

## Identifying and responding to organisational abuse ~ a regulatory perspective

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# Our vision, our purpose

**Why does CQC exist and what impact will we have?**

## Our vision

Everyone receives safe, effective and compassionate care.

## Our purpose

We regulate health and adult social care, we work together with the public, systems and providers of care to protect people, and to promote and improve quality of care.



# Defining organisational abuse

The Care and Support Statutory Guidance (14.17) defines organisational abuse as:

*‘including 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 and Support Statutory Guidance](#)

# CQC's role in identifying organisational abuse

CQC's main objective is to *'protect and promote the health, safety and welfare of people who use health and social care service.'*

*Section 3, Health and Social Care Act 2008*



# Provider quality concerns v organisational abuse

*There is a level of agreement that it is important to identify organisational abuse alongside individual concerns not least because ‘repeated safeguarding concerns, particularly if they form a pattern either for the same person or for different people, may be an indication that there are deeper problems in the way that a service operates or is managed. They may also show that interventions are not working, and new approaches may be required’ , **ADASS 2022***

A shared view of quality informed by collation of intelligence, is needed to identify organisational abuse, and / or the emergence of a closed culture.

# Hearing people's voices

**People's voice must underpin everything (people using the service, families, workers, professionals)**

**We want our staff to consider:**

- How they listen to people who raised concerns with us
- How they gather people's voices during planning of inspections
- How they undertake observations and gather feedback 'on-site'
- How they act on concerns



# Identifying themes and trends

**It is easy to see the individual tree, have you seen the forest?**

CQC is in a unique position to see deterioration if we handle concerns effectively, and look at the wider picture of quality

**We want our staff to consider:**

- Are risks to people being managed?
- Look at contextual information
- Be curious in exploring the information we hold
- Are there patterns evident?

Example – service user to service user abuse



# Working in partnership, putting the pieces together

**Effective multi-agency working is central to safeguarding**

CQC is part of a wider 'stakeholder landscape'

The Local Authority is responsible under the Care Act 2014. However, as the regulator CQC needs to refer as needed, seek assurance and manage regulatory risk effectively

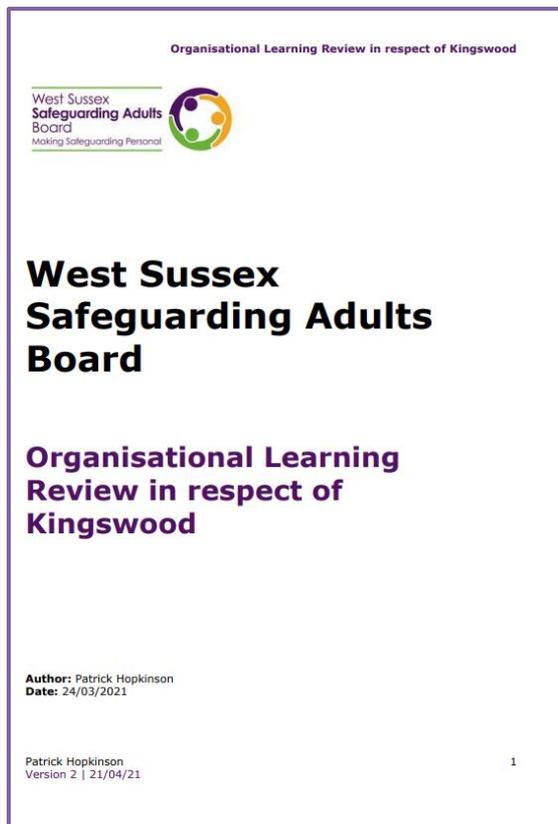
CQC holds power of entry (Section 62) to regulated premises

## **Consider:**

- Joint Working Protocol with ADASS
- Engagement with Safeguarding Adults Boards
- Provider engagement
- Involve CQC as soon as organisational abuse suspected



# Learning from Safeguarding Adult Reviews: Kingswood



- 20 bed care home - example of a 'silent service', no notifications.
- Requires improvement in March 2019
- NI/RM same person, lack of internal challenge
- Concerns alerted by ambulance service who found two people had died and others with signs hypothermia & dehydration
- Closed by CQC in February 2020
- On review, with all intelligence, there were markers of concern
- Demonstrates the need for professional curiosity, partnership working, and for raising awareness with all people who visit

<https://nationalnetwork.org.uk/2021/Kingswood%20Organisational%20Learning%20Review.pdf>

# Using the regulations

**Example - Regulation 13: Safeguarding service users from abuse and improper treatment** is intended:

*'to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005.'*

**Example - Regulation 17: Good governance**

Multiple regulatory breaches can be seen on inspection if organisational abuse is taking place.

# CQC Enforcement

## Two purposes of enforcement powers:

- To protect people who use regulated services from harm and the risk of harm, and to ensure they receive health and social care services of an appropriate standard (civil powers). Can impose conditions on registration, suspend a registration or cancel a registration.
- To hold providers and individuals to account for failures in how the service is provided (criminal powers). Certain regulations can be used for prosecution – the most used is Regulation 12 (Safe care and treatment).

