Organisational Abuse Policy

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1 Introduction

1.1 Barnsley Safeguarding Adults Board (BSAB) is committed to preventing harm to adults at risk by holding partners to account and monitoring commissioned services. If harm or abuse occurs BSAB will expect all relevant partners to work collaboratively to:

- Assess the risk and mitigate these by working with the health/social care provider, commissioners, and regulators.
- Agree an enquiry plan and deliver on agreed actions.
- Consult and keep adults and their advocates/representatives informed of the progress of the enquiry.
- When necessary, decide if organisational abuse has been substantiated.
- When appropriate agree a media strategy.
- Agree when the level of risk justifies exiting safeguarding.

1.2 The Care Act (2014) is clear about the nature of this partnership and the roles and responsibilities of all who work with adults at risk, placing a statutory duty on the Local Authority, Health, and the Police.

2 Organisational Abuse criteria

2.1 Organisational abuse, including abuse/neglect and/or poor care practice within a health or social care setting or in the person's own home, may result in an organisational abuse enquiry. The organisational abuse enquiry may be commenced because of:

- Repeated incidents of poor care/neglect including medication errors, missed calls, moving and handling issues, poor management of skin integrity, denial of visits by family and friends etc.
- Absence of person-centered care resulting in loss of dignity and respect to the adults using the service.
- An inability or unwillingness to implement changes agreed with commissioners and/or regulators, especially when this has involved enforcement action by either or both commissioners and regulators.
- Several safeguarding concerns involving adults in receipt of support from the service.
- Significant harm to one or more adult in receipt of service.
- A combination of the above.

2.2 **The Care Act defines 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 as a result of the structure, policies, processes, and practices within an organisation".

(Care Act 2014 Chapter 14.17).

2.3 BSAB Definition

The methodology used by Hull university research (2012) has been adopted as it provides a clear framework to identify areas of concern and it supports decision making about the need for an organisational abuse enquiry (See Appendix 1). The domains of concern are outlined at 2.4.

2.4 The six areas of concern are:

1. Concerns about management and leadership.
2. Concerns about staff skills, knowledge, and practice.
3. Concerns about residents' behaviours and wellbeing.
4. Concerns about the service resisting the involvement of external people and isolating individuals.
5. Concerns about the way services are planned and delivered.
6. Concerns about the quality of basic care and the environment.

2.5 Evidenced Risk Summary

Concerns evidenced in more than one domain listed above will generate evidence for the need to consider an organisational abuse enquiry, however concerns centered under one domain, for example – concerns about adults' behaviour and wellbeing may require an organisational response due to the negative impact on the adults involved.

Any assessment of impact should include the impact on everyone accessing the service or on all adults with a specific need (e.g. catheter care, support with eating and drinking etc.), rather than about the impact on an individual. Evidence for likelihood of recurrence will include previous adult safeguarding concerns (in the last eighteen months), lack of improvements despite service improvement or safeguarding plans, or inability to complete previous quality assurance/CQC action plans.

It is important to differentiate between concerns that require an organisational abuse S42 enquiry, and those that require an individual S42 enquiry and when an accumulation of individual enquiries will require an organisational enquiry. The role of commissioners and regulators in addressing poor practice should be considered before commencing an organisational abuse enquiry.

2.6 Principles for an Organisational Abuse Enquiry

All Adult Safeguarding activity must follow six key principles (Care Act 2014):

1. Empowerment

People using provider services, or their representatives, must be supported to be involved in any organisational abuse enquiries. This will need to include:

- Consulting service users about their experience of the quality of the service and changes they wish to see, for themselves and the service.

- Ensuring that people are well informed of what is happening on a regular basis, according to their needs and wishes.
- Advocates are involved for those adults who will struggle to engage with the safeguarding enquiry in line with the Care Act.
- Providing information about other action the adults can take to resolve their issues. This might include complaints, legal remedies, criminal enquiries etc.

2. Prevention

Providers will work with all relevant partners to ensure that the risk of abuse or neglect in their service is minimised, including compliance with both CQC standards and any contractual requirements. It is expected that all health and social care services will be well managed and well led, freely use the expertise of other professionals, keep staff well trained and supported and continually promote person centered good quality care. These actions will all contribute to minimising the possibility of organisational abuse.

Adults receiving support/care from providers should be aware of what they can expect in relation to their care and treatment and how they can raise concerns if these are not being met.

