# Provider Concerns

1. **Introduction:** This section considers a range of issues about quality and safety, positive practice and concerns about Providers that requires intervention. The intention of this section is to identify what is known to work well, detail the actions that might be taken where Providers are failing to meet standards or may place people at risk through business failures. It describes the role and responsibilities of the five groups that influence quality.[1]

    - Professionals and staff
    - Providers
    - Commissioners and funders
    - Regulators
    - The public, including people who use services, their families and carers

    It details the actions that professionals in health and adult social care may take in response to concerns about safeguarding matters and quality issues. It sets out how Providers might implement the six safeguarding principles and the relationship with commissioners who set expectations and standards. The role and responsibilities of contract monitoring that supports commissioning through their monitoring and regular communication with Providers. Together with the Care Quality Commission, these groups of professionals can assist in identifying when Providers are at risk of falling standards that might lead to wider concerns. The role of the Care Quality Commission, responsible for inspecting and monitoring Providers registered under the Health and Social Care Act 2008. The CQC has the statutory powers to inspect how well services are performing against Fundamental Standards of quality and safety and take proportionate enforcement action to ensure providers improve where there is poor care.. Finally, the safeguarding principles and these procedures aim to ensure that people have a voice to influence how services are delivered and where there are concerns, how their views and experiences lay at the heart of improvements.

    The Provider Concerns procedure is developed as a means for responding to potential business failure (contracts and commissioning responsibilities) and managing large scale safeguarding enquiries of care providers. Large scale safeguarding enquiries relate to patterns of reported abuse or neglect, about one provider, or where a single concern indicates a serious matter that warrants closer inspection of the provider (safeguarding responsibilities). In some instances, large scale enquiries may also be a consequence of concerns raised through a Safeguarding Adult Review.

2. **Definition of Provider**

    A Provider for the purposes of this policy and procedure is any care or health provider who delivers support and care to a group of individuals. This would include but is not exclusive to the following:

    - Domiciliary Care Providers
    - Residential Care Homes

[1] David Behan, Chief Executive Care Quality Commission

- Nursing Homes
- Supported Living
- Private hospitals
- NHS hospitals including mental health provision
- Day Care/Opportunities Providers
- Rehabilitation Units for people who misuse drugs or alcohol
- Voluntary agencies

## 3. Who does this procedure apply to?

The procedure applies to all care and support providers, whether they are directly commissioned by a Local Authority or Clinical Commissioning Group or not; irrespective of whether or not they are included in the Care Quality Commission market oversight regime.

Services provided directly by a local authority, or are an NHS provision aresubject to the same level of scrutiny through safeguarding as those commissioned by the local authority or Clinical Commissioning Group.

## Context

### Providers

Multiple Care Provision

Some providers may support people in or from a number of different establishments within the same geographical area. Where there is shared ownership and management structures, consideration should be given to checks and increased monitoring to those establishments that are not the primary source of safeguarding concerns. This may influence the capacity and capability of the Provider to implement improvements where agreed, and act as a check and balance that any concerns are not endemic and embedded in corporate cultures and systems.

Abuse of trust

A relationship of trust is one in which one person is in a position of *power or influence* over the other person because of their work or the nature of their activity. There is a particular concern when abuse is caused by the actions or omissions of someone who is in a position of power or authority and who uses their position to the detriment of the health and well-being of a person at risk, who in many cases could be dependent on their care. There is always a power imbalance in a relationship of trust. Where the person who is alleged to have caused harm is in a position of trust with the adult at risk, they may be deterred from making a complaint or taking action out of a sense of loyalty, fear, of abandonment or other repercussions. Where the person who is alleged to have caused the abuse or neglect has a relationship of trust with the adult at risk because they are a member of staff, a paid employee, a paid carer, a volunteer or a manager or proprietor of an establishment, the organisation will invoke its disciplinary procedures as well as taking action under the safeguarding adults policy and procedures.

Duty of candour

The Francis Report recommended the development of a culture of openness, transparency and candour in all organisations providing care and support. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 requires all regulated services to comply with the duty. The CQC

(CQC hyperlink) has set out for Providers the variables and key lines of enquiry in its inspection processes that will hold Providers to account for developing positive cultures. These are summarised below:

1) Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
2) Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
3) Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

Whistle blowing

'Whistleblowing' is when a worker reports suspected wrongdoing at work. Officially this is called 'making a disclosure in the public interest.' A worker can report things that aren't right, are illegal or if anyone at work is neglecting their duties, including:

- someone's health and safety is in danger
- damage to the environment
- a criminal offence
- the company isn't obeying the law
- covering up wrongdoing

The Public Interest Disclosure Act 1998 protects workers that disclose information about malpractice at their workplace, or former workplace, provided certain conditions are met. The conditions concern the nature of the information disclosed and the person to whom it is disclosed. If these conditions are met, the Act protects the worker from suffering detriment as a result of having made the disclosure. If the conditions are not met a disclosure may constitute a breach of the worker's duty of confidence to his employer. The above encapsulates the likely areas that whistleblowing about a safeguarding matter is likely to relate to.

All Providers should publish their whistleblowing policy and ensure that workers through inductions and training are aware of how to implement it.

**People who use services, their families and carers**

People who fund their own care

People, who arrange their own care and support, may not be known to either the local authority or its partners. In order to safeguard them and meet the duty of care to offer protection to all people who are in need of care and support, and unable to protect themselves (the majority of people living in a care setting), Providers are required to work with the local authority and its partners, to ensure that information and advice is readily available to enable people to make informed decisions about their continuing care and support. Where there are large scale enquiries, they are equally entitled to be safeguarded. This procedure, therefore applies equally to people who need care and support and receive a service from a Provider, regardless of how their care is funded..

Adults at risk who cause harm

Where the person alleged to cause harm is also an adult at risk, the safety and wellbeing of both the individual subject to possible abuse, and the person alleged to have caused harm needs to be addressed separately. The Provider Concerns process should only be invoked where there is a pattern of safeguarding concerns that indicate that the provider has not made any changes to reduce the number of incidents surrounding the same or similar situation regarding people who are also adults at risk. Consideration should be given about whether the Provider is able to provide care and support in a safe environment that respects the human rights of people in receipt of that care.

