

**Gateshead Safeguarding Adults  
Board  
Thematic Analysis of Safeguarding  
Practice  
Executive Summary  
February 2025**

# Introduction

Gateshead Safeguarding Adults Board (GSAB) commissioned an independent safeguarding adult review following a Panorama programme (aired December 2023) featuring a care home in Gateshead.

The programme highlighted quality of care (QoC) issues and safeguarding concerns raised previously by family members and professionals regarding care of residents (and concerns about the employment of overseas workers).

## **Focus of the Review:**

To consider the robustness of multi-agency enquiries undertaken in relation to the care home.

## **Purpose of the Review:**

Ascertain what, if any, learning there is for local multi-agency safeguarding processes.

# Terms of Reference

83 residents case files were reviewed where complaints, quality of care issues or safeguarding concerns were raised during the scoping period.

All relevant partners (including local authorities who placed clients within the care setting outside their local area), were asked to complete individual management reviews of their case files and comment on whether their local policies and best practice standards were applied.

Residents and family members were notified and invited to speak to the independent reviewers.

Multi-agency learning events with front-line practitioners who worked with residents of the care home also informed the findings and recommendations.

The review also had support from a panel of representative of partner agencies-providing oversight of the process.

# Key Lines of Enquiry

The period under review was from December 2021 to December 2023

Key lines of enquiry were to:

1. Review safeguarding adults' thresholds and triage processes in Gateshead
2. Review safeguarding adults' enquiry process
3. Provide systemwide assurance of care quality within residential care
4. Provide strategic oversight of safeguarding and quality of care incident reporting
5. Explore professional obligations to escalate concerns, 'speak up' and whistle blow
6. Analyse the interface between duties to conduct enquiry (S42) and learn lessons (S44)

# The people at the heart of this review

- Throughout the review 83 individual case files were examined.
- It was found that 14 concerns (relating to 7 people) were out of the scoping period, therefore only 76 individual case files were considered as part of the review.
- 159 safeguarding concerns, complaints or quality of care issues were identified and reviewed.
- 6 of the 76 people included in the review featured in the panorama programme.
- Families of 26 of the 76 adults at risk raised QoC concerns complaints or s42 concerns.
- 14 of the 76 adults were placed 'out of area' at this home.
- 46 of the 76 adults had Deprivation of Liberty Safeguards (DoLS) in place, 6 others capacity questioned but no DoLS in place and 2 were subject to MHA powers.

# Involvement of Families

In February 2024 the GSAB Independent Chair:

- Hosted face-to-face and online meetings with families of residents, present and former;
- Met with capacitated residents at the care home.

Regular updates provided to families for residents, present and former, via letter and email

In November 2025 reviewers:

- Met face to face and online with families of residents, present and former;
- Met with one capacitated resident at the care home.

Following conclusion of the review residents and family members were offered the opportunity to meet with the GSAB Independent Chair to review the recommendations.

# Information Gathering

Partners who provided information to be considered as part of the review:

- Local authorities who placed clients within the care setting outside their local area
- Northeast and North Cumbria ICB
- Advocacy providers
- Care Quality Commission
- Gateshead Health NHS Foundation Trust
- Northumbria Police
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Please note the provider declined to be directly involved in the review.

# KLOE 1 System Findings

## Safeguarding Adults thresholds and triage processes in Gateshead

- **Thresholds and pathways were not fully understood or applied consistently**
- Decision making tool required reviewing with all partners (review had already commenced)
- Partners need to agree how to **assure risk is reduced where incidents are diverted to alternative pathways** under the tool.
- There was an **over reliance on the LA's Safeguarding Adult Team (SAT)** to act as first responders to all incidents within provider settings
- **No dedicated police and clinical expert resource to support multi-agency information gathering** prior to triage of safeguarding concerns.

Recommendations [1](#) and [2](#)

# KLOE 2 System Findings

## Safeguarding adult's enquiry process

- There were **positive examples within the case files of principles under the Mental Capacity Act (MCA) and Making Safeguarding Personal (MSP)** being applied.
- Changes to process may improve adherence.
- Better understanding of the MCA and MSP required across the partnership.
- **Incidents, complaints and safeguarding concerns data needs to be used proactively to shape strategic preventative interventions.**
- Senior leaders need to **use performance measures to evidence compliance with MCA or MSP** and ensure this does not remain a 'transactional task'.