3. Proportionality

Responses must be proportionate to the level of, or risk of, harm evidenced by collating information from all sources. Support must be provided to adults and their families who use the service to contribute to the assessment of risk and harm.

4. Protection

Adults and their advocates should be empowered to speak up and report harm and abuse and receive a timely response from the health/social care provider. If this is not possible or providers do not respond appropriately, all partners will work together to ensure that adults at risk using provided services have their rights upheld and have access to the full range of supportive and protective measures needed to safeguard their wellbeing.

5. **Partnership**

Providers should always be informed of allegations against them or their staff and be treated with courtesy and openness (unless this would prejudice a criminal enquiry).

All allegations must be responded to in a timely and sensitive way to stop further abuse and neglect and to agree a transparent process for all involved.

Providers are a crucial part of any enquiry into organisational abuse, as they will have responsibilities under employment law and will be able to drive forward the necessary changes to improve the quality of the care.

Support a process of learning and improvement in practice by partnership working.

If a provider is unable to participate, for example because a corporate criminal issue is alleged, exploration of the role of the wider organisation in the enquiry may need to be agreed.

6. **Accountability**

The progress of the enquiry should be shared as openly and fully as possible with:

- The adults and or their advocates/families (including access to anonymised minutes etc.).
- The provider.
- Partners contributing to the enquiry.
- Commissioners.
- Regulators.

If information cannot be shared in full, the reasons for this need to clearly documented.

3 Organisational Abuse Enquiry

3.1 Purpose of the enquiry:

- To secure the safety of adults as soon as possible and reduce the risk of further harm by introduction of individual or organisational protection plans.
- Establish facts and assess the risks to determine if an organisation enquiry is required? If so, this will take priority and individual safeguarding enquiries will follow the conclusion of the organisational abuse enquiry if requested by the adult or their advocate. If the threshold for an organisational abuse enquiry is not met, individual safeguarding enquiries (Section 42 Enquiries) may be required to deliver the adults outcomes and reduce the risks of further harm. These S42 enquiries may be accompanied by action by commissioning and or regulators to improve the quality of the service. (possible exit point from organisational abuse enquiry – does not meet the threshold)
- Obtain the adult’s views and wishes directly or via an advocate or Independent Mental Capacity Advocate (IMCA.) Consider an advocate if the adult has capacity but will have difficulty engaging with the enquiry.
- Assess the adult(s) need for support and protection and decide how these might be met.
- Implement a protection plan to reduce the risk of further harm or abuse, in accordance with the wishes of the adult or best interest decision compliant with the Mental Capacity Act (MCA.)

- Agree an action plan to address areas of concern with the provider.
- Agree roles and responsibilities of each organisation for the enquiry, with timescales.
- Appoint a lead coordinator from Adult Social Care.
- Identify communication channels to senior managers if not involved in the meeting.
- Agree a communication strategy to update adults, families, advocates and if necessary, the media.
- Consider suspension of placements or arrangement of alternative provision to address risks.
- Share the findings of enquiries with the provider, adults, and their advocates/families.
- Ensure that any disciplinary action results in referral to appropriate bodies – e.g. DBS, professional registration, regulators etc.
- Decide if organisational abuse has been substantiated and if substantiated what actions must be completed before safeguarding will be exited.
- make decisions as to what follow-up action, if any, should be taken with respect to the person or organisation responsible for the abuse or neglect.
- Agree how commissioners and regulators will monitor quality and what will require consideration of further safeguarding enquiries on either an individual or organisational basis.

Flow chart- Organisational Abuse

STAGE 1 -CONCERNS

Safeguarding and /or commissioning concerns indicate the need to consider a safeguarding response. Protection plans put in place to reduce risk of further ham. Owner – ASC

STAGE 2 – DATA COLLECTION

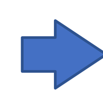
Data collated in line with the 6 domains of concern, in the policy, from all relevant sources.

Owner ASC, Regulators and Adult Joint Commissioning

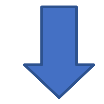
STAGE 3 – DECISION MAKING

Decision by ASC Service Director – organisational abuse, contract management, individual safeguarding. Protection planning in response to risks including need for embargo or review of placements.

Owner - ASC



Not organisational safeguarding. Record decision and agreed actions. Exit



Organisational abuse enquiry to commence.

STAGE 4 PLANNING/RISK MANAGEMENT

Identification of an enquiry coordinator (team manager or head of service?), risk management plan agreed and implemented, planning meeting set up, to be held within 5 working days of decision to commence organisational abuse enquiry. (see section 3 for roles and responsibilities)

Are any **individual** S42 enquiries required will these be complete AFTER or alongside the organisational abuse enquiry?

