Warrington Safeguarding Adults Procedures – Section 3: Understanding your role and how safeguarding fits in

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3 Understanding your role and how safeguarding fits in

3.1 The role of health services, GP commissioners and the NHS

NHS England, Clinical Commissioning Groups and NHS providers delivering health care have a statutory duty to ensure that they make arrangements to safeguard and promote the safety and welfare of children, young people and adults at risk of abuse and neglect.

Commissioners of health services have different roles than that of NHS providers. NHS Providers must deliver safe care and commissioners should be assured that the services are safe and effective. Across the whole of the health service there is a duty for all parties to have safe recruitment systems, training, internal reporting & investigation systems, up to date polices and effective interagency working.

Staff from these organisations also have a responsibility to maintain an accurate record of any circumstances where there is information to indicate that an adult is being abused or is at risk of being abused by any person who has care of or access to that adult and promptly alert the local authority (or police) to any safeguarding concerns.

3.2 Regulated Services

Regulated services are required to report to the Care Quality Commission within 24 hours any incidents which occur, which might affect the wellbeing of people within their care. (Care Homes Regulations 2001, regulation 37).

It is expected that any adults at risk are immediately safeguarded, and that a safeguarding concern is raised with safeguarding services and the police informed if a crime is suspected or known to have taken place.

The protection of adults must always be a primary concern when taking decisions about whether a member of staff continues to work, pending investigation of concerns, allegations or disclosures against them as an individual alleged to be responsible of abuse.

A safeguarding meeting or discussion is usually the vehicle for decision making and co-ordinating any investigations including disciplinary. It is important that agencies only take a first account and do not proceed with investigations before possible police involvement is decided as this may contaminate evidence.

The registered manager should also consider their organisations duty of candour to the adult and other relevant persons.

Commissioners of care or other professionals should only use safeguarding procedures in a way that reflects the principles above not as a means of intimidating providers or families.

Transparency, open-mindedness and timeliness are important features of fair and effective safeguarding enquiries. CQC and commissioners have alternative means of raising standards of service, including support for staff training, contract compliance and, in the case of CQC; enforcement powers may be used. Commissioners should encourage an open culture around safeguarding, working in partnership with providers to ensure the best

outcome for the adult.

3.3 Whistleblowing

If you are a member of staff who has concerns about your own organisation, you should have access to your organisation's whistle blowing, or protected disclosure procedures, and know what support is available to you. Responsible employers should have an open and transparent procedures and responses to concerns disclosed.

However, if after following those procedures you believe your concern has not been properly addressed and an adult is left at risk, then you can call the local authorities safeguarding services and your concerns will be taken seriously.

3.4 Subject to disciplinary procedures

Employer's internal guidelines should explain the rights of staff and how employers will respond where abuse is alleged against them.

Providers should be informed of any allegation against them or their staff and treated with courtesy and openness at all times. It is of critical importance that allegations are handled sensitively and in a timely way both to stop any abuse and neglect but also to ensure a fair and transparent process. It is in no-one's interests to unnecessarily prolong enquiries, however some complex issues may take time to resolve.

However, in certain circumstances the details of the safeguarding concern should not be discussed with the member of staff, or the circumstances investigated until the police decide on whether there is a criminal matter to be investigated as any discussion which takes place prior to a police interview may result in contamination of evidence.

Where applicable, employers must report workers to the Disclosure and Barring Service and to the statutory and other bodies responsible for professional regulation such as the General Medical Council or Nursing and Midwifery Council.

3.5 Carers

Circumstances in which a carer (for example, a family member or friend) could be involved in a situation that may require a safeguarding response include:

- A carer may witness or speak up about abuse or neglect
- A carer may experience intentional or unintentional harm from the adult they are trying to support or from professionals and organisations they are in contact with
- A carer may unintentionally or intentionally harm or neglect the adult they support on their own or with others

Assessment of both the carer and the adult they care for must include consideration of both their wellbeing. Section 1 of the Care Act includes protection from abuse and neglect as part of the definition of wellbeing and as such, an assessment is an important opportunity to explore the individuals' circumstances and consider whether it would be possible to provide information, or support that prevents abuse or neglect from occurring. Where that is necessary the local authority should make arrangements for providing it.

