Adults' Services Quality Assurance Annual Report: 2020/21

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Feedback

We welcome feedback about our policies, procedures and practice guidance. If you have any comments about this document, please E-mail: graham.tabbner@westsussex.gov.uk

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Quality Assurance Annual Report, 2020-21

1. Context

1.1. This report provides an update on Quality Assurance (QA) activity in Adults' Services from 1 April 2020 to 31 March 2021. The Quality Assurance Lead post was vacant until 1 November 2020 and so limited progress was made to that date.

1.2. During this period, West Sussex County Council has implemented significant changes to the governance of QA, and the process has been amended to take into account the change to the delivery of Mental Health Services and as a result of the Covid-19 Pandemic. The latter has made provision of services more complex and has, at times, impacted the availability and capacity of key officers to undertake QA activity.

1.3. Despite these challenges, there has been much progress in supporting Adults' Services to continue its journey to becoming a learning organisation, where continual improvement is a normal process, embedded in practice. This will be particularly important to prepare the service for the inspection framework proposed in the Health & Social Care White Paper (Feb 2021) and supports the authority with its ambitions for residents, as outlined in the County Council Reset Plan, 2021 – 2024.

2. Approach to Quality Assurance

2.1. Since November 2020, the basic tenet of the QA approach is the 'Plan, Do, Check, Act' cycle.

Plan: What do we want to achieve and how will we get there?
Do: Organise the work and deliver the plan.
Check: Measure the performance by audit, through performance and reviews. Are we meeting our aims?
Act: Analyse the data, identify the lessons, and implement the changes.

2.2. This quality management model is an iterative process, which encourages continual learning to be considered in the design and delivery of activity. Ultimately, this will lead to improvement in quality and supporting the service to design and commission provision which has quality embedded at its heart.

3. Governance

3.1. The governance of QA has developed significantly since November 2020 and now sits as a central responsibility of four key management boards, overseen by the Adults Directorate Leadership Team and connected as per the hierarchy shown here and described below:

Performance, Quality & Practice Board (PQP)

3.2. PQP is the strategic quality board, chaired by the Executive Director of Adults' Social Services and was established in March 2021. The purpose of PQP is to scrutinise the efficacy of performance and quality assurance arrangements in place across

Adults' Services and the adults' social care system in West Sussex, to inform service delivery, strategic planning, and commissioning.

3.3. The Board also promotes a culture of continuous improvement throughout the Adults' Services workforce and will deliver and monitor structures that continue to develop a learning service.

Safeguarding Steering Group (SSG)

3.4. The SSG is also chaired by the Executive Director of Adults' Social Services and, again, was established in March 2021. The purpose of the Safeguarding Practice and Performance Steering Group is to highlight key areas of learning identified through safeguarding audits, Safeguarding Adult Reviews (SARs), Serious Incident Reviews (SIRs) and any work identified by the Safeguarding Adults' Board, and to seek assurance that the recommendations have been embedded into practice. This board will report to PQP and support the activities of that strategic board.

Quality Assurance Management Board (QAMB)

3.5. Revamped and rebooted in March 2021, the purpose of the QAMB is to monitor and uphold care practice and standards in Adults' Services and is chaired by the Quality Assurance Lead. QAMB will inform and be overseen by PQP and will support PQP to achieve its strategic objectives. QAMB will also promote and celebrate good and outstanding practice, and identify, discuss and mitigate against quality assurance issues across Adults' Services.

3.6. As part of the revamping of the board, the membership has been amended to make the board more operationally focused and to enable a delineation between it and PQP.

3.7. The Board will focus on responses to action plans implemented as a result of Local Government Ombudsman (LGO) or Coroner inquiries, or from Serious Incident and Learning Reviews. It will also address data quality issues and seek to identify methods of engaging with frontline practitioners to disseminate learning quickly and effectively.

3.8. Attendance and participation will be extended to a representative Team Manager and a frontline practitioner, to help connect the realities of service delivery to learning, and to practice and guidance development.