Recommendations [3](#), [4](#) and [5](#)

# KLOE 3 System Findings

## Systemwide assurance of care quality within residential care

- Families felt residents were **let down by the failure** of commissioners and the regulator to act **to spot patterns of neglect** or consider triggering serious provider concern processes or a s42 enquiry into organisational abuse.
- Families **questioned how repeated neglect concerns, peer-on-peer assaults or unwitnessed falls could take place** if, as they had been assured by the provider **1:1 support was provided**.
- **Systems exist** within the LA, ICB and CQC **to enable trend analysis and triangulation but it is still fragmented**.
- Sometimes practice between services resulted in **informal discussions** which lacked the required structure, meaning that numerous concerns, quality of care concerns and complaints **did not trigger coordinated action**.
- Families, practitioners and managers are keen to see better systems of communication about provider concerns.
- **Clarity required within the Serious Provider Concern process**, of roles and responsibilities and more assertive reporting requirements are required to ensure GSAB can 'hold partners to account and gain assurance of the effectiveness of its arrangements'.

Recommendations [3](#), [4](#), [5](#) and [6](#)

# KLOE 4 System Findings

## Strategic oversight of safeguarding and quality of care incident reporting

- **Insufficient evidence** that commissioners were **triangulating concerns**, with family complaints or quality of care issues.
- Significant difference in the number of notifications sent by the provider to the LA, CQC and ICB. Triangulation would have evidenced inconsistency of practice.
- **Lack of clarity of how the Safeguarding Enquiry process correlated to commissioners' and regulators' responsibilities**, coupled with changes in strategic oversight of care homes and confusion over the purpose of different multi-agency forums, resulted in a loss of intelligence that could have identified serious provider concerns sooner.
- **Simplifying reporting and escalation routes locally is necessary.**

Recommendations [3](#), [4](#), [5](#), [6](#) and [8](#)

# KLOE 5 System Findings

## Professional obligations to escalate concerns, 'speak up' and whistle blow

- Freedom to speak up, whistleblowing and **formal escalation processes were not used effectively.**
- CQC have no records of following up 4 anonymous freedom to speak up concerns
- **Whistleblowing should not be identified as the first action or pathway within the local safeguarding policy.**
- Local policy should explain how whistleblowing legal protections, freedom to speak up policy initiatives and use of escalation processes to resolve concerns, **underscore the principle that safeguarding duties are everyone's business.**

Recommendation [4](#) and [7](#)

# KLOE 6 System Findings

## Interface between duties to conduct enquiry (s42) and learn lessons (s44)

- There is a need to **review the interface between the safeguarding enquiry and review processes**, especially in circumstances where the vulnerable adult has died (and the power of enquiry ceases)
- The decision-making records for the s44 Safeguarding Adults Review process show this is consistent with local policy and national expectations.
- However, more active consideration of family views and/or advocacy where the adult has died would strengthen the process, ensuring MSP principles were applied.
- **CQC, the LA and ICB should have been aware of the levels of concerns within the home, or of the patterns emerging of poor care.**

Recommendation [3](#)

# Conclusion

Not every resident or family member residing in the care home during the review period experienced poor care. Many family members, including some who had raised concerns, commended some care home staff members as caring, person-centred and professional. However, the frequency, nature and type of concerns raised by families, practitioners and the provider provided clear justification for coordinated enquiries to ensure care was being safely delivered. We have not made a finding that organisational abuse occurred during the period. We are, however, satisfied (as were those attending the learning events) that the threshold to instigate enquiries under s42 for organisational abuse were met. This should also have triggered stage 2 (the professional meeting and monitoring visits) prior to national media reports in December 2023.

# Conclusion

Whilst we have seen evidence that frontline staff (particularly within the LA's SAT) took steps to seek to triangulate concerns, there were missed opportunities to use information and the relational practice in a coordinated way to respond far sooner to patterns of poor care. Overreliance on the SAT to manage risk was unsafe, particularly as they lacked strategic or organisational support to hold partners and the provider to account. As with all agencies, SAT practitioners had to prioritise resource within their team against rising demand. Understandably, they appeared to focus practice improvements to where their sphere of influence was greatest e.g. supporting providers to apply the decision tool, developing strong relational practice via linked staff to each provider. The rationale for practice improvements detailed at 4.3 was so that safeguarding responsibility (and relevant skills) were owned across all ASC assessment teams. This overlooks the critical roles and responsibilities owed providers and the responsibility for LA and ICB commissioning teams and CQC to hold providers to account. Their limited engagement in the design and delivery of those innovations distorts organisational responsibility for ensuring quality of care. Families and residents raising concerns deserved better.

# Recommendation 1

- 1.1 Revise the decision-making tool and reporting pathways
- 1.2 Improvement in provider reporting to commissioners so that intelligence spot patterns or spikes in concerns.
- 1.3 Provider contracts should be amended so that failure to adhere to the requirement to report would trigger a serious provider concerns process.
- 1.4 Mirror good practice in the SAT to develop relationships and improve understanding of provider strengths and stressors.
- 1.5 Formal reporting of concerns from information sharing meetings.
- 1.6 Police, ICB teams and CQC should confirm how they will be involved in investigations.
- 1.7 Pathways should have clear reporting mechanisms to the GSAB.

