SAFEGUARDING ADULTS

Managing Large Scale Investigations (LSI) Protocol

Title: Managing Large Scale Investigations (LSI)	
Author	Howard Jones/ Sharon Cooper
File name	Managing Large Scale Investigations
Version	Four
Status (Draft/Final)	Draft
Date	January 2012
Approved by	
Date effective from	
Date for Review	
Policy / Strategy Lead	Kate Spreadbury/Wendy Cadman

SAFEGUARDING ADULTS
MANAGING LARGE SCALE INVESTIGATIONS (LSI)

INDEX
GLOSSARY

Glossary

The Strategic Coordination Management Group – the core membership of an LSI meeting.

This group are responsible for allocation of resources to the Emergency Team and for making high level decisions, they will risk manage the investigation at a strategic level and provide clear guidance and instructions. They will ensure the safeguarding strategy in relation to each individual agency is well co-ordinated and delivers its action plan. The group will receive reports and information, monitor progress, identify further areas for improvement and develop action plans as appropriate. They will ensure resources, knowledge and expertise are available to deliver the safeguarding improvement strategy. This group is also responsible for ensuring a co-ordinated media strategy is put in place. It will develop contingency plans in the event of service closure. The Chair will inform elected Members/Trust members on progress and outcome of the LSI .

The Virtual Safeguarding Team – A group of staff from partner organisations (including Health & Social Care) who work together to assess, plan and monitor in any case of institutional abuse. In LSI's this team will work under the direction of the senior manager leading the investigation.

- Core group:
- H&SC Safeguarding Coordination
- Safeguarding and Care Home Lead, BCH
- Police
- Quality Assurance and Commissioning staff

The preventative aspect of this model is not yet developed, further negotiations are needed regarding potential co location, funding of input from Bristol Community Health. However in any case of institutional abuse these agencies do work closely together as appropriate to risk assess, plan and manage the response.

The Emergency Team – staff from diverse agencies as appropriate who undertake actions to ensure the safety of people using the service, assess individuals, review, monitor and provide specific input as needed. Some members of the virtual team will also form the core membership of the Emergency Team (typically Safeguarding and Commissioning/QA staff). The emergency team resources are agreed by senior managers, their activities are coordinated and supported on a daily basis by the members of the virtual team.

Depending on the scale of response required, or the particular task to be carried out, the senior manager leading the investigation may designate additional staff members to work with the team for the purposes of the investigation and/or to ensure service user wellbeing.

There may be a need for :

- Mental Capacity Act support, including assessment of potential deprivations of liberty
- Access to social workers/ARCS
- Access to the mental health trust specialist staff
- Access to H&SC QA staff
- Virtual Team as appropriate

Two safeguarding adults senior practitioners are also available to the emergency team. Further negotiations are underway with Bristol Community Health to agree the involvement of a Band 6 and a band 7 nurse in managing homes in crisis.

Safeguarding Adults
Managing Large Scale Investigations (LSI)

This protocol is a working document which should be reviewed and amended in the light of experience and lessons learned from undertaking large scale investigations

1. Introduction

The majority of safeguarding adults institutional abuse investigations can be coordinated by 4th and, in cases of major concern, 3rd tier managers. However exceptionally a service of concern will present

- a high level of risk to the people using the service,
- And/or a requirement for extensive use of resources,
- And/or management of wide media interest.
- And/or a loss of confidence in the ability of management of the service of concern to address the risks identified
- And/or a risk of reputational damage to the local authority or health organisation

These institutional abuse investigations risk assessed as "persisting major concerns", will require oversight from a senior level of management (i.e. 2nd or 1st tier).

This protocol is intended to be used on a very exceptional basis, where a high level of management influence and coordination is required, above that which can be exerted in the normal institutional safeguarding investigations.

Appendix 5.1 Risk Assessment and Escalation Procedure for Institutional Abuse outlines a process of risk assessment that identifies the level of concern resulting from a safeguarding alert. This risk assessment will indicate the likely required response from safeguarding and commissioning staff to the alert under consideration.

This guidance describes the procedures for carrying out a large-scale service investigation that is required when risk assessment indicates, "persistent major concerns exist".

Staff carrying out risk assessments will need to be guided in part by ADASS (South West Region) guidance on Safeguarding Thresholds (See Appendix 5.8) and, in dealing with persistent major concerns, to the sections of the guidance referring to "whole service" or "institutional" abuse.

Whilst it is recognised that responsibility for co-ordinating Safeguarding Adults procedures lies with the Local Authority within whose boundaries an alert has been made, **a collaborative multi-agency approach will be required to deal with the issues**.

2. Procedure

2.1. Who decides to hold a LSI meeting?

The Safeguarding Adults Team, using information provided by the Virtual Safeguarding Team, will carry out a risk assessment. If the risk assessment concludes that "persisting major concerns" have been identified they will refer the risk assessment and their recommendation to the Service Director H&SC, who will be responsible for deciding on, convening and chairing an initial LSI meeting.

2.2 What are the indicators that a LSI is needed?

The Service Director should consider convening a LSI if any of the following circumstances apply:

1. There is a risk that serious abuse, involving death or serious harm, of an individual or individuals, will occur , or has occurred and/or

- Multiple cases of abuse and /or

The Virtual Team, on the basis of their risk assessment, cannot guarantee people using the service are safe immediately and /or

- Lessons have not been learnt - the Provider has received input from all commissioning services (i.e. Safeguarding Adults team, PCT and Health and Social Care) but they have failed to improve, or improvement is not sustained
- A range of resources and responses are needed that require a more senior level of authorisation and /or
- Service closure by CQC and /or
- Financial instability of the service or parent organisation linked to Safeguarding Adults concerns and/or
- Wide Media interest

2. The response required may include:

- Urgent review of most vulnerable service users
- A planned programme of reviews of all service users provided for by the service
- The need to deploy significant additional resources to ensure service user safety (e.g. the use of the Emergency Team to support a service's day to day operations)
- Sustained service monitoring by the Virtual Safeguarding Team
- A media strategy

3. If an assessment of all information to hand results in a loss in confidence in the organisation responsible for the service (this might relate to organisations' financial standing). This could lead to:

- Removal of service users from the service
- De-commissioning of the service

2.3 **Immediate actions required once a decision has been made to hold a LSI meeting**

- The Service Director H&SC, or in their absence a nominated deputy, will be the designated lead officer for the initial LSI meeting
- The Service Director H&SC will liaise with the Safeguarding Lead to decide how quickly a meeting should be held, based on the information provided.
- An urgent notification will be sent to the Strategic Director H&SC
- If the evidence suggests that a crime may have been committed, immediate contact must be made with the Police (Public Protection Unit), if not already done
- A safeguarding email must be sent to CQC, informing them that and LSI is being considered
- A list of all service users using the service needs to be obtained, along with information about the placing/funding authorities or care managers
- A list of attendees for the meeting should be drawn up and a notification and invitation to the meeting to be sent, in line with agreed safeguarding communication protocols

2.4 Timescales for convening a LSI meeting

The timescale for the initial meeting will be set by the Service Director H&SC, in liaison with the Safeguarding Lead, based on the risk assessment and information provided.

It is likely that a LSI meeting will be required urgently to deal with the concerns, almost certainly within a week and possibly the same or next day.

Therefore it is essential that managers and professionals likely to be involved in the LSI meeting are aware of its importance and will prioritise this meeting, and the subsequent investigation above all other work pressures.

2.5 Who Should Attend a Large Scale Meeting?

The meeting should be attended by a core group of managers/professionals referred to as the “Strategic Coordination Management Group”.

The people attending this meeting will either be currently working with the provider (i.e. Virtual Team members or other professionals) or will be at a senior level and able to allocate resources and time, and be authorised to make decisions about the direction and outcome of the investigation.

It is essential that managers and staff attending these meetings are fully aware of the importance of these meetings. If the named person cannot attend, they should assign a deputy to attend in their place.

The following should attend:

- Service Director H&SC (Chair)
- Service Director NHS Commissioning (if there are Health commissioned services involved)
- Safeguarding Lead H&SC
- Safeguarding Lead PCT
- AWP Lead Manager (when involved in the initial management of relevant alert)

- QA members of the Virtual Team or Emergency Team
- Commissioning Lead H&SC
- CQC Inspector for the Provider/service and their line manager

If the LSI is in relation to safeguarding concerns in a Health setting, the Service Director NHS Commissioning will take the role of chair. They will be responsible for informing and updating the Strategic Health Authority,

The following should be invited to attend:

- The Police (should always be consulted but may not attend if they consider that it is unlikely a crime has been committed).
- Representatives from Placing Authorities (attendance likely to be dependent on geographical distance and number of service users involved)

The following may be involved:

- Service Manager Care Management H&SC (if the need to arrange/co-ordinate a large number of individual reviews is indicated)
- And/or counterparts in Avon & Wiltshire Partnership and the Continuing Health Care Team
- Any professional whose involvement is central to allegations/alerts (e.g. GP, Specialist Nurse, Social Worker)
- Care Brokerage
- If specialist advice is required
  - Legal department representative
  - HR representative
- The Provider if appropriate (see 2.5 below for more information)

[See Appendix 5.2 for more information about the role of this group]

2.6 Involvement of the Service Provider

2.6.1 When to involve the Service Provider

The involvement of Service providers in multi agency planning is important in order to enable steps to be taken for the immediate protection of people using a service. However it can be necessary to hold an initial LSI meeting without the service provider present, for example if

- There is possible complicity by the services' staff and managers in the issues under investigation
- There is a possibility that the Service provider may tamper with or destroy evidence to protect themselves against allegations made
- Specific advice from the Police or CQC relating to the exercise of their statutory powers

2.6.2 Who should be invited to represent the Service Provider

Depending on the size of the Service Provider organisation, the nature of allegations and the circumstances at each investigation, consideration should be given to involving:

- The manager of the service (the registered manager if the service is subject to CQC Registration)
- The Area or Regional Manager, particularly if concerns relate to the conduct of the Service's Manager

- The owner, Company Director or Managing Director (the responsible person as registered by CQC may be the most appropriate person).

2.7 How to convene a LSI meeting

All of the relevant managers and professionals should be contacted as soon as possible, either by email or telephone. This should be followed up with a letter as and when necessary.

Contact details for potential members of the Strategic Coordination Management Group are included in this protocol [see Appendix 5.2] and should be available to all members of the Virtual Team. All managers on this contact group need to have an agreed deputy if they are unable to attend a meeting.

2.8 The Initial LSI Meeting

2.8.1 Purpose and Remit

An initial LSI meeting is a response to a risk assessment indicating that the final stage of the escalation procedure has been reached.

The purpose of the meeting is to devise a multi-agency strategy for the investigation of a Safeguarding Adults alert relating to whole service/institutional abuse at identified service or services, where persistent major concerns exist, according to agreed terms of reference. [See Appendix 5.2]

The meeting will need to consider:

- Terms of reference to be applied to the alert under consideration
- The concerns/nature of abuse alerted
- The position and views of vulnerable adults involved (and their carers)
- Information regarding alleged perpetrators
- Current risks
- Allocation of staff resources and protected time to the safeguarding investigation
- Whether a further LSI meeting needs to be scheduled

[See Appendix 5.2 and 5.5 for further details]

2.8.2 The Conduct of the Meeting

Please see Appendix 5.4 Ground Rules
Please see Appendix 5.5 Structure and Minutes

2.8.3 In considering steps to be taken in response to a persistent serious concern, the meeting will need to take the following into account:
(Some of the considerations highlighted are discussed in greater detail in Section 3 below).

2.8.3.1 The conduct of the Investigation

- The objectives – what concerns will be investigated and how service user safety will be ensured
- Who will do what and how the investigation will be co-ordinated

- How progress will be monitored – Who will report back to the meeting according to what timescale?
- How the Provider will be involved [See 2.4 and 5.5.6]

2.8.3.2 Involving Stakeholders [see 2.3]

- Communication with service users and their families or representatives [see 5.5.1 and 5.5.2]
- Involving and informing all funding authorities [see 3.1.2. and 5.5.3]
- Liaison with CQC (if the Commission does not want to participate fully in LSI meetings). [See 3.1.3 and 5.5.4]
- Provider involvement [see 2.4]

2.8.3.3 Contractual and Brokerage Issues

- Should contracted remedies be applied?
  - Action required of Providers in order to comply with service specification or contract
  - Breach procedures
  - Termination procedures
- Suspension of referrals/admissions [see 3.5]
- Are alternative services likely to be required?
  - Immediate/short term (Brokerage)
  - Longer term (Commissioning/Contracting)

2.8.3.4 Service User Review Strategy

- Agreeing a strategy regarding service user reviews
  - The potential need to review all service users
  - Criteria for prioritising service user review
  - Deciding who is best placed and appropriate to carry out the reviews (i.e. social workers, ARCs, CHC assessors?)
  - Agreeing/allocating responsibility for service user review
  - Deadline/timetable for reviews
  - Who will be responsible for overseeing service user reviews and ensuring any relevant information is fed back to the Safeguarding Adults investigation.
- Identifying and accessing required support to complete reviews, e.g.
  - are there issues requiring specialist input such as Mental Capacity, Deprivation of Liberty, Mental Health Act assessment, need for Advocacy Services.
  - freeing up reviewing staff from their normal duties and allocating protected time for them to assist with investigation

- Clear, concise guidance and information must be given to staff carrying out the reviews. They must be clear that they are looking at safeguarding concerns and should not revert to a standard care/support review**.**

2.8.3.5. Relationship of LSI to Individual Safeguarding Investigation

- Ensuring that arrangements are in place to follow up safeguarding alerts made with specific reference to identified individuals, in keeping with No Secrets Guidelines.
  - If there is a need to vary standard procedure relating to the above, then it may be necessary to set out the respective responsibilities of the Safeguarding Adult Lead and operational officers usually

responsible for investigating care of individual abuse, in this particular case.

- Outcomes from individual reviews must be fed back to the overall safeguarding investigation and any further LSI meetings
-

3. Further Guidance

3.1 Roles and Responsibilities

Organisations/Authorities

3.1.1 The Host Authority

(The Local Authority in which the abuse is alleged to have taken place)

- Takes the initial lead on responding to the referral and co-ordinating any investigation
- Co-ordinates information gathering and ensures prompt notification of other stakeholders
- Contact Safeguarding Adults leads in each of the South West local Authorities in accordance with guidance set out in the South West cross boundary information sharing protocol. [See appendix 5.9]
- Arranges for an LSI meeting to appoint a lead officer responsible for the overall conduct of the investigation and ensuring all the issues outlined in 2.5 above are addressed.
- Appoints a lead commissioner (if in a care home, supporting living, day care or domiciliary care etc a social care lead commissioner, if in a hospital or other health setting a health commissioner)

3.1.2 Other Placing Authorities/Agencies

Once information has been gathered it may become apparent that other authorities/agencies have funded individuals to receive a service from the Provider under investigation.

