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NOTICE

OF

MEETING

ADULTS, CHILDREN AND HEALTH OVERVIEW AND SCRUTINY PANEL

will meet on

WEDNESDAY, 30TH SEPTEMBER, 2020

At 6.15 pm

VIRTUAL MEETING - ONLINE ACCESS

TO: MEMBERS OF THE ADULTS, CHILDREN AND HEALTH OVERVIEW AND SCRUTINY PANEL

COUNCILLORS CHRISTINE BATESON, CAROLE DA COSTA, MAUREEN HUNT (CHAIR), JOHN STORY AND AMY TISI
MARK JERVIS (ACADEMY GOVERNORS' REPRESENTATIVE, DEREK MOSS (PRIMARY GOVERNORS' REPRESENTATIVE), TONY WILSON (OXFORD DIOCESE REPRESENTATIVE)

SUBSTITUTE MEMBERS
COUNCILLORS SIMON BOND, GREG JONES, HELEN PRICE AND CHRIS TARGOWSKI

Karen Shepherd – Service Lead - Governance - Issued: 22nd September 2020

Members of the Press and Public are welcome to attend Part I of this meeting. The agenda is available on the Council's web site at www.rbwm.gov.uk or contact the Panel Administrator **Andy Carswell** 01628 796319

Recording of Meetings –In line with the council's commitment to transparency the Part I (public) section of this virtual meeting will be streamed live and recorded via Zoom. By participating in the meeting by audio and/or video you are giving consent to being recorded and acknowledge that the recording will be in the public domain.
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AGENDA

PART I

ITEM	SUBJECT	PAGE NO
1.	ELECTION OF VICE CHAIRMAN To elect a Vice Chairman for the remainder of the 2020/21 municipal year.	-
2.	APOLOGIES FOR ABSENCE To receive any apologies for absence.	-
3.	DECLARATIONS OF INTEREST To receive any declarations of interest.	3 - 4
4.	MINUTES To approve the minutes of the meeting held on June 11th 2020.	5 - 10
5.	HEATHERWOOD HOSPITAL UPDATE To receive an update on the redevelopment of Heatherwood Hospital from Janet King, Director of HR & Corporate Services/Deputy CEO at Frimley Health NHS Foundation Trust.	-
6.	ANNUAL COMPLIMENTS AND COMPLAINTS REPORT To review and comment on the contents of the report.	11 - 68
7.	2020/21 Q1 PERFORMANCE REPORT To note the report and approve the recommendations.	69 - 90
8.	RESPONSE TO THE OMBUDSMAN PUBLIC INTEREST REPORT To discuss the report and to make any recommendations for action by Cabinet.	91 - 170
9.	WORK PROGRAMME To review the ongoing work programme.	171 - 172

MEMBERS' GUIDE TO DECLARING INTERESTS IN MEETINGS

Disclosure at Meetings

If a Member has not disclosed an interest in their Register of Interests, they **must make** the declaration of interest at the beginning of the meeting, or as soon as they are aware that they have a DPI or Prejudicial Interest. If a Member has already disclosed the interest in their Register of Interests they are still required to disclose this in the meeting if it relates to the matter being discussed.

A member with a DPI or Prejudicial Interest **may make representations at the start of the item but must not take part in the discussion or vote at a meeting.** The speaking time allocated for Members to make representations is at the discretion of the Chairman of the meeting. In order to avoid any accusations of taking part in the discussion or vote, after speaking, Members should move away from the panel table to a public area or, if they wish, leave the room. If the interest declared has not been entered on to a Members' Register of Interests, they must notify the Monitoring Officer in writing within the next 28 days following the meeting.

Disclosable Pecuniary Interests (DPIs) (relating to the Member or their partner) include:

- Any employment, office, trade, profession or vocation carried on for profit or gain.
- Any payment or provision of any other financial benefit made in respect of any expenses occurred in carrying out member duties or election expenses.
- Any contract under which goods and services are to be provided/works to be executed which has not been fully discharged.
- Any beneficial interest in land within the area of the relevant authority.
- Any licence to occupy land in the area of the relevant authority for a month or longer.
- Any tenancy where the landlord is the relevant authority, and the tenant is a body in which the relevant person has a beneficial interest.
- Any beneficial interest in securities of a body where:
  a) that body has a piece of business or land in the area of the relevant authority, and
  b) either (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body **or** (ii) the total nominal value of the shares of any one class belonging to the relevant person exceeds one hundredth of the total issued share capital of that class.

Any Member who is unsure if their interest falls within any of the above legal definitions should seek advice from the Monitoring Officer in advance of the meeting.

A Member with a DPI should state in the meeting: ***'I declare a Disclosable Pecuniary Interest in item x because xxx. As soon as we come to that item, I will leave the room/ move to the public area for the entire duration of the discussion and not take part in the vote.'***

Or, if making representations on the item: ***'I declare a Disclosable Pecuniary Interest in item x because xxx. As soon as we come to that item, I will make representations, then I will leave the room/ move to the public area for the entire duration of the discussion and not take part in the vote.'***

Prejudicial Interests

Any interest which a reasonable, fair minded and informed member of the public would reasonably believe is so significant that it harms or impairs the Member's ability to judge the public interest in the item, i.e. a Member's decision making is influenced by their interest so that they are not able to impartially consider relevant issues.

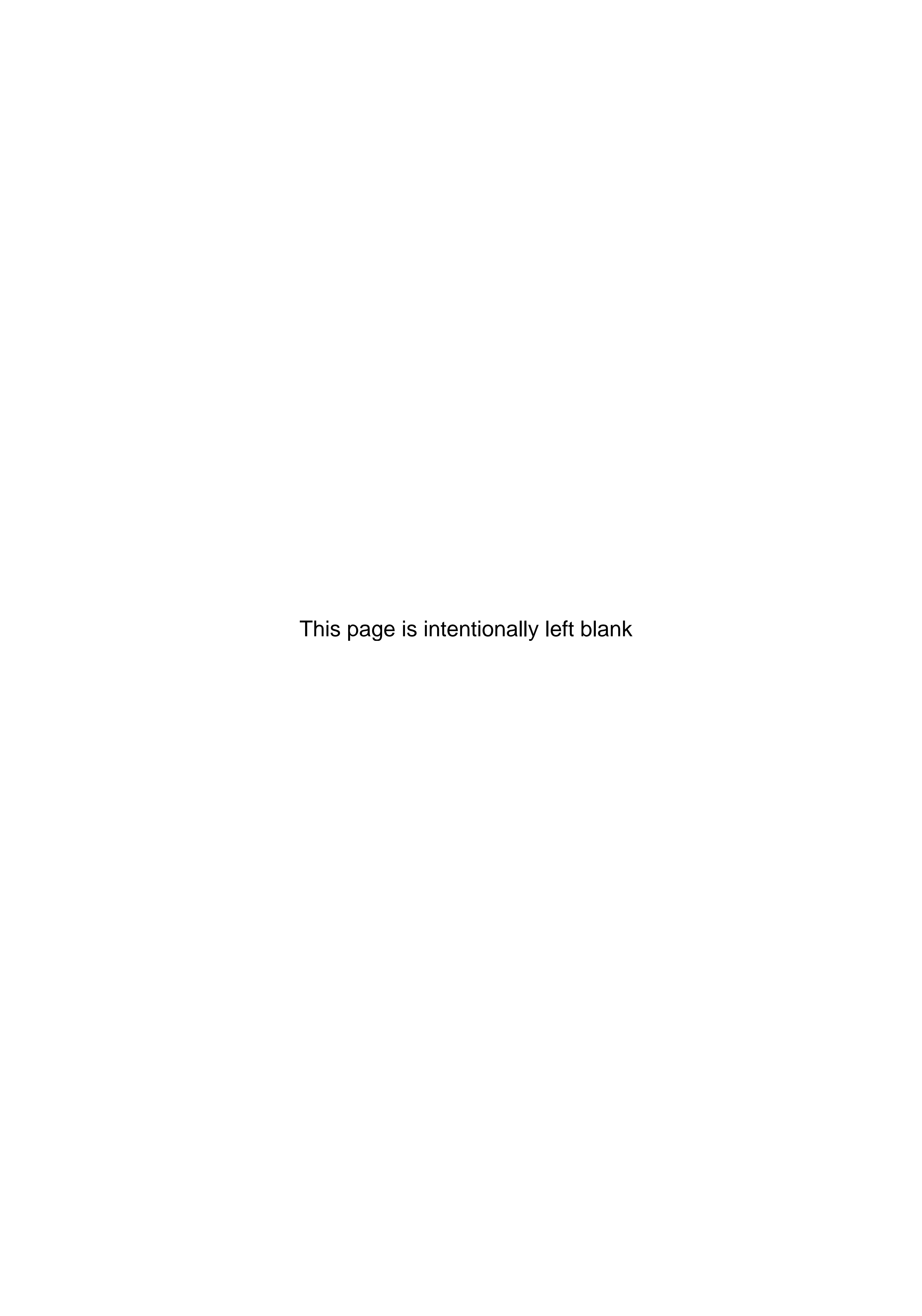
A Member with a Prejudicial interest should state in the meeting: ***'I declare a Prejudicial Interest in item x because xxx. As soon as we come to that item, I will leave the room/ move to the public area for the entire duration of the discussion and not take part in the vote.'***

Or, if making representations in the item: ***'I declare a Prejudicial Interest in item x because xxx. As soon as we come to that item, I will make representations, then I will leave the room/ move to the public area for the entire duration of the discussion and not take part in the vote.'***

Personal interests

Any other connection or association which a member of the public may reasonably think may influence a Member when making a decision on council matters.

Members with a Personal Interest should state at the meeting: ***'I wish to declare a Personal Interest in item x because xxx'. As this is a Personal Interest only, I will take part in the discussion and vote on the matter.***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ADULTS, CHILDREN AND HEALTH OVERVIEW AND SCRUTINY PANEL

THURSDAY, 11 JUNE 2020

PRESENT: Councillors Christine Bateson, Carole Da Costa, Maureen Hunt, John Story (Vice-Chair, in the Chair) and Amy Tisi

Also in attendance: Councillors John Baldwin, Gurpreet Bhangra, Simon Bond, Mandy Brar, Stuart Carroll, Phil Haseler, David Hilton, Gurch Singh, Chris Targowski and Simon Werner, and Mark Jervis, Derek Moss and Tony Wilson

Officers: Andy Carswell, Lin Ferguson, Hilary Hall, Lynne Lidster, Michael Murphy and Kevin McDaniel

ELECTION OF CHAIRMAN AND VICE CHAIRMAN

Cllr Story proposed a motion to appoint Cllr Hunt as chairman for the municipal year. This was seconded by Cllr Bateson and unanimously agreed by members.

Cllr Bateson proposed a motion to appoint Cllr Story as vice chairman for the municipal year. This was seconded by Cllr Story. A named vote was carried out, which resulted in a tie as Cllr Hunt was unable to take part due to technical issues. Cllr Da Costa proposed a motion to appoint herself as vice chairman for the municipal year. This was seconded by Cllr Tisi. A named vote was carried out, which resulted in a tie. It was agreed to defer the appointment of the vice chairman for the municipal year to the next meeting. It was proposed that Cllr Story should be appointed vice chairman for the duration of the meeting, in order for him to chair the meeting and allow it to take place. This was unanimously agreed by members.

APOLOGIES FOR ABSENCE

None.

DECLARATIONS OF INTEREST

None.

MINUTES

RESOLVED UNANIMOUSLY: That the minutes of the meeting held on May 14th 2020 be approved as an accurate record.

RESPITE CARE PROVISION FOR CARERS

Members were reminded that the topic had initially been put forward by a member of the public, who had contacted Adult Services at the start of the year. Input had since also been sought from Children's Services.

Officers were asked to outline the changes that had taken place in the six months since the question had been put forward by the resident. Kevin McDaniel, Director of Children's Services, said the Local Offer had been revamped in order to improve residents' right for access to information, which in turn had led to a number of services becoming much more accessible. However, he added that it had not been possible to operate some services during the Covid19 lockdown restrictions. Hilary Hall, Director of Adults, Health and Commissioning,

said a comprehensive list of services support for carers was now available on the Council's website.

Responding to a question from Cllr Da Costa, Lin Ferguson, Deputy Director of Children's Services, said that carers or parents had the choice of accessing services themselves or asking AfC to arrange it on their behalf. In the case of a carer for a disabled child, assessments could be carried out to see what alternative care support the carer was potentially eligible for. This could include a break, including an overnight break, for the carer or child. Lin Ferguson told the Panel that 114 children up to the age of 18 had received a short break; of those, 56 were in receipt of more than one type of respite care. The Panel was told that there were 24 youngsters between the ages of 18 and 24 who were in receipt of an Education Health and Care Plan, and many of these received more than one type of respite care. Assessments had been carried out by social workers to ascertain the most appropriate level or type of support for the children. Lin Ferguson said 11 people aged up to 25 had had an increase in the provisions in their respite care packages during the Covid19 pandemic.

Cllr Tisi asked about the appraisal process for care services. Lin Ferguson said all service users were given a questionnaire to give feedback on their satisfaction on service delivery. She said it was particularly important to receive this based on users' experiences during Covid19.

Cllr Story proposed a motion to thank the resident for raising the topic, but to note that no further review would be necessary as this would result in a duplication of work that was already being carried out. The comments made by Panel members would be noted and passed to the resident. This motion was seconded by Cllr Bateson. Cllr Da Costa requested an addition to the motion, to ensure that levels of success would be measured and asked how this could be done in future. It was agreed that officers would discuss the matter with Cllr Da Costa to agree a form of wording relating to the points she had raised.

It was RESOLVED UNANIMOUSLY that:

- **(i) The resident should be thanked for raising the discussion topic with Adult Services**
- **(ii) It be noted that no further review work should be carried out as it would result in a duplication of work for officers**
- **(iii) All comments made by the Panel members be noted**
- **(iv) Officers should discuss with Cllr Da Costa the specific questions she had raised.**

QUARTER 4 AND END OF YEAR PERFORMANCE REPORT

Cllr Story congratulated Council staff and officers for the achievements listed in the report, and stated he wanted to highlight the support that had been given to the 2,324 most clinically vulnerable people in the Borough during the Covid19 restrictions. He invited officers to give a commentary on the three 'red' areas listed in the report. Regarding delayed transfers of care from hospitals, Hilary Hall, Director of Adults, Health and Commissioning, explained that targets for local areas are set nationally. The local target was 1.5 delayed transfers of care per 100,000 population and the national target was 3; however, local performance was 3.6 delayed transfers of care per 100,000 population. In many cases this was due to difficulties experienced in transferring patients out of hospital and back to their homes with an appropriate care package; not all patients were medically fit when the time came for them to be discharged. Hilary Hall, Director of Adults, Health and Commissioning said performance had improved since October but the figures could be prone to further fluctuation. Since April during the Covid19 pandemic a number of patients had been transferred out of hospital in a timely manner. Members were told that there was strong domiciliary care support to assist with transfers of care.

Regarding cessation of child protection plans, Kevin McDaniel, Director of Children's Services, stated that the figures were impacted by two children from the same family being required to

stay under a child protection plan for longer than two years. The social care team had indicated they were satisfied that it was appropriate for the plan to remain in place for longer than the recommended two years. Kevin McDaniel, Director of Children's Services, acknowledged more work needed to be done but said the views of the social care team indicated that the plan was working. He added he was not concerned at the red rating as he was familiar with the circumstances of the family in question.

Kevin McDaniel, Director of Children's Services, explained there was a national target to complete assessments for children potentially needing an Education Health and Care Plan within 20 weeks. In the vast majority of cases where the assessments had not been completed by this time, it had been done with the agreement of the parents in order to make sure the right information was being collated. However some assessments were delayed as there was often a high turnover of SEN staff at the end of each academic year. Kevin McDaniel, Director of Children's Services, highlighted that although the performance level of having 86 per cent of assessments completed within 20 weeks was below the Borough's target of 90 per cent, it was still significantly higher than the national average of 60 per cent and the south east regional average of 60.4 per cent.

Cllr Story raised the issue of the new medical centre in Ascot and asked what was being done to ensure it would not compete with existing service providers. Hilary Hall, Director of Adults, Health and Commissioning, said there was an integrated care plan that had been put together following discussions with health colleagues and care providers to ensure the new centre would complement provision rather than providing competition.

Cllr Tisi asked what were the main risks associated with extending an EHCP assessment beyond 20 weeks and asked where the delays mainly came from. Kevin McDaniel, Director of Children's Services, said delays often came when the schools that were identified as being appropriate settings for a child were asked to respond; they had a deadline of 20 school days in which to respond but many did not reply until just before the deadline. This slowed the process as a draft EHCP could not be created without the input of the schools.

Cllr Tisi asked officers which targets they felt would be the most difficult to meet in the next review year. Kevin McDaniel, Director of Children's Services, said good progress had been made in recent years regarding therapeutic care but during the Covid19 restrictions there had been an increase in the number of young people who had not been able to access this service. The Borough had been working with the Local Parent Carer Forum to share practice on helping children in particularly challenging situations, but the chairman of this group had had to step down and it had not been possible to work with the group. Hilary Hall, Director of Adults, Health and Commissioning, said it was anticipated there would be an upsurge in demand for drug and alcohol treatment services post lockdown, particularly low-level support services. She said she was concerned there may be less ability to successfully meet targets relating to treatments. Cllr Carroll said he had been meeting regularly with the Borough's Primary Care Clinical Lead, Dr Huw Thomas, and raised tackling issues regarding substance dependence and related mental health problems, and this had been useful in building an understanding of the local situation. Public Health England modelling would be used to try to implement a longer-term strategy.

Cllr Carroll told the Panel that direction on tackling any second wave of Covid19 would be led by central government and the SAGE committee. Locally, a number of volunteer groups had helped to identify particularly vulnerable residents and it was acknowledged that the volunteers had been important in providing resilience to other services in the Borough. Hilary Hall, Director of Adults, Health and Commissioning told members that more than 700 volunteers had been recruited during the pandemic and it was important to embed them into future support networks. Cllr Carroll said the NHS Alliance Board was being used to help formulate an integrated care strategy across different care providers. Meetings were taking place every 6-8 weeks.

Kevin McDaniel, Director of Children's Services, said engagement from the public in terms of receiving feedback was generally positive. However feedback suggested working with services relating to SEND needed some improvement.

It was AGREED UNANIMOUSLY that Panel noted the report and:

i) Noted the 2019/20 Adults, Children and Health Overview and Scrutiny Panel Q4 and End of Year Performance Report in Appendix A.

ii) Requested relevant Lead Members, Directors and Heads of Service to maintain focus on improving performance.

DELIVERY OF SERVICES DURING COVID19 LOCKDOWN

Cllr Story said all staff should be thanked for finding new ways of working and doing a good job in difficult circumstances, and thanked officers for a good report.

Cllr Da Costa said she had seen comments regarding three serious case reviews that had been implemented due to serious injuries or deaths caused to babies or young children, all of which were outside of the Royal Borough. She asked for reassurances that health visitors would still be able to visit people's homes, particularly those who were in vulnerable families, after lockdown restrictions were lifted. She stated that it was harder to form judgements from a virtual meeting. Kevin McDaniel, Director of Children's Services, said health visitors had continued to make home visits throughout the pandemic and reiterated that visits did not require support staff to be in people's homes for long periods at a time. Lin Ferguson, Deputy Director of Children's Services, said of the three children that Cllr Da Costa referred to, one was from a family who had recently moved to Berkshire and was not known to the authorities locally. In a recent Ofsted meeting it had emerged that there had been a pattern of serious injuries happening to young children nationally during the Covid19 pandemic.

Lin Ferguson, Deputy Director of Children's Services, told members that a safe baby project involving the health visitor service and social care services was in the process of being implemented. It would be focussed on new parents and pregnant women in particular, in order to ensure children under the age of 12 months in those families were safe. However it had always been the intention for this service not to use virtual meetings with families, in order to get a better view of how babies operated in their home environment. Members were told that all health visitor clinics would resume from June 15th, on an appointment basis and with social distancing in place.

Cllr Carroll said health visitors and social care staff deserved enormous credit for the work they had carried out throughout the pandemic.

Responding to a question from Cllr Bateson about schooling for children in care during the pandemic, Lin Ferguson, Deputy Director of Children's Services, said the Council had access to a vibrant and robust virtual school and this had been an important resource. Members were told that the virtual school had been contacting carers on a weekly basis to ensure children were receiving an appropriate education.

30 per cent of children in care had been attending school throughout Covid19, which was higher than the national average, and since June this had increased to 45 per cent and this figure was still rising. In other locations attendance was 7 or 8 per cent, which tended to be rural authority areas where transport to school was more problematic. Cllr Da Costa said she was concerned at the impact of lockdown restrictions on children's future mental health.

The content of the report was noted by the Panel.

ANNUAL SCRUTINY REPORT

It was noted that a presentation on Heatherwood Hospital had taken place at the September 2020 meeting and it was agreed this should be referred to in the report. Members also agreed that they wanted an update on the project at the next meeting. Cllr Da Costa noted that a site visit of Heatherwood Hospital had been proposed at the September 2020 meeting but had never taken place; Members agreed they would like this possibility to be explored.

Hilary Hall requested that Optalis staff should be referenced in the 'thanks' section of the report. This was agreed by Panel members.

Members acknowledged they were still on a learning curve in terms of scrutiny, although it was felt a good discussion on the Family Hubs paper had taken place at the previous meeting.

Members unanimously agreed to forward the Annual Scrutiny Report to Full Council, subject to the proposed amendments above.

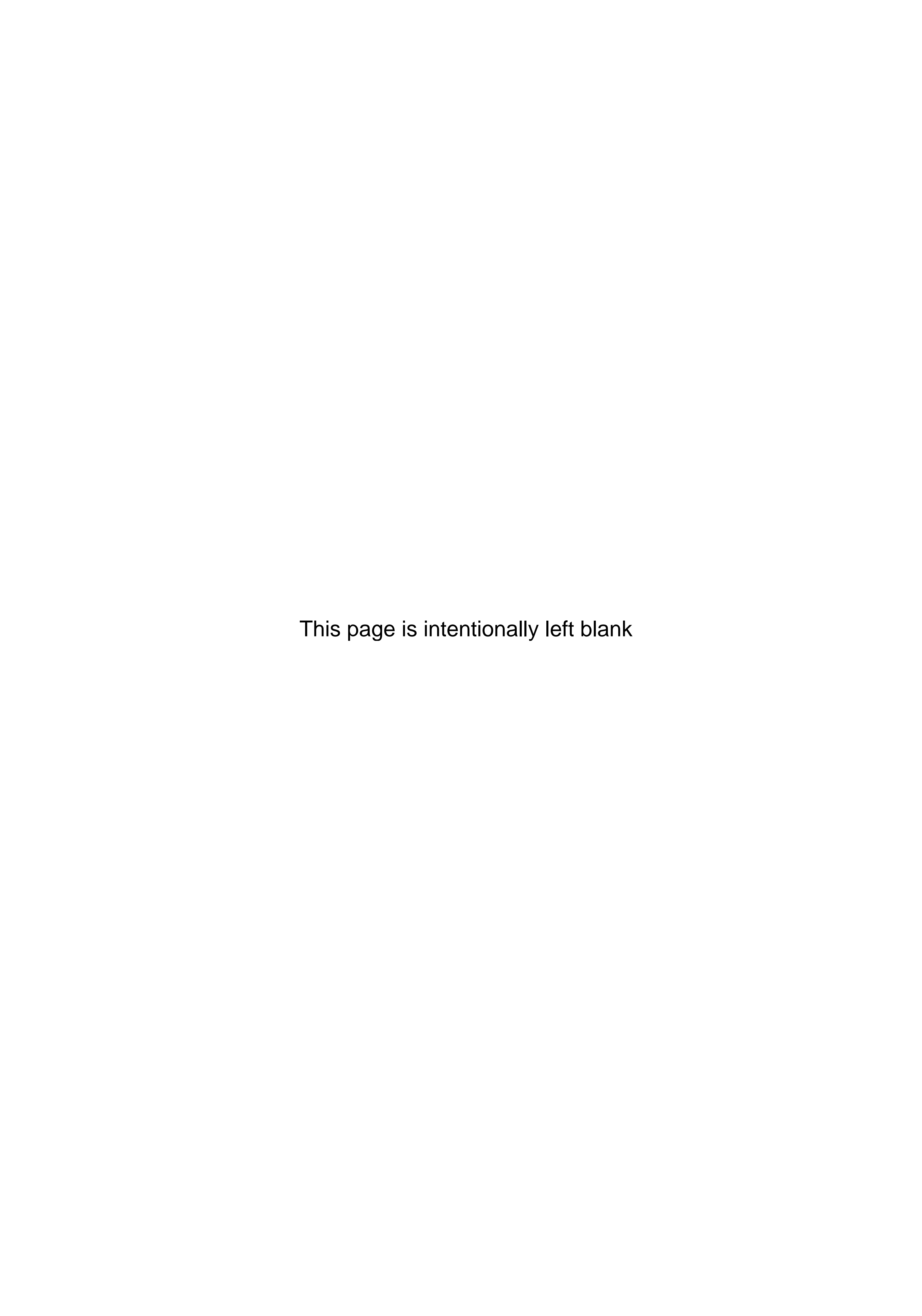
WORK PROGRAMME

It was agreed to add the item on Heatherwood Hospital to the agenda for September's meeting. It was confirmed that there were no changes to the timeline regarding preparing the paper on Universal Services.

The meeting, which began at 6.15 pm, finished at 7.52 pm

CHAIRMAN……………………………….

DATE………………………………..........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Agenda Item 6

Report Title:	**Annual Complaints and Compliments report 2019/20**
Contains Confidential or Exempt Information?	No - Part I
Lead Member:	Cllr Rayner Deputy Leader of the Council, Resident and Leisure Services, HR, IT, Legal, Performance Management and Windsor; Armed Forces Champion
Meeting and Date:	Adult, Children and Health Overview and Scrutiny Panel – 30 September 2020
Responsible Officer(s):	Adele Taylor, Director of Resources & Nikki Craig, Head of HR, Corporate Projects and IT
Wards affected:	None

REPORT SUMMARY

1. The purpose of the report is to share with Overview and Scrutiny the annual compliments and complaints report for 2019/20 before it is published on the council's website. Local authorities are only required to report on complaints submitted about adults and children's services, however the report for the Royal Borough covers all complaints, including those related to corporate activities.

2. The compliments and complaints report is produced annually and details all compliments and complaints made by or on behalf of customers, that are investigated under the:
   - Formal corporate complaints policy.
   - Statutory adults and children's complaints policies.

   NB: children's complaints taken under the corporate complaints policy are reported in Section 5 of the annual report (Appendix 1) with other information about children's complaints.

1. DETAILS OF RECOMMENDATION(S)

RECOMMENDATION: That Adult, Children and Health Overview and Scrutiny Forum notes the report and:

i) That the report is published on the Council's website.

ii) That the annual report continues to be produced and presented at Overview and Scrutiny panels,

2. REASON(S) FOR RECOMMENDATION(S) AND OPTIONS CONSIDERED

Options

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Table 1: Options arising from this report

Option	Comments
That the report is published on the Council's website and that the annual report continues to be produced and presented at Overview and Scrutiny panels. **This is the recommended option**	This is a requirement for children's and adults annual complaints information and good practice for other complaints areas.

2.1 The council's complaints and compliments report is compiled annually. There is a statutory requirement to publish information on adult and children's complaints and compliments and the report for April 2019 – March 2020 will be published in October 2020. While there is no requirement to publish information on complaints about other services provided by the council the decision has been taken to include this information in the annual report. This captures all the information about complaints and compliments to the council and ensures transparency and to provide an opportunity to ensure we maximise the learning opportunities from any outcomes from the complaints.

2.2 The report contains details of the:

- numbers of compliments received
- complaints received,
- themes of complaints
- timeliness of complaint responses
- outcomes of complaints,
- learning from complaints
- number of complaints made to and decided by the Local Government and Social Care Ombudsman (LGSCO).

Overview of all complaints to the council

2.3 There a number of complaints processes and which one is invoked will depend on the service and the reason for a complaint to be made. See appendix 2 of appendix 1.

2.4 Table 1 compares the number of complaints received across the council for 2019/20 with the figures for 2018/19. See Appendix 1, pages 6-7, 2.4-2.6, figure2.

Table 1

	2019/20	**2018/19**
Adult complaints	27	19
Children complaints	52	38
Complaints about other services	319	380
Total complaints	**400**	**437**

Complaints to services considered by Adult, Children and Health Overview and Scrutiny Panel

2.5 The number of complaints received for services considered at Adult, Children and Health Overview and Scrutiny Panel is shown below in table 2. For context, 1400 people are supported by the People with Disabilities and Older People's team with domiciliary care providers delivering over 3500 hours of care

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per week. Within children's services 1020 children and young people have Education Health and Care plans, 266 Children In Need were open to Children's Social Care in March 2020, 149 children were subject to Child Protection Plans in March 2020 and there were 121 Children In Care in March 2020.

2.6 The number of complaints received for adult services rose in 2019/20, compared with 2018/19. However, it should be noted that the number received in 2018/19 was particularly low and the number for 2019/20 was lower than in the years prior to 2018/19. The number of statutory complaints related to children's social care have decreased while there has been an increase in corporate complaints which typically relate to processes such as securing home to school transport, assessment for an Education, Health and Care plan, and communication and data handling. More detailed information is included in the annual report. See Appendix 1, pages 27-28, 4.2-4.8, figures 20-21 and pages 34-36, 5.2-5.10, figures 26-29.

Table 2

	2019/20	**2018/19**
Adult	27	19
Children	52	38
Total	**79**	**57**

Themes of complaints

2.7 Across the council, the theme with the highest number of complaints received in both 2018/19 and 2019/20 was 'lack of action'. More detailed information is included in the annual report. See Appendix 1, page 7, 2.7-2.8, figure 3.

2.8 For adult services, this was 'require help or intervention'. Many adult services complaints were requesting an explanation of some issue that was not understood, for example invoicing and the complaints process was then invoked in order to understand what information people had been given and resolve any queries. See Appendix 1, page 29, 4.9-4.10, figure 22.

2.9 For children's services, this was 'did not follow policy' for children's statutory complaints and 'failed to follow timescales' such as the completion of EHCPs within timescales. for children's corporate complaints. See Appendix 1, pages 36-37, 5.11-5.13, figures 30-31.

Timeliness of complaints

2.10 Across the council, timeliness of complaint responses being provided has decreased from 63% in 2018/19 to 59% in 2019/20. More detailed information is included in the annual report. See Appendix 1, page 8, 2.9-2.11, figure 4.

2.11 Timeliness for adult services was 56% in 2019/20, which is similar to the council average for this year, but lower than 2018/19, which was 74%. See Appendix 1, pages 29-30, 4.11-4.12, figure 23.

2.12 Timeliness for children's services was 47% in 2018/19 and 56% in 2019/20, which is similar to the council average. See Appendix 1, page 38, 5.14-5.19, figure 32.

Outcomes of complaints

2.13 Across the council, the number of complaints fully or partially upheld has fallen from 67% in 2018/19 to 61% in 2019/20, which means we are finding fault by a service less often. More detailed information is included in the annual report. See Appendix 1, pages 8-9, 2.12, figure 5.

2.14 The number of adult complaints fully or partially upheld was 52% in 2019/20, which is lower than the council average for this year and lower than 2018/19, which was 68%. See Appendix 1, page 29, 4.9-4.10, figure 22.

2.15 The number of children's complaints fully or partially upheld was 63% in 2019/20, which is higher than the council average and lower than 2018/19, which was 81%. See Appendix 1, page 38, 5.19-5.20, figures 33-34.

Complaints made to and decisions made by the LGSCO

2.16 Table 3 compares the number of complaints made to the LGSCO in 2019/20 against those made in 2018/19.

Table 3: complaints made to the LGSCO

	Adult Care services	Benefits and Council Tax	Communities and other services	Education and Children's services	Environment services	Highways and transport	Housing	Planning and Development	Other	Total
2019/20	9	1	2	10	7	6	4	9	1	49
2018/19	13	2	5	9	4	1	5	4	1	44

2.17 Table 4 compares the number of complaints decided by the LGSCO in 2019/20 against those decided in 2018/19.

Table 4: LGSCO decisions

					Detailed investigations			
	Incomplete or invalid	**Advice given**	**Referred back for local resolution**	**Closed after initial enquiry**	**Not upheld**	**Upheld**	**Uphold rate of detailed investigations**	**Total**
2019/20	4	0	14	16	8	7	47%	49
2018/19	3	0	15	11	5	12	71%	46

2.18 If we were to include those investigations closed after an initial enquiry to the council, then the upheld rate for 2019/20 is 23%. This is higher than in 2018/19 when under this calculation 42% would have been upheld.

2.19 The Ombudsman made 49 decisions during 2019/20 compared to 46 in 2018/19. This includes decisions on 6 enquiries submitted to the LGSCO in 2018/19 and 43 enquiries submitted in 2019/20. Enquiries made to the LGSCO in 2019/20 but with no decision made within that year will be included in the decisions reported in 2020/21.

2.20 Of the seven cases upheld in 2019/20, four of these were for adult services and included complaints about how Optalis works with care companies. See Appendix 1, pages 30-31, 4.14-4.16.

2.21 Of the 7 cases upheld in 2019/20, none were for children's services. See Appendix 1, page 40, 5.25.

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Overview of all compliments to the council

2.22 Table 5 compares the number of compliments received across the council for 2019/20 with the figures for 2018/19. More detailed information is included in the annual report. See Appendix 1, page 10, 2.22–2.23, figure 6.

Table 5

	2019/20	2018/19
Adult compliments	21	19
Children compliments	63	93
Compliments about other services	356	452
Total compliments	**440**	**555**

Compliments to services considered by Adult, Children and Health Overview and Scrutiny Panel

2.23 The number of compliments received for services considered at Adult, Children and Health Overview and Scrutiny Panel is shown below in table 6. See Appendix 1, pages 32-33, 4.19-4.22, figure 29, table 6 and pages 42-44, 5.34-5.35, figure 36, table 9.

Table 6

	2019/20	2018/19
Adult compliments	21	19
Children's compliments	63	93
Total	**328**	**165**

Options

Table 7: Options arising from this report

Option	Comments
Undertake to complete an annual report for 2019/20 that covers minimum of complaints in relation to adults and children's services.	To fulfil statutory obligations and to continue to learn from resident complaints
Do not undertake to complete an annual report for 2019/20	Statutory obligations will not be fulfilled.

3. KEY IMPLICATIONS

3.1 There are a number of indicators of success across the council. For last year these were all exceeded or significantly exceeded. For our current financial year. Improvements in all of these could indicate improvements in delivery

Table 8: Key Implications

Outcome	Unmet	Met	Exceeded	Significantly Exceeded	Date of delivery
Reduced percentage of upheld complaints	62-100%	61%	50-60%	<50%	31 March 2021

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Outcome	Unmet	Met	Exceeded	Significantly Exceeded	Date of delivery
Increased percentage of complaints completed within timescales	0-58%	59%	60-75% 59%	>75%	31 March 2021
Reduced percentage of complaints to the LGSCO are upheld	48-100%	47%	40-46%	<40%	31 March 2021

4. FINANCIAL DETAILS / VALUE FOR MONEY

4.1 There are no direct financial implications in the publishing of the annual report. There are implications for the council in getting things wrong including resources within service being redirected to complaints handling, remedy payments and reputational damage.

5. LEGAL IMPLICATIONS

5.1 The publishing of children's and adult complaints reports is statutory.

6. RISK MANAGEMENT

6.1 None

7. POTENTIAL IMPACTS

7.1 Equalities.. There are no implications under the equality act arising from this report.

7.2 Climate change/sustainability. There are no climate change or sustainability implications arising from this report.

7.3 Data Protection/GDPR. If personal data is being processed the decision maker must have due regard to the requirements of the Data Protection Act 2018 and the General Data Protection Regulation before making a decision. You should therefore indicate whether a Data Protection Impact Assessment (DPIA) has been completed and summarise the issues raised DPIA's are a lawful requirement under certain conditions. If you are unsure if a DPIA is required, please consult the Data Protection Officer for guidance. If a DPIA has been carried out it should be available as a background paper (and listed in Section 11 below). There are no data protections/GDPR implications arising from this report; as no personal data has been processed so a Data Protection Impact Assessment has not been carried out.

DRAFT

8. CONSULTATION

8.1 Consultation has happened with CLT in August 2020 and will happen with Overview and scrutiny panels in September 2020.

9. TIMETABLE FOR IMPLEMENTATION

9.1 N/A The annual report will be published on the Council website in October 2020.

10. APPENDICES

10.1 This report is supported by 1 appendix:

- Appendix 1 – Annual complaints report

11. BACKGROUND DOCUMENTS

- LGSCO Annual Letter (see Appendix1 of Appendix 1)

11.1 These are the annual summary of statistics on the complaint on complaints made to the Local Government and Social Care Ombudsman about the authority for the year ending 31March 2020. The annual letters and corresponding data tables were published on LGSCO website on 31 July 2020.

12. CONSULTATION (MANDATORY)

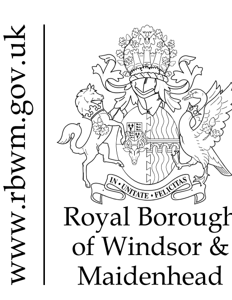
Name of consultee	Post held	Date sent	Date returned
Cllr Rayner		17/08/20	21/08/20
Duncan Sharkey	Managing Director	17/08/20	17/08/20
Russell O'Keefe	Director of Place	17/08/20	21/08/20
Adele Taylor	Director of Resources/S151 Officer	17/08/20	14/08/20
Kevin McDaniel	Director of Children's Services	17/08/20	21/08/20
Hilary Hall	Director Adults, Health and Commissioning	17/08/20	21/08/20
Andrew Vallance	Head of Finance	17/08/20	21/09/20
Elaine Browne	Head of Law	17/08/20	20/08/20
Mary Severin	Monitoring Officer	17/08/20	24/08/20
Nikki Craig	Head of HR, Corporate Projects and IT	17/08/20	14/08/20
Louisa Dean	Communications	17/08/20	21/08/20
Karen Shepherd	Head of Governance	17/08/20	18/08/20

REPORT HISTORY

Decision type:	Urgency item?	To Follow item?

DRAFT

For information	No	No
Report Author: Claire Burns		



Royal Borough of Windsor & Maidenhead
Annual Compliments and Complaints Report

1 April 2019 - 31 March 2020

“Building a borough for everyone – where residents and businesses grow, with opportunities for all”

Our vision is underpinned by six priorities:

Healthy, skilled and independent residents
Growing economy, affordable housing
Safe and vibrant communities
Attractive and well-connected borough
An excellent customer experience
Well-managed resources delivering value for money

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Appendix A – LGSCO annual review letter 2020

Appendix B - Council's complaints process and procedures

Appendix C - National and legislative context

Frequently used acronyms

LGSCO	Local Government and Social Care Ombudsman
RBWM	Royal Borough of Windsor & Maidenhead
ADR	Alternative Dispute Resolution

1. INTRODUCTION

1.1 The annual report covers the period 1 April 2019 to 31 March 2020 and details all compliments and complaints made by or on behalf of customers, that are investigated under the:

- Formal corporate complaints policy.
- Statutory adults and children's complaints policies.

1.2 Local Authorities are not required to produce an annual report on complaints relating to corporate activities. They are required under statute to report complaints submitted on adults and children's services. The complaints and compliments team produce an annual report capturing all complaints and compliments. This allows the Council to assess how residents experience the Council in its entirety. Learning taken from compliments and complaints informs the services for improved operational satisfaction and could feed into the training needs analysis.

1.3 The council is a multi-faceted business, for instance council activity during 2019/20 included:

- 162,246 phone calls
- 717,298 library loans from 980,145 visits
- 653 Births/Birth Declarations
- 597 Marriages/Civil Partnership ceremonies conducted
- 924 Notices of Marriage/Civil Partnership taken
- 993 Deaths registered
- 456 New British Citizens
- 65,252 visits to museums
- 60,823 tonnes of waste collected from residents, from over five million collections
- 1020 children and young people with Education Health and Care plans
- 144 Education Health and Care plans issued
- 862 contacts into the Single Point of Access (SPA) in March 2020
- 150 single assessments completed each month on average.
- 266 Children In Need open to Children's Social Care in March 2020
- 149 children were subject to Child Protection Plans in March 2020
- 121 Children In Care in March 2020
- 473 children and young people receiving early help services via the Early Help Hub as of March 2020
- 1,761 planning applications determined
- 98.29% of council tax and 98.23% of business rates collected.

1.4 In 2019/20 the Council received 440 compliments, a reduction on the 555 received in 2018/19, and 400 complaints, a reduction on the 437 received in 2018/19. The 400 complaints received is relatively low compared to the amount of activity and interactions with residents.

1.5 This report summarises the number and themes of compliments and complaints received. It provides details of compliments and complaints split by service area and response rate. For ease, the report is organised into sections:

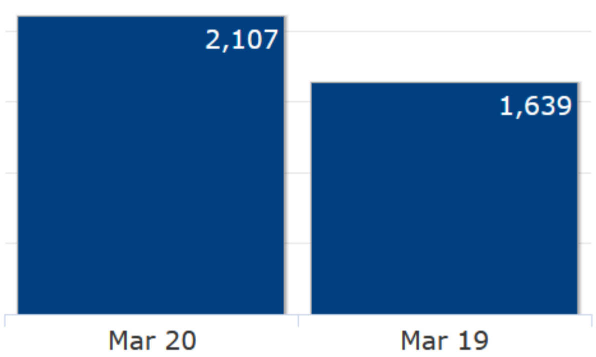
- Section 2 Summary of activity.
- Section 3 Formal corporate complaints and compliments.
- Section 4 Adult services complaints and compliments.

- Section 5 Children's services complaints and compliments.

2. SUMMARY OF ACTIVITY

2.1 In 2019/20, the council received 2,107 contacts from customers that were initially logged as complaints. This compares to 1,639 in 2018/19 (Figure 1), a 28% increase in contacts to the compliments and complaints team year-on-year.

Figure 1: Total contacts received

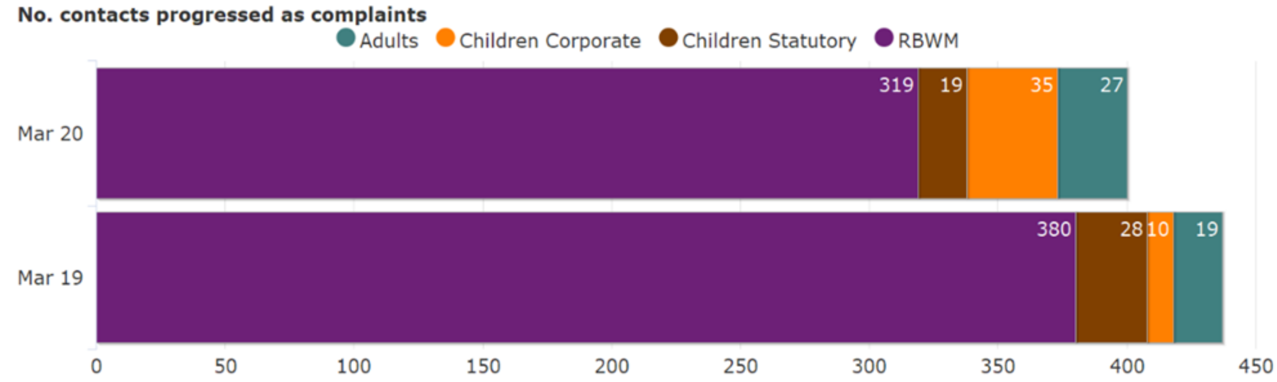


2.1 Contacts that were not progressed as complaints were signposted to an alternative means of resolution, for example, a service request or via an alternative appeals process, such as parking appeals or statutory tribunals or were withdrawn.

2.2 The total number of complaints that were progressed through stage 1 of the specific complaints process that they followed was 400 in 2019/20, a decrease on 2018/19 (437). Stage 2 and 3 complaints are escalations of stage 1 complaints and so are not counted as new complaints. Information on these is shown separately in this report.

2.3 This report will look at complaints according to whether they were made under the formal corporate, the statutory adult or the statutory or corporate children's complaints processes. Figure 2 provides a summary breakdown of volumes received against each complaints process in 2019/20 and 2018/19.

Figure 2: No. contacts progressed as complaints



Children's services complaints

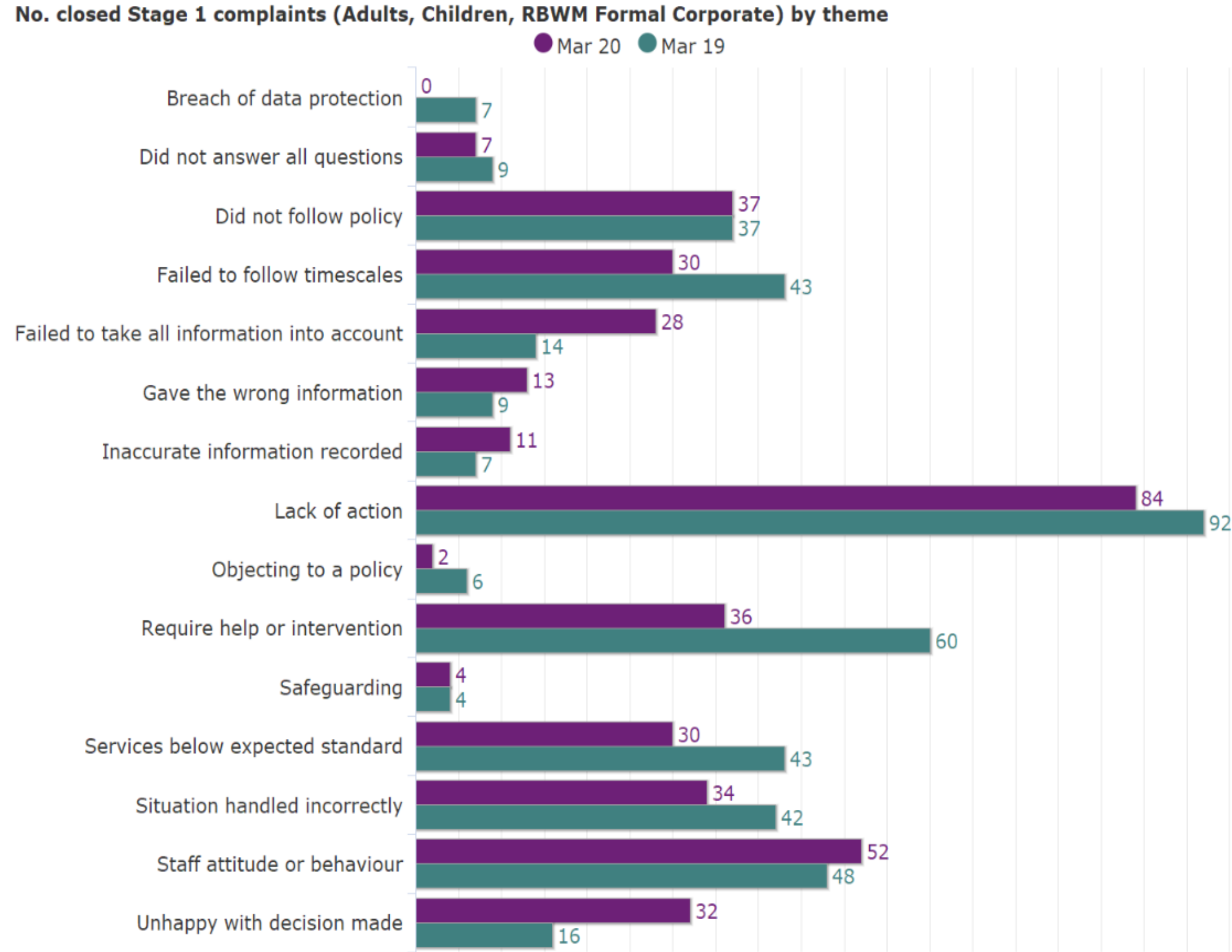
2.4 The reporting differentiates between children's statutory and children's corporate complaints. Both types of complaints are looked at within section 5.

