Health, Housing and Adult Social Care

Provider Concerns
Policy and Procedures
April 2016 to April 2017

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Foreword

People who use care services have an expectation that they will be safe and that the service which is delivered has quality embedded in all aspects. They expect that the care services will be delivered with dignity and respect by staff who have been suitably recruited, checked, trained and supervised.

The events at Winterbourne View Hospital and others relating to abuse in care homes awoke many people to a reality that care is not always synonymous to quality and that abuse can and does happen within provider service. This has evidenced that services are complex and partnership coordination and cooperation has to be key if we are to uncover failings in the system.

How Enfield Council has responded to concerns with the quality of care delivered by local providers has developed through a number of factors. The emphasis on prevention, as set out by the Safeguarding Adults Board’s first strategy in 2009, shifted the focus to preventing abuse in the first place rather than reacting to it once it had happened. We know that taking reasonable steps to improve the quality of care before significant failings or there is a detrimental impact on residents wellbeing will always be better than responding once harm has occurred. Furthermore, the fostering of relationships between the local authority, as lead for safeguarding adults, with organisations such as the Care Quality Commission, Clinical Commissioning Groups and the Police, has created a strong partnership committed to responding robustly to concerns raised within provider organisations.

This policy and practice sets out our aims and objectives in responding to concerns within providers of care services in the London Borough of Enfield. It has been reviewed to ensure consistency with the Care Act 2014 and the London Multi-Agency Adult Safeguarding Policy and Procedures. It provides a framework and local practice guidance on our understanding of best practice, drawing in lessons from other local authorities, recommendations from serious case reviews/safeguarding adult reviews and government guidance. The process set out can also usefully provide a foundation for Provider Failure as defined under the Care Act 2014, which sits within Commissioning and Contracts responsibilities. We also have a wealth of knowledge from our own internal organisational learning, drawn from when we have previously responded to concerns within care providers.

As such, this policy and procedures will be a live, working document, changing in the light of new ideas and ways of working which will enhance the process but more importantly, improve the wellbeing of those who use services.
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Introduction

The aims of the provider concerns process is to:

- Ensure the safety, dignity and care to those who use the service of the provider;
- Ensure that the customer is at the heart of the process;
- Share information appropriately in order to enable effective partnership working;
- Facilitate interventions where appropriate in order to gain assurances that the quality of care is improved;
- Take robust action in instances where a crime has been committed or to protect the wellbeing of those who use services.

Working together means recognising that no single agency can alone respond or improve the quality of care within a provider. Each organisation has its own remit, focus and skills, which together, has the potential to contribute to creating the best possible outcomes within a care provision. Working together, in the context of professionals and the care providers means:

- Information will need to be shared on a need to know basis and appropriately, but with the above aims in mind.
- Best practice and lessons learnt being effectively shared.
- Each organisation will commit sufficient resources in order to contribute to the enacting of the process, including enquiries or investigation, improvement planning and implementation, and quality assurance.
- The needs and safety of the people who use services will be paramount.

Learning from serious case reviews (now referred to as Safeguarding Adults Reviews) has taught us repeatedly that the early identification of failings within services and more open communication across partnerships had the potential to prevent harm and abuse from occurring. This policy can only be effective with the commitment of everyone in Enfield. The Care Act 2014 now specifies that local authorities must cooperate with each of their relevant partners and those partners must also cooperate with the local authority.

The most important partner within the provider concerns process if those who use the service. Those who use services should be supported to maintain their:

- choice and control
- safety
- health
- quality of life
- dignity and respect.

The first priority should always be to ensure the safety and well-being of the adult(s) using the service. The adult should experience the provider concerns process as empowering and supportive. Those working in the provider concerns process should seek to engage and develop outcomes in the planning of improvements based on the needs, wishes and aspirations of those that use services. However, there may be circumstances when consent cannot be obtained because the adult lacks the capacity to give it, but it is in their best interest to undertake certain actions. Whether or not the adult has capacity to give consent, action may need to be taken if others are at or will be put at risk if nothing is done or where it is in the public interest to take action because a criminal offence has occurred.

It is important that if a decision has to be made (for example there is a public interest or risk to others) that we communicate this decision to those using the service and try to navigate the outcomes they require while also meeting our duties to protect others.
In line with the above, this policy is informed by the safeguarding principles set out in the Care Act 2014:

1. **Empowerment**: a presumption of person-led decisions and informed consent.
2. **Protection**: support and representation for those in greatest need.
3. **Prevention**: it is better to take action before harm occurs.
4. **Proportionality**: a proportionate and least intrusive response appropriate to the risk presented.
5. **Partnership**: local solutions achieved via services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
6. **Accountability**: accountability and transparency in delivering safeguarding

Taking the above into account, this document is broken into two parts; the first section is the policy on provider concerns, detailing the decision making and arrangements which will support the process. The second is the procedures which will set out the actions to be taken upon receipt of concerns about the care in a provider, through to the closure of the provider concerns process.

This is a working document which will be reviewed regularly to ensure it reflects best practice, learning and the shifting national/local context.

**Policy Scope**

The Care Act specifies that safeguarding is not a substitute for:

- providers' responsibilities to provide safe and high quality care and support;
- commissioners regularly assuring themselves of the safety and effectiveness of commissioned services;
- the Care Quality Commission (CQC) ensuring that regulated providers comply with the fundamental standards of care or by taking enforcement action; and
- the core duties of the police to prevent and detect crime and protect life and property

A provider, for the purposes of this policy, is any organisation or institution which provides care to an individual or group of people. This would include, but is not limited to:

1. Residential Care Homes
2. Nursing Homes
3. Domiciliary Care Providers
4. Supported Living
5. Private hospitals
6. NHS provision
7. Day Care/Opportunities Providers
8. Rehabilitation Units for people who misuse drugs or alcohol
9. Voluntary agencies

The in house provision of any of these services is subject to the same level and depth of scrutiny through safeguarding as those commissioned by the council or by individuals through Personal Budgets. Those who fund their own care have the same entitlement to safeguarding as those funded by the Council or health service.

A provider concern is when there is an indication that a service, as a whole, has an area or number of areas working below standard and there is a risk to the health and well-being of residents. The provider concerns process can be instigated to both prevent abuse from occurring and improve standards of care, or where abuse has occurred and actions must be taken to protect residents.

Indicators that a provider meets the threshold for the provider concerns process includes:

- A pattern of individual safeguarding concerns, which seen collectively, indicate serious organisational level issues.
- A pattern of complaints made against a provider from a variety of external agencies and or carers and relatives.
- A very serious one off incident indicative of systemic and organisational abuse, such as that involving a death of a service user.
- A large scale investigation involving a high number of service users where abuse is suspected.
- A report of systemic and organisational abuse.
- Lack of contract compliance with indicates poor care and/or lack of organisational skills or commitment in complying with contractual requirements.
- The failure of an organisation to comply with the expected safeguarding protocols as set out in the London Multi-Agency Adult Safeguarding Policy.
• Poor CQC compliance report identifying non compliance with major risk concerns in one or more essential outcome areas.

• CQC compliance report identifying non compliance with essential outcome 7 and a major risk identified.

The above list is not exhaustive and the sharing of intelligence from partners assists in identifying a more holistic picture of concerns within a provider.

Single safeguarding alerts alleging abuse against a provider may raise wider issues within the setting. Organisation abuse as defined by statutory guidance 2014 is “the mistreatment or abuse or neglect of an adult at risk by a regime or individual within setting and services that adults at risk live in or use, that violate the person's dignity, resulting in a lack or respect for their human rights.”

