



# Safeguarding Adults Joint Establishment Concerns Procedure and Guidance

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## Document Control

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<b>Document Objectives:</b> This joint health and social care strategy has been developed as a means for managing large scale investigations of Care Providers.		
<b>Intended Recipients:</b> The procedure applies to all Haringey residents who receive a service from an establishment.		
<b>Monitoring Arrangements:</b> Haringey council and the Clinical Commissioning Group is committed to working in partnership with statutory partners, in particular the Regulator who retains the overall responsibility for the registration and monitoring of compliance of Fundamental Standards		
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## 1. Principles and values

The Care Act 2014 sets out the statutory framework for adult safeguarding 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 statutory guidance makes safeguarding a personalised experience: aiming to achieve the outcomes identified by adults at risk of harm and abuse.

This joint health and social care procedure and guidance has been developed as a means for managing large scale investigations of Care Providers. It is a response to the concerns raised in Safeguarding Adults Reviews (SAR) about the quality of care and safety of people, and the South Gloucestershire report on Winterbourne View Private Hospital<sup>1</sup>, the Francis Report on the failings found at Mid-Staffordshire NHS Foundation Trust,<sup>2</sup> and most recently the Norfolk's Safeguarding Adults Board ("NSAB") Safeguarding Adults Review (SAR) concerning the deaths of two adults at a private hospital. <sup>3</sup>

It is not however exclusive to the findings and recommendations of these reports, it has also taken forward the organisational learning from other SARs, management investigations, commissioning accreditation findings and safeguarding investigations managed by the lead agency for safeguarding - Haringey council.

This procedure is intended to reflect the Safeguarding Principles of:

- **Empowerment** - People are encouraged to make their own decisions and are provided with support and information.
- **Prevention** - Strategies are developed to prevent abuse and neglect that promotes resilience and self-determination.
- **Proportionate** – A proportionate and least intrusive response is made with people appropriate to the level of risk.
- **Protection** - People are offered ways to protect themselves, and there is a co-ordinated response to safeguarding concerns.
- **Partnership** - Local solutions through services working with their communities.
- **Accountability** - Accountability and transparency in delivering safeguarding.

### 1.1 Definition of Establishment

An Establishment for the purposes of this procedure is any care provider who delivers support and care to a group of individuals. This would include but is not exclusive to the following:

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<sup>1</sup>South Gloucestershire Safeguarding Adults Board Winterbourne View Hospital Serious Case Review by Margaret Flynn (2012)

<sup>2</sup> Final Report Of The Independent Inquiry Into Care Provided By Mid Staffordshire NHS Foundation Trust Published – Robert Francis QC

<sup>3</sup> [https://www.norfolksafeguardingadultsboard.info/document/634/SAR-Rpt-Joanna-JonBen\\_FINAL-PUBLICATION02-June2021.pdf?t=bf98d2814acafaae319f3503af61df624590c534](https://www.norfolksafeguardingadultsboard.info/document/634/SAR-Rpt-Joanna-JonBen_FINAL-PUBLICATION02-June2021.pdf?t=bf98d2814acafaae319f3503af61df624590c534)

- Domiciliary Care Providers
- Residential Care Homes
- Nursing Homes
- Supported Living
- Private hospitals
- Extra-care and Senior Living settings
- Shared Lives
- NHS hospitals including mental health provision
- Day Care/Opportunities Provisions
- Rehabilitation Units for people who misuse drugs or alcohol

## 1.2 Who does this document apply to?

1.2.1 Any resident who is deemed vulnerable by virtue of their need for a service is entitled to be safeguarded from abuse. This procedure applies equally to all Haringey residents who receive a service from an Establishment, regardless of any funding stream. People who fund their own care are equally entitled to be safeguarded and should be treated the same as other residents who are funded by the local authority or health services.

1.2.2 The in house provision of any of these services is subject to the same level of scrutiny through safeguarding as those commissioned by the council or by individuals through Personal Budgets.

## 1.3 Safeguarding Adults Reviews

The Care Act 2014 introduces Safeguarding Adults Reviews (previously known as Serious Case Reviews) and gives SABs flexibility to choose a proportionate methodology. The purpose of the Safeguarding Adults Review (SAR) must be to learn lessons and improve practice and inter-agency working. In Haringey the procedure is to follow that of the Care Act 2014 regulations and guidance, to arrange, where appropriate, for an independent advocate to represent and support an adult who is subject of a safeguarding enquiry or SAR where the adult has 'substantial difficulty' in being involved in the process and where there is no other appropriate adult to help them learning from near misses and situations where the arrangements worked especially well. It expects agencies to cooperate with the review but also gives Boards the power to require information from relevant agencies. The SAB may also commission a SAR in other circumstances where it feels it would be useful, including learning from "near misses" and situations where the arrangements worked especially well. The SAB decides when a SAR is necessary, arranges for its conduct and if it so decides, implements the findings.

## 1.4 Large scale Investigations and high level of identified risk

1.4.1 Safeguarding concerns that are to be managed through large scale investigations are predominantly about Providers and concerns which go beyond individual quality and contractual issues. A large-scale Safeguarding Adults investigation 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 of care:

- in a particular resource/establishment;

- where the same person is suspected of causing the abuse or neglect; and
- where a group of individuals are alleged to be causing the harm.
- Where there is significant management failure to provide care and support

1.4.2 In drawing up this procedure, Haringey Council and Haringey Clinical Commissioning Group are committed to working in partnership with statutory partners, in particular the Regulator who retains the overall responsibility for the registration and monitoring of care providers' compliance of fundamental standards. Other key partners and stakeholders are police colleagues, voluntary organisations and people who use services and those who support people who use services as family, friends and local residents.

1.4.3 Additionally there are services that are in a unique position to work collegially - safeguarding, commissioning, complaints teams, front line social care teams, Continuing Health Care teams, and community safety unit and health and safety teams.

