QUALITY ASSURANCE FRAMEWORK

Children and Adults – Commissioned Care and Support Services

QAF001 April 2026

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Introduction

Purpose

This framework sets out Shropshire Council's approach to assuring, improving and sustaining the quality and safety of all commissioned *and* Shropshire based noncommissioned care and support services for adults, children and young people, in and out of the Shropshire county boundary. It applies to regulated and non-regulated provision and forms part of our contractual and statutory arrangements with providers and partners.

Scope

This document applies to all commissioned care and support services for adults and for children and young people, including but not limited to: adult mental health; adult residential and nursing care (including learning disability and autism services); children's residential homes; domiciliary care for adults and children; extra-care; supported accommodation (16–17 and 18+); short breaks and adult respite; day opportunities; fostering and adoption support; internal regulated care and support services; mother and baby services and specialist therapeutic and youth services. Providers delivering services solely via direct payments are expected to meet this framework, noting the level of Council oversight may differ.

Service Category	Description / Examples
Children and Adult Mental Health Services	Commissioned mental health care and support for children and adults
Adult Residential and Nursing Care	Includes care homes for adults with or without dementia, including adults with a Learning Disability, with Autism and with Mental Health support needs; Soley commissioned or jointly commissioned with NHS ICB
Children's Residential Homes	Homes providing care and support for children and young people

Service Category	Description / Examples
Domiciliary Care Agencies	Home care and specialist support services for adults and children/young people (CYP)
Extra Care Housing Settings	Housing with on site care and support for older adults or those with additional needs
Residential Educational Settings	For looked-after children requiring education with care and support
Independent Fostering Agencies	External fostering provision commissioned by the Council
Supported Accommodation	For children, young people and adults aged 18+ (including Supported Living, Shared Lives, Supported Lodgings)
Adult Respite Services	Residential and nursing care or replacement care respite care and support for adults
Day Services	Community-based day opportunities for adults and young people
Internal Regulated Care Services	Council-operated regulated care and support provision
Adoption and Family Support Services	Support for adoptive families and family networks
Short Break Services	Planned short-term breaks for children, young people and families

Service Category	Description / Examples
Specialist Therapeutic Services	Targeted therapeutic interventions for children and adults
Youth Services	Services supporting young people's development and wellbeing
Mother and Baby Family Assessment	A structured service to evaluate a mother's ability to safely and adequately care for their baby, usually in a supported setting.
Voluntary, Community and Social Enterprise sector.	Contracts held with charities, community organisations, and social enterprises to deliver services that support Shropshire residents' wellbeing.
Early Intervention and Prevention.	Contracts held with services designed to prevent or delay the need for higher-level health or social care interventions.
Advice, Advocacy and Welfare Benefits (AAWB)	Contracts held with a consortium of Voluntary, Charity and Social Enterprise partners to provide residents with accessible, high-quality advice, advocacy, and welfare benefit support.
Independent Mental Health Advocacy (IMHA)	A commissioned statutory service required under the Mental Health Act (1983).

Roles and responsibilities

- Providers: responsible for delivering safe, effective, well-led services that meet contractual and regulatory standards, undertaking self-assessment and delivering improvement plans.
- Shropshire Council's social care market Contracts Team manages contracts that social care services are procured under and leads on proportionate Quality Assurance activity, triangulation of intelligence, undertakes visits and issues recommendations/contract notices and any service improvement activity resulting from contract management.

- Commissioners in Shropshire Council ensure that services commissioned for children, young people, and adults are safe, effective, and person-centred.
- The social care market Quality and Performance Group (QPG): multi-agency forum providing oversight, scrutiny and decision-making for Amber/Red concerns, chaired at Head of Service level across the Council.
- Regulators (CQC/Ofsted): regulate and inspect registered services and share intelligence.
- Safeguarding partners: coordinate safeguarding enquiries and multi-agency responses.
- People with lived experience, families and carers: provide feedback and co-produce improvements.

Strategic context

This framework supports delivery of the priorities set out within the Shropshire Council Corporate Plan 2026-2030, ensuring commissioned services contribute to safe, inclusive communities; improved health and wellbeing outcomes; a thriving economy; environmental sustainability; and a financially sustainable council with a high-performing workforce.

It supports collaborative system working with NHS partners through the Integrated Care System and the Staffordshire, Shropshire, Telford and Wrekin Integrated Care Board (ICB), among other integral partner agencies and Local Authority Peers.

Residential Care

The Social Care Contracts and Quality Assurance Team provides oversight of a mature and generally sufficient residential care market across Shropshire. Current market intelligence identifies 75 CQC-registered care homes offering 3,221 beds for people aged 65 and over. This includes 41 residential care homes and 34 nursing homes, with provision available both with and without dementia care.

Given Shropshire's large rural geography, residential and nursing care services are distributed across the north, south and central areas of the county, supporting local choice and reducing the need for individuals to move away from their communities. Through ongoing quality monitoring, provider engagement, CQC intelligence and market oversight activity, the Council is able to maintain assurance regarding both the quality and resilience of these services.

For adults under 65, there are 37 CQC-registered care homes providing 339 beds, predominantly supporting people with learning disabilities and autistic people. Current placement intelligence indicates that only a small proportion of people require out-of-county placements, providing assurance that the local market is largely meeting assessed needs and demonstrating continued sufficiency alongside quality provision.

Supported Living

The team also provides oversight of a diverse supported living market comprising 140 services supporting approximately 200 individuals across Shropshire.

The supported living offer includes a mixture of shared accommodation and individual tenancies, with varying levels of care, support and specialist provision designed to meet a wide range of needs. Quality assurance activity focuses on ensuring services promote independence, choice and control, whilst delivering safe, person-centred support and achieving positive outcomes for individuals.

Through contract monitoring, provider quality visits, stakeholder feedback, safeguarding intelligence and market engagement, the Council maintains ongoing assurance regarding service quality, sustainability and the ability of providers to respond to changing demand and complexity.

Domiciliary Care

Shropshire's domiciliary care market has developed over a number of years and is characterised by a significant number of small and medium-sized local providers. There are currently 81 CQC-registered domiciliary care providers operating across the county.

The Quality Assurance Framework recognises the importance of a diverse home care market in supporting people to remain independent within their own homes and communities. As a large rural authority, ongoing quality oversight is essential to ensure providers can deliver safe, effective and responsive care across geographically dispersed locations.

Quality assurance arrangements draw upon performance information, quality monitoring activity, stakeholder feedback, safeguarding concerns, contract compliance and regulatory intelligence to assess provider performance, identify emerging risks and support continuous improvement. This enables the Council to maintain assurance that commissioned services remain sustainable, accessible and focused on delivering positive outcomes for people who draw on care and support.

Legal and regulatory context

This document is underpinned by legislation and statutory guidance including (non-exhaustive):

Legislation / Framework	Key Focus
Care Act 2014 and Care and Support Statutory Guidance	Duties on local authorities, market shaping, managing provider failure, continuity of care
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Fundamental Standards	Minimum standards for regulated health and social care services
CQC Single Assessment Framework	Five key service areas and quality statements for assessing care quality
Working Together to Safeguard Children 2023	Statutory guidance on multi-agency safeguarding for children
Children Act 1989 and 2004; Children and Families Act 2014; Childcare Act 2006	Legal duties for safeguarding, family support, SEND, and childcare provision
Children's Homes (England) Regulations 2015 and Quality Standards; Ofsted SCCIF	Regulatory standards and inspection framework for children's homes and fostering agencies
Mental Capacity Act 2005 and Code of Practice; DoLS / Liberty Protection Safeguards	(Aged 16+) Decision-making for people lacking capacity; safeguards for deprivation of liberty
Equality Act 2010 (Public Sector Equality Duty)	Duty to eliminate discrimination and advance equality of opportunity

Legislation / Framework	Key Focus
Data Protection – UK GDPR and Data Protection Act 2018	Legal framework for processing and protecting personal data
Health and Care Act 2022	Duties of Integrated Care Boards and CQC system assessments
The Procurement Act 2023	Legal framework that aims to create a simpler, more transparent and fair public procurement system that delivers value for money and strengthens integrity and equal treatment.

Quality Matters

Vision

Our vision is to ensure that every Shropshire resident receives high-quality, person-centred care and support that upholds the Care Act 2014's core principles of wellbeing, prevention, and personal choice. We will fulfil our duties as a local authority by using the Quality Assurance Framework to help drive and shape a high quality, diverse, sustainable and safe social care market.

We are committed to offering services that deliver value for money, empower individuals to direct their own care, respect their rights, protect them from harm, and continually improve by listening to their feedback and acting upon the voices and experiences of the people and communities we serve.

In Shropshire, we want to ensure that the quality of our care and support services becomes everyone's responsibility, where information and intelligence are routinely and consistently shared and effectively responded to so that Supported People, family members and carers can be confident that the care and support being delivered is of good quality.

The Quality Assurance Framework fosters and embeds a high-quality culture and encourages continuous improvement in our care and support services across Shropshire and beyond. It fully embeds a whole system approach where quality standards and expectations are clearly communicated and owned, and key stakeholders work collaboratively to ensure that quality is delivered.

Central to this is the need for a collaborative approach in the way quality is driven and delivered in our care and support services, where positive and supportive relationships are built between the range of agencies, care and support providers and people of all ages and demographics using services to foster a culture of quality and continuous improvement.

Through supportive partnership-based working, continued quality improvement can be delivered with better, innovative and cost-effective outcomes that promote the well-being of people who need care and support.

Aims

The framework aims to set out our expectations for meeting a good level of quality that focuses on the delivery of outcomes for supported children, young people, adults, and families in receipt of care and support.

It establishes a contractual framework for assuring consistent, clear and transparent quality for those delivering services.

The framework outlines our commitment and approach to assuring quality, how standards and outcomes will be monitored and the action that will be taken to improve standards and outcomes where required.

It provides a consistent and coordinated means of responding to concerns where quality thresholds are not being met and where there is a clear need for service improvement to minimise risks to Supported People and the overall provider market.

This framework will:

- Set clear, outcome-focused quality standards for commissioned services.
- Assure quality using proportionate, risk-based monitoring that triangulates evidence from multiple sources, including lived experience.
- Provide consistent routes for escalation and de-escalation where concerns arise, with timely support for improvement.
- Protect people's safety and rights through robust safeguarding and contractual mechanisms.
- Promote market sustainability, innovation and workforce capability.

Key Principles & Values



The Quality Assurance Framework reflects Shropshire Council's PROUD values by promoting strong Partnerships across the health and care system; demonstrating Respect through person-centred and inclusive approaches; creating Opportunities for learning, innovation and continuous improvement; developing a deeper Understanding of quality, risk and lived experience through intelligence-led assurance; and adopting a Can Do approach that is proactive, solution-focused and committed to achieving positive outcomes for Shropshire residents. These values underpin all assurance, monitoring, improvement and governance activities undertaken through the framework.

The voices, experiences and outcomes that matter to people are central to planning, delivery and assurance activities. We celebrate good practice and support services to deliver person-centred care that promotes independence, dignity, choice and control.

Our Quality Assurance is informed by intelligence from providers, people who use services, carers, regulators, operational teams and partners. We use this information proactively to identify emerging risks, support early intervention and enable preventative action.

We work transparently and constructively with providers, our local health partners, regulators, safeguarding, people with lived experience and neighbouring authorities. We promote shared accountability, open communication and a culture where concerns can be raised and addressed promptly.

Our approach recognises the challenges facing providers and aims to support improvement through constructive challenge, guidance and partnership working. We seek to understand local contexts while maintaining a focus on safe, effective and high-quality services.

Assurance activity is responsive to changing circumstances and tailored according to risk, complexity and provider performance. Resources are targeted where they can have the greatest impact, ensuring oversight remains proportionate and effective.

Equality, diversity, inclusion and human rights principles are embedded throughout the framework. We actively promote fairness, tackle inequalities and support services that meet the diverse needs of Shropshire's communities.

We foster a culture of continuous learning, sharing good practice and encouraging innovation. Excellence is recognised and celebrated, whilst learning from challenges is used to drive improvement across the market.

A high-quality provider market is essential to ensuring sustainability, resilience, choice and availability of care. Our quality assurance activity actively supports provider development, strengthens market resilience, promotes continuous improvement and protects the capacity of services to meet current and future demand.

Setting standards

Quality standards are expressed through an outcomes-focused Quality Outcomes Framework that aligns with the Care Quality Commission’s five key questions and quality statements, and with Ofsted’s inspection frameworks for children’s social care (Appendix 1). For regulated services, the minimum standard expected from partner providers is “Good” overall and in relevant domains, with continuous improvement towards “Outstanding”. For non-regulated services the same expectations of safe, effective, person-centred practice apply and will be assessed proportionately.

Quality is Everyone's Business

Quality assurance approach

We operate a single, end-to-end, collaborative QA cycle covering:

- intelligence gathering
- monitoring and review; and
- response and action

Activities include due diligence (in- and out-of-county), provider self-assessment, desktop analysis, pre-monitoring questionnaires, quality concerns trend review, focused QA visits, routine monitoring visits (18–24 months as a guide), reactive activity in response to intelligence (including safeguarding), contract/performance reviews and review of regulator reports.

Supported people and carers' feedback is integral, alongside staff views, observations of practice and environment, and review of records and governance. Findings inform improvement actions, and the quality threshold level that is assigned. (Appendix 4)

Monitoring, thresholds and governance

After initial Quality Assessment, Providers are assigned to one of three quality threshold levels (Green – no/minor concerns; Amber – moderate concerns; Red – major concerns) known commonly as a RAG rating. Threshold assignment determines the frequency and intensity of monitoring and the governance route for decisions, including review by the multi-agency Quality Planning Group (QPG) meeting for Amber/Red cases and urgent escalation as required. (Appendix 2)

Collaborative approach

Quality oversight is delivered with partners across commissioned provision. For jointly commissioned services the Council and commissioning partners share intelligence, agree the lead organisation for Quality Assurance activity and undertake joint monitoring as appropriate. For out-of-area placements we liaise with host authorities and regional Quality Assurance networks to share intelligence and coordinate oversight. Quality assurance is also shared with all statutory regulators across both adults and children's services. Supported people are encouraged to participate in Quality Assurance to ensure their unique perspective is considered when assuring the quality of the social care market.

Contractual relationship and enforcement

All commissioned services are subject to contractual terms, specifications and performance measures. Quality concerns are considered in the context of contractual compliance and commissioned service specifications. Proportionate responses to noncompliance to contract terms and service specifications range from recommendations and service improvement action plans, through to default notices, placement suspension, and (where necessary) termination and/or cessation of commissioning in line with procurement law and contractual provisions as outline in Shropshire Councils Contract management guidance and other related policies and processes (Appendix 5).

Safeguarding

Any information indicating risk of harm or abuse will be acted upon in accordance with Shropshire Safeguarding Community Partnership procedures for adult safeguarding, and the statutory guidance Working Together to Safeguard Children (2023).

Information governance, confidentiality and equality

Quality assurance activity will comply with UK GDPR and the Data Protection Act 2018. Personal data will be collected and processed lawfully, minimally and securely. The Council will meet the Public Sector Equality Duty (section 149 Equality Act 2010), including completing Equality Impact Assessments where relevant, and will ensure accessible engagement and reasonable adjustments for providers and quality partnerships where required.

Appendix 1: Quality Outcomes Framework (Standards)

The Council's Quality Outcomes Framework supports providers to evidence continuous improvement towards "Outstanding". It aligns to the CQC's five key questions and quality statements and to Ofsted frameworks for children's services. The table below summarises strategic aims, outcomes for people and example measures.

Strategic Aim	Individual Outcome	Measure
Strategic Aim 1: To improve the health and wellbeing of everyone in Shropshire by enabling people to take greater control over their own health and the health of their families and helping people to remain independent within their own homes and communities.	Facilitates and empowers people to make choices about health and wellbeing and how it should be monitored and managed	All assessment of needs and care/support planning, service delivery and reviews are based on: • Respecting Individuals strengths and abilities (before need). • Care and support plans being person centered and reflect the Individuals aspirations. • Care and support delivery supporting Individuals to build, maintain their skills, abilities, identity, religious and spiritual needs, cultural beliefs, and autonomy. • Supporting Individuals to retain control of their health and wellbeing. • End of life care and support needs and wishes are known and respected. Individuals are: • Confident that they are listened to and that their views are taken into consideration when planning for their own care and support. • Enabled to improve beyond their baseline abilities, supported to facilitate choice and control over their own outcomes and goal setting. An Individual's care and/or support has: • A continuum of enabling independence by using assistive technology i.e., aids, adaptations, textures, flash cards. Services support and encourage Individuals with:

		• Positive management of health conditions to engage and promote and support healthy lifestyles i.e., nutrition, hydration, exercise, immunisation programs, sensory checks, mental health, socialisation. Where the service is responsible for medicines, staff work creatively with Individuals: • To actively involve them in the management and administration of their medicines, including non-prescribed medication, and • To evidence regular medication reviews that are appropriate and effective. Supporting and encouraging Individuals to: • Maintain relationships that are important to them within their own familiar groups and the wider community. • Continually engage with the wider community and actively encourage Individuals to access local support. • Look for new ways to promote independence and work closely with other agencies and advocates and in doing so Individuals participate in hobbies, activities and meaningful occupation with the experiences being recorded and evaluated.
Strategic Aim 2: To reduce inequalities in health (both physical and mental) across and within communities in Shropshire, resulting in additional years of life for citizens with treatable mental and physical health conditions.	I have access at the right time to services that supports my healthcare and social support needs.	Individuals have: • Choice in how and where their care and support is delivered. • Access to the information they need in the most appropriate medium to support an informed choice. • Supported access to appropriate health professionals. • The environment in which care and support is delivered is appropriate to the needs of the individual and reasonable adjustments are in place to support Individuals to access health and wellbeing services. Service providers: • Facilitate and support Individuals to have regular opportunities to access health and leisure facilities.

		• Engage in proactive and supportive key professional relationships to enhance care and support delivery. • The Individual is the decision maker with appropriate access to information through a planned and collaborative (MDT) approach to ensure health, emotional, psychological, and social care needs are supported. • Communication and information sharing is safe, appropriate, and timely. • Staff are competent with all relevant legislation e.g., MCA, and use innovative ways to make sure that Individuals participate in decisions about their health and wellbeing, so their human and legal rights and protected characteristics are respected and protected but best interest decisions are undertaken where appropriate. • Services recognise that everyone is different, and everyone has the right to be treated with dignity and respect.
Strategic Aim 3: To improve the quality and safety of health and care services thereby improving their positive contribution to improve wellbeing and enhancing the experience of Individuals.	It is safe to be me. I am valued as an individual, for the experiences I have and for the person I am.	Service Providers: • Have appropriate and robust security systems in place including but not limited to environment, information governance and health & safety policies. • Have preventative measures in place to minimise risk for Individuals, staff, visitors, and location. There is overall awareness of everyone to promote quality and safety with an enabling culture and ethos. • Where appropriate, service providers use “champions” to promote good practice in all areas. These champions will be proactive and put into practice new and emerging guidelines. • Build and support active engagement and value relationships including those with advocates and volunteers and has a shared learning ethos.

		• Have service improvement plans aligned with and go further than the regulatory framework. • Have a care management system that gives a comprehensive overview of the care provided. • Ensure that Individuals have a clean, safe and homely environment for people to live in free, from risks. • Actively involve Individuals in contributing, designing, creating and refurbishing the environment they are living in. • The service actively monitors incidents and events and facilitates shared learning to enhance care delivery. • Measures are in place and information is accessible to support Individuals to make informed decisions about health and wellbeing and keeping safe. Staff: • Are highly skilled at recognising when people are at risk of abuse or feel unsafe and are comfortable and proactive when challenging and reporting unsafe practice. Organisations have an "Identify, act, report" ethos. • Have time to build respectful and trusting relationships with individuals. • Participate in being "a resident for a day" or "a day in the life of…" Evaluate the experience to make improvements to service delivery. • The service culture actively encourages and empowers Individuals to raise concerns, acts positively to manage the risk and opportunities. These activities include whistleblowing policies, key worker meetings and supportive staff performance processes and training. • Individuals have autonomy and knowledge to raise concerns when practice is not right or inappropriate.

		• Individual opportunities are optimised using proactive, creative thinking to enable a balance between safety and positive risk taking through activity plans, 1:1's with Individuals and risk assessments. Individuals are: • Supported to understand what keeping safe means. • Encouraged to keep themselves safe and are empowered to raise any concerns. • Supported to keep safe with services using proactive ways to involve Individuals e.g., through accessible information, training, and promotion with staff. • Assistive technology is made available to enable opportunities, reduce risk and maximise safety for Individuals. Evidenced in care plans and observation of its use in practice, used 'for' the Individuals as well as 'with them' approach.
Strategic Aim 4: To ensure that we have sufficient workforce that is appropriately trained to provide the services our population requires.	Confidence and trust that my support is provided by people who understand my health and care needs and can deliver through a "look after me for me" value-based approach.	Services have: • An active platform to share appropriate and relevant information with Individuals e.g., meetings, forums. • Effective communication systems and current information (e.g., leaflets) is in a medium that is understandable to individuals and staff i.e., visual, audio, appropriate to level of understanding, sit down with time – inclusivity, easy read. • Have a "valuing staff with a proud to care" ethos: Through safe recruitment practices, induction programs, retention incentives, which promote wellbeing of staff, ongoing training over and above core requirements, well informed and committed teams. • Invest in workforce development through proactively promoting a career pathway of progression, recognising individuals and team who go over and above their role, succession planning using a variety of methods including mentoring and shadowing, nurturing and Continuing Professional Development. Evidence how this improves the quality-of-service provision.

		The workforce is: • Trained and supported to be compassionate, caring, creative and responsive. • Seen, visible, approachable, and responsive to needs of Individuals, evidenced through feedback and observation. • Within the staff group there are specific and designated thematic "champions" i.e., dignity champions, infection control champions, dementia champions, nutrition champions. • Services support staff and individuals through change and transitional programs. • Leaders ensure that staff in all roles are highly motivated and offer care and support that is exceptionally compassionate and kind. • Services have a strong, visible person-centred culture. • Service providers proactively engage with and contribute to local and national forums, recognised industry standards associations, educational events, other associated organisations, relevant guidance, legislation and resources, and use this to inform best practice and evidence-based care and support delivery. • Specialist services link into and access external professionals and experts and practice is endorsed by them. • Service recognises good practice and supports the improvement of things that are not working so well. • Organisations have an open culture, constantly adopt and adapt best practice guidance throughout systems and processes to ensure that all Individuals are safe and achieve best outcomes for them. • Service providers enable Individuals and staff to push boundaries and affect change.