Within an institution, adults at risk can be subjected to a range of abuse, including physical, emotional, discriminatory, sexual, financial, organisational, operational and neglect. While a report of abuse may be in regards to an individual act, the enquiry may find that the abuse is endemic and related to the culture or structure within the organisation.

Examples of organisational abuse include:

• Poor management structure, or rigid and authoritarian management
• Poorly trained or unsupervised staff
• Inadequate staffing levels
• Inappropriate use of physical restraint
• Medication misadministration, record keeping and storage
• Failure to act on incidents of poor practice
• Persistent failure to meet basic health and social care needs of residents.

Often organisational abuse is not in isolation and is coupled with other types of abuse, including a lack of dignity and care for residents.

Complaints and Safeguarding

Complaints are an expression of dissatisfaction that requires an investigation, response and remedial action; they are different from concerns raised under safeguarding adults in that any indication of abuse or harm to an adult at risk must be dealt with under the London Multi-Agency Adult Safeguarding Policy. Trends or patterns of complaints specific to a provider can contribute to a picture of the overall quality of care. As such, information from complaints should be fed into the provider concerns process but single complaints should continue to be dealt with under the Complaints Policy.

Managing concerns outside the scope of policy

There may be cases which do not fall under the scope of the provider concerns policy and procedures, but where a provider would benefit from further support and monitoring of improvements to ensure the long term, sustainable delivery of quality care. Alternative methods to managing low level concerns out of scope include:

• Contract monitoring process of commissioning body
• Review of care provision and recommendations made by placing authority
• Regulatory review and monitoring by Care Quality Commission

Care Act Provider Failure

It is not possible to promote wellbeing without establishing a basic foundation where people are safe and their care and support is on a secure footing. The Care Act puts in place a new framework for adult safeguarding and includes measures to guard against provider failure, to ensure this is managed without disruption to services.

The Care Act introduces the responsibilities for provider failure and other service interruptions. ‘Business failure’ is defined in the Care and Support (Business Failure) Regulations 2014. This is expressed by a list of different events such as the appointment of an administrator, the appointment of a receiver or an administrative receiver.

The Act imposes clear legal responsibilities on local authorities where a care provider fails.

The Act makes it clear that local authorities have a temporary duty to ensure that the needs of people continue to be met if their care provider becomes unable to carry on proving care because of business failure, no matter what type of care they are receiving. Local authorities will have a responsibility towards all people receiving care. This is regardless of whether they pay for their care themselves, the local authority pays for it, or whether it is funded in any other way.
In these circumstances, the local authority must take steps to ensure that the person does not experience a gap in the care they need as a result of the provider failing. The exit strategy section of the provider concerns procedures sets out useful process for ensuring those who need care can be provided with this as safely as possible and with their involvement.

There is a clear difference between a business failure as defined by the Care Act and when a provider comes under this provider concerns process due to safety of care and services from a safeguarding perspective. There may be instances in which a Provider falls under provider failure under the definition of the Care Act and in addition has concerns relating to safeguarding and the quality of care to residents. In these instances, agreement will need to be negotiated between the Strategic Safeguarding Adults Service and partners in Commissioning & Procurement as to the lead.

The framework for managing business failure and the market engagement can be accessed from Health, Housing and Adult Social Care’s Strategy & Resources Department.

Factors determining vulnerability

There are factors which can increase the likelihood of abuse occurring within provider settings. The University of Hull completed research titled ‘The Abuse In Care? Project’ in October 2012 which identified over ninety individual indicators or warning signs for concern; interestingly, the analysis revealed that these indicators fell under a number of distinct areas:

1. Concerns about management and leadership
2. Concerns about staff skills, knowledge and practice
3. Concerns about residents’ behaviours and wellbeing
4. Concerns about the service resisting the involvement of external people and isolating individuals
5. Concerns about the way services are planned and delivered
6. Concerns about the quality of basic care and the environment

Mental Capacity and DoLS

The Mental Capacity Act 2005 for England and Wales supports and protects people who may be unable to make some decisions. All adults at risk should be assumed to have capacity and to be able to make informed choices. When considering concerns within provider organisations, it is important to consider that some people may have capacity to contribute while others do not; appropriate support needs to be considered to ensure equality of access to services. If a person lacks capacity, best interest decision should be made, including referral for an Independent Mental Capacity Advocate (IMCA). In Enfield, the Best Interest and Decision Making Tool should be used and recording appropriately.

The Deprivation of Liberty Safeguards are for people who lack mental capacity and may require care or treatment in a hospital or care home where their freedom may need to be restricted to the point of depriving them of their liberty. This can only be done lawfully if appropriate authorisation for a Deprivation of Liberty Safeguard (DoLS) has been sought.

There is also a process for having such safeguards put in place for people in Supported Accommodation or other settings than a care home or hospital. These judicial DoLS have to be authorised by the Court of Protection who have now streamlined the application process for these cases.

A lack of consideration to human rights and freedom from restrictions can create an environment where concerns about care will exist. Providers of services which would be subject to consideration of deprivation of liberties for those they provide services to, need to evidence that actions are taken which are least restrictive and in the best interest to service users. Providers who place restrictions without appropriate authorisations in place may be indicative of not providing safe and appropriate care to people who lack capacity.

Death

As set out by the threshold for the provider concerns process, a death within a provider service where there are allegations that the provider contributed to or was responsible for the death, should be considered under the provider concerns process.
Where a death has occurred and abuse is believed to have contributed to this, the need for a Safeguarding Adults Review (SAR) must be considered. Please refer to the Enfield Safeguarding Adults Board Safeguarding Adults Review Protocol.

Concern may be raised towards the number of deaths within a particular care provider and with respect to the timeframe in which the deaths occur. Care Quality Commission has a role in monitoring the number of deaths and any concern can be shared with the Safeguarding Information Panel. During the course of a provider concerns there may be an indication that deaths are occurring which may be higher than expected and require further fact finding or investigation. Support on managing this process can be found in the procedures section of this document.

**Information sharing and Co-operation**

London Multi-Agency Adult Safeguarding guidance notes that information sharing between organisations is essential to safeguard adults at risk of abuse, neglect and exploitation. The way information is shared needs to be done to protect people from harm and prevent the likelihood of harm occurring. Most importantly, information needs to be shared to empower adults at risk and those who support them to make informed decisions.

A separate policy exists in relation to information governance in safeguarding adults and should be referred to.

This policy in addition acknowledges that good information sharing can help to identify concerns within provider services, both for preventative work and in terms of supporting failing services.

The Care Act states that ‘Co-operation between partners should be a general principle for all those concerned, and all should understand the reasons why co-operation is important for those people involved.’ The Act sets out five aims of co-operation between partners which are relevant to care and support and for this provider concerns process four are applicable and include:

- improving the quality of care and support for adults and support for carers (including the outcomes from such provision);
- protecting adults with care and support needs who are currently experiencing or at risk of abuse or neglect;
- identifying lessons to be learned from cases where adults with needs for care and support have experienced serious abuse or neglect.

Further, 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. The CQC 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 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.

We expect that under the Care Act providers will be open and transparent while sharing information; we hold ourselves to this same account in our work with organisations.

One of the mechanisms for sharing information in Enfield is through the Safeguarding Information Panel (SIP). The SIP was initiated in 2011 between the Councils Strategic Safeguarding Adults Team and the Care Quality Commission. This is a forum where information relating to the quality of care in providers is shared, bringing together information from partners such as Councils safeguarding adults data, health and safety, procurement and contracting, London Fire Brigade or London Ambulance Service and the Clinical Commissioning Group. The panel is instrumental in helping partners share their experiences and identify common areas of concern and emerging patterns and themes.
Where partners are not present on the panel, there is a referral form into the panel and a process to monitor actions requested by partners and agencies. This panel has identified providers where an initial provider concerns meeting is needed. The chart below highlights the information sources and the interventions for the Enfield Safeguarding Information Panel.