1.4.4 Integral to the effectiveness of managing an Establishment Concern 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 standard of care.

1.4.5 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. Haringey's policy and procedures adopt the Pan London guidance regarding organisations as detailed below.

## 1.5 Organisations working with adults at risk

- Staff have a duty to report in a timely way any concerns or suspicions that an adult at risk is being or is at risk of being abused.
- Actions to protect the adult from abuse should always be given high priority by all organisations involved. Concerns or allegations should be reported without delay and given high priority.
- Organisations working to safeguard adults at risk should make the dignity, safety and well-being of the individual a priority in their actions.
- As far as possible organisations must respect the rights of the person causing harm. If that person is also an adult at risk they must receive support and their needs must be addressed.
- Staff will understand their role and responsibilities in regard to this procedure.
- Every effort should be made to ensure that adults at risk are afforded appropriate protection under the law.
- Organisations will have their own internal operational procedures which relate to these multi-agency Safeguarding Adults policy and procedures, including complaints, and in respect of support to staff that raise concerns ('whistleblowing') to comply with the Public Interest Disclosure Act 1998.

- Organisations will ensure that all staff and volunteers are familiar with policies relating to Safeguarding Adults, know how to recognise abuse and how to report and respond to it.
- Organisations will ensure that staff and volunteers will have access to training that is appropriate to their level of responsibility and will receive clinical and/or management supervision that affords them the opportunity to reflect on their practice and the impact of their actions on others

## 1.6 Organisations working together in Safeguarding Adults

- Partner organisations will contribute to effective inter-agency working and effective multi-disciplinary assessments and joint working partnerships in order to provide the most effective means of safeguarding adults.
- Action taken under these procedures does not affect the obligations on partner organisations to comply with their statutory responsibilities such as notification to regulatory authorities under the Health and Social Care Act 2008, the Housing and Regeneration Act 2008, or to comply with employment legislation.
- Organisations continue to have a duty of care to adults who purchase their own care through personal budgets and are required to ensure that reasonable care is taken to avoid acts or omissions that are likely to cause harm to the adult at risk.
- Partner organisations will have information about individuals who may be at risk from abuse and may be asked to share this where appropriate, with due regard to confidentiality.

## 1.7 Working with Providers

- 1.7.1 Health and Social Care need to be transparent in its dealings with Providers. Providers are accountable for their actions and need to be informed of concerns that arise from safeguarding, quality checks and individual care management reviews. In some instances, Providers are able to take the lead in safeguarding planning for example, suspending a member of staff whilst an investigation takes place either through disciplinary procedures (overseen by the local authority) or through other investigations including criminal investigations.
- 1.7.2 Providers need to be part of **empowering** adults at risk to take the lead in safeguarding by creating a culture of being listened to with respect. Not all concerns will involve safeguarding but 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.
- 1.7.3 In turn Health and Social Care will work together to empower Providers by offering support and guidance where it is asked for or needed as identified by concerns.
- 1.7.4 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

council in ensuring that there is a clear commitment to **protection** in their policy and procedures that is evidenced in their practice.

- 1.7.5 Haringey Council and Haringey Clinical Commissioning Group are committed to working with Providers to protect people who are unable to protect themselves or at risk of abuse and will take proactive steps in early intervention.
- 1.7.6 Providers are expected to have a robust quality assurance framework in place. This should evidence their commitment to **prevention**. Early prevention is 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 is welcomed.
- 1.7.7 In partnership with key stakeholders the council and clinical commissioning group will regularly review intelligence about Provider activity as part of its own prevention strategy and monitoring arrangements. It will take necessary and appropriate action in consultation with partners, communicating with the Provider any concerns in a timely manner.
- 1.7.8 Action taken in response to safeguarding will be **proportionate**. Providers will be expected and encouraged to be able to discern what poor practice amongst their staff is, what a complaint is and what should be raised under safeguarding. The council and clinical commissioning group will strive to assure Providers that a proportionate and the least intrusive response is made to any concerns through the scrutiny of the Safeguarding Information Panel<sup>3</sup>. Safeguarding and quality concerns will be risk assessed to consider the most appropriate action to take by the council or its partners.
- 1.7.9 **Partnership** working on the management of Establishment Concerns is key to the effectiveness of quality outcomes. There will be a local response and solution through considered information sharing using the principles of Haringey council's Information Sharing protocol.<sup>4</sup> This procedure is inclusive to the needs of all residents and its implementation will include commitment from residents, staff, management, providers, partners, Elected Members and local services and organisations.
- 1.7.10 The procedure will be governed by a commitment to equality, embracing the diverse communities of Haringey acknowledging and recognising the need to seek a response that matches the specific needs of people who use services and their support networks.
- 1.7.11 **Accountability** of the safeguarding and quality work that the council holds management responsibility for will be reported through the mechanisms already in place. This includes the joint Health and Adult Social Care Commissioning Group. Specific concerns about providers that affect one particular client group for example learning disability will be shared at the Learning Disability Partnership Board if appropriate to do so. A summary of the work under Establishment Concerns will be prepared and presented at the

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<sup>3</sup> Six weekly meeting held between Safeguarding, Commissioning, Clinical Commissioning Group and the Care Quality Commission – Joint Quality and Safeguarding meeting.

<sup>4</sup> Haringey Safeguarding Adults Board <https://www.haringey.gov.uk/social-care-and-health/safeguarding-adults/haringey-safeguarding-adults-board-sab>



Safeguarding Adults Board and The Governing Body of the Clinical Commissioning Group, bearing in mind the need for confidentiality.

- 1.7.12 Providers are **accountable** to service users and commissioners for providing the standard of care which is expected and agreed in individual care plans and contracts and commissions. Providers are also accountable to the Care Quality Commission to meet the standards set in their registration compliance and legislation.

