

6. Supporting processes.

6.1. Information sharing and confidentiality.

Sharing the right information, at the right time, with the right people, is fundamental to good practice in adult safeguarding but has been highlighted as a difficult area of practice.

The Care Act 2014 s45 ‘supply of information’ duty covers the responsibilities of others to comply with requests for information from the Safeguarding Adults Board. Sharing information between organisations as part of day-to-day safeguarding practice is already covered in the common law duty of confidentiality, the Data Protection Act, the Human Rights Act and the Crime and Disorder Act. The Mental Capacity Act is also relevant as all those coming into contact with adults with care and support needs should be able to assess whether someone has the mental capacity to make a decision concerning risk, safety or sharing information.

Organisations need to share safeguarding information with the right people at the right time to:

- prevent death or serious harm
- coordinate effective and efficient responses
- enable early interventions to prevent the escalation of risk
- prevent abuse and harm that may increase the need for care and support
- maintain and improve good practice in adult safeguarding
- reveal patterns of abuse that were previously undetected and that could identify others at risk of abuse
- identify low-level concerns that may reveal people at risk of abuse
- help people to access the right kind of support to reduce risk and promote wellbeing
- help identify people who may pose a risk to others and, where possible, work to reduce offending behaviour
- reduce organisational risk and protect reputation.

Adults have a general right to independence, choice and self-determination including control over information about themselves. In the context of adult safeguarding these rights can be overridden in certain circumstances such as emergency or life-threatening situations.

The law does not prevent the sharing of sensitive, personal information **within** organisations. If the information is confidential, but there is a safeguarding concern, sharing it may be justified. In addition the law does not prevent the sharing of sensitive, personal information **between** organisations where the public interest served outweighs the public interest served by protecting confidentiality – for example, where a serious crime may be prevented.

The Data Protection Act enables the lawful sharing of information.

There should be a local agreement or protocol in place setting out the processes and principles for sharing information between organisations.

An individual employee cannot give a personal assurance of confidentiality. Frontline staff and volunteers should always report safeguarding concerns in line with their organisation’s policy – this is usually to their line manager in the first instance except in emergency situations. However, it is good practice to try to gain the person’s consent

to share information and as long as it does not increase risk, practitioners should inform the person if they need to share their information without consent.

Organisational policies should have clear routes for escalation where a member of staff feels a manager has not responded appropriately to a safeguarding concern. All organisations **must** have a whistleblowing policy.

The management interests of an organisation should not override the need to share information to safeguard adults at risk of abuse. All staff, in all partner agencies, should understand the importance of sharing safeguarding information and the potential risks of not sharing it. All staff should understand when to raise a concern with the local authority adult social services.

The six adult safeguarding principles (Empowerment, Protection, Prevention, Proportionality, Partnership and Accountability) should underpin all safeguarding practice, including information-sharing.

Ref: *SCIE Adult safeguarding: sharing information guide 2014*.

6.2. Duty of Candour.

The statutory duty of candour was introduced for providers of health and social care services under Regulation 20 of the Health and Social Care act 2008: Regulations 2014. The regulation applies to registered persons when they are carrying on a regulated activity.

The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

6.3. Record Keeping

Good record-keeping is an essential part of the accountability of organisations to those who use their services. Maintaining proper records is vital to an individual's care and safety. If records are inaccurate, future decisions may be wrong and harm may be caused to the individual. Where an allegation of abuse is made all agencies have a responsibility to keep clear and accurate records. It is fundamental to ensure that evidence is protected and to show what action has been taken and what decisions have been made and why.

It is equally important to record when actions have not been taken and why e.g. an adult with care and support needs with mental capacity may choose to make decisions professionals consider to be unwise.

Staff should be given clear direction as to what information should be recorded and in what format. The following questions are a guide:

- What information do staff need to know in order to provide a high quality response to the adult concerned?
- What information do staff need to know in order to keep adults safe under the service's duty to protect people from harm?
- What information is not necessary?
- What is the basis for any decision to share (or not) information with a third party?