### Prevention

Often we hear the saying that ‘prevention is better than cure’; in practice this is significantly more difficult to quantify or provide evidence of preventative outcomes in safeguarding. Kalaga and Kingston in their review of the literature on ‘effective interventions that prevent and respond to harm against adults’ categorise interventions at primary, secondary and tertiary levels:

- **primary interventions**: aim to prevent abuse occurring in the first instance
- **secondary interventions**: aim to identify and respond directly to allegations of abuse
- **tertiary interventions**: aim to remedy any negative and harmful consequences of abuse and to put in place measures to prevent future occurrences

In terms of primary interventions, commissioners should set out clear expectations of Providers in terms of quality of services and gain assurances that the standards are being met. Strategies to reduce the need for provider concerns through strong commissioning and robust contract monitoring can reduce the likelihood of provider concerns raising.

Primary interventions also include activities across organisations, for example:

- **Public awareness**: Raising awareness across the whole of society about abuse can help to prevent it.
- **Policies and procedures**: A range of policies and an open culture within an organisation can help prevent abuse, including whistleblowing policy.
- **Engaging the community in prevention and activities**.
- **Regulation** – by a range of organisations such as commissioners, Care Quality Commissioning, and contract monitoring functions.

Secondary and tertiary interventions relate specifically to this provider concerns process, Enfield Safeguarding Information Panel

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**Enfield Safeguarding Information Panel**

<table>
<thead>
<tr>
<th>Information Sources</th>
<th>Local authority</th>
<th>Health</th>
<th>CQC</th>
<th>Other sources</th>
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<td>Safeguarding Alerts</td>
<td>Health/GP referrals/ Pressure Care/Serious Incidents</td>
<td>CQC inspections</td>
<td>Fire brigade intelligence</td>
</tr>
<tr>
<td>Adult Social Care referral</td>
<td>Contract Monitoring Reviews</td>
<td>Community Health Assessment Team referral</td>
<td>Notifications of Deaths</td>
<td>Ambulance callout information</td>
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<tr>
<td>Complaints</td>
<td>Health/GP referrals</td>
<td>Change of manager notices</td>
<td>Other referrals</td>
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<td>H&amp;S audits</td>
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**Fact finding** (reviews/interviews)  

**Enfield Safeguarding Information Panel**  

**Analysis and discussion**  

**Panel assured of quality of care**

**Interventions**  

- **Local authority**: Provider Concerns process; social care specialist investigations; prioritised contract monitoring reviews
- **Health**: Health/GP/Nurse assessor/CQC Commissioners or Safeguarding lead monitoring and intervention
- **CQC**: CQC visits, with specialist if required/ CQC pharmacist visit/ Mental Health Act assessor

**Organisation Learning/ Recommendation/ Action Plan** → **IMPROVEMENTS**
Roles and responsibilities of organisations/partners

Provider Concerns Strategy Group
This is the group that will agree and steer the provider concerns process. This will be multi-agency and rest on partnership, collegial, collaborative working to recommend and reach decisions. Representation on this group will be from appropriate partners who have contact with the provider and may include Health, Metropolitan Police, Care Quality Commission, Commissioners and Contracts, and Senior Operational Service Managers. Other funding authorities will be invited to attend as partners in the Provider Concerns Strategy Group once identified.

The group will delegate work through the Co-ordinator and identify the knowledge, skills and experience needed to complete specific actions that will be carried out by individuals. The members of the group should be of sufficient seniority to assess the capacity of staff and authorise releasing staff to undertake work.

The Chair of the Provider Concerns Strategy Group will be responsible for identifying a provider concerns co-ordinator. This may be from within the service or other professionals as appropriate, such as health or contracting and procurement colleagues.

In the event that a member of the strategy group is unable or has no resource to undertake specific actions within their service area as agreed by the group or action plan, that strategy group member will be responsible for undertaking the work either by commissioning or negotiation with colleagues. The project cannot be effective without commitment to ensuring delivery within the specified timescale.

Provider Concerns Co-ordinator
The role entails ensuring that targets are met, work is progressed according to plan, evidence is collated and there is effective document control. The co-ordinator will be responsible for alerting the Provider Concerns Strategy Group through the Chair of any new risks, risks to achieving targets and plans, and take a key role in the communication strategy.

Partner Organisations
All partners have a role to play in the Provider Concerns Process. Partners are expected to work together, in the interest of safeguarding individuals and adults at risk using health and social care providers. Where providers fail to provide information or participate in the interest of achieving positive outcomes for adults at risk, every effort will be made by the Local Authority to engage under this policy. Where partners continue to fail to engage and share information, this will be escalated to senior management within their organisation and then to the Safeguarding Adults Board for support and action.

Enfield Clinical Commissioning Group (CCG) is responsible for commissioning sustainable, high quality, safe, effective and efficient healthcare services with a focus on improving patient experience on behalf of the population of Enfield. In this context the Enfield CCG will actively contribute towards the provider concerns process for those organisation’s it has commissioned which meet the threshold for provider concerns. As a clinically lead organisation, the governing body of ECCG would support partners and inform the process through collaboration with constituent members and stakeholders as appropriate.

Health Managers have clinical knowledge and expertise that can support nursing provision or other hospital settings where concerns exist. In addition to this, GPs have a significant role to play and are often attached to residential and nursing home settings. GPs have been involved in provider concerns process through both reviewing of health needs, ensuring appropriate health care is received and providing feedback on the quality of the health related care being provided.

Care Quality Commission, as the regulator for health and social care settings, can provide invaluable information to inform decision making within the provider concerns process. The CQC are also able to take action through enforcement notifications.

The Police are key partners in taking action where crimes are committed, and there are a number of instances where abuse within provider settings
constitutes a crime; for example, section 44 of the Mental Capacity Act makes wilful neglect against an adult who lacks capacity a crime. Prosecutions can also be made through colleagues in Councils Corporate Health and Safety, as well as providing expertise and advice on a range of issues relating to health and safety in the workplace.

Council’s Consumer Protection support safeguarding adults through attending the Safeguarding Information Panel meetings and sharing information with partners. Consumer Protection staff attend the provider concerns meetings and support giving health and safety advice and taking formal action in accordance with our enforcement policy. Consumer Protection will investigate deaths which are attributed to health and safety failings and investigate serious workplace accidents or incident to service users or staff. The team undertake a risk assessed programme of care home inspections to ensure compliance with Food and Health and Safety legislation.

Consumer Protection in conjunction with the partners will assess intelligence to determine if intervention is necessary for the purposes of compliance with Health and Safety legislation.

Over the past few years the key driver for the Commissioning Service in Health, Housing and Adult Social Care Enfield has been the personalisation agenda and more specifically increasing customers’ choice and control over their care services. Clearly this has had implications for the commissioning of safe services as there is a potential risk inherent in extending choice whilst the council diminishes its formal contracting arrangements. However, together with our partners in the NHS, Voluntary Community Sector and all other local stake holders, we have worked hard to develop local assurance models for commissioning. These have included accreditation frameworks for our new electronic market place, intensive market development and engagement programmes, and in conjunction with procurement colleagues, the reconfiguration of monitoring processes to capture outcomes. The commissioning service remains committed to ensuring that extending choice is balanced with mitigating risk.

Adult Social Care Professionals play an active role in reviewing and supporting those in provider settings, ensuring services are appropriate and contributing towards protection planning. 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 and falls prevention for example is essential.

