KSBP Organisational Abuse Policy

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Multi-Agency Guidance on

Organisational/Institutional Abuse and conducting Large Scale Investigations

January 2018

Contents

Introduction

These guidelines outline what the Multi-Agency response should be when the concerns are about an organisation. This guidance should be referred to when:

- A safeguarding concern about an individual has been received and the investigation gives rise to concerns that other adults may have been abused or be at risk of abuse. This can be in a regulated or commissioned care/support/health setting, such as care homes including nursing homes, domiciliary care services, community based support settings including supported living settings (Shared Lives), supported housing (including hostels),floating support, day services , other community care and support settings., hospitals and other health settings. This may also apply where support is being provided from an unregulated service to a number of people;
- Where a number of adults have experienced abuse, or are at risk of abuse; for example where an individual, or group of individuals, have targeted a number of service users;
- A whistleblowing referral has been made giving rise to safeguarding concerns;
- Concerns have been triggered about a provider; have been reported via the Service Monitoring Information Forms (LAS), relevant Commissioners / Contracts and Quality Team or the commissioning Clinical Commissioning Group (CCG);
- A trend analysis identifies a pattern of concern**;**
- A CQC inspection identifies significant concerns;
- Partner agencies may report concerns about a service e.g. through reviews, or one of the specialist health teams offering support to care homes;
- The Provider raises concerns/risks about their ability to provide a safe service.

This guidance should be read in conjunction with Keeping Adults Safe (KAS) Safeguarding Adults Multi-Agency Policy and the Early Intervention and Prevention Strategy. Prevention is one of the core principles of safeguarding: “It is better to take action before harm occurs” and as such forms a fundamental part of the Safeguarding Adults policy and procedures.

While this document is guidance, adherence to its content is expected unless there is clear justification for not doing so but does not replace or interfere with existing statutory duties, functions or obligations. Additionally it does not require local agencies to undertake any responsibility or functions which are currently managed by the Care Quality Commission.

Large scale investigations will involve a wide range of agencies concerned with both the protection of individual adults and quality of care issues. Understanding of the role of the Police and criminal investigations together with CQC as the regulator with inspection, enforcement powers and emergency powers, will be important to ensuring an effective response to organisational safeguarding concerns. Careful planning and co-operative multi agency working is required at all stages of the investigation. It is important to note that the Care Act 2014 specifically excludes the process from covering prisons, however it does stress that advice and support can be sought from the Local Authority and other agencies by the Prison Service.

Adult Safeguarding and Organisational Abuse

All adult safeguarding occurs within the legal framework of the Care Act 2014. The statutory guidance defines Adult Safeguarding as:

"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, whilst at the same time making sure that the adult's wellbeing is promoted."[1]

The following 6 principles that underpin all adult safeguarding work are:

Adult Safeguarding: The Principles of Adult Safeguarding

Empowerment – Presumption of person led decisions and informed consent.

Protection – Support and representation for those in greatest need.

Prevention – It is better to take action before harm occurs.

Proportionality – Proportionate and least intrusive response appropriate to the risk presented.

Partnership – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Accountability – Accountability and transparency in delivering safeguarding.

The Care and Support Statutory Guidance (update 24 February 2017) issued under the Care Act describes 'Organisational Abuse' as:

[1] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

"……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."[2]

The Care Act 2014 statutory guidance (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.

It differentiates between isolated incidents of poor or unsatisfactory professional practice, at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the hands of other. Repeated instances of poor care may be an indication of more serious problems and this can constitute Organisational Abuse.

Not all abuse that occurs within care services will be organisational; some incidents between service users 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), policies and procedures.

This guidance aims to reflect the Department of Health's Agenda for "Dignity in Care"; as outlined in the following.

High quality care services that respect people's dignity should:

1. Have a zero tolerance of all forms of abuse;
2. Support people with the same respect you would want for yourself or a member of your family;
3. Treat each person as an individual by offering a personalised service;
4. Enable people to optimise the maximum possible level of independence, choice and control;
5. Enable people to express their needs and wants;
6. Respect people's right to privacy and dignity;
7. Ensure people feel able to complain without fear of consequences;
8. Engage with family members and carers as care partners;
9. Assist people to maintain confidence and a positive self-esteem;

[2] Ibid

10. Act to alleviate people's loneliness and isolation.

Organisational Abuse violates the person's dignity and represents a lack of respect for their human rights. It occurs when the routines, systems and regimes of an organisation result in poor or inadequate standards of care and poor practice.

Anyone can witness or become aware of information suggesting that abuse or neglect is occurring. Organisational staff or visiting family members or friends are well placed to spot this form of abuse or neglect as in many cases they are the only people whom the adult may have contact.

Organisational abuse can occur where the culture of the organisation places emphasis on the running of the establishment and the needs of the staff above the needs and care of the person/people. A number of inquiries have highlighted that organisational abuse is most likely to occur when:

- Staff receive little support from management and are inadequately trained;
- There is inappropriate staff behaviour, such as the development of factions, misuse of drugs or alcohol, failure to respond to leadership;
- Staff are poorly supervised and poorly supported in their work;
- Recording of information is inadequate with planning risks and care plans missing;
- Service Users receive lack of stimulation or the development of their individual interests; and/or,
- Restriction of external contacts or opportunities to socialise;
- Service Users do not get medical intervention in a timely way to prevent a person's changing/deteriorating condition.

Safeguarding is Everyone's Business

Everyone has a responsibility to be vigilant on behalf of those unable to protect themselves. Concerns may come in a number of ways for example, the adult may say things that provide a hint they are not well, they may be quiet/withdrawn or present signs or symptoms that could lead a person to be suspicious. Concerns may also come in the form of a complaint, from another agency, an expression of concern or needs assessment. Regardless of how the concern is highlighted, everyone has a duty to do something and to get help and advice.

Staff have a duty to ensure they:

- Know about different types of abuse and neglect and their signs;
- Know how to support adults to keep safe;
- Know how to report suspected abuse and neglect;
- Know how to support adults and weigh up the risks and benefits of different options when exercising choice and control;
- Complete multi agency training.
- Follow the Whistleblowing Procedure if their concerns are not acted upon.

Organisations have a duty to:

- Meet fundamental standards of care as a condition of their registration with the CQC;
- Ensure that reasonable care is taken to avoid acts or omissions that are likely to cause harm to adults with care and support needs;
- Meet and set the standard of care that the adult should expect to receive;
- Demonstrate and aspire to adhere to a duty of candour. This means that the organisation must be open and transparent with adults and commissioners about their care and treatment when it goes wrong;
- Ensure Staff fully understand their role and responsibilities in regard to the adult safeguarding policy and procedures and that Staff have a duty to report promptly any concerns or suspicions that an adult with care and support needs is being, or is at risk of being, abused;
- Where care and / or environment is inadequate, to communicate concerns both internally and, where appropriate externally for example to the CQC;
- Be compliant with regulations e.g. Mental Capacity Act 2005/Deprivation of Liberty Safeguards, Criminal Justice and Courts Act 2015, Health and Safety etc.

Organisational abuse can be identified via the following processes:

- Through effective monitoring and quality assurance processes;
- By joining up the information gathered by various departments and agencies;
- Good incident reporting processes and having a process to enable overview and looking for patterns;
- Knowing what good practice and good care looks like; and
- Effective collaborative Multi-Agency working ;
- Whistleblowing.

Within this policy the responsibility for quality assurance of commissioned health, social care and support services remains within current arrangements for Commissioners and the Contracts and Quality Assurance Teams. However, in cases of Organisational Abuse it is recognised best practice that Commissioning and Contracts and Quality Assurance must work in partnership with the adult safeguarding process and their functions are not carried out in isolation.