6.4. Cooperation

It is important within adult safeguarding for all partners to cooperate and work in a joined-up way, to eliminate the disjointed care that is a source of frustration to adults with care and support needs, other individuals, and staff, and which often results in poor care, with a negative impact on health and wellbeing.

All organisations should work together and co-operate where needed, in order to ensure the wellbeing and safety of adults with care and support needs (including carers' support).

Co-operation between partners should be a general principle for all those concerned, and all should understand the reasons why such co-operation is important. The Care Act sets out five aims of co-operation between partners which are relevant to care and support, although it should be noted that the purposes of co-operation are not limited to these matters:

- promoting the wellbeing of adults needing care and support and of carers;
- improving the quality of care and support for adults and support for carers (including the outcomes from such provision);
- smoothing the transition from children's to adults' services;
- protecting adults with care and support needs who are currently experiencing or at risk of abuse or neglect;
- identifying lessons to be learned from cases where adults with needs for care and support have experienced serious abuse or neglect.

6.5. Risk assessment and management

Achieving balance between the right of the individual to control his or her care package and ensuring adequate protections are in place to safeguard well-being is a very challenging task.

The assessment of the risk of abuse, neglect and exploitation of people using services should be integral in all assessment and planning processes, including assessments for self-directed support and the setting up of Personal Budget arrangements. Assessment of risk is dynamic and ongoing, especially during the adult safeguarding process, and should be reviewed throughout so that adjustments can be made in response to changes in the levels and nature of risk.

Risk is often thought of in terms of danger, loss, threat, damage or injury, although in addition to potentially negative characteristics, risk taking can have positive benefits for individuals and their communities. As well as considering the dangers associated with risk, the potential benefits of risk-taking should therefore also be identified; a process which should involve the individual using services, their families and health or social care practitioners.

Positive risk taking is a process which starts with the identification of potential benefit or harm. The desired outcome is to encourage and support people in positive risk taking to achieve personal change or growth. This involves:

- assuming that people can make their own decisions (in line with the Mental Capacity Act) and supporting people to do so;
- working in partnership with adults with care and support needs, family carers and advocates and recognising their different perspectives and views ;
- developing an understanding of the responsibilities of each party;
- empowering people to access opportunities and take worthwhile chances;

- understanding the person's perspective of what they will gain from taking risks; and understanding what they will lose if they are prevented from taking the risk;
- promoting trusting working relationships;
- understanding the consequences of different actions;
- making decisions based on all the choices available and accurate information;
- being positive about risk taking;
- understanding a person's strengths and finding creative ways for people to be able to do things rather than ruling them out;
- knowing what has worked or not in the past;
- where problems have arisen, understanding why;
- supporting people who use services to learn from their experiences;
- ensuring support and advocacy is available;
- sometimes supporting short-term risks for long-term gains;
- ensuring that services provided promote independence not dependence.

Reference: A Positive Approach to Risk & Personalisation: A Framework Developed by ADASS West Midlands, Joint Improvement Partnership & NHS West Midlands.

6.6. Whistleblowing

The Public Interest Disclosure Act 1998 provides a framework for whistleblowing across the private, public and voluntary sectors. Each member organisation of the SAB will have its own whistleblowing policy. These policies should provide people in the workplace with protection from victimisation or detriment when genuine concerns have been raised about malpractice. The aim is to reassure workers that it is safe for them to raise concerns, and partner organisations should establish proper procedures for dealing with such concerns.

6.7. Complaints

Complaints received from any source about adult safeguarding practice or arising from the adult safeguarding process should be handled by the relevant complaints procedures of the organisation about which the complaint has been made. See local guidance for details.

6.8. MARAC (Multi Agency Risk Assessment Conference)

A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of the local police, probation, health, children and Adults Safeguarding bodies, housing practitioners, substance misuse services, independent domestic violence advisers (IDVAs) and other specialists from the statutory and voluntary sectors.

