Round table event – organisational abuse

Event date: 21 January 2026
Venue: National Council for Voluntary Organisations, London
Host: Organisational Abuse Expert Reference Group

Executive summary

Leaders in health, adult social care, commissioning, regulation, academia and lived experience met to examine organisational abuse through the lens of practice, culture and system leadership.

Participants agreed that while awareness, regulation and voice have increased, organisational abuse persists - often normalised, bureaucratised, and embedded within routine systems and language.

There was a number of commonly occurring themes: fragmented accountability across providers, commissioners and regulators; inconsistent definitions; weak alignment between safeguarding and patient safety; and disjointed data systems. There is also a need for a focus on organisational culture.

There was strong consensus that:

- a single cross-sector definition is required across the Care Act, patient safety and NICE frameworks
- organisational abuse must be understood as both a cultural and systemic phenomenon (latent conditions and active failures)
- data exists but is inconsistently recorded and insufficiently triangulated
- collective accountability must replace fragmented oversight
- public and family voices must be strengthened
- parity of value between safeguarding and patient safety is essential in NHS settings.

The next 12 months should focus on definitional alignment, data triangulation, strengthened cultural oversight (including inspection levers), commissioning reform and leadership behaviours and public engagement. These are some of the essential foundations for making connections across the system in prevention and joint responses to organisational abuse.

1. Where are we now?

1.1 Greater awareness — persistent harm

Participants described a system that is more regulated, more vocal, and more self-aware than ever before. However, organisational abuse has not disappeared; it has evolved.

It is often:

- framed as “resource pressure”
- justified as “risk management”
- labelled as “non-compliance”
- masked within performance dashboards.

Harm may be quieter, normalised, and bureaucratised, rather than overtly abusive, nevertheless atrocities and serious abuse persist.

1.2 Interface between safeguarding, patient safety and quality systems and criminal investigations

In NHS contexts, safeguarding was perceived as having lower status than patient safety. Safeguarding duties arising within hospitals are sometimes displaced by patient safety pathways (e.g. PSIRF), leading to blurred thresholds and missed opportunities for multiagency safeguarding responses under the Care Act S42 duty. Participants noted that ministers are highly focused on patient experience.

There is a lack of parity alongside the lack of alignment between the two. Positioning safeguarding (and the associated multiagency response) as integral to patient safety may strengthen its influence. Allied to that is the need for the alignment of the two processes.

1.3 Adults less visible than children

Delegates reflected that children's safeguarding frameworks have undergone repeated revision in recent years, whereas adult safeguarding statutory guidance has remained comparatively static since 2014.

There was interest in cross-learning between adult and children's systems, particularly in learning disability and Special Educational Needs and Disabilities (SEND) contexts, where organisational culture is identified as a common risk factor.

1.4 Organisational culture as the central risk

Discussions reinforced that organisational abuse arises from:

- **latent system conditions:** operating models, funding structures, commissioning decisions, weak procedures, professional hierarchies and inequalities.
- **active cultural failures:** normalised poor practice, fear of speaking up, defensive leadership, lack of compassion, failure to listen (to staff, patients, residents, relatives), failure to aggregate concerns, absence of a learning culture and stated values not put into action.

Indicators include staffing instability, lack of suitable and/or local provision isolating people receiving care, inflexibility, weak safeguards and failure to triangulate early patterns of concern.

The following knowledge questions were posed:

- What do we know?
- What should we know?
- Why do systems fail to act on what they know?

Alongside this, there were questions about 'doing':

- What have we tried?
- What have we learned about what can work?
- What next, in making an impact?

1.5 Data and information exists but is fragmented

Information is dispersed including across:

- Section 42 enquiries and SARs
- the Safeguarding Adults Collection (SAC)
- patient safety systems
- workforce and restrictive practice data
- complaints/PALS
- inspection intelligence
- coroners' Regulation 28 reports
- LeDer reports.

Local authority safeguarding systems and the national SAC dataset are structured around individual Section 42 enquiries, which can obscure wider organisational patterns. In hospital settings, including private providers, reporting through NHS and ICB governance routes concerns may sit within patient safety systems rather than local authority data, reducing cross-system visibility of organisational risk. The absence of routine triangulation results in missed early warning signals.

