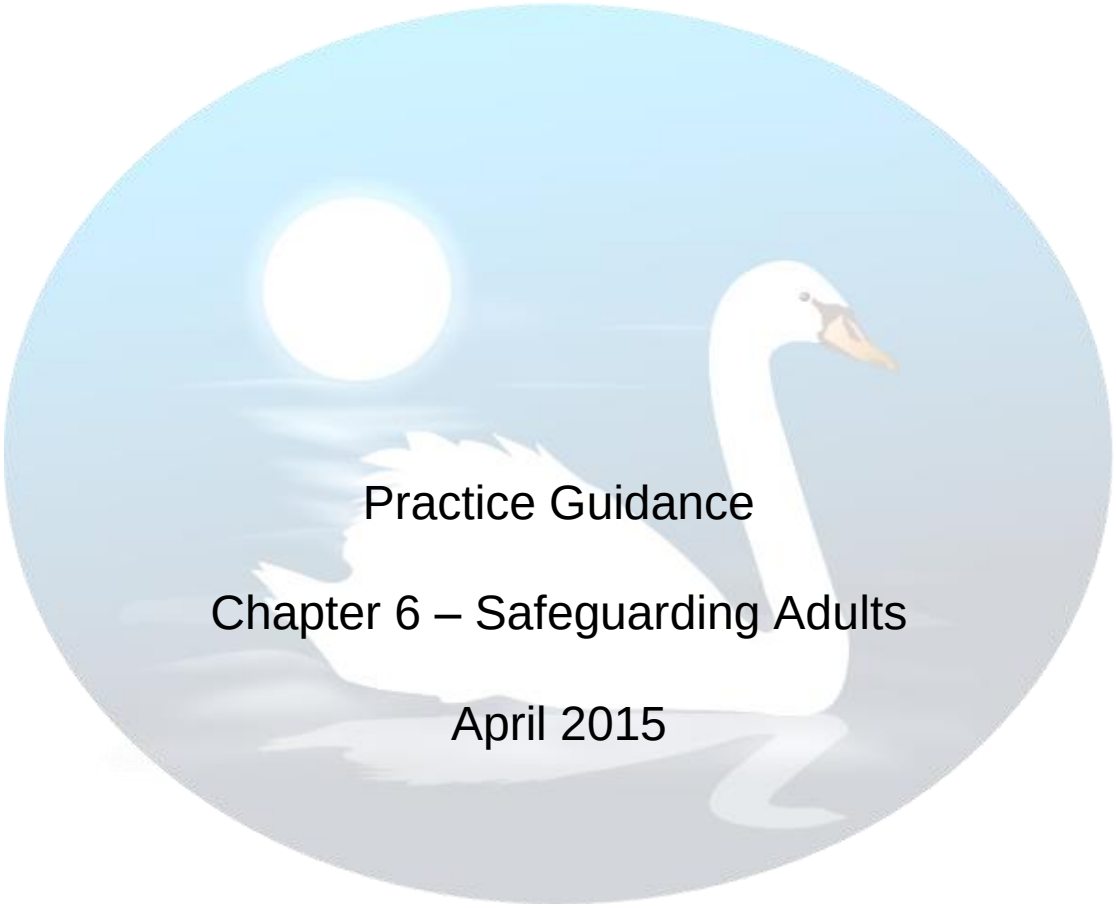
Bracknell Forest Council



Practice Guidance

Chapter 6 – Safeguarding Adults

April 2015

Summary of changes made for April 2015 version

Specific changes

- The statutory basis for undertaking safeguarding enquires is set out in section 5 of the guidance.
- Timeframe for decision making regarding if the concern should proceed to an enquiry changing from 24 to 48 hours. This is to facilitate person centred practice. This is set out in section 4 of the guidance.
- The timeframe for the initial safeguarding meeting to take place remains 5 working days, but practitioners are given the flexibility to not meet this target if it supports good multi agency working and or facilitating the adults involvement. However rational must be recorded in LAS. This is set out in section 6 of the guidance.
- The statutory requirement for advocacy is set out in section 9 of the guidance
- Changes to the 'post safeguarding questionnaire' to ensure it will be compliant with the Adult Social Care Outcomes Framework (ASCOF) return are contained in appendix D-F.

General changes

- The emphasis on making safeguarding person is embedded within the guidance.

Contents **Page**

1. Introduction

1.1 This document is written by Bracknell Forest Councils, Adult Social Care, Health and Housing department and applies to all staff within the department who undertake safeguarding enquires.

1.2 This document is to be read in conjunction with the Care Act Statutory guidance and the Berkshire Safeguarding Adults Policy and Good Practice manual. The Berkshire Safeguarding Adults Policy and Good Practice manual can be accessed via the following hyperlink http://berksadultsg.proceduresonline.com/index.htm

1.3 This guidance refers to Designated Safeguarding Managers (DSMs) and Safeguarding Assessors. The chart below sets out what these roles are and who may undertake them

Role	Detail	Who may undertake the role
Safeguarding Assessor	This practitioner will undertake safeguarding assessment and formulate protection plans with the individual and where appropriate their advocate, family and other relevant people	A Social Care Practitioner working within the community teams. However the practitioner must have undertaken a Level 2 (safeguarding) course within the last 3 years and be deemed competent by their manager.

Role	Detail	Who may undertake the role
Designated Safeguarding Manager (DSM)	The DSM is responsible for the management of the safeguarding process and ensuring that best practice is followed by the safeguarding assessor	This will typically be: • Senior Practitioner • Assistant Team Manager • Team Manager, • Community Services Manager • Head of Service • Chief Officer. However before undertaking this role the practitioner must have undertaken a Level 3 (safeguarding) course within the last 3 years and must be deemed competent by their manager. The Team Manager (in consultation with their Head of Service) can decide that a practitioner not in one of the above role undertakes the DSM role as part of their professional development, however they must be satisfied that they care competent.

2. Principles

2.1 All practitioners who support adults at risk will actively demonstrate and promote the following principles, which are demonstrated with a short exempla statement.

- **Empowerment** – People being supported and encouraged to make their own decisions and informed consent.

  "I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."

- **Prevention** – It is better to take action before harm occurs.

  "I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."

- **Proportionality** – The least intrusive response appropriate to the risk presented.

  "I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."

- **Protection** – Support and representation for those in greatest need.

  "I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."

- **Partnership** – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

  "I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."

- **Accountability** – Accountability and transparency in delivering safeguarding.

  "I understand the role of everyone involved in my life and so do they."

In addition to this all safeguarding interventions must be focused on the promotions of the adults' wellbeing and the prevention of harm.

2.2 In addition to the above the following practice standards are also to be followed.

- All allegations or suspicions of abuse will be taken seriously; action will be taken to protect those at immediate risk of harm.
- All safeguarding concerns will be responded to in a timely manner, with a decision being made whether or not to proceed to a safeguarding enquiry being made within 48 hours.

- Providing safe support and appropriate responses when abuse is identified
- When support is needed, it will be accessible, provided by people with expertise and knowledge.
- Written records will be kept on LAS and standards of record keeping will be in line with agreed policy.
- All Safeguarding referrals will be audited by the DSM at point of closure, with necessary actions and follow up being taken.

3. Responsibilities

3.1 All staff involved in the management of safeguarding concerns are responsible for undertaking any action assigned to them via the safeguarding plan, and ensuring that all relevant information is shared with the DSM and other appropriate parties.

3.2 If concerns are highlighted about a service provider that are not specific to an individual supported by that service, determining the management of these concerns is the responsibility of the Care Governance Board (CGB). In circumstances such as these the concerns will be discussed at the Care Governance Board and the services improvement plan will be reviewed and monitored by this board. The DSM is responsible for referring the concern to CGB (If there is significant risk this must take place immediately).

3.3 Then Older People and Long Term Conditions Team will respond to the safeguarding alert/referrals unless the person is:

- receiving support from another team i.e. CTPLD, ASD Team, CMHT, CMHT (OA)
- Or is support purchased through or arranged one of the above referenced teams.

In which case that team is responsible for responding to the alert.

3.4 If the individual is receiving support from Community Response and Reablement, then the Older Person and Long Team Conditions team will respond to the safeguarding alert. However a discussion will take place between the DSM and the duty manager for CR&R as to which team is best placed to respond to other presenting issues e.g. reablement and or other

assessment and support planning activities. Once agreement has been reached a clear record will be made in the person social care record and this will communicated to all parties, including the person to whom the safeguarding concern relates.