2.5 A children's statutory complaint is invoked when the complaint is by or on behalf of a child in need or a child in care. Complaints specifically regarding child protection conferences however are taken under the children's corporate complaints process. This is a national standard. All other children's complaints are taken under the childrens corporate complaints process.

Themes

2.6 Complaints are captured as themes. When logging their complaint via the council website, complainants self-select the theme themselves. As this is the theme they feel is most relevant to their complaint, the complaints and compliments team does not change this categorisation. When a complaint is logged by a member of the complaints team or the customer contact centre, the person logging will select the theme they believe is most appropriate. Only one theme can be selected for each complaint and the information from themes is therefore an indicator only of the reasons behind often complex complaints. Figure 3 outlines the volume of complaints by theme for 2019/20 and 2018/19 across all complaints processes.

Figure 3: No. closed Stage 1 complaints (all processes) by theme



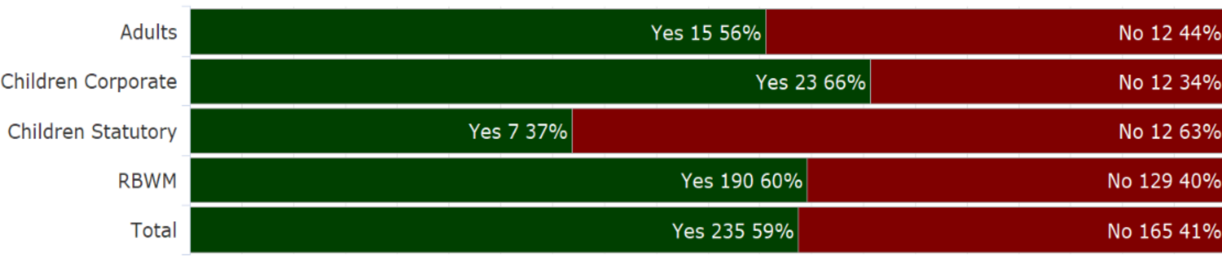
2.7 As with 2018/19, the theme with the highest number of complaints received across the council was "lack of action", making up 21% of all complaints in each year. This was the highest theme recorded for corporate complaints, See sections 3.22 and 3.23. The

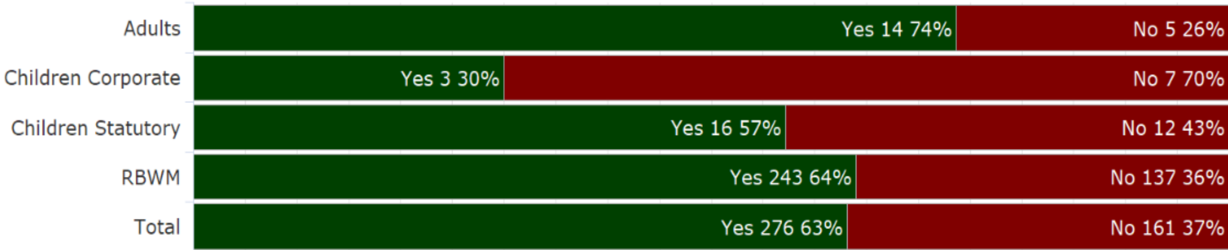
highest theme for adults was “require help of intervention”. See section 4.20. For children’s the highest themes were “failed to follow policy (statutory) and “failed to take all information into account” (children’s corporate). See sections 5.12 and 5.13

Timescales

2.8 Each stage of the individual complaint processes has indicative response times. However, these can be extended, or alternative timescales agreed from the outset with the complainant. Figure 4 shows that there was a slight decrease in the percentage of complaints (all processes) responded to within agreed timescales (59%) compared to 2018/19 (63%).

Figure 4: Complaints responded to within timescale (all processes)





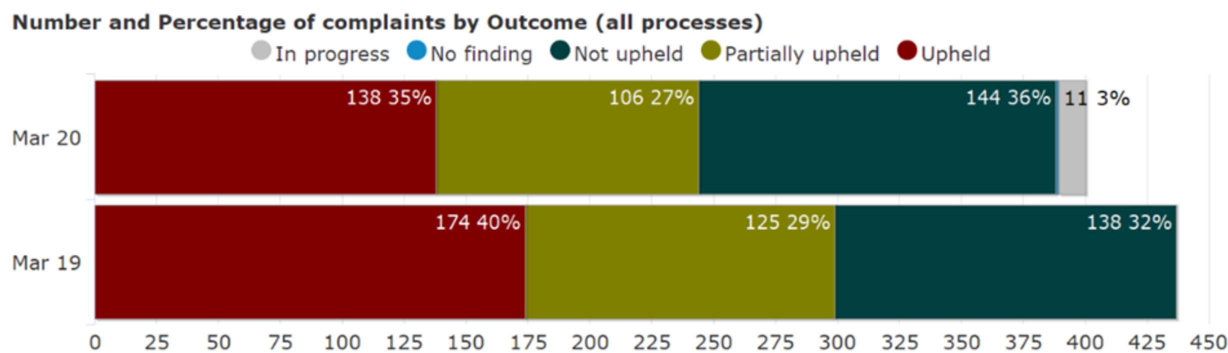
2.9 Processes are embedded to monitor the timeliness of responses more robustly, including weekly reports to services of all complaints. However, despite this, timescales continue to have been missed more frequently in a number of services. Reasons for this include complexity of complaints and officer resource pressures. See also further information in 3.30 and 3.31.

2.10 The council’s performance management software InPhase provides further opportunity for service areas to monitor their complaints; this is expected to be fully embedded in 2020/21.

Decisions

2.11 The outcome of complaints (all processes) is shown in Figure 5. In 2019/20 there was one case (0.3%) with an outcome of “no finding”, meaning that there was insufficient evidence to make a decision. At the time of this report’s preparation there are 11 cases (2.8%) in 2019/20 which have not yet been concluded.

Figure 5: Stage 1 complaints (all processes) by outcome



Local Government Social Care Ombudsman

2.12 The Local Government Social Care Ombudsman (LGSCO) received 49 complaints and enquiries about the council in 2019/20, compared to 44 in 2018/19, see table 1.

Table 1: complaints and enquiries received by the LGSCO

	Adult Care services	Benefits and Council Tax	Corporate and other services	Education and Children's services	Environment services	Highways and transport	Housing	Planning and Development	Other	Total
2019/20	9	1	2	10	7	6	4	9	1	49
2018/19	13	2	5	9	4	1	5	4	1	44

See appendix 1 for full details of decisions as per the 2019/20 LGSCO annual letter on cases upheld and not upheld.

2.13 The Ombudsman made 49 decisions during 2019/20 compared to 46 in 2018/19. This includes decisions on 6 enquiries submitted to the LGSCO in 2018/19 and 29 enquiries submitted in 2019/20. Enquiries that were made to the LGSCO in 2019/20, but no decision made within that year will be included in the decisions reported in 2020/21. See table 2.

Table 2: LGSCO decisions 2018/19 & 2019/20

					Detailed investigations			
	Incomplete or invalid	Advice given	Referred back for local resolution	Closed after initial enquiry	Not upheld	Upheld	Uphold rate of detailed investigations	Total
2019/20	4	0	14	16	8	7	47%	49
2018/19	3	0	15	11	5	12	71%	46

See appendix 1 for full details of decisions as per the 2019/20 LGSCO annual letter on cases upheld and not upheld.

2.14 If we were to include those investigations closed after an initial enquiry to the council, then the upheld rate for 2019/20 is *23%*. This is lower than in 2018/19 when under this calculation 42% would have been upheld.

2.15 The 7 complaints that were investigated and upheld were:

- Adult social care 4.
- Licencing 1.
- Housing 2.

See sections 3.41, and 4.14-4.16 for further details.

2.16 The upheld rate for detailed investigations is lower than in 2018/19 by around a third.

LGSCO reports

2.17 No public interest reports for the council were published in 2019/20.

Improvements in working with the LGSCO

2.18 The compliments and complaints team have attended training around adult care complaints as well as attending the Link Officer training. The LGSCO has set up an online group for local authority complaints officers to ask peers for advice and share good practice

Learning and improvements from complaints

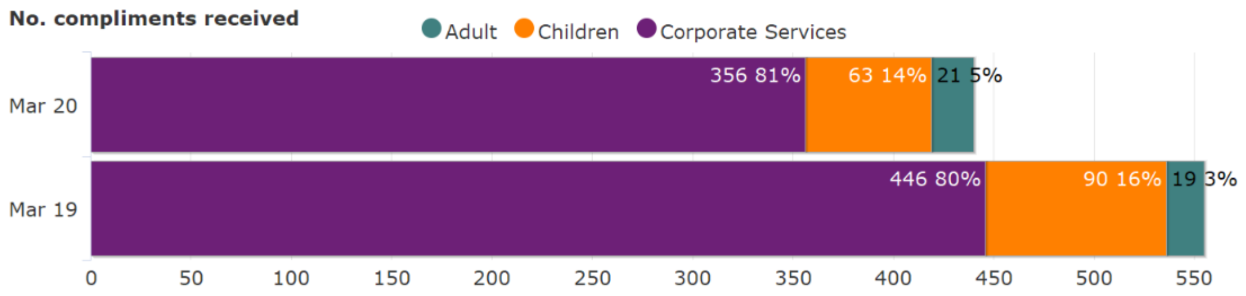
2.19 Understanding why complaints are made, establishing root causes, changing processes and delivering training as a result is essential to help drive improvements across the council. Listening to customers and reflecting on examples of where we did not get it right can highlight opportunities for improvement and increase satisfaction, fulfilling our strategic priority to provide an excellent customer experience.

2.20 Learning from complaints for specific services can be found in sections 3.42. 4.17 and 5.31.

Compliments

2.21 In 2019/20, a total of 440 compliments were recorded for teams or individuals across the council. Compliments received are fed back to the relevant service areas to ensure that due recognition is given to staff and that learning is shared and disseminated across the directorate. Figure 6 shows the breakdown of compliments by Adults, Children's and Corporate Services. For the purposes of this report, "Corporate Services" refers to compliments that were received by services other than those within adult and children's services.

Figure 6: Compliments received (Adults, Children's and Corporate Services)



2.22 Following continuing improvements in compliments recorded over previous years, there has been a fall from 555 in 2018/19 to 440 in 2019/20. This drop seems to be evenly spread across corporate, adult and children's services. Further analysis can be found in sections 3.44, 4.19 and 5.33.

3. FORMAL CORPORATE COMPLAINTS

Overall corporate complaints summary

3.1 In 2019/20 79.8% (319/400) of all complaints progressed were Formal Corporate, compared to 87.0% (380/437) in 2018/19.

Internal process

- 38.2% (122/319) were fully upheld
- 23.2% (74/319) were partially upheld
- 35.7% (114/319) were not upheld
- 2.8% (9/319) where a decision had not been reached at the time of data extraction for the preparation of this report.
- 59.6% (190/319) were responded to within timescales.
- 356 compliments were received.

External process

- 23 corporate complaints or enquiries were decided by the LGSCO, of these:
  - seven were fully investigated.
  - one was upheld.
  - six were not upheld.

NB: Internal figures as waiting for LGSCO letter.

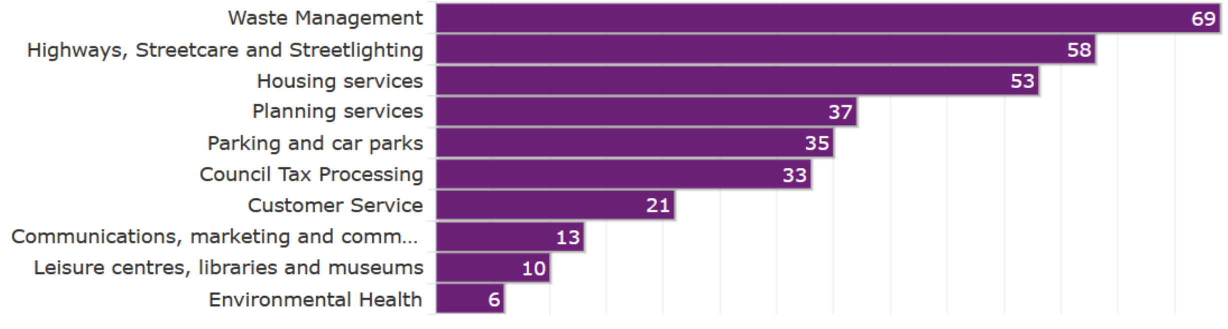
Complaints received

3.2 From 1 October 2019 the council's organisation structure changed, meaning that a full comparison of complaints by service across the last two years is not possible. To enable some comparison between 2018/19 and 2019/20 complaints have been broadly grouped by the area to which they relate and the top-10 are shown in Figure 7. These groupings will be refined in 2020/21 as part of a broader project to develop digital platforms that support reporting of complaints to the council and subsequent data reporting.

Figure 7: Top-10 Formal Corporate complaints by broad area

2019/20: Top 10 Formal Corporate complaints by area

Area	Complaints
Waste Management	83
Highways, Streetcare and Streetlighting	44
Housing services	39
Council Tax Processing	31
Planning services	30
Parking and car parks	20
Customer Service	12
Environmental Health	10
Debt Recovery	9
Housing Benefit and Council Tax Support	6



3.3 Figures 8 and 9 sets out the complaints received in 2019/20 by service and remit based on the organisation structure at the end the year.

Figure 8: 2019/20 Formal Corporate complaints by service

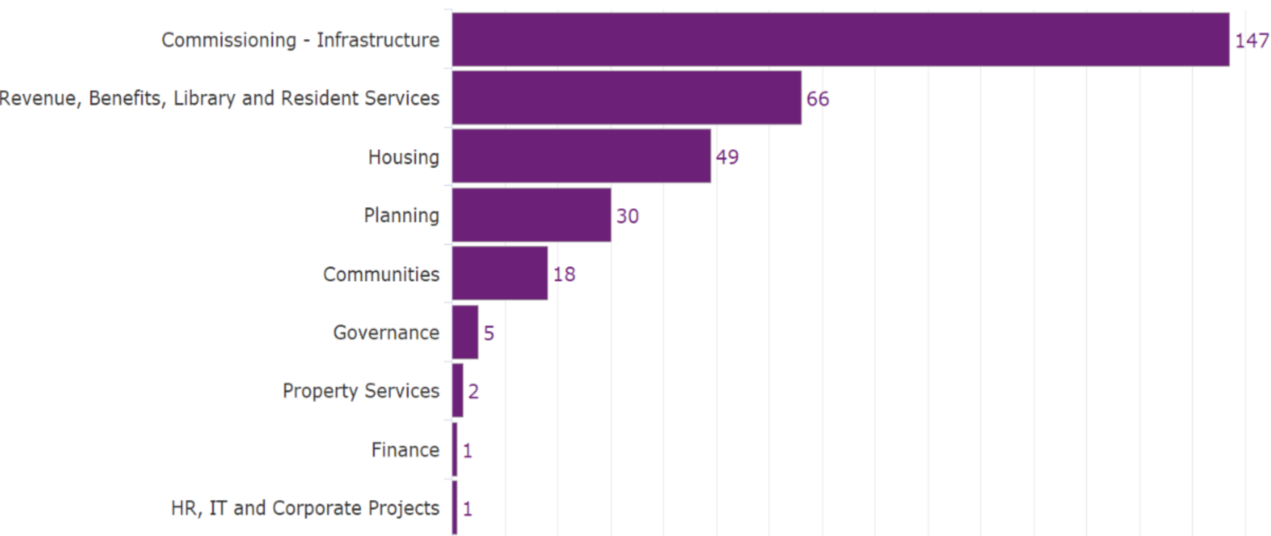
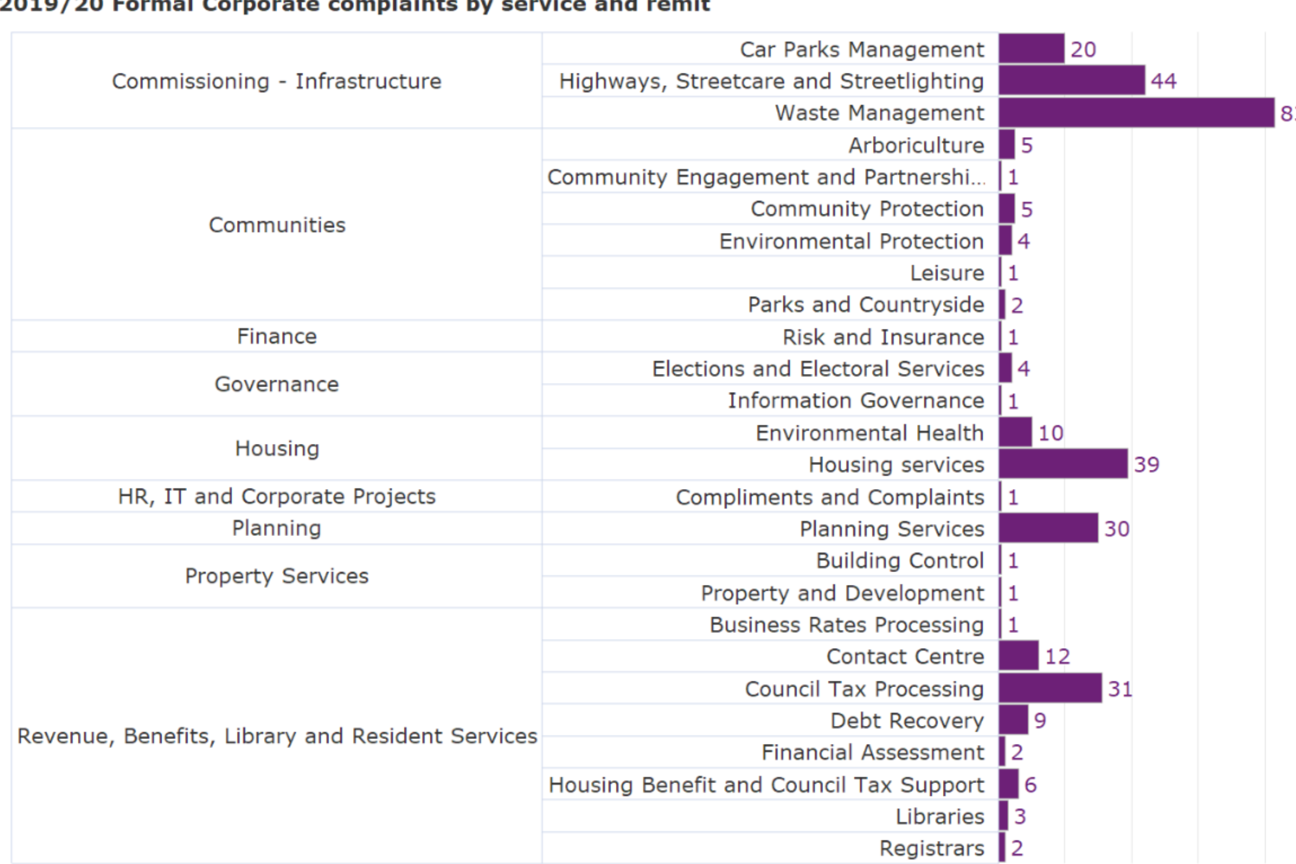


Figure 9: 2019/20 Formal Corporate complaints by service and remit



Commissioning Infrastructure

3.4 In October 2019 the Commissioning Infrastructure service was established incorporating relevant service areas from the former Strategy and Commissioning service. These resident-facing services impact upon every resident, household, business and visitor to the Royal Borough (for example: waste collections; highways;

management of road works, parking and parks). Services are often delivered which cause disruption (for example: road works); these are essential and widespread as the council continues to invest in infrastructure across the Borough. The number of complaints received by Commissioning Infrastructure is therefore expected to be higher in comparison to other service areas.

3.5 Despite this, the number of complaints across the service area as a whole decreased from 161 in 2018/19 to 147 in 2019/20. This is reflected in all areas within Commissioning Infrastructure apart from waste management, which represented 69 in 2018/19 compared to 83 in 2019/20.

3.6 Commissioning Infrastructure, the contact centre and the waste service contractor deal with high volumes of service requests and are working together to bring down the number that turn into complaints. Many of the contacts received are about operational issues and are requests for a service e.g. a missed bin. Where this is not an ongoing issue the contact is changed to a service request, but some will remain as complaints with a formal response identifying the problem and providing information on the remedies that have been put in place to ensure that the concern has been resolved.

3.7 To add context in terms of service contact, the service empties 6.2 million bins for residents at the kerbside each year. The complaint level represents between 0.001 and 0.002 %.

Revenues and Benefits

3.8 Revenues and Benefits saw a slight rise in the number of complaints made to them during 2019/20. The majority of complaints were made about council tax processing. While there was nothing obvious to account for this, there were periods where the team was recruiting/training new staff leading to increased levels of outstanding correspondence. In addition, complaints continue to be made around changes in legislation which had been in place for some time which see residents faced with increased levels of charge such as removing empty discounts and charging a Long-Term Empty Home Premium.

Library and Resident Services

3.9 Library and Resident Services achieved a 55% drop in the number of complaints received across services. A successful coaching and mentoring plan was implemented to raise standards and ensure staff have the skills and empathy to de-escalate difficult situations before they become formal complaints

Housing Services

3.10 The number of complaints relating to Housing Services dropped from 53 in 2018/19 to 39 in 2019/20 with a small drop in the overall percentage of formal corporate complaints. The level of complaints is reducing as a direct result of the training, support and advice provided to staff, including a joined up consistent approach to service delivery. From October 2019 the Environmental Health remit was moved from the former Communities, Enforcement and Partnerships service to Housing Services.

Planning

3.11 Complaints about Planning dropped from 37 in 2018/19 to 30 in 2019/20. The Planning department has updated its enforcement policy and templates to better set expectations of timeframes for investigations and what we can and can't investigate. Determination of applications is higher, and this has reduced complaints with regards applications

Communities

3.12 The Communities service encompasses a number of front-facing services which, by their nature, receive quite a large volume of service requests. Of these service requests a relatively small proportion can become formal complaints. The statutory nature of some of these services can result in complaints because the decisions may not meet with service users' expectations or ambitions, but they will be taken in accordance with the adopted service delivery plans and policies.

Property Services

3.13 Property Services received two complaints in 2019/20 which is the same as was received in 2018/19.

Finance

3.14 The Finance service received a single complaint, which was against Risk and Insurance and was not upheld.

Communications and Marketing

3.15 Following an unusual jump to 13 complaints in 2018/19 the Communications and Marketing service area received no complaints in 2019/20.

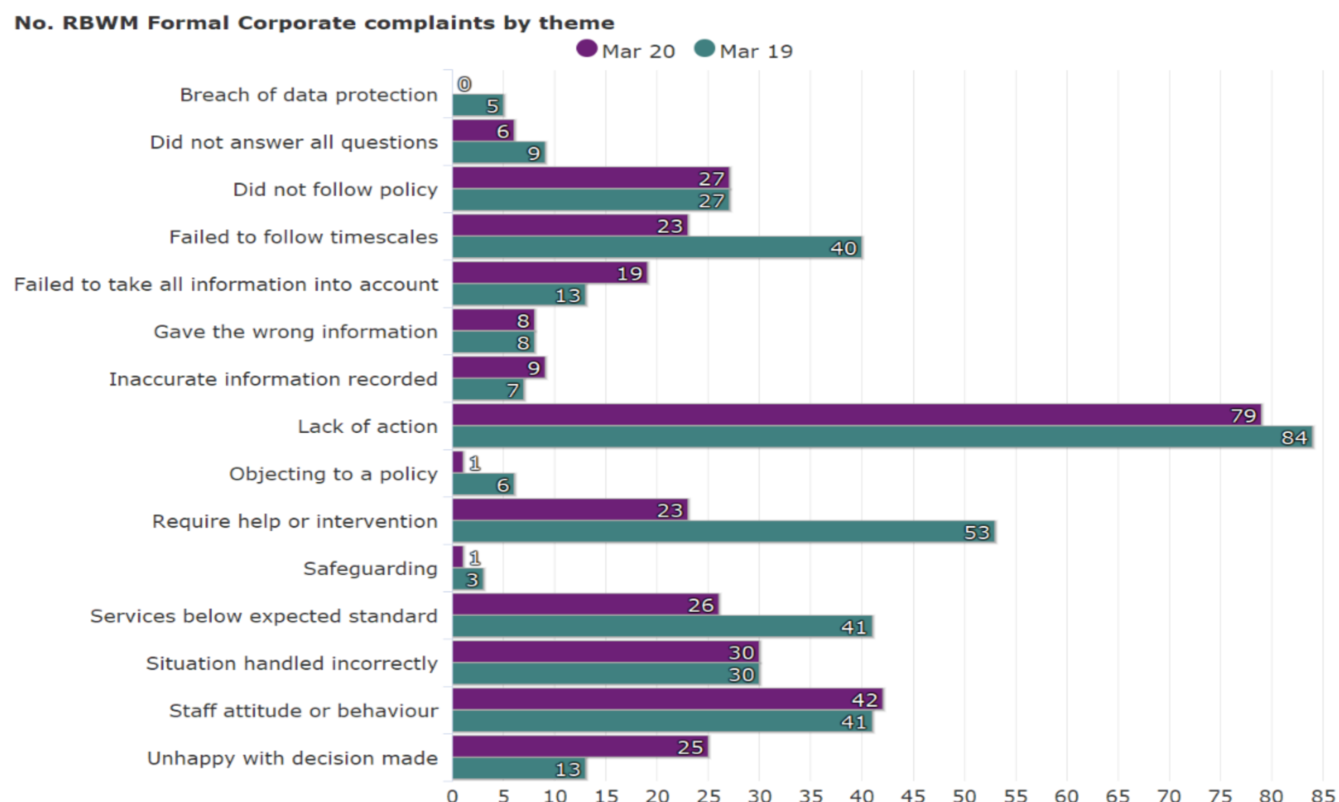
HR, Corporate Projects and IT

3.16 HR, Corporate Projects and IT received a single complaint about application of the complaints policy and procedure which was upheld.

Themes

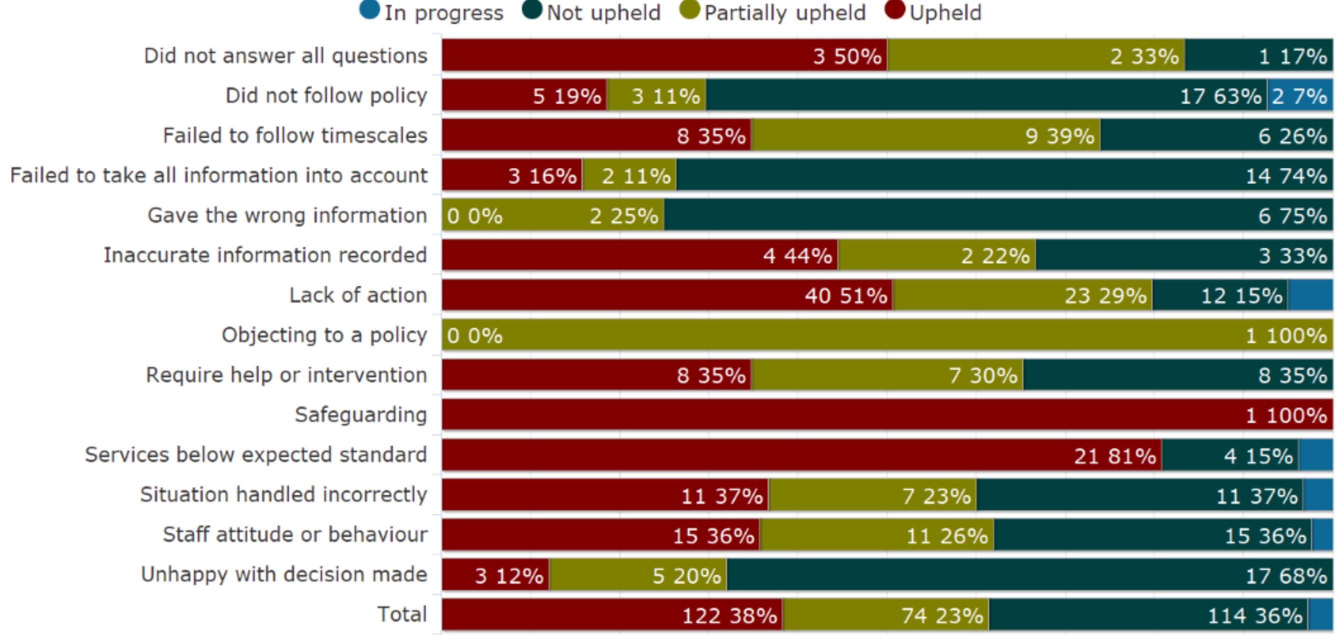
3.17 Themes of complaints are in the main self-selected by the person making a complaint and not all complaints fit neatly into a single category. Figure 10 shows a comparison of the volume of Formal Corporate complaints received by theme in 2019/20 and 2018/19.

Figure 10: No. complaints received by theme (Formal Corporate)

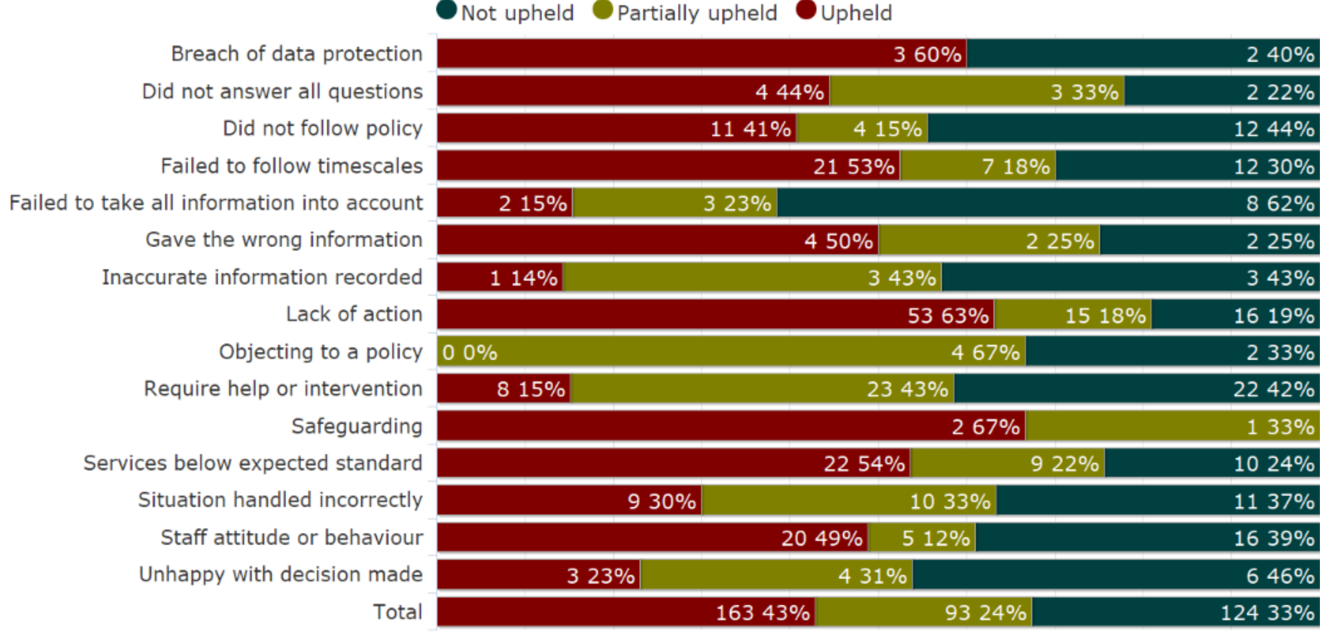


3.18 Figure 11 shows a breakdown of Formal Corporate complaints by theme and outcome. Note that in 2019/20 there were 9 complaints where a decision had not been reached at the time of data extraction for the preparation of this report.

Figure 11: Breakdown of Formal Corporate complaints by theme and outcome



2018/19 Number and percentage of RBWM Formal Corporate complaints by theme and outcome



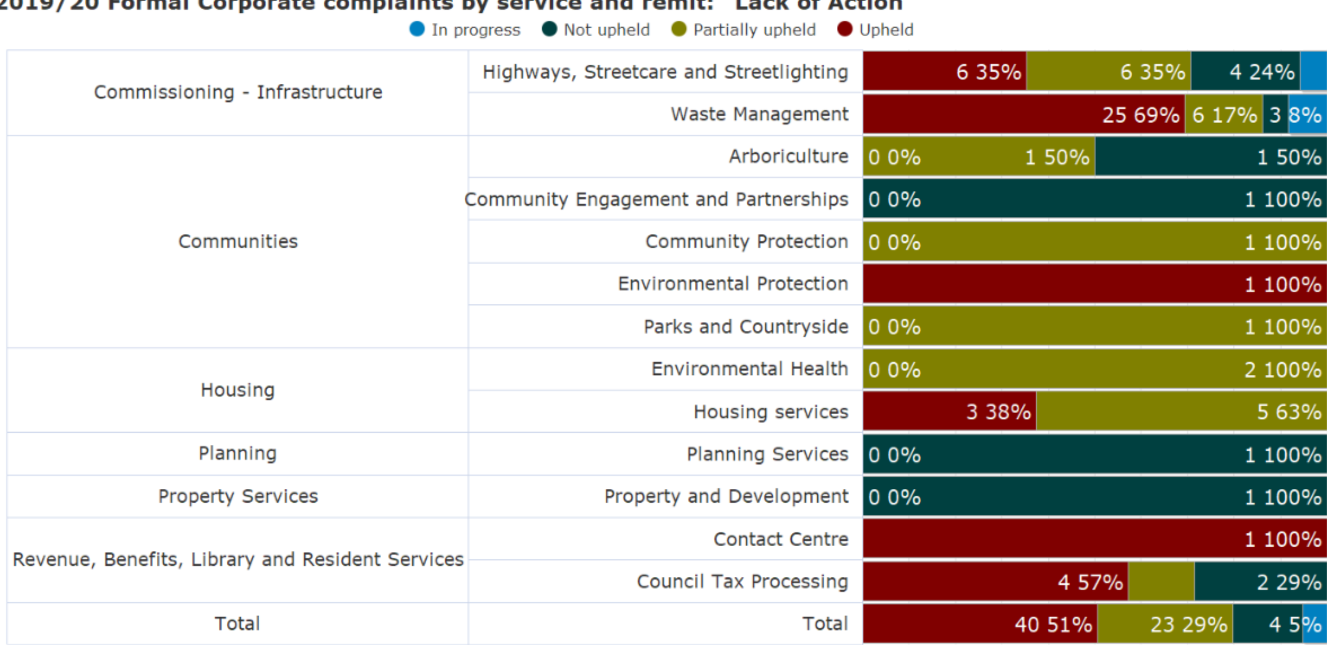
3.19 The number of complaints with a mainly self-selected theme of 'lack of action' remains the highest across the council. For complaints under the formal corporate complaints process this theme made up 79 of the complaints received, which is almost twice the next highest theme of 'attitude or behaviour of staff'. It is however worth noting that the

percentage of complaints taken under this theme that were upheld has reduced from 63% in 2018/19 to 51% in 2019/20. See figure 12, 3.22 for further information.

3.20 Complaints with a theme of ‘services below expected standard’ that were upheld have risen from 54% in 2018/29 to 81% in 2019/20. The majority of the 2019/20 complaints (72%) were in the Commissioning Infrastructure services. This compares to 47% in 2018/19.

3.21 Figure 12 shows the volume and percentage of Formal Corporate complaints relating to “lack of action” across Services. This information will be included in the complaints quarterly updates to Heads of Service.

Figure 12: Volume and percentage of Formal Corporate complaints relating to “lack of action” across all services



3.22 Commissioning Infrastructure service area received the highest number of complaints logged against this theme (53). Within this, the majority (36) were logged against Waste Management. Of these, 25 were upheld, six were partially upheld and two were not upheld. Three had not yet had a response and outcome when the report was run. None of these complaints were escalated to stage 2.

3.23 This level of complaints to this service area is likely to be due to the frequency, volume and immediate nature of the service and also reflects the number of complaints that relate to operational requests. Once the operational matters such as missed bins have been resolved complaints are not escalated further as reflected in the fact that none of the 36 were taken to Stage 2.

Timescales

3.24 Figure 13 shows that, overall, 60% of Formal Corporate Stage 1 complaints were responded to within timescale in 2019/20, a decrease from 64% in 2018/19. Figure 14 details the number and percentage of stage 1 complaints responded to within timescales for each service.

Figure 13: Total Formal Corporate Stage 1 complaints responded to within timescale

Figure 14: Breakdown of Stage 1 Formal Corporate complaints responded to within timescale by service

2019/20 Formal Corporate Stage 1 complaints within timescale

● No ● Yes

Directorate	Service	Yes	No
Commissioning - Infrastructure	Car Parks Management	19 95%	
	Highways, Streetcare and Streetlighting	20 45%	24 55%
	Waste Management	51 61%	32 39%
Communities	Arboriculture	1 20%	4 80%
	Community Engagement and Partnerships	1 100%	
	Community Protection	5 100%	
	Environmental Protection	3 75%	1 25%
	Leisure	1 100%	
	Parks and Countryside	1 50%	1 50%
Finance	Risk and Insurance	1 100%	
Governance	Elections and Electoral Services	4 100%	
	Information Governance	0 0%	1 100%
Housing	Environmental Health	7 70%	3 30%
	Housing services	6 15%	33 85%
HR, IT and Corporate Projects	Compliments and Complaints	1 100%	
Planning	Planning Services	11 37%	19 63%
Property Services	Building Control	0 0%	1 100%
	Property and Development	0 0%	1 100%
Revenue, Benefits, Library and Resident Services	Business Rates Processing	1 100%	
	Contact Centre	11 92%	
	Council Tax Processing	26 84%	
	Debt Recovery	8 89%	
	Financial Assessment	2 100%	
	Housing Benefit and Council Tax Support	5 83%	
	Libraries	3 100%	
	Registrars	2 100%	
Total	Total	190 60%	129 40%

3.25 Timescales for some services that received complaints have declined since 2018-19. For many service areas however, the small number of complaints received means that slight differences can look more significant than they actually are.

Revenues and Benefits

3.26 Revenues and Benefits response rates remained high with 88% of complaints responded to within timescales, maintaining the improvement seen in 2018/19.

Library and Resident Services

3.27 Library and Resident Services also remained high at 94%. Complaints are prioritised as they are received. All complaints are reviewed by the Library and Resident Services management team to track the robustness and timeliness of complaints and ensure that

any lessons arising are included in training. The reduction in complaints has enabled colleagues within the team to give greater attention to those received so that mistakes are corrected quickly. This good practice is being replicated across some other areas of the council as appropriate.

Communities

3.28 For teams in Communities, the total number of complaints received and responded to within timescales was very similar year on year.

Commissioning Infrastructure

3.29 Response times in the Commissioning Infrastructure service areas have also continued to improve across all teams with an overall rise from 55% in 2018/19 to 61% in 2019/20. The service has improved processes around the allocation and monitoring of complaints and will continue to seek further improvement in meeting timescales. Highways complaints are often complex and require detailed investigation and resolution. Where this is the case and can be identified early, an extension will be requested.

Housing Services

3.30 Housing Services response rates were low at 15%, in 2019/20, which is a decline from around 50% in 2018/19. During 2019/20 there were a number of staffing issues, both in the delivery of services as well as changes in the management of complaint responses within the service, which impacted on SLAs. Improvements initiated in 2019-20 are already showing improvement in 2020-21.

3.31 Remedial action was taken by bringing in a part time member of staff to focus on ensuring response times sit within the SLA and that action is taken to implement learning from responses. Complaints are now prioritised when they are received and responded to in a timely manner. Housing services have now adopted a 360-degree approach to complaints, to ensure that the whole team are provided with training where required, services are amended to take into account the learning from the complaint and staff are fully engaged in the new approach.

Planning

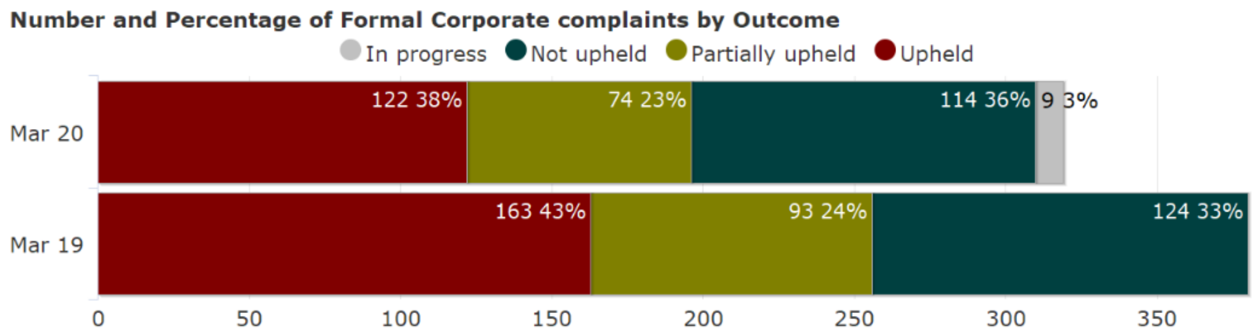
3.32 Planning has seen a decline in complaints completed within timescales following a rise to 51% in 2018/19 down to 37% in 2019/20. The new Head of Service has put in processes including oversight by a senior manager to ensure that complaints are prioritised and responded to more timely and we are already seeing improvements in Quarter 1.

3.33 Numbers of complaints and responses within timescales are shared in Heads of Service meetings on a quarterly basis. Weekly email updates of current open complaints continue to be sent to all service areas and dashboards are being built by the Strategy and Performance Team to enable routine monitoring of performance through InPhase.

Outcomes

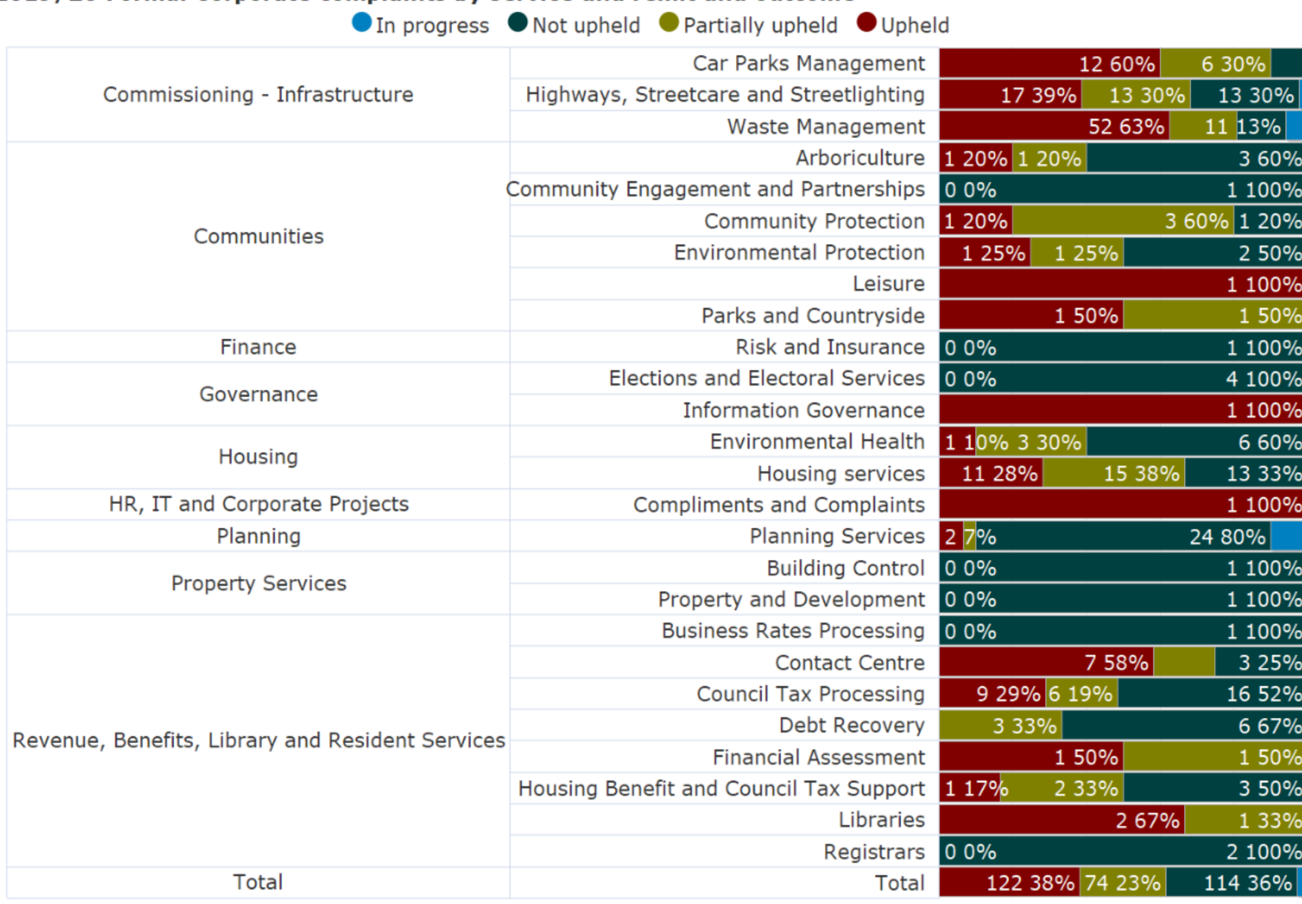
3.34 Figure 15 sets out the overall outcomes reached for all Formal Corporate complaints. Note that 2.8% (9/319) Formal Corporate complaints had not reached a decision at the time of data extraction for the preparation of this report.

Figure 15: Overall outcomes for Formal Corporate complaints



3.35 Figure 16 sets out the outcomes reached for all Formal Corporate complaints broken down by service and remit. Note that 2.8% (9/319) Formal Corporate complaints where a decision had not been reached at the time of data extraction for the preparation of this report.

Figure 16: Outcomes: breakdown by service area



3.36 Across corporate services there has been a drop in the percentage of complaints that were fully or partially upheld from 67% in 2018/19 to 61% in 2019/20. The percentage of upheld complaints gives a focus for services to learn from complaints.

