South Gloucestershire Safeguarding Adults Board

Multi- Agency Procedures

To be read in conjunction with the Safeguarding Adults multi-agency policy agreed by:

Safeguarding Adults Boards for Bath and North East Somerset, Bristol, North Somerset, South Gloucestershire and Somerset

December 2017

Ratified by South Gloucestershire Safeguarding Adults Board: December 2017

Review due: 1 year

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1. Reporting a Concern

If you urgently need to make a safeguarding referral the number for South Gloucestershire is:

01454 868007

Other neighbouring area contact points for safeguarding concerns are:

Bath and North East Somerset:	01225 396000
Bristol	0117 922 2700
Gloucestershire	01452 426868
North Somerset Council	01275 888801
Somerset County Council	0300 123 2224
Wiltshire	0300 456 0111

In principle the concern should be reported to the authority which covers the location where the abuse is alleged to have taken place.

2. Background and Overview

These procedures are designed to give further information for people working in South Gloucestershire who may need to use the Safeguarding Adults process.

These procedures must be read in conjunction with the procedure developed by the agency that you work for and the Safeguarding Adults Multi Agency Policy agreed by South Gloucestershire Safeguarding Adults Board (along with Bristol, Bath and North East Somerset, and Somerset Boards). These procedures give an overview of what needs to be done in the multi-agency process. Each agency must have its own procedures which detail the actions that staff should take and which link to these procedures at key points such as raising a concern, sharing information, and attending meetings. The key is to communicate the relevant information with the relevant people or organisations to safeguard the adult who is or maybe at risk.

Adult Safeguarding is now on a statutory footing. Both the policy and procedures are based on the Care Act 2014 and the Statutory Guidance published in 2017. Staff will need training in order to have the skills to work within these policies and procedures which do not attempt to replace good training.

The Social Care Institute for Excellence provide resources to support the understanding of adult safeguarding. Their website is: http://www.scie.org.uk/adults/safeguarding

The Safeguarding Adults multi-agency policy gives the detail of who is covered by Adult Safeguarding processes and the principles involved. It is worth remembering that underpinning these procedures are the principles of:

- Well being
- Mental Capacity
- Involving the person in their safeguarding and ensuring that their outcomes are kept central to the process.(Making Safeguarding Personal)

The statutory guidance to the Care Act 2014 also makes it clear that 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 (Chapter 14 Statutory guidance to Care Act 2014)

Who do we safeguard?

The safeguarding duties apply to the Local Authority in respect of an adult who:

- Has needs for care and support (whether or not the local authority is meeting any of those needs), and;
- Is experiencing, or is at risk of, abuse or neglect, and:
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

The responsible Local Authority is the one covering the location where the abuse has taken place.

Types of abuse (for further information see the multi-agency policy and/or the SCIE website)

- Physical abuse
- Domestic abuse
- Sexual abuse
- Psychological abuse
- Financial or material abuse
- Modern slavery
- Discriminatory abuse
- Organisational abuse
- Neglects and acts of omission
- Self-neglect

3. Process

3a Raising a concern

If the person you are concerned about appears to meet the criteria above, is a resident of South Gloucestershire and/or the harm has occurred in South Gloucestershire you need to telephone the Customer Service Desk at South Gloucestershire Council on:

01454 868007

(if it is out of office hours you will be directed to another number). If there is an imminent risk of serious harm and/or the matter might involve criminal activity please ring the police first using 999.

The Safeguarding Adults Multi Agency Policy describes types and patterns of abuse. It is essential that whenever there are concerns about a person that could amount to abuse, neglect or self-neglect this should reported. There will be some services where great care will be needed as a level of risk taking is appropriate. For example within planned rehabilitation and re-ablement where people may fall in attempting to

push themselves towards their goals. The expectation is that this will have been fully risk assessed and discussed with the person and form part of their support plan.

It is worth thinking about what has caused you to be concerned. Sometimes this is straightforward, for example you may have witnessed an incident. In other instances it can be more difficult and you may have a "feeling" that something is going on because of a change in the person's behaviour which causes you concern. If you are in any doubt you should phone the Customer Service Desk to talk through your concerns.

