Cornwall and Isles of Scilly Safeguarding Adults Board

Organisational Abuse Procedures

October 2017

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Responding to Concerns of Organisational Abuse

These procedures should be read in conjunction with the Cornwall and Isles of Scilly Adult Safeguarding Policy, Operational Procedure and General Guidance.

1. Introduction

Adult Safeguarding is about preventing harm to adults at risk, and, if harm occurs, working in partnership with providers, commissioners and regulators to create a proportionate plan to address concerns. The Care Act (2014) is clear about the nature of this partnership, and the roles and responsibilities of all who work with adults at risk.

Safeguarding is everybody's business. Providers must meet the fundamental standards of care, whilst adults using services are safeguarded additionally through monitoring by providers and commissioners, regulation and inspection. An adult's wellbeing should also be secured by good commissioning, contracts management and, for some people, by care management or other forms of review.

Instances of poor care or abuse may occur in services provided to adults at risk, including hospitals, care homes, supported housing, colleges, and care provided in a person's own home. Providers must be aware of the possibility of poor care or abuse, have policies and procedures to minimise the risk of poor care or abuse, and take timely action to respond to concerns. Providers have a responsibility to provide safe, and good quality, care and support.

Commissioners should encourage an open culture around safeguarding, working in partnership with providers to ensure the best outcome for adults. Commissioners must regularly assure themselves of the safety and effectiveness of the services they are commissioning. The Care Quality Commission (CQC) must ensure that regulated providers comply with the fundamental standards of care and take enforcement action to ensure compliance. The police also have core duties to prevent and detect crime and protect life and property.

The local authority has a legal duty to enquire into concerns about abuse or neglect. The local authority may undertake an enquiry or may ask the provider to do so. The local authority will coordinate and quality assure the work undertaken.

In certain circumstances, poor care or harm can result from the way in which a provided service is managed or delivered. The Care Act (2014) defines this as "**Organisational Abuse**". This policy and procedure describes how agencies must work together to respond to concerns about organisational abuse.

2. **Glossary**

CCG – Clinical Commissioning Group, responsible for commissioning a range of healthcare services including health trusts and community health, in Cornwall.

CFA – Children Family and Adults Social Services

CC AST – Cornwall Council Adult Safeguarding Team

CIoS SAB – The Cornwall and Isles of Scilly Safeguarding Adults Board.

CQC - Care Quality Commission, regulator of social care and health providers.

CQC Fundamental Standards – standards below which care must never fall. See http://www.cqc.org.uk/content/fundamental-standards for details of the standards.

Duty of candour - Providers of health and social care must be open and transparent with adults about their care and treatment, if something goes wrong, the provider must tell the adult what has happened, provide support and apologise.

Provider – service which provides health or social care services.

SAB – Safeguarding Adults Board, the CIoS SAB leads adult safeguarding arrangements across Cornwall, it oversees and coordinates the effectiveness of the safeguarding work of its member and partner agencies.

Service Improvement Plan - A service improvement plan is a high level plan used to measure the effectiveness of interventions to ensure safety, governance, compliance, and clinical effectiveness of the service. The plan will include a quality assurance framework specifying how evidence for change is to be collected and how improvements will be measured. Evidence will include the experience of the people using the service and their representatives. The service improvement plan is the agreed framework for achieving, assessing and monitoring progress.

Whistle blower – a whistle blower is a member of staff in an organisation who reports certain types of wrong doing to an external agency. Whistle blowers are protected by law if they report a criminal offence, e.g. fraud, or that someone's health and safety is in danger and the employing agency has not responded to the danger.

3. Organisational abuse

"Including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation".

Care Act 2014 Chapter 14.17.

When *the structure, policies, processes and practices within an organisation,* are believed to be causing harm concerns will be addressed through an organisational adult safeguarding route. The local authority will coordinate enquiries regarding concerns about organisational abuse, working closely with providers, commissioners, the Care Quality Commission (CQC) and other agencies, to create a proportionate response which can quickly identify and take protective action as needed to support adults at risk using the service.

It is important to differentiate between concerns that require an organisational abuse s42 enquiry, and those that require an individual s42 enquiry. Individuals may be harmed or neglected by an individual member of staff within a provided service. The incident does not reflect the overall working practices of the organisation, the organisation responds well to manage the situation and to prevent any future harm. These incidents can be described, as appropriate, as a type of abuse, e.g. physical, financial, neglect, and enquiries can be undertaken through individual adult safeguarding arrangements. The allegations against people in positions of trust policy and procedures (CIoS SAB 2017) should also be referred to where applicable.

4. Principles

All Adult Safeguarding activity must follow six key principles (Care Act 2014)

Empowerment

People using provider services, or their representatives, will be involved in activity to resolve organisational abuse concerns. This may be about consulting service users about their experience of the quality of the service and changes they wish to see, it may be about ensuring that people are well informed of what is happening. Individuals may

have decided that they do not wish an individual safeguarding enquiry to take place regarding allegations of harm to them and do not consent to individual safeguarding. The outcomes of an organisational abuse enquiry should still be reported to them and their involvement sought. Specific attention must be paid to any difficulties people may have in participating in the adult safeguarding process, and advocacy must be considered for people in care settings

Prevention

Providers will work with all partners to ensure that the risk of abuse or neglect in their service is minimised. Following the CQC fundamental standards, services will be well managed and well led, freely use the expertise of other professionals, keep staff well trained and supported and continually promote person centred good quality care. These actions will all contribute to minimising the possibility of organisational abuse.

Proportionality

Responses must be proportionate to the level of, or risk of, harm presented.

Protection

All partners will work together to ensure that adults at risk using provided services have their rights upheld and have access to the full range of supportive and protective measures needed to safeguard their wellbeing.

Partnership

Providers should be informed of allegations against them or their staff, and be treated with courtesy and openness at all times. It is of critical importance that allegations are handled sensitively and in a timely way both to stop any abuse and neglect but also to ensure a fair and transparent process. Providers are a crucial part of any enquiry into organisational abuse. If a provider is unable to participate, for example because a corporate criminal issue is alleged, attention must be paid to under what circumstances a partnership approach can be initiated.

Accountability

It is of critical importance that allegations are handled openly, sensitively and in a timely way both to stop any abuse and neglect and to ensure a fair and transparent process.

5. Roles and Responsibilities

5.1 Care Quality Commission

CQC's primary responsibilities for safeguarding are:

Using the CQC inspection regime to ensuring that providers have the right systems and processes in place to make sure children and adults are protected from abuse and neglect.
Publishing ratings and inspection reports, so people who use services can understand if providers have effective systems to safeguard people.
Working with other inspectorates (Ofsted, HMI Probation, HMI Constabulary, HMI Prisons) to review how health, education, police, and probation services work in partnership to help and protect children and young people and adults from significant harm.
Holding providers to account and securing improvements by taking enforcement action using intelligent monitoring, to collect and analyse information about services, and responding to identified risks to help keep children and adults safe.
Working with local partners to share information about safeguarding.

Taken from: Statement on CQC's roles and responsibilities for safeguarding children and adults 2015

CQC must always be informed of any organisational abuse allegation or concern in a service they regulate.

5.2 Commissioners

Commissioners from the local authority, NHS and CCGs are all vital to promoting adult safeguarding. Commissioners have a responsibility to assure themselves of the quality and safety of the organisations they place contracts with. They must ensure that contracts have explicit clauses that hold the provider to account for preventing and dealing promptly and appropriately with any example of abuse and neglect.

Commissioners have a responsibility to intervene where services fall below fundamental standards, contractual standards, or abuse is found to be taking place. This may be via a service improvement plan with support to the provider to make improvements.

If contracts are breached, commissioners must make decisions about whether there should be conditions on how the service is commissioned, or if commissioning should cease. Where breaches are a result of substantiated organisational abuse these decisions will be informed by risk assessments from the local authority adult safeguarding team as to the current or future risks and mitigations within the service under consideration.