The Host Authority will inform all Placing Authorities/Agencies of its concerns and such Authorities will be asked to:

- Make arrangements for any adult at risk funded to receive any necessary support
- The placing authority will also be responsible for supporting the adult at risks family and carers if necessary
- Nominate a link person for liaison purposes during the investigation
- Report any information collected with regard to funded individuals that is relevant to Safeguarding concerns to the Host Authority lead officer or nominated officer.
- Review their service users as soon as possible, if that is the recommendation from the LSI strategy group.

The Host Authority will expect the Placing Authority/Agency to ensure

- Appropriate representation at all strategy meetings
- That their service users' continued use of the service is safe, meets their needs and is in their best interests.

- That service users, families or representatives have been kept informed of the investigation.

3.1.3 The Police

- The Police (Public Protection Unit) must be informed immediately if it is believed that a crime may have been committed.

- According the circumstances it may be necessary to put all or some parts of an investigation on hold, whilst the Police investigate to ascertain if a crime has been committed or carry out a criminal investigation.

3.1.4 CQC

- Information sharing protocols in place between the Local Authority and the Commission will ensure that each organisation is made aware of the others' concerns. [See Appendix 5.11]. In terms of its involvement in the safeguarding process, the Commission will determine if a possible breach of regulations has taken place, which requires inspection.

- Whilst information will be shared between Commission and Local Authority parallel, rather than joint, inspection and safeguarding investigations will take place. Such investigations will have overlapping concerns since both will relate to the quality of care provided by the home (repeated instances of poor care is one definition of whole service or institutional abuse.)

- However, whilst both agencies will co-operate in order to safeguard vulnerable adults, some decisions will need to be taken independently following consultation with the other, rather than jointly by both, as agencies have differing responsibilities as regulators, commissioners and safeguarding leads.

3.1.5 Provider Partner Agencies – Health

If the safeguarding investigation concerns a hospital or health setting, then the LSI chair will be the Service Director NHS.

The role and responsibilities of NHS Commissioners and AWP Commissioners is referred to above under 3.1.2, other placing authorities.
However, it is recognised that NHS Providers (District Nurses, Community Matrons, Intermediate Care) and Hospital Trusts may also have information (such as reports of Serious Untoward Incidents) and/or a role to pay in any further investigation that needs to be included within an LSI plan if service users are to be protected in a comprehensive and cohesive manner.

The Strategic Health Authority, must be informed of any LSI meetings that are convened.

3.1.6 The Provider

- Decisions regarding Provider involvement in the safeguarding process are discussed in 2.4 above.
- A decision must be taken when convening the LSI about when to involve the Provider.
- Provider responsibilities during a LSI will almost certainly include all or some of the following:
  - The provision of information regarding each individual service user accommodated in respect of:
    - Their name
    - The authority funding their placement or if they are self-funding
    - The service users representative and/or N.O.K

  - The investigation of individual safeguarding alerts and the provision of written reports of their findings, actions taken or to be taken as a result
  - The investigation of incidents/allegations pertinent to whole service/institutional abuse issues and the provision of written reports of their findings, actions taken or to be taken as a result.
  - A detailed action plan, including milestones and review dates, setting out how service deficiencies will be remedied (the same Action Plan may be used to satisfy the requirement at both the Authority and CQC by agreement).
  - Attendance at safeguarding meetings as required.
  - Adherence to any agreements made through the Safeguarding Process including those relating to placement bars or restrictions on admission [see 3.5 below] and responsibilities for ensuring service users, their representatives and other stakeholders are kept informed of any institutional safeguarding proceedings taking place with regard the home.
  - The Provider must have a business continuity plan in place to assist them in working through any period of investigation

- A clear message must be given to the Provider regarding timescales of the investigation and realistic targets, including when they can pick up the investigation themselves.

Individuals

3.1.7 Service Director H&SC
- Makes the decision to hold a LSI meeting, based on the information and guidance provided by the Safeguarding Adults Lead
- Organises and chairs the meeting(s)
- Makes decisions about placement bars and restrictions
- Ensures the Strategic Director is fully informed of the situation
- Ensures the Communications/Media team are informed correctly and as necessary
- Prioritises the LSI and appoints a deputy if unable to chair the meetings

3.1.8 Service Director NHS Commissioning
- When the safeguarding concerns relate to a Health setting, organises and chairs the LSI meeting(s), as above (see 3.2.1 Service Director H&SC)
- Informs and updates the South West Strategic Health Authority

3.1.9 Safeguarding Lead H&SC
- Makes the decision that the correct stage in an investigation has been reached to escalate to the Service Director

- Coordinates the institutional safeguarding investigation carried out within the LSI process/strategy
- Provides expert advice and guidance on how the process should be managed
- Ensures information is shared with all other relevant agencies and authorities including South West Safeguarding Leads and Health colleagues
- Works with/informs members of the Virtual Safeguarding Team regarding the investigation process

3.1.10 Safeguarding Lead Health/PCT

- Provides expert advice and guidance on how the process should be managed
- Works with/informs members of the Virtual Safeguarding Team regarding the investigation process

3.1.11 Commissioning Lead H&SC

- Provides advice and guidance on contractual issues and concerns
- Takes a lead role where services need to be closed/ decommissioned as a result of the LSI and where alternative services need to be identified and commissioned

3.2 Keeping service users and their representatives informed

3.2.1 Host Authority and Placing Authority responsibilities are set out in 3.1.1 and 3.1.2 above.

3.2.2 Provider responsibility in this regard will be determined through the LSI process – see 3.1.6 above.

3.3 The Role of the Emergency Team

Assuring immediate safety, monitoring ongoing care provision

3.3.1 Following agreement at LSI the Emergency Team (core members and additional resources agreed) will be deployed at the service.

3.3.2 Membership of the Emergency Team may include some members of the Virtual Safeguarding Team, along with other professionals and practitioners, as agreed at, and allocated by, the LSI meeting.

3.3.3 The team's interventions, objectives and reporting regimes will be planned and co-ordinated by the Virtual Team to meet the requirement of the strategy agreed at LSI.

3.3.4 Team interventions may include:

- Advising and supporting the staff of the service under investigation
- Assessing and reviewing individuals
- Monitoring/QA of ongoing practice, recording and home management
- Liaison with relevant professionals

3.3.5 This team may come from or include representatives from another provider organisation, who can provide support and mentoring to existing staff.

3.4 The Virtual Safeguarding Team

3.4.1 Once strategy has been determined the Virtual Safeguarding Team will be responsible for running the large-scale investigation on a day-to-day basis.

3.4.2 The team should act as a clearinghouse for all information relating to the investigation. Team members all to be responsible for providing feedback to the LSI meeting and service specific line managers.

3.4.3 Membership of the Virtual Safeguarding Team includes staff from the four main agencies involved in quality assurance and safeguarding on a daily basis – Safeguarding Adults Team, Health and Social Care, Bristol Community Health and the Police.

3.4.4 A member of the Virtual Safeguarding Team may be given an overarching coordinating/ managing role.

3.5 Managing Admissions

3.5.1 Decisions to bar or restrict admissions may already have been taken at the stage of 'serious concern'. They may include:

- Restriction or ban on admission to a part of the home offering a particular service (e.g. to the dementia unit within a home)
- Restriction or ban on the ground of complexity (e.g. those meeting CHC funding criteria)
- Restriction or ban relating to specific care provision – for example end of life care
- Escalation to persistent serious concern requires that measures put in place be reviewed in the light of new evidence or concerns.

Decisions to bar or restrict admissions are the responsibility of the Service Director H&SC, based on information available. Such decisions will take account of, but be made separately from, CQC.

3.5.2 Informing other stakeholders of decisions taken at LSI meetings will be the responsibility of the designated member(s) of the Virtual Safeguarding Team, using agreed safeguarding communication protocols. Where organisations are not represented at the LSI the responsibility to inform will rest with the designated H&SC Virtual Safeguarding Team member.

3.5.3 The imposition of placement restrictions or ban will be reviewed at each LSI meeting.

Decisions taken will need to take account of any statutory action taken by CQC. Any conditions or restrictions imposed by the Commission with regard to admissions cannot be overridden at LSI meeting and any proposed change can only be implemented if the CQC is itself party to that decision at the LSI meeting.

3.6 Individual Service User Review

Which organisation is responsible for ensuring which Individual Service Reviews are carried out will be clarified at the LSI meeting, as well as deciding which staff are best placed to carry out the reviews (i.e. social workers, ARCs, CHC assessors staff known to the service users or not).

3.6.1 Individual service user reviews will be carried out in accordance with a strategy set out with reference to criteria described in 2.5.3.4.

3.6.2 Individual reviews may be a precursor to a service user/s removal from the service. In reaching a decision service user preference will need to be taken into account but so must the duty of care owed by the Authority.

Consequently, in exceptional circumstances the Authority may where safety and wellbeing cannot be assured, end a placement agreement against service user wishes

Service users and their representatives retain the right to request a move out of the service irrespective of any decisions regarding the overall safety of the service made as a consequence of the LSI.

3.7 Removal From Service

3.7.1 Service users' individual placements may be ended following review according to usual contractual procedures. Consequently, where the ending of a service results from the failur**e** of a service to ensure safety and wellbeing no notice period will be applicable.

3.7.2 When the service to be ended is a care home service, finding alternative accommodation will be a pressing concern. Where safeguarding concerns are such that a Home's contract rather than an individual service user's placement agreement is to be terminated, a large number of residents may be involved. In such circumstances the LSI meeting will be responsible for planning how new accommodation is to be identified and provided. A similar need to terminate arrangements to provide domiciliary or day care/support to a significant number of people will trigger the need for equivalent plans.

In both of the above circumstances, guidance must be sought from H&SC Commissioning Managers or Strategic Commissioning and Procurement on contractual terms and conditions, and commissioning alternative services.

Guidance and advice on how to deal with short notice home closures can be found on the SCIE (Social Care Institute for Excellence) website **http://www.scie.org.uk/publications/homeclosures/index.asp** which states that:

3.8.2.1 A decision to close a service must take account of:

- Continuity of care

- Assessment and choice
- Communications
- Information sharing
- Legal issues
- Capacity and resources

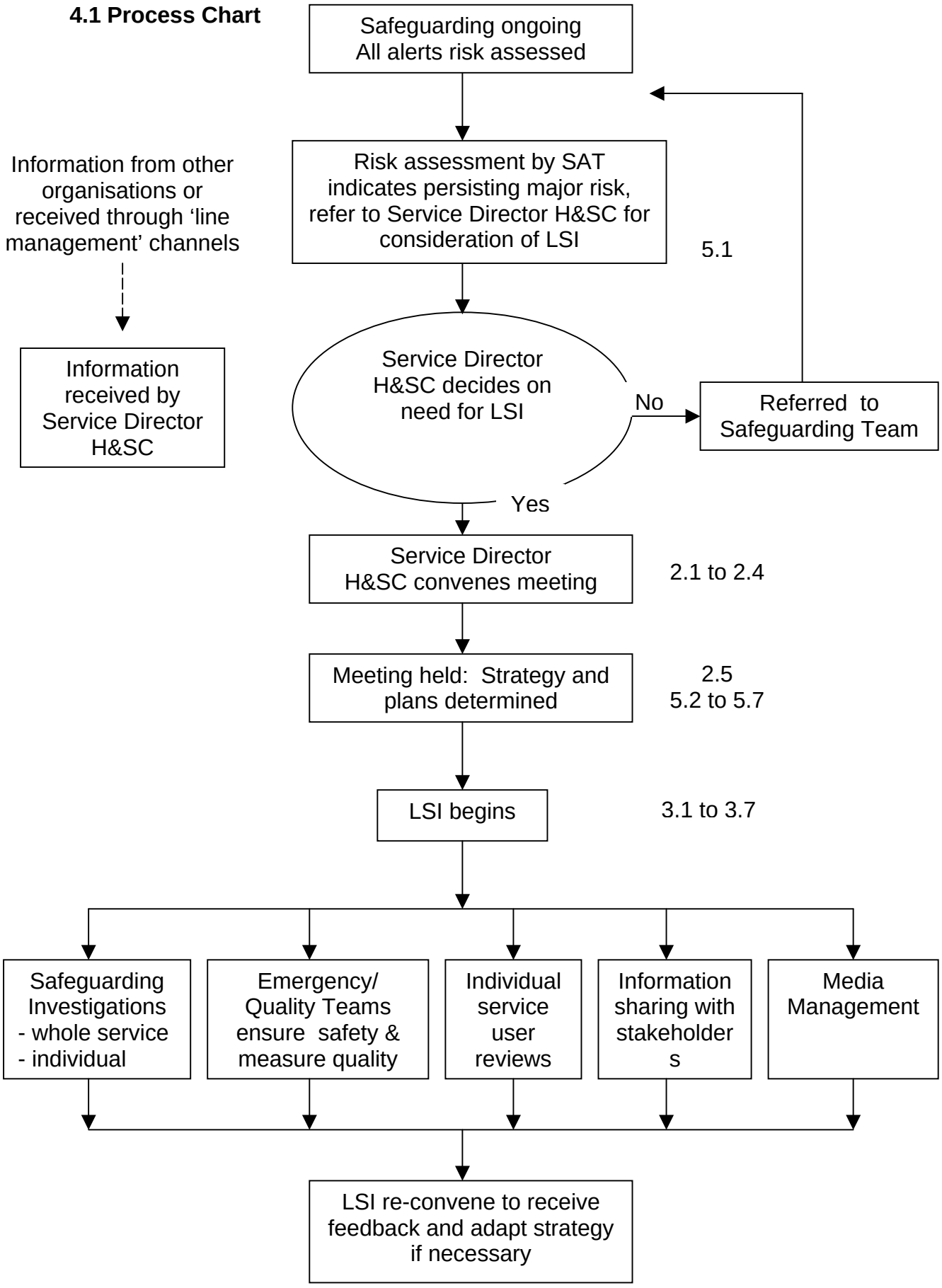
“Local authorities must undertake the transfer of residents to alternative accommodation in accordance with **safeguarding procedures**, good practice and due diligence within the law.

