North Lincolnshire Safeguarding Adults Board Organisational Abuse Policy and Procedure

Document control

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28 April 2023	Amendments	Reference change – NHS CCG to North Lincolnshire Health and Care Partnership
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3 May 2022	Final	Review May 2024

Contents

SECTION 1 - INTRODUCTION

1.1 Purpose

Living a life that is free from harm and abuse is a fundamental right of every person.

As defined by the Care Act 2014 **adult safeguarding** concerns:

"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 and neglect, whilst at the same time making sure the adult's wellbeing is promoted."

The Care Act 2014 requires that each local authority should work in partnership to lead **multi-agency arrangements** to prevent abuse and/or neglect and to deal with it effectively, should it occur. Safeguarding is therefore **everybody's business** and depending on the circumstances and the severity of the issues, responses can range from providing advice and information right through to criminal prosecution.

This policy and procedure detail the response required to safeguarding concerns across health and social care **whole service or provider organisation**. A whole service enquiry is a formal Care Act 2014 Section 42 enquiry, which forms part of the continuum of the multi-agency responses to allegations of abuse and/or neglect.

It is intended to be used in the most serious of circumstances where there is a high level of **risk of or actual harm to a number of individuals.**

This policy is issued by North Lincolnshire Safeguarding Adults Board (SAB) in recognition that a multi-agency partnership approach is the most beneficial and that a wide range of agencies frequently have a valid and useful contribution to make, in order to keep people safe in North Lincolnshire.

1.2 Scope

For the purposes of this policy and procedure 'a provider' is any care or health provider who delivers support and care to a group of individuals. Importantly, **this includes both regulated and unregulated provision.**

Examples include (but not exclusive to) the following:

- Domiciliary Care Providers
- Residential Care Homes
- Nursing Homes
- Supported Living / Extra Care Facilities
- Private Hospitals
- NHS Provision - including primary care, acute and community settings.
- Mental Health Provision
- Day Care / Opportunities Providers
- Rehabilitation Units for people who misuse drugs or alcohol.

- Voluntary Agencies
- Community / leisure facility

This policy and procedure apply to all care and support provision, whether directly commissioned or not by a local authority; North Lincolnshire Health and Care Partnership or NHS England / Improvement (NHS E/I); and irrespective of whether or not it is included in the Care Quality Commission (CQC) market oversight regime.

This includes care which is paid for by individuals themselves as the same duty applies to people funding their own care as to care which is commissioned or purchased by the local authority and/or the NHS.

Services managed by the local authority or NHS are subject to the same level of scrutiny as independent care providers.

Large scale abuse in the community involving multiple victims such as situations of sexual exploitation, forced marriage, and human trafficking, where the section 42 duty is triggered, are out of scope for this policy. These investigations are likely to be led in primacy by the Police and are usually managed as major incidents, cross border, or international investigations.

1.3 Principles

The policy and procedures are based on the **six principles of safeguarding** which underpin all safeguarding work.

Empowerment	Presumption of person led decisions and informed consent.	*'I am asked what I want as the outcomes from the safeguarding process, and these directly inform what happens.'*
Prevention	It is better to take action before harm occurs.	*'I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.'*
Proportionality	The least intrusive response appropriate to the risk presented.	*'I am sure that the professionals will work in my interests as I see them, and they will only get involved as much as needed.'*
Protection	Support and representation for those in the greatest need.	*'I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent I want.'*

Partnership	Local solutions through services working in their communities. Communities have a part to play in preventing, detecting, and reporting abuse and neglect.	*'I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary.'*
Accountability	Accountability and transparency in delivering safeguarding.	*'I understand the role of everyone involved in my life and so do they.'*

1.3.1 The following **local principles** also apply to whole service enquiries, as agreed by the SAB.

- The safety and wellbeing of adults using the service is paramount. Their views and wishes should be respected, central to decision making and balanced with the overall duty of care.
- Strong partnerships that promote cooperation between agencies and acknowledge the expertise and professional contribution of others.
- Openness, honesty, and transparency to achieve positive outcomes with information shared responsibly between agencies, including importantly with the provider.
- Joint accountability for risk between commissioners, safeguarding leads, providers, Police, the Local Authority, North Lincolnshire Health and Care Partnership, and other stakeholders who may be involved.
- Prudent targeted use of resources.
- The principle of 'no delay' with swift action being taken to prevent an increased risk of abuse and/or neglect or impact on the business viability of providers.

1.4 Whole System Approach

Prevention of harm is critical to the vision of the SAB and essential that the care and support system works actively together to promote wellbeing and independence. Prevention is one of the core principles of the multi-agency adult safeguarding policy which highlights a number of essential building blocks for preventing harm including:

- A well-trained workforce operating in a culture of no tolerance.
- People being able to freely exercise their rights.
- A sound framework for information sharing across agencies.
- Access to good universal, targeted and specialist services
- Availability of a range of options for support to keep safe from abuse tailored to people's individual needs.
- Public and community awareness
- Links with other strategic plans to ensure a joined-up approach.

1.4.1 Safeguarding is therefore 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.
- Effective clinical and care governance processes.
- Regulators ensuring that regulated providers comply with the expected standards of care and take enforcement action when necessary.
- Core duties of the Police and other agencies to prevent and detect crime and protect life and property.

Instances of poor practice that have not resulted in harm should be managed proportionately and worked through with providers using quality assurance processes where possible, not formal safeguarding procedures.

1.5 Legal Framework

- This policy is informed by the following legislation and national guidance:
- Care Act 2014
- Care and Support Statutory Guidance 2015
- Health and Social Care Act 2008
- Care Quality Commission (Registration) Regulations 2009
- ADASS Out of Area Safeguarding Arrangements 2012

1.6 Policy Framework

SCIE Short Notice Care Home Closures: A guide for local authorities

SECTION 2 – POLICY

2.1 Definition

Professionals and others need to look beyond single incidents or individuals to identify patterns of harm. Where there is an accumulation of serious quality issues, repeated instances of poor care or safeguarding concerns, this may be an indication of more serious problems. It may be appropriate to consider this at an organisational level and of what is now described as organisational abuse. The Care Act 2014 defines **'organisational abuse'** as:

"……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" (Care and Support Statutory Guidance, 2015)

2.2 Aims of the Enquiry

The purpose of the whole service enquiry is to undertake whatever enquiries are needed to establish the facts; agree on what action is needed to address the alleged abuse and / or neglect and to confirm the steps needed to ensure the safety and wellbeing of the individuals involved. The ultimate aim is to stop abuse or neglect from happening and to minimise the risk of it occurring in future.

2.3 Harm

In determining what intervention is needed, the concept of harm is used. This refers to:

- Ill treatment (including sexual abuse and forms of ill treatment which are not physical)
- The impairment of, or an avoidable deterioration in, physical or mental health and/or
- The impairment of physical, intellectual, emotional, social, or behavioural development.

The seriousness of harm or the extent of the abuse is not always clear at the point of the concern being raised. All reports or suspicions should be approached with an open mind.

2.4 Criteria

Each situation will differ in severity and/or complexity so the following criteria are offered as a guide.