The Customer Service Officer may discuss your concerns with a senior social worker (Senior Practitioner) and will come to one of three outcomes:

- The concern does not meet the threshold for a safeguarding enquiry and is better dealt with through other means, such as a care management review.
- The situation requires a notification only. This would be a concern which has not caused harm but still needs to be recorded. If this relates to a provider service then they will be asked to send in a copy of their own written incident report and /or risk assessments. Further information about the types of incidents that may require notification can be found in section 6 below.
- A full safeguarding concern needs to be raised so that further enquiries can be carried out. You may be asked to complete a safeguarding concern form (previously an alert form, also called an SA1). The Customer Service Desk will send you the correct form to complete. It is important that you fill it in and return it as soon as possible. It is essential that the information you provide is accurate and is clear about what has been seen/heard and what is opinion.

The Senior Practitioner will then gather further information if necessary and make a decision about whether a formal enquiry, under Section 42 of the Care Act 2014 is required.

3b Safeguarding Enquiry

The Care Act clarifies the responsibility of the Local Authority to manage the Safeguarding process and ensure that the most appropriate person carries out the enquiry and follow up. A social worker will co-ordinate the enquiry but may ask other practitioners to carry out some work on their behalf, for example liaising with the person, fact-finding or carrying out an assessment of capacity in relation to the safeguarding.

The Team Manager or a Social Work Senior Practitioner from the Access Team will be responsible for decision making, setting the framework for the enquiry and any meetings which are required. In other words the Local Authority manager maintains overall responsibility for the Safeguarding process.

Initially, there will be a strategy discussion to review the information that has been provided, discuss the risk and agree how the enquiry will take place. This will

normally be a discussion between the social worker and their manager. Others may not be directly included in the discussion but will be copied into the minutes. In more exceptional circumstances this discussion will be a larger multi-agency meeting. It is important to reduce risk as soon as possible. Ideally, a strategy discussion or meeting should be held within 5 working days of the safeguarding concern being raised.

If the risk is ongoing a safeguarding planning meeting will be held to decide on a further risk management plan/agreed actions. Ideally this will be held within 4 weeks of the concern being raised. If required, a review meeting will be held within 3 months. Further reviews can be arranged as required if the risk remains ongoing. There is flexibility within these timescales to meet individual's needs and ensure a proportionate response.

At any stage in this process the decision may be made that the situation does not need to remain in safeguarding. A letter to that effect will go to the referrer and will tell them what is happening e.g. the situation is now safe, the person has been referred for a social work review, or signposted to another service.

4. Involving the adult in their safeguarding (Making Safeguarding Personal)

Making Safeguarding Personal is now seen as core practice within safeguarding adults. It places people at the centre of any safeguarding that relates to them.

It is essential that people are involved as early as possible in the process. They should be made aware of the concern and why it is being raised as soon as possible. Ideally they should give their consent to the concern being raised. If they do not or cannot consent then it may still be necessary to carry out safeguarding enquiries in order to protect the person (if they lack capacity to consent or the risk is very high), or if there are risks to others.

The person should be included in discussions about them and where required they should be offered an advocate either from their family/friends if appropriate or through paid advocacy. Where possible people should attend meetings about them or have a representative/advocate who can do this.

The key element is establishing with the person from the beginning what they would like to happen. This is described as their desired outcomes. These outcomes may need to be re-negotiated but it is crucial to record and share them as soon as possible. During the process outcomes should be reviewed with the person and at the end there should be a discussion with them to see how far these have been met.

In South Gloucestershire everyone whose safeguarding incident progresses beyond the Strategy discussion/meeting stage is given the opportunity to give feedback on the process including the meeting of their outcomes.

5. Mental Capacity Act 2005

The Mental Capacity Act 2005 must underpin all work undertaken by professionals and other staff throughout the social care and health systems, however funded.

All staff must be familiar with the five statutory principles (as laid out in the Act and the Code of Practice) which are:

1. A person must be assumed to have capacity unless it is established that they lack capacity
2. A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

In respect of Safeguarding mental capacity becomes relevant at a number of points and separate assessments will be required for the specific decisions such as does the person have the capacity to understand what a safeguarding enquiry/process is? Have they capacity to understand "x" risk? Have they the capacity to understand the protection plan? All staff need to have had training on Mental Capacity appropriate to the work they are doing.

