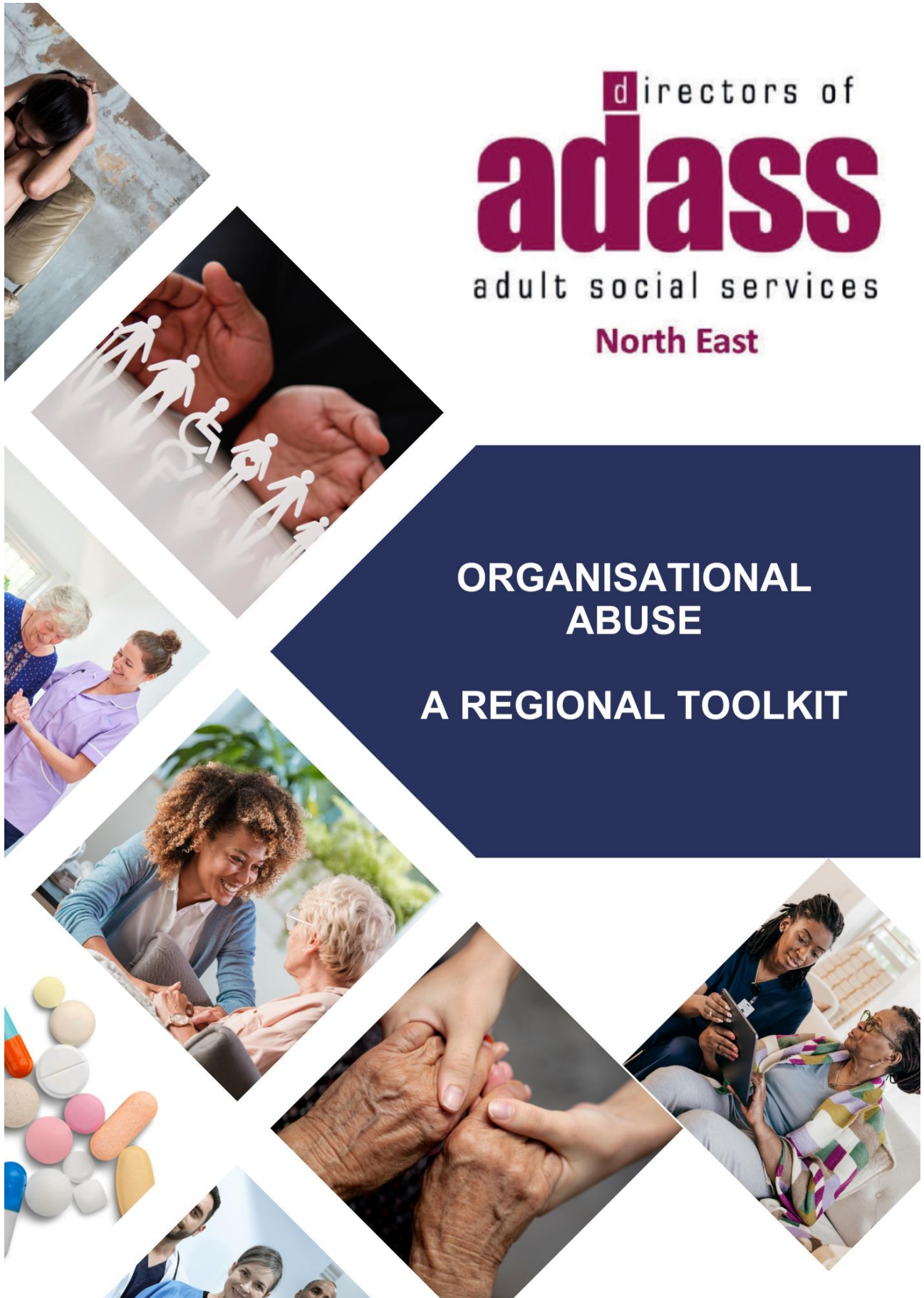


**ORGANISATIONAL
ABUSE**

A REGIONAL TOOLKIT



The following good practice toolkit has been developed with participation and contribution from colleagues across the North East Association of Directors for Adult Social Services Safeguarding Network:

- Darlington
- Durham
- Gateshead
- Hartlepool
- Middlesbrough
- Newcastle
- North Tyneside
- Northumberland
- Redcar
- South Tyneside
- Stockton
- Sunderland

It follows a regional benchmarking activity and survey completed by each area to identify what was needed to support more consistent practice relating to organisational abuse processes.

Introduction and purpose	Purpose of guidance
Definition and core messages	What is organisational abuse – Care Act legislation, core messages, case studies, reporting, responding and recording, wider learning and Safeguarding Adults Reviews, variations in language, pathways or processes, locations of organisational abuse/types of provision.
Developing a common understanding of Organisational abuse	Core principles for good practice, applying Care and Support guidance to provide greater consistency and links to NHS Digital/SAC guidance and individual S42 enquiries, closed cultures and secure settings, cross boundary and out of area guidance, interface with commissioning, complaints and CQC, making Safeguarding Personal, and outcomes for individuals
Key issues to improve consistency in reporting and responding to Organisational abuse	Roles and responsibilities of other agencies/services, Out of area/placing authorities and their role in organisational abuse enquiries, provider principles and requirements, sharing good practice examples, tools to support decision making
Further information	Appendices, i.e., additional resources

This guide/toolkit aims to support the bringing together of a range of legislation, guidance and local ways of working into a composite tool with helpful prompts and tips to support a more consistent way of working across the region. It is not prescriptive nor mandated but can be viewed as a helpful resource to support practice related to organisational abuse processes and or individual local authority policies.