Triggers for when a whole service enquiry is a proportionate response include circumstances where:

- There is a risk that serious abuse, involving death or serious harm of adult(s) at risk will occur or has occurred.

- There is clear evidence from safeguarding concerns relating to individual adult(s) at risk that other adults are at risk of significant harm and are deemed to be unsafe.
- It is suspected that a number of adults at risk have been abused by the same perpetrator or by a group of perpetrators in the same setting.
- There is clear evidence that despite contract monitoring, quality improvement input and / or CQC action planning there is insufficient evidence of improvements resulting in continued harm.

2.5 Interface with other Investigations or Enquiries

Other processes, including criminal investigations, HR investigations and complaints investigations may need to run alongside the whole service enquiry or happen as a consequence of the enquiry.

2.5.1 Individual Section 42 Enquiries

Individual safeguarding enquiries can be carried out prior to escalation into a whole service enquiry and alongside it, if warranted in the circumstances.

2.5.2 Criminal Investigations

Where it is suspected that a crime has been committed the Police will lead any criminal investigation and make a recommendation to the Crown Prosecution Service (CPS) on the basis of evidence. See section 4.4 regarding the role of the Police in whole service enquiries.

2.5.3 Allegations against People in Positions of Trust (PiPoT)

Where an allegation is against people in positions of trust (such as anyone working in a paid or unpaid capacity with adults with care and support needs) or registered professionals the employer will need to follow their own internal PiPoT policy and codes of conduct. This process should ensure that risks potentially posed by the person are appropriately managed, alongside the needs of the adult(s) at risk. The North Lincolnshire Safeguarding Adults Board Multi-agency PiPoT policy can be found at PiPoT-policy-FINAL-2022-24.pdf (northlincssab.co.uk)

2.5.4 Safeguarding Adult Reviews (SAR)

Throughout the whole service enquiry consideration should be given as to whether the concerns raised meet the criteria for referral to the SAB for a Safeguarding Adult Review.

A SAR is carried out under s44 Care Act 2014 and takes place when an adult at risk dies or is injured, abuse or neglect is known or suspected to be a factor in the death or injury and there are concerns about the way in which agencies have worked together. The North Lincolnshire Safeguarding Adults Board Multi-agency SAR Framework can be found at SAB-SAR-Framework-FINAL-.pdf (northlincssab.co.uk)

2.5.5 Role of the Coroner

Coroners are independent judicial officers who are responsible for investigating violent, unnatural, or sudden deaths of unknown cause and deaths in custody. The coroner may have specific questions arising from the death of an adult with care and support needs and may undertake an inquest. This is likely to fall into one of the following categories:

- Where there is an obvious and serious failing by one or more organisations.
- Where there are no obvious failings, but the actions taken by organisations require further exploration/explanation.
- Where a death has occurred and there are concerns for others (such as in a care home or hospital).

In the above situations the SAB should consider instigating a SAR (see section 2.5.4).

2.6 Making Safeguarding Personal (MSP)

The adult(s) at risk should remain at the centre of any safeguarding activity. MSP is about ensuring that the adult starts and remains at the centre of all enquiries and this principle should be applied to whole service enquiries.

The views of the adult(s) and the outcomes they are seeking must be incorporated. It is important that adults and/or their representatives are involved in decisions and kept updated.

Any individuals who are deemed to be at risk or who have suffered organisational abuse or neglect will also need to be considered individually as per the adult safeguarding process. This ensures that the adult can be involved directly, and their individual safeguarding needs can be considered with appropriate and proportionate safeguarding plans in place.

It would not be appropriate for individual service users or their representatives to attend a whole service enquiry meeting. This is because of the practicalities of managing attendance of multiple interested parties and the need to maintain confidentiality.

Where following a mental capacity assessment, the adult is deemed to lack capacity to safeguard themselves, other people will need to make those decisions. In doing so, they will act as the decision maker on the person's behalf, making best interest decisions. (See Mental Capacity Act 2005 and associated Code of Practice, as well as organisational policies).

Where a person lacks capacity, has substantial difficulty expressing their views and has no-one available to represent them, a referral for an independent mental capacity advocate (IMCA) should be made, in line with Care Act 2014 requirements.

2.7 Working with health and / care and support providers.

Integral to the effectiveness of this policy is the need to work in an open way. It is the intention to work with transparency, giving clarity of expectations when concerns arise, to assist providers to make necessary improvements. Open dialogue can only be achieved where there is trust and a willingness on all parties to work together.

Providers have a duty of care to protect adults at risk and meet safeguarding standards. Providers should always promote wellbeing and empower adults to fully participate in how services are run, creating a culture of dignity and respect.

Providers are expected to have a robust quality assurance framework in place that can evidence commitment to prevention and early intervention. Undertaking regular staff training, supervision and appraisals, self-audits and making changes as a result, reduces the risk of matters escalating to safeguarding action. Providers should publish an open and transparent complaints procedure with the assurance of no retribution; and offer ways of gaining customer feedback that supports empowerment and quality assurance. Independent advocacy and regular service user / carer / patient led meetings are equally important.

All providers are expected to ensure that their internal safeguarding policies are aligned to the North Lincolnshire multi-agency policy and procedures which can be found at North-Lincolnshire-MA-PP-FINAL-16.12.2022.pdf (northlincssab.co.uk)

Statutory agencies are committed to ensuring that for providers, action taken in response to safeguarding concerns is proportionate with the least intrusive response that will effectively manage risk.

2.8 Commissioning for Quality

The Care Act 2014 puts emphasis on greater integration of services by the local authority and its relevant partners to:

- create a service market of diverse and quality services.
- foster continuous improvements in the quality and effectiveness of provider services; and
- foster a workforce whose members are able to ensure the delivery of high-quality services.

Quality services are those that are evidenced through policy, procedures, standards, and structures for overseeing and maintaining service delivery in line with CQC requirements and / or by robust contract monitoring.

Commissioners should set out clear expectations of providers within contracts and monitor compliance.

Commissioning organisations should also offer support and guidance to providers through constructive dialogue. The Cross Sector Provider Partnership and Registered Manager Forums are a constructive mechanism for sharing best practice and identifying areas of risk.

The local authority Provider Development Team and NHS Integrated Care Board, Commissioning, and Safeguarding Leads are an additional support mechanism to providers, offering advice, sharing best practice, and driving improvements as well as identifying any areas of concern and / or areas of potential risk.

2.9 Poor Care

The Care Act 2014 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 other which may require a whole service enquiry.

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 from the organisation.