The four aims of a MARAC are as follows:

- to safeguard adult victims who are at high risk of future domestic violence;
- to make links with other public protection arrangements in relation to children, people causing harm and adults with care and support needs;
- to safeguard agency staff;
- to work towards addressing and managing the behaviour of the person causing harm.

6.9. Domestic homicide reviews (DHRs).

Domestic Homicide Reviews were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (DVCVA) 2004. For further guidance see - Home Office – Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.

A Domestic Homicide Review would be required when the definition in section 9 of the Domestic Violence Crime and Victims Act (2004) is met in that:

...the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by –

- (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- (b) a member of the same household as himself.

This provision came into force on 13 April 2011 and the purpose is to:

- establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result.
- apply these lessons to service responses including changes to policies and procedures as appropriate.
- prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

DHRs are not enquiries into how the victim died or into who is culpable and are not specifically part of any disciplinary inquiry or process. The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence by offering and putting in place:

- appropriate support mechanisms procedures
- resources and interventions with the aim of avoiding future incidents of domestic homicide and violence.

A DHR will also assess whether agencies have sufficient and robust procedures and protocols in place, which were in turn understood and adhered to by staff. The DHR process is similar to that of Safeguarding Adults Reviews (SAR's) and children's serious case reviews (SCRs). The main purpose is to learn lessons.

6.10. Multi-agency public protection arrangements

The purpose of the multi-agency public protection arrangements (MAPPA) framework is to reduce the risks posed by sexual and violent offenders in order to protect the public, including previous victims, from serious harm. The responsible authorities in respect of MAPPA are the Police, Prison and Probation Services who have a duty to ensure that MAPPA is established in each of their geographic areas and to undertake the risk assessment and management of all identified MAPPA offenders (primarily violent offenders on licence or mental health orders and all registered sex offenders). The Police, Prison and Probation Services have a clear statutory duty to share information for MAPPA purposes.

Other organisations have a duty to co-operate with the responsible authority, including the sharing of information. These include:

- local authority children, family and adult social care services
- NHS CCG's, other health trusts and the National Health Service Executive;
- Jobcentre Plus
- youth offender teams
- local housing authorities
- registered social landlords with accommodation for MAPPA offenders.

6.11. Child protection

The Children Act (CA) 1989 provides the legislative framework for agencies to take decisions on behalf of children and to take action to protect them from abuse and neglect.

Everyone must be aware that in situations where there is a concern that an adult with care and support needs is or could be being abused or neglected and there are children in the same household, they too could be at risk. Reference should be made to the local child protection procedures, the local Safeguarding Children Board, inter-agency guidelines and internal protocols dealing with cross-boundary working if there are concerns about abuse or neglect of children and young people under the age of 18. Referral must be made to the relevant children and families department and any multi-agency safeguarding children policy and procedures.

Professionals should be alert to the possibility of child sexual exploitation and must report any such concerns to local authority childrens services and/or the police. Child sexual exploitation (CSE) is a crime that can affect any child, anytime, regardless of their social or ethnic background. It is child abuse and involves perpetrators grooming their victims in various ways, such as in person, via mobiles or online, to gain their trust before emotionally and sexually abusing them. It can take place in many forms, whether through a seemingly consensual relationship, or a young person being forced to have sex in return for some kind of payment, such as drugs, money, gifts or even protection and affection.

The MCA 2005 applies to young people aged 16 years and over apart from the following aspects:

- only people aged 18 or over can make a lasting power of attorney
- the law generally does not allow anyone below the age of 18 to make a will
- DOLS authorisations under the MCA apply only to people aged 18 or over.

Information on decisions to refuse treatment made in advance by young people under the age of 18 is available at www.dh.gov.uk/consent.

6.12. Community Safety Partnerships.

Community safety partnerships (CSPs) are made up of representatives from the 'responsible authorities', which are the:

- police
- local authorities
- fire and rescue authorities
- probation service
- health

The responsible authorities work together to protect their local communities from crime and to help people feel safer. They work out how to deal with local issues like antisocial behaviour, drug or alcohol misuse and reoffending. They annually assess local crime priorities and consult partners and the local community about how to deal with them.