3.6 Safeguarding concerns raised on adults placed in Warrington by another authority

The Care Act Statutory Guidance and the Association of Directors of Adult Social Services (ADASS) offer definitions, responsibilities and guidance in respect of the responsibilities of the host and placing authorities in safeguarding situations.

The initial lead in response to a safeguarding concern should be taken by the host authority, the local authority where the incident occurred. The host authority will:

- Receive the concern
- Gather initial information
- Take immediate steps to protect the individual
- Notify the placing authority and gather information from it
- Involve the nominated person from the placing authority in the planning processes

Adult social care will co-ordinate the safeguarding process however we reserve the right to determine whether the host or placing authority is best placed to undertake any required safeguarding enquiry in light of the specific circumstances of the safeguarding concern.

3.7 Responding to historic allegations or where the adult is no longer at risk

In order to undertake a safeguarding enquiry under the s42 of the Care Act duty there has to be reasonable cause to suspect that the adult is 'experiencing, or is at risk of, abuse or neglect'. Therefore, the duty to make such enquiries relates to abuse or neglect to which an adult is believed to be being subjected, or where there is considered to be a risk of them experiencing abuse or neglect in the future.

On that basis, the statutory duty to undertake an enquiry does not apply to situations relating to historic abuse or neglect, where the person is no longer at risk. However dependent on the circumstances, there will be a number of situations for which responses are required to the identification of historic abuse.

In such situations it will be necessary to determine whether there is a current risk of harm to others and/or whether the situation requires criminal or other responses, such as complaints, or investigations by the commissioner or regulator.

3.8 Deaths

Where a safeguarding concern is received for an adult who has died particular considerations must be made. In accordance with the Care Act, a Section 42 enquiry will only be made where there is reasonable cause to believe other identifiable adults are experiencing, or are at risk of, abuse or neglect.

However where the SAB knows or suspects that the death resulted from abuse or neglect - whether or not it knew about or suspected the abuse or neglect before the adult died - and there is concern that agencies should have worked more effectively to safeguard the adult, there is a statutory requirement for the SAB to undertake a Safeguarding Adults Review under s44 of the Care Act. The SAB has a clear process in place for consideration as to whether the criteria for a Safeguarding Adults Review is met, which all agencies must be aware of and follow (see 3.9).

It is important that the death of any adult for whom a safeguarding concern has been made or is subject to a safeguarding enquiry is reported immediately to the local authorities

safeguarding service in order to consider what actions may need to be taken. This will include consideration of the evidence available and any other actions needed to establish the circumstances of the death, including liaison with the coroner and police. The process of establishing whether the death is related to any safeguarding concern can be complex and is often unclear at the point of notification.

Each health and social care agency has a duty of candour (3. 12) in respect of informing the deceased's family (and the relevant commissioners) where there may be concerns that the adults death was as a result of poor quality care, abuse or neglect. In balancing the need for sensitivity with transparency it may be appropriate to make initial enquiries in order to establish a sufficient degree of evidence or fact before disclosing concerns to the family.

The Care Act Statutory Guidance is clear that poor quality care is not always, in itself, a safeguarding matter, and should be responded to by the provider themselves, commissioners of the service, the Care Quality Commission and Warrington Safeguarding Adults Board.

It will be normal practice to inform the coroner of any concerns which could be directly relevant before burial or cremation. Contact with the Coroner should be via the local authority safeguarding services.

3.9 Safeguarding Adults Reviews

It is the duty of Warrington Safeguarding Adult Board to conduct any Safeguarding Adults Review in accordance with Section 44 of The Care Act. A Safeguarding Adults Review is not an investigation or reinvestigation; its purpose is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again.

The Care Act Statutory Guidance considers a Safeguarding Adults Review must take place when:

- An adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult; or
- An adult in its area has not died, but the Board knows or suspects that the adult has experienced serious abuse or neglect

The Board are free to arrange for a Safeguarding Adults Review in any other situations involving an adult in its area with needs for care and support. Safeguarding Adults Reviews may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

In the context of Safeguarding Adults Reviews, something can be considered serious abuse or neglect where, for example, the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life as a result of the abuse or neglect. Warrington Safeguarding Adult Boards Safeguarding Adults Review procedure should be followed.

Only Warrington's SAB can commission a Safeguarding Adults Review. Where an individual or agency believes or suspects there may have been circumstances where the threshold for holding a SAR has been met, they may refer a case to the Chair of the Adult Safeguarding Board to establish if there are important lessons for inter-agency work to be learnt from a case.