Overall, discussions highlighted fragmented accountability across organisations and systems, leading to inconsistent responses that reinforce a negative cycle feedback loop.

2. How do we define organisational abuse?

2.1 The case for a single cross-sector definition

Participants strongly supported development of a universally recognised definition across the Care Act, patient safety and NICE.

Concerns were raised that current interpretations can:

- attribute responsibility to individual practitioners following policy/procedures
- fail to interrogate organisational or commissioning factors
- vary significantly between sectors.

A shared framework should:

- distinguish individual failings from systemic and/or cultural causation

- include clear indicators and thresholds
- apply across provider, commissioner, regulatory and criminal contexts
- emphasise triangulation and pattern recognition
- Include co-production

2.2 Context, systems and accountability

Definitions must recognise that actions are shaped by:

- policy design
- funding models
- operating procedures
- organisational culture.

Participants emphasised stronger leadership accountability for organisational factors, not only individual error.

2.3 Consistency and recording

There is currently:

- no consistent way to record organisational abuse across systems
- fragmented data definitions
- limited cross-agency sharing.

A consistent definitional and recording approach is foundational to prevention.

3. What are the barriers?

3.1 Inspection

The role of the Care Quality Commission (CQC) was central to discussion.

Barriers identified:

- inconsistent inspection application
- variable focus on organisational culture

- limited systematic engagement with families fearful of repercussions due to the scarcity of provision and that relatives will remain in the setting
- weak follow-through on Regulation 28 reports
- time limits on criminal investigations.

Opportunities include strengthening[1] well-led assessments to scrutinise culture and early warning indicators more consistently.

3.2 Policy and legislative interfaces

Key challenges include:

- fragmented accountability between provider, commissioner and regulator
- weak interface between Section 42 duties and patient safety processes
- perceived under-use or inconsistent application of existing legislation
- weak implementation of learning from SARs
- weak interface between quality and safeguarding responses
- hospital safeguarding responses being subsumed within patient safety pathways, limiting opportunity for multi-agency oversight and action.

Participants queried whether Care Act statutory guidance requires strengthening to clarify expectations on organisational abuse especially on issues such as:

- collective accountability
- joint/multi-agency responses
- coordination and triangulation of data
- the current definition in the Care and Support Statutory Guidance.

[1] By removing variability between inspection teams who can show insufficient focus on cultural risk leading to reactive rather than preventative approaches to organisational abuse. This can lead to inconsistency in how early warning signs are weighted, therefore, strengthening means moving from descriptive cultural commentary to systematic cultural diagnostics.

3.3 Systems and commissioning

Commissioning and market pressures can create risk conditions:

- placements made where needs cannot safely be met
- funding disputes ("bun fights") between NHS and social care
- where commissioning errs on the side of a 'money and task' focus, rather than on outcomes and people
- contracts lacking explicit organisational safeguarding clauses.

Siloed commissioning disconnects accountability and weakens collective ownership of risk.

3.4 Culture and "us vs them"

"A blame-averse culture" and professional silos undermine collective responsibility. Rather than being accountable, there was a tendency to try and avoid/shift accountability to others.

Social care providers reported parity gaps and diminished professional esteem relative to other sectors.

Collective accountability agreements were viewed as a necessary corrective to the persistent "everyone thought someone else was watching" culture of its someone else's responsibility.

3.5 Public and family voice

A growing proportion of care is self-funded, yet:

- families may not understand safeguarding language
- routes for raising concerns are unclear
- public understanding of "good care" is underdeveloped
- opportunities for families'/patients' voices to be heard are not always welcomed or empowering.

There was interest in aligning with wider public awareness initiatives (e.g. ADASS Care Can't Wait) to broaden understanding of adult safeguarding, alongside learning from NHS whistleblowing and "Freedom to Speak Up" work to strengthen transparency and public confidence.

4. Where would we want to be in a year?

Participants articulated a focused 12-month ambition across six domains.

4.1 Common definition and guidance

- Agreement of a single cross-sector definition.
- Publication of aligned practice guidance.
- Updated Care Act statutory guidance, clarifying organisational abuse thresholds, expectations on triangulation and leadership accountability.