Version: ADASS North East Organisational Abuse – Good Practice Guide/Toolkit – V001

Issue Date: August 2024 **Review Date:** September 2025

Northeast Safeguarding Adults Network

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Introduction and Purpose

The aim of this 'good practice guide' is to illustrate a set of principles and support for local authorities as the lead agency for dealing with concerns relating to organisational abuse for both commissioned and non-commissioned providers.

It aims to set out a range of practice tips to inform and support a consistent and coordinated approach to addressing organisational abuse concerns and/or significant quality concerns about a service provider, inclusive of communication and information sharing minimum standards and consideration to parallel processes.

The Association of Directors of Adult Social Services (ADASS) North East agreed to develop a regional tool to support a shared understanding of 'what constitutes an organisational abuse enquiry'. It is recognised that each local authority will have their own internal mechanisms and structures in responding to organisational abuse, this tool aims to inform and support existing mechanisms rather than replace.

The tool kit has been informed by:

- [Understanding what constitutes a safeguarding concern and how to support effective outcomes](#)
- [Making decisions on the duty to carry out safeguarding adults enquiries](#)

Who can the toolkit support:

This tool aims to support the local authority leads for organisational abuse enquiries/processes and when working with, for example (not exhaustive):

Care Quality Commission (Regulated Services)
Data/Performance Leads
Health Commissioners
Integrated Care Commissioning
Local Authority/Social Care Commissioning and Contracting (host and placing)
NHS Commissioning and Contracting (host and placing)

NHS Foundation Trusts (Mental Health, Acute, Ambulance)
Performance Leads
Police (where criminality may have occurred – See Appendices)
Safeguarding Leads (including Strategic Managers)
Safeguarding Adults Board Business Managers
Safeguarding Adults Board Chairs
Safeguarding Adults Leads (all agencies)

Definitions

It is helpful as a starting point to outline definitions as prescribed in related [Care and Support statutory guidance](#).

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’ (14.7 Care and Support Statutory Guidance)

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

Neglect and/or acts of omission:

- ignoring medical
- emotional or physical care needs
- failure to provide access to appropriate health, care and support or educational services
- the withholding of the necessities of life, such as medication, adequate nutrition and heating

The guidance (14.9) also makes 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 including the duty to take enforcement action when standards are breached
- the core duties of the police to prevent and detect crime and protect life and property.

and that ‘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’ (14.17)

This tool encompasses ‘all providers’ both commissioned and/or non-commissioned inclusive of the community and voluntary sector, examples may include non-commissioned supported housing, domiciliary care, day centres etc. There may be limitations for the local

authority in some circumstances (e.g. non commissioned) nevertheless the local authority has an assurance role for adults at risk in its area.

Within the North East region there are examples of concerns emerging related to direct payments and/or individual service funds (ISF) and related to care and support provision. Whilst the most appropriate mechanism to address individual safeguarding concerns is Section 42 safeguarding enquiries, local authorities, commissioning and direct payment/ISF leads may wish to review internal processes, for identifying and monitoring safeguarding issues related to these commissioning activities, and what if any action is needed. This report related to direct payments from [‘think local, act personal’](#) gives some helpful reminders of the focus of direct payments, as well as points that may support commissioners with undertaking any local evaluation.

Safeguarding is Everybody’s Business and a daily responsibility

The statutory guidance provides key information on the response to abuse and neglect in a regulated care setting.

Employing Agencies/Provider Responsibility

- It is important that all partners are clear where responsibility lies where abuse or neglect is carried out by employees or in a regulated setting, such as a care home, hospital, or college. The first responsibility to act must be with the employing organisation as provider of the service. However, social workers or counsellors may need to be involved in order to support the adult to recover.
- When an employer is aware of abuse or neglect in their organisation, then they are under a duty to correct this and protect the adult from harm as soon as possible and inform the local authority, CQC and Clinical Commissioning Groups¹ where the latter is the commissioner.

Employing Agencies/Providers and conflict of interest

- The employer should investigate any concern (and provide any additional support that the adult may need) unless there is compelling reason why it is inappropriate or unsafe to do this. For example, this could be a serious conflict of interest on the part of the employer, concerns having been raised about non-effective past enquiries or serious, multiple concerns, or a matter that requires investigation by the police.
- An example of a conflict of interest where it is better for an external person to be appointed to investigate may be the case of a family-run business where institutional (*organisational*) abuse is alleged, or where the manager or owner of the service is implicated. The circumstances where an external person would be required should be set out in the local multi-agency procedures. All those carrying out such enquiries should have received appropriate training.

Legal literacy was identified as an improvement priority from an analysis of Safeguarding Adults Reviews (SARs)² and a key requirement of safeguarding adults practice. Criminal offences involving ill-treatment and wilful neglect are

¹ Now known as Integrated Care Boards

² [Analysis of Safeguarding Adults Reviews, April 2017 – March 2019, Local Government Association](#)

covered in the [Section 44 of the Mental Capacity Act \(2005\)](#) and [Sections 21 of the Criminal Courts and Justice Act \(2015\)](#). In addition, [Section 22-25 of the Criminal Courts and Justice Act](#) makes provision relating to the 'care provider offence'.

Local Authority Responsibility

- Where a local authority has reasonable cause to suspect that an adult may be experiencing or at risk of abuse or neglect, then it is still under a duty to make (or cause to be made) whatever enquiries it thinks necessary to decide what if any action needs to be taken and by whom. The local authority may well be reassured by the employer's response so that no further action is required. However, a local authority would have to satisfy itself that an employer's response has been sufficient to deal with the safeguarding issue and, if not, to undertake any enquiry of its own and any appropriate follow up action (e.g. referral to CQC, professional regulators).