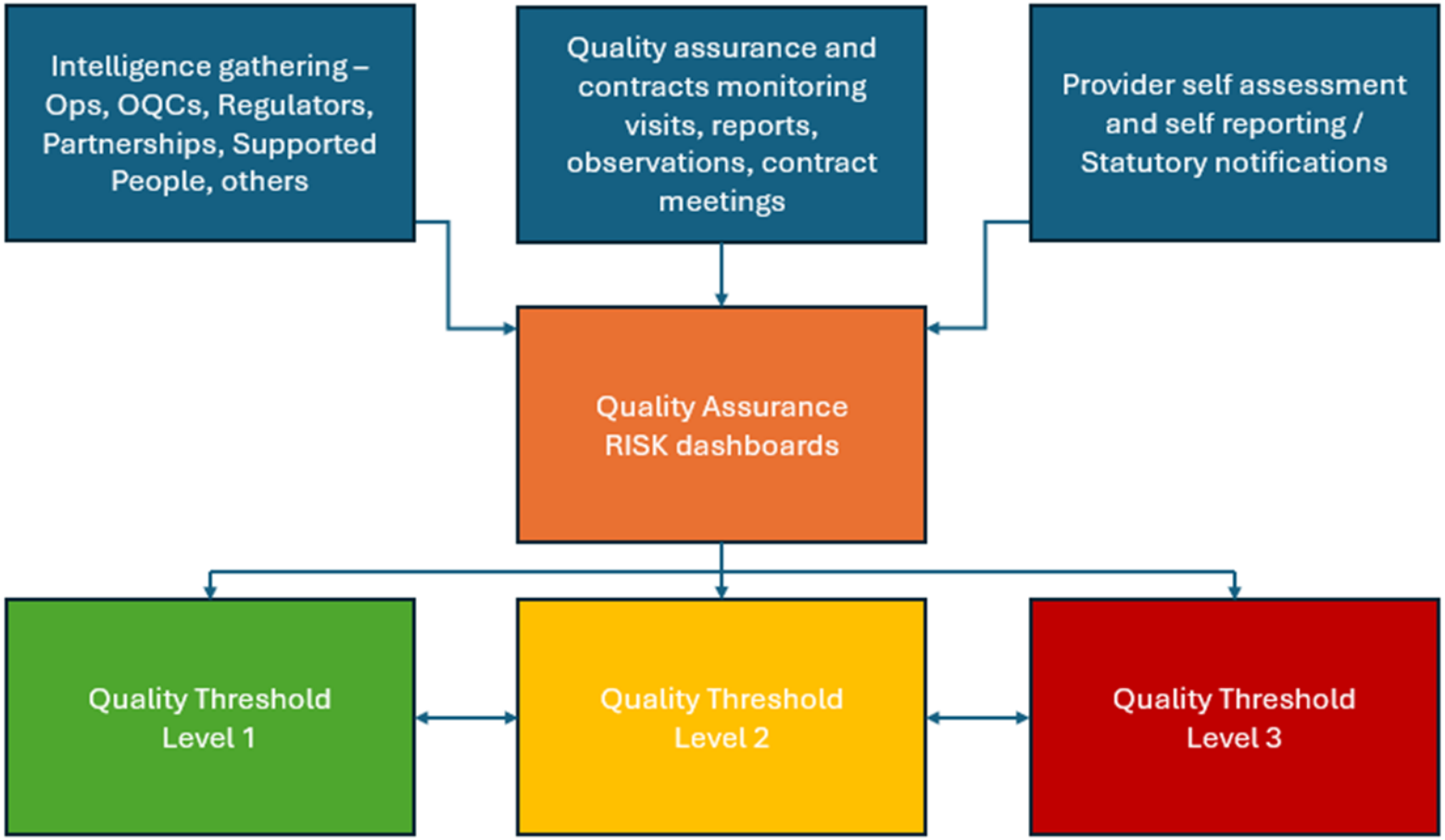
Appendix 2: Quality Assurance Thresholds or Areas of Concern

Level	Description	Indicators (illustrative)	Intervention (illustrative)
1 (Green)	No or minor concerns	Good/Outstanding regulator ratings; generally positive feedback; minor isolated concerns; safeguarding at expected levels; improvement actions on track; monitoring information submitted as requested.	Desktop and routine monitoring.
2 (Amber)	Moderate concerns	Requires Improvement in some domains; warning notices/compliance actions; repeated safeguarding or quality concerns; slippage on improvement plan; failure to submit monitoring; advisory notice or placement suspension.	Routine and/or reactive monitoring; discussion at QPG; improvement/action plan; possible default notice.
3 (Red)	Major concerns	Inadequate or widespread Requires Improvement; proposals to cancel/conditions imposed; persistent concerns; failure to improve; unwillingness to engage; extended suspension of placements.	Reactive monitoring; large-scale intervention; frequent multi-agency reviews; Improvement plans; Breach notices; consider contract termination.

Appendix 3: Quality Assurance Monitoring and Measures

Level	Description	Monitoring and measures	Intervention
1 (Green)	No or minor concerns	Annual self-assessment; proportionate QA visits/contacts and contract meetings; quarterly monitoring returns; feedback; recognition and sharing of best practice.	Desktop and routine monitoring.
2 (Amber)	Moderate concerns	Unannounced and focused visits; improvement/action plan; monthly multi-agency quality review; potential noncompliance notice and/or placement suspension.	Routine and/or reactive monitoring.
3 (Red)	Major concerns	Large-scale intervention; frequent multi-agency and contract monitoring meetings; repeated default notices; consider suspension/cessation of commissioning.	Reactive monitoring.

Appendix 4: Quality Assurance Process Overview (planned/business as usual):



Appendix 5: Related Policies and Processes

- **QAF2 Quality Assurance Framework Statement**
- **QAF3 Care Market Contract Management Guidance**
- **QAF4 Quality Assurance Monitoring Guidance**
- **QAF5 Due Diligence Guidance**
- **QAF6 Visit Guidance for Monitoring Officers**
- **QAF7 Organisational Quality Conern (OQC) Guidance**
- **QAF8 Provider Service Interuption Policy**
- **Shropshire Adults Safeguarding Policy**
- **Shropshire Childrens Safeguarding Policy**
- **Shropshire Whistleblowing Policy**

Appendix 6: Definitions

QA / QAF	Quality Assurance / Quality Assurance Framework. The systematic process and set of standards used by Shropshire Council to monitor, assure, and improve the quality and safety of commissioned care and support services.
CQC	Care Quality Commission. The independent regulator of health and social care services in England, responsible for registration, inspection, and rating of providers.
Ofsted	Office for Standards in Education, Children's Services and Skills. Regulates and inspects services that care for children and young people, including children's homes and fostering agencies.
ICB	Integrated Care Board. A statutory NHS organisation responsible for planning and commissioning health services in a local area, including partnership working with local authorities.
SEND	Special Educational Needs and Disabilities. Refers to children and young people who require additional support due to learning difficulties or disabilities.
GDPR / UK GDPR	General Data Protection Regulation (UK version). The legal framework governing the processing and protection of personal data in the UK.
BAU	Business as Usual. Refers to routine, planned activities and processes, as opposed to reactive or exceptional actions.
RAG Rating	Red-Amber-Green Rating. A system for categorising providers or services based on quality thresholds: Green (no/minor concerns), Amber (moderate concerns), Red (major concerns).
QPG	Quality and Performance Group. A multi-agency forum within Shropshire Council providing oversight, scrutiny, and decision-making for quality concerns in social care services.
MDT	Multi-Disciplinary Team. A group of professionals from different partnership disciplines working collaboratively to support decision making in the health and social care market.
Safeguarding Partners	Organisations (including local authority, police, NHS) that work together to protect adults and children from harm, abuse, or neglect.
Supported People	Individuals (adults, children, young people) receiving care and support services commissioned by the Council.
Providers	Organisations or individuals contracted to deliver care and support services to adults, children, and young people.
Commissioners	Council staff responsible for planning, procuring, and overseeing the health and social care market to ensure they meet local need.

Contractual Compliance	Adherence to the terms, specifications, and performance measures set out in contracts between the Council and service providers.
Self-Assessment	Process by which providers evaluate their own service quality and compliance against set standards, often as part of quality assurance activity.
Statutory Guidance	Official instructions issued by government departments that local authorities must follow in delivering health and social care services.
Regulated / Non-Regulated Provision	Services that are subject to statutory regulation and inspection (regulated) versus those that are not (non-regulated) but still expected to meet Council standards.
Direct Payments	Funds provided directly to individuals by the Council to arrange and pay for their own care and support services.
Equality Impact Assessment	A process to assess how policies or decisions may affect people differently, ensuring compliance with the Public Sector Equality Duty.
Safeguarding	Protecting people's health, wellbeing, and human rights, enabling them to live free from harm, abuse, and neglect.
Contract Notice / Default Notice	Formal notifications issued to providers regarding breaches of contract or required improvements.
Placement Suspension	Temporary halt to new placements with a provider due to quality or safety concerns.
Market Shaping	Local authority activity to develop and sustain a diverse, high-quality care market that meets local needs.
Continuous Improvement	Ongoing efforts to enhance service quality, safety, and outcomes for supported people.
Local Authority Peers	Other local councils (and their relevant officers) who work collaboratively with Shropshire Council to share learning, compare practice, exchange intelligence, and support improvement across adult and children's social care services.

Appendix 7: Useful Information and Links

Key legislation, statutory guidance, regulator frameworks and local safeguarding procedures (hyperlinked below).

References and key links:

Care Act 2014: Care and Support Statutory Guidance

CQC Assessment Framework (Single Assessment Framework)

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Working Together to Safeguard Children 2023

SCCIF: Children's Homes

SCCIF: Independent Fostering Agencies

Children's Homes (England) Regulations 2015 – guidance

Mental Capacity Act 2005 Code of Practice

Equality Act 2010 – Public Sector Equality Duty (guidance)

Data protection (UK GDPR and DPA 2018)

Health and Care Act 2022 – ICB functions

CQC Market Oversight

Shropshire Safeguarding Community Partnership – Adult procedures

The Shropshire Plan 2022–2025

Public Contracts Regulations 2015

SEND strategy – Shropshire 2024 - 2029

Appendix 8: Version Table

Version	6
Implementation date	April 2026
Last review	August 2026
Next scheduled review	March 2027
Owner	Social Care Market Quality Assurance & Contract Manager
Author	Contracts and Quality Assurance Team

Review	Date	Section(s) Updated	Reason for Change	Author	Approved By
1	April 2026		Creation of document	Carlo Ferri	QPG
2	August 2026	Key Principles and Values	Update to corporate values PROUD	Carlo Ferri	
3					
4					
5					
6					
7					

Our Quality Assurance Framework

Handbook for Providers

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Who this handbook is for

This handbook is for all providers delivering care and support services commissioned by Shropshire Council, for children, young people and adults.

Why this handbook exists

It explains, in plain language:

- What good quality looks like
- What Shropshire Council expects from providers
- How quality is checked and monitored
- What happens if there are concerns

This handbook sits alongside your contract, service specification, and regulatory requirements (for example CQC or Ofsted).

Our shared commitment to quality

Our vision is simple:

People in Shropshire receive safe, high-quality, person-centred care that supports them to live the best life they can.

Quality is **everyone's responsibility**. This includes:

- Providers
- Shropshire Council
- Partners (including health and safeguarding partners)
- People who use services, families and carers

We work best when we work **together**, share information early, and focus on learning and improvement.

Who the Quality Assurance Framework applies to

The QAF applies to **all commissioned and non-commissioned services**, including (this is not a full list):

- Residential and nursing care
- Domiciliary care
- Supported living and supported accommodation
- Children's residential homes, fostering and supported accommodation
- Mental health and learning disability services
- Day services, respite and short breaks
- Voluntary, Community, and Social Enterprises, prevention services, advocacy and other social care specialist services

If you deliver services funded through **direct payments**, you are still expected to meet the principles of this framework, although how we oversee quality may differ.

What good quality looks like

We expect all services to be:

Person-centred

- People are treated with dignity and respect
- Care and support is based on individual needs, strengths and wishes
- People are involved in decisions about their lives

Safe

- Risks are identified and managed well
- Safeguarding concerns are recognised and acted on promptly
- People feel safe and are supported to understand how to keep safe

Effective

- Support helps people achieve meaningful outcomes
- Staff have the right skills, training and support
- Care is reviewed and improves over time

Well-Led

- Leaders create a positive, open and learning culture
- Staff feel supported to speak up
- Good practice is recognised and shared

For regulated services, we expect a minimum of CQC or Ofsted "Good", with ongoing improvement towards "Outstanding".

Roles and responsibilities (who does what)

Providers

- Deliver safe, effective and high-quality care
- Meet your contract and regulatory requirements
- Complete self-assessments and reconcilliation activity when asked
- Work with us on improvement plans where needed

Shropshire Council

- Monitors quality in a planned, proportionate and risk-based way
- Uses information from many sources, not just inspections or visits
- Works with providers to support improvement
- Takes action where quality or safety concerns arise

Regulators and partners

- CQC and Ofsted regulate and inspect services
- Safeguarding partners lead on safeguarding enquiries
- Information is shared to protect people and improve services

How we monitor quality

Quality monitoring follows a simple cycle:

- Information gathering (for example feedback, safeguarding concerns, inspections, self-assessments)
- Monitoring and review (desktop reviews, visits, meetings, and analysis of trends)
- Response and action (support, improvement plans, or formal action if needed)

We look at **the whole picture**, including:

- Feedback from people using services and carers
- Staff views
- Observations of practice and environments
- Records, governance and assurance systems

Quality ratings (Green, Amber, Red)

After review, services are placed into one of three quality levels:

GREEN (No or minor concerns)

- Quality is good and risks are low
- Routine monitoring continues

AMBER (moderate concerns)

- Some concerns that need improvement
- More frequent monitoring
- Improvement plan agreed
- Discussed at multi-agency quality meetings

RED (major concerns)

- Serious or ongoing quality or safety issues or services that hold a high risk to the council
- Close and frequent monitoring
- Formal action may be taken where required
- Focus is on protecting people and stabilising services

Your quality level affects how often we monitor and what actions are taken.

What happens if there are concerns

If concerns are identified, we will:

- Share concerns clearly with you
- Explain what needs to improve
- Agree actions and timescales where possible

Actions may include:

- Support and guidance
- Improvement or action plans
- Contractual notices (where needed)
- Placement suspensions or other formal steps (only when necessary and last resort)

Our aim is always to work with you to improve quality and keep people safe, not to punish you.

Safeguarding

Safeguarding is everyone's responsibility.

If we receive information suggesting someone may be at risk of harm:

- It will be acted on immediately
- Relevant safeguarding procedures will be followed
- Information will be shared appropriately with our safeguarding partners

Providers must:

- Know safeguarding procedures
- Train staff to recognise and report concerns
- Act quickly and transparently

Information sharing and equality

Quality assurance activity will:

- Follow UK GDPR and data protection law
- Use only relevant and necessary information
- Respect confidentiality

We also expect services to:

- Promote equality and inclusion
- Make reasonable adjustments
- Ensure people can take part in quality processes in accessible ways

Working together

We are committed to:

- Open and honest relationships
- Early conversations about risk or pressure
- Learning from what works well
- Supporting a strong, sustainable care market

Good quality services protect people, support choice, and strengthen the whole system.

Where to get help

If you have questions about quality assurance, monitoring or expectations:

- Contact your usual Contracts or Quality Assurance lead
- Raise concerns early – we would rather know sooner than later

This handbook is a simplified guide. Full details sit within the Quality Assurance Framework statement and our related policies.

What providers often ask

This section answers common questions we hear from providers. It is designed to give clear, practical reassurance about how the Quality Assurance Framework works in practice.

Is this the same as a CQC or Ofsted inspection?

No. Quality Assurance activity by Shropshire Council does not replace or duplicate regulatory inspections.

- CQC and Ofsted remain responsible for formal inspection and ratings
- We use inspection outcomes as one source of information, alongside others
- We focus on how quality is experienced day-to-day and how risks are being managed

For regulated services, we expect at least a 'Good' rating and ongoing improvement.

How often will you monitor our service?

This depends on your **quality level (Green, Amber or Red)** and the level of risk.

- **GREEN**: routine, proportionate monitoring anything from annually to two yearly
- **AMBER**: increased monitoring while improvements are made
- **RED**: frequent and close monitoring to protect people and stabilise services

Monitoring is **risk-based**, not one-size-fits-all.

What information do you use to judge quality?

We look at the **whole picture**, not one issue in isolation. This may include:

- Feedback from people using services and carers
- Safeguarding concerns and trends
- CQC or Ofsted reports
- Provider self-assessments
- Visits to services, meetings and observations of practise
- Contract monitoring information

Positive practice and improvement are taken into account, not just problems, and risk ratings will often be influenced by risks separate from service delivery, such as cost of the service or the social impact a service has on the community.

What happens if concerns are raised about your service?

If concerns are identified, we will:

- Tell you clearly what the concerns are
- Explain what needs to improve
- Agree actions and timescales where possible

Most concerns are resolved informally through support and improvement planning. Formal action is used only when necessary to keep people safe.

Will concerns affect placements or referrals?

Sometimes, yes – but only where this is needed to manage risk.

- **GREEN** services: no impact on placements
- **AMBER** services: placements usually continue, with closer oversight
- **RED** services: placements may be paused or restricted until risks are reduced. In extreme circumstances, placements may be ended if there is a clear safety risk to a person Shropshire Council have placed.

Any decision about placements is proportionate and focused on safety.

Can we challenge or discuss our quality rating?

Yes. We expect open and honest discussion.

- Quality ratings are based on evidence from multiple sources
- You will have opportunities to discuss findings and provide additional information and context
- Ratings can change as improvements are made

Our aim is transparency, not surprise.

How does safeguarding fit into quality assurance?

Safeguarding is a priority.

- Safeguarding concerns are acted on immediately
- Patterns and themes are considered as part of quality monitoring

- Safeguarding concerns do not automatically mean poor quality, but repeated or unmanaged issues may raise risk

Providers must continue to follow safeguarding procedures at all times.

What do we expect from you as providers?

We expect providers to:

- Deliver safe, person-centred and effective care
- Be open about challenges or pressures
- Share concerns early
- Work with us on improvement when needed
- Learn from feedback and good practice

Early conversations help prevent issues from escalating.

Does this apply to non-regulated or VCSE services?

Yes.

- The principles of quality, safety and good outcomes apply to all commissioned services
- Monitoring will be proportionate to the type of service and level of risk
- Expectations are aligned to good practice, even where services are not regulated
- The way we monitor some of these services may be bespoke and not be consistent with the way other services are monitored.

Who do we contact if we are worried about quality or risk?

If you are concerned about quality, safety or service pressure:

- Contact Contracts@shropshire.gov.uk
- Log an Organisational Quality Concern (OQC) through our First Point of Contact (FPoC) front door service on 0345 678 9044
- Raise concerns early, support is available

We would always rather have an early conversation than respond to a crisis later.

Quality Assurance Monitoring Policy

April 2026

Shropshire Council – Commissioned Care & Support Services

QAF002

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Introduction and Background

The Council monitors commissioned services to ensure that all children, young people, adults and families receive safe, effective and high quality care and support. Monitoring provides the assurance that providers are delivering services in line with contractual, regulatory and statutory requirements, and that risks to people's wellbeing are identified and addressed promptly.

Monitoring is essential because it:

- **Assures Quality and Safety:** Monitoring enables the Council to verify that care is being delivered safely, consistently and in accordance with expected standards. It ensures the experiences and outcomes of people who use services are at the centre of our commissioning responsibilities.
- **Identifies and Responds to Risk:** Systematic monitoring allows early identification of emerging concerns, safeguarding issues, and operational or cultural risks within providers. It enables proportionate intervention and escalation before risks escalate or cause harm.
- **Ensures Contractual and Regulatory Compliance:** Monitoring provides the evidence needed to confirm that providers are meeting their contractual

obligations and complying with statutory requirements, including those set by CQC, Ofsted and other regulatory bodies.

- **Supports Continuous Improvement:** Monitoring provides constructive feedback to providers and informs Service Improvement Plans where required. It helps providers understand what good looks like, share best practice and address areas for development.
- **Strengthens Market Oversight and Stability:** Monitoring gives the Council insight into provider capacity, workforce stability, service performance, financial stability and market pressures, supporting effective market management and reducing the risk of provider failure.
- **Promotes Transparency, Accountability and Good Governance:** Monitoring ensures that decisions about quality, risk and commissioning actions are evidence based, recorded and subject to appropriate oversight. This supports the Council's statutory duties, public assurance and organisational integrity.

Through monitoring, the Council fulfils its responsibility to protect the wellbeing of people who rely on commissioned services, maintain high and consistent standards of care, and uphold the effectiveness and sustainability of the local care market.

This policy aims to provide a clear, consistent and defensible process for monitoring support services. Commissioned services operate in a complex environment involving statutory duties, regulatory oversight and contractual obligations; therefore, the Council must have a unified approach to monitoring providers that ensures risks are identified early, assessed proportionately and escalated appropriately and timely.

This Policy aims to standardise monitoring practice across all sectors and service types, ensuring that officers apply the same risk based approach, thresholds and processes regardless of service area as well as strengthen governance, oversight and accountability by providing a clear route for scrutiny of all provision and ensuring decisions relating to provider risk and safety are documented and defensible.

Scope

This Policy encompasses all care and support services for adults and children that have been commissioned and are delivered on behalf of the Council. It includes every aspect related to the monitoring of these services, specifically focusing on ensuring quality, safety, effectiveness, and adherence to contractual requirements for both in and out of county providers. Through this comprehensive approach, the Council seeks to maintain high standards and consistent practices across all commissioned provision, safeguarding the interests of service users and assuring the reliability of its providers.

The Policy applies to the following groups:

People Receiving Services

All individuals who receive care or support through commissioned provision, including:

- Adults supported in residential care, supported living, domiciliary care, day opportunities and community based services
- Children and young people placed in external residential care, fostering, supported accommodation, therapeutic services or other commissioned settings
- Families receiving commissioned family support or specialist interventions

Providers and Provider Staff

All commissioned providers and their employees, including:

- Registered managers
- Operational and frontline staff
- Agency and sessional staff
- Senior provider representatives responsible for service quality and compliance

Monitoring includes direct engagement with staff and validation of provider supplied information.

Families, Carers and Advocates

Individuals who support or represent people using services, including:

- Families and kinship networks
- Carers and personal representatives
- Independent advocates

Their views and feedback may form part of the monitoring process.

Professionals Involved in Care and Support

Professionals whose input contributes to quality assurance, including:

- Social workers
- Health professionals
- Independent Reviewing Officers (IROs)
- Education and SEND professionals

Feedback from partner agencies forms part of the Council's intelligence gathering approach.

Shropshire Council Staff Responsible for Monitoring and Oversight

The Policy applies to all Council staff involved in monitoring, market oversight and commissioning, including:

- Social Care Contracts and Quality Assurance Team
- Commissioning officers and managers
- Safeguarding partners (Adults and Children)
- Governance and market oversight groups (e.g., QPG)

These roles have specific responsibilities in assessing quality, managing risk and escalating concerns.

People with Lived Experience

The Policy also applies to engagement with people who provide lived experience insight, whose feedback is essential to understanding service quality and outcomes.