People alleged to have caused harm, should be supported to understand:

- the extent to which their behaviour impacts on other people
- how their behaviour might be modified to keep themselves and other people safe

The Provider is responsible for ensuring that actions are taken that support the person alleged to have caused harm, and the safety and wellbeing of people in receipt of services from them. This means that Providers, work with the person and their personal network, making early referrals and seeking advice of professionals. One means of achieving this might be through network meetings.

The same principles and responsibilities to report a crime apply in such situations, and care should be taken to ensuring that all eligible adults have the appropriate advocacy and support. Mental health services should be involved if the person alleged to have caused the abuse appears to have a mental illness or is showing signs of mental disturbance.

**Legal Implications**

The Care Act puts emphasis on greater integration of services provided by the local authority and its relevant partners. It also puts forward a new duty to create a service market of diverse and high quality service providers. Both these duties are pertinent to managing issues relating to Provider Concerns.

In respect of safeguarding, local authorities are required to

- **lead a multi-agency local adult safeguarding system** that seeks to prevent abuse and neglect and stop it quickly when it happens
- **make enquiries, or request others to make them,** when they think an adult with care and support needs may be at risk of abuse or neglect and they need to find out what action may be needed

Where there are safeguarding concerns relating to a Provider, delivering care and support to a number of people whether they are in a shared living environment, such as a care setting or whether they are supported in their own homes by the same Provider, the local authority must instigate appropriate enquiries. This policy and procedure is about managing large scale enquiries relating to Provider Concerns.

Where there are safeguarding concerns relating to an individual these should be managed under the usual procedure, and the outcome fed into any large scale enquiry.

Section 44 of the Act places a duty on the SAB to commission a SAR in circumstances where it feels it would be useful, and there is an indication that there are lessons to be learned and shared. A SAR however is not a substitute for a large scale enquiry, where there are ongoing concerns about the safety and wellbeing of people, which may be due to Provider negligence or poor management.

**Mental Capacity**

The principles of the Mental Capacity Act 2005 are significant in the process of managing large scale enquiries as it is likely that some people may have capacity, some fluctuating and others lack capacity to make specific decisions. Equal access to information and advice, and effective partnership working with people who use services, need to take into consideration, the degree of support required for advocacy and supported decision making for a range of people who may be subject to the same enquiry, but may have a different level of understanding about that enquiry.

**Ill treatment and wilful neglect**

Section 44 of the Mental Capacity Act makes it a specific criminal offence to wilfully ill-treat or neglect a person who lacks capacity. The police are responsible for criminal investigations, and need to take a leading role, relating to Provider Concerns about people who lack capacity to ensure that they have equal rights to the criminal justice system and are adequately protected.

## 4. Prevention

The Care Act strengthens the role prevention plays in reducing and delaying care needs from becoming more serious. Strategies to reduce the need for large scale safeguarding enquiries by taking proactive steps through strong commissioning and robust contract monitoring support the delivery of high quality diverse markets. This in turn reduces the likelihood of invoking suspensions on commissioning and consequently reducing capacity.

Quality issues are not always safeguarding matters; however it is likely that where there are safeguarding concerns there are probably issues relating to quality that might be addressed through contractual obligations rather than escalating to a large scale safeguarding enquiry.

**Commissioning for quality**

Quality services are those that place the health and welfare of people who use services as paramount and focus on positive outcomes. These are evidenced in the characteristics of the service through policy, procedures, standards, and structures for overseeing and maintaining service delivery to the requirements set by the Regulator (Care Quality Commission for regulated services) and by robust contract monitoring.

Commissioners should set out clear expectations of Providers within contracts and monitor compliance. Commissioners have a responsibility to ensure that commissioned services:

- know about and adhere to relevant Provider registration requirements and guidance;
- meet the CQC, legal or contract standards.
- ensure that all documents such as service specifications, invitations to tender, service contracts and service-level agreements adhere to safeguarding principles and standards set out in this document

Effective and strong commissioning under the Commissioning for Better Outcomes framework supports prevention strategies. The table below sets out the key criteria commissioners are seeking from Providers to evidence their commitment to providing a high quality, safe service.

Table: Commissioning for Better Outcomes Framework

| **Domain** | **Description** | **Standards** |
|---|---|---|
| **Person-centred and outcomes-focused** | This domain covers the quality of experience of people who use social care services, their families and carers and local communities. It considers the outcomes of social care at both an individual and population level. | 1. Person-centred and focuses on outcomes<br>2. Promotes health and wellbeing<br>3. Delivers Social Value |
| **Inclusive** | This domain covers the inclusivity of commissioning, both in terms of the process and outcomes. | 4. Co-produced with local people, their carers and communities<br>5. Positive engagement with providers<br>6. Promotes equality |
| **Well Led** | This domain covers how well led commissioning is by the Local Authority, including how commissioning of social care is supported by both the wider organisation and partner organisations. | 7. Well led<br>8. A whole system approach<br>9. Uses evidence about what works |
| **Promotes a sustainable and diverse market place** | This domain covers the promotion of a vibrant, diverse and sustainable market, where improving quality and safety is integral to commissioning decisions. | 10.A diverse and sustainable market<br>11.Provides value for money<br>12.Develops the workforce |

## 5. Business Failure and Service Interruptions

Impact for safeguarding

The Care Act 2014 sets out the statutory framework for managing provider failure and other service interruptions and is binding on local authorities, the police and the NHS but it also has relevance and messages for a much broader range of organisations and individuals.

The Care Act 2014 sets out the duties to promote the efficient and effective operation of the local market in care and support services. This gathering of market intelligence is relevant to both business failure and other service interruptions. Local authorities should have knowledge of market vulnerabilities in order to respond effectively to service interruptions. Periodic market analysis (market shaping) to assess capacity and viability of services is helpful to ensure that in the event that additional resources might be needed local needs can be met. The Care Quality Commission are charged with the responsibility for market oversight.