Where a commissioned service/provider is subject to these procedures on multiple occasions for continuing service failures, the service/provider may also be subject to commissioning/contract actions under the Working with Services which Deliver Poor Outcomes.

Criminal Liability in Health and Social Care Setting

Following the implementation of the Criminal Justice and Courts Act 2015, care workers and care providers can be prosecuted for the criminal offences of ill treatment or wilful neglect. Section 20 of the Act states that: "It is an offence for an individual who has the care of another individual by virtue of being a care worker to ill-treat or wilfully to neglect that individual." This offending relates to 'wilful' neglect carried out deliberately, NOT incidents of genuine error or accidental in nature. It also makes clear that the provisions apply to the treatment of any individual placed in their care and are not restricted to those who lack capacity or have a mental health condition (as per the previous provisions under the Mental Capacity Act 2005 and Mental Health Act 1983). Furthermore, the Act ensures that the company or care provider organisation can also be held accountable for such offending if the arrangement of their activities 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". It is considered a "gross" breach if the conduct alleged to amount to the breach falls far below what can reasonably be expected of the care provider in the circumstances.

Whilst the offence against individual workers focuses specifically on their behaviour and conduct towards individuals, the offence against the company/provider is based on the management of their activities and the duty of care owed to the individual. This legislation is intended to act as a deterrent for the type of conduct which has resulted in extreme cases of poor care or abuse but were not captured as specific offences under the previous legal framework.

The legislation applies to all professionals who hold a position that involves a duty of care towards another individual; including doctors, dentists and nurses. Further legal guidance with examples can be found here.

Patient Care and Safeguarding challenges within Care Settings

Safeguarding is also central to the quality of care and the NHS outcomes framework particularly:

- Domain 4 - Ensuring people have a positive experience of care;
- Domain 5 -Treating and caring for people in a safe environment and protecting them from avoidable harm.

Challenges to the delivery of safe, good quality care present themselves within all care settings so it is vital that care settings take the appropriate action and use prevention checklists to ensure that all of the below are prevented and the effects minimalised if they are discovered. For detailed guidance of the prevention of all of the below please refer to SCIE Guidance;

- Maladministration of medication;
- Pressure sores;
- Falls;
- Rough treatment, being rushed, shouted at or ignored;
- Poor nutritional care;
- Lack of social inclusion;
- Institutionalised care;

- Physical abuse between residents;
- Financial abuse;
- Poor recognition assessments and response to complex and deteriorating conditions/situations.

This list is not exhaustive

Differentiating between poor care and potential safeguarding issues

The aim of every commissioner and service provider should be effective, high-quality care and support for every individual (see Appendix 6). Standards such as the Code of Practice set out by the Nursing and Midwifery council are examples of standards that must be adhered to. When care and support falls short, people are put at risk and safeguarding referrals rise. There is **evidence** that many of the issues raised as safeguarding concerns – such as falls, pressure sores, wrongly administered medication or poor nutritional care – are rooted not in malicious harm but in poor practice and poor-quality care. Nonetheless, the impact on the adult at risk can be just as great, regardless of whether harm is intended.

It is important to differentiate between the two, in order to address problems in the right way, so that all adults at risk receive safe, high-quality care and support.

Examples of poor care

- A one-off medication error (although this could, of course, have very serious consequences);
- An incident of understaffing, resulting in a person's incontinence pad being unchanged all day;
- Poor-quality, unappetizing food;
- One missed visit by a care worker from a home care agency.

Potential causes for concern for Organisational Abuse

- A series of medication errors;
- An increase in the number of visits to A&E, especially if the same injuries happen more than once;
- Changes in the behaviour and demeanor of an adult with care and support needs;
- Nutritionally inadequate food;
- Not providing adequate hydration;
- Signs of neglect such as clothes being dirty, pads not being changed;
- Repeated missed visits by a home care agency;
- An increase in the number of complaints received about the service;
- An increase in the use of agency or bank staff;
- A pattern of missed GP or dental appointments;
- An unusually high or unusually low number of safeguarding concerns;
- Lack of consistent management/leadership.

Bristol multi-agency policies and procedures make it clear when to refer concerns about an adult at risk through local safeguarding channels, although you will always have to use your professional judgement on this, plus internal policies and procedures, supported by

your manager. **Where Organisational Abuse is likely or suspected a referral to the Safeguarding Adult's Team MUST be made**. The Police will advise on whether a crime has potentially been committed. Poor care should be identified and addressed by the service provider, using supervision, training and other mechanisms to improve practice.

It is good practice to keep the Commissioners and the Care Quality Commission fully informed of action that is being taken.

Whistleblowing

"Whistle-blowers often put the public good first at great personal risk. They can and do make a big difference in the fight against corruption and deserve our support, protection and admiration."[3]

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. The person may or may not have tried to raise the issue with their management. Ideally they should have done but clearly there are times when an employee will feel too intimidated to do so or have and no response or don't like response. Where a "whistleblowing" is actually a safeguarding concern about an individual this should be dealt with initially through individual safeguarding processes to ensure that the person is safe. Where there are wider implications these may need to be followed up through organisational safeguarding processes. Anonymity may not be guaranteed so it is important that the correct support and help is available and Whistleblowing codes of practice followed.

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 this will need to be balanced with other information.

[3] *Cobus de Swardt, Managing Director, Transparency International - https://www.transparency.org/files/content/activity/2013_Whistleblowing_SupportOurWork_EN.pdf*

Learning from Serious Case/Adult Reviews

A theme that has been identified by Safeguarding Adult Reviews is that abuse is also more likely to occur where the providers' quality assurance and monitoring systems are inadequate. (This has been regularly identified through Safeguarding Adult Reviews). Some of this learning has been captured below.

Information handling: record keeping and information sharing; Multi-Agency working; Training of commissioning staff; Staffing levels; Lack of staff training on dealing with people with complex needs/challenging behaviour, specific health needs, responses to emergencies, first aid and tissue viability; Inadequate risk assessment and planning.
Poor interagency communication; lack of awareness of safeguarding procedures among health and social care staff; lack of knowledge of whistle-blowing policies.
Staff training; management and leadership skills; whistle-blowing; practice standards and skill mix; practice and policy on control and restraint; adult protection policy and procedures; regulation and monitoring; supervision.
Multi-Agency working and communication; confusion over roles and responsibilities; safeguarding training; record-keeping; monitoring and supervision; weak leadership on safeguarding; poor management accountability; confusion about relationship between mental capacity, risk, choice and safeguarding; managing rather than protecting 'difficult' clients.
Training and continuing professional development; Supervision; Risk assessment and management; Organisational culture; Whistle-blowing; Information-sharing; Personalisation and mental capacity; Use of agency staff.
Systems and procedures fell short in commissioning patient care, and in reviewing and safeguarding the wellbeing of patients, inappropriate use of restraint, whistleblowing, regulation and monitoring.

Identifying services of concern and Organisational Abuse

Appendix 1 will assist in determining what action that is required if there are Safeguarding concerns. The University of Hull was commissioned by Birmingham Adults Safeguarding Board and developed a tool as a result of a research project on Early Indicators of Concern in Residential and Nursing Homes for Older People. This tool can be used by an individual, a group of people, including families and professionals to record information and collect concerns about a service from different sources. It could also be used by a team to review and reflect on their own service. Information contained and collated on service monitoring information forms is a simple but essential process where early indicators of concern could be highlighted and prevent people from been abused, neglected or harmed.

This collection of data assists in identifying where patterns or clusters of indicators are observed within a service which could suggest an increasing risk and the need for intervention and a safeguarding plan.

The information from the widest range of sources is gathered and organised into the following 6 indicators:

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.