Safeguarding encompasses six key concepts: empowerment, protection, prevention, proportionate responses, partnership and accountability. Social care organisations play an important role in the protection of members of the public from harm and are responsible for ensuring that services and support are delivered in ways that are high quality and safe.”

In the event of threatened or urgent suspension (of the service or regulated activity) or cancellation, commissioners should make contact with the Care Quality Commission (CQC) at the earliest opportunity.

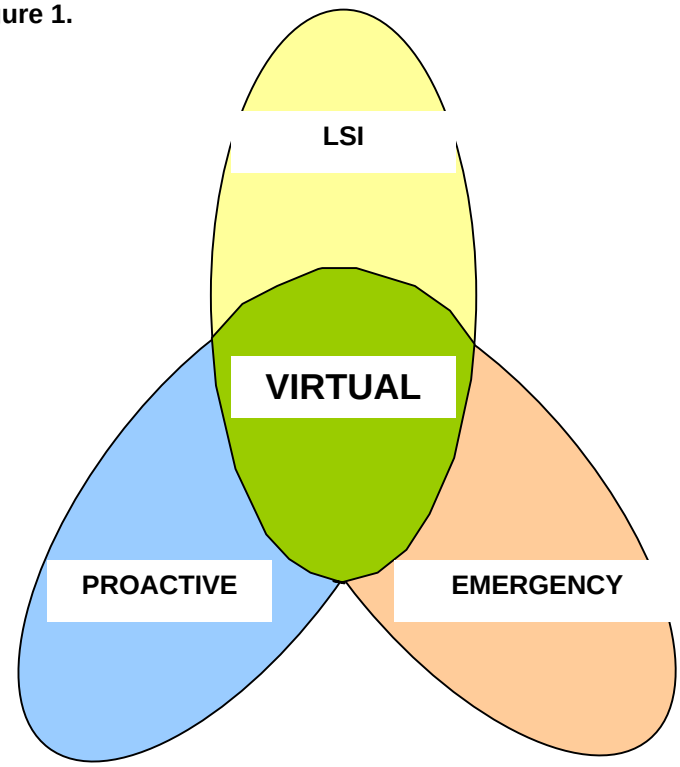
4. Process

4.1 Process Chart



4.2 Team Relationships in Strategy Group

Figure 1.



The above diagram illustrates the inter-relationship between the groups further described below. At the intersection of three distinct groups is a team of key people described as a 'Virtual Safeguarding Team'. They each have roles and responsibilities within separate organisations but work closely together when necessary in order to:

- ♦ Proactively monitor - drawing in additional group members as appropriate and, where necessary, informing the decision of the Safeguarding Adults lead to recommend that an LSI be convened.
- ♦ Act as the agents of the LSI meeting in actioning key decisions.
- ♦ Work co-operatively to oversee and co-ordinate work undertaken by the emergency team

4.3 Closing an LSI - Lessons Learned

Once all of the processes have been finalised and the Safeguarding investigation LSI is coming to an end, a review of both the process and the protocol must be carried out and lessons learned identified.

- What worked with the LSI protocol?
- What could have been done better?
- What actions were successful in securing safety and improvement?
- How can we apply these successes in future investigations?

5. APPENDICES

5.1 BRISTOL CITY COUNCIL HEALTH & SOCIAL CARE

RISK ASSESSMENT AND ESCALATION PROCEDURE FOR INSTITUTIONAL ABUSE (Draft v 3.0)

Definition
A definition of institutional abuse encompasses all types of abuse – neglect, emotional abuse, sexual abuse, physical abuse, financial abuse and discrimination.

Institutional abuse within a care environment will involve repeated incidents of poor care, ill treatment, neglect or unsatisfactory professional practices. The persistence of abuse over time, or the potential for this to develop is consequently a key characteristic. Poor management, an absence of policy and procedure [or their reliable use] and poor practice by a significant number of staff are also likely to be present.

Purpose of the Procedure
The risk assessment procedure set out below relates to concerns that have triggered Safeguarding Adults procedure thresholds. The procedure mirrors the approach to risk assessment set out in the CQC Judgement Framework – guidance about compliance. It is not a procedure to be applied narrowly to specific safeguarding standards, outcomes, processes and procedures only, but rather one that needs to be applied to all aspects of care/desired service user outcome in order to determine a level of concern. The outcome of the risk assessment will indicate the level of management that should oversee proceedings and the safeguarding and commissioning actions that need to be taken (see table).

RISK ASSESSMENT

1. When institutional abuse alert is made, the Safeguarding Adults team will carry out a risk assessment. The risk assessment will need to be revisited if circumstances change.

2. The risk assessment will consider
   - The impact the circumstances under consideration will have on people using the service.

3. A combination of assessed impact and likelihood will determine a level of concern as summarised in the table below.

Likelihood/Impact	Low	Medium	High
Unlikely	Minor	Minor	Moderate
Possible	Minor	Moderate	Major
Almost Certain	Moderate	Major	Major

IMPACT CRITERIA

LOW No, or minimal, impact on the safety of people who use services.

MEDIUM A moderate impact but limited provided remedial action is taken with no long term effects on peoples Health or well being

HIGH	A significant immediate impact on the safety of people who use services which will have a long term impact on their health or well being

LIKELIHOOD CRITERIA

UNLIKELY	This is unlikely to happen or recur due to control measures and process in place.
POSSIBLE	This may happen but it is not a persistent issue.
ALMOST CERTAIN	This will probably happen/recur frequently. This could be due to a breakdown in processes or serious concerns about control measures.

CONCERNS

MINOR	People are generally safe but shortfalls in quality of provision mean that outcomes may not be achieved and that they are potentially at risk if service provision deteriorates further.
MODERATE	People remain generally safe but there are specific identified risks to their health and wellbeing. There is an inconsistency in the quality of care given and the service's ability to meet complex needs is questionable. Appropriate policies and procedures are in place and known to most staff but they are not consistently applied to ensure the prevention of abuse. Most staff have received appropriate training but it is not comprehensive, up-to-date or reliably put into practice.
MAJOR	The number and/or seriousness of alerts made indicate that people are not protected against unsafe or inappropriate care. An absence of staff training and/or knowledge of appropriate policy and procedure and/or managerial failure to investigate concerns indicate that processes and actions that would serve to prevent abuse are not embedded with the provider/service.
PERSISTING MAJOR	Despite intervention by the Virtual Safeguarding Team at an institutional level, this provider persistently fails to improve, or improvements are not sustained leading to persisting serious concerns. This results in a loss of confidence in the provider and their ability to keep their service users safe.

LEVEL OF CONCERN	CIRCUMSTANCES	TIER OF MANAGEMENT OVERSEEING	ACTIONS SAFEGUARDING	ACTIONS QUALITY ASSURANCE?
MINOR Unlikely, possible low or medium impact (BLUE ALERT)	• The provider has a history of recent difficulties (poor care/complaints) • The individual safeguarding alert may indicate wider concern. • Whilst unlikely, there would be a medium impact on people if concerns applied widely across the home • The manager is complacent/not proactive in working to ensure preventions	4th tier Ops/QA? / Safeguarding	• An individual safeguarding meeting – outcomes and action plan may lead to institutional abuse meeting being called or provide evidence to be incorporated into institutional meeting	• The end of commissioners' involvement in safeguarding, contracting, quality monitoring and liaison with Ops teams means there is no longer a convenient single point of reference to a role which complements safeguarding activity. In the absence of clear information it is assume that QA will be the nearest equivalent in the new structure
MODERATE Almost certain low impact Possible medium impact Unlikely high impact (YELLOW ALERT)	• There have been a number of individual safeguarding alerts • Low impact service shortfalls are almost certainly taking place across the provider/service and medium impact shortfalls are possible • There is a failure at systems level to deliver service users' outcomes across a range of needs • The manager is failing to identify and act on the above	4rd tier	• Institutional safeguarding meeting and follow up • Action plan required from home	• Likely to be QA visits before or after safeguarding meeting
MAJOR (AMBER ALERT)	• Abuse/neglect is in evidence across a wide range of provision • Safeguarding team/Commissioners' lack of confidence in the managers to deliver appropriate care and prevent abuse	4th / 3rd tier (by agreement)	• A series of institutional safeguarding meetings • Action Plan required from the organisation	• Total or partial placement ban • QA monitoring visit • Targeted individual SU reviews
PERSISTING MAJOR (RED ALERT) (RED ALERT)	• There is a loss of confidence in the organisation • There have been a series of action plans relating to safeguarding concerns over a period of time, but improvements not sustained • There is a danger of reputational damage to the Authority	2nd tier	• A series of S/G meetings • Meeting with organisation senior managers • Action plan from organisation	• Series of QA visits • All service users reviewed according to agreed timetable • LSI must be instigated, see procedure
	• Service users are at constant serious risk	2nd tier		• Service user removal • Termination of contract

5.2 STRATEGIC COORDINATION MANAGEMENT GROUP

This is the membership of the LSI meeting who are responsible for allocation of resources to the Emergency Team and for making high-level decisions.

Terms of Reference:

1. To risk manage the investigation at a strategic level and to provide clear guidance and instructions.

2. To ensure the safeguarding strategy in relation to each individual agency is well co-ordinated and delivers its action plan.

3. To receive reports and information, monitor progress, identify further areas for improvement and develop action plans as appropriate.

4. To ensure resources, knowledge and expertise are available to deliver the safeguarding improvement strategy.

5. To ensure ad hoc representation to this meeting as required.

6. To ensure a co-ordinated media strategy is put in place.

7. To develop contingency plans in the event of service closure.

8. To inform Elected Members/Trust members.

5.3 Calling an LSI and Allocating Responsibilities

5.3.1 Calling the meeting

Responsibilities	Who	How
Making recommendations to Service Director H&SC to convene LSI	The Virtual Safeguarding Team	Written reports/direct feedback
Organising and chairing, initial LSI	Service Director Health & Social Care	Email/phone calls

5.3.2 Specimen allocation and responsibilities at LSI meeting

	Action/Responsibilities	Who	How
1.	Inform H&SC staff, partner agencies and other commissioners of placement restrictions/concerns	H&SC Safeguarding Adults lead	Using existing agreed communication protocols (by email or letter)
2.	Co-ordinate input from Emergency team to implement LSI strategy [Core and plus	Virtual Safeguarding Team	LSI meetings Direct supervision and feedback

	additional responses agreed at LSI meeting] Planning intervention in accordance with LSI strategy		
3.	Deployment at service i) Ensure wellbeing of service users ii) Ensure ongoing monitoring of service iii) Provide feedback to co-ordinating manager and safeguarding leads (H&SC & NHS Bristol)/Virtual Safeguarding Team	Emergency Team	On site presence Acting on instruction from the LSI group via Virtual Safeguarding Team Feedback to meetings Also phone calls/emails as needed
4.	Individual Service Users 4.1 To advise of need for priority review of individual 4.2 To advise of need for timetable to ensure every service user is reviewed 4.3 To timetable and co-ordinate reviews as necessary 4.4 To liaise with other placing Authorities re reviews	- Appropriate Virtual team member. - Appropriate virtual team member - Appropriate Host Authority Service Managers - A member of the Virtual team may be given an overarching coordinating/monitoring role - H&SC Safeguarding Adults lead	Urgent email to appropriate manager or agreement at meeting
5.	Safeguarding Adults Strategy Meetings - Whole service/institutional abuse meeting	Safeguarding Adults lead, H&SC	Set up using agreed coordinator's protocols
6.	Safeguarding Adults Strategy Meetings - Individual service user [If circumstances suggest that No Secrets guidance should be varied in any way, e.g. in terms of roles and responsibilities, this should be agreed at the LSI]	As indicated by No Secrets Guidance	Set up using agreed coordinator's protocols

7.	Informing Provider organisation of decisions taken (if not present) Service level Organisation level	- Virtual team member as decided at LSI - Senior manager as decided at LSI	Safeguarding meetings Written reports or letters
8	Informing service users and/or carers	Could be delegated to provider or carried out by placing team	Review meetings and/ or letters
8.	Liaison with CQC	- Virtual team member or Service Director as decided at LSI	Agreed communication protocols
9.	Police investigation liaison	Safeguarding Adults Lead, H&SC/NHS Bristol	Notifications to Public Protection Unit (PPU)/ agreed protocols
10.	Convening follow up LSI meeting	Senior manager as agreed at initial LSI	

Managing Ongoing Process

	Action/Responsibilities	**Who**	
1.	Advice to and support of Emergency team	Virtual team	Feedback from LSI meeting Supervision
2.	Briefing and supporting individual service user reviewing officers and co-ordinators	Separately or jointly by appropriate Virtual team member	Feedback from LSI meeting Supervision

3.	**Reporting Routes**		
	Intervention at Service Emergency team →	Virtual team →	Senior Managers via 1. Line management reporting arrangements 2. LSI meeting/process
	Safeguarding Individual strategy meeting co-ordinators →	Safeguarding leads →	Virtual team
	Monitoring/Ongoing QA →	QA	Virtual team

5.4. Relationship between LSI and Whole Service / Institutional abuse safeguarding meetings

- The LSI meeting determines strategy for dealing with persistent major concerns.
- An LSI meeting will only be called when the level of risk is considered so high that additional resources and a more senior level of decision making is required.
- Continued within the strategy will be a need for Safeguarding Adults process to be worked through at individual and institutional levels.
- The LSI meeting should not interfere with normal safeguarding processes.

To allow processes to operate concurrently and effectively.

Senior Managers should – pass any Safeguarding information directly received to the Safeguarding/Virtual team member delegated to act in this regard by the LSI strategy.

Except in exceptional circumstances, they should not take action outside of the agreed lines of responsibility.

Safeguarding/Virtual team members must – immediately advise senior manager co-ordinating of any information which comes to light which suggests a further LSI should be convened and strategy revised. For example:

- The level of risk is significantly higher than originally anticipated
- Investigation reveals further serious issues that may have legal or reputational implications.

They must not seek to manage these issues within the Safeguarding process alone.

5.5 Ground Rules for Managing Large Scale Investigation Meeting

1. **Confidentiality**
   The content of the meeting is strictly confidential and can only be shared on a need to know basis.

2. **Staying for the whole meeting**
   It is the intention that the meeting should not last more than 1½ hours. It is important for all members to contribute to the development of the protection or action plan. Every effort should be made to stay until the end of the meeting.

3. **Responsibility to speak out**
   Everyone needs to be open and honest in their contribution to the meeting.