## 2 Procedure

### 2.1 Introduction

- 2.1.1 In drawing up this joint procedure, there is reference throughout to the London multi-agency policy and procedures to safeguard adults from abuse.<sup>5</sup>
- 2.1.2 The procedure does not exempt services from managing safeguarding adults at risk who are supported by Establishments who are subject to single safeguarding concerns from the usual practice. In all cases single concerns should ensure that there is an outcome to determine whether or not the safeguarding concerns was substantiated through robust investigation and an effective protection plan is in place; it is not sufficient to state that the matter will be dealt with through an Establishment Concerns process.
- 2.1.3 Organisations should be assured that individuals are protected and specific issues relating to individuals are addressed. Attention to the needs of other people who are supported by the same Establishment should be made to ensure that the concerns raised on an individual do not affect the quality and safety of other people.
- 2.1.4 Where an Establishment Concerns process is already taking place, the two processes should run in parallel with a possible outcome that the issues in the single concerns are being addressed appropriately through the Establishment Concerns process and there is no need for additional action. At the very least the single concerns should be taken through both stage 2 – Referral and stage 3 – Safeguarding strategy discussion meeting and a decision recorded.
- 2.1.5 Establishment Concern Investigations will involve a wide range of organisations and a number of individual Safeguarding Adults processes and investigations. There will be an overarching strategy meeting or discussion and case conference for the Establishment Concern.
- 2.1.6 London multi-agency policy and procedures to safeguard adults from abuse states that, “Where the need for a large-scale investigation becomes apparent, senior managers in the local authority should identify a senior manager to take responsibility for coordinating the overall investigation with all other relevant organisations. If a crime is thought to have been committed, the usual principles and responsibilities for reporting to police apply. If the concern is within a health setting, the concerned party will contact the executive lead for Safeguarding Adults in that organisation, who will alert the CQC and NHS England (London). Together they will determine the next steps. The Safeguarding Lead for Adults in the local authority should also be informed as

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<sup>5</sup> <https://londonadass.org.uk/safeguarding/review-of-the-pan-london-policy-and-procedures/>

the local authority remains the lead organisation for all safeguarding matters within its jurisdiction.

2.1.7 Haringey council has adopted the principles set out in London multi-agency policy and procedures to safeguard adults from abuse, so that it can make a proactive response to concerns and take the proportionate action as outlined in its procedure.

## 2.2 Mental Capacity

2.2.1 All decisions taken in the Safeguarding Adults process must comply with the Mental Capacity Act 2005.

2.2.2 All adults at risk should be assumed to have capacity and to make informed choices about their own safety. The principles of the Mental Capacity Act 2005 is significant in the process of managing large scale investigations as it is likely that some people have capacity and others may lack capacity to make decisions. An equal access to services and interventions is required.

2.2.3 For those people who lack capacity decisions should be made on the basis of Best Interest. The Haringey Mental Capacity Tool and Best Interest Decision tool should be used for anyone who lacks capacity and where there are no other legal procedures in place.

2.2.4 The Independent Mental Capacity Advocate (IMCA) service in London Borough of Haringey is delivered by an independent advocacy service, VoiceAbility<sup>6</sup>.

2.2.5 Where there is no-one appropriate to consult, other than those in a professional capacity. The Managing Authority must inform the Supervisory Body, in the application for authorisation, who will refer at once to VoiceAbility.

2.2.6 Where the person or representative (if not a paid representative) requests that an IMCA is instructed to help them. This is to provide them with support and information, to represent the relevant person, and to help them make use of the review process or access the Court of Protection, if appropriate. It could happen more than once in an authorisation.

2.2.7 If the Supervisory Body believes that the person or representative may not use their rights to access a review or the Court of Protection. For example, occasionally, the representative may feel uncertain about making this request however much the Managing Authority or others gives them the relevant information and support to do so. The Supervisory Body must be informed of any concerns as decisions for this criterion would be on a case by case basis.

IMCAs have a statutory right of access to and copying of records that the record holder believes to be relevant to the decision. Clinicians and practitioners should be prepared to give access to files and notes but only to relevant information to the decision. Those responsible for patient / user records should ensure that third party information and other sensitive information not relevant to the decision at hand remains confidential.

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<sup>6</sup> [http://www.voiceability.org/in\\_your\\_area/london/barnet\\_enfield\\_and\\_haringey](http://www.voiceability.org/in_your_area/london/barnet_enfield_and_haringey)

2.3 Deprivation of Liberty Safeguards (DoLS)<sup>7</sup> apply to people who have a mental disorder and who do not have mental capacity to decide whether or not they should be accommodated in the relevant care home or hospital to be given care or treatment. These safeguards provide protection to people in hospitals and care homes. Care homes and hospitals must make requests to a local authority for authorisation to deprive someone of their liberty if they believe it is in their best interest. All decisions on care and treatment must comply with the Mental Capacity Act and the Mental Capacity Act Code. DoLS requests and authorisations are particularly relevant for this procedure as there may be issues relating to the number of inappropriate and unauthorised restrictions on people; the Provider may have failed in its duty to identify and request the statutory assessments. This in itself may be an indicator that care homes and hospitals may not be providing safe, quality care and support to people who lack capacity.

2.4 Ill treatment and wilful neglect - London multi-agency policy and procedures recommends that, "An allegation of abuse or neglect of an adult at risk who does not have capacity to consent on issues about their own safety will always give rise to action under the Safeguarding Adults process." Section 44 of the Act makes it a specific criminal offence to wilfully ill-treat or neglect a person who lacks capacity.

## 2.5 Categories of abuse – Institutional abuse

2.5.1 The types of abuse noted in single investigations are the same as those relating to Establishments. In particular for Establishments, "institutional 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."