Stage 2 complaints

3.37 If a complainant remains dissatisfied after receiving a response at stage 1 of the corporate

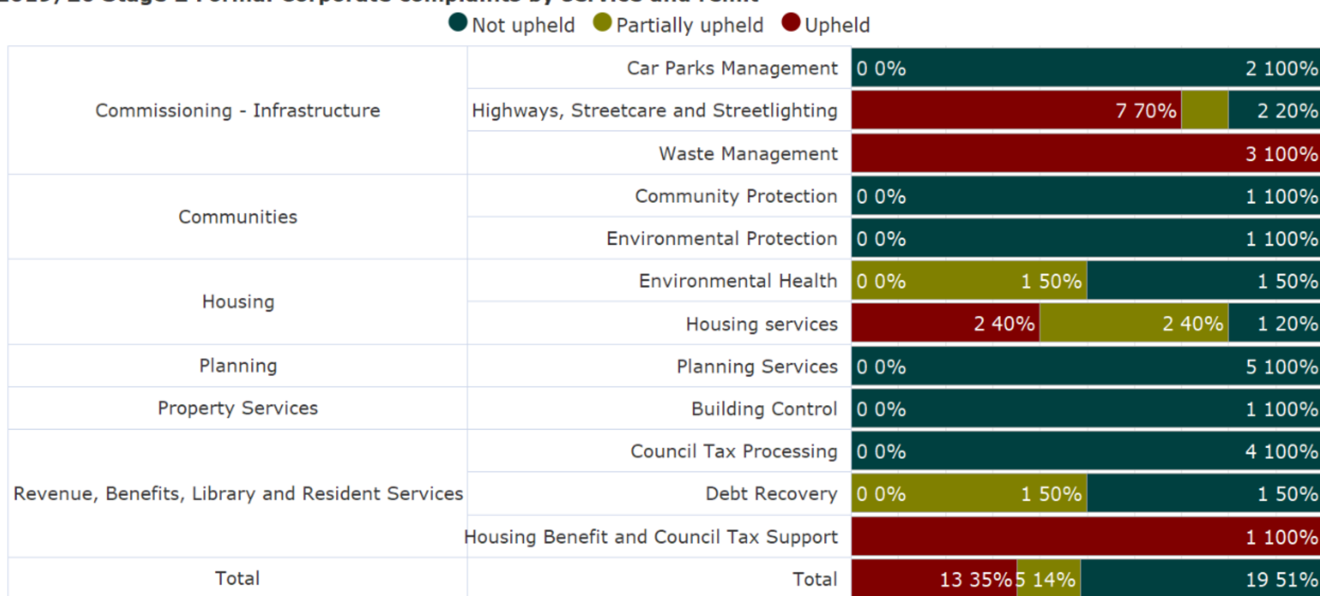
complaints process they may request a review by the service director.

3.38 The percentage of formal corporate complaints that were escalated to stage 2 rose from 12% in 2018/19 to 15% in 2019/20.

3.39 The timescale for response at stage 2 is within 20 working days. 96% of formal corporate complaints that went to stage 2 were answered within timescales. This is very much higher than the response rate in timescales at stage 1. It is not clear why this is, however the lead time for a response is 10 working days longer than given at stage 1. Additionally there are considerably fewer complaints at stage 2 which may mean that these can be prioritised more easily.

3.40 The number of upheld and partially upheld Stage 2 complaints is shown in Figure 17. In addition there are two Stage 2 complaints that are in progress.

Figure 17: Stage 2 Formal Corporate complaints by service, remit and outcome



Complaints to the LGSCO

3.41 The LGSCO made decisions about 30 complaints and enquiries for corporate services. 9 were decided following detailed enquiries and of these, 3 were upheld and 6 were not upheld. This leaves 16 that were not fully investigated. See appendix 1 for details on 2019/20 decisions.

Learning from complaints

3.42 An important part of the complaints process is capturing the learning and embedding good practice across the council. There were four key areas of learning from corporate complaints in 2018-2019 and an update on implementation is:

Environmental Health

- For cases of suspected food poisoning, the environmental health team will revisit procedures in order to reduce the risk of any delays.

Staff are now clearer with customers that information is required before we can take any further actions/investigate/visit the site etc. As a result of this there has been no further complaints made on this subject.

Housing

- All housing staff are receiving ongoing training on service standards and managing expectations to ensure a prompt response to enquiries and requests for updates.
- Customers have access to mobile numbers and email addresses for their case officers.
- Managers continue to closely manage cases.

There have been a number of changes in the housing team since the annual report 2018/19 was written. A review of services in housing is being undertaken; training and processes are being put in place to ensure that contact with customers takes place in a timely manner. It is thought that these improvements will show in next year's annual report.

This is reflected in the drop in the number of complaints to the Housing Service since 2018/19.

Waste

- The website and web form for van permits to be used at household waste and recycling centres has been updated to clarify the acceptable size and type of vehicle.

The website and web form for van permits to be used at household waste and recycling centres has been updated to clarify the acceptable size and type of vehicle.

The form changes were made in Feb 2019. These changes were to add additional vehicle types, and 'dead end' the form if a non-allowed one was picked.

In 2018/19 there were three complaints recorded about size and type of vehicle for van permits. The final complaint was in February 2019. In 2019/20 there were 0no complaints on this subject.

Planning

- The Planning department has updated its enforcement policy and templates to better set expectations of timeframes for investigations and what we can and can't investigate.
- Performance with regards determination of applications is high due to investment and improvements in service delivery. This has reduced complaints with regards applications.

The changes to the enforcement policy and templates along with the investment in resources around planning applications means that the number of planning complaints has been decreasing over the last 3 years:

- 2017/18: 63
- 2018/19: 39
- 2019/20: 30

3.43 Table 3 picks up some of the learning across corporate services during 2019/20.

Table 3: Learning from corporate complaints

Complaint area	Actions and learning
Housing services	• New measures have been implemented to ensure a triage service is provided to all customers, all customers then provided with accommodation or support within homelessness have full access to their data through a customer portal which is reducing enquiries and complaints
Libraries and Resident Contact	**Issuing of Advantage cards** • From 22nd August 2019, library staff accepted proofs of address from the last 12 months, instead of 3 months as well as valid driving licences. **Understanding the Waste processes better** • An advisor spent time with Waste to improve the team's understanding. Flow charts and information sessions have also been implemented **Improved de-escalation techniques** • Different de-escalation techniques were reviewed and assessed and an internal de-escalation process was implemented that made a significant impact on the number of complaints logged. **Staff training, coaching and mentoring** • One hour on a Wed morning is focused on staff training, coaching, mentoring and team-building. This has had a significant impact on staff morale, confidence and their ability to deal with complex enquiries. **Volunteer upskilling** • Where complaints have involved volunteers, volunteer awareness has been improved to ensure customers can expect a basic level of knowledge from volunteers.
Revenues and Benefits	**Clarity of letters to customers** • Staff advised that letters with standard text to be edited to ensure they are clear about what they are asking and the information to be provided.
Permitting and licensing	**Maintenance of trees** • Website and the way reports are raised/received has been reviewed • Procedures in place to ensure queries received in error are promptly assigned to the right department.

Complaint area	Actions and learning
Highways	**Bus timetables** • Monitoring of the council's reporting system to ensure that all reports are received and dealt with promptly.
Environmental Health	**Skin piercing licenses** • Improved on our website, to detail the steps including associated timescales that the Council needs to undertake to be able to issue a licence, • Staff procedures updated to ensure that timescales are set for each stage of the process to ensure that customers are provided with an efficient and effective service.
Disabled Facilities Grants (DFG) Panel	**DFG panel processes** • Improved information on our website, to detail the steps including associated timescales that the Council needs to undertake to be able to issue a licence, • Staff procedures updated to ensure that timescales are set for each stage of the process to ensure that customers are provided with an efficient and effective service.

Compliments

3.44 Corporate services received 356 compliments during 2019/20, a decrease on the 452 received in 2018/19. A full comparison of compliments by service and remit across 2018/19 and 2019/20 is not possible due to the changes to the organisation structure in October 2019. Figures 18 and 19 show the volume of compliments received by service and remit based on the organisation structure at the end of 2019/20.

Figure 18: Compliments by service

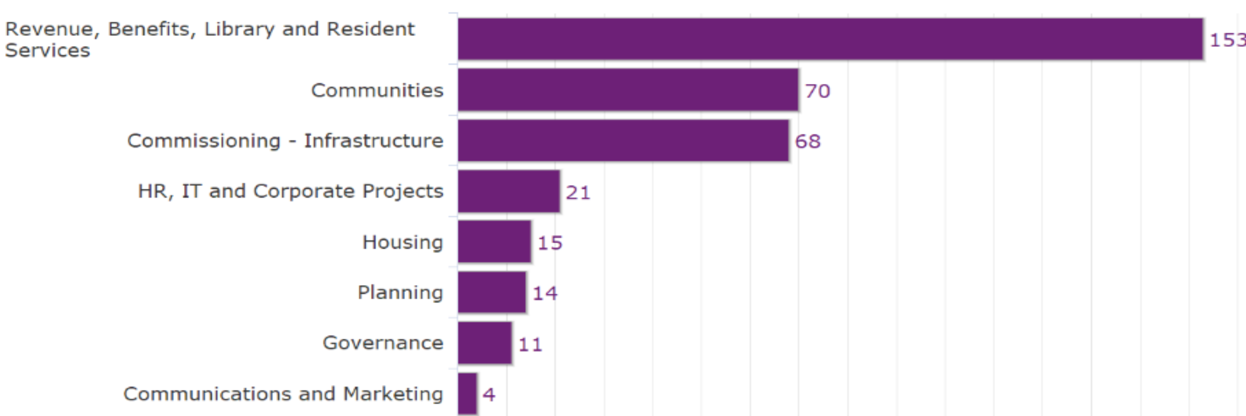
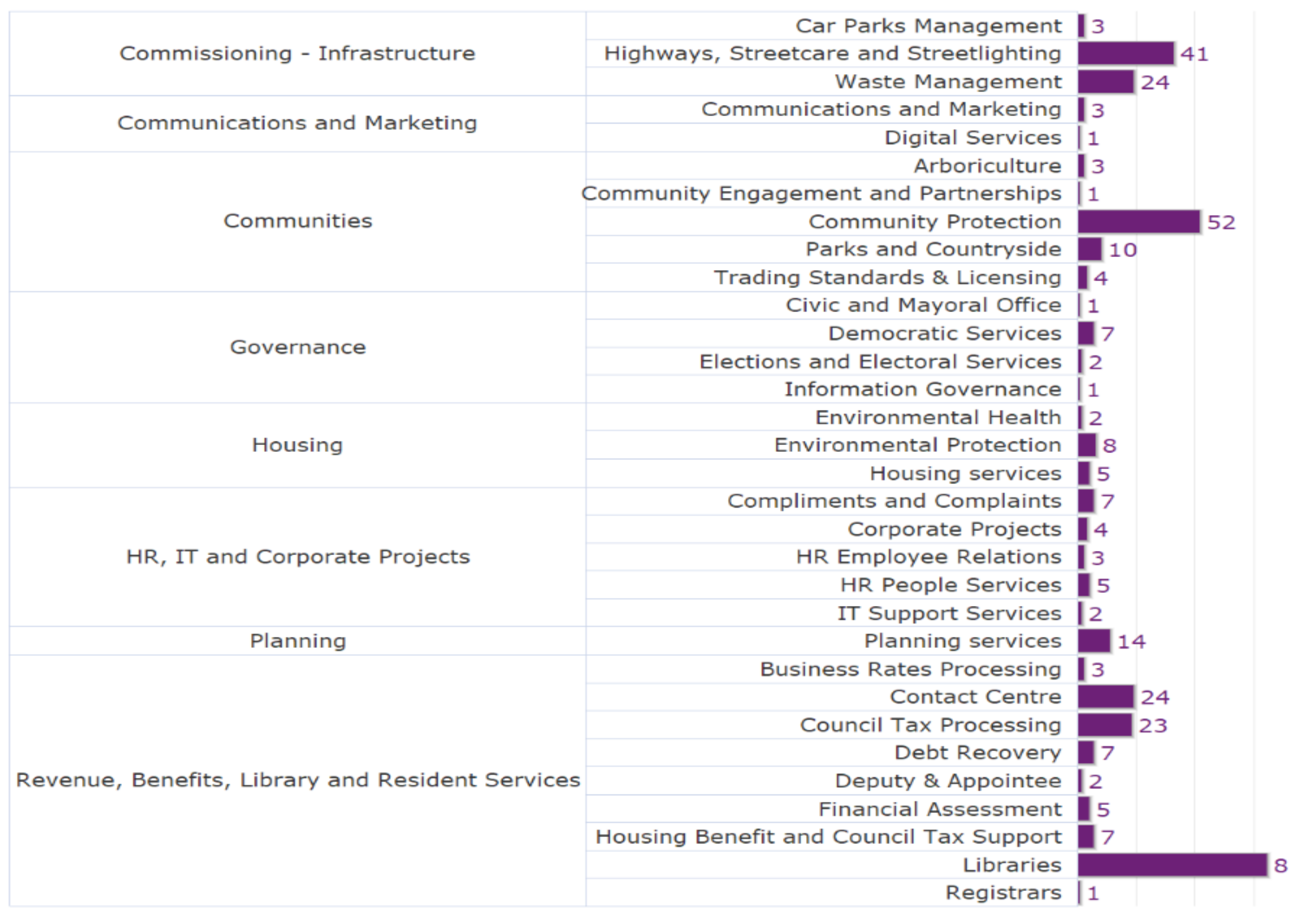


Figure 19: Compliments by service and remit



Revenue, Benefits, Library and Resident Services

3.45 Revenue, Benefits, Library and Resident Services received 42.9% (153/356) of all compliments for corporate services in 2019/20. Advisors are supported to exceed rather than meet the expectation of the customer whenever possible which results in high levels of compliments being received

Communities

3.46 The Communities service received 19.7% (70/356) of all compliments for corporate services in 2019/20, and 74.3% of these compliments were for the Community Protection team. This shows the very positive support for the Community Wardens who deal with diverse issues in often difficult circumstances.

Commissioning Infrastructure

3.47 The Commissioning Infrastructure service received 19.1% (68/356) of all compliments for corporate services in 2019/20. Highways, streetcare and streetlighting particularly stands out with 60.3% (41/68) of all compliments to Commissioning-Infrastructure. These compliments reflect the helpful approach officers demonstrate with residents, and the support of service-providers to resolve enquiries.

3.48 Table 4 outlines some examples of compliments received across service areas. Front-facing services that interact regularly with customers received the highest number of compliments in the same way as they also receive the highest volumes of complaints.

Table 4: Examples of compliments received

Service	Compliment received
Parks and Countryside	• Thank you for always keeping the parks and hanging baskets around Windsor looking so lovely. It really makes Windsor look wonderful and makes us happy much appreciated.
Arboriculture	• Thank you for superb planting as your work and communication with the community paid off. Many years ago you replaced some dangerous leylandii trees with a beautiful maple style tree which comes into its own at this time of year. You have delivered Autumn colour to our village. A great illustration to your team of superb planting choice.
Control Room	• I just wanted to let you know of the exemplary work your Control Room Operators have performed over the last couple of days. They have both prevented and helped us detect a number of shopliftings (some of which were high value bulk thefts) and have gone the extra mile to help a member of our team.
Community wardens	• I just wanted to say a massive thank you to all of the team for having me the past two days at RBWM and for giving me the opportunity to see the many different roles that the community safety team perform on a daily basis. It was very useful to see the different roles within community safety, and also how the team work closely with TVP to help keep our communities safe and involved. • Your job literally saves lives, and that is exactly what you did yesterday. You saved my puppy's life or at very least, saved me from spending a small fortune. […] You arrived super-fast, put me at ease, took control of, what for me was a hopeless situation and not only offered the best solution but actually made it happen. I've always loved our little town but even more so now. We have a special place here and thanks to people like you, who has the vocation and genuinely enjoy what they do, make our town the place it is.
Trading Standards and Licensing	• Had you not contacted us we would have continued these payments, not realising that this was a fraudulent transaction, and we are grateful to you for this. Regrettably, as a couple of OAPs, we're not as alert as we used to be!
Website	• Resident thinks RBWM website is fantastic. Easy to use and everything required is on there to be used.
Customer contact centre	• I have had problems scanning my Advantage Card since the installation of the new machines in the Royal Borough Car Parks in Windsor, in Alma Road and Alexandra Gardens. Last week on two occasions, and on the second in Alexandra Gardens when it was raining. Not only I, but two other residents were experiencing the same. The machine was not recognising our cards. I then called your Customer Services Number and spoke with an adviser in Library and Resident Services. She was more than helpful and immediately

Service	Compliment received
	progressed my issue and emailed me immediately to update me. She has since diligently followed it through.
Libraries	• A very happy customer of yours from Windsor has visited today to leave you a box of chocs. You advised her in Windsor about a council tax valuation query & she was able to resolve the issue because of your expert guidance. Awesome work. Well done.

3.49 The variety of compliments highlights the breadth of work carried out across the council and helps celebrate the good work carried out by a wide range of officers.

4. ADULT SERVICES

Overall adult complaints summary

4.1 In 2019/20 there were 27 complaints about the provision of adult social care services, compared to 19 in 2018/19. This represents 7% of all complaints received by the Council.

Internal process

- 22% of complaints were fully upheld
- 30% of complaints were partially upheld
- 48% of complaints were not upheld
- 56% were responded to within timescales.
- 21 compliments were received.

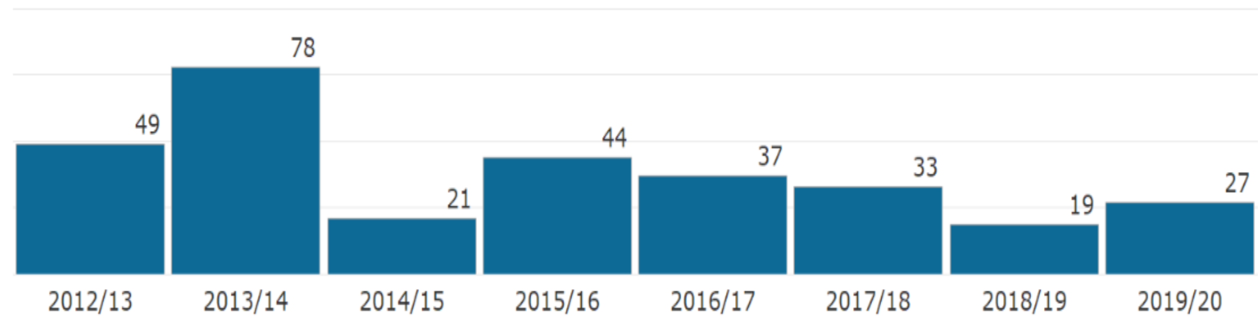
External process

- Six complaints or enquiries were decided by the LGSCO
  - Four were fully investigated.
  - Four were upheld.
  - Zero were not upheld.

Complaints received

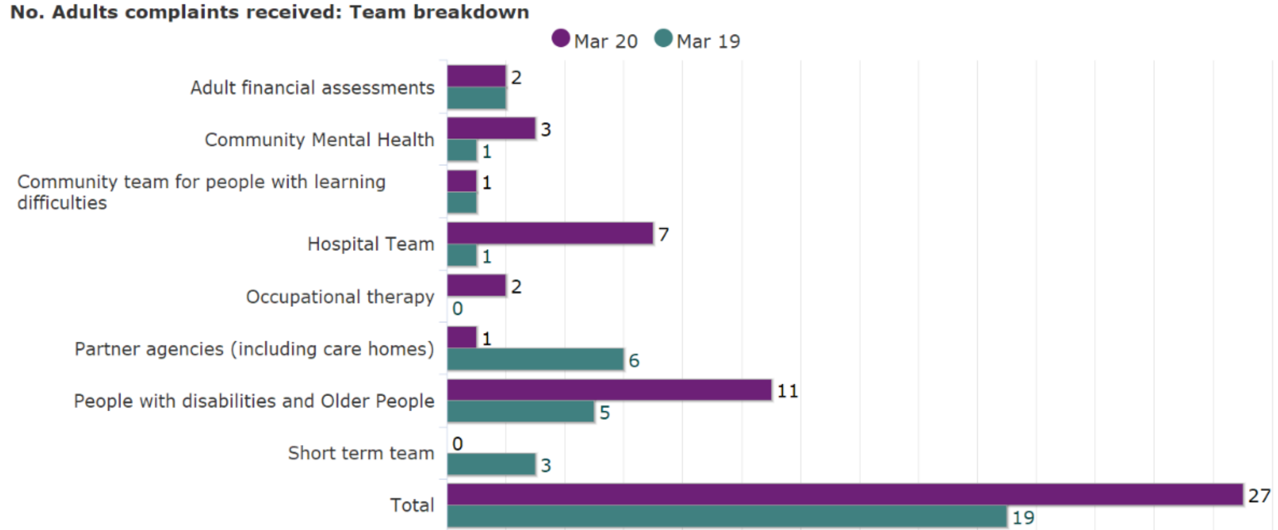
4.2 Although there was a rise in the number of complaints received for adult services from 2018/19, Figure 20 shows that over the last eight years there has only been two years where the numbers of complaints were lower. Analysis of the complaints would suggest that the rise related to seeking further explanation on issues that were unclear in relation to assessments or invoicing. The new Director of Statutory Services in Optalis is prioritising resolution of issues at an earlier stage and in particular clearer explanations of what are sometimes complex financial and care issues.

Figure 20: Total number of adult complaints, 2012/13-2019/20



4.3 Figure 21 details the volume of stage 1 complaints received by each team.

Figure 21: Volume of Adult complaints received by team



4.4 Most of the complaints to teams remained at a similar number to 2018/19; however, complaints to the People with Disabilities and Older People's team increased from five to 11 and complaints to the Hospital team rose from one to seven. Teams provide care and support to the highest number of residents on a day to day basis and it is understandable that they receive the highest numbers of complaints

4.5 It is worth noting that the overall number of complaints for adult social care is very low compared to the number of people that are supported. Whilst the most complaints were dealt with by the People with disabilities and Older people's team, 11 (41% of all adults complaints), at any one time in the year, 1,400 people are supported by this team.

4.6 A number of the complaints were about the information provided to service users and families in respect of the charging process. A review of how this information is provided will be undertaken in 2020/21 to ensure the process is more understandable and effective.

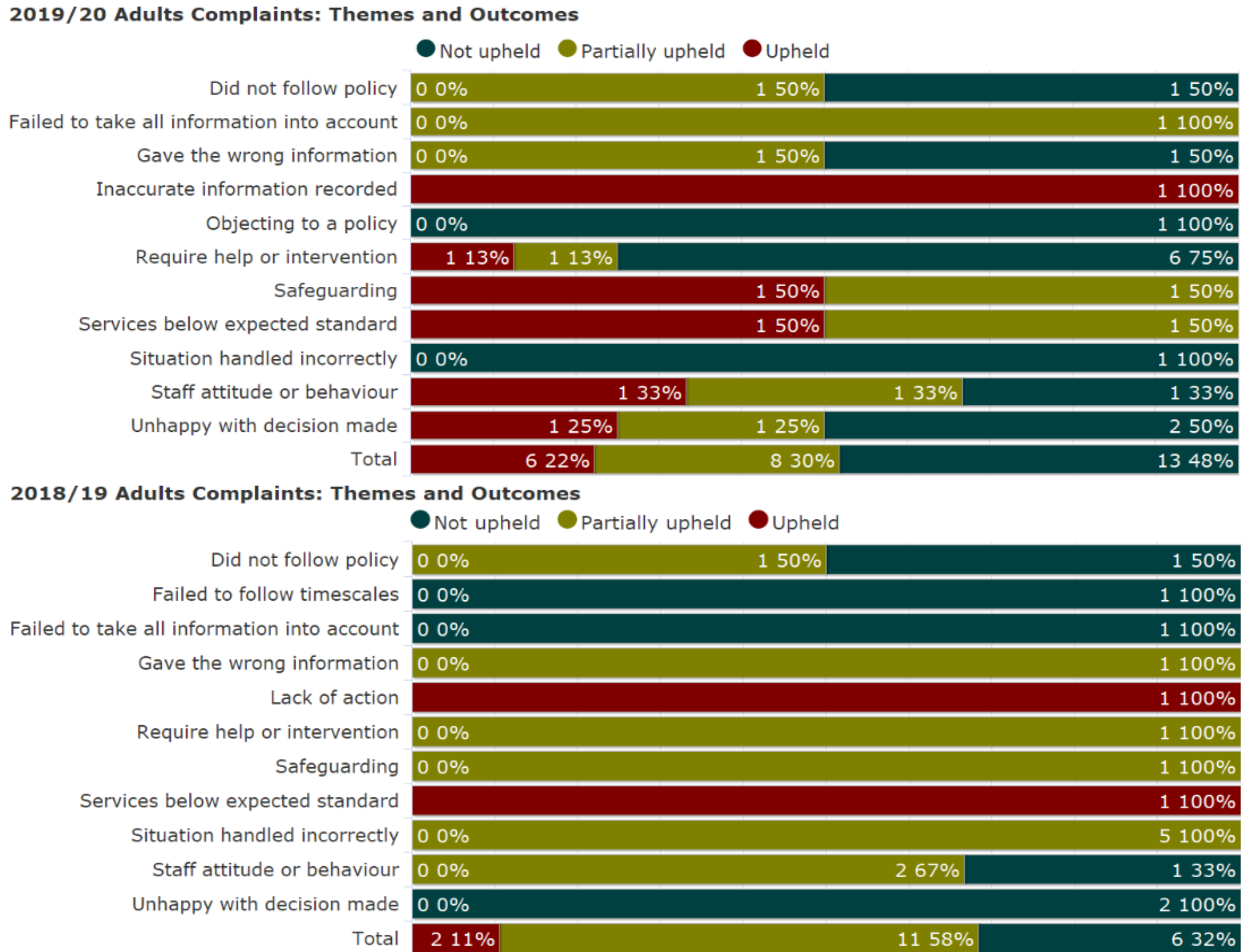
4.7 The number of complaints received by the council relating to external care providers (domiciliary care providers and care homes) has fallen from six to one or 32% to 4% of all adult complaints and is low compared to the number of people being provided with ongoing support- domiciliary providers deliver over 3,500 hours of care per week to 350 people in the community.

4.8 All complaints received relating to these external providers are managed through the contract monitoring process. Over the last year, the council and Optalis have worked in close and regular collaboration with the main providers, looking at their care practice and working with them to facilitate improvements in the management and delivery of their care services. Any issues or concerns arising from care delivered in the community are openly discussed between the provider and the council, or the provider and the person receiving the care service, so that improvements and changes can be made and agreed informally, wherever possible, without recourse to the complaints process.

Themes and outcomes

4.9 Figure 22 details the volume and percentage of complaints received to the Adults complaints process with a breakdown of both theme and outcome for both 2018/19 and 2019/20.

Figure 22: Breakdown of Adults complaints by theme and outcome

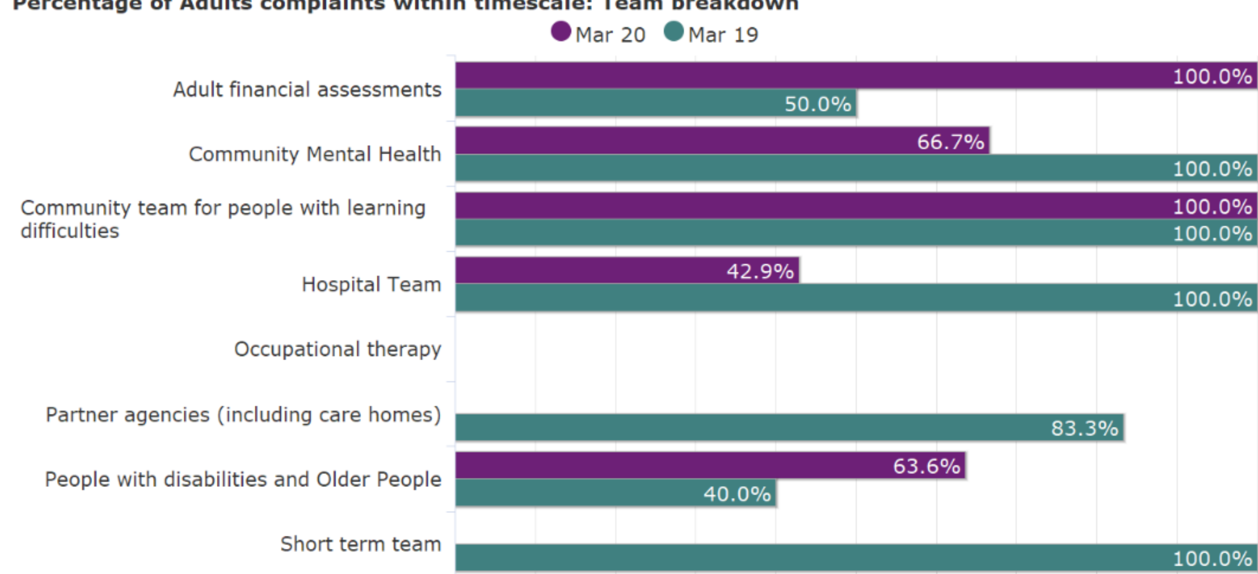


4.10 The highest number of complaints received were recorded under the theme of 'require help or intervention'. This is double the next highest theme. Most of the complaints in this category did not actively request a complaint; many were requesting an explanation of some issue that was not understood, for example invoicing. The need for clearer information and explanation has already been identified as a priority for 2020/21. In addition, work will be undertaken with the complaints team to refine the categories for complaints to better identify emerging themes that need addressing.

Timescales

4.11 Although there is no specified limit for statutory complaints about adult social care, the council's target for dealing with adult services complaints is 10 to 20 working days. This timescale may be increased for complaints that are particularly complicated. Of the 27 complaints received during 2019/20, 56% (15) were responded to within agreed timescales. This is a drop from 2018/19 where 74% were responded to within timescales Figure 23 provides a breakdown of responses within timescale for each team.

Figure 23: Percentage of complaints dealt with within timescale

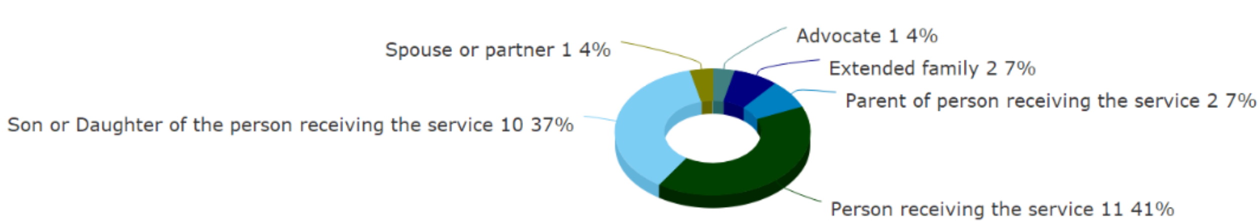


4.12 The response times in 2019/20 were longer due to staffing capacity pressures and the complexity of some of the complaints. Complaints in the hospital team primarily involved charging and finance matters which were complex to resolve. The service will review the process for managing these complaints and how the timescales are set to ensure that performance is more optimal going forward. It is of note that the percentage of complaints fully or partially upheld reduced from 2018/19 which indicates that more initial decisions were correct.

Complainants

4.13 The majority of complaints made in 2019/20 were by the person receiving a service, followed by the son or daughter of the person receiving the service. Figure 24 provides a full breakdown.

Figure 24: People making adult complaints



Complaints and enquiries to the LGSCO

4.14 The LGSCO made decisions about nine complaints and enquiries for adult services that were referred to them following complaints that were made about services provided by or on behalf of adult social care. Four were decided following detailed enquiries and of these, four were upheld. The remaining five were closed without a full investigation. See appendix 1 for details on decisions.

4.15 This is half the number of decisions about adult service that were decided by the LGSCO in 2018/19.

4.16 It is pleasing that the number of LGSCO decisions has reduced since 2018/19 largely due to more robust local investigation. However, in four cases, the Ombudsman upheld the complaint, which indicates a need to keep our approach under review.

Learning from complaints

4.17 There were four key areas of learning from complaints in 2018/19 and an update on implementation is:

Day centre:

- The service has been asked to re-look at their procedure when customers go into hospital, to ensure that the process is clear for all staff to follow, with a simple check list in place.

Following a complaint, the service implemented a simple check list to ensure that staff were clear on the procedure to be followed when a service user went into hospital. The checklist is fully embedded and forms part of the induction training for new staff. There have been no further complaints on this subject.

Domiciliary care:

- The council has implemented an action plan to improve the service from a care agency. This includes monitoring the care agency's daily records for three months to ensure it is delivering the service expected

Further intensive support measures were introduced, including monthly meetings with the care agency, facilitated by the council and Optalis; and quality monitoring across all aspects of the care agency's practice. Since then, the service has significantly improved. Sample monitoring of daily records forms part of the ongoing contract monitoring for all providers. Complaints regarding domiciliary care have dropped from 32% to 4% of all adult complaints.

People with Disabilities and Older People's Team and General training:

- Training was successfully delivered around duties under the Care Act 2014 and the Mental Capacity Act 2005 and refresher training is built into the ongoing training and development programme.
- There is ongoing training with staff to ensure that any issues are resolved at the earliest point to prevent complaints arising.

Mental capacity is discussed in supervisions, team meetings and on a case by case basis. Staff are supported by seniors and service managers. The team are also in the process of securing new training for all new staff. Refresher training will also be available.

Evidence from 2019/20 complaints suggests that more work is required and this is a priority for the new Director of Statutory Services in Optalis

4.18 Table 5 picks up some of the learning across adult services during 2019/20.

Table 5: Learning from adult complaints during 2019-20

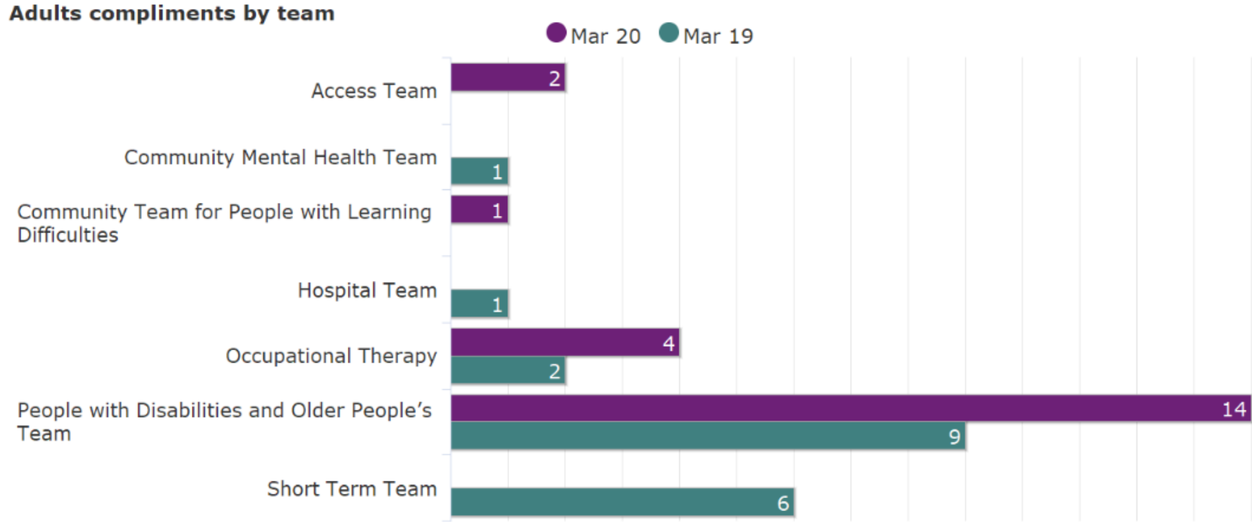
Complaint area	Actions and learning
Day centre	• The service has implemented a simple check list, which includes 'can the service be safely manned

Complaint area	Actions and learning
	by reducing staffing levels to escort a customer'.
General	• We have introduced a Quality Assurance Panel that assures senior management that the Every Step Together (EST) approach is fully understood and provides checks that carers and relatives are included at all stages and in all aspects of a person's life.
General	• Introduction of the Strength Based Approach: Optalis QA team visit providers on a regular basis, they check recording when visiting the home in order to ensure that the home is compliant with CQC requirements and those required by RBWM commissioners of service. Should they feel that communication of this nature is lacking in any way then they will inform the responsible manager.
Too many complaints are exceeding agreed timescales.	• The service will introduce a revised quality assurance and process monitoring framework to ensure that complaints are responded to in a timely way by September 2020
Services provided by an external domiciliary care agency that had been sub-contracted to another provider	• The council now commissions all care directly, it does not allow providers to subcontract and all providers are monitored directly
Some complaints indicate potential variability in information provision to services users and families.	• The service will introduce a revised quality assurance and process monitoring framework to ensure that information is provided to services users and families in a clear and consistent manner by September 2020

Compliments

4.19 Adult services received 21 compliments during 2019/20. This is similar to 2018/19 when there were 19 compliments received. Figure 25 shows the breakdown of compliments across adult services.

Figure 25: Compliments by service



4.20 As with complaints, the highest number of compliments received were for the people with disabilities and older people's team.

4.21 There were 21 compliments in 2019/20, which was similar level to 2018/19. This compares with higher compliment numbers in 2017/18 where 57 compliments were recorded. It is not clear why the number of compliments has fallen; but is possible that they are not being passed to the compliments and complaints team for logging. Reminders to send compliments on is being reiterated in team meetings and it is hoped this will be reflected in next year's annual report.

4.22 Table 6 shows examples of compliments received across adult services.

Table 6: Examples of compliments received

Service	Compliment received
Duty	• He commented that RBWM adult social services are "knocking it out of the park". He stated he's had such a speedy and positive experience since walking into the reception on Friday and has felt supported.
PDOPT	• This is more than ok. I cannot express my thanks to you for organizing this. You have been brilliant, and I would appreciate you sharing this email with your Manager. You really are a credit to your organization- thank you.

5. CHILDREN'S SERVICES

Overall children's complaints summary

5.1 In 2019/20 there were 54 children's complaints, 19 of these followed the statutory children's complaints process and 35 followed the formal corporate complaints process. This compares to 38 children's complaints in 2018/19 (28 statutory and 10 corporate).

Internal process

- 19% of complaints were upheld
- 44% of complaints were partially upheld
- 17% of complaints were not upheld
- 56% were responded to within timescales.
- 63 compliments were received

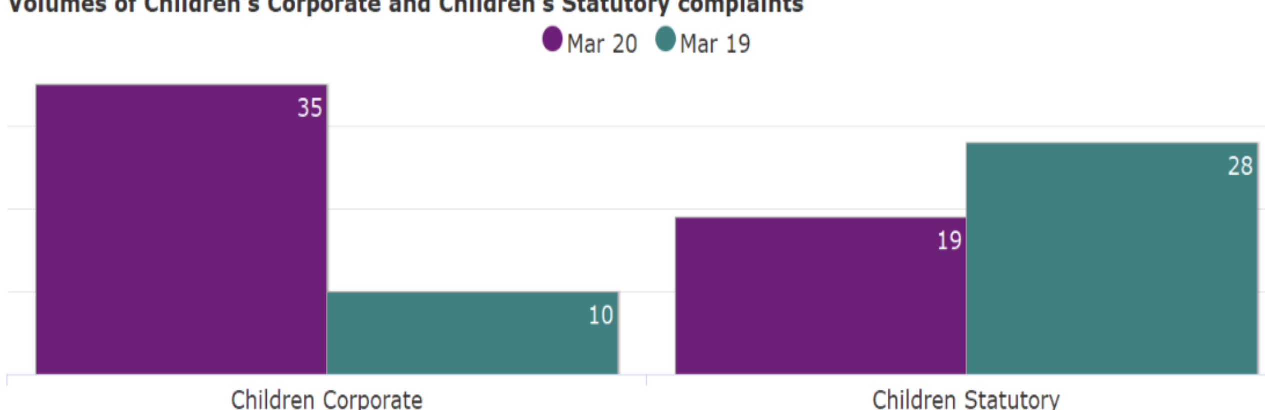
External process

- four complaints or enquiries were decided by the LGSCO.
  - two were fully investigated
  - None were upheld
  - two were not upheld.

Complaints received

5.2 Figure 26 provides a breakdown of the total volumes of Children's Statutory and Children's Corporate complaints received in both 2019/20 and 2018/19. There is a change seen in the balance of complaints with a drop in children's statutory complaints (from 28 to 19) and a rise in children's corporate complaints (from 10 to 35).

Figure 26: Children Services overview



5.3 The number of complaints relating to children's services has varied over the last eight years, peaking at 90 in 2013/14, see Figure 27 for an annual breakdown for the period 2012/20.

Figure 27: Complaints received comparison 2012/13-2019/20

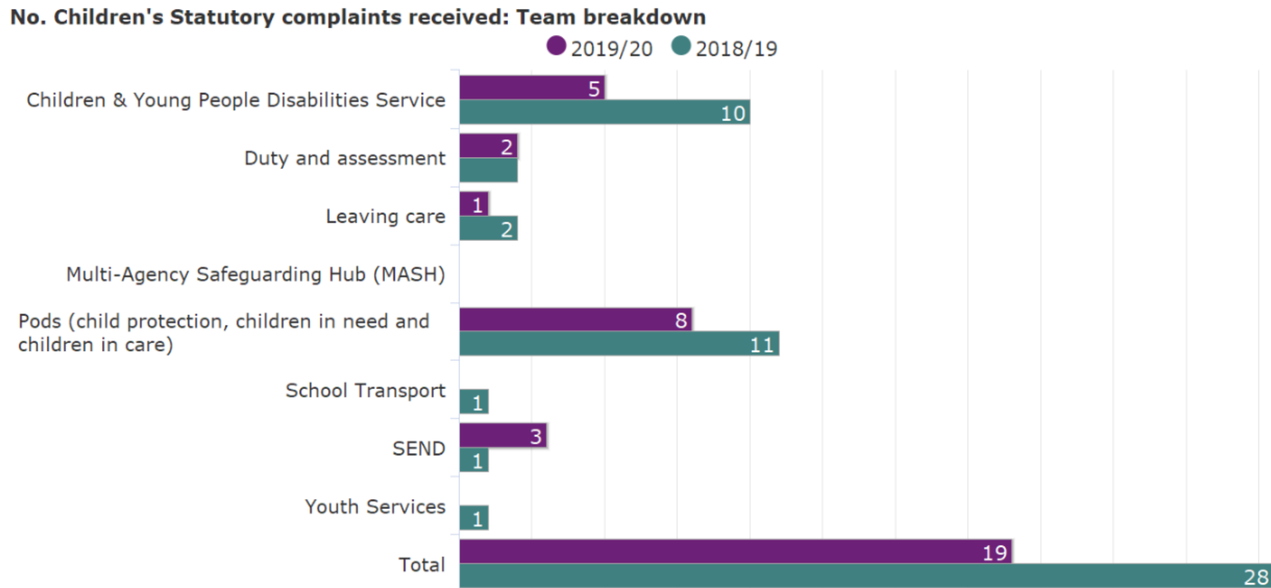
Total volume of complaints (Children's Corporate and Statutory)

2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
43	90	61	81	36	37	38	54

5.4 The rise is seen mainly in the number of complaints to the SEND team, where the number of complaints rose from 7 to 17 (3 statutory and 14 corporate). There was some churn in staff during 2019/20. The team is more stable now and this should be reflected in next year's annual report.

5.5 Figure 28 provides a breakdown of Children's Statutory complaints by team.

Figure 28: Statutory complaints received in 2019/20 and 2018/19

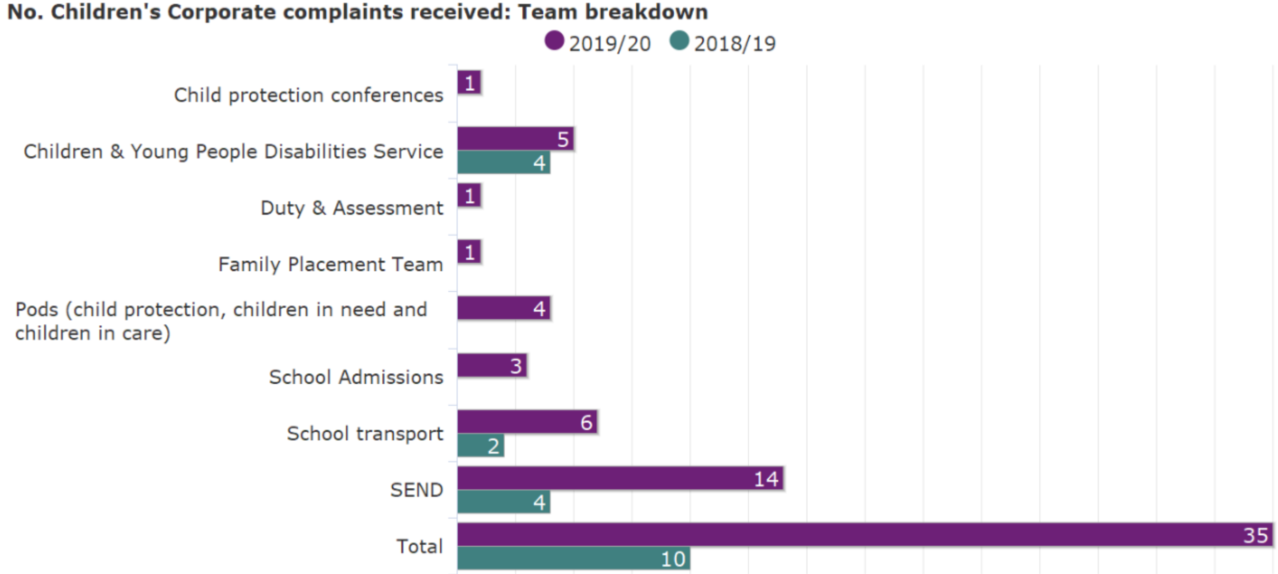


5.6 Statutory complaints are taken where a complaint is made by or on behalf of a child or young person who is receiving a statutory service from children's social care. In 2019/20, the majority of statutory complaints received related to Pods, with slightly fewer in CYPDS. These teams carry the majority of statutory cases.

5.7 During this year there was a high turn-over of staff and this has had an impact on the consistent delivery of some of our services, leading to associated complaints. It also had an impact on how complaints have been responded to, due to the movement of managers. However, we now have a more stable staff group, particularly managers and this in itself should lead to a more consistent delivery of services and response to complaints.

5.8 Figure 29 provides a breakdown of Children's Corporate complaints by team.

Figure 29: Corporate complaints received in 2019/20 and 2018/19



5.9 Children's corporate complaints are taken where a complaint is made by or on behalf of a child or young person who does not receive a statutory service from children's social care, or where the complaint is not on behalf of the child or young person. The majority of children's corporate complaints received related to the SEND team. This has more than doubled since 2018/19. These varied from complaints about school placements to delays in completing a child or young person's Education Health and Care Plans (EHCPs).

