Strategic review of the care home sector across the county of Nottinghamshire and of Nottingham city

30 January 2014

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1. Introduction

In early 2013 the Chief Executive of the former Nottingham City and Nottinghamshire County Primary Care Trust and the Directors of Adult Social Care for Nottinghamshire County and Nottingham City Councils commissioned a strategic review of the care home sector in Nottinghamshire. Subsequently the seven local Clinical Commissioning Groups (CCGs) also commissioned the review. The CCGs are Bassetlaw CCG; Newark and Sherwood CCG; Mansfield and Ashfield CCG; Nottingham North and East CCG: Nottingham West CCG; Rushcliffe CCG and NHS Nottingham City CCG.

Context

There has been considerable interest in the quality of services provided in care homes nationally. The organisational collapse of the largest care home provider in England at the time, Southern Cross, along with media interest following the discovery of care practices at Winterbourne View and other high profile events have highlighted the risks of poor quality and financial viability in the care home sector.

This review was also informed by local media interest in the number of care homes across Nottinghamshire, which the Care Quality Commission (CQC)[1] had judged as non-compliant across 5 of the essential standards of quality and safety. This assessment of the care home sector in December 2012 showed Nottingham City and Nottinghamshire County to be outliers in comparison with other councils in the East Midlands. More recent information has shown that Nottinghamshire care homes have by no means the highest levels of non-compliance.

As a result of the Care and Support White Paper 2011 and the Care Bill 2013, there are a number of national initiatives and tools to help drive development and quality improvement in the sector. The strategic review has been designed to dovetail with these initiatives and the work was conducted through the establishment of a board.

[1] Care Quality Commission is the single, independent and national regulator for health and social care; see appendix 1 for CQC roles and responsibilities

The sponsors for this review are listed within the Terms of Reference. See Appendix 2.

The review board

A strategic review board was established with key partner agencies being invited to participate. The invitations were extended and accepted by representatives from the following partner agencies.[2] Nottinghamshire County Council, Nottingham City Council, Newark and Sherwood Clinical CCG, Mansfield and Ashfield CCG, Nottingham North and East Nottingham West CCG, Rushcliffe CCG, NHS Nottingham City CCG, CQC, Nottingham City and Nottinghamshire County Healthwatch[3] and the Community Programme[4].

The Nottinghamshire Care Association was also invited to participate in the review but they were not able to attend the majority of the meetings.

The board was chaired by the Independent Chair of the Nottinghamshire Safeguarding Boards, Mr Allan Breeton and the review report has been completed by Rosamunde Willis-Read, a Compliance Manager with CQC, working on secondment within the County Council.

A schedule of monthly meetings was arranged where the terms of reference were determined and the work streams flowing from these crafted.

I would like to acknowledge the contribution of the following people, who represented their respective organisations in compiling this report,

Alison Minkley, Allan Breeton, Amanda Jones, Anita Astle, MBE, Becky Stone, Caroline Baria, Cheryl Crocker, Chris West, Gemma Shelton, Joe Pidgeon, Nicola Ryan, Ruth Rigby, Sally Seeley, Sharon Rosenfeld, Shazia Khalid and Steve Oakley.

Terms of Reference

The Terms of Reference set the programme of work to complete the strategic review.

[2] Appendix 2: Strategic review - Terms of reference, which includes board membership

[3] Healthwatch is the independent champion for health and social care in England: www.healthwatch.co.uk

[4] The Community Programme was launched in July 2011 to identify issues between primary and secondary care to improve the patient, carer and clinical experience and has developed 10 projects to deliver this. www.nuh.nhs.uk/community programme

The key tasks were identified as follows;

- To review the measures that are currently in place to identify and monitor risks to service users arising from poor quality provision.

- To note the strengths of existing arrangements and identify any gaps with a view to making recommendations on how these measures can be improved

- To establish the details on current care home provision across Nottinghamshire County and Nottingham City, including identifying gaps in provision.