London Fire Brigade personnel visit people in their homes when carrying out a Home Fire Safety Visit. Personnel carry out the visit in accordance with London Fire Brigade guidance and policy, providing fire safety advice and installing, where appropriate, one or more smoke alarms. Where personnel have a concern about an adult at risk they follow procedure and inform their line manager who then takes action, which may involve referral to another agency. Where other agencies visit people in their homes, the London Fire Brigade advises those staff to look for any indication of fire risk. This may include: burn marks made by carelessly discarded smoking materials; evidence of hoarding, where access may be impeded or could be fuel for a potential fire; and a build-up of grease on cooking equipment (chip pans in particular). The use of oxygen is also noteworthy, particularly where the user is also a smoker. Staff from other agencies are not expected to become fire safety experts or to deal with risks they may observe, but they should be aware of the potential risk and advise the local fire station so that they may contact the occupier to arrange for a Home Fire Safety Visit.

When there are service level concerns with a provider in Enfield, the London Fire Brigade will consider whether consultation and advice to the provider will enable a safer living environment for residents as part of service improvement planning. Repeat call out to providers which indicate there may be risk will be shared with Enfield Safeguarding Adults Partners.

Support for those involved (service users, family members)

The intent of this policy is that adults at risk are kept at the centre of the process and are supported and enabled to contribute to decision making where appropriate. Raising concerns can often be a frightening experience and it is important for service users and their families to be encouraged and supported to raise concerns and complaints in regards to care.
Care Act requires that Local authorities must involve people in decisions made about them and their care and support. Involvement requires the local authority helping people to understand how they can be involved, how they can contribute and take part and sometimes lead or direct the process. People should be active partners in the key care and support processes and the provider concerns process is a chance for individuals and their families/friends to help shape the services that are provided to them. No matter how complex a person’s needs, local authorities are required to involve people, to help them express their wishes and feelings, to support them to weigh up options, and to make their own decisions.

Issues of support to service users can be addressed through mechanisms, such as:

- Encouraging the use and support of an advocate, either paid or from their own support networks. Consideration should be given to using an advocate that reflects the adult at risk’s culture, religion or lifestyle where possible. An example may be a family member or a friend.
- Representation by Independent Mental Capacity Advocate where someone lacks capacity
- Service users and their families should be given information in a form that is most suited to their communication requirements
- Use of a translator or speech and language therapist or other person that is able to understand the communication methods of the service user. This may be a family member, trusted friend, volunteer or paid professional.
- Use of bi-lingual workers where possible
- Culturally sensitive approaches

**Arrangement for managing the provider concerns process**

**Communication Strategy and Information Governance**

The communication strategy addresses both internal and external communications. It details how the Co-ordinator will send information to and receive information from the wider organisations involved with or affected by the provider concerns process. In the case of organisational abuse a formal stakeholder will be the proprietor and manager of the organisation and all correspondence and engagement from them should be recorded.

The focus for the strategy will be how communication is evaluated and the impact on actions within the project and what methods will be used to ensure that all parties are informed at each stage of the process.

The initial provider concerns meeting will set out whom information should be shared with and the information governance surrounding information sharing. Each partner organisations own internal information governance policies should be adhered to in terms of how information is stored and securely transmitted.

Throughout the life of the process all documents are to be uploaded onto CareFirst and clearly badged within the Document section. 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 the Co-ordinator may also be the Document Controller, although for high risk cases it would be helpful if administrative support to the Co-ordinator was available.

Check list for information to:

- Director Need to Know Form
- Commissioning/Procurement and Contracts
- Safeguarding to decide on when to discuss matters direct with the Provider
- If a suspension on admissions is considered how this is communicated to front line staff
- Alerting other local authorities who have made placements
- Alerting Health colleagues on any Continuing Care placements
- Information letter to the Provider
- Regulated activity to CQC
- Press release discussion with Enfield Press Office
- Briefing paper for Chief Executive and or Elected Members
- Consider the need to consult with any other stakeholders, e.g. residents and relatives, self-funders, and agree as part of strategy how to manage this.

Communication with people who use services is key. Those who use services should have the opportunity of shaping and influencing the quality of services; this should be in the context of independence from the organisation. How communication is completed will vary depending on the type of organisation but can include:
• Arranging a Family and Friends meeting
• Meeting with those who use the service, either in a group or individually
• Through completion of questionnaires which are simple and clear
• Through providing dedicated name and number of individual outside of the provider

Communication can include wellbeing calls, which aim to ensure that people are safe and record their views to be included in the organisational risk assessment and risk management plan.

**Risk Management**

Risk management addresses the probability of risk and the likely impact of risk on the safety of service users. Risk assessments in the provider concerns process will systematically identify and assess risk and then plan and implement a response to the risk.

The purpose of the risk assessment is to agree the level of acceptable risk. In this instance the major decision is when is it unsafe for people to remain in an establishment or with a provider? And what are the risks of moving people to an alternative placement. A major inhibiting factor in achieving good outcomes for people is where there exists a fear of putting the organisation at risk, both financially, in terms of public relations, reputation or in breach of the law. The strategy group will need to acknowledge that there will often be some risk, and that trying to remove it altogether can outweigh the quality of life benefits for service users while continuing existing arrangements for safeguarding people. Balance and proportionality are vital considerations in encouraging responsible decision making. Reasonable risk is about striking a balance and exploring each issue in context. A good approach to risk within the framework of safeguarding is to base risks on human rights, and it is important that the needs of service users are paramount in deciding the level of acceptable risk.

The principles for safeguarding adults risk assessments in the provider concerns process is as follows:

• A referral into the provider concerns process will always trigger a risk assessment.
• The provider concerns process risk assessment should be clearly recorded, precise, specific and timely. It should be reviewed frequently. It should be communicated to all relevant people in each case. Good risk assessment will support and provide evidence for protective decision making, but remember that it may also need to be used later in any court proceedings.
• Clear, thorough recording of risk assessment, a multi-agency risk discussion and subsequent protection planning are essential.
• One of the main reasons we assess risk at the strategy stage is to facilitate and guide protection planning.
• Risk should be assessed and recorded at the referral stage and repeated at other stages of the process as appropriate. Particular attention should be paid to making a multidisciplinary risk assessment.

The level and range of risks should be made clear at the initial and subsequent strategy discussion and meeting stages to ensure all decisions are based on information which is both up-to-date and gathered from several sources.

For each of the concerns or issues identified in the risk assessment an action to mitigate or minimise the risk will need to be identified. The risk assessment should be updated by the Co-ordinator throughout the provider concerns process.

**Safeguarding Plan**

This should include:

• The action to ensure the safety of any individual relating to a single alert and the wider actions taken to safeguard all who use the service
• The details of the services available to those who use the provider, including both short and long-term supports
• Any changes to the services since the provide concerns process began
• A plan for support for those who use the provider, if there is on-going legal action
• Review of the risk assessment and discuss the plans to limit this risk
• Monitoring and reviewing arrangements
• Agreed contingency plans

These plans need to provide assurance that risk has been assessed an agreed plan is in place for all partners to contribute towards safety of those who use the service.

**Quality Assurance**

The Enfield Quality Improvement Framework is Enfield Councils plan to ensure that “our services
provide the best possible outcomes for our service users and carers”. The provider concern process will work towards meeting both the requirements of this framework and the standards as set out in the Dignity Strategy, enabling the desired benefits of these standards to be experienced by service users.

Quality assurance is about independently checking that for each concern or issue identified as poor or not meeting the needs of service users, the action taken will deliver the quality of care and standards expected. The quality assurance strategy agreed by the provider concerns strategy group will plan how their shared understanding of quality will be measured. This will provide a secure basis 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 Provider Concerns Strategy Group may also commission individuals, internal or external, and providers to complete or contribute to the quality assurance role.

