North Somerset Safeguarding Adults

Organisational Abuse Protocol

This is an approved North Somerset Safeguarding Adult Board document and should not be edited in any way

Reference Number: NSSAB001.1
Target Audience: Multi-agency
Sources of advice in relation to this document: Care and Support Statutory Guidance March 2016
Replaces if appropriate: North Somerset Organisational Abuse Protocol NSSAB001
Type of Document: Protocol
Approved by: NSSAB
Date: June 2017
Date displayed on NSSB web site: Sept 2017
Date due to be reviewed by responsible person or body: June 2018

1. Purpose

These guidelines are to supplement the Multi Agency Policy (joint with Bath and North East Somerset, Bristol, North Somerset and Somerset) and the North Somerset Multi agency procedures. The Care Act 2014 introduced the concept of 'organisational abuse'. As such concerns around a 'whole service' are now referred to as 'organisational abuse concerns'.

These procedures outline the multi-agency response when concerns are raised about an organisation, examples of when they can apply are:

- A safeguarding concern about an individual has been received and the investigation gives rise to concerns that other adults may have been abused or be at risk of abuse in a regulated or commissioned care/support/health setting, such as care homes including nursing homes, domiciliary care services, 'Supported Living' settings (including 'floating support'), hospitals and other health settings. This may also apply where support is being provided from an unregulated service to a number of people.
- A whistleblowing referral has been made giving rise to safeguarding concerns
- A number of concerns about a provider, have been reported via the monitoring system set up by the Organisational safeguarding team and/or via the service monitoring system set up by the Local Authority Commissioning and Contracts and Compliance Team or the commissioning Clinical Commissioning Group (CCG).
- An alert has been triggered by the local intelligence and information group (made up of the local Council, CQC and Clinical Commissioning Group).
- A CQC inspection identifies significant concerns
- Partner agencies may report concerns about a service e.g. through reviews by CHC, or one of the specialist health teams offering support to care homes.

This guidance should be read in conjunction with the North Somerset Safeguarding Adults Policy and Procedures.

2. Definition

Key definitions can be found in the policy document and come from the Care Act 2014 and its statutory guidance. The Care Act 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. Repeated

instances of poor care may be an indication of more serious problems and this can constitute organisational abuse (Appendix 1).

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

3. Triggers that may support identifying Organisational Abuse

There is a need for assessment and judgement in determining when poor practice becomes an adult safeguarding issue. Addressing Four Key Questions will support the decision to initiate an organisational abuse investigation:

1. Is the incident of a **type** to indicate organisational abuse?
2. Is the incident of a **nature** to indicate organisational abuse?
3. Is the incident of a **degree** to indicate organisational abuse?
4. Relating to these 3 questions, is there a **pattern and prevalence** of concerns about the organisation?

Indicators of Organisational Abuse - Signs and Symptoms

The following are examples only.

3.1. The **Type** of Incident

- Inappropriate or poor care
- Restricted access to required health or social care services
- Misuse or inappropriate use of medication
- Neglect of service user(s)
- Absent or inadequate policies and procedures
- Misuse of restraint or inappropriate restraint methods
- Unauthorised Deprivation of Liberty
- Non-adherence to the Mental Capacity Act
- Sensory deprivation - denial of spectacles, hearing aids
- Restricted mobility – denial of access to mobility aids
- Restricted access to toilet/bathing facilities
- High number of complaints, accidents or incidents

- Care regime exhibits lack of choice, flexibility and control
- Care regime impersonal and lacks respect for dignity
- Lack of personal clothing and possessions
- Denial of visitors or phone calls

3.2. The **Nature** of the Incident

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

3.3. The **Degree** evidenced by the Incident

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

3.4. The **Pattern and Prevalence** of Incidents

- Are the same incidents reported over time
- Is there a frequency of concerns (which may encompass previous safeguarding alerts, complaints, whistleblowing, CQC inspection outcomes, contract monitoring reports etc)

In summary, common themes in organisational abuse are:

- a history of concerns that may not have been previously connected to a wider view of the care service/setting
- poor standards of care
- rigid routines
- inadequate staffing
- poor supervision and training of staff
- poor recording in care plans, incident logs

- culture and behaviours suggesting a lack of transparency and openness
- a failure to learn from previous incidents.