4. **Respect for each other's views**
   It is everyone's responsibility to actively listen to the views of others and not interrupt. Everyone will be given the opportunity to speak.

5. **Outcomes**
   Professionals should record any actions for themselves pending arrival of meeting minutes that will be circulated as soon as possible.

6. **Minutes**
   Minutes should be sent out within 5 working days of the meeting and if sent electronically should be password protected. They will not be reproduced without the express permission of the chair.

Ensuring the accuracy of the minutes is everyone's responsibility. Send any important omissions or corrections to the Chair of the meeting within 5 working days of receipt.

5.6 Large Scale Investigation Strategy Meeting – suggested agenda structure and minutes

1. **Introduction and Ground Rules** – see 5.4

2. **Purpose of meeting –** summary of concerns, actions taken, issues to be addressed

3. **Terms of reference for the investigation:**

   Could include:
   - Immediate or further action required to safeguard residents
   - Safeguarding considerations of any referrals so far
   - Planning any further investigations – roles and responsibilities
   - The need to undertake reassessment of needs for all residents – based on the evidence provided

4. **Reports on issues raised so far**

   Could include:
   - Safeguarding Referrals – details and investigation actions so far and any outcome
   - Information from Virtual and Emergency team
   - Information from other agencies, e.g. GPs, Nurses, Ambulance Service

5. **Information regarding all residents in the Care Home**

   Could include:
   - Those placed and funded by Bristol H&SC
   - Those placed and funded by NHS Bristol
   - Those placed and funded by AWP
   - Out of area placements
   - Self funders

6. **Decision regarding full scale investigation**

   - Decide on how to proceed
   - Proposed timescale for investigation

7. **Action**

Who is responsible for each action and timescales for achieving them -See 5.3 above

8. Recording

These meetings must be clearly recorded. Minutes should be distributed with the following heading - 'These minutes must not be photocopied or the contents shared outside the meeting without the agreement of the Chair' and should be password protected.

Minutes should be kept in the Adult Services Safeguarding Unit; and within the relevant Safeguarding/Risk Department in partner agencies

Recording must ensure that, in addition to the wider issues raised around the investigation, the individual safeguarding investigations and outcomes are recorded as well.

Decision-making and the reasons for decisions taken must be clearly evidenced in the records.

9. Minutes

Minutes should include:

- Those present (name of individual and agency they represent)
- Chair of meeting
- Date of meeting
- Purpose of meeting
- Agenda
- Issues raised and any disagreements or alternative positions
- Agreed decisions and actions (with lead individual/agency) and time scale
- Date and venue of next meeting
- The Chair should approve and sign the minutes

5.7 Letter template

Appendix 5

This letter should be sent out in a Senior Manager's name. If a joint agency approach is required and the letter is going out in both agencies' name then advice should be taken in each agency as to which Senior Manager this should be.

Full Postal Address

Direct Line:
Fax
Email:
Our Ref:
Date:

«Title» «First Name» «Last Name»
«Address Line 1»
«Address Line 2»
«Address Line 3»
«Town»
«Postcode»

Dear «Title» «Last Name»

Re: «Name of Home»

I am writing to inform you that due to a number of concerns relating to the care provided at the ''Name of Service'', -------- have stopped making any further placements at the home.

Adult Services and the Care Quality Commission are monitoring the situation and plans are in place to ensure that each service users individual care needs are being appropriately met.

If you have any questions relating to the above or to someone who is placed at the «Name of Service», please contact «First Name» «Last Name», «Position», «Section»,on «Telephone» or if the issue is a contractual one «First Name» «Last Name» on «Telephone».

Please be assured we are working hard to improve the services at «Name of Service».

Yours sincerely

«First Name» «Last Name»
«Position»

This letter should go out in the ADASS - letter to go to placing authority leads

Full Postal Address

Safeguarding Lead's name

Direct Line:
Fax
Email:
Our Ref:
Date:

«Title» «First Name» «Last Name»
«Address Line 1»
«Address Line 2»
«Address Line 3»
«Town»
«Postcode»

Dear «Title» «Last Name»

Re: «First Name» «Last Name»

We are currently undertaking a Safeguarding Investigation in relation to allegations of abuse against a number of residents placed in «Name of Home», of which «First Name» «Last Name» is one.

We are fulfilling our obligations in relation to Safeguarding Adults as the 'host' authority.

Our role is defined as:

- Take the initial lead on responding to the referral
- Co-ordinate initial information gathering, background checks and ensure a prompt notification to the 'placing authority' and other relevant agencies
- Co-ordinate any investigation

The placing authority is responsible for providing support to the vulnerable adult and planning their future care needs, either as an alleged victim or alleged perpetrator. The placing authority should nominate a link person for liaison purposes during the investigation. They will be invited to attend any Safeguarding Adults Strategy meeting and/or may be required to submit a written report.

I am writing to suggest that you satisfy yourself that:

- Representation has been provided at strategy meetings.
- The continued placement is safe, meeting the needs of the individual and is in their best interests.
- The relatives or advocates of the individual have been kept informed of the investigation and the process your staff have put in place to inform them of the outcome.

The ongoing placement for «First Name» «Last Name» is a matter for your Commissioning Manager to decide and not something we as the ‘host’ authority can decide or advise upon.

I hope you find this letter helpful in clarifying the current position.

Yours sincerely

«First Name» «Last Name»
«Position»

5.8 Guidance for Concluding Report for Large Scale Investigation

Minutes should include:

- Date of incident
- Agencies involved
- Outline of concerns
  - Individual
  - Institutional
- Outcome of the allegations for each individual (initials only). The outcomes and any actions taken should also be recorded on each individual's case file
- Summary of outcomes of investigation
- Lessons learned:
  - What was successful in this investigation?
  - How can we apply this to future cases?
  - What could have been done better?
  - Did the protocol help?
  - Does the protocol need to be reviewed?

If a Serious Case Review is to be requested as a result of the large-scale investigation this has to be made in writing by a Board Member to the Chair of the Safeguarding Board.

ADASS South-West Region

South West Safeguarding Adults Thresholds Guidance March 2011

South West Region
Thresholds Guidance
March 2011

Contents

Author:

Kate Spreadbury (Project Officer, South West Safeguarding Adults JIP) Kate.Spreadbury@n-somerset.gov.uk

Published: March 2011

Introduction

This guidance explains the processes involved in making a decision about whether an “alert”, regarding an adult who appears to be at risk of harm or is being harmed, is progressed through the safeguarding adults’ procedures. Such “threshold decisions” are crucial in ensuring that members of the population who meet the definition of “vulnerable adult” (No Secrets 2000) are able to receive the assistance they need. By definition, these adults are not able to protect themselves or claim their civil or human rights without assistance.

If the adult is experiencing harm which causes “impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, intellectual, emotional, social or behavioural development” (Law Commission, Who decides, 1997), i.e., “significant harm”, then they have a right to specialist preventative and protective services. Not everyone who needs support to live their everyday lives is in need of such services, therefore it is important to target resources on those who do. Resources must also be used proportionately, i.e. some people will need the safeguarding adults procedures to be used to fully protect them, in other situations the safeguarding adults procedures can be used to enable a person to self protect in the present, or future, circumstances.

The guidance is intended to underpin local procedures and practice as an indicator of best practice in threshold decision making. It does not replace local guidance, but should be used to review the adequacy of arrangements.

Definitions used in making threshold decisions are explained, together with factors to be considered in decision making, and the rationale for timescales. An adult at risk who appears to need safeguarding adults procedures must be assured that their rights will be upheld throughout the procedures, these are documented in **appendix 6.**

Self neglect is excluded from this guidance, the definitions of abuse or harm are those used in “No Secrets” 2000, i.e. “Abuse is a violation of an individual’s human and civil rights by any other person or persons**.** “

The terms “adult at risk” and “person” are used throughout this document, an “adult at risk” meets the definition of “vulnerable adult” as used in No Secrets 2000.

Thresholds: Why an issue now?

The rate of referrals for safeguarding adult's procedures continues to rise nationally on a year by year basis. Despite this annual increase, research (Kings Fund prevalence study 2007) indicates that much abuse in the community is unreported. This suggests that referral rates have not yet peaked and there is still an unknown potential for further increases.

The definition of "a vulnerable adult" (No Secrets 2000) or "adult at risk" is contested and confused by the identification of vulnerable groups in other legislation and policy or protocols, for example, The Safeguarding Vulnerable Groups Act (2006), and by common use of the word "vulnerable". Awareness of the human and civil rights of vulnerable groups continues to promote reporting of abuse in services used by adults at risk. New procedures (Clinical governance and safeguarding 2010) identify routes of referral of "vulnerable people" in health settings. Clarity about thresholds is needed in responding to a potential widening of the definition of "vulnerable adult" or "adult at risk".

At the same time resources in local authorities are limited with further restrictions to capacity likely over the next few years. There is a risk that budgetary constraints across all statutory and third sector services will affect multi agency responses to safeguard adults at risk as will the reorganisation, abolition and creation of statutory agencies.

Many local authorities have already begun to review their thresholds in order to:

- Promote clarity and consistency in decision making
- Ensure resources reach the most vulnerable people within agreed timescales

Guidance

1. Definitions:

Clarity of definition is essential in ensuring safeguarding adults procedures address concerns about the population they are intended to serve. No Secrets 2000 was issued under Section 7 of the local authority social services act 1970. As such it requires every local authority to follow the directions in the No Secrets 2000 policy. There is no requirement to use protective services for people outside of this definition.

> **"A "vulnerable adult" or "adult at risk" is a person over 18 years old**:
>
> **"who is or may be in need of community care services by reason of mental or other disability, age or illness;**
>
> **AND**
>
> **who is or may be unable to take care of him or herself,**
>
> **OR**
>
> **unable to protect him or herself against significant harm or exploitation."**
>
> **For the purposes of this guidance 'community care services' will be taken to include all care services provided in any setting context."** No Secrets 2000

ADSS 2005 confirms the first part of the definition as **"**Adults who *may be eligible for community care services* are those whose independence and wellbeing would be at risk if they did not receive appropriate **health and social care support"**

The last two parts of the definition are crucial:

- is this person dependent on others for basic needs including protection from abuse (i.e. is or may be unable to take care of him/herself) **OR**
- because of circumstances (e.g. living in a care setting; does not have capacity to decide on risk; is under duress from others) they are unable to protect themselves against significant harm or exploitation.

To be an "adult at risk" or "vulnerable adult", a person needs to meet the first part of the No Secrets 2000 definition and one of the second two parts, i.e. is unable to take care of him or herself, or is unable to protect him or herself against significant harm or exploitation.

In terms of wider society the population 'No Secrets' is targeted at is very small, i.e. those people who are unable to claim their own human and civil rights and have to rely on others support or actions to have those rights. Because this group are not able to protect themselves, any concerns that "significant harm" is being experienced will need to be alerted via the point of access to safeguarding adults procedures.

Abuse

Although the population served is small, the definition of "abuse" is wide

> "**Abuse is a violation of an individual's human and civil rights by any other person or persons"**

All alerts need to be assessed against these two definitions, i.e. is the person an adult at risk and are they allegedly being abused by a third party. If these two criteria are fulfilled the alert can go through to the referral stage and on for the decision to be made about whether the safeguarding adults procedures need to be used.

Safeguarding Adults procedures

Safeguarding Adults procedures are multi agency in nature, governed by safeguarding adults information sharing protocols, and have the following stages:

- Alert
- Referral
- Decision (or threshold decision)
- Safeguarding Assessment Strategy (meeting or discussion)
- Safeguarding Assessment (or "Investigation")
- Safeguarding Plan (or "Protection plan")
- Safeguarding Plan Review

All actions within the procedure should be recorded and monitored.

"Multi agency" can mean all statutory partners, together with independent providers/agencies, working together, or may mean two agencies working together whilst keeping a third agency informed.

It should be noted that the steps of the safeguarding adults procedure can be followed in the way that is most appropriate to the circumstances. For example, if a number of agencies are involved and the matter is complex, then a safeguarding assessment meeting will be necessary. If urgent action to reduce risk is required key agencies may liaise via telephone with discussions and action plans recorded and disseminated. Early parts of the process might be managed, for example via telephone discussion, without meeting until the safeguarding planning stage.

It should also be remembered that the process can be stopped at any point, for example, the adult at risk wants no further action taken, the allegation is unsubstantiated, or no significant harm appears to have been caused and the concern can be managed using other routes and resources.

Eligibility criteria

Wrongful application of eligibility criteria can confuse the decision as to whether to pass an alert onto the referral stage for threshold decision making. Even if a person is assessed as being at a "low" or "moderate" risk of losing independence a concern about the possibility of abuse will move them into a higher band (with current FACS criteria: "Critical or Substantial risk). FACS eligibility criteria for adult care services should not be used in making decisions,

the essential factor is whether the person meets the criteria of “vulnerable adult” (No Secrets 2000).

2. Significant harm

If an alert meets the criteria, “is this person an adult at risk” and “is abuse/neglect by a third party alleged” a referral is accepted. In order to assess whether a referral crosses the threshold for use of the safeguarding adults procedures, the decision needs to be made as to whether “significant harm” is likely to have occurred or not. This decision should be made by a manager or senior practitioner in the lead agency for safeguarding adults, most usually the local authority adult social care department, but may be also an agency to whom safeguarding coordination responsibilities have been delegated (e.g. a mental health trust).

Not all breaches of human rights need a safeguarding adults response, only those that cross the threshold of “significant harm”. The definition of significant harm used in safeguarding adults comes from a definition given by the Law Commission (Who Decides? 1997) which builds on the definition used in the Children Act 1989

> **“ ‘harm’ should be taken to include not only ill treatment (including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, intellectual, emotional, social or behavioural development’.”**

The issue of impairment of development is particularly pertinent to people who have a learning disability or a cognitive impairment, and who may need support to be able to fulfil their potential to have best possible experience of life.

Assessing “significant harm”

Significant harm varies between individuals. This requires careful assessment using as much information as available before a threshold decision is made and includes consideration of the possibility of future significant harm. The seriousness or extent of the abuse or neglect is often not clear when the alert is made, some incidents may not have caused immediate significant harm but if they were to recur it is highly likely that there would be significant harm to the adult at risk, other adults at risk, or children. If there are no well managed measures in place to prevent another incident, a situation which has a high likelihood of potential serious significant harm, should cross the threshold for use of safeguarding procedures. Whether abuse is intentional or not is irrelevant, what is important is the harm done and whether the abuse might be repeated.