- To identify the range and nature of support available to care homes by different agencies and the extent to which these are accessed by specific care homes

- To identify what, if any, additional measures commissioners and providers could consider taking to develop quality across the care home sector

- To consider emerging government and Care Quality Commission initiatives and make recommendations to enable early implementation

The outcomes from these identified and agreed key tasks are mapped through the remaining sections of this report.

2. Processes to measure quality

Currently both councils, the respective CCGs and CQC all use different tools and processes to assess quality of service provision. Some of this is explained by the different roles. For example, the regulator was required to set out the essential standards of quality and safety and measure care providers compliance against them. Commissioners of care are tasked with ensuring the safety of people whose care they commission.

CQC

The full CQC methodology is freely available to partner agencies, the public and care providers via their website[5]. Current CQC methodology requires the inspector to select one outcome area from each of the outcome groups based on available intelligence, which is termed a risk based model. Inspectors are not expected to assess and make judgements across all 16 outcome areas. On occasion this has resulted in the council and CCG monitoring staff having identified areas of concern, such as infection control or medicines management, whilst the most recent CQC methodology shows the service to be compliant as different outcome areas have been assessed by commissioners and the regulator.

[5] www.cqc.org.uk

CQC supplied information in the form of area profile for both of the local authority areas to inform the strategic review.[6] The analysis of compliance levels from CQC also showed that current inspection methodology allows inspectors to judge that the provider has appropriate systems and processes in place to effectively assess, monitor and manage quality to reduce risk to people in receipt of service, whilst judging other outcome areas to be non-compliant. Quality assurance is a key element to the successful functioning of any business, therefore meaningful assessment is crucial in determining if the provider understands and effectively operates their care business in service users' best interests.

CQC is currently revising its inspection methodology, with plans to encompass the following 5 domains in future practice: Is the service safe, effective, responsive to people's needs, caring and well-led? **See recommendation: 1.**

Nottinghamshire County Council

The County Council uses different auditing processes and tools for younger adults and older people's care homes. The younger adult's services are audited annually following accreditation by the council. The larger number of care homes for older people has a quality banding system in operation, which awards the relevant banding and corresponding payment for placements at each service. The banding currently ranges from band 1 at the lowest quality level through to band 5, being the highest.

The process involves a visit to the service to assess the level of quality in relation to a set of standards and corresponding descriptors. There is also a set of environmental standards, which signal the future commissioning needs of those who require residential care.

The quality monitoring officers also complete responsive visits to monitor care provision at services following receipt of information of concern. In both cases, recommendations to improve practice are set as necessary.

Whilst this system is comprehensive in detailing the standards covered, the focus is on processes, policies and inputs but will be enhanced by looking at how and what outcomes are being delivered for the residents.

Nottingham City Council

The City Council also utilise a quality banding system. A separate environmental assessment is not included within this process. The quality banding system is determined through an annual audit visit similar to the process carried out by the County Council staff.[7]

[6] CQC; all current social care organisations non-compliance by outcome in Nottingham and Nottinghamshire; appendices 4&5 as at October 2013.

[7] See Appendix 3 c) Quality information for banding information as at October 2013 across the City Council and the County Council;

Clinical Commissioning Groups

The quality monitoring of services by the CCGs is via a combination of regular audits based on risk assessment and reactive audits informed through a system of early warning measures (safeguarding referrals, pressure ulcers, and soft intelligence from other agencies etcetera and similar to the systems used by both councils.)

All the CCGs in Nottinghamshire and Nottingham City undertake an annual quality audit process of those care providers who have been awarded an 'Any Qualified Provider' (AQP)[8] contract following an initial accreditation process. The monitoring staff also set recommendations and request action plans from providers where improvements are needed. As with the councils' work, CCG staff complete follow up and additional visits to assess quality as determined by intelligence available. CCG quality monitoring officers and other key members of staff also provide extensive support when a care home is considered to be failing. This includes regular visits (these can take the form of infection control advice, medicines management advice and support, education from quality monitoring officers). This level of support is resource intensive and current CCG structures no longer allow for this level of support to continue, with the exception of Nottingham City. This CCG has different staff and teams, which support care homes when concerns escalate. In the 6 other CCGs, whilst officers are supporting one home they are unable to monitor quality in others. CCGs offer extensive support in terms of project work, on-going support from primary care (the model of support varies across the county and city).