Information Sharing with wider partners

- There should be a clear understanding between partners at a local level when other agencies such as the local authority, Care Quality Commission or Clinical Commissioning Groups³, (CCGs) need to be notified or involved and what role they have. Association of Directors for Adult Social Services (ADASS), CQC, Local Government Association (LGA), and Association of Chief Police Officers (ACPO)⁴ and NHS England previously produced a joint high-level guide on these roles and responsibilities⁵.

Local authorities may also wish to consider the role of advocacy provision as a valuable source to gain information relating to providers. See also – [A review of advocacy for people with a learning disability and autistic people who are inpatients in mental health, learning disability or autism specialist hospitals](#) (National Development Team for Inclusion, 2023).

Promoting wellbeing

- The focus should be on promoting the wellbeing of those adults at risk. It may be that additional training or supervision will be the appropriate response, but the impact of this needs to be assessed. Commissioners of care or other professionals should only use safeguarding procedures in a way that reflects the principles above and not as a means of intimidating providers or families. Transparency, open-mindedness and timeliness are important features of fair and effective safeguarding enquiries. CQC and commissioners have alternative means of raising standards of service, including support for staff training, contract compliance and, in the case of CQC, enforcement powers may be used.

³ As above

⁴ Now known as [National Police Chiefs Council \(NPCC\)](#)

⁵ [CQC ADASS NHSE LGA ACPO - Safeguarding Adults - Roles and Responsibilities - revised draft - final version \(6\) \(local.gov.uk\)](#)

Commissioners

- Commissioners should encourage an open culture around safeguarding, working in partnership with providers to ensure the best outcome for the adult. A disciplinary investigation, and potentially a hearing, may result in the employer taking informal or formal measures which may include dismissal and possibly referral to the Disclosure and Barring Service.
- If someone is removed by being either dismissed or redeployed to a non-regulated activity from their role providing regulated activity and following a safeguarding incident, or a person leaves their role (resignation, retirement) to avoid a disciplinary hearing following a safeguarding incident the employer/volunteer organisation feels they would have dismissed the person based on the information they hold, the regulated activity provider has a legal duty to refer to the [Disclosure and Barring Service](#). If an agency or personnel supplier/employer has provided the person, then the legal duty sits with that agency. In circumstances where these actions are not undertaken then any other agency can make a referral (this may be agreed within organisational abuse enquiry meetings). In addition, employing agencies should always consider onward referral to the relevant professional bodies, such as, Health and Care Professionals Council (HCPC), Nursing and Midwifery Council (NMC), General Medical Council (GMC).

Local authorities and wider partners should refer to their own Safeguarding Adults Board/Partnership multi-agency guidance related to 'people in positions of trust' or equivalent.

In addition to the above, local authorities and health and social care personnel providers should be minded to the [code of practice guidance](#) issued by the Department of Health and Social Care (DHSC) and related to 'international recruitment' to ensure that they are upholding ethical recruitment and employment practices. See also [Establishing modern slavery risk assessment and due diligence in Adult Social Care: A commissioning officer's Guide](#).

The Care and Support Statutory guidance makes clear the responsibilities related to the commissioning of adult care and support and specifically the principles which should underpin market-shaping and commissioning activity⁶:

- focusing on outcomes and wellbeing
- promoting quality services, including through workforce development and remuneration and ensuring appropriately resourced care and support
- supporting sustainability
- ensuring choice
- co-production with partners
- the steps which local authorities should take to develop and implement local approaches to market-shaping and commissioning:
 - designing strategies that meet local needs
 - engaging with providers and local communities
 - understanding the market
 - facilitating the development of the market
 - integrating their approach with local partners
 - securing supply in the market and assuring its quality through contracting

⁶ See also Section 5 of the Care Act 2014.

Monitoring the effectiveness of safeguarding adults' arrangements is a key function of Safeguarding Adults Boards (SAB), commissioners should ensure that they continue to inform the local SAB of any emerging concerns relating to market stability for their local authority area that may indicate safeguarding issues.

Determining Organisational Abuse

This toolkit is a means of support and should be read in conjunction with relative legislation and guidance, internal policy and procedures. A range of terminology is used in the North East related to instigating enquiries into organisational abuse, or related forums, for example:

- Organisational Abuse Enquiries or Strategy
- Organisational Concerns Strategy
- Organisational Safeguarding Meetings
- Provider Concerns Enquiries
- Organisational Strategy meeting
- Executive Strategy Meeting (ESM)/Process
- Significant Provider Concerns Group
- Assurance meetings
- Information Sharing Meetings
- Quality Assurance Meetings
- Responding to and Addressing Serious Concerns (RASC) Policy and Procedure
- Managing Safeguarding at an Organisational level process

What is consistent is that most local authorities are using the Care Act definition of 'Organisational abuse' with some local guidance documents providing an expanded definition (see additional resources). Most local authorities also adopt some form of risk tool and guidance to support identifying indicators and examples (see common understanding).

Local authorities may also wish to take an opportunity to adopt the same terminology and language between commissioning and safeguarding for consistency of practice, for example, agreeing on use of embargoed, suspended, breach, default etc. Regardless of any localised terms adopted, decision makers will need to consider a range of issues, patterns and/or practice when determining whether organisational abuse has occurred and whether any local multi-agency processes should be triggered. The below offers some generic guidance to support decision-makers:

- Has there been an increase in safeguarding reporting or no safeguarding reporting (important to consider if a closed culture may be evident, a closed culture can exist even when reporting takes place)?
- Are the concerns of a nature that indicate issues with culture and/or behaviours of staff?
- Are the concerns of a nature that indicate rigid/inflexible routines?
- Are the concerns of a nature that indicate the needs of adults are ignored (for example, medical/physical and/or emotional needs)?
- Are the concerns relative to poor or inaccurate record keeping?
- Are the concerns of a nature that indicate withholding necessities of life, nutrition/hydration?