3.5 The **Designated Safeguarding Manager** (DSM) is responsible for the management of the safeguarding process and ensuring that best practice is followed by the safeguarding assessor. DSMs will ensure that staff in their teams are aware of who is the 'duty DSM'

3.6 **Team Managers/ Services Managers** are responsible for ensuring that this document is complied with within their team/s. It may be the case that Team Managers/Services Managers also act as DSMs, but where they do not, they are responsible for quality assuring the practice of DSM within their team i.e. where Senior Practitioners and Assistant Team Managers act as DSMs

3.7 **Heads of Service** are responsible for ensuring staff in their service areas have appropriate levels of training and knowledge to respond to safeguarding alerts. This includes having sufficient numbers of DSMs and safeguarding assessors (staff who have undertaken safeguarding level 2 courses) within their service area. Heads of Service are also responsible for ensuring the quality of safeguarding work within their service areas.

3.8 The **Head of Adult Safeguarding** is responsible for setting the safeguarding practice framework and for ensuring there is robust and effective partnership working at a strategic level, and that trends and themes in safeguarding alerts are analysed with the relevant Head of Service and Team Managers/Services Managers on at least a quarterly basis.

3.9 **Safeguarding Development Workers** are responsible for supporting front line teams in delivering effective and person centred responses to safeguarding alerts. Safeguarding Development Workers are responsible for chairing safeguarding meetings, monitoring alerts to ensure that any trends are identified and supporting DSM with monitoring of best practice. However, it should be noted that the responsibility for individual safeguarding alerts rests with the relevant DSM.

3.10 **Safeguarding Assessors** are responsible for assessing risk and creating protection plans in partnership with the adult at risk and where appropriate, their advocate, families and support networks. The safeguarding assessor is responsible for ensuring that accurate records are maintained.

3.11 **Safeguarding Minute Takers** are responsible for organising (sending out invites, arranging a venue etc.) safeguarding meetings, in partnership with the DSM and or Chair and for taking accurate and legible minutes of safeguarding meetings. IN addition to this they are responsible for ensuring that the minutes are recorded in LAS and sent to the Chair of the meeting for approval within 4 working days of the meeting. Once the minutes have been approved by the chair, the safeguarding minute taker is responsible for distributing the minutes to all relevant parties It should be noted that training will be made available for safeguarding minute takers to enable them to undertake the role.

4. On receipt of a safeguarding concern

4.1 If on the basis of the initial information the practitioners assess that there is 'a reasonable cause to suspect abuse' (this is a very low threshold) then the practitioner must follow this guidance. If there is not a reasonable cause to suspect abuse, the practitioner should, provide information and advice, refer to another agency and or start the support self-assessment process as appropriate.

4.2 On receipt of the concern the following steps must be taken immediately.

- If the concern indicates the individual is at risk of immediate harm or in need of medical attention appropriate services **must be called immediately** i.e. police, ambulance or GP.
- However, this will not always be necessary, and in the majority of situations the most appropriate response will be for the Safeguarding Assessor to visit. The presumption is that the Safeguarding Assessor will visit on the day the concern comes to light. However if this is not the case the rational must be recorded in LAS.
- The duty DSM must be informed of the concern.
- A safeguarding Assessor must be allocated to the alert
- The safeguarding assessor must undertake an initial risk assessment and risk management plan involving the individual, unless they are not able or willing to engage. When completed this must be presented to the DSM.

If an immediate visit has not taken place on the day the safeguarding concern was raised with the council a visit must always be undertaken within 48 hours, unless it is assessed that the individual is not

- Physically or psychologically well enough to receive a visit e.g. in hospital

Or

- It is assessed that a visit may increase the risk to the individual.

Or

- It is clear from the presenting information that the criteria outlined in paragraphs 4.3 - 4.6 will not apply. In which case the Safeguarding Assessor and DSM can decide not to proceed to a safeguarding enquiry without having first visited the adult

4.3 The outcome of the above is to determine the following:

A. Whether the person to whom the concern relates, has care and support needs, regardless of who commissions the support to meet those needs

B. Whether the person to whom the concern relates experiencing, or at risk of, abuse or neglect.

C. As a result of their care and support needs, whether the adult unable to protect themselves

4.4 If the answer to the above three questions is **yes**, then the council has a **statutory duty** to make a safeguarding enquiry.

4.5 The only exception to this is if the individual declines to engage in the safeguarding enquiry, and they have capacity to make this decision, in which case no further action under the safeguarding procedures will be taken unless:

- Others are identified as at risk

or

- There is a public interest in continuing without the adult's involvement.

4.6 If the safeguarding concern relates to an **informal carer**, who does not:

- have **care** and support needs,

but

- has been, or is at risk of abuse

and

- is unable to protect themselves as a result of their caring role

the council will undertake safeguarding enquires even though it is not under a statutory duty to do so, unless paragraph 4.5 applies.

5. What is a safeguarding enquiry

5.1 Local authorities are under a **statutory duty** to undertake safeguarding enquiries in the circumstances set out in section 4 of this document. Neither the Care Act nor the associated statutory guidance prescribes what action must be undertaken in order to fulfil this duty.

5.2 An enquiry could range from a conversation with the adult, or if they lack capacity or have substantial difficulty in understanding the enquiry their representative or advocate, right through to a much more formal multi-agency plan or course of action. Whatever the subsequent course of action, the practitioners concerned should record the concern, the adult's views and wishes, any immediate action taken and the reasons for those actions.

5.3 The following circumstances will require a formal safeguarding assessment to take place where the criteria set out in section 4.5 or 4.6 are met:

- The Police are considering or undertaking a formal investigation
- The Care Quality Commission are considering, or undertaking enforcement action
- The presenting safeguarding concern is part of a pattern of abuse or there are concerns that the adult is being targeted as a result of their perceived vulnerability
- There is a need for a multi-agency response to resolve the issues or concerns.

5.4 The purpose of the enquiry is to decide whether or not the safeguarding assessor or another organisation, or person, should do something to help and protect the adult. If the local authority decides that another organisation should make the enquiry, for example a care provider, then the local authority should be clear about timescales for that organisation to complete their enquiry and the need to know the outcomes of the enquiry and what action will follow if this is not done.

5.5 Wherever Possible what happens as a result of an enquiry should reflect the adult‘s wishes, as stated by them or by their representative or advocate. If they lack capacity it should be in their best interests if they are not able to make the decision, and be proportionate to the level of concern.

5.6 The adult **MUST** always be involved from the beginning of the enquiry unless there are exceptional circumstances that would increase the risk of abuse or they choose not to engage in the process. If the adult has substantial difficulty in being involved, and where there is no one appropriate to support them, then the safeguarding assessor **MUST** arrange for an independent advocate to represent them for the purpose of facilitating their involvement.

5.7 Appendix A should be used by Safeguarding assessors and DSM as a prompt for issues to be considered at this stage.

6. Safeguarding meetings.

6.1 Neither the care act nor the statutory guidance talks about the need to hold safeguarding meetings. However holding a safeguarding meeting can assist in ensuring that the individual is aware of what the different parties are doing in response to the safeguarding concern. In addition to this having a formal meeting can assist in ensuring all parties are aware of the individual’s wishes and desired outcomes.

6.2 To ensure that the adult and other relevant parties can attend a safeguarding meeting, sufficient notice has to be given to attendees. In order to give sufficient notice, meetings should aim to be held within 5 working days of the day the safeguarding enquiry commencing, however if holding the meeting within 5 days will prevent some parties from attending when their involvement is crucial then it should take place as soon as possible. The reason for the delay **MUST** be recorded in LAS.

6.3 The meeting must be held at a time and location that is convenient to the adult, as the safeguarding meeting is **their** meeting, which is facilitated by the council. Furthermore the chair should also ensure all reasonable steps have been taken to enable the individual to fully participate in the meeting. The only reasons not to invite the adult to their own safeguarding meeting are:

- Their presence will prejudice the investigation / evidence gathering process.
- Their attendance at the meeting may be distressing for them.
- They lack capacity and/or it is thought that their attendance would be distressing for them.
- They choose not to attend.
- If other crucial professionals or practitioners to the meeting refuse to attend if the individual is present i.e. the police may hold information about the person or a 3rd party that it is not appropriate to share with the individual and or informal support networks *(the chair should try to resolve this before the meeting, and consideration should be given to the individual attending for part of the meeting. It is not acceptable for the person about whom the alert relates to be excluded from their safeguarding meeting purely because another party request it).*
- The information being shared relates to more than one individual and there are issues of confidentiality. *(Again the chair of the meeting should attempt to resolve this prior to the meeting and consideration should be given to each individual; attending for part of the meeting).*

6.4 The possible attendees of the meeting will be determined by the circumstances of the concern. Discussion must take place at an early stage with the adult or their advocate regarding possible attendees. If the adult indicates that they do not want a particular individual and or organisation to be present at their safeguarding meeting, this request should be adhered to.