Commissioners must work with the local authority adult safeguarding team whilst enquiries into organisational abuse are undertaken. Commissioners will share the outcomes of quality assurance monitoring, as appropriate give support to providers as part of any service improvement plan and undertake assessment and monitoring of service improvement plans.

The service improvement plan will be over seen by commissioners and quality assurance teams who will report on progress to the CFA adult safeguarding team manager coordinating the work at agreed intervals.

Commissioners will be able to assist in identifying placing health services and local authorities and in communication with the placing authorities.

5.3 Providers

All service providers, including NHS, housing and housing support providers, should have clear operational policies and procedures that reflect the adult safeguarding framework set by the CIoS SAB. This includes what circumstances would lead to the need to report safeguarding concerns. Concerns must be reported to the local authority even where the provider is taking action themselves.

Providers must show leadership in their services and routinely monitor quality, they must meet the required fundamental and contractual standards. Staff must be trained in safeguarding procedures, and these must be effectively implemented. Providers must

investigate and respond appropriately to incidents, complaints and whistle-blowers, including undertaking section 42 enquiries when caused to do so by the local authority, and they must take action regarding staff who have abused or neglected people in their care.

Provider agencies should produce a set of internal guidelines for their staff which relate clearly to the CIoS SAB adult safeguarding multiagency policy; and which set out the responsibilities of all staff to operate within it. These should include guidance on:

- identifying adults who are particularly at risk
- recognising risk from different sources and in different situations and recognising abusive or neglectful behaviour from other service users, colleagues, and family members
- routes for making a referral and channels of communication within and beyond the agency
- organisational and individual responsibilities for whistleblowing
- assurances of protection for whistle blowers
- working within best practice as specified *in contracts with commissioners*
- working within and co-operating with regulatory mechanisms
- working within agreed operational guidelines to maintain best practice in relation to: challenging or distressing behaviour, personal and intimate care, control and restraint, gender identity and sexual orientation, medication, handling of people's money, risk assessment and management
- Internal guidelines should also explain the rights of staff and how employers will respond where abuse is alleged against them within either a criminal or disciplinary context.
- Providers must promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning. The Duty of Candour of Health and Social Care providers is specified in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

5.4 Police

Everyone is entitled to the protection of the law and access to justice no matter where they live. A criminal investigation by the police takes priority over all other enquiries or

investigations. Organisational abuse enquiries will involve agencies who can ensure the well-being of the adults at risk involved whilst the police undertake investigations. Potential offences may have occurred under the Mental Capacity Act section 44, or the Criminal Justice and Courts Act 2015, or under any other legislation. **See Appendix 4 Potential Criminal Offences in Provided Services.**

Police have a duty under legislation to assist those witnesses who are vulnerable and intimidated. A range of special measures are available to facilitate the gathering and giving of evidence by vulnerable and intimidated witnesses. These include:

- Giving evidence in court from behind a screen or ensuring privacy by having the public gallery cleared. Giving evidence from outside the courtroom via live video link or video recording a statement to be played in court.
- The assistance of a home office registered Intermediary to help the adult to understand the questions being asked, either during a police interview or in court, and to give the adult's answers accurately. Intermediaries are communication specialists who can help victims and witnesses who have difficulty communicating; they are not interpreters.

5.5 The local authority (Children, Families and Adults Directorate - CFA)

The local authority has a legal duty under section 42 of the Care Act 2014 to enquire into concerns or allegations about abuse or neglect for persons who are in its area, have a need for care and support and are experiencing or at risk of abuse and neglect and as a result of those needs are unable to protect themselves against the abuse or the risk of it. The Local Authoritywill take the lead role in all cases which invoke the organisational abuse procedures.

After information gathering from the provider, local authority Quality Assurance team, commissioners, and other agencies, the local authority adult safeguarding team will undertake an initial risk assessment and determine if the threshold for the use of the organisational abuse policy and procedures has been met.

The CFA Adult safeguarding team will determine the level of managerial oversight needed for an organisational abuse enquiry – **see appendix 2 table 2.**

The local authority adult safeguarding team will coordinate the enquiry, may undertake enquiries itself and may ask other agencies to contribute to an enquiry. The local authority adult safeguarding team will coordinate enquiries and quality assure the work

undertaken by others

The CFA adult safeguarding team will formulate a risk assessment with the input of multi-agency partners at each stage of the organisational abuse procedure, i.e. at the initial decision making regarding threshold, at the strategy meeting planning stage, during the enquiry, and whilst assessing progress of the safeguarding plan. The risk assessment will be shared with the provider. The risk assessment will be shared with commissioners and form part of assessments carried out by commissioners for the purpose of decision making about any restrictions on commissioning.

The CFA adult safeguarding team is responsible for coordinating the formulation of a safeguarding plan with multi-agency partners and providers to address the risks identified within the safeguarding risk assessment.

The local authority will, as the host authority, liaise with placing authorities who have responsibilities for people placed within the service of concern. When identification of placing authorities relates to a specialist health facility the assistance of health commissioners in particular will be appreciated.

The CFA adult safeguarding team will continue to coordinate and review organisational safeguarding plans until risks to adults using the service have diminished to a level that promotes well-being. The team will also support multi-agency processes for the purposes of a service improvement plan in services where abuse has been substantiated. The service improvement plan will be over seen by commissioners and quality assurance teams who will report on progress to the CFA adult safeguarding team at agreed intervals.

6. Indicators of Organisational Abuse

6.1 Organisational abuse or neglect may be exposed by one serious incident which results in the death or serious injury of an adult at risk, however the usual presentation will involve repeated incidents of poor care, unpleasant/negative service user experience, ill treatment, neglect or unsatisfactory professional practices. The persistence of abuse over time, or the potential for this to develop is consequently a key characteristic.

6.2 Identifying a spread or range of indicators is not proof of abuse, but an indication that further exploration is needed. Indicators can appear as external reports from third parties, for example external professionals, whistle-blowers, regulators or family /service user representatives. Reports from the provider themselves can also indicate concerns.

The importance of contact and conversations with the people using the service cannot be over emphasised. They will know directly what the experience of the service is. Where a spread of indicators is revealed, suggesting a pattern of concerns, this is not proof that people have been abused or neglected. Conversely, abuse can happen when concerns have not been previously indicated.

6.3 A pattern of indicators of concern does suggest that actions need to be taken to change and improve the service delivered and lower the risk that abuse or neglect will take place. Research undertaken by Hull University (*Early Indicators of Concern in Residential and Nursing Homes for Older People & Residential & Support Services for People with Learning Disabilities'.* October 2012) is used throughout this document to inform identification of risk indicators, risk assessment and safeguarding plans. The areas of concern identified by the research have been used effectively by regional and local authorities in England and Wales. Hull Researchers focused on care environments.

Many of the risk indicators found in the Hull studies have been identified by research carried out into care of older people on hospital wards by researchers on the Prevention of Abuse and Neglect in the Institutional Care of Older Adults (PANICOA) abuse and mistreatment of older people research programme. The findings are captured in "Respect and Protect" (2013) and highlight the absence of good leadership on a ward, lack of skill or knowledge of hospital staff on working with older people, especially those with dementia, time pressures, fast turnover of staff and poor environment as concerns that may lead to abuse or neglect of older people in a hospital setting. Whilst mental health and acute trust may have other, context specific indicators, the framework offered by the Hull research is a well-tested starting point in considering risk in a provided service.

6.4 The six areas of concern are

1) Concerns about management and leadership

2) Concerns about staff skills, knowledge and practice

3) Concerns about residents' behaviours and wellbeing

4) Concerns about the service resisting the involvement of external people and isolating individuals

5) Concerns about the way services are planned and delivered

6) Concerns about the quality of basic care and the environment

When practitioners notice indicators of concern in one single area only this is less likely to be associated with a high risk of abuse or neglect. This does not mean that action should not be considered or taken with regard to the concerns identified, but it does suggest that the level of actual risk may be lower. When concerns appear across several areas the level of risk to adults using the service is increased.