Examples of poor care that can be managed through a quality improvement approach include:

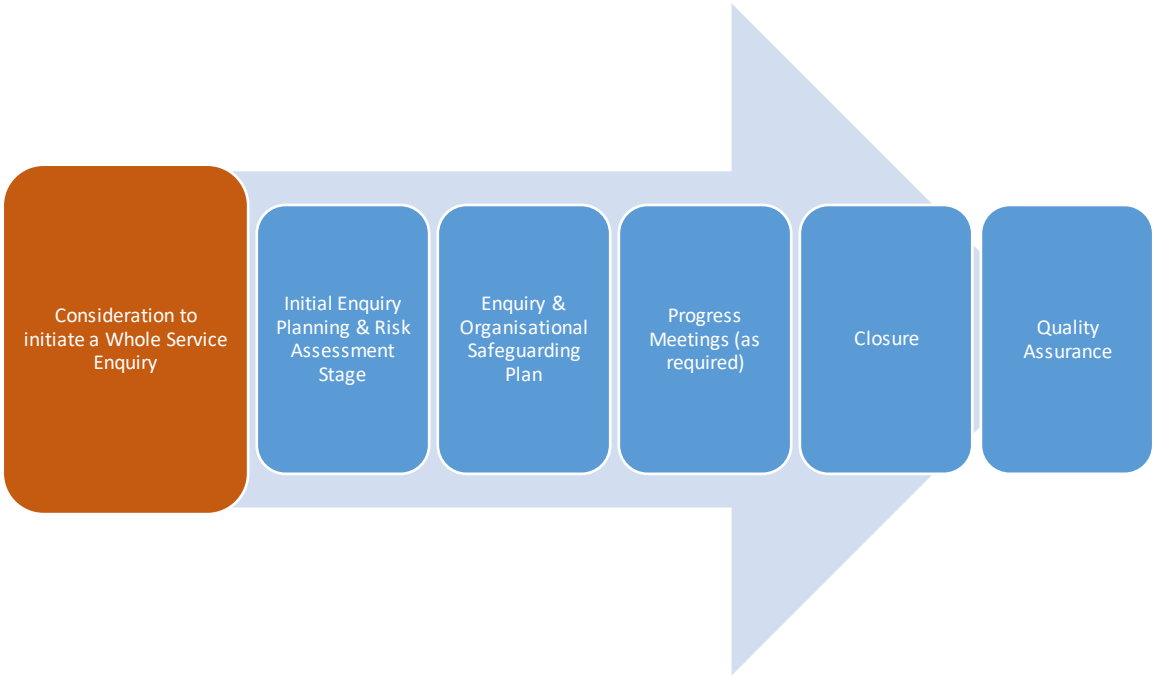
- A safeguarding concern in relation to a one-off failure to meet a service user's care / support needs (i.e., appropriate moving and handling procedures not followed, or staff not trained to use the required equipment, but person does not experience significant harm).
- An incident of under-staffing, where no harm has occurred.
- Poor quality, unappetising or nutritionally inadequate food.
- One missed visit by a Care Worker from a Home Care Agency.
- Concerns in relation to the quality of the environment within the organisation such as run down or unkempt buildings.
- Complaints received about the service.
- Missed GP or dental appointments.

SECTION 3 – PROCEDURES

This section outlines the stages of the whole service enquiry.

There are 6 stages to the whole service enquiry process.

3.1 Step 1 – Consideration to initiate a Whole Service Enquiry



This stage of initial decision making involves gathering and screening information to determine if the circumstances engage the statutory duty to undertake a whole service enquiry.

Referrals for consideration of a potential whole service enquiry should be made to the North Lincolnshire Safeguarding Team via the safeguarding concern form, which can be found on the North Lincolnshire Safeguarding Adults Board website here - https://www.northlincssab.co.uk/reporting-abuse/

The referral must clearly state why the referrer believes there is an allegation of organisational abuse and outline what the indicators are.

3.2 Indicators of Organisational Abuse

When considering if the threshold is met for a whole service enquiry the following questions should be referred to as a guide.

1) Are incidents of a **type** to indicate organisational abuse?
2) Are incidents of a **nature** to indicate organisational abuse?
3) Are incidents of a **degree** to indicate organisational abuse?

Related to these questions, is there a **pattern and prevalence** of concerns about the service and/or organisation?

Organisational abuse within a care environment typically involves repeated incidents of poor care, ill treatment, neglect, or unacceptable professional practice.

3.2.1 Examples of 'types' of Incidents

- Poor care which leads to malnutrition/dehydration/skin damage/pressure ulcers / unmanaged continence / falls / fractures / unexplained injuries.
- Restricted access to appropriate medical or social care.
- Misuse or inappropriate use of medication.
- Absent or unsafe policies, procedures including risk assessments.
- Poor or lack of basic staff training.
- Misuse of restraint or inappropriate restraint methods (physical, chemical).
- Nonadherence to the legal framework such as application of Mental Capacity Act 2005, Mental Health Act 1983 (as amended 2007) or unauthorised deprivation of liberty safeguards (DoLS).
- Sensory deprivation (denial of hearing aids, glasses) and/or restricted mobility (denial of access to mobility aids).
- Care regimes with a lack of choice, flexibility, and personal control (for example, early rising, rigid bathing routines, lack of personal possessions and clothing).

3.2.2 Examples of the 'nature' of Incidents

- Behaviour which is widespread within the setting.
- Repeated instances being witnessed / reported.
- General acceptance and tolerance within the setting.
- Practice sanctioned by supervisory and management staff.
- Resourcing and / or environment issues.

3.2.3 Examples of the 'degree' of Incidents

- Vulnerability of service users and complexity of need.
- Length of time the alleged abuse has been occurring.
- Significant impact on service users resulting in a clear deterioration.
- Risk of repeated or escalated incidents.
- A history of similar concerns such as previous complaints, whistleblowing, CQC outcomes, contract monitoring reports, intelligence from partner agencies, previous safeguarding concerns.

3.3 Decision Making

Multi-agency discussion and professional decision making will need to be applied in each situation, with clear evidence for decisions.

The local authority is the decision owner, with decisions made in consultation with partners. The decision to manage concerns under the whole service enquiry policy should be authorised by the Head of Service responsible for safeguarding or their allocated deputy.

If the threshold has been met and a decision made that a whole service enquiry should take place, the local authority safeguarding team will usually coordinate the enquiry. The local authority also has the discretion to nominate another lead agency to co-ordinate the enquiry if more appropriate and where different expertise would be beneficial. In these circumstances, the lead agency will be responsible for oversight of the process.