2.5.2 Institutional 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 fulfilment of adults at risk.

2.5.3 Institutional abuse can occur in any setting providing health and social care. A number of inquiries into care in residential settings have highlighted that institutional 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
- receive inadequate guidance.

2.5.4 The risk of abuse is also greater in institutions:

- with poor management
- with too few staff
- which use rigid routines and inflexible practices
- which do not use person-centred care plans
- where there is a closed culture

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<sup>7</sup> The Deprivation of Liberty Safeguards (DoLS): Where the service user is over 18 and is resident in a care home or a hospital the deprivation can be authorised using the Deprivation of Liberty Safeguards (DOLS); a detailed procedure prescribed by the Mental Capacity Act 2005. This involves the care home or hospital applying to the local authority who may grant an authorisation if certain criteria are met. The authorisation must be monitored and kept under review.

2.5.5 A full Multi-Agency Risk Matrix<sup>8</sup> will be made on Establishments where there are concerns. The Risk Matrix will map out the concerns and level of risk and be the basis upon which Service Improvement Plans are made.

## 2.6 Adults at risk who cause harm

2.6.1 Where the person causing the harm is also an adult at risk, the safety of the person who may have been abused is paramount. Organisations may also have responsibilities towards the person causing the harm, and certainly will have if they are both in a care setting or have contact because they attend the same place (for example, a day centre). The person causing the harm may themselves be eligible to receive an assessment. In this situation it is important that the needs of the adult at risk who is the alleged victim are addressed separately from the needs of the person causing the harm. It will be necessary to reassess the adult allegedly causing the harm. This could involve a network meeting where the following could be addressed:

- the extent to which the person causing the harm is able to understand his/her actions;
- the extent to which the abuse or neglect reflects the needs of the person causing the harm; and
- the likelihood that the person causing the harm will further abuse the victim or others.

2.6.2 The same principles and responsibilities to report a crime apply. The appropriate community mental health team (CMHT) would be involved if the person alleged to have caused the abuse appears to have a mental illness or is showing signs of mental disturbance.

## 2.7 Abuse of trust

2.7.1 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.

2.7.2 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.

2.7.3 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.

2.7.4 If a crime is suspected a report must always be made to the police, and referral must be made to the Disclosure and Barring Service (DBS) if they have been found to have harmed or put at risk of harm an adult at risk. If the person who is alleged to have caused the abuse is a member of a recognised professional

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<sup>8</sup> See appendix – updated January 2022

group the organisation will act under the relevant code of conduct for the profession as well as taking action under this procedure.

## 2.8 Public interest

2.8.1 If the adult at risk has the mental capacity to make informed decisions about maintaining their safety and they do not want any action to be taken, practitioners have a duty to share the information with relevant professionals to prevent harm to others. This is particularly relevant for people who are in shared living arrangements. The fear of retribution for service users and families may be high and it is incumbent upon the professionals involved to provide assurances through rigorous and robust safeguarding plans.

2.8.2 In those instances where people are adamant that they do not wish to take matters further, action should still be undertaken by the council and its partners to consider options for monitoring the Establishment either through Safeguarding or other procedures.

## 3 **Roles and responsibilities**

### 3.1 Establishment Concern Strategy Group

This is the body that will approve and steer actions. This will be multi-agency and rest on partnership, collegial, collaborative working to recommend and reach decisions. Representation on this group will be from Health, Metropolitan Police, Care Quality Commission, Commissioners, and Senior Operational Service Manager as appropriate. If it is known who the other funding authorities are they will be invited to become a member of the group.

3.1.1 The members of the Establishment Concerns Strategy Group (ECSG) should be of sufficient seniority to assess the capacity of staff and authorise releasing staff to undertake work. In the event that the ECSG member is unable or has no resource to undertake specific actions within their service, they will be responsible for undertaking the work either by commissioning or negotiation with colleagues. The strategies that are put in place cannot be effective without commitment to ensuring delivery within specified timescales.

3.1.2 The Head of Safeguarding (local authority) in consultation with the Head of Commissioning (local authority) has a responsibility to appoint a chair to manage the work as soon as reasonable to do so.

3.1.3 In instances where the local authority does not commission services from the Provider, it remains the lead agency responsible for the safeguarding and may request that, an appropriate chair from health is delegated the role.

3.1.4 The Chair of the ECSG will delegate work through identifying the knowledge, skills and experience needed to complete specific actions that will be carried out by professionals and co-ordinated by the chair of the ECSG.

### 3.2 Other professionals

3.2.1 **Adult Social Care and Health professional staff.** Throughout the life of the process a number of tasks and actions will be identified. This may include undertaking specific investigation of an issue, collating resident reviews,

interviewing personnel undertaking announced and unannounced inspection visits, file audits, review 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. Occupational Therapy has a key role to play in large scale investigations in nursing and residential care and their particular skills in assessing manual handling techniques for example is essential.

3.2.2 **Health Managers.** The government White Paper, *Liberating the NHS* (DH, 2010a), makes clear that patients must be at the heart of the NHS. Services will be accountable to patients for the quality of care, shared decision making will become the norm and patient safety is put above all else. Health colleagues play an equal role in the implementation of this procedure. They hold expertise and knowledge of health provision and in particular 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 Establishment specialises in. A system whereby health managers compliment adult social care managers is the most effective way to support Providers and safeguard adults at risk.

3.2.3 **GPs'** have a significant role in Safeguarding Adults 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. GP's, are in a unique position to assess how well people's health needs are met by establishments, especially those in a residential or nursing provision. Their role includes:

- making a referral to a Safeguarding Adults referral point should they suspect or know of abuse, in line with these procedures
- playing an active role in strategy discussions or meetings, case conferences and protection planning.

GP Federation have a responsibility to ensure that effective training and reporting systems are in place to support GPs and their practices in this work. The CCG has systems in place to support GP's in their changing role to consolidate knowledge of safeguarding processes.

