support staff, including nursing staff, have left the service within the last 12 months? **What were the main reasons stated for leaving?**	
Has the service ever made a referral to the Disclosure and Barring Service or the Nursing and Midwifery Council?	**Please delete as appropriate:** **YES/NO** If Yes, please provide details of the referral and how you dealt with the issues
Does the service ever provide support to	**Please delete as appropriate:**

children or young people under 18 years of age on behalf of Wokingham Borough Council? **If Yes, has the service ever completed & submitted a LSCB Section 11 Audit Self-Assessment?** **If Yes, please state the date fof the last submission & who it was sent to**	**YES/NO** **YES/NO** **Date Submitted:** **Name of Contact at WBC the last submission was sent to:**
How did you find completing this tool?	

WOKINGHAM BOROUGH COUNCIL

Wokingham Borough Council

Provider Self-Assessment Toolkit: Guidance for completion of the Toolkit

Self-assessment is best approached constructively, as an opportunity to learn about your organisation. Once current performance has been assessed, ideas for improvement can be developed.

Please provide an honest assessment of how your organisation is currently meeting each standard. To justify your rating to need to provide written evidence in this document, there is no word limit for any question. However, unless we request copies of any documents under any individual standard, we will not read or review any other documents submitted as evidence of your rating.
On receipt of the self-assessment toolkit, providers will have 2 weeks to return the completed toolkit together with any attachments to the team mailbox: QAcommissioning@wokingham.gov.uk
If you have any queries with the completion of this toolkit, please do not hesitate to contact us, via the team mailbox above, or by telephone on 0118 9088368 and ask to speak to one of the Care Quality Specialists on the team.
The self-assessment tool is made up of 10 worksheets.
Each worksheet focuses on an important set of standards and outlines the criteria services should aim to achieve.
Follow the links below to each worksheet where you enter the evidence to show how you are meeting each standard, your self-assessed rating and what the plans are to meet or improve upon the current standards.
1. Leadership and Accountability
2. Staffing
3. Personalisation and Inclusion
4. Health and Safety
5. Safeguarding
6. Complaints and Compliments
7. Information Sharing and Communication
8. Policies and Procedures
9. Equality and Diversity
10. Quality Assurance

After you have completed your rating please review the 'Score Summary' to see an evaluation of your responses and review the 'Agency Action Plan Summary' to see your generated action plan.

Appendix 6. Serious Concerns Meeting Template

CARE GOVERNANCE AND SAFEGUARDING SERIOUS CONCERNS MEETING	
PROVIDER	
DATE	
VENUE	
CHAIR	
TYPE OF MEETING	initial / review / additional concerns

Confidentiality Statement:

This meeting is held under in accordance with the Care Governance Protocol. The matters raised are confidential to members of the meeting and the agencies they represent, and all discussions are held in accordance with agreed information sharing protocols.

Minutes of this meeting are distributed with the strict understanding that they are kept confidential and in a secure place and are not distributed further without the explicit permission of the Chair. In certain circumstances it may be necessary to make the minutes available for legal or regulatory purposes.

Equality & Diversity Statement

WBC policies and procedures recognise that certain people are the subject of discrimination and disadvantage. Comments that contribute to this discrimination are not acceptable and will be challenged by the Chair and other meeting members.

These minutes will aim to reflect that all individuals who are discussed at this meeting should be treated fairly, with respect and without improper discrimination. All work undertaken at the meeting will be informed by a commitment to equal opportunities and effective practice issues in relation to all protected characteristics.