Communication plan to be agreed.

Share anonymised minutes with adults and/or their representative/advocate.

Owner – ASC and relevant partners (Police, Regulatiors, Commissioning, Health etc.)

STAGE 5 – REVIEW and AMEND

Evaluate information from: - Reviews of placement, progress against agreed action plans (commissioning and/or CQC), feedback from families and adults, specialist feedback from health, advocacy etc. Review risks and amend risk management plan to address remaining or escalating risks. If risks removed and everyone is satisfied with progress, consider exiting.

Repeat this stage until we can decide to either exit safeguarding or take more formal action against the provider.

Owner – ASC and partners

STAGE 6 – REVIEW AND DECISION MAKING – Exit or escalation

Multi-agency decision about organisational abuse linked to the 6 criteria.

Agree ongoing monitoring of progress against any outstanding actions (if any)

Outline criteria for return to organisational abuse enquiries.

Consider if a lesson learnt, or SAR may be appropriate.

Share findings with adults/families/advocates.

Consider removal of adults if placements remain unsafe.

Owner – ASC and partners

4 Roles and Responsibilities

4.1 Placing and Host Authorities

4.1.1 The placing authorities must be notified of concerns and their involvement ensured. It is the responsibility of Barnsley Council Adult Joint Commissioning, as the "Host" authority to inform placing authorities of concerns relating to the service. Placing authorities may include both social care and health commissioners and for some specialist service providers, such as secure mental health or learning disability services, may involve both local and 18 regional specialised commissioning teams.

4.1.2 Host authorities may need to be supported by commissioning colleagues in health and social care in identifying and contacting placing authorities in specialist settings.

4.1.3 Good practice guidance on organisational enquiries involving many placing authorities is included in the ADASS (2016) Out of Area Safeguarding Arrangements at https://www.adass.org.uk/out-of-area-safeguarding-adult-arrangements/ .

4.1.4 When an organisational abuse enquiry is instigated and several placing authorities are involved, a strategic management meeting may be required. This group will invite placing authorities to identify the most appropriate senior manager to represent their organisation and take responsibility for any required actions, setting up a sequence of meetings if required, to aid communication and wider strategic decision making.

4.2 Care Quality Commission

4.2.1 CQC monitors, inspect and rate all providers to support adults and their families to choose a high-quality and safe service. They can hold providers to account, outside of safeguarding, by taking enforcement action and agreeing action plans to drive improvements. CQC should be informed of all safeguarding and commissioning concerns about a provider to support their monitoring. They will always contribute to an organisational abuse enquiry. CQC have powers to remove registered managers and /or close a service, via the courts, if required. CQC work closely with commissioners to share information and intelligence to support robust evaluation of services.

4.3 Commissioners

4.3.1 Commissioners have a responsibility to assure themselves of the quality and safety of the organisations they place contracts with. All contracts should include specific requirements about safeguarding. Commissioners have a responsibility to intervene where services fall below fundamental or contractual standards, or abuse is found to be taking place. This may be via a service improvement plan with regular monitoring. If contracts are breached and the service improvement plan has not delivered the required change, commissioners must make decisions about the viability of the service provider. Commissioners will be involved in organisational abuse enquiries and will take the lead on monitoring service improvements and providing updates to the organisational abuse enquiry. Commissioners will be able to assist in identifying placing health services and local authorities and in

communication with the placing authorities.

4.4 **Providers**

4.4.1 Providers must promote a culture that encourages candour, openness, and honesty at all levels. (The Duty of Candour of Health and Social Care providers is specified in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014)

4.4.2 Providers must meet the fundamental standards of care (set out in CQC KLOE's and contractual obligations), supported by:

- Monitoring by senior management within the provider organisation.
- High quality care management and reviews, completed in a timely manner by both social care and health.
- Monitoring and inspection by commissioners.
- Monitoring and inspection by regulators.

4.4.3 Providers must engage with both individual and organisational abuse enquiries, this may include:

- Investigating and responding appropriately to incidents, complaints, and whistle- blowers,
- Undertaking section 42 enquiries when caused to do so by the local authority.
- Taking appropriate action regarding staff who have abused or neglected people in their care.
- Contributing to an action plan, showing evidence of how they have made the required changes and how this will be monitored to demonstrate they are embedded.
- Contacting the police if a crime has been committed.
- Providing a voice to adults receiving a service and /or their families/advocates.