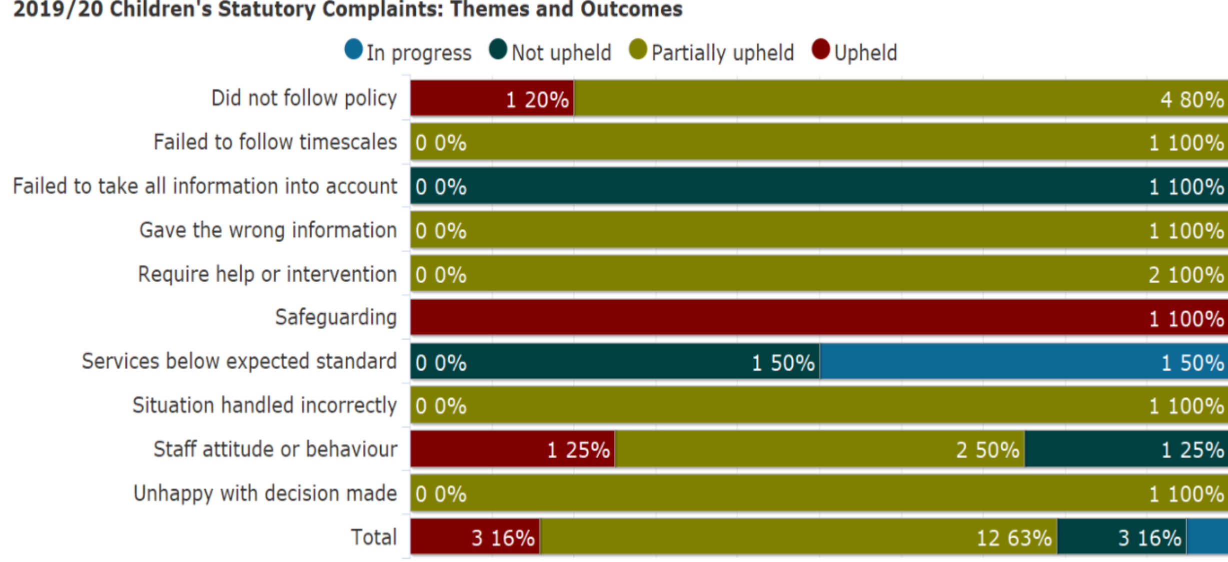
5.10 There are approximately 1000 children with EHCPs and there has been a significant national growth in the demand for these from schools and parents. The SEN Code of Practice states that we have to take into account the efficient use of public resources when identifying school placements, which can cause disappointment and dissatisfaction for some families when we aren't able to agree with their school preference. In a year of significant staff turnover there have also occasionally been delays in the management of some cases, which has impacted on the number of complaints received within this service. The service's staffing is now more settled, and training is in place, so it is anticipated that this will be reflected in the number of complaints reported in next year's annual report. Where any service deficit has impacted upon the young person we have acknowledged this and apologised to the family.

Themes and outcomes

5.11 Figures 30 and 31 set out the themes of children's statutory and corporate complaints during 2019/20. Themes of complaints are in the main self-selected by the person making a complaint and not all complaints fit neatly into a single category. In 2019/20 there was one children's corporate complaint relating to staff attitude or behaviour where there was no finding as a result of insufficient evidence. There was one children's corporate complaint regarding failure to follow timescales which was still in progress at the time of this report's preparation, and therefore there is no outcome listed. Similarly, there is one children's statutory complaint relating to services below expected standard that was in progress at the time of this report's preparation and therefore there is no

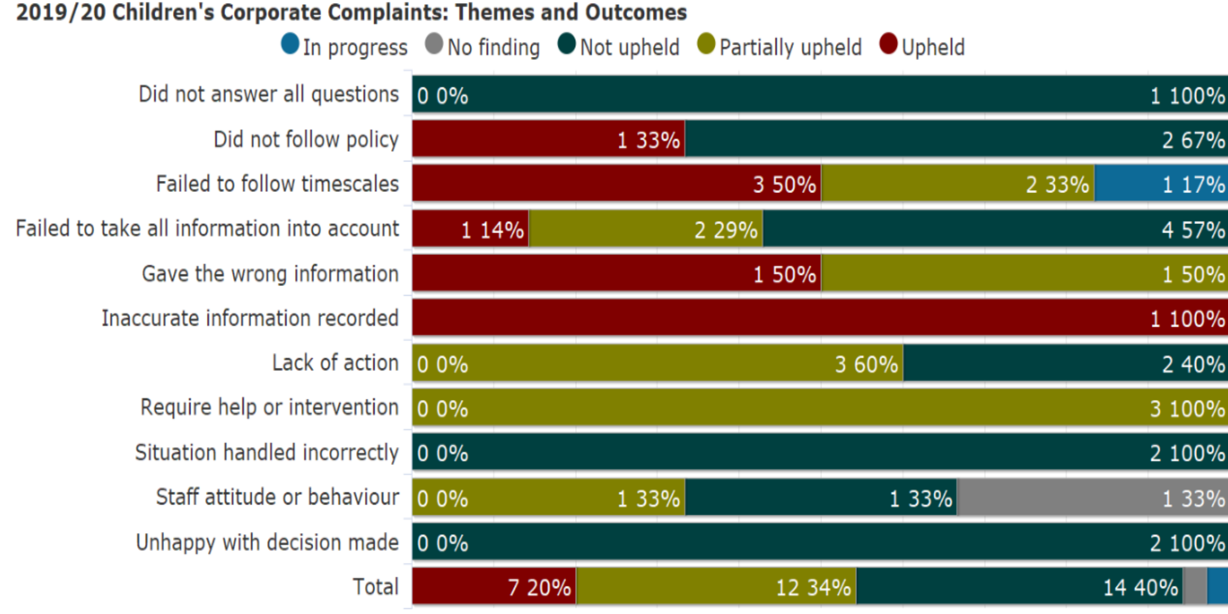
outcome listed.

Figure 30: 2019/20 Children's Statutory complaints by theme and outcome



5.12 For children's statutory complaints, the highest volume of complaints received related to the theme "did not follow policy" (5), followed by "staff attitude or behaviour" (4). Although the numbers are small, they are indicative of many of the complaints received where they may be differences of opinion between families and the teams they are working with. It is also noted that only two of these seven complaints was fully upheld.

Figure 31: 2019/20 Children's Corporate complaints by theme and outcome



5.13 For children's corporate complaints, the highest volume of complaints received related to the theme "failed to take all information into account" (7), followed by "failed to follow timescales" (6) and "lack of action" (5). When a parental school preference is not agreed the complaint is often that the service has failed to take all information into account, even though all information has been considered when reaching a view. In other cases the relevant information was not made available at the time of the original

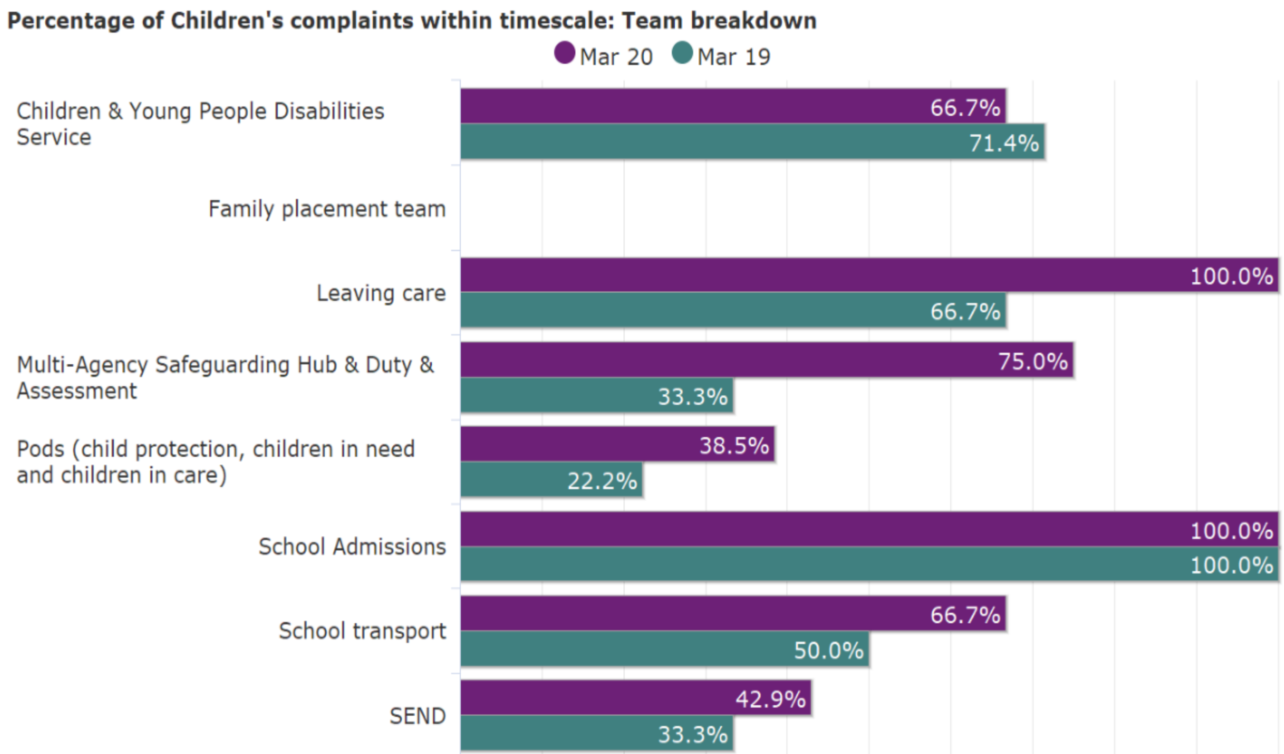
decision.

Timescales

5.14 The timescale for dealing with children's statutory and children's corporate stage 1 complaints is 10 working days. However, this can be extended to 20 working days for more complex complaints or if additional time is required.

5.15 Figure 32 details the number and percentage of complaints responded to within timescales for each service.

Figure 32: Response timescales



5.16 Of the 54 complaints that were received during 2019/20, 56% were responded to within timescales, which is an improvement from 2018/19 when 47% were responded to within timescales

5.17 Those responding to complaints are advised to give sufficient time to respond to the complaint and to ensure that all elements of each complaint are addressed. Based on this, some complaints have not been upheld, because there is limited evidence to support them. However, complaints will be upheld if there is evidence to demonstrate that actions fell short of our usual high standards

5.18 The complaints and compliments team continue to send weekly reports of outstanding complaints to heads of services and directors. They also meet with the managers investigating complaints to clarify the complaint and ensure the scope of this is understood. Staff have provided some reassuring feedback on the relationship with the complaints team and this collaborative relationship has had a good impact on timeliness and quality.

Outcomes

5.19 See Figure 33 for the breakdown of children's statutory complaints by outcome and Figure 34 for the breakdown of children's corporate complaints by outcome. It should

be noted that at the time of this report's preparation one Children's Statutory complaint was still in progress and so an outcome is not shown here. Similarly, there is one Children's Corporate complaint still in progress and one where there was no finding as a result of insufficient evidence.

Figure 33: Outcome of children's statutory complaints

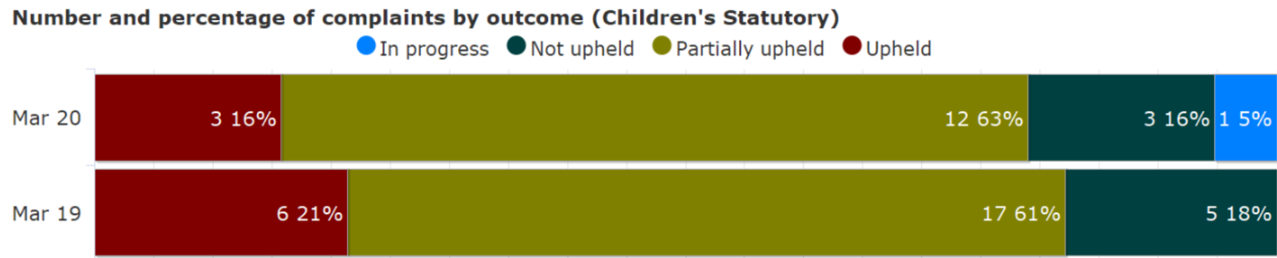
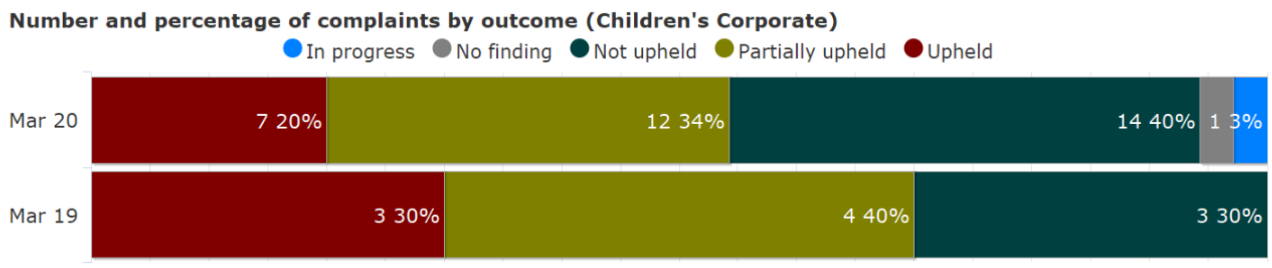


Figure 34: Outcome of children's corporate complaints

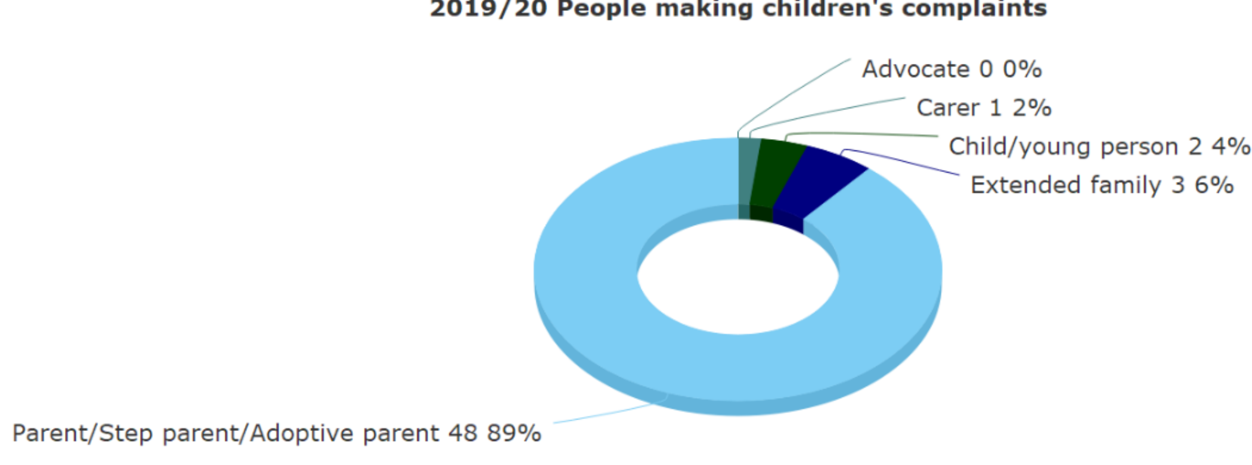


5.20 Achieving for Children as a learning organisation take complaints that have an element of wider learning which are used as examples to improve practice

Complainants

5.21 The vast majority of complaints (89%) made in 2019/20 were by parents. Two formal complaints were made by young people, no complaints were made by advocates. Figure 35 provides a breakdown of complainants.

Figure 35: People making children's complaints



Stage 2 complaints

5.22 Seven complaints were resolved at stage 2 during 2019/20. Two of these were investigated under the statutory children's complaints process; both were partially upheld. Five were investigated under the children's formal corporate complaints

process; two were fully upheld, one was partially upheld and one was not upheld. One statutory complaint remains in progress.

5.23 Zero statutory complaints were resolved at stage 3 in 2019/20.

5.24 Complaints resolved under the formal corporate complaints process are reported within the children's services annual report to give an overview of all complaints about children's services.

Complaints and enquiries to the LGSCO

5.25 The LGSCO made decisions on 10 enquiries regarding complaints for children's services during 2019/20. None of these decisions was upheld, six were referred back for local resolution, one was closed after initial enquiries, one was invalid and two were not upheld. See appendix 1 for details on 2019/20 decisions.

Representations

5.26 Representations are comments by children and young people, normally within a child's review. These can be positive or negative and are acted upon by referring these comments to the social care team working with the child or young person so this can be acted upon and responded to by that team.

5.27 A new electronic feedback system for seeking feedback from children, young people and families is now in place, although it is still early days. This will replace the ad hoc arrangements that previously existed for gathering feedback. One week in every month, those who attend child protection conferences and reviews for children in care are also asked to complete an electronic feedback form. Feedback was also received from our children in care and care Leavers in February 2020 in the form of a questionnaire. The Director of Social Care and Early Help continues to offer to meet with any child or young person who makes a formal complaint.

5.28 If a child or young person makes a complaint they are supported to appropriately use the compliments and complaints service.

Case concerns

5.29 In addition to complaints under the children's services statutory complaints and the formal corporate complaints processes, we have captured information regarding case concerns. Case concerns are recorded when an issue has been raised with the complaints and compliments team but has been dealt with informally by children's services.

5.30 Figures for case concerns do not count towards the overall number of complaints but are useful to help identify issues and help promote timely resolutions. In addition they can show if there is a pattern if a complaint is raised later.

5.31 In 2019/20 there were 11 case concerns recorded. Table 7 shows the split across children's services for case concerns received.

Table 7: Case concerns across children's services 2019/20

Leaving care	Pods	CYPDS	MASH/Duty and Assessment
1	3	3	4

Learning from complaints

5.32 There were four key areas of learning from complaints in 2018-2019 and an update on

implementation is:

Children and young people disability service
- Consideration will always be given to each parent regarding sharing of email content and other information between separated parents without agreement, unless there are immediate safeguarding concerns.
- Further documentation is being developed to clarify the difference between supported contact, rather than supervised contact for young people over 18 years of age.

There have been no further complaints on these issues in 2019-20.

Leaving Care team
- The Local Authority now have a designated 16+/ Care Leavers team which will ensure that young people in care and young asylum seekers are given the right support and work is progressed as quickly as possible.

This is embedded and progressing to 15+ which will support even better and earlier focus for young people in care. Although small numbers, complaints against the 15+/Care Leavers team have dropped from two in 2018/19 to one in 2019/20.

Pods
- Any Child in Need meetings or similar is now chaired by a Manager.
- Within Team Meetings we have discussed with the managers and staff the importance of agreed actions being followed up within timescales, alongside realistic timescales being initially set.

CiN Meetings were discussed at a huddle and it was agreed that ATM's/TM's will chair the first CiN Meeting and the midway review CiN meeting. The number of statutory complaints to children's services fell in 2019-20.

General
- Actions from responses are now being captured. Meetings are being put in place with the complaints team in order to ensure that all learning is captured and acted upon.
- Actions and recommendations have been raised with teams for updating as learnings from complaints.

There is now a mechanism for the children's teams to keep the compliments and complaints team updated with regards to actions.

5.33 Table 8 sets out learning from children's complaints

Table 8: Learning from children's complaints

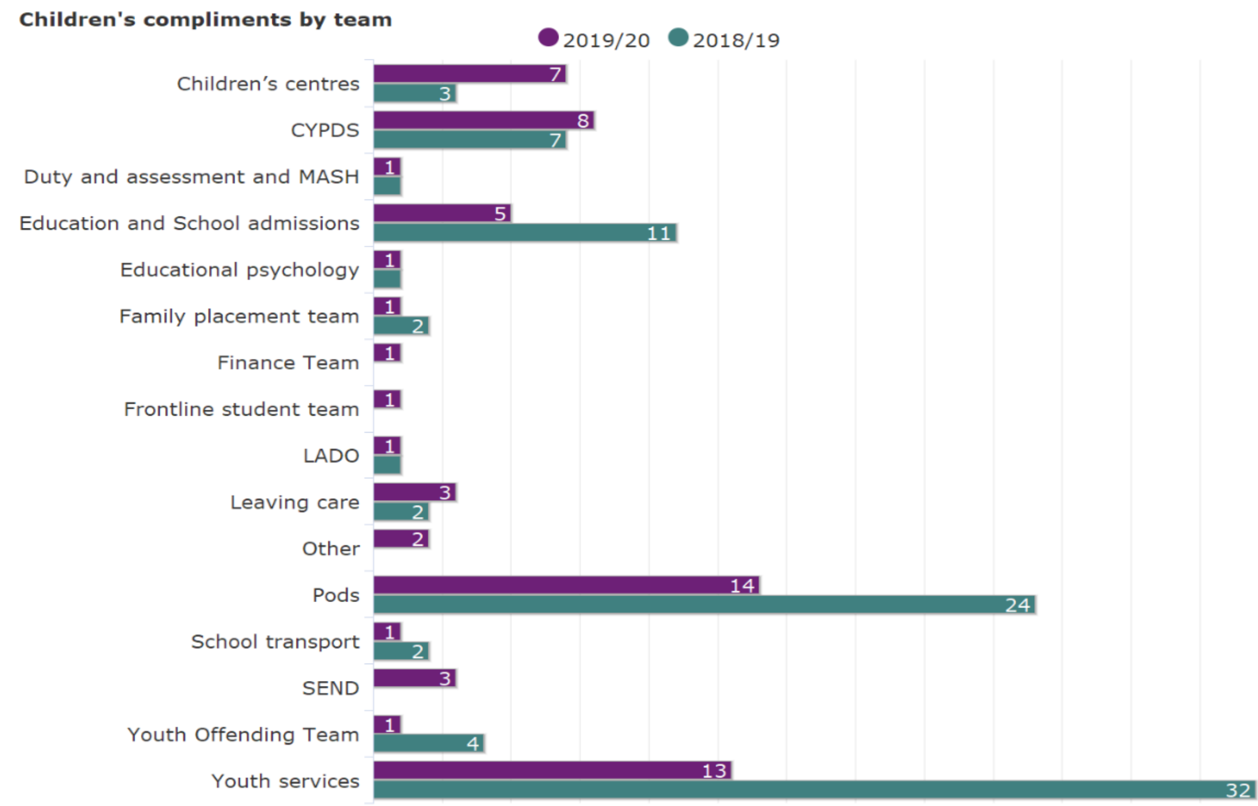
Complaint area	Actions and learning
Children and young people disability service	**OT Service** • The organisation has had a discussion with our key partner agencies i.e. Health to try and address the issue that we are facing in recruiting and retaining an Occupational Therapist.
SEND	• All final EHCPs are forwarded to the CYPDS inbox after signing so they can be sent out promptly. • Ensure that we approach a number of potential school

Complaint area	Actions and learning
	placements at the same time rather than on an individual basis to minimise the time taken. Keep parents better informed about the placement search process and the likelihood of schools being able to offer a place so that parents do not spend time visiting schools unnecessarily.
Pods	• Grandparents are clearly made aware of whether they are expected to supervise contact between their grandchildren and their parents and have a written agreement in place to reflect this. • Revisited the training offered in respect of our duties as part of the transition into adulthood. This included expectations around the reviewing of packages of care and support. • We are exploring how as a service for our Children in Care we can centralise all the Pod arranged contacts through the Contact Service to ensure consistency across the board and have contingency plans, should circumstances change. Our Contact Service supports with all contacts for looked after children that are placed out of area. This will ensure better oversights and communication to ensure contacts can run efficiently. We encourage staff to think more creatively on how we can keep consistency for our children in care.
Transport	• CYPDS staff received further training from School Transport around the transport application process and criteria.
CYPDS	**Respite support packages:** • Review of communications with parents around the internal panel process.

Compliments

5.34 63 compliments were recorded for children's service in 2019/20. This is lower than the 90 compliments recorded in 2018/19. It is not clear why this is, however, teams within the organisation will continue to be encouraged to share compliments they receive with the compliments and complaints team so that they can be logged. Figure 36 provides a breakdown of compliments received by team.

Figure 36: Number of compliments by children's services teams



5.35 Table 9 shows examples of compliments received across children's services.

Table 9: Examples of compliments received

Service	Compliment received
Youth Service	• In December 2018 a review was undertaken and it was decided that our child didn't need any support from Social Services. The Social Worker offered a referral to a Youth Worker, […] who contacted us immediately by phone to introduce himself and arrange to meet with our child. He was very accommodating and was able to meet within a week. Our child was very positive after the first meeting and arranged for a follow up session. We are only disappointed that our child couldn't have been referred to a youth worker many months ago when unable to attend school and would have really benefited from the support.
SEND	• We would like to express our Thanx and heartfelt appreciation for the time, Care and genuine accuracy taken over our sons report for submission to the borough for his EHCP. It reads brilliantly and takes into account All the expert reports as well as our thoughts And experiences as his parents, as well as your skill and time spent with him at our home. We could not have asked for More. Thank you ...
Leaving Care	• I can't imagine anything greater than catching my dream. I also can't imagine having all these achievements without your help and support. It's been four long years for me waiting for this day to say a huge thank you to you, for all your encouragements,

Service	Compliment received
	guidance, emotional and financial supports. You are the best person out there.
Frontline	• We really don't know where to start to say thank you. Your professional caring and understanding manner towards us has ensured we have one very happy little child. You have been such a huge support during tough times. You have constantly been on hand and on the phone. With your help we now have X in a stable environment to face the future ahead. Your guidance is so appreciated. For what you have done, are doing and will continue to do we all thank you from the bottom of our hearts.

Appendices

Appendix A: LGSCO Annual Letter 2019-20

22 July 2020

By email

Mr Sharkey
Managing Director
Royal Borough of Windsor and Maidenhead Council

Dear Mr Sharkey

Annual Review letter 2020

I write to you with our annual summary of statistics on the decisions made by the Local Government and Social Care Ombudsman about your authority for the year ending 31 March 2020. Given the exceptional pressures under which local authorities have been working over recent months, I thought carefully about whether it was still appropriate to send you this annual update. However, now, more than ever, I believe that it is essential that the public experience of local services is at the heart of our thinking. So, I hope that this feedback, which provides unique insight into the lived experience of your Council's services, will be useful as you continue to deal with the current situation and plan for the future.

Complaint statistics

This year, we continue to place our focus on the outcomes of complaints and what can be learned from them. We want to provide you with the most insightful information we can and have made several changes over recent years to improve the data we capture and report. We focus our statistics on these three key areas:

Complaints upheld - We uphold complaints when we find some form of fault in an authority's actions, including where the authority accepted fault before we investigated. A focus on how often things go wrong, rather than simple volumes of complaints provides a clearer indicator of performance.

Compliance with recommendations - We recommend ways for authorities to put things right when faults have caused injustice. Our recommendations try to put people back in the position they were before the fault and we monitor authorities to ensure they comply with our recommendations. Failure to comply with our recommendations is rare. An authority with a compliance rate below 100% should scrutinise those complaints where it failed to comply and identify any learning.

Satisfactory remedies provided by the authority - We want to encourage the early resolution of complaints and to credit authorities that have a positive and open approach to

resolving complaints. We recognise cases where an authority has taken steps to put things right before the complaint came to us. The authority upheld the complaint and we agreed with how it offered to put things right.

Finally, we compare the three key annual statistics for your authority with similar types of authorities to work out an average level of performance. We do this for County Councils, District Councils, Metropolitan Boroughs, Unitary Councils, and London Boroughs.

This data will be uploaded to our interactive map, Your council's performance, along with a copy of this letter on 29 July 2020, and our Review of Local Government Complaints. For further information on how to interpret our statistics, please visit our website.

Resources to help you get it right

There are a range of resources available that can support you to place the learning from complaints, about your authority and others, at the heart of your system of corporate governance. Your council's performance launched last year and puts our data and information about councils in one place. Again, the emphasis is on learning, not numbers. You can find the decisions we have made, public reports we have issued, and the service improvements your Council has agreed to make as a result of our investigations, as well as previous annual review letters.

I would encourage you to share the tool with colleagues and elected members; the information can provide valuable insights into service areas, early warning signs of problems and is a key source of information for governance, audit, risk and scrutiny functions.

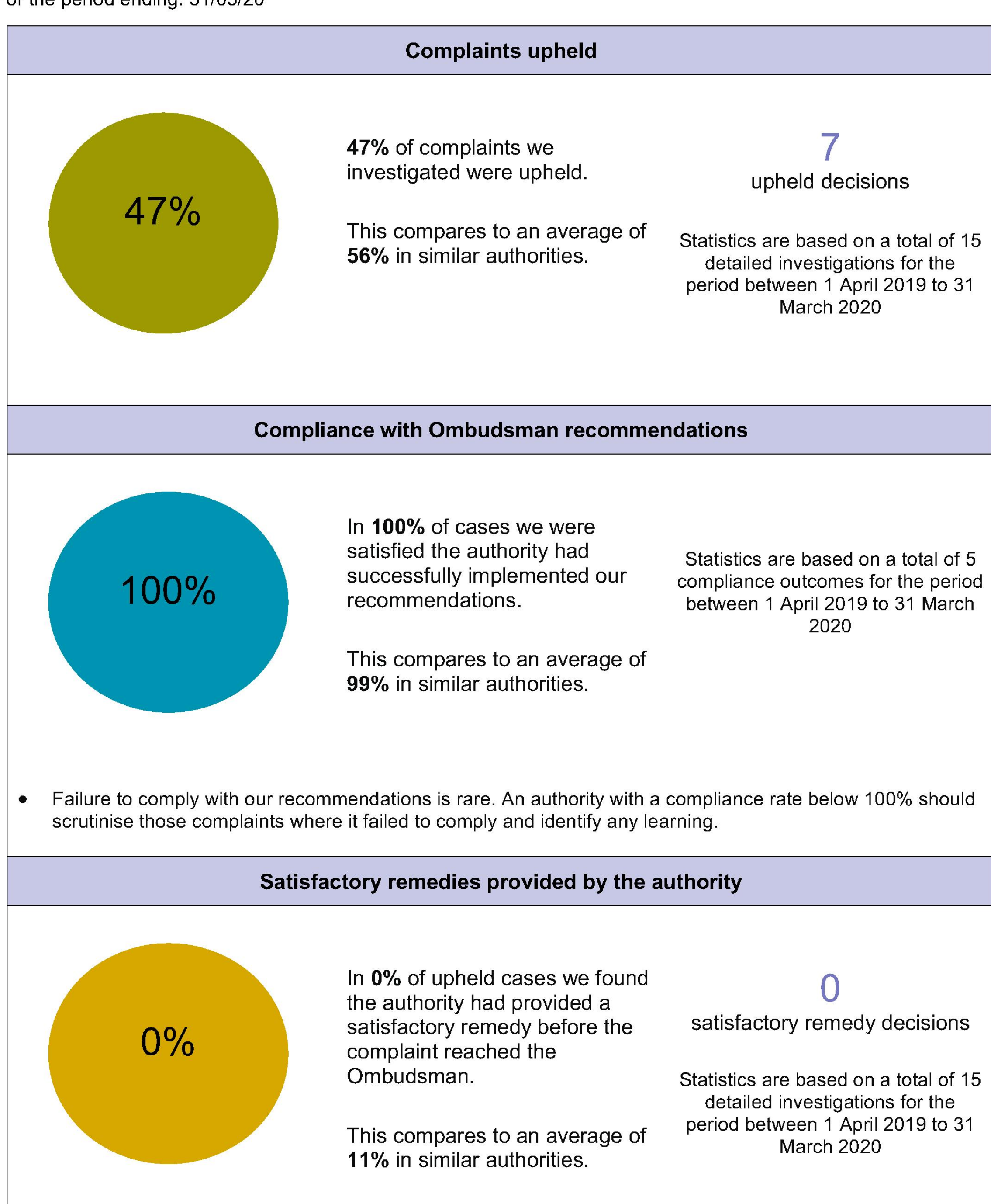
Earlier this year, we held our link officer seminars in London, Bristol, Leeds and Birmingham. Attended by 178 delegates from 143 local authorities, we focused on maximising the impact of complaints, making sure the right person is involved with complaints at the right time, and how to overcome common challenges.

We have a well-established and successful training programme supporting local authorities and independent care providers to help improve local complaint handling. During the year, we delivered 118 courses, training more than 1,400 people. This is 47 more courses than we delivered last year and included more training to adult social care providers than ever before. To find out more visit www.lgo.org.uk/training.

Yours sincerely,

Michael King
Local Government and Social Care Ombudsman
Chair, Commission for Local Administration in England

Royal Borough of Windsor and Maidenhead Council
For the period ending: 31/03/20



Appendix B: COUNCIL'S COMPLAINTS PROCESS AND PROCEDURES

The principle behind the council's complaints procedure is to ensure that every opportunity for resolution is sought through dialogue or local resolution before a complaint is submitted. Where agreement is not achieved someone has the right to complain and the complaints process has different stages dependant on the area of service the complaint is about.

Complaints made about the council's services are dealt with under three processes. The formal corporate complaints process for general council activity such as: council tax; housing; highways; communications; democratic services and so on; and the statutory adult and statutory children's processes.

The different complaint processes have different stages, however regardless of which policy a complaint is investigated under, or the outcome, the complainant still has the right to refer their complaint on to the Local Government and Social Care Ombudsman. The different stages are:

The formal corporate complaints process contains two stages.

- The adult complaints process contains one stage
- The children's complaints process contains three stages.

Although customers can refer complaints to the Local Government and Social Care Ombudsman (LGSCO) at any stage, the LGSCO will not normally investigate until the council have exhausted their complaints processes.

Complaints are made by email, phone call, letter, face to face or by logging the complaint online. All complaints received, along with comments and compliments, are recorded on the council's complaints database (Jadu). The Jadu system provides for compliments and complaints to be captured by number, types, themes, postal address and timeliness of complaint.

The council's complaints policies are intended for use by service users, customers, residents, businesses and visitors or their chosen representatives, which may include councillors.

The council's complaints process is managed through one team. This means the team is independent of the two statutory adult and children's services, ensures independence from services, removes the possibility of conflicts of interest and secures impartial challenges.

Quality assurance

Effective complaint management is crucial to allow confidence on the part of complainants to submit complaints in the understanding that the council will take these seriously and respond.

When a complaint is received the complaints and compliments team focus on ensuring:

- The process for investigating the complaint is followed and on time.
- Complaint responses answer the questions asked and are clear and easy to read.
- Lessons learned and recommendations are captured to secure continual improvement – this includes one to one training/advice/meetings with relevant employees providing them with support and guidance on how best to resolve a complaint.
- Any actions or recommendations are noted on Jadu and monitored.

Complaints processes

	Adult services complaints	Children's services complaints	Corporate complaints	Not within the formal complaints process
Incoming concern	Received via online form, email, telephone call or face to face contact. However received, all complaints are logged on the complaints database (Jadu) for monitoring and tracking. Once logged the complaint is acknowledged within 3 working days and customer informed whether this will be taken as a complaint and if so, under which complaints process			
Stage 1	**Statutory** No specific timescale but aim to respond within 10 working days. Response from Service Manager or higher.	**Statutory** Up to 10 working days. Can agree extension for a further 10 working days. Response from Head of Service.	Up to 10 working days. Can agree extension for a further 10 working days. Response from Head of Service.	N/A
Stage 2	N/A	**Statutory** 25-65 working days. Completed by independent complaints investigators and report produced. Adjudicating letter in response to report completed by Children's Director of Social Care.	Up to 20 working days. Review of stage 1 complaint and response by Director.	N/A
Stage 3	N/A	**Statutory** Stage 3 independent panel. Up to 70 working days. Panel of three independent members who produce a report. Letter in response to the report completed by the Directors of Children's Services.	N/A	N/A
LGSCO	Can complain to the Local Government and Social Care Ombudsman			N/A
Alternative appeal process	N/A	N/A	N/A	Customer given timescales for response

Appendix C: NATIONAL AND LEGISLATIVE CONTEXT

Formal corporate complaints

The council's formal corporate complaints policy is discretionary and has been developed based on the Local Government and Social Care Ombudsman's guidance 'Running a complaints system - Guidance on good practice'.

Adult services

The council has a statutory duty, under the NHS and Community Care Act 1990, to have in place a complaints procedure for Adult Social Care services and is required to publish an annual report relating to the operations of its complaints procedures.

The Local Authority Social Services and NHS Complaints (England) Regulations 2009 introduced a single approach for dealing with complaints for both the NHS and Adult Social Care, the key principles of which are:

- Listening - establishing the facts and the required outcome.
- Responding - investigate and make a reasoned decision based on the facts/information.
- Improving - using complaints data to improve services and influence/inform the commissioning and business planning process.

Children's services

The procedure for dealing with children's statutory complaints and representations is determined by the following legislation:

- The Children Act 1989, Representations Procedure (England) Regulations 2006.
- The Children & Adoption Act 2002 and Children (Leaving Care) Act 2000 and
- The accompanying guidance 'Getting the Best from Complaints' (DfE July 2006).

Qualifying individuals are defined in national guidance as the child or young person, their parent, carer or foster carer or 'anyone who could be seen to be acting in the best interests of the child.'

Under the regulations, the council is required to produce and publish an annual report.

Report Title:	**2020/21 Q1 Performance Report**
Contains Confidential or Exempt Information?	No - Part I
Lead Member:	
Meeting and Date:	Adults, Children and Health Overview and Scrutiny Panel, 30 September 2020
Responsible Officer(s):	Hilary Hall, Director of Adults, Health and Commissioning Kevin McDaniel, Director of Children's Services
Wards affected:	All

REPORT SUMMARY

1. The Council Plan 2017-21 and associated strategic priorities remained current up to the 30 July 2020 when Cabinet approved an Interim Council Strategy 2020/21 for immediate adoption. The Interim Council Strategy was adopted in acknowledgement that the Covid-19 pandemic has significantly altered the context in which the Council is currently operating and that resources are now focused in an entirely different way. The priorities and objectives of the approved Interim Council Strategy therefore supersede those of the original 2017-21 Council Plan.

2. Appendix A sets out Q1 performance for all measures relating to the Adults, Children and Health Overview and Scrutiny Panel's remit under the strategic framework that was current in Q1. Performance of measures related to the Interim Strategy will be reported from Q2 onwards. These reports will also include performance of the measures set out in Appendix A, grouped by the lead service, as it is acknowledged that these measures remain important for the future and so ongoing visibility of trends is desirable.

1. DETAILS OF RECOMMENDATION(S)

RECOMMENDATION: That the Adults, Children and Health Overview and Scrutiny Panel notes the report and:

- **i) Notes the 2020/21 Adults, Children and Health Overview and Scrutiny Panel Q1 Performance Report in Appendix A.**

- **ii) Notes that from Q2 onwards performance of measures relating to the Interim Council Strategy will be reported, along with the measures included in Appendix A which will be grouped by lead service.**

- **iii) Requests relevant Lead Members, Directors and Heads of Service to maintain focus on improving performance.**

2. REASON(S) FOR RECOMMENDATION(S) AND OPTIONS CONSIDERED

Options

Table 1: Options arising from this report

Option	Comments
Accept the recommendations in this report relating to Q1 performance reporting and the intentions for reporting in Q2 and beyond. **This is the recommended option**	This will allow continuing monitoring of performance and trends against the council's agreed priorities and objectives in order to aid decision-making and maintain focus on continuous improvement.
Reject the recommendations in the report.	The failure to use relevant performance information to understand delivery against the council's agreed priorities and objectives impedes the council's ability to make informed decisions and seek continuous improvement.

2.1 The Council Plan 2017-21 remained current up to the 30 July 2020 when Cabinet approved an Interim Council Strategy 2020/21 for immediate adoption, acknowledging that the Covid-19 pandemic has significantly altered the context in which the Council is currently operating and that resources are now focused in an entirely different way.

2.2 Appendix A sets out Q1 performance for all measures relating to the Panel's remit under the strategic framework that was current in Q1. It shows that:

- 8 of the 14 measures met or exceeded target,
- 3 measures fell just short of target, although still within the tolerance,
- 3 measures were out of tolerance and require improvement.

2.3 Detailed commentary on all the indicators is included in Appendix A.

3. KEY IMPLICATIONS

3.1 The key implications of this report are set out in table 2.

Table 2: Key Implications

Outcome	Unmet	Met	Exceeded	Significantly Exceeded	Date of delivery
The council is on target to deliver its strategic priorities	< 100% priorities on target	100% priorities on target			30 June 2020

4. FINANCIAL DETAILS / VALUE FOR MONEY

4.1 There are no direct financial implications arising from the recommendations.

5. LEGAL IMPLICATIONS

5.1 There are no legal implications arising from the recommendations.

6. RISK MANAGEMENT

6.1 The risks and their control are set out in table 3.

Table 3: Impact of risk and mitigation

Risks	Uncontrolled risk	Controls	Controlled risk
Poor performance management practices resulting in lack of progress towards the council's agreed strategic priorities and objectives.	HIGH	Robust performance management within services to embed a performance management culture and effective and timely reporting.	LOW

7. POTENTIAL IMPACTS

7.1 There are no Equality Impact Assessments or Data Protection Impact Assessments required for this report. There are no climate change or data protection impacts as a result of this report.

8. CONSULTATION

8.1 Ongoing performance of the measures within the Performance Management Framework, alongside other measures and business intelligence information, is regularly reported to the council's four Overview and Scrutiny Panels. Comments from the Adults, Children and Health Overview and Scrutiny Panel will be reported to Lead Members and Heads of Service as part of an ongoing performance dialogue.

9. TIMETABLE FOR IMPLEMENTATION

9.1 The full implementation stages are set out in table 4.

Table 4: Implementation timetable

Date	Details
Ongoing	Comments from the Panel will be reviewed by Lead Members and Heads of Service.

10. APPENDICES

10.1 This report is supported by one appendix:

- Appendix A: Adults, Children and Health Overview and Scrutiny Panel Q1 Performance Report.

11. BACKGROUND DOCUMENTS

11.1 This report is supported by two background documents:

- Council Plan 2017-21: https://www3.rbwm.gov.uk/downloads/file/3320/2017-2021_-_council_plan
- Interim Council Strategy 2020/21: https://rbwm.moderngov.co.uk/ieListDocuments.aspx?CId=132&MId=7763&Ver=4

12. CONSULTATION (MANDATORY)

Name of consultee	**Post held**	**Date sent**	**Date returned**
Hilary Hall	Director of Adults, Health and Commissioning	28.08.20	02.09.20
Kevin McDaniel	Director of Children's Services	28.08.20	

REPORT HISTORY

Decision type: Non-key decision	**Urgency item?** No	**To Follow item?** No
Report Author: Rachel Kinniburgh, Strategy and Performance Team Leader, 01628 796370		

Adults, Children and Health Overview and Scrutiny Panel

Q1 2020-21 Data and Performance Report

Date prepared: 1 July 2020

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1. Executive Summary

1.1 The Council Plan 2017-21 remained current up to the 30 July 2020 when Cabinet approved an Interim Council Strategy 2020/21 for immediate adoption, acknowledging that the Covid-19 pandemic has significantly altered the context in which the Council is currently operating and that resources are now focused in an entirely different way.

1.2 This report sets out Q1 performance for all measures relating to the Adults, Children and Health Overview and Scrutiny Panel's remit under the strategic framework that was current in Q1, and which had been suitably modified to reflect the changed climate during the Covid-19 pandemic.

1.3 As at 1 July 2020 performance of all measures related to the Panel's remit in Q1 can be broadly summarised as:

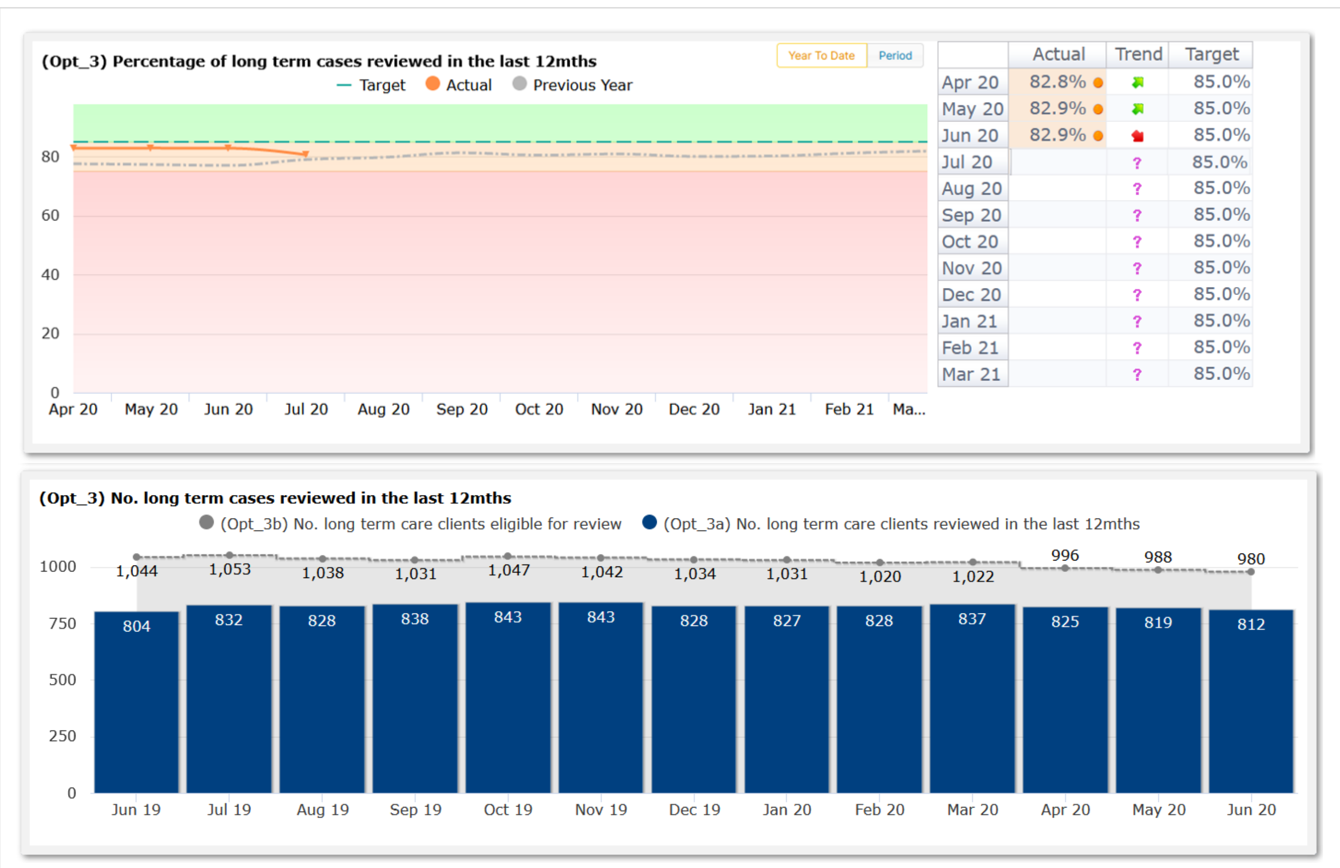
Q1 RAG Status	No.	Measures
Red (Needs improvement)	**3**	• Percentage of carers assessed or reviewed in the last 12mths • Percentage of children subject to a Child Protection Plan for 2+yrs on ceasing • Percentage of re-referrals to children's social care within 12mths
Amber (Near target)	**3**	• Percentage of long-term cases reviewed in the last 12mths • Percentage of rehabilitation clients still at home after 91 days • Percentage of care-leavers in education, training and employment (19-21yr olds)
Green (Succeeding or achieved)	**8**	• No. permanent admissions to care for those aged 65+yrs • Percentage safeguarding service user satisfaction • Percentage of borough schools rated by Ofsted as Good or Outstanding • Percentage of eligible children receiving a 6-8wk review within 8wks • Percentage of EHCP assessments completed within 20wks (including exceptions) • Percentage of successful treatment completions (alcohol) • Percentage of successful treatment completions (non-opiates) • Percentage of successful treatment completions (opiates)
Total	**14**	

2. Key activities and milestones achieved

Strategic Priority	Item	Q1 Achievements and key milestones
Covid-19 response	**Covid-19 community response**	The Covid-19 Community Response was established to support residents across the borough during the Covid-19 pandemic. A coordinated team of staff drawn from all services in the council maintained regular contact with residents who were shielding and took any action that may be appropriate to ensure that these individuals' needs were met. This role has now been taken on by the Library and Residents service who continue to make contact with residents and to be a helpline to any vulnerable service users in the borough. Using community groups, either already established or newly formed, in response to the pandemic has helped to identify where we can help the vulnerable. A database of all contacts was quickly compiled to support a public-facing online directory of Covid-19 Support Groups to which residents may turn to for particular needs.
	Outbreak Control Plan Summary	The Outbreak Control Plan Summary was published to the RBWM website on 30 June 2020 in line with national instruction from the Department of Health and Social Care. The plan exists to guide our response to the ongoing Covid-19 pandemic, to put in place measures to identify and contain outbreaks and protect the public's health.
Healthy, skilled and independent residents	**Ofsted inspection of Children's Services**	During January and February 2020 the local authority services were inspected by Ofsted for the first time since 2015. The service overall was graded Good, a significant improvement from the previous Requires Improvement. It was acknowledged at the time that there is still work to do to further improve services for care leavers and children in our care, and a targeted action plan was provided to Ofsted in Q1.
Safe and vibrant communities	**New safeguarding arrangements**	Following implementation of the new safeguarding arrangements in September 2019, priorities for the partnership have been developed and actions are in place to take them forward.
	Children's Centres Consultation – Family Hubs	In June Cabinet agreed in principle to the early help model of Integrated Family Hubs, which would prioritise services for children, young people and families most in need. A second stage of public consultation was agreed to seek views on the proposed implementation of the Family Hub model at a local level. Based on this consultation the final model will be developed and brought back to Cabinet in October for the final decision.