Risk assessing to determine Organisational Abuse

There are a number of different risk assessments used by Social Care and Health to assist in determining where poor practice or is likely to become safeguarding Issue and whether to initiate an Organisational Abuse enquiry.

By addressing the four Key Questions it will support the decision to initiate an organisational abuse investigation:

1. Is the incident of a **type** to indicate organisational abuse?

2. Is the incident of a **nature** to indicate organisational abuse?

3. Is the incident of a **degree** to indicate organisational abuse?

4. Relating to these 3 questions, is there a **pattern and prevalence** of concerns about the organisation?

It is good practice where a concern is being raised to the Local Authority that as much information as possible is given including consideration of these four points on their referral.

Indicators of Organisational Abuse - Signs and Symptoms

The following are examples only.

The **Type** of Incident

- Inappropriate or poor care
- Restricted access to required health or social care services
- Misuse or inappropriate use of medication
- Neglect of service user(s)
- Absent or inadequate policies and procedures
- Misuse of restraint or inappropriate restraint methods
- Unauthorised Deprivation of Liberty
- Non-adherence to the Mental Capacity Act
- Sensory deprivation - denial of spectacles, hearing aids
- Restricted mobility – denial of access to mobility aids
- Restricted access to toilet/bathing facilities
- High number of complaints, accidents or incidents
- Care regime exhibits lack of choice, flexibility and control
- Care regime impersonal and lacks respect for dignity
- Lack of personal clothing and possessions
- Denial of visitors or phone calls

The **Nature** of the Incident

- Is the behaviour widespread within the setting?
- It is evidenced as repeated instances
- Is it generally accepted within the setting?
- Is it sanctioned by supervisory and management staff?
- Is there an absence of effective management monitoring and oversight?
- Are there environmental factors that adversely affect the quality of care?
- Are there systematic deficits embedded in the care setting?

The **Degree** evidenced by the Incident

- The vulnerability of service users
- The nature and extent of the abuse
- The length of time it has been occurring
- The impact on service user(s)
- The risk of repeated or escalated incidents

The **Pattern and Prevalence** of Incidents

- Are the same incidents reported over time
- Is there a frequency of concerns (which may encompass previous safeguarding alerts, complaints, whistleblowing, CQC inspection outcomes, contract monitoring reports, service monoitoring forms, quality assurance visit outcomes etc.)
- The concerns have been raised internally but there has been an inadequate response by those meant to address them.

Thresholds for a large scale investigation of organisation abuse

Concerns about potential 'organisational abuse' or a need for a' large scale investigation' will need a threshold decision to be made about what scale of an investigation is required (Appendix 2).

Whilst it is recognised that responsibility for co-ordinating Safeguarding Adults procedures lies with the Local Authority within whose boundaries where concerns have been made, a collaborative Multi-Agency approach will be required to ensure a robust response. A **strategy meeting** will be convened led by a Safeguarding Adults Team (Bristol City Council) to review and evaluate all current sources of evidence, undertake a risk assessment and formulate an initial safeguarding plan to ensure the ongoing safety of all users of the service.

The Police

- The Police (Safeguarding Coordination Unit) must be informed immediately **(in working hours Mon-Friday outside of these hours contact 101**) if it is believed that a crime may have been committed. Where criminal offences may have been **committed it is crucial that the first enquiries are done by or with the police. This will be decided in the strategy meeting/discussion.**
- Strategy meetings agree actions for all agencies to support the enquiry. Resources may need to be agreed with senior managers within and between organisations.

According the circumstances it may be necessary to put all or some parts of an investigation on hold, whilst the Police investigate to ascertain if a crime has been committed or carry out a criminal investigation. Guidance must be taken from the Police and if necessary CPS regarding this.

A witness may be eligible for the assistance of an intermediary whose function is to communicate to the vulnerable witness, 'questions put to the witness, and to any persons asking such questions, the answers given by the witness in reply to them, and to explain such questions or answers so far as necessary to enable them to be understood by the witness or person in question'. A witness is eligible for the assistance of an intermediary if they satisfy the test in section 16 of the 1999 Act which are;

- A witness in criminal proceedings (other than the accused) is eligible for assistance by virtue of this section '(a) if under the age of 17 [now 18] at the time of the hearing; or (b) if the court considers that the quality of evidence given by the witness is likely to be diminished by reason or any circumstances falling within subsection (2)' (section 16 (1) of the 1999 Act);
- The circumstances falling within subsection (2) are '(a) that the witness (i) suffers from mental disorder within the meaning of the Mental Health Act 1983; or (ii) otherwise has a significant impairment of intelligence and social functioning; (b) that the witness has a physical disability or is suffering from a physical disorder' (section 16 (2) of the 1999 Act);
- Section 16 (5) of the 1999 Act says that 'references to the quality of a witness's evidence are to its quality in terms of completeness, coherence and accuracy; and for this purpose "coherence" refers to a witness's ability in giving evidence to give answers which address the questions put to the witness and can be understood both individually and collectively.'

All agencies need to support the Police with information or other resources as agreed to ensure that the investigation proceeds in a timely way. The Police need to keep the responsible manager informed of progress and any other risks.

The CQC

- Information sharing guidelines must be followed between the Local Authority and the Commission. This will ensure that each organisation is made aware of the others' concerns. In terms of its involvement in the safeguarding process, the Commission will determine if a possible breach of regulations has taken place, which requires inspection.

- Whilst information will be shared between the Commission and Local Authority parallel, rather than joint, inspection and safeguarding investigations will take place. Such investigations will have overlapping concerns since both will relate to the quality of care provided by the home (repeated instances of poor care is one definition of whole service or organisational abuse.) However, whilst both agencies will co-operate in order to safeguard vulnerable adults, some decisions will need to be taken independently following consultation with the other, rather than jointly by both, as agencies have differing responsibilities as regulators, commissioners and safeguarding leads.

Keeping Adults Safe (KAS)

The Chair of the KAS must be informed at the earliest opportunity if;

- The severity of the incident triggers concerns that the KAS should be made aware of; there is a likelihood that a media response will be required, reporting of concerns is anticipated;
- that a case(s) may reach the criteria for a Safeguarding Adult's Review.

An agency does not participate in assisting with a called enquiry; Escalation/challenge should follow. **Escalation Procedure Resolution of Professional Disagreements in Work Relating to the Safeguarding of Adults at Risk.**

Initial Strategy Meeting

Responding to organisational abuse is likely to require a complex coordination of different organisations both for information and for direct involvement in the investigation. Drawing upon the knowledge and expertise of Clinical Commissioning Group (CCG), Police, and other 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 (appendix 5) and their duty to cooperate in the enquiry.

The strategy meeting should be organised and held as soon as possible by the Coordinator Safeguarding Adults Service manager or People Director. Depending on the level of risk and the complexity, severity, a balance may be needed between ensuring the maximum number of partners round the table and ensuring people's immediate safety. Where the situation is extremely serious an immediate strategy meeting/discussion may be required to start the enquiry process. This should be a rare occurrence but it is expected that all partners will respond when this is required.

Strategy meetings should be held within 2 days and should involve the key partners to carry out a full enquiry. This is likely to include the Local Authority operational managers, health commissioners, provider and police at a minimum. The strategy meeting will need to undertake a preliminary risk assessment based upon existing knowledge and agree an interim safeguarding plan covering both individual alerts and the care setting. This must include a plan to keep existing service users safe. The risk assessment should also include the option of suspending further placements.

Throughout these meeting use Appendix 2 Risk Assessment to provide evidence of where the risks are and at what level they are at each stage. This will provide clarity throughout the process and illustrate the change in the level of risk.

