Gloucestershire Safeguarding Adults Board

Framework for Responding to Organisational Failure or Abuse

Background

Within the local Multi-Agency Safeguarding Adult Procedures, prior to the Care Act 2014, there was provision to conduct Whole Service Investigations (WSIs) in situations where there were concerns about widespread institutional abuse or a range of safeguarding issues accompanied by regulatory or other failings.

The WSI process has become well embedded and has contributed to the co-ordination of multi-agency efforts to address service failures and to hold providers to account where there have been systematic failures.

The WSI process has been coordinated and chaired by the Gloucestershire County Council Safeguarding Adults Team. This has sometimes led to unrealistic expectations regarding the powers of the local authority in relation to its safeguarding role. It has also created an over reliance on safeguarding intervention by other agencies and teams in some cases.

In the majority of WSIs, the major concerns were symptomatic of care quality issues or were regulatory in nature; safeguarding concerns have only been a small part of the whole picture. Typically, WSIs have identified issues of ineffective leadership, lack of supervision, poor care planning and risk management, staffing, clinical care (e.g. pressure ulcers), communication, financial management, selection and assessment and compatibility of individuals using the service, staff training, infection control, medication and poor moving and handling.

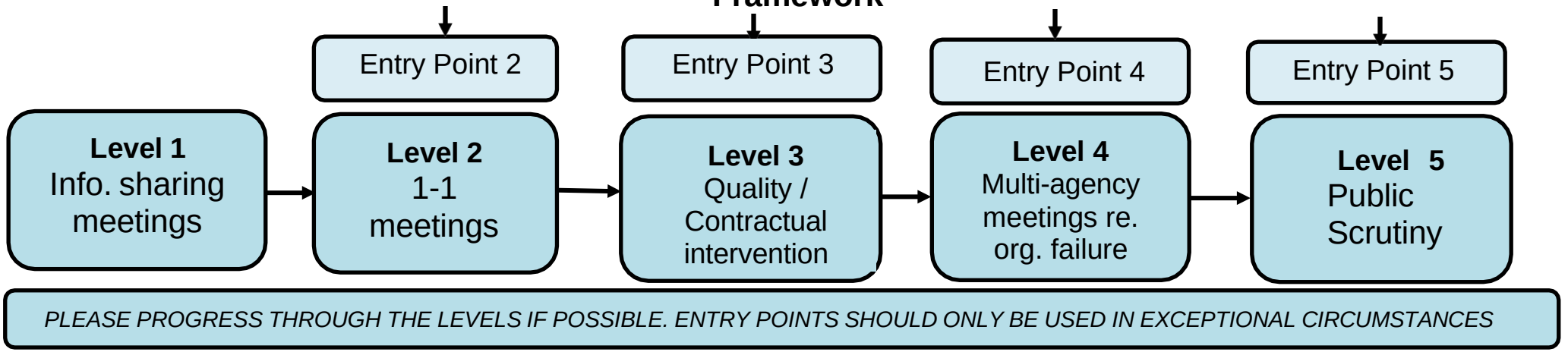
An alternative approach must now be taken, given the clarity in the Care Act Guidance that says "*safeguarding is not a substitute for:*

- *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; and*
- *the core duties of the police to prevent and detect crime and protect life and property*".

The primary purpose of this framework is to ensure safe service provision and prevent organisational failure.

N.B. The use of this framework is not a replacement for day to day information sharing processes that exist between agencies when there are concerns about individuals which must be raised as per the Gloucestershire Adult Safeguarding Policy and Procedures. Individual enquiries should not be delayed whilst waiting to convene 1-1 meetings or multi-agency meetings about organisations.

Framework



PLEASE PROGRESS THROUGH THE LEVELS IF POSSIBLE. ENTRY POINTS SHOULD ONLY BE USED IN EXCEPTIONAL CIRCUMSTANCES

Level 1 Guidance

This level represents the regular meetings that take place between the Local Authority, CQC, Integrated Care Board (ICB) and NHS England. Concerns can be raised by any partner at these meetings or Quality Surveillance Group. At this meeting the concerns will be clarified and the response required, if any, will be agreed.

Level 2 Guidance

Face to face meetings will be called between the "owner" of the organisation and the professional most appropriate to lead the discussion e.g. CCG Quality Lead where the issues are mainly clinical. The discussion should centre on what the issues are and what action might be taken. A low key but formal record of this discussion should be produced to suit both parties e.g. an email to summarise the discussion and actions agreed.

Level 3 Guidance

Where concerns persist as a result of the failure of the organisation to improve their service, commissioners will consider what options are available to them. This may include quality monitoring visits and the production of action plans or contractual action such as preventing new placements or the issuing of remedy letters.

Level 4 Guidance

In the event of organisational failure e.g. financial collapse, major regulatory sanctions (e.g. multiple warning notices, persistent 'Inadequate' ratings, proposal to cancel registration), a meeting will bring together the relevant parties including the failing organisation. Who leads this meeting will be decided by considering the predominant issues e.g. systemic, ongoing abuse would be led by Safeguarding. Meetings should ensure that contingency, media and communications plans are in place.

Level 5 Guidance

Public scrutiny can take place in a number of ways including escalation to Gloucestershire Safeguarding Adult Board (GSAB) or through conducting a Safeguarding Adult Review (SAR). Additionally, consideration may be given to asking all involved (including the failing organisation) to appear at a publically held Scrutiny Committee in order to explain what action will be taken to improve the service and within what timescales.

With grateful thanks to Staffordshire County Council and the West Midlands Editorial Group