Organisational Abuse Procedures

Contents

Acknowledgements

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1 Introduction

1.1 This document provides guidance for a multi-agency approach to responding to concerns in relation to the Organisational Abuse of adults with care and support needs.

1.2 Its purpose is to help staff give better informed and more effective support to people who need an adult safeguarding service because of Organisational Abuse.

1.1 It applies to all services that work with adults with care and support needs, regardless of who is funding their support or whether they are regulated by the Care Quality Commission (CQC) or not.

1.3 The following appendices must be referred to by any professional who is unsure about the scenario they have encountered or who is unfamiliar with this type of abuse and neglect:

- Appendix A: Definition
- Appendix B: Whistleblowing
- Appendix C: Early Indicators of Organisational Abuse

2 Deciding if the criteria are met for an Organisational Abuse Enquiry

2.1 There is a need for professional assessment and judgement in determining when poor practice becomes Organisational Abuse. Addressing the following four key questions will support the decision to initiate an Organisational Abuse enquiry:

i. Are the concerns of a type to indicate Organisational Abuse? Do they feature on the Early Indicators of Concern Full Checklist? (Appendix D)

ii. Are the concerns of a nature to indicate Organisational Abuse? Is the behaviour widespread or generally accepted within the setting? Is it sanctioned, accepted, or ignored by management and/or supervisory staff? Does it occur against the wishes of an ineffectual management group?

iii. Are the concerns of a degree to indicate Organisational Abuse? How long has it been occurring and what is the impact on the adults using the service? Is there a risk of repeated or escalating incidents?

iv. Is there a pattern and prevalence of concerns about the organisation? Are the same incidents reported over time or by a number of different agencies?

2.2 It is not necessary for all four questions to be answered positively. A one-off serious incident may be enough to trigger consideration regarding whether Organisational Abuse has/is taking place.

2.3 This will include a review of all the concerns and an evaluation of all current sources of evidence, including making enquiries of an appropriate range of

people and services including:

- Concerns raised by adult(s) involved or their family or friends.
- the previous safeguarding history of the provider (including other services operated by the provider)
- reports by CQC if within the last year – the previous and current status of the service/organisation
- Local Authority and relevant Clinical Commissioning Group (CCG) Contracts/Quality Assurance Teams – previous or current evidence of non-compliance
- Local Authority feedback/complaints function – history of concerns/complaints (and positive feedback)
- police – past or current concerns
- health professionals who may visit e.g. GPs, district nursing, ambulance service, Care Home Support/Liaison etc. Also, if relevant, the history and pattern of referrals to secondary care or emergency department attendances
- practitioner views – any feedback arising from reviews or individual safeguarding enquiries
- Feedback from commissioners – any feedback arising from commissioning and contract management processes
- Contact from whistle-blowers and or family members that allege organisational abuse
- Where the service is a provider of NHS funded care the involvement of the commissioner should be considered

2.4 Where Organisational Abuse (or any other form of abuse) has been identified as potentially taking place a Raising Concerns Meeting must be called as soon as possible after the concerns have been identified.

2.5 The decision-making process should evaluate the issues that are identified under the headings of the seven key themes outlined in Appendix C, and should include a recommendation about next steps. This recommendation should be reviewed by the appropriate member of staff with responsibility on behalf of the Local Authority for deciding whether or not to initiate open an Enquiry under the Section 42 of the Care Act (2014) into the allegations of Organisational Abuse and record this decision. Where the service provides NHS funded care the Local Authority may wish to involve the commissioner of the service in the decision-making process. See Appendix E for further information on risk assessment and levels of response.

2.6 If the decision is made not to proceed with an Organisational Abuse Enquiry then the person with responsibility for making the decision should record how the issues arising are to be followed up, for example through contractual or quality management processes or a safeguarding process for an individual adult.

2.7 Depending on the level of risk and the complexity of the concerns a balance may be needed between ensuring the maximum number of partners are able to participate in the meeting and ensuring people's immediate safety. Where the situation is extremely serious an immediate Raising Concerns Meeting meeting/discussion may be required. However, it is important to remember that:

- **where criminal offences may have been committed it is crucial that consultation takes place with the police, with the involvement of CQC, unless they have confirmed otherwise.**
- **Where the service also supports people aged under 18 the Local Authority Designated officer (LADO) must also contacted.**

2.8 The meeting should be formally minuted with actions agreed and allocated to named individuals/organisations. If the service is regulated and CQC are not already involved in the process then one of the actions must include informing them immediately.