Definitions

Term / Abbreviation	Definition
All Age Portfolio	Shropshire Council's unified commissioning and quality assurance remit covering *all* externally commissioned care and support services for children, young people, adults, and older people. It includes both regulated and non-regulated provision across the full life course, ensuring that the OQC process, risk management, monitoring, and QA standards are applied consistently regardless of the age group served.
Brokerage	Internal team that sources placements and provides intelligence related to capacity, delays or service pressures.
CQC (Care Quality Commission)	Regulator for adult health and social care; regulatory findings form part of provider risk assessment.
Contract Default Notice	Formal notification issued when a provider fails to meet contractual requirements, requiring corrective action.
De-escalation	Reduction in monitoring intensity following sustained provider improvement and reduced risk.
Desktop Monitoring / Desktop Analysis	Off-site review of documents, data and intelligence to assess risk and compliance.
Digital Dashboards	Council systems used to record monitoring activity, track risk, and maintain oversight of provider performance.

Due Diligence	Process for assessing the suitability, governance, and stability of providers prior to or during commissioning.
Escalation	Formal process for increasing oversight when risks or concerns rise beyond acceptable thresholds.
Governance Forums (e.g., QPG)	Oversight groups that scrutinise risk, escalation decisions and provider improvement progress.
Healthwatch	Independent consumer champion providing service user feedback and intelligence to support monitoring.
Incident Data	Reports of incidents, safeguarding issues or errors that contribute to provider risk assessment.
Intelligence	All data, reports, feedback, incidents, regulatory information and performance data used to assess quality and risk.
Market Intelligence	Information on provider capacity, workforce, financial health or wider market issues used to inform monitoring decisions.
Market Oversight	Council responsibility to ensure the local care market is stable, safe and able to meet demand.
Mandatory Training	Required training for monitoring officers to ensure competency in QA, risk assessment and governance.
Monitoring Report	Formal report summarising monitoring findings, evidence and risk level.
Multi-Disciplinary Team (MDT)	A group of professionals from different partnership disciplines who work collaboratively to support decision making in the health and social care market.
OQC (Organisational Quality Concern)	Significant systemic concerns relating to provider quality, safety or compliance requiring Council assessment or escalation.
Ofsted	Regulator for children's social care; inspection findings inform children's services monitoring.
Placement Suspension	Temporary pause on placing people with a provider due to concerns about quality or safety.

Provider Failure	Situation where a provider becomes unable to operate safely or sustainably, triggering the failure protocol.
Provider Risk Review meeting	A formal internal governance meeting convened by the Council to review and assess identified quality, safeguarding, operational, financial, or contractual risks associated with a care and support provider, bringing together relevant commissioning, contracts, quality assurance, safeguarding, and other appropriate officers to consider available intelligence, determine the level of risk, and agree proportionate, auditable actions and maintain effective market oversight
QA (Quality Assurance)	Systematic process to ensure commissioned services are safe, effective, compliant and delivering good outcomes.
QA Monitoring Cycle	Framework covering intelligence gathering, monitoring activity and response/action.
QPG (Quality Planning Group)	Governance forum that oversees Amber/Red-rated providers and scrutinises risk and improvement plans.
Quality Threshold Levels	A risk-based categorisation that enables the systematic identification and assessment of concerns, ensuring appropriate responses are triggered according to the severity and recurrence of issues. • **Level 1 – Green:** No/minor concerns • **Level 2 – Amber:** Moderate, emerging, or repeated themes • **Level 3 – Red:** Major concerns requiring intensive intervention
Reactive Monitoring	Unplanned or urgent monitoring triggered by serious risks, concerns or regulatory actions.
Regulator Updates	Notifications, inspection findings or enforcement actions from CQC, Ofsted or other regulatory bodies.
Regulatory Compliance	Requirement for providers to meet legal, contractual and regulatory obligations.
Risk Levels (Green / Amber / Red)	The Council's three monitoring thresholds reflecting levels of concern and required oversight.

Risk Review Meeting	A formally convened, multidisciplinary internal meeting held to assess, evidence and determine the Council's response to identified organisational failure, unsafe practice, or high-risk activity within a social care provider.
Routine Monitoring	Planned monitoring visits for providers with low–moderate risk or ongoing oversight needs.
Safeguarding Concern	Information indicating possible risk or harm to an adult or child that may influence monitoring action.
SCCIF (Social Care Common Inspection Framework)	Ofsted's inspection framework for children's social care settings.
Self-Assessment	Provider-completed documentation summarising compliance, performance and risk.
Service Improvement Plan (SIP)	Formalised set of improvement actions, responsibilities and timelines issued when significant concerns exist.
Service Interruption Policy	Council framework for responding to disruption or closure of commissioned services.
Service Specification	Document defining required standards, expectations and contract requirements used to assess compliance.
Strategy Meeting	Multi-agency meeting called in response to significant concerns to determine immediate actions and risk level.
Triangulation	Validating evidence by comparing multiple intelligence sources to ensure accuracy and reliability.

Principles

- Risk Based and Proportionate Monitoring – Monitoring activity is determined by the assessed level of risk and the potential impact on people receiving services. Resources are targeted where concerns are greater or emerging.
- Intelligence Led Assurance – Monitoring is triggered, informed, and prioritised based on safe, timely and accurate intelligence from multiple sources, including service user feedback, professional concerns, safeguarding alerts, self assessment returns, and regulatory data.

- Collaboration – The Council will work closely with providers, commissioners, safeguarding partners, health agencies, regulators, host authorities (where relevant) and regional/local QA networks.
- Transparency and Accountability – Findings, improvement actions, and escalation decisions are recorded, traceable and available to governance forums.
- Continuous Improvement – Monitoring outcomes support improvements in practice, contract compliance, service quality, and market stability.
- And is underpinned by Shropshire's values: PROUD



Roles and Responsibilities

The Social Care Contracts & Quality Assurance Team

- Lead and coordinate all contract monitoring and QA activities
- Conduct desktop, routine and reactive monitoring
- Triage concerns and Organisational Quality Concerns (OQCs)
- Produce assurance reports and oversee improvement plans
- Provide market intelligence and assurance to governance groups
- Recommend escalation measures where required

Commissioners

- Supply relevant intelligence to inform monitoring and risk assessment
- Support the implementation of contractual actions
- Engage with providers on strategic issues, service development and improvements

Providers

- Cooperate fully with the Council's monitoring processes
- Submit required information within specified timescales
- Implement improvement actions within agreed deadlines
- Maintain compliance with legislation, regulation and contract requirements

Regulators / Partners

- Share intelligence and participate in joint assurance activities where appropriate
- Support multi-agency approaches to quality and safety

The QA Monitoring Cycle

Monitoring activity follows a single, end-to-end cycle: commencing with the systematic gathering and evaluation of intelligence from a variety of sources to establish a comprehensive understanding of quality, safety, effectiveness and potential risks. This intelligence is then used to inform the subsequent monitoring and review stage, where ongoing assessment takes place to ensure standards are maintained and that any necessary improvements are identified and actioned in a timely manner.

Stage 1: Intelligence Gathering

Collection, analysis and triangulation of intelligence to assess quality, safety, effectiveness and risk.
Sources include (but are not limited to):

- Provider self-assessment returns
- Contractual documentation
- Due diligence records
- Feedback from people and carers
- OQCs, safeguarding concerns, incident reports
- Health partners, regulators, regional QA groups
- Performance, workforce and environmental data

Stage 2: Monitoring and Review

Monitoring may take the form of (but is not limited to):

- Relationship building meetings

- Desktop review
- Routine/planned monitoring visit
- Reactive/targeted quality review
- Multi-agency assurance activity

Outcomes may include (but are not limited to):

- Confirmation of sustained quality
- Recommendations for improvement
- Service improvement plans
- Contractual actions

Stage 3: Response and Action

Actions may include (but are not limited to):

- Implementation and monitoring of improvement plans
- Advisory notices or contract breach notices
- Increased monitoring
- Placement suspension or provider failure process
- Multiagency escalation

Threshold Levels

The Council applies three threshold levels which determine the monitoring approach. Each level reflects the degree of risk and necessary oversight, ranging from light-touch monitoring for low-risk providers to more intensive, reactive scrutiny in high-risk circumstances. This graduated framework ensures that intervention is proportionate and targeted, allowing the Council to address concerns promptly, support improvement where possible, and escalate actions appropriately when provider performance or compliance fails to meet required standards.

- **Level 1 – Desktop / Light-Touch Monitoring - Low risk (GREEN)**; minor or isolated concerns; positive feedback; CQC/Ofsted “Good” or “Outstanding”.
- **Level 2 – Routine / Enhanced Monitoring - Moderate risk (AMBER)**; repeated concerns; inconsistent improvement; regulatory actions; missed deadlines; reduced provider engagement.
- **Level 3 – Reactive Monitoring - High risk (RED)**; serious concerns; failures to improve; safeguarding patterns; “Inadequate” or widespread “Requires Improvement”; persistent contractual breaches; provider instability.

Escalation and Governance Framework

The Council’s escalation and governance processes are integral to the effective monitoring of commissioned care and support services. These organisational

controls are designed to identify, manage, and oversee both emerging and actual risks related to service quality, safety, contractual compliance, and market stability. By ensuring that risks are recognised early and handled proportionately, these mechanisms promote accountability, transparency, and consistency across all services.

Escalation Triggers and Pathways

Escalation is initiated when the assessed level of risk surpasses the threshold of the current monitoring approach, or when persistent concerns remain unresolved despite previous support or interventions. The Council utilises a graduated response model, closely aligned to the three quality assurance (QA) threshold levels. This model ensures that responses are proportionate to the nature and severity of the risk.

A range of escalation pathways are available, including:

- Issuing advisory notices or contract default notices
- Increasing the frequency of monitoring
- Convening strategy meetings
- Implementing placement suspensions
- Holding Provider Risk Assessment Review Meetings
- Escalating concerns to the Quality Planning Group (QPG) for moderate or major issues
- Activating provider suspension (Appendix 4) or provider failure and service interruption processes (Appendix 5)

All decisions arising from the escalation process are systematically recorded within the Council's contract monitoring and quality assurance systems. These records are then shared with the relevant governance forums to ensure comprehensive oversight.

Governance Oversight

Governance bodies play a crucial role in overseeing escalated concerns, challenging risk management decisions, and maintaining a consistent approach. The level of oversight is determined by the severity of the concern, and may involve several forums, including:

- Quality Planning Group (QPG): Responsible for receiving and scrutinising providers rated as Amber or Red. The QPG ensures that risk ratings, improvement plans, and subsequent actions are appropriate to the level of concern.
- Strategic Commissioning Leadership Groups: These groups review summary assurance reports and endorse decisions relating to provider suspension, major contractual interventions, or significant commissioning risks.

- Multi-agency and Regulatory Partners: Joint oversight is provided when concerns pertain to safeguarding, clinical governance, or instances of regulatory non-compliance.
- Regional Quality Assurance and Commissioning Partnership Networks: These networks contribute to oversight by facilitating collaborative learning, sharing best practice across local authorities, and supporting consistent approaches to provider performance and risk management.

These structures collectively ensure that decision-making is robust, consistent with statutory duties, and properly embedded within the Council's wider commissioning and governance frameworks.

De-escalation Process

De-escalation is initiated when the provider has shown sustained improvement and the associated risks have been mitigated. The governance bodies are responsible for confirming that all actions set out in the Service Improvement Plan (SIP) have been satisfactorily completed. Additionally, they must ensure that quality and safety concerns have stabilised, indicating that risks have been effectively managed and reduced to an acceptable level.

Once these criteria have been met, it is determined that monitoring can revert to the appropriate routine level. The decision to de-escalate will be formally communicated to the provider, and all relevant details of the decision will be recorded within the established monitoring systems to ensure transparency and continuity.

Supporting SOPs

This Policy is supported by Standard Operating Procedures: Desktop Analysis (Intelligence Gathering), Routine Monitoring (Planned Monitoring), and Reactive Monitoring (Trigger-Based Response),Out of county Monitoring and ISF monitoring, each detailed in the subsequent appendices. These SOPs outline the processes for gathering intelligence, conducting both scheduled and responsive provider monitoring, and establish clear ownership and purpose for each stage, ensuring that provider risk is assessed and addressed through defined, systematic actions overseen by the Social Care Contracts & QA Team. The SOPs describe the scope and procedural steps for monitoring.

- SOP 1: Desktop Analysis (Intelligence Gathering) Appendix 1
- SOP 2: Routine Monitoring (Planned Monitoring) Appendix 2
- SOP 3: Reactive Monitoring (Trigger-Based Response) Appendix 3

Training Standards

All Quality Assurance (QA) and contract monitoring officers are required to complete a comprehensive role-specific induction, as well as all mandatory training relevant to their position. This ensures that each officer possesses a clear understanding of the expectations and responsibilities associated with their role.

Officers must maintain up-to-date knowledge of applicable regulatory frameworks. This ongoing commitment to learning ensures that practices remain compliant with current legislation and sector standards, thereby supporting the Council's governance and commissioning objectives.

Furthermore, officers are expected to demonstrate competency in several core areas: risk assessment in social care, report writing, and effective provider engagement. These competencies are essential for the accurate identification and management of provider-related risks, the production of reliable and informative reports, and the establishment of constructive relationships with service providers.

Associated Documents

- Quality Assurance Framework (QAF)
- Organisational Quality Concerns (OQC) Guidance
- Provider Failure and Service Interruption Policy
- Contract Management and Enforcement Procedures
- Safeguarding Policies (Adults & Children)
- Complaints, Representations and Whistleblowing Policies
- CQC Single Assessment Framework
- Ofsted Social Care Common Inspection Framework (SCCIF)
- Children's Homes (England) Regulations 2015
- Due Diligence and Provider Approval Processes
- QA Monitoring Templates and Tools

Policy Review and Scheduling

This Policy shall be subject to review on a two yearly basis to ensure ongoing relevance and effectiveness. In addition to this scheduled review, the Policy will also be revisited in response to any changes in regulatory or legislative frameworks that may impact its content or application. Furthermore, reviews will be triggered by learning outcomes from escalated cases or events involving provider failure, as well as following any modifications to systems, processes, or governance arrangements. This approach ensures that the Policy remains up to date, responsive, and aligned with best practice.

The Quality Assurance (QA) Team holds primary responsibility for leading the process of revising this Policy. Any proposed updates prepared by the QA Team must be formally approved by the Service Manager to ensure they meet operational and strategic requirements. Before the Policy is published, all changes are to be endorsed through the appropriate governance forums, thereby upholding the integrity and transparency of the approval process.

All amendments to this Policy must be documented within the version control table. In line with information governance requirements, previous versions and records of changes must be archived accordingly, ensuring a clear audit trail and supporting organisational accountability.

Appendix 1

SOP 1: DESKTOP ANALYSIS

Purpose

To set out the standardised process for collecting, analysing and recording intelligence to assess provider risk and determine the appropriate monitoring response.

Process Steps

Documentation Request

The Monitoring Officer will request the provider complete and return required documentation within defined timescales, including:

- Self Assessment (Microsoft Form or equivalent)
- Due Diligence documentation
- Insurance certificates
- Training matrix
- Policy checklist
- Any other service specific returns

All returned documents must clearly state provider name, year, and document type.

Internal Intelligence Gathering

Requests for internal intelligence (e.g., Brokerage, Finance, Adult/Children's Social Care teams) will be issued with a 2 week completion deadline.

Desktop Review

The Monitoring Officer will:

- Verify completeness and accuracy of submitted documentation
- Identify gaps and request clarification or resubmission
- Analyse feedback from internal stakeholders

- Review OQC themes, regulator updates, and incident data
- Assess performance against contract requirements
- Determine initial risk level (Level 1, 2 or 3)

Initial Provider Engagement

Within the first 6–8 weeks for new providers:

- Hold an introductory meeting with provider and professionals (e.g., Brokerage, Finance)
- Review service activity, initial intelligence and contractual expectations

Decision and Recording

The Monitoring Officer will:

- Complete the Desktop Monitoring Report
- Update risk matrix and monitoring spreadsheet / digital dashboards
- Submit findings to QA Manager for confirmation of next steps

Next steps may include:

- No further action (continue Level 1 monitoring)
- Routine Monitoring
- Recommendation for Reactive Monitoring

SOP 2: ROUTINE MONITORING

Purpose

To define the process for conducting planned monitoring visits and ongoing review to ensure contractual compliance, service quality and safeguarding.

Process Steps

Pre Visit Preparation

- Review all desktop intelligence and previous monitoring outcomes
- Confirm scope, including contract requirements and identified themes
- Coordinate with partners where appropriate (e.g., Health, Regional QA colleagues)
- Provide at least 7 days' notice for announced visits

Visit Activities

Monitoring Officers will:

- Conduct environmental and practice observations
- Review records and documentation
- Meet with managers, staff and (where appropriate) people using services
- Triangulate feedback from families and professionals

- Review OQC themes, training, medication, leadership and management indicators
- Gather evidence against the service specification and contract clauses
- Verify safeguarding processes, incident reporting and regulatory compliance

Post Visit Reporting

The Monitoring Officer will:

- Provide verbal or written feedback summarising initial findings
- Complete the full Monitoring Report
- Set clear improvement actons where required
- Submit the report to the Delegated Contract Officer/QA Manager for approval

Once approved:

- Issue the report and any actions to the provider
- Set deadlines for provider responses
- Upload all documentation to the Council's digital platform

Ongoing Monitoring

- Monthly or quarterly quality visits may be required where risk is elevated
- Continued failure to improve may result in escalation to Reactive Monitoring
- Monitoring Officers will update risk dashboards and maintain oversight of improvements

SOP 3: REACTIVE MONITORING

Purpose

To set out the Council's process for responding promptly and proportionately to significant or escalating concerns relating to service quality, safety, compliance or provider viability.

Triggers

Reactive monitoring may be initiated when:

- A serious Organisational Quality Concern (OQC) is received
- Safeguarding concerns increase or escalate
- CQC/Ofsted place conditions, warnings or enforcement actions
- Serious incidents occur repeatedly or without adequate response
- Provider fails to improve within expected timescales
- Contractual breaches or default notices are issued
- Market intelligence indicates instability or risk

Process Steps

Immediate Intelligence Review

The Monitoring Officer will gather intelligence from:

- Internal teams (Adults/Children's Social Care, Safeguarding, Brokerage, Finance)
- Health partners
- Healthwatch
- CQC/Ofsted
- Other commissioning authorities

Reactive Visit

- Visit planned within 1–2 working days (risk dependent)
- Visits are normally unannounced
- Use the targeted Reactive Monitoring Forms available to you.
- Focus on the area(s) of concern (e.g., medication, leadership, staffing, safety)

Internal Risk Assessment Meeting

This is often referred to as a Strategy meeting or and MDT and should be held within 5–10 working days, involving:

- Provider senior management
- Commissioners
- QA/Contracts Officers
- Other partners as required

The meeting will determine:

- Findings from the reactive visit
- Risk level and immediate safety measures
- Whether placements should continue, be paused or be suspended (see Appendix 3)

Shropshire Council acknowledges that, when there is a report or disclosure of significant risk to individuals or to the council, referrals to a provider may be suspended prior to reactive monitoring activity taking place, to protect those using support services while the disclosed risk is assessed (Appendix 3).

Service Improvement Plan (SIP)

Within 10 working days, a provider SIP will be implemented including:

- Specific actions
- Timescales
- Responsible persons
- Expected outcomes
- Review frequency

Weekly or monthly quality visits may be required.

Ongoing Oversight and Escalation

If insufficient progress is made, the Council may:

- Increase monitoring frequency
- Issue advisory or contract default notices
- Recommend placement suspension (Appendix 3)
- Initiate the Provider Failure or Service Interruption process
- Escalate to QPG/MQA for scrutiny and decision making
- All actions and decisions must be recorded on the Council's monitoring systems.

Provider Right to Respond

Providers have the right to respond to, and where appropriate challenge, the findings set out within a monitoring report before the report is finalised. The provider will be given 10 working days from receipt of the draft report to submit any factual corrections, comments, evidence or representations. Where no response is received within this period, the report will be finalised and issued as the Council's confirmed position. Where the provider submits a response that challenges the findings, the Council will review the additional information and, where required, engage with the provider to clarify, negotiate and agree the final wording of the report. This process should normally be completed within 20 working days of receipt of the provider's response. If agreement cannot be reached, the Council will finalise the report based on the available evidence, ensuring that the provider's position and any unresolved points of challenge are recorded appropriately.

SOP 4: OUT OF COUNTY MONITORING

Purpose

To establish a consistent and proportionate approach for quality assurance and monitoring of providers located outside Shropshire Council's geographical boundary where Shropshire Council commissions, funds or arranges placements.

The SOP ensures:

- Monitoring activity is intelligence-led and proportionate.
- Existing quality assurance activity undertaken by the Host Authority is utilised wherever possible.
- Duplication of monitoring is avoided.
- Concerns identified by Shropshire Council are appropriately shared with the Host Authority.
- Learning and intelligence are fed into local, regional and national quality assurance networks.

- Placing authorities work collaboratively to safeguard people and improve service quality.

Process Steps

Initial Intelligence Gathering

When undertaking desktop analysis, routine monitoring or reactive monitoring of an out of county provider, the Monitoring Officer will first obtain available intelligence from the Host Authority before determining whether additional monitoring activity is required.

Process Steps

Information requested may include:

- Current quality assurance assessment outcomes.
- Monitoring reports.
- Service improvement plans.
- Organisational Quality Concerns (or equivalent).
- Safeguarding intelligence.
- Contract compliance concerns.
- Placement suspensions or restrictions.
- Regulatory engagement.
- Market stability concerns.
- Ongoing improvement activity.

The Monitoring Officer should allow reasonable time for the Host Authority to respond unless urgent safeguarding or quality concerns require immediate action.

Review and Risk Assessment

The Monitoring Officer will:

- Review Host Authority intelligence alongside Shropshire Council intelligence sources.
- Consider feedback from social workers, care managers, brokerage teams, children's services, commissioned services and families.
- Review CQC, Ofsted and other regulatory information.
- Triangulate all available intelligence.
- Assess whether identified risks are being appropriately managed through existing Host Authority arrangements.

Where the Host Authority is already actively managing concerns and appropriate oversight arrangements are in place, Shropshire Council will normally rely on those arrangements and avoid undertaking duplicate quality assurance activity.

Additional Assurance Activity

Additional monitoring activity may be undertaken where:

- Significant concerns affect a person funded or placed by Shropshire Council.
- The Host Authority is unable to provide sufficient assurance.
- Intelligence suggests an immediate risk to safety or wellbeing.
- There is evidence of deteriorating service quality.
- Escalated concerns require direct validation.

Such activity may include:

- Service review meetings.
- Multi-agency discussions.
- Placement specific reviews.
- Joint visits with the Host Authority.
- Reactive monitoring activity.
- Attendance at provider risk meetings.

Whenever possible, monitoring activity should be coordinated jointly with the Host Authority.

Communicating Findings to the Host Authority

Where Shropshire Council identifies concerns relating to an out of county provider, the Monitoring Officer will formally communicate findings to the Host Authority within five working days of confirmation.