3.4 Decision not to proceed to Whole Service Enquiry

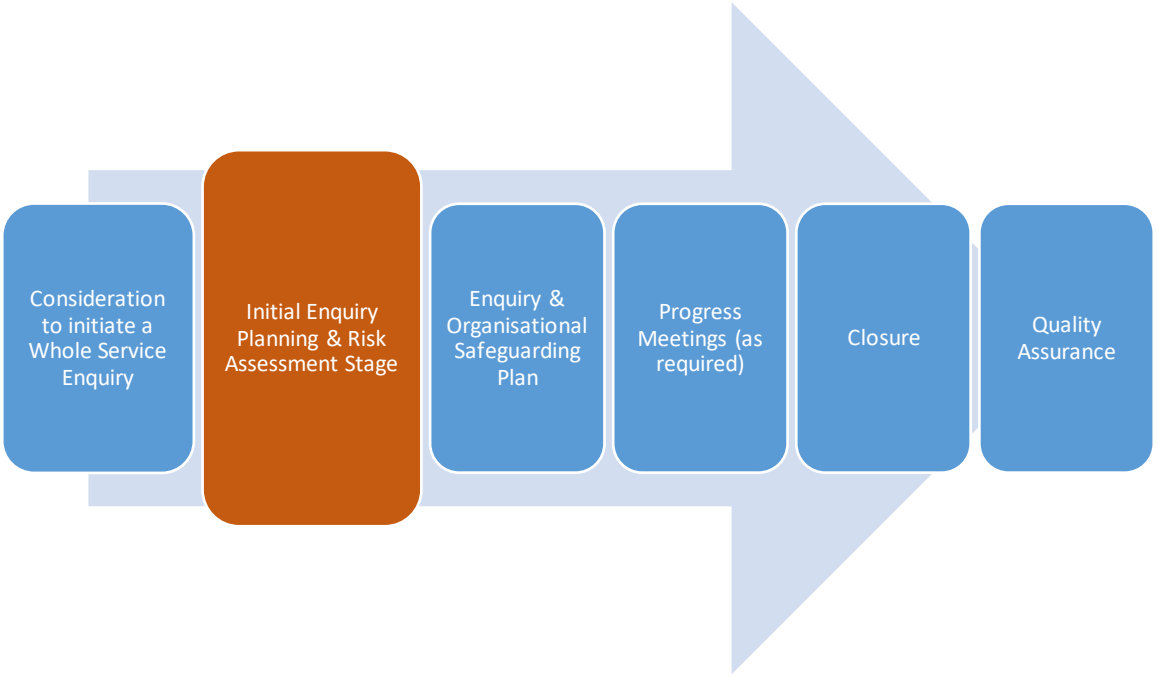
Should a referral for a whole service enquiry be received that can be managed in an alternative way then a plan must be agreed with the referrer as to how the concerns will be addressed.

Examples include:

- enhanced quality monitoring by partner agencies, commissioners, CQC etc
- multi-agency risk management
- individual s42 enquiries.

Timescale: Decision to be taken within 3 working days of the referral being received.

3.5 Stage 2 – Enquiry Planning & Risk Assessment Stage



3.6 This stage usually involves an initial meeting and an assessment of risk. The information presented at the planning meeting will inform the decision making going forward. It is each attendee's responsibility to adequately prepare for the meeting and ensure all relevant information is considered.

The meeting should have full access to the following:

- Information regarding individual service users, funding arrangements, service user's representatives and / or their next of kin including DoLS status and any current paid advocacy in place.
- Information and intelligence related to individual safeguarding concerns.
- Regulatory activity and any potential outcomes.
- Business continuity plans and financial details of the provider (if available) and any concerns related to market failure.
- Any information related to recent incident reporting. Where this is a health provider, this may include a Serious Incidents (SI) Root Cause Analysis (RCA) investigation.

3.7 Representatives at the meeting should consider the following:

3.7.1 The resources needed to support the whole service enquiry.

This may involve discussions with senior colleagues and managers to ensure there are adequate resources and expertise to support the enquiry. Whole service enquiries can challenge capacity of one service / organisation, it is therefore important that there is a shared approach.

3.7.2 Managing New Admissions / New Referrals to the Service

A decision to restrict referrals and admissions should be undertaken in accordance with contract terms and conditions and the relevant organisational policy. Options may include:

- A temporary cease to purchase across a whole service.
- Restriction on admissions offering a particular service (for example, a dementia wing within a home).
- Restriction on the grounds of complexity (for example, those meeting continuing healthcare (CHC) criteria).
- Restriction relating to specific care provision (for example, end of life care).
- The service provider may themselves choose to impose a voluntary restriction on admissions.

Informing the service provider and other stakeholders of decisions taken to manage admissions / referrals is the responsibility of the relevant commissioner. Where concerns are in relation to an acute, private or community hospital the North Lincolnshire Health and Care Partnership will make the decision, in consultation with NHS E/I.

The imposition of placement restrictions should be reviewed at every meeting, risks assessed frequently and where restrictions are in place, decisions made and when reviews have taken place will be detailed in the minutes of the whole service enquiry.

3.7.3 Arranging Individual Service User Reviews

Where there are concerns about a whole service, it is important for individual reviews to take place for each person in receipt of a service. Decisions should be taken as to who is best placed to undertake the reviews (for example, social workers, CHC assessors or other staff known to the service user). The response may require an urgent review of the most vulnerable service users or a planned programme of reviews. The criteria against which to undertake the reviews should be discussed at the planning meeting with clear, concise guidance and information available to staff carrying out the reviews so they are aware of the specific risks that have been identified.

3.8 Risk Assessment and Management

When a concern of organisational abuse is reported, a risk assessment should be carried out. The risk assessment will consider the severity of the circumstances and the impact on people using the services. The risk assessment should be drawn up and updated throughout the process.

A combination of assessed impact and likelihood will determine the level of concern.

Likelihood/Impact	Low	Medium	High
Unlikely	Minor	Minor	Moderate
Possible	Minor	Moderate	Major
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 if remedial action is taken.

HIGH A significant immediate impact on safety and wellbeing

Likelihood Criteria

UNLIKELY This is unlikely to happen or reoccur.

POSSIBLE This may happen but it's not a persistent issue.

CERTAIN This will probably happen / reoccur frequently.

3.8.1 The Threshold table below provides some guidance towards defining the level of abuse (Major, Moderate or Minor) together with examples of the impact on service users and potential actions to resolve the concerns.

Thresholds **Example thresholds for provider concerns process**	**Level of risk**	**Impact on people using the service**	**Potential action**	**Lead**
• A death related to a safeguarding concern. • Concern related to serious abuse or neglect. • CQC enforcements related to quality of care. • Criminal proceedings relating to poor care	**Major**	People who use the service are not protected from unsafe or inappropriate care. The provision of care does not meet quality & safety standards	Immediate suspension of new placements Contact with the Police Possible SAR referral	Safeguarding, Provider Development Team, Police & relevant commissioning teams
			Increased monitoring activity	Provider Development Team, North Lincolnshire Health and Care Partnership
			Formal meeting with provider following Police advice	Safeguarding, Provider Development Team & Commissioning Appropriate partner agencies such as

				the North Lincolnshire Health and Care Partnership, CQC
• Information linking concerns about the manager or responsible person. • High use of agency staff, with poor induction and training	**Moderate**	People who use the service are generally safe, but there is a risk to their health and wellbeing. Provision of care is inconsistent and may not always meet quality & safety standards.	Suspension or 'place with caution'	Commissioning, Provider Development Team, Consultation with safeguarding
			Increased monitoring activity	Commissioning, Provider Development Team & Care Reviews
			Formal meeting with provider following Police advice	Commissioning, Provider Development Team & Safeguarding Partner agencies North Lincolnshire Health and Care Partnership, CQC
• A disproportionate number of low-level concerns identified, from contract monitoring, North Lincolnshire Health and Care Partnership, or community care reviews	**Minor**	People who use the service are safe, but care provision may not always meet safety and quality standards	Monitoring visit	Commissioning, Provider Development Team Partner agencies, North Lincolnshire Health and Care Partnership, CQC
			Formal meeting with provider if necessary	Provider Development Team, NHS commissioning teams Partner agencies North Lincolnshire Health and Care Partnership, CQC

3.9 The outcome of this initial enquiry planning and risk assessment stage should be to:

- Assess any immediate safety issues.
- Consider whether a criminal offence may have been committed and consult with Police if needed.
- Agree lead agency, chairing arrangements and who needs to be involved.