3. Healthy, skilled and independent residents: Detailed Trends and Commentary

3.1 Care package reviews



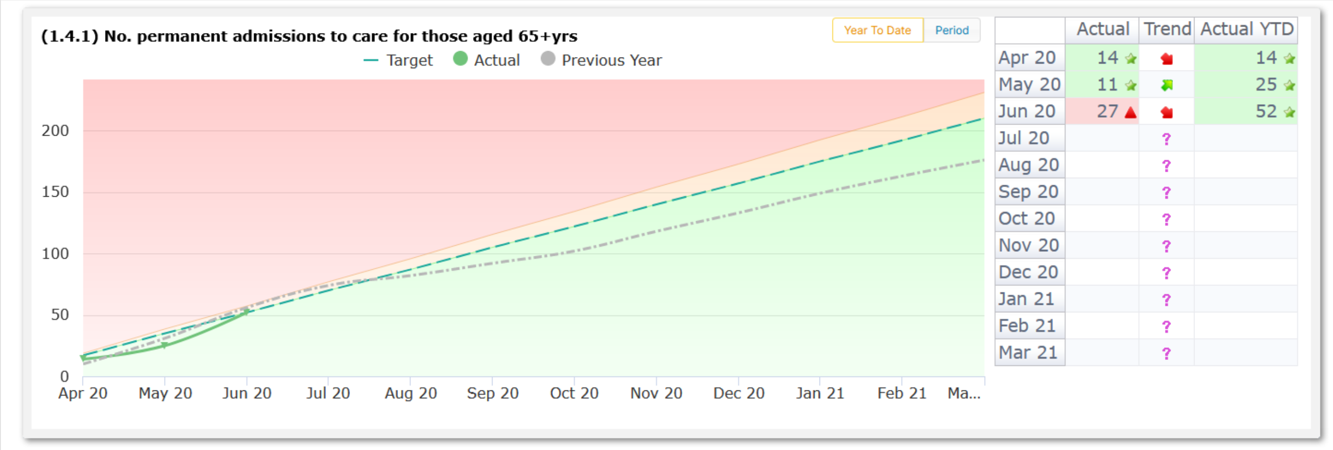
	Actual	Trend	Target
Apr 20	82.8%		85.0%
May 20	82.9%		85.0%
Jun 20	82.9%		85.0%
Jul 20		?	85.0%
Aug 20		?	85.0%
Sep 20		?	85.0%
Oct 20		?	85.0%
Nov 20		?	85.0%
Dec 20		?	85.0%
Jan 21		?	85.0%
Feb 21		?	85.0%
Mar 21		?	85.0%

Q1 Commentary

The target and tolerance thresholds are unchanged from 2019/20.

Performance in this area remains below the target of 85% though within tolerance for the measure at 82.9% (819 / 988). Reviews are a key mechanism for ensuring that the care package in place for each resident is fit for purpose and meeting their needs. The volume of long-term care clients reviewed was at its lowest (980) in June 2020 due to resources being diverted to Covid response. Overall, however, there has been a consistent upward trend in performance since December 2019 (80.1%), reflective of focused resource and successful implementation of the strengths-based approach to ensure that reviews are triggered where they are required and not for isolated issues (e.g. one-off equipment).

3.2 Permanent admissions to care



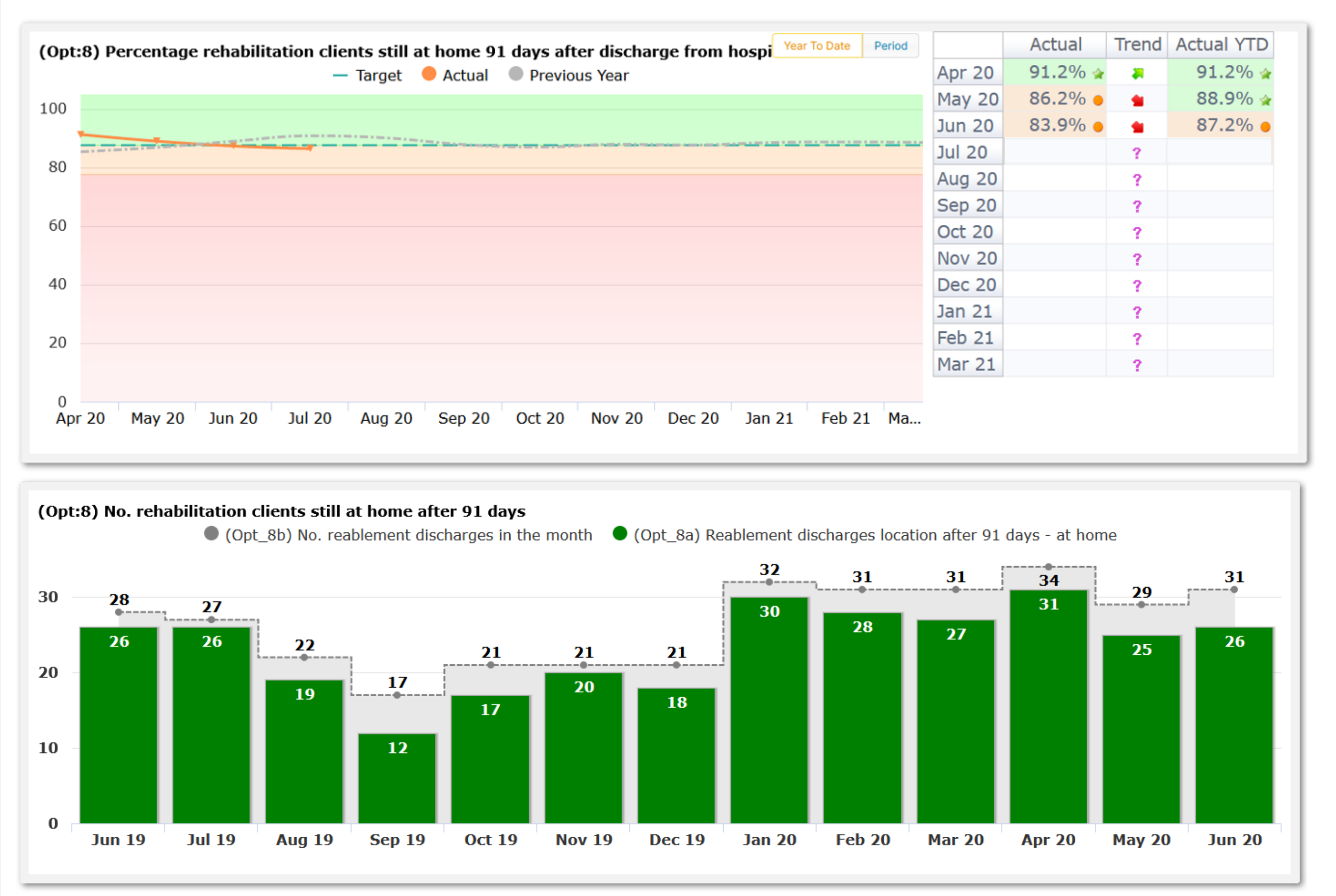
	Actual	Trend	Actual YTD
Apr 20	14		14
May 20	11		25
Jun 20	27		52
Jul 20		?	
Aug 20		?	
Sep 20		?	
Oct 20		?	
Nov 20		?	
Dec 20		?	
Jan 21		?	
Feb 21		?	
Mar 21		?	

Q1 Commentary

The target and tolerance thresholds are unchanged from 2019/20.

The total volume of permanent admissions to care in Q1 is 52, fractionally lower than Q1 2019/20 (56). The highest volume of permanent admissions occurred in June (27). Overall, the focus on prevention and keeping people living in their own homes is having a positive impact on admissions to care, although when they are subsequently assessed as needing care their needs are higher and more complex.

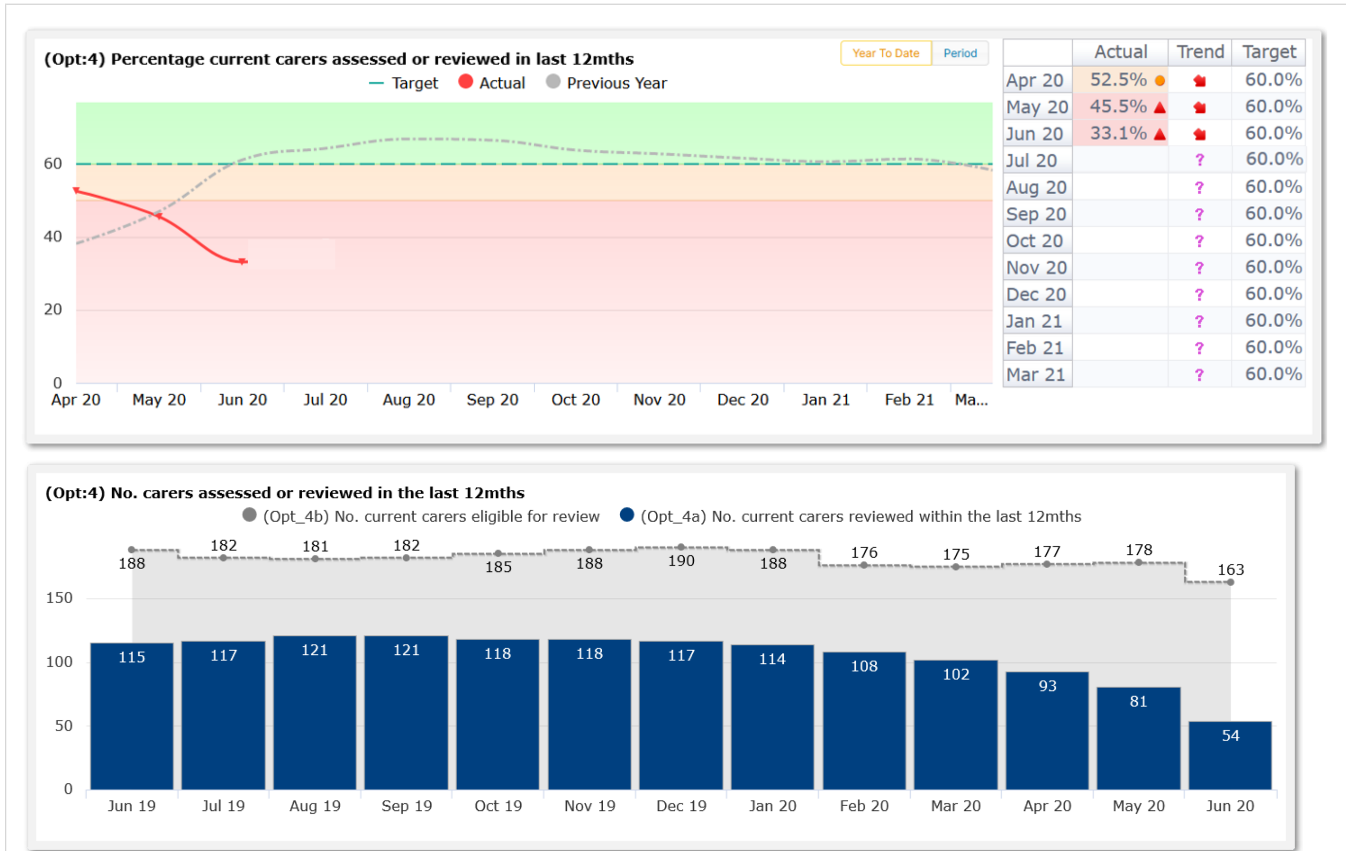
3.3 Reablement



Q1 Commentary

The target and tolerance thresholds are unchanged from 2019/20.
As at the close of Q1, YTD performance stands at 87.2% (82 / 94), short of target (87.5%) but within tolerance for this measure. Generally the cohort of individuals have particularly complex needs and frailties, and outcomes are heavily influenced by this. It is therefore encouraging that year-to-date performance across the year has consistently remained on target.

3.4 Carers' assessments



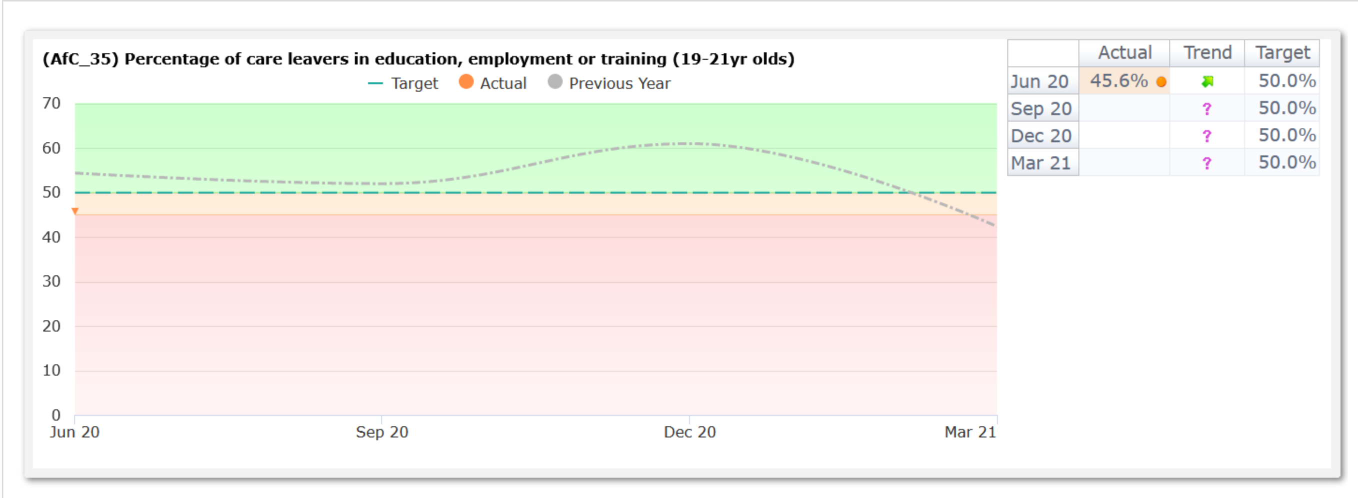
	Actual	Trend	Target
Apr 20	52.5%		60.0%
May 20	45.5%		60.0%
Jun 20	33.1%		60.0%
Jul 20		?	60.0%
Aug 20		?	60.0%
Sep 20		?	60.0%
Oct 20		?	60.0%
Nov 20		?	60.0%
Dec 20		?	60.0%
Jan 21		?	60.0%
Feb 21		?	60.0%
Mar 21		?	60.0%

Q1 Commentary

The target and tolerance thresholds are unchanged from 2019/20.

As at the close of Q1 performance stands at 33.1% (54 / 163), off target (60%) by 26.9. Performance against this measure was significantly below target in Q1 with an actual year-to-date of 33.1%, below target (60%) by 26.9. This was due to formal carers reviews not taking place during the Covid-19 initial response period. It was recognised that carers in particular were under even more pressure in their role and therefore the service prioritised being in contact with all carers offering support, information and guidance on a more informal and frequent basis.

3.5 Care leavers



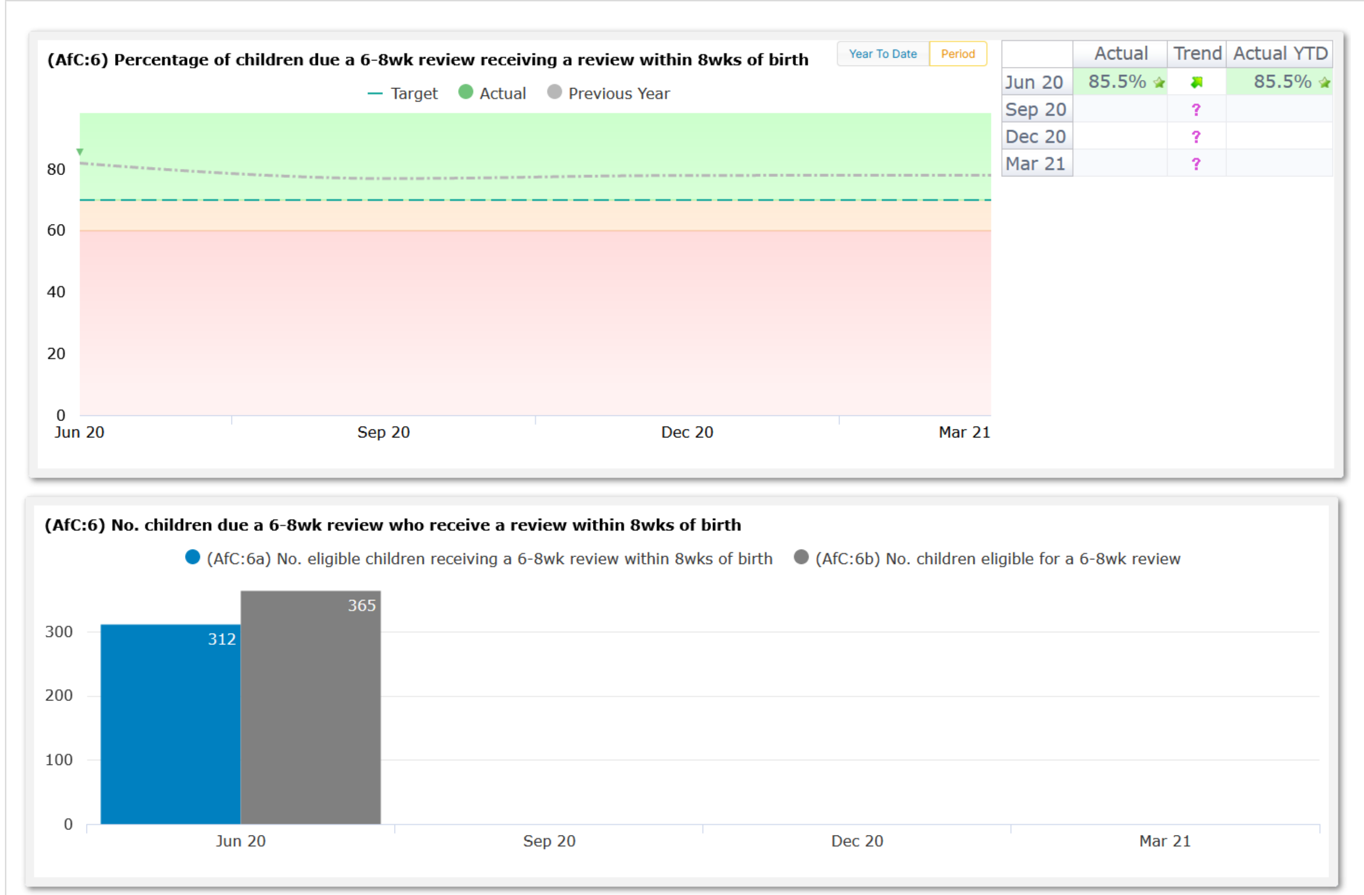
	Actual	Trend	Target
Jun 20	45.6%		50.0%
Sep 20		?	50.0%
Dec 20		?	50.0%
Mar 21		?	50.0%

Q1 Commentary

The target and tolerance thresholds are unchanged from 2019/20.

As at the close of Q1 performance stands at 45.6% (26 / 57), off target (50%) but within the tolerance for the measure. A number of young people lost employment in the low pay sector as the Covid-19 pandemic began to impact the economy. A number of young people were also enrolled in training to start after Easter which was cancelled. The care leavers service continues to focus on ensuring these young people are able to access accommodation and food during the pandemic; however, this number is not expected to bounce back until education and employment opportunities re-open in sufficient volume in late 2020 or early 2021.

3.6 Health visiting

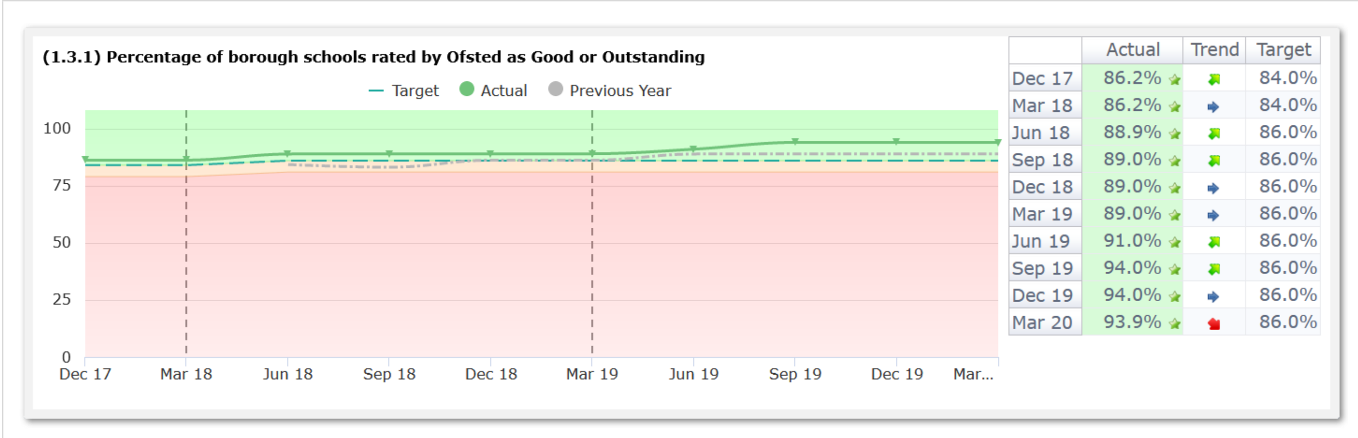


Q1 Commentary

The target and tolerance thresholds are unchanged from 2019/20.

It was anticipated that performance of this measure would fall in Q1 due to reduced service-availability as a result of Covid-19 restrictions. This has not proved to be the case and Q1 performance stands at 85.5% (312 / 365) against the target of 70%.

3.7 School Ofsted ratings

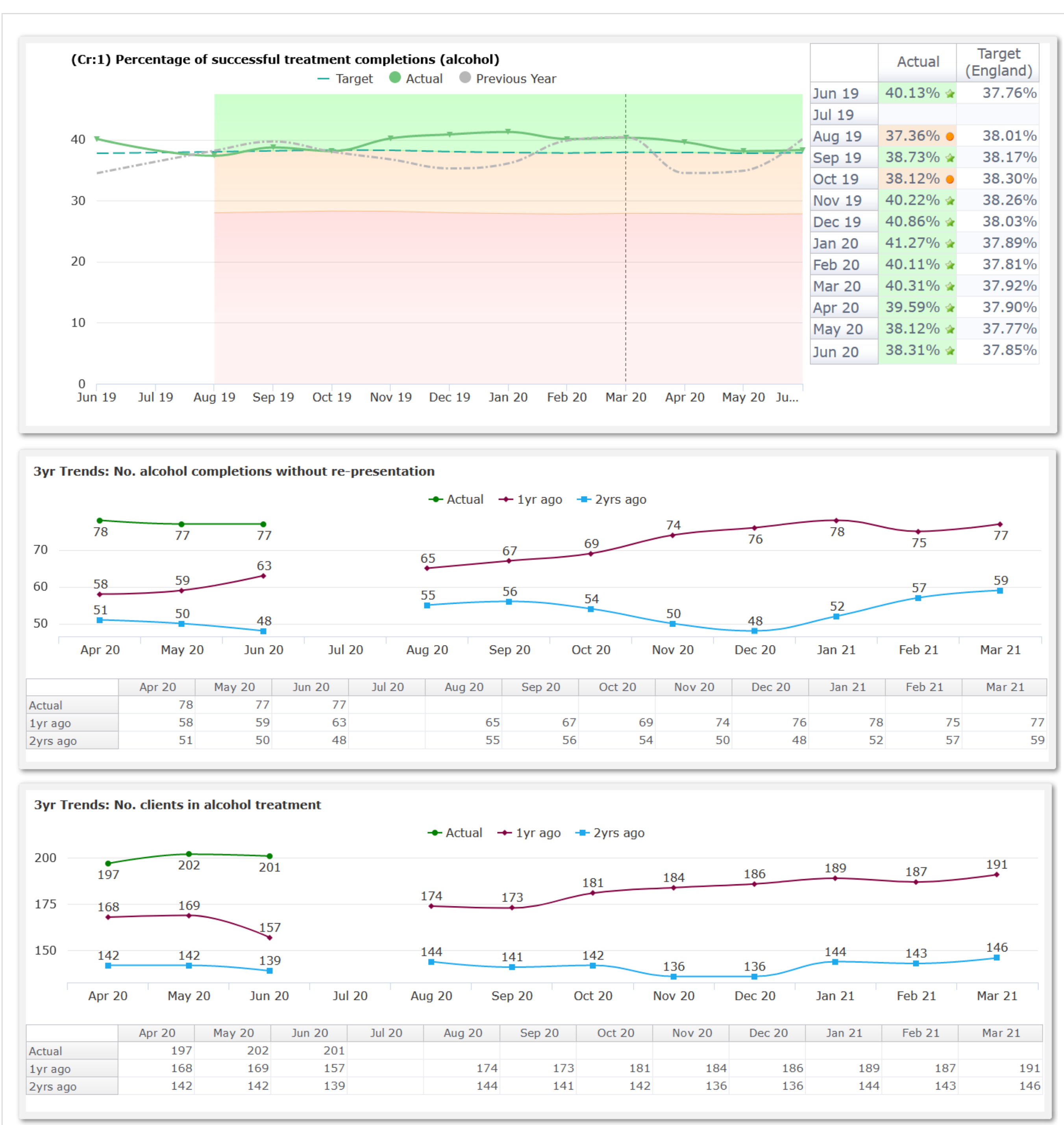


	Actual	Trend	Target
Dec 17	86.2%		84.0%
Mar 18	86.2%		84.0%
Jun 18	88.9%		86.0%
Sep 18	89.0%		86.0%
Dec 18	89.0%		86.0%
Mar 19	89.0%		86.0%
Jun 19	91.0%		86.0%
Sep 19	94.0%		86.0%
Dec 19	94.0%		86.0%
Mar 20	93.9%		86.0%

Q1 Commentary

Inspections in Q4 were positive and no schools were considered inadequate. There will be no inspections until the autumn so this indicator will not change until Q3 of 2020/21 at the earliest. Based on recent performance the target has been increased to 90% for 2020/21 from 86% in 2019/20 and the tolerance thresholds narrowed to a permissible variance of 5 from the target (previously a permissible variance of 10 from target).

3.8 Substance misuse: Alcohol



	Actual	Target (England)
Jun 19	40.13%	37.76%
Jul 19		
Aug 19	37.36%	38.01%
Sep 19	38.73%	38.17%
Oct 19	38.12%	38.30%
Nov 19	40.22%	38.26%
Dec 19	40.86%	38.03%
Jan 20	41.27%	37.89%
Feb 20	40.11%	37.81%
Mar 20	40.31%	37.92%
Apr 20	39.59%	37.90%
May 20	38.12%	37.77%
Jun 20	38.31%	37.85%

3yr Trends: No. alcohol completions without re-presentation

	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Actual	78	77	77									
1yr ago	58	59	63		65	67	69	74	76	78	75	77
2yrs ago	51	50	48		55	56	54	50	48	52	57	59

3yr Trends: No. clients in alcohol treatment

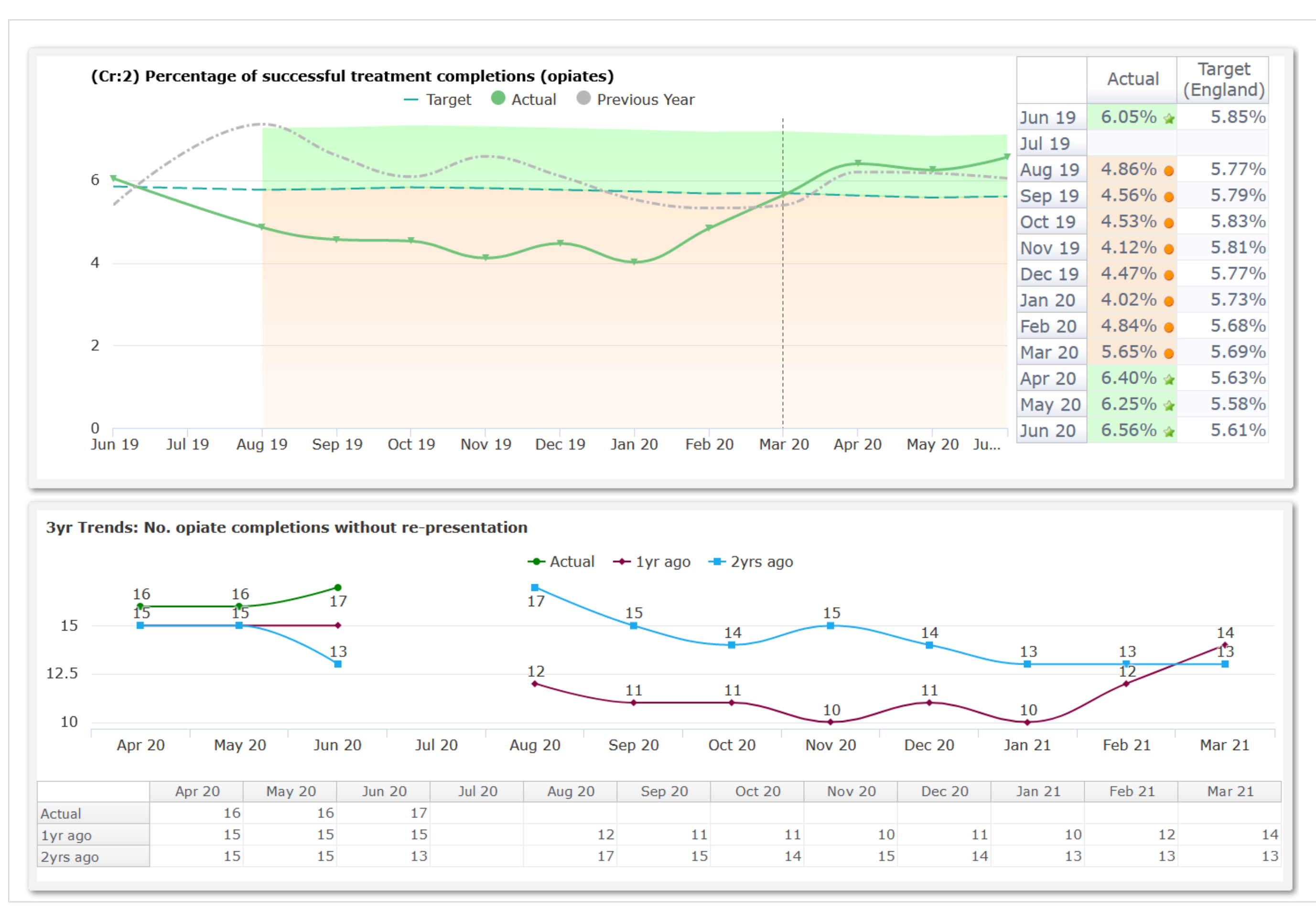
	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Actual	197	202	201									
1yr ago	168	169	157		174	173	181	184	186	189	187	191
2yrs ago	142	142	139		144	141	142	136	136	144	143	146

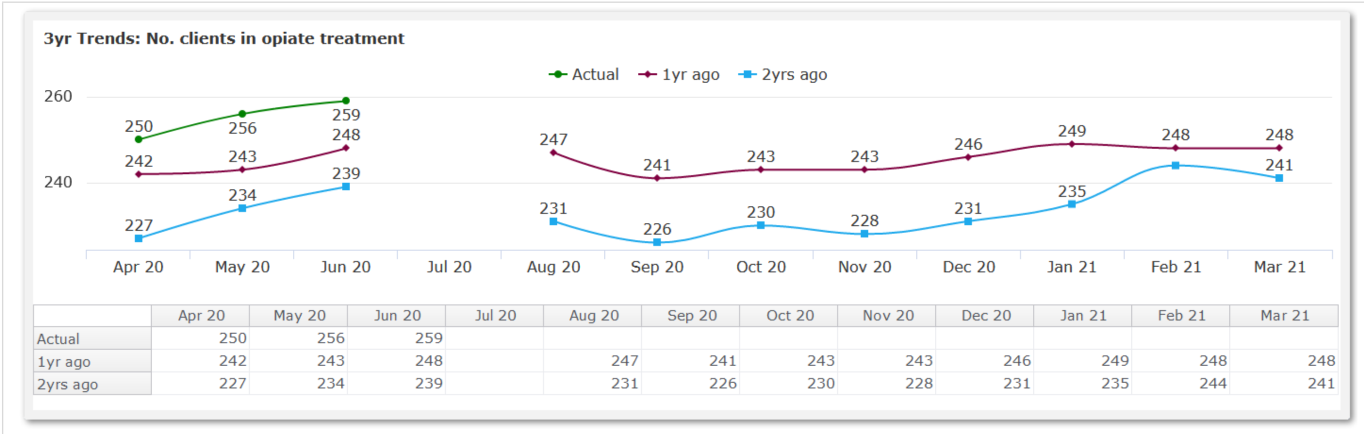
Q1 Commentary

The definition of this measure is the number of alcohol users that left structured treatment successfully (free of alcohol dependence) who do not then re-present to treatment within six months expressed as a percentage of the total number of alcohol users in structured treatment. Local performance is tracked against the reported figure for England. The National Drug Treatment Monitoring Service (NDTMS) is closed during July, meaning that no data is reported for this month. The Resilience service is available to anyone over the age of 18 living in the borough who is experiencing problems with alcohol and/or drugs. The service can be accessed via self-referral or a referral from GPs or other professionals.

At the end of Q1 local performance has remained above the England target (37.85%) at 38.31%. This relates to 77 completions without re-presentation out of 201 clients in treatment. Generally, it tends to be lifestyle drugs like alcohol that people find easier to abstain from, and the growing market for non-alcoholic drinks may also be a contributing factor to successful treatment completions.
It was acknowledged in the Q4 performance report that lockdown restrictions as a result of the Covid19 pandemic may impact trends going forwards as individuals use lockdown as an opportunity to abstain from alcohol or, conversely, make recourse to home-drinking as a coping mechanism. Whilst the number of clients in alcohol treatment has increased in Q1 compared to previous years, it is considered too early to draw firm conclusions at this point and trends will continue to be monitored for an emerging evidence-base.

3.9 Substance misuse: Opiates





	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Actual	250	256	259									
1yr ago	242	243	248		247	241	243	243	246	249	248	248
2yrs ago	227	234	239		231	226	230	228	231	235	244	241

Q1 Commentary

The definition of this measure is the number of users of opiates that left drug treatment successfully (free of drug(s) dependence) who do not then re-present to treatment again within six months as a percentage of the total number of opiate users in treatment. Local performance is tracked against the reported figure for England.
At the close of Q1, local performance stands at 6.56%, which relates to 17 completions without re-presentation out of 259 clients in treatment. June performance is the highest point reached for this measure. This is possibly due to the changes in service-provision implemented as a consequence of Covid-19 and associated lockdown restrictions. Psychosocial interventions have been moved to online platforms and attendance and commitment has improved. It is considered too early to draw firm conclusions at this point as to whether this trend will continue, and data will continue to be monitored.

3.10 Substance misuse: Non-opiates

	Actual	Target (England)
Jun 19	38.14%	34.78%
Jul 19		
Aug 19	39.00%	34.52%
Sep 19	42.27%	34.45%
Oct 19	47.42%	34.26%
Nov 19	50.00%	34.22%
Dec 19	49.44%	34.17%
Jan 20	46.07%	33.99%
Feb 20	44.68%	34.08%
Mar 20	47.37%	34.24%
Apr 20	48.35%	34.40%
May 20	47.78%	34.32%
Jun 20	47.19%	34.25%

	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Actual	44	43	42									
1yr ago	34	37	37		39	41	46	44	44	41	42	45
2yrs ago	28	25	23		30	32	28	30	31	35	32	31

	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Actual	91	90	89									
1yr ago	94	103	97		100	97	97	88	89	89	94	95
2yrs ago	89	92	92		98	94	93	93	93	96	91	94

Q1 Commentary

The definition of this measure is the number of users of non-opiates that left drug treatment successfully (free of drug(s) dependence) who do not then re-present to treatment again within six months as a percentage of the total number of non-opiate users in treatment. Local performance is tracked against the reported figure for England.

Performance for this indicator has remained consistently high, at the close of Q1 47.19% of treatment completions were successful for non-opiates, against the England target of 34.25%. This related to 42 completions without re-presentation out of 89 clients in treatment. Generally, it tends to be lifestyle drugs that people find easier to abstain from and change behaviour and both alcohol and non-opiates are therefore less problematic than opiates. There is also an increasing prevalence of online support networks and programmes that complement established national programmes as an additional support between formal key work sessions

and which therefore aid recovery. As a result of Covid-19 and associated lockdown restrictions, clients have been directed to more online self-support services, and this may account for the decrease in the volume of clients in treatment. It is acknowledged however that, for some, the lockdown restrictions may have afforded opportunity to embrace positive abstinent behaviour. It is considered too early to draw firm conclusions at this point as to whether current performance trends will continue, and data will continue to be monitored.

4. Safe and vibrant communities: Detailed Trends and Commentary

4.1 Adult safeguarding

	Actual	Trend	Actual YTD
Apr 20	92.0%		92.0%
May 20	90.0%		91.5%
Jun 20	100.0%		92.1%
Jul 20		?	
Aug 20		?	
Sep 20		?	
Oct 20		?	
Nov 20		?	
Dec 20		?	
Jan 21		?	
Feb 21		?	
Mar 21		?	

	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Actual	92	27	10									
1yr ago	107	108	138	164	224	48	135	39	119	90	95	40
2yrs ago	90	82	97	53	151	161	91	34	55	72	60	135

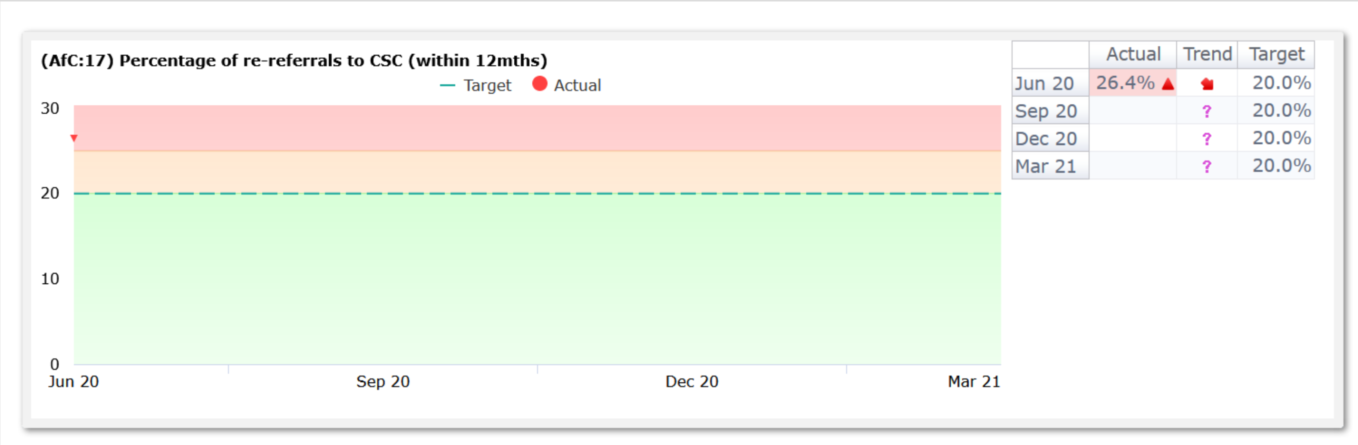
	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Actual	100	30	10									
1yr ago	130	130	160	180	230	50	140	40	120	90	100	40
2yrs ago	100	100	110	60	180	170	110	40	70	80	90	150

Q1 Commentary

The target has been increased to 85% in 2020/21 from 80%.

This measures the satisfaction of residents at the end of a safeguarding investigation and process. In Q1 the YTD performance stands at 92.1% (129 / 140), an increase of 8.1 when compared with Q1 2019/20 (84%, 353 / 420). The consistently high performance of this measure against the 2019/20 target of 80% has led to the target being raised in 2020/21 to 85%. High performance is an encouraging indication that existing processes are sound.

4.2 Children's social care

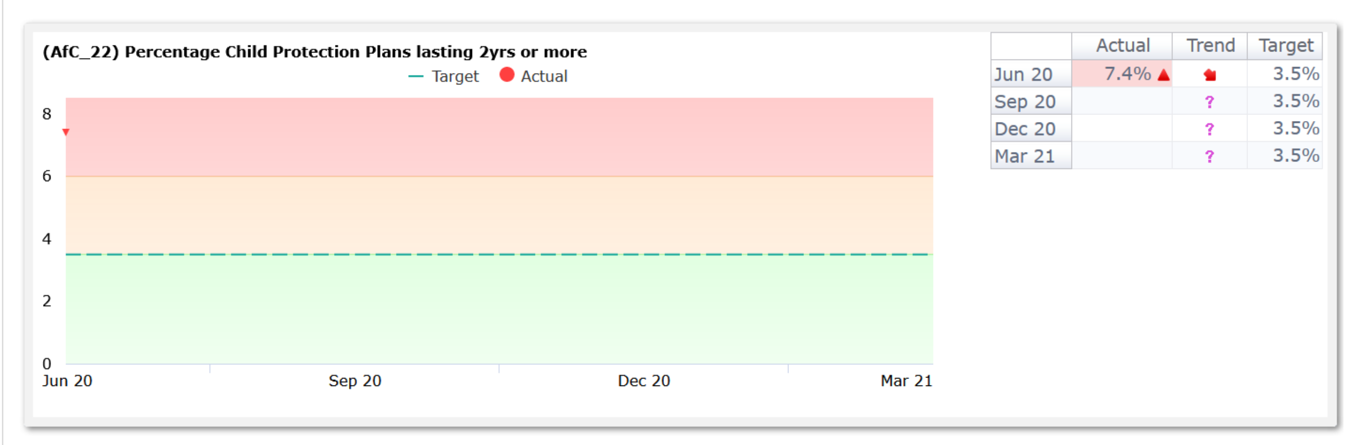


	Actual	Trend	Target
Jun 20	26.4% ▲		20.0%
Sep 20		?	20.0%
Dec 20		?	20.0%
Mar 21		?	20.0%

Q1 Commentary

The target and tolerance thresholds are unchanged from 2019/20.

The percentage of re-referrals to Children's Social Care (CSC) is a consistently changing indicator in which peaks and troughs are seen on a monthly basis. Historically there has been an increase often towards the end of academic terms. At the end of Q1 this measure was at 26.4% (38/144), off target (20%) by 6.4. There is a likely link to the Covid-19 pandemic and associated partner anxiety due to schools shutting down and the reduction in face-to-face services for non-statutory services. Service Managers scrutinise all cases of children who are re-referred at monthly performance boards. This provides reassurance that we are confident about thresholds and enables learning on an individual case basis to be shared.



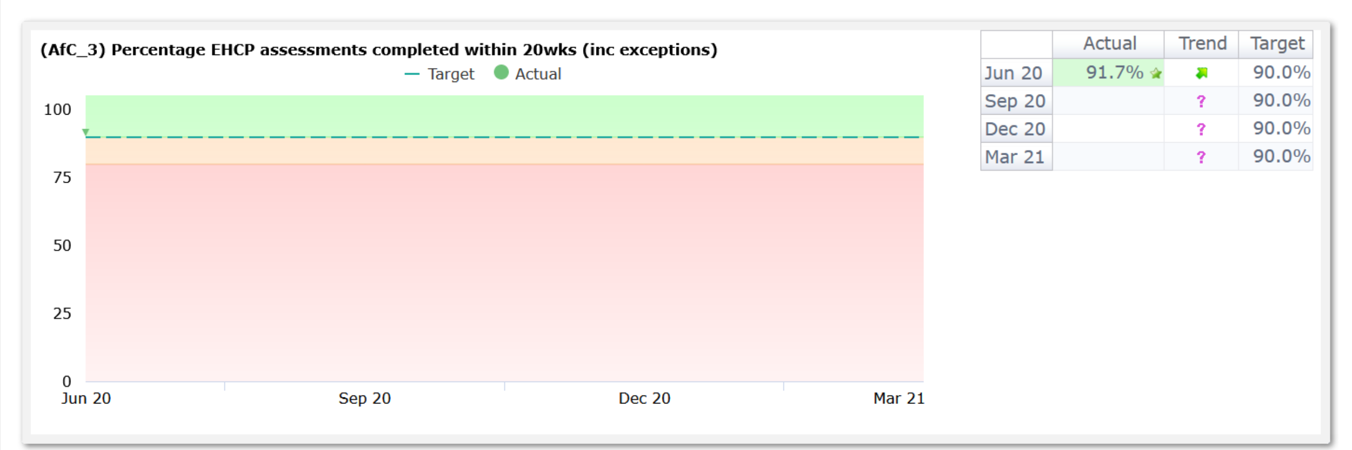
	Actual	Trend	Target
Jun 20	7.4% ▲		3.5%
Sep 20		?	3.5%
Dec 20		?	3.5%
Mar 21		?	3.5%

Q1 Commentary

The target and tolerance thresholds are unchanged from 2019/20.