4.5 **Police**

4.5.1 Everyone is entitled to the protection of the law and access to justice no matter where they live. A criminal investigation by the police takes priority over all other enquiries or investigations.

4.5.2 Potential offences may have occurred under the Mental Capacity Act section 44, or the Criminal Justice and Courts Act 2015, or under any other legislation. (See Appendix 2- Potential Criminal Offences in Provider Services)

4.5.3 Police have a duty under legislation to assist those witnesses who are vulnerable and intimidated. The Youth Justice and Criminal Evidence Act and the Achieving Best Evidence provide adults with access to a range of special measures to assist them to engage with the criminal justice system. It is vital the police are asked to explore possible offences at an early stage in an organisational abuse enquiry.

4.5.4 Organisational abuse enquiries will be managed by specialist officers in the Protecting Vulnerable Adults team (PVP). Ideally the same officer will attend all meetings to improve consistency of responses.

4.6 **The Local Authority**

4.6.1 Adult social care will take the lead role in all safeguarding cases, including organisational abuse. They will obtain initial information from the provider, commissioners, safeguarding records, CQC and health to inform a risk assessment and associated protection plan. If the threshold for the use of the organisational abuse policy and procedures has been met, this will be approved by either a Head of Service or Director of Adult Social Care.

4.6.2 Senior managers from all relevant organisations will be involved in the initial planning meeting which will address risks, create an enquiry plan, and notify placing authorities.

Adult Social care will be responsible for organising subsequent meetings to progress the enquiry and make sure appropriate people attend.

4.6.3 Care reviews of all placements should be organised as soon as possible, and feedback obtained from out of area reviews completed on adults receiving a service. If necessary, or at the request of the adult or their advocate, alternative services should be identified.

4.6.4 Records of previous safeguarding cases, within the last 18 months, should be collated to identify trends and to evaluate the providers ability to deliver required changes to improve the quality and safety of the service.

5 Rights of the Adult(s) and/or their Representatives

5.1 Adults and/or their representative must be supported to contribute to the enquiry. They will have expert knowledge of their experiences of the service and may have a view on how it can be improved. Consideration must be given to:

- Use of independent advocates who may work with the adult on a 1 -1 basis or may be able to hold group meetings in the service (Section 68 of the Care Act, requires use of advocates in a safeguarding enquiry)
- Individuals or groups may be consulted by the worker(s) undertaking the enquiry.
- The provider and local authority may hold joint short meetings with people who use their services.

5.2 It is good practice for organisations involved in the enquiry to spend time within the environment where they can be approached by adults, their representatives or family members.

5.3 Families and representatives should be supported to share information with named members of the enquiry.

5.4 It is the Provider's role to keep the people using services and/or their representative updated regarding adult safeguarding enquiries, safeguarding plans, and service improvement plans in line with agreements reached with the Local Authority. The local authority or as appropriate health commissioner must monitor and support the Provider to do so by regular visits or contact with the manager(s).

6 Whistleblowing

6.1 "Whistle-blowers often put the public good first at great personal risk. They can and do make a big difference in the fight against corruption and deserve our support, protection, and admiration."

6.2 A whistleblowing referral may be the catalyst for identifying wider concerns about a service. Whistleblowing should be distinguished from a complaint in that a whistleblowing referral will be made typically, by an employee of the organisation. The person may or may not have tried to raise the issue with their management. Ideally, they should have done it but clearly there are times when an employee will feel too intimidated to do so or have no response or don't like response.

6.3 Where a "whistleblowing" is a safeguarding concern about an individual this should be dealt with initially through individual safeguarding processes to ensure that the person is safe. Where there are wider implications, these may need to be followed up through organisational safeguarding processes.

6.5 Anonymity may not be guaranteed so it is important that the correct support and help is available and Whistleblowing codes of practice followed. It is essential that information is taken carefully from whistle-blowers whatever their motives appear to be, just because someone has fallen out with an employer does not necessarily mean that the information, they are passing on is not valid. As with any other enquiry this will need to be balanced with other information.

University (2012) and PANICOA (2013))

The term "adult(s) used below refers to people who may live in a care setting, supported living setting etc. or be patients on a hospital ward or use a provided home care service.