Because of the need for a timely response, information gathered to inform the threshold decision can not be as detailed as that gathered in a formal safeguarding adults assessment or investigation. Formulating good processes for inter agency discussions (e.g. significant contacts, information sharing protocols) will help elicit timely multi agency information.

Factors to be considered:

1. Does the alleged abuse involve actual (or potential) harm or exploitation of a vulnerable adult / adult at risk as defined in No Secrets
2. If there is alleged actual or potential abuse, what helps or hinders the person in protecting themselves?
    - Is this person reliant on others assistance to meet their basic needs?

- Have they the capacity to assess risk or decide on courses of action to take to protect themselves?
- Are they able to act on the assessed risk or courses of action in the situation they are in?
- Are they under duress? Duress increases vulnerability in all cases, particularly so if those exerting duress are in control of the persons life (e.g. controlling access to services; delivering care; living at the same address). This dynamic is common in domestic abuse situations.
- Does the person have family or friends who will speak up on their behalf? If they are isolated vulnerability to harm or abuse is increased.
- Hindering factors in the above circumstances can also be increased by other factors, for example has the person experienced previous abuse (domestic/ institutional or other) which has diminished their ability to protect themselves, is the person or the alleged abuser addicted to substances or gambling.

3. Impact of the alleged abuse on the person:

This requires careful person centred assessment and, if it does not increase risk to the adult at risk, consultation with them and, if appropriate, the people close to them. Impact can vary from serious injury or the possibility of death, to emotional distress which damages the persons' quality of life. Consideration of hindering factors as above needs to be factored into assessment of actual or likely impact.

The adult at risks' preferred course of action needs to be considered in the light of possible impact on other adults at risk, or on children. If the adult has been assessed as not having the capacity to make this decision, then it has to be decided what course of action is currently in their best interest, and what course of action would be in the public interest.

Examples of checklists used in assessing potential significant harm are provided in **Appendix 1.**

3. Reaction and prevention

Safeguarding procedures must be used not only to react to significant harm which has occurred, but to prevent significant harm where there are clear indicators of vulnerability and risk. An alert may initially appear innocuous; however assumptions should not be made. Careful assessment of past information may indicate that although significant harm has not occurred on this occasion, it is highly likely to in the future, therefore a multi agency response under safeguarding procedures is the best course of action, for example:

> *Miss Jones has limited mobility and learning difficulties. She requires constant supervision as she has epilepsy, with fits likely to be life threatening (status epilepticus) The police attended her parents at home last night after receiving reports from neighbours about a domestic disturbance. Both parents were intoxicated and had been arguing, no physical violence had taken place. Miss Jones was unharmed on this occasion, but her parents were too affected by alcohol to attend to her needs.*

If this situation remains unchanged the likelihood of significant harm occurring in the future is high, the level of harm is also likely to be serious.

4. Poor practice and abuse or neglect

The difference between poor practice and neglect is much contested. If a person is totally dependent on others assistance to meet basic needs, continual "poor practice" can lead to serious harm or death.

Useful elements in deciding if poor practice has occurred which does not require a safeguarding adults response are to ascertain if the concern:

- is a "one off" incident to one individual
- resulted in no harm
- indicated a need for a defined action.

Examples of the difference between poor practice and neglect can be seen in **Appendix 2** Incidents which indicate that poor practice is impacting on more than one adult, that poor practice is recurring and is not a "one off", must result in safeguarding adults procedures being initiated as these incidents can be good indicators of more wide spread, "institutional" abuse.

Sometimes a "one off" incident is an indication of a lowering of standards by health or care providers. Early indications of poor practice must be challenged and can be addressed using other systems, such as commissioners' quality assurance processes; care management reviews; complaint investigations; or human resources systems. All of these will ensure that the issue is properly investigated, recorded, resolved and monitored. Commissioners need to collate records of poor practice concerns and keep the safeguarding adults lead informed of any escalating concerns about individual agencies.

5. Abuse of one adult in a care setting by another

The significance of the harm caused to the person, rather than the relationship to the person who has abused them, is the most important factor. If both adults are living in a care setting the frequency and risk of harm can be increased and compounded by the emotional distress of living with an abusive person. Within the South West Region, incidents between people who live in the same care setting have included manslaughter, rape and sexual assault, grievous bodily harm and common assault, many of which may have been prevented by a careful analysis of more minor incidents.

Multi agency safeguarding procedures will not be needed if it does not appear any significant harm has occurred, that the incident was an isolated one and that risk assessment and management plans have been amended and monitored to ensure the incident is not repeated. A care management review of the success of the risk management plan should be undertaken after an appropriate period of time.

(Examples are provided in **Appendix 2**)**.**

6. Safeguarding Thresholds in Health settings

"Safeguarding adults is an integral part of patient care. Duties to safeguard patients are required by professional regulators, service regulators and supported in law" (Safeguarding Adults; the role of the Health Practitioner, DoH 2011, page 5)

Recent guidance (Safeguarding Adults; the role of the Health Practitioner DoH 2011) clearly states that any abuse of people defined as vulnerable adults in No Secrets 2000 must be alerted as a safeguarding adults referral using the multi agency safeguarding procedures.

"Multi agency procedures apply where there is concern of neglect, harm or abuse to a patient defined under No Secrets guidance as 'vulnerable'. " (ibid page 10)

And

"Responses to safeguarding adults referrals are coordinated by the local safeguarding adults service. Multi agency procedures set out the roles and responsibilities of staff within the service and within partner agencies." (ibid page 24)

"Abuse" is also as defined in No Secrets 2000. DoH Guidance is available to inform the internal processes within a health setting which inform the decision to make an alert to the local authority (Safeguarding Adults; the role of the Health Practitioner DoH 2011)

After an alert is received from a health provider or commissioner the procedures are used as with any other alert, i.e. the threshold decision is made by the local authority as the operational lead on safeguarding adults, and the same criteria of significant harm should be applied. The same thresholds for institutional abuse also apply (see section 7 below)

Timescales for referrals made by a Health commissioner or provider will be safeguarding adults procedures timescales, and all actions relating to the safeguarding adults and any other investigations, e.g. clinical incident or complaints, must be agreed and recorded via a strategy meeting or discussion.

This will ensure that investigations are prioritised and, when appropriate, run in parallel. Good communication protocols between safeguarding adults and clinical governance teams must be used to ensure that different processes are clear and understood, and all assessment and investigative processes inform each other.

"This integrated approach is supported by the national patient safety framework for investigating serious incidents. This framework defines allegations of abuse as serious incidents to be investigated through local safeguarding adults procedures" (ibid page 25)

The best practice issues, as described above, need to inform all local arrangements for safeguarding adults in health settings. Protocols for alerting, safeguarding assessment, safeguarding planning and review need to be agreed and approved by local Safeguarding Adults Boards. Existing partnerships between health commissioners and providers and local authorities will facilitate the development of local protocols for reporting and investigation. These must include clarity about who is covered by the definitions in No Secrets, internal processes for decision making about alerts, actions to be taken after an alert is received by the local authority, roles and responsibilities, and specialist input available. Once roles and responsibilities are defined, a workforce development strategy within health services will also need to be agreed.

Integrating safeguarding adults into clinical governance provides a twofold benefit for both the patient and the service.

For the patient

- Sharing information between agencies, improves the understanding of risk and the patient's needs i.e. brings together a jigsaw of small concerns related to the person or service
- Improves the quality of the investigation through access to wider multi disciplinary perspectives and expertise
- Other agencies can assist in the patient's care
- The patient has confidence their concern is managed in an open and transparent way
- Ensures the focus is on outcomes for the patient rather than the service
- Provides a 'safety net' for citizens with greatest need

For the service and their partners

- Enables the service to collate vital information about their safeguarding adults responsibilities
- Identifies and addresses emerging concerns within a service
- Provides more robust and transparent investigative process
- Manages patient and organisational risk
- Avoids duplication – the safeguarding adults investigation also meets investigations required by the service.
- Improves scrutiny, accountability and assurance for patients; the service; commissioners and regulators
- Enables learning within and between organisations
- Provides opportunity for a multi agency approach to service improvement

7. Thresholds for "whole service investigation " or "institutional abuse"

No Secrets (2000) refers to institutional abuse as "pervasive ill treatment or gross misconduct …. Repeated instances of poor care may be an indication of more serious problems and this is sometimes referred to as **"Institutional abuse"**.

Concerns about potential "institutional abuse" will lead to the need for a threshold decision to be made about whether a safeguarding adults whole service investigation is required. As institutional abuse can be indicated by a number of instances of poor practice, making a whole service investigation threshold decision can be difficult and sometimes untimely. A systematic way of flagging up alerts, concerns and complaints about commissioned services is needed in order to identify a pattern of poor practice which would indicate serious problems.

The presentation of concerns might result from

- Investigation into the care of one person which then indicates that the practices within the service may be putting other vulnerable people at risk.
- A whistle blower within the service

- A poor CQC review outcome
- Reports from commissioners undertaking QA monitoring
- Reports or complaints from service users, professionals or family members and friends.

The common thread is a significant breach of CQC essential standards of quality and safety (2010). Problems may emerge as:

- poor hydration/nutrition
- widespread neglect of other basic needs such as medical care, medication and hygiene
- lack of dignity and respect
- poor care planning
- poor risk assessment and/or management
- lack of person centred approaches
- ignorance of health and safety, including moving and handling
- dirty environments
- a high number of medication errors

Underpinning these is often a lack of clear leadership and a culture of poor practice. Occasionally, there may be members of staff who plan to exploit these environments, in these cases patterns of theft, sexual assault or physical assault may emerge.

“Institutional abuse develops where there is a lack of leadership and supervision, poor staffing levels and where staff fail to see the essential humanity of each patient. The consequence is that neglect or abuse can grow unrecognised or unchallenged” (Safeguarding Adults: A Guide for NHS Commissioners & Provider Boards 2011, page 10).

The numbers of people already affected is not significant, if these factors are present early identification and multi agency action plans may prevent further abuse and neglect.

To effect any change in such an environment, the multi agency safeguarding procedures are essential in bringing together key agencies (i.e. police, CQC, commissioners, safeguarding nurses, providers and social workers) to plan the investigation; arrange immediate support for people living in the care home or using the service; agree action plans to remedy failings; communication plans, etc. Cultural changes in institutions can take a long time to embed, forming a ‘core group’ of advisors and monitors will support these changes and lead to effectively implemented and monitored action plans.

8. Alerts which fall below the threshold

It is vitally important that the person who made the alert is informed as soon as possible that safeguarding adults procedures are not thought to be appropriate. An alerter who believes that action is being taken may cease to monitor or take protective action in the belief that others are involved. Alerters are also keen to learn whether the alert has been appropriate or not, by providing information and feedback inappropriate referral patterns can be changed. If the adult concerned has made an alert or was aware that the alert had been made they must also be informed that procedures will not be used. (Please see **appendix 3** for examples of follow up letters).

Any further action or recommendations made must be recorded and care taken to ensure that these are carried out. For example, if a provider is asked to change a support plan to reduce the risk of a further incident then this action should be followed up with a care management review.

Consistency of threshold decision making can be hard to achieve. A number of methods can be used to ensure that decisions made are consistent with local procedures, for example audit of letters to referrers, case file audits, or use of a recorded threshold decision making sheet (see **Appendix 4**) which can then be audited, any areas of poor decision making addressed, and areas of good practice identified and disseminated.

9. Timescales

Because of the potentially very urgent nature of an alert it is vital that some initial risk assessment (e.g. is there a danger of imminent serious harm? Has a crime been committed?) has to be done at the point of alert. A threshold decision about whether the safeguarding process is needed needs to be made close to the time of the alert, i.e. one, or at most two, working days. The process of making the threshold decision will give further guidance as to how quickly a safeguarding assessment strategy discussion is needed and who should be involved. If immediate investigation and /or protection are needed, then convening an urgent meeting with one or two key agencies, or holding a telephone strategy discussion, should be undertaken as soon as possible.

In all cases a safeguarding assessment strategy discussion needs to occur during the first week after the alert. In exceptional cases if a meeting is needed and key agencies cannot attend within the first week **AND** an initial risk assessment indicates that the person(s) who has been or is at risk of harm is safe, then a slight delay in meeting is acceptable. A longer delay (i.e. more than 10 days) is unacceptable, if the person is unable to protect themselves and at risk of significant harm then there is no justification for delaying further. If the meeting is delayed by the unavailability of agencies the coordinating manager should review the need for that agency to attend, and ask for a deputy if attendance is crucial to the purpose of the meeting.

The purpose of safeguarding assessment strategy meetings are to identify known risk, areas which need further investigation/assessment and protection plans which need to be in place whilst further information is gathered or, if all information is known, action plans are devised. The coordinating manager may need to set times for reporting back during the assessment or investigation period and ensure that action plans are pursued proactively in order to minimise the possibility of delay.

The interval between the safeguarding assessment strategy discussion and safeguarding planning (or protection) meetings (also known as safeguarding case conferences) is dependant on the timescales agreed at the safeguarding assessment strategy meeting or discussion. However it should be borne in mind that the safeguarding planning meeting will agree the formulation and acceptance or non acceptance of the protection plan by the adult at risk. For this reason the safeguarding planning meeting should be held no more than 4 weeks after the referral is received.

Review intervals should be defined by the nature of the person's circumstances, the risk and safeguarding plan. A review of the usefulness of the safeguarding plan should occur within 6 weeks of the plan being agreed. It does not need to be a full meeting but must involve a

discussion with the person using the protection plan or, where they do not have the capacity to understand risk or agree to the plan, a discussion with their carers or other supporters. It is imperative that the protection plan continues to be reviewed whilst it is still active because there is a continued risk of abuse. Review intervals can be every 3-6 months and involve discussion with agencies who are part of the protection plan as well as with the person concerned or their carers/supporters. (See **appendix 5** for a summary of activities and timescales).

10. Systems to support safeguarding responsibilities

Safeguarding adults at risk is a multi agency responsibility, capacity to do this is increased by excellent partnership working and diminished when this is absent. Whilst local authorities have the lead responsibility to coordinate safeguarding adults assessments and safeguarding planning, their staff are not the only, and sometimes not the best, resource for investigation or protection.

Robust systems for exchange of information under safeguarding adults information sharing protocols, knowledge of who can undertake different types of assessment and investigation, developing confidence in an agency's' ability to investigate/assess, and recognition of the skills and knowledge of others, is essential in developing good partnership working.