3.2.4 The **Care Quality Commission** 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 harm or may receive an allegation or a complaint about a service that could indicate potential risk of harm to an individual or individuals. Where the CQC receives information about a possible Safeguarding Adults situation or issue, then that information must be immediately brought to the attention of the lead regulatory inspector for the service, or the duty inspector. If, on a review of the information, there appears to be a Safeguarding Adults concern, the CQC should pass the information to the local authority through the locally determined referral point. As a key stakeholder in the joint Quality and Safeguarding meeting, there is opportunity to work closely on managing concerns prior to invoking this procedure.

All health and adult social care providers registered with CQC will have to meet the fundamental standards. These are the basic requirements that providers should always meet, and the standard of care and service that patients or care-

users should expect. They will be legal requirements and CQC will be 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. The Report recommended the introduction of new fundamental 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.

Care providers will be required to meet the fundamental standards as part of the requirements for registering with CQC, and on an ongoing basis. The standards are intended to be common-sense statements that describe the basic requirements that providers should always meet, and set the outcomes that patients or care-users should always expect. In summary, these are:

- a) care and treatment must be appropriate and 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) care and treatment must be provided in a safe way.
- e) service users must be protected from abuse and improper treatment.
- f) service users' nutritional and hydration needs must be met.
- g) all premises and equipment used must be clean, secure, suitable and used properly.
- h) complaints must be appropriately investigated and appropriate action taken in response.
- i) systems and processes must be established to ensure compliance with the fundamental standards.
- j) sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed.
- k) persons employed must be of good character, have the necessary qualifications, skills and experience, and be able to perform the work for which they are employed (fit and proper persons requirement).
- l) registered persons must be open and transparent with service users about their care and treatment (the duty of candour).

Each outcome is supported by a small number of other conditions – these provide CQC with a means of taking appropriate enforcement action where providers are found to be slipping, but have not yet breached the requirement. This supports CQC's new approach to inspection and enforcement which is based less around checking compliance with detailed regulations, 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 Compliance Manager and Inspectors is central to all actions. The CQC in their role as Regulator 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 the Provider. Their expertise in working with Providers and standard setting will be considered in the Service Improvement Plans and quality assurance strategy.

Neither the council nor the CCG is responsible for Enforcement Action as that is the prerogative of the CQC. Where there are issues relating to compliance and safeguarding the ECSG will agree with the Provider, a means by which improvements are managed that will meet both compliance and the safeguarding standards.

**3.2.5 Metropolitan Police/Community Safety Unit.** The investigation of crimes against adults at risk is managed in accordance with the Safeguarding Adults at Risk Standard Operating Procedures. These give clear guidance to police officers and staff to ensure the safety and protection of adults at risk by providing a quality service to service users whether as employees, colleagues, victims, witnesses or strategic partners, and so on. Their role in this procedure 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 will be utilised within the strategy groups. Community Safety Units can make valuable contribution to protection plans, for example targeting resources in specific areas where there are known concerns.

**3.2.6 Health and Safety Inspection Unit.** Colleagues in health and safety units will support safeguarding plans by making both announced and unannounced inspections. Residential units are legally obliged to ensure that their premises are compliant with health and safety legislation. Where there are specific concerns around environmental issues, infection control and staff welfare the expertise and advice from health and safety will play an important part in both the fact finding and quality assurance processes.

**3.2.7 Commissioners.** Commissioning colleagues should set out clear expectations of provider agencies and monitor compliance. Commissioners have a responsibility to:

- ensure that commissioned services know about and adhere to relevant registration requirements and guidance
- meet the standards set out in Haringey Quality Standards
- ensure that all documents such as service specifications, invitations to tender, service contracts and service-level agreements adhere to the multi-agency Safeguarding Adults policy and procedures

Commissioners will work closely with the Safeguarding Adults Team, both Heads of Service assuring that the Safeguarding Information Panel takes place on a regular basis. Where the commissioned service is solely from NHS commissioners, the local authority team will take a step back in the process but be available for consultation on safeguarding practice and the standards of the local authority. Where there are concerns around block contracts the commissioning service will play a lead role in the safeguarding process.

**3.2.8 Legal Services** will provide advice in instances where Providers instruct solicitors and mount a challenge to safeguarding matters. The ECSG will take precautionary steps in its dealings with solicitors but will always aim to work



and have open dialogue with Providers without recourse through legal channels. In the event that legal advice is required, the case will in the first instance be discussed with the Director of Adult Social Services in consultation with the Assistant Director of Commissioning.

Lawyers are required to provide a timely response to casework involving safeguarding. Legal services will be consulted in the rare case that a decision has been reached to decommission a service, and how this information is presented to relatives, residents and other funding authorities.

**3.2.9 Performance Team/Mosaic.** The statistical information required by the Department of Health AVA returns and information for the Safeguarding Adults Board, will be collated from adult social care database), by the local authority Performance team.

The fields in the safeguarding adult's episodes will identify whether the concern relates to an Establishment and be a mandatory field determined by Mosaic. This information is presented to the SIP and to the SAB. From recording accurate details, patterns and themes of concerns are identified at an early stage and flagged up to the Head of Safeguarding and QA in the monthly performance data.