6.5 If the individual or organisation the adult did not want to attend, hold particular relevant information the safeguarding assessor needs to gather this information and ensure that it is shared with relevant parties.

6.6 Where the Chair of the meeting is the Safeguarding Development Worker, they will need to closely liaise with the DSM and Safeguarding Assessor to identify which agencies / people should be invited to the meeting. The Chair of the meeting will also confirm with the Assessing officer/DSM if the adult has been invited and if so how they will be supported to fully participate in their safeguarding meeting.

6.7 The Chair will also need to agree with the DSM and Safeguarding Assessor what support is needed for participants of the meeting to ensure that all participants are able to engage in the meeting.

6.8 The Police and Adult Social Care, Health and Housing must be represented if a criminal offence is suspected, but if police are unable to attend, their views must be ascertained (ideally in a written report) prior to the meeting. The Chair will need to ensure that a clear route for informing the police of the outcomes of the meeting is agreed.

6.9 In some circumstances it may be appropriate to invite the person thought to have caused the harm to the safeguarding meeting, however this should be carefully considered and adult, to whom the safeguarding enquiry relates, must be consulted first. If the adult does not agree to the person thought to have caused the harm attending, then they will not be invited to the meeting.

6.10 In the majority of situations the meeting will be chaired by a Safeguarding Development Worker. However there will be some occasions when the allegation is particularly complex, or there is a possible conflict and it may be appropriate for the relevant Head of Service or the Head of Adult Safeguarding chair the meeting. These occasions may include the following:

- Organised networks or trafficking
- Institutional abuse
- The council is considering the need for legal redress.
- The referral comes from Broadmoor Special Hospital.

6.11 The Chair is responsible for acting as an independent person in the safeguarding process, to support the adult at risk to participate in **their** safeguarding meeting, and to support DSMs in discharging their responsibilities. The chair is responsible for ensuring that:

- The individual is fully engaged in the development of their safeguarding plan to the greatest possible extent
- All appropriate agencies are invited to, and engage in, the meeting
- Minutes of the meeting are taken by an appropriately trained person and circulated to attendees (in line with the safeguarding information sharing protocol)

- A safeguarding plan is clearly identified at the end of each meeting and that all parties are in agreement with it, where possible. Where organisations or individuals are not in agreement this needs to be accurately reflected in the minutes of the meeting.

6.12 In the event that a Safeguarding Development Worker is not available to chair a meeting, particularly when their time is already committed elsewhere and a meeting is needed urgently, this must be discussed with the DSM as a matter of urgency. **In these situations, the meeting must proceed without delay and either the DSM/Team Manager/ Head of Service/Head of Adult Safeguarding will chair.** The Safeguarding Development Worker can provide assistance and advice before and after any such meeting if required.

Appendix B should be used as guidance by chairs to enable them to ensure the meeting is conducted in line with best practice.

6.13 To request that a Safeguarding Development Worker chair a safeguarding meeting an e-mail must be sent to Safeguarding.Adults@Bracknell-Forest.gov.uk giving a brief outline/overview of the situation. This request must be made at the earliest opportunity in order for the safeguarding development worker to plan for the meeting.

6.14 There are two possible outcomes of the meeting:

- No further action under the safeguarding procedures (i.e. the safeguarding enquiry duty has been discharged)
- A further safeguarding meeting is required. In which case a safeguarding meeting will need to be completed by the safeguarding assessor.
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7. Safeguarding Assessment

7.1 The written Safeguarding Assessment MUST be completed within 4 weeks of day the safeguarding enquiry commencing.

7.2 The assessment will be undertaken by a practitioner who has received the appropriate level of safeguarding training (Level 2) such as:

- Social Worker
- CPN

- Personal facilitator
- Occupational Therapist
- Physiotherapist
- Registered Manager

7.3 The purpose of the assessment is to identify the adult's desired outcomes and the risks to the adult. Following the assessment the safeguarding assessor, in partnership, with the adult, will formulate a protection plan that can reduce, remove or manage the risk whilst meeting the individual's desired outcomes. The process of assessment may involve more than one discipline and a joint assessment may be the most appropriate way of identifying and addressing the risks.

7.4 The assessment must be shared with the individual so they can comment on its accuracy. If the individual is not able to engage in the assessment and they have an advocate, consideration should be given to sharing with their advocate where appropriate. The safeguarding assessor must then share the assessment with the DSM. The DSM must sign off the assessment once they are satisfied that it is accurate and addresses all the identified risks.

7.5 The Safeguarding assessment must be completed in time for the safeguarding meeting and should be shared with participants at least 2 days ahead of the meeting (with the adults consent where appropriate)

8. Safeguarding Plan.

8.1 The safeguarding plan must be focused on mitigating or removing the identified risk to the adult, whilst at the same time achieving their desired outcomes. The plan will also focus on maximising the adults' wellbeing and preventing further incidents of abuse where ever possible.

8.2 It is likely that a Safeguarding Plan will be implemented and reviewed at various stages of the safeguarding process. For example any initial measurers taken and a plan formulated at the decision stage, will be reviewed at the initial safeguarding meeting and further reviewed and amended (where necessary) as part of the safeguarding assessment.

9. Advocacy

9.1 The Council has a **statutory duty** to arrange for an independent advocate to facilitate the involvement for a person to whom a safeguarding enquiry relates as well as the person thought to have caused harm, if they have care and support needs, if two conditions are met.

- That if an independent advocate were not provided then the person would have **substantial difficulty** in being fully involved in the safeguarding process **and**
- The person has no friends or family to support/advocate for them.

9.2 The test for 'substantial difficulty' is the test for capacity i.e. the person must not be able to understand, retain, weigh up or communicate their views in relation to the safeguarding enquiry.

9.3 The council recognises the value of independent advocacy and believes that all people subject to a safeguarding enquiry should be offered the opportunity to have an independent advocate to support them to fully engage in their safeguarding enquiry. Therefore the safeguarding assessor will, at the earliest opportunity, discuss with the adult what independent advocacy is and how this may be of benefit to them.

9.3 The role of the independent advocate is to support and represent the person and to facilitate their involvement in their safeguarding enquiry

9.4 The 'independent advocate' does not necessarily need to be a formal advocate; it may be that they are a friend or family member of the adult. However they must not be implicated in the safeguarding enquiry and must be able to facilitate the adults' involvement.

9.5 Formal advocacy may be provided by a number of providers including the IMCA service. However if the person is already supported by an advocate a different advocate should not be instructed unless there is a conflict of interest with the original advocate, or the individual requests it.

10. Quality Assurance

10.1 Prior to concluding a safeguarding enquiry the DSM **MUST** undertake a Quality Assurance audit of the adult's LAS record to ensure that best practice has been followed. Annex F is the quality assurance tool to be used.

10.2 The DSM **MUST** enter a case note to identify that the Audit has been completed. The completed QA tool should be uploaded on to the individuals LAS record and the outcomes of the QA audit should be discussed with the safeguarding practitioner at the earliest opportunity.

11. When a Safeguarding enquiry should be closed.

11.1 A safeguarding enquiry will only be closed when the Designated Safeguarding Manager is satisfied that all safeguarding concerns have been addressed and the Safeguarding Plan has been successfully implemented. Furthermore the Designated Safeguarding Manager must be satisfied that the person thought to have caused harm does not pose a risk to other adult with care and support needs or to the wider community. If it is assessed that they do, it would be appropriate to consider alternative methods of addressing the risk e.g. referral to the Disclosure and Baring service for paid staff or volunteers, to MAPPA (where the perpetrator is a high risk offender) or for the Designated Safeguarding Manager to consider referring the matter to the Care Governance Board if the issues are in relation to a service provider.