This group will collate information and discuss the following:

- Terms of Reference, purpose of the meeting, background and concerns;
- The previous safeguarding history of the Provider (including other services/institutions owned by the Provider);
- CQC – previous and current status of institution/Provider. Previous and current evidence of non-compliance;
- Contracts and Quality Team and Commissioners – previous and current evidence of non-compliance, quality assurance, concerns or complaints;
- Status of funded placements and feedback received from placement reviews
- Status of Out of Area placements;
- Continuing Health Care (CHC) and Free Nursing Care (FNC) feedback – status of placements and history of concerns/complaints;
- Police – past or current concerns NHS - history and pattern of clinical referrals (for example; Emergency Department attendances)
- Health and Social Care Practitioner views – any concerns arising from engagement, involvement or reviews;
- It is also important to obtain any information relating to positive feedback;
- Nomination of specific leads within that particular agency should a large scale investigation need to be convened;
- 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;
- Information Sharing;
- Investigation of initial concerns for one service user identifies risks for others;
- Number of vulnerable adults adversely affected;
- If adult/family/advocate meeting is required;
- Whether criminal offences may have been committed;
- Possible multiple breaches of the Care Standards Act;
- For the most serious situations where serious harm has taken place or is suspected The Head of Safeguarding at Bristol City Council must be informed. A decision will then be made about information being passed to senior managers to ensure appropriate involvement and support from services;
- Where criminal offences may have been committed it is crucial that the first enquiries are done by or with the police;
- Identify and agree the initial internal resources to co-ordinate and undertake the investigation/assessment, including legal advice;
- Organise further Strategy meetings to review the risk assessment and safeguarding plan covering both individual allegations and the organisational setting;

- Identify and implement a clear communication strategy;
- Ensure the potential need for advocacy informs the enquiry;
- Agreed Timescales;
- Communications strategy how service users, their representatives and advocates are kept informed. Identify communication pathways with placing authorities;
- Media Strategy if needed;
- Ensure all parties know what their actions are and when they are to be delivered by and reported to whom.

Who Leads?

Bristol City Council will coordinate all large scale safeguarding investigations including the chairing of all strategy meetings.

Each participating organisation will nominate a lead to support the investigation a discussion needs to take place about the relationship between social care and police/criminal investigation these will need to be confirmed for each individual enquiry/investigation. The balance is between preserving evidence and enabling the police to pursue their investigation and ensuring that all residents are safe within the setting.

The strength of partnership is manifested in each principal safeguarding organisation – in particular, the Local Authority, Police, Clinical Commissioning Group and Care Quality Commission – having a specific role and functions that dovetail to create an effective safeguarding process. Operationally, this requires careful coordination and avoidance of deference to, or dominance of, any single organisational perspective or function.

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. It will be important to understand the service providers own mechanisms for example, disciplinary procedures, and how any intention to deploy these relates to the safeguarding concern and aligns to the safeguarding plan. It is key that the service provider take 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 become part of the investigation.

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. Where these are not adhered to consideration must be given to how to escalate the concerns to ensure they are managed.

Engagement with Adults, Carers, families and advocates

The Multi-Agency Team will make the decision if and when an adult/family/advocate meeting should be held. The meeting will be followed up with a letter to all relatives outlining concerns and proposed actions.

The full and appropriate engagement of Adults, their families and representatives/advocates at all stages of the enquiry is fundamental **unless** it compromises any part of the enquiry. Service users must be informed of any decision that impacts on them in a professional, timely and supportive manner.

The Care and Support Guidance (para 14.10) makes clear that we MUST arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them. The Guidance also makes clear that we must consider the provision of advocacy for a carer in cases where the carer has harmed of been harmed by the adult at risk.

The Enquiry

Central to the enquiry the objectives under Section 42 of the Care Act must be met. These 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;
- Involvement of Adults and their representatives;
- Confirm sustainability plan.

Strategic Oversight

Appendix 3 will assist in determining the scale of investigation required and who should have strategic oversight. In most instances the process outlined will be sufficiently robust to ensure a full and thorough enquiry can be undertaken and arrangements made to keep people safe, however there may a small number of situations where it becomes evident that the degree and severity of the safeguarding and the complexity of the situation requires additional strategic oversight.

Complex adult safeguarding enquiries with multiple service users/victims

A safeguarding assessment where necessary between Health and Social Care should be completed for all service users who may have been subject to, or at risk from, the alleged abuse. Where this assessment shows evidence of actual abuse the Police must be informed immediately.

Police – The Safeguarding Coordination Unit and the Chair of the Enquiry will discuss the matter. A further strategy meeting may be needed to review risk and actions as new information is gathered.

CQC - Must be informed of any concerns relating to a regulated service or any Health and Safety breaches.

Commissioners and Contracts and Quality Team - must be informed of safeguarding concerns relating to any provider operating in Bristol, irrespective of whether services are commissioned.

Environmental Health where there are Environmental concerns identified concerns

Fire Services where fire risk is identified

Health where services are commissioned by the Clinical Commissioning Group, NHS England or Public health e.g. via Continuing Health Care(CHC), Funded nursing care (FNCC) or as part of a joint package the Clinical Commissioning group must be informed.

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

Where safeguarding issues relate to a council provided service (provision or assessment etc.) then care must be taken to ensure that there is a separation of interests i.e. all staff involved in the safeguarding investigation should have no direct relationship to the matters under investigation If this is not possible then this should be assessed by a coordinator.

Bristol City Council may delegate to someone else to ensure that everyone is informed. If an agency has agreed these delegated responsibilities they must keep coordinator informed of progress or issues.

Responsibility of the Host or Funding Organisations

It is the responsibility of Bristol City Council as the "Host" authority to inform funding 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 funding authorities involved. Funding 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. While the council retains the lead safeguarding role for all safeguarding alerts, funding commissioning bodies retain a duty of care towards the service user and should be expected to fulfil this role in co-operation with the safeguarding investigation.
Good practice guidance on organisational enquiries involving many funding 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 strategy meeting 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.

Safeguarding Review Meeting

Follow up meetings will be needed to ensure that actions are followed up and plans revised as required. Including:

- Implementation of enquiry / assessment plan;
- Report completed by investigator(s);
- Evaluation of enquiry /assessment activity and evidence obtained;
- Determine if abuse/neglect has taken place covering both individual alerts and the care setting (organisational abuse);
- Agree further detail on Communications strategy;

- Agree further detail on Media Strategy;
- Consider the circumstances and potential needs of perpetrator(s);
- Agree ongoing Safeguarding Plan which is likely to have both short and medium term actions;
- Agree time scales for review of Safeguarding plan;
- Agree circumstances where re-evaluation of the situation will be required;
- Agree action plan for the service provider;
- Monitoring and review of action plan for service provider;
- Debrief and consider learning points and wider implications;
- Receive 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, Health and Care Professional Council (HCPC);
- Consider referral to the Keeping Adults Safe (SAR) or other actions across the safeguarding partnership;
- Frequency of reviews;
- Case closure – (see beneath).

Meetings can be managed in a number of ways but the key is to ensure the correct people are involved. Sometimes it will be appropriate to meet first without the provider to ensure that information is shared. Best practice would then be for a smaller group to meet immediately afterwards to talk the provider through the concerns. It is essential that commissioners are involved in both these meetings.

It is essential that all participants are aware that meetings are confidential and will be minuted.
For occasions where the situation is less serious but meets a level of concern where action is required this will be managed by the safeguarding adult's team using the same principles as above.

Organisational Abuse: Safeguarding Closure

Where organisational abuse has been investigated and progressed to multi agency meetings it is important that the decision to close the safeguarding is agreed in partnership. It is therefore essential that key agencies remain involved in the safeguarding process. The Multi-Agency meeting will need to be satisfied that:

- All required safeguarding actions have been undertaken and completed;
- There is evidenced reduction in risk to a safe level;
- victims/involved service users 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;
- Reflect on learning and make changes where necessary;
- Agreement on continuing protective measures if necessary – who will monitor, how etc.