1. Concerns about management and leadership

The first section is about the people who manage the home, ward or

other service and other managers in the organisation. What are they doing, or not doing, that gives you cause for concern? Is there evidence from the referral information, from other information gathering or enquiry that:

- There is a lack of leadership by managers, for example managers do not make decisions and set priorities.
- The service is not being managed in a planned way but reacts to problems and crises.
- The manager is unable to ensure that plans are put into action.
- The managers know what outcomes should be delivered for the service user/patient group but appear unable to organise the service to deliver these outcomes, i.e. they appear unable to 'make it happen'.
- Senior as well as operational managers appear unaware of serious problems in the service.
- Managers do not promote the Duty of Candour when incidents occur.
- Managers do not encourage staff to report concerns.
- The service does not respond appropriately when a serious incident has taken place. They do not appear to be taking steps to reduce the risk of a similar incident happening again.
- Managers appear unable to ensure that actions agreed at reviews and other meetings are followed through.
- Managers do not appear to be paying attention to risk assessments or are not ensuring that risk assessments have been carried out properly.
- Managers do not appear to have made sure that staff have information about
  individual adult's needs and potential risks to adults.
- The manager leaves staff to get on with things and gives little active guidance. The manager fails to model good practice to the staff team. They are not involved in practice with adults.
- The manager is very controlling of staff, visitors and the environment and is reluctant to take on suggestions.
- The managers have low expectations of the staff and allow poor practice to exist without intervention.
- There is a high turnover of managers.
- The service is experiencing difficulties in recruiting and appointing managers.
- The manager leaves suddenly and unexpectedly.
- The manager is new and doesn't appear to understand what the service is set up to do.
- A responsible manager is not apparent or available within the service, for example they may be on holiday or covering other services.
- Arrangements to cover the service whilst the manager is away not working well.
- The services' resources are not being deployed effectively to meet the needs of the adults. For example, there is a high turnover of staff, staff are working long hours, staff.

  are working when they are ill, there is poor staff morale. There has

been a lack of investment in the environment which has resulted in hygiene and safety issues.

2. Concerns about staff skills, knowledge, and practice

This section is about the people who work in the home, on a ward or other service. Is there evidence from the referral information, from other information gathering or enquiry that:

- Staff appear to lack the information, knowledge and skills needed to support older people and/or people with dementia/people with learning difficulties, mental health issues or disabled people.
- Staff appear challenged by some adult's behaviours and do not know how to support them effectively.
- Staff do not manage adult's behaviours in a safe, professional, or dignified way.
- Members of staff perceive the behaviours or attributes of adults as a problem – and blame the adult.
- Staff blame the adult's confusion or dementia for all their difficulties, needs and behaviours; other explanations, i.e. physical, environmental, cultural, or individual needs do not appear to be considered.
- Members of staff are controlling of adult's choices about clothing, eating, visits etc.
- Adults are punished for behaviours which are seen to be inappropriate.
- Staff treat adults roughly or forcefully.
- Staff ignore adults' requests for help or need for social interaction.
- Staff shout at adults and are impatient.
- Staff shout or swear at adults.
- Staff talk to adults in ways which are not complimentary or are derogatory.
- Staff do not seek consent from the adult they are working with.
- Staff share information about adults without their knowledge and/or consent on social media etc.
- Staff do not alter their communication style to meet individual needs.
- Members of staff use negative or judgmental 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 adults when providing personal care or undertaking a medical examination or procedure.
- Record keeping by staff is poor.
- Staff do not appear to see keeping records as important.
- Risk assessments are not completed or are of poor quality.
- Incident reports are not being completed.
- There is a particular group of staff who strongly influence how things happen in the service.
- Staff informally complain about the managers to visiting professionals.
- Staff lack training in how to use equipment.

3. Concerns about adult's behaviours and wellbeing

This section is about the people who live in the home or service or are patients on a ward.

Is there evidence Is their evidence from the referral information, from other information gathering or enquiry that that one or more of the adults:

- Show signs of injury due to lack of care or attention (e.g. through not using wheelchairs or manual handling equipment carefully or properly).
- Appear frightened or show signs of fear.
- Behaviours have changed.
- Appearances have changed, for example they have become unkempt or are dressed in inappropriate or undignified clothing.
- Are showing weight loss when there is no medical evidence to explain this.
- General health is suffering as simple nursing needs are not being met.
- Are developing pressure areas which could be prevented.
- Have overflowing catheter bags, dirty dressings.
- Are not having basic care needs met and the person is unkempt, e.g. dirty fingernails, smells, bed linen is unchanged.
- Moods or psychological presentation have changed.
- Behaviour is different with certain members of staff/when certain members of staff are away.
- Engage in inappropriate sexualised behaviours.
- Do not thrive in the care environment and there are no physical reasons to prevent this.
- Do you experience the overall atmosphere as flat, gloomy, or miserable?
- Or noisy, frantic, and rushed.