Service users, relatives, carers and third sector organisations will play a major role in the quality assurance strategy which will ensure that we place service users at the heart of the process.

**Managing Provider Concerns Health Commissioned Service**

The Care Act makes clear that safeguarding should not be a substitution for commissioners regularly assuring themselves about the safety and quality of those provider services they commission. The Provider Concern Process has recognised that there is a need for commissioners, and specifically relating to those providers with a relationship to the Clinical Commissioning Group, to be a central part to this process.

In addition, it is important that providers are not requested to provide duplicate information and reporting lines relating to a number of action plans.

In order to ensure a smooth process the following actions should be undertaken:

- Agreement by senior manager in LBE and CCG as to the chair (who may be independent if required)
- An integrated improvement plan that meets the requirements of both organisations
- Co-ordinator to be identified, which may include joint project management where this has a dual quality assurance function
- Multi-agency meetings which include both LBE and CCG
- Clear communication and information sharing strategy

For large or high risk providers a terms of reference can provide clarity to all those involved, including the provider.

The CCG have the option of acting as lead within the parameters of these procedures; they are a statutory partner in safeguarding and with the agreement of the Local Authority may chair and co-ordinate provider concerns under this policy and in line with London Multi-Agency Adults Safeguarding Policy and Procedures.
Procedure

Introduction

These procedures have been written with reference to the London Multi-Agency Adult Safeguarding Policy and Procedures, Making Safeguarding Personal and the Care Act 2014.

The provider concerns process requires alerts being raised with regards to adults at risk in providers currently under the process to be managed under the usual single alert process. All single alerts raised with regards to adults at risk should be progressed in order to achieve outcomes for the person being harmed but taking into account local practice guidance relating to public interest and where a crime may have been committed. This information will inform the provider concerns process and it is not sufficient to state that the single alert will be dealt with through the provider concerns process. The provider concerns process can provide a mechanism for recommendations and learning from single alerts to be managed as part of improvement planning where appropriate.

Timescales are set out by London Adult Safeguarding Policy. In the context of working to improve quality of care within services there are a number of factors which may impact on bringing this process to a conclusion; the paramount concern is with respect to the safety and wellbeing of those who use the services.

Raising a concern and invoking the procedures

The provider concerns process is evoked through the Councils Strategic Safeguarding Adults Service. Information and concerns are raised through a number of methods, which may indicate that an organisation should be considered under the provider concerns process; an initial meeting under this process does not necessarily mean that this policy will have to be evoked in its entirety, but provides an opportunity to share information and assurances of the level of care.

Concerns come to light, most notably via:

- Safeguarding Information Panel
- Partner organisations, such as Care Quality Commission or Clinical Commissioning Group
- Adult Social Care

Any individual or organisation is able to raise their concerns through the usual method of contacting adult social care.

When there is a body of information or sufficient risk to indicate proactive steps need to be taken, these will be considered against the threshold tool for the provider concerns process.
Step 1: Decision for Provider Concerns

In practice, this step can be undertaken with step 2, as a formal initial provider concerns meeting where it is clear that the risks which present itself meet the threshold to initiate the process.

As set out in the London Adult Safeguarding Procedures, the action taken when a decision is made to initiate the process includes:

- Immediate checks on welfare of people using the service
- Consult police about whether there are criminal matters
- Contact placing authorities
- Agree chair and lead organisation
- Appoint provider concern co-ordinator
- Convene provider concerns meeting
- Set up meeting with the provider
- Map out risks and risk management plan
- Consider commissioning intentions

The above actions are expected within five working days.

Step 2: Initial providers concerns meeting and fact finding

The initial concerns meeting is facilitated by the Strategic Safeguarding Adults Service. A meeting will be convened with all funding or commissioning authorities where this is known. Once this provider is notified that the provider concerns process has been evoked, a request will be made to the Provider by the Strategic Safeguarding Adults Service for all funding authorities, including self-funders, to be identified.

This initial provider concerns meeting is the opportunity to discuss and share information held by all parties that is relevant to keeping people safe and assuring the quality of care. Information will be shared in order to assess risk and identify any gaps in information which is essential for providing assurance of the level of care and dignity provided.

As set out in London Adult Safeguarding guidance the purpose of the meeting is to:

- Safeguarding planning to consider the type of enquiries, leads and timescales
- Risk management
- Consider commissioning intentions
- Set date for findings meeting

Protective actions will be considered at this meeting. In many cases, this includes reviewing those currently in receipt of a service from the provider to assure that an acceptable level of social care and/or health services are being received. If self funding applies, the locality in which the provider is based is responsible for offering reviews to those who are self funding.

A Co-ordinator is to be appointed who will be the link to the strategy group and the Provider.

Actions for further fact finding will be determined by the group to both test concerns further and identify any additional risks. The Co-ordinator will oversee the fact finding process with support from strategy group members; staff identified to undertake specific task need to have capacity and that this work is prioritised under safeguarding. Fact finding may be commissioned to an external source where this is appropriate and more specialist role is required. This may be commissioned to an individual or a provider, both internal to strategy group members or external.

Fact Finding

This can include but is not exclusive to the following:

- Service user reviews – by adult social care and continuing health care
- Occupational therapy assessments of staff in manual handling (especially helpful for people with high dependency needs)
- Pharmacy Audits
- Unannounced visits
- Health and Safety inspections
- Information or reviews from community health professionals, such as district nurses
- Previous or planned Care Quality Commission inspections
- Performance and Contract Service monitoring visits

Fact finding also presents an opportunity to consider whether there are commercial difficulties that puts the continuation of the business under threat. Any indication through the provider concerns process that there is a risk that the provider may be unable to continue its business should be escalated.
as per the Health Housing and Adult Social Care Framework on Provider Failure. This can contribute towards any preventative work to manage risk, which may reduce the uncertainty faced by people receiving care and support.

The initial provider concerns meeting will need to draw up and agree risk, quality and communication strategies. A review of risks will be undertaken to assess the level of risk to resident safety and will be reviewed throughout the process to ensure that risks are being removed or at the minimum managed to an acceptable level. The Co-ordinator will document all risks both high and low level as they occur. The Quality strategy will begin to be formulated, taking into account how people's experience and outcomes will be measured. The Communications strategy will outline how, when and who information will be provided to and from to ensure that all information is processed and acted upon to safeguard service users.

Meeting Providers
A meeting with the Providers should take place within five working days of the initial provider concerns strategy meeting. This is an opportunity to share with the provider, in a transparent and open manner, the concerns raised via the strategy meeting. The provider will be given the opportunity to draw together a service improvement plan, which details the actions to be undertaken to raise the standard of care. This plan must be signed off by the strategy group and it is the responsibility of the co-ordinator to have oversight and update this plan accordingly.

It is important the work with the provider is proportionate and fair; proportionate in that the actions taken can be justified and balanced against the level of risk, and fair in that there is an opportunity for the provider to put across their account and without bias. Working with the provider means balancing two competing imperatives:

- Business as usual – in the overwhelming majority of cases service users will remain resident or user of the provider and it is important that the service quality is of an acceptable standard to continue to operate and that there is a continuous customer relationship with the Provider.
- Transformation of the business operation to meet required changes and that these are introduced to best effect for the benefit of service users.

A distinction need to be made between the manager and operational lines of a provider, and the proprietor/owner. Organisational learning from previous provider concerns identified that the proprietor must be contacted, made clear their accountability in the process, and that they are able to drive forward and adequately resource the service improvement plan. Where there is a lack of engagement and compliance from a provider, this should be escalated to their chief executive (where applicable). Providers who fail to engage within reasonable timescales, and this is impacting on reasonable improvements in care where significant harm is occurring, reference should be made to the need to suspend or terminate commissioning.

