Managing Organisational Safeguarding Concerns Policy

(Treatment, Care and Support Services for adults in care homes and in people's own homes - both personal and nursing care)

Suffolk Safeguarding Partnership

February 2020

Contents

1. Introduction

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. For the purposes of this policy patients, service users, customers, adults with care and support needs will be referred to as the adult/s.

The Care Act 2014 statutory guidance (14.9) makes it clear that Safeguarding is not a substitute for:

- providers' responsibilities to provide safe and high-quality care and support
- commissioners regularly assuring themselves of the safety and effectiveness of commissioned services
- the Care Quality Commission (CQC) ensuring that regulated providers comply with the fundamental standards of care or by taking enforcement action
- the core duties of the police to prevent and detect crime and protect life and property

This guidance is written in conjunction with the Suffolk Safeguarding Partnership Vision, Mission & Values which are informed by the six principles of safeguarding adults; these should inform and guide the ways in which professionals and other staff work with adults, these are:

EMPOWERMENT

Adults being supported and encouraged to make their own decisions and informed consent

PREVENTION

It is better to act before harm occurs

PROPORTIONALITY

The least intrusive response appropriate to the risk prevented

PROTECTION

Support and representation for those in greatest need

PARTNERSHIP

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

ACCOUNTABILITY

People being supported and encouraged to make their own decisions and informed consent

Making Safeguarding Personal

In keeping with the six key principles, it is essential that the customer/service user is at the heart of the safeguarding enquires.

Making Safeguarding Personal means the enquiry should be person-led and outcome-

focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing, and safety. Nevertheless, there are key issues that local authorities and their partners should consider if they suspect or are made aware of abuse or neglect.

Some people may express desired outcomes or wishes that are not possible, and this provides opportunities for discussion to establish what the next best option is within some broader boundaries and principles that they have stated. For other people, their desired outcomes may not be possible for instance if they do not want the police involved but the person who has abused or neglected them is in a position to do the same to others. Again, there will be opportunities to explain this honestly and to find ways to meet their wishes most closely. Further information, including a toolkit to ensure the inclusion of the adult at risk may be found at:

https://www.local.gov.uk/msp-toolkit

This policy provides guidance for managing organisational safeguarding concerns within regulated services (which may also include Organisational/Institutional Abuse) and aims to ensure that proportionate action is taken based on the seriousness of the allegation that has been made. This action may include day-to- day contract monitoring; unannounced spot checks; robust recording; information sharing; escalation to appropriate individuals/bodies; and attendance at safeguarding meetings.

The Care Act defines “institutional abuse/organisational abuse” as one of the 10 types of harm. It includes neglect and poor care practice within a specific care setting. This could be a hospital or a residential or care home, or in the adult’s own home, for example by a service that provides home care.

Organisational abuse concerns can result in complex safeguarding enquiries because there are likely to be several people at risk, several professionals involved and wider strategic implications.

Not all abuse that occurs within care services will be organisational abuse; some incidents between adults or actions by individual members of staff may occur without any failings on the part of the organisation. Organisational abuse refers to those incidents that derive to a significant extent from an organisation’s practice and culture (particularly reflected in the behaviour and attitudes of managers and staff) policies and procedures. As such the guidance

includes a description of the continuum of harm that may happen because of organisational issues and the expected response from key individuals/teams/agencies with respect to the level of harm. Following receipt of the concern, it is the responsibility of the Suffolk Multi-Agency Safeguarding Hub (MASH) the determine whether this meets the three statutory criteria for a safeguarding enquiry under the Section 42 of the Care Act 2014.

The guidance is applicable across all the different types of provider organisations e.g. residential or nursing care; domiciliary care; day care; housing-related support; temporary accommodation; health services.

This guidance should be read in conjunction with the Suffolk multi-agency safeguarding adult's policies and procedures including the Suffolk Safeguarding Framework https://www.suffolkas.org/assets/Working-with-Adults/Policies-and-Procedures/Safeguarding-Adults-Framework/2019-07-23-Safeguarding-Adults-Framework-V.8.pdf. The Framework alongside the MASH professionals Consultation Line (03456061499) is for people to use to determine when to raise a safeguarding concern.

2. The Care Act (2014)

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. It can be through neglect or poor professional practice because of the structure, policies, processes and practices within an organisation"

The statutory guidance (14.68- 14.75) goes on to provide advice on the response to abuse and neglect in a regulated care setting:

- It is important that all partners are clear where responsibility lies where abuse or neglect is carried out by organisations 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 to support the adult to recover.

- When an organisation 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 Group (CCG) where the latter is the commissioner. 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).

- There should be a clear understanding between partners at a local level when other agencies such as the local authority, CQC or CCG need to be notified or involved and what role they have. ADASS, CQC, LGA, ACPO and NHS England have jointly produced a high-level guide on these roles and responsibilities[1].

- 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 set out above, 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.

- 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 following a safeguarding incident, or a

person leaves their role (resignation, retirement) to avoid a disciplinary hearing during or following a safeguarding enquiry and 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 has provided the person, then the legal duty sits with that agency. In circumstances where these actions are not undertaken then the local authority can make such a referral.

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[1] https://www.local.gov.uk/sites/default/files/documents/safeguarding-adults-roles-3e9.pdf

3. Prevention

The Health and Social Care Sector in Suffolk is diverse, ranging from day opportunity schemes, through to care homes, private hospitals, and health trusts. Health services are commissioned by the CCG, Social Care services are commissioned by CCG and / or Adult and Community Services (ACS).

Commissioners of Health and Social Care services in Suffolk have contract management arrangements in place. These include monitoring Key Performance Indicators, Serious Incidents, Contract management meetings and visits and quality assurance visits. Where concerns are identified commissioners work with the service to develop an improvement plan, and appropriate support is given. Where there are joint commissioning arrangements between health and social care, there are regular information sharing and joint action plans to ensure support is co-ordinated and proportionate. When there are significant concerns about quality of care these there is an escalation process where the commissioners Business Continuity process is evoked.

ACS is supported by System Partners, including commissioners within Suffolk County Council (SCC) and the CCG, Care Development East (CDE) and Suffolk Association of Independent Care Providers (SAICP). These partners provide a range of support to the adult care market as a whole and to individual providers or locations as required. This support varies from 'Business as usual', to Quality Improvement and Service Recovery.
The table in appendix 2 outlines the different levels support available from the partners.

4. Identifying concerns within organisations

Indicators

There are key elements that could be early indicators of concern. Information and awareness about these early indicators can support practitioners to identify concerns and feel confident that what they have observed is valid, enabling them to act to protect people from abuse. These indicators are detailed in full in Appendix 1. However, this is not a definitive list and practitioners may identify other indicators not listed.

The indicators can be grouped into six key themes. These themes provide important information about key aspects of service design and delivery which increase the risks of abuse and harm for people.

As with all concerns about abuse or neglect, there will be a continuum of harm. The following link provides information within the Suffolk Safeguarding Framework about the different indicators of abuse and to assist practitioners with decision making on what interventions are required.

https://suffolksp.org.uk/working-with-children-and-adults/adults/safeguarding-adults-framework/

It is expected that concerns related to low level harm and/or poor practice are dealt with by individual organisations, commissioning, complaints and/or CQC procedures as set out in the **Suffolk Safeguarding Framework.** If a decision is made not to make a referral, the individual agency must make a record of the concern and any action taken. Concerns should be recorded in such a way that repeated, low level harm incidents are easily identified and subsequently referred. Not referring under safeguarding adults' procedures, does not negate the need to report internally or to regulators/commissioners as appropriate.

Regular, low level concerns can amount to a far higher level of concern which then requires more in-depth investigation or assessment under safeguarding adults' procedures.

Low level concerns

If a low-level of harm or poor practice concern is reported via the safeguarding adults' procedures, it is unlikely that an in-depth organisational abuse enquiry will be undertaken.