- Map out risk and formulate a risk management plan.
- Agree an initial communication plan with provider, placing authorities, service users and representatives and address appropriate advocacy and support.
- Agree Terms of Reference for the enquiry.

3.10 Terms of Reference

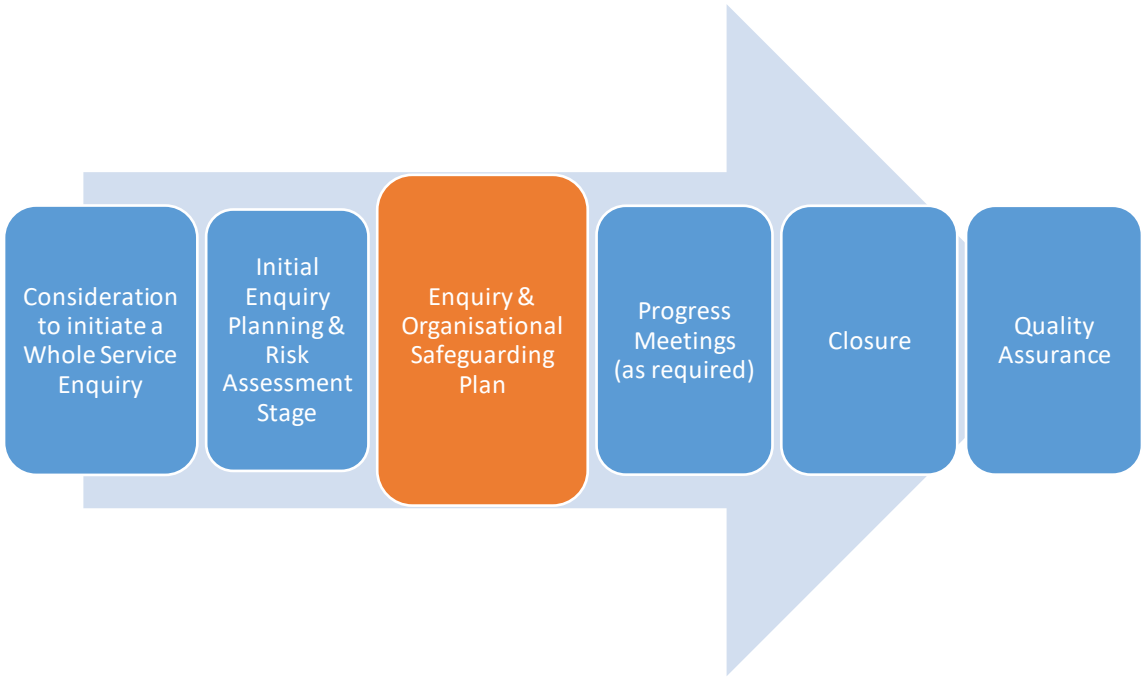
Terms of reference for the enquiry are essential to ensure that all those participating are clear on the concern, what is being considered and roles and responsibilities in the enquiry process. Care must be taken not to enquire into issues outside of the remit, however if further safeguarding concerns are identified during the course of the enquiry they should be included.

The Terms of Reference should cover the following:

- Clarify issues to be investigated.
- Agree roles and responsibilities for each agency (e.g., local authority, Police, GP, provider, North Lincolnshire Health and Care Partnership, CQC).
- Agree timing of enquiry actions (including responses to complaints, whistleblowing alerts, any disciplinary or HR action, as well as maintaining oversight of other processes such as SI and RCA investigations).
- Identify all people affected by the enquiry and the support required.
- How consent and information sharing will be managed.
- Agree a communication plan, including regular briefings and information sharing.
- Advocacy services – including IMCA and Independent Mental Health Advocate (IMHA).
- Interface with any other processes and / or investigations.

Timescales: actions to plan the enquiry and undertake the initial risk assessment should aim to be completed within 5-10 working days.

3.11 Stage 3 – Enquiry and Organisational Safeguarding Plan



3.11 The enquiry stage should enquire into the concerns, as per the agreed Terms of Reference.

This is likely to involve the need to evaluate evidence obtained from:

- Background reports, service records and previous history
- Individual reviews and feedback from service users, their representative and/or advocates and families
- Medical, clinical and care records
- Witness statements
- Staff records and supervision documentation
- Incident reports
- Feedback from visiting professionals
- Information from the provider
- Consideration of previous safeguarding concerns and / or intelligence from partner agencies

3.12 Involving the Provider

Involving the provider is important from the outset.

Clear information must be shared with the provider regarding timescales of the enquiry, realistic outcomes, and their responsibilities in the enquiry process.

The provider should be invited to all meetings, with an option for additional professional meetings or holding meetings in 2 parts should this be necessary to meet without the provider to prepare for meetings or share information between agencies in advance.

It may be necessary to hold meetings without the provider in exceptional circumstances such as:

- On specific advice from the Police or CQC related to the exercise of their statutory powers.
- Possible complicity by staff and managers in the issues under enquiry.
- Possibility that the service provider may tamper with or destroy evidence to protect themselves against the allegations made.

Judgement will need to be applied but depending on the size and complexity consideration should be given to notifying and involving the Registered Manager, the Area or Regional Manager and the Owner, Director, or Managing Director.

Whilst active and co-operative behaviour of the service provider is expected, it may not be appropriate that responsibility for the enquiry process is delegated to the provider given the serious nature of the concerns.

3.13 Safeguarding Planning

Actions need to be able to support a factual based assessment of the validity, severity, and impact of the alleged abuse or neglect. Intelligence as far as possible should be triangulated and the source of information identified and based on (a) views of adults using the service (b) factual information for example staff rotas and (c) professional assessment of documentation for example care plans and risk assessments.

Safeguarding planning will address alleged issues with suggested methodology for enabling decision making related to whether improvements are needed or not and expected actions as a result.