Attendees

Name	Organisation and Role	Contact details

Apologies

Name	Organisation and Role	Contact details

SUMMARY OF BACKGROUND TO CONCERNS (what led to visit)	
Presented by	
COPY OF RELEVANT REPORT CONTAINING EVIDENCE BASE FOR DISCUSSION	
SUMMARY OF FINDINGS IN REPORT INCLUDING RISK AREAS	
Presented by	
FEEDBACK AND VIEWS FROM PROVIDER, INCLUDING PRESENTATION OF ACTION PLAN	
RECORD OF ANY KEY DISCUSSION to include all agencies present	

Confirmation of Caution List Status

AMBER / RED / move to RADAR

Please detail any disagreement with this decision

ACTIONS AGREED incl. any decision around new admissions

What	Who	When

TIME SCALE FOR REVIEW

COMMUNICATIONS including agencies and individuals

ANY OTHER BUSINESS

Appendix 7. Safeguarding Threshold Guidance

WEST OF BERKSHIRE ADULT SAFEGUARDING THRESHOLD GUIDANCE

This document has been developed to support a shared understanding of thresholds for adult safeguarding. It supports decision-making around when an issue is suitable for a standard agency response (green), when a consultation with the safeguarding service should be undertaken (amber) for further advice and when the threshold for raising a safeguarding concern is clearly met (red). It should be noted that this guide uses examples of behaviours or issues that may be encountered, but it is not exhaustive and as such, professional judgement must be used alongside it. If in any doubt, consultation should be made with the safeguarding service.

Definitions:

Agency response

- Notification to Local Authority quality team, using agreed mechanism.
- CQC notification where required.
- Internal fact-finding and lessons learned.
- Internal processes such as performance or capability.
- Duty of Candour.

Requires Consultation
Contact should be made with the Local Authority safeguarding service to discuss the specifics of the issue identified as this will enable an appropriate threshold to be considered. The outcome of this consultation will be that either advice is provided, actions agreed, and this is recorded as a case note and onto the Care Governance log as a consultation, or a request will be made for it to be formally raised as a safeguarding concern.

Always reportable
Issues of this nature should automatically be raised as a formal safeguarding concern.

Physical Abuse

Agency response	Requires consultation	Always reportable
• Incident causing no/little harm, e.g., friction mark on skin due to ill-fitting hoist sling, minor/small accidental skin tear. • Light marking or bruising found on one occasion with no other concern, where probable cause is known. • Minor events that still meet cr iteria for 'incident reporting'. • Isolated incident* involving service user on service user where no harm or residual distress is caused.	• Recurrent incidents causing some harm. • Unexplained marking, lesions, cuts, or finger marks on one occasion, or lesser marks on more than one occasion. • Accumulation of minor incidents. • Incident with potential serious consequences. • Recurrent incidents involving service user on service user, or one incident where harm or residual distress is caused.	• Unexplained fractures or other serious injuries. • Inappropriate restraint. • Withholding of food, drinks, or aids to independence. • Alleged assault. • Deliberate maladministration of medications. • Covert administration without proper medical authorisation. • Service user on service user incident(s) where the perpetrator has capacity or where there is intent or where there is targeting or where injury occurs.
Supporting Guidance Note – *any* incident which *may* constitute sexual abuse should be referred, regardless of whether it is an isolated incident.		

Neglect & Acts of Omission

Agency response	Requires consultation	Always reportable

• Isolated incident of missed or late service delivery where no harm or distress is caused, and no other customers are affected same day. • Failure to deliver care/support (such as not assisted with meal/drink) on one occasion and no harm occurs. • Care not delivered in the way customer would like but no harm occurs (possible complaint). • One incident of inadequate care that causes discomfort or inconvenience (e.g., left wet on an occasion) but no significant harm occurs. • Isolated incident of not having access to aids for independence that have been provided. • Isolated medication error which did not cause or carry risk of harm. • Provider not following care plan or agreed actions, but no significant harm occurs.	• Recurrent incidents of missed or late service delivery where risk of harm escalates. • One incident of missed or late service delivery where harm occurs. • Missed or late service delivery where more than one customer is affected. • Hospital discharge without adequate planning and harm occurs. • Isolated medication error, which did not cause harm, but carried risk of harm. • Repeated failure to follow care plan or agreed actions.	• One off omission or act that causes or carries risk of significant harm. • Repeated or ongoing lack of care, or failure to adhere to the care plan, to the extent that health and wellbeing deteriorate significantly e.g., pressure wounds, dehydration, malnutrition, loss of independence or confidence. • Failure to arrange access to important or lifesaving services or medical care. • Undue delay in arranging access to important or lifesaving services or medical care, which impacts on outcomes. • Failure to intervene in dangerous situations where the adult lacks capacity or *may* lack capacity to assess risk or make relevant decisions. • Isolated medication error that caused harm, a pattern of medication errors, or a medication error that affected more than one customer.