All placing commissioning bodies and CQC should be notified of the safeguarding closure once confirmed and receive copies of minutes if appropriate.

The Head of Safeguarding, KAS Chair, Mayor, Press Office, etc. should be notified of safeguarding closure also.

Publicity and Media

Public and media interest may arise in safeguarding cases. Specifically in all organisational safeguarding situations it is essential that under no circumstances should media comment be made without reference to the **Bristol City** Council Communication Team.

Where media interest is likely the Service Director for Care and Support Adults (or their delegated lead) will proactively manage this with the Communications Unit.

Escalating responses to safeguarding concerns – Appendix 1

Please note this is pre Care-Act and is a guide only.

Adapted from Collins, M. Thresholds in Adult Protection**,** the Journal of Adult Protection Volume 12 Issue 1, February 2010
The terms “person” or “adult at risk” refer to adults with care and support needs who are unable to protect themselves from abuse or neglect.

Allegations which may not carry a duty to enquire under S.42 of the Care Act 2014	**Allegations which will pass carry a S.42 Duty to enquire**	**Organisational abuse?**
Person does not have within their care plan/service delivery plan/treatment plan a section that addresses a significant assessed need such as: • management of behaviour to protect self or others • liquid diet because of swallowing difficulty • cot sides to prevent falls and injuries No harm occurs	Failure to specify in a persons’ plan how a significant need must be met. Inappropriate action or inaction related to this results in harm* such as injury, choking etc.	If this is also a common failure in all care plans in the care service/hospital/care agency will pass the threshold for organisational safeguarding enquiry.
Person’s needs are specified in a treatment or care plan. Plan not followed, needs not met as specified but no harm occurs.	Failure to address a need specified in the person’s plan results in harm. This is especially serious if it is a recurring event.	If this practice is evident throughout the care service/hospital/care agency, and not just being perpetrated by one member of staff, this will pass the threshold for organisational safeguarding enquiry.
Person does not receive necessary help to have a drink/meal on one occasion	Recurring event. Harm occurs: weight loss, hunger, thirst, constipation, dehydration, malnutrition, tissue viability problems.	If this is a common occurrence in the setting, or there are no policies/protocols in place regarding assistance with

		eating or drinking passes threshold for organisational safeguarding enquiry.

Allegations which may not carry a duty to enquire under S.42 of the Care Act 2014	**Allegations which will pass carry a S.42 Duty to enquire**	**Organisational abuse?**
Person does not receive the necessary help to get to the toilet to maintain continence, or have appropriate assistance such as changed incontinence pads on one occasion.	Recurring event. Harm: pain, constipation, loss of dignity and self-confidence, skin problems	If this is a common occurrence in the setting, or there are no policies/protocols in place regarding assistance with continence needs, this passes threshold for organisational safeguarding enquiry.
Person who is known to be susceptible to pressure ulcers has not been formally assessed with respect to pressure area management but no discernible harm has arisen yet.	Person has not been formally assessed/advice not sought with respect to pressure area management, or plan not followed.	If this is a common occurrence in the setting, or there are no policies/protocols in place or evidence of staff knowledge of pressure sore risks, this passes threshold for organisational safeguarding enquiry.
Medication is not administered as set out in the care plan to a person as prescribed or is not given to meet the persons current needs	Recurring event, or is happening to more than one person. Inappropriate use of medication that is not consistent with the persons needs or harm occurs	Continual medication errors, even if they result in no significant harm, are a strong indicator of poor systems, staff compliance or training. Urgent remedial action, either via safeguarding adults or quality improvement strategies, must be undertaken.
Person does not receive recommended assistance to maintain mobility on one occasion.	Recurring event. Evident impact in the wellbeing of people or person using the service	If this practice is evident throughout the care service/hospital/care agency, and not just being perpetrated by one member of staff, this will pass the threshold for organisational safeguarding enquiry.

Appropriate moving and handling procedures not followed or staff not trained and competent to use the required equipment but person does not experience harm.	Person is injured, or common non-use of moving and handling procedures make this very likely to happen.	If this practice is evident throughout the care service/hospital/care agency, and not just being perpetrated by one member of staff, this will pass the threshold for organisational safeguarding enquiry.

Allegations which may not carry a duty to enquire under S.42 of the Care Act 2014	**Allegations which will pass carry a S.42 Duty to enquire**	**Organisational abuse?**
Person has been formally assessed under the Mental Capacity Act and lacks capacity to recognise danger e.g. from traffic.	Restraint/possible deprivation of liberty is occurring (e.g. cot sides, locked doors, medication)	
Steps taken to protect them are not 'least restrictive'. Steps need to be reviewed and referral for Deprivation of Liberty Safeguards may be required. Monitor via DoLs team	and person has not been referred for a Deprivation of Liberty Safeguard assessment although this had been recommended. Best interest has been ignored or presumed.	Evidence of restrictive practices or silo working and decision making across an organisation.
Person is spoken to once in a rude, insulting and belittling or other inappropriate way by a member of staff. Respect for them and their dignity is not maintained but they are not distressed. The matter is identified by the care provider and appropriate actions are taken to address the practice.	Recurring event. Insults contain discriminatory, e.g. racist, homophobic abuse. Individual(s) experience harm1	If this practice is evident throughout the care service/hospital/care agency, and not just being perpetrated by one member of staff, this will pass the threshold for organisational safeguarding enquiry.
Person does not receive a scheduled domiciliary care visit and no other contact is made to check on their well-being, but no harm occurs.	Person does not receive scheduled domiciliary care visit(s) and no other contact is made to check on their well-being or calls are being missed to more than one adult at risk. Or harm* occurs	If this practice is evident throughout the care agency, and not just being perpetrated by one member of staff, this will pass the threshold for organisational safeguarding enquiry.

Person with challenging behaviour whose plan of care stipulates that they should not go into the local town without two staff supporting them is taken by one member of staff to avoid disappointment	Person is regularly taken out by only one member of staff, with no review of care plan, and is therefore regularly put at risk.	If this is an indicator of poor practice by several members of staff, or poor management of the setting, others may be affected, organisational safeguarding enquiry should be considered.
Adult at risk in pain or otherwise in need of medical care such as dental, optical, audiology assessment, foot care or therapy does not on one occasion receive required/requested medical attention in a timely fashion.	Adult at risk is provided with an evidently inferior medical service or no service, and this is likely to be because of their disability or age or because of neglect on the part of the provider.	If there is evidence that others have also been affected, or that there is a systemic problem within the provider service organisational safeguarding enquiry must be initiated.
Housing providers Person is known to be living in housing that places them at risk from predatory neighbours or others in community and housing department/association is slow to respond to their application for urgent re-housing – but no harm occurs.	Housing provider fails to respond within a defined and appropriate timescale to address the identified risk. Harm occurs	Repeated incidences affecting multiple tenants
Housing providers A tenant or adult at risk in a warden supported housing complex reports that s/he finds the warden overbearing and intrusive	At least one tenant or adult at risk is intimidated and feels bullied by the warden and they are frightened to talk about why.	
Housing providers Adult at risk needs housing repairs arranged by their landlord. There is undue delay but repairs done eventually and no harm has occurred.	Landlord persists in not arranging repairs that are urgently required to maintain the safety of the person's environment. Harm occurs or evidence of serious risk of harm in multiple areas of the home.	A significant level of aggressive incidents between adults living in care or health settings can be an indicator of poor staff attitude, training, risk assessment and risk management, or poor supervision and management of the service. Organisational safeguarding enquiry should be considered.