Instead the concern will be recorded by the Local Authority under the provider's section on the recording system and proportionate action taken to manage the risks that have been identified. This may include sharing information with commissioning, CQC, or care management staff; provision of information or advice; referral to another agency or professional; assessment of care and support needs.

However, all safeguarding concerns that are raised about an organisation are logged by the Multi Agency Safeguarding Hub on the provider record. These will be monitored for significant concerns and emerging themes, to determine if a full screen for Organisational abuse enquiry is required and aid future decision making in MASH. This action is particularly important in ensuring that an accumulation of low level of concerns is not allowed to manifest into a higher level of collective issues which amount to abuse.

The number of safeguarding referrals which constitute an organisational abuse enquiry is deliberately not specified as the criteria relates to the seriousness, complexity, uniformity, and systemic nature of allegations.

MASH Decision Making for Organisational Abuse Enquiries

There is a need for professional assessment and judgement in determining when poor practice becomes an adult safeguarding issue. Addressing four key questions will support the decision making as to whether the statutory criteria under the Care Act for an organisational abuse enquiry is:

1. Are the concerns of a type to indicate organisational abuse? Do they feature on the Early Indicators of Concern Full Checklist?

2. **Are the concerns of a nature to indicate organisational abuse?** Is the behaviour widespread or generally accepted within the setting? Is it sanctioned by management and supervisory staff?

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

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

It is not necessary for all four questions to be answered positively. A one-off serious incident may be enough to trigger the decision to hold a multi-agency strategy discussion to decide whether to proceed with further enquiries into Organisational Abuse and this decision will be

recorded on the organisation record held by the Local Authority.

The decision making will include a review of all the concerns and an evaluation of all current sources of evidence, including making enquiries of an appropriate range of services including:

- the previous safeguarding history of the provider (including other services owned by the provider)
- the rating given by the Care Quality Commission – the previous and current status of the service/organisation
- local authority contracts section – previous or current evidence of noncompliance
- local authority feedback team – history of concerns/complaints (and positive feedback)
- police – past or current concerns
- health professionals who may visit e.g. GPs, district nursing, ambulance service, Care Home Clinical Quality Team, etc. Also, if relevant, the history and pattern of referrals to secondary care or emergency department attendances
- practitioner views – any feedback arising from reviews or individual safeguarding enquiries

The decision making will evaluate the issues that are identified under the headings of the six key themes and will include a recommendation about next steps.

This recommendation will be reviewed by the MASH who will decide whether to open a formal Organisational Safeguarding Enquiry and record this decision.

If the decision is made not to proceed with an Organisational Safeguarding Enquiry then the MASH should record how the issues arising are to be followed up e.g. by a safeguarding visit to the provider, by the ACS Contracts Team, through individual enquiries, by a visit from the CCG or the CQC, or by Adult Social Care Services as appropriate to the provider. The outcome of these actions should be recorded on the service provider's section on the recording system and shared with CCG Care Homes Team and Continuing Healthcare Team.

5. Powers of Enquiry

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

The Care Act 2014 makes provides that the Local Authority has lead responsibility for adult safeguarding concerns. As part of the safeguarding adults process, the local authority may appropriately delegate this responsibility. As such there may be multiple enquiries undertaken by several different agencies.

In carrying out this lead responsibility the Local Authority will co-ordinate the overall organisational abuse enquiry and ensure that all relevant agencies are involved, confirming specific enquiries/investigations are referred to the right person and are of an appropriate standard.

The Local Authority

The depth of any safeguarding enquiry depends upon the initial concern and the level of harm that has occurred or is suspected to have occurred.

Section 6(1) of the Care Act (2014) states:

> A local authority must co-operate with each of its relevant partners, and each relevant partner must co-operate with the authority, in the exercise of—
>
> (a)their respective functions relating to adults with needs for care and support,
> (b)their respective functions relating to carers, and
> (c)functions of theirs the exercise of which is relevant to functions referred to in paragraph (a) or (b).

This specifically includes cooperating to fulfil the following duties:

> (d)protecting adults with needs for care and support who are experiencing, or are at risk of, abuse or neglect, and
>
> (e)identifying lessons to be learned from cases where adults with needs for care and support have experienced serious abuse or neglect and applying those lessons to future cases.

(Section 6 (6), Care Act 2014)

6. Organisational abuse enquiries

The indicators for an organisational abuse enquiry may present at any point of the safeguarding adults process (refer to checklist 1). When this occurs a safeguarding concern must be raised via Customer First https://earlyhelpportal.suffolk.gov.uk/web/portal/pages/adultsa#h1 or if a discussion is

required contact the MASH CONSULTATION LINE 0345 606 1499.

An organisational abuse enquiry will need to draw upon information from a variety of sources (e.g. service provider investigations, CQC, Commissioners, recent safeguarding adults enquiries about adults linked to the provider/organisation, complaints), as well as identifying further enquiries which may be needed (e.g. wider review of the service/adult's care and support needs, criminal investigation).

If it is suspected that abuse has occurred within an organisation it may however not be necessary to commence an organisational abuse enquiry and an individual safeguarding enquiry may be more appropriate e.g. because the allegation/concern does not affect the whole service/multiple victims.

An organisational abuse enquiry will need to consider the needs of any individuals affected by the alleged risk or harm.

Where an organisational abuse enquiry is undertaken, a Safeguarding Meeting will be held. This can run alongside individual meetings if they are ongoing and still required.

7. Who to Involve in an organisational abuse enquiry?

The decision to progress to an Organisational Safeguarding enquiry is made within the MASH after consideration of the concerns and discussion with partners.

Responding to organisational abuse is likely to require complex coordination of different organisations both for information and for direct involvement in the enquiry. Drawing upon the knowledge and expertise of the Clinical Commissioning Group and other health partners, Care Quality Commission and Police partners will be an important early step in formulating an effective approach. It is important that everyone involved is aware of their respective roles and responsibilities and their duty to cooperate in the enquiry.

As the "host" authority Suffolk County Council will lead and co-ordinate organisational abuse enquiries within Suffolk, but multi-agency knowledge, skills and information sharing are essential for best practice, sound decision making and securing positive outcomes for adults. Active and co-operative behaviour by the service provider is expected and essential. Depending on the type of concerns and the level of staff involved it may or may not be appropriate for the provider to actively make enquiries. This will need to be decided in each situation by the local authority as the body with overall responsibility for the safeguarding

enquiry. It will be important to understand the service providers own mechanisms, for example disciplinary procedures, and how any intention to deploy these relates to the safeguarding concern and aligns to the safeguarding plan. It is key that the service provider takes responsibility for the abuse and the impact of it. Where their internal procedures are likely to have set/allowed a culture where abuse can take place it is essential that this become part of the enquiry.

It is essential that where providers are undertaking enquiries arrangements for what these should cover, timescales and how they will be fed back are clear. Where these are not adhered to consideration must be given to how to escalate the concerns to ensure they are managed. Support in undertaking enquiries will be provided by Suffolk County Council and/or the CCG.

When an enquiry involves several people who have experienced abuse, or are at risk of abuse, the issues are often complex, involving standards of service as well as a series of individual enquiries.

The meetings will be chaired by a supervisor or manager overseeing the enquiry. Involvement at the meeting should be limited to those who need to know and can contribute to the decision-making process.

Key Partners and information sharing

Police –The chair of the individual safeguarding enquiry will liaise with the police as appropriate. Where criminal offences may have been committed it is crucial that the first enquiries are done by or with the police

Care Quality Commission - must be informed of any concerns relating to a regulated service.

Local Authority Contracts and Service Development - must be informed of safeguarding concerns relating to any provider contracted with the Local Authority operating in Suffolk, irrespective of whether services are currently commissioned.

