Guidance for Managing and Responding to Organisational Safeguarding Concerns

The Southend, Essex & Thurrock (SET) Safeguarding Adults Boards

July 2017

Document Control Sheet

Title of guidance:	SET Guidance for Managing and Responding to Organisational Safeguarding Concerns
Purpose of guidance:	To define roles and responsibilities when managing organisational safeguarding concerns and enquiries
Type of guidance:	Operational guidance
Target audience:	Everyone involved in commissioning, providing, supporting or delivering Services to adults pan Essex.
Date guidance approved: **Review Date:**	20 July 2017 July 2018
This guidance should be read alongside:	SET Safeguarding Adults Guidelines (March 2017) SET MCA and DoLS Policy Care Act 2015 Local Authority Suspension of Care Services Protocol ADASS Interauthority Local area guidance such as: Market Provider Failure Policy
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Date/Version	July 2017 / DRAFT Version 1.0

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1. INTRODUCTION

The primary aim of any procedures for dealing with safeguarding concerns (including organisational abuse) is that the well-being and best possible outcomes for the service users are of the highest priority for all of the agencies concerned.

The purpose of this document is to provide guidance to those involved in managing organisational safeguarding concerns

This guidance does not cover Market Provider Failure; Investigation and Suspension of Care Services Protocol; Managing of Service User's Finances and Property. Please refer to local policies.

See also section 5 of the statutory guidance to support sections 19 and 48-57 of the Care Act 2014 which provides clear statutory guidance in managing provider failure and other service interruptions:

http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

2. DEFINITION OF ORGANISATIONAL ABUSE

2.1 "Organisational abuse…neglect and poor care practice within an institution or specific care setting such as hospitals or care homes, 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 result of the structure, policies, processes and practices within an organisation" (Care and Support Guidance 2016, Para 14.17)

2.2 Organisational abuse is the mistreatment or abuse or neglect of an adult at risk by a regime or individuals within settings and services that adults at risk live in or use, that violate the person's dignity, resulting in lack of respect for their human rights. Organisational abuse occurs when the routines, systems and regimes of an organisation result in poor or inadequate standards of care and poor practice which affects the whole setting and denies, restricts or curtails the dignity, privacy, choice, independence or fulfilment of adults at risk.

3. INDICATORS OF ORGANISATIONAL ABUSE

3.1 Organisational abuse can occur in any setting providing health and social care. A number of enquiries into care in organisational settings have highlighted that organisational abuse is most likely to occur when staff:

- Receive little support from management
- Are inadequately trained
- Are poorly supervised and poorly supported in their work
- Receive inadequate guidance

The risk of abuse is also greater in organisations:

- With no registered manager/ ineffective manager
- Large nursing homes
- With poor management
- With too few staff
- Which use rigid routines and inflexible practices
- Which do not use person-centred care plans
- Defensiveness to criticism
- Lack of openness
- Acceptance of poor standards
- Where there is a closed culture

3.2 Organisational types of abuse can often be the most misunderstood type of concern, sometimes assumptions are made that any safeguarding issue that arises in a large care home or care service is an organisational concern.

When identifying organisational abuse the following should be considered;

- Do we have concerns that people are at risk or experiencing harm, abuse, mistreatment or neglect?
- Do the concerns relate to quality or contractual concerns as opposed to safeguarding?
- Trends or patterns are emerging from data that suggests poor quality care in a particular resource/establishment
- Where the same person is suspected of causing abuse or harm
- Where a group of individuals are alleged to be causing harm
- Repeat or previous history of safeguarding concerns for the individual
- History of quality issues; suspensions/terminations relating to the provider

- CQC reports – is the service rated as safe? Are people protected from abuse and avoidable harm?
- Is there a registered manager?
- Were concerns raised at the last assessment or review for the individual

3.3 Abuse by another adult who has care and support needs

Where the adult alleged to be causing harm is also a service user, this should always result in a safeguarding concern being raised to establish whether any actions by the provider has resulted in the incident occurring. The safety of the person who is experiencing harm is paramount. Organisations must;

- Ensure the immediate safety of the adult experiencing harm
- Provide support and medical attention as appropriate
- Consider removing the adult causing harm from contact with the adult

Organisations will have responsibilities to the adult causing the harm;

- Reassess the extent to which the adult causing the harm is able to understand his or her actions
- The likelihood that the adult causing the harm will further abuse the adult or others
- Establish whether the adult causing harm is having their needs met
- Undertake a risk assessment
- Develop and implement a risk management plan that supports the care and support plan
- Carry out a reassessment of the adults needs

3.4 If a criminal offence consider reporting to the police - consider whether there was intent to cause harm; the impact of the harm on the adult; did actions of the provider contribute (for example, was the care plan for both adults being followed).