Supporting Guidance

Pan Berkshire Pressure Ulcer Pathway - https://www.berkshiresafeguardingadults.co.uk/wokingham/procedures/?procId=1454 For easy reference:

- Grade 3 and 4 *always* refer as Safeguarding with as much information as possible about how pressure ulcer pathway was followed.
- Grade 1 and 2 refer where there is any concern that there *may have* been a lapse in care, an omission or the pressure ulcer pathway may not have been followed.
- Multiple (more than 1) of any grade – always refer.

Financial & Material

Agency response	Requires consultation	Always reportable
• Non-payment of care fees where customer has capacity, is not relying on another person to do this, and there are no concerns of coercion or undue influence.	• Staff personally benefit from customers funds, e.g., accrue 'reward' points on their own loyalty cards when spending with/for customer. • Money not recorded safely or appropriately. • Adult not routinely involved in decisions about how their money is spent or kept safe and capacity in this respect is not clear. • Adult's monies kept in a joint bank account with unclear arrangements around proceeds and/or access. • Incidences of scamming of a person with care and support needs where they lack capacity or *may* lack capacity. • Non-payment of care fees where another party is managing finances, (even under a legal framework) or there is concern of coercion or undue influence.	• Misuse/misappropriation of property, possessions, or benefits by a person in a position of trust or control • Misuse of legal Power such as LPA, Deputyship etc. • Personal finances removed from adult's control with no appropriate legal framework in place or concerns of coercion/undue influence. • Exploitation relating to benefits, income, property, or wills. • Adult denied access to his/her own funds or possessions. • Theft or fraud. • Mate crime. • Cuckooing.
Supporting Guidance Mate Crime – 'When a person is harmed or taken advantage of by someone, they thought was their friend". Cuckooing – targeting of the home of a vulnerable adult for purposes of exploitation, drug dealing and other criminal activities.		

Self-Neglect

Agency response	Requires consultation	Always reportable
• Self-care causing some concern – no signs of harm or distress. • Property neglected but all main services work. • Lack of essential amenities. • No access to support. • Some evidence of hoarding – no major impact on health/safety (clutter index 1-3) • First signs of failing to engage with professionals.	• Refusing medical treatment where capacity to make that decision is unclear and implications serious. • Moderate level of clutter or hoarding (clutter index 4-5). • Insanitary conditions in property impacting on wellbeing. • Continued non-engagement with professionals with concerns for wellbeing. • Potential fire risks/gas leaks. • Multiple reports of concern from others. • Chaotic behaviours which risk serious harm or death, and where adult lacks capacity or may lack capacity.	• Self-neglect is life threatening. • Lack of self-care results in significant deterioration in health or wellbeing. • Environment injurious to health. • Imminent fire risk or gas leak. • Others affected by self-neglect. • Multiple reports of significant concern from other agencies • Access to/in property severely compromised. • Clutter Index rating 6-9.
Supporting Guidance *Only exceptional cases will trigger a safeguarding response. All proportionate interventions must be used first to manage risk, e.g., assessment, case management, CPA, MDT, MARM Clutter Index tool - https://hoardingdisordersuk.org/research-and-resources/clutter-image-ratings/		

Psychological

Agency response	Requires consultation	Always reportable

• Isolated incident where adult is spoken to in a rude or other inappropriate way – respect and dignity undermined but no or little residual distress caused.	• Adult receiving occasional taunts or verbal outbursts from others, with negative impact on them. • Withholding of information to disempower them. • Treatment that undermines adult at risks dignity and esteem with negative impact on them. • Denying or failing to recognise adult's choice or opinion. • Adult receiving frequent verbal outbursts or harassment from others.	• Humiliation. • Taunting, mimicking, inappropriate treatment by a person in a position of trust or control. • Emotional blackmail e.g., threats of abandonment or harm • Frequent and frightening verbal outbursts. • Hate crime. • Denial of basic human right/civil liberties, e.g., over-riding advance decisions, blanket decisions around DNA-CPR. • Prolonged or repeated intimidation. • Vicious or personalised verbal attack. • Adult is being targeted.
Supporting Guidance Hate crime – ''Any criminal offence which is perceived by the victim or any other person, to be motivated by hostility or prejudice based on a person's race or perceived race; religion or perceived religion; sexual orientation or perceived sexual orientation; disability or perceived disability and any crime motivated by hostility or prejudice against a person who is transgender or perceived to be transgender'.		

