WBSAB

Guidance for Evaluating

Safeguarding Referrals

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1. Purpose

The purpose of this document is to provide concise guidance aiding safeguarding teams to evaluate safeguarding referrals. It is expected that all referrals are assessed in a timely manner within timescale as specified within the Act. Every case should have recorded a clear rationale for any actions taken. It is expected that safeguarding teams apply sound judgement and analysis to each case received. This policy will contain a checklist to aid with this.

The purpose of safeguarding is not to bring every case into the multi-agency safeguarding arena or to replace risk management processes which can and should be completed by social work teams and other agencies. Evaluation is an opportunity to analyse risk and come up with a coherent plan and recommendation. Some cases will involve risk or acts of abuse and neglect that warrant a multi-agency process while others can safely be left to care management with appropriate advice and direction given. We want to avoid multi-agency safeguarding becoming overloaded so it is important to have a clear understanding about what should and should not be brought into the coordinated multi-agency strategy meeting process.

2. Persons Affected and Scope

This policy is designed for members of the Adult safeguarding Team. This includes safeguarding teams, social workers, deputy managers, team managers and safeguarding personnel across other agencies. It is not intended as a document for general distribution to members of the public or to those likely to make referrals.

3. Referral Received Checklist

Referral received	
Immediate Risk? What actions if any are urgent?	If there is immediate risk what actions are necessary? E.g. Emergency Services. Move someone to a place of safety? Record actions as appropriate.
Enquiry stage (up to 7 working days to complete). This can sometimes be completed the same day. Some cases will require longer as more information will be required.	What questions do I need answered? What is the concern? Write a clear remit and commission the enquiry. Record this on appropriate system.
Capacity and consent issues.	What is the capacity of the individual subject to the process? What are their wishes? Is it appropriate to discuss with family. Is an advocate required? Record any decisions and findings in relation to this.
Person Centred Process.	It is vital to ensure that the individual or their representative/family are kept updated of the process. It needs to be agreed with a member of the multi-agency team who will be best placed to do this. This decision needs to be recorded and the designated person must provide regular feedback and record this as appropriate.

Determination following enquiry – using and recording sound judgement	
Determining the risk and level of response.	There are potentially three levels of response: • Multi-agency strategy meeting • Care management response • No further action
Multi agency strategy meeting and investigation	A multi-agency meeting will help determine further actions and the potential for a criminal / non-criminal investigation.
Care Management response	Where the risk can adequately be managed and addressed by care management then the case should be closed to safeguarding. Clear advice and rationale should be recorded and the case passed to care management to continue their role and support. For example, it may be the recommendation that a social work assessment is required so that an adult at risk can access the care they need.
No further action	If no further actions are required a clear rationale needs to be recorded to determine this.

Guidance for application of Determination This is guidance only and sound judgement and analysis should always be the main determining factor (see section on sound judgement and analysis). The acid test is can this case and associated risks be managed by case management or the provider agency? Some factors which might indicate a multi-agency safeguarding response: significant harm, systemic failings, recurring events, risk to the public and reputation of the Local Authority or Health Board, death or serious injury.		
Risk which can be met by a care management team or provider agency		Risk which will likely require a multi-agency safeguarding meeting with the allocation of a coordinator.
1.	A person does not have their **care plan** met but no harm occurs. This can be addressed by care management and the agency to improve practice.	Failure to meet a need in a care plan results in significant harm such as choking or injury.
2.	One off events such as failing to have a meal or drink as required. Missed **medication** with no resultant harm.	Systemic or recurring events potentially resulting in harm to one or more individuals that requires a formal response from the multi-agency team to ensure improvements.
3.	Person does not receive assistance on time in relation to a **toileting** need resulting in **soiling**.	Recurring event leading to significant loss of dignity and risk. Systemic problem requiring multi agency response.
4.	Not assessed in relation to a significant need, e.g. **pressure sores** but no harm results.	Pressure sores or other harm results from a failure to identify risk and seek advice for a person in a high risk situation for example someone who becomes bedfast or immobile or has a significant change in behaviour.
5.	A person is not assisted to **mobilise** on one occasion no harm results. Chair sensor not placed on one occasion. Deviation from care plan but not routine.	Recurring event - failure to put in place sensors as specified in a care plan resulting in a fall and injury. A person loses confidence as they are routinely not assisted to mobilise.
6.	**Moving and handling** procedures are not followed but does not result in harm.	Injury as a result of not following moving and handling procedures.
7.	An adult who is assessed under **the Mental Capacity Act** as lacking capacity does not have needs met in the least restrictive way but this does not result in significant harm.	Serious misuse or failure to follow the principles of the Act. E.g. being deprived of their liberty without authorisation following DoLS assessments. No best interest decision for a significant decision. Failure to involve an advocate or family and friends in significant decision making, e.g accommodation.
8.	An adult at risk is spoken to **rudely** or inappropriately by a member of staff. Staff may need extra training or supervision.	Recurring event or is happening to more than one adult resulting in harm and demoralisation.
9.	Inappropriate **discharge** from hospital without appropriate planning. No harm occurs.	Discharged without adequate planning and experiences significant harm as a result.