Incident between **two adults living in a care setting**: One adult 'taps' or slaps another adult but has left no mark or bruise and victim is not intimidated and harm has not occurred. Or One adult shouts at another in a threatening manner, victim is not intimidated and harm has not occurred.	Predictable and preventable (by staff) incident between two adults where bruising, abrasions or other injuries have been sustained and/or emotional distress caused. Harm* occurs	A significant level of aggressive incidents between adults living in care or health settings can be an indicator of poor staff attitude, training, risk assessment and risk management, or poor supervision and management of the service. Organisational safeguarding enquiry should be considered.

Risk Assessment for Organisational Abuse– Appendix 2

Organisational abuse encompasses all types of abuse – neglect, emotional abuse, sexual abuse, physical abuse, financial abuse and discrimination.

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

Purpose of the Procedure
The risk assessment procedure set out below relates to concerns that have triggered Safeguarding Adults procedure thresholds.

RISK ASSESSMENT

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

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

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

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

IMPACT CRITERIA

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

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

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

LIKELIHOOD CRITERIA

UNLIKELY	This is unlikely to happen or recur due to control measures and process in place.
POSSIBLE	This may happen but it is not a persistent issue and there are measures in place to prevent a reoccurrence.
ALMOST CERTAIN	This will probably happen/recur frequently. This could be due to a breakdown in processes or serious concerns about control measures, loss of confidence in the provider's ability to care for people safety.

CONCERNS

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.

LEVEL OF CONCERN	CIRCUMSTANCES	TIER OF MANAGEMENT OVERSEEING/PARTNERS INVOLVED	ACTIONS SAFEGUARDING AND SHARING INFORMATION	ACTIONS CONTRACTS & QUALITY ASSURANCE
MINOR Unlikely, possible low or medium impact (BLUE ALERT)	• The provider has a history of recent difficulties (poor care/complaints) • The individual safeguarding alert may indicate wider concern. • Whilst unlikely, there would be a medium impact on people if concerns applied widely across the home • The manager is complacent/not proactive in working to ensure preventions	To be decided at Strategy meeting what further Involvement is needed but include; • Locality Team • Provided service • Relevant Contracts & Quality Assurance Team • Police	• An individual safeguarding meeting or S42 Enquiry with the Adults consent or in the best interest if they do not have the capacity to consent – outcomes and action plan may lead to organisational abuse meeting being called or provide evidence to be incorporated into the meeting	• Relevant Contracts & Quality team Support/monitoring from the providers' senior/safeguarding managers and where appropriate Contracts &Quality Teams.
MODERATE Almost certain low impact Possible medium impact Unlikely high impact (YELLOW ALERT)	• There have been a number of individual safeguarding alerts • Low impact service shortfalls are almost certainly taking place across the provider/service and medium impact shortfalls are possible • There is a failure at systems level to deliver service users' outcomes across a range of needs • The manager is failing to identify and act on the above **ORGANISATIONAL ABUSE THRESHOLD MET**	To be decided at Strategy meeting what further Involvement is needed but include; • Provider • BCC • Contracts & Quality Team • CCG • CQC • Police **Oversight by BCC Adult Safeguarding Team**	• Organisational safeguarding procedure • Adult Safeguarding Risk assessment • Consider need for organisational Safeguarding Plan • Information shared with CQC to inform decision making re inspection/actions • Monitoring via Adult Safeguarding/QA follow up	• Likely to be QA visits before or after safeguarding meeting • Consider need for a Service Improvement plan • Commissioners/ Contracts & Quality Team 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
MAJOR (AMBER ALERT)	• Abuse/neglect is in evidence across a wide range of provision • Residents/patients are all at risk	To be decided at Strategy meeting what further Involvement is needed but include;	• Longer term organisational safeguarding activity. • Need for safeguarding plan	• Total or partial placement ban • Recommended CQC random inspection

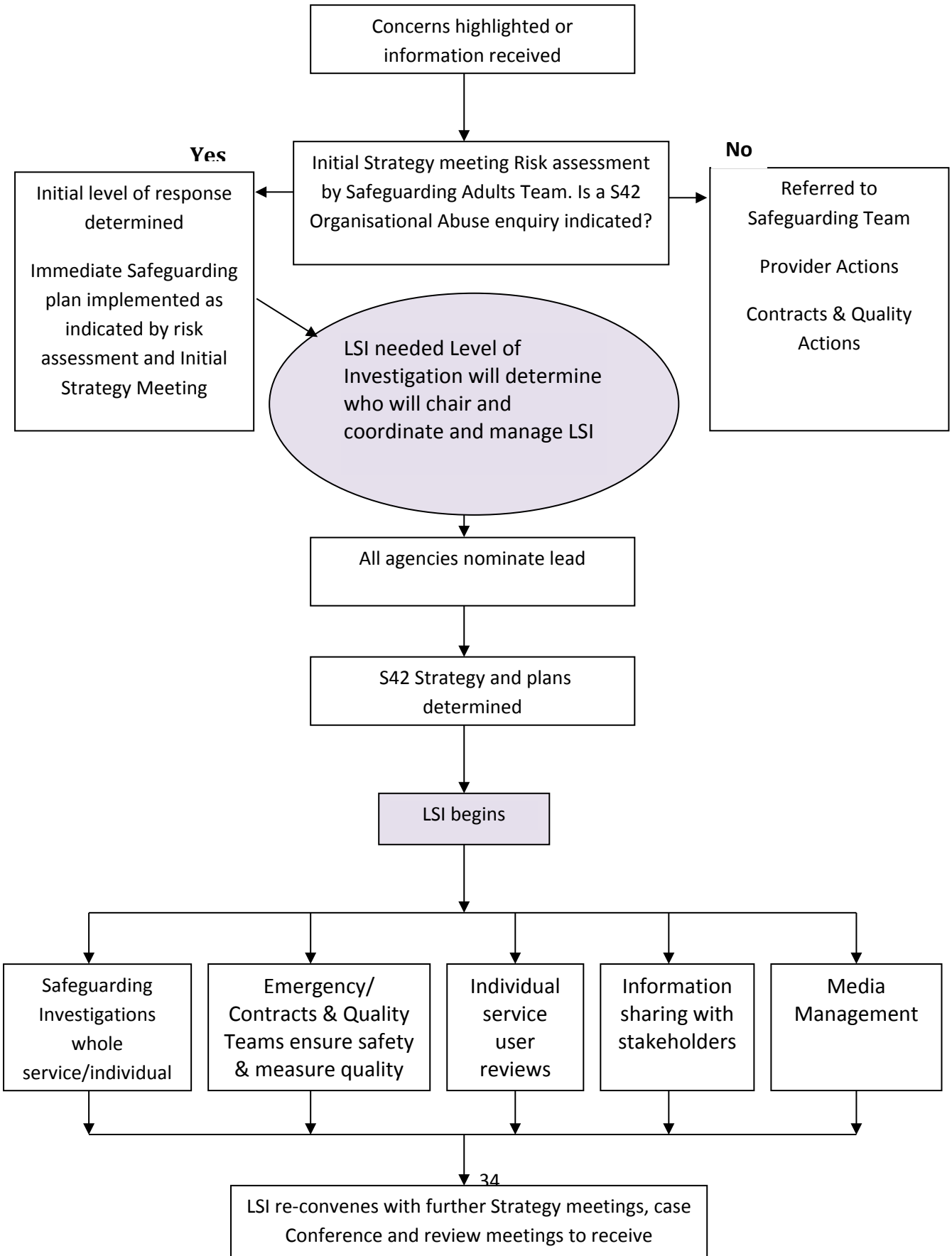
	of harm • Medium and major impact shortfalls evident • Quality of life is affected. • Lack of support from the wider provider organisation • Safeguarding team/Commissioners' lack of confidence in managers to deliver appropriate care and prevent abuse **ORGANISATIONAL ABUSE THRESHOLD MET**	• Provider • BCC • Contracts & Quality Team • CCG • CQC • Police **Oversight by BCC Adult Safeguarding Service Manager**	• Service Improvement plan indicated if provider will engage.	• Targeted individual reviews of residents/patients • Commissioners/ Contract & Quality Team 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.
PERSISTING MAJOR (RED ALERT)	• There is a loss of confidence in the organisation • There have been a series of action plans relating to safeguarding concerns over a period of time, but improvements not sustained • There is a danger of reputational damage to the Authority or Commissioning agencies • People using the service are unsafe	To be decided at Strategy meeting what further Involvement is needed but include; • Provider • BCC • Contracts and Quality Team CCG • CQC • Police • Media Officers **Oversight by BCC Service Director**	• A series of Safeguarding Meetings • Action plan from organisation • Service User removal • 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	• Series of QA visits • All service users reviewed according to agreed timetable • LSI must be instigated, see procedure • Consider termination of contract • Recommended CQC random inspection • Contracts and Quality Team review any restrictions already in place • Consider need to plan for service closure