3 Organisational Safeguarding Enquiries

3.1 Partnership Working: Key Points

3.1.1 Responding to Organisational Abuse is likely to require complex co-ordination of different organisations both for information and for direct involvement in the enquiry. **Drawing upon the knowledge and expertise of the CCG and/or the lead commissioner of the service, CQC and police partners will be an important early step in formulating an effective approach.** It is important that everyone involved is aware of their respective roles and responsibilities and their duty to cooperate in the enquiry.

3.1.2 It is important that where a criminal act has been potentially been committed that it is clearly communicated to the provider that they should not commence their own investigations, including interviews with staff, without the agreement of the police.

3.1.3 The first step of a Raising Concerns Meeting should **always** be to consider if people are safe and, if not, what needs to be done (and who should do it) to ensure they are and remain so, including removing any members of staff about which there is a concern. Actions should be clearly recorded and circulated without delay.

3.1.4 The relevant senior managers, including the nominated individual of the provider organisation where the organisational abuse is alleged to be happening must be involved in planning the enquiry unless they are:

- regarded as complicit in the alleged abuse, or
- directly responsible for a service where Organisational Abuse is alleged to

have taken place, or

- are suspected of committing a criminal offence or other act which may lead to prosecution with regard to these matters, that may be prosecuted.

3.1.5 In some circumstances a two-part meeting might be convened, with the service provider being invited to the second part, where the terms of reference can be communicated. Each part of the meeting will be separately minuted, with the provider receiving minutes for the parts of the meeting they attend.

3.1.6 The Service Provider will need to be given the opportunity to give an account of what has been alleged. They should also be given an appropriate and reasonable amount of time to provide a response to allegations. However, in the interim they must be able to commit to a response that ensures the immediate safety of all adults.

3.1.7 If the allegation leads to a criminal investigation led by the police, CQC or any other body with the power to prosecute the police and CQC must provide guidance on how the provider is to be involved. This guidance must then be followed by all the agencies and organisations involved.

3.2 **Roles and Contributions of Different Agencies and Leading the Process**

3.2.1 A Raising Concerns Meeting can be convened by any agency. The meeting attendance must include the Local Authority, which will also advise on whether attendance should be agreed jointly between the Local Authority and any agency with a power to prosecute. It is expected that any agency that has concerns about organisational abuse will have taken any immediate steps available to them to address any immediate safety issues. It is also expected that any professional that believes abuse or neglect has taken place will have communicated the concerns to the service as soon as practicably possible, unless doing so could potentially impede a criminal investigation or place people at further risk. **No action, beyond that which is necessary to ensure immediate safety, will be taken until this meeting has taken pace.**

3.2.2 The Local Authority where the service is located has responsibility for leading and co-ordinating Organisational Abuse Enquiries, as well as deciding whether an enquiry will be initiated under Section 42 of the Care Act[1]. However, multi-agency knowledge, skills and information sharing are essential for best practice, sound decision making and securing positive outcomes for adults. Each participating agency/organisation will therefore nominate a lead to support the enquiry who has sufficient authority to make decisions on its behalf at meetings.

[1] https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted

3.2.3 The strength of partnership is manifested in each organisation – in particular, the Local Authority, police, CCG, key commissioners and CQC – have specific roles and functions that dovetail to create an effective safeguarding process. Operationally, this requires careful co-ordination and avoidance of deference to, or dominance of, any single organisational perspective or function.

3.2.4 It is key that the service provider takes responsibility for the abuse and the impact of it. Where their internal procedures are likely to have set/allowed a culture where abuse can take place it is essential that this is considered as part of the Enquiry.

3.2.5 Active and co-operative behaviour by the service provider is expected and essential. Depending on the type of concerns and the level of staff involved it may or may not be appropriate for the provider to actively make enquiries. This will need to be decided in each situation by the Local Authority as the body with overall responsibility for the Organisational Abuse Enquiry, in consultation with any agency with a power to prosecute.