4. Indicators for Large Scale Enquiries

At the point of contact/referral, and throughout the course of an individual Safeguarding enquiry, all managers overseeing safeguarding enquiries will need to consider whether the alleged abuse indicates that there could be a risk to other adults at risk. This may arise for example when:

- The abuse has taken place as a result of a poorly managed service.
- The alleged perpetrator is a care worker (or group of care workers) and has contact with a number of vulnerable people.
- The alleged perpetrator is a service user who shares living arrangements or services with other vulnerable people.
- There is a history of concerns about the service

5. Responding to a trigger

Where organisation abuse triggers have been raised the Adult Safeguarding Manager will arrange a review of the concerns and 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/institutions owned by the provider)
- CQC – previous and current status of the institution/provider
- Contracts and compliance team – previous or current evidence of non-compliance
- Health Comissioners' Feedback – history of concerns/complaints (and positive feedback)
- Police – past or current concerns
- NHS – Health Professionals who may visit e.g., GPs, district nursing, dieticians, ambulance services, etc. . Enquiries may include the history and pattern of referrals to secondary care of emergency department attendances.
- Practitioner views – any concerns arising from reviews etc.

The review and evaluation process may be a 'desktop exercise'; a formal strategy discussion or strategy meeting at the discretion of the Safeguarding Manager/Lead Manager and proportionate to the Trigger issues raised.

The review outcome and how it has been determined must be recorded including, where safeguarding is not to proceed, how issues arising are to be followed up e.g. by a safeguarding visit to the provider; by Contracts and Complaince, through the individual enquiries, by a visit from another service e.g. CQC, Community Health Services, Clinical Commissioning Group. All follow-up actions should be recorded for the Trigger response.

Where individuals in the care of the service under review are commissioned as an out of area placement, commissioners must be advised of the outcome and any recommendations of the review e.g. review of placement, review of care plan etc, should be communicated formally in writing.

5.1. Risk assessment

If there is an organisational abuse concern a risk assessment should be completed to consider the risks (the impact the circumstances under consideration) will have on the people using the service.

The risk assessment should look at:

The **likelihood** of harm / abuse and the **impact** on people using the service.

(Appendix 2 details the risk assessment criteria)

5.2. Examples of risk assessment

5.2.1. MINOR – people are generally safe but, for example;

Shortfalls in quality of provision mean that outcomes may not be achieved and that they are potentially at risk if service provision deteriorates further

5.2.2. MODERATE

People remain generally safe but there are specific risks to health and wellbeing.

For example:

- There is inconsistency in care given and the services ability to meet complex needs is questionable.
- Appropriate policies and procedures are in place and known to most staff but they are not consistently applied to ensure the prevention of abuse
- Most staff have received training but it is not up to date, comprehensive or reliably put into practice
- Concerns about financial mismanagement

5.2.3. MAJOR

The number and / or seriousness of the concern(s) indicate that people are not protected against unsafe or inappropriate care.

For example:

- An absence of staff training and / or knowledge of appropriate policy and procedure.
- Managerial failure to investigate concerns indicate that processes and actions that would serve to prevent abuse are not embedded with the provider / service
- Non-compliance with both CQC and contract compliance with evidence that people using the service face a high likelihood of harm

Evidence of financial mismanagement, particularly involving service user's finances and affecting multiple individuals

5.2.4. PRESISTING MAJOR

- Despite intervention this provider persistently fails to improve, or improvements are not sustained leading to persisting serious concerns.
- Includes persistent non-compliance with contract compliance and CQC requirements with evidence that people using the service have come to harm
- Resultant loss of confidence in the provider and their ability to keep people using their service safe
- Evidence of financial mismanagement (particularly of service user's finances) and a lack of engagement from the service in addressing the issue

6. Responses

According to the outcome of the risk assessment, the response will be as follows:

Level of concern		
Minor	**Example circumstances**	
	Provider has a history of recent difficulties (poor care / complaints) An individual safeguarding alert may indicate a wider concern around care provision within the service Whilst unlikely, there would be a medium impact on people if concerns applied widely across the service The manager is complacent / not proactive in identifying issues and working to ensure preventions	
	Safeguarding action:	An individual safeguarding meeting consider partners: health commissioners and providers, CQC, Outcomes and action plan may lead to organisational safeguarding abuse meeting being called or provide evidence to be incorporated into organisational safeguarding meeting Communicate outcomes of individual enquiries to contract compliance team
	Contracts action:	Discuss outcomes with safeguarding team and review risk level
Moderate	**Example circumstances**	
	A number of safeguarding alerts Low impact service shortfalls are almost certainly taking place and medium impact shortfalls are possible There is a failure at a systems level to deliver service users outcomes across a range of needs The manager is failing to identify and act on the above	

	Safeguarding action:	Organisational safeguarding meeting held and followed up Improvement plan required from the Service A lead worker will be established Safeguarding plan developed at safeguarding meeting and distributed to stakeholders within 48 hours
	Contracts action:	Contract Compliance visit prior to the Safeguarding meeting and subsequent follow ups Place with Caution status Inform other commissioners

Major	**Example circumstances**	
	Abuse / neglect is evident safeguarding Team/ Commissioners lack confidence in managers to deliver appropriate care and prevent abuse	
	Safeguarding action:	Organisational safeguarding meeting held and follow up Improvement plan required from the organisation A lead worker will be established Safeguarding plan developed at safeguarding meeting and distributed to stakeholders within 48 hours Consider request for review of all users of the service
	Contracts action:	Suspension of new placements Contract Compliance visit prior to the meeting and subsequently Inform other commissioners
Persisting Major	**Example circumstances**	
	Loss of confidence in the organisation Series of action plans relating to safeguarding concerns over a period of time but improvements not sustained Service users are at constant risk Persistent non-compliance with contractual and CQC requirements with evidence that people using the service have come to harm	
	Safeguarding action:	Organisational safeguarding meetings at 4 – 6 week intervals Meetings attended by seniors form the organisation Improvement Plan required from the organisation Safeguarding plan developed at safeguarding meeting and distributed to stakeholders within 48 hours

		A lead worker will be established Request reviews of all users of the service
	Contracts action:	Suspension of new placements Agreed review of all service users Compliance visits made at frequent intervals Inform other commissioners

7. Partnership Working: Key Points

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

As the "host" authority North Somerset Council will lead and co-ordinate large scale investigations within North Somerset, but multi-agency knowledge, skills and information sharing are essential for best practice, sound decision making and securing positive investigation outcomes for service users.

When an investigation involves a number of 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 investigations.

A large scale investigation may require a series of individual safeguarding adult investigations to address allegations of abuse specific to each individual. Under The Care Act 2014, the Local Authority has lead responsibility for adult safeguarding issues however it can delegate responsibility for enquiries to appropriate agencies. In carrying out this responsibility the Chair will co-ordinate the overall investigation and ensure that all relevant agencies are involved.

7.1. Who Leads?

The Safeguarding Adults Manager or delegated professional will coordinate all large scale safeguarding investigations including the chairing of all strategy meetings. Exceptionally if this is not possible or the concerns are of a very severe type the Safeguarding Adults Manager will consult and agreement reached about an appropriate chair.

Each participating organisation will nominate a lead to support the investigation. These will need to be confirmed for each individual enquiry/investigation. If the police are involved the Adults Safeguarding Manager will liaise carefully to

ensure the balance between preserving evidence and enabling the police to pursue their investigation and ensuring that all residents are safe within the setting is ensured.

7.2. Complex adult safeguarding enquiries with multiple service users/victims

A safeguarding assessment should be completed for all service users who may have been subject to, or at risk from, the alleged abuse. Where this assessment shows evidence of actual abuse, an individual safeguarding concern must be raised.

- CQC - Must be informed of any concerns relating to a regulated service.
- Commissioning & Contracts - must be informed of safeguarding
- concerns relating to any provider operating in North Somerset, irrespective of whether services are commissioned.
- Health - where services are commissioned by the Clinical Commissioning Group, NHSE 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.
- Where placements are commissioned by another commissioning body for example, another local authority, they should be notified of the referral and involved throughout. While the council retains the lead safeguarding role for all safeguarding alerts, placing commissioning bodies retain a duty of care towards the service user and should be expected to fulfil this role in co-operation with the safeguarding investigation.