## Principles guiding the use of enforcement:

- Being on the side of people using regulatory services
- Proportionality
- Consistency
- Transparency

## What can we enforce?

- Unregistered providers
- Registered persons (meaning registered providers and registered managers)

# Links to 'culture'

*"The way things are done around here"*

*"Everyday actions of every individual"*

*"What happens when nobody is looking"*

*"The pattern of shared basic assumptions"*

[Rapid Literature Review – Improvement Cultures](#)  
[Rapid Literature Review – Safety Cultures](#)

# Closed cultures (can occur in any service)

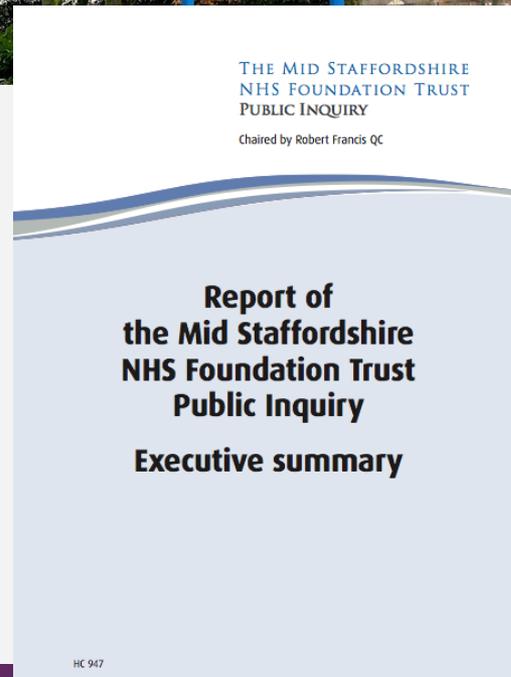
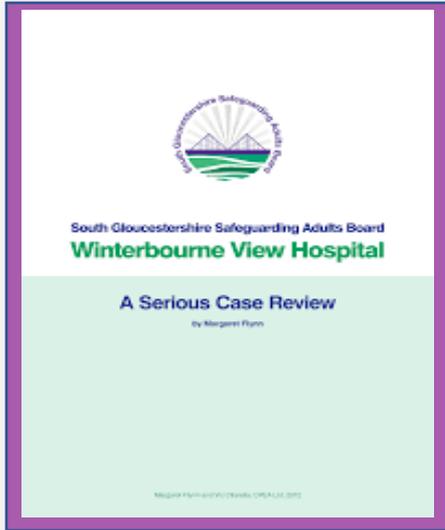
*A poor culture that can lead to harm, including human rights breaches such as abuse. In these services, people are more likely to be at risk of deliberate or unintentional harm.*

Certain features increase the risk of a closed culture:

- Services where people are unable to leave of their own accord
- Live-in services such as shared lives, supported living services
- Any service where one-to-one care is provided
- A provider changing the type of service it offers in response to market or other influences

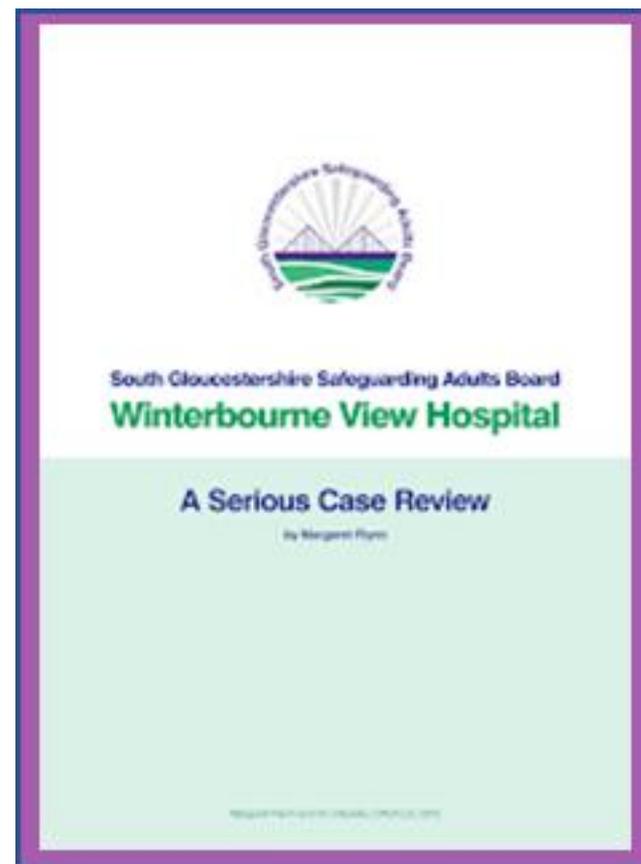
[CQC Closed Culture Guidance](#)

# Why does speaking up matter within regulation?



# Learning from Safeguarding Adult Reviews: Winterbourne View

- Independent hospital, run by Castlebeck
- Systemic abuse of people with a learning disability and other complex needs
- Expose by BBC, hospital closed in June 2011
- CQC Internal Management Review also published
- Failure from CQC to respond to whistleblowing concerns
- Failure to explore themes and trends, and to work in partnership



# Listening, Learning and Responding to Concerns Review – March 2023

- Holding the mirror up to review our own practice and culture
- Taking steps to learn and improve
- Need to create safe cultures across health and social care to empower people to speak up

**Each one of us has a responsibility to be aware and alert – we must speak up and share when things are not right.**





## Provider Bulletin

<https://www.cqc.org.uk/news/newsletters-alerts/email-newsletters-cqc> or Search: CQC bulletin



## Social

@CQCProf @CQCProf



youtube.com/user/cqcdigitalcomms



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## Digital platform

<https://cqc.govocal.com/en-GB/>  
or Search: GoVocal CQC



## Podcasts

Wherever you listen to podcasts  
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## Blogs

<https://medium.com/@CareQualityComm>  
or Search: Medium CQC

# Stay informed and stay in touch

## Improving how we work

Find the latest updates, links and information on how to get involved here:

<https://www.cqc.org.uk/guidance-regulation/improving-how-we-work>