Health - where services are commissioned by the Clinical Commissioning Group, NHS England, or public health e.g. via Continuing Health Care (CHC), Funded nursing care (FNCC) or as part of a joint package, the Clinical Commissioning Group must be informed. In all other instance's information will be shared within the MASH

Other Local Authorities - where placements are commissioned by another commissioning

body for example, another local authority, they should be notified of the referral and involved throughout. While Suffolk County Council retains the lead safeguarding role for all safeguarding concerns, placing commissioning bodies retain a duty of care towards the adult and should be expected to fulfil this role in co-operation with the safeguarding enquiry.

The following should be considered to attend:

- Service Provider
- Contract and Service Development Officer
- Safeguarding Lead Clinical Commissioning Group
- Quality Lead Clinical Commissioning Group
- Care Quality Commission
- Lead practitioner and/or Senior social work manager
- Police
- Representatives from any placing authorities
- Any professional whose involvement is relevant to the allegations/ alerts (e.g. Ambulance, GP, Specialist Nurse, Physiotherapist.
- Legal Advisor

In all cases where the organisational abuse enquiry involves a regulated Service Provider, the following agencies will always be notified.

- Care Quality Commission
- Local Authority Contracts and Service Development Team
- Clinical Commissioning Group

Their involvement in any ongoing safeguarding adult's enquiry or investigation will be dependent upon the circumstances of the case. If the regulated service provider is commissioned to provide nursing level of care, then a member of the Clinical Commissioning Group (CCG) should be involved in the enquiry even if the service users named in the individual safeguarding concerns are not assessed as requiring nursing level of care.

In enquiries of this nature, it is not feasible to have attendance at the safeguarding meeting for the adult at risk or their representative. However, consideration must be given to how they will be informed and kept updated of the safeguarding adult's enquiry.

8. Organisational Concerns Initial Safeguarding Meeting

The initial safeguarding meeting should be called as soon as possible by the Safeguarding Manager. Depending on the level of risk and the complexity of the concerns a balance may be needed between ensuring the maximum number of partners round the table and ensuring people's immediate safety.

The initial safeguarding meeting will discuss risk factors based upon existing knowledge and agree an interim safeguarding plan covering both individual concerns and the care setting as a whole. This must include a plan to keep existing adults safe. The interim risk assessment should also include the decision to suspend further placements to the home.

- Identifying who will undertake the enquiries into the concerns/allegations
- Collating investigation information
- Identifying risks and agreeing improvement and/or safeguarding plans
- Identification of themes and trends
- Ensure the right agencies are invited and are able to contribute
- Ensure each agency is clear about their respective responsibilities
- Agreeing how adults at risk/representatives will be kept informed and updated
- Ensuring out of area arrangements are reflected and taken into account
- Agreeing how key stakeholders will be kept updated (e.g. senior managers, the Suffolk safeguarding partnership, elected members/MPs).
- Considering how any potential media interest will be managed.

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

- implementation of the enquiry / assessment plan
- report(s) completed by investigator(s)
- evaluation of enquiry /assessment activity and evidence obtained determine if abuse/neglect has taken place covering both individual concerns and the care setting (organisational abuse)
- consider the circumstances and potential needs of perpetrator(s)
- agree an ongoing Safeguarding Plan which is likely to have both short- and medium-term actions
- agree time scales for review of Safeguarding plan
- agree circumstances where re-evaluation of the situation will be required
- agree an action plan for the service provider

- receive feedback of follow up by provider
- case closure

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

9. Cross-Boundary Arrangements

A Provider of concern may be 'hosting' adults from neighbouring authorities, referred to as 'placing authorities'. In organisational safeguarding enquiries, placing authorities have a duty to assist the host authority in ensuring no further risk is posed to the adults affected.

The guidance issued by ADASS.
https://www.adass.org.uk/media/5414/adass-guidance-inter-authority-safeguarding-arrangements-june-2016.pdf
outlines the roles and responsibilities in out of area safeguarding cases. The chair of the safeguarding enquiry meeting should involve placing authorities in the arrangements where required, and co-ordinate any actions requested.

In exceptional and high-profile organisational concerns, a strategic management group may be convened. This group involves electing a senior manager from each relevant agency and is not solely confined to the hosting and placing authorities but may be extended to agencies as outlined in section 6. More information can be found in the above ADASS guidance.

10. Potential outcomes of an organisational abuse enquiry

These will be dependent upon the nature of the concerns. Outcomes may include:

- Human Resources processes and procedures
- Introduction/ review of policy and procedures
- Contract review and/or monitoring
- Placement sanctions and/or embargo's
- CCG monitoring
- Social Work reviews and monitoring
- Further investigation

- Review of systems
- Staff training
- Suspension of provider; either voluntary or enforced (this can be alerted to Social Workers via the care planning alert function on LAS)
- Referral to the Disclosure and Barring Service
- Referral to Professional Registration Bodies
- Criminal prosecution
- CQC enforcement actions

Safeguarding Adult Reviews[4]

Safeguarding Adults Reviews (Section 44 enquiries) must be undertaken by the local Suffolk safeguarding partnership (SSP) when the following criteria has been met.

> A SSP must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—
>
> (a) There is reasonable cause for concern about how the SSP, of it or other persons with relevant functions worked together to safeguard the adult, and
> (b) Condition 1 or 2 is met. Condition 1 is met if—
> (a) The adult has died, and
> (b) The SSP knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).
> Condition 2 is met if—
> (a) The adult is still alive, and
> (b) The SSP knows or suspects that the adult has experienced serious abuse or neglect.
> An SSP may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Cases should be referred to the Safeguarding Adults Review Panel (SARP) for consideration, if an adult at risk of abuse or neglect has died or been seriously harmed and abuse or neglect are believed to have been a factor. This form can be completed by any professional who has become aware of a case where the above criteria is met.

The following link is where you will find further information and the referral form:https://www.suffolkas.org/about-us/priorities-and-vision/SearchForm?Search=SAR&action_results=Search

11. Meeting the needs of individuals at risk

Where there are concerns the organisation is not able to confidently meet the assessed needs of the adults it is currently caring for or supporting, then individual

care management or health reviews may be required. The decision for these to be will be discussed at the initial safeguarding meeting and subsequent.

Where placements are commissioned by out-of-area authorities then undertaking of reviews will be the responsibility of the relevant commissioning authority.

Adults at risk who fund the placement themselves (often referred to as self-funders), will also be offered a review by the most appropriate organisation.

12. Communication

Involvement of organisation, adults at risk and their relatives

The purpose of the organisational abuse enquiry is to discuss the collective issues and concerns raised about an organisation which may affect several adults at risk. For reasons of privacy and confidentiality it is not appropriate for the adult(s) at risk or their representative(s) to be present at the meeting. The responsible Safeguarding Manager will appoint someone to act in a liaison role with the organisation, service user and/ or their representative (this may include formal advocacy services where applicable).

The liaison role is to ensure the views of the service user and/ or their representative is ascertained and shared at the meeting(s). At the meeting and within the guidelines of confidentiality and data protection consideration will be given to what is appropriate to be shared. The nominated liaison professional would then provide this feedback, to the organisation, service users and/or their representative. Any actions relating to an individual service user's care provision must be made in partnership with the individual and/or their representative.

Informing other adults not directly affected

Other adults may need to be informed. This will be particularly relevant where there are widespread concerns and where clear communication would be helpful in providing reassurances that actions are being undertaken. Consideration must be given at any

safeguarding meeting if such communication is required and how often it should occur throughout the safeguarding process.

Informing staff or partner agencies

Specific information relating to the reasons for a decision to suspend or terminate commissioning should only be shared on a need to know basis. ACS contracts and service development team will notify ACS social work teams of any suspensions. They would also make the CCG's, CQC and any regional colleagues aware.