When referring to the police ensure;

- That it is clear that both adults have care and support needs
- Provide information on the incident and whether there are issues around mental capacity and communication needs
- Request that plain clothes officers attend the establishment
- Arrange for both adults to have support at the interview

4. ENGAGEMENT WITH ADULTS, CARERS, FAMILIES AND ADVOCATES

4.1 The Senior Management Team within the local authority/mental health trust will make the decision if and when a relatives meeting should be held. The relatives meeting will be followed up with a letter to all relatives outlining concerns and proposed actions.

4.2 In any event the appointed senior manager must to keep the relatives informed about what is happening. 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.

4.3 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.

5. AGENCIES ROLES AND RESPONSIBILITIES (SEE APPENDIX 1)

It is the responsibility of Safeguarding Adults' Board to ensure that learning is identified from serious case reviews such as Winterbourne View. We MUST be confident that;

- Because of the way we commission health and social care, we have the right services locally
- Health and social care services across Essex, and those we commission elsewhere, are safe. We know about the quality of care delivered, what risks there are in those services, and how those risks are managed
- We people know what people using our services, and their families, say about those services
- The assessments we do with people are thorough. These lead to sound decisions around care and support
- We use the Mental Health Act and Mental Capacity Act when we should, and we use them properly
- We do all we should to prevent adult safeguarding concerns arising
- When an adult safeguarding concerns arise, our services recognise them and work together to respond to them appropriately

6. PROCESS - KEY ACTIONS FOR S42 ORGANISATIONAL SAFEGUARDING ENQUIRIES

6.1 Referral and Screening **–** Concerns relating to possible organisational abuse may come to the attention of relevant professionals in a variety of ways. These could include referrals from the public via the front door of Social Care of each local authority; CCGs; CQC; Contracts/Quality Improvement Teams and operational staff within services.

In Essex, SCD will refer all organisational safeguarding concerns to Organisational Safeguarding Team (OST) for initial screening. (See **Appendix 3** Organisational Safeguarding Team how to refer guide and **Appendix 2** Organisational Safeguarding Concerns pathway and screening process).

OST will determine whether there is an organisational safeguarding concern and assign to the relevant quadrant to lead on the safeguarding enquiry.

In Southend, the Access Team will refer all organisational safeguarding's through to the relevant locality team/SEPT.

In Thurrock, all organisations safeguarding's will be referred to the safeguarding adult's team/SEPT as appropriate.

6.2 Where there are a number of organisations and a number of individual safeguarding adult's processes and enquiries there will be an overarching safeguarding meeting or discussion and case conference. It is important that all aspects of the enquiry are planned and the organisations and individuals are clear about their roles and responsibilities.

6.3 If residents are privately funded they must be offered an assessment, in line with our duties under para 6.28 of the Care and Support Guidance 2016.

6.4 The host authority will take the lead on the enquiry for other funding authorities but invite them to take part if they wish. If requested the host local authority will undertake reviews for those placed in the establishment by other local authorities.

TABLE 1: PROCESS (TO BE READ IN CONJUNCTION WITH THE SET SAFEGUARDING GUIDANCE)

Stage	Actions
Responding to the Safeguarding Concern	• Take any immediate management action to identify and address the risk • Report to the police, if a crime • Gather initial information/ clarify the facts • Identify if other adults at risk from the alleged abuse • Decide if a safeguarding meeting or discussion is needed • Raise a safeguarding concern on relevant care management system for each named individual. Or raise a safeguarding concern on a SET SAF 1 for the organisation concerned with all relevant information re individuals
Contact with the adult/s	• What they would like to happen should be sought, recorded and taken into account • Consent to the safeguarding enquiry • Do we have concerns around the persons mental capacity • Is a referral to an advocate required
Safeguarding discussion or meeting	The Safeguarding discussion/meeting is • A meeting of professionals • Plans the enquiry • Takes place before the enquiry It MUST • consider the wishes of the adult/s at risk • agree how the enquiry will be conducted and by whom • undertake risk assessment • agree an interim safeguarding plan for each individual where a safeguarding concern has been raised
Notifications to inform of safeguarding concern	• Director of Local Delivery- Head of Service/Service Manager/Team Manager • Decision to hold a relatives meeting • Contracts/Quality Improvement Team • Organisational Safeguarding Team (OST)/Localities Team • CQC • Other LA's where appropriate • Police where a crime • CCG Safeguarding Adult Lead • NHS or Mental Health Trusts Safeguarding Adult Leads • DoLS Team