It is recognised that each CCG has developed a quality monitoring position based on the National Institute for Health and Care Excellence (NICE) guidance. As with both councils' current quality monitoring tools, this would benefit from a focus on outcomes for residents.

Although the CCGs are relatively new in existence, having taken over responsibility for quality and patient safety across the care home with nursing sector in April 2013, it must be recognised that positive and shared approaches with the respective local authority quality monitoring teams have continued since the disbanding of Strategic Health Authorities and Primary Care Trusts in March 2013.

Work is at an advanced stage in the development of a single quality monitoring process and tool for use across Nottinghamshire enabling a fully integrated partnership approach by County CCGs and Council staff. This approach involves an annual audit, which focuses on outcomes for people in receipt of care and support through observation of their lived experience. The care and support of people accommodated will be case tracked, involving interviews with the people themselves, staff, relatives and visitors and the examination of supporting records, along with a period of observation of the delivery of care and support. Separate to the audit process on the day will be

[8] Bassetlaw CCG has not adopted the AQP process.

a desk top review of contractually required documents including insurance, training matrices, policies and procedures etc. This methodology will be rolled out in April 2014 and uses some of the learning from CQC inspections, but has been designed to give the assurance of quality to the commissioners of care.

Whilst it is not necessary for all commissioners across the City and County to use the same quality monitoring tools, it should be acknowledged that having the same focus would better enable all agencies to speak the same language in terms of expectations for citizens across the piece. **See recommendation 2.**

3. State of current care home sector

Following the gathering of information as outlined in the terms of reference, analysis was completed and has been attached as appendices to this report. It has been divided into three sections; a) care home statistics, b) funding and c) quality. The information was looked at in terms of the following areas at a specific point in time. All this information is subject to change over time.

- Service user group such as younger adults or older people,
- Service type, for example, residential or nursing home, specialism as indicated by the provider including provision of dementia care, learning disabilities or autistic spectrum etc.
- Quality banding, where applicable
- Location/district
- Risk register entries
- Contract suspensions and terminations
- Compliance levels with CQC Essential standards of quality and safety
- Care home without a registered manager
- Regulated services v commissioned
- Award of dementia quality mark
- Funding source and cost of placements

This information[9] shows that with 377 services there are just shy of 400 care homes across the two local authority boundaries, with a ratio of 3:1 across Nottinghamshire to Nottingham City. The ratio is however the same for both councils in relation to residential homes to nursing homes of 2:1. When this information was broken down into districts[10], the number of residential homes exceeded the nursing home provision in all but one district; this being Gedling. Nursing home provision ranged from 7 to 16 across the districts with Rushcliffe having the least and the City the most. The City commissioners currently fund approximately 20% of nursing care in County located nursing homes, some of which can be explained by people's choice of nursing home. Citizens of Rushcliffe, in particular are likely to face displacement from their

[9] Appendix 3: Nottinghamshire Care Home a) statistics, b) funding and c) quality information and analysis

[10] District assigned for the purposes of analysis were Ashfield, Bassetlaw, Broxtowe, Gedling, Mansfield, Newark, Rushcliffe and Nottingham City

home district should they require nursing support in a care home. **See recommendation 3.**

It is acknowledged that the continued direction of travel for councils is to reduce the number of people admitted into residential care, with the aim of supporting people to live at home for longer. This means that people are placed in care homes much later and they have much higher dependency levels than, for example, 5 or even 2 years ago, as a result what is now required from the market is more services with increased specialism such as dementia care and nursing homes.

The information gathered and analysed shows that the majority of care homes deliver good or high quality outcomes for the people accommodated. However, there remain a small number of care homes which fail to provide safe and appropriate levels of care to the residents or sustain the improvements needed after support and advice from health and social care staff ceases.