11.2 Where appropriate i.e. the person subject to the concern has consented to the sharing of information or it is thought to be in the person's best interest to share the information, the referrer should be informed of the outcome of the safeguarding process and assessment. If considering sharing information on the basis of best interest then due consideration must be given to the data protection act.

12. When the alleged perpetrator of abuse is an employee of Bracknell Forest Council

12.1 In circumstances where the alleged perpetrator is an employee of BFC, the relevant Chief Officer and Head of Adult Safeguarding MUST be informed immediately. The Chief Officer will decide who is most appropriate to act as Safeguarding Assessor and DSM.

12.2 In these circumstances neither the DSM nor the safeguarding assessor will be working in the same service area as the alleged perpetrator. Consideration will be given (if the circumstances require it) to appointing someone independent of Bracknell Forest Council to act as safeguarding assessor and or DSM.

13. Obtaining the views of the individual about the safeguarding process and practice.

13.1 In order to continually improve the quality of safeguarding work undertaken by Safeguarding Assessors and DSM it is important to gather the views of the adult. Therefore the Designated Safeguarding Manager or the Safeguarding Assessor will, at the point of closing the safeguarding enquiry, inform the Safeguarding Team that the safeguarding issues have been concluded and that the adult needs to be given the opportunity to provide their views on the department's safeguarding practice. The Safeguarding Team should be notified via e-mail (Safeguarding.Adults@Bracknell-Forest.gov.uk). The Safeguarding Team will then arrange to contact the adult and give them to opportunity to provide feedback on the safeguarding practice.

13.2 Only individuals whose circumstances resulted in a safeguarding meeting will be contacted to ascertain their willingness to complete this questionnaire. The manner in which the questions are asked will be down to the skill and expertise of the interviewer.

14. Working with Providers of Care and Support

14.1 Providers of care and support can play an important role in the development of safeguarding plans for an individual. Furthermore providers are often the first to raise concerns about an individual's safety and wellbeing.

14.2 However on occasion a provider or members of their workforce maybe implicated in the safeguarding concern. In these situations the Registered Manager (or if the services is not a registered service, the manager) of the service should be invited to be an active participant in all relevant safeguarding meetings (with the adults consent). The manager should be asked to consider undertaking a management investigation into the alleged actions of their employee with a request that the outcomes of their investigation are reported back to subsequent safeguarding meetings. It should be noted that the manager is not obliged to give information about their investigation as this is confidential to the organisation and employee. However in the order to safeguard the individual it would be reasonable to

request an overview of investigation and the outcomes i.e. further training, formal action under the disciplinary process etc. from the employer.

14.3 If the Registered Manager (or manager for non-registered services) is implicated in the safeguarding concern, they should not be invited to the safeguarding meetings. However it is important that the service is represented at the safeguarding meeting. Therefore the DSM should extend an invite to the Registered Managers' line manager to the meeting. If there is no line manager then the Head of Adult Safeguarding should be consulted for advice.

14.4 When working in partnership with providers the following principles should be applied

- Providers should be seen as equal partners in the safeguarding of adults at risk.
- They should be given the relevant information 48 hours ahead of any meetings (unless the need to protect individual/individuals dictates that this timeframe is not appropriate) so that they can consider the information, and where necessary take action. This should include informing them of which other agencies will be present at the meeting.
- If the concern relates to a provider service and the DSM/Chair has invited a representative from Legal Services to the safeguarding meeting the provider must be informed of this 48 hours ahead of the meeting, so that they can consider whether they wish to have legal representation.
- DSMs/ Chairs should ensure that safeguarding meetings are not used as an opportunity to seek to address issues that are outside the scope of the safeguarding concern.

14.4 Where the safeguarding issues centred on the provider action or inaction, the provider should be formally informed at the end of the safeguarding assessment of the following:

- What the conclusion of the safeguarding assessment is
- What action (if any) the Council will be taking any action under its Care Governance protocols
- What actions the Council expects the provider to take to reduce the risk of further safeguarding concerns (where appropriate and possible)

15. Record keeping.

15.1 All practitioners who are involved in safeguarding matters must keep accurate and timely records in line with the established recording policy.

15.2 The safeguarding meeting minute taker will take minutes of the meeting and summarise agreed actions at the end of the meeting. The formal minutes of the meeting will be sent (via IAS) to the chair within 4 working days. Once the chair has agreed that the minutes are an accurate reflection of the meeting they will be circulated to all participants and the details of where they are stored should be noted on IAS. Appendix C is a template for minute takers to use at safeguarding meetings. The minute taker will also ask all attendees to complete the sign in sheet, which will be uploaded into IAS, it should be noted that attendees are not mandated to complete sign in sheet.

15.3 To enable the department to accurately identify trends and themes practitioners are required to input information into LAS in an accurate and timely manner. Appendix E sets out the mandatory data required within IAS and explanation of the terminology to assist practitioners.

16. Bracknell Forest Council's responsibilities when the alleged victim/perpetrator is funded by Bracknell Forest but lives outside of Bracknell Forest boundaries.

16.1 When a Safeguarding concern is received, the responsibility for co-ordinating the safeguarding process rests with the local authority in which the incident is alleged to have taken place.

Should Bracknell Forest receive the referral first practitioners **MUST**:

- Pass this information onto the appropriate local authority for safeguarding enquires,
- Agree our participation in any safeguarding meetings and
- Agree how relevant information regarding the on-going assessment will be communicated.

16.2 Bracknell Forest retains 'care management' responsibility for the person concerned and a social care practitioner from BFC **must** undertake a review to ensure that the individual's needs are being met and that they are appropriately safeguarded. This visit should take place within 2 working days, unless the person is living so far away from Bracknell that a visit could not be completed within a working day, in these circumstances the visit must be completed within a week of the issue coming to light.

16.3 Practitioners **MUST** record on LAS (under the factors and risk tab on the Personal Details screen) the safeguarding concern and which Local authority is leading and co-ordinating the safeguarding enquiry. No details need to be recorded on the safeguarding module.

16.4 The Practitioner **MUST** updated details recorded under paragraph 16.3 when the safeguarding enquiry has been completed.

17. When the individual subject to the safeguarding alert is funded by another local Authority, the NHS or privately but living within Bracknell Forest.

17.1 As the host authority Bracknell Forest is responsible for co-ordinating all safeguarding enquires within the area. Therefore should Bracknell Forest Council receive a safeguarding concern in relation to anyone residing in Bracknell Forest it is Bracknell Forest Council's responsibility to respond.

17.2 The funding authority (where there is one) retains 'care management' responsibility; therefore on receipt of an alert or referral the practitioner will ascertain the funding arrangements of the support package and where appropriate inform the funding authorities as soon as possible.

17.3 In respect of privately funded support arrangements the adult **MUST** be offered support throughout the process in the same way as an individual funded by the department.

18. The Role of Legal Services

18.1 Legal Services are available at any time during the safeguarding process to give advice to staff on specific issues of law. However, to ensure that routine matters are not referred inappropriately to Legal Services and that those teams undertaking Safeguarding enquires develop their knowledge referrals should go to

- Designated Safeguarding Manager, if further advice is required
- Safeguarding Adults Development Worker, if further advice is required
- The relevant Head of Service, if further advice is required
- The Head of Adult Safeguarding and Practice Development, if further advice is
- Legal Services via Head of Adult Safeguarding and Practice Development.
- The relevant Chief Officer

18.2 In circumstances where legal advice is sought the DSM should, as a matter of courtesy, should inform the relevant Chief Officer so they can be apprised of the situation in case formal legal processes are entered into.

18.3 If an urgent response is needed or the Council is considering taking immediate steps to safeguard someone and the Designated Safeguarding Manager, Safeguarding Adults Development worker, the relevant Head of Service and the Head of Adult Safeguarding and Practice Development are unavailable the DSM should contact the relevant Chief Officer for advice.

19. Information Sharing

19.1 The Berkshire Safeguarding Adults Policy and Good Practice manual has an information sharing protocol attached to it. For full information on this issue practitioners are advised to refer to it. However there are 6 basic principles for practitioners to consider when receiving a request for information.

- Is there informed consent from the relevant person to share the information requested? For example, taking into account the seriousness of the issue, does the person want the police involved?

- Where it is not possible to obtain informed consent due to the person lacking capacity, the practitioner should consider if it would be in the person best interest to share the information
- Does the person requesting the information have a right to know?
- Is the sharing of that information going to assist in keeping the alleged victim safe?
- Are there other people at risk?
- Only share the information pertinent to the issue raised
- Information shared must be on a need to know basis.