Safeguarding Enquiry	• Conduct section 42 enquiry where required for individuals identified • Re-evaluate risk • Collate evidence and share with involved organisations • Produce and distribute report
Safeguarding Enquiry closure	• Review enquiry evidence • Decide if a safeguarding meeting is required to agree outcomes of the enquiry • Notify all parties of outcomes • Record whether outcomes were met • Close and sign off Safeguarding Adults process • Decide if a referral to a safeguarding adult review is required

APPENDIX 1: Enquiry Checklist

IDENTIFICATION OF THE ISSUES INDICATING THE REQUIREMENT OF A LARGE SCALE SAFEGUARDING ENQUIRY		
The relevant Local Authority will maintain the lead and coordination of the enquiry and resulting actions.		
ACTIONS	**OUTCOMES**	**BY WHOM AS DESIGNATED BY LEAD LOCAL AUTHORITY WITH PARTNERS**
Meeting convened of all relevant partners involved in provision, contracting, reviewing etc. e.g. CCG, CQC, Police etc.	• A clear picture of the issues and concerns raised and all identified residents/vulnerable adults. • Identification of a core group to take actions forward and set the agenda for the enquiry. (most relevant to the issues raised) • Identification of a Chairperson of the Core Group.	
• Commission a full risk assessment • Meet with Core Group & Report regularly to Head of Service/Director (as determined). • To ensure all core group members are invited or involved in meetings updates and discussions.	Risks identified and minimised immediately.	Core Group Chairperson

• To take the lead at relatives meetings. • Act as a link with Council Members • To agree any press statements • To ensure senior management cover agreed times for advice and information as required.		

ACTIONS	**OUTCOMES**	**BY WHOM AS DESIGNATED BY LEAD LOCAL AUTHORITY WITH PARTNERS**
• Attend meetings or contribute information as requested. • Assist with decision making relating to actions to be taken, both urgent and long term. • Consider all information submitted to the Group • Review and update action plans as required • Collaborate on a lessons learned report at the end of the process.		Core Group Members
• Identification of a core team of practitioners to lead on the enquiries. Including health funded, OOB funded and self-funded people.	All placements are reviewed and all issues addressed, giving relatives the opportunity to raise any other concerns to identified practitioners, and	Identified lead on the Safeguarding Issue With administrative

ACTIONS	OUTCOMES	BY WHOM AS DESIGNATED BY LEAD LOCAL AUTHORITY WITH PARTNERS
• Provide representation and feedback to the core group. • To act as main contact point with other agencies, including Police, CQC, CCG and other Local Authorities etc. • Liaison with press and comms team in conjunction with Core Chairperson • Update Emergency Duty Team as required. • Ensure support mechanisms in place for residents and their relatives. • Ensure that staff at the establishment/agency are appropriate supported. • Ensure contact details are circulated between all relevant staff.	make a point of contact available for relatives to voice concerns. All records of meetings, discussions and decisions are maintained and chronology log updated.	assistance
• Undertake reviews of all residents/service users involved or affected. • Provide feedback to Identified Lead on any further issues raised. • Assist with any urgent actions required in relation to re-provisioning if identified	Appropriate capacity assessments are undertaken if decisions re moves or changes in care are made. Advocates instructed Appropriate DOL authorisation requests submitted. Collation of relevant	Core Team of Practitioners

ACTIONS	OUTCOMES	BY WHOM AS DESIGNATED BY LEAD LOCAL AUTHORITY WITH PARTNERS
	information for any police investigation.	
• Provide a summary of CQC reports to the core group. • Review immediate evidence available against potential breaches in contracts. Maintain regular reviews of the gathered information. • Identify commercial information about the provider. • Identify local commercial impact if contract were to cease. • Assist provider with the compilation of an action plan. • Audit the action plan	To have a full record of information gathered and risks and impact identified for possible use in future legal proceedings.	Contracts team
• To review the legality of any decisions made by the Core Group.	To ensure that all actions taken or proposed are legal	Legal Team representative