Information shared may include:

- Monitoring outcomes.
- Identified risks.
- Safeguarding concerns.
- Contractual concerns.
- Service user experience and feedback.
- Required actions.
- Recommendations for further review.

The communication should explicitly request that the Host Authority consider the intelligence through its own quality assurance, safeguarding or provider oversight arrangements.

The Host Authority retains responsibility for coordinating provider-wide quality assurance activity within its geographical area unless alternative arrangements have been formally agreed.

Escalation

Where concerns are significant or risks continue to increase, the Council may:

- Request a multi-agency meeting led by the Host Authority.
- Seek participation in existing provider oversight arrangements.
- Share concerns with regulators.

- Escalate internally through the Provider Risk Review Process.
- Consider commissioning restrictions or placement suspension decisions in accordance with Appendix 3.

Any escalation should be communicated to the Host Authority and recorded within Council systems.

Feedback Into Quality Assurance Networks

Where there are regional or partner Quality Assurance network arrangements in place, the Social Care Contracts and Quality Assurance Team will ensure that significant learning and intelligence obtained through out of county placements is shared appropriately through:

- Regional Quality Assurance Networks.
- Regional Commissioning Networks.
- Care Market Oversight Forums.
- ADASS Quality Assurance Groups.
- West Midlands commissioning and quality assurance networks.
- Other recognised inter-authority partnership arrangements.

Information shared should focus upon:

- Emerging risks.
- Good practice.
- Learning from provider quality concerns.
- Service interruption risks.
- Provider failure intelligence.
- Market sustainability issues.
- Thematic quality assurance findings.

Information sharing must comply with data protection, confidentiality and information governance requirements.

Recording Requirements

The Monitoring Officer must record:

- Requests made to the Host Authority.
- Intelligence received.
- Risk assessments completed.
- Monitoring decisions.
- Communications issued.
- Escalation activity.
- Follow-up actions and outcomes.

All records must be retained within the Council's approved quality assurance and contract monitoring systems.

Governance and Reporting

Out of county provider concerns that meet Amber or Red thresholds will be reported through existing governance arrangements, including Provider Risk Review Meetings and Quality Planning Group processes.

Where significant concerns are identified, summary intelligence should also be shared with relevant regional quality assurance partnerships to support wider market oversight and cooperation duties under the Care Act 2014.

Appendix 3

Provider Suspension Process:

This process is designed to outline the actions that need to be taken by the Commissioning and the Social Care Contracts and Quality Assurance Team when referrals to a contracted service from a provider are suspended temporarily.

The circumstances leading up to a suspension, and the associated decision-making processes will vary depending on the reason for the suspension. Suspensions can result from any or all the following:

- Significant safeguarding concerns, where there is evidence or credible intelligence that individuals are at risk of harm and immediate action is required to prevent further exposure to risk.
- Significant performance or quality concerns, including persistent failure to deliver safe, effective, or person centred care, particularly where concerns are repeated, escalating, or remain unresolved despite prior monitoring or action plans.
- Fundamental breaches of contract, such as loss of required regulatory registration, failure to comply with essential contractual conditions, or actions that directly undermine the Council's ability to rely on the provider to deliver commissioned services.
- Contractual non-compliance specific to service delivery, including the handing back of care packages or withdrawal from agreed provision in a manner that contravenes contract terms, particularly within domiciliary care or supported living services.
- Indicators of provider instability or emerging failure, where intelligence suggests that the provider may be unable to deliver services safely or consistently, and suspension is required to prevent further placements while risks are assessed and mitigated.

The Council will apply provider suspension lawfully, proportionately, and consistently, in accordance with contractual provisions, statutory duties, and its Quality Assurance

framework. Suspension is a preventative and protective measure, used to manage risk and safeguard individuals, and is not intended to be punitive.

Suspension decisions will be guided by the following principles:

- **Safeguarding First**
  The safety, wellbeing, and rights of individuals using services are the primary consideration. Where there is evidence or credible intelligence that continuing to place or refer individuals would expose them to unacceptable risk, suspension will be considered as a necessary protective action.
- **Proportionality and Risk Based DecisionMaking**
  Suspension will be applied only where risks cannot be adequately managed through routine monitoring, support, or service improvement activity. The scope and duration of any suspension will be proportionate to the nature, severity, and immediacy of the identified risks.
- **Evidence Led and Defensible**
  Decisions to suspend will be based on a clear and recorded assessment of available intelligence, including quality monitoring findings, safeguarding information, regulatory activity, contractual compliance, and other relevant risk indicators. All decisions must be capable of withstanding internal and external scrutiny.
- **Clear Governance and Authorisation**
  Suspension decisions will follow an internal risk review involving relevant services and will be authorised at the appropriate senior level, in line with delegated authority arrangements. Oversight will be maintained through established quality and market assurance forums.
- **Transparency and Communication**
  Providers will be informed in writing of the reasons for suspension, the expectations placed upon them, and the conditions required for review or lifting of the suspension, unless doing so would compromise safeguarding or legal processes. Relevant internal teams and partner agencies will be notified as required.
- **Review and Time Limitation**
  Suspension will be kept under active review and will remain in place only for as long as necessary to manage identified risks. Progress against required actions will be monitored, and decisions to maintain, amend, or lift a suspension will be formally recorded.
- **Continuity of Care and Market Stability**
  Where a provider is suspended, the Council will take reasonable steps to ensure continuity of care for individuals already placed and will consider the wider

impact on market stability and service capacity, in line with its Care Act market oversight duties.

Where it is believed Shropshire Council need to suspend referrals to a provider:

- The final authority to suspend rests with the Service Director at minimum, unless it has been formally delegated to a suitable service manager.
- Recommendations for suspension must come from the Contract manager or their delegated officer following an internal risk review meeting, held involving operational, safeguarding, commissioning, and Social Care Contracts Team colleagues. The Contract Manager or delegated officer will chair the Provider Risk Review meeting. Decisions must be based on shared, tangible evidence. Recommendations should match the level of evidenced risk and aim to improve service delivery through a supportive approach to managing the identified risk. All meetings must be minuited then saved to the provider SharePoint folder and logged on the Risk
- A recommendation to suspend must be made in writing (see appendix 4(b)) by the Contract Manager, or their delegated officer, to the appropriate Service Manager and the relevant Social Care Director.
- The Service Manager will discuss the authorisation of suspensions with the Service Director and communicate any subsequent decision to the Contract Manager or their delegated officer.
- The suspension will also need to be logged and discussed at the monthly Market Quality Planning Meetings (QPG).

In exceptional circumstances of **elevated** risk, a recommendation to suspend can be made directly to the Commissioning Service Manager by a Senior Safeguarding Practitioner; Operational Service Manager Practitioner, or relevant Contracts or Commissioning Lead.

Except in circumstances of high risk where a fast track decision is sought ((d)), a potential suspension should be highlighted to the provider by a Contracts Officer, and where insufficient improvement has not been evidenced after two weeks the suspension warning letter may be issued (setting out the reasons why a suspension is being considered, and explaining next steps that the Council intends to take.

Where a suspension of referrals is authorised.

Immediate Actions:

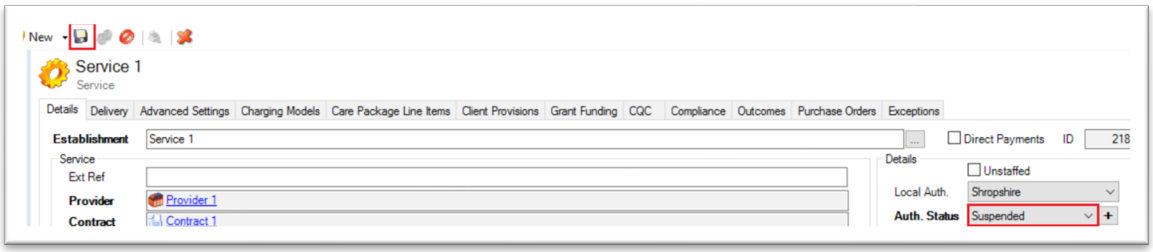
Once a decision has been made to suspend at Assistant Director level the relevant Contract Manager or their delegated officer will complete the following actions.

- The provider is to be contacted via telephone and advised that a suspension letter will be issued in the first instance.

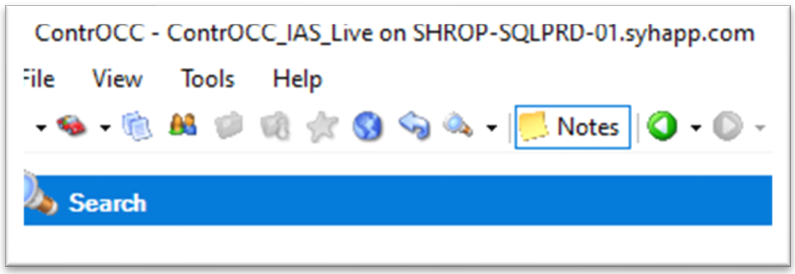
- After the provider has been informed via a phone call. A letter must be sent to the provider within 24 hours of them being informed (Appendix 4a). The suspension letter must include:
    - All the specific reasons for the suspension.
    - Any requirements for sharing of information related to people being supported at the providers service, whether funded by Shropshire council or self funding. It is useful to include a template to secure all the relevant information relating to the individuals. The template should include; name & date of birth; next of kin; details of mental capacity; authorities involved in the placement/funding (with contact details)
    - The actions and improvements required from the provider with a clear time frame for the completion of actions and improvements.
    - A minimum time frame for review of the suspension arrangements including the next steps/arrangements for validation of the improvements made by the provider, how we will check that improvements have been made.
    - Contact details for the contract officer in the council for queries the provider may have regarding the suspension arrangements.
    - The appeals process for providers to appeal the decision.
- If the letter is a requirement under the terms of the contract, it must be sent to the legal entity for that provider. The contract will also set out any requirements for how the letter must be sent to the provider or their legal entity. This letter must be authorised by the Contracts Manager and have their signature block on.
- Information on the suspension must be shared by relevant contract lead with ALL operational/social work and commissioning service team managers (ensuring hospital SW teams and EDT are included) as soon as possible following the decision to suspend.
- The information about the suspension should also be shared with:
    - Adults:
        - Brokerage Brokerage@shropshire.gov.uk
        - ASC Payments & Financial Reconciliation Teams ASCPayments@shropshire.gov.uk.
    - Childrens:
        - Placements Team CPSduty@shropshire.gov.uk
        - Childrens Payments Team: Businessinvoices@shropshire.gov.uk
    - The ICS team:
        - Ruth Bowen ruth.bowen4@nhs.net
        - Wendy Richardson wendy.richardson5@nhs.net
    - Any relevant local authority partner where they also commission placements at the service being suspended.

- After all the communications have been done, all provider trackers, case records will need to be updated and the provider processed for suspended on ContrOCC:
    - For adults: The Contract Manager or their delegated officer should advise Admin staff that a provider has been suspended and request that ContrOCC is updated to reflect this position, and that the Provider Database is also updated to indicate there is a suspension in place with a provider.
    - For Childrens: The Contract Manager or their delegated officer should request that ContrOCC is updated through the children's payments team at businessinvoices@shropshire.gov.uk and then let the team admins know that a suspension is in place so they can update the Provider Database.

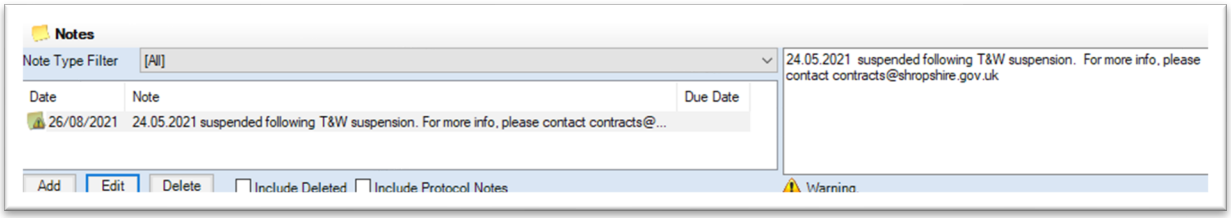
Suspend on ContrOCC: Search for the provider and click on the service. Click on the down arrow by Auth Status and select Suspended.



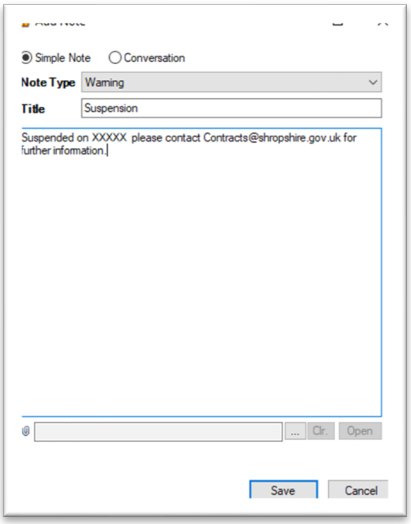
A note will also need to be added to the service by member of Commissioning and Governance Team, to provide more information with regards to the suspension i.e. date suspended, reason and to contact Commissioning and Governance Team for more information. To do this, click on the Notes button on the top left of the ContrOCC screen:



This will then open a notes section at the bottom of the screen. Click on the Add button



This will then allow you to add Note Type, title, and information as below:



Click Save.

Contracts Compliance & Monitoring Officers and relevant Contract Leads will update the Comms Log and Risk Matrix with information about the suspension.

Follow up actions:

The following actions will need to be taken forward by relevant staff within social operations and the Commissioning and Governance Team as appropriate:

- Shropshire Council staff involved in the initial recommendation to suspend will agree how they intend to engage with provider, secure information relevant to the actions/improvements required and the process for validating actions/improvements.
    - If the Risk Assessment team is focused on a safeguarding issue, then colleagues in Ops will chair the meeting.
    - If the Risk Assessment team is focused on a provider quality issue, then the Contract Manager or their delegated officer will chair the meeting
- In addition to the Risk Assessment meetings, focused meetings and additional activities may also be required by the Lead Officer.
- A follow up Risk Assessment meeting is to be held within 28 days of the suspension, along with any other relevant meetings addressing issues of the suspension, which will be scheduled and agreed with the provider.

- The Contract Manager or their delegated officer, will need to secure the list of individuals placed with the provider and advise other placing LAs/authorities of the suspension, including the headline information regarding why the suspension has been put in place and any actions agreed for improvement. *To note: Shropshire Council does not routinely contact other local authorities in the region to inform them of the suspension of referrals. However, if any other local authority contacts Shropshire Council about the provider they should be informed of the suspension and the process for its review.*
- The Contract Manager or their delegated officer will share the list of names placed with the provider with the relevant Operational/Social Work Lead. (i.e. giving regard to the location of the home/staff engaged with the suspension).
- Self-funding individuals: The Contracts Officer or their delegated officer will also advise the relevant ASC Operational/Social Work Lead of any self-funding individuals who are receiving care from the suspended provider.
- The Contract Manager or their delegated officer and Contract Monitoring Officers will support the work required on the Service Improvement Plan from provider as appropriate, and will also maintain relevant information in the Commissioning and Governance Team communications Logs. This may involve additional monitoring visits and reporting to the relevant officers on findings.

Suspension to be Lifted:

- The Contract Manager may recommend lifting a suspension after a Risk Assessment follow-up meeting, referring this to the Service Manager for Commissioning or Market Oversight. While most recommendations arise from these meetings, Service Managers can also consider relevant staff group input if appropriate.
- The recommendation will outline proposed arrangements for phasing out the suspension, including specific limits on package numbers or types and associated timescales (such as a maximum of two placements per week), and designated service locations. Risk assessment and care home occupancy will be taken into account, and in certain cases, a full suspension lift may be recommended where it is safe to agree.
- If the suspension lift recommendation is agreed the following actions should be carried out by the Contracts Manager or their designated officer:
    - Inform the provider immediately of the decision by sending a letter. The correspondence should outline arrangements for any phased suspension, ongoing monitoring, completion of an action plan, and any further required actions. You may email the letter, but must confirm its delivery, receipt, and opening.
    - Request an updated resident list from the provider.

- Immediately notify ALL operational/social work and commissioning service and team managers (ensuring hospital SW teams and EDT are included) of the decision to lift the suspension (providing details of any phasing of the suspension).
- The decision should also be shared with the appropriate payments and quality assurance colleagues.
- Immediately notify other Local Authorities or partner agencies who have placements with the provider.
- Commissioning and Governance Team records need to be updated and the provider unsuspended on ContrOCC.
    - For Adults: The Contract Manager or their designated officer should advise Admin staff that the suspension of a provider has been lifted and whether this is full or partial; request that ContrOCC is updated accordingly, and that the Provider Database is also updated to indicate that the suspension has been lifted. Please ensure you delete the note which was added to ContrOCC.
    - For Children: The Contract Manager or their designated officer should advise the children's payments team that the suspension of a provider has been lifted and whether this is full or partial; request that ContrOCC is updated accordingly, and then let contract admins know that the Provider Database also needs to be updated to indicate that the suspension has been lifted.

Appendix 4(b) – Suspension Recommendation Request Form

Version to view:



20032026
Suspension Recommx

Editable Version:

Suspension Recommendation Request Form

Appendix 4(c) - Example letter to provider confirming suspension

Dear [INSERT CONTACT]

[INSERT PROVIDER]

I am writing to you to advise that due to [REASON FOR SUSPENSION], the Council is, with immediate effect, placing a suspension of new referrals at [INSERT PROVIDER] in accordance with [INSERT SUSPENSION/TERMINATION CLAUSE] of the Pre-Placement Agreement for [INSERT CONTRACT].

this means that Shropshire Council will not place new [RESIDENTS/PLACEMENTS] for the duration of the suspension and that you are asked not to admit other [RESIDENTS/PLACEMENTS] such as self-funding [RESIDENTS/PLACEMENTS] or [RESIDENTS/PLACEMENTS] from other placing authorities until the suspension of referrals is lifted. Whilst there is no contractual protocol for the home to cease admitting self-funding [RESIDENTS/PLACEMENTS] or [RESIDENTS/PLACEMENTS] funded by other placing authorities to [INSERT PROVIDER], it is regarded as good practice on behalf of the [INSERT PROVIDER].

Council officers, other placing authorities, the CQC and ICS will also be notified of the temporary suspension of referrals to [INSERT PROVIDER].

With regard to residents not funded by Shropshire Council, could I request, also in line with [INSERT CLAUSE] of the contract, that you provide the Council with a list of residents at the home, including details of the placing/funding authority (including any Health funded residents) and relevant contact, and for self-funding residents contact details of their family and/or representatives.

An MDT will be arranged in due course to discuss with you the issues that have led to this suspension.

Please do not hesitate to contact me if you have any questions regarding this letter.

Yours sincerely

[Signature here]

Contracts Manager
Commissioning & Governance Team
People Directorate

Tel: 01743 XXXXXX

Appendix 5

Transition from Quality Assurance Monitoring to the Provider Failure and Service Interruption Policy

Purpose

This appendix defines the point at which activity under the Quality Assurance Monitoring Policy must transition into the Provider Failure and Service Interruption Policy. It ensures that escalation is timely, proportionate and auditable, while maintaining clear ownership of quality assurance, contractual, safeguarding, operational and continuity-of-care actions.

The transition is not a closure of quality assurance activity. Monitoring evidence, risk assessments, outstanding provider actions and contractual records remain live and form the evidence base for the response under the Provider Failure and Service Interruption Policy. The two policies therefore operate as a connected pathway: the Quality Assurance Monitoring Policy identifies, validates and escalates risk; the Provider Failure and Service Interruption Policy coordinates the Council response where safe or sustainable service delivery is, or may become, disrupted.

Principles governing transition

- Safety and continuity first: the immediate safety, wellbeing, rights and continuity of support for children, young people and adults take priority over routine monitoring timescales.
- Evidence-led and proportionate: transition decisions must be based on triangulated intelligence and the nature, severity, scale and immediacy of risk.
- No delay caused by process: the absence of complete information must not prevent urgent protective, safeguarding or continuity action where credible evidence indicates significant risk.
- Clear accountability: a named lead must be identified for the quality assurance response and, on transition, for the service interruption or provider failure response.
- Single record of decision-making: the rationale, authorisation, actions, owners and review dates must be recorded in the Council's approved contract monitoring, risk and governance systems.
- Coordinated communication: information must be shared lawfully and on a need-to-know basis with operational teams, safeguarding, commissioning, brokerage or placements, finance, regulators, health partners, host or placing authorities and the provider.
- Person-centred planning: people receiving services, and where appropriate their families, carers, advocates and corporate parenting representatives, must be involved in decisions affecting their care and support.

When transition must be considered

Transition must be considered where monitoring identifies that concerns have moved beyond provider improvement and routine contractual oversight and now create a credible risk to continuity, viability or safe delivery. Indicators may arise individually or in combination and include:

- The provider is temporarily unable, or is likely to become unable, to deliver all or part of the commissioned service safely or consistently.
- The provider states an intention to close, withdraw from a service, hand back multiple packages or placements, or cease trading.
- There is actual or threatened loss of essential staffing, premises, utilities, registration, insurance, supply chains, digital systems or other resources necessary for safe delivery.
- Financial, operational or governance intelligence indicates insolvency, administration, unsustainable trading or a material risk that contractual services cannot continue.
- Repeated or serious quality, safeguarding or contractual failures remain unresolved and create a risk that existing packages or placements cannot safely continue.
- The provider cannot demonstrate an adequate business continuity response or fails to activate its business continuity plan effectively.
- Regulatory action, enforcement, imposed conditions or cancellation of registration affects the provider's ability to operate.
- A major incident, emergency, outbreak, environmental event or infrastructure failure materially affects service availability.
- The scale of the issue requires coordinated identification, prioritisation or transfer of people receiving services.
- The cumulative impact across several services, locations or a provider group presents a material market-capacity or system-stability risk.

Transition thresholds

Position under the Quality Assurance Monitoring Policy	Required response	Policy position
Level 1 - Green	Continue desktop or routine monitoring. Record intelligence and review for emerging continuity risks.	Quality Assurance Monitoring Policy remains the lead policy.
Level 2 - Amber	Undertake enhanced monitoring and provider risk review. Test business continuity, capacity, staffing, financial and operational resilience.	Quality Assurance Monitoring Policy remains the lead policy, with preparatory continuity planning where indicated.

Position under the Quality Assurance Monitoring Policy	Required response	Policy position
	Establish whether disruption is credible or imminent.	
Level 3 - Red, but service remains deliverable	Implement reactive monitoring, safeguarding and contractual action, including suspension where authorised. Maintain active assessment of continuity and viability.	Quality Assurance Monitoring Policy remains the lead policy unless a transition trigger is met.
Level 3 - Red with actual, imminent or credible service disruption or provider failure	Initiate the transition process immediately. Convene the appropriate risk response arrangements and protect continuity of care.	Provider Failure and Service Interruption Policy becomes the lead policy. Quality assurance and contract monitoring continue as supporting workstreams.