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

Are the people in the home, ward or service cut off from other people? Family? Friends? Visiting professionals? Advocates or representatives? Their community? Is it a "closed" or an "open" sort of place? Is there evidence from the referral information, from other information gathering or enquiry that:

- Managers and/or staff do not respond to advice or guidance from practitioners, advocates, representatives, and families who visit the service.
- The service is not reporting concerns or serious incidents to families, external practitioners, advocates, representatives, or agencies.
- Managers/the service do not share safeguarding concerns/low level concerns and serious incidents with either commissioning/CQC and/or adult social care or do not share in a timely manner.
- The service does not pass on information and communicate with adult's families, advocates, representatives, and external practitioners as appropriate.

- Managers do not appear to provide staff with information about adults from meetings with external people, for example review meetings.
- Staff or managers appear defensive or hostile when questions or problems are raised by external practitioners, advocates, representatives, or families.
- Staff are hostile towards or ignore practitioners, advocates, representatives, and families who visit the service.
- The service does not liaise with families or friends and ignores their offers of help and support.
- Staff do not tell the truth or minimise issues to family or friends/professionals.
- Managers or staff are defensive and concerned to avoid blame when things go wrong or there are problems.
- There is no support for the duty of candour.
- Staff or managers give inconsistent responses or account of situations.
- There are adults who have little contact with people from outside the service, no befriender or advocate involved.
- There are adults who are not receiving active monitoring or reviewing (e.g. people who are self-funding, people who are subject to Deprivation of Liberty safeguards) and have no friends, family or representative.
- Adults are being kept isolated in their rooms and are unable to move to other parts of the building independently ('enforced isolation').
- Adults without capacity are not provided with the necessary support to manage their finances and avoid exploitation.

5. Concerns about the way services are planned and delivered.

This is about the way in which the service is planned and delivered to individuals and to groups. Is there evidence from the referral information, from other information gathering or enquiry that:

- There is a lack of clarity about the purpose and the nature of the service.
- The service does not appear able to deliver the service or support it is commissioned to provide.
- The service accepts adults whose needs and/or behaviours are different from or incompatible with those of the adults previously or usually admitted.
- The service is accepting adults whose needs they appear unable to meet.
- There appear to be insufficient staff to support adults appropriately.
- There is a lack or absence of a training plan for staff or a lack of positive impact on practice,
- There is a fast turnover of staff.
- Adults' needs as identified in assessments, care plans or risk assessments are not being met.
- The layout of the building does not easily allow adults to socialise and be with other people.

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

Are basic needs being met? What is the environment like? Is there evidence from the referral information, from other information gathering or enquiry that:

- There appear to be insufficient staff to meet adults' needs.
- There is poor or inadequate support for adults who have health problems or who need medical attention.
- Adults are not getting the support they need with eating and drinking or are not getting enough to eat or drink.
- The service is not providing a safe environment.
- Staff are not checking that adults are safe and well.
- There are a lack of activities or social opportunities for adults.
- Adults do not have as much money as would be expected.
- Adults lack basic things such as clothes and toiletries.
- Support for adults to maintain personal hygiene and cleanliness is poor.
- There is a lack of care for adults' property and clothing.
- The service does not have the equipment needed to support adults.
- Equipment is not being used or is not being used correctly.
- Equipment or furniture is broken.
- The service is not providing equipment to keep adults safe.
- Staff are not using manual handling equipment / wheelchairs safely and correctly.
- Staff are not using correct pressure mattresses or cushions, other pressure relieving equipment.
- The environment is dirty and shows signs of poor hygiene.
- The quality of the environment has deteriorated noticeably, broken articles are not replaced, areas are undecorated.
- Levels of activity for adults have declined noticeably.

Potential criminal offences linked to health and social care settings. (not necessarily an organisational abuse case)

This is not an exhaustive list and the police, as statutory partners, should be involved at an early stage in the enquiry.

1. **Physical abuse**

Mental Capacity Act 2005 Section 44 – offence of deliberate ill treatment or willful neglect of a person who lacks capacity.