Before making this request, the individual should consider guidance, and discuss with relevant individuals within their organisation. Usually, the circumstances of any suspected Safeguarding Adults Review will be consistent with safeguarding concerns and the process as outlined in the multi-agency safeguarding policy and procedures should be followed.

However, there may be circumstances where safeguarding concerns are not obvious or evident, for example, where the individual may have experienced suicide and there are concerns that partner agencies could have worked more effectively to protect the adult.

3.10 Interface between a SAR and other types of serious incident investigations

There are a number of types of review and investigation that may interface with a Safeguarding Adults Review (SAR) and it is important to identify any other processes which may be running in parallel or being considered. These include a Child Serious Case Review (SCR), Domestic Homicide Review (DHR), Mental Health Homicide Review, safeguarding and serious incident investigations, criminal justice processes and Coroner inquests.

In setting up a Safeguarding Adults Review, the SAB must consider how that review will dovetail with other processes or investigations. Important principles in planning include ensuring adherence to any separate statutory requirements, ensuring appropriate expertise and knowledge, reduction of duplication, maximising effectiveness and learning; and minimising the impact on those affected by the case.

A Domestic Homicide Review must be conducted when the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by either a person with whom they were related or with whom they had been in an intimate relationship, or a member of the same household as themselves. A DHR takes place with a view to identifying the lessons to be learnt from the death.

Where there are possible grounds for more than one review, such as a DHR and a SAR, a decision should be made at the outset by the respective decision making bodies as to how they will coordinate the reviews, engagement and reporting. This may result in some areas of joint commissioning and oversight, or one board leading such as the Community Safety Partnership or the Adults or Children's Safeguarding Boards with the same or different reports being taken to each commissioning body.

3.11 Serious Incident Investigations

All agencies will have their own internal or statutory procedures to investigate serious incidents and to promote reflective practice or learning, and the procedure is not intended to duplicate or replace these, but they must be concordant with this procedure, legislation and associated guidance.

Serious Incidents in the NHS include: (Serious Incident Framework NHSE 2015)

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in: Unexpected or avoidable death of one or more people. This includes suicide/self-inflicted death; and homicide by a person in receipt of mental health care within the recent past.

- Unexpected or avoidable injury to one or more people that has resulted in serious harm;

- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:— the death of the service user; or serious harm;

- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where healthcare is not taking appropriate action/intervention to safeguard against such abuse occurring; or where abuse occurred during the provision of NHS-funded care.

- This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident.

From the outset, the circumstances in which a serious incident occurred should be considered in the context of multi-agency safeguarding procedures. Where there are grounds to consider that the adult has care and support needs and is experiencing or at risk of abuse or neglect, at any stage, these procedures should be followed.

It is important that while there should be adherence to any separate statutory requirements, the interface between serious incident investigations and requirements of the Care Act are maintained and are managed in accordance with the principles of reduction of duplication, maximising effectiveness and learning; and minimising the impact on those affected by the case. In each case the interface must be clear to those involved including those affected by the case.

3.12 Duty of Candour

Given that often the purpose of any investigation is to demonstrate openness and transparency, as well as focus on learning by identifying and implementing improvements to prevent reoccurrence of future similar incidents, it is crucial that the adult and/or their representative are involved in this process whenever possible.

Under the 2014 regulations of the Health and Social Care Act regulated providers are required to be open and transparent with people who use services and other relevant persons in general in relation to care and treatment.

This ‘duty of candour’ sets out some specific requirements that providers must follow when things go wrong including that the provider must:

- Make sure it acts in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity
- Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable patient safety incident has occurred, and provide support to them in relation to the incident, including when giving the notification
- Provide an account of the incident, which to the best of its knowledge is true, of all the facts about the incident as at the date of notification
- Offer an apology

- Follow this up by giving the same information in writing, and providing an update on the enquiries
- Keep a written record of all communication with the relevant person
- Advise the relevant person what further enquiries it believes are appropriate as a result of the patient safety incident

The regulation applies to registered persons when they are carrying out a regulated activity. The CQC may take other regulatory action, and can prosecute for a breach of parts 20(2)(a) and 20(3) of this regulation and can move directly to prosecution without first serving a warning.