Level of Investigation – Appendix 3

Not safeguarding – Quality and Contract Monitoring Concerns	Large scale investigation	Exceptional large scale investigation
Managed by Commissioning and Contract monitoring	**Managed by operational managers – determined at local level**	**Managed at senior level – determined locally**
Provider has recent history of difficulties (poor care complaints) CQC inspector raises alert about quality concerns which do not meet the threshold for safeguarding Other professionals raise concerns about quality There are concerns about Management arrangements e.g. frequent change of management Series of unconnected one off safeguarding alerts which are quickly resolved and risk assessed with appropriate action plan in place if required. Anonymous alerts indicating quality concerns Whistleblowing alerts indicating quality concerns	There have been a number of safeguarding alerts, complaints, review feedback and /or quality concerns which together indicate an emerging pattern of significant harm or abuse Anonymous alerts indicating pattern of significant harm or abuse taken together with other concerns Whistleblowing alert/s indicating a pattern of significant harm or abuse Regular failure of processes and practices which lead to individual needs being unmet e.g. under staffing which leads to significant harm or abuse Concerns about management /organisational ability to deliver a safe service e.g. failure to notify relevant people/agencies of serious incidents CQC enforcement action is being taken indicating there are concerns about significant harm or abuse Stark or Spartan living environment causing sensory deprivation Financial instability of the service or parent organisation linked to Safeguarding Adults concerns	As large Scale and has some or all of the following additional factors: Potential for wide media interest High volume and severity of risk E.g. Widespread consistent ill treatment Culture of dangerous practices E.g. over-medication and/or inappropriate restraint used to manage behaviour o And/ or low staffing levels which result in serious injury or death (corporate manslaughter) The need for high level coordinated response Single or several people/organisations with significant power and authority misusing this to cause considerable harm Pattern of suspicious, preventable deaths, Pattern of serious harm, A culture of institutional practices Repeated failure to comply with action plans to improve quality and safety Significant criminal investigations

	Significant criminal investigation.	

Process diagram for Large Scale Investigation (LSI) – Appendix 4



Roles and responsibilities – Appendix 5

Large Scale investigations may involve a wide range of organisations and a number of individual Safeguarding Adults processes and investigations. They can also often cross local authority boundaries and may involve services that are not commissioned by Health or Social Care. It is therefore crucial such processes are tightly coordinated and managed**.**

The different roles and responsibilities of some key organisations are detailed below:

The Host Authority will have overall responsibility for coordinating the safeguarding adult investigation and for ensuring clear communication with all placing authorities, especially with regards to the scheduling of meetings;

The Placing Authority will have a continuing duty of care to their adult at risk of harm. They will contribute to the investigation as required, and retain overall responsibility for the individual they have placed;

Commissioners (Health or Local Authority)
All Commissioners must ensure through contracts and service specifications, or service level agreements that the provider, has arrangements in place for protecting adults at risk of harm and for managing concerns, which are compliant with local (host authority) Multi-Agency safeguarding adults policy and procedures. Placing commissioners must ensure that arrangements are in place for ongoing contract monitoring and review.
In cases where a service is not commissioned by Health or Social Care an agreement must be reached at the outset of the process on which commissioners will take responsibility for overseeing the service. For example in a private hospital the host health commissioner will take the lead and for residential or domiciliary care the host local authority will take the lead.;

Police

The Police are responsible for the investigation of crimes, securing and preserving evidence.

CQC

The Care Quality Commission's (CQC) responsibility is to ensure compliance with relevant legislation and minimum standards and take appropriate action in relation to non-compliance;

NHS

NHS providers have a responsibility to participate and co-operate with any investigations and to provide appropriate information as requested by the Investigation Officers in a timely manner;

Service Providers

There are different types of large scale abuse e.g. where the organisation as a whole is alleged to have abusive care practices or where individual members of staff are alleged to have caused harm to a number of people. On a case by case basis a decision must be made on who, how and when the provider or individuals alleged to have caused harm will be notified of the allegations against them. This is to ensure a fair right of reply as part of the large scale investigation process. Organisations also have a proactive role in the

development and implementation of protection plans for adults at risk and improvement plans for the Service;

Other agencies, organisations and other Local Authority Departments that may be involved in Large Scale Investigations include: Health representatives – such as GP, District Nurses etc.
The Coroner,
Care &/or Support Contracts &/or Quality Manager & the service contract &/or quality monitoring officer,
Specialist professionals such as Tissue Viability Nurse, Medicines Management, Infection Control etc.
Health and Safety officers,
Advocates and/or Independent Mental Capacity Advocates,
Department of Work and Pensions,
Environmental Health and Trading Standards,
Fire or Ambulance Service and
Housing organisations.

This list is not exhaustive and the roles and responsibilities of those involved will need to be agreed as part of any Large Scale Investigation;

Person or Persons alleged to have caused harm

On a case by case basis a decision must be made on who, how and when the person or persons alleged to have caused harm will be notified of the allegations against them. They have a right to a fair opportunity of reply as part of the safeguarding adult's process. If there is a criminal investigation police advice must be sought before any contact is made.

Defining Best Practice – Appendix 6

If we look at the learning form Serious Adult Reviews we will be able to use this learning to make changes at all levels. We need to ensure that this learning is disseminated and cascaded effectively and efficiently through organisations through to the Individual worker where it is embedded into practice and implemented therefore eliminating the risk of abuse. The below areas are highlighted by SCIE.[4]

Record keeping

The importance of recording everything – and regularly reading what has been recorded by everyone – cannot be overstated. Only through good recording can patterns of incidents over time be tracked and analysed, and therefore addressed. A trend analysis could identify a pattern of concern

All records must be written clearly, and in a manner that can be easily understood by others. They must be accessible to everyone who needs to see them. Any records that contain personal information should be kept in secure storage that is only accessible to those who have authorisation to access these records. Case notes should always be written in a way that respects the person's dignity. Records that are no longer needed should be disposed of confidentially, in line with your organisation's policy on this matter.

Good record-keeping is central to effective safeguarding, even if 'safeguarding' is not required and I particularly important when you are assessing a person's capacity to make their own decisions. People benefit from records that promote good communication and high-quality care.

Failing to keep accurate records of decisions you have made and actions you have taken can put people at risk. It also puts the organisation you work for in a difficult position, and risks its reputation.

The term 'records' covers various types of documents, including:

- case notes;
- any statements that the person has made about their wishes;
- care plans;
- risk and other assessments (such as Mental Capacity Act 2005 assessments);
- incident reports;
- safeguarding referrals and enquiries;
- medication records and administration sheets;
- end-of-life care plans or advance decisions;
- referrals to other organisations and professionals;
- handover documents;
- staff supervision and training records;
- Complaints.