Case study: A care worker becomes frustrated with an older man in his care who is slow to eat. The care worker picks up the piece of bread the man is eating and rubs it into his face and eyes. When the man gets up and shouts the care worker pushes him, causing him to fall and crack his head on the table. The man has an eye injury and bruising. Although the care worker did not intend the man to be injured, he is still arrested, and a charge is made of common assault and assault causing actual bodily harm (ABH). An ABH investigation may only require an intention to apply unlawful force to someone, not an intention to cause actual bodily harm. The older man's injuries are evidence of the harm caused. The charge of common assault relates to rubbing bread into the man's face. Offences against the Person Act 1861 Section 18 - Wounding with intent to do grievous bodily harm. Section 20 – Inflicting bodily injury with or without weapon. Section 47 - Assault occasioning actual bodily harm. Criminal Justice Act 1988 Section 39 – Common assault and battery - offence of common assault relates to any physical contact. (individual S42 safeguarding enquiry)

Case study: A care worker is arrested on a charge of deliberate ill treatment of an elderly man with dementia. The man had fallen to the floor. The worker dragged him to his feet and threw him onto his bed. As a result, he sustained a shoulder injury, was bruised and shaken. A colleague witnessed this and reported this to her manager. The care worker said that she had thought the man had "put himself on the floor" and did not "deserve" for her to use a hoist to lift him. (may be organisational abuse if this is the "culture in the care setting)

Case study: A man has died in a care home for disabled people in need of nursing care. The cause of death is established as hypothermia. The care home provider was aware that the central heating was broken and that there would be no heating in the Home. The provider had taken no steps to address this or mitigate any risk. Although the Home was short staffed the provider had also refused to authorise any bank or agency staff. The man appeared to have fallen from bed during the night and was not found until the day shift came on duty at 8am. Individual care workers were initially charged with neglect, but subsequently the registered manager and owner were charged with offences under section 21 of the Criminal Justice and Courts Act 2015 including an individual who, as paid work, supervises or manages individuals providing such care or is a director or similar officer of an organisation which provides such care. Section 21 Ill-treatment or willful neglect: care provider offence. A care provider commits an offence if - (a)an individual who has the care of another individual by virtue of being part of the care provider's arrangements ill-treats or willfully neglects that individual, (b)the care provider's activities are managed or organised in a way which amounts to a gross breach of a relevant duty of care owed by the care provider to the individual who is ill-treated or neglected,

and (c)in the absence of the
breach, the ill-treatment or willful neglect would not have occurred or would have been less likely to occur. Criminal Justice and Courts Act 2015 These offences can be committed against people who have the mental capacity to make decisions about their care as well as those who do not.
Section 20 – offence of ill treatment or willful neglect by a care worker. Care worker" means an individual who, as paid work, provides— (a)health care for an adult or child, other than excluded health care, or (b)social care for an adult. (Organisational abuse)

2. **Financial abuse**

Theft and fraud Theft Act 1968
• Offence of dishonest appropriation of property belonging to another, intending to deprive the owner of it permanently.

Fraud Act 2006 - Section 4 - Fraud by abuse of position

Case study: A support worker has been arrested after using the bank details of a man she was supporting to set up numerous loans and internet shopping accounts. The worker had access to account details after offering to support him to administer his own finances. (individual S42 enquiry, unless management of staff not robust)

3. **Sexual Offences**

Sexual Offences Act 2003
- Sections 30-44 – offences against persons with a mental disorder.
- Sections 30-33 - offences against people who cannot legally consent to sexual activity because their mental disorder impedes their choice.
- Sections 34-37 - people who may not be legally able to consent because they are vulnerable to threats, inducements, or deceptions because of their mental disorder.
- Sections 38-42 - care workers and their involvement with people who have a mental disorder.

Offences include:
- 'Touching' in a sexualised manner i.e. offences are not all about penetration.
- Causing people to engage in sexual activity which does not involve touching by threats, deception etc.

Case study: A healthcare assistant is arrested after colleagues reported concerns that he was seen to carefully wash the breasts of patients on the unit for women.(May be a sexual assault and/or a sexual abuse safeguarding enquiry)

4. **Neglect**

See above, Mental Capacity Act 2005 and Criminal Justice and Courts Act 2015.