Commissioners of services need to ensure that there are very robust systems of quality assurance, particularly in view of the reduction in regulatory inspection by CQC. If there are good protocols in place to address concerns regarding poor practice in commissioned services, with good oversight from commissioners, then leaving "one off" concerns about poor practice outside of the safeguarding process is a reasonable and justifiable risk. If there are no such protocols or working partnerships then attention must be paid to developing these before any such threshold is agreed.

All policies and protocols concerning self directed services need to describe how Self Directed Support (SDS) employers who may also meet the criteria of "adult at risk", will be supported to address concerns about poor practice. This may include ensuring advocacy and advice is available to employers, that they are clear about use of the safeguarding procedures, and that there is clarity about who provides legal support to people employing personal assistants under SDS.

Useful documents:

Clinical Governance and Adult Safeguarding - An Integrated Process, Department of Health 2010

National Framework for Reporting and Learning from Serious Incidents Requiring Investigation; National Patient Safety Agency, 2010

ADSS Safeguarding Adults: A National Framework of Standards for good practice and outcomes in adult protection work 2005

No Secrets: Guidance on Developing and Implementing Multi Agency Policies and Procedures to Protect Vulnerable Adults from Abuse; Department of Health 2000

Safeguarding adults: report on the consultation on the review of *No Secrets,* Department of Health 2009

Self Assessment Quality & Performance Framework for Adult Safeguarding: South West ADASS/SHA 2010

Safeguarding Adults; the role of the Health Practitioner, Department of Health 2011

Safeguarding Adults**:** The Role of Health Service Managers & their Boards, Department of Health 2011

Safeguarding Adults**:** The Role of NHS Commissioners, Department of Health 2011

Appendix 1 – Threshold decisions

Threshold decisions are made in relation to whether or not an alert concerning an adult, who meets the definition of "vulnerable adult" in No Secrets and who is allegedly subject to abuse by a third party, is in need of the safeguarding adults procedure.

Threshold decisions are made on the basis of a combination of the factors below, the most important of which is **significant harm** to the individual concerned. The power dynamic between people in a harmful situation also needs to be assessed as a contributor to significant harm as powerlessness to stop or prevent on-going abuse (i.e. being unable to protect oneself).

Consideration	**Get information from**	**Decide**
Nature of alleged abuse	Persons own account Witness account Reports to police, CQC Alerter account	Does this alleged abuse meet the definitions of abuse in No Secrets? Did the alleged abuse lead to actual harm? Is there a strong possibility it will lead to future harm? Is there significant harm?
Power issues		
The person needs the assistance of others to attend to their basic needs	Persons own account Alerter account Agency records	Is the person experiencing difficulties in accessing protection or ensuring their own human or civil rights are met? Is there potential for the risk to increase because the alleged perpetrator is responsible for the persons care or well being?
The person lacks the mental capacity to assess risk or decide on protective courses of action	Mental capacity assessment	Is the person's vulnerability and likelihood of significant harm increased as a result of them being unable to assess risk or decide on a course of action increases?
The person is under duress	Persons own account (interview separately) Accounts of others, e.g. alerter, other agencies Records	Are there others in control of the person's life, either by controlling access to services, delivering care, living at the same address, who are exerting duress?
The person is isolated	Persons own account /Accounts of others, e.g., alerter, other agencies Records	Is the isolation making it hard for the person to self protect or get assistance? Do they have family or friends who will speak up on their behalf if needed? Is there the likelihood of the person being targeted by people who want to exploit them?

Consideration	Get information from	Decide
The person has experienced previous abuse	Persons own account/accounts of others, e.g. alerter, other agencies Police records Other records	Does the person's internalised feelings of worthlessness, powerlessness, or low expectations of others people (possibly as a result of experience of either their own abuse or the abuse of others) Has the person experienced domestic abuse? are they still in an abusive relationship? Does the person feel powerless and unable to change their situation? If a previously abusive partner or family member is now dependent on the person they have abused (domestic abuse or child abuse) there is a possibility of retribution, or maintenance of previous power dynamics.
The person, or person allegedly harming them, is addicted to substances or gambling	Persons own account /Accounts of others, e.g., alerter, other agencies Records	Is the addiction affecting the alleged abusive situation? Is it likely to prevent action being taken to resolve the safeguarding situation? Is the person dependent on the alleged abuser to sustain their addiction? Is the alleged abuser focused on using the person to maintain their habits and not on the person's well being? Is the influence of addiction leading to risky behaviour, disinhibition and poor judgments?
Impact of the alleged abuse on the person		
Physical impact	Documented injuries Accounts/reports from medical practitioners Persons own account /accounts of others	Safeguarding adults procedures are designed to protect people who are unable to protect themselves without assistance, therefore any physical injury should lead to consideration of use of SA procedures
Emotional impact	Persons own account Observations of others	What impact is the emotional distress having on the persons' quality of life? Is the impact immediately obvious? Is there potential that it will emerge at a later date?

Consideration	Get information from	Decide
		Does the person appear to be having difficulty remembering the cause of the incident or event, but is showing general anxiety or fearfulness? Is the person having difficulty articulating their feelings?
Other risks		
This has occurred in the past	Records Persons own account/accounts of others	Is there a pattern of incidents suggesting this is not a “one off “event and that there is potential that the person, or others, are still at risk.
Likelihood that the risk will occur again	Risk assessment using all the above	Does the allegedly abusive person still have contact with the person? Is the person still living in circumstances that mean other incidents may occur if risk factors are not explored?
Others, including children, are at risk of further harm	Records Persons own account/accounts of others	Is there a need to make a referral to safeguarding children’s services? Should information be passed to MAPPA and MARAC? If others are at risk safeguarding procedures will need to be used
Course of action		
What is the persons preferred course of action?	Persons own account	Has the person concerned indicated that they want no further action taken? Is there any early information on what their preferred outcomes are? Are they aware of what the use of the SA procedures can offer to help? Is the person at great risk of further significant harm? Does the person lack mental capacity to make this decision? is a best interest decision required?

Appendix 2 - Examples of when the Safeguarding Adults procedure may/may not be needed

Adapted from Collins, M. Thresholds in Adult Protection**,** the Journal of Adult Protection Volume 12 Issue 1, February 2010

The terms “person” or “adult at risk” refer to adults described as “vulnerable adults” in No Secrets 2000

Allegations which may not pass the threshold for use of the Safeguarding Adults procedure	**Allegations which will pass the threshold for use of the Safeguarding Adults procedure**
Poor practice: Person does not have within their care plan/service delivery plan/treatment plan a section that addresses a significant assessed need such as: • management of behaviour to protect self or others • liquid diet because of swallowing difficulty • cot sides to prevent falls and injuries but no harm occurs.	Possible abuse: Failure to specify in a persons’ plan how a significant need must be met. Inappropriate action or inaction related to this results in harm such as injury, choking etc. *If this is also a common failure in all care plans in the care home/hospital/care agency will pass the threshold for whole service investigation.*
Poor practice: Person’s needs are specified in treatment or care plan. Plan not followed, needs not met as specified but no harm occurs.	Possible abuse : Failure to address a need specified in the person’s plan results in harm This is especially serious if it is a recurring event or is happening to more than one adult. *If this practice is evident throughout the care home/hospital/care agency, and not just being perpetrated by one member of staff, this will pass the threshold for whole service investigation.*
Poor practice: Person does not receive necessary help to have a drink/meal on one occasion	Possible abuse: Recurring event, or is happening to more than one adult. Harm: weight loss, hunger, thirst, constipation, dehydration, malnutrition, tissue viability problems. *If this is a common occurrence in the setting, or there are no policies/protocols in place regarding assistance with eating or drinking passes threshold for whole service investigation*.

Allegations which may not pass the threshold for use of the Safeguarding Adults procedure	**Allegations which will pass the threshold for use of the Safeguarding Adults procedure**
Poor practice: Person does not receive the necessary help to get to the toilet to maintain continence, or have appropriate assistance such as changed incontinence pads on one occasion.	Possible abuse Recurring event, or is happening to more than one adult. Harm: pain, constipation, loss of dignity and self-confidence, skin problems *If this is a common occurrence in the setting, or there are no policies/protocols in place regarding assistance with continence needs, this passes threshold for whole service investigation*.
Poor practice Person who is known to be susceptible to pressure ulcers has not been formally assessed with respect to pressure area management but no discernable harm has arisen yet.	Possible abuse Person has not been formally assessed/advice not sought with respect to pressure area management, or plan not followed. Harm: avoidable significant tissue damage. *If this is a common occurrence in the setting, or there are no policies/protocols in place or evidence of staff knowledge of pressure sore risks, this passes threshold for whole service investigation*.
Poor practice Medication is not administered as set out in the care plan to a person as prescribed or is not given to meet the persons current needs	Possible abuse Recurring event, or is happening to more than one person. Inappropriate use of medication that is not consistent with the persons needs. Harm: pain not controlled; physical or mental health condition deteriorates / kept sleepy/ unaware; side effects; put at risk. *Continual medication errors, even if they result in no significant harm, are a strong indicator of poor systems, staff compliance or training. Urgent remedial action, either via safeguarding adults or quality improvement strategies, must be undertaken.*

Allegations which may not pass the threshold for use of the Safeguarding Adults procedure	**Allegations which will pass the threshold for use of the Safeguarding Adults procedure**
Poor practice Person does not receive recommended assistance to maintain mobility on one occasion.	Possible abuse Recurring event, or is happening to more than one adult resulting in reduced mobility. Harm: loss of mobility confidence and independence. *If this practice is evident throughout the care home/hospital/care agency, and not just being perpetrated by one member of staff, this will pass the threshold for whole service investigation.*
Poor practice Appropriate moving and handling procedures not followed or staff not trained and competent to use the required equipment but person does not experience harm.	Possible abuse Person is injured, or common non use of moving and handling procedures make this very likely to happen. Harm: injuries such as falls and fractures, skin damage, lack of dignity. *If this practice is evident throughout the care home/hospital/care agency, and not just being perpetrated by one member of staff, this will pass the threshold for whole service investigation.*
Poor practice Person has been formally assessed under the Mental Capacity Act and lacks capacity to recognise danger e.g. from traffic. Steps taken to protect them are not 'least restrictive'. Steps need to be reviewed and referral for Deprivation of Liberty Safeguards may be required. Monitor via DoLs team	Possible abuse Restraint/possible deprivation of liberty is occurring (e.g. cot sides, locked doors, medication) and person has not been referred for a Deprivation of Liberty Safeguard assessment although this had been recommended. Best interest has been ignored or presumed. Safeguarding Adults and DoLS team Harm: loss of liberty and freedom of movement, emotional distress.

Allegations which may not pass the threshold for use of the Safeguarding Adults procedure	**Allegations which will pass the threshold for use of the Safeguarding Adults procedure**
Poor practice Person is spoken to once in a rude, insulting and belittling or other inappropriate way by a member of staff. Respect for them and their dignity is not maintained but they are not distressed.	Possible abuse Recurring event, or is happening to more than one person. Insults contain discriminatory, e.g. racist, homophobic abuse. Harm: distress, demoralization, other abuses may be occurring as rights and dignity are not respected *If this practice is evident throughout the care home/hospital/care agency, and not just being perpetrated by one member of staff, this will pass the threshold for whole service investigation.*
Poor practice Person is discharged from hospital without adequate discharge planning, procedures not followed but no harm occurs.	Possible abuse Person is discharged with significantly inadequate discharge planning, procedures not followed and experiences significant harm as a consequence. Harm: care not provided resulting in risks and/or deterioration in health and confidence; avoidable readmission. If the incident shows poor discharge planning throughout a hospital trust or on a specific ward *Urgent remedial action, either via safeguarding adults whole service investigation, or quality improvement strategies, must be considered*
Poor practice Person does not receive a scheduled domiciliary care visit and no other contact is made to check on their well-being, but no harm occurs.	Possible abuse Person does not receive scheduled domiciliary care visit(s) and no other contact is made to check on their well-being or calls are being missed to more than one adult at risk. Harm: missed medication and meals, they are put at risk of significant harm including neglect. *If this practice is evident throughout the care agency, and not just being perpetrated by one member of staff, this will pass the threshold for whole service investigation.*

Allegations which may not pass the threshold for use of the Safeguarding Adults procedure	**Allegations which will pass the threshold for use of the Safeguarding Adults procedure**
Poor practice Person with challenging behaviour whose personal plan of care stipulates that they should not go into the local town without two staff supporting them is taken by one member of staff to avoid disappointment when the other worker reports sick at the last moment. No harm occurs.	Possible abuse Person is regularly taken out by only one member of staff, with no review of care plan, and is therefore regularly put at risk. Harm: may injure self or others. *If this is an indicator of poor practice by several members of staff, or poor management of the setting, others may be affected, whole service investigation should be considered.*
Poor practice Adult at risk in pain or otherwise in need of medical care such as dental, optical, audiology assessment, foot care or therapy does not on one occasion receive required/requested medical attention in a timely fashion.	Possible abuse Adult at risk is provided with an evidently inferior medical service or no service, and this is likely to be because of their disability or age or because of neglect on the part of the provider Harm: pain, distress and deterioration of health *If there is evidence that others have also been affected, or that there is a systemic problem within the provider service whole service investigation must be initiated.*
Poor practice by housing providers Person is known to be living in housing that places them at risk from predatory neighbours or others in community and housing department/association is slow to respond to their application for urgent re-housing – but no harm occurs.	Possible abuse Housing provider fails to respond within a defined and appropriate timescale to address the identified risk. Harm occurs Harm: financial, physical, emotional abuse.
Poor practice by housing providers A resident in a warden complex reports that s/he finds the warden overbearing and intrusive.	Possible abuse At least one resident is intimidated and feels bullied by the warden and they are frightened to talk about why. Harm: emotional/psychological distress.
Poor practice by housing providers Adult at risk needs housing repairs arranged by their landlord. There is undue delay but repairs done eventually and no harm has occurred.	Possible abuse Landlord persists in not arranging repairs that are urgently required to maintain the safety of the person's environment. Harm: physical and/or emotional e.g. from dangerous wiring, damp, or lack of security

Allegations which may not pass the threshold for use of the Safeguarding Adults procedure	**Allegations which will pass the threshold for use of the Safeguarding Adults procedure**
Family non cooperation Failure to meet agreed contribution to residential care cost by family member or attorney, but resident still has personal allowance and placement not at risk (should be treated as failure to meet lawful debt).	Possible abuse Failure to meet agreed contribution to cost of residential care by family member or attorney results in a failure to provide personal allowance and/or jeopardises placement.
Incident between **two adults living in a care setting**: One adult 'taps' or slaps another adult but has left no mark or bruise and victim is not intimidated and significant harm has not occurred. Or One adult shouts at another in a threatening manner, victim is not intimidated and significant harm has not occurred.	Possible abuse: Predictable and preventable (by staff) incident between two adults where bruising, abrasions or other injuries have been sustained and/or emotional distress caused. *A significant level of violent incidents between adults living in care or health settings can be an indicator of poor staff attitude, training, risk assessment and risk management, or poor Supervision and management of the service. Whole service investigation should be considered.*

Appendix 3 - Examples of follow up letters to alerters
(adapted from Cornwall safeguarding adults)

1. Letter explaining that the alert has not reached the threshold for use of safeguarding adults procedures.

Dear [name]

Safeguarding Adults Alert

On [date] you contacted [the safeguarding access point] to make a safeguarding adults alert. This means that you had a concern that a vulnerable person (as defined by the "No Secrets" local guidance) had been, or may have be at risk of harm, abuse or neglect.