6. Safeguarding Notifications

Sometimes harm does occur, but after screening it is apparent that proportionate measures have been taken and no safeguarding enquiry is required. However it is still important that this information is reported and logged.

Sometimes situations occur which have not caused any harm to the person but which may indicate that there is a culture of poor professional practice within an organisation. This could be as a result of the structure, policies, processes or practices within that organisation. These situations will not normally require a full safeguarding enquiry, but need to be logged so that any patterns or themes can be easily identified.

The organisation should contact the Customer Service Desk to report incidents. The Customer Service Officer will advise them if they need to provide a written incident report/risk assessment. This should cover what appears to have gone wrong and what actions have been taken. For example: is this a training issue for staff, have staff not followed the care plan, have the person's needs changed and do they need a reassessment?

You should contact the CSO desk to report the following incidents:

6a. Falls

Where someone is having falls in any community location they should have the opportunity to have a falls screen through the appropriate local service such as district nursing, occupational therapy or physiotherapy. All reasonable efforts should be made to reduce risk through the use of correct aids, managing trip hazards etc. These actions should be documented in the person's care plan along with the appropriate risk assessments. It is essential that where there are issues of Mental Capacity these are properly assessed.

Care plans and risk assessments should always cover falls where these are likely. The crucial issue is whether there was any neglect in relation to the fall or the care that was provided afterwards.

- Falls should be reported to the Customer Service Desk whenever there is harm. This may be an injury such as a cut, a bruise or a fracture, but may also be emotional harm for example serious and lasting loss of confidence.
- Falls should be reported whenever there is evidence that the care plan, including manual handling guidance has not been followed.

It is not normally necessary to report a fall where no harm has occurred. However, if a person falls frequently then this should be discussed with the Customer Service Desk so that a decision can be made whether or not this needs further investigation.

6b Medication errors

These should all be reported to the Customer Service Desk (except where they occur in a health setting where there is an internal reporting system through to the CCG). When medication errors are reported it is essential that the information provided includes whether there was harm, that health advice has been sought, received and followed, what has happened to ensure there is not a recurrence and what has happened to the staff member(s) responsible.

6c Person on Person incidents

These can range from extremely serious assaults including sexual assaults to more minor incidents which may not appear to cause harm. In Care Homes it must be understood that these are incidents which are happening within a person's normal home, in a place where they should be able to feel safe and relaxed. It is important that the needs of the perpetrator are not seen as outweighing the rights of other people who live with them. These situations will need careful risk assessment leading to robust plans.

Some of these incidents will reach the threshold for criminal investigation and these must always be reported to the police as well as safeguarding. All Person on Person incidents in a care home setting must be reported to the Customer Service Desk.

6d Missed Visits

Missed visits to service users own homes by domiciliary care agencies should be reported to the Customer Service Desk in the following circumstances:

1. If the visit is missed because of a fault by the agency – such as the carer misreading the rota and not turning up; or
2. If the visit is cancelled by the agency; or
3. If the agency contacts the service user to rearrange the timing of the visit and the alternative time offered is not acceptable to the service user, so the visit is then cancelled

It is important to note that the above list of notifications is not complete. If any incident occurs which you feel may be a result of abuse, neglect or self-neglect, even if no harm has occurred, you should contact the Customer Service Desk for advice.

Care Quality Commission (CQC)

All registered providers will also need to consider reporting to the CQC. "Providers must notify CQC of all incidents that affect the health, safety and welfare of people who use services. The full list of incidents is in the text of the regulation" http://www.cqc.org.uk/content/regulation-18-notification-other-incidents#full-regulation.

7. Criminal Offences and Adult Safeguarding

Everyone is entitled to the protection of the law and access to justice.

Behaviour which amounts to abuse and neglect can also constitute specific criminal offences under various pieces of legislation. Although the local authority has the lead role in making safeguarding enquiries, where criminal activity is suspected then the early involvement of the police is likely to have benefits in many cases.