The Care Quality Commission are charged with the responsibility for market oversight of adult social care in England. This is, a statutory scheme through which the CQC assesses the financial sustainability of those care organisations that local authorities would find difficult to replace (due to their size, specialism or concentration in the market) should they fail and become unable to carry on delivering a service. The Care Quality Commission must give local authorities an early warning of likely failure affecting people receiving care in their areas, so that local authorities can make contingency plans to enable them to meet their statutory duty to ensure continuity of care should the Provider fail. [Failure will not always occur, even where the provider meets the three tests for notifying local authorities of likely failure, business can be turned around]

The local authority must weigh up the consequences of their actions before deciding how to respond, in particular, how their actions might impact on the likelihood of the service continuing. There is a balance to be struck between knowing there is a serious risk to the continued provision of a service, (when the local authority may consider not using that service temporarily or reassigning people using that service to an alternative service) and intervening in whatever way it can to improve the Providers chances of continuing to provide the service and avoiding a business failure.

Most service interruptions are relatively small scale and low risk and are therefore easily managed, but those on a larger scale have much greater potential impact. A key learning point from major commercial failures in recent years was that few local authorities could respond effectively without working with their partners, including other Providers.

Where the continued provision of care and support to those receiving services is at major risk and there is no likelihood of returning to a “business as usual” situation in

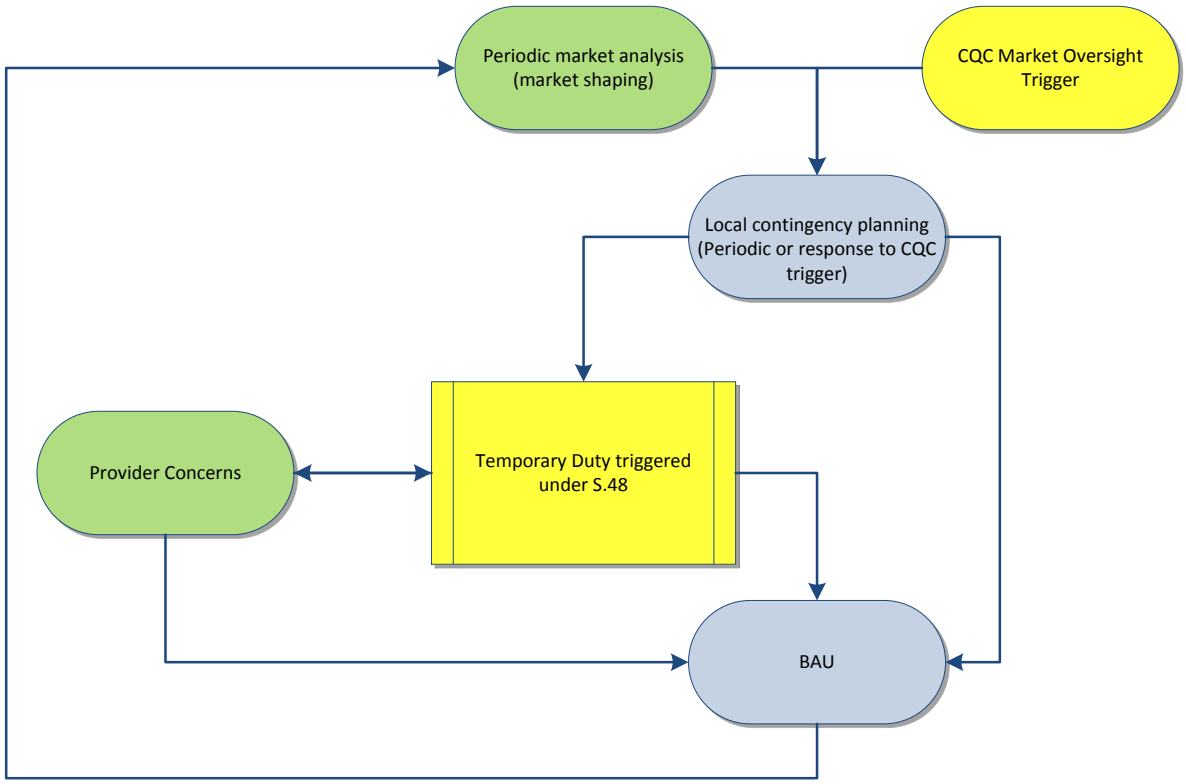
the immediate future, adults may have urgent needs which need to be met, including safeguarding.

Contingency planning

The aim should be that contingency planning for social care sits alongside authorities' other emergency planning activities. As part of contingency planning, authorities should discuss with local providers which services they would be willing and able to provide if the need arose because another local provider had failed. This should help to facilitate a prompt response that would help to maintain continuity of care for the people affected. Through its market shaping activities, authorities should encourage trust between the parties so that effective relationships exist where urgent needs are to be met.

Not all situations where a service has been interrupted or closed will warrant local authority involvement because not all cases will have the same risks associated with safeguarding. For example, if a care home closes and residents have agreed to the Provider's plans to move the residents to a nearby care home that the Provider also owns, the level of risk for the need to invoke safeguarding will be lessened. The aim is to return to Business As Usual, wherever possible, and with the least disruption to people who use the service.

Figure One: Flowchart – impact on safeguarding




## 6. Safeguarding

Categories of abuse – Organisational abuse

The types of abuse identified through Provider Concerns are the same as those noted in single safeguarding enquiries. Particularly relevant for Provider Concerns however, is organisational abuse.

"Organisational abuse is the mistreatment or abuse or neglect of an adult at risk by a regime or individual's within settings and services that adults at risk live in or use, that violate the person's dignity, resulting in lack of respect for their human rights." (Statutory Guidance, 2014)

Organisational abuse occurs when the routines, systems and regimes of an institution result in poor or inadequate standards of care and poor practice which affects the whole setting and denies, restricts or curtails the dignity, privacy, choice, independence or fulfillment of adults at risk.

Organisational abuse can occur in any setting providing health and social care. A number of inquiries into care in residential settings have highlighted that Organisational abuse is most likely to occur when staff:

- receive little support from management;
- are inadequately trained;
- are poorly supervised and poorly supported in their work; and
- Receives inadequate guidance.

**Safeguarding - early identification**

Hull University (Abuse in Care Project, 2012), identified over ninety individual indicators or warning signs for concern. A summary of factors which can increase the likelihood of abuse occurring within provider settings are drawn from these indicators:

- management and leadership
- staff skills, knowledge and practice
- residents' behaviours and wellbeing
- the service resisting the involvement of external people and isolating individuals
- the way services are planned and delivered
- the quality of basic care and the environment

**Safeguarding – thresholds for Provider Concerns**

Drawing up a local matrix for when a matter may become safeguarding is helpful to determine potential action by the local authority and its partners.