Organisational

Agency response	Requires consultation	Always reportable

• Lack of stimulation or opportunities for social and leisure activities, but no harm caused. • Customers not given sufficient voice of involved in the running of the service, but no harm caused. • Denial of individuality and opportunities for customers to make informed choices and take positive risks. • Care planning documentation not personcentred, but with no harm caused.	• Rigid or inflexible routines. • Decisions made for the convenience of the organisation, to the detriment of the customer. • Customer's dignity is undermined.	• Bad practice not being reported and/or addressed. • Unsafe or unhygienic living environments. • Staff misusing their position of power over customers. • Poor practice at a systemic nature, which has detrimental impact or causes harm to customers. • Overuse of medication to sedate. • Inappropriate use of restraint to manage behaviour. • Recurrent ill-treatment or wilful neglect.
Supporting Guidance Definition of organisational abuse (taken from Care & Support Statutory Guidance updated 24 June 2020) – "Including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation".		

Discriminatory

Agency response	Requires consultation	Always reportable

• Isolated incident of teasing motivated by prejudicial attitudes towards an adult's individual differences with no harm or residual distress caused. • Isolated incident of taunting which is linked to the person's protected characteristics, causes no harm or residual distress, and is dealt with through other frameworks. • Isolated incident of care planning that fails to address an adult's specific diversity associated needs for a short period of time, with no significant or lasting harm caused.	• Inequitable access to service provision as a result of a diversity issue. • Recurring failure or undue delay to meet care and support needs associated with diversity. • Being refused access to essential services in relation to a protected characteristic. • Seemingly punitive responses to customer having made a complaint. • Denial of civil liberties, e.g., voting	• Humiliation or threats on a recurring basis. • Recurring taunts that are linked to protected characteristics. • Hate crime resulting in injury or a fear for safety/life.
Supporting Guidance **Note – any concern involving behaviours by a person who is in a position of power (paid employment or voluntary work) must as a minimum have a consultation with the Local Authority.**		

Sexual

Agency response	Requires consultation	Always reportable

• Isolated or low frequency incidents of unwanted peer flirtation, which causes no harm or residual distress and that is effectively addressed.	• Verbal sexualised insults or 'banter' that causes harm or distress. • Incidents of unwanted sexualised attention (verbal or physical) directed at a vulnerable adult, whether or not mental capacity exists.	• Recurring sexualised touching or attention without consent. • Masturbation in front of another vulnerable adult without their valid consent. • Voyeurism without consent. • Being subject to indecent exposure. • Coercion. • Attempted penetration by any means (whether or not it occurs within a relationship) without consent. • Made to look at pornographic material against will or consent not valid. • Sexual contact by/with a person in a position or power, in a relationship characterised by authority, inequality or exploitation. • Sex without valid consent (rape). • Grooming. • Concerns of sexual exploitation.
Supporting Guidance Any concern of sexual behaviour that involves someone in a position of Power **must** be referred under Safeguarding.		