APPENDIX 2: ROLES AND RESPONSIBILITIES – as required

Local Authority	Contracts Team	• Collate list of available placements if moves are required
	Social Care Team	• Ensure all relevant assessments are collated and any transfers include arrangements for financial payments, and personal allowances. • Advise new establishments of any DOL authorisation request requirements.
	Counter Fraud Team	• Provide support to the Police or DWP in the event of a criminal investigation.
	Finance Teams	• Ensure all changes to payments are taken forward including updating financial contribution assessments as required. • Change personal allowance payments as required. • Ensure Corporate Finance Team is updated with information relating to those where they hold deputyship
	Legal Team	• Provide advice at all stages of the process
	Communications Team	• To work with Core Group Chair and Director of Services and other partners to ensure appropriately, accurate and timely press releases and information.
	Councillors	• Key councillors, including those of the ward/s where the issues are occurring, should be aware of the issues
	Environmental Health	• Involved as required
	Health and Safety	• Involved as required.
Partner Agencies	Advocacy	• Provide support for all identified individuals as identified through assessments
	Police	• Manage any criminal prosecution • Advice practitioners and other parties about evidence requirements and collation.

		• Consider involvement of Health and Safety Executive if required.
	Clinical Commissioning Group	• Provide staff to undertake all reviews etc. relating to health funded clients. As part of the core team of practitioners. • Assist with the re registration of GPs if transfers are required. • Undertake any investigation into primary care services as identified. • Assistance with assessment of specific health issues. E.g. infection control, medicines management, pressure area care.
	Care Quality Commission	• Will be notified of and invited to all core group meetings and updated on progress.
	Mental Health Trust	• Carry out safeguarding enquiries for adults with serious and enduring mental health problems • Undertake a Serious Incident Report • Carry out urgent mental health assessments as required

APPENDIX 3: Safeguarding Enquiry Root Cause Analysis Tool

Root Cause Analysis Tool	**Date RCA Tool Started;** *give details of when this form was started*	**Lead Investigator;**	**Case File ID;**

Questions	**Findings**
1. Give a background history and description of this concern.	*Guidance notes;* *Outline who was involved, what happened, who witnessed it, how it was reported, and what the subsequent outcomes were and how key parties feel about it.* *Wishes and views of the adult/s*
2. Give day, date, time incident occurred, and was reported.	*Give details of when and where the incident occurred, (and how this is known), and details of when/how/who reported it.*
3. What are the key issues to be analysed?	*What key issues will be examined and what aspects of the incident need to be analysed, e.g. why was the adult given the wrong medication at the wrong time? What caused staff member to hit the adult?*
4. What evidence has been gathered to inform this analysis?	*Outline the sources of evidence that have informed the analysis, e.g.* *Care plans, risk assessment, medication records, daily care records;* *Staff supervision, training & appraisal records;*

	Internal and external policies and procedures; *Interview, statements or other written records, etc.*
5. Did existing systems or processes, or a deviation of current systems or processes, contribute to this incident?	Yes / no *Guidance notes – issues to consider in this section include:* *Internal/external policies or procedures (or the lack of them); i.e. whistleblowing/safeguarding* *Are these up to date, available at appropriate locations and widely known?* *Are these accurate, understandable, clear, and available in a range of languages and formats?* *Did staff follow these appropriately?* *Do members of staff agree with the policy, procedure or process and is there ownership?*
6. Did service-user factors contribute to this incident?	Yes/no *Guidance notes – issues to consider in this section include:* *Medical conditions or care needs e.g. complexity of clinical care or need, general health, pre- existing or new illnesses/disabilities, poor sleep pattern, malnourishment/dehydration;* *Language or communication needs;* *Social factors e.g. culture/religious beliefs; lifestyle choices – alcohol/drugs/smoking/diet, living conditions (dilapidated/unsafe), support networks;* *Mental or psychological factors e.g.*