**Information Sharing**

Collating all information is essential to making good decisions about care and support. The need to share information on quality and safeguarding, strengthening the relationship and knowledge sources from front line practitioners, procurement and commissioning and safeguarding services may assist in driving up standards, if appropriately shared with Providers.

Formal mechanisms for sharing information between agencies are a useful way for deciding action to any concerns raised about quality and safety, and determining the most proportionate response and the best person/agency to manage further enquiries. The purpose of such mechanisms is to ensure information and intelligence, soft and hard, available within the local authority and from its partners is brought together in an effective and cohesive manner to ensure that safeguarding and quality concerns are raised and acted upon.

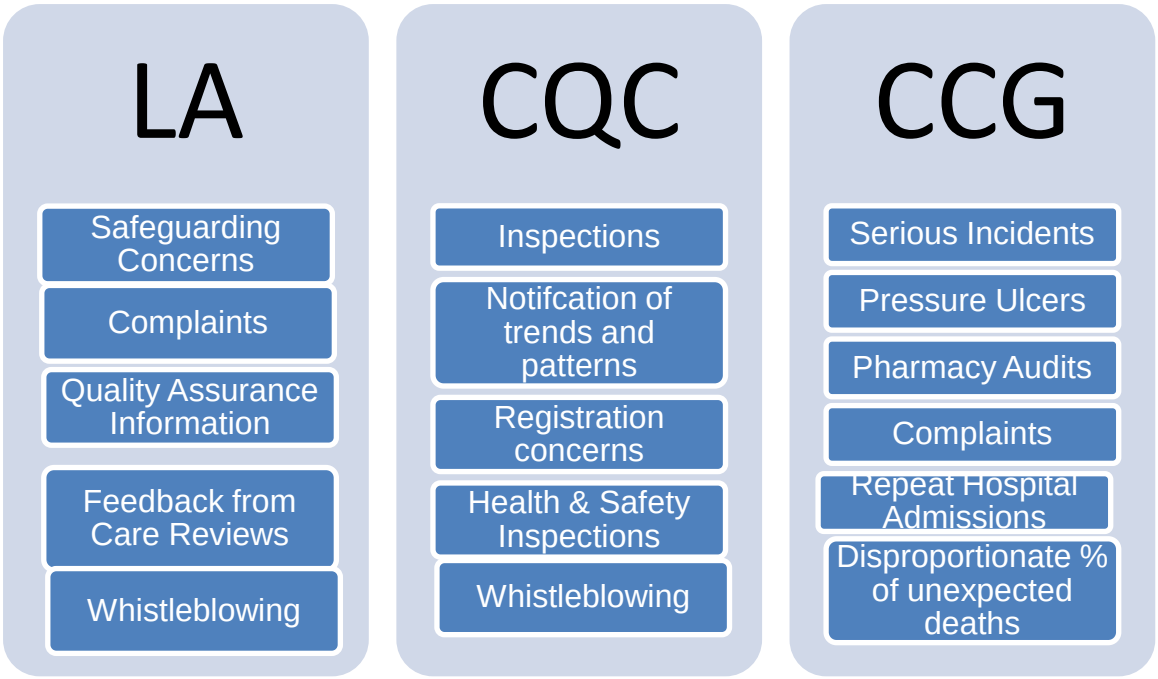
Most local authorities have implemented a formal information sharing meeting, with key partners from the Care Quality Commission and the Clinical Commissioning Group. These 'Safety & Quality Information Panels' have the ability to set out key objectives:

- Reduce the need for large scale safeguarding enquiries under the Provider Concerns procedures, by taking proactive steps to improve quality.
- Enhance the standards of care and support by sharing with Providers early warning signs
- Target resources effectively
- Improve services through lessons learnt exercises
- Are an integral component of prevention strategies
- Support continuous service improvements

In drawing up the terms of reference for these groups an agreed set of principles should be established. The following are suggested areas to take into account:

1) The wellbeing of people is paramount
2) Partnership working is not dependent on individual agency priorities
3) Decisions are binding on all parties
4) Resources are made available to implement agreed action
5) Information is shared responsibly in line with legislation and the Caldicott principles
6) Commitment to regular attendance and providing information as required
7) Any conflict of interest is declared and confidentiality respected

The following illustration is example of the key organisations and the information that they might gather and share.




The above are the core agencies that hold or have access to information that can support the key objectives set out above. Other organisations that might be involved, may include, London Ambulance Service, Healthwatch, Community Nursing Services. Each locality will determine which organisations they share information with, determined by local needs, locality size and other locally determined protocols.

**Large scale Enquiries**

Large scale safeguarding enquiries are predominantly about concerns which go beyond quality and contractual issues. A large-scale safeguarding enquiry would be indicated when a number of adults at risk have been allegedly abused, or patterns or trends are emerging from data that suggest concerns about poor quality and safety of care.

Large scale enquiries can be time consuming and it is important that there is a shared approach to such enquiries, breaking down barriers between agencies to provide a joined up, one team approach.

<u>Working with providers</u>

Integral to the effectiveness of managing a large scale enquiry is the need to work in a transparent and open way with Providers. It is not the intention of this procedure to be punitive in its dealings with Providers but to implement the safeguarding principles by supporting and giving a helpful steer when concerns arise, to assist Providers in getting back on track. A shared goal should always be that people can expect and receive a safe, quality service.

Where there are issues for safeguarding open dialogue and agreed actions for improvements can only be achieved where there is trust and a willingness on all parties to work together.

Roles and responsibilities

A commitment to working in partnership between all partners is a helpful means of effective safeguarding.

ADASS has provided agreed responsibilities for the host and funding authorities. (hyperlink to ADASS document)

Additionally there are services within the local authority whose work requires close co-operation procurement and contracting services, safeguarding services, commissioning, complaints teams, operational care management teams, and community safety units.