Specific descriptions of each of the six areas of concern can be found in **Appendix 1**

7. Responding to Organisational abuse:

7.1 Initial Decision – is an organisational abuse enquiry indicated? If so, at what level of response.

Concerns may be referred to the CFA adult safeguarding team regarding a direct concern about an individual incident or series of incidents. Or concerns may be identified by commissioners or quality assurance teams, by the regulator CQC or via trend analysis of patterns of concern around a service.

The CFA adult safeguarding team will gather a range of information from key agencies, including the provider, with which to a) assess the need for an organisational abuse response and b) to initiate a risk assessment which will inform the proportionate level of response needed.

The CFA adult safeguarding team will need to consider – is there a possibility that a crime has been committed? If so the police will need to be informed of the concern at the earliest stage to establish if any crimes have been committed that require a police role. **See Appendix 4 – potential criminal offences in provided services**

The Hull (2012) research areas of concern (**Appendix 1)** can be used to inform the decision whether there are a range of concerns which indicate that an enquiry is needed to determine whether organisational structures, policies and practices are the cause of reported abuse or neglect of adults at risk; and how improvements can be made so that service users' wellbeing is ensured whilst they are using the provided service.

Tools with which to assess the level and type of response according to the risk presented, can be found in **Appendix 2.**

If there is a possibility that a crime may have been committed an early discussion with police colleagues is indicated. If there are concerns about alleged criminal activity on the part of the manager or owner, it may not be possible to inform or involve the provider at this early stage.

7.2 Consent. If the referral is made by an adult at risk, whistle blower or member of the public consent must be sought to share the information they have given. Risks to their well-being and safety, and the well-being and safety of others, must be carefully discussed with them, preferably face to face. If an allegation or concern regarding a provided service requires an organisational abuse response this means that other people who use the service may be at risk of abuse or neglect, a refusal to consent can be overridden in the interests of the safety of others.

If there is a risk to the referrer or they refuse consent to disclose their identity, then every effort should be made to keep referrer anonymity. Whistle-blowers need to be aware that their identity may need to be disclosed during criminal or disciplinary investigations, and that if employed, part of their professional registration may include the duty to identify and take action when abuse or a risk of abuse is identified. However, whistle-blower anonymity or refusal to consent must not exclude undertaking enquiries into organisational abuse allegations and concerns, as others are or may be at risk of harm.

7.3 Involvement of adults at risk and their representatives.

Adults who use, or live in, a provided service will have expert knowledge on their experience of the service. They will also have thoughts on how the service may be improved. Adults may find it hard to talk about their experiences, they may be fearful of perceived repercussions or may be experiencing communication or mental capacity difficulties or be unwell. Several approaches can be used to enable the adult to inform and influence the enquiry and safeguarding plan.

- Independent advocates may be allocated to the service to represent adults who have difficulty in being involved in their own safeguarding and have no family or friends able to represent their views.
- Advocates may hold informal group meetings in the service.
- Individuals or groups may be consulted by the officer undertaking the enquiry.

- The provider and local authority may hold joint short meetings with people who use services
- A meeting with representatives may be held.

If the adults using services are unable to inform the enquiry or Safeguarding plan specific attention must be paid to their day to day lived experience of using the service. The enquiry may be informed by the formal observations from a dementia, head injury or learning disability professional.

Consideration of the best interests of people who do not have the capacity to make decisions about their own safeguarding **must** be taken during decision making and planning any enquiry or safeguarding plan. This means that a formal best interests decision must be made and documented regarding the adults needs during the enquiry; and how the subsequent safeguarding plan will uphold the person's best interests.

The adults' representatives, including families and friends, may also have experiences and thoughts to share. The enquiry officer may spend time within the environment where they can be approached by representatives, or can arrange to meet with representatives. The enquiry officer and provider may meet with representatives if appropriate.

Families and representatives may be encouraged to contact the enquiry officer or adult safeguarding team.

It is the Provider's role to keep the people using services, and where necessary their representatives, updated regarding adult safeguarding enquiries, safeguarding plans and service improvement plans. The local authority or as appropriate health commissioner, must monitor and support the Provider to do so.

7.4 Strategy meeting

An organisational abuse enquiry can be complex and involve several agencies. For this reason, the plan for any enquiry will be formulated in a strategy meeting rather than a series of discussions. Agencies, including providers, should have a clear agenda for any strategy meeting sent to them at least three days before hand, unless concerns are of such severity that an emergency meeting is needed. The agenda should detail the

concerns and what information the participant must bring to the meeting. Meetings must be minuted.

7.4.1 The purpose of the strategy meeting is to plan an enquiry into the allegations or concerns to establish the facts and the actions required to protect adults using the service. It must also assess any current known risks and immediate actions needed to protect adults in the service.

7.4.2 The Strategy Meeting will need to include:

- Sharing information about the safeguarding concerns and allegations. This may include reviewing previous referrals or trends, or outcomes from previous adult safeguarding enquiries. There may be information from other agencies, e.g. ambulance trust on call outs, acute trust on admissions or attendances at accident and emergency departments, GPs, care homes or domiciliary care provider son unsafe discharges, police.
- Sharing information from the Provider's own quality assurance systems.
- Sharing risk assessments and planning any immediate actions needed to protect adults using the service. **The interim Safeguarding plan** will need to include safeguarding actions, timescale and who is responsible, how will they report into the enquiry coordinator.
- Who is living in/a patient of, or using this service? What is known about their current experience, e.g. complaints, compliments, outcomes, reported incidents?
- Is a section 42 enquiry the most appropriate and proportionate response to concerns? For example, a period of monitoring by commissioners, with a follow up multi agency meeting may address the level of concern expressed.
- Terms of reference for the enquiry:

What is the most proportionate response to the level of risk posed? Are joint enquiries needed? **See table 1 in 7.6 below.**

- Are there senior managers in the provided service who can undertake a staff related enquiry?
- Confirm who is coordinating the enquiry and/or chairing meetings according to the level of concern (**see appendix 2**)

- Who will undertake these, how will these be prioritised, coordinated and supported?
- Police investigations into potential criminal activity take precedence over other forms of enquiry, for example staff disciplinary, fitness of managers. However, with good coordination it will still be possible to undertake enquiries which will contribute to the wellbeing and safety of adults using the service, e.g. health needs assessments. Whilst a police investigation is taking place the safety and wellbeing of adults using a service must still be addressed by the multi-agency partnership.
- What are the timescales involved?
- How will the adults using the service be involved? How will they be supported to express their views and wishes? Is there a need for advocacy and how will this be commissioned, for example an advocate may represent several adults in one setting.
- How will their representatives be involved?
- Are extra resources needed to ensure the safety of adults at risk – who will identify and contribute these?

- Communication strategy, including how the provider will be involved if they have not been invited to the meeting due to concerns listed below. How will adults using the service, their representatives, advocates be kept informed? Identifying placing authorities and confirming communication pathways with them together with expectations of their response during the enquiry.

- Media strategy, who needs to be notified and updated in agency press offices, what are the risks to adults at risk, the provider's reputation and the commissioners if there is media interest.

7.4.3 **Who should be involved in a Strategy Meeting?**

Attendees will be representatives from agencies who will be:

- undertaking enquiries into the allegation of abuse or neglect assessing the risk
- developing or carrying out the interim Safeguarding Plan
- taking action in relation to the person alleged to have caused harm

- undertaking related investigations such as those relating to complaints, serious incident, disciplinary, criminal investigation etc.

Representatives of the organisation subject to organisational abuse concerns should attend. They will be in a position to share and clarify information and will need to agree their participation in the interim safeguarding plan, enquiry and any subsequent safeguarding plan. However, provider representatives may not be able to attend the strategy meeting if:

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

Depending on the size of the Service Provider organisation, the nature of allegations and the circumstances of each enquiry, consideration should be given to involving:
• The manager of the service, this will be the registered manager if the service is regulated by CQC
• The Area or Regional Manager, or a senior manager, particularly if concerns relate to the conduct of the service's manager
• The owner, Company Director or Managing Director, in regulated services this will be the responsible person as registered by CQC.