7.3. Role of the service provider

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 themselves to actively make enquiries. This will need to be decided in each situation. It will be important to understand the service provider's own mechanisms for example, disciplinary procedures, and how any intention to deploy these relates to the safeguarding concern and aligns to the safeguarding plan. It is key that the service provider take responsibility for the abuse and the impact of it. Where their internal

procedures are likely to have set/allowed a culture where abuse can take place it is essential that this become part of the investigation.

It is essential that where providers are undertaking enquiries arrangements for what these should cover, timescales and how they will be fed back are clear. Where these are not adhered to consideration must be given to how to escalate the concerns to ensure they are managed.

8. Organisational Abuse Safeguarding Meetings

A collaborative multi agency approach applies to the organisational abuse safeguarding response.

An organisational safeguarding meeting should be convened within 7 working days of the risk assessment being carried out.

8.1. Who should attend

The following people must attend an organisational abuse meeting:

- Head of contracts and commissioning as Chair (unless otherwise delegated by them)
- Safeguarding Adults Manager or Senior Safeguarding Adults Officer
- Health Commissioner (if commissioning placements)
- Safeguarding Lead - CCG
- Safeguarding Lead North Somerset Community Partnership (if relevant)
- Contracts & Commissioning Team – Contracts Manager
- CQC views should be represented

The following should be invited to attend:

- The Police
- Representatives from other Placing Authorities
- Any professional whose involvement is central to the concerns
- CQC inspector

Consideration may be needed about invitations to:

- Legal representative depending on the nature of the concerns
- HR representative depending on the nature of the concerns

Circumstances may dictate that it is not appropriate to involve all agencies at all times. For example CQC may not wish to be part of full safeguarding meetings in order to maintain boundaries around their role.

8.2. Involving the Service Provider

Frank information sharing may also be required without the presence of the provider. A 'pre-meeting' without provider presence should be considered on every occasion.

The involvement of the Provider is important to ensure an immediate safeguarding plan can be agreed however it may be necessary to hold an initial meeting without them if:

- The services' staff and managers are under investigation
- There is a possibility that the provider may tamper with evidence, or;
- Specific advice is given by the Police or CQC.

8.3. The meeting

A standard agenda format is attached at Appendix 3 below. It is recommended that this is individualised and distributed prior to any organisational abuse meeting in order to capture the specifics of each case.

8.4. Communication and monitoring

Care and support statutory guidance states:
(14.18) … *Professionals and others should look beyond single incidents or individuals to identify patterns of harm, just as the CCG, [sic] as the regulator of service quality, does when it looks at the quality of care in health and care services. Repeated instances of poor care may be an indication of more serious problems and of what we now describe as organisational abuse. In order to see these patterns it is important that information is recorded and appropriately shared.*

Formal monitoring and information sharing procedures are in place:

Meeting	**Purpose**	**Frequency**	**Cohort**
Bi-monthly provider monitoring meeting	Analysis of care provider data to feed into CQC liaison meeting	Bi-Monthly	Business intelligence data analyst Safeguarding adults manager

Meeting	Purpose	Frequency	Cohort
	Feeds into areas of focus for contract compliance		
Quality Surveillance Group	Sharing high level information across a wide regional area	Monthly	Senior representatives of health and social care partners from across the BNSSG area
CQC Liaison meetings	Tracks activity around providers from a broad range of partner agencies	Bi-monthly	Police CQC CCG NSCP Safeguarding NS Contracts and commissioning Brokerage Ambulance Trust
Safeguarding/ contracts meeting	Share information around services of concern locally	Monthly	Safeguarding adults team Contract compliance team Contracts & Commissioning team

The contracts and commissioning team are co-located with the safeguarding team which enables day to day case by case discussions among these essential partners.