Decision and authorisation

The Contract Manager, or delegated lead officer, will coordinate an immediate review of the available intelligence with relevant commissioning, operational, safeguarding and finance colleagues. The review will determine whether the matter remains within quality assurance escalation or requires activation of the Provider Failure and Service Interruption Policy.

Where the risk is urgent, the decision may be made through an expedited discussion with the relevant Service Manager or senior officer under the applicable delegated authority arrangements. The decision must then be documented retrospectively at the earliest opportunity. Activation of the Provider Failure and Service Interruption Policy does not remove the need for separate authorisation of contractual measures, placement suspension, emergency expenditure or safeguarding action where those decisions require specific approval.

The recorded decision must include:

- the provider, service or location affected;
- the nature, source and date of the intelligence;
- the people or cohorts potentially affected, including funding and placing authorities where known;
- the current quality and continuity risks and any immediate protective measures;
- the transition trigger or triggers met;

- the decision, authorising officer and date and time of activation;
- the named lead officer and governance route;
- actions, owners, deadlines and review arrangements; and
- the communication and information-sharing plan.

Transition and handover process

1. Stabilise immediate risk

Take urgent action to safeguard people, preserve essential service delivery and address any immediate safeguarding, clinical, environmental or staffing risks. Escalate to emergency planning arrangements where the incident meets relevant emergency or major incident thresholds.

2. Validate scope and impact

Confirm which services, locations and individuals are affected or potentially affected. Obtain current service-user or placement lists, care and support information, funding responsibility, key contacts, staffing and rota information, business continuity arrangements, and the provider's proposed recovery or closure plan.

3. Convene the response structure

The relevant senior lead will establish the Service Interruption and Provider Failure Risk Response Team where the scale or impact requires coordinated management. Membership will be proportionate and may include Contracts and Quality Assurance, Commissioning, Social Care Operations, Safeguarding, Brokerage or Placements, Finance, Legal, Procurement, Emergency Planning, Communications and partner agencies.

4. Complete the formal handover

The Monitoring Officer or Contract Manager will provide the response lead with the current risk assessment, monitoring reports, OQC and safeguarding intelligence, regulatory information, contractual notices, Service Improvement Plan, provider correspondence, placement or package information, financial or market intelligence, key decisions and outstanding actions.

5. Agree workstream ownership

The Risk Response Team will identify leads for individual safety and reviews, service continuity, provider liaison, market capacity, contractual and legal action, finance, communications, information governance, regulatory liaison and governance reporting.

6. Confirm communication arrangements

Agree who will communicate with the provider, people receiving services, families or carers, advocates, social workers, corporate parenting representatives, staff, regulators, health partners, other placing authorities and elected members. Communications must be accurate, coordinated, proportionate and recorded.

7. Maintain monitoring and assurance

Quality assurance officers will continue to validate provider claims, monitor residual services, track improvement or closure actions and report emerging intelligence into the Risk Response Team. Duplicate meetings and records should be avoided through a single coordinated action log.

8. Review, de-escalate or close

The Risk Response Team will review the response at an agreed frequency. It may return lead responsibility to the Quality Assurance Monitoring Policy when continuity risk has stabilised and the provider can safely sustain services, or close following an orderly transfer or cessation once all people are safe, records are complete and learning has been captured.

Minimum handover information

Handover area	**Minimum information required**
Risk and evidence	Current RAG level; risk summary; monitoring findings; OQCs; safeguarding intelligence; regulatory findings; incidents; complaints; whistleblowing; provider representations; unresolved evidence gaps.
People affected	Current list of people receiving services; service location; funding or placing authority; allocated practitioner; priority or vulnerability factors; communication, advocacy, capacity and consent considerations.
Provider position	Provider legal entity and key contacts; affected services; current staffing; business continuity plan; recovery, sale, transfer or closure proposals; regulator position; administrator or insolvency contacts where applicable.
Contract position	Relevant contract and specification; breaches or notices; suspension status; termination or step-in provisions where applicable; outstanding improvement actions and deadlines.
Continuity arrangements	Immediate safety measures; alternative provision and market capacity; arrangements for medicines, equipment, records, transport, accommodation and staffing; dependencies on health or other authorities.
Governance and communications	Decision log; authorisations; meeting schedule; named workstream leads;

Handover area	Minimum information required
	stakeholder map; communication plan; confidentiality and information-sharing controls; reporting route.

Roles during and after transition

Role	Responsibility
Contract Manager or delegated lead	Coordinates the transition decision, preserves the audit trail, provides the formal handover and continues to advise on contractual and provider-risk matters.
Monitoring Officer	Maintains and updates evidence, validates provider information, monitors residual risk and supports person-centred assurance activity.
Service Manager or authorised senior officer	Confirms activation where required, appoints the response lead, secures resources and ensures appropriate senior governance and decision-making.
Risk Response Team lead	Owns the coordinated response under the Provider Failure and Service Interruption Policy, chairs meetings, allocates actions and maintains oversight of continuity, communication and closure or recovery.
Social Care Operations	Leads individual risk assessment, review, safeguarding and care or placement planning, including communication with people and their representatives.
Commissioning, Brokerage or Placements	Assesses market capacity, sources alternatives and supports orderly transfer or replacement provision.
Finance, Legal, Procurement and other corporate services	Provide specialist advice and action in line with their professional responsibilities and delegated authority.
Provider	Activates business continuity arrangements, supplies accurate and timely information, maintains safe services for as long as required and cooperates with transition, recovery or closure planning.

Interface with safeguarding, suspension and emergency arrangements

Safeguarding enquiries, child protection processes, contractual action, placement suspension and emergency planning may run alongside either policy. Activation of the Provider Failure and Service Interruption Policy does not replace these

processes. Each workstream must have a clear lead, and decisions must be coordinated through the agreed governance structure to avoid gaps, conflicting instructions or duplicated demands on providers and operational teams.

A suspension of new referrals may reduce further exposure to risk but does not, by itself, constitute activation of the Provider Failure and Service Interruption Policy. Transition is required when there is an actual, imminent or credible threat to continuity or safe delivery for people already receiving services, or where the scale of provider instability requires coordinated continuity planning.

Return to quality assurance monitoring

Lead responsibility may transfer back to the Quality Assurance Monitoring Policy when the Risk Response Team is satisfied that the immediate continuity risk has been controlled, people are safe, the provider has a credible and sustainable operating plan, and any remaining concerns can be managed through routine or enhanced monitoring, a Service Improvement Plan and normal contractual governance.

The return decision must be formally recorded and must specify the revised risk level, outstanding actions, monitoring frequency, provider reporting requirements, named owner, review date and any conditions attached to continued operation or future referrals. Relevant governance forums and stakeholders must be informed, and the digital risk dashboard, contract record and provider file updated.

Post-incident learning and assurance

Following recovery, transfer or closure, the lead officer will coordinate a proportionate review. The review should consider the effectiveness of early warning, monitoring, escalation, communication, co-production, safeguarding, continuity planning, market response and governance. Agreed learning must be incorporated into provider risk records, commissioning and market-development activity, training, templates and future reviews of both policies.

Appendix 5 transition checklist

Completed	Control
☐	Immediate safety and safeguarding risks assessed and acted upon.
☐	Affected services, locations and people identified.
☐	Provider business continuity arrangements obtained and tested.
☐	Transition trigger and decision recorded, including authorisation.
☐	Response lead and workstream owners appointed.

Completed	Control
☐	Formal handover pack completed and shared securely.
☐	Operational, commissioning, safeguarding, brokerage or placements, finance and relevant partners notified.
☐	Provider, individuals and representatives communication arrangements agreed.
☐	Alternative provision and market-capacity options assessed.
☐	Contractual, legal, regulatory and emergency-planning interfaces confirmed.
☐	Single action and decision log established with review frequency.
☐	De-escalation, return to monitoring or closure decision recorded.
☐	Post-incident learning completed and policy or process changes assigned.

Version Table

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Owner	Carlo Ferri
Author	Social Care Market Contracts & QA Team

Monitoring Visit Policy for Monitoring Officers

April 2026

QAF003

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Introduction and Background

Shropshire Council has a statutory and contractual responsibility to ensure that commissioned care and support services deliver safe, effective, and high quality outcomes for the people who rely on them. Monitoring visits are a core element of this assurance framework. They allow the Council to see firsthand how services are operating, verify compliance with contractual and regulatory requirements, and identify emerging risks before they lead to avoidable harm or service failure.

In recent years, the complexity of commissioned services has increased, alongside rising expectations around safeguarding, accountability, workforce stability, and the consistency of care delivery. At the same time, internal intelligence systems, desktop monitoring processes, and market oversight mechanisms have become more sophisticated. As a result, Monitoring Officers now draw on a wider range of evidence, including performance data, provider submitted documents, incident trends, CQC intelligence, and multiagency feedback.

This Visit Policy is therefore required to provide clear, standardised, and transparent guidance on how Monitoring Officers plan, prepare for, conduct, and report on visits. It ensures that visits are undertaken consistently across all commissioned services, regardless of type, risk level, or provider size. It also supports alignment with the wider Quality Assurance Monitoring Policy, the Contract Monitoring Process (Desktop, Routine, and Reactive), and the Organisational Quality Concerns (OQC) pathway.

This policy sets out what Monitoring Officers, providers, and partner professionals can expect when a monitoring visit takes place. Specifically, the policy:

- Explains the purpose and scope of monitoring visits and how they fit into the wider QA and contract management framework.
- Defines visit types, planned (routine), reactive (concern triggered).
- Describes the required steps before, during, and after a visit, ensuring a consistent and evidence based approach.
- Clarifies roles and responsibilities, ensuring Monitoring Officers, Contracts Officers, The Social Care Market Contracts and QA Manager, and providers understand their duties.

- Sets expectations for communication and reporting, including feedback timelines, action planning, and documentation standards.
- Outlines escalation processes, safeguarding considerations, and how visit findings contribute to risk management and improvement planning.

By following this policy, Monitoring Officers will deliver visits that are structured, fair, proportionate, and transparent. Providers will understand what is expected of them during the monitoring process, and the Council will maintain a robust and accountable system of quality oversight that protects supported people and supports continuous improvement.

Scope of Monitoring Visits

This policy applies to all monitoring visits conducted as part of the quality assurance and contract management framework. Specifically, it covers the following types of visits:

- Relationship visits (Planned or ad-hoc): Initial and ongoing visits to introduce monitoring officers and foster constructive relationships throughout the duration of professional engagement.
- Routine (Planned) Monitoring Visits: Regularly scheduled visits carried out to assess ongoing compliance and quality within in and out of county commissioned services.
- Reactive/Unannounced Visits: Visits prompted by specific concerns or incidents, conducted without prior notice to address immediate risks or issues.

All visits, regardless of type, are subject to the standards and procedures outlined in this policy to ensure consistency, transparency, and accountability throughout the monitoring process.

Definitions

Term	Definition
ASC	Adult Social Care services within the Council.
Action Plan	A formal document outlining required improvements, responsible persons, and timescales.

CQC	The Care Quality Commission, the regulator of health and social care services in England.
Evidence-Based Practice	Approach relying on validated information and professional standards to inform findings.
Experts-by-Experience	Individuals with lived experience who contribute perspectives to monitoring visits.
OFSTED	The Office for Standards in Education, Children's Services and Skills, responsible for inspecting services for children and young people.
OQC (Organisational Quality Concern)	A formal process for identifying, escalating, and managing provider quality concerns.
Performance Data	Quantitative information used to assess service performance, outcomes, and compliance.
Provider Submissions	Documents or data provided by a service provider for monitoring purposes.
QA (Quality Assurance)	A systematic process for ensuring services meet required standards and deliver safe, effective care.
Reactive/Unannounced Visit	A visit triggered by concerns or incidents, conducted without prior notice.
Regulatory Compliance	Adherence to statutory and regulatory requirements such as CQC or Ofsted standards.
Risk Thresholds	Defined levels indicating severity or likelihood of risks that guide monitoring intensity.
Routine Monitoring Visit	A planned, scheduled visit intended to assess ongoing compliance and quality.
Triangulation	Verification of evidence using multiple sources such as observations, documents, and interviews.

Principles

The following principles set out the standards and expectations that guide the planning, delivery, and evaluation of monitoring visits across commissioned care and support services. They ensure that visits are consistent, proportionate, evidenced, and aligned to the Council's wider Quality Assurance (QA) and Contract Management frameworks.

- **Risk Based and Proportionate Oversight**
  - All monitoring activity must be proportionate to the assessed level of risk, complexity, and potential impact on people using the service. Monitoring levels and visit types (desktop, routine, reactive) must be selected in accordance with the Council's QA risk thresholds and risk rating processes.
- **Person -Centered and Outcome Focused- Practice**
  - Monitoring visits must prioritise the experiences, voices, and outcomes of children, young people, adults, and families. Evidence should clearly demonstrate how services promote safety, wellbeing, independence, and positive day-to-day experiences for individuals.
- **Evidence Led Decision Making and Triangulation**
  - Monitoring findings must be grounded in verified, triangulated evidence. This includes:
    - environmental and practice observations,
    - review of records and documentation,
    - discussions with managers and staff,
    - (where appropriate) engagement with supported people and families, and
    - crosschecking against intelligence from safeguarding, commissioning, health partners, regulators and any historical monitoring outcomes.
- **Transparency, Fairness and Consistency**
  - Monitoring Officers must apply consistent standards and processes before, during, and after visits. Providers should have clarity about the purpose of visits, the evidence required, reporting expectations, and any actions or improvements identified. Monitoring outcomes must be shared in an open and balanced manner to promote trust and accountability.
- **Collaboration and Shared Accountability**

- Monitoring is a collaborative activity undertaken with providers, internal Council partners (such as ASC, Safeguarding, Public Health, Brokerage and Finance), and relevant external regulators or regional QA groups. Shared responsibility for safety, quality and improvement must underpin all interactions before, during and following visits.
- The Council is committed to strengthening collaborative quality assurance by promoting the meaningful involvement of Experts by Experience in monitoring activity. ***Where appropriate***, individuals with lived experience may participate in monitoring visits to provide insight into the quality, culture, and impact of services from the perspective of those who use them.

- **Timely, Accurate and Action Oriented Reporting**
  - Monitoring Officers must provide timely verbal feedback at the end of the visit and produce written reports within required timescales. Reports must:
    - present clear, factual, triangulated findings,
    - identify strengths and areas requiring improvement,
    - set out requirements/recommendations with timebound expectations, and
    - highlight any escalation triggers or risk indicators quickly.
- **Governance Aligned and Escalation Ready Practice**
  - Monitoring visit outcomes must align with the Council's QA and Contract Management governance arrangements, escalation pathways, and organisational quality concern (OQC) processes. Where concerns arise, the appropriate escalation route, improvement planning, increased monitoring, contractual action, regulatory liaison, suspension, or multiagency escalation, must be applied consistently and proportionately.
- **Statutory, Regulatory and Contractual Compliance**
  - Monitoring visits must assess compliance with statutory duties, CQC and Ofsted frameworks, local policy requirements, safeguarding standards, and the service's contract specification. Any noncompliance should be clearly documented and addressed through appropriate contractual actions.
- **Prepared, Planned and Intelligence Informed Approach**
  - Monitoring Officers must prepare for visits thoroughly by reviewing:
    - self-assessment returns,

- previous monitoring outcomes,
- contract documentation,
- incidents, complaints, OQCs, and safeguarding information,
- performance data, and
- intelligence from internal partners and regional QA groups. Visits should have a defined scope based on identified themes, concerns, or contractual requirements.

- **Respectful, Inclusive and Ethical Conduct**
  - All monitoring activity must be conducted with professionalism, respect, and sensitivity, ensuring fairness, dignity, and inclusivity for individuals and staff. Officers must take account of equality, diversity and human rights considerations and ensure safe and appropriate access to people, staff and records in line with legal and ethical professional standards.
- **Time Critical Circumstances**
  - It is recognised that in certain time critical or high risk circumstances, it may not be possible to undertake planned or prenotified monitoring visits. In such situations, Monitoring Officers may be required to carry out unannounced or expedited visits to ensure organisational practices are not impacting the immediate safety and wellbeing of individuals, where safeguarding threshold has not been met . While the usual planning steps may not be achievable, the core values and principles set out in this policy, including fairness, proportionality, evidence based practice, transparency, and respect, will continue to be upheld wherever it is appropriate and feasible to do so.

All our contract monitoring and quality assurance activity is underpinned by Shropshire's values: PROUD.



Roles & Responsibilities

Monitoring Officers – Monitoring Officers are responsible for the operational delivery of the Council's contract monitoring function. They must:

- **Intelligence Gathering & Preparation**
  - Collect and analyse intelligence from multiple sources, including incident data, safeguarding information, CQC reports, complaints, provider self assessments and notifications, and feedback from internal teams.
  - Review previous monitoring outcomes, action plans, and performance themes to identify areas requiring focus during the visit.
  - Liaise with relevant internal partners (ASC, Safeguarding, Public Health, Brokerage, Finance, Commissioning) to gather uptodate context and concerns.
- **Visit Planning & Coordination**
  - Determine the appropriate type of visit (routine, reactive, desktop triggered) based on risk, thresholds, and policy guidance.
  - Provide appropriate notice for routine visits and plan unannounced visits where required.
  - Ensure relevant documentation and assessment tools are prepared in advance.

- **Conducting the Visit**
  - Lead or colead the visit in a professional, objective, and evidence based manner.
  - Carry out environmental, observational, and practice based assessments.
  - Review provider records in accordance with the contract service specification.
  - Engage directly with managers, staff, and, where appropriate, people using the service and families.
  - Triangulate evidence to verify findings and ensure accuracy.
- **Reporting, Communication, and Follow Up**
  - Provide clear, timely verbal feedback at the end of the visit and highlight any immediate risks or improvements required.
  - Prepare a comprehensive written monitoring report within required timescales.
  - Ensuring the provider takes ownership of developing and delivering an action plan to address required improvements.
  - Providing oversight, challenge and assurance against the providers action plan.
  - Submit the report for internal approval and ensure providers receive final documentation within policy deadlines.
  - Monitor provider progress, check completion of actions, and determine whether further visits or escalation are required.
- **Escalation and Risk Management**
  - Identify and escalate concerns promptly through the correct pathways (OQC, safeguarding, CQC notifications, or management escalation).
  - Contribute to risk dashboards and ensure that intelligence is accurate and up to date.
  - Participate in cross service meetings, strategy discussions, or case conferences where a provider's risk level requires multiagency oversight.

Contracts Officers / Social Care Contract and QA Manager – Contracts Officers and the Social Care Contract and QA Manager provide oversight, assurance, and decision-making support. They must:

- Approve monitoring reports where needed, agree requirements and recommendations on high risk providers to ensure proportionality, consistency and quality.
- Provide guidance to Monitoring Officers on thresholds, risk classification, and escalation decisions.
- Ensure monitoring activity aligns with the wider commissioning, market oversight, and quality assurance framework.
- Support problem resolution, complex case discussions, and joint work with other internal teams.
- Lead or support escalations such as OQC processes, contract variations, suspensions, or commissioning reviews.

Service Providers – Service Providers play a central role in the monitoring process. They must:

- Cooperate fully and transparently with all monitoring activity.
- Provide access to premises, staff, service users (with consent), and all relevant records and documentation.
- Engage constructively with Monitoring Officers and respond to reasonable requests for information within agreed timeframes.
- Participate in feedback discussions and implement required actions promptly.
- Ensure senior management oversight of monitoring outcomes and embed learning into practice and governance processes.
- Notify the Council of significant incidents, concerns, staffing issues, regulatory changes, or other contractual requirements in a timely manner.

Internal Partners (ASC/Children's services, Safeguarding, Public Health, Brokerage, Finance, CQC/OFSTED Liaison) – Key internal teams contribute to monitoring by:

- Sharing intelligence that may influence visit planning or risk assessment.
- Participating in joint visits or review meetings where relevant.
- Providing professional expertise (e.g. safeguarding thresholds, clinical practice issues, funding concerns).
- Supporting follow up actions where risks relate to multiagency issues (care management, safeguarding enquiries, operational practice).

Senior Management / Governance Groups – Senior leaders ensure appropriate oversight and accountability by:

- Reviewing escalated cases, thematic concerns, or providers requiring enhanced monitoring.
- Ensuring resourcing and strategic support for the monitoring function.
- Overseeing governance pathways such as the Quality Performance Group (QPG), or relevant escalation panels.
- Approving high risk decisions such as contract suspensions, provider closure planning, or service contingency arrangements where required.

Visit Workflow

This workflow applies to all Quality Assurance Monitoring visits, including Routine, Reactive (concern-triggered), and Desktop-triggered (after document analysis) visits.

Pre-Visit Planning

- Begin the pre-visit planning process by thoroughly reviewing all available intelligence related to the provider or service. This includes analysis of intelligence received, and any relevant communications.
- Once the intelligence has been reviewed, clearly confirm the scope of the upcoming visit. Define the specific objectives, focus areas, and any key issues that need to be addressed during the visit.
- Coordinate with relevant partner agencies or teams to ensure alignment and collaboration in approach. This may involve sharing information, agreeing on roles, or scheduling joint activities as appropriate.
- **For Planned Visits:** Provide at least 7 days advance notice of the visit to the provider or service, outlining the purpose and scope of the visit to promote transparency and preparedness.
- **For unannounced Visits:** No notice is required to visit after receiving a 'trigger level' Organisational Quality Concern (OQC) about a provider or service being delivered under any of Shropshire Council's contracts. It would, however, still be expected of the Monitoring Officer to outline the purpose and scope of the visit to promote transparency and preparedness, upon arrival at the service's registered address. Visits may be required out of "normal" working hours.

Visit Execution

Council staff are required to carry their staff identification badge during all visits and must present it prior to entering any service address. Additionally, aspects of the assessment may pertain to service security as an example, the expectation to show

their badge can be used to identify potential areas of good practice or for areas of improvement. During the visit, conduct observations, review documentation, meet with key stakeholders, verify compliance with established standards, and gather supporting evidence as needed to inform your findings. Following the completion of these tasks, move directly into the post-visit reporting process by providing initial feedback to the provider, completing a comprehensive report, developing an actionable plan addressing any identified issues, submitting documentation for approval, issuing finalised materials to the provider, and ensuring all records are uploaded and stored in accordance with established procedures.

Post-Visit Reporting Process

After the completion of the visit, provide initial feedback to the provider. This feedback should summarise the main observations and findings from the visit, giving the provider a clear understanding of any immediate issues or areas of good practice identified during the review.

Next, complete a comprehensive report that documents all relevant details gathered during the visit. The report should include a summary of activities undertaken, evidence reviewed, and any compliance issues or best practices noted.

Your report should clearly identify and emphasise areas where the provider demonstrates best practice and innovation. Highlighting these achievements acknowledges the provider's commitment to quality and supports a positive working relationship and encourages the continuous improvement of services.

Where practice does not meet the standards detailed in the Quality Assurance Framework commitment (QAF001), set a series of requirements or recommendations for improvement to address any issues that were identified. These requirements or recommendations should outline specific steps, responsible parties, and timelines for implementation.