Criminal investigation by the police takes priority over all other enquiries, although a multi-agency approach should be agreed to ensure that the interests and personal wishes of the adult are considered throughout, even if they do not wish to provide evidence or support a prosecution. The welfare of the adult and others is paramount and requires continued risk assessment to ensure the outcome is in their interests and enhances their well-being.

If the adult has mental capacity and does not want any action to be taken this does not preclude the sharing of information between relevant professionals. Professionals need to be able to assess the risk of harm and be confident that the adult is not being unduly influenced, coerced or intimidated. They also need to be confident that no one else is at risk.

The police have a range of special measures available to facilitate the gathering and giving of evidence by vulnerable and intimidated witnesses, and these should be considered from the onset of any police investigation.

8. Resolution of professional differences (Escalation)

Continual feedback is an important part of self-improvement and raising standards. Listening and responding to concerns and complaints enables us to adjust and improve services and systems. Providing a formal but clear way for concerns to be expressed and taken seriously is one way in which we can demonstrate our respect for our partners and stakeholders. Partner organisations should refer to the Resolution of Professional Differences (Escalation Policy) for information about the process.

9. People in Positions of Trust:

It is important that there is a clear process for managing situations where people working with adults at risk (whether in a paid or unpaid capacity) behave in ways which could put the adult at risk. Where an incident has occurred as part of their work/volunteer role this can be dealt with through the individual safeguarding process. This should include ensuring that where appropriate referrals are made to the Disclosure and Barring Service (DBS) and/or professional bodies such NMC, HCPC.

Where the incident occurs outside of work then the Safeguarding Adults Manager at the Local Authority should be informed so that a similar process can be put in place although it will not be linked to a specific service user. Separate guidance is currently being drafted to cover this in more detail.

10. Information sharing/confidentiality

The sharing of information is a key activity in keeping adults who are at risk of harm safe. This has been highlighted by a large number of Serious Case Reviews and Safeguarding Adults Reviews which have sometimes stated that if professionals or other staff had acted upon their concerns or sought more information then death or serious harm might have been prevented.

Where an adult has suffered harm or is at risk of it then consideration must always be given to the sharing of information. Where risk does exist then the decision to share information or not must be recorded and an explanation given. Wherever possible the person's consent should be obtained to share information in line with the Making Safeguarding Personal principles of keeping people at the centre of their safeguarding. However there are circumstances where the right to privacy has to be balanced against the right to live free from harm and abuse.

If you are unsure then speak to the Customer Services Desk and seek advice.

Personal, Identifiable Data is protected by the Data Protection Act and for health records the Health Records Act also applies. Neither legislation precludes the sharing of information. Where a crime has or may be committed the Crime and Disorder Act applies.

The Safeguarding Adults Board has an information sharing agreement for its members. There are also specific requirements within the Care Act about information sharing when a Safeguarding Adults Review is required and this will be included in the relevant procedures.

11. Historic abuse

Where an adult reports abuse which happened whilst they were a child it is essential to seek advice from the adult safeguarding team who will make the necessary contacts. These situations are often complex and decisions will be required about who should lead on the investigation, who will offer support to the adult etc. The following will all be considered by the safeguarding team.

- If the adult does not have care and support needs they will be supported to go to the police who will decide whether or not they can investigate.

- The Children's department of the Local Authority where perpetrator is needs to be informed so they can check the current situation in terms of other children at risk e.g. grandchildren.

- If the person is/was a professional working with children then the LADO should be informed.

Where the abuse is historic but happened to an adult this would be followed up in the normal way under the Safeguarding Adult multi-agency policy and procedures with decisions to be made about which area would take the lead.

12. Managing multiple investigations

There will be many occasions when there need to be multiple investigations for example a safeguarding enquiry, a police investigation, a complaint, a root cause analysis, and/or disciplinary investigation. It is essential that there is agreement about the priority and order of these to ensure that one process does not impede another. The strategy discussion should lay out this process and ensure that all the relevant agencies/personnel are aware of their part in the process and timescales.

13. Organisational Safeguarding (previously Institutional Safeguarding)

There is a separate multi-agency procedure and guidance covering this which is available on the website. It will be reviewed during 2018.

14. Safeguarding Process Flowchart