As part of service improvement planning, consideration needs to be made with respect to:

- Staffing has been reviewed by provider and is sufficient to both meet the needs of residents and the service improvement plan
- Large improvement plans do not always set the priorities, such as clinical care, resulting in actions being completed which are less urgent. Targeted improvement plans will mean that items relating to risk, care and medication can be seen as prioritised over other issues.

Engaging service users, relatives and friends
Those who use services, their families and friends are crucial to the provider concerns process. They are the main point of contact for understanding the nature of the concerns- how dignity and respect, or a lack of, is experienced- as well as quality assurance means to ensure that there is significant improvement which has been sustained.

Those who use services and their families should be informed at an early stage that the provider concerns process has been invoked. This should include arranging a meeting, without members of the provider present where appropriate, to gain feedback on their experiences of care. In organisations where care is received at home, information can be shared via letter, including to all self-funders or those on a Direct Payment, ensuring they have a contact point to talk to someone direct about the concerns.

It is important that the outcomes the residents, families or friends want to see within the service are determined and every effort to achieve these outcomes; this may involve, for example, including
changes suggested into the service improvement plan. For this reason, it is important a meeting is arranged early on in the process to identify these outcomes and quality assurance of evidence is benchmarked as to whether they meet this.

Care and attention should be made to ensure no individuals who are under the single alert process are named, or any other personal details of those who have made complaints or whistleblowers can be identified. The purpose of the meeting is to assure service users and others that the Council and partners are actively engaging and working with the provider to improve the standard of care.

Consideration should be made to having a single point of contact outside of the provider where concerned service users or their families and friends can contact to raise additional concerns or provide information in confidence.

Residents, friends and family who are able to, with or without support, form part of the quality assurance group should be encouraged in this role.

The timescales set by London Adult Safeguarding guidance aims for the above to be completed within 10 working days.

**Step 3: Findings meeting**

The purpose of the meeting is to:

- Assess and agree the findings from ‘fact finding’ enquiries
- Draw up issues for a service improvement plan
- Update the risk management plan and agree safeguarding measures
- Consider actions to monitor the safety of people and agree triggers to escalate risk, whilst improvements are being made
- Consider commissioning intentions
- Preserve information that may be helpful to police investigations

Meeting with the provider by the chair and lead commissioner should be undertaken after this meeting to share information. The provider is expected to develop the improvement plan within 48 hours of this meeting.

**Project Management meetings**

The co-ordinator will meet with the provider throughout this stage of the process. The frequency of meetings should be agreed in advance and based on needs, but as a general guide is weekly in the beginning to support the provider with embedding of change and to assure the immediate improvement of high risk needs.

These meetings present an opportunity to review in depth the service improvement plan, highlighting areas of high risk for focus. The service improvement plan is key in this process, as it sets out clearly the expectation in respect to areas for improvement, timescales and the measurement of evidence required which will be quality assured. Service improvement plans allow the provider concerns strategy group and provider to have oversight of the areas which are progressing and those still requiring completion.

The project management meetings also provide an opportunity for the provider to identify areas they feel improvements have been made or request for additional support. As example, the strategy group may be able to assist with identifying trainers, examples of best practice recording tools or specialist services the provider can link to for ongoing service support.

As change continues to be embedded, the frequency of project management visits can be reduced. The co-ordinator should provide feedback to the Chair on progress with the service improvement plan, which will be shared with the strategy group.

**Step 4: Update meetings**

Update strategy meetings will be held as and when required, but are likely in response to areas of risk not being managed or corrected by the provider. As risks are brought to the attention of the chair and the strategy group, update meetings are held in response to bring together senior level resources and expertise from across the partnership which can assist in resolving barriers.

Update strategy meetings will consider risk which will addresses the probability of risk and the likely impact of risk on the safety of people who use services. The meeting will consider if is it unsafe for people to continue to receive a service from the provider; furthermore the meeting will also consider the risks of moving people to an alternative provision.
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.

**Step 5: Quality Assurance**

Quality assurance of the improvements and their sustainability will be undertaken throughout the provider concerns process. Feedback from adults and their carers will act as control measures to assess whether there has been noted difference in the service delivery. A target time of 10 working days is recommended in the London Adult Safeguarding Procedures; this timescale may be useful for planned quality assurance activities which are above and beyond those being undertaken throughout the process i.e. support from local Healthwatch or quality checkers as an activity.

**Step 6: Closing the Provider Concerns Process**

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.

Feedback obtained from the quality assurance strategy will evidence whether the level of improvement and change that has taken place. These quality assurance activities may include, for example:

- Validation of service improvement plan by social care or health professional
- Feedback from service user, family and friends
- Review by third party, such as partner local authority
- Visit by a Enfield Quality Checker

Upon an agreed strategy group decision that satisfactory improvements that are sustainable has been achieved, the strategy group responsibility will come to an end and the relevant parties, including the provider, will be formally notified.

**Organisation Learning**

The provider strategy group may consider whether an organisational learning meeting is required. If this is agreed, the Strategic Safeguarding Adults Service or a partner will convene a Learning Meeting, which the Provider will also be invited to. The aim of the meeting is to establish what went well and what could be helpful to inform any future project and what might have been done differently.

Organisational learning identified through service users, families or their friends should be included, linking in to how outcomes they identified could be achieved and can be shared with other providers to improve the prevention of abuse and quality of services.

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.

**Review**

Contract monitoring review by the commissioning body is required in order to ensure that the improvements have been sustained. This should take place within three months of the case conference.

Where there are multiple commissioning bodies, an agreement should be sought on the lead and any resource agreements put in place.

**Interventions for high risk provider concerns**

**Concern with deaths in care providers**

It has been recognised that in some instances the monitoring of death rates can be a useful tool in identifying poor practice. The question is whether the quality of care could have contributed to the earlier death of residents, while recognising that care providers are often looking after people who may be unwell, poorly or in end stages of their life.

The Provider Concerns Strategy group may become aware of a number of deaths within a timeframe which it is believed is not within reasonable rates and that further factfinding would be of benefit. This is generally within a provider where there is concern with the quality of health and social care provided. In this instance a review of the health and social care records of deceased residents is required. It is recommended that this is completed by a health professional who can triangulate between how care, medical needs and recording is completed which
would provide an indication of how provider has met/has not met the needs of the service user.

In some instances access to medical records may be required in order to identify that the provider was following medical advice and confirm that appropriate information was in the health and social care records. This may be for example reviewing the files held by the GP. Advice should be sought from the Information Officer for guidance around access to information of deceased residents.

Where there is any indication through fact finding that quality of care could have contributed towards early death or the death of a resident then the Police should be informed and requested to undertake Section 42 enquiry. It is expected that prior to this point good practice is to have involvement of the police for serious cases involving provider concerns.

A balance needs to be sought between how much information at the initial fact finding stage to share with the deceased relatives; in completing preliminary fact finding into deaths it may be inappropriate and potentially distressing for relatives to be aware of this fact finding should there in actuality be no cause for concern noted.

**Escalation Process**

High risk provider concerns should be escalated to assistant director and director level in Housing, Health and Adult Social Care and the senior individual in the commissioning body. An agreed plan for management of the concern will be made, which may include consideration of the need for an independent chair, investigators or additional resources to assure the safety of those who use the provider.

The case will be escalated via the acting chair of the provider concerns process to the Head of Safeguarding Adults, Quality and Complaints, whom will then make a decision with regards to notifying Assistant Director and Director. A meeting will be convened and decision taking as to next steps, this can include but is not limited to:

- Need to appoint senior chair or independent chair
- Additional resource to protect current residents
- Decision to move residents or plan exit strategy
- Formulating response to other key stakeholders, including members
- Agreeing statement for press

**Suspension**

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 by the Strategy Group as to suspension of placement or removal of residents.