3.2.6 One of the outcomes of the Raising Concerns Meeting is that a protection plan may commence

3.2.7 It is also important to understand the service provider's own mechanisms, for example disciplinary procedures, and how any intention to deploy these relates to the Organisational Abuse Enquiry and aligns to the overall Protection Plan for the service and any potential criminal investigation or other prosecutor action. Clear instructions must be given to the provider, and recorded, to manage the risk of any of these processes interfering with the Enquiry and/or any potential prosecution. These instructions and any provider actions agreed must be regularly reviewed to ensure that they remain appropriate if new information emerges.

3.2.8 It is essential that, where providers are undertaking enquiries, arrangements for what these should cover, timescales and how they will be fed back are clear and are communicated to the provider in a timely way. Where these are not adhered to, consideration must be given to how to escalate the concerns to ensure they are managed.

3.2.9 When an investigation involves a number of people who have experienced abuse, or are at risk of abuse, the issues are often complex, involving standards of service as well as a series of individual enquiries. Regardless of the breadth of the overall enquires and who is carrying them out it is essential that all individual enquiries are, without exception, founded on the principles of Making Safeguarding Personal and that the views and wishes of those people affected are considered at every stage of the process.

3.2.10 An Organisational Abuse Enquiry that involves a large service or multiple services operated by the same provider, may require a series of individual safeguarding adult enquiries to address allegations of different types of abuse and/or neglect specific to each individual adult. While, under the Care Act (2014), the Local Authority has lead responsibility for adult safeguarding, it can cause enquiries to be made by other organisations and agencies as appropriate to the circumstances of each individual. In carrying out this responsibility the Chair of the Organisational Abuse Enquiry meetings (see section 4) will co-ordinate the overall Enquiry and ensure the coordination of activity and information between it and the individual enquiries being conducted for specific adults.

3.3 **Key Partners**

- **Police** – required when the safeguarding concerns are a potential criminal matter (see Appendix F). The Chair should liaise with the police as appropriate.
- **Care Quality Commission** - must be informed of any concerns relating to a regulated service.
- **Local Authority Commissioning & Contracts** - must be informed of safeguarding concerns relating to any provider, irrespective of whether services are commissioned.
- **NHS Host commissioners:** Whenever the service of concern provides NHS care, the Clinical Commissioning Group in which the service is located will be invited as the responsible/host commissioner.
- **Other NHS Commissioners, organisations and services** - where services are commissioned by any Clinical Commissioning Group or NHS England and Improvement. When some or all of the people affected receive any care funded by the NHS, the funding Clinical Commissioning Group must be invited. This includes, for example, Continuing Health Care, (CHC), packages of care funded under section 117 of the Mental Health Act (1983)[2], and Funded Nursing Care (FNC). When the service is commissioned by NHS England and NHS Improvement direct commissioning team or provider collaborative, then the relevant team must be invited. When a commissioner delegates its commissioning function to another body or a consortium, then that body must also be invited.
- **Other Local Authorities** - where placements are commissioned by another commissioning body for example, another Local Authority or CCG, they should be notified of the referral and involved throughout. While the host Local Authority retains the lead safeguarding role for all safeguarding concerns, placing commissioners retain a duty of care towards the adult and must fulfil this role in co-operation with the Organisational Abuse Enquiry.

[2] https://www.legislation.gov.uk/ukpga/1983/20/section/117

Any failure to cooperate should be escalated to senior managers within the organisation concerned or, if this is unsuccessful the Independent Chair of the relevant Safeguarding Adults Board.

3.4 The Provider

3.4.1 Whether an internally or externally commissioned service, an understanding of the specific contractual requirements of the provider and their own policies and procedures will be an important reference source.

3.4.2 Where the safeguarding concerns relate to a Local Authority operated service (direct provision or assessment etc., including 'arm's length' entities) then care must be taken to ensure that there is a clear separation of interests i.e. all staff involved in the Organisational Abuse Enquiry should have no direct relationship to the matters under enquiry.

3.5 Strategic Oversight where the impact of abuse is severe and extensive

3.5.1 In most instances the process outlined below will be sufficiently robust to ensure a full and thorough enquiry can be undertaken and arrangements made to keep people safe the response led by appropriate operational staff. In Somerset these arrangements are detailed in in a Joint contract, risk management and quality policy.