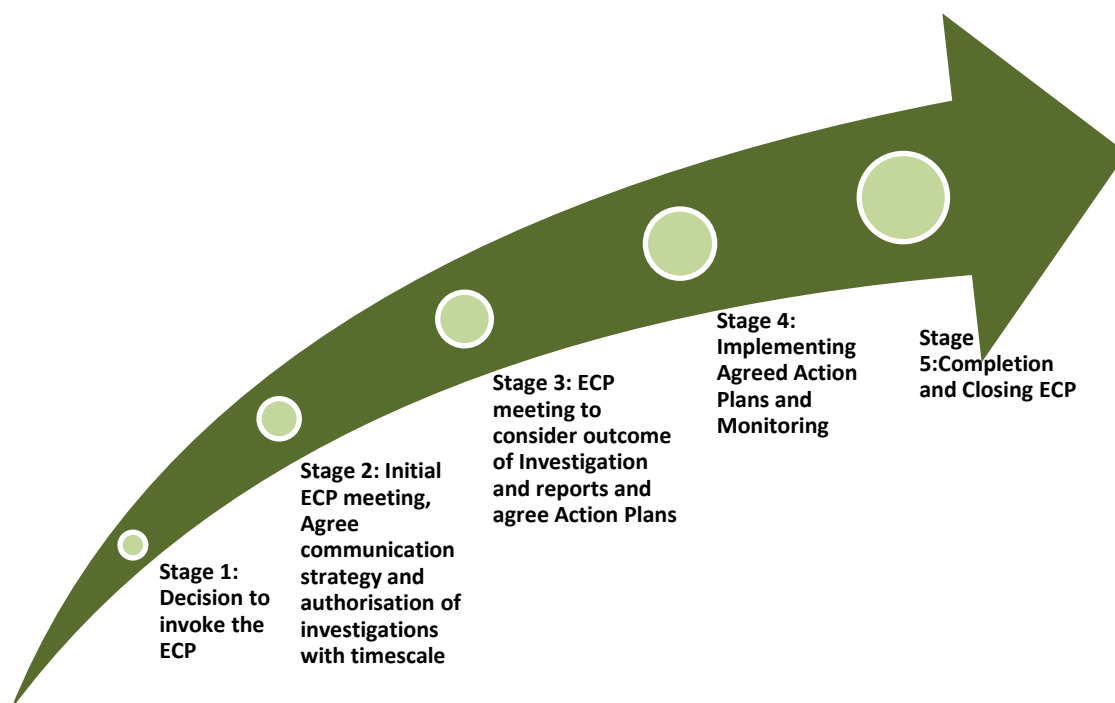
- 3.3 People who use services - People who use services are responsible for protecting themselves as far as is possible. Speaking out is not easy for people who are reliant upon care services and have limited access to the wider community. Service users need to be encouraged and supported to raise complaints, 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. Providers need to ensure that a culture of feeling safe to raise issues without fear of retribution is in place. Service Providers have a duty to encourage users of their service to raise any concerns and ensure that all service users are aware of their whistleblowing process, and that the contact details of Haringey's Safeguarding Team and CQC is clearly displayed and available in the Service User's handbook. Professionals have a duty to meet users of the service on their own and preferably away from the service to enable them to talk freely and to be supported to challenge poor quality of care.
- 3.4 Family/friends/visitors - Informal support to service users provides additional safeguards that issues are raised in a timely way. They may also be concerned about retribution and reluctant to raise matters but should equally be considered as potential partners in safeguarding plans. A clear process is in place to encourage family/friends and visitor to report concerns and to question when care is not provided according to care plans; or care is not delivered when expected; or when care is not provided with dignity and respect. As part of their monitoring of a service, Quality Assurance Team, Social Workers, and other Professionals visiting a care provision are to ensure that information on how and who to contact to raise a concern is clearly displayed in the service for all to see. Furthermore, such information is also be included in the service user handbook.
- 3.5 Advocates - The use of advocates in safeguarding is essential for people who lack capacity and have no relatives to support them. Referrals to Independent Mental Capacity Advocacy are to be made to Voiceability who is currently commissioned to provide this service. This should be addressed by the ECSG, with a mind to equal opportunities for all adults at risk.

Other advocates may be considered. Where there is no Family and friends to act in the role of advocates; assurance regarding conflict of interest and that they are acting according to the wishes and preferences of the adult at risk should always be made.

- 3.6 Document Control - Throughout the life of the process all documents are to be uploaded centrally onto adults social care database and clearly kept within the Document section of the Establishment. The Document Controller is responsible for ensuring that the agreed minutes are uploaded. Copies of action plans are updated and that there is one version in use at a time that is accessible to all relevant parties. In some cases there may be a nominated Document Controller. The CCG will retain documents of Establishment Concerns through its Safeguarding Adults Lead. Access to these documents will be on a strictly need to know basis.

#### 4 Establishment Concern Procedure

The Establishment Concern Procedure (ECP) will follow a 5 stage process detailed below:



##### 4.1 Stage 1: Decision to invoke the Establishment Concerns Process (ECP)

- 4.1.1 The decision to invoke the ECP will be jointly proposed by the Head of Assessment & Safeguarding and Assistant Director Commissioning giving reasons to invoke ECP to the Director of Adult Social Services.
- 4.1.2 The decision to Invoke ECP will be taken by the Statutory Director of Adult Social Services.
- 4.1.3 In instances where the concern is in a health setting the Director of Adults Social Services will consult with the senior manager of that health setting. The safeguarding process may run concurrent with a Serious Incident procedure but the safeguarding adults' process will take precedence.

## 4.2 Stage 2: Initial Strategy Meeting

4.2.1 Once it has been agreed to invoke the ECP, a senior manager will be appointed as Chair.

4.2.2 The Chair will call a meeting with all the relevant parties supported by the administrative support in the Safeguarding Adults and DOLS team.

4.2.3 The Chair will confirm with the CQC that the ECP has been invoked; and the establishment about which the concern has been raised will be notified in writing that the ECP has been invoked. They will be informed of the allegations/concerns at the earliest possible opportunity if it is safe to do so.