Potential attendees are also listed **in Appendix 2 table 2.**

7.5 Responsibilities of Host and Placing Authorities

The communication plan must cover how placing authorities will be notified of concerns and their involvement ensured. It is the responsibility of Cornwall Council as the "Host" authority to inform placing authorities of concerns relating to the service. It can be particularly complex and demanding for a host authority to manage its responsibilities if there are many different placing authorities involved. Placing authorities may include both social care and health commissioners, and, for some specialist service providers, such as secure mental health or learning disability services, may involve both local and

regional specialised commissioning teams. Host authorities may need to be supported by commissioning colleagues in health and social care in identifying and contacting placing authorities in specialist settings. Good practice guidance on organisational enquiries involving many placing authorities is included in the ADASS (2016) Out of Area Safeguarding Arrangements at

https://www.adass.org.uk/out-of-area-safeguarding-adult-arrangements/

When concerns are major or persistently major (**see appendix 2, table 2**) and several placing authorities are involved a strategic management meeting may be required. This group will invite placing authorities to identify the most appropriate senior manager to represent their organisation and take responsibility for any required actions, setting up a sequence of meetings if required, to aid communication and wider strategic decision making.

7.6 The enquiry

The objectives of an enquiry under section 42 of the Care Act are to:

- establish facts
- ascertain the adult's views and wishes
- assess the needs of the adult for protection, support and redress and how they might be met
- protect from the abuse and neglect, in accordance with the wishes of the adult;
- make decisions as to what follow-up action should be taken with regard to the person or organisation responsible for the abuse or neglect
- enable the adult to achieve resolution and recovery

These objectives are applicable to enquiries into the concerns about an organisation. **See section 7.3 on involving adults and their representatives**.

Organisational abuse enquiries may involve separate, but coordinated, strands:

Table 1

Enquiry	Who could undertake
Establishing the views of the adults using the service Understanding the service from the viewpoint of the	The most appropriate person in the situation. This could be the professional who knows the adult best and who the adult trusts. Where an adult has substantial difficulty in being involved in the adult safeguarding enquiry, an appropriate person should be identified to represent

adults using it. Where particular individuals are affected, making sure they understand and are informed of the concerns and any proposed actions.	them, and if no appropriate person, an independent advocate must be appointed Formal observations by specialist staff may also be considered, for example dementia, head injury or learning difficulty specialists
Are care and support needs being met? Adults well- being and safety in the service? Establish any concerns about how the service is meeting the needs of individual adults and any actions/additional services needed during the enquiry to ensure wellbeing and safety	Social services / mental health team.
Are health needs being met i.e. physical /dental etc.? Establish concerns about how the service is meeting health needs. Are any actions/ additional services required during the enquiry to ensure wellbeing and safety.	NHS CCG nurses / mental health team / community health teams
Is the environment safe? Are the premises fit for purpose and safe? Is equipment safe? Are infection control measures being taken?	CCG Infection control nurses CFA Quality Assurance team for care providers Health commissioners for health settings. In regulated settings, CQC In non-regulated the HSE
Is the home meeting contractual standards?	CFA Quality Assurance team for care providers CCG commissioners for health providers
Are there criminal activities?	Police

Are there concerns about the fitness of the registered service Provider?	CQC
Serious Incident (SI) in NHS settings	Root cause analysis investigation by relevant NHS Provider
Unresolved serious complaint in health care setting	CQC, Health Service Ombudsman
Breach of rights of person detained under the MCA 2007 Deprivation of Liberty Safeguards (DoLS) (Schedule A1 of the MCA 2005) Adults unlawfully deprived of their liberty	CQC, Local Authority, Court of Protection.
Breach of terms of employment / disciplinary procedures	Employer
Breach of professional code of conduct	Professional regulatory body.

A CFA adult safeguarding manager from the adult safeguarding team will lead and coordinate enquiries. **All enquiry officers must keep the adult safeguarding manager updated and bring any newly identified risks or need for changes in interim safeguarding plans to the managers' attention**.

Throughout the enquiry risk assessments must be undertaken and the initial risk assessment will be updated and shared with all involved by the adult safeguarding manager as facts emerge. Actions to address and mitigate risk must also be recorded.

The provider should be kept informed of risk identified in order to implement mitigating actions and to begin formulating a service improvement plan.

7.7 **Outcomes and Planning case conference**

The purpose of the meeting is to:

7.7.1 discuss and agree the findings from the **enquiry:**

- Is the service safe, does the service meet the expected quality standards, does the service support the well-being of the people using it?
- Is there need for further enquiry? If so what and who by? timescales.
- Review risk assessments – are people using the service safe?
- Do Commissioners need to make decisions about current use of the service?

7.7.2 Immediate safeguarding plan – is it effective, still needed, changes to the plan, further actions needed.

- if still needed confirm **the safeguarding plan**
- confirm the route for escalation should further risk be identified/safeguarding plan fail.

Generally, the safeguarding plan will address acute safety issues. For example:

- The manager's actions or lack of action is putting adults at serious risk
- Basic needs are not being met, i.e. there is no heating, no hot water, people are not offered food or drink, basic health needs are not attended to.
- The call system is broken and no practical alternative has been found.
- Staff behaviours are placing adults at serious risk of harm.
- Staff do not have the skills to care for people with particular clinical needs and this is placing adults at serious risk.
- Adults have been injured including deterioration in pressure areas or serious issues with catheter care etc.

These issues need immediate resolution and will be addressed by a safeguarding plan. Until these issues are resolved it will not be possible to begin to improve the quality of the overall service.

7.7.3 there concerns about service quality – are improvements needed? Is there a need for a **Service improvement plan?**

A service improvement plan is a high level plan used to measure the effectiveness of interventions to ensure safety, governance, compliance, and clinical effectiveness of the service. The plan will include a quality assurance framework specifying how evidence for change is to be collected and how improvements will be measured. Evidence will include the experience of the people using the service and their representatives. The

Service Improvement Plan is the agreed framework for achieving, assessing and monitoring progress. The CFA adult safeguarding manager, quality assurance officers and the provider will retain a copy. The plan will be reviewed at timescales agreed at the case conference. In some circumstances only a Service Improvement plan will be needed.

If a service improvement plan is needed the case conference will review any action plan drawn up by the provider and agree:

- the issues that need to be included in the service improvement plan
- how progress will be evidenced and evaluated
- the escalation pathway should improvements not progress as agreed
- timescales for the improvement plan.

7.7.4 he conference will

- agree a communication plan for interaction with placing authorities, people using the service, other stakeholders.
- agree a media plan, the input of council media officers will be useful to the meeting.
- Agree any update meetings needed and review intervals for the safeguarding plan and/or service improvement plan.

7.8 **Reviewing Plans:**

The frequency of reviews will be agreed at the Outcomes and Planning case conference. An escalation route will also be agreed should issues with either the safeguarding plan or service improvement plan be identified by any agency, including the provider. The review meeting will consider:

- Are adults safe? Is a new safeguarding plan needed?
- Has a need for further enquiry been identified?
- Progress on the service improvement plan as evidenced by the quality assurance framework.