- Are the concerns being reported by more than one agency with 'eyes on'?
- Are the concerns being reported by family, representatives, advocates?
- Are the concerns as a result of whistleblowing/whistleblowers?
- Are the concerns of a nature that indicate potential criminal offences have occurred?
- Are the concerns relative to staffing levels, for example low levels/inadequate staffing, retention and/or recruitment concerns?
- Are the concerns relative to staffing skills and/or training needs?
- Is there an acceptance of behaviours and/or culture by the workforce and/or management?
- Do the concerns indicate a pattern? Repeat reporting?
- Has there been a significant one-off incident? For example, a death.
- Is there an escalation in the nature of the concerns being reported?

When considering the above, decision-makers may also seek out views and/or information from a range of sources, for example:

- Adults, their representatives and/or families
- Commissioning and Contracting Officers
- Police (reported incidents)
- Primary Care/GP Practices
- District Nursing
- Pharmacy Leads
- Tissue Viability Leads
- NHS Trust Safeguarding Leads (Acute, Ambulance, Mental Health)
- Placing Commissioners (Health and Social Care)
- Social Workers/Safeguarding Staff
- Complaints Officer(s)
- Care Quality Commission Inspectors
- Organisational Memory of Provider Reports/Concerns

The above is not exhaustive, and any or several of the above may result in a need to trigger an organisational abuse enquiry/process into potential or actual abuse. However, any need for individual S42 Safeguarding Enquiries to be undertaken in line with the Care Act 2014 and Making Safeguarding Personal principles will also apply, organisational abuse processes do not negate that requirement. How those processes take place and link to organisational abuse enquiries/processes is for individual local authorities/decision makers to determine and minded to any wider considerations such as the NHS Digital Safeguarding Adults Collection annual data submissions.

Potential Criminality

There should always be consideration to the potential for criminal offences to have occurred, and the role of the police for organisational abuse concerns. Advice should always be sought at the earliest opportunity so as not to hamper/impede any potential criminal investigation, that should coincide with seeking confirmation from the provider of any internal HR/disciplinary procedure and following that police advice. A range of offence types can occur, for example:

- Assault (actual bodily harm)
- Common assault (any physical contact)

- Wounding with intent
- Inflicting bodily injury (with or without weapons)
- Theft
- Fraud (abuse of position)
- Sexual Offences (against the person) including against adults who cannot consent, or are vulnerable to threats, inducement, or deception
- Sexual Offences (related to care workers)
- Wilful Neglect
- Ill treatment

There is additional guidance from the National Police Chiefs Council for Senior Investigating Officers (SIOs) investigating unexpected death and serious harm in healthcare settings (see additional resources). This guidance can be supportive for wider circumstances, for example, any instances that are high profile, whistleblowing and/or expose instances with multiple perpetrators and/or serious or significant harm. Advice should always be sought from police in all circumstances where potential criminality has occurred.

In addition, where any high profile, whistleblower or expose instances occur there should be consideration to any communications and media related activity in line with local policy including whether the local Safeguarding Adults Board should be informed via the respective Board Chair and/or Business Manager.

Professional Judgement and Decision Making – Illustrative examples

Below are some brief examples of concerns where professional judgement, professional curiosity and decision making may instigate/trigger organisational abuse processes or alternative action(s) in line with local authority agreed process:

Case Example 1: A support worker in Supported Living reported her concern/s about a client's increased bill for Satellite TV and adult channels. The Provider Manager spoke to the adult (with learning disabilities) who disclosed that a Waking Nights Support Worker would sit with her on an evening and show her pictures and programmes, and that he asked her to show him parts of her body. The female adult did not understand what had been happening to her and said the Waking Nights Support Worker had been going into other female's rooms. On review of safeguarding concern records for the provider, there have been several reports to the local authority for different clients related to resident-to-resident abuse and sexualised behaviours over the last year. On checking with the provider, the Waking Nights Support Worker has been employed for a total of 13 months, there have been several family complaints during that period for a client who has lost a significant amount of weight. The support worker has been arrested and suspended. There is a criminal investigation underway and related to sexual offences and causing people to engage in sexual activity as well as fraud. There have been no organisational abuse enquiry processes before for the provider. **What could inform decision making: the potential for multiple victims given sexualised behaviour reports and indication other/s may have been at risk, the concerns may coincide with the staff member commencement/time in employment, several complaints for one client for significant weight loss (could it be attributed to or result of serious abuse), serious criminal offences, whistleblowing report(s).**

Case Example 2: Concerns have been reported by family and professionals regarding an ISL service, these include restrictions on service user activities; staff are shopping on service users' behalf, service users pre-planned events are being cancelled. Concerns regarding items belonging to service users being thrown away without consent, verbal abuse towards service users witnessed. Staff reported to be using their mobile phones on duty. It is unclear what level of management oversight there is and if this extends to other ISL's overseen by the same satellite manager. **What could inform decision making: number of service users affected, concerns raised about a closed culture, restrictions of liberty. Any whistle blowing concerns, are these new concerns, has something changed within the service or has this been hidden.**