Thank you for taking this action, it is vitally important that matters of this nature are reported. However, after careful consideration of the situation based on the information provided, it has been decided that, on this occasion, the matter will not go forward for investigation under the safeguarding adults procedures. The reasons for this are as follows:

e.g. *- not a vulnerable adult as defined by "no secrets" local authority guidance*
- no evidence of abuse or neglect
- others?

Please be assured that the needs you reported and described were taken very seriously and the action that we will take is as follows ..... *specify*

OR

The alternative course of action you may wish to take are.....*specify*

If you would like to discuss this further please phone [number] and ask for [name].

Should you come across anything in the future which makes you concerned that a person at risk of harm may be being abused or neglected, please do not hesitate in bringing this to our attention.

Yours Sincerely

2. Letter confirming that the alert has reached the threshold for use of safeguarding adults' procedures.

Dear [name]

Safeguarding Adults Alert

On [date] you contacted [the safeguarding access point] to make a safeguarding adults alert. This means that you had a concern that a vulnerable person (as defined by the "No Secrets" local guidance) had been, or may have be at risk of harm, abuse or neglect.

Thank you for taking this action, it is vitally important that matters of this nature are reported. On careful consideration of the situation based on the information provided it has been decided that this does need to go forward for investigation under the safeguarding adults procedures.

If you would like to discuss this further please phone [number] and ask for [name]. *We will keep you informed about the progress of this matter (add if appropriate).*

Should you come across anything in the future which makes you concerned that a person at risk of harm may be being abused or neglected, please do not hesitate in bringing this to our attention.

Yours sincerely

Appendix 4 Decision making form – Alert to threshold decision

Decision maker			
Name of Team Manager/ Senior Practitioner			
Details of adult at risk			
Surname	Forename	Date of Birth	Electronic record number

Funding details of adult at risk				
Funded by Social Care ☐	Funded by another authority ☐	Funded by Continuing Health Care ☐	Self funded ☐	Not in receipt of funded care ☐

Alert to threshold decision	
Information gathered	**Yes/No**
Is the person a "vulnerable adult" as defined in No Secrets 2000?	☐ **Yes** ☐ **No**
Is the abuse or neglect perpetrated by a third party or parties?	☐ **Yes** ☐ **No**
Is there actual, or risk of, significant harm?	Actual ☐ **Yes** ☐ **No** Risk ☐ **Yes** ☐ **No**
Risks identified at this stage to adult	Provide detail of risks:
Risks identified at this stage to others	Provide detail of risks:
Other specialist protocols considered, e.g. MAPPA, MARAC, Pressure areas protocol	Detail protocols considered:

Alert to threshold decision	
Adult at risk's preferred course of action, if known	☐ consent given to use SA procedures ☐ does not consent to use of SA procedures ☐ unable to give consent ☐ consent not able to be ascertained at present Detail any specific preferences or desired outcomes expressed by the adult at risk:
Does the situation meet the threshold for use of safeguarding adults' procedures?	☐ Yes ☐ No Specify rationale for decision:
Further Actions	
Detail initial plans under SA procedures, (e.g. immediate protection action to be taken, strategy discussion planned with x agency) *OR* *If adult has not met threshold, describe action taken (e.g.who referred on to, what advice given, etc)*	
Consent of adult at risk to information sharing? ☐ **Yes** ☐ **Not yet obtained** ☐ **No** Describe reason if consent not obtained**:** (*e.g. adult unable to consent, unable to make contact without a multi agency risk management plan*)	
Alerter notified of outcome of threshold decision ☐ **Yes** ☐ **No** Describe reason if alerter not notified:	
Date of threshold decision	

Appendix 5 Timescales and activity

Timescale	Stage	Activity	AVA definition	Notes
	Alert received	Details recorded Immediate risk assessment – is there immediate danger to the adult at risk, children, other adults at risk?	**Alert**	Immediate risks to adults at risk or children may need an urgent response from either the emergency services or via a fast track through to SA procedures
No more than 1 working days of receipt of alert, immediately if a adult at risk or child is at immediate risk	Alert assessed, information gathered and passed on as a referral for a threshold decision	Information gathered ▪ Is the person a "vulnerable adult" as defined in No Secrets? ▪ Is this third party abuse or neglect? ▪ Likelihood of significant harm ▪ Risk Assessment ▪ Consent of adult at risk to information sharing and use of safeguarding processes ▪ Views of adult at risk, including their initial preferred outcomes ▪ Cross reference to other specialist protocols, e.g. pressure ulcer protocol, MARAC, MAPPA		Authorities who have screening or "triage" workers will use these resources for assessing the alert; all others will use locality resources to assess. Assessment needs to be sufficient to give an indication of likelihood, given the timescales it cannot be rigorous

Timescale	Stage	Activity	AVA definition	Notes
Within 2 working days of receipt	**Decision:** Threshold decision made - either a referral elsewhere or a referral for use of the safeguarding adults procedure	Judgement made about the likelihood of significant harm occurring. If significant harm has, or is likely to occur, or if this is hard to establish because of lack of information, accept as a safeguarding adults referral into the safeguarding adults procedure	**Referral**	If there is any doubt whether significant harm is occurring or not go onto SA referral. Inform the alerter of outcome of threshold decision
Within 5 working days of receipt of referral	**Safeguarding Assessment Strategy Meeting or Discussion**	Evidence reviewed How will the alleged abuse be investigated? If not already done, how will the views and preferred outcomes of the adult at risk be ascertained? Risk assessments • Adult at risk • Other vulnerable people/children • Investigators/assessors Further mental capacity assessments needed? Plan for support needs of adult(s) at risk throughout investigation/assessment process, including access to advocates, intermediaries etc. Assessors/investigators agreed		Use the strategy meeting to agree a clear, risk assessed plan of how the adult at risk will be involved in all stages of the process. If the adult at risk has been assessed as lacking the mental capacity to make specific decisions about risk, what will be done to ensure that they remain as involved as possible. Does an IMCA need to be instructed because the person has been assessed as lacking capacity and needs someone to represent their best interests.

Timescale	Stage	Activity	AVA definition	Notes
		Assessment/Investigation plan agreed All activities agreed recorded and disseminated amongst participants in strategy discussion		
As agreed by strategy discussion, usually within a 10 working day time limit, earlier if abuse is likely to recur	**Safeguarding Assessment (investigation)**	▪ Desired outcomes of the adult at risk ascertained if not done so previously ▪ Assessment/Investigation plan implemented		
After completion of safeguarding assessment, within four weeks of receipt of referral	**Safeguarding Planning Meeting (case conference)**	▪ Outcome of case agreed ▪ Plan discussed ▪ Person accepts/declines protection plan or plans are made to elicit persons agreement ▪ Contingency plans agreed ▪ Review date agreed	**Completed referrals by case conclusion, i.e. substantiated/ partially substantiated/inconclusive/not substantiated** **Acceptance of protection plan**	The adult at risk, or their representative, e.g. IMCA, must be able to discuss and inform the protection plan prior to this meeting.

Timescale	Stage	Activity	AVA definition	Notes
Initial review within 6 weeks of initiation of protection plan, thereafter as the person's circumstances require, but at least between 3 – 6 months	**Safeguarding Plan Review**	▪ Review protection plan ▪ Is the person safer as a result? ▪ Do they feel safer? ▪ What risks remain? ▪ What changes need to be made? ▪ Is the protection plan still needed? ▪ Does the person agree to continue the plan?		The adult at risk, or their IMCA, are the essential participants in any review process.

Appendix 6 Principles underpinning the safeguarding adults procedure

The UK government (2011) agreed the following principles for safeguarding adults: the descriptors are adapted from “Safeguarding Adults: The Role of Health Service Practitioners “

Principle 1 – Empowerment - Presumption of person led decisions and consent
Adults should be in control of their care and their consent is needed for decisions and actions designed to protect them. There must be clear justification where action is taken without consent such as lack of capacity or other legal or public interest justification. Where a person is not able to control the decision, they will still be included in decisions to the extent that they are able. Decisions made must respect the person’s age, culture, beliefs and lifestyle.

Principle 2 – Protection - Support and representation for those in greatest need
There is a duty to support people to protect themselves. There is a positive obligation to take additional measures for people who may be less able to protect themselves.

Principle 3 – Prevention
Prevention of harm or abuse is a primary goal. Prevention involves helping the person to reduce risks of harm and abuse that are unacceptable to them. Prevention also involves reducing risks of neglect and abuse occurring within all services.

Principle 4 – Proportionality. Proportionality and least intrusive response appropriate to the risk presented
Responses to harm and abuse should reflect the nature and seriousness of the concern. Responses must be the least restrictive of the person’s rights and take account of the person’s age, culture, wishes, lifestyle and beliefs. Proportionality also relates to managing concerns in the most effective and efficient way.

Principle 5 – Partnerships. Local solutions through services working with their communities.
Safeguarding adults will be most effective where citizens, services and communities work collaboratively to prevent, identify and respond to harm and abuse.

Principle 6 – Accountability. Accountability and transparency in delivering safeguarding
Services are accountable to service users, patients, public and to their governing bodies. Working in partnerships also entails being open and transparent with partner agencies about how safeguarding responsibilities are being met.

South West additional principles:

Once safeguarding procedures have been initiated an adult at risk should be assured:

- That their views, needs and well being are held to be central in any investigation, protection planning, or other process.

- That their human and civil rights, including the right to self determination, will be upheld throughout the process.

- That they will be supported to access the same services and have the same rights as all other citizens, or those rights and services will be accessed on their behalf if they are unable to do this with support.

- That information about them will be shared only under safeguarding adults information sharing protocols

- That any investigation or planning done with them, or on their behalf, will be multi agency, accessing the best possible and most appropriate resources.

- That responses will be timely and proportionate.

- That there is a built in planning and reviewing process which will mean that their protection is paramount in the minds of all involved, until the need for such protection has finished. Actions stated in any safeguarding plan must be carried out and individuals will be held to account for these.

South West cross boundary information sharing protocol – Final June 2011

Terminology

Host Authority – The Local Authority in which the alleged abuse has occurred

Placing Authority – The Local Authority or Health Authority that has commissioned a service from a provider that is located outside their Authority, or the Local Authority from which an individual at risk is ordinarily resident.

Introduction

The south west cross boundary information sharing protocol enables a host local authority to communicate concerns about poor care homes or services to other local authorities or health services who are also commissioning the service. Inter authority communication is essential to ensure that:

- Placing authorities are aware of permanent or temporary commissioning bans.
- Placing authorities can identify people they have placed in a setting and undertake reviews to ensure those people are well and still appropriately placed.
- Host and placing authorities can work together from the outset to safeguard people living in settings or using services where there are safeguarding adults concerns

The expectation is also that placing authorities, who identify concerns about a care home or service during an individual's assessment or review, report these to the host authority immediately. It is the host authorities' responsibility to notify other potential placing authorities.

Placing authorities are also reminded of their responsibility, when considering placing an individual outside of their local authority area, to ensure that the placement meets the individual's needs. Before making a placement the placing authority must contact the host authority (contracts team, safeguarding adults team and local CQC contacts) to ensure that the placement is suitable and that no current restrictions apply. The placing authority must also notify the host authority when the placement is made.

This protocol specifies:

1. In what circumstances information will be shared about a service of concern
2. How this information would be shared across LA boundaries and with CQC
3. Host authority responsibilities
4. Placing authority responsibilities
5. Safeguarding adults further actions

1 In what circumstances information will be shared about a service of concern.

1.1 Information should be shared where there are indications that a number of people using the service may be adversely affected by the concerns expressed. Poor practice which appears to have occurred on one occasion, affected one individual and been displayed by

one member of staff would not normally result in a need for cross boundary information sharing as it is unlikely others have been affected, unless there are indications to the contrary. However several incidents, e.g., accidents resulting from poor manual handling practice, may well be affecting others using the service.

1.2 Information should also be shared when:

- A “whole service” investigation is indicated.
- Quality audits from commissioning teams indicate concerns about neglect, failure to follow polices, absence of key policies and protocols to safeguard service users, poor staff training, poor leadership, i.e. there are indications of potential or actual institutional abuse
- CQC report significant non compliance with the Essential standards of quality and safety.
- The host authority is planning to/has suspended placements or has issued “place under caution” advice.
- There are concerns about the registered owner or managers “fitness” to fulfil this role, e.g., they are subject to police investigation, or have been suspended from duty, or are subject to other disciplinary measures.

2. How this information would be shared across LA boundaries and with CQC

Placing authority safeguarding adults’ leads will initially be notified by the host authority safeguarding adults lead via an email. It is not necessary to share all information known in this email, for reasons of confidentiality and security it is sufficient to advise that there are concerns about a care home/service and invite placing authorities to make contact with a named person for further information.
It is the placing authority safeguarding leads responsibility to inform commissioners in both health and social care authorities, of the email notification of concern.

The host authority safeguarding adults’ team is responsible for sharing information according to agreed CQC/ADASS information sharing protocols (Appendix 1) with the relevant CQC compliance inspector.

Once information is shared about a service of concern, this will be monitored at the bi-monthly CQC and Commissioners meetings

3. Host Authority responsibilities

3.1 The host local authority will use its own internal procedures in identifying potential and actual concerns about institutional abuse.

3.2. On identification of concerns the safeguarding adults lead should consider, what is the likelihood of the concern impacting on the welfare of others in the setting?