7.9 **Closing the organisational abuse procedures**:

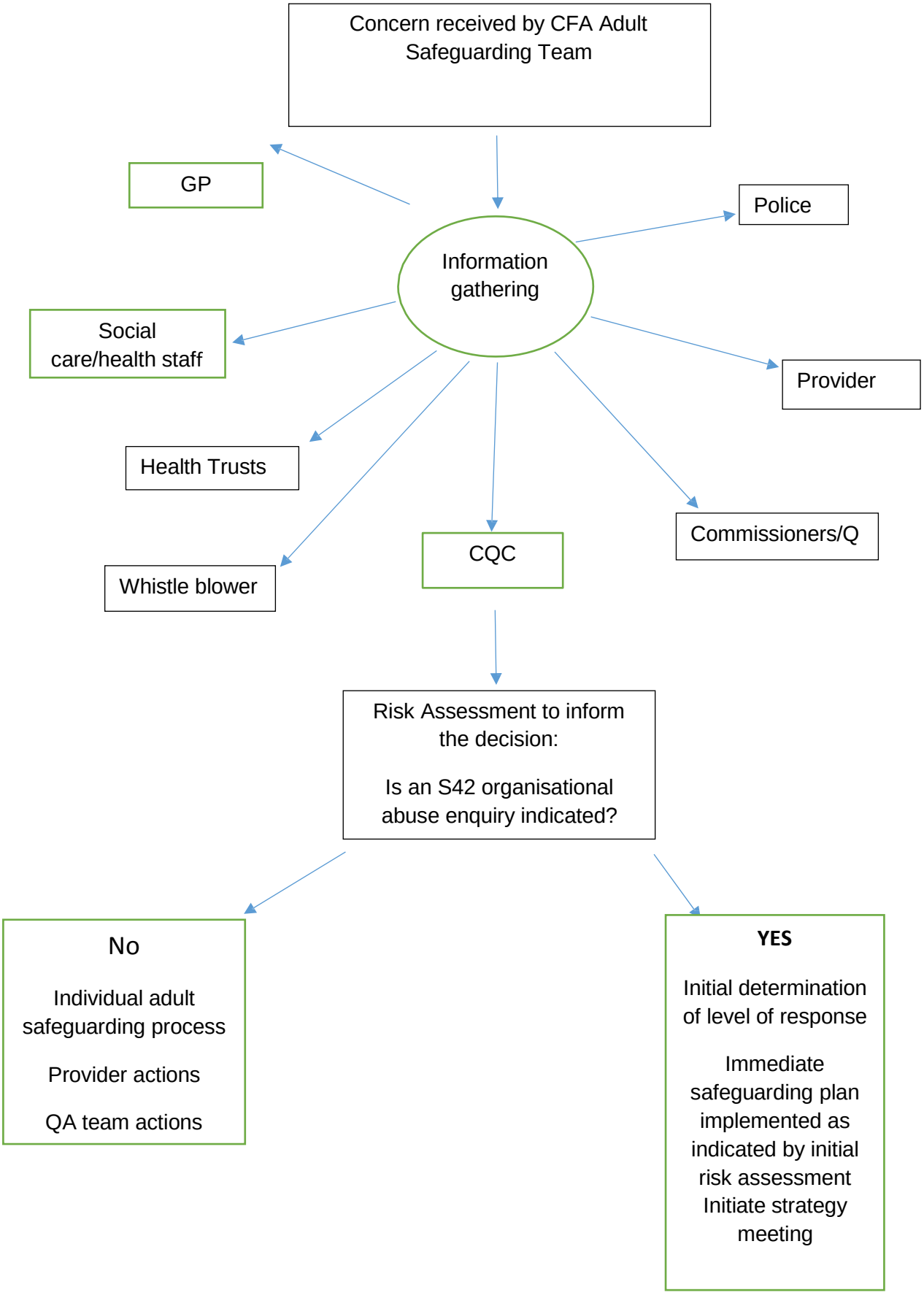
Once adults are safe, improvements are complete and can be evidenced as sustained, the process will formally come to an end and the relevant parties including

the provider and the CQC will be notified in writing by the CFA adult safeguarding manager.

8. Reflection on learning. In some cases, an event to share reflections on learning may be helpful after the conclusion of the adult safeguarding process. All involved can consider what worked in resolving concerns, what helped the service improve? What were the challenges? How were the adult safeguarding procedures experienced by the provider? Feedback from service users or their representatives will form part of the event. A summary of the findings and learning from the event can be presented to the CIoS SAB.

Flow Chart of Organisational Abuse Procedures 1

Decision Making



Flow Chart of Organisational Abuse Procedures 2

Organisational Abuse Section 42 Enquiry

Strategy Meeting

Share information

Review risk assessments and safeguarding plan. Determine if extra resource is needed to ensure safety

Confirm S42 proportionate response

Plan enquiry, including how adults will be involved, advocacy resource needed.

S42 Enquiry

Enquiries are managed and coordinated by the CFA adult safeguarding team.

Risk assessments and safeguarding plan continually updated

Outcomes and Planning case conference

Share and agree findings from the S42 enquiry

Review risk – are adults safe?

Review and make changes to the safeguarding plan

Does the service meet contractual standards?

If indicated agree a service improvement plan with specific QA framework to be implemented after the safeguarding plan is concluded.

Agree communication plan, media strategy, stakeholder updates, review intervals, escalation pathways

Flow Chart of Organisational Abuse Procedures 3

Assess and Review

Review meetings at agreed intervals:

Are adults safe? Is a new safeguarding plan needed?

Any need for further enquiry?

Progress on service improvement plan as evidenced by the quality assurance framework

People continue to be safe

Improvements are complete and can be sustained

Adult Safeguarding procedure complete and concluded

Adult Safeguarding service manager confirms in writing to provider and CQC

Lessons learned summary completed – what has been learned? What worked?

Appendix One – Descriptors for the six areas of Concern – adapted from Hull University (2012) and PANICOA (2013)

The term "adult(s) used below refers to people who may live in a service, be patients on a hospital ward or use a provided service.

1. **Concerns about management and leadership**

The first section is about the people who manage the home, ward or other service and other managers in the organisation. What are they doing, or not doing, that gives you cause for concern?

Is there evidence from the referral information, from other information gathering or enquiry that:

- There is a lack of leadership by managers, for example managers do not make decisions and set priorities
- The service is not being managed in a planned way, but reacts to problems and crises
- The manager is unable to ensure that plans are put into action
- The managers know what outcomes should be delivered for the service user/patient group, but appear unable to organise the service to deliver these outcomes, i.e. they appear unable to 'make it happen'
- Senior as well as operational managers appear unaware of serious problems in the service
- Managers do not promote the Duty of Candour when incidents occur.
- Managers do not support staff to report concerns
- The service does not respond appropriately when a serious incident has taken place. They do not appear to be taking steps to reduce the risk of a similar incident happening again
- Managers appear unable to ensure that actions agreed at reviews and other meetings are followed through
- Managers do not appear to be paying attention to risk assessments or are not ensuring that risk assessments have been carried out properly
- Managers do not appear to have made sure that staff have information about individual adult's needs and potential risks to adults.
- The manager leaves staff to get on with things and gives little active guidance. The manager is not role-modelling good practice to the staff team. They are not involved in practice with adults.
- The manager is very controlling
- The managers have low expectations of the staff
- There is a high turnover of managers
- The service is experiencing difficulties in recruiting and appointing managers

- The manager leaves suddenly and unexpectedly
- The manager is new and doesn't appear to understand what the service is set up to do
- A responsible manager is not apparent or available within the service, for example they may be on holiday or covering other services
- Arrangements to cover the service whilst the manager is away are not working well
- The services' resources are not being deployed effectively to meet the needs of the adults. For example, there is a high turnover of staff, staff are working long hours, staff are working when they are ill, there is poor staff morale. There has been a lack of investment in the environment which has resulted in hygiene and safety issues.

2. Concerns about staff skills, knowledge and practice

This section is about the people who work in the home, on a ward or other service. What are they like? What are they doing or not doing, that gives you cause for concern?