10.	Scheduled **home care visit** is not received. No harm occurs.	No contact made following missed call and adult at risk suffers harm. Systemic problem putting adults at significant risk.
11.	One service user **slaps or taps** another service user but no injury or mark apparent. One off or isolated event. Clear plans put in place.	Predictable and preventable (by staff) incident between two service users where significant harm or injury results.
12.	Failure to meet **payments** for a service by a family member but person does not suffer loss of service or personal allowance and is not being financially exploited. Dubious or unrecorded spending by a family member where advice and guidance is required.	Family member not paying resulting in service provision put at risk. Suspicion of significant financial abuse.
13.	Adult at risk is **contemplating suicide** but this is long standing and not deemed high risk. Adult at risk is being supported but disagreement about the level of support provided. Appropriate response would be an MDT by the professionals involved.	Person is known to be high risk and concerns are raised about level of support provided and whether the right approach is being taken. Adult continually puts them self in a place of danger but no change in approach from support agencies.
14.	Adult at risk is not getting the support they require to **visit a place of worship** or other similar activity which is identified as important to them in their care plan.	Systemic failure to meet an important need. Adult at risk may be subject to DoLs and their deprivation is not proportionate or the least restrictive. Conditions in the DoLs authorisation are routinely flouted.
15.	Adult at risk who has a care plan that stipulates **double staffing** for trips is taken by one member of staff to avoid stress. No harm occurs.	An adult at risk is routinely only provided with a single member of staff for a given task when their care plan states double staffing. This puts them at significant risk and may cause harm or injury to the adult at risk and others.
16.	Adult at risk presents at hospital or surgery with **minor injury and doubtful explanation**. Doctor fails to check for previous incidents but none recorded. No significant harm.	Adult at risk has injuries of dubious explanation. Doctor fails to check for previous incidents or does check and identifies some but fails to refer. Physical and or emotional harm continues.
17.	Adult at risk in **pain** does not receive medical attention in a timely fashion.	Adult at risk is provided with an evidently inferior service or no service and this is likely linked to their disability or age. Discrimination occurs.
18.	Adult at risk is living in **housing** which places them at risk from predatory neighbours or others in the community and housing department or association is slow to respond to their application for urgent rehousing but no harm occurs.	Housing provider fails to respond within their own timescales and guidance to an urgent need and the adult at risk suffers abuse.
19.	A resident reports a warden as being **over bearing and intrusive.**	It comes to light that at least one resident is intimidated and feels bullied by the warden and they are frightened to say why.
20.	Adult at risk needs **housing repairs** to be arranged by their landlord and there is	Failure to carry out repairs leads to serious risk or injury and significant harm to well-being is likely.

	undue delay but repairs eventually done. No harm occurs.	

4. Sound Judgement and Analysis Checklist for safeguarding

Step	
Taking account of all relevant factors **S 1.**	**Have you taken into account someone's learning disability? Is there something you are unclear about, should you explore this further? Could it influence your decision? Has the family been consulted? Are you relying on one view over another? What significance is mental capacity in this case?**
Giving appropriate weight **S 2.**	**Are you giving preference to one thing over another? Have you ignored a medical recommendation but given a lot of weight to a carer's view? Has the citizen's wishes been taken into account? What is the view of all the multi-agency team?**
Considering all options/alternatives **S 3.**	**Has the multi-agency team considered all the available options? Is the protection plan the least restrictive? Is it person centred? What is the adult at risk saying?**
Keeping an open mind **S 4.**	**For example, starting out with a theory and then finding evidence to support your theory: rather than looking at all the evidence and reserving judgment.**
Knowing and acting in accordance with the law **S 5.**	**Social work is a statutory profession governed by legislation. If you are unsure in relation to the 'legal position' you should, via your manager, seek further advice and clarification and record this advice. Are you clear on the legal rights of an adult at risk?**
Considering relevant guidance **S 6.**	**Guidance is written to support decision making. Guidance helps you to interpret legislation and promotes good practice. Helps to challenge cultural practices for example where thresholds are drawn, what constitutes a vulnerable adult referral. Guidance helps to make sound decisions and should be consulted when required.**