Media interest

Each partner's senior leader must be informed of any suspected media interest as soon as possible. Under no circumstances should an attendee of the safeguarding meeting provide a comment, statement, or interview to the press.

As soon as it is identified that there may be media interest in an enquiry, the responsible senior leader should liaise with their relevant Communications Team regarding a plan to manage this.

Organisational Safeguarding Case Closure

It is important that the decision to end the Organisational Abuse Enquiry is agreed by the whole meeting membership. It is therefore essential that key agencies remain involved in the safeguarding process.
The multi-agency meeting will need to be satisfied that:
 all required safeguarding actions have been undertaken.
 there is evidenced reduction in risk
 involved adults have received feedback
 any necessary notifications to regulatory bodies e.g. Disclosure and Barring Agency, Nursing and Midwifery Council, have been undertaken
 any remaining concerns can and will be managed through contract monitoring, care management processes etc.
 lessons learned have been identified and taken forward

The organisation will be notified that the safeguarding enquiry is closed and any actions to be taken forward as business as usual. Additionally, all placing commissioning bodies and CQC should be notified of the safeguarding closure once confirmed.

APPENDIX 1.

Indicators of Concern in Care Services Checklist

The checklist will be used as a decision-making tool initially by the MASH and then throughout the whole process. It is important to note that this is not a definitive checklist, other indicators may be identified that do not appear on this list. Equally abuse can happen when indicators of concern

1. **Concerns about management and leadership**

The manager of the service

• The manager leaves suddenly and unexpectedly

• The service has not had a registered manager in post over an extended period

• Arrangements to cover the service while the manager is away are not working well

• The manager is new and does not appear to understand what the service is set up to do

• A responsible manager is not apparent or available within the service and has little involvement with the adults

• The manager leaves staff to get on with things with little active guidance or modelling of good practice

• The manager is very controlling

Management Culture

• The service is not being managed in a planned way, but reacts to problems and crises

• The service does not respond appropriately when a serious incident has taken place

• The service fails to learn from previous incidents and does not appear to be taking steps to reduce the risk of a similar incident happening again

• Policies, procedures, and practice guidance are absent or inadequate

The management teams

• Senior staff have been in post a long time and have a high level of authority and entrenched views

• There have been multiple managers over a short period of time

• The service is having trouble in recruiting and appointing managers

• There is a lack of leadership by managers, for example managers do not make decisions and set priorities

• Managers appear unaware of serious problems in the service

• Managers do not appear to be attending to risk assessments or are not ensuring that risk assessments have been carried out properly

• Managers do not appear to have ensured that staff have information about individual adults' needs and potential risks to adults

• Managers appear unable to ensure that actions agreed at reviews and other meetings are followed through

• There is a lack of effective reporting and/or monitoring by senior staff – including support to night staff and checks on them

• The managers know what outcomes should be delivered for adults, but appear unable to organise the service to deliver these outcomes, i.e. they appear unable to 'make it happen'

Staffing

• Staff who raise issues are not listened to

Continued lack of staff

• Staff are not being deployed effectively to meet the needs of adults

• There is a high turnover of staff

• Staff are working long hours

• Staff are working when they are ill

• There is poor staff morale

• Recruitment processes are inadequate

• The service employs high numbers of family/friends

• There is a failure to identify concerning behaviour by staff e.g. stressed staff behaving unusually, growth of cliques, failure to work to best practice, cutting corners

• The managers have low expectations of the staff

• Staff have poor pay and conditions of employment

2. Concerns about staff skills, knowledge, and practice

Supervision and Training

• Staff receive little/no supervision, appraisals, or opportunities for development

• Induction processes are inadequate

• Poor quality or no training is provided

• Staff appear to lack the information, knowledge and skills needed to support the people the service is set up to support

• Staff lack training in how to use equipment

Recording

• Record keeping by staff is poor with limited or poor care plans

• Staff do not appear to see keeping records as important

• Risk assessments are not completed or are of poor quality. For example, they lack details or do not identify significant risks

• Incident reports are not being completed

• Records are value laden and judgemental

Mental capacity and DOLS

• There is non-adherence to the principles of the Mental Capacity Act

• There is a lack of understanding of DOLS

• DOLS referrals are not being made resulting in people being unlawfully deprived of their liberty

Interactions with Adults

• Staff appear challenged by some adults' behaviours and do not manage these in a safe, professional, or dignified way

• Staff perceive the behaviours of adults as a problem – and blame the adults

• Staff blame adults' medical condition for all their difficulties, needs and behaviours; other explanations do not appear to be considered

• Adults are punished for behaviours seen to be inappropriate

• Staff treat adults roughly or forcefully

• Staff ignore adults

• Staff are impatient with adults

• Staff talk to adults in ways which are derogatory/not complimentary

• Staff shout or swear at adults

• Staff do not alter their communication style to meet individual needs. For example, they speak to people as if they are children, they 'jolly people along'

• Staff use negative or judgemental language when talking about adults

• Staff do not see adults as individuals and do not appear aware of their life history

• Staff do not ensure privacy for people when providing personal care

• Staff tell adults to use their incontinence pads rather than assist them to use the toilet

Culture

• There is a group of staff who strongly influence how things happen in the home

• Staff informally complain about the managers to visiting professionals

• Staff appear to lack interest and commitment

• Staff appear to lack concern for the adults

• Staff appear unable to relate to a particular adult

• Staff are complacent about the quality of care they provide and appear defensive when challenged

3. **Concerns about adults' behaviours and wellbeing**

Individual adults

• Show signs of injury due to lack of care or attention (e.g. through not using wheelchairs carefully or properly, or the development of pressure injuries due to lack of or inappropriate use of pressure relieving equipment)

• Appear frightened or show signs of fear

• Behaviours or appearances have changed, for example they have become unkempt or are no longer taking pride or interest in their appearance

• Residents isolated with lack of activities – lots of people remain in bed all day or beyond reasonable 'get up time'

• Behaviour is different with certain members of staff/when certain members of staff are away • Engage in inappropriate sexualised behaviours

• Do not progress as would be expected

• Experience sensory deprivation – e.g. going without spectacles or hearing aids

• Experience restricted mobility by being denied access to mobility aids

• Experience restricted access to toilet/bathing facilities • Lack personal clothing and/or possessions

General Service concerns

• The overall atmosphere is flat, gloomy or miserable

• There is a high number of low-level incidents such as medication errors or falls

• There is a high number of incidents between adults

• There are a high number of upheld complaints about the service

• There is evidence of inappropriate restraint methods or misused restraint, including the inappropriate use of medication

• The care regime exhibits lack of choice, flexibility, and control

• The care regime appears impersonal and lacks respect for individual's privacy and dignity

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

Information sharing

• The service has few visitors/minimal outside contacts

• The service does not report safeguarding concerns

• The service does not communicate with or report concerns to external practitioners and agencies

• The service does not liaise with families and ignores their offers of help and support

• Managers and/or staff do not respond to advice or guidance from practitioners and

families who visit the service

• Managers do not appear to provide staff with information about adults from meetings with external people, for example reviews

• Staff or managers appear defensive or hostile and concerned to avoid blame when questions or problems are raised by external practitioners or families

• Managers or staff give inconsistent responses or accounts of situations

Staff

• Staff work alone on a one to one basis with adults

• Staff work in silos e.g. night staff who never workdays

• Staff are hostile towards or ignore practitioners and families who visit the service

Adults

• There are adults who have little contact with people from outside the service

• There are adults who are not receiving active monitoring or reviews (e.g. people who are self-funding)

• Adults are kept isolated in their rooms and are unable to move to other parts of the building or outside independently ('enforced isolation')