Is there evidence from the referral information, from other information gathering or enquiry that:

- Staff appear to lack the information, knowledge and skills needed to support older people and/or people with dementia/people with learning difficulties, mental health issues or disabled people.
- Staff appear challenged by some adult's behaviours and do not know how to support them effectively
- Staff do not manage adult's behaviours in a safe, professional or dignified way. For example, staff send adults to their rooms, use medication inappropriately or ignore an adult's behaviour which challenges without an agreed plan to support this.
- Members of staff perceive the behaviours or attributes of adults as a problem – and blame the adult.
- Staff blame the adult's confusion or dementia for all their difficulties, needs and behaviours; other explanations, i.e. physical, environmental, cultural or individual needs do not appear to be considered
- Members of staff are controlling of adults
- Adults are punished for behaviours which are seen to be inappropriate
- Staff treat adults roughly or forcefully
- Staff ignore adults' requests for help or need for social interaction
- Staff shout at adults and are impatient
- Staff shout or swear at adults
- Staff talk to adults in ways which are not complimentary or are derogatory
- Staff do not alter their communication style to meet individual needs. For example, they speak to adults as if they are children, they 'jolly people along'
- Members of staff use negative or judgemental language when talking about adults

- Staff do not see adults as individuals and do not appear aware of their life history
- Staff do not ensure privacy for adults when providing personal care or undertaking a medical examination or procedure
- Record keeping by staff is poor
- Staff do not appear to see keeping records as important
- Risk assessments are not completed or are of poor quality. For example, they lack details or do not identify significant risks
- Incident reports are not being completed
- There is a particular group of staff who strongly influence how things happen in the service
- Staff informally complain about the managers to visiting professionals
- Staff lack training in how to use equipment

3. Concerns about adult's behaviours and wellbeing

This section is about the people who live in the home or service or are patients on a ward. How are they? Is there anything about their behaviour or presentation that gives you cause for concern?

Is there evidence Is there evidence from the referral information, from other information gathering or enquiry that that one or more of the adults:

- Show signs of injury due to lack of care or attention (e.g. through not using wheelchairs or manual handling equipment carefully or properly)
- Appear frightened or show signs of fear
- Behaviours have changed
- Appearances have changed, for example they have become unkempt or are dressed in inappropriate or undignified clothing
- Are showing weight loss when there is no medical evidence to explain this
- General health is suffering as simple nursing needs are not being met
- Are developing pressure areas which could be prevented
- Have overflowing catheter bags, dirty dressings
- Are not having basic care needs met and the person is unkempt, e.g. dirty fingernails, smells, bed linen is unchanged.
- Moods or psychological presentation have changed
- Behaviour is different with certain members of staff/when certain members of staff are away
- Engage in inappropriate sexualised behaviours
- Do not progress as would be expected in a caring environment
- Do you experience the overall atmosphere as flat, gloomy or miserable?
- Or noisy, frantic and rushed?

4. Concerns about the service resisting the involvement of external people and isolating individuals

- Are the people in the home, ward or service cut off from other people? Family? Friends? Visiting professionals? Advocates or representatives? Their community? Is it a “closed” or an “open” sort of place?

Is there evidence from the referral information, from other information gathering or enquiry that:

- Managers and/or staff do not respond to advice or guidance from practitioners, advocates, representatives and families who visit the service
- The service is not reporting concerns or serious incidents to families, external practitioners, advocates, representatives or agencies
- The service does not pass on information and communicate with adult’s families, advocates, representatives and external practitioners as appropriate
- Managers do not appear to provide staff with information about adults from meetings with external people, for example review meetings
- Staff or managers appear defensive or hostile when questions or problems are raised by external practitioners, advocates, representatives or families
- Staff are hostile towards or ignore practitioners, advocates, representatives and families who visit the service
- The service does not liaise with families or friends and ignores their offers of help and support
- Managers or staff are defensive and concerned to avoid blame when things go wrong or there are problems
- There is no support for the duty of candour
- Staff or managers give inconsistent responses or account of situations
- There are adults who have little contact with people from outside the service, no befriender or advocate involved.
- There are adults who are not receiving active monitoring or reviewing (e.g. people who are self-funding, people who are subject to Deprivation of Liberty safeguards) and have no friends, family or representative.
- Adults are being kept isolated in their rooms and are unable to move to other parts of the building independently (‘enforced isolation’)

5. Concerns about the way services are planned and delivered

This is about the way in which the service is planned and delivered to individuals and to groups.

Is there evidence from the referral information, from other information gathering or enquiry that:

- There is a lack of clarity about the purpose and the nature of the service

- The service does not appear able to deliver the service or support it is commissioned to provide. For example, it is unable to deliver effective support to people with distressed or aggressive behaviour
- The service is accepting adults whose needs and/or behaviours are different from or incompatible with those of the adults previously or usually admitted
- The service is accepting adults whose needs they appear unable to meet
- There appear to be insufficient staff to support adults appropriately
- There is a fast turnover of staff
- Adults' needs as identified in assessments, care plans or risk assessments are not being met.
- The layout of the building does not easily allow adults to socialise and be with other people

6. **Concerns about the quality of basic care and the environment**

Are basic needs being met? What is the environment like?

Is there evidence from the referral information, from other information gathering or enquiry that:

- There appear to be insufficient staff to meet adults' needs
- There is poor or inadequate support for adults who have health problems or who need medical attention
- Adults are not getting the support they need with eating and drinking, or are not getting enough to eat or drink
- The service is not providing a safe environment
- Staff are not checking that adults are safe and well
- There are a lack of activities or social opportunities for adults
- Adults do not have as much money as would be expected
- Adults lack basic things such as clothes, toiletries
- Support for adults to maintain personal hygiene and cleanliness is poor
- There is a lack of care for adults' property and clothing
- The service does not have the equipment needed to support adults
- Equipment is not being used or is not being used correctly
- Equipment or furniture is broken
- The service is not providing equipment to keep adults safe
- Staff are not using manual handling equipment / wheelchairs safely and correctly
- Staff are not using correct pressure mattresses or cushions, other pressure relieving equipment
- The environment is dirty and shows signs of poor hygiene
- The quality of the environment has deteriorated noticeably, broken articles are not replaced, areas are undecorated.
- Levels of activity for adults have declined noticeably

Appendix 2 Risk assessment and levels of response.

When an organisational abuse concern is received, the Adult Safeguarding team will carry out a risk assessment. The risk assessment will need to be revisited throughout the process as circumstances change. The risk assessment will focus on **the impact the circumstances under consideration will have on people using the service.**

A combination of assessed impact and likelihood will determine the **level of concern** (Minor. Moderate, Major), as summarised in the table below.

1: Determining level of concern

Table 1

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

1.1 Impact Criteria

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

MEDIUM: A moderate impact on wellbeing and safety but limited provided remedial action is taken with no long-term effects on the wellbeing or safety of people using the service.

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

1.2 Likelihood Criteria

UNLIKELY This is unlikely to happen or recur due to control measures and process in place.

POSSIBLE This may happen but it is not a persistent issue and there are measures in place to prevent a reoccurrence.

ALMOST CERTAIN This will probably happen/recur frequently. Remedial processes are not effective or there are serious concerns about the control measures, loss of confidence in the provider's ability to care for people safely.

1.3 Level of Concern.

The indicators in Appendix 1 can be used to provide detail to the level of concern, i.e. minor, moderate, major and persistently major. Judgements should be evidenced so that all involved can identify the areas of risk that need to be addressed (table 2 evidenced risk summary).

MINOR People are generally safe and their wellbeing is upheld, but shortfalls in quality of provision mean that outcomes may not be consistently achieved. There may be minor concerns in one or two of the Concern areas, there are no concerns about service users' behaviours or wellbeing, or about the quality of basic care. There is a registered manager in place and evidence that they will identify and act on concerns.

MODERATE People remain generally safe and their wellbeing is upheld, but there are specific identified risks to their health and wellbeing. There is an inconsistency in the quality of care given, i.e. there are a persistent number of minor concerns over a period of time. The service's ability to the needs of people with more complex conditions is questionable. Appropriate policies and procedures are in place and known to most staff but they are not consistently followed to ensure the prevention of abuse or neglect. Most staff have received appropriate training but it is not comprehensive, up-to-date or reliably put into practice. A registered manager is in place and but does not consistently identify and action concerns. There are concerns in three or four Concern areas.

MAJOR The number and/or seriousness of referrals made indicate that people are not protected against unsafe or inappropriate care. There are concerns across the Areas of concern including service user's behaviours and wellbeing, and the quality of basic care. There are concerns about the manager's ability to improve the service and/or the organisations support to do so.

PERSISTING MAJOR: There have been previous organisational abuse safeguarding enquiries and safeguarding plans but the provider is still unable to address the safety and wellbeing of the people using the service. There are significant concerns across all areas of concern, including service user's behaviours or wellbeing, the quality of basic care and the management and leadership of the service.