	motivation, stress – family pressures/financial pressures; *Emotional trauma, existing or new mental health needs;* *Interpersonal relationships – service-user to staff, service-user to service-user, family relations*
7. Did circumstances relating to the person alleged to have caused harm/abuse contribute to this incident?	*Guidance notes – issues to consider in this section include:* *Issues relating to carer responsibilities and support which may have resulted in additional stress to the carer*
8. Did staff behaviour contribute to this incident?	*Yes/no* *Guidance notes – issues to consider in this section include:* *Physical & mental health e.g. fatigue, disability, stress, depression, impairment due to illness;* *Substance misuse e.g. drugs, alcohol, etc.;* *Staff motivation e.g. boredom, low job satisfaction, overload, distraction, pre-occupation;* *Personality issues e.g. low/over self-confidence, risk averse/risk taker, shy/timid or outspoken;* *Staff member domestic or lifestyle issues;* *Interpersonal relationships with service-users, colleagues, managers*
9. Did communication factors contribute to this incident?	Yes/no *Guidance notes – issues to consider in this section include:*

	Did poor or inadequate communication affect the incident? *Were verbal commands/directions clear and unambiguous, made to the right person, use of language correct for the situation, was style of delivery appropriate & effective, were established communication channels used and were they effective?* *Written communications – as above, plus were records easy to read and available in the right location when required? Are records complete or are records missing or been tampered with?* *Any non-verbal communication issues e.g. aggressive or intimidating behaviour, body language e.g. closed, open, relaxed, stern faced, etc.* *Did communication systems (or lack of these) influence the incident/event e.g. handover, communications book, etc.?*
10. Did staff training/skill contribute to this incident?	Yes/no *Guidance notes – issues to consider in this section include:* *Level of staff knowledge, skills, length & quality of experience, familiarity with tasks;* *Availability of an up to date job description;* *Regularity of testing or assessment of relevant staff knowledge & skills;* *The quality and content of local induction training or other relevant training, for example MCA and DoLS awareness;* *Regularity and quality of staff supervision, appraisal and/or mentoring;* *Access to refresher training and opportunities*

	to maintain CPD.
11. Did staff resources or work conditions contribute directly to the incident?	Yes/no *Guidance notes – issues to consider in this section include:* *Skill mix, use of agency/bank staff, workload/dependency assessment. Staff turnover/retention;* *Workload & hours of work e.g. shift related fatigue, staff to service-user ratio;* *Breaks during work hours, extraneous tasks, social relaxation, rest & recuperation;* *Time pressure, delays caused by process design or failure of systems or processes;* *Recruitment practice*
12. Did an absence or malfunction of equipment contribute to the adverse incident?	Yes/no *Guidance notes – issues to consider in this section include:* *Was the equipment subject to an up to date maintenance programme, correctly stored, labelled, relevant instructions in place & legible, new or familiar to the user(s), fit for purpose?* *Was the equipment familiar to those using it and if so were they competent to use it?* *Did a safety mechanism fail?*
13. Did management or leadership affect this incident?	Yes/no *Guidance notes – issues to consider in this section include:* *Were the relevant roles in staff team known, understood & followed?* *Were lines of reporting and accountability*

	clear?
14. Did culture or organisational factors affect this incident?	Yes/no *Guidance notes – issues to consider in this section include:* *Type of culture and ethos in the service;* *Organisational issues e.g. value driven practice or hierarchical/inflexible structures and routines, closed culture, not conductive to information or problem sharing/discussion, lack of safety culture or over focus on safety;* *Organisational priorities e.g. safety driven, financially focussed, performance driven, risk averse;* *Staff morale, motivation;* *Style of conflict management.*
15. Did controllable environment factors directly affect the outcome?	Yes/no *Guidance notes – issues to consider in this section include:* *Design of physical environment e.g. cramped, temperature, panic buttons, lighting, noise levels?* *Environment issues e.g. water on the floor, a door that was locked preventing entry/exit?* *Has the relevant environment/task been subject to a risk assessment? If answering yes, provide a copy. If answering no, state why.*
16. Are there any uncontrollable external factors truly beyond the organisation's control? Give reasons why	Yes/no *Guidance notes – issues to consider in this section include:* *Examples might include an internal or external agency staff strike, adverse weather*

	conditions, national pandemic, a failure of telephone systems, etc.
17. Are there any other factors that have directly influenced this outcome?	Yes/no *Please give details.*
18. Summary of conclusions	*Guidance notes;* *Use this section to list the findings from the investigation and analysis, and summarise the conclusions reached* *Record outcome for the adult* *Feedback outcome to adult/s or advocate* *Feedback outcome to referrer*