## KLOE 1

# Recommendation 2

- 2.1 Safeguarding partners should urgently review the s42 triage process so that criminal and clinical expertise is available for all concerns (including those reported within residential settings) to assist with evidence/ information gathering within the 'golden hour'.
- 2.2 The local safeguarding policy and decision-making tool should specify within descriptors, circumstances where specialist clinician resource or forensic investigations should be requested and set out who is the lead agency for securing that resource in a timely way.

KLOE 1

# Recommendation 3

- 3.1 The LA, ICB, CQC and provider representatives should revise the SPC process considering the findings of this review:
- Simplify the procedural requirements;
  - Offer greater clarity around governance and recordings of decision making.
- 3.2 The revision should include active consideration given to running the process concurrently with an organisational abuse enquiry.
- 3.3 Information meetings (and all subsequent meetings) should:
- Include representation from advocacy or patient safety reps.
  - Provide opportunities to triangulate information from friends and family surveys, Healthwatch
  - Families should be supported, prior to any serious provider investigation, to understand what good care looks like and to ensure they understand the local processes for raising concerns, quality of care issues or complaints.
- 3.4 GSAB should also review their s44 Safeguarding Adults Review decision making process to enable input from friends and family or advocacy.

KLOE [2](#), [3](#), [4](#), [6](#)

# Recommendation 4

- 4.1 Partner agencies should review their quality assurance and safeguarding policies and confirm to the GSAB how these clearly set out expectations for commissioners and contract managers to seek assurance from providers around safe staffing ratios, vacancy rates and staff competency.
- 4.2 Guidance should be produced for practitioners and the public about how to challenge and, if necessary, escalate when there are disagreements about safeguarding enquiry decisions, and how to raise concerns to national bodies
- 4.3 Where appropriate, residents and family members may need to be offered access to advocacy support for these processes.

KLOE [2](#), [3](#), [4](#), [5](#)

# Recommendation 5

- 5.1 GSAB partners agree training requirements for providers to ensure sufficient expertise to undertake 'provider enquiries'.
- 5.2 Compliance with this should be monitored as part of the ICB and LA's contract monitoring arrangements.
- 5.3 Newly appointed registered manager should, as part of their induction, be required to evidence they have the required knowledge and skills to conduct a provider enquiry.
- 5.4 Where commissioners, safeguarding or CQC have reasonable concerns that a registered manager lacks expertise or there is a conflict of interest to undertaking 'provider enquiries' this practice should be suspended.
- 5.5 Equally, where CQC has judged the service leadership to 'require improvement' or 'inadequate' under any category there should be a presumption that the care home manager will not be suitable to conduct a 'provider enquiry' under the safeguarding enquiry process.

KLOE 2, 3, 4

# Recommendation 6

Police, ambulance, ICB and hospital designated leads should work with GSAB to agree clear guidance for emergency responders on gathering information or persevering evidence in sexual abuse, physical abuse, neglect/ act of omission and organisational abuse enquiries so that police and specialist forensic examiners can meet National Police Chiefs Council (NPCC) and Crime Prosecution Services (CPS) expectations in response to offences against vulnerable adults.

KLOE [3](#), [4](#)

# Recommendation 7

- 7.1 The GSAB should discuss this review at regional level and (if regional leads agree), escalate to the National SAB Chairs Network the risks that emerged in this review due to gaps in national services or protocols.
- 7.2 GSAB and their partners may want to support the National SAB Chairs Network's call for the regulation of ASC labour providers under the Gangmasters and Labour Abuse Authority (GLAA).
- 7.3 The ICB and LA should provide assurance that, in line with their market shaping duties (s5 Care Act), they have oversight of providers' workforce sustainability plans and mechanisms within local quality assurance and safeguarding processes to identify concerns.

KLOE 5

# Recommendation 8

- 8.1 CQC should provide assurance to GSAB of the actions they have taken to learn lessons from this review.
- 8.2 CQC's assurance report should also detail the actions they have taken locally to assess if the findings from the national report apply locally and, if so, their action plan to enact the recommendations.

KLOE 4

# The Report and Next Steps

The final draft of the report was presented to the GSAB on 5<sup>th</sup> March 2025, by the independent reviewers, the GSAB approved the findings and recommendations of the report, which was subsequently circulated to family members and to the homeowners.

The report was formally published on the SAB Website on 2<sup>nd</sup> April 2025 and shared with the National SAB Chairs network for publication within the National SAR Library. The report was also circulated to the NE Regional SAB Chairs Network and the NE Regional SAR Champions group.

Residents and family members were offered the opportunity to meet with the GSAB Independent Chair to discuss the recommendations from the report.

A multi-agency panel, chaired by Nicola Bailey, SAB Independent Chair has been created to monitor the actions and ensure partner agencies work in together to deliver the recommendations within the report.