Providers

Providers should **empower** adults at risk to participate fully in safeguarding by creating a culture of listening to people and showing them respect. Providers can enable people to talk freely, for example publicising an open and transparent complaint procedure that assures people that there will be no retribution and offering other ways of gaining customer feedback which can be anonymous if people wish. Providers who facilitate independent advocacy and hold regular service user/carer led meetings are able to demonstrate more effectively their commitment to empowering adults at risk.

In turn Health and Social Care might work with Providers to empower them by offering support and guidance where it is asked for or needed as identified by concerns.

Providers have a duty of care to protect adults at risk and meet the standards either set out by the Regulator (if they are subject to registration) or by the commissioner in ensuring that there is a clear commitment to **protection** in their policy and procedures that is evidenced in their practice.

Providers are expected to have a robust quality assurance framework in place. This should evidence their commitment to **prevention.** Early intervention and prevention are about recognising potential abuse and learning from past situations to inform better practice. Prevention strategies evidencing that Providers undertake regular staff training, supervision and appraisals together with customer feedback under a robust quality assurance framework are welcomed.

Action taken in response to safeguarding should always be **proportionate.** Providers are expected and encouraged to be able to discern what constitutes poor practice, what is a complaint and what should be raised under safeguarding. Safeguarding leads will strive to assure Providers that a proportionate and the least intrusive response are made to any concerns. Safeguarding and quality concerns will be risk assessed to consider the most appropriate action.

Providers are **accountable** to people using their services and commissioners for meeting the expected standard of care and agreed in individual care plans, contracts and commissions. Providers are also accountable to the Care Quality Commission to meet the standards set in their registration compliance and legislation. Non-regulated provision has an obligation under Section 2 of the Local Government Act 2000 known as the 'well-being powers'.

Adult Social Care and Health professional staff.

Throughout the safeguarding processes a number of tasks and actions will be identified. This may include undertaking specific enquiries, collating resident reviews, gathering and releasing relevant case notes, interviewing personnel, undertaking announced and unannounced inspection visits, file audits, reviews of policy and procedures. This is not an exhaustive list but an indication of the kind of activity that professionals might be required to do.

Health professionals hold expertise and knowledge of clinical practice. Providers delivering nursing provision will find it helpful to consider improvements with the support of clinical experts with experience in the field that the Providers specialise in. Where there is a clinical expertise needed appropriate CCG support is required.

A system whereby health professionals complement adult social care colleagues is the most effective way to support Providers and safeguard adults at risk for most enquiries.

Therapists and specialists services

In some instances clinical knowledge will be needed for example if there are concerns surrounding manual handling in a care home, the assessment would most appropriately be made by a trained occupational therapist. Medication errors may need the expertise of a trained pharmacist.

General Practitioners

GPs have a significant role in safeguarding and are often attached to particular residential and nursing provision. Where there are specific clinical concerns, the role of the GP in monitoring the health needs of people is essential to the safeguarding process. Their role includes:

- Raising a safeguarding concern to the local authority Safeguarding Adults referral point should they suspect or know of abuse, in line with these procedures
- playing an active role in enquiries and safeguarding plans
- Maintaining a programme for monitoring individual patient care plans

GP collaboratives should make sure that effective training and reporting systems are in place to support GP practices in this work. The CCG is keen to support GPs whose CQC registration requires them to consolidate knowledge of safeguarding processes.

The Care Quality Commission (CQC)

The CQC regulates and inspects health and social care services including domiciliary services, and protects the rights of people detained under the Mental Health Act 1983. It has a role in identifying situations that give rise to concern that a person using a regulated service is or has been at risk of abuse and neglect, or may receive an allegation or a complaint about a service that could indicate potential risk to an individual or individuals.

All health and adult social care providers registered with CQC will have to meet standards.These are the basic legal requirements and the CQC is able to take enforcement action, including prosecution, when they find breaches.

The fundamental standards have been developed in response to the Francis Inquiry report, to ensure that standards in the health and care sector will not be allowed to fall below what people expect. Francis recommended the introduction of standards as legal requirements, which should be easy for all to understand and give CQC the power to take swift action where they are not being met.

The standards are intended to be common-sense statements that describe the basic requirements that providers should always meet, and set the expected outcomes. In summary, these are:

a) care and treatment must reflect service users' needs and preferences;
b) service users must be treated with dignity and respect;
c) care and treatment must only be provided with consent;
d) all care and treatment provided must be appropriate and safe;
e) service users must not be subject to abuse;
f) service users' nutritional needs must be met;
g) all premises and equipment used must be safe, clean, secure, suitable for the purpose for which they are being used, and properly used and maintained;
h) complaints must be appropriately investigated and appropriate action taken in response;
i) systems and processes must be established to ensure compliance with these Fundamental Standards;
j) sufficient numbers of suitably qualified, skilled and experienced staff must be deployed to meet these standards;
k) persons employed must be of good character, have the necessary qualifications, skills and experience, and be capable of performing the work for which they are employed.

Each outcome is supported by a small number of other conditions – these provide CQC with a means of taking appropriate enforcement action to effect improvement where providers are found to be slipping, but have not yet breached the requirement. This supports CQC's approach to inspection and enforcement which is based less around compliance of set outcomes, and instead focuses on five key questions about care:

- Is it safe?
- Is it effective?

- Is it responsive?
- Is it caring?
- Is it well-led?

The role of the CQC through its inspectors should be considered in Provider Concerns. The CQC acts independently, and is a valued partner in the process of information sharing and working to tackle areas of common concern. It is acknowledged that there will be some decision making that the Regulator would need to abstain from, namely whether or not commissioners choose to suspend or terminate business with a Provider. Their expertise in working with Providers and standard setting may support improvement plans and quality assurance strategies.

Metropolitan Police Service /Community Safety Team.

The investigation of crimes against adults at risk is managed in accordance with police procedures. Their role is to lead on any criminal investigation and in particular Section 44 of the Mental Capacity Act, where there is consideration to wilful neglect. Expertise on fact finding and investigative practice if needed might helpfully be utilised. Community Safety Units can make valuable contribution to safeguarding plans, for example targeting resources in specific areas where there are known concerns.

Legal Services

Legal advice may be required where Providers instruct solicitors and mount a challenge to safeguarding matters or where Contract Law may be involved. It is preferable for open dialogue with Providers without recourse to legal processes. Lawyers are required to provide a timely response to casework involving safeguarding. Legal services might be consulted where a decision has been reached to decommission a service, and how this information is presented to relatives, residents and other funding authorities.