Case Example 3: Three residential care workers have been arrested after a new member of staff reported their concerns to the Care Quality Commission. That report included that they had witnessed the staff being verbally and physically abusive, repeatedly pushing and slapping an older male with dementia living at the setting. The communal corridor has a Closed-Circuit TV (CCTV) in place. The Provider Manager has shared footage recorded with the police. A family member has also contacted the local authority within the same week and advised they had placed a hidden camera in their relative's room, resulting in a serious complaint being raised with the care setting, and they have shared the detail of the complaint with the Care Quality Commission. The home was last inspected two years ago, with a rating of requires improvement. On review of safeguarding concerns reported to the local authority it has been established that there have also been several reports for two residents within the last week of unexplained injuries, which include significant bruising and fractures. Those reports have come from different professionals visiting the setting, and S42 safeguarding enquiries have been triggered for those two clients. A criminal investigation is also underway related to ill-treatment for the three residential care workers arrested. The provider was last in organisational abuse enquiry processes two years ago, the registered manager is new in post. **What could inform decision making: potential for multiple victims, multiple people alleged to have caused harm, footage, covert/hidden cameras, regulator findings, number of safeguarding reports and the nature, a new manager in post.**

Case Example 4: An 89-year-old male was placed by a neighbouring authority temporarily in residential care and whilst his immediate family/relatives were on holiday. He had been there for three days, of a fourteen day stay. He was found on the floor of his room unresponsive. From records it appears he was last seen/checked at 10.30pm the previous night, and that he was found at 8.30am. Death was confirmed by the ambulance trust at 9.20am. The police attended and the coroner has been notified. A falls risk assessment had been completed by the placing authority and the provider has confirmed they had received it, and a detailed care plan. The previous day had been the hottest day of the year to date. Reports have also been made a few days previously and by relatives of other clients. Adult Social Care have passed those to the commissioning team, the reports related to jammed windows and reports that the heating was faulty and was raising the temperature. It was also reported that the Registered Manager and Provider were aware and that they had shared it was the process of being corrected. The ambulance crew passed their concerns to the police that the room was 'stifling hot' when they arrived at 8.50am. A local authority Safeguarding Lead has also shared that information with the police. The police have informed they have revisited the setting and seized care home records. A safeguarding adult's review referral has been submitted by the local (host) authority. The provider exited organisational abuse processes five months ago, some of their action(s) had been reported as being complete, those action(s) included issues relating to the condition of the care home environment. **What could inform decision making: death within a setting, whether risk assessments were followed, what checks were carried out by staff, was any heatwave plan in place and followed, what steps were taken by the provider to address the heating issue, the provider exited organisational abuse enquiry processes a short time ago, what checks were undertaken for the allocated provider action(s), what if any S42 safeguarding enquiries are ongoing, and with the exception of the deceased male.**

Learning from Safeguarding Adult Reviews - Learning from a range of Safeguarding Adults Reviews and emerging themes has a place when forming a professional judgement and decision making as to whether organisational abuse enquiries should be triggered. Examples to draw from include:

Year	Review	Key messages and themes
2012	Winterbourne View Serious Case Review , South Gloucestershire	Whistleblowing and reporting, culture, advocacy offers, and commissioning.
2018	Mendip House, Safeguarding Adults Review , Somerset Safeguarding Adults Board	Whistleblowing, over reliance on internal (provider led) investigations.
2019	Atlas Review Safeguarding Adults Review , Devon Safeguarding Adults Partnership ⁷	Whistleblowing, negative culture, commissioning and out of area placements and history
2020	Long Leys Court , Lincolnshire Safeguarding Adults Board	Whistleblowing, Assessment and Treatment Unit (ATUs), Closed, culture, inappropriate restraint, seclusion
2021	Cawston Park , Norfolk Safeguarding Adults Board	Assessment and Treatment Units, long stays. Repetitive cycles of organisational safeguarding activity, safety and wellbeing and lack of trauma informed practice and consideration to placement transition. Staffing levels (including agency). Important to note from this review is that 'self-harm' should have been viewed as organisational abuse.
2023	Whorlton Hall , Durham Safeguarding Adults Partnership	Whistleblowing, ATUs, long stays repetitive cycles of organisational safeguarding activity. toxic and/or closed cultures, staffing levels (including agency), out of area placements and history. See also – how I should be cared for in mental health hospital (Restraint Reduction Network)

⁷ (2nd review, first SCR 2013)

Generic Guiding Principles

Regardless of the term adopted at a local level, enquiries into organisational abuse should be a multi-agency process that supports an effective 'action-led' response to concerns in relation to a service provider. It applies to all services that work with and provide services to adults with care and support needs, regardless of who funds that provision. A range of agencies should work closely together to support local processes. The below outlines some of the considerations and generic guiding principles when triggering an organisational abuse enquiry and when working collaboratively and cooperatively⁸ including 'working with' providers:

- Demonstrate respect for all representatives/agencies/involved parties
- Offer 'equity of opportunity' to fully participate in the process
- Be expected to 'air' and 'share' concerns in a 'safe' environment
- Have 'opportunity' to 'review and explore' the issues and causes openly and with transparency
- Support the effective identification of learning and actions for change (including any mechanisms for monitoring and/or additional support requirements to sustain change)
- Value all voices, including the voice of adult(s) in receipt of service(s) and their representatives (where appropriate)
- Commit to the principle of 'working towards ensuring everyone remains as safe as possible through the service(s) they receive'
- Commit to maintaining an effective collaborative/inter-agency ethos of 'working with' throughout the process

Best Practice Considerations

In addition to guiding principles, there are wider elements to consider when instigating 'organisational abuse' enquiries. Drawing on the below suggested areas can support a consistent approach across the North East and encourage best practice.

Organisational Memory

Keeping robust records of organisational abuse concerns can support building the organisational memory of provider concerns/issues and their retention, it may also inform and direct local and regional learning, for example:

- Do you hold a register of organisational abuse and/or provider concerns referrals?
- Does the register include information such as: Provider Name, Parent Organisation, Registered Manager, Provider Type?
- Does the register include reasons for an enquiry for example, breach of contract, regulatory breaches, potential media attention, multiple failures/persistent non-compliance?