• Adults have restricted access to visitors or phone calls

• Adults have restricted access to health or social care services

5. Concerns about the way services are planned and delivered

The nature of the service

• The service does not have a clear philosophy/purpose

• The service does not appear able to deliver the service or support it is commissioned to provide. For example, it is unable to deliver effective support to people with distressed or aggressive behaviour

• Decisions about what service is commissioned for an individual are influenced by a lack of suitable alternatives

• The service is accepting adults whose needs and/or behaviours are different to those of the adults previously or usually accepted

• The service is accepting adults whose needs they appear unable to meet

• Adults' needs as identified in assessments, care plans or risk assessments are not being met. For example, adults are not being supported to attend specific activities or provided with specific support to enable them to remain safe

Person-centred care

• Staff are task focussed and not providing person-centred care

• Adults are treated en-masse

• The service follows strict, regimented routines – for mealtimes, bedtimes, etc

• Adults lack choice about food and drink, dress, possessions, activities and where they

want to spend their time • Members of staff are controlling of adults

• There are misunderstandings about confidentiality

Resources

• There is a failure to provide and/or maintain correct moving and handling and other equipment such as pressure relieving mattresses

• The service is under resourced – whether staff, equipment, or provisions

• There appear to be insufficient staff to support adults appropriately

Audits

• There is a lack of audits of practice and process

• There is a failure to follow up on issues raised by audits

• There is a failure to monitor the use of call bells including checking they have not been Disabled – especially at night

6. Concerns about the quality of basic care and the environment

Person-centred care

• There is a lack of privacy, dignity, and respect for people as individuals

• There is a lack of provision for dress, diet, or religious observance in accordance with adults' individual beliefs or cultural backgrounds

• Adults do not have as much money as would be expected

• Adults lack basic things such as clothes, toiletries

• Support for adults to maintain personal hygiene and cleanliness is poor and they appear unkempt

• Adults are not getting the support they need with eating and drinking, or are not getting enough to eat or drink

• There is poor or inadequate support for adults who have health problems or who need medical attention

• Staff are not checking that people are safe and well

• There are a lack of activities or social opportunities for adults

• There is a lack of care for adults' property and clothing

Resources

• There appear to be insufficient staff to meet adults' needs

• The service does not have the equipment needed to support adults and keep them safe

• Equipment or furniture is broken

• Equipment is not being used or is not being used safely and correctly

Environment

• The service is not providing a safe environment

• The environment is dirty and shows signs of poor hygiene

•The quality of the environment has deteriorated noticeably

APPENDIX 2

System Partners Support to the Adult Social Care Sector in Suffolk

The table below outlines the different levels support available from the partners.

	Business as Usual	Quality Improvement	Service Recovery
SCC Service Development and Contracts – Learning Disabilities, Mental Health and Autism	-Contract Management Relationship – each service has a named contract manager. Frequency of contact is based on a risk assessment, with a minimum of an annual visit. -Learning Disability Partnership Board -Learning Disability Strategy	-Responsive Contract Management visits -Develop an improvement plan with the provider -Visit to service office, may visit 1 or more individual schemes. -Progress meetings with providers and other stakeholders -Liaise with Social Work Services – consider need to review care packages.	-As for Quality Improvement -Consider if new placements should be suspended to allow provider time to improve. -Monitoring arrangements to ensure care needs are met e.g. monitoring rotas. -Step in service delivery to ensure continuity of service (very short term) -Liaise with Social Work Services -Liaise with CYP
SCC Service Development and Contracts – Residential, Nursing and Home Care	-Contract Management Relationship – each service has a named contract manager. Frequency of contact is based on a risk assessment, with a minimum of a quarterly meeting (monthly for larger providers) which are attended by Social	-Responsive Contract Management visits – may be announced or unannounced. -Work with provider to understand what issues are and root cause(s) - Issues may be care related or business issues.	-Evoke Business Continuity plan if appropriate. -Encourage provider to put voluntary suspension in place or consider formal suspension of new placements to allow provider time to improve.

	Work Services. Minimum of 1 assessment visit per year, minimum of 3 yearly monitoring visit (ADASS). Residential and Nursing Care Home (RANCH) meetings -Locality based Provider Forums for Home Care	-Refer to PST for support -Liaise closely with CQC -Multiagency working, especially with CCG -Issues may be at location or provider level -Planned and phased return to Business as Usual once the service has improved. -Service may not recognise concerns / may not wish to engage with support – in this instance SCC would put in monitoring to ensure safety of people using service.	-Consider reducing number of care packages (home care), source alternative provider for people with highest / most complex care needs. -Refer to PST and other agencies e.g. CCG -Liaise with CQC -Step in service delivery to ensure continuity of service (very short term) -Use of Provider of Last Resort (POLR) -Provide external agency staff (recharged to provider) e.g. where provider cannot get credit with agencies. -Request Social Work Service review individual's care needs and assess if service can meet those needs. Best Interests Decision meetings for people who do not have capacity in respect of where they live. -Working with front line staff -Ensure multiagency comms plan with CQC,

			CCG and provider where possible. -If service repeatedly reaches recovery point and does not sustain and embed improvements after support from agencies, SD&C may not continue to provide recovery support – will continue to monitor service and respond if service is not meeting people's assessed care needs or if there is an unacceptable level of risk to people using the service.
SCC Service Development and Contracts – Housing Related Support	-Contract Management Relationship – each service has a named contract manager. Frequency of contact is based on a risk assessment, with a minimum of an annual visit. -Framework forum takes place bi-monthly for current and prospective providers -Locality based housing forums, attended by Providers, SCC, Housing Options teams, Charities and	-Responsive announced visit to the scheme manager. -Discuss improvement plan and support with problem solving -Escalate to service manager if necessary -Concerns may be sector wide e.g. County lines / Cuckooing – raise issues with framework panel and source support e.g. Arrange briefing sessions from County lines team – provide advice and	Situation has not occurred with HRS in Suffolk. -Look at alternative providers -Advice Suffolk Housing Board of potential risk of homelessness if the service closes

	District and Borough Councils.	information on support available. -If concerns are not being resolved, escalate to Suffolk Housing Board – Housing Managers from District and Borough Councils, ACS and CYP.	
SCC – Provider Support Team	-Quarterly locality Safeguarding and Best Practice forums -My Home Life Graduates	-Work closely with SD&C, Safeguarding and CCG – co-ordinated response. -Intensive tailored support to the service, working with individual location managers and front-line staff. -Solution Focussed approach -Root cause analysis of issues through toolkits -Support to home through workshops for staff to contextualise training. -Coaching / mentoring support to manager -Liaise with CQC	-As for Quality Improvement -Weekend / Out of Hours visits to ensure safe care. -If Business Continuity Plan is evoked, join Tactically Management Team -If service cannot be recovered – support safe transfer of residents: Provide on-site ACS leadership – liaise between TMT and on-site team, stabilising support in the home – support, advice to manager regarding safe transfer, pastoral care to staff, spend 1:1 time with residents who may be distressed. Co-ordinate visiting professionals to the

			home to reduce impact on people living there.
Clinical Commissioning Groups	-CHC reviews for individual's whose care is funded through CHC. -Frequency of visits is set by a Priority Criteria -2xCare home forums quarterly (1 East, 1 West). -Newsletter to providers quarterly -Clinical training sessions quarterly. -Dementia study day (1st one in 2019 – planned to be annual) -Mailshots with bitesize information approx. 3xweekly. -Enhanced Health in Care Homes Programme – Red Bag Scheme, NHS Mail, Purple Book.	-Joined up working between commissioners. -Joint monthly action plan meeting with SD&C and the provider. -Response linked to Priority Criteria. -CHC may not have assurance to continue making placements. CHC reviews may need to take place. -Joint work with ACS with services not commissioned by CCG – system approach to care quality, admission prevention etc. Joint working Memorandum of Understanding in place. -Undertaking Safeguarding enquiries.	-Joint ACS / CCG Business Continuity Plan, usually evoked by ACS when required. CCG would form part of the Tactical Management Team. -Consider Suspension of new placements. -Review CHC funded care packages -CHC may work with ACS to do joint reviews for people whose care is not funded by CHC e.g. FNC or to identify unmet health needs. -CCG Care homes team – supportive role, ensuring primary healthcare and Community healthcare services are involved. -Facilitate support to the service -In complicated situations where Acute setting are affected, Serious Incident Process may be evoked, including statutory reporting to NHSE. -Escalate to NHSE QSG