4.2.4 If there is a Police investigation, the provider will be informed in accordance with Police advice.

4.2.5 The initial strategy meeting will clarify **roles and responsibilities**, particularly:

- The Chair (who will be responsible for coordinating all pieces of work within the process).
- The link worker for user/carer/relatives
- The link officer for the provider

### 4.2.6 Actions from the initial strategy meeting

- The initial strategy meeting will assess the level of risk and put in place a Protection Plan whilst investigations are being made.
- The meeting will consider the actions and tasks that need to be completed to determine whether abuse has taken place or is likely to take place.
- An Action Plan will be drawn up with named leads and a timescale for completing each action to be brought back to a reconvened strategy meeting.
- Organisational Risk Assessment (See Appendix 1) will be undertaken at this stage.

The initial strategy meeting will agree a communication strategy which addresses both internal and external communications.

#### Check list for information:

- Senior Management - Need to Know
- Strategy decision on when to discuss matters direct with the Provider
- If a suspension on admissions is considered how this is communicated to front line staff
- Notification to ADASS around embargos and removal of embargos
- Concerning other local authorities who have made placements
- Concerning Health colleagues on any Continuing Care placements
- Updating quality assurance provider risk register
- Information to the Provider
- Press release discussion to Communications Team
- Briefing paper for Chief Executive and or Elected Members
- Consider how to consult with any other stakeholders, e.g. residents and relatives without raising anxiety

- Agree as part of strategy how to include self-funders.
- Agree date of next and any subsequent meeting.

#### 4.3 Stage 3 Establishment Concern Reconvened Strategy meeting

- 4.3.1 The meeting would be informed of the outcome of the individual investigations which will be the basis of the discussion to agree an action plan unless there are exceptional reasons for further investigation to be undertaken. This is to minimise the repeated questioning of the adults at risk and witnesses.
- 4.3.2 The meeting will consider the Organisational Risk Assessment and consider risk which will address the probability of risk and the likely impact of risk on the safety of people who use services. The meeting will consider if it is unsafe for people to continue to receive a service from an establishment furthermore the meeting will also consider the risks of moving people to an alternative provision.
- 4.3.3 In cases where it has been assessed that the risk of continuing placements or allowing residents to stay in a placement are too high, consideration should be made as to suspension of placement and / or removal of residents. Where appropriate, voluntary embargo would be considered as an option.
- 4.3.4 A **suspension of commissioning** can be imposed while more information is gathered on the issues of concern, or other action is taken in accordance with agreed plans to reduce risk. A **termination of commissioning** will include changing services or placements. This action will only be taken if it has not been possible to improve standards of care to an acceptable level within a reasonable timeframe or if the risks to service users are immediate and unacceptable.
- 4.3.5 **Suspension** should be considered in the following instances as part of the risk strategy discussion:
- If at any stage there are strong indicators that there is a risk of significant harm to other people using services receiving services from the same Provider and that this risk is continuing; and/or;
  - If a serious criminal investigation is underway where it would place service users at risk, for example an unacceptable low level of staff; and/or;
  - If any other relevant and serious incident/ concern/situation warrants such action.
  - If the Care Quality Commission reports significant regulatory issues.
- 4.3.6 Consideration to **decommission services** in the following circumstances:
- If at any stage there are strong indicators that there is a risk of significant harm to other people using services receiving services from the same Provider and that this risk is continuing and it has not been possible to improve standards of care and support to an acceptable level within a reasonable timeframe or the risks to service users are immediate and unacceptable or
  - If any other relevant and serious situation warrants such action.
  - In all cases legal advice should be sought and such decisions ratified by the Director of Adult Social Services.

- 4.3.7 If the Provider operates more than one service consideration should be given to whether the suspension or termination should apply to those other services also. This will depend on the nature of the concerns and the circumstances.
- 4.3.8 Where it is considered that a suspension is necessary this recommendation should be escalated to the relevant person. For the local authority this will be the Assistant Director of Commissioning, other Heads of Services, always in consultation with the Director of Adult Social Services. For the CCG this will be the Chief Officer
- 4.3.9 Full details of the concerns and actions together with the identified risk should be provided by the Chair.
- 4.3.10 In the exceptional case that there is a recommendation to decommission a service, reference should be made to **placement contracts**.
- 4.3.11 The agreed **Service Improvement Plan** will be the High Level plan for all subsequent safeguarding to ensure safety, governance, compliance, clinical effectiveness referencing throughout the experience of the adult at risk and their informal network.

#### 4.4 Stage 4 Implementing Service Improvement Plan and Monitoring

- 4.4.1 A Service Improvement Plan will be formalised into the overall Protection Plan for the immediate safety of people at risk of abuse when there is an agreed mandate to manage an establishment when institutional abuse is suspected. It will be the key document that is drawn up with the Provider to address the concern.
- 4.4.2 The Service Improvement Plan will be risk assessed for priority, timescale for improvement and updated in agreement with the ECSG.
- 4.4.3 Underneath this high level plan there may be a number of individual protection plans for people whom a safeguarding concerns has been raised.
- 4.4.4 An officer would be appointed to monitor the progress of improvement plan and report back to future reconvened strategy meetings.
- 4.4.5 Monitoring:
- Quality services are excellent services with dignity and respect at their heart of service provision. The Quality Assurance strategy will focus on meeting business expectations as set out in the Department of Health Dignity Standards and the council's Quality Standards. Quality assurance is about independently checking that for each concern or issue identified as poor or not meeting the needs of people using services, the action taken will deliver the quality of care and standards expected.
  - The purpose of quality planning is to provide a secure basis for the ECSG to agree on the overall quality expectations and the associated quality criteria, the means by which quality will be achieved and assessed, and ultimately the acceptance criteria by which the evidence will be judged. The specific treatment for quality will focus on the outcome for people who use services. The definition of quality for each area will include criteria considered good practice.

- People who use services, relatives, carers will play a major role in the quality assurance strategy which will ensure that people who use services remain at the heart of the safeguarding process.
- The ECSG will assign staff with the right kind of experience, skill and knowledge to assess whether the provider has implemented a sustainable change; and that there is assurance that the improvements are embedded in practice.