3.14 Organisational Safeguarding Improvement Plan

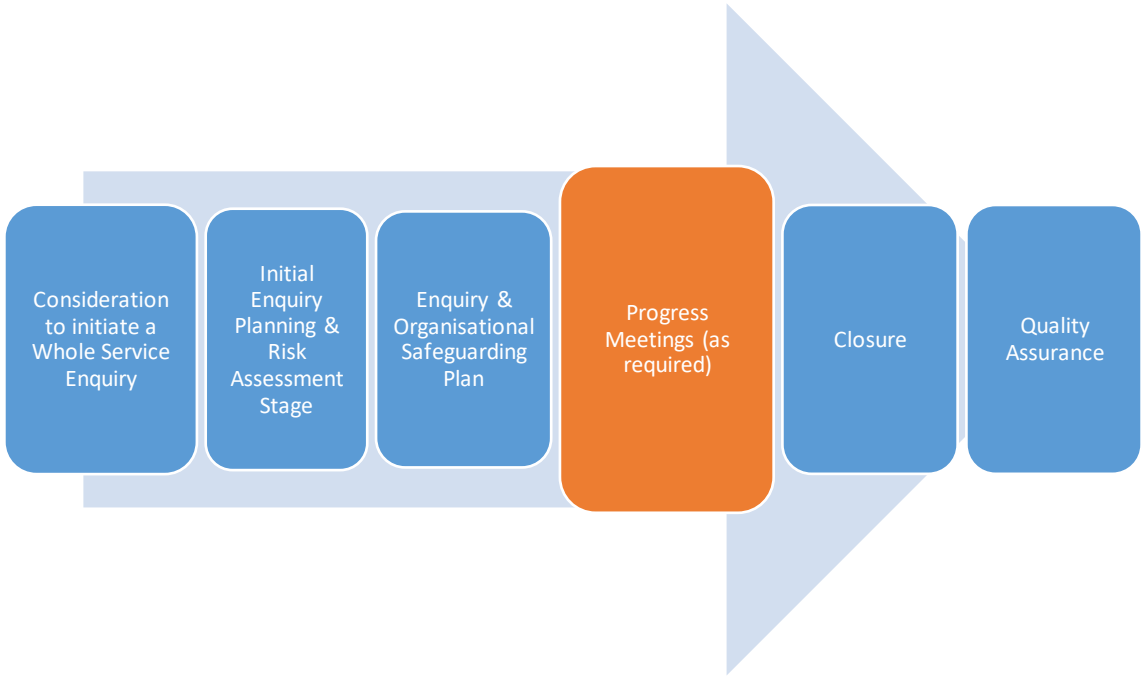
This is the high-level plan for determining actions required to improve safety and reduce the risk of harm. It should be used to measure the effectiveness of interventions to ensure safety, governance, compliance, clinical effectiveness referencing throughout the experience of adults using the service and their informal network. The organisational safeguarding improvement plan will be the agreed reference point for assessing and monitoring progress and the coordinator, relevant parties and the provider will retain a copy and update it through a series of progress meetings.

The plan should set out the concerns and risks and the expectations of the provider and / or other parties in response to the risks identified with clear and agreed timeframes.

If the provider advises that they are unable to make the improvements or of possible service failure or interruptions, a further assessment of risks and impact on the individuals should be undertaken.

Timescale: action should aim to be completed within 20 working days.

3.16 Stage 4 – Progress Meetings



3.16 Progress meetings should be agreed as and when necessary. Where there are wide reaching, complex concerns, and there is high risk, it is likely that progress meetings are needed more frequently. Focus should be on safety and risk and the impact on adults using the service.

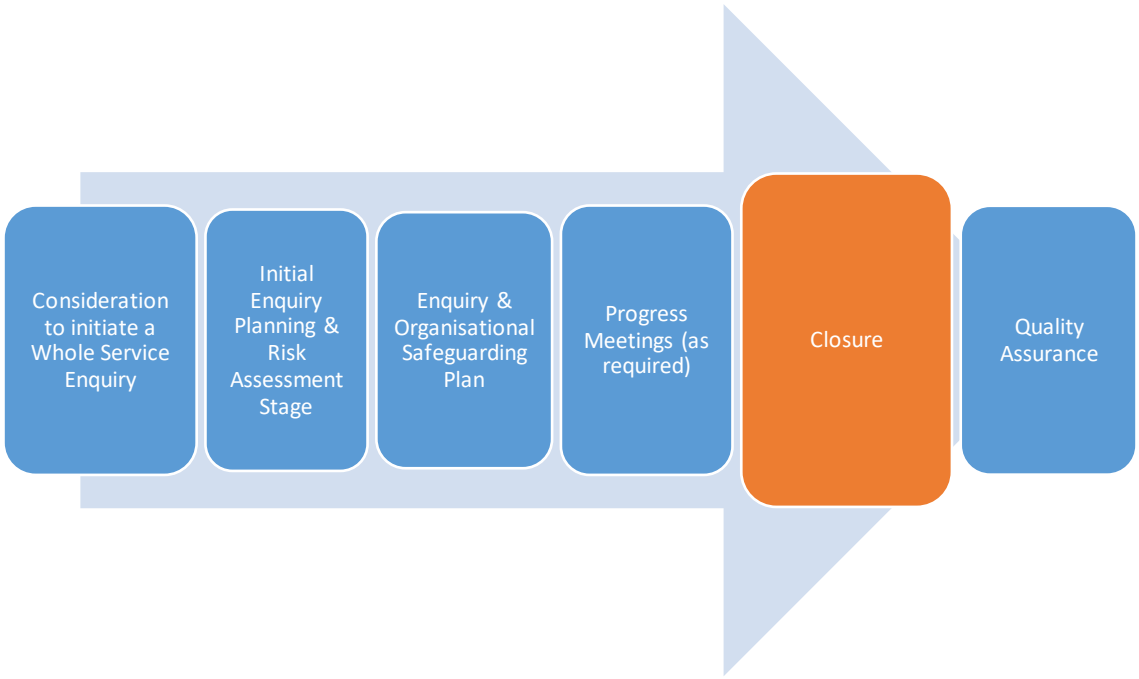
Timeframes should be given at each meeting for the next stage and attention should be paid to operating at pace, to ensure any impact on the provider's business is kept within a necessary timeframe.

Where there is a high risk and likely need to source alternative provision, commissioners should hold a specific contingency meeting.

Information and evidence gathered since last meeting and outcomes of all enquiries should be continually reviewed at each meeting, to ensure risks to service users are reassessed and any new information considered.

Timescales for further safeguarding meetings are dependent upon progress of the organisational safeguarding improvement plan and the level of risk.

3.17 Stage 5 – Closure



3.17 Final Meeting

Whole service enquiry procedures can only be closed when there is agreement within a formal whole service enquiry meeting. Decision making at the end of the whole service enquiry should relate back to the original Terms of Reference for the enquiry.

Following evidence-based improvement and completion of the organisational safeguarding plan, the process will come to an end via a formal minuted meeting.

The relevant parties including the provider and CQC will be notified in writing by the Chair.

At the final meeting there should be confirmation that the action plan has been completed satisfactorily and that people are safe.

3.18 Learning

A de-briefing lesson learnt exercise should be held to actively determine feedback from all stakeholders, to ensure that all relevant learning opportunities are taken forward. This may include:

- What was successful in this enquiry?
- How can this be improved in future?
- Did this policy and procedure help?
- Does this policy need amending?

This feedback should be reported to the SAB Protection & Accountability subgroup together with a summary report detailing the concerns, actions taken, outcomes and the effectiveness of safeguarding.

It is essential to know what works well to support a positive culture of co-operation and information sharing with joint accountability for risk and benefits.