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 for individuals already funded by the involved commissioning agencies. 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.

Suspension to 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 service users receiving services from the same Provider and that this risk is continuing; and/or;
- If a criminal investigation is underway; and/or;
- If any other relevant and serious incident/concern/situation warrants such action.
- If the Care Quality Commission reports significant regulatory issues.

Consideration to terminate commissioning from a Provider in the following circumstances:

- If at any stage there are strong indicators that there is a risk of significant harm to other service users 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 Health and Adult Social Care.

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.
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 Head of Commissioning, Head of Procurement and Contracts, Assistant Director. Full details of the concerns and actions together with the identified risk should be provided by the Strategy Group Chair and/or the Coordinator.

In the exceptional case that the strategy group recommends decommissioning the service and this is ratified by the Director an Exit Strategy Meeting is to be convened and chaired by an Assistant Director. All efforts should be made to cause the minimum of distress to service users, as detailed in the exit strategy below.

Notification to other authorities on the decision to suspend or decommission a service is done via the Association Directors of Adult Social Services.

**Exit Strategy**

A European Court of Human Rights ruling on a Care Home resident being moved stated that “there is a professional burden on practitioners to identify hazards and minimise risks by adopting best practice in preparing residents and their families.” If the preparation, planning and implementation of an exit strategy become necessary within the provider concern process, all stakeholders will be entering a highly pressurized and uncertain period.

This section is designed to provide a map of the key issues that need to be considered and Enfield Council’s response to these issues.

**Context:**

There are three situations where an exit strategy is necessary:

1. CQC take the decision to de-register a home
2. HSE/Environmental Health take the decision to close a home
3. The local authority decides that the home is not meeting the needs of the service users that have been placed there.

An exit strategy requires the safe movement of residents, their belongings and any information regarding their care/support needs from the failing home to another placement safely.

Exit strategies can be: immediate, semi-planned or planned, depending on the notice period the Provider Concerns Strategy group has been given. The pressures and priorities for each type of exit strategy cover the same dimensions: initiation, engagement, information, co-ordination, implementation and review.

**Initiation:**

Once the Provider Concerns Strategy group has agreed that preparations for an exit strategy are necessary, an Exit Strategy group needs to be established. This group will include: the Provider Concerns Strategy group chair, co-ordinator, placing authority representatives, health representative, exit strategy co-ordinator (who will focus on information gathering and sharing, and logistics), and anyone else the chair feels is necessary, based on the specifics on the exit strategy. LBE have an emergency planning service which may be key within this partnership where an immediate closure is required.

**Engagement:**

There are a variety of stakeholders that may be engaged. Many of the stakeholders will already be part of Provider Concerns Strategy meeting. However, to ensure a well-informed, co-ordinated and safe exit strategy the following representatives must be contacted as appropriate and briefed regularly:

- Residents and their families and friends and or advocates, IMCAs and registered attorneys.
- Provider (at various levels depending on size of provider)
- Senior managers of the lead Local Authority
- Other placing authorities
- Health colleagues (Pharmacist, GPs)
- Ambulance service/private ambulances
- Police
- Lead local Authority’s care teams
- Lead local Authority’s OTs and equipment providers
- Lead local Authority’s Emergency planning teams
- Lead local Authority’s Press office
- Lead local Authority’s Legal and Insurance teams
- Lead local Authority’s Transport services
- Lead local Authority’s Adult social care Procurement/Brokerage
- Lead local Authority’s Emergency Planning Service
- Packing and removal company
Once an exit strategy has been initiated all or some of these stakeholders need to be contacted and advised that an exit strategy, with the relevant timescales, is underway.

The role of these stakeholders will be discussed in greater detail below, under co-ordination. Depending on their role within the exit strategy they will have to be contacted at regular intervals. The frequency of contact with the stakeholders must be agreed by the Exit Strategy group and noted as part of a communication plan.

**Information:**
Gathering accurate information is crucial for the exit strategy to work effectively. It is the basis for the co-ordination element of the exit strategy process and facilitates effective risk management and planning. The information will help identify the service users identified as high risk for a variety of reasons. These service users will need the most and or specialist support for a successful transition.

The following information is needed to effectively manage an exit strategy:

- **Resident care information**
  - Including, most recent reviews and OT assessments covering information such as mobility; continence; eating and drinking; epilepsy/seizures; challenging behaviour;
  - OT assessment information, carried out specifically for move; equipment requirements; moving and handling notes;
  - Risk assessment to address support requirements during transition and transport;
  - Residents assessed as high risk to be highlighted;
  - Transition plan.

- **Resident health info**
  - Continuing care reviews for clients with nursing needs, detailing health specific needs;
  - GP details;
  - Medication, controlled medication;
  - Pressure care.

- **Resident capacity**
  - DoLS in place;
  - Orientation/confusion;
  - Advocacy/IMCA requirements.

- **Location within care home**
  - Floor/room number.

- **Transport requirements**
  - Equipment/support needed to move resident to ambulance – hoist/wheelchair;
  - Transport to bring support workers back from placement;
  - Details of “precious” belongs that must accompany the service user/the rest will be moved by removal company.

- **Family information**
  - To ensure that all aspects of support have been taken into account (culturally specific information);
  - Main carer present on day of move to provide support.

- **Placement information**
  - This may not be available until the day of the move;
  - Friendship groups considered when identifying new placements and in support planning;
  - Ensure that equipment is in situ prior to the move date;
  - Ensure medication is available at new placement prior to the move date.

This is not an exhaustive list. The detail that is required and the time pressures for analysing and disseminating this information will vary depending on whether the move is immediate, semi-planned, or planned. However, the above list provides an indication of the key areas that must be considered.

The information will need to be compiled into a variety of different formats to support different functions during the exit strategy: resident packs to stay with the support worker; floor plans with names and room numbers for floor co-ordinates and so on (see Implementation).