			-Serious issues escalated to CCG Exec.
Suffolk Association of Independent Care Providers			
Care Development East	-Support with sourcing Training, Information, Advice and Guidance. -Draw down funding for training - Registered Managers forum (Currently in central Suffolk, expanding to North and West Suffolk) -Responding to what the sector wants e.g. recently commissioned Mental Health First Aid training. -Action Learning Sets – funding for this has just ended, exploring ways for network to continue as self-sustaining. -Commission Business advice from MENTA -Commission 'Health checks' for care services -Support with Recruitment and Retention – 2-year recruitment programme has just	-Open and honest conversations with manager / provider -Safeguarding referral if appropriate -Share concerns with CQC -Signpost providers to support	-Previously commissioned to provide Red to Green scheme, looking at training needs and fast-tracking access to training. -Honest conversations with providers – reflect on issues to support them to recognise issues and signpost them to support.

	ended, which included recruitment audits. Ambassador, Apprenticeships and Careers advice continue.		

It was noted that local knowledge and oversight of the Care Market in Suffolk allows emerging concerns to be identified, timely support offered, and risks mitigated.
Multi -agency learning events are held after BC plans have been concluded – these have helped shape the Business Continuity plan.

Appendix 3

ASK THE VARIOUS PROFESSIONALS TO CHECK THEIR PART-

Roles and responsibilities and suggested responses to the level of harm

	Dealt with via commissioning / complaints procedures	**Must be dealt with via safeguarding adults' procedures – safeguarding adults' referral must be made or accepted. All roles should consider notifying the Police if it is felt a crime has or may have been committed.**	
	Poor practice/low level harm	**Significant harm**	**Critical/serious harm**
MASH Adult Team	• Record information against organisation on LAS as appropriate. • MASH Liaise with health and/or social care commissioners as appropriate	• Record information against organisation on LAS • Decision making with partners regarding whether statutory criteria for a safeguarding enquiry is met	• Record information against organisation on LAS. • Decision making with partners regarding whether statutory criteria for a safeguarding enquiry is met
Central Safeguarding Team	• Support with advice and guidance regarding safeguarding matters and risk assessment	• Co-ordinate Safeguarding Meeting • Commissioning staff to be invited to safeguarding adults meeting – specify if attendance important. • If suspension needs to be considered by Commissioning reflect this in organisational Plan/ discuss in strategy meeting. • Invite CQC Inspector – specify if CQC protocol* is met for attendance. • Confirm any out of area placements and notify and engage as appropriate.	• Co-ordinate Safeguarding Meeting • Commissioner invited to safeguarding adults meeting. Escalate if apologies sent. • CQC Inspector to be invited to Safeguarding Meeting. Escalate if apologies sent. • Confirm any out of area placements and notify and engage as appropriate. • Lead and co-ordinate organisational abuse enquiries • Liaise with customer/relative/ representatives

Placing Authority (where different to Host Authority)	• Record information against organisation on electronic system as appropriate. • Liaise and engage with commissioning as appropriate.	• Attend safeguarding adults meeting. • Consider review of adults placed in establishment. • Contribute to safeguarding adults plan as appropriate.	• Consider review of adults placed in establishment. • Consider whether previous, current, new adults need to be informed of safeguarding adults concerns.
Commissioning action (health or social care)	• Record information against organisation on LAS organisational module	• Provide information or attend safeguarding adults meeting. • Contribute to safeguarding adults plan as appropriate. • Commissioning action as appropriate. This can include suspension and decommissioning of services. • Notify out of area, health, and/or social care commissioning teams/bodies (e.g. Quality Surveillance Group) as appropriate. • Carry out unannounced spot check of service if appropriate.	• Attend safeguarding adults' meetings. • Consider suspension or closure. • Consider whether decommissioning process is to be instigated, or application of any other action in the event of a contract default. • Notify out of area, health, and/or social care commissioning teams/bodies (e.g. Quality Surveillance Group) as appropriate. • Consider what communication (if any) needs to be sent to care managers.

	Dealt with via commissioning / complaints procedures	**Must be dealt with via safeguarding adults' procedures – safeguarding adults' referral must be made or accepted. All roles should consider notifying the Police if it is felt a crime has or may have been committed.**	
	Poor practice/low level harm	**Significant harm**	**Critical/serious harm**
Care Management action (e.g. Social Workers, Continuing Health Care)	• Record information about any named individuals on LAS. • Forward a copy of the initial enquiry form to commissioning. • If report was given over the phone by an individual social worker, e-mail commissioning with name, LAS number and brief outline of issue. • Option to record information on Safeguarding alert but should not progress due to not meeting threshold of Sec 44.	• Attend safeguarding adults meeting. • Consider review of adults placed in establishment. • Contribute to safeguarding adults plan as appropriate.	• Attend safeguarding adults meeting. • Consider review of adults placed in establishment. • Consider whether previous, current, new service adults need to be informed of safeguarding adults concerns.

Care Quality Commission (or other regulatory body) action	• Regulatory action as appropriate. • Liaise with commissioning and safeguarding as appropriate.	• Inspector to attend if CQC protocol[5] threshold met. • Contribute to safeguarding adults plan as appropriate. • Regulatory action as appropriate. • If no attendance, information to be provided to chair before safeguarding adults meeting and throughout safeguarding adults' enquiry.	• Inspector must attend safeguarding adults' meetings (consider escalation to senior manager at CQC). • Regulatory action as appropriate. • Consider requesting voluntary suspension or formal suspension (will safeguard future out of area and private placements).

[5] CQC Inspector will attend safeguarding adults meeting if: a person or people registered with CQC to provide services are directly implicated; urgent or complex regulatory action is indicated; any form of enforcement action has started, or is under consideration, in relation to the service or location involved and which relates to risks to people using the service or their quality of their care.

	Dealt with via commissioning / complaints procedures	Must be dealt with via safeguarding adults' procedures – safeguarding adults' referral must be made or accepted. All roles should consider notifying the Police if it is felt a crime has or may have been committed.	
	Poor practice/low level harm	**Significant harm**	**Critical/serious harm**
Complaints action	• Record information against organisation on LAS (or equivalent) as appropriate. • Liaise with commissioning as appropriate. • Undertake complaints investigation. Escalate into safeguarding adults procedures if required.	**If case is also open as a complaint:** • Provide information or attend safeguarding adults meeting. • Continue to manage complaints process. • Update Chair of Safeguarding meeting with any developments in complaints process, including outcome of complaints investigation.	**If case is also open as a complaint:** • Complaints to attend safeguarding adults' meetings. • Continue to manage complaints process. • Update Chair of Safeguarding meeting with any developments in complaints process, including outcome of complaints investigation.
Provider action (independent sector, community and voluntary sector and NHS)	• Report in any concerns via the adults' initial enquiry form available on the Suffolk Council website. • Review and manage any risks to adults. • Liaise with commissioners and regulators as appropriate. • Manage complaint process if applicable. • Follow any clinical governance procedures.	• Manager[6] of service to attend safeguarding meeting(s). • Undertake investigation and contribute to safeguarding adults plan as required. • Provide information about adults within the service concerned. • Review and manage any immediate risks to adults, including taking disciplinary action against staff who have abused or neglected people in their care (e.g. may involve suspension without prejudice of staff/volunteers involved). • Notify commissioners and regulator as appropriate.	• Senior manager[1] to attend safeguarding meeting(s). • Undertake investigation and contribute to safeguarding adults plan as required. • Provide information about adults within the service concerned. • Review and manage any immediate risks to adults including taking disciplinary action against staff who have abused or neglected people in their care ((e.g. may involve suspension without prejudice of staff/volunteers involved or placing voluntary