6.13. Harm Reduction Forums and Anti-Social Behaviour processes

Such forums are also known as VARMS - Vulnerable Adult Risk Management Strategy and many were set up in response to the Stephen Hoskins and Fiona Pilkington Serious Case Reviews to effectively case manage and provide a multi-agency response to vulnerable individuals who may be victims of hate crime, anti-social behaviour and repeat callers to emergency services and partner agencies.

The purpose of the Forums is to coordinate services in response to the identified needs of individuals in order to prevent, protect and address behaviour affecting the individuals and/or to address their needs.

6.14. Children's Serious Care Review and Child Death Overview Processes

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. For further guidance see – HM Government - Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children 2013.

A serious case review would be undertaken when abuse or neglect is known - or suspected - and either:

- a child dies
- a child is seriously harmed and there are concerns about how organisations or professionals worked together to protect the child

Child Death Overview Process (CDOP). The Local Safeguarding Children's Board (LSCB) is responsible for ensuring that a review of each death of a child normally resident in its area is undertaken by a Child Death Overview Panel (CDOP). The purpose of this review is to conduct a comprehensive, multidisciplinary review of child deaths, to better understand how and why children die, and use the findings to take action that can prevent other deaths and improve the health and safety of children.

6.15. Multi Agency Public Protection Arrangements (MAPPA) Serious Case Review

A MAPPA SCR is required when the main purpose is to examine whether the MAPP arrangements were effectively applied and whether the agencies worked together to do all they reasonably could to manage effectively the risk of further offending in the community.

6.16. Serious Further Offending (SFO) Notification and Review Procedures

SFO Notification and Review Procedures are intended to ensure rigorous scrutiny of those cases where offenders under the management of the NPS or a CRC have been charged with a specified violent or sexual offence in order that:-

- the public may be reassured that the NPS, CRCs and all other providers of probation and community services are committed to reviewing practice in cases where offenders managed by them are charged with certain serious offences;

- areas of continuous improvement to risk assessment, risk management and offender management practice and policy within the NPS, CRCs and all other providers of probation and community services (together with other parts of the NOMS Agency or beyond as appropriate) are identified and disseminated locally and nationally, as appropriate; and
- Ministers, the NOMS Chief Executive, other senior officials within NOMS and the wider Ministry of Justice (MoJ), where appropriate, can be informed of noteworthy cases of alleged serious further offences committed by offenders whilst under supervision. The responsibility for this currently sits in the NOMS Offender Management and Public Protection Group (OMPPG).

6.17. NHS Serious Incidents

Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare (NHSE, 2015).

Serious incidents are often triggered by events leading to serious outcomes for patients, staff and/or the organisation involved. (NHSE, 2015). They may be identified through various routes including, but not limited to, the following:

- Incidents identified during the provision of healthcare by a provider e.g. patient safety incidents or serious/distressing/catastrophic outcomes for those involved;
- Allegations made against or concerns expressed about a provider by a patient or third party;
- Initiation of other investigations for example: Serious Case Reviews (SCRs), Safeguarding Adult Reviews (SARs), Safeguarding Adults Enquiries (Section 42 Care Act), Domestic Homicide Reviews (DHRs) and Death in Custody Investigations (led by the Prison Probation Ombudsman). NB: whilst such circumstances may identify serious incidents in the provision of healthcare this is not always the case and SIs should only be declared where the definition above is fulfilled;
- Information shared at Quality Surveillance Group meetings;
- Complaints;
- Whistle blowing;
- Prevention of Future Death Reports issued by the Coroner

Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

Serious Incidents in healthcare settings will usually be reported and investigated retrospectively, with the incident itself and resultant risk having been already managed. However, in some circumstances, the serious incident will indicate that an identified

adult with care and support needs is experiencing or is at ongoing risk of abuse or neglect. In such cases, the Care Act section 42 duty of Enquiry may be triggered, and the Serious Incident investigation process may form all or part of the Enquiry process to decide what action is required in the adult's case.