3.19 Possible Remedies

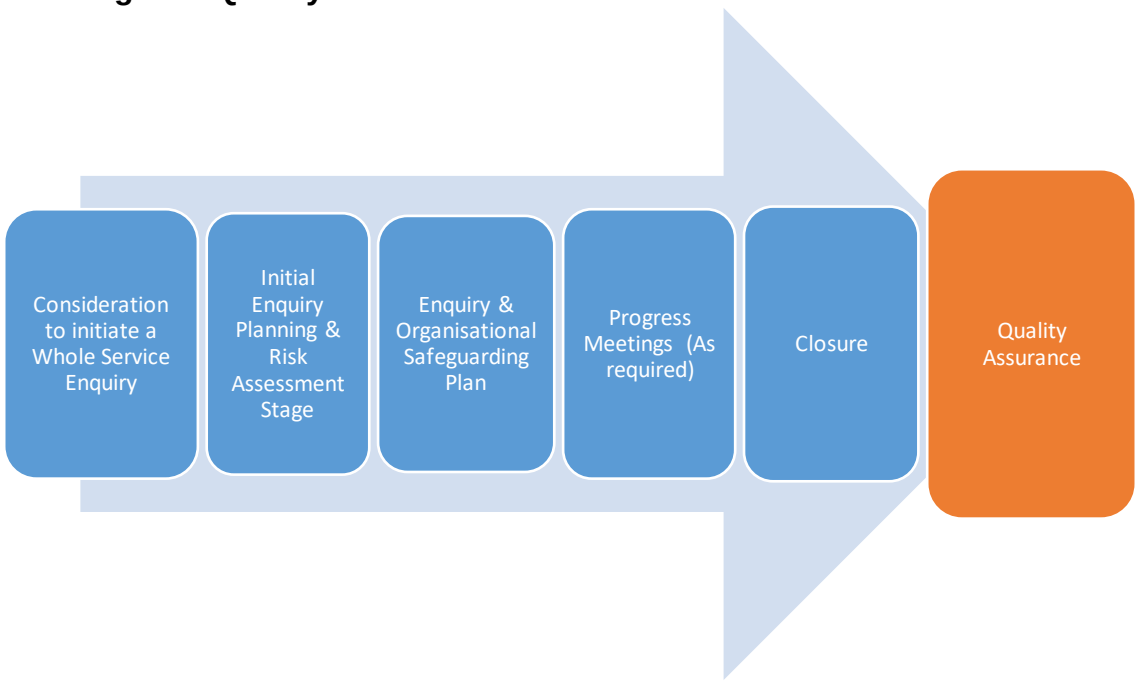
There are several possible remedies and conclusions that may be an outcome of the whole service enquiry.

Examples may include:

Criminal investigation and / or prosecution	**Prevention, detection, and investigation of crime** There are a number of possible offences which may apply, including the specific offences: Section 44 Mental Capacity Act 2005 makes it a specific criminal offence to wilfully illtreat or neglect a person who lacks capacity. Section 127 Mental Health Act 1983 creates an offence in relation to staff employed in hospitals or mental health nursing homes where there is ill-treatment or wilful neglect. Sections 20 to 25 of the Criminal Justice and Courts Act 2015 relate to offences by care workers and care providers.
Internal care concerns, misconduct by staff	**Employer action** HR action, supervision, training, capability, disciplinary processes, DBS, fitness to practice referrals and service improvement processes.
Unsafe care and regulatory breaches	**Regulatory action** Enforcement action taken by CQC, Fire Service, Health & Safety Executive, or other regulators to address unsafe, abusive care and non-compliance with regulatory standards.
Concerns about people who lack mental capacity	**Mental capacity act provisions** Court of Protection, Office of the Public Guardian, court visitors, Power of Attorney, section 44 MCA offences, authorised use of DoLS, DWP investigation, change of Appointee.
Poor care and quality issues	**Internal care governance** Enhanced contract monitoring and compliance, quality improvement, patient safety mechanisms, implement findings from root cause analysis investigations.

Breach of rights of a person detained under the MHA 1983	**Regulatory and enforcement action** Action by CQC (Mental Health), specialist service input

3.20 Stage 6 – Quality Assurance



3.20 A quality assurance plan may need to be agreed that will rigorously test whether improvements have been sustained, including how this will be monitored.

This is likely to include CQC, North Lincolnshire Health and Care Partnership and the Provider Development Team. This should detail actions to include milestones and review dates, setting out how issues will be remedied.

This will involve staff with the right knowledge, skills, and experience to assess the viability of the improvements and might be the same staff involved in the enquiry so that they can provide a comparative narrative. Quality assurance activities may include assessing the impact of training by competency testing staff and reviewing the application of policies and procedures and care governance processes. It is likely to involve visiting the service, assessing records, and speaking to people accessing the service, their representatives and staff and managers.

Feedback from adults and carers will act as a control measure to assess whether there has been any noted difference in the service delivery.

Support from local Healthwatch may be appropriate, or other locally managed groups for example, Experts by Experience to add an independent view.

3.21 Strategic Quality Assurance Forums / Assurance Panels / Commissioning Groups

There are a number of quality assurance forums across the partnership.

Sharing information on quality and safeguarding, strengthening the relationship and knowledge sources from commissioning, safeguarding, CQC, NHS Integrated Care

Board and front-line practitioner's assists in driving up standards. The purpose is to ensure both soft and hard intelligence, from all available agencies is brought together in an effective and cohesive manner to facilitate timely action. Formal mechanisms for sharing information are undertaken within the groups below.

3.21.1 North Lincolnshire Health and Care Partnership - Quality Surveillance Groups (QSG)

QSG's are routine, *"proactive and supportive forum for collaboration and intelligence sharing. By triangulating intelligence from different organisations, they provide the health economy with a shared view of risks to quality, and opportunities to coordinate actions to drive improvement."*

There is a local and regional Quality Surveillance Group established across the Humber to bring together different parts of health and care economies locally to routinely share information and intelligence to safeguard the quality-of-care individuals receive.

Concerns relating to a provider can also be shared via the Local Quality Surveillance Group.

3.24.2 Assurance and Commissioning Panel

The Assurance and Commissioning Panel provides a mechanism to bring together key managers within the local authority to review the sufficiency, quality, and viability of commissioned services for adults with care and support needs. The group utilises multi-agency safeguarding data and quality intelligence and assesses the risk that a given provider of any type of care and support may be experiencing difficulties in delivering its commissioned responsibilities.

The objectives of the group are -

- To agree the criteria to be used to identify any provider who may be at risk of failing.
- To share information on the published CQC outcomes of regulated provision.
- To share safeguarding intelligence and relevant information from contract monitoring.
- To ensure all commissioned services are being contract managed.
- To ensure the commissioning and procurement cycle is appropriately managed for regulated services.
- Agree an effective way of addressing underperformance of provision and agree who will take what action.
- To make recommendations to celebrate good to outstanding outcomes and to share best practice.
- To provide high level monitoring oversight on any agreed improvement plans.
- To understand themes arising from inspections and safeguarding enquiries that the Council can collectively support providers to improve upon.
- To ensure the voice of the individual is heard in relation to service quality.
- To discuss and agree action where there is identified risk of a provider being unsustainable.

A target time of 6 weeks to complete the quality assurance process should be factored into the strategy.