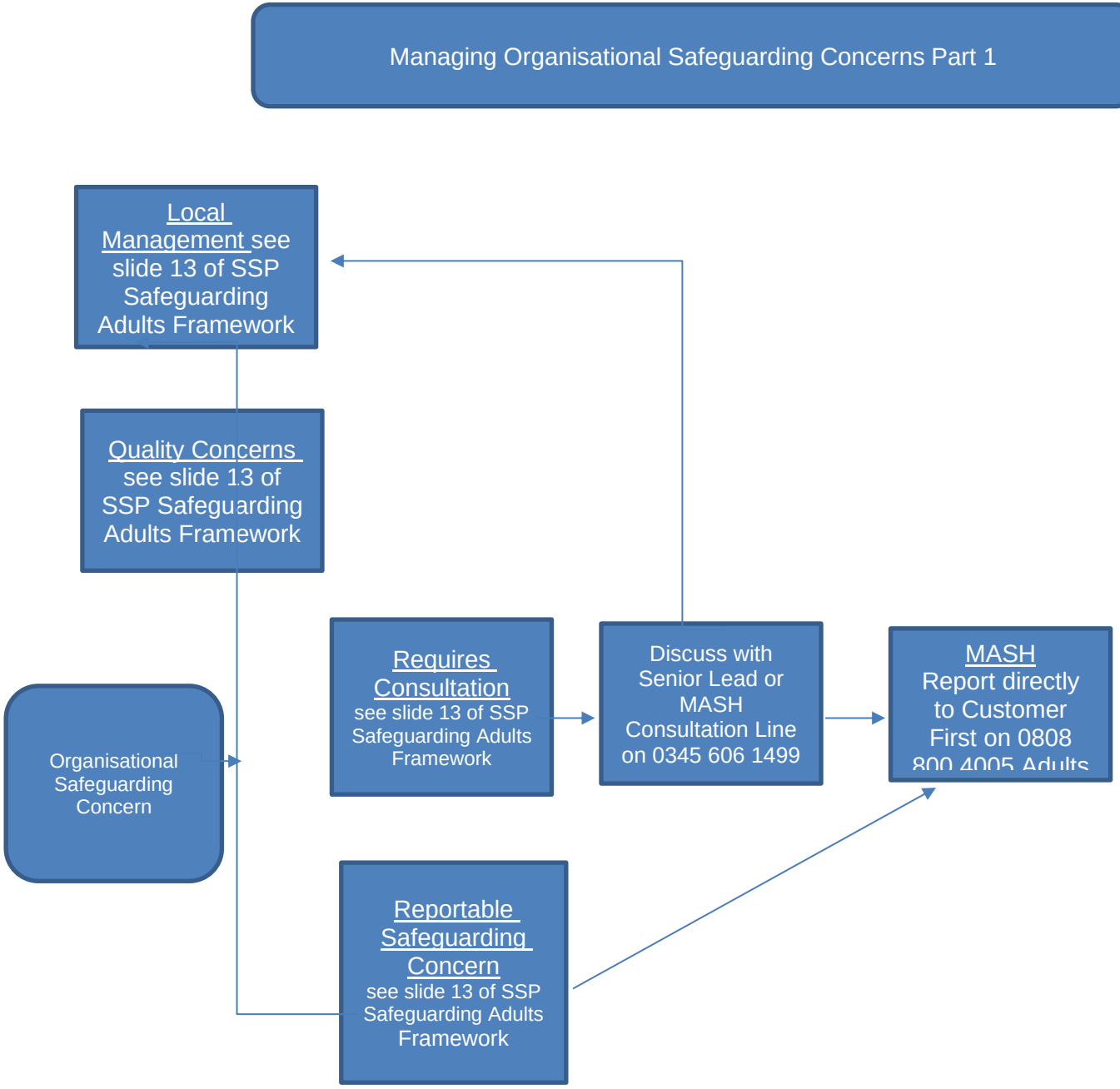
			suspension on admissions). • Notify commissioners and regulator as appropriate.
	Dealt with via commissioning /	**Must be dealt with via safeguarding adults' procedures – safeguarding adults' referral must be made or**	

[6] Where the representative is directly implicated (or attendance may prejudice the planning of an organisational abuse enquiry) it may not be appropriate for them to present at the initial safeguarding meeting. It may also be necessary to hold subsequent safeguarding enquiry meeting without the Service Provider if a directive to do so has been received from Police or Care Quality Commission. In these circumstances it must be decided how the service provider will be informed, how they will be communicated with, from what stage and by whom. It is vital at the initial safeguarding meeting that a member from the local authority is named at the liaison officer ensuring the service provider's involvement is continuous throughout the process.