3.9. Capturing the customer voice is crucial and customer and carer participation will be co-designed with the Customer & Carer Group, which is supported by the Adults' Engagement & Information Team.

Mental Health Quality Assurance Steering Group (MHQA)

3.10. Reflecting the end of the Section 75 agreement with Sussex Partnership NHS Foundation Trust (SPFT) and the responsibility for delivery of all adult Mental Health services by West Sussex County Council, the MHQA was formalised from November 2020 and is chaired by the Assistant Director: Operations.

3.11. As with the other boards, the purpose of the MHQA is to scrutinise the efficacy of performance and quality assurance arrangements and will promote a culture of learning, specifically in relation to Mental Health Services.

4. Quality Assurance Frameworks (QAFs)

Adults' Services QAF

4.1. A new quality assurance framework for Adults' Services was approved and uploaded to the Professional Zone in March 2021. This document outlines how we will ensure a culture of performance and continuous improvement, which identifies the things we do well, celebrates success and, where required, takes action to improve.

4.2. It does this by:

- Describing the approach to quality assurance that the service will adopt
- Outlining the governance arrangements that oversee our performance and delivery, including the importance of external challenge and customer voice
- Confirming the professional standards that staff will be expected to achieve and maintain
- Describing how supervision and performance development will be provided to improve practice and to support individual learning and growth
- Outlining how audits will be used to check the quality of service delivery and to identify themes for learning which can be used to drive guidance and practice development
- Confirming the minimum standards for the use of Mosaic and case recording

Service Specific QAFs

4.3. To meet the specific needs of individual services, a 'lite' version of the Quality Assurance Framework has been developed. This version focuses much more on the particulars of the service area, including the competencies required when related to a specialism, e.g. Mental Health services. It does, however, contain the core principles of the overall QAF in order to maintain a 'golden thread' and to enable practitioners to only refer to one version.

4.4. As of March 2021, engagement has taken place with both the Approved Mental Health Professional (AMHP) Hub and the Combined Placement & Sourcing Team to develop QAFs pertinent to their areas of service delivery. The intention is to launch both frameworks by the end of June 2021.

5. Core Standards

5.1. In addition to the QAFs, and as part of the Council's ongoing commitment to high quality and to improvement, the Council has developed core standards for its staff.

5.2. These standards reflect the minimum standard of quality expected and it is essential that all operational staff achieve them. The standards are not task-specific and should be applied to all activities. They cover the following areas of practice:

- Involvement
- Equality and diversity
- Communication
- Advocacy
- Mental capacity
- Deprivation of Liberty Safeguards (DoLS)

- Safeguarding
- Risk
- Proportionality
- Working with other professionals
- Recording
- Accountability

5.3. All interventions must promote wellbeing which must be clearly evidenced throughout all activities and practitioners will use a person-centred and strengths-based approach in all their work. Working in partnership with customers, carers and communities, they will support service users to achieve the outcomes they have identified, to build on strengths and maximise wellbeing and protect their right to live in safety, free from abuse and neglect.

6. Audit Outcomes 2020/21

6.1. The following audits took place against the backdrop of Covid-19, which caused some audit activity to be paused and impacted the capacity of senior to staff to engage with audit activity.

Care Act Assessment Audits, June 2020

6.2. In summer 2020, audits were undertaken on 26 cases with respect to the application of the Care Act in practice. This audit took place across locality teams, CarePoint 2 and the Independent Living Service at a time when the service was adapting to the realities of working during the Covid-19 pandemic.

6.3. The audit highlighted the following areas of learning:

- Practitioners to be supported to have better understanding of and to follow agreed processes on the case management system, Mosaic
- For Mosaic to be the core IT system for recording by seconded staff – currently evidence that it is being used as a tool through which to agree continued funding
- Increased use of Mosaic case notes
- Reason for surplus in personal budget / direct payment should always be checked at review
- Organisation needs to be clear on practice and recording expectations
- Increased evidence of application of strengths-based approach
- Improved timeliness of assessments and the consequent impact on financial charging
- Recognition of safeguarding issues and considering and acting upon individual concerns
- Recording of consent
- Joint working between teams and disciplines
- Weighting of risks and recording of same
- Involvement of customer and gaining their views
- Mental Capacity Assessment needs and completion
- Personalising outcomes / wellbeing write ups

6.4. Team managers were engaged in the outcomes of the audits undertaken and an action plan was developed which concluded in January 2021. This focused heavily on the engagement of the teams involved with thematic learning centred on:

- Recording of discussion and decisions
- Use of Mosaic
- Mental capacity needs

6.5. The audit tool and supporting materials described in 7 also address this and the new Audit Framework (see below) will also enable the service to monitor practice development and compliance to standards.