2. **Evidenced Risk Summary**

It is important to remember that one risk indicator domain does not in itself indicate that the organisational safeguarding concern needs to be addressed using the organisational abuse procedures. Research (Hull 2012) has shown that a spread of concerns across three or four domains are more likely to indicate the need for an organisational abuse enquiry. In considering impact it is important to think about the impact across all using the service, or across adults with a specific need, rather than about the impact on an individual. Evidence for likelihood of recurrence will include previous adult safeguarding concerns (in the last year), lack of improvements despite service improvement or safeguarding plans, or inability to complete previous quality assurance/CQC action plans.

Table 2

Indicator of concern	**Evidence for assessment**
Concerns about management and leadership	
Concerns about staff skills, knowledge and practice	
Concerns about residents' behaviours and wellbeing	
Concerns about the service resisting the involvement of	

external people and isolating individuals	
Concerns about the way services are planned and delivered	
Concerns about the quality of basic care and the environment	

Level of Concern	**Summary**

A worked example:

Indicator of concern	Evidence for assessment
Concerns about management and leadership	Previous QA action plan requirements to train all staff in manual handling are not complete, currently the service is 60% compliant. All adults in the service need careful manual handling and five require the use of specialist manual handling equipment. The manager has cited inability to release staff from the rota as a reason for non-completion. The manager is unable to ensure that trained members of staff are always on rota.
Concerns about staff skills, knowledge and practice	40% of staff are unskilled in manual handling of people, three substantiated adult safeguarding referrals in the last two months relate to poor use of equipment or injuries sustained during manual handling. A fourth referral has just been received regarding unsafe use of a hoist and consequent psychological harm to the adult concerned.
Concerns about residents' behaviours and wellbeing	Three service users have been injured during poor manual handling. Relatives and visiting professionals have expressed concerns about the dignity, emotional wellbeing and safety of other adults.
Concerns about the service resisting the involvement of external people and isolating individuals	None noted, however the service has not responded to requests to remedy concerns from visiting professionals or relatives and has not complied with the CFA QA team action plan.
Concerns about the way services are planned and	Further staff have not been released to attend manual handling training and there is no evidence of plans to adjust rotas to allow this to happen. It is not yet known whether rotas can allow for sufficient flexibility to respond to other

delivered	training or service requirements.
Concerns about the quality of basic care and the environment	All adults currently at risk as the service is not providing a safe environment; systems to promote safety; i.e. manual handling equipment, is being used in an unsafe way; adults are being moved unsafely and as a result are being injured.

Level of Concern	**Summary**
Major	All adults in the service are at risk of harm as all staff working with them are not sufficiently qualified to undertake correct manual handling. The manager is aware but has not acted to remedy this. Harm continues to be caused by shortfalls in the service. The impact of harm is high, and the likelihood almost certain as untrained members of staff continue to be on rota. Although other aspects of the service appear compliant, for example the staff are caring and other aspects of the care and environment good, the risk of injury or even death in a frail population from unskilled manual handling, coupled with a loss of confidence in the management and leadership of the service to remedy the shortfall, place these concerns in a “Major” category.

Table 3 Responses to levels of concern				
LEVEL OF CONCERN **MINOR** **Unlikely, possible low or medium impact**	**Area of concern** • There is a referral about an individual • Overall the service is not materially affected and quality of adults' life is not significantly affected, although there is a risk of low impact shortfalls. • Residents/Patients are not at risk of harm. • Managers can retain quality with increase support from own organisation/QA teams. **DOES NOT MEET THRESHOLD FOR ORGANISATIONAL ABUSE**	**Action needed** An individual S42 enquiry with the adults consent or in their best interest if they do not have the capacity to consent. Support/monitoring from the providers' senior/safeguarding managers and where appropriate QA teams Information to CQC/Commissioners	**Partners involved** CFA locality teams Provided service Relevant QA team	**Oversight** Relevant quality assurance team

Level of concern	Area of concern	Action needed	Partners Involved	Oversight
MODERATE	• There have been several individual safeguarding concerns or one major concern • Medium impact service shortfalls are taking place across the service and major impact shortfalls are possible • There is a failure at systems level to deliver service users'/patients outcomes across a range of needs • The manager is failing to consistently identify and act on the above **ORGANISATIONAL ABUSE THRESHOLD MET**	Organisational safeguarding procedure Adult Safeguarding Risk assessment Consider need for organisational Safeguarding Plan Consider need for a Service Improvement plan Information shared with CQC to inform decision making re inspection/actions Monitoring via Adult Safeguarding/QA follow up Commissioners consider need to review commissioned service/temporary restrictions may need to be negotiated with provider whilst improvements take place. If negotiations fail restrictions can be imposed and reviewed via organisational abuse process	Provider CFA QA CCG CQC	CFA Adult Safeguarding Team

MAJOR	• Abuse/neglect is in evidence across a wide range of provision • Residents/patients are all at risk of harm • Medium and major impact shortfalls evident • Quality of life is affected. • Lack of confidence in the managers to deliver appropriate care and prevent abuse • Lack of support from the wider provider organisation **ORGANISATIONAL ABUSE THRESHOLD MET**	• Longer term organisational safeguarding activity. • Need for safeguarding plan • Service Improvement plan indicated if provider will engage. • Recommended CQC random inspection • Targeted individual reviews of residents/patients • Commissioners consider Review of commissioned service/temporary restrictions to be negotiated with provider whilst improvements take place. • If negotiations fail commissioners may consider imposing restrictions reviewing with provider via organisational abuse process.	Provider CFA QA CCG CQC Police	CFA Adult Safeguarding Service Manager

Level of Concern	Area of concern	Action needed	Partners involved	Oversight of concerns
PERSISTENTLY MAJOR	• People using the service are unsafe • There is a loss of confidence in the organisation • There have been a series of safeguarding and/or service improvement plans relating to safeguarding concerns over a period of time, but improvements are not sustained • There is a danger of reputational damage to the Commissioning agencies **ORGANISATIONAL ABUSE THRESHOLD MET**	• Longer term organisational safeguarding • Safeguarding Plan in place • Meeting with organisation senior managers • Some potential for service improvement plan if provider will fully engage • Recommended CQC random inspection • All service users reviewed according to an agreed plan of priority and timescale • Commissioners review any restrictions already in place • Consider need to plan for service closure	Provider CFA QA CCG CQC Police Media Officers	Service Director, CFA

Appendix 3

Working with services which deliver Poor Outcomes

Cornwall Council

April 2017

Introduction

1. The aim of this policy is to ensure that people who use services commissioned by Adults Care and Support are:

• Provided with at least a minimum standard of quality in service provision.

• Protected when that level of quality falls below the minimum standard.

• Supported wherever possible to retain their service of choice through Education, Health and Social Care supporting providers to improve their standards.

2. The key principles which underpin this policy are:

• Protection – of the Human Rights of vulnerable people who use services,

• Equality – working to ensure that people who use services, staff and providers are treated equally and fairly and in accordance with the Equality Act 2010,

• Diversity – working to support the diverse needs of people,

• Partnership – working with service providers, with people who use services and with family carers and representatives to maintain and improve outcomes for people,

• Transparency and Accountability – working to ensure that people know what standards are expected from commissioned services, how standards and outcomes will be monitored and how action will be taken to improve standards and outcomes where required.

3. This policy covers the approach to services which are providing poor outcomes for people and the responsibilities of Cornwall Council staff in monitoring and responding to these services. We will work in partnership with the Care Quality Commission (CQC) who are responsible for regulating many care services (for

example, Care Homes or Domiciliary Care Agencies) and with our colleagues in the NHS.

4. Services which provide poor outcomes are defined as:

• Services where multi-agency safeguarding proceedings identify systemic issues which place numbers of service users at potential risk.
• Services where a high number of practice and/or environmental concerns have been reported by professionals and which place numbers of service users at potential risk.
• Services where the proportion of concerns identified through the Contract Management system result in risk to service users.