Case Study: Two-night care staff workers are arrested when they "downed tools" following a dispute with their manager. Day staff arrived to find the eight older people on the unit were cold, and in wet and soiled bedding or out of bed semi clothed. Both workers were given eight-month prison sentences once convicted of "willful neglect" under section 44 of the Mental Capacity Act. (Organisational abuse)

REPORT TO SAFEGUARDING OPERATIONAL GROUP	**REF:**	09/22

SUBJECT:	**BARNSLEY SAFEGUARDING ADULTS BOARD ORGANISATIONAL ABUSE POLICY**				
DATE:	September 2022				
PURPOSE:		*Tick as applicabl e*			*Tick as applicable*
	For decision/approval			*Assurance*	☐
	For review			*Governance*	
	For information	☐		*Strategy*	
PREPARED BY:	**Lindsay Hood – Named Nurse for Adult Safeguarding Rebecca Slaytor- Named Nurse for Adult Safeguarding Tracy Church – Clinical Governance and Compliance Manager**				
SPONSORED BY:	**Gill Pepper – Head of Safeguarding Dawn Gibbon- Head of Safeguarding**				
PRESENTED BY:	**Rebecca Slaytor- Named Nurse for Adult Safeguarding**				

STRATEGIC CONTEXT

The Barnsley Safeguarding Adult Board (BSAB) through the Pathways and Partnership Subgroup, requested that Partner agencies review the BSAB Organisational Abuse Policy and how this relates to the Organisation that they represent.

EXECUTIVE SUMMARY

A review of the BSAB Organisational Abuse Policy was completed in September 2021 in order to review that BHNFT governance processes, policies and meetings take account of any identified safeguarding concerns. This was in order to provide assurance that there are systems and processes in place to review and identify any signs of organisational abuse at BHNFT.

An action from the Pathways and Partnership sub - group will be shared to share this report.

The plan was originally for this paper to be presented at the Safeguarding Steering Group in November 2021, which was cancelled and there was no rescheduling for presentation. In view of this the paper was reviewed in September 2022 safeguarding steering group for review and comment.

RECOMMENDATIONS

The group is asked to review the content of the report.

1.0 Background

Barnsley Safeguarding Adults Board (BSAB) Organisational Abuse policy was approved on the 25 March 2021 and shared with all member organisations.

The Trust's Named Nurse for Safeguarding Adults has reviewed the policy and met with relevant stakeholders to provide assurance that there are systems and processes in place to review and identify any signs of organisational abuse at BHNFT.

2.0 Identifying organisational abuse at BHNFT in line with the Barnsley Safeguarding Adult Board policy through the following processes.

- There is effective communication between the Tissue Viability Team and Safeguarding Team, all pressure ulcer RCA investigations and SI investigations consider safeguarding issues. The Policy includes the reporting of hospital acquired pressure damage as per national guidance.

- Consideration of any safeguarding concerns will be added to the CBU report template presented at Medicines Management Committee (or equivalent group) where themes and learning from medication incidents are shared and discussed.

- Safeguarding has been added to the monthly inpatient falls report presented at Falls Prevention Group to ensure any themes or concerns are highlighted and discussed.

- A programme of 'observations of care' is being launched which will also be an opportunity to look at the quality of care provided across the Trust and how Policies are followed.

- BHNFT have their own PIPOT Policy, the Deputy Director of Nursing and Quality is the Organisational Lead in relation to allegations against staff.

- Staffing incidents are discussed at JPF monthly, and any staffing risks are reported to the Quality and Governance Meeting.

- BHNFT has a Freedom to Speak Up Guardian who attends the Patient Safety and Harm Group and will consider and liaise appropriately with the Safeguarding Team where safeguarding concerns are identified to seek advice on the next steps.

- There is Safeguarding representation at the CQC Oversight Group to provide assurance regarding Safeguarding action plans/activity across the Trust.

- A Safeguarding Operational Group is also held bi - monthly with any risks being escalated to the Safeguarding Steering group that is also held bi - monthly.

- Complaints that are raised to the Trust are shared with the Safeguarding Team when safeguarding is identified within the complaint.

<u>Significant harm to one or more adult in receipt of service</u>

The serious incident (SI) process and serious incident investigation report

prompt the investigation team to use the BSAB Decision Support Guidance 2021-2023 to consider if the incident has safeguarding issues using a Think Family approach. If safeguarding issues are identified at any point during an SI investigation a member of the Trust's Safeguarding Team provides specialist/professional input into the investigation.

3.0 Conclusion

The Trust has systems and processes in place to review and identify any signs of organisational abuse at BHNFT. This paper has highlighted some additional activities and reports that can be used to provide further assurance of this.