Other organisations

Other agencies and individuals may be called upon to provide bespoke or specialist support to a safeguarding enquiry and an open mind should be held about who needs to be involved and the level of their involvement.

People who use services

Speaking out is not easy for people who are reliant upon care services and may have limited access to the wider community. Service users need to be encouraged and supported to raise complaints, concerns and question when care is not provided according to care plans; or care is not delivered when expected; or care is not provided with dignity and respect. For people in shared living arrangements, a culture of feeling safe to raise issues without fear of retribution needs to be in place. Professionals have a duty to meet people on their own to enable them to talk freely and to be supported to challenge poor quality.

Family/friends/visitors

Informal support to service users provides additional safeguards that issues are raised in a timely way. Family and friends may also be concerned about retribution and reluctant to raise matters, but should equally be considered as potential partners in safeguarding enquiries.

Advocates

The use of advocates in safeguarding is essential for people who lack capacity and need representation in their best interest. This should be addressed at the earliest opportunity, with a mind to equal opportunities for all adults at risk. The Care Act is explicit in regards to advocacy in safeguarding matters stating that independent advocate to represent and support a person who is the subject of a Safeguarding Enquiry if they need help to understand and take part in the enquiry or review and to express their views, wishes, or feelings. (see policy section x )

## Procedure for Large Scale Enquiries

**Stage 1: Decision to invoke a large scale enquiry**
The recommendation to invoke the safeguarding process may be the outcome of sharing intelligence, or considered through individual issues meeting agreed thresholds criteria. As the lead agency for safeguarding, the local authority will have oversight of all large scale enquiries, regardless of whether or not they are managed by another organisation.

Example Threshold Tool

| Yes | No | Does the concern contain information relating to |
|---|---|---|
| | | A death occurred that is related to a safeguarding concern linked to the Provider. |
| | | Three or more allegations relating to poor care or neglect in the past 3 months disproportionate to the number of people supported by the Provider |
| | | Concern or information relating to a person experience serious abuse or neglect (e.g. requiring hospitalisation) indicating poor practices by the Provider |
| | | Concerns or information from a professional/professional body indicating multiple concerns relating to care provided |
| | | Information linking serious concerns, including financial matters about the manager or responsible person |
| | | CQC enforcements or Health and Safety enforcement relating to quality of care or health and safety or criminal proceedings relating to poor care |
| | | Information or concerns relating to immigration issues on a wide scale |
| | | A disproportionate number of low level concerns identified, from for example CQC, contract monitoring, Health and Safety, CCG, or Community Care Reviews |

The above list is not exhaustive and there may be other situations which may warrant initiation of a large scale safeguarding enquiry. Building up a threshold matrix might be part of a lessons learnt exercise following large scale enquiries, or taking lessons from safeguarding adult reviews, or complaints and recommendations made by the Ombudsman.

Care should be taken, not to substitute safeguarding procedures when dealing with systematic poor care.

The decision to progress under safeguarding might be made by the DSAM in consultation with senior officers. In the event that a recommendation is not agreed alternative action will be directed by senior managers in consultation with relevant partners.

The DSAM or Safeguarding Lead will appoint an Enquiry Officer and SAM. The SAM will formally advise the Care Quality Commission if they are not already involved, and map out the current known risks with the Enquiry Officer and set a date for the initial meeting with stakeholders and the first meeting with the Provider.

The first priority is to ensure the immediate safety of people and any action needed should be co-ordinated by the SAM. Immediate checks on the health and safety of people should be put in place as an interim measure until the first meeting of stakeholders is convened. The local authority Safeguarding Team will take a leading role, directed by the SAM, consulting with other key officers in commissioning, contracts, frontline services and partner organisations.

Meetings with the Provider

The SAM will inform the Provider that it is subject to the Provider Concerns process and that a large scale safeguarding enquiry may take place. The SAM should share with the Provider as much information as possible, without compromising any subsequent lines of enquiry. The Provider will be informed of the process and provisional timescales if available. If there is a Police investigation, the Provider will be informed in accordance with police advice.

Regular meetings with the Provider should be established as part of the process as this evidences a commitment to work in partnership, sharing information responsibly to put matters right at the earliest opportunity. Meetings with the Provider should be held with the DSAM or senior Safeguarding Lead, and senior officer within commissioning or contract monitoring. The ethos of the meetings should be non-adversarial and promote a culture of partnership. Where there is a criminal investigation, the police will provide the remit for discussions with the Provider so evidence is preserved.

The first enquiry meeting should be convened by the SAM **within 5 working days** or sooner if the risk indicates high risk wider concerns.

**Risk**

The level of risk should be shared with the Provider and frank discussions about any proposed action that might be taken by the commissioners, providing people are not put at further risk by doing so. Providers should be encouraged to find solutions to mitigate against risk. Actions might include, suspending staff, providing additional management to support improvement planning, sourcing training and implementing competency testing.

Example Risk Matrix

| **Level of Risk** | **Impact on People Using the Service** | **Potential Action** |
|---|---|---|
| **Major** | People who use the service are not protected from unsafe or | 1) Immediate suspension of new placements. |

| | | |
|---|---|---|
| | inappropriate care. The provision of care does not meet quality & safety standards. | 2) Increased monitoring activity.<br>3) Formal meeting with provider – invoke Fact Finding process. |
| **Moderate** | People who use the service are generally safe, but there is a risk to their health and wellbeing. Provision of care is inconsistent and may not always meet quality & safety standards. | 1) Suspension or 'place with caution'<br>2) Increased monitoring activity.<br>3) Formal Meeting with provider – consider invoking Fact Finding process. |
| **Minor** | People who use the service are safe, but care provision may not always meet safety and quality standards. | 1) Monitoring visit.<br>2) Formal meeting with provider if necessary |

**Stage 2 Initial Large Scale Enquiry Meeting**

Who should attend

The Provider may not be present at the meeting, but a follow up Provider meeting arranged to discuss any additional concerns and the outcomes of the Enquiry meeting shared where it will not compromise Fact Finding. The following agencies/services represent those typically involved:

1) Local Authority
    - Safeguarding
    - Commissioning
    - Contracts
    - Front line service related to the client group the concern is about
2) Clinical Commissioning Group
    - Safeguarding
    - Commissioning (optional if no person is supported by CHC)
3) Metropolitan Police
4) Care Quality Commission (if involves a registered Provider)
5) Other funding agencies if known

The Chair

The Chair of the Enquiry Meeting will be determined by the nature of the concerns. If the issues are predominantly clinical it might be appropriate for the Clinical Commissioning Group to chair and act as the SAM, with the CCG Safeguarding Lead the Enquiry Officer. It may also be appropriate for the senior commissioning officer to chair the meeting or the senior safeguarding officer in the local authority.