3.5.2 However, there may be a small number of situations where it becomes evident that the degree and severity of the Organisational Abuse and the complexity of the situation requires additional strategic oversight. In such instances the host/responsible Local Authority will initiate a strategic management group inviting executive leadership attendance from placing Local Authorities, CQC, police, NHS (this may include NHS Commissioners, organisations and services), legal etc. to identify the most appropriate person to attend. The purpose of this group is to provide oversight to the process ensuring all areas are followed through (see ADASS guidance on Out of Area Safeguarding Adults Arrangements June 2016 and our local guidance on how we manage safeguarding enquiries for a service when there are multiple commissioners based that is based on it for further details).

4 Organisational Abuse Enquiry Meetings

The initial Raising Concerns Meeting will undertake a preliminary risk assessment based upon existing knowledge and agree a Protection Plan covering both individual concerns and the care setting. This must include the steps that all the agencies involved will take keep all adults in contact with the service safe. An interim risk assessment should be complied that includes the option of suspending further placements and this may include supporting people to find alternative care arrangements.

4.1.1 **Depending on the seriousness of the concerns there will need to be decisions made between safeguarding, commissioners and contracting representatives from the agencies involved.**

For the most serious situations where serious harm has taken place or is suspected these may include:

- Decisions regarding what will be shared at an initial stage with the individuals involved, or potentially involved, and/or their families.
- Decisions about communication to senior managers to ensure appropriate involvement and support from services.
- Identifying the initial resources to co-ordinate and undertake the enquiry/assessment, including legal advice
- Organising a strategy discussion to agree an 'Enquiry/Assessment Plan' covering both individual allegations and the organisational setting
- Identifying and implementing a clear communication strategy, agreeing a joint media statement, and ensuring the media teams from relevant organisations are informed.
- Ensuring the potential need for advocacy informs the enquiry

4.2 Further meetings will be needed to monitor and review the situation as the Enquiry progresses to ensure that actions are followed up and plans revised as required. These will usually be chaired by a senior representative from the Local Authority. Areas of focus for these meetings include:

- Implementation of the enquiry / assessment plan
- How the safety and wellbeing of every individual in the service will be determined, and how those who are at highest risk of more severe harm will be identified and prioritised
- As assessment of whether it is safe for the service to continue to provide care to some or all of the individuals, including whether alternative care arrangements may be sought
- An assessment of whether the provider has both the ability and resources at its disposal to keep people safe immediately and to maintain safety and well-being in the longer term
- Report(s) completed by those investigating the allegation(s)
- Evaluation of enquiry /assessment activity and evidence obtained
- Determining if abuse/neglect has taken place covering both individual concerns and the care setting (Organisational Abuse)
- Considering the circumstances and potential needs of perpetrator(s)
- Agreeing an ongoing Protection Plan which is likely to have both short- and medium-term actions
- Agreeing time scales for review of Protection Plan
- Agreeing circumstances where re-evaluation of the situation will be required
- Agreeing an action plan for the service provider

- Monitoring and review of the action plan for the service provider
- Debriefing and consider learning points and wider implications
- Receiving feedback of follow up by provider e.g. disciplinary processes, referral to Disclosure and Barring Service (DBS) and/or appropriate professional bodies such as Nursing and Midwifery Council (NMC), Social Work England, or the Health and Care Professions Council (HCPC)
- Considering a referral to the Safeguarding Adults Board for consideration for the commissioning of a Safeguarding Adults review (SAR) or other actions across the safeguarding partnership
- Case closure – (see section 5)

4.3 These meetings can be managed in a number of ways, but the key is to ensure the correct people are involved with decision making authority for their organisation, and were deemed appropriate providers should be involved unless the police or other agency with prosecuting powers needs to make a decision. It is also important that these meetings are used to ensure that the enquiry proceeds at an appropriate pace so that concerns are addressed in a timely way and unnecessary delays do not result in additional distress to those involved.

4.3.1 In some circumstances a two-part meeting might be convened, with the service provider being invited to the second part, where the terms of reference can be communicated. Each part of the meeting will be separately minuted, with the provider receiving minutes for the parts of the meeting they attend. If this approach is taken it is essential that commissioners are involved in both meetings.

4.3.2 If is considered that the provider should not be involved in these meetings, alternative arrangements need to be made to meet and/or provide updates.