As at the close of Q1 performance stands at 7.4% (2 / 27), off target (3.5%) by 3.9. The service has reviewed and relaunched the approved escalation process. Children subject to a Child Protection Plan for 18+ months are regularly scrutinized by senior managers via the Windows into practice Panel. Working in partnership with social care teams to identify viable contingency plans. Family network meetings to be put in place to prevent plans drifting going forward.

4.3 Special Educational Needs and Disability



	Actual	Trend	Target
Jun 20	91.7%		90.0%
Sep 20		?	90.0%
Dec 20		?	90.0%
Mar 21		?	90.0%

Q1 Commentary

As acknowledged in the Q4 performance report, the service was re-staffed from September following the resignation of all case coordinators. The revisit of the Area SEND services in October 2019 indicated sufficient progress was being made to improve the quality of services. The 2019/20 target of 100% was considered unrealistic with the revised expectations of co-production with families and young people and the 2020/21 target has therefore been updated to 90% to allow for exceptions. Whilst it was anticipated that performance would fall in Q1 as a result of service pressures impacted by the Covid-19 pandemic, performance for Q1 stands at 91.7% (33/36), above target (90%) by 1.7.

Subject:	Response to the Ombudsman Public Interest Report
Reason for briefing note:	To provide an update to the Adults, Children and Health Overview and Scrutiny Panel on the actions the Royal Borough and Optalis has taken following the Ombudsman's recommendations, and progress against them.
Responsible officer(s):	Michael Murphy, Director of Statutory Services Optalis and Deputy DASS
Senior leader sponsor:	Hilary Hall, Director of Adults, Health and Commissioning
Date:	30 September 2020

SUMMARY

This report provides information on the public interest report issued by the Local Government and Social Care Ombudsman on 3 September 2020 and details the response of the Royal Borough and Optalis to the recommendations and the actions taken to date. The Royal Borough and Optalis accept in full the recommendations of the Ombudsman and is committed to learning from what has happened and ensuring sustainable improvements to its processes.

1 BACKGROUND

1.1 The actions of the Royal Borough and Optalis were the subject of a public interest report by the Local Government and Social Care Ombudsman (Ombudsman) on 3 September 2020, see appendix 1. The report is summarised by the Ombudsman as follows. '*Mr X complains on behalf of his late parents. He says the council did not properly consider the risks of separating them after 59 years of marriage or of Mr Y (his father) living on his own. He complains about the quality of care the council provided to them both and says it did not deal adequately with his concerns and complaints. He also complained that the safeguarding process was flawed, and the Council would not give him a copy of Mr Y's assessment*.'

1.2 The outcome was that the Ombudsman found fault causing injustice and recommendations were made. The Ombudsman stated that he had completed his investigation and upheld Mr X's complaints that the council:

- *did not properly consider the risks in supporting Mr Y to remain at home on his own;*
- *did not properly consider the impact of separation after 59 years on Mr Y and his wife, Mrs Y;*
- *did not provide Mr X with a copy of Mr Y's assessment;*
- *did not provide an adequate quality of care to Mr Y;*
- *did not deal adequately with Mr X's concerns and complaints.*

1.3 The Ombudsman did not uphold Mr X's complaint that the Council carried out a flawed safeguarding process.

1.4 One of the requirements placed upon the Royal Borough was that the report be considered in a public council meeting. The Overview and Scrutiny Panel is, therefore, asked to consider the report and the council's response and to make any recommendations to Cabinet.

2 KEY IMPLICATIONS

2.1 The report was published on 3 September 2020, and the Ombudsman identified the following recommendations to remedy the injustice identified:

- *apologise to Mr X and Ms Z (his sister) setting out the faults identified in this report and the actions the council will take or is taken to put this right*
- *pay Mr X and Ms Z £750 each in recognition of the distress caused in failing to properly consider the risks of separating Mr and Mrs Y.*
- *pay Mr a further £500 for the time and trouble and distress he was caused in bringing his complaint*
- *review any cases where couples are separated by their care needs to ensure the risks and human rights will fully considered for both parties also, that adequate contact is included in care and support plans.*
- *review assessment practice across the council to ensure it is consistent and Care Act compliant. It should do this using the quality measures and reporting processes it has implemented since these events*
- *ensure that it has an effective mechanism for following up where complaints about poor practice have been received and to check improvements are made and sustained*
- *put in measures to ensure complaints about several agencies receive a coordinated response and review its commissioning practice when services are rated 'requires improvement' to ensure it considers any increased risk to people.*

2.2 In addition to public scrutiny of the report, the Ombudsman also requires the Royal Borough to report to him within three months on the measures taken to address the recommendations in the report.

3 DETAILS

3.1 The Royal Borough and Optalis accept in full the recommendations of the Ombudsman and is committed to learning from what has happened to ensure sustainable improvements to its processes. Actions taken in response to the issues identified in the Ombudsman report are as follows:

1. We have written letters of apology to Mr X and Ms Z providing an update on actions taken so far and including the relevant offer of financial recompense.

2. We have reviewed our assessment and care management processes to ensure that all practitioners are absolutely clear on what they are required to do and to ensure that any issues are identified at the earliest opportunity. This review was undertaken in late 2018 and the various stages of the process refined so that they reflected the Care Act nomenclature as well as the Each Step Together process that was adopted within the Royal Borough in 2016 in response to the implementation of the Care Act 2014. The initial presentation to Overview and Scrutiny in 2016 on Each Step Together is attached as appendix 2.

3. As part of the routine management of the contract with Optalis by the Royal Borough, the number of assessments that are completed within six weeks is reported each month. This indicator measures that assessments are being completed within reasonable timescale and identifies any outliers for specific attention. Current performance in this area indicates that 68% of all assessments were completed within

timescale in August 2020. This is outside the target of 80% but performance has been impacted by Covid and people taking annual leave in August. Performance is anticipated to be back on track by October.

The performance monitoring process indicated a lack of clarity around monitoring requirements and expectations. Guidance has been issued, see appendix 3, which requires managers and senior practitioners to have full oversight of performance. The operation of this guidance is monitored via supervision.

4. The clear need to improve practice has been taken forward through a quality circle approach which involved two meetings on 21 November 2019 and 14 July 2020, see appendix 4 for a note of the meetings. As a result, we amended our Quality Assurance Panel process to ensure that staff identify and record where couples are likely to be affected and the actions that we are taking to safeguard relationships. The Quality Assurance Panel forms require the worker and their manager to answer the following questions
   - *Is there a significant person that lives with the service user? (examples- Husband, Wife, Partner, Sister, Brother, Friend).*
   - *Has the impact of the panel application been considered for the significant person and how the potential impact can be minimised? Provide details.*

   The Quality Assurance Panel is chaired by the Director of Statutory Services or the Head of Older Persons Services and approves packages of care or directs mitigating actions for representation. Following a review of the Panel's operation, further mandatory practice guidance was issued in September 2020 which required senior social workers to ensure that key standards were met where couples were at risk, see appendix 5.

5. In addition, we are in the process of identifying all people whose care needs, and arrangements, are related and for whom there is a risk of separation and loss of contact. We have identified 27 cases so far where this is the case and have thoroughly reviewed 22, with the remainder to be completed by the end of September 2020. These reviews will ensure that people's needs, and wishes are followed in respect of loss of contact, in accordance with the Human Rights Act. The Director of Statutory Services has reviewed the current case file recording in these cases and has identified that in most cases the appropriate steps were being taken and that there were several examples of good practice in these cases. This exercise will be routinely undertaken as part of the ongoing quality assurance and audit work across the service.

6. As part of the wider adult social care transformation programme, we identified that our public information needs to be significantly updated to ensure that residents and their families are fully aware of the processes that we use to ensure that people's needs are met in the most appropriate manner. This work is now underway and we will be inviting residents and their families to review the information and the way it is presented.

7. We have implemented an action log process for ensuring that any quality improvement actions arising from complaints are embedded in routine procedures. Progressing these actions is seen as a critical component of quality assurance within Optalis and is reported to the Optalis Board on a regular basis.

8. We have reviewed our complaints process to ensure that a co-ordinated response is provided in cases where complaints are made against several agencies. All complaints are notified to the relevant senior manager who oversees the process to ensure a co-ordinated response and each response is quality assured by the Director of Statutory Services before it is issued.

9. Both the Royal Borough and Optalis work with providers of care to improve quality. The council has employed a dedicated commissioning officer to monitor domiciliary care providers and to work with the care quality team in Optalis to ensure improvements. Within Optalis, the care quality assurance team operates a robust care governance process which regularly monitors the quality of domiciliary care and care homes within a well-established multiagency framework. The monitoring framework is attached as appendix 6.

10. Four out of five of the council's domiciliary care providers are rated good with the Care Quality Commission with one remaining as "requires improvement", the brokerage team within Optalis prioritises the providers that are rated good. The Royal Borough is committed to working only with providers that are rated good or outstanding and on that basis is seeking to terminate contracts with other providers as early as possible.

11. Whilst the Ombudsman did not uphold the complaint that the safeguarding process was flawed, we are, however, midway through a fundamental review of our safeguarding processes. This will include the issue of effective communication with families and other parties.

4 NEXT STEPS

4.1 The view of the Adults, Children and Health Overview and Scrutiny Panel on the actions taken by the Royal Borough and Optalis in response to the Ombudsman's report are invited, including any further recommendations to Cabinet.

4.2 The outcome of the scrutiny and a further report will be sent to the Ombudsman in three months' time updating on progress.

4.3 Quarterly updates on progress against the actions will be presented to the Adults, Children and Health Overview and Scrutiny Panel.

Report by the Local Government and Social Care Ombudsman

Investigation into a complaint against Royal Borough of Windsor and Maidenhead Council (reference number: 18 015 872)

25 August 2020

The Ombudsman's role

For more than 40 years the Ombudsman has independently and impartially investigated complaints. We effectively resolve disputes about councils and other bodies in our jurisdiction by recommending redress which is proportionate, appropriate and reasonable based on all the facts of the complaint. Our service is free of charge.

Each case which comes to the Ombudsman is different and we take the individual needs and circumstances of the person complaining to us into account when we make recommendations to remedy injustice caused by fault.

We have no legal power to force councils to follow our recommendations, but they almost always do. Some of the things we might ask a council to do are:

- apologise
- pay a financial remedy
- improve its procedures so similar problems don't happen again.

Section 30 of the 1974 Local Government Act says that a report should not normally name or identify any person. The people involved in this complaint are referred to by a letter or job role.

Key to names used

Mr X	The complainant
Mr Y	His father
Mrs Y	His mother
Ms Z	His sister
Optalis	agency which provides the Council's adult social care
Bespoke	care provider
Carewatch	care provider

Report summary

Adult social care – home care

Mr X complains on behalf of his late parents. He says the Council did not properly consider the risks of separating them after 59 years of marriage or of Mr Y living on his own. He complains about the quality of care it provided to them both and says it did not deal adequately with his concerns and complaints. He also complained that the safeguarding process was flawed, and the Council would not give him a copy of Mr Y's assessment.

Finding

Fault found causing injustice and recommendations made.

Recommendations

To remedy the injustice caused, we recommend the Council:

- apologise to Mr X and Ms Z setting out the faults identified in this report and the action the Council will take, or has taken, to put this right;
- pay Mr X and Ms Z £750 each to recognise the distress it caused in failing to properly consider the risks of separating Mr and Mrs Y;
- pay Mr X a further £500 for the time and trouble and distress he was caused in bringing his complaint;
- review any cases where couples are separated by their care needs, to ensure the risks and human rights were fully considered for both parties. Also, that adequate contact is included on the care and support plans;
- review assessment practice across the Council to ensure it is consistent and Care Act compliant. It should do this using the quality measures and reporting processes it has implemented since these events;
- ensure it has an effective mechanism for following up where complaints about poor practice have been received and to check that improvements are made and sustained;
- put in measures to ensure complaints about several agencies receive a coordinated response; and
- review its commissioning practice when services are rated "Requires improvement" to ensure it considers any increased risk to people.

The complaint

1. The complainant, whom we shall refer to as Mr X, complains that the Council:
   - did not properly consider the risks in supporting Mr Y to remain at home on his own;
   - did not properly consider the impact of separation after 59 years on Mr Y and his wife, Mrs Y;
   - did not provide Mr X with a copy of Mr Y's assessment;
   - did not provide an adequate quality of care to Mr Y;
   - carried out a flawed safeguarding process; and
   - did not deal adequately with Mr X's concerns and complaints.
2. Mr X says the whole process has been distressing for him and his family. Mr Y was devastated at being separated from Mrs Y; he experienced poor care as well as being on his own, and this badly affected his quality of life. Although Mrs Y was less aware, she was more disrupted than she needed to be because Mr Y was not there with her. Mr X spent a lot of time and trouble dealing with the various issues and ultimately, with his complaints. Mr and Mrs Y have since died.

Legal and administrative background

3. We investigate complaints about 'maladministration' and 'service failure'. In this report, we have used the word 'fault' to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. We refer to this as 'injustice'. If there has been fault which has caused an injustice, we may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1), as amended)***
4. We may investigate a complaint on behalf of someone who has died or who cannot authorise someone to act for them. The complaint may be made by:
   - their personal representative (if they have one), or
   - someone we consider to be suitable.

   (Local Government Act 1974, section 26A(2), as amended)

   In this case, Mr X was attorney for Mr Y and we consider him a suitable person to complain on his behalf.
5. This case involves three commissioned agencies, Optalis, which provides the Council's adult social care, and Bespoke and Carewatch who are care providers. When a council commissions another organisation to provide services on its behalf it remains responsible for those services and for the actions of the organisation providing them. So, although we found fault with the service of the agencies, we have made recommendations to the Council.

The Care Act

6. The Care Act 2014 (the 2014 Act) sets out local authorities' duties around adult social care. The Care and Support Statutory Guidance sets out how the Care Act should be applied.

Assessment, eligibility, and support planning

7. Sections 9 and 10 of the 2014 Act say local authorities must assess the needs of any adult who appears to need care and support. Authorities must do this regardless of whether they think the person has eligible needs and regardless of the person's finances. They must involve the person and their care worker or any other person they might want involved.

8. Local authorities must carry out the assessment over a suitable and reasonable timescale considering the urgency of needs and any variation in those needs. They should tell the individual when their assessment will take place and keep the person informed throughout the assessment. An assessment must always be appropriate and proportionate and can be combined with another person.

9. Where a local authority determines that a person has eligible needs, it must meet these needs. It must also give the person a copy of its decision.

10. The 2014 Act also places a duty of promoting individual wellbeing on local authorities. It sets out nine areas of wellbeing which include:
    - physical, mental and emotional health;
    - domestic, family and personal relationships;
    - personal control; and
    - suitability of living arrangements

11. The following requirements are also relevant to this case. Local authorities must:
    - consider how to prevent needs developing or escalating at every interaction with a person;
    - take a person centred approach to assessment and balance the person's own view with that of others;
    - place prevention and early intervention "at the heart of the care and support system";
    - complete a person centred and person-led care and support plan and provide a copy to the person. It must ensure the principles of promoting wellbeing and preventing or delaying the development of needs is reflected in the plan.

12. The statutory guidance says "The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life".

Mental capacity

13. The Mental Capacity Act 2005 (the 2005 Act) sets out how to decide for people who lack the mental capacity to decide for themselves. The 2005 Act and the Code of Practice (2007) describe the steps a person should take when dealing with someone who may lack capacity to decide for themselves. They describe when to assess a person's capacity to decide, how to do this, and how to decide on behalf of someone who cannot do so themselves.

14. A person must be presumed to have capacity to decide unless it is established that they lack capacity. When someone's capacity is in doubt a council must assess their ability to make a decision.

15. The 2007 Code of Practice says:

- Capacity should always be reviewed:
    - whenever a care plan is being developed or reviewed;
    - at other relevant stages of the care planning process; and
    - as particular decisions need to be made.
- The person who lacks capacity is at the centre of the decision to be made. Their wishes, feelings, beliefs and values should be taken into account, but the final decision must be based entirely on what is in the person's best interests.
- The decision-maker will need to find a way of balancing disagreements over best interests or deciding between them. Ultimate responsibility for working out best interests lies with the decision-maker.
- If there is a serious disagreement about the need to move the person that cannot be settled in any other way, the Court of Protection can be asked to decide what the person's best interests are and where they should live.
- "Any staff involved in the care of a person who lacks capacity should make sure a record is kept of the process of working out the best interests of that person for each relevant decision, setting out:
    - how the decision about the person's best interests was reached
    - what the reasons for reaching the decision were
    - who was consulted to help work out best interests, and
    - what particular factors were taken into account".

Human rights

16. The Human Rights Act 1998 (the 1998 Act) sets out the fundamental rights and freedoms that people can expect.

17. Article 8 of the 1998 Act says everyone has the right to respect for their private and family life, their home and their correspondence. Public authorities may be obliged to actively protect rights under this article and may interfere with these rights to protect the rights of other people or the public interest. The public authority must interfere with the right as little as possible.

Complaint handling

18. Our "Principles of complaint handling in combined authorities and devolved settings" says:

- "Where more than one organisation is involved in the complaint, they work together to provide a single, coordinated response".
- "Those responding to complaints have the authority and expertise to get at the facts and recommend remedies".
- "There is 'no wrong door' for complaints. People can make a complaint without needing to understand and navigate the roles and responsibilities of the different bodies".
- "There is a seamless route to redress…".

The Care Quality Commission

19. The Care Quality Commission (CQC) is the statutory regulator of care services. It keeps a register of care providers who show they meet the fundamental

standards of care, inspects care services and issues reports on its findings. It also has power to enforce against breaches of fundamental care standards and prosecute offences.

20. CQC inspected Carewatch (Windsor), on 13 June 2018. This inspection found the service required improvement in four of the five areas inspected and was inadequate in the remaining area. It rated the service "requires improvement" overall. Some of the issues identified in this inspection reflect some of the issues raised about Carewatch during the events described below.

21. A follow up inspection in January 2019 found some improvements but the overall rating remained "requires improvement". This service was run by Carewatch Care Services Limited which ceased trading early in 2019 and went into administration.

How we considered this complaint

22. We produced this report after examining relevant documents and interviewing the complainant and relevant employees of the Council.

23. We gave the complainant and the Council a confidential draft of this report and invited their comments. The comments received were taken into account before the report was finalised.

What we found

What happened

24. Mr and Mrs Y were married for nearly 60 years and lived at home. Mr Y cared for Mrs Y. Her health and disabilities caused her various difficulties including with hearing, mobility, and understanding. Mr Y had difficulties with pain, mobility and frailty. For some time, Mr X and his sister, Ms Z, visited daily to help Mrs Y to bed and provide general support but in late 2016 they could not continue.

25. Optalis assessed Mrs Y in January 2017 and she received a package of care from Bespoke. The assessment noted Mr Y was providing Mrs Y with background support and was to have his own assessment. Optalis assessed Mrs Y again in March 2017 and noted Mr Y could no longer help her with dressing or with feeding. It also noted the need to consider Mrs Y's mental capacity as she was only able to make simple choices. Mrs Y began attending a day centre for social stimulation and to give Mr Y a break from his caring role. In August 2017 the Council completed an initial assessment for Mr Y. It identified a need for social inclusion. Mr Y began attending a social club regularly and the Council closed his case.

26. In January 2018, Mr and Mrs Y were both admitted to hospital.

Mrs Y's story

27. Mrs Y was dehydrated and had diarrhoea when she was admitted to hospital. She was discharged home after a few days with an increased care package but readmitted to hospital the following day.

28. Ms Z reported concerns about the care Mrs Y had been receiving from Bespoke. She said Mrs Y was "very irritable" and was refusing to drink or just taking sips. She did not believe care workers were prompting Mrs Y with fluids, did not stay the full time and may have fed her food which was too hot as Ms Z thought Mrs Y had a burn on her tongue. The Council completed a safeguarding enquiry. It identified that:

- calls were between 5 and 40 minutes short. On one occasion Mr and Mrs Y lost a total of one and a half hours in one day which the Council noted was significant and could have been used to prompt them with fluids;
- care logs did not record care workers prompting Mrs Y with fluids;
- care workers had not identified Mrs Y's burnt tongue.

29. The Council told Bespoke it should complete the time it was paid for and effectively record the actions completed. Bespoke put a food and fluid chart in place to monitor intake. The Council substantiated the concerns about the call times but not the concerns about the burnt tongue. It was possible the burn happened at the day service Mrs Y attended.

30. The Council noted four calls a day would no longer meet Mrs Y's needs and she needed 24 hour care. Mrs Y's case notes state that her family wanted a live-in care worker or care home placement. The notes say "We also discussed the option of long term care for mum, however [Ms Z] is concerned that this would impact on both her mother's and father's mental health and wellbeing as they have been married for a significant amount of time". At this point the Council told Ms Z it might not meet the cost of a live-in care worker and discussed the possibility of combining Mr and Mrs Y's budgets.

31. In March, Optalis assessed Mrs Y in hospital. It noted she had been in hospital twice recently for dehydration, diarrhoea and a urinary tract infection. She now needed two people to support with personal care in the mornings. The assessment also noted Mr and Mrs Y had been married for many years and it was important to them both to remain together. It said Mr Y had declined since Mrs Y had not been at home.

32. The family discussed the possibility of live-in care with the Council. Council records note a proposal to use a direct payment for both Mr and Mrs Y and fund a live-in care worker. The family mentioned the possibility of topping up the Council funding if it was not enough. Mr Y's support plan, dated 8 March, says the Council was waiting for the family to come back about this.

33. On 12 March, the social worker emailed the operations manager. She gave an outline of the case and said "[Mrs Y] and her husband have been married for over 50 years and the importance of remaining together appears important to both [Mr and Mrs Y]. [Mrs Y] will noticeably react to her husband's visits to her in hospital placing his face in both her hands. [Mr Y] has also noticeably declined since [Mrs Y] has not been at home, becoming withdrawn and less able to manage his personal care and nutritional needs". The social worker said she had completed a care needs assessment, mental capacity assessment, and a best interests decision but said "these have not been recorded yet". Our investigation found no evidence of these. The social worker said it was hoped that a direct payment for both Mr and Mrs Y would be enough to cover the cost of a live-in care worker but this takes a long time to arrange. She asked the manager to agree to a nursing home placement for Mrs Y until this could be arranged. The manager agreed, so Mrs Y was admitted to the care home.

34. On 20 March, the social worker phoned Ms Z to advise that Mrs Y had settled into the care home and was eating and drinking well. They discussed a possible return home, but Ms Z was undecided. She could see the benefits for Mrs Y but was unsure how Mr Y would feel. They agreed to wait until the family had discussed this and make a best interests decision about Mrs Y's long term care. That same day, the Council recorded Mrs Y's placement as permanent.

35. The Council also completed a safeguarding enquiry following a fall at the care home. We have not included any further information about this as it found no cause for concern and completed the process effectively.

Mr Y's story

36. In January 2018, three days after Mrs Y, Mr Y was also admitted to hospital with dehydration.

37. When Mr Y was ready for discharge, Mr X complained that home was not a suitable place for him. He asked Optalis to send a copy of Mr Y's assessment electronically. Eventually it sent an electronic copy but gave him the wrong password. Mr X asked for the correct password but Optalis did not respond and Mr X did not see the assessment. In fact, the Council did not complete an assessment of Mr Y although it provided us with support plans which it referred to as assessments.

38. The Council says Mr Y was clear with staff that he wanted to go home from hospital. Mr Y went home with a package of care from Bespoke. Shortly after, Mr Y was again admitted to hospital.

39. Mrs Y was still in hospital at the beginning of March. As another team was responsible for Mr Y, her social worker requested a review of his care package. Council notes say "[Mrs Y's social worker] is aware that separating [them] will have a severe impact on both [their] mental health – if [Mrs Y] was placed in residential care she would be constantly asking for [Mr Y]". The social worker "would like to consider the possibility of a live-in care worker who would meet both [their] care needs and would be a more financially economical solution to their joint care needs". Ms Z advised that Mr Y was "very low" as Mrs Y was in hospital. She said he was not eating or drinking properly and had lost a lot of weight.

40. On 6 March, a student social worker visited Mr Y at home for a "review assessment". This noted some background details and that Mr Y currently received three 30-minute care calls every day. The student social worker noted the way forward was the possibility of Mrs Y being discharged home with support to meet both their needs. Mr Y's support plan said Mr Y was unable to continue caring for Mrs Y "but would like to continue living with his wife". Also, Mr Y used to enjoy going to a social club "but since [Mrs Y's] admission to hospital six weeks ago has not been willing to go out. Family report he spends a lot of time in bed". She noted there were no changes needed to the support plan.

41. In mid-March, Mrs Y moved into a care home while Mr Y remained at home. At the end of March, Mr Y was admitted to hospital with sepsis and acute kidney infection.

42. Early in April, while Mr Y was still in hospital, Ms Z asked about him going into the care home with Mrs Y. The social worker told him Mr Y would have to be assessed as needing 24 hour care and agree to it. The social worker spoke to Mr Y and noted that he asked about Mrs Y and said he had only been to see her once since she moved into the care home. She also noted that she asked Mr Y if he would like to go to "somewhere like" the home where Mrs Y was, and he said he wanted to go to his own home.

43. Mr Y was discharged home after around three weeks, following an Occupational Therapist (OT) assessment. The Council increased his package of care to four calls daily. It asked Bespoke to encourage Mr Y to eat and drink and to ensure this was documented on food and fluid charts.

44. Mr Y was readmitted to hospital the following day. The ambulance service raised a safeguarding alert citing concerns of neglect and acts of omission. A care worker had visited and was not able to help Mr Y to mobilise as he was too weak and unstable and there were no mobility aids available. Mr X says he was not aware of this safeguarding concern. The Council says it will apologise as it has no record of advising the family of the concern or outcome.

45. A support plan for Mr Y said he had not been eating or drinking enough and was struggling with personal hygiene. He "suffers with low moods and is taking antidepressants" also that he "has lost a lot of weight". Mr X raised concerns that:

- Mr Y was not eating and drinking;
- his bedtime calls were early;
- he was depressed and missing Mrs Y;
- Mr Y had been in hospital three times in two months and Mr X felt he would end up dead if they did not break the cycle.

46. The social worker said they would need to meet in the hospital and plan Mr Y's discharge once all reports were completed and he was medically fit.

47. The hospital would not discharge Mr Y until an OT had visited his home to assess it and he had support in place. The deputy head of nursing considered the safeguarding concerns and emailed the lead nurse for safeguarding. She said the "comprehensive" OT report had identified risks around loneliness, malnutrition and engagement if Mr Y was discharged home. She said there were no clinical findings other than chronic conditions and he did not need hospital for these. She also said there was shared learning on this case because his wife was in a care home and his family had raised concerns about him returning home and being left alone. The OT discussed plans with the family and they said they would like Mr Y to be at home with Mrs Y because of his depression due to being away from her. They said Mr Y would end up back in hospital if discharged home without 24-hour care.

48. Mr X says he and Ms Z were slightly late to the meeting at the end of April to discuss Mr Y's care. The Council says Mr X and Ms Z were 30 minutes late to the meeting. Mr X was disappointed to find the meeting had already discussed care plans with Mr Y and they were told Mr Y wanted to return home. He says later in the meeting, officers used leading questions such as "you want to go back and live in your bungalow don't you?". Council records note "Spoke to [Mr Y] previous to meeting he explained that he wished to go home to his bungalow". The OT said she felt Mr Y's needs could be met at home with care workers. She said she would order a hospital bed for him and do a home assessment. The family expressed concerns about Mr Y's low mood, missing Mrs Y and not eating or drinking enough. Also, the risk of falls, the time of the care calls, and that care workers were not staying the allocated times. The social worker said Mr Y did not try to get up unattended and would wait until care workers came to help. The Council increased the length of the calls so that care workers had enough time to prompt Mr Y with food and drink. Mr Y's care calls now totalled three hours daily over four calls.

49. Mr X wrote to the Council and said it had given no consideration to Mr and Mrs Y being married for nearly 60 years. Mr Y would spend his days sitting in the same chair all day except when care workers visited and helped him to the toilet. He asked when Mr Y would have support to visit Mrs Y. The Council said "We understand and empathise with your father's current situation with regard to being

separated from his wife and would like to explore providing support for him to visit her regularly". It said it would not be appropriate for Mr Y to move into a care home. "This has been established through assessments carried out by both Health and Social Care professionals". It said if the family could no longer support Mr Y there were voluntary organisations that could help with shopping and he could pay privately for cleaning and ironing. Voluntary organisations could also provide a befriending service if Mr Y wanted company at home. Our investigation did not find any adequate assessments for Mr Y.

50. A support plan dated 1 May noted Mr Y had been re-admitted to hospital 24 hours after discharge and this was his third admission this year. It said he wanted to return home and was able to make his own decisions but may need family for support. It also noted family felt he should go to the same care home as Mrs Y. It said "steps taken to address any difficulties and risks" and "care is also encompassing of social needs and his long marriage to his wife who resides at [the care home]". On 3 May, the Council arranged for Carewatch to take over from Bespoke as Bespoke could not restart at the required time.

51. On 10 May 2018, Mr Y was discharged from hospital again. The next day, Mr X emailed the social worker to say he had visited Mr Y the night before and found him in urine-soaked clothes and pad from that morning. He had helped him to bed. A care worker from Carewatch had visited and left before Mr Y returned from hospital. Family provided him with an evening meal as he had none, and when a carer turned up at 8:20pm (40 minutes early), Mr Y had said it was too early to go to bed so was left fully clothed in his chair. The care worker stayed 10 minutes, not the required 30, and did not toilet Mr Y, left all the lights on and left Mr Y's walking stick far from his chair. Mr Y tried to get this unaided as he had been sent home without a walking frame. Mr X said there were no food and fluid charts in place. The Council followed up with Carewatch about the failed visits and lack of food and fluid charts, and with the hospital to get the walking frame delivered. A social worker visited and noted Mr Y was happy to be at home. She explained to Mr Y what the care workers should do during each call and spoke to Carewatch to stress that Mr Y should be helped to bed on the last call. She asked Carewatch to arrange for the quality officer to visit Mr Y and this also took place the same day.

52. On 16 May, the Council completed a risk assessment for Mr Y to go and visit Mrs Y twice a week with a care worker. It agreed a total of three hours weekly for the two visits to Mrs Y.

53. Sadly, towards the end of May, Mr Y collapsed and died in his home with a care worker present. The care worker called an ambulance. A few minutes later he realised Mr Y was not breathing and called back; the ambulance arrived at this point.

54. The ambulance staff asked the care worker if he had performed cardiopulmonary resuscitation (CPR). The care worker said he had been told by Carewatch not to perform CPR at all. Because of this the ambulance service raised a safeguarding alert with the Council.

55. The safeguarding investigation found the allegation was not substantiated. We have not included all the detail here but have considered the chronology and all the information available. We found the safeguarding enquiry was satisfactorily concluded within a reasonable timescale given the nature of the investigation.

56. We asked for Carewatch's daily notes for Mr Y, but these were not provided. We did receive Carewatch's individual needs assessment dated 11 May 2018 as

completed by the quality officer. This included care plan information such as "ensure eats and drinks plenty", "complete food and fluid chart", "leave plenty of fluids on table beside". The purpose of the evening call is noted as "Help me get ready for bed and into bed" and the plan includes "assist me to commode and wash and change my pad". We also received various other documents which appeared to provide comprehensive information necessary to provide care to Mr Y. We did not receive any documents relating to the first day of Carewatch's responsibility for Mr Y's care.

57. When we asked about the lack of adequate Care Act assessments for Mr Y, the Council told us it had experienced high staff and management turnover. Mr and Mrs Y, who were under different teams, experienced different approaches to assessment. Since then, the Council says it has implemented various quality measures and is working to achieve a consistent level of best practice. It acknowledges that it failed to assess the impact of separating Mr and Mrs Y. The Head of Service now ensures that service managers are aware to check joint issues, potential risks and impacts when assessing couples. We are pleased to note these improvements.

Complaint handling

58. The Council's initial responses to Ms Z's complaints about the quality of care provided to Mrs Y, and Mr X's complaints about the quality of care provided to Mr Y, are detailed above within the individual stories.

59. Mr X raised many complaints some of which we have not detailed above but which included issues around:

- delivery of a bed;
- difficulty with Mr Y accessing transport to the day centre;
- Carewatch not sharing information despite being advised by Optalis that it should do so.

60. Due to the varied and ongoing nature of these complaints, Mr X dealt with several people across the different agencies.

61. Several of the issues were not dealt with as formal complaints. As a result, Mr X received various responses but no final conclusions until he sent in a detailed list of the issues he considered outstanding. By this stage, the complaint had become unwieldy and confusing for both Mr X, the Council and the agencies involved. Mr X felt his complaint had not been adequately considered. This investigation is the first point at which all the issues were brought together.

62. There is too much information about the complaints handling to detail it in this report so we have only mentioned some events which illustrate the difficulties. We have considered all the correspondence and records in coming to a decision.

63. In dealing with Mr X's complaints about the care workers' actions when Mr Y died, Carewatch inadvertently told Mr X that the deputy manager was to attend a coroner's hearing for Mr Y. When Mr X chased for information about this, Optalis advised him that the Coroner's office had confirmed there had been no post-mortem or further investigation. The deputy manager had fabricated the appointment.

64. The Council advised Mr X that Carewatch had been subject of serious concern and Optalis had been supporting it to improve performance. Additionally, two managers were found to be inappropriately employed with Carewatch and left on

the day this came to light. Mr X said he wanted Carewatch decommissioned; the Council advised him that was its main care provider so this would not happen. Mr X could not understand why this was not an option when the quality of care was so poor and not disputed.

65. On 4 December 2018, Optalis responded to Mr X's complaint about Mr Y returning home. It said:

- two hospital practitioners had spoken to Mr Y to explore his wishes around the care he received and where he would be discharged. The family had not resisted this happening and it is good practice to understand the wishes of the person concerned;
- due to Mr Y's low mood, the practitioners may have come across as directive but this was necessary to facilitate discharge planning;
- when the OT spoke to Mr Y, he wanted to go home;
- the professionals concerned had no reason to doubt Mr Y's mental capacity and he was therefore able to decide to return home. Due to concerns from the family, the care package was increased;
- Mr Y had told the practitioner that he was happy at home and care was working in May 2018. They also discussed social inclusion support so that he could visit Mrs Y in the care home;
- all concerns about Carewatch had been shared with the quality team who were working with the Agency to improve processes;
- there were inconsistencies in the events leading to Mr Y's death but the care worker was not asked to perform CPR and therefore there was no need to investigate further.

66. It apologised to Mr X for not providing the correct password and failing to send the assessment and said this had been addressed with the staff concerned.

67. In March 2019, following further correspondence with Mr X, the Council wrote with a further response about the investigation into the care workers' actions when Mr Y died. It said:

- Carewatch did not train staff to carry out CPR and this was acceptable. Staff were trained to call 999 and follow the instructions given;
- the two managers left the company on the same day the Council raised serious concerns and were replaced immediately;
- there was no delay completing the minutes of the discharge meeting but in sending them to Mr X.

Conclusions

The assessments

68. It is not our role to decide if a person has social care needs, or if they are entitled to receive services from the Council. Our role is to establish if the Council assessed a person's needs properly and acted in accordance with the law. In this case, the Council failed to do so.

69. The Council took seven months from January to August 2017 to assess Mr Y's needs in his own right. This was too long. It was at fault here and this meant

Mr Y's needs were not adequately met for many months putting him at an avoidable, increased risk of harm.

70. We have not found any adequate assessments which properly considered Mr Y's needs in line with the Care Act (as outlined in paragraphs 6 to 12) following his admission to hospital in January 2018. This is fault. As a result, there was no consideration of the risk to Mr Y despite the numerous concerns raised by family and the social workers. We would expect the consultation with Mr Y's family to openly discuss the options so Mr Y understood and could make an informed decision. This did not happen despite the support plan noting that he may need family to support with this.

71. The Council did not give due consideration either to a live-in care arrangement, or a placement with Mrs Y, despite having said it would. This meant the Council could not be clear about the support Mr Y needed or that it met his needs adequately. The Council's records suggest it left the decision with the family at one point, but it is the Council's responsibility to ensure needs are met. We do not know if Mr Y would have decided to go home had a full discussion taken place. Professionals did not dispute Mr Y's health and wellbeing was being badly affected by the separation from Mrs Y. We have therefore decided this caused Mr Y significant and undue distress and risk of harm. On the balance of probabilities, it also caused him actual harm as all accepted this contributed to his worsening condition.

72. We have also not found any evidence of the decision for Mrs Y's residential placement to become permanent. This is fault. Although Mrs Y seemed to settle well in the care home, we cannot know whether she would have been better had she stayed with Mr Y. We also cannot know whether this caused her distress, but the social worker said there was a risk to her if separated from Mr Y. Mr X also said the transfer to the care home would have been smoother had she been with Mr Y. We are therefore satisfied this caused her to be at an increased, and undue, risk of harm. Mrs Y did not have capacity to decide about her own care so a best interests decision was needed for this. This should have balanced professionals' views with those of the family and Mrs Y's likely view where known. We have seen no record of a best interest decision. This is also fault and means the Council could not be clear whether the action it took was in Mrs Y's best interests.

73. Mr Y's separation from Mrs Y due to her move to the care home and the expressed concerns about this, engaged article 8 of the Human Rights Act. We have not seen any evidence that the Council considered whether it was appropriate to limit this right in the circumstances, or any consideration of their human rights at all. The Council's failure to demonstrate how it had given regard to its responsibilities around this is fault. The Council's failure to adequately assess means that despite many concerns about his need to be with his wife, nothing was in place to ensure Mr Y had this opportunity. Two months after she moved to the care home, the Council agreed to arrange support for Mr Y to visit her. This was just over one week before he died. This fault caused significant and undue stress, frustration and outrage to Mr X and Ms Z as they repeatedly raised their concerns.

74. Sadly, Mrs Y has also now died, and we cannot therefore put right the injustice caused to her and Mr Y.

Quality of care

75. It is clear from the evidence that Bespoke provided a poor service to Mr and Mrs Y prior to January 2018. This was fault. Care workers cannot force people to drink or eat, so we do not know whether Mr and Mrs Y would have done so if the care workers had provided adequate support. However, the failure to provide the care as planned put Mr and Mrs Y at an increased and undue risk of harm.

76. Mr Y was also left without the care he needed from Carewatch. This was also fault and caused Mr Y to be at an increased and undue risk of harm. On the balance of probabilities, this is also likely to have caused him some distress.

Complaint handling

77. When Ms Z complained about the care being provided when Mrs Y first went to hospital in January 2018, the Council took appropriate action and we found no fault in this element or in the way it dealt with the complaints which resulted in safeguarding enquiries.

78. However, the arrangement with Optalis and Carewatch caused much confusion for Mr X. The Council did not satisfactorily explain this and it appeared to Mr X that the Council was being difficult. All his complaints were linked but we saw no evidence the Council, or the agencies concerned, considered dealing with them as one. The Council also did not adequately deal with Mr X's level of involvement. Due to his high level of concern, Mr X expected more information and engagement than many complainants, and neither the Council nor the agencies managed this well. They should have involved him fully and kept him actively informed or managed his expectations and explained what they could do and when. This would have helped him know what to expect and what questions to ask. This was fault and caused Mr X significant and undue time and trouble, stress and outrage.

Recommendations

79. The Council must consider the report and confirm within three months the action it has taken or proposes to take. The Council should consider the report at its full Council, Cabinet or other appropriately delegated committee of elected members and we will require evidence of this. ***(Local Government Act 1974, section 31(2), as amended)***

80. To remedy the injustice identified above, we recommend the Council:

- apologise to Mr X and Ms Z setting out the faults identified in this report and the action the Council will take, or has taken, to put this right;
- pay Mr X and Ms Z £750 each to recognise the distress it caused in failing to properly consider the risks of separating Mr and Mrs Y;
- pay Mr X a further £500 for the time and trouble and distress he was caused in bringing his complaint;
- review any cases where couples are separated by their care needs, to ensure the risks and human rights were fully considered for both parties. Also, that adequate contact is included on the care and support plans;
- review assessment practice across the Council to ensure it is consistent and Care Act compliant. It should do this using the quality measures and reporting processes it has implemented since these events;

- ensure it has an effective mechanism for following up where complaints about poor practice have been received and to check that improvements are made and sustained;
- put in measures to ensure complaints about several agencies receive a coordinated response; and
- review its commissioning practice when services are rated “Requires improvement” to ensure it considers any increased risk to people.

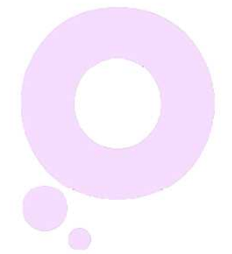
Decision

81. We have completed our investigation and uphold Mr X’s complaints that the Council:
    - did not properly consider the risks in supporting Mr Y to remain at home on his own;
    - did not properly consider the impact of separation after 59 years on Mr Y and his wife, Mrs Y;
    - did not provide Mr X with a copy of Mr Y’s assessment;
    - did not provide an adequate quality of care to Mr Y;
    - did not deal adequately with Mr X’s concerns and complaints.
82. We do not uphold Mr X’s complaint that the Council carried out a flawed safeguarding process.

Adult Services & Health Overview & Scrutiny Panel

Each Step Together

an innovative approach to work with and for local people



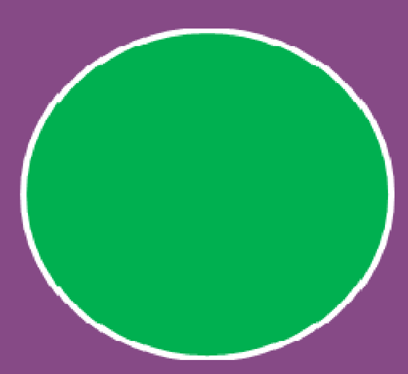
ANGELA MORRIS
DIRECTOR OF OPERATIONS

Each Step Together (EST)

The Care Act 2014 underpins social and health care in England, emphasising Wellbeing as a guiding principle, keeping it at the heart of care and support. It is accompanied by principles of Preventing, Reducing and Delaying needs, which inform our new approach to delivering services for the Royal Borough of Windsor and Maidenhead.

EST focuses on development of a community based whole system of support that works with health and community partners, resulting in fewer people needing ongoing social care support. It is referred to as 'three conversations model' and it has been established through an evidence based approach first started in the Royal Borough of Windsor and Maidenhead in July 2016.

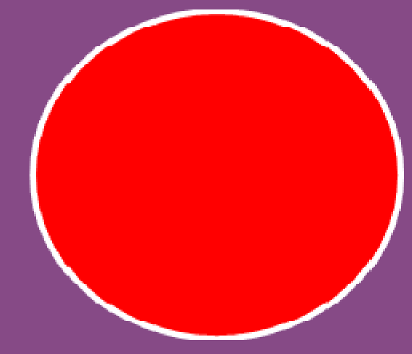
Each Step Together (EST) Three Conversation Model



Help you to help yourself

How can I connect you to things that will help you get on with your life

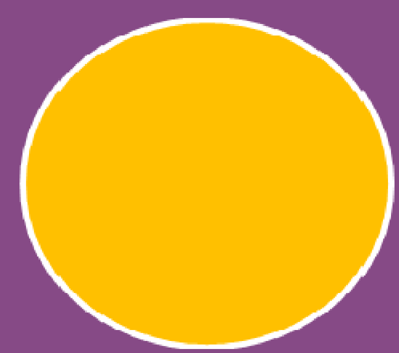
Your assets, strengths and those of your family and neighbourhood.



Help when you need it

When people are at risk: 'What needs to change to make you safe?

How can I pull things together in an 'emergency plan' and stay with you to make sure it works'?



Ongoing support for those that need it

What is a fair personal budget and where do the sources of funding come from?

How can I help you use your resources to live the life you want?

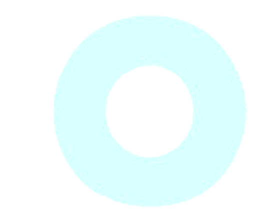
Each Step Together (EST)

Supporting the Health and Social Care Integration Agenda

3 Conversations help us to understand how we can help

Each Step Together (EST)

Golden Rules of New Way of Working



We are working WITH people, not doing things TO people or FOR people.

Crisis is when: “Someone is at imminent risk of loosing independence and/or losing control over their life-if nothing changes, it is likely that there will be significant impact on mental, physical and/or emotional wellbeing”.

We never ever plan long term support when person is in crisis.
Instead we offer to listen hard to understand the crisis as this helps to resolve it.

We stay around and provide consistent support (no hand offs or transfers to another person).

We are not the experts in person’s life, the person and their family are, however we may have expertise that could help them.

Each Step Together (EST)

Golden rules of new way of working

- We focus on the person and what they are telling us is important to them
- We explore this in Conversation 1 and 2 before we even consider Conversation 3 (long term plan)
- Conversations don't have to be in order, we are guided by the person and their circumstances, so it is ok to repeat Conversation 1 and 2
- Formal care services are always the **LAST** thing in our conversation, as we focus and explore person's assets, strengths and community resources **FIRST**
- We can't work on our own, we need to work closely with all our community based partners as equals
- We recognise the need to invest in supporting family carers
- We need to know our local partners to access local information in order to maximise persons links with their community

Each Step Together (EST)

Our success

Consistent and attentive approach builds resilience and trust

Greater insight into person's true needs, desires and wishes, offering deeper level of understanding of person's situation and wider family/network involvement.

Thinking differently about what and how we work with another human being

Engagement with local residents / health colleagues

- Consultation at customer led Partnership Boards
- Older People's Forums
- Learning Disability Partnership Boards
- Autism Partnership Boards
- Agenda item at CCG meetings
- Agenda item at BHfT meetings

Compliments from residents

To the many wonderful caring men and women who have looked after me over the weeks I thank you and miss you very much. I need your gentle chiding to get me going but it does work, I think of what you are saying and get on with it.

Million thanks for all your help. All work done was first class. Can't thank you enough for making me feel so much safer in my own home. I'll always be grateful to you, so kind, helpful and lovely.

It was lovely to meet you today and I thank both of you for taking the time to think through ways to improve my situation whilst at the same time retaining my sense of independence. I enjoyed your visit (despite my tears) and, for the first time in many years I feel positive about the future. I seem to have been fighting for some help for so many years that I can hardly believe that there is now a good chance that my life will get better instead of getting worse by the day.

I must also thank you both for the reassurance that I won't have to go through the horrors of returning home after surgery to be faced by an empty house and the hopeless task of trying to care for myself whilst recuperating. I feel that, with support, I will recover quickly and will be able to put the cancer behind me.

Bless you for your continuing support of my daughter as I do know how difficult she can be.

Thank you for advising us on the way to make our house safer for two geriatrics who still get around!

- To commence the pilot in the Mental Health Teams

- To ensure that the model is reflected in the integrated care system

InPhase Dashboard Standards

Document Control

Document Ref:	Inphase Dashboard Standards	Date:	3/8/2020
Version:	1	Revision due:	
Owner:	Pauline D'cunha - Head of Physical Disabilities and Older Peoples Service		
Reviewer:	Service Managers/Sharon Whitehead-Lead Senior Social Work Practitioner		

The goal of the InPhase monitoring system is to improve the efficiency and effectiveness of the performance through constantly keeping track on the actual performance of front-line staff. It is a system for management and not just for evaluation of the performance, it also helps keep performance on the right track.