If the matter relates to a large scale criminal investigation the police will chair and act as lead supported by the local authority, who will lead on safeguarding people and provide the care management and therapeutic support that might be needed.

Stakeholders will be required to bring to the meeting pertinent information. This will include:

- Commissioning/Contracts – Volume of contract, identity of service users
- CQC - capacity of the service, any concerns from inspection visits
- Safeguarding – number and severity and impact of safeguarding concerns
- Information from Information Sharing meetings
- CGG – concerns from CHC teams, any clinical concerns
- Any other information relating to specific concerns and enquiries

The meeting agenda should cover the following:

1) Identify and clarify concerns
2) Consultation strategy with people using the service
3) Advocacy and support requirements
4) Views of the Provider
5) Safeguarding plan - fact finding
6) Identify roles and responsibilities for implementing the plan
7) Organisational risk assessment
8) Ongoing communication with people using the service
9) Communication strategy with the Provider
10) Timescales

<u>Large Scale Safeguarding Enquiry Action Planning</u>

The plan needs to be able to support a factual based assessment of the validity and likelihood of allegations, the severity and impact of concerns and identify any new concerns through talking with people who use the service, talking with relatives and carers, speaking with staff to assess their ability to meet the needs of people using the service. Intelligence as far as possible should be triangulated and the source of information be based on (a) views of people using the service (b) factual information for example staff rotas and (c) professional assessment of documentation for example care plans and risk assessments. The plan will map out the known issues with suggested methodology for enabling a decision to be made about whether improvements are needed or not.

The plan will identify key personnel to undertake the required fact finding who have the best skills and experience to provide an assessment on the quality and safety of each issue. For example, if there are concerns around infection control, the CGG lead will be called upon to assess with other health professionals the steps taken to reduce and prevent infection by the Provider and what else may be needed.

Support plans and risk assessments will be assessed by staff across health and adult social care to ensure that they are outcome focussed and personalised to meet the needs of the individual. Local Authority frontline services may be required to support actions. For example, if a care review is due, the allocated worker might be asked to fact find for the wider concerns in addition to undertaking the care

management review. Where the care management responsibilities lie with another organisation, other than the host authority, the funding authority will carry out agreed actions.

Case Example 1

A serious safeguarding concern about a domiciliary care Provider was raised and managed by older people care management team. A second concern of a similar nature is managed by the Continuing health Care team. A number of concerns representing a pattern of possible neglect by two individual support workers were raised to the local authority by the district nursing service and relatives. A number of low level concerns were raised relating to the quality of the service were considered by commissioning following a contract monitoring visit. At the recent information sharing meeting a whistleblower letter stated that quite often one worker instead of two visited people whose care plans stated that the person needed to be supported by two people, also that workers had not received training on manual handling.

Agreement was reached for this to be escalated through to Provider Concerns, and a large scale enquiry was invoked. The Provider had a 20% market share, and also provided services to a number of neighbouring authorities.

The local authority led on the enquiry and the SAM nominated from the Safeguarding Team, with joint Enquiry Officers from contract monitoring and the safeguarding team. A detailed safeguarding plan was made, relating to documentation for care plan and risk assessment, review of staff rotas, training records, recruitment processes and the complany's quality assurance for contingency planning.

Front line practitioners in care management services, reviewing officers and the Continuing Health Care team were deployed to undertake quality and safety checks prioritising people with complex needs requiring the support of two workers, and people living alone where there was a known diagnosis of a cognitive impairment. At the checks people were advised about concerns and asked for their views. People who were unable to respond to questions were supported by their relative or other appropriate advocacy.

Initial Fact Finding confirmed that there were concerns and the decision was made to suspend further commissioning until both the Clinical Commissioning Group and the Local Authority could be satisfied that people were safe.

The police investigated concerns about one person and considered action under Section 44 of the Mental Capacity Act, however a capacity assessment determined the person as having full capacity. The police took no further action. Therefore all future actions were determined by the Enquiry Group, chaired by the local authority.

Case Example 2

A number of single concerns relating to inappropriate restraint, medication errors, lack of stimulation for a group of people living in an independent hospital for people with a learning disability. All the people were funded by the Clinical Commissioning Group, with the exception of two people who were funded by a local authority outside of the borough boundary.

The Clinical Commissioning Group led on the enquiry, chairing the meeting and was supported by the integrated learning disability team based in the local authority. The safeguarding plan was worked through and a number of other high level concerns established, including no clinical lead in place, and a temporary manager promoted from a senior support staff member, with no leadership training or experience.

Staffing levels fell short of being able to provide people with the one to one care that was commissioned; people had no personalised support and spent their days locked in the communal area, or in their own rooms.

Initially the Provider agreed to support improvement plans, but was unable to complete agreed actions in a timely manner and the service failed to meet standards. In this case, the Provider disagreed with the findings of both the Care Quality Commission inspection report and the fact finding led by the CCG supported by the local authority. Refusal to work in partnership led to a joint decision to support people and their families and representatives acting in their best interest to consider alternative provision.

Case Example 3

A medium sized family run residential care home for older people (24 beds) came to the attention of the local authority following visits by the district nursing service, and repeat hospital admissions. People had lived at the home for a number of years and the homely atmosphere was appreciated by people and their families. The Provider failed to inform the local authority when people's needs increased and they required nursing care, which the district nursing service was unable to sustain on a long term basis. Staff had received minimal training, and management was governed by family loyalties rather than professional informed decision making.

The local authority led on the safeguarding enquiry, supported by the Clinical Commissioning Group. A mixture of onsite training was delivered, to support the staff. Best interest decisions were made on two people and Advanced Care Plans made with the support of the local authority and CCG.