19.2 If you have any queries in relation to information sharing you should contact your Team Manager. If further advice is required contact should be made with the Chief Officer: Adults and Joint Commissioning who is the Caldicott Guardian for the Council.

20. Links to Child Protection/Children's Social Care.

20.1 If at any point during the safeguarding process a practitioner becomes aware that a child or young person is or may be, at risk of harm they **must refer to Children's Social Care immediately.**

20.2 The practitioner should inform the young person's parents or guardian that they are making a referral to Children's Social Care unless it is thought that this will increase the risk of harm to the young person, or this would cause a delay in notifying Children's Services.

20.3 Children's Social Care can be contacted via the Duty team on 01344 352020

21. Referral to the Disclosure and Barring Service (DBS) or professional registration body

21.1 Where the alleged perpetrator is a paid employee or volunteer (including when they are not 'employed' by Bracknell Forest Council) and they have been removed from regulated activity (please see the DBS website for detailed explanation of regulated activity), the DSM must consider making a referral to the DBS and or their professional registration body (if applicable).

21.2 To support DSM in making this decision:

- Reference should be made to the DBS website

Discussions should be had with:

- The relevant Head of Service
- The Head of Adult Safeguarding and Practice Development
- Legal services.
- Head of Human Resources
- The relevant Chief Officer.

21.3 All employers who employ or use volunteers to provide regulated activity are under a **duty** to refer to the DBS where they have removed someone from providing regulated activity due to significant harm. The DSM should ensure that where this is the case the employer reports the employee to the DBS and obtain written confirmation from the employer when they have done so.

21.4 If the Department receives a request from the DBS to provide information about an individual referred to them the DSM must seek advice from legal services regarding what information (if any) can be disclosed) and then share this with their Head of Service and Chief Officer before any information is submitted to the DBS.

22. Where a person using direct payments has dismissed their PA/Support Worker (who were providing regulated activity) due to them satisfying the 'harm test'

22.1 Where an individual in receipt of a DP dismisses their employee satisfying the harm test (refer to DBS website for information on this) they are not under a duty to refer to the DBS (where the employee was providing regulated activity). However the individual does have a **power** to refer.

22.2 The social care practitioner and direct payments team should decide with the person who is best placed to support the individual to make the referral to the DBS if they wish to.

22.3 If the individual does not want to refer their former employee to the DBS then adult social care will make the referral if the department is satisfied that the criteria for referral have been met (see DBS website for referral criteria)

23 The role of the Emergency Duty Service (EDS)

23.1 The Emergency Duty Service acts as the single point of contract for social care emergencies outside of 'normal working hours'. The service does not undertake planed work but does and will respond to emergencies including Adult Safeguarding concerns.

23.2 On receipt or identification of a safeguarding referral the EDS will undertake an assessment of risk and put in place the support or steps needed to reduce, remove or mitigate the immediate risk of harm.

23.3 The duty EDS Social Worker will contact the EDS duty manager when a safeguarding alert is received or a concern is identified. Therefore the EDS duty manager will act in the role of the Designated Safeguarding Manager until the referral is passed on to the relevant community team

23.4 EDS will retain responsibility for ensuring the individual's safety (as far as is reasonably practical) until the next working day.

24 Links to further information where to go to for expert advice.

24.1 There is a wealth of experience and advice available to practitioners within their team, in the first instance practitioners should look to their colleagues for advice and guidance where required. In addition to this Head of Service are available for advice and consultation as is the Safeguarding Team.

24.2 In addition to the support outlined in 24.1 Practitioners are also able to contact legal services for advice as set out in section 18 of this document.

24.3 The following organisations are also available to practitioners to provide support on specific areas of adult safeguarding practice.

Name	Detail	Web-link
Department of Health	Lead Government department for adult safeguarding, MCA and DoLS	www.dh.gov.uk/en/index.htm
Home Office	Lead Government department for Domestic abuse and domestic homicide	www.homeoffice.gov.uk/
CAADA	A charity established to encourage the use of independent advocacy as a way to increase the safety of Survivors.	www.caada.org.uk/index.html
Thames Valley Police	Local Police force for Bracknell Forest	www.thamesvalley.police.uk/
Action on elder abuse	Campaigning charity. Provides briefings and training on adult safeguarding issues	www.elderabuse.org.uk/
Care Quality Commission	Regulator of Health and Social Care Services in England	http://www.cqc.org.uk/
Social Care Institute for Excellence (SCIE)	Undertakes practice based research and provides evidence based guidance on a wide range of issues including adult safeguarding.	www.scie.org.uk/Index.aspx
Association of Directors of Adult Social Services (ADASS)	Represents directors of adult social services departments and provides policy guidance and contributes to government policy/consultations	www.adass.org.uk/

Name	Detail	Web-link
Disclosure and Barring Service	Is responsible for managing Pre-appointment checks (formally CRB) and processing referrals relating to members of the adult and or children's workforce for inclusion on the barring lists	http://www.homeoffice.gov.uk/agencies-public-bodies/dbs/
Mind	Campaigning charity focused on increasing awareness and support of mental health issues.	www.mind.org.uk/
Practitioners alliance for safeguarding adults	Organisation for health and social care organisation aimed at promoting best practice in adult safeguarding work.	www.pasauk.org.uk/home
British and Irish Legal Information Institute (BAILI)	Website that details British and Irish case law & legislation, European Union case law, Law Commission reports, and other law-related British and Irish material.	http://www.bailii.org/

Appendix A

Issues to consider at the Decision stage.

- Is the individual at immediate risk or in need of immediate medical attention?
- Is the individual safe to remain in their current accommodation? If not what needs to be done to ensure they are?
- Do the police need to be called in order for evidence to be secured?
- Does the situation meet the threshold for a safeguarding enquiry?
- Which practitioner will be the Safeguarding Assessor?
- Are others at risk i.e. does the individual live with other people or does the alleged perpetrator support other adults at risk?
- Does the person thought to have caused the harms employer need to be informed?
- Do we need to inform the appropriate regulator?
- Does the individual in need of support retain capacity to make the necessary decisions
- When will the adult be visited?
- What are the outcomes the adult wishes to achieve via the safeguarding process?
- Is there a need to share information in order to protect the adult and or others with care and support needs? If it is proposed to share information with a 3rd party the consent of the adult must be gained. If it is not possible to gain the adults consent then practitioners must give due consideration to the pan Berkshire adult safeguarding information sharing protocol.

The above is not an exhaustive list but is intended as a prompt for staff when holding the strategy discussion.

Appendix B

Safeguarding Meeting – Guidance for Chairs

To enable safeguarding meetings to be conducted in line with best practice, the Chair is required to be both confident and knowledgeable. To support Chairs in this regard the points identified below should be used as a prompt of issues to be considered/addressed during safeguarding meetings.

- The confidentiality statement must be read out at the start of every meeting.
- The Chair should advise all attendees that nothing is 'off the record' and that the minute taker will record everything that is said.
- At safeguarding meetings, the appropriate standard of proof to be engaged is the balance of probability as to whether an abuse occurred. Reasons with regard to the evidence relied upon to reach a decision must be recorded fully in the minutes. The names and direction people voted in must be listed.
- Whichever 'category of abuse' has been agreed to have taken place, the definition for it should be read out by the Chair. Alternatively, laminated copies of the definitions can be made available at the meeting for attendees to read.
- If the Police are involved, consideration should be given to 'Achieving Best Evidence' and a sub-section called 'special measures' and a record kept of what assistance has been given to the person to support them during the police interview process.
- The individuals at the centre of the safeguarding concern is entitled to have a 'supporter' with them. The supporter is not there to speak on the individuals behalf but to offer moral support.
- Where an advocate is present the chair should clarify if they have been asked to represent the individual and therefore speak on their behalf before the meeting starts.
- If an interpreter is required to assist any person during the meeting, appropriate arrangements should be made in advance. Where the assistance of a language interpreter is required, careful consideration should be taken to ensure there are no discrepancies with regard to dialect.
- The minute taker should not be asked to take something out of the minutes and can refuse to do so. If an attendee wants something removed from the minutes, they have to go through the Chair. If the Chair agrees that something can come out of the minutes, the minute-taker must keep a record of what they were asked to remove and by whom and what reason was given.
- Notebooks in which Minutes are written must be kept in line with the council retention policy.
- During meetings and in the minutes, abusers can be named in full only if the word 'alleged' precedes their name.