Domestic Abuse

Agency response	Requires consultation	Always reportable

• Capacitated adult with no care and support needs or additional vulnerabilities identified or suspected. • Isolated incident of an abusive nature, which does not cause or carry risk of significant harm. • Occasional taunts or verbal outbursts where the victim has no current fears and there are adequate protective factors.	• Adult has care and support needs and the outcome of the DASH indicates moderate risk. • Inexplicable, or incidents resulting in, marking, lesions or grip marks. • Victim is believed to have capacity but is believed to be subject to coercion and control.	• Adult has care and support needs and the outcome of the DASH indicates high risk. • Adult at risk *may* lack or *does* lack capacity around relevant decisions. • Assault causing serious harm. • Indicators of stalking or harassment. • Sexual assault. • Victim is afraid. • Coercion and control impacting victim's ability to protect self. • Regular violent behaviour. • Threats to kill/choke/suffocate. • Sex without valid consent (rape). • Female Genital Mutilation. • Concerns of Forced Marriage. • Indicators of Honour Based Abuse.
Supporting Guidance • Where Domestic Abuse is disclosed and children are part of the household, or present, a referral must be made to Children's Services. • Disclosures of Domestic Abuse should trigger an offer of referral to Domestic Abuse services for early intervention. • A DASH-RIC should be completed for each new incident of Domestic Abuse - https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf • A DASH-RIC with an outcome of high risk **must** be referred to MARAC (Multi-agency Risk Assessment Conference). Standard or medium risk cases may be referred using professional judgement. Where there are repeat incidents that do not meet the threshold for MARAC, consideration should be given to a MATAC referral.		

Modern Slavery & Human Trafficking

Agency response	Requires consultation	Always reportable

	• Adult with care and support needs or additional vulnerabilities who appears to be under the control of another or fearful. • Adult at risk is spending long periods of work. • Adult at risk is unable to seek medical treatment. • Adult at risk appears to have poor living conditions and low wages.	Adult is being regularly moved to avoid • detection. Living in workplace. • • Indications the person is working in a place with no health and safety against their will. • Indicators the person is under the control of others. • Subject to violence or threats or is fearful. • Indicators of physical or psychological harm. • Living in a shed, outbuilding, lockup or container. • Lack of freedom or unable to leave. • Risk or organ harvesting. • Wages used for debt. • Not in possession own ID or passport.
Supporting Guidance Modern Slavery is the severe exploitation of other people for personal or commercial gain.		

Appendix 8. Care Governance Operational Group: Terms of Reference

WOKINGHAM BOROUGH COUNCIL

Care Governance Operational Group

Terms of Reference

Overall Purpose and Aims of the Operational Group

The Operational Board is a sub-group of the Care Governance Board. The Operational Group are responsible for monitoring the Care Governance activity via the log, where all quality issues, safeguarding concerns and any other intelligence will be recorded. The group are responsible for making recommendations to the Care Governance Board for the Board to make decisions. The Operational Group will be responsible for delegating actions and following up to ensure they are completed. The aim of the Operational Group is to empower members to be accountable for the activity around Care Quality that needs to take place across services.

The output is to - steer and provide recommendations to the Care Governance Board prior to the 6-weekly meeting.

Functions of the Operational Group:

- Where it is apparent (CQC Reports) that providers or services are not sufficiently meeting regulatory outcomes, the Operational Group will escalate via the Care Governance Board for a decision about what level of action is required.
- To monitor the Care Governance log for thematic quality issues that may trigger concerns of organisational abuse and to escalate these coherently to the Care Governance Board for decisions about whether a large-scale enquiry is required.
- To monitor the Care Governance log for thematic quality issues that are not at the threshold for concerns of organisational abuse, but never-the-less impact on the priority risk rating for proactive QA and make decisions about moving them up the schedule accordingly. To keep Care Governance Board informed of these.
- To discuss Quality Assurance reports following either proactive or reactive visits, share information and intelligence, agree and delegate actions and monitor progress on these.
- To make recommendations to the Care Governance Board in respect of movement on the Cautions List and Radar list.

Membership of the Board:

The Operational Group will be chaired by the Care Quality Manager (or ASH Manager in their absence), and will consist of:

- Care Quality Manager
- ASH Manager
- Care Quality Specialist(s)
- Senior Social Worker(s) ASH
- Care Home Support Team
- Operational Commissioning Manager
- Intelligent Purchasing
- Adults Commissioning representative
- Review Team Manager
- Older People's Mental Health Team
- CHC Manager
- CCG Quality Team
- CMHT by invitation

In addition, particular expertise will be called upon to support the work of the group as and when necessary. If a member of the Group is unable to attend, they will send a suitable deputy from their service.