4.4 The action plan should be monitored at each meeting and carried over from one meeting to the other. Where actions are not completed an explanation must be recorded as to why.

4.5 Each meeting must include an agenda item to agree what will be communicated to the adults involved, their families and staff, and who will do this and how. The purpose of this item should be to ensure consistent, substantiated, information is given in an appropriate way without unnecessary delay. Where a decision is made not to share particular information the reason for this must be recorded.

4.6 It is essential that all participants are aware that meetings are confidential and will be minuted. Minutes and communications about Organisational Abuse Enquiries must be carried out securely, in line with information governance policies.

5 Organisational Safeguarding Closure

5.1 It is important that the decision to end the Organisational Abuse Enquiry is

agreed by the whole meeting membership. It is therefore essential that key agencies remain involved in the process. The multi-agency meeting will need to be satisfied that:

- The coroner, police and other agencies with a power to prosecute have been consulted.
- All required actions have been undertaken
- There is evidenced reduction in risk
- involved adults and/or their families have received feedback
- any necessary notifications to regulatory bodies e.g. Disclosure and Barring Agency, Nursing and Midwifery Council, have been undertaken
- any remaining concerns can and will be managed through contract monitoring, care management processes etc.
- lessons learned have been identified and taken forward

5.2 All placing commissioning bodies and CQC should be notified of the Enquiry closure once confirmed.

5.3 Senior management should be notified as appropriate.

6 Publicity and Media

6.1 Public and media interest may arise in Organisational Abuse Enquiries. Please refer to local policies and procedures in relation to the involvement of the media, however in general individual professionals should not respond directly to enquiries from the media but refer them to the Local Authority communications team, as the lead agency for the Enquiry. Co-ordination with other organisations' communication teams may also be necessary, and this should be supported/facilitated by the Local Authority communications team.

Definition

1. Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect
2. The Care and support statutory guidance (section 14.9) makes it clear that Safeguarding is not a substitute for:
   - providers' responsibilities to provide safe and high-quality care and support
   - commissioners regularly assuring themselves of the safety and effectiveness of commissioned services
   - the Care Quality Commission (CQC) ensuring that regulated providers comply with the fundamental standards of care or by taking enforcement action
   - the core duties of the police to prevent and detect crime and protect life and property
3. Local Authorities should not limit their view of what constitutes abuse or neglect, as they can take many forms and the circumstances of the individual case should always be considered.
4. **Remember: if it doesn't feel right, it probably isn't. if you have concerns about a person or a service, you should report this.**
5. The Care and support statutory guidance defines Organisational Abuse as:

   > 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

6. The majority of abuse that occurs within services will be not be organisational; some incidents between adults or actions by individual members of staff may occur without any failings on the part of the organisation. Organisational Abuse refers to those incidents that derive to a significant extent from an organisation's practice and culture (particularly reflected in the behaviour and attitudes of managers and staff) together with the organisation's policies and procedures and how these are used.

Whistleblowing

1. A whistleblowing referral may be the catalyst for identifying wider concerns about a service. Whistleblowing should be distinguished from a complaint in that a whistleblowing referral will be made typically by an employee of the organisation.
2. The person may or may not have tried to raise the issue with their organisation's management. Ideally, they should have done so, but clearly there are times when an employee will feel too intimidated to do so. Where a whistleblowing is actually a safeguarding concern about an individual this should be dealt with initially through individual processes to ensure that the person is safe. Where there are wider implications these may need to be followed up through Organisational Abuse processes.
3. It is essential that information is taken carefully from whistle-blowers whatever their motives appear to be. Just because someone has fallen out with an employer does not necessarily mean that the information they are passing on is not valid. As with any other enquiry the information given by a whistle-blower will need to be balanced with other information.
4. All organisations are expected to provide information to staff on whistleblowing and how they can seek independent guidance about something they are worried about.
5. The Care Quality Commission National Customer Service Centre can be contacted on 03000 616161
6. NHS England Guidance on Whistleblowing can be found here: https://www.england.nhs.uk/ourwork/whistleblowing/

Early Indicators of Organisational Abuse

1. A combination of research and safeguarding practitioner experience has identified a number of elements that could be early indicators that Organisational Abuse could be taking place. Information and awareness about these early indicators can support practitioners to identify concerns and feel confident that what they have observed is valid, enabling them to act to protect people from abuse.