At this point the report can be issued to the provider and follow up visits arranged to check on progress against the requirements and recommendations.

For more complex or high risk providers, once the report is complete, submit the report and plan to the Contract Officer for approval. This ensures that all requirements and recommendations are reviewed and validated for proportionality, before being shared externally.

After approval, issue the finalised report to the provider. This communicates the outcomes of the visit and the expectations for follow-up arrangements.

Finally, upload all related documentation, including the report and any supporting evidence or documents, to the appropriate SharePoint folder. Ensure that records are maintained in accordance with organisational requirements and data management protocols.

Following the report being issued, a feedback form should be sent to the provider to collect their reflections on the process, including any comments regarding the visit, review, communication, and any subsequent support received. Providers are encouraged to complete the form and return it within a set timeframe. Responses are collated and analysed to identify trends, highlight areas for improvement, and inform future quality assurance visits. Gathering this feedback ensures that the process remains transparent, responsive, and continually develops in line with provider needs. This feedback is managed through Provider Feedback: Shropshire Council Contract Monitoring Microsoft Form and can be accessed by any member of the social care team.

Escalation and Follow-Up Actions

If persistent risks are identified during the visit or through ongoing monitoring, the provider's status may be escalated to reflect the heightened level of concern. In such cases, the frequency of quality assurance visits may be increased to ensure closer oversight and timely intervention. Additionally, strategy meetings will be convened within defined timeframes to address and manage the ongoing risks, ensuring that appropriate actions are taken to mitigate any issues and support the provider in achieving compliance.

Recordkeeping & Intelligence Management

All documentation related to the visit, including reports, action plans, and supporting evidence, must be stored in the designated SharePoint folder and Liquid Logic System where available to do so. This ensures that records are maintained securely and can be accessed as needed, in accordance with Shropshire's data management policies.

Intelligence gathered during the visit should be shared appropriately with relevant stakeholders including the providers and operational teams. Information must be

disseminated in line with established GDPR and confidentially procedures to support effective decision-making and maintain compliance with organisational policies.

Related Documents

- QAF 001 Quality Assurance Framework
- QAF002 Quality Assurance Monitoring Policy
- QAF004 Organisational Quality Concerns (OQC) Process
- Contract Monitoring Process
- Provider Feedback Form

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Shropshire Council – Contract Management & Quality Assurance Due Diligence Guidance for Commissioned Services

September 2026

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Introduction and Purpose

Shropshire Council's responsibility to undertake due diligence is rooted in a wide range of statutory duties that require the Council to ensure that any organisation it commissions is safe, legally compliant, financially stable and capable of delivering high quality services. These responsibilities arise from core legislation including the Care Act 2014, the Children Act 1989 and 2004, the Local Government Act 1999 and the Data Protection Act 2018 (GDPR), all of which place clear duties on the Council to protect children, adults and families, ensure continuous improvement and value for money, and maintain the security and lawful handling of personal data. In addition, the Procurement Act 2023 establishes new obligations for public bodies to verify supplier suitability, check for exclusion grounds, and maintain transparent, defensible decision making throughout the procurement and contract lifecycle.

Alongside these, the Council must ensure ongoing compliance with a wide range of other legal requirements that apply to contracted services, including safeguarding, health and safety, equalities, TUPE, modern slavery, fraud prevention, and serious and organised crime legislation, as well as regulatory frameworks such as CQC and Ofsted. Collectively, these duties require the Council to undertake proportionate, evidence-based and continuous due diligence before awarding contracts, during mobilisation, and throughout the duration of service delivery, ensuring that risks are identified early, public funds are protected, and commissioned services remain safe, lawful and effective.

This policy outlines the requirements established by Shropshire Council for conducting due diligence across all stages of the contracting cycle. The policy aims to ensure the Council's practices are robust, thorough, and consistent in assessing and managing its providers.

Objectives of the Policy

The due diligence process is designed to achieve the following:

- Appoint providers who are safe, compliant with relevant regulations, financially stable, and suitable for the intended service.
- Maintain continuous oversight of each provider's stability and regulatory compliance throughout the duration of their contract.
- Identify emerging risks at the earliest possible stage to enable timely intervention and risk mitigation.
- Ensure that the Council fulfils its statutory obligations and meets its commissioning responsibilities efficiently and effectively.

Scope

This policy applies to:

- All officers involved in procurement, commissioning, contract management and market oversight.
- All contracted services commissioned by Shropshire Council, including children's, adults', public health, corporate services, social care, and third-sector contracts.
- All stages of the contract lifecycle; pre-contract, mobilisation, in-contract, and exit.

It applies to all providers, including:

- regulated services (CQC, Ofsted),
- unregulated services,
- small voluntary/community organisations,
- national organisations delivering local services.

Definitions

Term	Definition
Adult Social Care (ASC)	Support services for adults with care and support needs.
Audited accounts	Financial statements independently reviewed to confirm accuracy and compliance.
Business continuity plan	A provider's plan to maintain service delivery during disruption.
CCJ	County Court Judgment issued for unpaid debts.
CQC	Care Quality Commission, the regulator for health and social care services.
CQC Provider ID	Unique identification number assigned to a registered CQC provider.
Care Act 2014	Legislation outlining local authority duties for adult care and support.
Children Act 1989	Legislation governing the safeguarding and welfare of children.
Children Act 2004	Legislation establishing integrated children's services and safeguarding duties.
Commissioning	Process of assessing needs, planning, procuring and monitoring services.

Conflicts of interest	Situations where personal or organisational interests could improperly influence decisions.
Contingency arrangements	Plans to ensure service continuity during unexpected events.
Corporate Due Diligence Declaration	A provider's formal statement confirming compliance with corporate requirements.
DPS	Dynamic Purchasing System used for procurement of services.
Data Protection Act 2018	UK law governing data protection and incorporating GDPR.
Due diligence	Process of verifying a provider's suitability, safety and compliance.
GDPR	General Data Protection Regulation governing data privacy and security.
Governance structure	Framework outlining leadership, accountability and decision-making.
ICO	Information Commissioner's Office, UK data protection regulator.
Illegal Provision	A service that should be regulated (e.g. by CQC or Ofsted) but is operating without the required registration.
Intelligence dashboards	Tools used to monitor provider performance and risk indicators.
Mobilisation	Preparation period between contract award and service start.
Ofsted	Office for Standards in Education, Children's Services and Skills - inspects and regulates services providing education, skills, and care for children and young people.
OQC	Operational Quality and Compliance, internal quality oversight process.
Operational intelligence	Information from partners or monitoring used to assess service performance.

Procurement Act 2023	Legislation governing public sector procurement.
QA	Quality Assurance processes for monitoring service quality.
Regulatory monitoring	Ongoing review of regulatory inspection outcomes and compliance.
Regulatory notifications	Mandatory information reported to regulators.
Risk rating	Assessment of provider risk based on evidence and monitoring.
Safer recruitment	Processes ensuring staff suitability to work with vulnerable people.
Service specification	Document outlining required service standards and delivery expectations.
SharePoint	Council platform for storing and managing documents.
TUPE	Regulations protecting employees when services transfer between employers.
Triangulated evidence	Use of multiple independent sources to validate information.
Unregulated Provision	A lawful service that does not require registration with a regulator.
URN	Unique Reference Number assigned by Ofsted.
Winding-up petition	Legal action indicating potential insolvency.

Principles

- Alignment with Council Vision: All due diligence activity should be carried out in support of the Council's priorities: Healthy People, Healthy Economy, Healthy Environment, and Healthy Organisation and the council's PROUD Values:



- Proportionate and Risk-Based; The level of due diligence must correspond to the complexity, risk, and statutory nature of the service.
- Evidence-Led and Triangulated; All checks must be based on verifiable information from trusted sources.
- Transparent and Fair; Providers must understand the information required and why it is needed. Officers must apply checks consistently.
- Continuous and Not One-Off; Due diligence is not limited to procurement; it is a continuous activity throughout the contract lifecycle.
- Safeguarding-Centered; Decisions must prioritise the safety, wellbeing and rights of children, adults and families.

Roles & Responsibilities

Commissioning & Contracts and QA Monitoring Officers

- Carry out mobilisation and ongoing due diligence checks
- Maintain intelligence dashboards
- Lead enhanced due diligence when concerns arise

Contracts Officers

- Monitor provider compliance

- Ensure due diligence forms are completed and assessed
- Review financial/operational intelligence

Procurement

- Ensure pre-contract due diligence is consistently applied
- Support use of procurement questionnaires and corporate due diligence declarations

Safeguarding/ASC/Children's Services

- Provide intelligence where required
- Support due diligence checks linked to service delivery, service safety, welfare of people and risk

Finance

- Provide financial health assessments when required at each stage of the due diligence process

Legal

- Advise where concerns have been raised and require contractual or compliance actions

Due Diligence Requirements

The Council will undertake due diligence at four key points:

Pre-Contract Due Diligence (Award Stage) - To determine whether a provider is safe, legitimate, capable and compliant to be awarded a contract.

- **Required Checks:**
  - **Corporate & Legal**
    - Company registration, trading status
    - Governance structure and leadership
    - Conflicts of interest declarations
    - Professional registrations (e.g., Ofsted, CQC)
    - Required statutory authorisations
  - **Financial Viability**
    - Audited accounts (2–3 years where available)
    - Credit checks/financial risk scoring
    - Evidence of insurance cover
    - VAT registration and tax compliance
  - **Regulatory & Compliance**
    - CQC/Ofsted rating status and enforcement history
    - Regulatory registration numbers (e.g., Ofsted URN, CQC provider ID)
    - Historic non-compliance or restrictions
  - **Quality & Safety**
    - Safeguarding track record
    - Serious incidents/notifications
    - Complaint trends
    - Workforce stability and safer recruitment arrangements
  - **Policies & Governance**
    - Key policies as required in contract scheduling and service specifications
    - Business continuity/resilience plans

        - Data protection compliance (ICO registration)
    - **Past Performance**
        - References from other local authorities
        - Contract history with Shropshire Council
    - **Tools used:**
        - Provider Due Diligence Form
        - Corporate Due Diligence Declaration
        - DPS/Procurement Questionnaire
        - Regulatory portals (CQC, Ofsted, Charity Commission, Companies House)

Mobilisation Due Diligence (Pre-Go-Live) - To confirm readiness to deliver the service safely and compliantly.

- **Required Checks:**
    - Staffing levels, qualifications, training
    - Policies and procedures fully in place
    - Premises readiness and safety checks
    - IT, reporting and data-handling capability
    - Service specification compliance
    - Contingency and escalation arrangements
    - Completion of mandatory training (e.g., safeguarding)
    - Verification of new regulatory requirements if applicable
- **Mobilisation may involve joint checks with:**
    - Safeguarding
    - Public Health
    - Commissioning/QA
    - Legal/Procurement

Contracts and Quality Assurance Ongoing Due Diligence (Throughout Contract) - To continuously verify provider suitability, stability and risk profile.

- **Required Checks:**
    - **Quality Assurance**
        - QA monitoring visit findings
        - Action plan progress
        - Complaints, incidents and trend data
    - **Regulatory Monitoring**
        - New CQC/Ofsted inspection outcomes
        - Enforcement action
        - Regulatory notifications
    - **Financial Health**
        - Material changes in accounts or credit ratings
        - Evidence of instability (winding-up petitions, director changes, CCJs)
    - **Workforce & Staffing**
        - Staffing shortages or high turnover
        - Safer recruitment breaches
        - Training deficits
    - **Market and Operational Intelligence**

- Feedback and references from partners (health, safeguarding, regional QA groups)
- Changes in service model or structure

Trigger-Based Due Diligence (Enhanced Checks) - To provide a targeted and thorough assessment of a provider or organisation when certain risk indicators, illegal activity or contractual concerns arise. These can be triggered by:

  - Safeguarding concerns
  - OQC raised
  - Serious incident
  - Provider financial instability
  - Negative regulatory outcome
  - Complaints patterns
  - Media concerns
  - Change in legal status, ownership or leadership

- Enhanced due diligence may include:
  - Immediate QA visit
  - Intensified monitoring
  - Requesting further evidence (e.g., bank statements, business continuity plans)
  - Multi-agency escalation
  - Legal review
  - Re-assessment of risk rating

Documentation & Recordkeeping

All due diligence activity must be:

- Recorded on SharePoint or the Contract Management system
- Stored securely in line with data protection standards
- Logged in the provider's risk and intelligence profile
- Shared appropriately with internal partners

Decision-Making & Escalation

- Due diligence findings will inform:
  - Contract award decisions
  - Risk ratings
  - QA visit frequency
  - OQC escalation
  - Decision to suspend placements or terminate contracts
- Where significant risks are identified, the Council may:
  - Decline to award a contract
  - Delay mobilisation
  - Initiate enhanced monitoring/OQC

- Suspend new placements
- Take contractual enforcement action

Training and Continuous Professional Development

All staff involved in Due Diligence activity must complete regular training covering legal updates, social value, digital tools, and best practice in line with their contract management training responsibility. The Council will provide access to resources and support to facilitate ongoing professional development.

Each Head of Service must ensure their teams carrying out due diligence complete training related to their role, address skills gaps and resource needs, and utilise the council's training options based on the requirements of this activity.

Monitoring, Reporting, and Review

This guidance will be reviewed regularly to ensure its ongoing relevance and compliance. Regular evaluation will incorporate feedback from stakeholders, reflect any changes in legislation or best practice, and address emerging needs within contract management processes.

Related Documents

- Quality Assurance Framework
- Quality Assurance Monitoring Policy
- OQC Guidelines
- Procurement & Tendering Procedures
- New Provider Due Diligence Form
- New Provider (Novation) Due Diligence Form
- Corporate Requirements Due Diligence Declaration
- CQC/Ofsted regulatory guidance

Version Table

Version	1
Implementation date	01.09.2026
Last review	December 2025
Next scheduled review	December 2027
Owner	Deborah Webster
Author	Carlo Ferri

Appendix 1: Initial Due Diligence Checklist (Pre-Contract / New Provider Approval)

Area	Evidence Required	Checked (Y/N)	Risk Rating	Comments / Actions
Company registered with Companies House (where applicable)	Registration number verified			
Charity Commission registration (where applicable)	Registration verified			
Governance structure reviewed	Directors, trustees, senior leadership identified			
Professional registrations confirmed	CQC, Ofsted, Social Work England etc.			
Regulatory enforcement action reviewed	CQC/Ofsted warning notices, conditions, restrictions			
Financial accounts obtained	Previous 2-3 years accounts reviewed			
Financial health assessment completed	Finance review undertaken			
Credit checks completed	Credit rating satisfactory			
Insurance certificates obtained	Public liability, employer liability, professional indemnity			
ICO registration verified	Current and valid			
Safeguarding policies reviewed	Current and appropriate			

Recruitment policy reviewed	Includes DBS and safer recruitment			
Business continuity plan reviewed	Current and robust			
Health & safety arrangements reviewed	Policy and arrangements adequate			
Equality & diversity policy reviewed	Current and compliant			
Modern slavery statement reviewed	Applicable organisations			
References obtained	Minimum two satisfactory references			
Contract performance history checked	Existing council intelligence reviewed			
Regional intelligence reviewed	Quality networks / neighbouring authorities			
Conflicts of interest declaration completed	No concerns identified			
Overall risk assessment completed	Low / Medium / High			
Recommendation to proceed	Approved / Conditional / Not Approved			

Authorisation

Role	Name	Signature	Date
Reviewing Officer			

Service Manager			
Head of Service (where required)			

Appendix 2: Ongoing Due Diligence Checklist (Contract Monitoring)

To be completed at least annually and more frequently where risk levels require.

Area	Evidence Reviewed	Status (RAG)	Comments / Actions
Latest CQC/Ofsted inspection reviewed	Inspection outcome recorded		
Regulatory notifications reviewed	Significant notifications assessed		
Safeguarding concerns reviewed	Patterns and trends assessed		
OQC concerns reviewed	Open concerns monitored		
Complaints and compliments reviewed	Trend analysis undertaken		
Provider action plans reviewed	Progress satisfactory		
Workforce stability reviewed	Vacancy, turnover and agency usage assessed		
Training compliance reviewed	Mandatory training maintained		
Financial position reviewed	Annual accounts or financial assessment completed		
Companies House changes reviewed	Directors, ownership, insolvency indicators		

Insurance certificates updated	Current and valid		
Business continuity plan refreshed	Reviewed within last 12 months		
Contract KPIs reviewed	Service performance satisfactory		
QA monitoring outcomes reviewed	Previous visits and findings assessed		
Service user feedback reviewed	Engagement evidence assessed		
Intelligence from partners reviewed	NHS, safeguarding, police, regional groups		
Service model changes assessed	Material changes identified and evaluated		
Placement trends reviewed	Demand and occupancy reviewed		
Risk score updated	Intelligence profile updated		
Required escalation considered	Enhanced monitoring required?		

Outcome

Outcome	Tick
No Concerns Identified	
Routine Monitoring Required	
Enhanced Monitoring Required	
OQC Required	
Legal Advice Required	

Financial Review Required	
Contract Enforcement Considered	

Appendix 3: Reactive Due Diligence Checklist (Enhanced / Unregulated / Illegal Service Assessment)

Purpose: To be completed when considering using, continuing to use, or responding to concerns regarding an illegal, unregulated, emergency placement, unsupported accommodation provider, specialist service, or any provider where standard assurance mechanisms do not exist.

Area	Evidence Required	Outcome	Comments
Reason for reactive due diligence documented	Referral/concern recorded		
Nature of service understood	Service description obtained		
Regulatory status confirmed	Why service is unregulated documented		
Ownership and legal entity verified	Companies House or equivalent checked		
Identity of responsible persons verified	Directors / proprietors identified		
DBS arrangements confirmed	Relevant staff checked		
Safeguarding arrangements reviewed	Policies and reporting pathways evident		
Staff qualifications verified	Relevant competency evidence obtained		
References obtained	Previous commissioners contacted		
Insurance verified	Current and appropriate		

Financial viability assessed	Audit evidence reviewed		
Property planning correct	Evidence reviewed		
Premises risk reviewed (where applicable)	Visit completed		
Health and safety arrangements reviewed	Fire, risk assessments, maintenance		
Service user risk assessment completed	Individual risks considered		
Local intelligence reviewed	Social care, QA, safeguarding, police, health		
Internet/media searches completed	Adverse information considered		
Previous incidents or complaints reviewed	Factored into assessment		
FOR ILLEGAL PROVISIONS: Have all placement searches been exhausted that could meet the person's assessed needs?	Evidence observed placement paperwork / MDT and placement meetings		
Benefits outweigh risks assessment completed	Decision documented		
Senior Management Team approval obtained	Required approvals recorded		
Review frequency agreed	Weekly/monthly/quarterly		

All-age provider organisational quality concerns (OQC) guidance

March 2026

Shropshire Council – Commissioned Care & Support Services

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Introduction and Background

Shropshire Council is responsible for ensuring that all externally commissioned care and support services for children, young people and adults are safe, effective, and person-centred. As part of this responsibility, the Council operates an Organisational Quality Concern (OQC) process, used to identify, assess and respond to concerns about the quality, reliability or governance of commissioned providers.

The OQC process forms a core component of the Council's all-age Quality Assurance Framework (QAF) and supports our statutory duties under the Care Act 2014, the Children Act, and associated regulatory frameworks. It enables the Council to take a proactive, intelligence-led approach to monitoring the provider market, using information from a wide range of sources to detect patterns of concern that may indicate organisational weakness or the potential for service failure.

Shropshire Council commissions a diverse range of regulated and non-regulated provision, including domiciliary care, supported living, residential care, short breaks, and specialist therapeutic services. This complex market makes it essential that the Council maintains a consistent, risk-based mechanism for gathering intelligence and escalating issues. The OQC process ensures that concerns which go beyond isolated incidents – such as persistent staffing problems, poor leadership, missed calls, unsafe care practices, or repeated complaints – are recognised early and addressed robustly.

By identifying systemic risks at an early stage, the OQC process helps the Council to protect individuals, uphold contractual and regulatory standards, and maintain service continuity across Shropshire's provider landscape. It also supports collaborative working with partners such as the Integrated Care Board (ICB), safeguarding teams, regulators, and other local authorities, ensuring that oversight is coordinated and that providers are held to account when quality falls below acceptable levels.

Ultimately, the OQC process strengthens Shropshire Council's ability to maintain high-quality, stable and resilient care markets, ensuring that those who rely on commissioned services are safeguarded and supported to live the best life possible.

OQCs:

- Provide early warning of provider-level risk; OQCs help the council identify trends such as repeated complaints, poor staffing, management instability, or non-compliance – issues that may not be visible when looking at individual incidents alone. This allows earlier intervention and reduces the likelihood of provider failure.
- Protect children, young people, and adults receiving care; Systemic concerns often impact many people, not just isolated individuals. By addressing

organisational issues, Shropshire strengthens safeguarding and reduces the risk of harm or service disruption across its provider market.

- Ensure commissioned services meet contractual and regulatory standards; OQCs form part of the evidence base for contractual action, performance notices, or, if necessary, provider suspension. This supports clear accountability and compliance with regulations such as Care Act duties and Ofsted/CQC requirements.
- Support consistent, intelligence-led quality assurance across the whole market; Shropshire's OQC policy emphasises a unified, all-age QA system, ensuring adults' and children's services are monitored with the same rigour and structure.
- Provide a clear reporting route for internal staff, partners, and external professionals; Providers, practitioners; and provides partners (e.g., health, social workers, ex-employees) with guidance on what an OQC is and when it should be raised, ensuring that concerns reach the right part of the council in a timely manner.
- Support market stability and prevent service disruption; By identifying organisational fragility early, Shropshire can plan contingencies and avoid crises where providers suddenly cannot deliver safe care.

Scope

This policy applies to all externally commissioned care and support services across Shropshire's children's, young people's, adults', and older people's services. It covers both regulated and non-regulated provision, delivered inside or outside of Shropshire, and includes (but is not limited to):

- Children's residential care, fostering, supported accommodation, domiciliary care, short breaks, and specialist therapeutic services
- Adult residential and nursing care, supported living, domiciliary care, extra care, day opportunities, respite, mental health and learning disability services
- Jointly commissioned or integrated services delivered with the NHS/ICB and regional commissioning partners
- Any provider or organisation delivering contracted support, whether through block contracts, framework arrangements, spot purchasing, or individual placements
- Voluntary and Community Services (VCS)
- Early help and preventative services

This policy applies to all council staff and partner agencies involved in commissioning, contract management, quality assurance, operational social care practice, and partnership working. It covers the identification, reporting, assessment, escalation,

monitoring, and resolution of Organisational Quality Concerns (OQCs) relating to any commissioned service.

This policy does not apply to concerns about individual cases of care and support that require safeguarding or casework intervention (though such concerns may generate OQCs and organisational learning where they are caused by systemic poor practise).