Safeguarding Initial Decision Making, July 2020

6.6. In order to provide assurance with respect to the new Safeguarding Hub model introduced in July 2020, an audit of 40 randomly selected cases was undertaken to test whether safeguarding decisions are being triaged robustly.

6.7. Summary of Findings:

- County Council safeguarding decision-making is robust
- Immediate risk is being addressed
- The safeguarding decision-making within the Hub is consistently good
- Customer outcomes are being recorded and adults or their representatives are being spoken to
- Feedback is being consistently provided to the referrer
- Safeguarding activity should always be recorded on the enquiry form
- A 'proportionate' response and use of the correct pathway should be promoted
- Information should be provided on how to raise a section 44 referral

6.8. Summary of Recommendations:

- Feedback to all practitioners involved (completed)
- Celebrate the outstanding cases and follow up areas of improvement (completed)
- Consider opportunities for locality staff to work in the hub on a rota (not progressed)
- Promote Safeguarding Adults' Board threshold guidance (completed)
- Present findings to QAMB (completed July 2020)

Working Age Mental Health Safeguarding Audit, September 2020

6.9. 40 audits were undertaken to gain assurance that Working Age Mental Health Safeguarding Concerns are being completed robustly.

6.10. Summary of Findings:

- The initial decision making is robust and completed in a timely way
- The quality of safeguarding practice decreases once passed for a section 42 enquiry
- Significant drift identified once a section 42 has started

- The development of Making Safeguarding Personal is required to help demonstrate adult involvement throughout the process
- Summary of Recommendations:
- Action plan produced and signed off by West Sussex County Council and Sussex Partnership Foundation Trust senior management team (completed)
- The Adult Safeguarding Hub to continue to triage working age mental health safeguarding concerns to free up capacity for the professional lead to support the Lead Enquiry Officer (LEO) role and function (this remains in place)
- Bespoke mental health safeguarding training is provided on the key areas of improvement (delivered Nov 2020)
- Individual feedback is shared with the professional leads and or the identified LEO (completed)
- A sample of the cases audited are independently moderated to validate the findings (completed)
- A further audit is undertaken in 6 months' time to assess progress (outstanding)

Adult CarePoint 2 Wellbeing Conversation Audits, September 2020

6.11. An audit of 10 wellbeing conversations completed at Adults Care Point 2 was undertaken in September 2020. The work cases were randomly selected by the service and the audits were undertaken using the ethical decision-making audit tool, developed over the last 6 months of 2020/21.

6.12. Identified strengths:

- Work was completed quickly on allocation to an assessment officer
- The recording of intervention was generally proportionate to the level of need and required intervention was provided with minimal delay
- Outcomes that could be addressed at care point only were done so, and work passed to locality teams for further intervention were generally done so with good reason and an appropriately suggested red, amber or green rating. Responsibility for meeting outcomes were passed back to the person where appropriate to do so, encouraging them to take actions forwards themselves with the relevant information and advice provided
- The record of conversation was often highly personalised, and targeted to the person or referrer's particular concerns, and sign off of work was sought appropriately and completed in a timely way

6.13. Areas for improvement:

- Involvement of the person: Some conversations did not involve the individual, and only consulted with the referrer. Consequently, outcomes were not from the person's perspective but from the carer's/referrer's instead and did not represent the person's own views and wishes limiting the ability to undertake a person-centred assessment
- Recording consent: Consent has not been recorded for any of the conversations that had taken place and would be a concern particularly for scenarios where the person has not been consulted with
- Need for support in the process: With a few exceptions, the need for support to take part in the process had not been considered to a significant extent. If the person did not need support, there was limited detail as to how we know; and where the person was identified as needing support, there was no record of what

that support may have entailed or what we are doing/have done to support that person's participation