**Co-ordination:**
Once an Exit Strategy group has been established, it will need to work through the tasks below. These tasks represent the minimum requirement, and the Exit Strategy group will need to decide if additional tasks are required to effectively implement the exit strategy.
<table>
<thead>
<tr>
<th>Task 1: Develop robust project plan</th>
<th>Task 4: Equipment to be identified by OT reviews</th>
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</thead>
<tbody>
<tr>
<td>As part of the department’s emergency planning processes, a draft project plan outlining the key tasks, roles, responsibilities and processes needed should already be developed. The parameters of the project then need to be modified to reflect the time scale and complexities of the exit.</td>
<td>Residents’ equipment requirements should be identified prior to the move and new placements to confirm they are able to provide the required equipment. A summary of this information needs to be provided to the Procurement team, who will ensure that placements can provide it. If placements cannot provide the equipment, then brokerage/internal equipment stores need to be contacted to source the equipment before the resident arrives at the new placement. A copy of the OT reviews must be included in the Residents’ packs.</td>
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<tr>
<td>Dependencies:</td>
<td></td>
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<tr>
<td>• Provider Concerns Strategy meeting</td>
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<td>• Exit Strategy group has approved</td>
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<tr>
<td>• Key information about the residents and the move have been gathered</td>
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<tr>
<td>Task 2: Briefing for staff members responsible for tasks</td>
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<tr>
<td>The group of officers who will be moving residents need to be briefed on required actions. They will need their resident packs and transition plans which will include key resident information and their latest reviews. Staff will be run through the timetable for the moves. Having the transport provider at this meeting would be advantageous. Key concerns will be addressed.</td>
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<tr>
<td>Dependencies:</td>
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<td>• Staff identified and agreed by senior managers.</td>
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<tr>
<td>• Staff notified and prepared for emergency scenario</td>
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<tr>
<td>• Time table finalised</td>
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<tr>
<td>Task 3: Contacting Residents and their families and friends and placement prior to move</td>
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<tr>
<td>The care workers/support staff who will be supporting residents need to contact residents and their family and friends prior to the move to let them know what is taking place and the timescales.</td>
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<tr>
<td>Dependencies:</td>
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<tr>
<td>• If time has permitted, family members and friends and main carers will have already been briefed. Ideally, placements should be identified prior to the day of the move.</td>
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<tr>
<td>Task 5: Care Management teams and Procurement to identify and agree placements</td>
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<tr>
<td>Once it is confirmed that an exit strategy is going to be implemented, Procurement will negotiate the cost of placements identified by the social care practitioners based on needs identified by service user assessment and other supporting information. All placements identified at providers on the Provider Concerns process to be discussed with the Strategic Safeguarding Team prior to the agreement of any placements.</td>
<td></td>
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<tr>
<td>Dependencies:</td>
<td></td>
</tr>
<tr>
<td>• OT reviews are completed</td>
<td></td>
</tr>
<tr>
<td>• All reviews are up-to-date</td>
<td></td>
</tr>
<tr>
<td>• Resident packs have been completed</td>
<td></td>
</tr>
<tr>
<td>• Social care assessment</td>
<td></td>
</tr>
<tr>
<td>Task 6: Briefing for other Lead Local Authority partners</td>
<td></td>
</tr>
<tr>
<td>The Local Authorities Press Office, Legal Team and Emergency planning are to be notified, and updated as often as feasible. These partners will be able to assist with unknown elements of the move (for example, press desk on site; emergency provision and so on). The Local Authority’s Insurance officer needs to be contacted to understand the key risks and what the Local Authority is covered for. Transport need to be advised that significant requirements will be necessary. Legal team to review correspondence and statements made to the public domain to ensure information is accurate and legally compliant.</td>
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</table>
**Task 7: Preparing staff resources in case care home staff walk out**

This risk increases when the planned move is to happen over a number of weeks. At Enfield Council, our in-house provider services have made staff available to provide emergency cover if necessary. These local authority members of staff will play a crucial role if care home staff were to walk out. Procurement/Brokerage will also need to be engaged if there is a total staff exodus.

**Task 8: External Partners need to be engaged (GPs)**

GPs will need to be advised of the move and a pharmacist identified to dispense medication if required. Staff facilitating the move to have a list of useful contact details should they be required or need additional support.

**Timescales:**
- Partners should be engaged as soon as possible. Where feasible, they should be invited to staff briefings.

**Task 9: Partnership working with placing authorities**

Placing authorities will have sight of the risks and have either completed, or be in the process of completing, reviews. Key officers during the move (for example, the floor leads) will need to be in regular contact with placing authorities’ decision makers to ensure all preparations are in hand and residents will have a safe move. Placing authorities have, where possible, identified officers to be onsite. If communication is not possible, or preparations are not completed by the placing authority, emergency measures will have to be put in place on their behalf by the lead local authority.

**Timescales:**
- On-going, until all placing authority residents are moved.

**Task 10: Suppliers need to be forewarned of demand without specifics (Ambulance, removal company, bags etc.)**

Suppliers will need to be briefed (without being told of specifics) so that adequate provisions for the move can be made. The key suppliers are the ambulance providers and the removal company. The rest of the requirements can be sourced with an emergency P-card. It may be necessary to contact transport providers.

**Key suppliers:**
- **Ambulance**
  If an exit strategy becomes necessary, private ambulance providers (for example St. John’s ambulance service or Red Cross) will need to be contacted immediately and liaison officer included in all briefings and exit strategy meetings. They will be able to assist with things like controlled medication and so on. Note: it may be possible to move more than one client in an ambulance.
  The private ambulance staff should be trained in patient handling and have their own processes that need to be understood.
- **Removal**
  Identify two removal companies that can undertake the required task. This should include packing, removal and unpacking. Depending on the number of residents that need to be moved, and the number and distance on placement, there may be implications on timelines for delivery which must be considered by the Exit Strategy group.
- **Transport**
  Where officers are providing support to residents during the move, internal transport services may be able to organise Taxis to bring them back. Transport services may also be sourced vans to move resident’s belonging where someone has family or friend support to pack and doesn’t have any furniture.
- **Brokerage**
  The brokerage/purchasing team’s key task will be to identify care home placements for residents; however they will also be able to source care/support workers or other specialist officers to ensure there are sufficient members of staff and expertise during the exit.
Implementation:
To effectively implement the exit strategy, key officers will need to be identified to carry out the roles below:

<table>
<thead>
<tr>
<th>Strategic roles</th>
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</thead>
<tbody>
<tr>
<td>Operation lead:</td>
<td>Director</td>
</tr>
<tr>
<td>Commissioning/Procurement lead:</td>
<td>Assistant Director</td>
</tr>
<tr>
<td>Care Management:</td>
<td>Assistant Director</td>
</tr>
<tr>
<td>Procurement/Placement lead:</td>
<td>Head of Service</td>
</tr>
<tr>
<td>Care staff and support:</td>
<td>Head of Service</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>On site leads</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Operation lead:</td>
<td>Head of Safeguarding</td>
</tr>
<tr>
<td>Social care lead:</td>
<td>Head of Care Management</td>
</tr>
<tr>
<td>Health lead:</td>
<td>Head of Continuing Care</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Key support on site</th>
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</thead>
<tbody>
<tr>
<td>For every floor there should be a lead:</td>
<td>Safeguarding/Social Work Manager</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Health partners</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacists:</td>
<td></td>
</tr>
<tr>
<td>Nurses CHAT, GPs:</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Logistics</th>
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</thead>
<tbody>
<tr>
<td>Logistics lead:</td>
<td>Exit Strategy Co-ordinator</td>
</tr>
<tr>
<td>Logistics officers:</td>
<td>Transport/Brokerage/Procurement staff</td>
</tr>
</tbody>
</table>

In addition, care staff will be needed to support the move:
- they will ensure family and friends are consulted where possible;
- that the service user is made as comfortable as possible;
- and that all the risks identified with the move are mitigated as far as reasonably possibly;
- liaising with care management to ensure that placement is identified and that key equipment is in place;
- they will also ensure that all of the residents belongings are clearly labelled for the removal company and that the overnight bag is packed carefully;
- they will consult with the pharmacist regarding medication;
- and ensure all transfers into wheelchairs/ambulances are conducted in a safe manner.

The number of care staff required to support the move needs to be determined by the exit strategy group after careful consideration of the support needs of the residents. The involvement of friends and family at this stage also needs to be taken into account. To cover for illnesses and serious unforeseen circumstances, contingency care staff will also need to be briefed.

This is not an exhaustive list and it will need to be adapted to suit the specific provider concern.

The tasks detailed in the co-ordination phase and other activities deemed necessary by the Exit Strategy group need to be implemented according to the agreed project plan.

The operational lead will have responsibility for ensuring that the plan is adhered to and that all officers are aware of key issues and timescales during the exit.

Review:
Once the exit has been completed it is imperative that the Provider Concerns Strategy group review the exit strategy process within a three month period and ensure that any lessons learnt during the process are acted upon.

To effectively undertake this review all residents will need to be reviewed prior to the process review meeting.

Exit strategies are always a last resort and represent an uncertain, anxious and stressful time for everyone involved. Effective planning, communication and risk management will significantly reduce the uncertainty and risk. Every Exit Strategy group must agree on the best approach based on the individual provider concerned, the information above offers a framework for these discussions and decision making.