⁸ 14.63 Care and Support Statutory Guidance: Local authorities must cooperate with each of their relevant partners, as described in section 6(7) of the Care Act, and those partners must also cooperate with the local authority, in the exercise of their functions relevant to care and support including those to protect adults.

- Is this information reported to the local Safeguarding Adults Board in some form to support ‘oversight of the effectiveness of local safeguarding adults’ arrangements’?

Providers

There is an onus upon providers to meet essential/fundamental standards of care and that people using services are safeguarded additionally through monitoring by providers and commissioners, regulation and inspection. People’s wellbeing⁹ and welfare should also be secured by good commissioning, contracts management and, for some people, by care management or other forms of review¹⁰. For any organisational abuse process there may be a requirement to seek information direct from the provider, the below offers an outline of what may inform discussions and/or actions.

- Information specific to the concerns reported or issues raised
- Compliments and/or Complaints
- Staffing detail (levels, training, skills, behaviours, culture and recording practices, instigated HR processes and progress, recruitment practice/retention, work patterns/groups/breaks¹¹)
- Historic involvement (organisational memory)
- Adherence to regulation/s and/or legislation
- Where potential criminal act(s) have occurred, the provider must not carry out their own investigation.

Meetings and Wider Forums

Some local authorities may already have established networks and/or forums in place that may support and inform decision making as to whether organisational abuse processes apply and/or whether alternative early intervention action/steps can be taken which may negate or prevent the need for those processes. Examples may include:

- Joint multi-agency information sharing forums (Local authority, Commissioners including health, Safeguarding leads, Health Professionals, Care Quality Commission, Police).
- Provider Planning meetings or pre-planning meetings where provider concerns exist to determine whether an organisational abuse process is required. These may include placing authority commissioning and wider colleagues (see above).

These may be particularly helpful where there a range of concerns relating to quality of care, cultural issues or suspected hidden harm emerge, and early interaction and working with the provider can be supportive. Where decisions have been reached to trigger an organisational abuse process, it is recommended that a standardised approach be adopted regardless of the provider type and/or the Chairing agency or lead:

- Is there a Terms of Reference?
- Is there a confidentiality statement?
- Are agenda, minutes and action plan templates in place?

⁹ Section 1 of the Care Act – Promotion of wellbeing

¹⁰ [Safeguarding Adults - Roles and Responsibilities](#)

¹¹ Recently emerged issues relating to some providers in the country for international recruitment have driven [Establishing modern slavery risk assessment and due diligence in adult social care a commissioning officers guide.pdf](#) (University of Nottingham, October 2023)

- Are timescales set for circulation of minutes and completion of actions?
- Are there clear leads for actions?
- Is there a process for disagreements in and out with of meetings?

Communication

For any organisational abuse process, it is essential that a robust approach to communication (including media approaches) is adopted, with all interested/involved parties. As a starting point, any process should give consideration to the below, with clarity of who will complete any activity and the timescale:

- Identify the methods of communication (email, telephone, correspondence)
- Identify recipients (stakeholders, adults, and/or family, advocates)
- Identify the key Contacts (e.g. Commissioning and Contracting, Media and Communications, Legal, Host and/or Placing Authorities)
- Sensitivity/Confidential Information Sharing requirements (e.g. secure email requirements/document marking/redactions)
- Identify what will be shared (key messages, updates, action logs)
- Identify a centralised point of contact for information flow
- Consider development of a communications plan so that all parties are clear

The above can also be utilised for communication between agencies when an organisational abuse process has not been triggered but concerns exist.

Key Considerations and Oversight

It is essential that any organisational abuse process and/or the Chair of any meeting pay particular attention to ensuring information flow is a consideration with internal management structures and wider relevant parties, for example:

- Internal Operational Management
- Internal Senior Management (Directors/Assistant Directors/Heads of Service)
- Safeguarding Adults Board Business Managers and/or Chairs (particularly where there may be media interest)
- Legal Services

In high-profile instances or concerns resulting from exposes, there may be additional need to consider additional layers of management input and oversight for example, by adopting a higher-level coordinated approach to run parallel to the organisational abuse enquiry. Any additional layer should also consider as a minimum:

- All Local Authorities who are involved
- Care Quality Commission
- Police
- All Integrated Care Boards (formerly Clinical Commissioning Groups i.e. Health Commissioners) who are involved
- Legal Services/Representatives
- Media and Communication Leads

In any such instances, how information will be communicated is of particular importance inclusive of notifications to wider parties for example, Directors of Adult Social Services where adults are placed within a host local authority, Safeguarding Adults Board Chairs

and Units, Out of Area Placing Commissioners/Authorities¹². This helpful guide (below) informs upon the broader responsibilities and powers for a range of agencies. It may be helpful for health and social care commissioners to include within provider contractual arrangements, specific clauses for communication requirements. For example, including clauses for when a provider should inform another local authority area that they are subject to organisational abuse processes in another authority area in which they are commissioned, and who should be informed. * Commissioners could also consider capturing/incorporating into any monitoring activity.

