West Midlands Regional Adult Safeguarding Leads

Framework for Responding to Organisational Failure and/or Abuse

WEST MIDLANDS REGIONAL ADULT SAFEGUARDING LEADS

DEVELOPING POLICIES AND PRACTICE ACROSS THE REGION

Purpose

The purpose of this high-level framework is to promote safe service provision, prevent organisational failure and support a consistent approach across the West Midlands. While undertaking enquiries in relation to adults at risk of organisational abuse is a safeguarding function under the Care Act 2014, responding to organisational failure is a general responsibility for local authorities under the Act. However, in practice, these issues can often overlap, and adult safeguarding responsibilities should integrate with processes for responding to organisational failure.

Background

Managing provider failure and other service interruptions

Service interruptions and failure can arise from a number of different causes, for example:

- a provider faces commercial difficulties that put the continuation of their business under threat.
- a meningitis outbreak at a care home.

Most service interruptions are on a small scale and are easily managed but service interruptions on a large scale pose far greater problems. If a provider which operates nationwide fails, few local authorities are likely to be able to respond effectively on their own. Local authorities should consider how they would respond to different service interruptions and, where the involvement of neighbouring authorities would be essential to maintain services, ensure effective information sharing arrangements are set up in advance.

Business failure' is defined in The Care and Support (Business Failure) Regulations 2015. Local authorities are under a temporary duty to meet people's needs when a provider is unable to continue to carry on the relevant activity because of business failure. It does not matter whether or not the authority has contracts with that provider, nor does it matter if all the people affected are self-funders (for example, arranging and paying for their own care). There are restrictions on the provision of health services by local authorities, and these apply to meeting needs in provider failure cases (section 52(7)). A local authority may not meet needs in provider failure cases by, for example, providing NHS Continuing Healthcare. This duty to provide NHS Continuing Health Care falls on the NHS.

Section 5 of the Care Act 2014 and the associated guidance sets out authorities' duties to promote the efficient and effective operation of the local market in care and support services (see chapter 4).

Defining Organisational Abuse

The Care and Support Act Statutory Guidance (updated July 2025) 14.9 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 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".*

As already stated here, organisational failure happens for a range of reasons, and abuse is not always present. The definition of organisational abuse provided in the Statutory Care and Support Guidance has the potential to cause confusion when submitting data for the Safeguarding Adult Collection suggesting that it can be both a one-off incident and systemic failure. For the purposes of this framework, the focus should be on "… ***neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation***".

The Safeguarding Adult Collection captures data about individuals affected by abuse. For data to be added to the Safeguarding Adult Collection, an individual must have experienced abuse because of the ***structure, policies, processes and practices within an organisation*** and not one incident that has happened to one person by one member of staff. The following points are helpful in considering whether organisational abuse is factor:

- Consider if a closed culture may be evident
- Are there issues with culture and/or behaviours of staff?
- Are there rigid or inflexible routines?
- Are the needs of adults are ignored (for example, medical/physical and/or emotional needs)?
- Are the concerns being reported by multiple families, representatives, advocates or other visitors?
- Are the concerns as a result of whistleblowing/whistleblowers?
- Is there an acceptance of behaviours and/or culture by the workforce and/or management?
- Do the concerns indicate a pattern? Repeat reporting?

In the event of organisational abuse, there should always be consideration that criminal offences may have occurred. Advice should always be sought at the earliest opportunity so as not to affect any potential criminal investigation and offer challenge to police forces if they are not considering criminal investigations. A range of offence types can occur, for example:

- Assault
- Theft
- Fraud
- Sexual Offences
- Ill treatment or willful neglect (individual or provider offence)
- Corporate manslaughter

International Recruitment and other resources

The International Recruitment Programme (launched in 2023) is being funded via the Department of Health and Social Care's International Recruitment Fund to help address the unique challenges of international recruitment in adult social care aiming to:

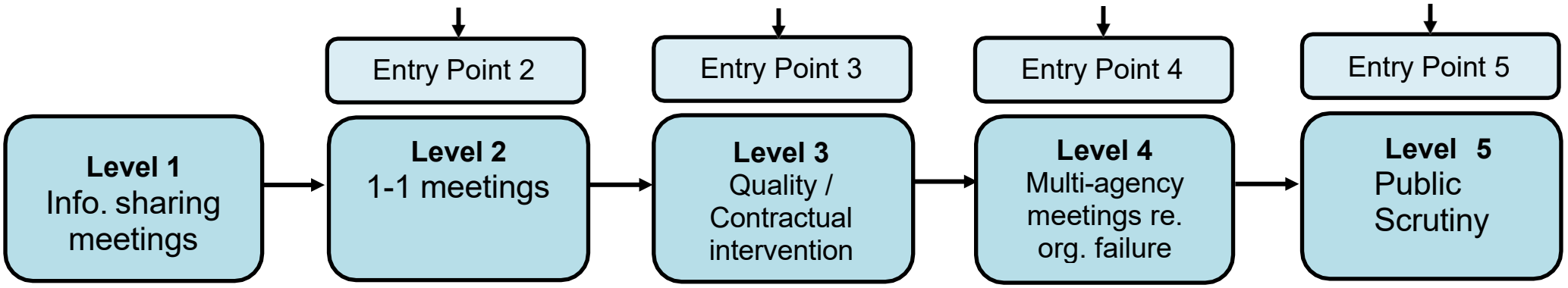
- Help care providers tackle recruitment challenges
- Strengthen safeguards to protect care workers from exploitation

WM ADASS have been involved in the production of a range of resources to support this and other work. Please find the links below:

- IR West Midlands
- Combatting modern slavery and exploitation | WMADASS
- wm-safeguarding-wellbeing-directory-29th-april-2025.pdf

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 West Midlands Adult Safeguarding Policy and Procedures. Individual enquiries should not be delayed whilst waiting to convene 1-1 meetings or multi-agency meetings about organisations. Local Authorities should feel free to develop more detailed guidance to sit under this framework should they think it required or embed it into their Business Failure processes.

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, Care Quality Commission, Commissioning NHS organisations and others.

Concerns can be raised by any partner at these meetings or Quality Surveillance Groups. Concerns will be clarified and the response required (if any) will be agreed including **who** will be taking what action and by **when**.

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. Integrated Commissioning Board 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 or abuse a meeting will be organised to 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 could be led by a senior safeguarding lead.

Meetings should ensure that contingency, media and communications plans are in place.

See appendix1 for further guidance on handling concerns about unethical and exploitative recruitment practice.

Level 5 Guidance

Public scrutiny can take place in a number of ways including escalation to the Safeguarding Adult Board (SAB) or through conducting a Safeguarding Adult Review (SAR).

Additionally, some local authorities may want to consider how they involve their Scrutiny Committees in holding people to account and getting assurance about what action will be taken to improve the service and within what timescales.

Appendix 1.

Pilot Information Sharing Process about Unethical and/or Exploitative Employers