West Midlands Regional Adult Safeguarding Network

Framework for Responding to Organisational Failure or Abuse

Background

Within the local Inter-agency Adult Procedures prior to the Care Act 2014 there was provision for the conduct of Large Scale Investigations (LSIs) in situations where there were concerns about widespread institutional abuse or a range of safeguarding issues accompanied by regulatory or other failings.

The LSI process has become well embedded and has contributed to the co-ordination of multi-agency efforts to address service failures and to hold providers to account where there have been systematic failures.

The LSI process has been led by Safeguarding Teams. This has sometimes led to unrealistic expectations regarding the powers of the local authority in relation to its safeguarding role. It has also created an over reliance on safeguarding intervention by other agencies and teams in some cases.

In the majority of LSIs, the major concerns are symptomatic of care quality issues or are regulatory in nature and safeguarding concerns have only been a small part of the whole picture. Typically, LSIs have identified issues of leadership, lack of supervision, poor care planning and risk management, staffing, clinical care (e.g. pressure ulcers), communication, financial management, selection and assessment and compatibility of service users, staff training, infection control, medication and poor moving and handling.

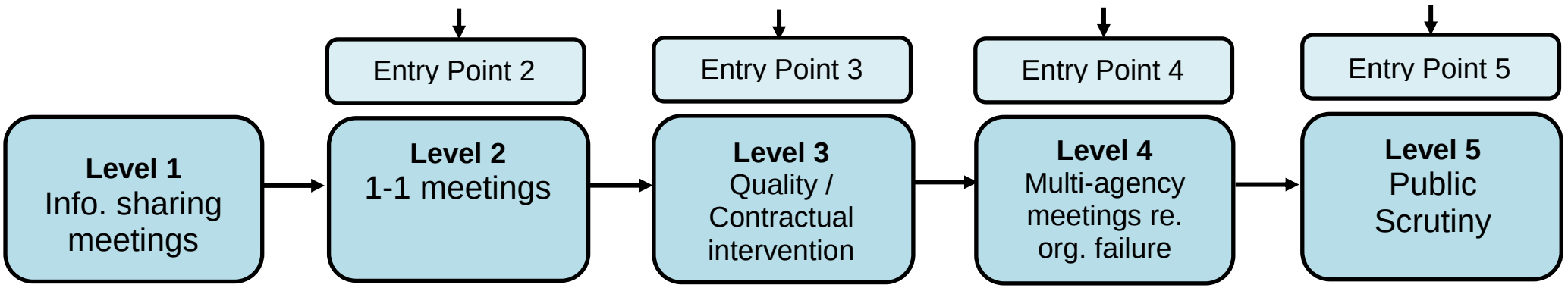
An alternative approach must be found given the clarity in the Care Act Guidance that says "*safeguarding is not a substitute for:*

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

The primary purpose of this framework is to ensure safe service provision and prevent organisational failure.

N.B. The use of this framework is not a replacement for day to day information sharing processes that exist between agencies when there are concerns about individuals which must be raised as per the West Midlands Adult Safeguarding Policy and Procedures. Individual enquiries should not be delayed whilst waiting to convene 1-1 meetings or multi-agency meetings about organisations. Local Authorities should feel free to develop more detailed guidance to sit under this framework should they think it required or embed it into their Business Failure processes.

Framework



PLEASE PROGRESS THROUGH THE LEVELS IF POSSIBLE. ENTRY POINTS SHOULD ONLY BE USED IN EXCEPTIONAL CIRCUMSTANCES

Level 1 Guidance

This level represents the regular meetings that take place between the local authority, CQC, Clinical Commissioning Groups (CCG) and NHS England. Concerns can be raised by any partner at these meetings or Quality Surveillance Group. At this meeting the concerns will be clarified the response required, if any, will be agreed.

Level 2 Guidance

Face to face meetings will be called between the "owner" of the organisation and the professional most appropriate to lead the discussion e.g. CCG quality lead where the issues are mainly clinical. The discussion should centre on what the issues are and what action might be taken. A low key but formal record of this discussion should be produced to suit both parties e.g. an email to summarise the discussion and actions agreed.

Level 3 Guidance

Where concerns persist as a result of the failure of the organisation to improve their service, commissioners will consider what options are available to them. This may include quality monitoring visits and the production of action plans or contractual action such as preventing new placements or the issuing of remedy letters.

Level 4 Guidance

In the event of organisational failure e.g. financial collapse, major regulatory sanctions (e.g. multiple warning notices, persistent 'Inadequate' ratings, proposal to cancel registration), a meeting will bring together the relevant parties including the failing organisation. Who leads this meeting will be decided by considering the predominant issues e.g. systemic, ongoing abuse would be led by the locality. Meetings should ensure that contingency, media and communications plans are in place.

Level 5 Guidance

Public scrutiny can take place in a number of ways including escalation to the Safeguarding Adult Board (SAB) or through conducting a Safeguarding Adult Review (SAR).

Additionally, some local authorities may want to consider how they involve their Scrutiny Committees in holding people to account and getting assurance about what action will be taken to improve the service and within what timescales.

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