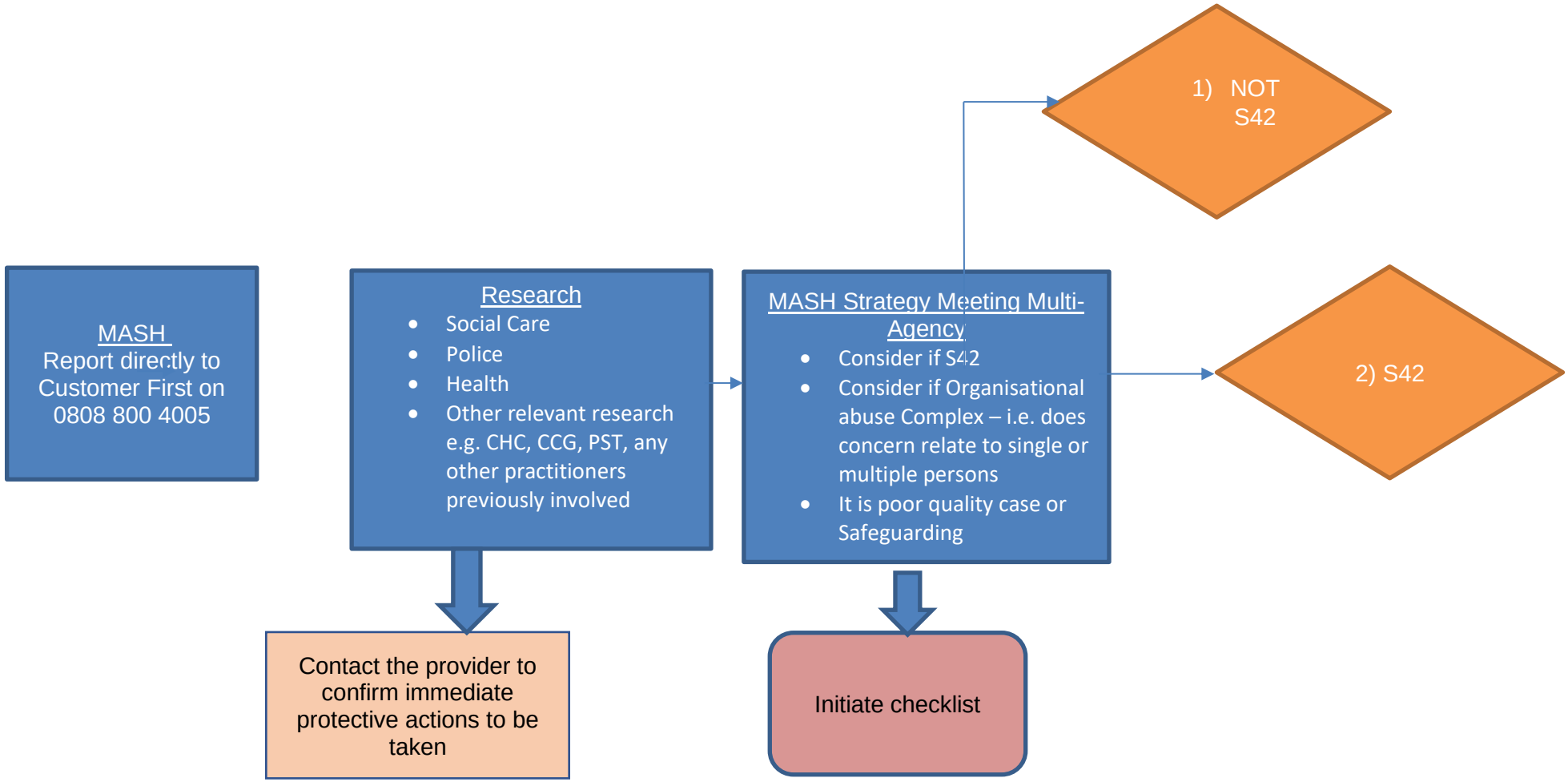
	complaints procedures	**accepted. All roles should consider notifying the Police if it is felt a crime has or may have been committed.**	
	Poor practice/low level harm	**Significant harm**	**Critical/serious harm**
Police action	• MASH Police to assess Concern in partnership with Health and Local Authority as low level - can be sent to Local Authority to manage as unlikely to progress in safeguarding adults' procedures because it is low level harm.	• Provide any relevant information to or attend safeguarding meeting. • Consider whether any of allegations could be pursued as crimes and investigate as appropriate. (e.g. Section 44 wilful neglect/ill treatment, corporate manslaughter). Criminal investigations will take priority over other enquires. The Police and partner agencies will discuss the coordination of how and when other agency enquires are conducted to ensure the police investigation is not compromised and there is no unnecessary delay in commencing the safeguarding enquiries.	• Police to attend safeguarding meeting if required. • Consider whether any of allegations could be pursued as crimes and investigate as appropriate. (e.g. Section 44 wilful neglect/ill treatment, corporate manslaughter). Criminal investigations will take priority over other enquires. The Police and partner agencies discuss the coordination of how and when other agency enquires are conducted to ensure the police investigation is not compromised and there is no unnecessary delay in commencing the safeguarding enquiries.
CCG action	• MASH Health to assess concern in partnership with Police and Local Authority. • Log via their usual procedures and inform CCG Care Quality Team	• Attend safeguarding meetings • Contribute to the protection plan. • Contribute to the investigation/ monitoring of progress where required.	• Attend safeguarding meetings • Contribute to the protection plan. • Contribute to the investigation/ monitoring of progress where required. • Contribute to decision making around suspension/ voluntary suspension. • Escalate to management where required about decisions around nursing placements.

Healthwatch action	• Liaise with individual service and/or regulator as appropriate with concerns. • Signpost people to raise complaints with individual service/regulator/ ombudsman.	• Provide information for or attend safeguarding meeting. • Escalate concerns to Healthwatch England, CQC or NHS England as procedures require.	• Provide information for or attend safeguarding meeting. • Escalate concerns to Healthwatch England, CQC or NHS England as procedures require.

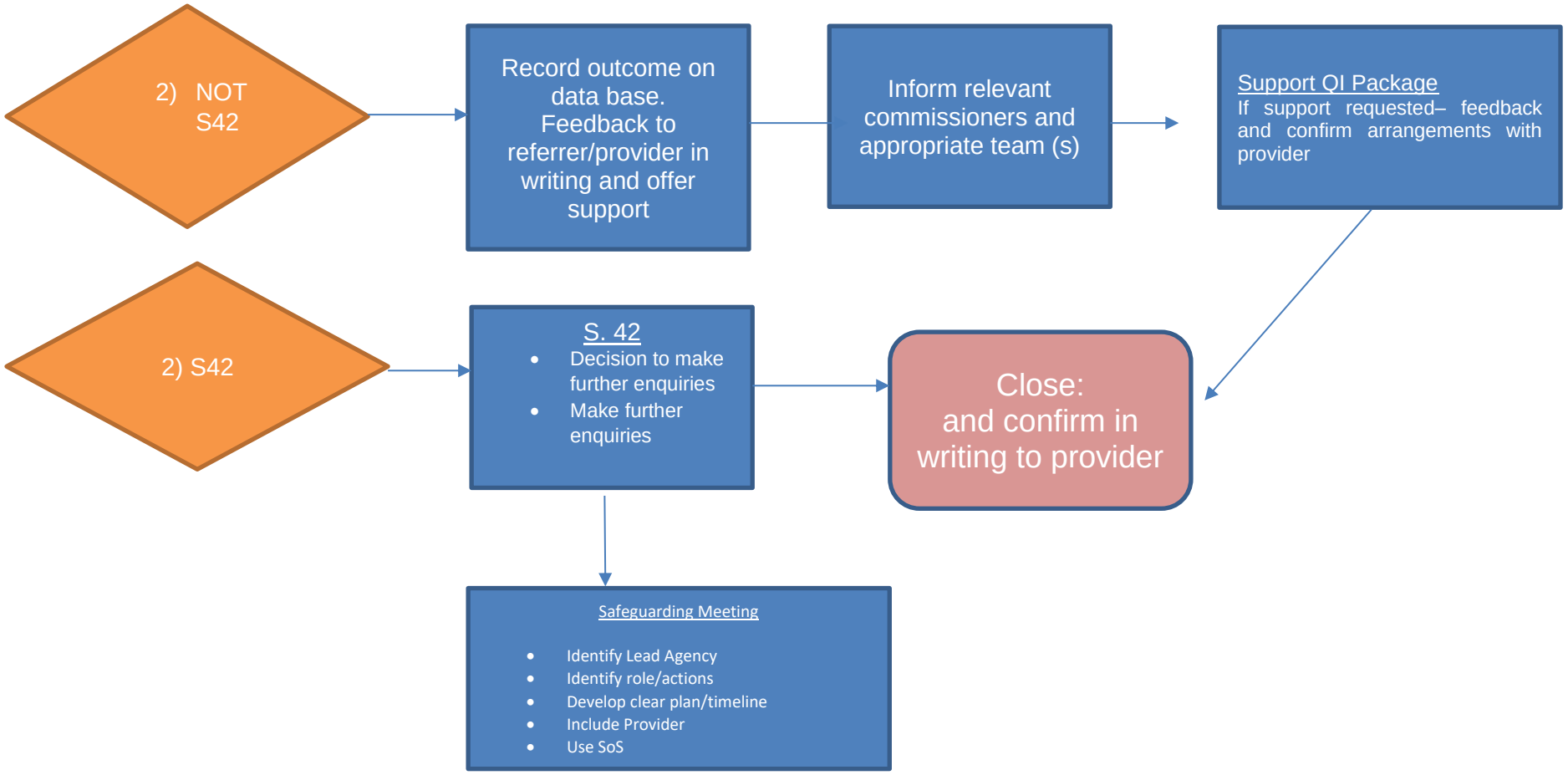
1.


Managing Organisational Safeguarding Concerns Part 1
Local Management see slide 13 of SSP Safeguarding Adults Framework
Quality Concerns see slide 13 of SSP Safeguarding Adults Framework
Organisational Safeguarding Concern
Requires Consultation see slide 13 of SSP Safeguarding Adults Framework
Discuss with Senior Lead or MASH Consultation Line on 0345 606 1499
MASH Report directly to Customer First on 0808
Reportable Safeguarding Concern see slide 13 of SSP Safeguarding Adults Framework

Managing Organisational Safeguarding Concerns Part 2



Managing Organisational Safeguarding Concerns Part 3



Managing Organisational Safeguarding Concerns Part 4