#### 4.5 Stage 5: Completion and Closing of ECP

- 4.5.1 The final meeting would consider the current level of risk, the sustainability of changes and customer feedback from people who use services and their relatives/friends.
- 4.5.2 Where the risk continues and there is cause for further concern the meeting would review the current protection plan against the level of risk to assess the viability of working with the provider to improve services or consider alternative options for example decommissioning the service.
- 4.5.3 The tolerances on time for making any improvements would be dependent upon the level of risk to people who use the service.
- 4.5.4 Upon an agreed ECSG decision that satisfactory improvements that are sustainable has been achieved, the process will formally come to an end and the relevant parties including the provider and the CQC will be notified formally by the chair. Following which appropriate notifications will be sent to professionals involved in the process, other placing authorities and ADASS.
- 4.5.5 A Lessons Learnt exercise may be considered by the group as a whole and in some instances with Provider participation. Any lessons learnt can be fed into the commissioning cycle, improve the safeguarding adults function and raise awareness with other staff members. Any changes made to practice to improve the quality and safety for people who use services can be disseminated within organisations bearing in mind the need for confidentiality.

**SAFEGUARDING ADULTS**  
**Establishment Concerns**  
**ORGANISATIONAL RISK ASSESSMENT**

<b>Concerns Meeting Chair:</b>	
<b>Time and Date:</b>	
<b>Professionals involved in the risk assessment and management plan:</b>	
<b>Establishment:</b>	<b>Lead CQC inspector:</b>
<b>Address:</b>	
<b>Postcode:</b>	
<b>Number of service users supported by the provider:</b>	
<b>Number of staff employed by the provider:</b>	
<b>List (including contact details) all other local authorities / CCG that commission with this provider:</b>	

RISK INDICATORS/FACTORS	YES	NO	N/A	LEVEL OF CONCERN INDICATED High, Medium, Low
Is the Establishment CQC registered?				
Are there any improvements /enforcements in place?				
Is the responsible person working in partnership with the authority?				
Does the Establishment have a registered manager in place?				
Does the Establishment have a stable and experienced staff team?				
Does the Establishment have a robust on call system?				
Does the Establishment have a clear managerial/Clinical Lead?				
Does the Establishment have a history of safeguarding concerns relating to neglect and/or institutional abuse?				
Does the Establishment have a history of complaints about quality and safety?				
Does the Establishment have a history of poor care management?				
Is the Establishment likely to work with people that may have diminished or lack of capacity on issues of care and personal safety (e.g., caters for people with cognitive impairment, dementia, learning difficulties)?				
Does the Establishment have adequate arrangements for assessment of capacity and/or best interest decision making?				
Does the Establishment respect people's privacy and dignity?				
Does the Establishment have a Safeguarding policy which includes a zero tolerance on all forms of abuse which staff are aware of through up to date training which is embedded in practice?				
Does Establishment work with people that have serious and complex health problems?				



Does the Establishment work with people that have communication difficulties including English as a second language?				
Are the wishes and views of people using services central to the care planning process?				
Have concerns been raised regarding the quality of care plans?				
Have concerns been raised regarding the quality of risk assessments?				
Have concerns been raised regarding the storage, recording and distribution of medication?				
Are people's health care needs properly identified, planned for and reviewed?				
Do people living in the Establishment have access to NHS services?				
Is the staff team appropriately qualified, trained and supported?				
Does the Establishment have appropriate methods to quality assure staff training?				
Does the Establishment work with people that are isolated and have no or few visitors?				
Does the Establishment act to alleviate loneliness and isolation?				
People who use services have access to carers and professionals to put forward their views and listen to their needs and wants?				
Is there evidence from customer feedback that there is dissatisfaction with the service and no action has been taken?				
Does the Establishment work with high-risk service users that may pose a risk to other residents, staff or members of the public?				
Does the Establishment have a policy and understanding of deprivation of liberty standards?				
Does the Establishment have a cordless or mobile phone available for calls to other parts of the home and for use when calling emergency services (e.g., in CPR situations)?				
Are the proprietors of the Establishment fully involved and working towards compliance with the improvement plan?				

Are there health and safety concerns within the Establishment?				
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**Additional risks not listed in the matrix:**

**Are all of the risks addressed within the improvement plan? If not please list actions to address these risks in the management plan, which can then be incorporated into the improvement plan:**

<b>Management plan</b>					
<b>Risk</b>	<b>Actions</b>	<b>Date these will start</b>	<b>Outcome for Provider and adults at risk</b>	<b>Who will do this</b>	<b>Review – when and whom</b>

<b>Risk Assessment at</b> <b>Date:</b>

## SAFEGUARDING ADULTS

### Establishment Concerns Feedback Form

<b>Name of the person completing this form:</b>	
<b>Date</b>	
<b>Name of the Establishment:</b>	<b>Lead CQC inspector</b>
<b>Address:</b>	
	<b>Postcode:</b>
<b>Number of service users supported by the provider</b>	
<b>Number of staff employed by the provider</b>	
<b>List (including Contact details) all other local authorities / CCG that you have come into contact:</b>	

**Detail experience of using Establishment Concern, including notifications, support, timescale or any other aspect of the process that you think it is relevant**

**Overall how do you rate the following**

**Notifications and timeliness (Excellent, good, needs improvement, poor)**

**Support - (Excellent, good, needs improvement, poor)**

**Process- (Excellent, good, needs improvement, poor)**

**Timescale - (Excellent, good, needs improvement, poor)**

**Outcome - (Excellent, good, needs improvement, poor)**

**Outline any suggestion that you may have below**

**Pease return the completed for to [farzad.fazilat@haringey.gov.uk](mailto:farzad.fazilat@haringey.gov.uk)**

End