SECTION 4 – ADDITIONAL CONSIDERATIONS

4.1 Communication Strategy

Each stage in the process and at each meeting there should be a clear communication strategy agreed. The strategy should address both internal and external communications. A check list for who needs to be communicated with might include:

- Adult(s) at risk
- Relatives, informal carers, and representatives
- Provider senior management and legal owner
- Senior management within own organisation
- Stakeholders and partners
- Out of area authorities and/or commissioners
- Lead Member and relevant Councillors

4.2 Media Enquiries

Agencies should not underestimate the potential for media attention in complex abuse enquiries. Each agency represented in the enquiry should ensure that their organisations are appropriately briefed on the potential for media interest. Each organisation is requested to discuss a media strategy with the Council comms team via the council Safeguarding Team. Staff should not talk directly to the press as this contact will need to be handled organisationally.

4.3 Visits to the Provider

It is essential that visits from professionals should be co-ordinated and managed to ensure minimum disruption. Visits should have a clear remit and providers and service users should be notified that visits will take place, the nature of the visit, duration and who will be attending. Where providers and service users are not notified a clear rationale must be agreed.

4.4 Criminal Investigations

The primary role of the Police in adult safeguarding is the investigation of potential crimes. To ensure that the Police can fulfil this role effectively they need to make early decisions about the conduct of an enquiry, including the securing of evidence.

The Police should be consulted at the earliest opportunity if it is suspected that a crime has occurred.

The following are examples of alleged abuse that the Police would need to assess as potential criminal offences:

Financial or material – theft, fraud, internet scamming, coercion in relation to financial matters and wills, misuse of property or inheritance.

Physical – including assault, hitting, slapping, pushing, kicking or other forms of violence, restraint or inappropriate use of sanction or misuse of medication for sedation for example.

Neglect and acts of omission – ignored medical, emotional, or physical care needs, failure to provide necessities of life such as medication, nutrition, and heating.

Sexual – rape, indecent exposure, sexual harassment, subjection to pornography, acts not consented to.

Psychological – emotional abuse, threats of harm or abandonment, restraint, deprivation of contact.

4.5 Impact on business sustainability, business failure and service interruptions

The Care Act 2014 seeks to ensure that the care and support needs of people receiving services continues to be met, should a provider experience a temporary or permanent business interruption.

The local authority has a 'temporary duty' to meet people's needs when a provider is unable to carry on the relevant activity because of business failure. This applies to all individuals, regardless of whether they are funding their own care or for care funded by another authority / NHS.

The financial health of certain care and support providers is overseen by CQC. This market oversight duty specifically applies to large, hard to reach providers because of their size, geographic consideration, or other factors, would be difficult for one or more local authorities to replace, therefore requiring national oversight.

Providers will be expected to have business continuity plans in place. Where market failure is expected as part of a whole service enquiry, these should be shared, and appropriate contingency arrangements put in place.

North Lincolnshire has a provider failure policy which should be following in these circumstances.

4.6 Data and Information Sharing

Due to the sensitive nature of whole service enquiries, care must be taken by all participants to keep information that they receive as part of the enquiry safe, secure, and confidential at all times and in accordance with the GDPR and Data Protection legal framework and their organisation's policies and procedures. When sharing information by email, organisations must ensure that information is sent via a secure email system.

4.7 Multiple Care Provision

Where providers support adults in or from a number of different establishments, care should be taken that one establishment is not seen in isolation. This is to ensure that any failings are not endemic and embedded in corporate cultures and systems. This may impact on the capacity and capability of the provider to implement agreed improvements.

4.8 Emergency Closure

In extreme situations there may be a need to consider the immediate or urgent removal of a number of residents from their care setting or to change a domiciliary care support provider where there are serious risks. The legal and evidence basis for such an action must be discussed within an emergency multi-agency planning meeting with supporting evidence from agencies such as the Police, CQC and NHS.

If a decision is taken to cancel a provider's registration or that a service must be closed, the whole service enquiry process should continue to facilitate the safe removal of residents.

Emergency closures may involve complex casework and assessment, increased levels of distress and anxiety to adults at risk, their families / representatives and all parties involved.

In the event of a decision to remove residents on the basis of a safeguarding intervention it may be necessary to make an urgent referral to the Court of Protection for anyone who lacks mental capacity in respect of this decision.

The following document by SCIE brings together best available knowledge and practice-based learning into a suite of practical materials to support commissioners who may be called upon to manage unplanned care home closures.

https://www.scie.org.uk/publications/homeclosures/files/home-closure-guide.pdf

SECTION 5 – APPENDICES

Appendix 1 Roles and Responsibilities

North Lincolnshire Health and Care Partnership (NLH&CP) – North Lincolnshire Health and Care Partnership is the NHS commissioning body. The North Lincolnshire Health and Care Partnership may also lead on the enquiry, especially where the concern is about health provision, as their clinical knowledge and expertise is likely to be critical. The principle on who is best to lead on an enquiry should always be determined by the issue, who the lead commissioner is, and the knowledge and expertise required.

Care Quality Commission (CQC) – CQC is the regulator of health and social care services, including services for people detained under the Mental Health Act 1983. CQC have a role in identifying situations that given rise to concern that a person using a regulated service is at risk of harm, or they may receive an allegation or complaint about a service. Only CQC has the authority to take appropriate enforcement action, this is done by varying, removing, or applying conditions. CQC safeguarding protocols describe their role in safeguarding.

Disclosure and Barring Service (DBS) – the primary role of the DBS is to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. The DBS was established under the Protection of Freedoms Act 2012 and merged the functions previously carried out by the Criminal Records Bureau (CRB) and the Independent Safeguarding Authority (ISA).

Healthwatch – Healthwatch is an independent consumer champion who ensures the views and feedback from patients and carers are an integral part of local commissioning. They have 'enter and view' powers and provide advice, support, and advocacy.

Local Authority – has the overall legal responsibility for the coordination of safeguarding enquiries. In most cases, the local authority safeguarding adults' team will oversee the whole service enquiry.

Police – it is the Police who lead investigations where criminal offences are suspected by preserving and gathering evidence and interviewing witnesses. In cases where criminal proceedings are deemed appropriate, the Police will work in partnership to share information as they are able to and agree courses of action.

Providers - are accountable for meeting the expected standard of care agreed in individual care plans, service specification and terms and conditions of the contract.

Individuals may also have a role as outlined below:

Agency / Individual	Responsibilities/Tasks
Commissioners	Setting contract terms and service specifications that include safeguarding responsibilities. Regular reviewing of services, care plans and risk assessments

	Contract monitoring including improvements
Social workers / managers Case workers Performance Officers	Review care plans and risk assessments Analyse staff rotas Check incidents / accident reports. Review policies and procedures Mental Capacity and DoLS audits Monitoring Improvements
Nurses Occupational Therapists Physiotherapists Behavioural therapists Pharmacists	Infection control leads Review nursing and treatment plans Manual handling assessments Safety and use of equipment Falls policies and strategies to reduce falls. Medicine management. Monitoring Improvements
General Practitioners	Raising safeguarding concerns Maintaining a programme for monitoring individual patient care plans
Legal services	Advise where there are legal challenges to safeguarding or contractual decisions. Advise on suspension and decommissioning decisions
Advocates Family / friends Visitors	Supported decision making. Best interest decisions Raising concerns, monitoring improvements