Nottinghamshire County Council has been a vanguard council in producing a market position statement to explain the council policy and requirements for future provision but the care home market has been slow to respond to this to date, despite provider forums, public messaging and regular engagement with the Nottinghamshire Care Association. Health and social care commissioners would benefit from more focussed and detailed discussions with care providers to enable the development of specialist services. **See recommendations 4 and 5.**

The quality banding information showed that for older people's homes, where the banding is applied both across the county and city, the numbers peak in band 3. Slight differences can be seen regarding the numbers of quality banded services in relation to district, but there are no significant outliers from which any conclusions can be drawn.

The largest group of homes falls into the service user categories of older people, followed by dementia care provision and then younger adult's provision. The proportion of older people's care home services to younger adults is almost 2:1. Younger adults care homes are not subject to the quality banding system across Nottinghamshire.

The quality indicators currently being used by all partner agencies[11] show that there are more concerns about quality in older people's care homes. This is further borne out by the numbers of contract suspensions over the year.

Recent analysis of compliance levels with CQC essential standards for Nottinghamshire care homes has shown that several other councils in the East Midlands have more care homes judged non-compliant than the County and City. This analysis indicated a rise within the past 6 months of the identification of major and moderate concerns in Nottinghamshire. The

[11] Quality audits conducted by council and CCG commissioners and compliance levels judged by CQC

secondments between the County Council and CQC have increased partnership working between the two organisations and clarity on what constitutes evidence from CQC's perspective has resulted in more robust information sharing from the County Council quality monitoring staff to inform CQC inspections. Similar information sharing occurs between City commissioners and CQC.

4. Identified areas of overlap

The Health and Social Care Act (2008) gave the providers and commissioners of care responsibility for the quality of care provision. The secondment between the County Council and CQC has enabled an increased understanding of the respective organisation's roles and remit. Moreover, it has also allowed a close examination of the methodology and processes utilised presently to map and understand any areas of overlap and craft ways of working, which complement and strengthen partnership working between commissioners and the regulator.

Commissioners' approach to monitoring the quality of service provision covers a wider range of areas and is reflective of contract contents, the legislation that underpins CQC's essential standards as well as NICE guidance.[12]

CQC's inspection methodology requires the inspector to select one outcome area from each of the 6 key outcome groups[13]. CQC also conduct responsive inspections where information and intelligence indicates the need or might bring forward a scheduled inspection to facilitate this.

Care providers have been publicly vocal in indicating that they find the amount of regulation and assessment burdensome. It is therefore incumbent upon those charged with responsibility for assessing quality in regulated and commissioned services to work together to achieve respective outcomes fairly and proportionately. Increased sharing of findings and trust between organisations has resulted, rather than repeating the same information gathering processes, often involving multiple agencies visiting care homes about the same issues. This has become a lot more streamlined and effective across the whole of Nottinghamshire, mainly as a result of the development and implementation of routine monthly information sharing meetings between respective councils, CCGs and corresponding CQC representatives. Healthwatch has plans to commence exercising its 'enter and view' powers in care homes in 2014. It is therefore also essential for commissioners and the regulator to include Healthwatch in information sharing to inform the scheduling of visits.

Whilst the coordination of communications regarding issues of poor quality has improved, this also needs to be extended to all care homes in relation to

[12] NICE guidance can be referenced at www.nice.org.uk

[13] CQC key outcome groups are Involvement and information, Personalised care, treatment and support, Safeguarding and safety, Suitability of staffing, Quality and management, and Suitability of management

visits by partner agencies to reduce the potential duplication of visits. **See recommendation 6.**

Similarly, this work has improved knowledge of the restrictions and accountabilities of each respective agency, for example, the enforcement processes and legislative timeframes that CQC work to and the responsibility of CCGs in relation to patient safety. This has also resulted in a reduction of all agencies attending a service because of the same concerns.