Reports to

The Care Governance Board

Agenda

The standard agenda will include –

- Review of previous actions – current work
- Discussions around completed Quality Assurance reports where issues have been identified.
- Looking forward - CQC reports –
    - Providers or services not sufficiently meeting regulatory outcomes.
    - Cautions, alerts or references from other Local Authorities.
    - Safeguarding intelligence from the log via the Adult Safeguarding Hub (ASH).
    - Quality referrals made by internal and external parties.
    - Other sources of intelligence as appropriate (Statutory Reviews, Complaints, MP enquiries and Member enquiries, Financial checks, Insurance checks, Performance Information, Policies and Procedures, Feedback from Individuals)
- Recommendations to Care Governance Board

Administration of Meetings

The administration of meetings will be undertaken by the Quality Assurance Administrator.

Frequency of meetings

Meetings will be 6-weekly and occur 1 week before the Care Governance Board sits

Approvals:

Sign off on Care Governance work is with the AD Adult Social Care

Appendix 9. Care Governance Board: Terms of Reference

WOKINGHAM BOROUGH COUNCIL

Care Governance Board

Terms of Reference

Overall Purpose and Aims of the Care Governance Board

1. To provide a Senior Management level forum, for bringing together and discussing evidence of quality or safeguarding issues in relation to services and providers.
2. To make decisions on behalf of the Local Authority in relation to actions needed regarding safeguarding and quality issues in Provider Organisations, through use of the Cautions List and Radar processes.
3. To ensure a consistent and transparent response to issues arising around care quality or organisational abuse.
4. To provide support to the Care Governance Operational Group by resolving or removing 'blocks' to delivery of the operational work of that group.
5. To support the delivery of the Care Governance framework via appropriate specialist input via themselves or their teams, where this is required by the nature of the work.
6. To provide a forum to develop good practice in the areas of care quality and organisational safeguarding and to ensure there is an effective interface between ASC operations and Strategic Commissioning in relation to Provider Services.
7. To monitor agreed Key Performance Indicators.
8. To report and advise on its work and outcomes.

Membership of the Board:

- Assistant Director, Adult Social Care
- Head of Adult Safeguarding & Care Governance
- Either of QA Manager / ASH Manager
- Head of Brokerage & Support
- Head of Prevention & Support Services
- Assistant Director, Integrated Mental Health
- Designated Head of Safeguarding, Clinical Commissioning Group
- Lead Specialist for Placements, Strategy & Commissioning
- Category Manager, Adults Commissioning

Head of Adult Safeguarding & Care Governance will act as Chair in the absence of AD, ASC.

Additional staff may be asked to attend to support decision-making around specific issues, on occasions.

Quoracy

For a meeting to be quorate there must be a minimum of representation from: Adult Safeguarding, Quality Assurance, Commissioning and 2 other operational service areas.

Where a member is unavoidably unable to attend a Board Meeting, they should seek to send a delegate in their place. As this is a decision-making group, that delegate must be of sufficient seniority to have authority to make decisions.

Agendas

Although not an exhaustive list, the agenda will as a minimum cover the items below:

- Presentation of current Cautions List.
- Discussion on any cases requiring a decision:
    - new concerns that may require a decision to move onto cautions list (including review of any fast-track decisions that have been required between Boards),
    - or existing cases that may be ready for review to downgrade their status.
- Escalation of any blocks being experienced by the Care Governance Operational Group with discussion for resolution.
- Review of work undertaken against the KPIs.
- High level discussion regarding any specialist input required in relation to forthcoming Quality Assurance or Organisational Safeguarding work.
- Relevant feedback from partner organisations and any other formal Quality Assurance groups and networks.

Governance

The Board will report on activity to the ASC Leadership Team monthly via a Dashboard summary. A more detailed report will be produced quarterly detailing high risk areas.

Administration of Meetings

The administration of meetings will be undertaken by Care Quality Team Administrator.

Frequency of meetings

Meetings will be 6-weekly. Where decisions are required outside these meetings a fast-track meeting or contact will be held, and decisions made by AD ASC and Head of Adult Safeguarding & Care Governance in discussion with other stakeholders and Senior Managers as needed.