2. However, this is not a definitive list and practitioners may identify other indicators not listed.

   The indicators can be grouped into seven key themes. These themes provide important information about key aspects of service design and delivery which increase the risks of abuse and harm for people, although it is recognised that some types of concerns, for example if there are allegations of multiple breaches of the Human Rights Act (1998), may fall under more than one these. The seven themes are:

   i. The experience of the people using the service

   Is it clear that the service being run for the prime benefit of the people who use it and not the combined benefit of the staff and/or management? Is there evidence of a breach their rights under the Human Rights Act (1998)? Are their human rights being protected?

   ii. Concerns about management and leadership

   The people who manage the service and other managers in the organisation. What are they doing, or not doing that might put people at risk of abuse?

   iii. Concerns about staff skills, knowledge and practice

   The people who work in the service. Howe do they behave towards the adults – how do they speak to them? What are their skills and practice like? What are they doing that might put people at risk of abuse? This is not just people who work as care workers or nursing staff. It could also include the practice of managers and other non-care staff who work in the service, including volunteers.

   iv. Concerns about adults' behaviours and wellbeing

   The people who live in, or use, the service. How are they? Are they behaving in ways which suggest they may be at risk of abuse? Are they behaving in ways that might put other people who live in or use the service at risk?

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

   Are the adults cut off from other people? Is it a "closed" or an "open" service? Does the service resist support from external agencies or professionals? Can

visitors access all communal areas, including the persons bedroom (where appropriate and they are able to give consent).

vi. **Concerns about the way services are planned and delivered**

The way in which the service is planned and whether what is actually delivered reflects these plans. Are people receiving the levels of care which have been agreed? Are the adults who use the service a compatible group? Is the service clear about the kind of support it is able to deliver? Are there enough staff on duty throughout the day to meet the adult's needs?

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

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

3. It is important to note:

a) This guidance will help practitioners to record, reflect, talk to someone and **ACT**.

b) It is not necessary for there to be concerns in each of the seven key themes for there to be a concern about a whole service.

c) A pattern of concerns is *not proof* of abuse and **abuse can happen when indicators of concerns are not apparent.**

d) The use of this guidance **does not replace listening directly to people who use services**. On the contrary, it gives an important reason to listen more closely before and after concerns are raised.

Early Indicators of Concern in Care Services Checklist

It is important to note that this is not a definitive checklist. Other indicators may be identified that do not appear on this list. Equally abuse can happen when indicators of concern are absent

1 Concerns about management, leadership and experience of the person

1.1 People who use the service

- There is evidence of one or more breaches of their rights under the Human Rights Act (1998).
- People who use the service say they feel unsafe, frightened or that they have been abused or neglected
- Is it unclear whether the service being run for the prime benefit of the people who use it and/or the combined benefit of the staff and/or management?
- Staff fail to treat people with dignity or respect
- People appear frightened or distressed in the presence of certain members of staff or management
- People's behaviours change without an obvious reason
- People's behaviours improve without obvious therapeutic input
- People's skills change – for example they become less independent, self-care or continence management deteriorates.
- People behave differently in different environments, for example if they attend a different service on a certain day each week
- Peoples who appear distressed are either ignored or experience unacceptable delays in having their emotional support needs met
- People who require it are not supported to eat their meals / drinks
- People appear hungry or thirsty and show signs of dehydration
- People express a desire to stop using the service or move to a new service provider and the reasons for this have not been explored, or are not understood

1.2 The manager of the service

- The manager leaves suddenly and unexpectedly
- The service has not had a registered manager in post over an extended period
- Arrangements to cover the service while the manager is away are not working well
- 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 and has little involvement with the adults
- The manager leaves staff to get on with things with little physical presence,

active guidance or modelling of good practice
- The manager is inappropriately controlling

1.3 **Management culture**

- The service is not being managed in a planned way, but reacts to problems and crises
- The service does not respond appropriately when a serious incident has taken place
- The service fails to learn from previous incidents and does not appear to be taking steps to reduce the risk of a similar incident happening again
- Policies, procedures and practice guidance are absent, out of date or otherwise inadequate