Safeguarding Adults Boards			
• Hold partners to account • Monitor outcomes and effectiveness		• Use data and intelligence to identify risk and act on it • Co-ordinate activity	
Social Care and Health Providers • Show leadership and routinely monitor activity. • Meet the required service quality standards. • Train staff in safeguarding procedures and ensure they are effectively implemented. • Investigate and respond effectively to incidents, complaints and whistle-blowers. • Take disciplinary action against staff who have abused or neglected people in their care		Social Care and Health Commissioners • Build safeguarding into commissioning strategies & service contracts* • Review and monitor services regularly. • Intervene (in partnership with the regulator) where services fall below fundamental standards or abuse is taking place.	
Clinicians • Apply clinical governance standards for conduct, care & treatment & information sharing • Report incidents of abuse, neglect or undignified treatment • Follow up referrals • Consult patients and take responsibility for ongoing patient care. • Lead and support enquiries into abuse or neglect where there is need for clinical input.	Social Workers/Care Managers • Identify and respond to concerns • Identify with people (or their representatives or Best Interest Assessors if they lack capacity) the outcomes they want • Build managing safeguarding risks and benefits into care planning with people • Review care plans • Lead and support enquiries into abuse or neglect	Specialist Safeguarding staff • Be champions in their organisations • Provide specialist advice and co-ordination • Respond to concerns • Make enquiries • Work with the person subject to abuse • Co-ordinate who will do what – e.g., criminal or disciplinary investigations.	Police • Investigate possible crimes • Conduct joint investigations with partners • Gather best evidence to maximise the prospects for prosecuting offenders • Achieve, with partners, the best protection and support for the person suffering abuse or neglect – including victim support
Professional Regulators • Set the culture and professional standards • Apply the Fit to Practise test • Take action where professionals have abused or neglected people in their care		Care Quality Commission • Register, monitor, inspect and regulate services to make sure they provide people with safe, effective, compassionate, high- quality care • Intervene and take regulatory action on breaches • Publish findings including performance ratings	
Taken from: Advice note - commissioning out of area care and support services (local.gov.uk)			

See also [Out of Area Safeguarding Adults Arrangements, 2016 \(Association of Directors of Adults Social Services, ADASS, Policy Network\)](#)

¹² See also Secure Settings and Assessment and Treatment Units

Secure Settings and Assessment and Treatment Units

Learning has emerged from a range of Safeguarding Adults Reviews (SARs), some of related to a focus upon secure settings and/or Assessment and Treatment Units (ATUs).

NHS England has worked in conjunction with the Local Government Association (LGA), Association of Directors for Adult Social Services (ADASS) and Partners in Care and Health (PCH) and have developed a set of guiding principles for integrated care systems. Those principles set out how partners in local systems can work together and promote/foster a partnership approach to improve the lives and outcomes of people with a learning disability and autistic people. Those principles also support the learning emerged from recent SARs such as Joanna, Jon and Ben, Cawston Park Hospital, Norfolk and Whorlton Hall, Durham.

Local authorities, health and social care commissioners, and safeguarding leads are encouraged to utilise and consider this guidance, and this toolkit, and in particular when information is receipted that relates to provider concerns.

[Joint guiding principles for integrated care systems – learning disability and autism, NHS England \(last updated October 2023\)](#)

For example:

- How many adults have been placed within the host authority area for that provider, and who are the placing authorities?
- Who will lead on contacting placing authorities for any adults placed in the host authority area, and what is the ask of them to inform local processes and/or meetings?
- Who will notify the placing authority of any meetings (e.g. information sharing meeting, organisational abuse process) being convened?
- Who will lead on any update(s), and what is the ask of the placing authority for progressing any action/s?
- Who will lead and coordinate any media, regulator and/or criminal investigation updates if required?

The above examples can also be applied across other provider types, for example, residential and/or nursing care, and therefore is not limited to secure and/or ATU settings.

In circumstances that are high profile or expose instances the guidance from the National Police Chiefs Council for Senior Investigating Officers (SIOs) investigating unexpected death and serious harm in healthcare settings may also be helpful – see additional resources.

Common understanding:

In support of this regional toolkit, local authorities' representatives under the umbrella of North East ADASS have agreed that the regional understanding of what constitutes 'organisational abuse' as a minimum should include the below. This does not replace individual local authority decision making processes or tools, and serves as a guide only to support consistent consideration of what may constitute and trigger organisational abuse processes:

Organisational Safeguarding Decision Support Tool This revised decision support tool is based on guidelines 'Safeguarding Adults in Care Homes', National Institute of Health and Care Excellence (NICE, NG189), 2021 and risk indicators of organisational abuse. The Care and Support Statutory Guidance (2014) describes organisational abuse as: "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." In addition, there continues to be learning from SARS in relation to organisational abuse- links (Norfolk/ Whorlton Hall. CQC defined a closed culture as 'a poor culture that can lead to harm, including human rights breaches such as abuse'. In these services, people are more likely to be at risk of deliberate or unintentional harm. It is anticipated this revised tool, will support decision makers along with a suite of tools and guidance.			
Organisational Abuse (includes one or any combination of the other forms of abuse)	Concerns may be notified to the Local Authority, but these are likely to be managed at Initial Enquiry stage only. Professional judgement or concerns of repeated lower-level harm will progress to further stages in the safeguarding adult's process.	Concerns of a significant nature will receive additional scrutiny, and progress further, under safeguarding adult's procedures. Some examples of significant harm include criminal offences which will need to be referred to the Police.	Concerns of a critical nature will receive additional scrutiny, and progress further, under safeguarding adult's procedures. The Police will need to be contacted.
	Low – isolated incidents of:	Significant	Critical
	- Lack of stimulation/ opportunities for people to engage in social and leisure activities. - Service users not given sufficient voice or involve in the running of the service. - Denial of individuality and opportunities for service user to make informed	- Rigid/inflexible routines - Service user's dignity is undermined e.g. lack of privacy during support with intimate care needs, sharing under-clothing - Bad/poor practice not being reported and going unchecked. - Unsafe and unhygienic living environments	- Staff misusing their position of power over service users - Over-medication and/or inappropriate restraint used to manage behaviour - Widespread consistent ill-treatment - Adult at risk experiences significant harms or dies, and neglect or acts of omission are evident.