	Record what the guidance says to support your decision.
Knowing and applying procedures or why deviated **S 7.**	**For example, the procedure for Adult at Risk referrals are clearly stated in guidance. If you decide to deviate from the procedure then it is essential you record why you did this.**
Consulting appropriately **S 8.**	**Unilateral decisions are less sound than multi-disciplinary decisions where views are challenged and different perspectives and expertise are brought to the table. Are there other agencies with a duty of care or expertise that we need to consult with to make a sound decision? All decisions involving 'high' risk should be signed off by a multi- disciplinary group. Is an advocate involved and if not why not?**
Acknowledging lack of information and expertise and its impact **S 9.**	**If you do not have access to information or expertise what is the impact of this? Record what information you have and what information is still required. What can you reasonably do until you get access to information and advice? It's important to record all attempts where you have tried to consult. Put requests in writing whenever possible so you have a clear audit trail.**
If provisional - what more needed **S 10.**	**Provisional actions should be recorded as such. A provisional action is not long term but a temporary arrangement until other things are in place. What are those other things and how will they be acquired? Provisional actions should always be monitored and revisited.**
Human Rights Perspective **S 11.**	**Are your actions and decisions compatible with the Human Rights Act? Are you depriving someone of their rights under this Act by trying to protect them or others for example? If in doubt seek clarity via your manager who can where necessary consult with legal advisors.**
Accurate recording of the above **S 12.**	**This checklist should assist you with making more sound and reasonable judgements. However, if considerations and analysis are not recorded you have no evidence to support that you acted reasonably. When making decisions it is important you consider the steps outlined here.**

5. Policy Principles and Prevention

The aim of this policy is to ensure that a robust safeguarding service is offered to the people of the Western Bay region. This will not be achieved by bringing all cases of risk into the multi-agency safeguarding arena.