The InPhase performance data is updated weekly by Daryl the Performance and Information officer. The Paris data is live data so it is important to remember that the two systems may not always display the same data.

InPhase performance excel reports and Paris data to be sent to the PDOPT service managers and Head of Service weekly by the lead senior social work practitioner to support with monitoring the performance data.

PDOPT Performance Overview Areas within InPhase:

Percentage of current carers reviewed in the last 12 months
Percentage of safeguarding enquiries completed within timescale of 60 days
Percentage of support plan assessments in timescale of 42 days
Percentage of Tier 2 conversations closed in timescale. Used only for STS&R referral
Percentage of Tier 1 conversations ending with no further action
Percentage of SDS clients receiving direct payment
Percentage of safeguarding concerns progressing to enquiries
Percentage of safeguarding concerns allocated within timescale
Percentage of referrals allocated within timescale
Percentage of long-term care clients reviewed in the last 12 months
Discharge of Transfer of Care -DTOC (Hospital Team)

Weekly data Quality Checks required for:
(Performance Overview, Activity, Data quality and workload)

- Referrals (24-hour timescale)
- Assessments (Mental Capacity, Best Interest)
- Assessment/Support Plans (42-day completion timescale)
- Each Step Together
- Reviews
- Carers
- Safeguarding (24-hour allocation timescale) & (60-day completion timescale)

Standards Required

All Seniors/Supervisors

- All seniors have access to and have received training on the use of InPhase monitoring system.
- Undertake weekly data quality checks for all supervisees on Inphase covering Performance Overview, Activity, Data quality and Workload sections. Considering all timescales and the timely progress of work to conclusion with the focus of improving performance standards.
- Timely allocation of referrals across the service.
- Sign off from triage concern progressing to enquire completed in 24 hours.
- Ensure all Safeguarding Section 42 Enquires sent for signoff are completed within 48 hours, unless signoff scrutiny has highlighted the need for additional work on the case.
- Check supervisees are completing the Safeguarding Customer feedback survey on completion of the Section 42 Enquire.
- Ensure your supervisees work signoff/closure requests are completed within 48 hours unless signoff scrutiny has highlighted the need for additional work on the case.
- Make sure staff are not signing off and dating the assessments/support plans etc before the work is completed and ready for supervisor/senior sign off.
- Annual review allocations to be monitored and allocated to ensure upcoming reviews are allocated and completed in timescale, including Carers Reviews.
- Performance monitoring and timescales to be discussed and recorded in supervision with supervisees.
- Carry out weekly workload checks required for individual supervisees regarding case allocation numbers, considering hours worked.
- Case audits for supervisees to be completed on a regular basis to improve awareness of the current caseload levels and activity undertaken within caseloads or otherwise.

Hospital Seniors/Supervisors-

Additional responsibilities:

- Work with front-line staff to avoid delay in transfer of care
- Review Optalis InPhase reports to identify patterns of delays over time and highlight areas where delays are increasing or where input is required to reduce the number of delays.
- Ensure Team Manager is made aware of any case where discharge is likely to be delayed and the reasons for this.

All Service Managers

- Make sure all supervisor/seniors have access to and have received training on the InPhase performance monitoring system.
- Undertake weekly data quality checks for your service area on InPhase covering Performance Overview, Activity, Data quality and Workload sections.
- Discuss any performance issues relating to the Inphase data directly with supervisors/seniors for the required action.
- Ensure that case audits are undertaken by supervisors/seniors in accordance with requirements to free capacity for allocations and to promote the continuous turnover of caseloads.
- Ensure all Safeguarding referrals sent for closure are signed off within 48 hours unless sign off scrutiny has highlighted the need for additional work on the case.
- Check the Safeguarding Customer feedback survey has been completed.
- All annual review allocations to be monitored within InPhase to ensure upcoming reviews are allocated and can be completed in timescale.
- Weekly workload checks required for the service area on individual case allocation numbers.
- InPhase performance monitoring to be discussed and recorded in supervision with seniors.
- Highlight any potential or ongoing performance data monitoring issues and associated reasons to the Head of Service.

Hospital Service manager

Additional Responsibilities:

- Receive DTOC reports on Friday's from each of the four hospitals and review/amend.
- Provide report figures to Governance and Quality Assurance Team Management Information officer on Monday's for forwarding on as appropriate.
- Have an on-going working knowledge of the residents in hospital and support staff to ensure wherever possible delays in transfer of care are avoided.
- Review Optalis InPhase reports to identify patterns of delays over time and highlight areas where delays are increasing or where input is required to reduce the number of delays.

- Raise concerns with Senior Managers where there are consistent delays in discharge as a result of lack of services ('Bottle necks') or other so that these can be addressed.

Head of Service

- The Head of service will have an overview of all PDOPT InPhase data, and any performance concerns highlighted will be discussed directly with service managers for the required action.
- InPhase performance data monitoring will be discussed and recorded in supervision with service managers.
- Report any highlighted PDOPT performance concerns and associated reasons to the Director of Statutory Service as required.
- Lead Senior Social Worker will be working closely with the Head of Service in identifying any performance activity data not actioned in the teams.

PDOPT Performance Meeting

- There will be a regular monthly meeting with PDOPT management team and the Performance and Information officer to discuss InPhase and the performance data generated.
- Any anomalies with the InPhase/Paris data can be highlighted and discussed at this meeting.
- Discuss any possible improvements in relation to capturing and recording the data on InPhase.

Supervision

- The Individual caseloads of each worker will be subject to ongoing monitoring using the established processes of monthly supervision, this will seek to establish a balance of workload and activity alongside the measure of performance standards.

LGO RECOMMENDATIONS ACTION - QUALITY CIRCLE WORKSHOPS

The Quality Circle workshop/forum in Physical Disabilities and Older peoples service is held once a month and is a platform to enable front line staff and managers to use as a critical reflective learning to discuss good practice case -studies as well as areas / learning to improve practice.

Two Quality Circle workshops were conducted on 21 November 2019 and 14 July 2020 in relation to the LGO Mrs Y & Mr Y report . Over 20 staff attended the 2019 session and 30 staff attended the 2020 session. These staff included service managers, senior social workers, Senior OT's, OT's, social workers and social care practitioners

The following issues were discussed

Care Act Requirements

When preparing to make an assessment it is useful to ask yourself the following questions in relation to the legal duties for the Care Act 2014.

- What needs to be considered to ensure the assessment is appropriate and proportionate?
- How will you ensure a strengths-based approach has been considered?
- How do answers to the first two questions above affect the way this assessment is conducted?
- Who will be involved with the assessment?
- In preparing for the assessment, what additional issues or obstacles need to be considered (if any) – and how can they be dealt with?
- Have you considered the individual's needs over an appropriate period to ensure they have all been accounted for?

- What information and advice would be helpful?
- What preventative measures (to prevent, delay or reduce needs) will you consider?
- Have you considered the extent to which the adult's needs meet the three conditions of the national eligibility criteria? (Have you looked at this in the context of their desired outcomes?)
- Have you considered the extent to which there is any impact on the carer's/ couple's ability to achieve the separate carer's eligibility criteria? (Have you looked at this in the context of their desired outcomes?)

Determining Eligibility

A determination of eligibility cannot be made without a need's assessment. Determination must consider the minimum eligibility threshold criteria, which are:

Adult
- Do the needs for care and support arise from a physical or mental impairment or illness?
- Do these needs mean the adult is unable to achieve two or more of the listed outcomes?
- As a consequence of being unable to achieve the outcomes, is there, or is there likely to be, a significant impact on the adult's wellbeing?

Carer
- Do the carer's needs arise as a consequence of providing necessary care to an adult?
- Is the carer's physical or mental health affected or at risk of deteriorating, or is the carer unable to achieve any of the listed outcomes?
- As a consequence of being unable to achieve any of the outcomes, is there, or is there likely to be, a significant impact on the carer's wellbeing?

Key theme's and learning points from the Ombudsman Investigation.

The key themes of the complaint were discussed.

1.NATURE OF THE COMPLAINT

Mr X complains on behalf of his late parents. He says the Council did not properly consider the risks of separating them after 59 years of marriage or of Mr Y living on his own. He complains about the quality of care it provided to them both and says it did not deal adequately with his concerns and complaints. He also complained that the safeguarding process was flawed, and the Council would not give him a copy of Mr Y's assessment.

2. LEGAL AND ADMINISTRATIVE BACKGROUND

The Care Act

The Care Act 2014 (the 2014 Act) sets out local authorities' duties around adult social care. The Care and Support Statutory Guidance sets out how the Care Act should be applied particularly in the process of assessment, eligibility, and support planning.

Mental Capacity

The Mental Capacity Act 2005 (the 2005 Act) sets out how to decide for people who lack the mental capacity to decide for themselves. The 2005 Act and the Code of Practice (2007) describe the steps a person should take when dealing with someone who may lack capacity to decide for themselves

Human Rights

The Human Rights Act 1998 sets out the fundamental rights and freedoms that people can expect. Article 8 of the 1998 Act says everyone has the right to respect for their private and family life, their home and their correspondence. Public authorities may be obliged to actively protect rights under this article and may interfere with these rights to protect the rights of other people or the public interest

d. Safeguarding Adults Section 42 enquiry in the Care Act 2014

Service area – operational guidance and flowchart used. Discussed the importance of using these two documents to guide front line practitioners and managers in making the right safeguarding decision to protect the adults at risk of any form of abuse or harm. These enable staff to follow the correct process to discharge our statutory duty of care , support and protection .

3. LEARNING FROM THE COMPLAINT HANDLING

We have implemented an action log process for ensuring that any quality improvement actions arising from complaints are embedded in routine procedures. Progressing these actions is seen as a critical component of quality assurance within Optalis and is reported to the Optalis Board on a regular basis.

We have reviewed our complaints process to ensure that a co-ordinated response is provided in cases where complaints are made against several agencies. All complaints are notified to the relevant senior manager who oversees the process to ensure a co-ordinated response and each response is quality assured by the Director of Statutory Services before it is issued.

Both the Royal Borough and Optalis work with providers of care to improve quality. The council has employed a dedicated commissioning officer to monitor domiciliary care providers and to work with the care quality team in Optalis to ensure improvements. Within Optalis, the care quality assurance team operates a robust care governance process which regularly monitors the quality of domiciliary care and care homes within a well-established multiagency framework.

4. REFLECTION POINTS

- What else did you think about?
- What else might apply/be relevant in your authority?
- What might you do differently? Why?
- What have you learned?

5. PRACTICE /SYSTEM CHANGES IMPLEMENTED

- EST support plan document reconfigured on PARIS as EST assessment & Support Plan
- Good practice of risk assessing the significant impact of separation of couples in service provision – Non- violation of Article 8 of the Human Rights
- Social workers assigned to each of the couple to work collaboratively
- Collated a list of Couples open to the service area. Review of the couples completed. We have identified 27 cases so far where this is the case and have thoroughly reviewed 22, with the remainder to be completed by the end of September 2020. These reviews will ensure that people's needs, and wishes are followed in respect of loss of contact, in accordance with the Human Rights Act. in a timely manner
- Safeguarding process to be robust and timely feedback to the referrer

PAULINE D'CUNHA

Professional Standards Working with Couples
Each Step Together

Document Control

Document Ref:	EST- Working with Couples Standards	**Date:**	27/8/2020
Version:	1	**Revision due:**	27/8/2021
Owner:	Pauline D'cunha – Head of Physical Disabilities and Older Peoples Service		
Reviewer:	Sharon Whitehead- Lead Senior Social Work Practitioner		

Professional Standards in relation to the significant impact and identified risk for couples when joint working.

- When cases are allocated, staff must check to identify if another worker is allocated to the other member of the couple.
- When two workers are working with a couple; collaborative working must take place by both workers involved with each member of the couple.
- There must be clear case recordings on Paris detailing the joint working and communication involved for both members of the couple.
- Advocacy must be considered for both members of the couple, if required.
- Best interest outcomes for the couple must be considered when progressing care plans.
- A risk assessment must be completed for both individuals detailing any separation issues when meeting the care needs of each or one member of the couple. The significant impact of any possible separation issues due to a placement of any kind must be recorded in the risk assessment. (positive or negative)
- If couples are to be separated the support plans for both must include adequate contact arrangements to ensure the relationship is maintained and supported after separation.
- Consider any possible safeguarding issues during the process, and progress safeguarding if required.
- The risk assessment for both members of the couple to be evidenced in the risk section of the EST assessment & support plan.

- Seniors to check the Quality Assurance Panel to ensure the points mentioned above are cited before progressing with panel comments and sign off
- Service managers to check the above actions have been completed by the senior prior to QAP authorisation.
- Seniors must check the risk section of the EST assessment & support plan to ensure it has been completed before authorisation of the support plan.
- Seniors, Service Managers and the Head of Service to discuss with all supervisees the importance of the Professional Standards when working on complex cases with couples.
- Seniors/Service mangers to include the Working with Couples Standards as a regular agenda item in team meetings as a check measure to remind staff and ensure this practice is embedded in practice.
- Non adherence to the Standards will lead to performance management.

"Couples" can include; husband and wife, same sex couples, two close friends living together long term, two other family members living together long term.

*****

Optalis:

Quality Monitoring Framework – CQC Regulated Adult Social Care Providers

November 2019

Vision

To fulfil the potential of every customer, colleague and community we work with

Mission

To be a resilient, efficient and growing social care company capable of delivering high quality, innovative services to more customers delivered by passionate and skilled staff

Our Core Values

- Customer Service
- Respect
- Transparency and Integrity
- Communication
- Continuous Development
- Enjoyable and Rewarding

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Frequently used and nationally known acronyms

RBWM	Royal Borough of Windsor and Maidenhead
CQC	Care Quality Commission (Regulator)
KLOE	CQC Key Lines of Enquiry CCG
CCG	Clinical Commissioning Group
CHC	Continuing Health Care
GP	General Practitioner (Medicine)
DoLS	Deprivation of liberty safeguards
NHS	National Health Service
BHFT	Berkshire Health NHS Foundation Trust
FHFT	Frimley Health NHS Foundation Trust
NQB	National Quality Board
NICE	National Institute for Health and Care Excellence

1. **INTRODUCTION:**
   1.1. Optalis is a local authority trading company owned by and delivering adult social care on behalf of the Royal Borough of Windsor and Maidenhead (RBWM) and Wokingham Borough Council.
   1.2. This quality monitoring framework for Care Quality Commission (CQC) regulated adult social care providers is owned by Optalis and currently applies to the adult social care services delivered for the Royal Borough of Windsor & Maidenhead (RBWM) council.
   1.3. Optalis values the residents it serves. Our vision emphasises putting residents first and working with partners to provide quality, sustainable adult social care services which deliver good value for money. This focus is central to this Optalis Quality Monitoring Framework.
   1.4. Optalis is committed to assuring the quality of these local services and ensuring a diverse market to allow residents good choices for planning their personalised care. This framework aims to support Optalis in achieving this.
   1.5. Of particular relevance to the Framework, the Care Act 2014[1] (Chapter 23 Part 1 care and support) places some statutory duties upon local authorities to work in an integrated fashion with health colleagues to develop and maintain a high quality, diverse and sustainable adult social care market. Also responsibility for providing care to service users of CQC regulated adult social care providers in certain circumstances if they fail. The care act comments specifically:
   - General responsibilities of local authorities:
     - Section 3 Promoting integration of care and support with health services etc. states: … *"(1) A local authority must exercise its functions under this Part with a view to ensuring the integration of care and support provision with health provision and health-related provision where it considers that this would—…(c) improve the quality of care and support for adults, and of support for carers, provided in its area (including the outcomes that are achieved from such provision)."*
     - Section 5 - Promoting diversity and quality in provision of services states: *…"(1) A local authority must promote the efficient and effective operation of a market in services for meeting care and support needs with a view to ensuring that any person in its area wishing to access services in the market—(a) has a variety of providers to choose from who (taken together) provide a variety of services; (b) has a variety of high quality services to choose from; (c) has sufficient information to make an informed decision about how to meet the needs in question… (2) In performing that duty, a local authority must have regard to the following matters in particular—… (d) the importance of ensuring the sustainability of the market (in circumstances where it is operating effectively as well as in circumstances where it is not); (e) the importance of fostering continuous improvement in the quality of such services and the efficiency and effectiveness with which such services are provided and of encouraging innovation in their provision; (f) the importance of fostering a workforce whose members are able to ensure the delivery of high quality services (because, for example, they have relevant skills and appropriate working conditions)…"*

[1] Care Act 2014 http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

- Provider failure:
  - Section 48 -Temporary duty on local authority states: *"(1) This section applies where a person registered under Chapter 2 of Part 1 of the Health and Social Care Act 2008 (a "registered care provider") in respect of the carrying on of a regulated activity (within the meaning of that Part) becomes unable to carry on that activity because of business failure. (2) A local authority must for so long as it considers necessary (and in so far as it is not already required to do so) meet those of an adult's needs for care and support and those of a carer's needs for support which were, immediately before the registered care provider became unable to carry on the regulated activity, being met by the carrying on of that activity in the authority's area by the provider….".*

1.6. As a local authority, RBWM must meet the statutory duties set out above. The council have retained accountability and direct provision of some duties, and have delegated powers to Optalis to provide services which enable RBWM to meet others. To highlight some key features relevant to this framework

- RBWM have retained the strategic adult social care provider market management and oversite. They are responsible for the procurement, implementation, management and monitoring of contracts for a range of adult social care services, including CQC regulated and unregulated provision. They create and update the standard contractual documentation for block and spot social care placement contracts.
- On behalf of RBWM, Optalis are responsible for the operational service user placement commissioning and monitoring, within the context of above. Optalis execute the resident placement documentation that is part of the council's contract. This placement purchasing may be via the councils block contract arrangements, or on a spot basis within agreed financial parameters.
- Also, where adult social care providers are located within Borough borders, or are commissioned to meet RBWM residents' social care outcomes, Optalis deliver the quality assurance and quality monitoring of these organisations for RBWM.

1.7. This Quality Monitoring Framework sets out the quality assurance and monitoring function with respect to external CQC regulated adult social care providers, which Optalis deliver for RBWM. Whilst this is quality rather than contract monitoring, the associated monitoring tools make reference to the contractual standards set by RBWM where relevant.

1.8. CQC are the independent regulator of health and social care in England. CQC register services to deliver certain types of regulated activities, and monitor and inspect to ensure providers meet fundamental standards and thus operate safely and legally. CQC have powers to act where providers are consistently evidenced to be found non-compliant with these standards, and this includes removing registrations or placing restrictions upon them.

1.9. This Quality Monitoring Framework is targeted at adult social care providers who fall within the scope of CQC registration. This therefore includes residential care homes with or without nursing, domiciliary care services, extra care housing, shared lives schemes, and some residential supported living schemes.

1.10. This Quality Monitoring Framework focuses on the services delivered by the Optalis Care Quality Assurance Team who sit within the wider Governance and Quality Assurance Team. It explains the quality assurance and service improvement approach, and sets out the roles and responsibilities of key stakeholders. It describes how Governance and Quality Assurance Team monitors the quality and supports adult social care providers to deliver outcome focused person centred care.

1.11. For the Optalis Care Quality Assurance Team to deliver this function adult social care providers will be quality monitored in the most agile and efficient way, using an intelligence led approach. Bureaucracy will be minimised, and existing national or local validated data sources will be used where possible to reduce the burden on providers and Optalis.

1.12. Having this Quality Monitoring Framework assists in assuring the Optalis board that target outcomes are achieved or improved for adults in receipt of care services, who can be considered some of the most vulnerable or at risk of harm in our society. This allows for assurance to RBWM of the same.

2. PURPOSE:

2.1. This Quality Monitoring Framework sets out the scope of the Care Quality Assurance Team's quality assurance activity and how they, along with relevant stakeholders, monitor and act on specific and cumulative quality indicators.

2.2. It sets out the purpose of quality assurance and service improvement activity, and the desired outcomes.

2.3. It describes the expected quality standards, quantitative and qualitative data monitored, its purpose and scope.

2.4. It identifies roles and responsibilities of key parties involved in assuring quality, allowing accountability. It ensures person centred practice, so that people who use services are involved and that quality assurance is inclusive of adult social care providers. Through building positive relationships and supportive partnership based working, continuous quality improvement can be delivered, with better, innovative and cost-effective outcomes that promote the wellbeing of people who need care and support.

2.5. It sets out the arrangements for governance and oversite so that the Optalis board and owning organisations can satisfy themselves Optalis is discharging its responsibilities properly.

2.6. The over-arching aim of this Quality Monitoring Framework is to ensure Care Quality Assurance Team support Optalis; and in turn RBWM; to achieve their vision.

2.7. Quality assurance is at the heart of all Care Quality Assurance Team activity, and the Quality Monitoring Framework overviews the main activities in order to:

- Ensure appropriate systems and procedures are in place to capture intelligence in order to provide a holistic market and specific provider view
- Provide clarity of Care Quality Assurance Team focus and intended outcomes
- Enable Care Quality Assurance Team to use the Quality Monitoring Framework to ensure consistent proactive and proportionate response
- Ensure relevant governance and oversight.
- Manage partners' expectations

- Allow for complimentary business processes to be developed within other teams and organisations, ensuring best use of Care Quality Assurance Team output to improve outcomes for adults in receipt of care.

3. CONTEXT:

3.1. The Royal Borough of Windsor & Maidenhead has approximately 147,000 residents; around 2750 of whom are in receipt of support from Optalis adult services.[2]

3.2. As detailed above, to reflect the requirements set out by the Care Act 2014 and the contractual relationship between RBWM and Optalis, Care Quality Assurance Team provides the non-contractual quality assurance of commissioned external CQC regulated adult social care locations, as well as all external CQC regulated adult social providers within the borough's boundaries. This includes both quality monitoring and service improvement activity.

3.3. On average, Care Quality Assurance Team work with approximately 170 different CQC regulated locations. Of these 59 are within borough boundaries, 111 are outside in other local authority areas.

3.4. Whilst Care Quality Assurance Team are not responsible for monitoring Optalis run locations or adult support services that fall outside the scope of CQC registration, where the team are aware of these services being geographically located in the borough or commissioned for RBWM funded residents, the organisations are added to the Care Quality Assurance Team "Provider. List" Excel workbook. Intelligence received about them is captured in team systems, and they are included in the provider risk assessment process. If monitoring or improvement action is identified as required for an organisation of this type, the decision about where this activity best sits would be determined by the Director, Statutory Services on a case by case basis.

3.5. The current structure of the Care Quality Assurance Team, and extended Governance and Quality Assurance Team is attached in appendix 1.

3.6. The current structure of the CQC regulated adult social care market in the borough is attached in appendix 2.

3.7. Care Quality Assurance Team do not currently have a corporately supported database, and instead have created in-house systems which capture information with respect to provider performance and team activity. Data is held in several flat systems which work in isolation rather than as a relational database, many being Excel workbooks. As a result, the information management systems are somewhat task focused, and some reconciliation and analysis tasks are completed manually rather than being automated. As much automation as possible has been built in, within resource constraints, with links between data sets in attempt to ensure efficiency with each piece of data ideally only entered once.

3.8. These systems allow information held across Optalis, and external partner departments to be brought together to provide an overview of how an adult social care provider is performing.

3.9. Statistical dashboards are available with respect to provider and team performance. These dashboards are dynamic and change as required.

[2] Council Strategic Plan 2016-20

Current examples include: numbers of monitoring visits; volumes of feedback or safeguarding alerts received; CQC ratings of providers.

3.10. To make best use of the available Care Quality Assurance Team resource, quality monitoring and service improvement activity is scheduled on a risk assessed basis. Priority is therefore given to intelligence led targeted preventative monitoring and service improvement of particular providers, rather than broad scale routine monitoring of all.

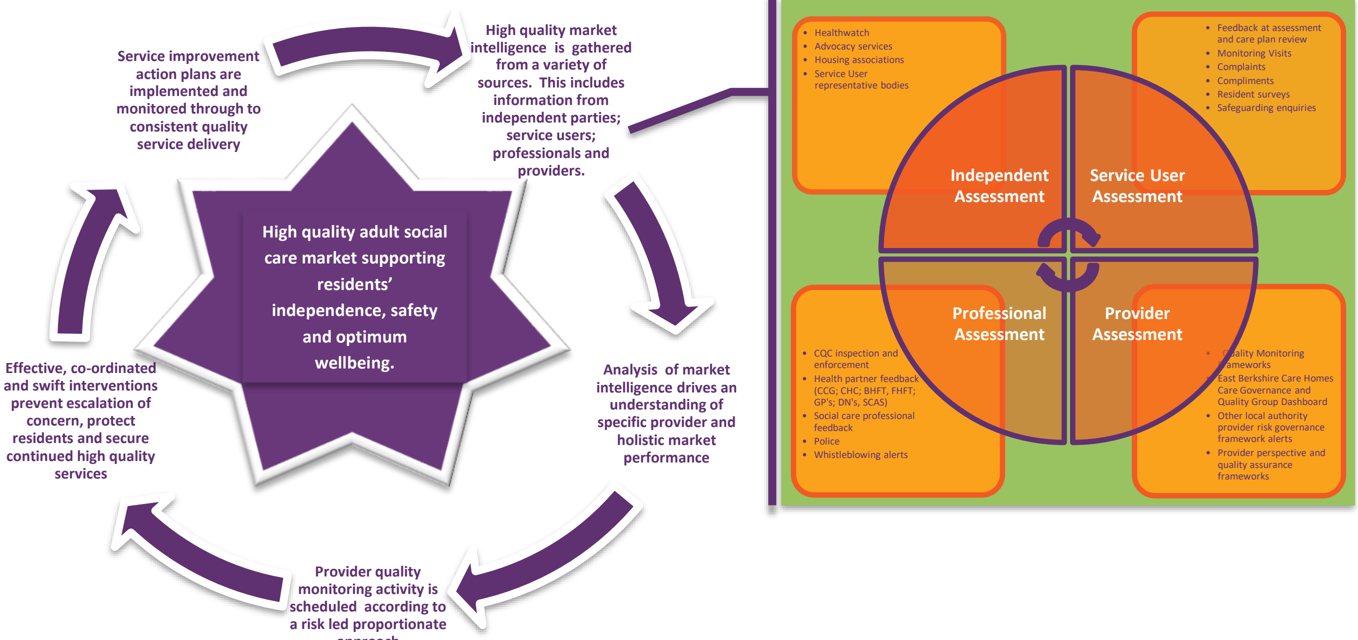
3.11. Provider concerns or achievements are identified through various means, including for example: feedback from Optalis staff, other local authorities or stakeholder organisation staff; CQC compliance ratings; or analysis of provider quality performance indicators.

3.12. The majority of the targeted monitoring activity is led by activities described later in this framework , including: the Risk Matrix, thematic review, Care Governance and Quality Assurance Meeting or organisational safeguarding provider risk governance framework procedures [currently Serious Concerns and Standards of Care frameworks].

3.13. Whilst this targeted monitoring could be viewed as reactive in nature; being implemented as a result of the identification of provider thematic concern. It is the routine monitoring cycle that detects the thematic concern so arguably could be more accurately described as preventative; facilitating provider improvement action before concern escalates. This routine monitoring cycle, including the capture of intelligence and analysis is detailed later in this document.

3.14. The aim of using a risk based preventative approach is to ensure co-ordinated multi-disciplinary action is swift, targeted and proportionate; to raise standards where most required. Also, to limit further or escalated concern ensuring continued resident safety and satisfaction.

3.15. Essentially the Optalis quality assurance approach has five key principles as outlined in the diagram below:



3.16. Information Sharing:

- Quality care is everyone's business, and to ensure services are high quality Optalis involve relevant stakeholders in all stages of the quality assurance cycle.
- To ensure the safety and welfare or service users, Optalis may share quality assurance information with relevant stakeholders, including but not limited to:
  - Relevant Optalis staff
  - The adult social care provider
  - Relevant staff within local authorities and Clinical Commissioning Groups in Berkshire, including relevant staff in commissioned services such as Berkshire Health Foundation Trust (BHFT), Frimley Health Foundation Trust (FHFT), South Central Ambulance Service (SCAS), and local General Practitioners (GP's)
  - Other local authorities and Clinical Commissioning Groups that have commissioned care or support for service users from the adult social care provider
  - CQC
  - Police
  - Healthwatch

3.17. Where of benefit, there is a joint monitoring or quality assurance approach between different Optalis teams, and other outside organisations such as those listed above.

3.18. Care Quality Assurance Team monitor providers' overall performance, and by default the quality of care received by residents. However, responsibility for ensuring individual resident safety and appropriateness of care remains the responsibility of the operational service teams, including the Physical Disabilities and Older People Team; Community Team for People with a Learning Difficulty; the Mental Health Team for Older People; and the Community Mental Health Team. Care Quality Assurance Team provide intelligence to these service teams in order to assist them with their remit and achieving this outcome.

3.19. As well as the preventative targeted work with particular providers, there are various forms of routine planned monitoring activity which review quantitative and qualitative information.

3.20. Key types of provider quality assurance activity includes:

- Monitoring of commissioned provider use, in borough providers, and compilation of a holistic provider list
- Monitoring of volumes and themes of safeguarding alerts and enquiries
- Monitoring of volumes and themes of complaints
- Gathering provider feedback from Optalis staff
- Monitoring resident provider feedback
- Monitoring of feedback supplied by partners (e.g. Healthwatch[3], other local authorities, or health service colleagues)
- Monitoring of significant provider events
- CQC compliance monitoring and regional Pan Berkshire CQC Board Meeting
- Development and maintenance of a provider risk matrix assessment and prioritisation tool

[3] http://www.healthwatch.co.uk/

- Care Governance and Quality Assurance Meeting (monthly)
- Provider and holistic market thematic review
- Organisational safeguarding Provider Risk Governance Frameworks and associated service improvement activity [currently Serious Concerns and Standards of Care Frameworks]
- Monitoring of other local authority caution lists
- The East Berkshire Care Homes Quality Group Meeting steering board and project bi-monthly meetings
- Onsite provider monitoring visits
- Provider service improvement action plans

3.21. The overarching Care Quality Assurance Team approach is one of having clear standards; set out in the RBWM contracts, this Optalis Quality Monitoring Framework and associated organisational safeguarding procedures; with quality assurance, monitoring and service improvement activity to ensure adherence to such.

3.22. In delivering this function, all of the Care Quality Assurance Team activity is framed in a transparent no blame culture and context of continuous learning for Optalis, providers and all stakeholders.

4. ROLES AND RESPONSIBILITIES IN THE QUALITY MONITORING FRAMEWORK

4.1. Optalis Governance and Quality Assurance Team

- The Governance and Quality Assurance Team assure the quality of services delivered by Optalis operational adult service teams, and for adults in receipt of external adult social care services commissioned by those teams. The Governance and Quality Assurance Team is made up of:
- **Optalis Director, Statutory Services:**
- The Director, Statutory Services is accountable to the Optalis Chief Executive for ensuring comprehensive governance and quality assurance procedures are in place and are consistently delivered. This includes having a quality monitoring framework for regulated adult social care providers
- The Director, Statutory Services supports this Quality Monitoring Framework by:
  - Chairing the monthly Care Governance and Quality Assurance Meeting, and owning the multi-disciplinary team agreed actions, minutes and their circulation.
  - Sharing information with the Care Quality Assurance Team and wider Governance and Quality Assurance Team as appropriate. Including, but not limited to, updates regarding RBWM and Optalis contractual arrangements and actions with respect to external providers, and any notification from CQC of enforcement action or notices of proposal.
  - Proposing, agreeing and reporting to RBWM on key performance indicators for the Governance and Quality Assurance Team service, including outcomes of these quality monitoring framework procedures.
  - Owning the routine and ad hoc escalation of placement and quality assurance intelligence, activity and outcomes to RBWM; including key outcomes from this quality monitoring framework approach.

- Agreeing any Optalis commissioning restrictions or placement re-locations deemed required by organisational safeguarding or commissioning procedures. Also escalating these to RBWM as required to allow appropriate contractual action. Sharing any remedial contractual action with the Care Quality Assurance Team and the wider Governance and Quality Assurance Team as appropriate.

- **Care Quality Assurance Team:**
- Working with relevant internal and external partners and stakeholders, the Care Quality Assurance Team assist in ensuring relevant elements of the Optalis, and in turn the council's, vision is achieved by developing, promoting and implementing this Quality Monitoring Framework re high quality external provider services.
- The scope and remit of the team is as detailed in the sections above.
- The Care Quality Assurance Team support this Quality Monitoring Framework by:
  - Completing the forms of quality assurance, quality monitoring and service improvement activity detailed within it.
  - Reviewing this framework with the Care Quality Assurance Team Manager on a bi-annual basis.
  - Feeding into internal and external partner strategies and operational activity to ensure there is a diverse high quality, constantly developing care market available to residents. Allowing residents to have the control to make personalised choices about their care.
  - Contributing to strategic and operational commissioning activity to confirm value for money, ensuring the highest quality services are commissioned within financial constraints.
  - Capturing relevant market intelligence and quality performance indicators; sharing this data to inform relevant activities and strategies, such as commissioning, safeguarding, or service user review.
  - Identifying and addressing themes of poor quality external provider performance swiftly and proportionately, within agreed frameworks. Escalating these via monthly Care Governance and Quality Assurance Meetings to ensure appropriate accountability and oversight from senior management.
  - Supporting individual and organisational safeguarding procedures to ensure vulnerable residents are protected from harm.
  - Supporting Providers through various service improvement or development initiatives.
  - Identifying learning opportunities, both from serious concerns and best practice events, sharing with partners to aid continuous improvement.
  - Working with internal and external colleagues to develop the quality of the sector workforce; to assist adequate availability of appropriate training and in turn competency, and also safe recruitment practices delivering a workforce with the right values.
  - Providing intelligence to service and commissioning teams, as well as RBWM via Care Quality Assurance Team Manager and/or Director,

Statutory Services, in order to assist them with their fulfilling their remits and intended outcomes.

- Attending local and regional quality assurance and intelligence meetings including the Care Governance and Quality Assurance Meeting; East Berkshire Care Homes Quality Group Meeting and the Pan Berkshire CQC Meeting.

- **Safeguarding Adults and Deprivation of Liberty Team:**
- The Safeguarding Adults Team provide the direction, scrutiny and quality assurance of the design and implementation of the organisational (appendix 9) and individual safeguarding procedures[4] within Optalis.
- They assist this Quality Monitoring Framework by:
    - Ensuring safeguarding enquiries and deprivation of liberty safeguards (DoLS) are co-ordinated and of good quality.
    - Capturing and analysing intelligence with respect to volumes, and details of safeguarding alerts, enquiries, investigations and outcomes. Sharing this data with Care Quality Assurance Team.
    - Capturing and analysing intelligence with respect to volumes and details of DoLS's referrals and outcomes.
    - Via a Care Quality Monitoring Form (appendix 3) sharing any individual high risk or potential organisational safeguarding alerts or complaints as well as any whistle-blowing reports with Care Quality Assurance Team as they are identified, or ensuring the relevant Care Manager has done so.
    - Reporting any other provider concerns to the Care Quality Assurance Team via a Care Quality Monitoring Form. This includes any safeguarding themes of concern identified about a provider.
    - Reporting any provider compliments to the Care Quality Assurance Team via a Care Quality Monitoring Form.
    - Sharing any identified good practice with the Care Quality Assurance Team via a Care Quality Monitoring Form.
    - Consulting with the Care Quality Assurance Team about any monitoring or service improvement action that may be required following a safeguarding incident, organisational safeguarding framework or DoLS.
    - Reporting any organisational safeguarding concerns and frameworks to the Care Quality Assurance Team and leading the organisational safeguarding framework procedures. Escalating these to the Strategic Adult Safeguarding Coordinator and/or Director, Statutory Services to ensure appropriate accountability and oversight from senior management.
    - Ensuring appropriate safeguarding response where the Care Quality Assurance Team intelligence or monitoring suggests safeguarding procedures are required.
    - Ensuring restrictions on placements or re-locations are implemented where required, and according to relevant safeguarding and commissioning procedures. Escalating these to Strategic Adult Safeguarding Coordinator and/or Director, Statutory Services to

[4] http://www.sabberkshirewest.co.uk/practitioners/berkshire-safeguarding-adults-policy-and-procedures/

ensure appropriate accountability and oversight from senior management.
- Attending and feeding into Care Governance and Quality Assurance Meetings; identifying provider based themes.

- **Optalis Commissioning Team/ Care Brokerage and Placements Coordinators:**
- Care Brokerage and Placements Coordinators have significant direct contact with residents, and therefore have a wealth of information about the quality of commissioned services.
- The Coordinators execute RBWM standard block and spot placement contracts by arranging adult social care providers to meet the assessed outcomes of eligible adults with care and support needs.
- The Co-ordinators support this Quality Monitoring Framework by:
  - Ensuring there are placement and operational commissioning strategies, policies and procedures in place that support commissioning with the best quality and value services.
  - Ensuring there is a quality assurance element to the placement policy and procedure, and involving the Care Quality Assurance Team in its review.
  - They ensure placement commissioning procedures make clear any placement actions to be taken against providers who consistently deliver poor quality care, or who are subject to organisational safeguarding framework procedures. This includes but is not limited to restrictions on placements or placement re-locations. Also ensuring the procedures include routes for escalation to RBWM, clarifying links to contractual action such as termination of service or any other contractual activity such as default notices.
  - Assisting the Care Quality Assurance Team to maintain an accurate list of commissioned and in borough adult social care services by advising of newly commissioned providers, placements, or termination of contracts or placements.
  - Ensuring appropriate placement documentation, with relevant quality assurance elements.
  - Maintaining records of external provider placements, sharing details and volumes of provider placements with the Care Quality Assurance Team.
  - Via a Care Quality Monitoring Form, reporting any individual, thematic, or placement provider concerns to the Care Quality Assurance Team.
  - Reporting any provider compliments to the Care Quality Assurance Team via a Care Quality Monitoring Form.
  - Sharing any identified provider good practice with the Care Quality Assurance Team via a Care Quality Monitoring Form.
  - Attendance and input or placement volume reporting into the Care Governance and Quality Assurance meeting.
  - Responding to the Care Quality Assurance Team requests for information or action in a timely manner.

4.2. Director, Statutory Services:

- The Director has oversite for the management of all Optalis operational staff, and is accountable to the Optalis board and RBWM for ensuring adequate and comprehensive business systems and processes are in place to deliver the services laid out in the contract with RBWM.
- The Director supports this Quality Monitoring Framework by:
  - Via the line management of the Care Quality Assurance Team Manager, owning this framework with all associated procedures.
  - Sharing information with the Care Quality Assurance Team and wider Governance and Quality Assurance Team as appropriate, including but not limited to updates regarding RBWM and Optalis contracting arrangements with external providers, and any notification from CQC of enforcement action or notices of proposal.
  - Reviewing the minutes of the monthly Care Governance and Quality Assurance Meeting, and directing any further provider related action deemed required or changes to the multi-disciplinary agreed actions.
  - Maintaining oversite of the reporting to RBWM, and directing any additional or ad hoc notifications required as a result of this Quality Monitoring Framework activity.

4.3. Operational Service Teams Occupational Therapy Team and First Contact and Duty Team:

- Service area teams retain responsibility for ensuring care is appropriate to meet the needs and outcomes of individual residents, and for maintaining resident safety.
- By the nature of the service, care management, first contact and duty team members, and occupational therapy colleagues have the most contact with residents, who can supply much feedback about the quality of commissioned adult social care services.

- These teams , support this Quality Monitoring Framework by:
  - Managing Optalis response to individual safeguarding alerts, complaints and compliments.
  - Reporting any provider concerns to the Care Quality Assurance Team via a Care Quality Monitoring Form. This includes individual safeguarding enquiry or investigation outcomes, complaints and lower level concerns, but also any themes of concern identified about a provider.
  - Sharing any individual high risk or potential organisational safeguarding alerts with the Care Quality Assurance Team as they are identified via email.
  - Reporting any provider compliments to the Care Quality Assurance Team via a Care Quality Monitoring Form.
  - Sharing any identified provider good practice with the Care Quality Assurance Team via a Care Quality Monitoring Form.
  - Attending and feeding into the monthly Care Governance and Quality Assurance Meeting at service or team manager level.
  - Arranging a representative volume of reviews or spot welfare checks to gather further intelligence when provider based themes of concern or CQC non-compliance are identified.

- Ensuring appropriate service response where the Care Quality Assurance Team intelligence or monitoring suggest safeguarding or care management procedures are required.
- Responding to the Care Quality Assurance Team requests for information or potential action in a timely manner.

4.4. Royal Borough of Windsor & Maidenhead (RBWM):

- RBWM have a direct impact on this Quality Monitoring Framework. The scope of their role that applies has been detailed above in section 1.
- RBWM support this Optalis Framework by:
  - Within the agreed communication channels, sharing anything of relevance to this Framework with the Care Quality Assurance Team Manager and/or Director, Statutory Services for distribution to the Care Quality Assurance Team as relevant, such as:
    - Assisting the Care Quality Assurance Team to maintain an accurate list of commissioned and in borough social care services by advising of new providers, contracts or termination of contracts/ placements.
    - Managing block contracting arrangements and advising of changes.
    - Ensuring availability of appropriate block and spot contractual documentation, containing relevant quality assurance elements.
    - Ensuring strategic commissioning procedures and or contractual documents make clear any actions to be taken against providers who consistently deliver poor quality care, including but not limited to restrictions on commissioning or placement activity; termination of service or any other contractual activity such as default notices.
    - Sharing any individual, thematic, or contractual provider concerns.
    - Sharing any provider compliments.
    - Sharing any identified good practice.
    - RBWM monitor and manage provider contract performance, including contract review procedures, and will share outcomes as relevant.
    - Arranging market development activity, including provider forums, and inviting Optalis to attend or input to the agenda.
    - Agreeing relevant performance reports and indicators for the Governance and Quality Assurance Team, including outcomes of the Framework procedures.
- **RBWM Finance Team:**
  - Optalis purchase services from the RBWM Finance Team. The finance team ensure providers receive appropriate agreed compensation for the services delivered to adults in receipt of care.
  - They support the Quality Monitoring Framework by:
    - Assisting the Care Quality Assurance Team to maintain an accurate list of commissioned and in borough social care services by sharing their commissioned provider spreadsheets on a monthly basis.

5. QUALITY STANDARDS:

5.1. The Care Quality Assurance Team review providers' performance by shaping the monitoring approach and tools using relevant standards set out in legislation, and the guidance published by nationally recognised bodies. Some examples of these include:

- Quality Matters[5]
- CQC regulations[6]
- The National Institute for Health and Care Excellence (NICE) relevant guidelines and quality standards[7]
- The Care Act 2014[8]
- The Social Care Institute for Excellence (SCIE) guidance[9]
- Skills for Care guidance[10]
- Care Improvement Works[11]
- Research in Practice for Adults (RIPFA) resources[12]
- My Homelife[13]
- The Institute of Public Care (IPC)[14]
- Department of Health (DoH)[15]
- Nursing and Midwifery Council (NMC)[16]
- Royal College of Nursing (RCN)[17]
- Public Health England (PHE)[18]
- NHS England[19]
- Think Local Act Personal (TLAP)[20]
- Health and Safety Executive (HSE) [21]
- Association of Directors of Adult Social Services (ADASS)[22]
- Local Government Association (LGA).[23]

5.2. The Care Quality Assurance Team adhere to standards set by relevant internal and local procedures, including for example the Berkshire Multi-agency Safeguarding Adult's Policy and Procedures[24], and commissioning procedures. The Care Quality Assurance Team ensure quality assurance activity supports and compliments these.

5.3. The Care Quality Assurance Team also incorporate relevant contractual indicators into the quality monitoring process and tools.

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[5] https://www.gov.uk/government/publications/adult-social-care-quality-matters
[6] http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulations-service-providers-managers
[7] https://www.nice.org.uk/guidance
[8] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
[9] https://www.scie.org.uk/atoz/
[10] http://www.skillsforcare.org.uk/home.aspx
[11] http://www.careimprovementworks.org.uk/
[12] https://www.ripfa.org.uk/
[13] http://myhomelife.org.uk/
[14] http://ipc.brookes.ac.uk/about-ipc.html
[15] https://www.gov.uk/government/organisations/department-of-health
[16] https://www.nmc.org.uk/
[17] https://www.rcn.org.uk/
[18] https://www.gov.uk/government/organisations/public-health-england
[19] https://www.england.nhs.uk/
[20] https://www.thinklocalactpersonal.org.uk/
[21] http://www.hse.gov.uk/
[22] https://www.adass.org.uk/home
[23] https://www.local.gov.uk/
[24] https://www.berkshiresafeguardingadults.co.uk/

6. FORMS OF QUALITY ASSURANCE AND MONITORING:

- An overview document detailing the over-arching quality monitoring assurance framework business process is attached in appendix 4; and complimentary processes for capturing provider intelligence (appendix 5) and recording monitoring action and outcomes (appendix 6) are also attached.
- Main data held by the Care Quality Assurance Team is illustrated by the attached database overview in appendix 7.

6.1. Monitoring of commissioned provider use:

- It is important that the Care Quality Assurance Team have an accurate record of providers currently commissioned by Placement Co-ordinators and service teams for long-term placements; in order to ensure these providers are subject to ongoing quality assurance and monitoring activity.
- The Care Quality Assurance Team maintain an Excel workbook “Provider. List” that details commissioned and in borough providers the team are aware of. This includes CQC regulated providers, but also any unregulated adult social care supported living providers the team are aware of.
- Of commissioned providers, only those with long-term placements are included on the Provider List, and therefore subject to this Framework (i.e. excluding interim, respite or temporary placements which would include property disregard placements).
- For interim, respite or temporary placements, the pre-placement checks completed by service teams and the Placement Co-ordinators, as well as care management activity perform the quality assurance function.
- The population of this Provider List workbook is supported by the following Excel workbooks which allow for the auto population of some details:
  - “Data.Brokerage.for.Provider.List”
  - “Data.Finance.for.Provider.List”
  - “Data.CQC.Location.for.Provider.List”
  - “Data.CQC.Rating.for.Provider.List”
- The commissioning type, service area and status of providers, including any new or de-commissioned providers, is manually updated on a monthly basis, by the end of the second week of any month. This is done by reconciling against the RBWM Finance Team placement spreadsheets and Brokerage performance reports. This ensures accuracy of content, and thereby efficient use of resource and focused activity.
- The regulated provider location details, including the address, overall provider group, regulated activity, service type, service user categories, and CQC overall compliance rating are downloaded on a monthly basis from the CQC website: https://www.nhs.uk/service-search/performance/downloaddata
- The unregulated provider location details including the address, overall provider group, service type, and service user categories are updated on a six monthly basis. The Care Quality Assurance Team contacts providers directly to do this.
- Email addresses for the provider, including the Registered Manager and Nominated Individual are manually updated.
- Full procedures for the update and maintenance of data can be found within the respective workbooks.