CQC has of course signalled plans to review the adult social care methodology in a document entitled, 'A fresh start for regulation and inspection of adult social care',[14] which is due to commence imminently. This might lead to a more holistic approach to the inspection methodology going forward. In any case, commissioners of care must be mindful that any redesigns of quality monitoring processes are future proof to ensure that the creation of overlap with the regulator is prevented. **See recommendations 7 and 1.**

5. Gaps in the sector

Challenges for providers

The recent publication of the State of Care report by CQC[15]; shows that there is still an issue with medication management and good quality staff. In addition, there is a national shortage of nursing staff across the acute NHS sector and the current strategy is looking to recruit from other countries. This also has an impact on the pool of nursing staff available and able to work within the care home sector. NHS pay and conditions are, in the main, more attractive than those in the private sector, with some notable exceptions,[16] which might account for some of the recruitment difficulties, however as the nursing home market remains stable; it is incumbent upon providers to develop strategies to support the recruitment and retention of key staff, whilst also raising at a national level to further support progress to improve. **See recommendation 8.**

Compliance and regulation

An analysis of quality monitoring since January 2013, supported by data provided by CQC has highlighted a significant theme across services failing to provide good quality, consistent care and support. This theme is a lack of leadership and management or having sufficient competency for the role.

CQC data[17]shows that 18% of care homes across Nottingham City and County boundaries do not have a registered manager in post. In many cases this is because providers have not encouraged new managers to apply to CQC for registration until they have completed their probationary period or

[14] 'A fresh start for the regulation and inspection of adult social care ',CQC, October 2013
[15] 'State of Care 2012/13', CQC, November 2013 and available via www.CQC.org.uk
[16] Bupa is a private sector organisation which operates 300 care homes across the UK
[17] Referenced within appendix 3a.Care home statistics

later. CQC have developed a strategy to encourage registration of managers by writing to identified providers requiring action to rectify the situation and follow up with enforcement, where appropriate. The targeting of this work has been determined by how long the service has not had a registered manager in post, rather than a risk based approach, for example, focussing on services that are non-compliant or showing signs of poor outcomes for the people they accommodate. This work began in earnest in October 2013 and will take time to bear results. In the meantime, the commissioners of care need to continue to flag this issue to ensure the care home sector recognise the impact and respond more effectively. **See recommendation 9.**

In April 2011, with the creation of the CQC, the underpinning legislation changed around the regulation and inspection of regulated services. Previously all regulated services were inspected in relation to conditions[18] of registration, for example, care providers had to declare and provide services only to service users who fell into the categories the provider had elected to register for. Examples include older people, younger adults, mental health, learning disabilities, dementia care etc.

Although lack of adherence to registration categories could lead to enforcement action by the regulator, they were often not referenced by social workers making placements or followed by care home providers. They were often reported to cause unnecessary restrictions on placements to services, where people's assessed needs could be met. With the inception of CQC, registration conditions were replaced by regulated activities, which are more generic[19].

As a result of this care providers have less restriction on who they admit to their care facilities, although it remains incumbent on them to assess the care needs of a service user and identify if they can meet their care needs before admitting them to their service. Under the Health and Social Care Act (2008) care providers are empowered to indicate what specialist services they provide, if any, within their statement of purpose and are inspected against their declaration by CQC.

Dementia Quality Mark

In April 2013, the County Council initiated the award of a Dementia Quality Mark (DQM) for care homes delivering high quality dementia care. The number of care homes for older people totalled 188. Of this number 138 had declared themselves to offer dementia care as a specialism. 107 of the 138 applied to take part in the audit and following the application of an audit tool, based on best practice dementia care, 31 services were successful in achieving the DQM. This means that 18% of care providers who specialise in the care and support of people with dementia have been assessed as

[18] Conditions of registration have been known within the health and social care sector as 'categories', although this terminology has not been used by the regulator for some years.