3.3 If the concern is likely to have an impact on the welfare of others, the safeguarding adults lead must consider sharing this information with other organisations who may be funding the care of people in the setting. Use this boundary protocol to share information, via other safeguarding adults leads, with placing local and health authorities.

3.4 If the concern or any subsequent outcome of investigation leads to any of the circumstances described in 1.2 above, do share using this protocol. If there is a criminal investigation in hand check any limitations on disclosure with the police investigating officer.

3.5 Contact the safeguarding adults lead and/or their nominated deputy, in each of the South West authorities using the information sharing email group (appendix 3 and available on the South West Community of Practice webpage- give address). The email address should be the team address, where available, and the email should be marked “service of concern”. As above, it is not necessary to share all information known in this email, for reasons of confidentiality and security it is sufficient to advise that there are concerns about a care home/service and invite placing authorities to make contact with a named person for further information.

3.6 The host authority safeguarding adults’ team will also be responsible for sharing information according to agreed CQC/ADASS information sharing protocols with the relevant CQC compliance inspector

4. Placing authority responsibilities

4.1.On receipt of a service of concern email, the safeguarding adults lead in the authorities notified should inform their local commissioning teams and check if the authority has commissioned placements or services from the provider in question. Health commissioners in the area should be notified by the notified local authority safeguarding adults team and invited to also make checks.

4.2 If the authority is a placing authority, i.e. it has commissioned the service for people ordinarily resident in its area, the placing authority safeguarding adults team must inform the designated contact in the host authority of any placements it funds within **2 working days** of receiving the service of concern email.

5 Safeguarding adults further actions

All further actions must be consistent with the agreed ADASS Out of Area’ Arrangements and ‘Cross Border’ Issues protocol, see Appendix 2 which details the responsibilities of host and placing authorities in undertaking safeguarding adults procedures.

Appendix 1 – CQC/ADASS agreed information sharing protocols
Appendix 2 - ADASS cross boundary protocol (not yet agreed by national ADASS but draft attached)
Appendix 3 - Safeguarding adults contact details.

A protocol between CQC and councils with social services responsibilities

– showing how we intend to coordinate our respective relationships with providers of adult social care registered under the Health and Social Care Act 2008

Introduction

1. The Care Quality Commission (CQC) and councils with social services responsibilities (councils) both have clear and distinctive roles in overseeing the practices of adult social care providers. This protocol outlines the responsibilities and duties of each and provides a framework for CQC and councils to work together with the aim of reducing unnecessary administrative burdens on regulated providers.

2. In particular, it provides an overarching framework for joint working and the basis for the design and development of a formal information sharing agreement between CQC and councils in the coming months. This will be essential to assure effective, rapid and timely exchange of contemporaneous data and information between CQC and councils which will also be made available to regulated providers.

3. This protocol does not override the statutory duties and powers of either CQC or councils, and is not enforceable in law. The protocol and local working arrangements will be communicated to, and consulted on, with regulated providers, people who use services and their relatives.

4. The protocol outlines:

   The statutory responsibilities of CQC and councils in relation to adult social care providers with:

   - An agreed set of principles that will inform the way that CQC and councils will approach their relationships with each other and with regulated providers of social care including private, voluntary, third sector and council providers.

- Further work to be undertaken to deliver an ‘information sharing agreement’ that will support electronic data and information exchange between CQC and councils.
- Review arrangements for the protocol in six months.

Principles

5. CQC and councils are committed to putting people first and making sure that regulated providers deliver good and effective services that meet the needs of people who use these services. In doing this we will make sure that:

    - Requests for information are not duplicated.
    - CQC regulatory assessment activity and councils’ procurement and commissioning activity are complementary.
    - We use resources effectively and efficiently so that the impact for all parties leads to less burden.

Statutory responsibilities of CQC and councils in working with registered adult social care providers (see Annex A for detailed description)

6. The Care Quality Commission (CQC) was created under the Health and Social Care Act 2008 as the national regulator for health and adult social care services in England. Its main functions linked to this protocol are the registration and ongoing monitoring of all providers of social care services within England whose activities meet the definition of a regulated activity and this includes council-run regulated activity.

7. Legal guidance for councils was set out in 2006 under section 7(1) of the Local Authority Social Services Act 1970, regarding oversight of adult care. Alongside this legal framework sits best practice guidance, with a clear responsibility to ensure the quality of adult social care services across the local authority area in all sectors, irrespective of whether or not services are provided directly by the council.

General principles of working together (See Annex B)

8. CQC and councils will have open and transparent dealings with each other, which may result in them routinely sharing information about the standard of care of regulated providers. There will need to be further work to develop a portal mechanism between CQC and councils to deliver this.

9. Both CQC and councils have an interest in the quality of services provided by regulated providers. Through the application of this protocol CQC and councils will work in partnership to improve services provided.

10. CQC registers adult social care providers and monitors those providers for their ongoing compliance with standards. Councils monitor the quality of services provided in line with contractual provisions. To ensure there is no overlap in their

monitoring activities, CQC and councils will share any related data and information routinely with each other as part of the statutory requirement to reduce administrative impacts and burdens on providers, to ensure the safety and quality of services, to improve outcomes, and to safeguard vulnerable adults.

11. In particular, CQC operational staff and councils' contract management staff will share:

    - Information held by both organisations regarding the quality of services provided by regulated providers.
    - Information and outcomes about quality of services from CQC assessments and inspections or council contract monitoring.
    - Information held by CQC, or the council, on progress against improvements identified in either CQC regulatory assessment and inspections or council quality assessment.

12. CQC will collate data and information from a range of sources and will, where relevant, transfer it into an organisational quality and risk profile (QRP). This may include data and information from councils. Councils hold contemporaneous data and information about providers, including views of people who use services, which will be used to maintain the currency of the data and information held in the QRP.

13. The QRPs will be shared with both providers and councils to inform their own monitoring processes.

14. Information held by both CQC and councils may give rise to concerns about a registered provider or service when practices within a regulated service severely compromise the safety and wellbeing of people. CQC and the council(s) will work together to ensure a coordinated approach is taken. CQC, the councils(s) and the provider will agree an appropriate course of action.

15. In addition CQC and the council will:

    - Inform the other as soon as reasonably possible of any matters that have come to its attention that may require action or a response from the other party.
    - Inform the other about any action being taken in relation to registered providers that may be relevant to the functions of the other; this will include notification in advance when appropriate to do so.

16. CQC and the council will keep each other fully informed about developments in their compliance and monitoring approach and methodologies. This will include, but is not limited to the:
    - Development of CQC's Compliance Framework, regulatory requirements and risk ratings.
    - Development of councils' commissioning and monitoring frameworks, tendering documentation and premium payments for quality services.
    - Development of the assessment methodology.
    - Development of reviews, including any ratings.

17. CQC will consult councils as it develops its approach to new quality ratings for regulated providers. This protocol will need to be reviewed in the light of developments on quality ratings as new methodologies are implemented.

Improvement

18. CQC and the council will work in partnership to promote improvement in the quality of services provided, including cascading information and other guidance that may be issued regarding best practice.

19. At times, CQC may identify issues that are impacting nationally, regionally or locally on practices in the social care market and will share its findings as far as possible with any affected council.

Press and publications

20. CQC and the council will seek to ensure that they give each other adequate warning of, and sufficient information about, public announcements regarding their monitoring of registered adult social care providers.

21. CQC and the council will respect the confidentiality of any documents shared in advance and generally will not cause the content of those documents to be made public ahead of the planned publication date.

Operation, implementation and review of the protocol (see Annex c)

22. The Protocol may be amended at any time by agreement between CQC and councils. The Protocol will be regularly reviewed and evaluated, and will include the input of regulated providers of adult social care services. Where appropriate, the protocol will be updated to take account of any changes to legal responsibilities.

23. Reviews will be undertaken by the project group responsible for the design of the protocol, who will report respectively into the ADASS Standards and Performance Committee, CQC/ADASS Executive Meetings and for the providers into the Social Care Market Review Group.

24. The first review of the Protocol will take place in January 2011.

Richard Jones

Cynthia Bower

Annexe A – Statutory roles and responsibilities of the Care Quality Commission and councils

Role of the Care Quality Commission

The Care Quality Commission is the independent regulator of health and adult social care in England. The Care Quality Commission was established in April 2009, replacing the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection.

The Care Quality Commission regulates health and adult social care services provided by the NHS, local authorities, private companies and voluntary organisations. It performs a range of regulatory activities:

- Registration, ongoing monitoring of compliance and enforcement against national essential standards of quality and safety.
- Regular assessments of quality of providers' care and the quality of care secured by commissioners for their local communities.
- Special reviews and studies looking at pathways of care, specific themes or value for money.
- The Care Quality Commission's Mental Health Act Commissioners monitor the care of people whose rights are restricted under the Act, check how legal powers of compulsory care and treatment are being used and make sure that people's interests are protected.

The main objectives as set out in the Act are:

- To protect and promote the health, safety and welfare of people who use health and social care services.
- Improvement of health and social care services.
- Encouraging the provision of health and social care services in a way that focuses on the needs and experiences of people who use those services.
- Encourage the efficient and effective use of resources in the provision of health and social care services.

In doing this, CQC must take into account the views of members of the public, people who use services and local involvement networks (LINks). The need to protect and promote the rights of people using services, including those detained under the Mental Health Act 1983, those deprived of their liberties under the Mental Capacity Act 2005 and other vulnerable adults.

Role of local authorities in commissioning and performance management of services

Legal guidance for councils was set out in 2006 under section 7(1) of the Local Authority Social Services Act 1970, regarding oversight of adult care services. Alongside this legal framework sits best practice guidance, with a clear responsibility to ensure the quality of adult social care services across the local authority area in all

sectors, irrespective of whether or not services are provided directly by the local authority. Councils receive additional guidance which gives detailed information about their role when developing and shaping the adult social care provider market.

Councils have the responsibility to:

- Assess, plan and commission adult social care services to meet the needs of all within their area for those who are entitled to public funding and those who are self-funding, carers, people from ethnic minority backgrounds and people living in rural communities.
- Organise procurement, commissioning and contract monitoring arrangements with providers in line with the Department of Health guidance on effective commissioning for outcomes.
- Monitor services commissioned from another agency (whether that agency is in the public, private, voluntary or community sector) to ensure they deliver effective and efficient services.
- Require improvements in outputs and outcomes to be delivered as necessary and as specified in contracts with adult social care providers.
- Provide monitoring and improvement information to adult social care providers.

Annex B – What will the protocol achieve?

For people who use services, their families and friends

People who use services, their family and friends should expect to receive the best standards of care, be valued as an individual and should expect to be made aware of the quality of the services that are available.

This protocol aims to ensure that improving standards of care and improving customer outcomes is the ultimate focus for the monitoring undertaken by CQC and councils and that this is done in a cost effective way. Making sure that relevant staff groups are clear about their roles and responsibilities and that information is shared in an effective way to achieve these outcomes.

People who use services, their families and friends should understand the purpose of this protocol. Their experience is vital to ensuring that these outcomes are delivered.

CQC, the council and regulated providers should ensure that customers, families and friends are fully informed of the current 'Quality Rating' and council 'Quality Scheme' outcome. CQC and the councils will ensure the information is available and improves the choice and control people have when choosing to use a regulated provider.

For CQC and councils

CQC and councils are required to monitor the way that adult social care is delivered in England, and the obligations placed on the two types of bodies mean that we are striving to achieve many of the same outcomes when overseeing the practices of adult social care providers. CQC is obliged by the Health and Social Care Act 2008 to work in cooperation with public authorities, and we are therefore adopting this Protocol to provide the basis on which we will work together with councils to achieve those shared outcomes. It is important that the systems that CQC and councils use for assessing providers are complementary and that these are communicated to providers, people who use services and relatives.

This collaboration and cooperation will ensure that the following outcomes are achieved:

- It contributes most to improvements in quality of social care services.
- It ensures regulated providers are clear about the requirements placed on them, and the mechanisms for holding them to account.
- Regulated providers are effectively held to account.
- The regulation and commissioning of adult social care providers is proportionate, effective and efficient in line with Better Regulation principles.

All potential concerns regarding the provision of adult social care services, will be reported to, and dealt with by, the body best placed to take action

For regulated providers

- Providers expect regulatory activity to be based on the five principles of better regulation (transparent; accountable; proportionate; consistent and targeted at cases where action is needed).
- The aim of responsible providers is to **provide high quality care and to** work with regulators and councils to simplify and modernise existing approaches to regulatory activity, to change attitudes and approaches to regulation, to make it more efficient and effective in improving quality outcomes and to ensure that it represents good use of public funds.

Providers should expect:

- That their local council endorses the protocol and that the council and CQC have placed a copy on their websites.
- To be consulted about any changes to the protocol or its implementation.
- That council or CQC information on providers logged in the shared information portal when this is implemented is first verified with the provider concerned.
- That councils and CQC in working with providers will be open and transparent.
- That councils, the CQC and providers will inform their local/national representative association on how the protocol is being implemented locally.

Council Contract Monitoring and/or Quality Schemes

Providers should expect:

- That any council contract monitoring and/or quality schemes do not overlap CQC registration and quality ratings activity and where information is requested there is a clear rationale. The council will avoid unnecessary duplication and unreasonable administrative demands on providers.
- To be consulted, within a reasonable timeframe, and be kept informed about any local council quality scheme.
- That any council Quality Scheme over and above contract monitoring processes, is open to appeal from providers and that council-run services are treated in the same way as independent provider services.
- To be able to challenge requests that duplicate monitoring/regulatory activity with the lead officers responsible for implementing the protocol and request a halt to such activity until these concerns have been adequately addressed.

CQC and councils partnership

Providers should expect:

- That councils and CQC actions will be clearly based on their statutory roles and responsibilities outlined in Annex A.

- That councils and CQC will have regular meetings to discuss how the protocol is working and share key messages from these meetings with providers.

- That the timing and purpose of visits to providers by CQC and council officers are coordinated.

- That councils and CQC will advise providers on any documents relating to the provider they propose to share with the other.

- That councils and CQC respect provider and client confidentiality as required by the Data Protection Act.

Annex C

Operational contacts

There will be specific points of contact between the CQC Regional Directors, operational teams for CQC and Directors of Social Services (DASS).

Strategic and policy issues related to the protocol
The specific contacts on all strategic and policy issues will be:

CQC: Alan Rosenbach, Head of Strategy and Innovation
ADASS: Tom Cray – DASS for Rotherham
Providers: Social Care Market Review Group