Safeguarding Adults Team

Safeguarding Adults Manager	01275 88 5257
Senior Safeguarding Adults Officer	01275 88 5293
Senior Safeguarding Adults Officer	01275 88 5284

Contracts and Commissioning Teams

Role/Specialism	Contact
Service Leader Contracts and Commissioning	01934 427611
Contracts and Commissioning Manager	
Contract Compliance Manager x 1	
ICES Partnership Manager	
Contracts and Commissioning Officers x 4	
Contract compliance officers x 4	

9. Organisational Abuse: Safeguarding Closure

Where organisational abuse has been investigated and progressed to multi agency meetings it is important that the decision to close the safeguarding is agreed by the 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;
- victims/involved service users have received feedback
- any necessary notifications to regulatory bodies e.g. Disclosure and Barring Agency, Nursing and Midwifery Council, have been undertaken
- any remaining concerns can and will be managed through contract monitoring, care management processes etc.

All placing commissioning bodies and CQC should be notified of the safeguarding closure once confirmed.

Appendix 1 – Escalating responses to safeguarding concerns

Care and Support Statutory Guidance March 2016: (14.17) **Organisational abuse;**
"… neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation."

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

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

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

Allegations which may not carry a duty to enquire under S.42 of the Care Act 2014	Allegations which will pass carry a S.42 Duty to enquire	Organisational abuse?
Person has been formally assessed under the Mental Capacity Act and lacks capacity to recognise danger e.g. from traffic.	Restraint/possible deprivation of liberty is occurring (e.g. cot sides, locked doors, medication)	
Steps taken to protect them are not 'least restrictive'. Steps need to be reviewed and referral for Deprivation of Liberty Safeguards may be required. Monitor via DoLs team	and person has not been referred for a Deprivation of Liberty Safeguard assessment although this had been recommended. Best interest has been ignored or presumed.	Evidence of restrictive practices or silo working and decision making across an organisation.
Person is spoken to once in a rude, insulting and belittling or other inappropriate way by a member of staff. Respect for them and their dignity is not maintained but they are not distressed. The matter is identified by the care provider and appropriate actions are taken to address the practice.	Recurring event. Insults contain discriminatory, e.g. racist, homophobic abuse. Individual(s) experience harm[1]	If this practice is evident throughout the care service/hospital/care agency, and not just being perpetrated by one member of staff, this will pass the threshold for organisational safeguarding enquiry.
Person is discharged from hospital without adequate discharge planning, procedures not followed but no harm occurs.	Person is discharged with significantly inadequate discharge planning, procedures not followed and experiences harm as a consequence.	If the incident shows poor discharge planning throughout a hospital trust or on a specific ward, urgent remedial action, either via safeguarding adults organisational safeguarding enquiry, or quality improvement strategies, must be considered
Person does not receive a scheduled domiciliary care visit and no other contact is made to check on their well-being, but no harm occurs.	Person does not receive scheduled domiciliary care visit(s) and no other contact is made to check on their well-being or calls are being missed to more than one adult at risk. Or harm* occurs	If this practice is evident throughout the care agency, and not just being perpetrated by one member of staff, this will pass the threshold for organisational safeguarding enquiry.
Person with challenging behaviour whose plan of care stipulates that they should not go into the local town without two staff supporting them is taken by one member of staff to avoid disappointment	Person is regularly taken out by only one member of staff, with no review of care plan, and is therefore regularly put at risk.	If this is an indicator of poor practice by several members of staff, or poor management of the setting, others may be affected, organisational safeguarding enquiry should

[1] 'Harm' may be classified as physical, emotional or psychological. The severity of which can be assessed by considering the acuity and duration of harm. It is also important to keep the service user's views at the centre of decision making; as such the adult at risk's views must also be sought to determine if harm has occurred on a case by case basis and as defined by the individual.