**Communication**

The Enquiry Meeting will agree a communication strategy which addresses both internal and external communications. Check list for information to:

- Senior Management - Need to Know
- Information to the Provider and how ongoing communication will be managed
- If a suspension on admissions is considered how this is communicated to front line staff
- Information sharing with other local authorities and health commissioners
- Press release
- Briefing for Chief Executives and /or Elected Members
- Consultation with any other stakeholders, e.g. people who use services and family carers without raising anxiety
- Agree as part of strategy how information and advice is provided to include people who fund their own care

Communication with people who use services

People who use services should have their experiences central to the process. In the case of a large scale enquiry in a residential setting, service users and their families may become anxious about any increased activity. For people who have support at home, they should be made aware of concerns and provided with the means of sharing their experiences independently of the provider. In short, service users should be provided with the opportunity of shaping and influencing the quality of services.

Where there is opportunity for presenting to service users and carers through a Resident and Carer meeting, negotiation with the Provider should take place about how this is managed. In those instances where people receive support at home, as part of the safeguarding plan, care management staff should make targeted visits to (a) ensure that people are safe and (b) record their views so that they are considered in the organisational risk assessment and the risk management plans.

If it is deemed necessary a link worker for service users and their families should be identified and a dedicated phone line for people to raise any concerns about the Provider.

At the very minimum, the SAM should ensure that the Provider has taken action in relation to complaints and has undertaken and acted upon a service user surveys.

**Timescale**

A timescale for the completion of Fact Finding and will be agreed by the meeting but shall not exceed 20 working days.

At the initial meeting and all subsequent meetings, consideration will be made whether or not to suspend commissioning based on the information available and the risks posed to people. All parties will contribute to such discussion with the exception of the Regulator who will offer views in as far as their governance arrangements permits. The final decision on suspension will be taken in consultation with senior management of all funding authorities.

**Stage 3 Enquiries Outcomes meeting**

The meeting will focus on the outcome of all the Fact Finding activities. This will be the basis to draw up a Service Improvement Plan unless there are exceptional reasons for further enquiries to be undertaken. This is to minimise the repeated questioning of the adults at risk and witnesses.

**Service Improvement Plan** will be the high level plan for measuring the effectiveness of interventions to ensure safety, governance, compliance, clinical effectiveness referencing throughout the experience of the adult at risk and their informal network.

Following the initial enquiry meeting, a further meeting should be held with the Provider. Commissioning/contracts might helpfully be part of the meeting and offer any contractual advice and guide the Provider through the implication of any default on the contract.

The Provider will have **48 hours** to provide a response to the plan and agree how it will work to reduce risk to people using the service. The Service Improvement Plan will be the reference point for assessing and monitoring progress. The Provider is required to take ownership and keep the SAM and Enquiry lead informed of timescales and how it will implement sustainable changes.

The meeting will consider risk which addresses the probability of risk and the likely impact of risk on the safety of people and update the risk assessment.

Regular meetings will be held with the Enquiry Lead and Provider the Service Improvement Plan and advise on any possible delays and identify any new concerns. The Enquiry Officer will update the SAM accordingly.

In the event that the Provider advises of possible service failure or interruptions a further meeting with all stakeholders will be convened to assess such risks and consider the effect on service users.

Where the Care Quality Commission is taking action with the Provider, and there is already an Action Plan in place, the Provider shall share this plan with the Enquiry meeting so that there is an understanding of all the concerns. Agreement may be reached with all three parties for one overall Improvement Plan.

Underneath this high level plan there may be a number of individual safeguarding plans for people whom a safeguarding enquiry, serious incident report, or serious complaint raised to address individual need for safety. Individual safeguarding plans should be monitored by the allocated enquiry officer, for that particular concern. The outcome should be shared with the Enquiry Lead and SAM for the large scale enquiry.

**Stage 4 Implementing & Monitoring of the Service Improvement Plan**
Further meetings to update stakeholders will be made if and when necessary. Where there are wide reaching, complex concerns, and there is high risk, it is likely that updated meetings to assess progress and risk are needed more frequently. Where there are serious delays by the Provider to implement improvements, a further meeting should always be held to consider the level of risk and appropriate action. If there is cause for further concern the Enquiry Meeting should risk assess the concerns and the meeting base its commissioning decisions on the likelihood of the Provider meeting adequate quality standards.

Timescales for further meetings will be dependent upon the Service Improvement Plan progress made by the Provider and the level of risk.

**Stage 5 Quality Assurance**
Testing for the effectiveness and sustainability of the Service Improvement Plan is a key stage in determining whether safeguarding can be closed down. A Quality Assurance strategy should be agreed by the Enquiry Meeting that will rigorously test whether improvements have been attained. This may involve a range of professionals with the right knowledge, skills and experience to assess the viability and sustainability of the improvements.

Quality Assurance activities may include testing an on-call emergency out of hour's system by calling at the evening and weekend; assessing the impact of training by competency testing the support staff; making both announced and unannounced visits.

Feedback from service users and carers will act as a control measure to assess whether there has been any noted difference in the service delivery. This may be obtained from holding a follow up meeting with people in care settings or from a sample of telephone calls to those service users who said that they had experienced through a poor service, to see if there view has changed. Support from Healthwatch may be appropriate, or other locally managed groups for example, Quality Checkers.

A further Enquiry Meeting should be held to agree the outcomes of the quality assurance testing. Future monitoring arrangements will be agreed, including whether a formal review is required.

A maximum of 10 working days to complete the QA process should be factored into the quality assurance strategy.

**Stage Six– Closing the Provider Concerns process**

Following satisfactory improvement, the process will formally come to an end and the relevant parties including the Provider and the CQC will be notified in writing by the SAM.

A Lessons Learnt Exercise with stakeholders and representatives from across the services involved. Feedback from the Provider will be collated by the Enquiry Lead, and from service users/families. This feedback will be reported to the Safeguarding Adults Board together with a short report detailing the issues, and the effect on people using the service.

Assurances should be made that people know how to raise any further concerns. The closing narrative and any correspondence with people shall be agreed in a final meeting with the Provider, Commissioning and Safeguarding.

*Insert Process map*