Definitions

Term	Definition (in the context of this policy)
All Age Portfolio	Shropshire Council's unified commissioning and quality assurance remit covering *all* externally commissioned care and support services for children, young people, adults, and older people. It includes both regulated and non-regulated provision across the full life course, ensuring that the OQC process, risk management, monitoring, and QA standards are applied consistently regardless of the age group served.
Intelligence	Information gathered from a range of sources including: • CQC/Ofsted ratings • regulatory notifications • complaints • provider returns • provider audits • Health/ICB input • stakeholder reports • OQCs • performance reports • safeguarding trends • contract meeting outcomes.
Multi-Disciplinary Team (MDT)	A group of professionals from different partnership disciplines who work collaboratively to support decision-making in the health and social care market.
Organisational Quality Concern (OQC)	A concern relating to provider practice or organisational capability, not a single individual case. Examples include (but is not limited to): • Poor leadership or management • Staff training/gaps • Poor record-keeping • Staffing levels and turnover of staff • Medication management issues • Environmental concerns • Recurrent missed calls or reliability issues • Failure to follow policies/procedures

	• Persistently poor communication
Quality Assurance (QA)	The systematic process of assessing and improving the quality, safety, and effectiveness of commissioned services through intelligence, monitoring, and action.
Quality and Performance Group (QPG)	The Council's formal governance forum for overseeing and managing quality, performance, and risk within the social care provider market, with authority to scrutinise concerns, agree corrective actions, and make decisions on escalation where provider quality or safety is compromised and deemed high risk.
Quality Threshold Levels	A risk-based categorisation that enables the systematic identification and assessment of concerns, ensuring appropriate responses are triggered according to the severity and recurrence of issues. • **Level 1 – Green:** No/minor concerns • **Level 2 – Amber:** Moderate, emerging, or repeated themes • **Level 3 – Red:** Major concerns requiring intensive intervention
Risk Review Meeting	A formally convened, multidisciplinary internal meeting held to assess, evidence and determine the Council's response to identified organisational failure, unsafe practice, or high-risk activity within a social care provider.
Service Improvement Plan (SIP)	A structured, timebound action plan that Shropshire Council requires a provider to implement when an Organisational Quality Concern (OQC) has been substantiated and the provider needs to make demonstrable improvements to address systemic or repeated quality issues.

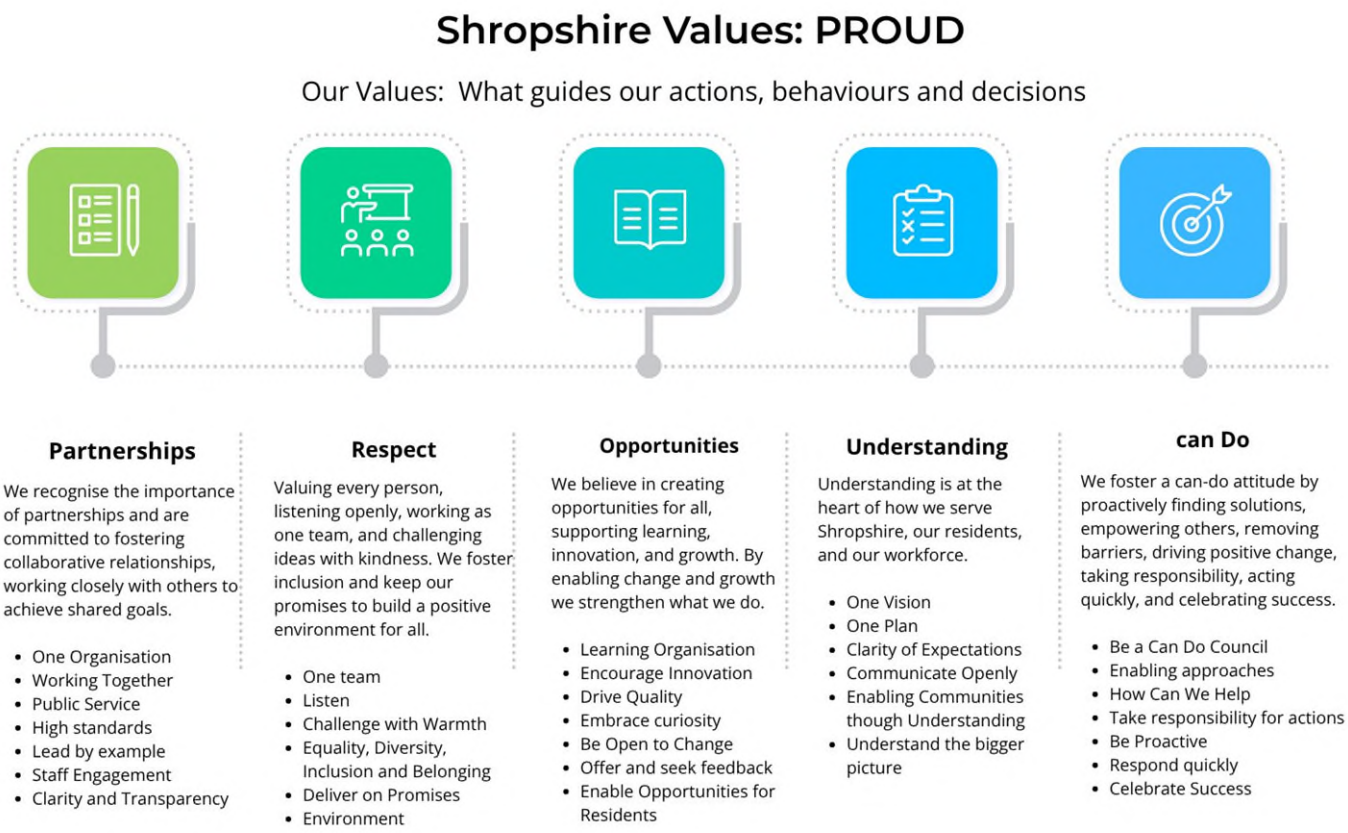
Principles

This policy is based on the following key principles:

- **All-age consistency:** Adults and children's services follow a unified QA cycle, adapted only where statutory requirements differ.
- **Proportionate monitoring:** The level and frequency of oversight is aligned to risk, complexity, and vulnerability the concern raised presents.
- **Intelligence-led:** Decisions use triangulated, high-quality data.
- **Collaboration:** QA is shared across Council teams, partner agencies, providers, and regulators.
- **Transparency:** Providers are informed of concerns, expectations, and actions required.

- **Continuous improvement:** The system supports providers to improve and sustain positive outcomes for individuals. This also applies to Shropshire Council processes.

And is underpinned by Shropshire's values: PROUD



Roles & Responsibilities

Contracts and Quality Assurance Team:

- Lead triage of OQCs
- Conduct reactive quality monitoring visits
- Coordinate SIPs and improvement activity
- Maintain Contract and QA dashboards
- Provide assurance reports to governance
- Provide contract intelligence
- Issue contractual notices where required
- Review compliance with service specifications
- Maintain market provider oversight and report on this when required
- Issue and manage contractual actions (non-compliance, defaults, variations, suspensions).

- Maintain the central contracts register and monitor renewal cycles.

Commissioners:

- Lead market shaping, sufficiency planning, and strategic commissioning.
- Provide contract intelligence to the Contracts and QA team and support risk-based decision-making.
- Support any reactive monitoring with the Contracts and QA team (visits, SIPs, triangulation) when requested to, to ensure stability of provider relationship through any investigation process.
- Develop service specifications and support procurement processes.
- Facilitate provider engagement, partnership working, and feedback mechanisms.
- Use data and intelligence to influence service improvement and future commissioning cycles.

Social Care Operational Team:

- Identify and escalate OQCs and provider quality concerns (OQCs, safeguarding, complaints), quickly using the correct systems and processes.
- Provide intelligence to QA/Commissioning to support monitoring and provider oversight.
- Participate in QA visits, audits, and evidence-gathering when required.
- Support risk assessment processes by sharing operational insight.
- Contribute to improvement activity and implement learning from QA findings.
- Collaborate with Commissioning, QA, and partner agencies on service improvement planning and monitoring.

Safeguarding (Adults & Children):

- Lead case-specific safeguarding processes
- Attend risk/QA meetings where there are safeguarding themes
- Provide advice on thresholds

Providers:

- Maintain compliance with statutory and contractual requirements
- Cooperate fully with the OQC process and any subsequent monitoring
- Implement required actions within required agreed timeframes
- Notify the Council of significant incidents, changes, or risks

Organisational Quality Concerns (OQC) Process

The OQC process provides a structured route for logging, triaging, and responding to concerns about systemic poor provider practices.

When to raise an OQC

Raise an OQC when concerns relate to service-wide or organisational issues, such as:

- Recurrent reliability issues (missed calls, early/late visits)
- Concerns about staff competence, training, or supervision
- Provider culture or management oversight issues
- Persistent record-keeping errors
- Medication administration recurring problems
- Environmental or safety concerns
- High turnover or workforce instability
- Repeated complaints with similar themes

When NOT to raise an OQC

Do ***not*** use OQC for:

- Named individual's care concerns → follow safeguarding/complaints pathways
- Providers Shropshire Council does not contract with
- Health funded only / Hospitals / acute settings
- Single, isolated incidents unless they form a significant pattern (systemic)

Logging an OQC

All OQCs for Adult Services are submitted via Liquid Logic (LAS). Staff must re-allocate completed submissions to the CONTRACTS team so they can be processed accordingly.

Children's Services – OQCs are to be completed using the MS Form (OQC), accessible via laptops and optimised for use on smartphones and tablet devices. Submissions will be sent directly to the Contracts and QA team via email for processing.

External Agencies, Partners or Providers should log OCQs using out First Point of Contact service (FPOC) on 0345 66779044

When submitting an OQC, the information must be complete, specific, and factual, so that screening, risk assessment, and triage can be carried out accurately.

Referrer Information (Who is raising the concern?)

Include:

- Full name
- Position / job title
- Organisation (e.g., Shropshire Council team, provider, external professional)
- Contact details:
    - Phone number
    - Email address

This is required so QA or FPOC can clarify details and verify legitimacy.

Provider Information (Who the concern relates to?)

You must include:

- Name of the provider
- Exact service location / home name (if the provider operates multiple homes or branches)
- Whether the person raising the concern knows any LA-funded individuals currently placed there

This helps avoid errors due to providers appearing under different banners or contract arrangements.

Category of Concern

Choose the most accurate concern category (or categories) from the OQC form.
Selecting the right category helps the Contracts/QA team to identify trends across the provider market.

Description of the Concern

This is the most important part.
Provide a clear, factual, chronological description covering:

- What happened (facts only: no opinion or assumptions)
- When it happened (include dates/times if known)
- Who was involved (roles, NOT names of service users)
- What harm, risk, or potential risk was observed
- Whether it is:
    - a one-off incident,
    - a repeated pattern,
    - or part of a wider organisational issue

The clearer the narrative, the easier it is for QA/Contracts officers to triage accurately.

Evidence or Intelligence Available

State what evidence you have, such as:

- Emails
- Observations
- Visit notes
- Complaints raised
- Conversations with staff
- Agency reports
- Repeated themes in calls/visits
- CQC/Ofsted reports (if relevant)

If you do not have evidence yourself, explain where the information came from (e.g., "reported by multiple professionals", "noted during monitoring visit").

Whether Other Professionals Have Been Informed

You MUST state:

- Who else is aware? (e.g., social worker, safeguarding, health professional, commissioning officer)
- Whether the concern has already been reported elsewhere
- Whether the provider has been made aware

This stops duplication and ensures the correct team leads the next action.

Funding Status

Confirm:

- Whether the person(s) affected are funded by Shropshire Council
- Whether Shropshire Council arranged the care
- Provision is in or out of county

This determines whether the concern falls within Shropshire Council's remit.

Triage

Once an OQC has been submitted, the Contracts and QA Team complete an initial screening to determine:

- Severity
- Credibility
- Scope
- Level of risk
- Immediate action required

This is the point where it will be decided at department level, whether the OQC will progress through the formal OQC process or not. Where the OQC is determined not to

meet the scope for formal action, a case note will be added to the OQC and it will be closed down for reference later should further OQCs be submitted for a provider.

If the team needs more information to make a fair decision about progressing the OQC to a formal process, your submission may be reassigned and you must resubmit the OQC with additional details. Sometimes, a team member will contact you for clarification or refer you to another service.

OQCs closed due to lack of scope cannot be used as evidence for future actions.

If an OCQ meets the criteria for formal investigation, it will be documented and proceed to risk assessment and allocation.

Risk Assessment & Risk Rating Allocation

Once an OQC is accepted as requiring investigating, the concern is evaluated against the provider's current QA risk rating as well as any additional intelligence held by Shropshire Council regarding the provider in question. Following this assessment, a decision will be made to allocate a Risk Rating (RAG rating) to determine next steps and appropriate actions to facilitate improvement for the provider, thereby aiming to reduce the likelihood of future concerns. Risk ratings must be proportionate and fair and are made in line with Shropshire's Quality Assurance Framework (QAF) RAG rating thresholds. Steps to determine a RAG rating are:

Intelligence Review

When an OQC is received, the Contracts/QA team gathers and reviews all relevant intelligence, which may include:

- Previous OQCs
- Complaints
- Safeguarding themes
- CQC/Ofsted outcomes
- Staffing/leadership concerns
- Non-compliance notices
- Incident patterns
- Feedback from social workers or health teams

This step ensures concerns are understood in context, not in isolation.

Initial Risk Screening

The QA/Contracts team screens the concern for:

- Severity (actual or potential harm to people, provider, markets of Shropshire Council reputation)

- Likelihood (is this isolated, recurring, or worsening?)
- Impact (on supported people, workforce, or continuity of care)
- Scope (one event vs. systemic organisational problem)

Contract and Quality Assurance Officers assess if a concern is low, moderate, or high risk, or refer it on to a more appropriate department, as needed.

Allocation to a Quality Threshold Level

The OQC is then assigned one of the Council's three threshold levels:

Level 1 **Green** — Low Concerns

- Minor issues or isolated incidents
- No immediate risk of harm
- Provider has capacity and systems to resolve issues internally
- Managed by the Contracts Team using routine or additional monitoring

Level 2 **Amber** — Moderate Concerns

- Repeated or developing themes
- Emerging patterns (e.g., staffing instability, communication issues, multiple complaints)
- Provider may be struggling to maintain quality
- Reviewed at the Quality Planning Group (QPG) multi-agency meeting

Level 3 **Red** — Major Concerns

- Serious concerns about safety, governance, leadership or compliance
- Evidence of significant failures (e.g., severe staffing shortages, medication safety issues, failed inspections)
- Possible risk of provider failure, suspension, or enforcement
- Automatically escalated to the MQA meeting for urgent review and multi-agency decision-making

Joint Decision-Making for Level 2 and 3

For Amber and Red concerns, decisions are not made in isolation.

The case is reviewed at the Quality Performance Group (QPG) Meeting, chaired at Head of Service level, with representation from:

- Contracts & Quality Assurance Team
- Commissioning

- ICB (for jointly commissioned services)
- Safeguarding
- Operations (Children & Adult services)
- Other partners as needed

This group:

- Reviews all intelligence
- Confirms or adjusts the risk level
- Decides on escalation or de-escalation
- Agrees required actions (e.g., SIP, reactive visits, suspensions)

When an urgent risk is identified, the QPG functions as Shropshire Council's joint decision-making forum, with key colleagues to promptly assess the severity of the issue, determine necessary actions, ensure the protection of service users, stabilise the provider, and assign a provisional risk level. In such situations, the QPG may convene in a non-traditional manner, with decisions made by those available to prioritise safety. These decisions should subsequently be reviewed with the wider QPG at the earliest opportunity to provide justification for the actions taken. Typically, the most senior individual present with decision-making authority will make these determinations.

What Risk Levels Trigger

Each OQC risk level has defined monitoring and intervention routes:

Level 1 – **Green**

- Routine monitoring
- Provider-led improvements
- May include a low-level action plan
- Saved intelligence to identify patterns forming

Level 2 – **Amber**

- Increased monitoring
- Targeted visits
- Service Improvement Plan (SIP) required
- QPG oversight

Level 3 – **Red**

- Immediate intensified monitoring
- Possible temporary suspension of placements
- Contractual enforcement
- High-level oversight by QPG and senior leadership

- Potential provider failure planning

Dynamic Review

Risk levels are not permanent.

They are re-evaluated regularly based on:

- Evidence submitted
- Improvement progress
- Visit findings
- New intelligence
- Regulatory updates

The QPG may escalate or de-escalate a provider each month.

Decision-Making

Contracts and Quality Assurance meet with Commissioners, Safeguarding (where relevant), and partner agencies monthly as the QPG or as required (depending on severity of the OQC) to agree the required response to OQCs submitted, which may include in-person visits, the necessity for a Service Improvement Plan (SIP), and whether there is justification for considering contract default or suspension. Providers are then given clear information detailing the concerns identified, the actions they must take, specific timeframes, the evidence required to demonstrate compliance, and the consequences should they fail to meet these requirements.

Decisions required arising from provider failure or significant market or business risk will be determined at an internal Provider Risk Management meeting. This meeting will always involve participation from a delegated member of the commissioning or contracts team. Furthermore, these matters must be discussed with the Head of Commissioning and / or Contracts to ensure appropriate oversight and alignment with organisational protocols.

Provider Communication

Providers receive clear information outlining:

- The concern(s) raised
- Required actions
- Timeframes
- Evidence required
- Consequences of non-compliance

Response & Action

Where concerns are substantiated and improvement is required, it would be expected in the first instance that the provider will make the required changes through informal means or a service improvement plan, in line with its own quality assurance policies and procedures, however where the Council feels that concerns are not managed by the provider one or more interventions by the council may occur:

Improvement Support

- Service Improvement Plan (SIP)
- Increased casual visit frequency
- Targeted support from the Council's Operational Team, Health Colleagues or other or other interested partners.
- Official Monitoring meetings (monthly/fortnightly as required)

Contractual Responses

- Recommendations and contract compliance action plans
- Default Notices / Non-compliance letters
- Placement pause / suspension (temporary halt to new placements)
- Contract variation review
- Escalation to senior management / governance
- In severe cases: termination

Governance

- Amber/Red cases will be reviewed via our internal QPG team meetings
- Quarterly summary reports shared with our wider Strategic Commissioning Board and commissioning partnerships
- Cross-agency intelligence sharing for jointly-commissioned services including with regulatory bodies
- Learning is fed into market-shaping and sufficiency planning through the council's commissioning processes

Where concerns are unsubstantiated, the investigating officer will update the OQC case record with their findings and close the concern, after which they will communicate their decision to the provider and the professional logging the OQC.

Communication & Transparency

The Council will:

- Communicate findings and expectations clearly
- Share timescales and consequences of non-compliance
- Ensure providers have opportunity to clarify or challenge information

- Work collaboratively to support improvement

Providers must:

- Maintain open communication
- Share accurate information promptly
- Notify the Council of changes in management, staffing, or service delivery
- Provide evidence of improvement

Associated Documents

- Quality Assurance Framework Statement (QAF)
- Quality Assurance Policy
- Contract Management Policy
- Provider Failure & Service Interruption Policy
- Planned & Reactive Monitoring Protocols
- Safeguarding Policies (Adults & Children)
- Complaints Policy
- Provider Handbook / Specifications
- OQC Form & Reporting Guidance

Review Cycle

This policy will be reviewed:

- Annually
- Following significant legislative/regulatory change
- Following learning from escalated OQC or provider failure cases
- Following system change or major policy updates

Version Table

Version	1
Implementation date	April 2026
Last review	March 2026
Next scheduled review	March 2027
Owner	Deborah Webster
Author	Carlo Ferri

ORGANISATIONAL QUALITY CONCERNS

Provider Concerns

The Social Care Contracts and Quality Assurance Team has a role to play in supporting improvements by care providers, and the submission of Organisational Quality Concern (OQC) forms via LAS to the team is a way in which social work teams, FPOC etc can communicate concerns.

OQCs are to be used to gather intelligence from a variety of sources to ensure that the providers we contract with offer a good quality service of care.

We need staff to ensure they log these issues and refer them via LAS to the Social Care Contracts and Quality Assurance Worktray as soon as they are aware of the issues.

Examples:

- Residential/Nursing Homes - apparent low staff numbers, poor care witnessed, poor environment.
- Domiciliary Care – apparent low staff numbers, poor care, continual examples of missed/late calls
- Supported Living – apparent low staff numbers, poor care, poor environment.
- Day Opportunities – apparent low staff numbers, poor care, poor environment.
- Voluntary Care Sector – apparent low staff numbers, referral times.

When OQCs should NOT be used:

- To raise concerns about the care of named individuals.
- To raise concerns about providers we don't contract with
- For safeguarding concerns
- To report a complaint

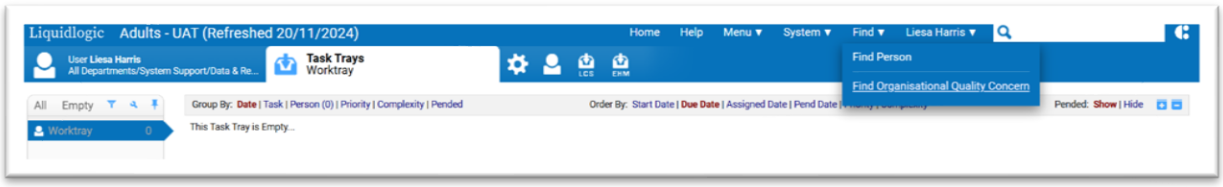
In some cases, OQC forms are being used to submit issues that the Social Care and Quality Assurance Team are not able take forward. Our expertise and capacity does not allow the team to investigate concerns that relate to the care that individuals are receiving.

We are also not able to respond directly to individuals or families. The focus of our work is to engage with providers about organisational and operational aspects of their business. For example: the way they recruit; the training that staff receive; the adoption and implementation of policies and procedures; the management arrangements that the provider has in place. This work also involves working to a schedule of care provider visits to check and validate improvements; follow up on requirements made by CQC and Healthwatch and in relation to formal complaints.