The needs of those affected should be the primary concern of those involved in the response to and the investigation of serious incidents. Patients and their families/carers and victims' families must be involved and supported throughout the investigation process.

There is no definitive list of events/incidents that constitute a serious incident and lists should not be created locally as this can lead to inconsistent or inappropriate management of incidents. Where lists are created there is a tendency to not appropriately investigate things that are not on the list even when they should be investigated, and equally a tendency to undertake full investigations of incidents where that may not be warranted simply because they seem to fit a description of an incident on a list.

Serious Incidents must be declared internally as soon as possible and immediate action must be taken to establish the facts, ensure the safety of the patient(s), other services users and staff, and to secure all relevant evidence to support further investigation. Serious Incidents should be disclosed as soon as possible to the patient, their family (including victims' families where applicable) or carers. The commissioner must be informed (via STEIS and/or verbally if required) of a Serious Incident within 2 working days of it being discovered. Other regulatory, statutory and advisory bodies, such CQC, Monitor or NHS Trust Development Authority, must also be informed as appropriate without delay. Discussions should be held with other partners (including the police or local authority for example) if other externally led investigations are being undertaken. This is to ensure investigations are managed appropriately, that the scope and purpose is clearly understood (and those affected informed) and that duplication of effort is minimised wherever possible (NHSE 2015).

Serious Incidents should be closed by the relevant commissioner when they are satisfied that the investigation report and action plan meets the required standard.

Healthcare providers must contribute towards safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Board. Where it is indicated that a serious incident within healthcare has occurred the necessary declaration must be made.

Whilst the Local Authority will lead Safeguarding Adults Reviews and initiate Safeguarding Enquiries, healthcare must be able to gain assurance that, if a problem is identified, appropriate measures will be undertaken to protect individuals that remain at risk and ultimately to identify the contributory factors and the fundamental issues (in a timely and proportionate way) to minimise the risk of further harm and/or recurrence. Providers and commissioners must liaise regularly with the local authority safeguarding lead to ensure that there is a coherent multi-agency approach to investigating and responding to safeguarding concerns, which is agreed by relevant partners. Partners should develop a memorandum of understanding to support partnership working wherever possible.

Incidents can be closed before all actions are complete but there must be mechanisms in place for monitoring on-going implementation. This ensures that the fundamental purpose of investigation (i.e. to ensure that lessons can be learnt to prevent similar incidents recurring) is realised.

6.18. Responding to organisational failure and abuse.

The Care and Support statutory guidance clarifies that the Adult Safeguarding duties under the Care Act are 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) assuring 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.

Local areas will generally have arrangements and systems in place that are designed to respond to quality and safety concerns in provider services. In most areas there will be regular information sharing meetings between commissioners and regulators, for example, the Local Authority, the CQC, Clinical Commissioning Groups, NHS England, or there will be frameworks in place that can call such meetings as and when required. The West Midlands region have produced a "*Framework and Guidance for Responding to Organisational Failure or Abuse*" that is available to be adopted or adapted by local Safeguarding Adults Boards - check your local arrangements.

Local quality surveillance/quality escalation frameworks will often need to interface closely and work alongside responses under this procedure. This will need to reflect the individual circumstances of individual cases, but could be, for example, to pass information arising from adult safeguarding concerns and enquiries to commissioners and regulators to inform quality monitoring and regulatory processes, to help to address concerns raised that relate to service quality but that do not meet the criteria for the Section 42 duty of Enquiry, or to seek to address and remedy underlying service quality concerns that are leading to risk of abuse or neglect in identifiable cases.

It is recognised that in a critical few cases where the service quality and safety issues are so great and pose such a high risk to users of that service that consideration of the duty of Enquiry applying to all or groups of individuals may apply. However, it is expected that such circumstances would be rare, and that the statutory principals of proportionality and protection should be balanced carefully when considering extending the Care Act section 42 duty of Enquiry to all or groups of individuals in organisational settings.