- Exploring strengths: Personal capabilities were often explored well, determining what the person could physically or mentally engage in independently. Wider strengths however, including the person's family and friends' network, and their wider community networks, were rarely explored to a significant extent. This meant it was difficult to determine what strengths the person could draw on to support them, but also to explore where gaps in the person's current support network existed.
- Recording risks: The conversations generally explored some risks that the person may be exposed to, but rarely did not generally take a risk enablement approach to these. There were some opportunities missed to have a more robust discussion about risks and what the person wishes to do to reduce these where necessary, and particularly to document these discussions to support ongoing work with the person
- Clarity between outcomes and needs: There was some confusion between outcomes and needs, with outcomes occasionally being a service or solution, and needs tending to repeat the outcome. Further clarity between these may be warranted to ensure that it is clear to both the practitioner and the person what it is that we are aiming to address and would support reviews of intervention to determine if outcomes have now been met
- Providing copies of assessment: There was limited evidence that people had been routinely offered or sent a copy of their assessment to support them in the future or to clarify the outcome of their discussion. If this was provided to people, then there was rarely an accompanying case note to indicate as such
- Identifying carers: Where a carer was involved, there were some missed opportunities to identify those carers, and to offer support to the carer in order to sustain their caring

Audits and Quality Assurance for Directly Provided Services

6.14. The Quality Assurance team for Directly Provided Services undertake regular audit activity of its services.

6.15. In addition to this compliance monitoring, audits have taken place this year for 3 services: Ball Tree, Tozer House and Hammonds. These audits follow the Care Quality Commission framework of considering against the domains of Safe, Well- Led, Effective, Caring and Responsive. The reports do not score or rate the service but provide a list of actions / remedies which are prioritised from high to low, which have been summarised in **Appendix A**. Progress against actions is monitored via monthly performance meetings.

Internal Audit

6.16. In December 2020, Internal Audit reported on its findings from a review which focussed on safeguarding in response to the risks brought about by Covid-19 and the impact of pandemic and developments in QA. This followed an Internal Audit in May 2020 which could only provide 'Limited Assurance'.

6.17. The audit looked at depth into:

- Risk assessments, Covid secure workspaces and protective personal equipment accessibility

- Section 42 work practices developed and effective (Section 42 requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect).
- Impact of pandemic on safeguarding analysed and shared with Adults' and Health Leadership Team and the Safeguarding Adults' Board
- Input to Covid practices by Principal Social Worker and the Adults' and Health Leadership Team
- Opportunities for staff to contribute / feedback
- QAF review processes and plans to launch QA
- 'Quality Audit' approach and regular oversight

6.18. The outcome of the audit was that: 'There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited'. This resulted in a rating of 'Reasonable Assurance'.

Common Themes for Improvement

6.19. Across these audits there are common themes for practice improvement:

- Use of Mosaic and recording of discussions and details, including the recording of consent
- Consideration of a person's strengths and the networks that could also support them to achieve their outcomes
- Although the initial management of risk is well managed, the enablement of risk needs better consideration and decision-making

6.20. As well as the individual action plans that have been developed as a result of the audits, these themes will be taken to the Quality Assurance Management Board to discuss methods for addressing areas for development.

7. Audit Development and Audit Framework

7.1. An audit framework is in development which will require 2 audits, per worker, per year. These should be End to End audits unless there is a service specialism (e.g. DoLS) which overrides this.

7.2. These will be completed with the worker to enhance opportunities for learning and to promote the culture of continuous improvement. Results will be captured as per the dashboard shown below:

7.3. In addition to the above, an Ethical Decision Making, or End to End Audit Tool, was built on Mosaic, to enable consistent auditing of cases from referral to review and an audit selector tool, to enable randomised selection of cases by team managers, has been developed. Guidance in relation to completing Case File and Ethical Decision-Making Audits have also been produced, to provide staff with an indication of what constitutes what level of audit outcome. This will enable them to consider their own practice against these standards and to develop their skills in order to identify and make improvements.