1.4 **The management team**

- Senior staff have a high level of authority and entrenched views over a number of years
- There is a high turnover of managers or other senior staff
- The service is experiencing difficulty in recruiting and appointing managers
- There is a lack of leadership by managers, for example managers do not make decisions and set priorities
- Managers appear unaware or dismissive of serious problems in the service
- Managers do not appear to be attending to risk assessments or are not ensuring that risk assessments have been carried out properly
- Managers do not appear to have ensured that staff have information about individual adults' needs and potential risks to adults
- Managers appear unable to ensure that actions agreed at reviews and other meetings are followed through
- There is a lack of effective monitoring by senior staff – including support to night staff and checks on them
- The managers know what outcomes should be delivered for adults, but appear unable to organise the service to deliver these outcomes, i.e. they appear unable to 'make it happen'.

1.5 **Staffing**

- Staff who raise issues are not listened to
- Staff are not being deployed effectively to meet the needs of adults
- There is a high turnover of staff
- Staff are working long hours
- Staff are working when they are ill
- There is poor staff morale
- Recruitment processes are inadequate
- The service employs high numbers of family/friends
- There is a failure to identify concerning behaviour by staff e.g. stressed staff

behaving unusually, there is insular culture within the staff group, a growth of cliques, recruitment of friends/relatives, failure to work to best practice, cutting corners
- The managers have low expectations of the staff
- Pay and working conditions do not meet national standards

2 Concerns about staff skills, knowledge and practice

2.1 Supervision and training

- Staff receive little/no supervision, appraisals or opportunities for development
- Induction processes are inadequate
- Poor quality or no training is provided
- Staff appear to lack the information, knowledge and skills needed to support the people the service is set up to support
- Staff lack training in how to use equipment

2.2 Recording

- 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
- Records are value laden and judgmental

2.3 Mental capacity and the Deprivation of Liberty Safeguards (DoLS)

- There is non-adherence to the principles of the Mental Capacity Act
- There is a lack of understanding of DoLS
- DoLS referrals are not being made resulting in people being unlawfully deprived of their liberty

2.4 Interactions with adults

- Staff appear to be inappropriately challenged by some adults' behaviours and therefore do not manage these in a safe, professional or dignified way
- Adults are blamed by staff who appear to perceive their behaviours as a problem
- Adults' medical condition are given as an explanation for all their difficulties, needs and behaviours; other explanations do not appear to be considered
- Adults are punished for behaviours seen to be inappropriate by staff
- Adults are treated roughly or forcefully
- Adults are ignored by staff
- Adults experience staff being impatient with them
- Adults are talked to by staff in ways which are derogatory/not

complimentary
- Adults are shouted or sworn at by staff
- Adults do not experience their individual communication styles been met by staff. For example, they speak to people as if they are children
- Staff use negative or judgmental language when talking about adults
- Staff do not see adults as individuals, do not appear aware of their life history or talk about them as if they are not there even though they are present
- Staff do not ensure privacy for people when providing personal care
- Adults experience staff telling them to use their incontinence pads rather than assist them to use the toilet

2.5 Culture

- There is a particular group of staff who strongly influence how things happen in the home
- Staff informally complain about the managers to visiting professionals
- Staff appear to lack interest and commitment
- Staff appear to lack concern for the adults
- Staff appear unable to relate to a particular adult
- Staff are complacent about the quality of care they provide and appear defensive when challenged

3 Concerns about adults' behaviours and wellbeing

3.1 Individual adults

- Show signs of injury due to lack of care or attention (e.g. through not using wheelchairs carefully or properly, or the development of pressure injuries due to lack of or inappropriate use of pressure relieving equipment)
- Appear frightened or show signs of fear
- Behaviours or appearances have changed, for example they have become unkempt or are no longer taking pride or interest in their appearance
- 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
- Experience sensory deprivation – e.g. going without spectacles or hearing aids
- Experience restricted mobility by being denied access to mobility aids.
- Experience restricted access to toilet/bathing facilities
- Behave in ways that might put other people who live in or use the service at risk
- Lack personal clothing and/or possessions

3.2 General service concerns

- The overall atmosphere is flat, gloomy or miserable
- There is a high number of low-level incidents such as medication errors or falls
- There is a high number of incidents between adults
- There are a high number of upheld complaints about the service
- There is evidence of inappropriate restraint methods or misused restraint, including the inappropriate use of medication
- The care regime exhibits lack of choice, flexibility and control
- The care regime appears impersonal and lacks respect for individual's privacy and dignity