[19] Examples of regulated activities relevant to care home sector include personal care, accommodation for people who require nursing or personal care, treatment of disease, disorder or injury, diagnostic and screening

delivering high quality dementia care. This does not mean that many of the other care providers continue to deliver good quality dementia care, but it is a worrying statistic in terms of care providers' own ability to assess and monitor the quality of their own service provision. Similarly, this finding is not co-terminus with research[20] which indicates an increasing growing need as our elderly population live longer and commissioners will therefore require increased provision for people who have needs associated with this condition, including nursing.

Quality monitoring

Additionally, information gleaned through quality monitoring of care homes between January and November 2013 shows that the highest input and activity from the council and CCG monitoring staff has been in relation to older people's care homes. There have been two contract terminations in the county, both of which were with nursing homes whose statement of purpose[21] declared the service provision to support people with complex needs and specialise in dementia care. This situation has been mirrored in the City with one contract termination of a similar service. In addition to this the number of contract suspensions in the County over the same period also reflects the highest proportion of services causing concern have been nursing homes for older people and who declare having a specialism with dementia care.

6. Current methods used to address poor quality in care home

The support offered and used by care homes has been looked at in reviewing the sector. There have been a considerable number of opportunities provided by organisations such as the Nottinghamshire Partnership for Social Care Workforce Development and the previously mentioned Community Programme, which have respectively been offering competency based support, help with coaching, bespoke in house training as well as information, support and guidance all through a variety of methods to accommodate different learning needs and styles. The development of many of the learning opportunities have been informed through the information gathered through quality monitoring of partner agencies.

This is positive in terms of commissioners meeting their statutory responsibilities to the care home sector and the healthy take up of these means that some care providers realise the opportunities for learning and development. However, from the identification of some persistent problems with ensuring consistency in the delivery of care and support in the sector, it begs the question as to whether those care providers who want to deliver good quality care are self-selecting, accessing information, support and guidance when they identify the need. The larger issue is how to reach those care providers who seem unable to identify and measure the quality of care offered by their own services.

[20] 'Policy Brief; The Global Impact of Dementia 2013-2050', Alzheimer's Disease International, December 2013

[21] Statement of purpose is a legislative requirement for regulated services under the Health and Social Care Act (2008) in which care providers declare the specifics of their service provision.

Similarly, CCGs continue to support care home providers through auditing, support and guidance around key areas of need such as tissue viability, medicines management, infection prevention and control etc. These opportunities are usually afforded the staff of services where an issue has been identified that requires improvement.

The amount and variety of information, support and guidance from CCGs is considerable. Although it has been difficult to quantify the levels of input in order to compare and contrast across the geographical boundaries of the various CCGs, it has been clear that the focus of support offered to care homes in the City has been in residential homes. The analysis of quality monitoring and CQC compliance levels does however show the largest number of concerns about quality have been with the nursing homes in this vicinity.

From the information supplied by CCGs, it is clear that significant resources have been commissioned to support the care home sector. Work continues to evaluate the impact and to inform ways of working in the most efficient and effective manner. The current variety of models of support could lead to what might be perceived as a postcode variation, which would need to have clarity on rationale. **See recommendation 10.**

Similarly commissioners also offer specialist support regarding End of Life care, falls prevention, continence management and dementia care from respective outreach teams.

Additionally, care home staff are supported to learn lessons to inform future practice through safeguarding investigations.

The training and learning opportunities from both councils perspective are, in the main provided by an independent partnership group. There is a potential opportunity to focus resources to engender improvement in care home quality through targeting competency based learning for care homes where quality outcomes are not being achieved for the people accommodated. **See recommendation 11.**

A risk register has been developed and implemented within the County Council. Following the gathering of information and intelligence from a variety of sources, including audit and monitoring visits[22], services are given a Red, Amber or Green (RAG) rating dependent on the level of quality and impact of risk on people using the services. The award of the appropriate rating determines the next steps and timing of actions by council staff, in partnership with CCGs and CQC, to drive the necessary improvement in outcomes for people.

[22] Intelligence used includes other agency findings, safeguarding outcomes, whistleblowing, quality referrals etc.