7.4. Due to the delivery of these tools and because of technical issues in the Mosaic Hosting project, implementation of the framework and dashboard remain in development.

8. Learning Opportunities

8.1. Capturing, sharing and learning the lessons from practice, both good and bad, is crucial to the process of continuous improvement and is a key step in the Plan, Do, Check Act cycle.

8.2. In addition to audits, learning opportunities are provided by reviews of cases, and external challenge. When those opportunities arise, the Council must be able to quickly identify, monitor and enact the learning to improve the services that it provides.

Action Plans: LGO Decisions, Serious Incident Reviews & Learning Reviews

8.3. LGO decisions and reviews undertaken when services have not been as effective as the Council would wish, allow the Council to look in depth at the decisions, actions and outcomes resulting from its interventions.

8.4. To support this, a new template has been established for capturing the actions and learning identified as a result of LGO decisions and learning reviews. This approach establishes owners and deadlines for agreed actions, and these are regularly monitored and tracked by the Quality Assurance Lead.

8.5. The themes of learning are also captured in an Action Plan register and a register of LGO decisions. This will enable for data to be extracted and to identify themes for learning which can be fed back to the quality governance structures as described in section 3.

Learning Bulletins

8.6. In addition to practice briefings issued by the Principal Social Worker, new Learning Bulletins have been devised to enable fast dissemination of key messages and learning.

8.7. The first of these has been developed with West Sussex Fire & Rescue Service to share important learning resulting from a review of fatal fire and considerations for Adults' Services practitioners. These will also be developed and shared for Serious Incident Reviews and Learning Reviews and have been shared with partners via the Safeguarding Adults' Board.

9. Quality Assurance Priorities 2021/22

9.1. The planned work for Quality Assurance this year is to:

- Design and implement the 2021/22 Audit Schedule for audit activity across Adults' Services (not including Directly Provided Services), with identified learning captured and plans for development monitored and delivered enacted
- Complete and embed the Audit Framework, as described above, to identify areas of service and professional development, and to embed regular scrutiny of practice and performance
- Complete and embed Quality Assurance Frameworks in the Approved Mental Health Professional Hub and for the Combined Placement Sourcing Team
- Develop new processes for the undertaking of Serious Incident Reviews and Learning Reviews to promote consistency with an emphasis on improvement

- Communicate Quality Assurance activity and developments across the directorate to promote quality as a culture and to raise awareness
- Develop the Quality Assurance Management Board and secure Customer & Carer involvement so that the customer voice is captured and developments in practice can be co-designed
- Develop a quality governance board for Contracts & Commissioning in order to support that function to monitor quality, develop tools and learn from performance
- Develop a web page for Quality Assurance to connect more readily to the business and to improve visibility
- Develop a Quality Assurance Community of Practice to provide mutual support and to share practice

9.2. These plans and progress against them will be reported via the governance structures described in section 3.

Appendix A – Directly Provided Services Audit Actions

The information below highlights the actions identified as a result of the audits undertaken at Ball Tree, Tozer House and Hammonds.

Ball Tree Croft

High Priority Actions:

- Staff Member to complete Mandatory Training as required. Password training to be completed by remaining staff members
- Day Opportunity staff to continue to support over the 5 days as agreed
- Medication forms dated 2017 in medication file to be reviewed
- Updated Visit Record (embedded in risk assessment 9 to be used with visitors) as this now includes a question around travel abroad).
- Peoples intended outcomes re goals set to be recorded on support plan
- Ball Tree Croft requires Wi-Fi access and a Wi-Fi enabled tablet to support contact with family and access to additional activities. Wi-Fi access is seen as business critical.
- Primrose fire system to have permanent repair to enable temporary fix (Wire across Lounge ceiling) to be removed

Medium Priority Actions:

- Feeling Safe Audit to be reviewed, staff to sign up to feeling safe charter.
- Copy of Gas Safety, Electrical Wiring and Legionella Certificate to be obtained
- Inventory to be updated once new furniture arrives
- Team meetings to be resumed (asap).
- Appraisals to be completed (as required)
- New staff to be issued with Skills for Care Codes of Conduct
- Continue to monitor actions identified in Catering Audit.
- Access to Makaton Training to be investigated

Low Priority Actions:

- Consider nominating a member of staff to be a Safeguarding Champion and Health Champion

Tozer House

High Priority Actions:

- All broken, unwanted items of furniture and equipment (including washing machine and dishwasher) from both inside and outside the home to be removed (skip to be organised)
- Information posters to be at eye level (inside the area pertaining to the poster) and to either be laminated or covered by Perspex to support Infection Control.
- Artwork to be displayed under a wipeable surface.
- Remaining actions from Infection Control Audit to be completed

- Wi-Fi needs to be installed to support communication/connection with family and facilitate further access to activities. Wi-Fi is essential to support the electronic support planning system.
- Risk Assessments and Support Plans need updating to consider and reflect the changes to support re COVID-19 please see detail in this report (E1). Risk Assessments should look at impact of isolation, wellbeing, limited contact with family/friends change of activities, environment, support to stay safe etc.
- Health appointment information to be held within support plan.
- Annual Health Checks to be re-arranged or to discuss possibility of virtual appointments.
- Maintenance detailed in E6 is to be escalated by Service Manager (photos have been sent).
- Pedal bins to be purchased to replace open bins in all areas.
- Activity Hub needs investment Service Manager to discuss with Operations Manager.
- Asset list is updated regarding new purchases.
- Individual storage boxes to be purchased to easily identify additional medication kept in spare medication cupboard

Medium Priority Actions:

- Minutes of Team meeting to provide more detail as to what was covered/discussed and note who is responsible for further actions.
- Involving People meeting agenda and minutes to have improved Easy Read version.
- Health Check Record within the suite of generic risk assessments to be used.
- Staff Appraisals to be completed by end of October.

Low Priority Actions:

- Add dates to thank you notes on Appreciation Board
- Recommend that additional champion roles are considered and allocated to staff: for example, Equality and Diversity, Health, Safeguarding.

Hammonds

High Priority Actions:

- Safeguarding to be standard item on team meeting agenda
- Legionella Risk Assessment Actions to be followed up (actioned) and regular monitoring arranged
- Staff member administering medication to be reminded to not sign until medication has been seen to be taken.
- Staff to use Visit Record embedded in generic risk assessment to monitor visitors to the service.
- Hammonds requires Wi-Fi access to support contact with family and access to additional activities. Wi-Fi access is seen as business critical.
- Mental Capacity Assessments to be reviewed
- Concerns/complaints book to be compiled, concerns to be recorded along with the outcome and the date the outcome was relayed back to person raising concern.
- All staff to attend Infection Control Training (re COVID -19)

- People have annual health check arranged/booked

Medium Priority Actions:

- Easy read CQC rating to be displayed
- Address of Health and Safety Executive Offices to be added to Health and Safety Poster.
- Feeling Safe Audit to be reviewed and copy sent to Quality Assurance Lead.
- Deprivation of Liberty Authorisations for people using short breaks to be reviewed/renewed when service re-opens
- Health and Safety Audit Tree Assessment required
- New staff to be issued with Skills for Care Codes of Conduct
- Pictures/posters to be laminated/framed (covered with wipeable surface)
- Staff Appraisals to be completed
- Tell Us What You Think Survey to have proposed actions (what we will do) completed on poster.
- Staff to complete Mandatory Training as required (for example, Health and Safety, Mental Capacity, Equality and Diversity, Safeguarding (adults and Children).
- Staff to complete Display Screen Equipment Assessment (DSE) for this year
- Facilities to be requested to complete outstanding work

Low Priority Actions:

- Senior team to continue to undertake staff supervision to ensure they take place in line with West Sussex County Council
- Continue to monitor actions identified in Catering Audit.