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

4.1 Information sharing

- The service has few visitors/minimal outside contacts
- The service does not report safeguarding concerns
- The service does not communicate with or report concerns to external practitioners and agencies
- The service does not liaise with families and ignores their offers of help and support
- Managers and/or staff do not respond to advice or guidance from practitioners and families who visit the service
- Managers do not appear to provide staff with information about adults from meetings with external people, for example reviews
- Staff or managers appear defensive or hostile and concerned to avoid blame when questions or problems are raised by external practitioners or families
- Managers or staff give inconsistent responses or accounts of situations

4.2 Staff

- Staff work alone on a one to one basis with adults
- Staff work in silos e.g. night staff who never work days
- Staff are hostile towards or ignore practitioners and families who visit the service

4.3 Adults

- There are adults who have little contact with people from outside the service
- There are adults who are not receiving active monitoring or reviews (e.g. people who are self-funding)
- Adults are kept isolated in their rooms and are unable to move to other

parts of the building or outside independently ('enforced isolation')
- Adults have restricted access to visitors or phone calls
- Adults have restricted access to health or social care services

5 Concerns about the way services are planned and delivered

5.1 The nature of the service

- The service does not have a clear philosophy/purpose
- 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
- Decisions about what service is commissioned for an individual are influenced by a lack of suitable alternatives
- The service is accepting adults whose needs and/or behaviours are different to those of the adults previously or usually accepted
- The service is accepting adults whose needs they appear unable to meet
- Adults' needs as identified in assessments, care plans or risk assessments are not being met. For example, adults are not being supported to attend specific activities or provided with specific support to enable them to remain safe

5.2 Person-centred care

- Staff are task focused and not providing person-centred care
- Adults are treated en-masse
- The service follows strict, regimented routines – for mealtimes, bedtimes, etc.
- Adults lack choice about food and drink, dress, possessions, activities and where they want to spend their time
- Members of staff are controlling of adults
- There are misunderstandings about confidentiality

5.3 Resources

- There is a failure to provide and/or maintain correct moving and handling and other equipment such as pressure relieving mattresses
- The service is under resourced – whether staff, equipment or provisions
- There appear to be insufficient staff to support adults appropriately

5.4 Audits

- There is a lack of audits of practice and process
- There is a failure to follow up on issues raised by audits
- There is a failure to monitor the use of call bells including checking they have not been disabled – especially at night

6 Concerns about the quality of basic care and the environment

6.1 Person-centred care

- There is a lack of privacy, dignity and respect for people as individuals
- There is a lack of provision for dress, diet or religious observance in accordance with adults' individual beliefs or cultural backgrounds
- 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 and they appear unkempt
- Adults are not getting the support they need with eating and drinking, or are not getting enough to eat or drink in terms of their individual dietary requirements
- There is poor or inadequate support for adults who have health problems or who need medical attention
- Staff are not checking that people are safe and well
- There are a lack of activities or social opportunities for adults
- There is a lack of care for adults' property and clothing

6.2 Resources

- There appear to be insufficient staff to meet adults' needs
- The service does not have the equipment needed to support adults and keep them safe
- Food is of poor quality
- Equipment or furniture is broken
- Equipment is not being used or is not being used safely and correctly

6.3 Environment

- The service is not providing a safe environment
- The environment is dirty or shows signs of poor hygiene
- The environment is poorly maintained and/or its quality has deteriorated noticeably.

Risk assessment and levels of response

When an organisational abuse concern is received, a risk assessment should be completed. 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.**

1 Determining level of concern

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

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.

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

Table 1

2 Level of Concern.

1.1 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 (the SSAB Service Monitoring Checklist should be used to record this evidence).

- **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 evidence of good, effective, leadership and direction in place.
- **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. Leadership is in place does not 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.

Potential Criminal Offences in provided services

This appendix is **not** a definitive statement of the law and is intended to give examples rather than being an exhaustive list of offences. The police should always be consulted before any other enquiry takes place about an adult safeguarding concern which may indicate a potentially criminal act.

1 Physical abuse

1.1 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.

1.2 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.

1.3 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.

1.4 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

2.1 Theft Act 1968

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

2.2 **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

3.1 **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 (offences are not only 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.