Allegations which may not carry a duty to enquire under S.42 of the Care Act 2014	Allegations which will pass carry a S.42 Duty to enquire	Organisational abuse?
when the other worker reports sick at the last moment. No harm occurs.		be considered.
Adult at risk in pain or otherwise in need of medical care such as dental, optical, audiology assessment, foot care or therapy does not on one occasion receive required/requested medical attention in a timely fashion.	Adult at risk is provided with an evidently inferior medical service or no service, and this is likely to be because of their disability or age or because of neglect on the part of the provider.	If there is evidence that others have also been affected, or that there is a systemic problem within the provider service organisational safeguarding enquiry must be initiated.
Housing providers Person is known to be living in housing that places them at risk from predatory neighbours or others in community and housing department/association is slow to respond to their application for urgent re- housing – but no harm occurs.	Housing provider fails to respond within a defined and appropriate timescale to address the identified risk. Harm occurs	Repeated incidences affecting multiple tenants
Housing providers A resident in a warden complex reports that s/he finds the warden overbearing and intrusive	At least one resident is intimidated and feels bullied by the warden and they are frightened to talk about why.	
Housing providers Adult at risk needs housing repairs arranged by their landlord. There is undue delay but repairs done eventually and no harm has occurred.	Landlord persists in not arranging repairs that are urgently required to maintain the safety of the person's environment. Harm occurs or evidence of serious risk of harm in multiple areas of the home.	
Incident between **two adults living in a care setting**: One adult 'taps' or slaps another adult but has left no mark or bruise and victim is not intimidated and harm has not occurred. Or One adult shouts at another in a threatening manner, victim is not intimidated and harm has not occurred.	Predictable and preventable (by staff) incident between two adults where bruising, abrasions or other injuries have been sustained and/or emotional distress caused. Harm* occurs	A significant level of aggressive incidents between adults living in care or health settings can be an indicator of poor staff attitude, training, risk assessment and risk management, or poor supervision and management of the service. Organisational safeguarding enquiry should be considered.

Appendix 2: Risk assessment criteria

***Likelihood* criteria**

UNLIKELY – this is unlikely to happen or recur due to control measures and processes in place

POSSIBLE – this may happen but is not a persistent issue

ALMOST CERTAIN – this will probably happen / recur. This could be due to a breakdown in processes or serious concerns about control measures

***Impact* criteria**

LOW – no, or unlikely, impact on people using the service

MEDIUM – moderate impact but limited provided remedial action is taken with no long term effect on people's health or well-being

HIGH – significant impact on safety of people which may have a long term effect on people's health or well being

A combination of the assessed impact and likelihood will determine the level of concern as follows:

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

Appendix 3 – Organisational Abuse Safeguarding Meeting Agenda

Organisational Safeguarding Meeting Agenda

An organisational abuse meeting will take three parts in order to ensure that the care provider is appropriately involved in discussions and also that information can be shared frankly.

Part 1 Professionals Only:

1.1 Introductions
1.2 Feedback and discussion from stakeholders
1.3 Any other business for agenda

Part 2 Main Agenda:

2.1 Introduce care provider to the meeting
2.2 General introductions
2.3 Confidentiality

2.4 Context:
- 2.4.1 Description of the service
- 2.4.2 Concerns under consideration/what has prompted the organisational abuse enquiry?

2.5 Data:
- 2.5.1 Numbers
- 2.5.2 Themes
- 2.5.3 Outcomes
- 2.5.4 Findings from **significant** individual enquiries

2.6 Evidence based feedback from stakeholders:
- 2.6.1 CQC
- 2.6.2 Feedback from contract/compliance manager NSC
- 2.6.3 Feedback from SA leads in Health
- 2.6.4 SA Leads from other commissioners

2.7 Safeguarding plan review
2.8 Review of provider's improvement plan

2.9 Review and update safeguarding action plan (Some actions may not be shared with the provider i.e. unannounced visits)

2.10 Previous meeting:
- 2.10.1 Agree minutes
- 2.10.2 Matters arising not covered above

2.11 Review communication plan for:
- 2.11.1 Alleged adults at risk
- 2.11.2 Family / relatives
- 2.11.3 Commissioners
- 2.11.4 South West Region
- 2.11.5 Other

2.12 Provider leaves
(Consideration given to how feedback from Part 3 will be given

Part 3: Confidential Conversation

3.1 Review of risks

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

3.2 Review risk of media attention and agree any necessary action

3.3 Placement status

3.4 Confidential actions

3.5 Confirm whether case can be closed or whether needs to remain open

3.6 Feedback to provider

3.7 Date of next meeting (if required)

3.8 If decision to close safeguarding organizational abuse enquiry gain consent from all and clearly document with follow up plans