- Following best practice, meetings should last a maximum of 2 hours. Therefore the chairs needs to keep attendees focused on the issues at hand. Attendees should not use a safeguarding meeting to discuss issues that are not relevant to the current safeguarding concern/s.

- The Chair should spend time after the meeting with the minute taker to ensure that :

    - The Chair can look at the notes and satisfy themselves that an accurate record has been made of the meeting

    - the minute-taker has the opportunity to discuss any issues of relevance arising out of the meeting

- If the person at the centre of the safeguarding referral is at the meeting, they should be asked whether they agree with the action plan and their response should be noted in the minutes.

- The exact start and finish times should be included in the minutes as well as the times and duration of any breaks.

- Minutes should be circulated no later than 10 working days after the meeting and the action plan sent out within 24 hours.

- Before circulation, the Chair should sign off a hard copy of the Minutes signifying they are approved. This should be uploaded/scanned into ESCR.

Appendix C

Bracknell Forest Council

(Number, i.e. 1st, 2nd, 3rd) SAFEGUARDING MEETING FOR (Insert Name)

Date:

Location: (Place & Room)

Time: (Start & Finish)

PRESENT

APPOLOGIES

ABSENT

IN ATTENDANCE
(Name of Minute taker) – Minutes

WELCOME & INTRODUCTIONS
(Insert Name) welcomed all to the meeting and introductions were made. (Insert Name) read out the Standard Confidentiality Statement:

'This meeting is convened under Berkshire Multi Agency Safeguarding Adults Policy and Procedures and is subject to equal opportunities and anti-discriminatory criteria. The note of the meeting and all information discussed at the meeting is strictly confidential and must not be disclosed to any other person without the express permission of the Chair. In making the decision whether or not to disclose the Chair is required to apply the Freedom of Information Act and Data Protection Act Principles".

PURPOSE OF THE MEETING

DETAILS OF THE INCIDENT/ALLEGATION & ACTIONS TAKEN

VIEW OF THE PERSON INVOLVED (OR THEIR REPRESENTATIVE)

IS AN MCA ASSESSMENT NECESSARY?

INITIAL FEEDBACK FROM ALL PARTIES

WHAT LEVEL OF RISK REMAINS?

DECISION – (i.e. substantiated, partially substantiated or un-substantiated)?

TYPE OF ABUSE

SA PROTECTION PLAN / ACTION PLAN

	ACTION	WHO	TO BE COMPLETED BY
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			

DATE OF NEXT MEETING:

CLOSURE & SAFEGUARDING QUESTIONNAIRE

Appendix D

Interview Schedule - adult at risk

INSTRUCTIONS FOR INTERVIEWER:

Identify the persons desired outcomes from the safeguarding intervention and if these were met.

Desired Outcome…….

Was this outcome met (Yes, No, Not achievable)……..

Desired Outcome…….

Was this outcome met (Yes, No, Not achievable)……..

Desired Outcome…….

Was this outcome met (Yes, No, Not achievable)……..

1. Did you feel listened to during conversations and meetings with people about helping you feel safe?
☐ I was **always** listened to
☐ I was listened to **quite a bit**
☐ I was **not** listened to **very much**
☐ I was **not** listened to **at all**
☐ Not answered

2. Did you get information during the concern? (This could be spoken or written)
☐ I got **a lot** of information
☐ I got **quite a lot** of information
☐ I did **not get very much** information
☐ I did **not get any** information
☐ Not answered

3. Were you able to understand the information given to you when people were trying
to help you stay safe?
☐ I was able to understand **all** of the information
☐ I was able to understand **most** of the information
☐ I was **not able** to understand **much** of the information
☐ I was **not able** to understand **any** of the information
☐ I did **not get any** information
☐ Not answered

4. How happy are you with the end result of what people did to try and keep you safe?
☐ I am **very** happy with the end result
☐ I am **quite** happy with the end result
☐ I am **not very** happy with the end result
☐ I am **not at all** happy with the end result
☐ Not answered

5. How happy are you with how people dealt with the concern throughout?
☐ I am **very** happy with how people dealt with the concern
☐ I am **quite** happy with how people dealt with the concern
☐ I am **not very** happy with how people dealt with the concern
☐ I am **not at all** happy with how people dealt with the concern
☐ Not answered

6. Do you feel that you are safer now because of the help from people dealing with your concern?
☐ I feel that I am **a lot** safer now
☐ I feel that I am **quite a bit** safer now
☐ I feel that I am **not much** safer now
☐ I feel that I am **not at all** safer now
☐ Not answered

7. Is there anything else you think the council (or other organisations) could have done better during the time of this concern?

8. Is there anything you would like to tell us about the questions or taking part in this interview?

Appendix E

Interview schedule: Independent Mental Capacity Advocates (IMCAs)

Identify the desired outcomes from the safeguarding intervention and if these were met.

Desired Outcome…….

Was this outcome met (Yes, No, Not achievable)……..

Desired Outcome…….

Was this outcome met (Yes, No, Not achievable)……..

Desired Outcome…….

Was this outcome met (Yes, No, Not achievable)……..

1. Did you feel listened to during conversations and meetings with people about helping the adult feel safe?
☐ I was **always** listened to
☐ I was listened to **quite a bit**
☐ I was **not** listened to **very much**
☐ I was **not** listened to **at all**
☐ Not answered

2. Did you receive information during the concern? (This could be spoken or written)
☐ I got **a lot** of information
☐ I got **quite a lot** of information
☐ I did **not get very much** information
☐ I did **not get any** information
☐ Not answered

3. Were you able to understand the information given to you when people were trying to help the adult stay safe?
☐ I was able to understand **all** of the information
☐ I was able to understand **most** of the information
☐ I was **not able** to understand **much** of the information
☐ I was **not able** to understand **any** of the information
☐ I did **not get any** information
☐ Not answered

4. How happy are you with the end result of what people did to try and keep [the person you support/your client] safe?
☐ I am **very** happy with the end result
☐ I am **quite** happy with the end result
☐ I am **not very** happy with the end result
☐ I am **not at all** happy with the end result
☐ Not answered

5. How happy are you with how people dealt with the concern throughout the process?
☐ I am **very** happy with how people dealt with the concern
☐ I am **quite** happy with how people dealt with the concern
☐ I am **not very** happy with how people dealt with the concern
☐ I am **not at all** happy with how people dealt with the concern
☐ Not answered

{ASK 6a IF ADULT IS ALIVE}
6a. Do you feel that the person is safer now as a result of the help from people dealing with the concern?
☐ I feel that the person in this case is **a lot** safer now
☐ I feel that the person in this case is **quite a bit** safer now
☐ I feel that the person in this case is **not much** safer now
☐ I feel that the person in this case is **not at all** safer now
☐ Not answered

{ASK 6b IF ADULT HAS DECEASED}
6b. Do you feel that the person was made safer as a result of the help from people dealing with the concern?
☐ I feel that the person in this case was **a lot** safer
☐ I feel that the person in this case was **quite a bit** safer
☐ I feel that the person in this case was **not much** safer
☐ I feel that the person in this case was **not at all** safer
☐ Not answered

7. Is there anything else you think the council (or other organisations) could have done better during the time of this concern?

8. Is there anything you would like to tell us about the questions or taking part in this interview?

Appendix F

Interview Schedule – relative, friend or carer

Identify the desired outcomes from the safeguarding intervention and if these were met.

Desired Outcome…….

Was this outcome met (Yes, No, Not achievable)……..

Desired Outcome…….

Was this outcome met (Yes, No, Not achievable)……..

Desired Outcome…….

Was this outcome met (Yes, No, Not achievable)……..

1. Did you feel listened to during conversations and meetings with people about helping your relative or friend feel safe?