The County Council risk register is used as the template for information sharing with partner agencies on a monthly basis. The risk register is a live record of service concerns, which is also currently shared with council members and planned to be made more widely available within the council. For example, it will soon be available to safeguarding teams and district social work teams to inform their work.

The City Council is currently developing a 'dashboard' which will use information gathered about individual care homes to identify the level of quality of each service. It is planned for this to be publicly available on the City Council website.

As mentioned previously the County Council has been refining the methodology for quality auditing and monitoring with CCG partners and have based this on outcomes for people.

The annual audit processes conducted by commissioners offers a holistic assessment of the quality of service provision. Additional visits are also carried out in response to specific issues or areas of concern.

Commissioners' powers and options with failing care provision range from issue of improvement notices, through contract suspensions to contract terminations. The use of accepting voluntary agreement by providers not to admit further service users to a home is also used by a number of the commissioners[23], when appropriate.

Both the City and County councils have been looking at creative ways of using the tools and options available, such as issuing improvement notices prior to a contract suspension and when lifting one to maintain a close watching brief, setting specific timescales for improvement, which might lead to contract termination if not achieved. The requirement to map the improvements in a SMART[24] action plan has also been effectively used more recently coupled with close monitoring and support (unlike CQC) via regular provider meetings (monthly). County Council commissioners have also started to look at issues at provider level. The regulator is restricted to taking enforcement action at care home rather than provider level if each respective care home has been registered separately with Companies House[25]. This is not an issue for commissioners whose work is related to the individual contracts with providers.

There are, however still ways of working much more effectively such as integration of the Council and CCG quality monitoring functions. **See Recommendation 12.**

Use of the quality banding system and introduction of a Dementia Quality Mark for those assessed as delivering high quality dementia care, have

[23] Nottingham City Council does not use this option.

[24] Specific, Measurable, Attainable, Realistic and Time bound

[25] **Companies House** is an executive agency of the Department for Business Innovation and Skills with the main functions are to: incorporate and dissolve limited **companies**

continued to be models to encourage incentive used by the County Council. The levels of care homes increasing in quality banding has risen year on year and it is envisaged that this will also happen with services delivering dementia care to improve the quality provision across the council boundary.

In light of the government requirement for CQC to develop a rating system for regulated services in the near future, the use of a risk based model might have to be revisited. It might seem incomplete to award a rating to a service that has only been judged on a small number of outcome areas and could be argued as not sufficient on which to base a judgement and award a corresponding rating reflective of the whole picture of service provision.

The importance of raising resident's expectations is vital and so is ensuring that their voice is heard through the monitoring of quality and holding the care providers to account. The involvement and inclusion of local Healthwatch representatives within the information sharing processes would further integrate organisations working together to achieve better outcomes for people accommodated in care homes. **See recommendation 13.**

Establishing a mechanism to retain oversight of this work would benefit the coordination of and accountability in the activities of partner agencies in dealing with poor quality service delivery to very vulnerable people. This could be achieved through regular reporting about how any concerns about quality have been managed. **See recommendation 14.**

7. Conclusion

From quality monitoring evidence, it can be seen that there remains a steady stream of issues within some care homes, which could be mitigated if the care home providers and managers understood and delivered on their legislatively determined responsibilities.

The messaging from commissioners about specific commissioning needs of good quality care must be robustly delivered and followed up in terms of actions.

There are significant numbers of care provider organisations delivering good quality care whose learning could help support those working in isolation. However care providers must be held accountable for the quality of care they deliver, the staff they employ and how well they support and understand their own care provision, or face not surviving in the market place.

Despite working with the providers of care and to the same underpinning legislation, the commissioners of care and the regulator have different roles and responsibilities as well as powers and ways of working. There has been a significant improvement in partnership working with these partner agencies over the last year. This has come about because of better understanding of how and where roles fit and overlap. This partnership will face further challenges to this improved working through changes to respective ways of working and increased roles resultant from the Care Bill.

With the changes to the health landscape that created the CCGs, including changing methodology, responsibilities and geographical boundaries, challenges to partnership working have been faced. This work will also need to continue to bear fruit. Additionally, measurement of success could lead to streamlining or more effective use of support to care homes and also quality monitoring resources.