[4] http://www.scie.org.uk/publications/guides/guide46/underlyingcauses/index.asp

You should record decisions and actions that you decided not to take, as well as ones that you did, and explain your rationale in each case. You should also make very clear what is factual information and what is your own opinion or the opinion of other people.

Where an adult's finances are managed on their behalf – for example, by a care home, because they lack capacity to manage their own affairs, or because they have chosen to pass the handling of their money to the home – records must be subject to robust and regular checks.

Records should be kept of routine staff supervision, with written evidence that actions are followed up. Record-keeping practice should be reviewed regularly, with input from frontline staff.

How complaints are handled is an important aspect of an organisation's record-keeping, and your records should show that complaints are used to improve quality and practice. All complaints should be taken seriously, recorded fully and followed up. Where complaints highlight problems with a service, changes should be made and outcomes monitored.

Information sharing

Given the duty to cooperate in the Care Act 2014, there are only a limited number of circumstances in which it would be acceptable not to share information pertinent to safeguarding with relevant multi-agency safeguarding partners. These would be where the person involved has the mental capacity to make the decision in question and does not want their information shared, and:

- their 'vital interests' do not need to be protected;
- nobody else is at risk;
- there is no wider public interest;
- no serious crime has been or may be committed;
- the alleged abuser has no care and support needs;
- no staff are implicated;
- no coercion or duress is suspected;
- the risk is not high enough to warrant a referral to a Multi-Agency Risk Assessment Conference (MARAC);
- No other legal authority has requested the information.

For detailed guidance on Information sharing refer to KAS Multi Agency Guidance on Information Sharing. If there is continued reluctance from one partner to share information on a safeguarding concern, or in instances where an alerting organisation thinks that the local authority response is not sufficient, then the matter should be Escalated using the Escalation Policy and if not resolved refer to the Keeping Adults Safe (KAS).

Good Leadership, Recruitment, Training and Supervision

Poor practice in recruitment, induction and supervision can be the root cause of many safeguarding issues and is the learning that comes out of many serious case reviews. Good practice will prevent abuse.

Commissioners should examine recruitment procedures of the home to ensure they are robust.

Good practice can prevent abuse and can consist of:

- The manager(s) and senior staff demonstrate good leadership skills;
- The home/setting closely scrutinises applications for employment and actively investigates any gaps in employment history;
- The home/setting always checks references rigorously and makes further enquiries where necessary;
- At interview the home/setting establishes that the candidate has the appropriate attitudes and values to be considered for their role;
- The home/setting employs care staff with a good understanding of English (or other language spoken by the majority of residents) to ensure good and clear communication;
- The home/setting has a comprehensive induction programme and evidence that it is provided for all staff;
- The induction programme includes safeguarding practice and procedures and the individual's responsibility to raise concerns;
- New staff are mentored by existing staff and their practice is monitored.
- There is evidence of regular supervision which monitors safeguarding practice and encourages staff to raise concerns;
- The home has a robust training regime that extends beyond statutory requirements.
- The local authority offers safeguarding training to all providers and addresses issues of cost and staff cover within contractual arrangements;
- Staff receive training in safeguarding, mental capacity and Deprivation of Liberty Safeguards as part of their induction and attend regular refresher courses;
- The home carries out a regular training needs assessment within a culture of continuous improvement;
- People who use services are included in the provision of staff training;
- All night staff have the same access to training as daytime workers;
- There is a trained first-aider on duty at all times;
- Each member of staff has a plan for progression and development;
- Staff can demonstrate the benefits of their training and identify changes in practice resulting from it;
- The home/setting demonstrates that it learns from mistakes that lead to safeguarding referrals and includes issues raised in the training programme;
- The home/setting has a culture of continuous improvement taking account of the views of residents, relatives and frontline staff.

Staffing levels

Staffing levels that are inadequate to meet the assessed needs of individuals can be one of the reasons for poor quality care. Please see guidance. There are a number of problems that lead to inadequate staffing that are interrelated such as poor training and support for staff, staff feeling stressed, rushed and overworked leading to low morale, burnout and potentially poor standards of care, high levels of sickness increasing pressure on the remaining staff in the workplace, high staff turnover resulting in wasted training resources and high recruitment costs.

This can be avoided if;

- Commissioners and providers agree on adequate levels of staffing to meet individual needs and ensure contracts are adhered to;
- Commissioners provide sufficient funding for agreed staffing levels, including absence cover, and monitor to ensure agreed levels are consistently maintained;
- Care workers in the home are valued, respected and properly supported. They are well trained, supervised and adequately paid;
- The home/setting has a register of regular bank staff and is not reliant on agency care workers;
- Staff show a good awareness of how to access external support (e.g. community health teams, voluntary organisations).

Policy and procedure

All care homes should have policies and procedures in place to cover all areas of care home practice, including those highlighted. These policies and procedures should be submitted as part of the Care Quality Commission (CQC) registration process and subsequent inspections. However, it is often the case, particularly with regard to safeguarding referrals, that procedures are not followed.

To ensure good quality services and good safeguarding practice, commissioners must make regular checks to ensure that the procedures are followed.

Good Practice would be:

- The home/setting demonstrates good quality leadership and management;
- The home/setting has robust policies and procedures in place;
- The home/setting has clear guidance for staff to support decisions on making safeguarding referrals;
- There is clear guidance for staff on when to call out emergency services and what to do when they arrive;
- All staff, apart from those in induction and direct supervision, have signed to confirm they have read and understood the policies and procedures;
- The home has a whistleblowing policy, which includes the option of alerting externally through the local authority, and staff are aware of their individual responsibility to raise concerns.

Choice of service

From the perspective of people using services, it is clear that as long as there is a lack of choice and alternatives in service provision, poor services will continue to operate. There are many reasons why people may use services that are poor including lack of alternatives, affordability, location, choice and pressure from family members.

With real choice, individuals would choose not to use poorer services and such services would consequently have to improve or go out of business. This is a key point for commissioners as they must, where the market has failed, encourage variety and flexibility in provision to promote quality, choice and control for individuals. This in turn will reduce the risk of abuse, neglect and harm.

Good Practice would be:

- Commissioners plan, through the Joint Strategic Needs Assessment, to meet future identified care needs in the area;
- People are not placed far away from their local area due to lack of provision.
- Local services offer a good range of choice and flexibility;
- Gaps in the local market are identified by commissioners and they work with people using services and providers to address local need;
- Existing providers are encouraged to diversify the services they offer.

Dehumination

People using care services often report the experience of being treated in a way that is 'less than human' or 'dehumanising'. Institutionalisation can also lead to dehumanisation as the regimes and routines of the home are placed above the needs of individuals. Dehumanisation can be experienced in a number of different ways including being:

- discriminated against or treated differently to others;
- isolated, dismissed or ignored;
- disrespected, mocked or belittled;
- deprived of dignity and privacy;
- deprived of choice and control;
- stripped of one's identity;
- deprived of basic needs (e.g. food;
- abused physically, sexually or in any other way.

Good practice would be:

- Staff are respectful towards residents, treating them as individuals, promoting choice and upholding their rights;
- Staff are respected and valued;
- Residents participate in staff training and exercises that encourage empathy are included
- The home offers person-centred care and promotes dignity for all, including those who lack capacity or have problems with communicating their needs;
- Staff are encouraged to get to know residents, their preferences and their personal histories;
- Staff work in close partnership with residents' friends and family;
- Residents are encouraged to make a 'life story book';
- Particular effort is made to ensure that people who lack capacity or have problems with communicating are treated as individuals and every effort is made to ascertain their wishes.