☐ I was **always** listened to
☐ I was listened to **quite a bit**
☐ I was **not** listened to **very much**
☐ I was **not** listened to **at all**
☐ Not answered

2. Did you get information during the concern? (This could be spoken or written)

☐ I **got a lot** of information
☐ I **got quite a lot** of information
☐ I **did not get very much** information
☐ I did **not get any** information
☐ Not answered

3. Were you able to understand the information given to you when people were trying to help you stay safe?

☐ I was able to understand **all** of the information
☐ I was able to understand **most** of the information
☐ I was **not able** to understand **much** of the information
☐ I was **not able** to understand **any** of the information
☐ I did **not get any** information
☐ Not answered

4. How happy are you with the end result of what people did to try and keep you safe?

☐ I am **very** happy with the end result
☐ I am **quite** happy with the end result
☐ I am **not very** happy with the end result
☐ I am **not at all** happy with the end result
☐ Not answered

5. How happy are you with how people dealt with the concern throughout?

☐ I am **very** happy with how people dealt with the concern
☐ I am **quite** happy with how people dealt with the concern
☐ I am **not very** happy with how people dealt with the concern
☐ I am **not at all** happy with how people dealt with the concern
☐ Not answered

{*ASK IF PERSON ALIVE}*
6a. Do you feel that your relative/freind is safer now as a result of the help from people dealing with the concern?

☐ I feel that they are **a lot** safer now
☐ I feel that they are **quite a bit** safer now
☐ I feel that they are **not much** safer now
☐ I feel that they are **not at all** safer now
☐ Not answered

LOOKING AT SHOWCARD G
{*ASK IF PERSON HAS DECEASED}*
6b. Do you feel that your relative/freind was safer as a result of the help from people dealing with the concern?

☐ I feel that they are **a lot** safer now
☐ I feel that they are **quite a bit** safer
☐ I feel that they are **not much** safer
☐ I feel that they are **not at all** safer
☐ Not answered

7. Is there anything else you think the council (or other organisations) could have done better during the time of this concern?

8. Is there anything you would like to tell us about the questions or taking part in this interview?

APPENDIX G - Safeguarding Data - mandatory data

Data Item	Guidance
Primary support reason i.e. • *Learning Disability* • *Mental Health support* • *Physical support - access and mobility* • *Physical care - personal care support only* • *Sensory support - duel impairment* • *Sensory support - hearing impairment* • *Sensory support - visual impairment* • *Social support - asylum seeker* • *Social support - substance misuse* • *Social support - support for social isolation/other* • *Social support - support to carer* • *Support with memory and cognition*	Check that the individuals primary support reason is correctly recorded in LAS and reflects their current situation.
Placed by authority from outside council area	This is where someone is 'placed' by another local authority or the NHS but they are living in Bracknell Forest Area. This is recorded on the contact form in L`AS
Source of referral 1. Social care staff (LA & independent sector staff) • *Domiciliary staff* • *Residential care staff* • *Day care staff* • *Social worker/care manager* • *Self-directed care staff – these staff are employed by the service user by direct payment* • *Other* 2. Health staff • *Primary health/community health staff (GP, Acute PCT, Community-based professions allied to medicine, etc.)* • *Secondary health staff (accident and emergency, hospital*	This relates to who is informing the local authority of the safeguarding concern. E.g. the manager of a care home tells a practitioner of her concern, the source of the referral is service provider not the practitioner. Or the police phone EDS to share a concern about an individual and EDS fax the report thought to the relevant community team, the source of referral is the Police not EDS. Care should be taken to record this information correctly as it enables referrals trends to be identified. This is recorded in the record of strategy meeting/discussion area of the safeguarding module

occupational therapist, ward, hospice, community hospital, etc.) • *Mental health staff – joint teams* • *Other sources* 3. Self-referral (the individual refers themselves) 4. Family member 5. Friend/neighbour 6. Other service user 7. Care Quality Commission 8. Housing (including *supporting people*) 9. Education/training/workplace establishment 10. Police 11. Other (including probation, anonymous, contract staff, MAPPA, MARAC)	
Nature of alleged abuse ***Physical abuse*** - including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions. ***Sexual abuse*** - including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting; ***Emotional/psychological abuse*** - including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks ***Financial abuse*** - including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits; ***Neglect*** - including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating;	It may be appropriate to record more than one categories of abuse, and practitioners should ensure that all appropriate categories of abuse are recorded. This is recorded in the record of strategy meeting/discussion area of the safeguarding module

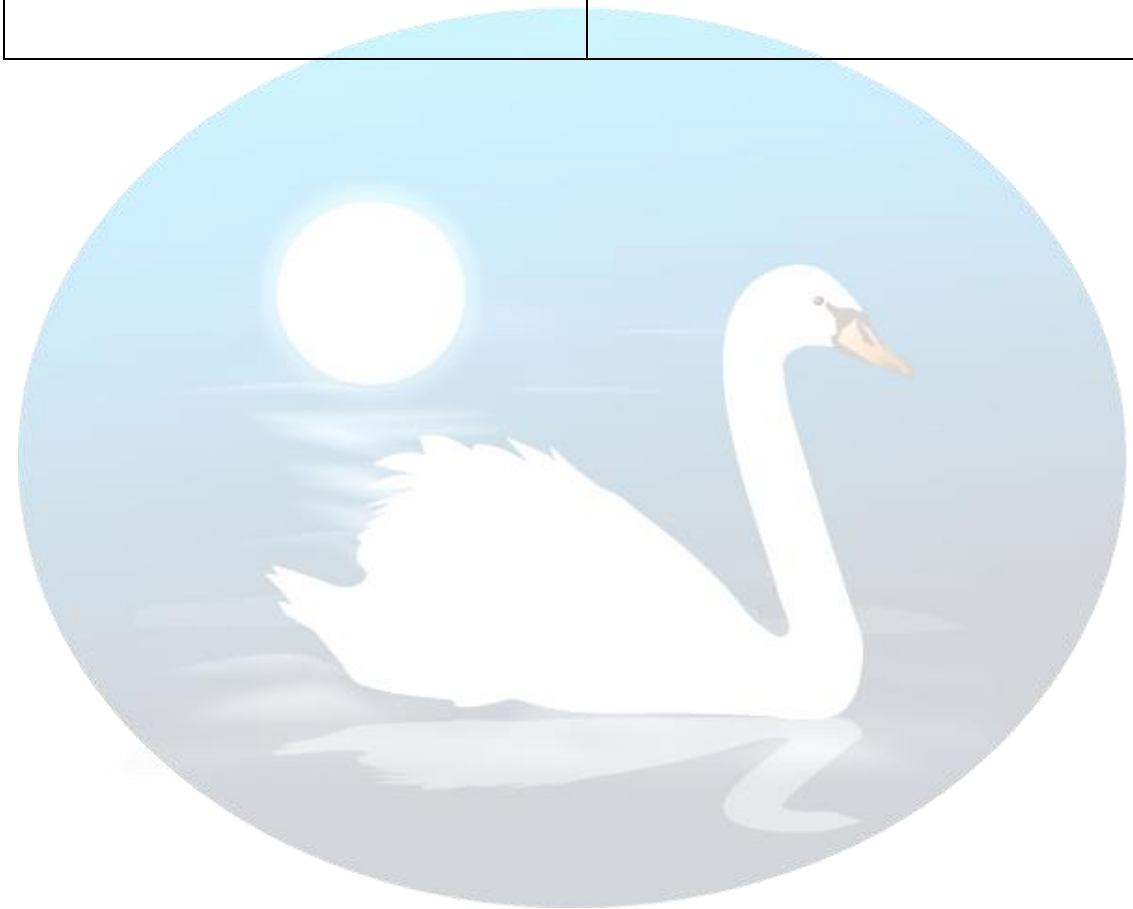
Discriminatory abuse - including abuse based on a person's race, sex, disability, faith, sexual orientation, or age; other forms of harassment, slurs or similar treatment or hate crime/hate incident. ***Institutional abuse*** - neglect and poor professional practice. This may take the form of isolated incidents of poor or unsatisfactory professional practice, at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other. Repeated instances of poor care may be an indication of more serious problems. Any or all of these types of abuse may be perpetrated as the result of deliberate intent, negligence or ignorance. **Domestic Abuse -** Any incident or pattern of incidents of controlling, coercive (to force someone to do something) or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality **Modern Slavery** - encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment. **Self-neglect –** this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.	
Location alleged abuse took place 1. Own home 2. Care home - permanent 3. Care home with nursing - permanent 4. Care home - temporary 5. Care home with nursing - temporary 6. Alleged perpetrator's home 7. Mental health inpatient setting 8. Acute hospital 9. Community hospital 10. Other health setting (include hospices) 11. Supported accommodation (including	Practitioners must make sure they record the location where the alleged abuse occurred rather than where the individual was when the abuse was disclosed, as there may be a difference. E.g. the care home manager informs the practitioner that one admission to the care home Mrs X was found to have unexplained bruising on her arms, Mrs X was admitted from hospital. Therefore the location should be recorded as the acute hospital not the care home.