- Services where the Care Quality Commission have issued Warning Notices or

Section 1: Response to Services that are Providing Poor Outcomes.

Subsection 1.1: Safeguarding Concerns

Reports of safeguarding concerns related to providers will be monitored by the Quality Assurance Team in the Children Families and Adults Directorate. Regular assessments will be undertaken where there are repeated or multiple reported concerns. The Quality Assurance Team and Social Care operational staff will, where appropriate, work together to agree proportionate action. This can range from the implementation of QA Action plans through to suspension of commissioning any new business

.

In instances where a safeguarding meeting identifies further concerns of such significance that people are deemed to be at significant risk then this will be reported immediately to the Quality Assurance Team who will assess the levels of risk. A decision will be taken by the Head of Quality Assurance and Service Improvement, which can range from suspension of commissioning new business and recommend the removal of some or all the people from that service.

Subsection 1.2: Other Quality Concerns

Feedback from colleagues working on the front line, including statutory partner agencies, will be monitored by the Quality Assurance Team and regular reviews of the situation will be undertaken where there are repeated or multiple reported concerns. The Quality Assurance Team, along with the appropriate Head of Service will confirm appropriate action to address concerns. This can range from the implementation of service improvement plans through to suspension of commissioning new business,

Section 2 Roles and Responsibilities of Staff

Subsection 2.1: The Quality Assurance Team

The Quality Assurance Team will regularly review:

- Feedback from safeguarding proceedings,
- Feedback from operational care management colleagues and partner agencies,
- Self -reporting from providers,
- Provider Performance Monitoring Forms (PPMFs)

and will assess all the information received and the services identifying those which may be providing poor outcomes.

The Quality Assurance Team will maintain a database of services where there are concerns about quality using a Traffic Light system, and will update all Team Managers, Heads of Service, and relevant partner agencies, including other Local Authorities, at regular intervals on the status of these services.

The Head of Quality Assurance and Service Improvement Service will write to any service where a decision has been made to suspend commissioning new placements. This will include the reasons for suspension and the next steps.
Where the service is also commissioned by NHS Kernow Clinical Commissioning Group, the decision to suspend placements will be made jointly.

The Head of Quality Assurance and Service Improvement Service will ensure that all stakeholders, including partner agencies, are advised in writing of any decisions to suspend contracting.

Quality Assurance staff will work with a provider identified as providing poor outcomes to support a service improvement plan, with timescales, and will monitor progress against this plan. The exception to this is where the risk to people is deemed to be so high as to require removal of people from the service.

Subsection 2.2 Operational Staff

Operational care management colleagues will assure themselves of the quality of the service when locally commissioning services on behalf of an individual using the range of available tools, e.g. Quality Assurance database and Traffic Light system and local knowledge.

Operational staff will report any concerns on provider performance to the Quality Assurance Team and will advise the provider immediately of any concerns they have and any remedial action that should be taken.

Operational care management colleagues will work with the Quality Assurance Team to monitor the progress of any agreed improvement plan.

Operational care management colleagues will monitor individual service user satisfaction in any service which is assessed as providing poor outcomes, and where appropriate will support individual service users to change their support service.

Section 3 Review of the Policy

This Policy will be reviewed annually and any changes will reflect developments in the Care Quality Commission regulations, essential standards and practice and changes to contractual arrangements with providers across the health and social care sector.

Appendix 4

Potential Criminal Offences in provided services

This appendix is **not** a definitive statement of the law. The police should be consulted before any other enquiry takes place about an adult safeguarding concern which may indicate a potentially criminal act.

1. Physical abuse

Offences against the Person Act 1861

- Section 18 - Wounding with intent to do grievous bodily harm.
- Section 20 – Inflicting bodily injury with or without weapon.
- Section 47 - Assault occasioning actual bodily harm.

Criminal Justice Act 1988

- Section 39 – Common assault and battery - offence of common assault relates to any physical contact

Case study: A care worker becomes frustrated with an older man in his care who is slow to eat. The care worker picks up the piece of bread the man is eating and rubs it into his face and eyes. When the man gets up and shouts the care worker pushes him, causing him to fall and crack his head on the table. The man has an eye injury and bruising.

Although the care worker did not intend the man to be injured he is still arrested and a charge is made of common assault and assault causing actual bodily harm (ABH). An ABH investigation may only require an intention to apply unlawful force to someone, not an intention to cause actual bodily harm. The older man's injuries are evidence of the harm caused.

The charge of common assault relates to rubbing bread into the man's face.

Mental Capacity Act 2005 Section 44 – offence of deliberate ill treatment or wilful neglect of a person who lacks capacity

Case study: A care worker is arrested on a charge of deliberate ill treatment of an elderly man with dementia. The man had fallen to the floor. The worker dragged him to his feet and threw him onto his bed. As a result, he sustained a shoulder injury, was bruised and shaken. A colleague witnessed this and reported this to her manager. The care worker said that she had thought the man had "put himself on the floor" and did not "deserve" for her to use a hoist to lift him.

Criminal Justice and Courts Act 2015

These offences can be committed against people who have the mental capacity to make decisions about their care as well as those who do not.

Section 20 – offence of ill treatment or wilful neglect by a care worker. Care worker" means an individual who, as paid work, provides—

(a)health care for an adult or child, other than excluded health care, or

(b)social care for an adult,

including an individual who, as paid work, supervises or manages individuals providing such care or is a director or similar officer of an organisation which provides such care.

- Section 21 Ill-treatment or wilful neglect: care provider offence. A care provider commits an offence if—

(a)an individual who has the care of another individual by virtue of being part of the care provider's arrangements ill-treats or wilfully neglects that individual,

(b)the care provider's activities are managed or organised in a way which amounts to a gross breach of a relevant duty of care owed by the care provider to the individual who is ill-treated or neglected, and

(c)in the absence of the breach, the ill-treatment or wilful neglect would not have occurred or would have been less likely to occur.

Case study: A man has died in a care home for disabled people in need of nursing care. The cause of death is established as hypothermia. The care home provider was aware that the central heating was broken and that there would be no heating in the Home. The provider had taken no steps to address this or mitigate any risk. Although the Home was short staffed the provider had also refused to authorise any bank or agency staff. The man appeared to have fallen from bed during the night and was not found until the day shift came on duty at 8am. Individual care workers were initially charged with neglect, but subsequently the registered manager and owner were charged with offences under section 21 of the Criminal Justice and Courts Act 2015.

2. **Theft and fraud**

Theft Act 1968

- Offence of dishonest appropriation of property belonging to another, intending to deprive the owner of it permanently.

Fraud Act 2006

- Section 4 - Fraud by abuse of position.

Case study

A support worker has been arrested after using the bank details of a man she was supporting to set up numerous loans and internet shopping accounts. The worker had access to account details after offering to support him to administer his own finances.

3.Sexual Offences:

Sexual Offences Act 2003

- Sections 30-44 – offences against persons with a mental disorder;
- Sections 30-33 - offences against people who cannot legally consent to sexual activity because their mental disorder impedes their choice;
- Sections 34-37 - people who may not be legally able to consent because they are vulnerable to threats, inducements or deceptions because of their mental disorder;
- Sections 38-42 - care workers and their involvement with people who have a mental disorder.

Offences include:

- 'Touching' in a sexualised manner i.e. offences are not all about penetration.
- Causing people to engage in sexual activity which does not involve touching by threats, deception etc.

Case study

A healthcare assistant is arrested after colleagues reported concerns that he was seen to carefully wash the breasts of patients on the unit for women with learning disabilities. Further enquiries found that he had pornographic pictures on his phone which he showed to the patients “for their education”. None of the patients could understand what was happening or make reports themselves.

4. Neglect

See above, Mental Capacity Act 2005 and Criminal Justice and Courts Act 2015.

Case Study

Two night care staff workers are arrested when they “downed tools” following a dispute with their manager. Day staff arrived to find the eight older people on the unit were cold, and in wet and soiled bedding or out of bed semi clothed. Both workers were given eight month prison sentences once convicted of “wilful neglect” under section 44 of the Mental Capacity Act.