By continuing with the current trajectory of tackling poor quality care across partner agencies, along with implementing additional recommendations, the improvement agenda will be better achieved for citizens in Nottingham and Nottinghamshire.

The consequence of not adopting and implementing the review recommendations is that the care provision required now and for the future will not be established.

8. Recommendations

1. Share the findings of the Strategic Review with CQC, at the earliest opportunity, to inform the development of new adult social care methodology for inspection during the consultation period.

2. Enhance future quality audits through focussing on expectations and outcomes for people and include the requirement for care home providers to demonstrate their own quality assurance processes.

3. Adopt a targeted approach to both commissioning of care home provision according to geographical need, where gaps have been identified as well as the potential of re-commissioning residential as nursing/dementia care/complex needs provision.

4. Utilise increased engagement with care home providers on both a national and local level to better understand the changing market needs and in planning and delivering the provision required.

5. Launch the commissioning strategy publicly with strong message about commissioning high quality care.

6. Improve co-ordination of visiting priorities and timing of visits between CQC, commissioners and Healthwatch work to ensure more effective monitoring and to reduce duplication of visits across all care homes.

7. Provide feedback to CQC on local secondment outcomes in relation to improved ways of working across commissioners and regulator to inform better national working partnerships.

8. Highlight the discrepancies nationally to the Chief Nurse for NHS England, Public Health England, Royal College of Nursing, Unison Unite of the skill mix and numbers of nursing staff in the care home sector currently.

9. Use a targeted and proactive approach by commissioners to lack of leadership/management issue, including consideration of a contractual obligation to inform commissioners when managers leave, apply for registration and interim management arrangements, baseline training, induction standards, competency and quality assurance framework (partnership)

10. Evaluate the effectiveness of existing clinical and specialist support to care homes.

11. Use the evidence from quality monitoring findings to inform a programme of competency based opportunities by training and learning partnership agencies.

12. Consider options for alignment of the CCG and Council quality monitoring functions to use resources across nursing and residential homes and reduce duplication in the assessment of care home providers.

13. Include Healthwatch in information sharing processes and use information acquired through 'enter and view' to build picture of quality of care for people for use in quality monitoring by commissioners.

14. Partner agencies to provide regular reports to the Nottingham City and Nottinghamshire Safeguarding Adults Board. These would supply information regarding the activities undertaken to ensure ongoing improvement in the quality of delivery of services within care homes is achieved.

9. Proposed next steps

The completed review will be forwarded to the Chief Officers of the respective sponsor and commissioner organisations. Responses from each will be expected in line with current governance arrangements. It is proposed that a working group be organised to identify the resources needed to drive implementation of this joint initiative to improve quality of care across the geographical area in care homes. The CQC employee secondment extension has been agreed and the Compliance Manager will lead the monitoring and

implementation of the recommendations in the County. This process will be carried out by the Market Development Team in the City.

It is also recommended that the progress of implementation is formally monitored for Nottingham City area via the care homes steering group and for the Nottinghamshire area via the Nottinghamshire Adult Safeguarding Board.

As the quality of care in care homes has remained in the public domain, the development of a media strategy for the public reporting of the review recommendations is suggested.

10. Mitigating risks to progress

The risks of not adopting and driving forward the learning from this review will result in a care home market, which is not in line with the commissioners intentions nor able to support the needs of the ageing population currently and in the future.

The achievements progressed regarding efficient partnership working would be difficult to sustain and build upon further without planned and coordinated implementation of the review recommendations. This would be a missed opportunity to effectively improve outcomes for people through advancing the improved partnership working.

Additionally, the wrong message would be sent to the public about the value of older people in society and the importance in which partner agencies hold the quality of their care.

It is important to recognise and acknowledge the good quality care homes services that operate now. In order to progress this further it would be beneficial for health and social care commissioners to undertake further work with care home providers to develop the care home market to meet present and future needs.