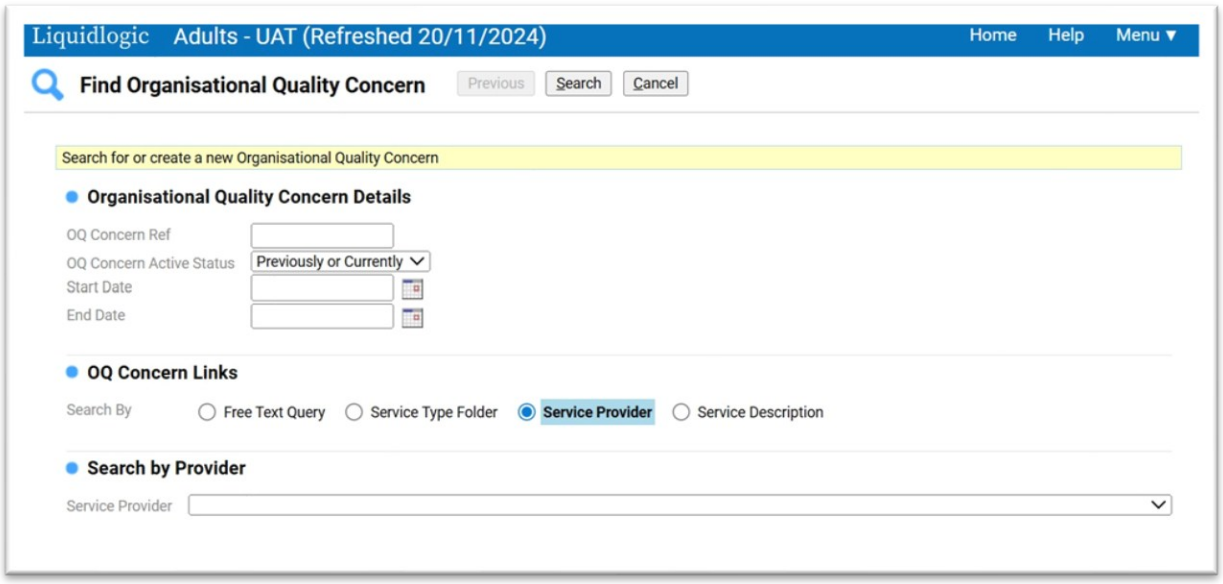
ORGANISATIONAL QUALITY CONCERNS

Creating an Organisation Quality Concern in Liquidlogic

1. From the Home screen click **Find** and select **Find Organisational Quality Concern**



The following screen will appear:



2. Complete the required information:

   Organisational Quality Concern Details

   OQ Concern Ref– if known and existing, otherwise ignore

   Start Date – only if searching for an existing concern

   OQ Concern Links

   Search By - click the **Service Provider** radio button

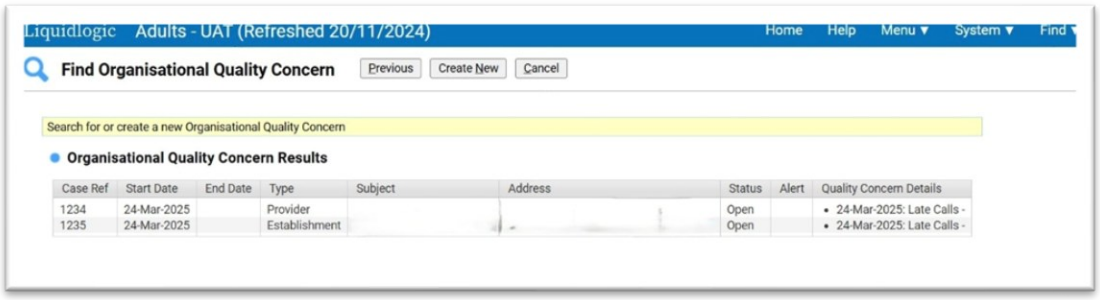
   Search by Provider

   Service Provider - from the drop-down menu, select the relevant provider

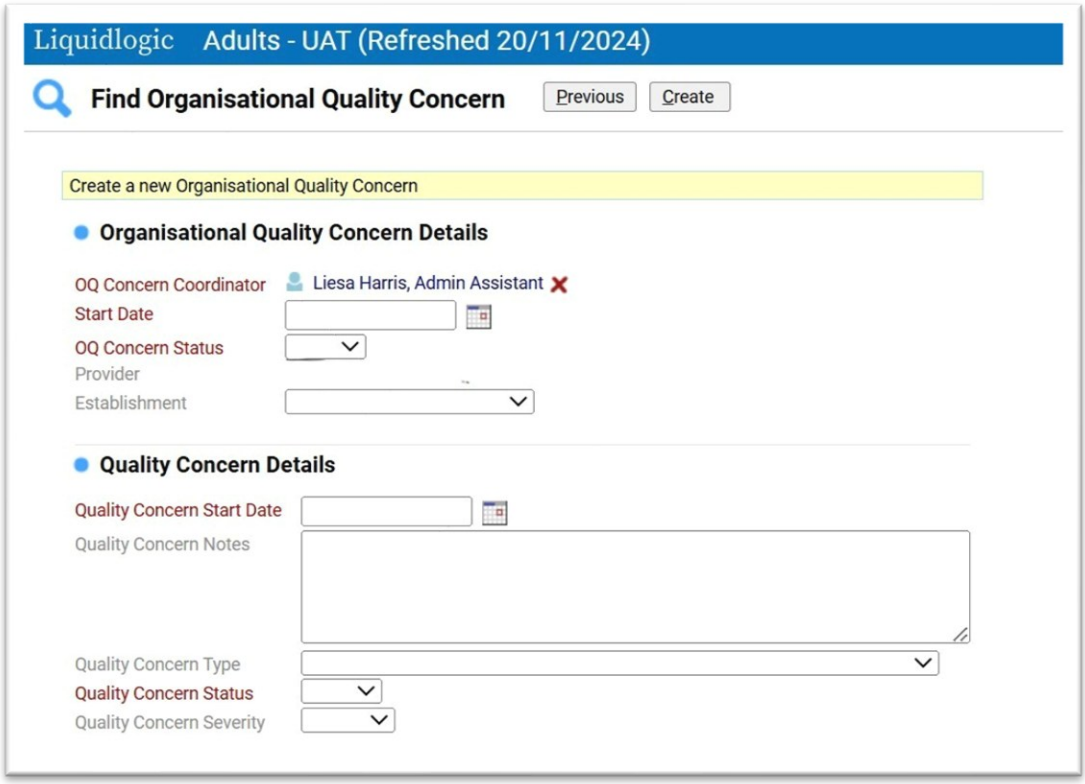
   Note: Some providers may appear multiple times – each variation relates to the type of contract they are under on ContrOCC. If in doubt, select the first one from the list

3. Click on **Search** at the top of the screen.

4. The following screen will appear showing any previous concerns for the selected provider. If it is a new concern, click **Create New** or review the details of any previous concerns, then click **Create New**



5. The following screen will appear:



Complete as much information as you have.

Organisational Quality Concern Details

Start Date - today's date

OQC Concern Status – select **Open** from the drop-down menu

Provider Establishment – will be pre-populated with the name selected on the previous screen

Quality Concern Details

Quality Concern Start Date – the date the concern was identified/witnessed

Quality Concern Status – select **Open** from the drop-down menu

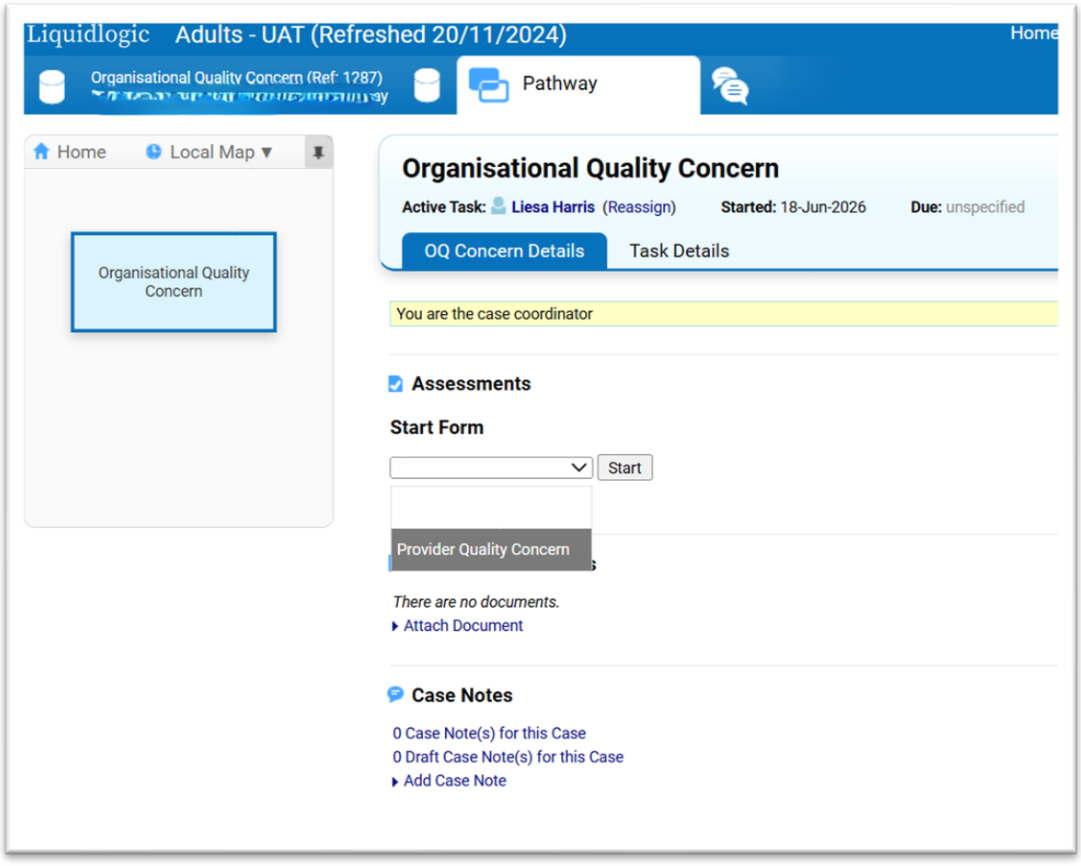
6. Click **Create** A warning message will appear asking if you are sure you want to start a new OQ Concern for your selected provider.



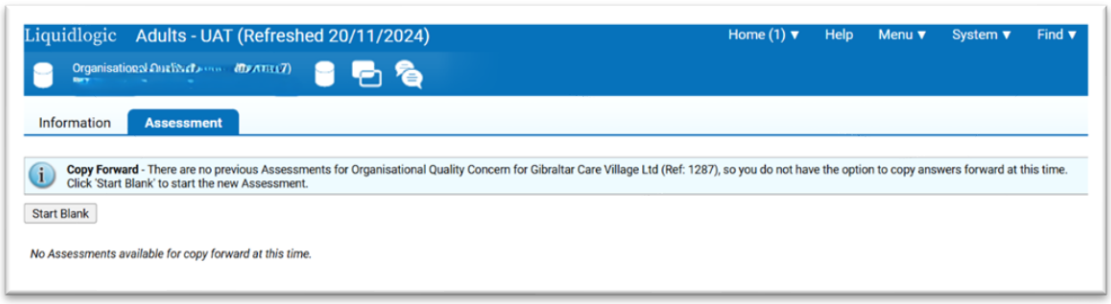
7. Click **OK** if it is the correct provider.

8. The following screen will appear.

   Start Form - Select **Provider Quality Concern** from the drop-down list then click **Start**

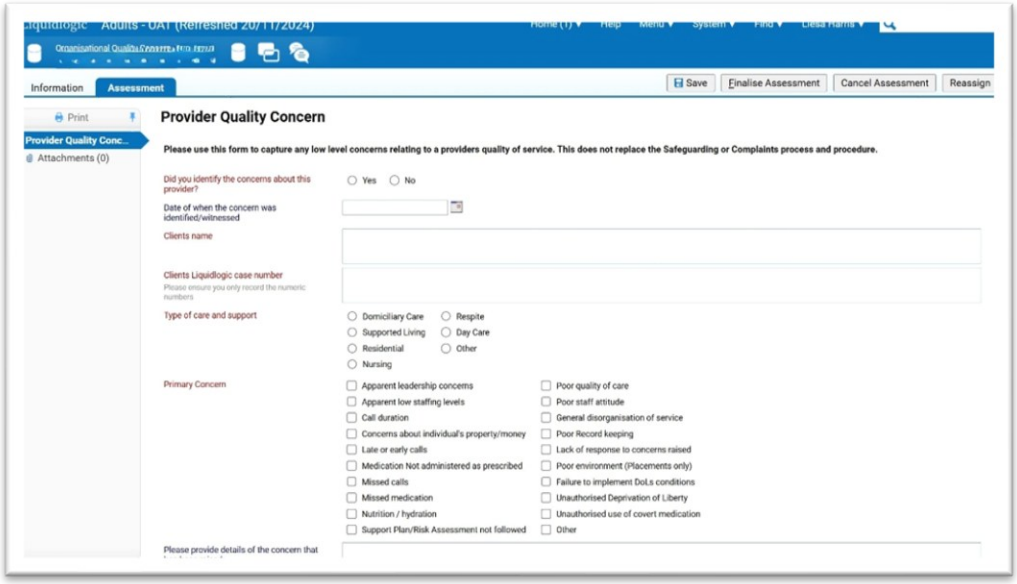


9. The following screen will appear. If you are adding to a previous concern, you can use **Copy Forward**. If you are starting a new OQ concern, click **Start Blank**



10. On the following screen, complete the form with as much detail relating to the concern as possible.

Note: Certain fields (coloured red) are mandatory: Did you identify the concerns about this provider?; Clients name; Clients Liquidlogic case number; Type of care and support; Primary Concern; Have you contacted the provider?; and Please select the applicable outcome for the concern raised.



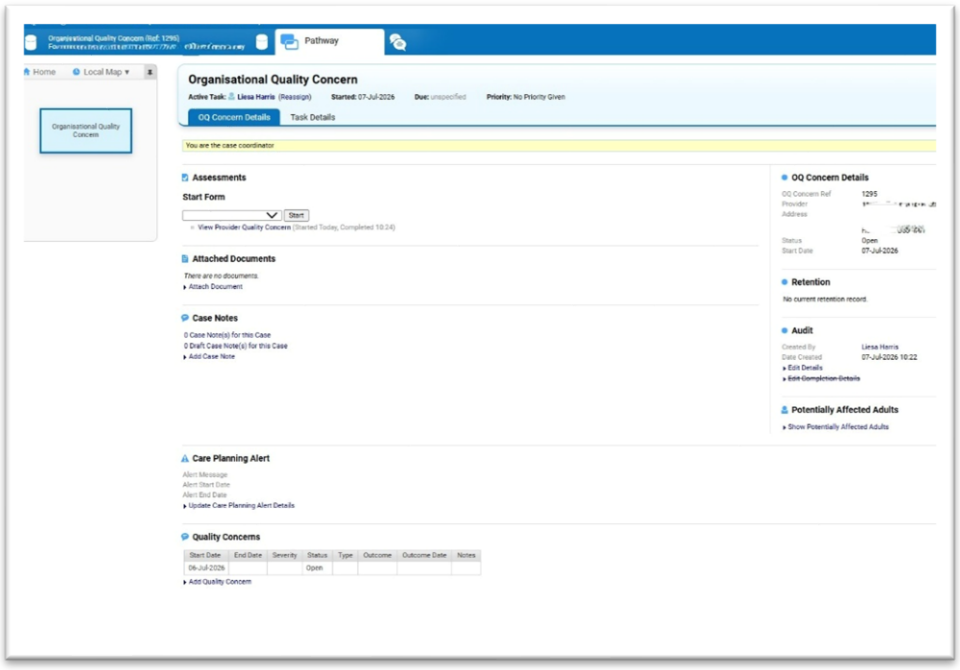
*Note: **Clients name** and **Clients Liquidlogic case number** should be N/A if the concern is intended for the Social Care Contracts and Quality Assurance Team.*

11. Click on **Finalise Assessment** at the top of the screen. The following warning message will appear.



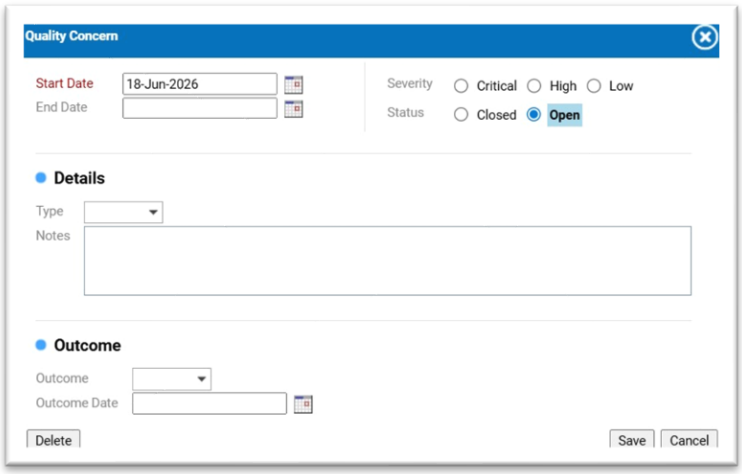
12. Click **OK** if you are happy to finalise the assessment.

13. The screen below will appear.



If your concern requires action from the Social Care Contracts and Quality Assurance Team. ***jump to step 20*** *now and continue from there. If you are dealing with the concern yourself (this should be the case if it relates to an individual) continue with this step.*

If you have resolved the concern you need to specify the outcome by clicking anywhere in the table appearing under **Quality Concerns**. The following window will appear:



Complete the necessary information.

End Date – enter the date the concern was resolved

Severity – click on the appropriate radio button to specify whether the severity is **Critical**, **High** or **Low**

Status - click on the **Closed** radio button

Details

Type – from the drop-down menu select the relevant type of concern e.g. Apparent leaderships concerns, General disorganization of service, Late calls, Medication not administered as prescribed – with symptoms, Support plan not followed etc.

Notes – add notes where necessary

Outcome

Outcome – select the relevant outcome from the drop-down menu e.g. Contracts to carry out reactive visit, No further action, Share with CQC etc

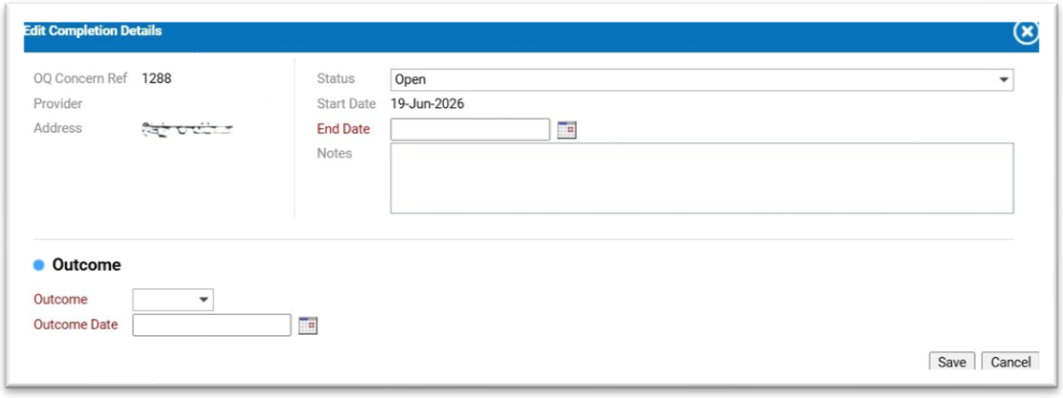
Outcome Date – enter the date of the outcome.

14. Click on **Save**

15. Under the **Audit** heading on the right of the screen, click on **Edit Completion Details**



16. The following window will appear:



Complete the necessary information.

Status – from the drop-down menu change the status from Open to **Closed**

End Date – add date the concern was resolved

Outcome – select relevant outcome from the drop-down menu

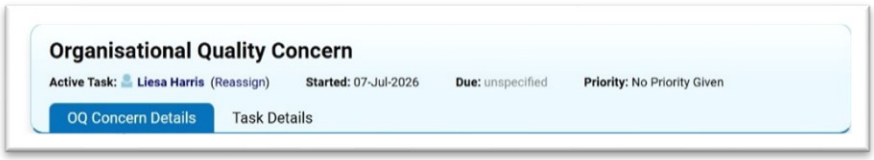
Outcome Date – add the outcome date

17. When the form is complete, click **Save**

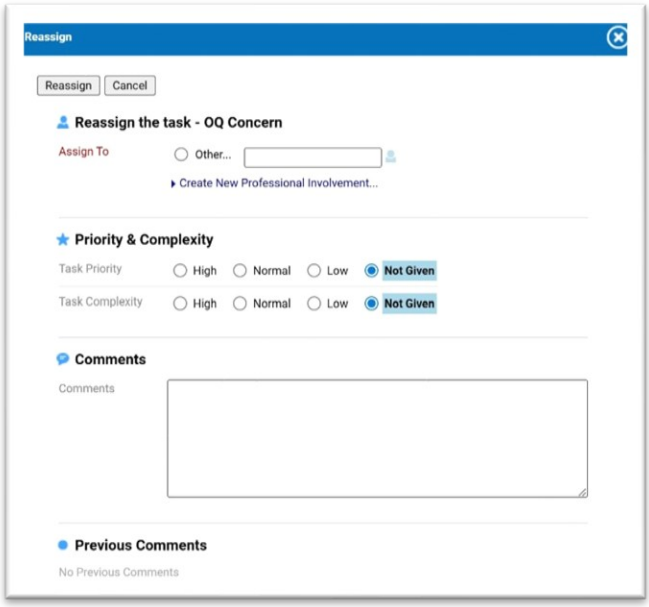
18. You now need to complete the Retention Record. Click on **Open Retention Record** and the following screen will appear

19. Click on **Finalise**

20. If your concern requires action from the Social Care Contracts and Quality Assurance Team (i.e. only if not in relation to an individual) after step 13, click on **Reassign** towards the top of the screen alongside your name.

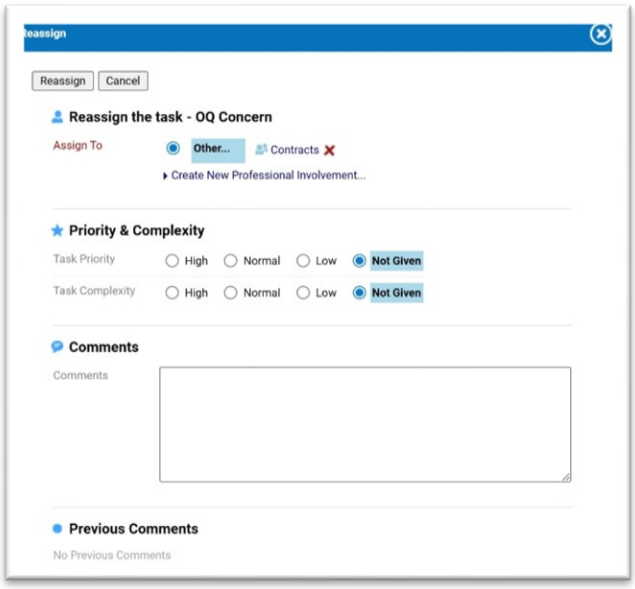


The following window will appear:

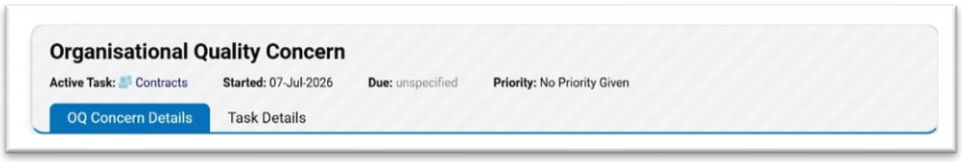


21. Click in the **Other** radio button and type **Contracts** in the box.

22. Click on **Reassign** in the top left of the window.



23. The task has now been reassigned to Contracts and your involvement ends here.



Social Care Contracts and Quality Assurance Team

Pick up the OQC from the Contracts Worktray

Go to your Worktray and click on the OQ Concern Task

Complete your investigation and then follow the process from step 13.