- The Provider List workbook facilitates reporting on the structure and characteristics of the commissioned and local social care market, as well as their CQC inspection outcomes. The Care Quality Assurance Team have created various pivot tables and charts to illustrate this, details are attached in the database overview.

6.2. Tracking of safeguarding cases, complaints, Optalis, Service User/Resident and other partners feedback:

- Market intelligence is important to ensure monitoring activity is appropriately informed and resourced to maintain and improve performance, and prevent concerns or risk to residents. It is vital to inform the targeted monitoring plan for specific providers.
- Information sharing from stakeholders is encouraged, with various procedures or information sharing protocols in place ensuring the Care Quality Assurance Team receive relevant information regarding provider performance and quality.
- The Safeguarding Officer manages the recording of individual safeguarding alerts via the “Safeguarding.Alert.Tracker” Excel workbook. The Care Quality Assurance Team have created and maintained provider based pivot tables and charts to create a visual dashboard illustrating provider based safeguarding themes and trends.
- To uniform the approach to feedback and ensure efficiency and consistency, where possible feedback is requested via a Care Quality Assurance Team Care Quality Monitoring Form This includes feedback from: compliments, complaints, review feedback, safeguarding enquiry or investigation feedback, DoLS review feedback, health review feedback, Healthwatch or voluntary sector feedback, whistleblowing alerts, and general monitoring information.
- There is an example template of the Care Quality Monitoring Form attached, appendix 3. The Care Quality Monitoring Form captures the details of the feedback, whether it is generally positive or negative, as well as the outcomes of any action taken by the referrer, and the appropriateness of the provider’s response. The form is mapped to CQC standards and regulations. This allows for individual provider, and holistic market analysis of thematic strengths and weaknesses tied to the CQC standards. It also equips the team to provide detailed feedback to CQC requests for intelligence, and focused individual and strategic market improvement support to providers.
- The Care Quality Assurance Team have an Excel workbook “Provider.Intelligence.Database” where this feedback is recorded and volumes are analysed, supported by the routine qualitative analysis of content. The form has been built in a way that allows for the leanest approach to data entry, with the referrer typing details, as they would in an email or other notification, selecting from pre-formatted drop down lists where possible to ensure consistency. This simply requires The Care Quality Assurance Team to copy and paste content into the main cumulative workbook.
- The Care Quality Assurance Team have developed a dashboard of pivot tables and charts that illustrate key elements and trends in the provider based feedback allowing both a thematic and chronological view of performance.

- The Care Quality Assurance Team intelligence is reviewed as it is received and escalated to other service areas where required, ensuring appropriate placement commissioning, review and safeguarding action can be taken if deemed required by relevant teams. The Care Quality Assurance Team Manager and/or Director, Statutory Services escalates to RBWM as needed via the agreed communication channels. Service areas are requested to advise The Care Quality Assurance Team if they intend to take any further action, as per the attached business processes.
- The intelligence is also reviewed on a more holistic risk assessed basis at monthly intervals via the Risk Matrix and Care Governance and Quality Assurance Meeting and the associated thematic review which are explained in more detail in the sections below.
- Themes are identified and escalated to relevant internal colleagues as established, and also more routinely via the Care Governance and Quality Assurance Meeting to enable appropriate oversight, accountability and multi-disciplinary decision making on action required. The Care Quality Assurance Team may implement broad provider level service improvement activity, but the service areas remain responsible for ensuring individual resident safety.
- Themes may also potentially be shared with external stakeholders via information sharing agreements, for example at the Pan Berkshire CQC Board meeting or at the bi-monthly East Berkshire Care Homes Quality Group Meeting.
- Any Care Quality Assurance Team actions deemed necessary from data receipt or analysis are recorded in the Excel workbook "Provider.Monitoring.Action.Database" and followed through to completion.
- The data and analysis can also be used in individual resident and organisational safeguarding processes, to identify broader or repeat themes which may require action either by Optalis or the provider.
- Where appropriate, The Care Quality Assurance Team may attend individual safeguarding meetings where there are concerns about the provider's performance and the relevant resident consents to such.
- There are development opportunities in these areas of monitoring, and if resources ever allow, the intention is to develop more formal benchmark and comparator systems for the different types of feedback, potentially allowing further development of the Risk Matrix and risk grades for the various elements.
- Another development would be to enhance the routine monitoring of service user feedback. Service user feedback is gathered via review feedback, and safeguarding enquiry or investigation feedback, as well as onsite at monitoring visits.

6.3. Provider significant events:

- Provider significant events are known to have potential to impact on the quality of care delivered.
- Where notified or identified, The Care Quality Assurance Team record significant provider events in the "Provider.Intelligence.Database". These include for example: changes in management, location, overall provider group, and de-registration or closure.

- This allows for both a chronological and volume assessment, for example the number of management changes in a 12 month period, or similar.
- This data is assessed as part of the thematic review, and may in future be added to the Risk Matrix as this process is developed.
- Significant events are escalated to other service areas where required ensuring appropriate placement commissioning, review and safeguarding action can be taken if deemed required by relevant teams. The Care Quality Assurance Team Manager and/or Director, Statutory Services escalates to RBWM as needed as per agreed communication arrangements. Service areas and Care Brokerage/Placement Co-ordinators are requested to advise The Care Quality Assurance Team if they intend to take any further action as per the attached business processes; the service areas remain responsible for ensuring resident safety, and that appropriate contractual and placement documentation is in place.

6.4. CQC compliance monitoring and the Regional Pan Berkshire CQC Board Meetings

- The scope of CQC regulated activity can be found at:
- http://www.cqc.org.uk/content/regulated-activities
- The standards that apply to different forms of regulated providers and activity can be found at:
  - http://www.cqc.org.uk/content/regulations-service-providers-and-managers
- Compliance with regulations is considered a key quality performance indicator of the market and The Care Quality Assurance Team monitor this in order to ensure poor practice is improved and good practice is shared, to facilitate a culture of continuous improvement.
- The Care Quality Assurance Team attend the joint bi-monthly regional CQC, local authority and healthcare Pan Berkshire CQC Board. Local authorities and healthcare colleagues share information regarding provider contractual and quality performance (often in the form of framework or caution lists), and CQC share intelligence and inspection activity. Hard and soft intelligence is shared, and brief action logs are recorded for the meetings. The Pan Berkshire CQC Care Quality Board ensures timely and appropriate action from all parties and therefore safeguards vulnerable residents.
- The Care Quality Assurance Team also sign up to CQC provider inspection alerts for commissioned regulated providers, and all in borough regulated providers regardless of commissioning status. This ensures The Care Quality Assurance Team receive accurate timely information with respect to regulatory action and provider performance.
- The Care Quality Assurance Team sign up to CQC newsletters and publications in order to keep up to date, maintain knowledge, and in order to share any relevant information with providers.
- As mentioned in an earlier section, on a monthly basis, by the second week of the month, The Care Quality Assurance Team download the current CQC published ratings for social care providers into the "Provider. List" Excel workbook, allowing a snapshot view of current commissioned and local social care market performance.

- The Care Quality Assurance Team also capture the CQC compliance of said provisions within the "Provider.Intelligence.Database". Within this workbook, The Care Quality Assurance Team track compliance status with respect to the overall rating, and more specifically with respect to the CQC 5 Key Lines of Enquiry (KLOE's). Data is captured for each new CQC site review whilst also retaining previous review results. This allows for a chronological view of provider compliance performance; as well as for the market as a whole.
  The Care Quality Assurance Team circulate changes to providers' current compliance status to relevant Optalis management teams and Care Brokerage/Commissioning Team Placement Co-ordinator as alerts come in, ensuring appropriate placement commissioning, review and safeguarding action can be taken if deemed required by relevant teams. The Care Quality Assurance Team Manager and/or Director, Statutory Services escalates to RBWM as needed.
- For the RBWM based providers whom Optalis/RBWM commission with the Care Quality Assurance Team implement prevention focused targeted monitoring tasks where a provider is rated by CQC as inadequate or requires improvement overall. Dates and outcomes of this are recorded on the "Provider.Monitoring.Action.Database". Where relevant The Care Quality Assurance Team:
  - Contact the provider to request their CQC action plan and progress update. Assess whether the action plan should address the areas of non-compliance, and within an appropriate time-frame.
  - Assess information held by Optalis regarding the Provider, such as volumes of complaints, safeguarding or provider feedback received by The Care Quality Assurance Team
  - Assess whether all of the above information should reasonably reduce or escalate the compliance concerns. If the assessment increases concern, The Care Quality Assurance Team escalate this to service teams, Care Brokerage/Placement Co-ordinators and Director, Statutory Services, and set a timescale for reviewing the situation.
- The Risk Matrix (identified in 6.5.)allows for Providers rated by CQC as inadequate or requiring improvement overall and for whom there is new feedback identified via 6.2 to be distinguished and discussed at the Care Governance and Quality Assurance Meeting, in order to ensure prompt action where required.
- Provider CQC ratings are routinely reviewed within the monthly Care Governance and Quality Assurance Meeting with a focus on the most non-compliant provisions; to ensure any action is agreed in a multi-disciplinary fashion, co-ordinated, implemented and monitored routinely to ensure effective and swift impact.

6.5. Risk Matrix:

- The Care Quality Assurance Team maintain a monthly risk assessment and prioritisation tool within the Excel workbook "Risk Matrix".
- The Risk Matrix details risk rated quality and location characteristic indicators for all commissioned and in borough located providers.

- There are quantitative and qualitative indicators within the Risk Matrix, including, where applicable to the service type:
  - **Risk Rating Indicators:**
    - Whether the provider location is regulated or unregulated
    - Whether the provider location is located within the borough
    - Whether there are current Optalis funded placements
    - The category of placements (such as residential or supported living etc.)
    - Whether the provider location is subject to a block or spot contract
    - Whether the provider location is a supported living site, housing a number of residents
    - Whether Care Quality Assurance Team monitor the provider as a regulated provider supplying staff to an unregulated site (such as a supported living scheme)
    - If a care home or supported living site, the size, identified by the maximum number of available beds
    - Whether there is a Registered Manager / manager of unregulated site in place
    - Whether the provider location has been subject to CQC enforcement action within the last 12 months
    - Whether the last published CQC site inspection is older than 1 year
    - The latest CQC ratings:
      - Overall
      - Safe
      - Effective
      - Caring
      - Responsive
      - Well-led
    - The latest published food hygiene rating
    - Annual staff turnover level (included if the provider supplies information to the National Minimum Data Set, NMDS[25])
    - Annual registered nurse turnover (included if provider supplies information to the NMDS)
    - Optalis organisational framework status as illustrated currently by the Quality Improvement List (QUIP 1)
    - Other local authority caution list status as illustrated currently by the Quality Improvement List 2(QUIP 2)
    - Whether the last care quality assurance team comprehensive monitoring visit is older than 1 year
    - Last care quality assurance team comprehensive visit rating
    - The care quality assurance team current monitoring rating
    - Short term monthly positive provider feedback benchmark performance
    - Short term monthly negative provider feedback benchmark performance
    - Short term monthly safeguarding volume performance benchmark

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[25] https://www.nmds-sc-online.org.uk/

  - Longer term annual provider positive feedback benchmark performance
  - Longer term annual provider negative feedback benchmark performance
  - Longer term annual safeguarding volume performance benchmark
- **Quality Assurance Intelligence Indicators:**
  - Short term monthly count of positive provider feedback
  - Short term monthly count of negative provider feedback
  - Short term monthly count of safeguarding alerts alleging abuse at this location/ for community care: involving this location
  - Longer term annual count of positive provider feedback
  - Longer term annual count of negative provider feedback
  - Longer term annual count of safeguarding alerts alleging abuse at this location/ for community care: involving this location
- **Overall Ratings:**
  - Cumulative risk indicator rating
  - Cumulative quality assurance intelligence rating
  - Total overall risk rating

▪ The individual indicators are weighted and prioritised according to their inherent risk level. This is determined by both their risk to the quality of care, potential impact on service users, and also their risk level and potential impact on Optalis and RBWM as the commissioner or host authority. Details of weightings and priorities are contained within the workbook.

▪ These individual indicators' risk rating scores are summed to create a cumulative risk indicator rating, a cumulative quality assurance intelligence rating, and a resultant total overall provider risk rating which is illustrated as high, medium to high, medium, or low. The overall outcome determines possible further action.

▪ It is important to note that this rating is an internal indicator only; further action and analysis, including a provider risk assessment, is required to establish and validate the actual level of risk presented by the specific provider and the actions required to reduce this.

▪ Some indicators are downloaded from My NHS: https://www.nhs.uk/service-search/Performance/DownloadData and are held in a supporting Excel workbook: "Data.NHS.Care.Homes.for.Risk.Matrix". These include the food hygiene rating and staff turnover indicators. They are updated on a monthly basis, by the second week of the month, and auto-populated into the risk matrix. Full procedures can be found in the relevant workbook.

▪ Remaining indicators are populated from other care quality assurance team workbooks, and this process is automated where possible. Where the process is automated the relevant indicators are updated continuously as the source workbooks are updated. Otherwise, they are updated on a monthly basis prior to the Care Governance and Quality Assurance Meeting. Full procedures can be found in the relevant workbook.

▪ The data is refreshed holistically on a monthly basis, by the end of the second week of any month, and reflects the data collected for the previous

month. The Risk Matrix has been built to allow for a monthly review of provider status at the Care Governance and Quality Assurance Meeting. Changes in risk status will not be identified or reviewed between meetings as the norm.

- Providers rated overall as medium to high or high risk will be reviewed at the Care Governance and Quality Assurance Meeting, where any required risk reduction actions will be agreed and monitored. The providers will have an allocated monitoring, safeguarding and service area lead where required. This process is explained further in the section below.
- The Care Quality Assurance Team keep a monthly cumulative history of provider ratings for each indicator in order to create a chronological view of provider and market performance.

6.6. Care Governance and Quality Assurance Meeting:

- [Currently, on a monthly basis a thematic review takes place and considers providers with 3 or more safeguarding alerts or care quality assurance team feedback alerts in the previous month; and on a quarterly basis any providers with 8 or more or 2 or less safeguarding alerts or care quality assurance team provider feedback alerts over the previous rolling 12 month period. The Care Quality Assurance Team thematic dashboards are reviewed for these providers and required actions are identified. The outcomes of the thematic review and proposed actions are escalated to the Care Governance and Quality Assurance Meeting and agreed on a multi-disciplinary basis there].
- This meeting provides the relevant governance, oversite and scrutiny of any quality assurance, monitoring, service, placement or commissioning activity. Thus, ensuring consistency across Optalis and partners, and for providers.
- This monthly meeting is organised by the Care Quality Assurance Team, and will always be chaired by the Director, Statutory Services or Strategic Adult Safeguarding Coordinator.
- The meeting will usually be held in the third week of any month, and will review the data and intelligence captured up to and including the previous month.
- The meeting has a set terms of reference and will follow a set agenda and risk assessment procedure (appendix 8).
- Brief minutes are circulated to all invitees as soon as possible following the meeting according to the terms of reference.
- Invitees are:
  - Director, Statutory Services
  - The Care Quality Assurance Team
  - A representative from the Business Support Team (minutes)
  - Strategic Adult Safeguarding Coordinator, and Officer
  - Service Leaders/Team Managers for each of the adult social care service areas
  - Optalis Care Brokerage/Placement Co-ordinator
  - Continuing Health Care (CHC) Placement and Governance Lead
  - Continuing Health Care (CHC) Commissioning Manager
  - Clinical Commissioning Group (CCG) nominated safeguarding lead

- Berkshire Health Foundation Trust (BHFT) nominated safeguarding lead
- CQC Regional Compliance Manager
- RBWM Strategic Commissioning Team

- The Care Quality Assurance Team uses the "Risk Matrix" workbook to determine providers requiring discussion and further review; those rated as medium to high or high overall risk rating will be scheduled for review in the meeting.
- The meeting is time limited, so providers are reviewed following this risk based methodology. So, a provider with a higher risk rating, or a high risk rated provider for whom there is new intelligence will be prioritised for discussion.
- Where Providers rated as medium to high or high are not discussed, this is made clear in the minutes so that recipients can escalate if they are aware of any information that would require this decision to be reviewed, or an additional meeting to be arranged.
- For providers who are newly rated as medium to high or high by the Risk Matrix, stakeholder intelligence is shared and provider thematic dashboards held by The Care Quality Assurance Team are reviewed. This allows for both recent and longer term themes and trends to be identified and any appropriate action agreed.
- For providers for whom the meeting has previously set actions that remain open, or that were rated overall as medium to high or high at the previous month's meeting and remain as such, any new intelligence will be reviewed to determine whether previously agreed decisions or actions remain valid, or whether any further action is required.
- Providers rated overall as medium or low who were rated as medium to high or high in the last month's meeting will have any ongoing actions reviewed to ensure appropriateness given the decreased overall risk status. However, the decreased overall status could be due to the impact of the risk reduction actions that are in hand so the change in rating should not lead to automatic ceasing of action.
- Internal and external stakeholders, including health and regulator partners, are expected to contribute to the meeting and to be able to provide data with respect to their intelligence held about providers. (Further development would be for this data to be held in shared systems).
- Providers who are currently within an organisational safeguarding framework also have their service improvement action progress monitored at this meeting. This assists in ensuring consistency and equity of the framework approach.
- As well as reviewing provider based themes, the meeting also identifies and acts on other contextual and market based themes identified in the data, such as quality of workforce, care delivery or training. Therefore ensuring escalation of such for strategic level activity.
- The meeting also aims to identify any good practice, to ensure recognition and sharing of best practice to facilitate learning.
- Any required preventative or remedial actions and roles are agreed on a multi-disciplinary basis, with timescales proposed. The intention of any action would be to reduce the overall risk level, within an appropriate time frame.

- Consideration is always given to complimentary policies and procedures, such as the Berkshire Multi-Agency Safeguarding Policy and Procedures; Optalis organisational safeguarding and provider failure procedures, NHS England's serious incident framework[26], and the local Safeguarding Adults Partnership Board's safeguarding adults review procedure[27].
- Where a provider is identified, by the Risk Matrix, as medium to high or high overall risk rating (including any subsequent review of intelligence) is identified, a threshold decision will be made as to whether an organisational safeguarding provider risk governance framework procedure will be implemented by the Strategic Adult Safeguarding Coordinator (see section 6.8 below).For other providers, agreed risk reduction actions may include some of the other forms of monitoring detailed in this document. For example, a deep dive provider thematic review may be requested; the meeting may trigger an organisational safeguarding framework threshold meeting; an onsite visit or the implementation of a service improvement action plan.
- Attendees at the Care Governance and Quality Assurance Meeting are responsible for escalating any provider, process or action based concerns at the meeting. The Chair of Care Governance and Quality Assurance meetings carries the decision making responsibility and accountability, and is responsible for ensuring delegation of tasks to appropriate roles.
- Where the meeting has proposed actions which are not deliverable due to resource constraints, conflicting priorities or for any other reason, the Chair of Care Governance and Quality Assurance meeting must decide on appropriate alternative risk reduction measures to assure ongoing safety of residents, and quality of the market.

6.7. Provider Thematic Review:

- The Care Quality Assurance Team hold much intelligence regarding providers. When requested, or when the need is identified; for example by any of the other quality assurance processes mentioned and in particular the Care Governance and Quality Assurance Meeting; The Care Quality Assurance Team can analyse this data to identify any provider thematic trends of concern or commendation.
- Data is analysed to identify both short term and long term themes and trends.
- The team have created various pivot tables and charts that extract the data from the teams systems, assist with this process and provide a visual illustration of performance; (details can be seen in appendix 7). However, deep dive thematic reviews can also be performed. These are more qualitative in nature, reviewing the content of intelligence rather than just the category.
- As detailed in the section above, for providers identified in the Care Governance and Quality Assurance Meeting as medium to high or high overall risk rating by the Risk Matrix, this headline thematic analysis will be completed within the meeting where possible. If a further deep dive analysis is required, this will be requested by the meeting.

[26] NHS England: Serious Incident Framework- Supporting learning to prevent recurrence
[27] RBWM Safeguarding Adults Board: Safeguarding Adults Review (SAR) Framework

- The outcomes of the thematic review are recorded in the "Provider.Monitoring.Action.Database” in terms of whether it caused the provider monitoring action to escalate or de-escalate, and whether any further monitoring action was required as a result of the review.
- The recording of the detail of any identified trends is dependent on the process that dictates the initial need, but will likely be in the form of an email; or via verbal report at the Care Governance and Quality Assurance Meeting which will be captured in the minutes.

6.8. Provider Risk Governance Frameworks and Provider Risk Governance List 1:

- The current organisational procedures are Serious Concerns and Standards of Care Frameworks (appendices 9 and 10), and the framework list is called a Quality Improvement List (QUIP) 1 (appendix 11)].
- Optalis have delegated statutory safeguarding duties to protect adults' right to live safely, protected from significant harm as a result of abuse or neglect. These duties apply to any adult who has care and support needs and is experiencing or is at risk of abuse or neglect, and is unable to protect themselves from either the risk of, or experience of abuse or neglect because of those needs. This includes adults regardless of their mental capacity, eligibility for local authority social care support, or funding status.
- Optalis also therefore have the delegated authority to manage organisational level safeguarding concerns, where adults meeting the criteria above have experienced or are at risk of experiencing abuse or neglect due to an organisations practice.
- Serious quality assurance concerns, or concerns regarding a provider's operational or financial stability could also lead to organisational level safeguarding concerns as it is possible they have or will impact these service users.
- The Strategic Adult Safeguarding Coordinator retains responsibility for the management and co-ordination of this area of quality assurance and safeguarding activity.
- As explained in the section above; in the Care Governance and Quality Assurance Meeting if a provider is deemed to be of "high" risk, and therefore of organisational level safeguarding concern, a Provider Risk Governance Framework is implemented by the Strategic Adult Safeguarding Coordinator. If urgent provider concerns arise between the monthly Care Governance and Quality Assurance Meetings, the identifying service area report this to the Care Quality Assurance Team, the Strategic Adult Safeguarding Coordinator and Director, Statutory Services via a Serious Incident Notification Form (Appendix 13). A virtual provider risk assessment is then completed by relevant parties to determine whether an organisational safeguarding framework approach is required. If so, the framework would be implemented without delay, with the outcome of this ad hoc assessment and any action taken being reported back to the next Care Governance and Quality Assurance Meeting for multi-disciplinary review and agreement.
- The full procedure and criteria for assessing the threshold for entry into a framework, and the process to be followed once the threshold has been met is attached in appendices 9 and 10.

- This process may determine that commissioning activity, such as placement restrictions, re-commissioning or placement re-locations are required. Where this is the case, the Strategic Adult Safeguarding Coordinator will agree this with the Director, Statutory Services and notify relevant parties.
- The Care Quality Assurance Team are a key participant in Provider Risk Governance Frameworks; with each provider subject to such having an allocated quality assurance lead. The Care Quality Assurance Team attend the main and sub-group meetings, and complete any requested quality monitoring activity that falls within remit.
- In the spirit of candour and partnership working, relevant external stakeholders are invited to join these frameworks, including CCG/ CHC/ BHFT safeguarding leads, CQC, and other commissioners purchasing the provider's services. Other parties may be invited to join the framework if required and relevant, and details are specified in the attached procedure.
- When a provider enters a provider risk governance framework they are entered onto the Quality Improvement List (QUIP) 1 (appendix 11). This document provides some headline details, and sets out any commissioning restrictions.
- The Quality Improvement List (QUIP) 1 is maintained and circulated within 1 working day after the Care Governance and Quality Assurance meeting by the Safeguarding Officer.
- This live document is saved on a secure shared drive accessible to Optalis service operational staff. It is shared upon update with Berkshire local authority, CCG, CHC and BHFT safeguarding leads, RBWM Deputy and Appointeeship Team, the Emergency Duty Team and CQC. Updates are provided to RBWM by the Strategic Adult Safeguarding Coordinator /or Director, Statutory Services via the communication channels agreed.
    - Providers subject to a provider risk governance framework must implement a service improvement action plan to address the concerns and reduce the presented risk level within an appropriate timescale. The actions must be specific, measurable, achievable, realistic, and time-scaled (SMART).
- Providers on this list are subject to increased multi-disciplinary quality monitoring activity.
    - For operational service teams, this may be in the form of spot welfare checks, or increased reviews, with governance provided by the Care Governance and Quality Assurance Meeting.
    - For the Care Quality Assurance Team , this activity could take any of the forms detailed in this Quality Monitoring Framework, and will be determined as part of the organisational safeguarding framework process with governance provided by the Care Governance and Quality Assurance Meeting.
    - For the Safeguarding Team, as well as leading the framework approach, this may include for example further individual or organisational level safeguarding enquiries, or safeguarding awareness raising activity with the provider.
    - External stakeholders may also implement actions, for example reviews, inspections, or regulatory activity.

- The Strategic Adult Safeguarding Coordinator ensures appropriate records are kept at each stage of the framework, as per the procedure.
- Start and end dates of the frameworks, and whether they resulted in escalation or de-escalation are recorded by The Care Quality Assurance Team in the “Provider.Monitoring.Action.Database”.
- As detailed above, the Provider Risk Governance Framework and the resultant service improvement action plan progress is a routine agenda item for reporting at the Care Governance and Quality Assurance Meeting which provides the oversite and governance for these procedures.
- The Director, Statutory Services report on a routine monthly basis to RBWM on the Optalis key performance indicator: percentage of establishments in a serious concerns framework moved on within 6 months (target 50%).

6.9. Other Local Authority Provider Risk Governance Frameworks :

- Local authorities often have “caution lists”, where providers identified as having performance concerns and or placement embargoes are listed, this includes those providers subject to organisational safeguarding frameworks. Some local authorities share these lists with others in their region.
- Within the “Provider.Intelligence.Database”, the Care Quality assurance Team capture the provider detail of all local authority caution list alerts, regardless of Optalis commissioning status. Providers rated as “red”-embargoed, “amber” - place with caution, or “green” are recorded.
- Upon receipt, the Care Quality assurance Team share this information with the Optalis Commissioning Team (Care Brokerage /Placement Co-ordinators) and with the operational service teams to ensure appropriate placement decisions are made with respect to future placements; and consideration of reviews for any existing placements at the earliest opportunity.
- Dates of application of any placement restriction and removal are recorded to build a chronology and to allow a longer term view of a Provider’s performance.
- Other than Risk Matrix review if required, the Care Quality assurance Team would not routinely complete further monitoring activity for providers outside RBWM identified by these other local authority alerts, as this would duplicate action in place by the host authority.
- Service teams should ensure their respective procedures include confirming existing placement safety, and contacting the host authority to ensure representation at any provider meetings if required.
- Providers on the other local authority “caution lists” for whom there is new intelligence received in the relevant month will be illustrated on the Risk Matrix, and therefore reviewed where relevant in the Care Governance and Quality Assurance Meeting the Care Quality assurance Team review the “Provider.Intelligence.Database” and specific provider chronologies via a thematic review if the meeting deems necessary.

6.10. East Berkshire Care Homes Care Quality Group Meeting (Currently Bi-monthly):

- This is a joint meeting between East Berkshire local authorities, CCG and health trusts.

- It includes some projects funded by the Better Care Fund[28] and Frimley Health Sustainability and Transformation Partnership[29] (STP); with objectives shared across East Berkshire organisations.
- There is a possibility this group will expand to include all of the Frimley Health Sustainability and Transformation Partnership footprint.
- This is the steering group for the care homes quality projects, and the overarching aim is to improve quality of care in care homes and thereby reduce non-elective hospital admissions, and delayed transfers of care.
- Outcomes from the Care Governance and Quality Assurance Meeting and Pan Berkshire CQC Board meeting feed into this group as relevant, and vice versa, to ensure information sharing and targeted prompt activity, avoiding duplication and allowing for the best use of resources.
- The steering group have produced a shared dashboard which illustrates some provider and activity indicators, this includes volumes of safeguarding alerts, hospital admissions, and South Central Ambulance Service call-outs for example. The dashboard is built to facilitate strategic level analysis, but it is hoped it will continue to develop to allow provider level analysis.
- The steering group now have a dedicated Care Homes Quality Project Manager who co-ordinates the various projects and reports on progress and outcomes.
- The Care Quality assurance Team and the Strategic Adult Safeguarding Coordinator represent Optalis at this meeting, and contribute to plans and activity.

6.11. Onsite Monitoring Visits:

- With Optalis taking a risk led approach to monitoring, routine planned onsite visits across all providers are not the norm. Instead, as detailed above, targeted preventative monitoring dominates.
- Onsite monitoring visits are completed where routine planned monitoring activity, as detailed in this Quality Monitoring Framework , has identified a theme of concern with a particular provider and the Care Governance and Quality Assurance Meeting or other monitoring procedure has identified a visit is necessary.
- There are occasions where visits may be completed at the request of a Strategic Adult Safeguarding Coordinator/or Director, Statutory Services or other manager in response to a specific one-off complaint, safeguarding case, or concerning piece of intelligence.
- Visits can be joint with operational colleagues in Optalis; and often take a multi-disciplinary approach preventing duplication of monitoring across internal and external colleagues, e.g. Health and CQC.
- When in response to an organisational safeguarding framework, the remit for visits are agreed by the multi-disciplinary team at the relevant framework meeting.
- If the visit is in response to intelligence, thematic review or the Care Governance and Quality Assurance Meeting, but outside of an organisational safeguarding framework, remits would be agreed at the time of request or identification of need.

[28] https://www.gov.uk/government/publications/integration-and-better-care-fund-policy-framework-2017-to-2019
[29] https://www.england.nhs.uk/stps/

- Monitoring visits have several purposes; for example they can be used to gather further intelligence; seek a view of current practice; to validate reports or evidence submissions from providers; to validate progress reports on agreed service improvement action plans; or to benchmark performance against national and local standards.
- Visits often consist of one or more of the following:
  - meeting with the provider management
  - environmental observations
  - review of service user records
  - review of personnel records and supervision arrangements
  - review of staff training and records
  - monitoring of audits and management records, and the providers holistic quality assurance approach
  - general care observations (care homes)
  - seeking service user feedback
  - seeking staff feedback
- Various monitoring tools have been devised to support targeted and comprehensive monitoring visits, and are attached in appendices12. The tools include:
  - Provider comprehensive visit quality standards Excel workbook - "Provider.Comp.Visit.QS.Database"
  - File audits:
    - Service User
    - Personnel
  - Staff feedback
  - Service User feedback
  - Observational rating criteria
  - IAuditor web-based tool (https://safetyculture.com/iauditor/)
  - Visit record of actions
  - Service improvement action plan
- The tools have been built in a way that allows some flexibility in monitoring approach so that they can be used to target specific areas, but also to allow room for professional judgement that is benchmarked against national guidance.
- As mentioned earlier in this Quality Monitoring Framework, the tools are based on guidance from national bodies, national and local standards, and also the experience of the team as to what is important to service users and areas that may impact on the overall quality of service.
- Some of the tools allow for the outcome to be risk rated (red, amber, or green). This rating is assigned based on the professional observations, and is guided by the observational rating criteria guidance.
- Visits may be announced to the provider in advance, or may take place on an unannounced basis. Unannounced visits would generally take place if there are concerns identified and an assessment is needed of the day to day service delivery in order to substantiate or remedy the concern.
- Visits can take a full comprehensive approach to reviewing holistic service delivery, or a themed targeted approach:
  - **Targeted visits:**
    - May use any of the tools determined as appropriate to assess the area of concern.

- Elements of the comprehensive visit quality standards tool may be reviewed but the visit will not result in an overall comprehensive visit rating.
- Key outcomes from the specific tools used will however be recorded in the “Provider.Monitoring.Action.Database”.
- This allows a chronological record of provider visit volume and performance, for assessment of performance over time, and also comparison and benchmarking.
- This type of visit will impact on the Care Quality Assurance Team current monitoring rating on the Risk Matrix.

- **Comprehensive visits:**
  - These require each domain within the comprehensive visit quality standards tool “Provider.Comp.Visit.QS.Database” to be assessed.
  - This tool has been built with future integration strategies in mind and is structured to compliment the quality domains set out by the National Quality Board (NQB[30]) Quality Matters[31]; which also compliments the CQC’s fundamental standards and Key Lines of Enquiry (KLOE’s).
  - Guidance from nationally recognised bodies, including NICE and the CQC, is included in a quality standards reference tool under each domain.
  - Each domain also has a supporting worksheet allowing the monitoring officer to record which quality standards they have reviewed at any visit, and the outcome as to whether the standard was met.
  - Summarised outcomes will be recorded in the Excel workbook “Provider.Comp.Visit.QS.Database”
  - Performance area averages and the resultant overall comprehensive visit rating will be captured in the Excel workbook “Provider.Monitoring.Action.Database”.
  - This type of visit will therefore result in a comprehensive visit rating which will be added to the Risk Matrix, and will impact on other governance and quality assurance tasks as detailed above in earlier sections.
  - If completing this type of visit, it is likely feedback will also be sought from relevant GP’s, CCG colleagues including the medicines optimisation team and District Nurses, Healthwatch and potentially other commissioners.

- The Care Quality Assurance Team circulate a brief observation and action based summary of the visit to relevant colleagues following completion, and usually within 10 working days.
- Providers are given full verbal feedback at the end of the visit, and any required actions are agreed and documented, with the provider being requested to sign an immediate Visit Record of Agreed Actions, see appendix 12g.

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[30] Shared Commitment to Quality from the National Quality Board.

[31] https://www.gov.uk/government/publications/adult-social-care-quality-matters

- Visits often result from or require a service improvement action plan, as detailed in the section below.
- Dates of visits and some key information; such as areas reviewed, average outcomes of tools used, whether the visit required the creation or continuation of an action plan, and date of outcome circulation; are recorded on the Excel workbook “Provider.Monitoring.Action.Database”.
- If the team was resourced to complete planned routine monitoring visits, the comprehensive monitoring tool could be used annually in its entirety and allow for a holistic benchmark of specific providers and the markets’ performance.

6.12. Service Improvement Action Plans:

- A Service Improvement Action Plan is requested from the provider within an organisational safeguarding framework to address concerns. A template is offered to the provider (template is included within the procedure document. (Appendix 12h)
- They can also be requested by the Care Quality Assurance Team following concerns being identified or as a result of a monitoring visit for example. Often a Visit Record of Actions form will be implemented at a visit, and this will be reviewed by the Care Quality Assurance Team at a set schedule. One of the actions within this document may be the creation of a wider service improvement action plan. A template is available in appendix 12h.
- The Care Quality Assurance Team can assist a provider to develop their action plan upon request, or where required.
- Actions should be SMART (specific, measurable, achievable, realistic and time-scaled). They should seek to address the concerns, and reduce the overall risk level presented by the provider.
- Where possible, service improvement action plans should detail specific improvement actions where tools from recognised national bodies can be used to evidence progress on such, or which can be assessed against Optalis’ own monitoring tools as detailed above.
- Once in place, a frequency for progress updates is agreed between Optalis and the provider. Routine updates are then sent by the provider, along with any supporting evidence of progress.
- Progress on action plans can be monitored through any of the methods detailed above in this Quality Monitoring Framework. The focus of this activity is on evidence triangulation, assuring that the provider progress update is both valid and reliable.
- Until all actions are complete, or progress is sufficient to deem the provider competent of consistent continued improvement performance, the Service Improvement Action Plan remains in place.
- If a multi-disciplinary procedure is in place, such as an organisational safeguarding framework or CQC compliance monitoring for example, these action plans are monitored on a multi-disciplinary basis, directed by the lead in whichever process. The Care Quality Assurance Team can be requested to process the supplied supporting evidence to offer a view on status, or may be requested to complete any of the other forms of monitoring within this Quality Monitoring Framework.
- If the action plan sits outside of a multi-disciplinary process, the Care Quality Assurance Team monitor the action plan and update the multi-

disciplinary team on an ad hoc basis, and more routinely on a monthly basis via the Care Governance and Quality Assurance Meeting.

- If an action plan is in place (whether Care Quality Assurance Team or a multi-disciplinary action plan), this is recorded within the “Provider.Monitoring.Action.Database". This allows for assessing volumes and the timeliness or repeat of improvement activity and outcomes.

7. Live Databases:

7.1. See attached database overview at appendix 7.

7.2. Care Quality Assurance Team also hold the supporting download workbooks:

- Data.Brokerage.for.Provider.List
- Data.Finance.for.Provider.List
- Data.CQC.Location.for.Provider.List
- Data.CQC.Rating.for.Provider.List
- Data.NHS.Care.Homes.for.Risk.Matrix

7.3. In addition, the team hold a local authority key contacts Excel workbook. This contains the contact details of other local authority quality assurance, contracts, and safeguarding teams, where known.

8. All Appendices:		
1.	Care Quality Assurance Team Structure	2019.11.11.QMF Appendix 1.pdf
2.	Structure of the In Borough CQC Regulated Adult Social Care Market	2019.11.11.QMF Appendix 2.pdf
3.	Copy of Template Care Quality Monitoring Form	QMF Appendix 3.xlsx
4.	Quality Monitoring Framework Overview Business Process	2019.11.20 QMF Appendix 4.pdf
5.	Provider Intelligence Business Processes	2019.11.20 QMF Appendix 5.pdf
6.	Provider Monitoring Action Business Processes	2019.11.11.QMF Appendix 6.pdf
7.	Database Overview	2019.11.11.QMF Appendix 7.pdf
Appendices 8 - Care Governance and Quality Meeting Documents		
8.	Care Governance and QA Meeting Agenda Template	2019.11.20 QMF Appendix 8.pdf
a.	Care Governance and QA Meeting Minutes Template	2019.11.20 QMF Appendix 8a.pdf
b.	Care Governance and Quality Assurance Meeting Terms of Reference	2019.11.20 QMF Appendix 8b.pdf
Appendices 9 & 10- Provider Governance Framework Documents		
9.	Serious Concerns Framework Protocols	2019.11.20 QMF Appendix 9.pdf
a.	Serious Concerns Framework Step by Step Process	2019.11.20 QMF Appendix 9b.pdf
b.	Serious Concerns Framework Flowchart	2019.11.20 QMF Appendix 9b.pdf

c.	Serious Concerns Framework Discussion Form Template	2019.11.20 QMF Appendix 9c.pdf
d.	Initial letter to Provider Template	2019.11.20 QMF Appendix 9d.pdf
e.	Initial Letter to Other Agencies	2019.11.14.QMF Appendix 9e.pdf
f.	***Safeguarding Chronology Record (currently not being used)***	2019.11.12.QMF Appendix 9f.pdf
g.	Initial Serious Concerns Framework Meeting Agenda Template	2019.11.20 QMF Appendix 9g.pdf
h.	Serious Concerns Framework Review Meeting Agenda Template	2019.11.20 QMF Appendix 9h.pdf
i.	Serious Concerns Framework Review Meeting Minutes Template	2019.11.20 QMF Appendix 9i.pdf
j.	Serious Concerns Framework Core Group Meeting Notes Template	2019.11.20 QMF Appendix 9j.pdf
k.	Serious Provider Concerns Action Plan	2019.11.12.QMF Appendix 9k.pdf
10.	Standards of Care Framework Protocols	2019.11.20 QMF Appendix 10.pdf
a.	Standards of Concerns Framework Discussion Form Template	2019.11.20 QMF Appendix 10a.pdf
aa.	Initial letter to Provider Template	2019.11.20 QMF Appendix 10aa.pdf
b.	Standards of Care Framework Meeting Registration Template	2019.11.20 QMF Appendix 10b.pdf
c.	Standards of Care Framework Meeting Agenda Template	2019.11.20 QMF Appendix 10c.pdf

d.	Standards of Care Framework Meeting Minutes Template	2019.11.20 QMF Appendix 10d.pdf
e.	Standards of Care Framework Review Meeting Agenda Template	2019.11.20 QMF Appendix 10e.pdf
f.	Standards of Care Framework Review Meeting Minutes Template	2019.11.20 QMF Appendix 10f.pdf
g.	Standards of Care Framework Conclusion Letter Template	2019.11.20 QMF Appendix 10g.pdf
11.	Quality Improvement List (QUIP) Template	2019.11.14.QMF Appendix 11.pdf
12.	***Adult Social Care Provider Monitoring Visit Tools:***	
a.	File Audit – Service User/Resident	2019.11.13.QMF Appendix 12a.pdf
b.	File Audit - Personnel	2019.11.13.QMF Appendix 12b.pdf
c.	Staff Member Feedback	2019.11.13.QMF Appendix 12c.pdf
d.	Service User/Resident Feedback	2019.11.13.QMF Appendix 12d.pdf
e.	Monitoring Visit Report Template	2019.11.13.QMF Appendix 12e.pdf
f.	Observational Rating Criteria	2019.11.13.QMF Appendix 12f.pdf
g.	Visit Record of Agreed Actions	2019.11.13.QMF Appendix 12g.pdf
h.	Service Improvement Action Plan	2019.11.13.QMF Appendix 12h.pdf

13.	Serious Concerns Notification Form Template	2019.11.20 QMF Appendix 13.pdf

Document Name	Quality Monitoring Framework- CQC Regulated Adult Social Care Providers, November 2019		
Document author	Kay Spicer, Care Quality Assurance Team Manager		
Document owner	Care Quality Assurance Team Manager		
Accessibility	Available in electronic format.		
File location	Y:\Soc_Serv\GOVERNANCE_AND_QA_TEAM\Provider.Gov.and.QA\POLICIES_AND_PROCEDURES\QMF		
Destruction date	Not applicable		
How this document was created	Version 1	Care Quality Assurance Team Manager - draft	November 2016
	Version 2	Care Quality Assurance Team Manager – draft Optalis version with 2017-18 action plan	June 2017
	Version 3	Care Quality Assurance Team Manager – draft Optalis version capturing former Service Lead – Governance Quality Assurance feedback and new framework approach	November 2017
	Version 4	Care Quality Assurance Team Officer - draft Optalis version capturing current and developed monitoring framework approach	November 2019
Circulation restrictions	Currently; Internal, Bracknell Forest Council, Slough Borough Council		
Review date	November 2021		

WORK PROGRAMME - ADULTS, CHILDREN & HEALTH OVERVIEW AND SCRUTINY PANEL

DIRECTORS	• Duncan Sharkey (Managing Director- RBWM) • Kevin McDaniel (Director of Children's Services -AFC) • Hilary Hall (Director Adults, Health & Commissioning and Director of Adult Social Services) • Lin Ferguson (Director of Children's Social Care- AFC)
LINK OFFICERS AND HEADS OF SERVICES	• Lynne Lidster (Head of Commissioning- Adults and Children) • Nikki Craig (Head of HR, IT and Corporate Projects)

MEETING: 21 JANUARY 2021

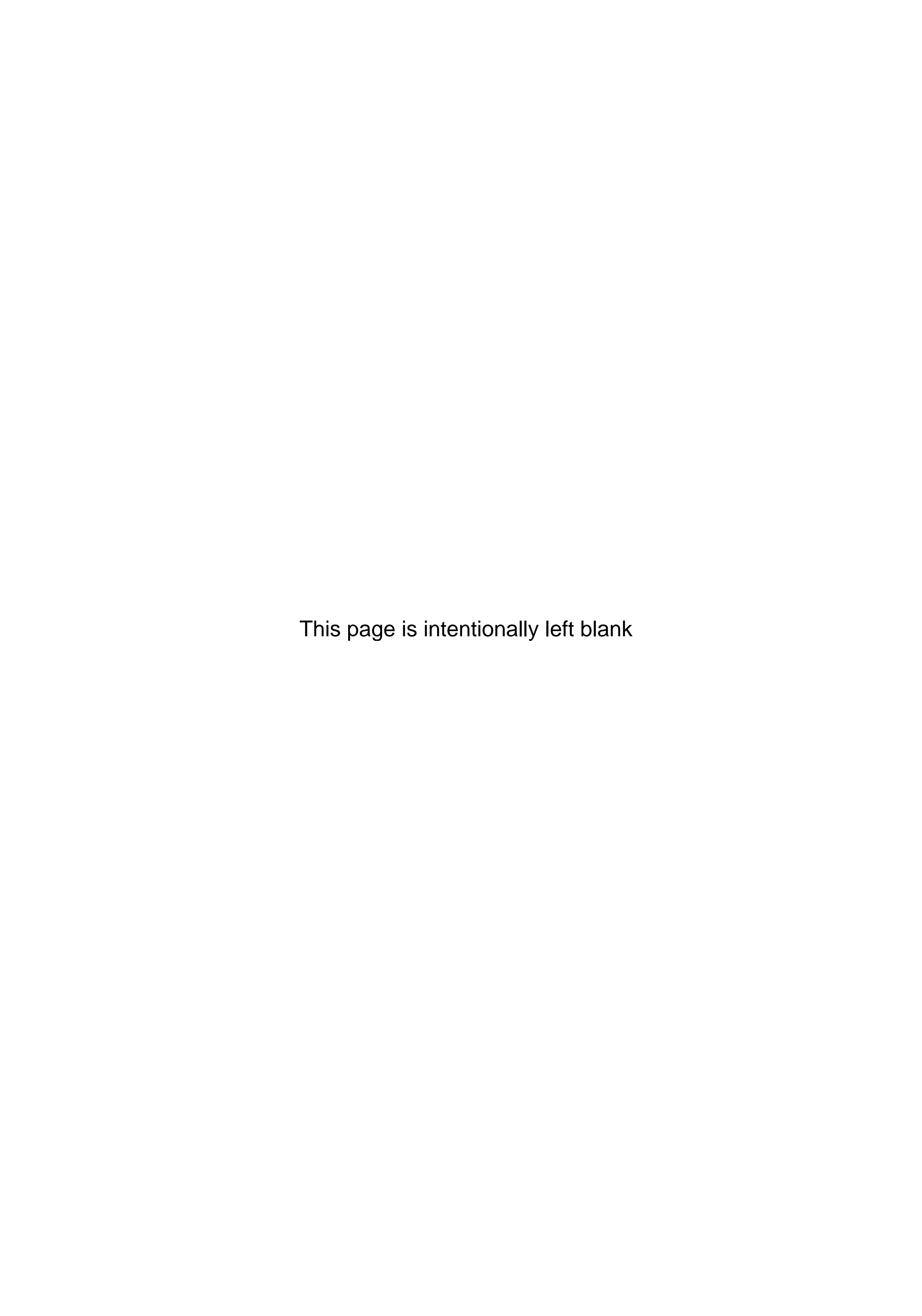
ITEM	RESPONSIBLE OFFICER
Budget Report	**Finance**
Q2 Performance Report	
Refresh of the Joint Health and Wellbeing Strategy	**Hilary Hall,** *Director of Adults, Health & Commissioning*
Work Programme	Panel clerk
TASK AND FINISH	

ITEMS SUGGESTED BUT NOT YET PROGRAMMED

ITEM	RESPONSIBLE OFFICER
Long term funding of social care	**Hilary Hall**, *Director of Adults, Health & Commissioning*
Impact of school funding changes	**Hilary Hall**, *Director of Adults, Health & Commissioning*
Update on Lynwood Clinic	
Task and Finish: Streams of funding to support care leavers and children in care	Terms of reference to be drafted by **Kevin McDaniel**, *Director of Children's Services*

Future Meeting Dates:

22 April 2021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