4.2 Data, Triangulation and Transparency

- Implementation of a minimal multi-agency “Triangulation Core Set” (including incidents, staffing, complaints, safeguarding data, inspection intelligence, coroners’ notices, Police intelligence and information from local authority/safeguarding board quality monitoring approaches).
- Routine joint review through shared dashboards.
- Improved IT recording, enabling explicit capture of organisational abuse in hospitals, care providers and social care.
- Explicit information-sharing agreements covering risk of organisational abuse.

4.3 Inspection and regulatory levers

- Greater consistency in CQC inspections regarding culture and organisational abuse.
- Systematic lived experience input into inspection.
- Strengthened follow-through on Regulation 28 reports.
- Review of time-limits on CQC criminal investigations (where feasible).

4.4 Commissioning and market oversight

- Contracts mandating triangulation, joint risk registers and transparent escalation.
- Joint NHS–social care funding accountability for complex placements.
- Commissioning for engagement and active lives rather than containment.
- Co-production embedded in service design.

4.5 Culture, leadership and workforce

- Establishment of a cross-system leadership compact on culture.
- Explicit “speak up/listen up” expectations and psychological safety standards.
- Embedding Quality Improvement (QI) methodology within safeguarding practice.
- Publishing positive practice vignettes through regional networks.
- Ensuring parity of esteem across sectors.

4.6 Public and family voice

- Co-designed routes for families to raise concerns.
- Public communication aligned with awareness campaigns.
- Lived experience directly informing commissioning, inspection and learning - not only complaints systems.

4.7 Extending the scope

- Exploration of how organisational abuse principles apply within Children’s Services, particularly in LD/SEND contexts.
- Alignment of adult and children’s cultural risk frameworks.

In facilitating the above, identify and support wider use of research and resources (including case studies) that offer support and advice.

5. Next steps

The ERG is currently refining the key priorities and associated action plans for 2026-27 that would be achievable within the capacity and remit of the group. Steps will be taken in parallel to seek representation as appropriate from other bodies such as the National Safeguarding Board, National SAB Chairs and Managers networks, DHSC, etc.

6. Existing system risks and mitigation

Risk: performative scrutiny without accountability.
Mitigation: named cross-agency leads; published progress updates.

Risk: data sharing impeded by governance/IT barriers.
Mitigation: start with a minimal non-identifiable core set; embed in contracts and SAB frameworks.

Risk: safeguarding duties displaced by patient safety pathways.
Mitigation: clear joint protocol; routine audit; reporting to SABs and ICBs.

Risk: safeguarding duties displaced by provider quality forums.
Mitigation: clear protocols with routine reporting to SABs and ICBs.

7. Emerging priorities

The following are a set of suggested priorities which have emerged from the roundtable and subsequent reflections:

1. Develop a single cross-sector definition and shared framework.
2. Establish collective accountability agreements across partners.
3. Ensure parity between safeguarding and patient safety.
4. Strengthen triangulation and improve recording systems.
5. Mandate cross-organisational information sharing agreements.
6. Enhance CQC cultural diagnostics and lived experience input.
7. Strengthen commissioning oversight of organisational risk.
8. Promote joint funding models for complex placements.
9. Strengthen follow-through on coroners' Regulation 28 reports.
10. Develop a national leadership compact on culture.
11. Embed QI methodology in organisational safeguarding work.
12. Update Care Act statutory guidance to reflect organisational abuse expectations.

13. Review legislative gaps and under-used powers.
14. Co-design clearer routes for families to raise concerns.
15. Explore cross-application to children's services.

8. Acknowledgements

Thank you to all attendees for candid, constructive contributions and for ensuring strong regional representation.

Particular thanks to speakers, facilitators and table leaders, whose insights on culture, systems and accountability shaped this consolidated report.

Overall conclusion

Organisational abuse remains a systemic and cultural risk within health and social care.

The roundtables confirmed that prevention requires definitional clarity, shared intelligence, collective accountability, strengthened leadership behaviours and a more confident public voice.

The next year presents a practical opportunity to move from reflection to implementation - replacing fragmentation with aligned, prevention-focused action across the system.