	choice and take responsible risks. • Care-planning documentation not person-centred • Poor record keeping • Mental capacity not evidenced, considered, or assessed. • Poor infection control practices • Lack of transparency • Few or no safeguarding concerns, are reported, and the provider is not engaged within other forums where best practice and learning is shared. • Lack of leadership and supervision. • A run down or overcrowded service- setting. • Lack of dignity, basic care • Service design or environmental factors.	• Incidents of abuse or neglect not reported. • A sudden increase in safeguarding concerns • Frequent unexplained decline in service users' health and wellbeing. • Mismanagement of safeguarding concerns • Mental capacity not evidenced, considered, or assessed. • Multiple hospital admissions leading to safeguarding enquiries. • Overuse of restrictive practices. • Misuse of residents' money • Provider fails to improve in response to reviews, inspections, and audits. • Abusive and disrespectful attitudes • Unclear roles and responsibilities within the organisation, regarding the safeguarding lead (s) and nominated individual. • Adult at risk sustains significant harm and evidence of neglect and acts of omission. • Denying adult at risk access to professional support and services such as advocacy. • Incidents of abuse or neglect not reported. • A sudden increase in safeguarding concerns	• Lack of access (see also <u>CQC identifying closed cultures and responding</u>) • Whistleblowing/complaints • Lack of leadership and supervision • Concerns regarding culture: evidence of negativity, conflict, mistrust which is impacting on the delivery of the service. • Intentionally or knowingly failing to adhere to Mental Capacity Act • Punitive responses to challenging behaviours • Failure to refer disclosure of abuse. • Recurrent incidents of ill treatment by care provider to more than one service user over a period. • Service design where group of adults living together are incompatible and harm occurs.
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		• Frequent unexplained decline in service users' health and wellbeing. • Mental capacity not evidenced, considered, or assessed. • Multiple hospital admissions leading to safeguarding enquiries. • Overuse of restrictive practices • Misuse of residents' money • The provider fails to improve in response to reviews, inspections, and audits.	
Patterns of abuse	• Isolated incident	• Repeated incidents	• Repeated incidents which have continued for a significant period.
Impact on adult at risk	• No impact or short- term impact	• Some impact but not long-lasting	• Serious long-lasting impact
Intent	• Unintended or ill informed	• Opportunistic or serious unprofessional response	• Planned and deliberately malicious
Illegality	• Poor or bad practice but not illegal	• Criminal act	• Serious criminal act
Risk of repetition	• Very unlikely to recur	• Unlikely to recur if significant changes are made, e.g., training, supervision, support.	• Very likely even if changes are made or more support provided.
Please see factors below: are any of the following risk factors present? Please note, these are not listed in an order of seriousness, they are risk factors that if present in addition to the above indicators are likely to suggest a higher risk of harm.			
• Out of borough placements; unclear personal and professional boundaries; the host authority do not contract with the service; it is an unregulated service; out-dated practice; no manager or temporary manager; staff not aware of duty to protect; high staff turnover; management and support functions not working effectively; high use of agency staff; lack of training.			

Related sources of support and guidance

What constitutes a safeguarding concern and how to carry out an enquiry

Section 42 Adult Safeguarding Enquiries in Secure Settings (East of England ADASS, 2021)

Understanding what constitutes a safeguarding concern and how to support effective outcomes (LGA/ADASS, 2020)

Making decisions on the duty to carry out Safeguarding Adults Enquiries (LGA/ADASS, 2019)

Safeguarding Adults Collection (SAC) guidance and publications

Out of Area Safeguarding Adults Arrangements, 2016 (Association of Directors of Adults Social Services, ADASS, Policy Network)

ADASS commissioning note (2022) to add

Safeguarding Adults in Care Homes, 2021 (National Institute for Health and Care Excellence, NICE, NG189)

Safe Care at home review, June 2023 (Department of Health and Social Care, DHSC and Home Office)

Section 42 Adult Safeguarding Enquiries in Secure Settings, 2021 (East of England, ADASS)

Identifying and responding to closed cultures (Guidance for CQC staff), Care Quality Commission

Safeguarding People in 'closed environments', 2021 (ADASS)

Advice Note for Directors of Adult Social Services: Commissioning Out of Area Care and Support Services, (LGA/ADASS), 2022

How I should be cared for in a mental health hospital resource (Restraint Reduction Network)

Joint guiding principles for integrated care systems – learning disability and autism, NHS England (last updated October 2023)

Additional sources of support and guidance (with acknowledgement to North East Local Authorities and their respective Safeguarding Adults Boards, SABs)

Essex SAB – Guidance on Organisational Safeguarding Concerns	 ESAB guidance-managing-
North of Tyne – Organisational Abuse Enquiries	 Organisational-abus e-enquiries.pdf
Teeswide SAB – Decision Support Guidance	 Decision-Support-G uidance-V5.1.pdf
Gateshead SAB – Decision Making Tool	 Gateshead SAB Decision Makng Tool
Darlington Safeguarding Partnership – A Practice Tool to Aid Decision Making	 practice-tool-to-aid- decision-making-safe
Newcastle SAB – Organisational Abuse and Closed Cultures	 Organisational Abuse and Closed Cu
Durham SAB – ESM Provider Briefing Note & <u>Closed Cultures Briefing</u>	 ESM Provider Briefing Note - 2022,  Risk Monitoring Tool .pdf
A Senior Investigation Officers (SIOs) Guide to Investigating unexpected death and serious harm in healthcare settings (National Police Chiefs Council, NPCC – Homicide Working Group)	 SIO - Death in Healthcare Settings -
Patient Safety Incident Response Framework, NHS England	NHS England » Patient Safety Incident Response Framework
Safeguarding People in closed environments (ADASS)	 safeguarding-people -in-closed-enviroinme