extra care housing, *supporting people*, sheltered housing) 12. Day centre/service 13. Public place 14. Education/training/workplace establishment 15. Other 16. Not known	This is recorded in the record of strategy meeting/discussion area of the safeguarding module
Type of service • Own council commissioned services • No Services. • Service funded by health • Service funded by another council (CASSR) • Self-Funded	This area highlights who is supporting the individual at the point of the safeguarding referral and who is commissioning the service (where there is one. This is recorded in the record of strategy meeting/discussion area of the safeguarding module
Relationship to alleged perpetrator 1. Partner 2. Other family member 3. Health care worker (Incl. GPs, nurses, consultants) 4. Volunteer/befriended 5. Social care staff • *Domiciliary care staff* • *Residential care staff* • *Day care staff* • *Social worker/care manager* • *Self-directed care staff – these staff are employed by the service user by direct payment* • *Other* 6. Other professional 7. Other vulnerable adult 8. Neighbour/friend 9. Stranger 10. Not known 11. Other (incl. milk-person, post-person, taxi driver)	This is recorded in the record of strategy meeting/discussion area of the safeguarding module
Case conclusion **Substantiated:** If, for a given referral, all allegations of abuse can be proved on the balance of probabilities then the case conclusion should be recorded as *substantiated*. **Partly substantiated***:* If some, but not all allegations of abuse can be proved on the balance of probabilities, then this should	This information is recorded in the case closure section of the safeguarding module

be recorded as *partly substantiated*. **Example:** a referral includes allegations of physical abuse and neglect. The physical abuse can be proved on the balance of probabilities, but there is not enough evidence to support the allegation of neglect, then this should be recorded as *partly substantiated* **Not substantiated**: If none of the allegations of abuse can be proved on the balance of probabilities, i.e. there is not enough evidence to support any of the allegations or there is evidence to disprove all the allegations (or a combination of these two), the case conclusion should be recorded as *not substantiated* **Not determined / inconclusive**: The case conclusion should only be recorded as *not determined / inconclusive* when it is not possible to record the outcome against any of the other categories. This is expected to be infrequently used category. **Example**: if an investigation could not reach a conclusion on the balance of probabilities, such as in the event of the death of the perpetrator, victim or a key witness before statements could be taken.	
Outcome of completed referral – Adult at risk • Increased Monitoring • Adult at risk removed from property or services • Community care assessment and services • Civil action • Application to the court of protection • Application to change appointee-ship • Referral to advocacy scheme • Referral to counselling/training • Moved to increase/different care • Management of access to finances • Guardianship/use of mental health act • Review of self-directed support (IB) • Restriction / management of	This information is recorded on the Case Closure section of the safeguarding module It's possible to record more than one outcome for individuals if this is appropriate. The Outcome of No further action is unlikely to be used routinely.

access to alleged perpetrator • Referral to MARAC • Other • No further action	
Number of completed referrals leading to serious case review Yes No Unknown	This information is recorded on the Case Closure section of the safeguarding module A Serous case review will only be commissioned where an adult at risk has died as a result of abuse or where the harm caused was so significant that it was felt by the safeguarding adults partnership board that serious case review was appropriate
Acceptance of protection plan Accepted Not accepted Could not consent Not applicable	This information relates to the individuals protection plan and if they were in agreement with it. It will be rare that the individual is not in agreement with their protection plan. Could not consent will be used where the individual lacks capacity to consent to the plan. Not applicable will be used where the referral could not be fully completed as the individual, the perpetrator or another witness to the alleged abuse died or withdrew from the safeguarding assessment, or where the individual moved to another area. This information is recorded in the case closure section of the safeguarding module
Outcome of completed referral – alleged perpetrator • Criminal Prosecution / formal caution • Police action • Continued Monitoring • Removal from property or services • Management of access to Adult at risk • Community care assessment • Referral to DBS	This information is recorded on the Case Closure section of the safeguarding module

• Referral to registration body • Disciplinary action • Action by CQC • Counselling/training/treatment • Referral to court mandated treatment • Referral to MAPPA • Action under the Mental Health Act • Action by contract compliance • Exoneration • Other • No further action • Not known	



Annex H

Adult Safeguarding Practice Audit Tool

This practice audit tool has been developed to facilitate 'deep dive' audits of Adult Safeguarding practice can been undertaken. This tool has been devised so that the following areas of practice can be monitored:

- Compliance with the safeguarding procedures
- Person centred practice
- Quality of record keeping
- Multi agency working

With each area of the audit tool there are grade descriptors to support the consistency of judgement. At the foot of this tool is a matrix which sets out the overall grade of the safeguarding intervention.

IAS number of the Safeguarding referral audited……..
Responsible Social Care Team…….
Who completed this practice audit……

The following are the grade descriptors to be used when awarding a grade to each area of practice

Outstanding – Compliance with all areas audited against, or clear and acceptable rational given for 'none compliance'

Good - Compliance with 3 areas audited against, or clear and acceptable rational given for 'none compliance'

Requires improvement - Compliance with 2 or less of the areas audited against and or rationale is limited or none existent

Compliance with the procedures

Focus area	**Yes/No**	**Supporting rational**
Was a decision regarding whether the safeguarding alert should proceed to a referral made within 48 hours?		
Was a strategy meeting held within 10 working days		
Was the Safeguarding assessment completed within 28 days of the start of the safeguarding process		
Was the individual offered an advocate		
If the adult lacked capacity were they provided with an advocate		
Overall grade		

Person centred practice

Focus area	Yes/No	Supporting rational
Was the individual invited to their safeguarding meetings		
Was the individual supported to identify their safeguarding outcomes		
Were the persons outcomes met		
Was the individual given the opportunity to provide feedback on our practice?		
Overall grade		

Quality of record keeping

Focus area	Yes/No	Supporting rational
Were there clear and accurate minutes of all safeguarding meetings, with an associated protection/safeguarding plan		
Is there a completed and comprehensive safeguarding assessment that clearly articulates the safeguarding issues, views of all parties, and provides an analysis of the risk/s.		
Is there evidence that the DSM has been involved at all relevant stages of the safeguarding process and that they have audited the safeguarding module at the time of closure.		
Has the safeguarding module been completed accurately (including the outcome judgements)?		
Overall grade		

Use the following grade descriptors when awarding a grade to the multi-agency working section of the practice audit tool.

Outstanding – Compliance with all (relevant) areas audited against, or clear and acceptable rational given for 'none compliance'

Good - Compliance with 2/3 areas audited against, or clear and acceptable rational given for 'none compliance'

Requires improvement - Compliance with 2 or less of the areas audited against and or rationale is limited or none existent

Multi agency working

Focus area	**Yes/No**	**Supporting rational**
Having reviewed the 'file' were all relevant partner agencies involved and engaged in the safeguarding process?		
If a partner agency did not engage was this escalated within the team/department to ensure their engagement		
Did partner agencies complete the action assigned to them within the agreed timescale.		
Is there evidence of appropriate communication between involved agencies outside of formal safeguarding meetings		
Overall grade		

Overall grade for this safeguarding intervention

To ascertain the overall grade for this safeguarding intervention, put an X in the relevant box below i.e. if the compliance with safeguarding procedures was graded as good put a cross in the good box. Once you have completed this for each of the four sections add the points up and using the key at the foot of this page, provide the overall grade.

	Outstanding – 3 points	**Good – 2 points**	**Requires improvement – 1 point**
Compliance with the safeguarding procedures			
Person centred practice			
Quality of record keeping			
Multi agency working			

Overall Grade for this safeguarding intervention …….

Grade descriptor	**Point boundaries**
Outstanding	10 -12 points
Good	9 - 6
Requires improvement	5 points or less

For Files that have been selected for Auditing ahead of the Quarterly Meeting with the Head of Safeguarding ONLY

Is there evidence in the IAS record that the audit was completed ahead of the safeguarding episode being closed YES/NO?

Practice development action plan

For all sections that are graded good or requires improvement, a practice development action must be assigned. All actions must be SMART actions

Are of practice for development	Grade descriptor given	Proposed action/s to further develop practice	Does this apply to an individual practitioner or a whole team	Timeframe for completion.

Action plan approved by

Team Manager's Signature……..

Head of Services Signature……..