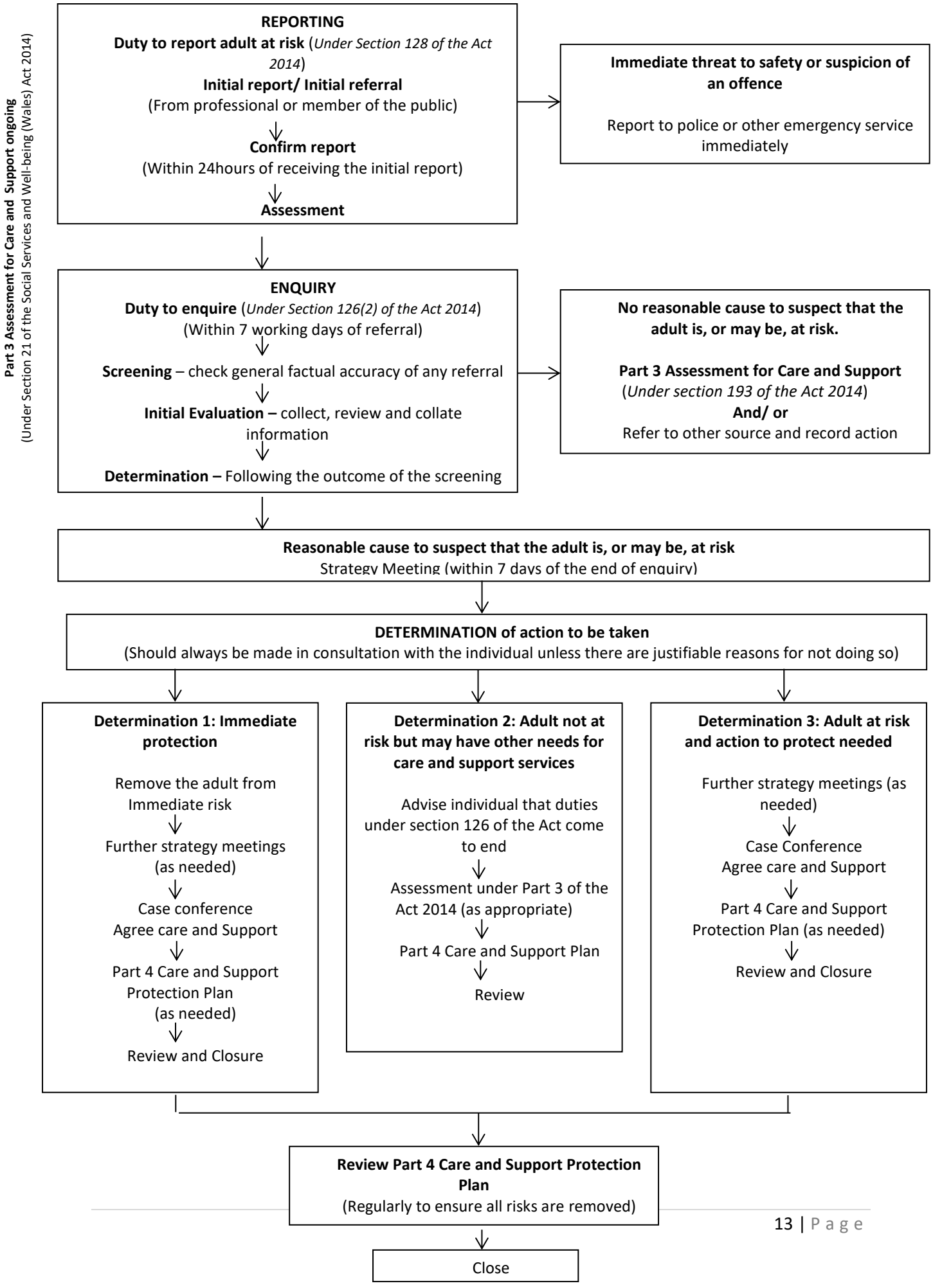
This document will be reviewed on a regular basis to ensure it is up to date and current. Safeguarding is everyone's business and the multi-agency safeguarding arena is one aspect of this. It is crucial that good practice is promoted with all partner agencies and professionals. It is important that everyone understands their duties in relation to adults at risk and how they can raise concerns and put things right when things to go wrong. But more importantly prevention is key. Prevention is intricately linked to well-being in the Act and promoting well-being is the duty of everyone in the community. The safeguarding team will play a role in promoting prevention and education in relation to safeguarding as well as respond when things go wrong.

The individuals voice should be central to the safeguarding process. It is essential that safeguarding teams promote the best possible outcome for the individuals. The individuals voice must be heard throughout the process.

6. Roles and Responsibilities

To ensure the team follow the principles of this policy and that decisions made are defensible and reasonable. To have overall responsibility for promoting good practice in relation to safeguarding adults corporately and across the community including partner agencies and professionals.

The role of the chair is central to the whole process. They have responsibility for coordinating a response to referrals and ensuring that appropriate decisions are made. They do this by guiding and advising the multi-agency team in relation to their responsibilities. They have to ensure that any decisions are robust and adequately recorded. Safeguarding chairs also have a role in promoting well-being and prevention in relation to safeguarding and offering advice to members of the public and fellow professionals.


Part 3 Assessment for Care and Support ongoing
(Under Section 21 of the Social Services and Well-being (Wales) Act 2014)
REPORTING
Duty to report adult at risk (Under Section 128 of the Act 2014)
Initial report/ Initial referral
(From professional or member of the public)
Confirm report
(Within 24hours of receiving the initial report)
Assessment
Immediate threat to safety or suspicion of an offence
Report to police or other emergency service immediately
ENQUIRY
Duty to enquire (Under Section 126(2) of the Act 2014)
(Within 7 working days of referral)
Screening – check general factual accuracy of any referral
Initial Evaluation – collect, review and collate information
Determination – Following the outcome of the screening
No reasonable cause to suspect that the adult is, or may be, at risk.
Part 3 Assessment for Care and Support
(Under section 193 of the Act 2014)
And/ or
Refer to other source and record action
Reasonable cause to suspect that the adult is, or may be, at risk
Strategy Meeting (within 7 days of the end of enquiry)
DETERMINATION of action to be taken
(Should always be made in consultation with the individual unless there are justifiable reasons for not doing so)
Determination 1: Immediate protection
Remove the adult from Immediate risk
Further strategy meetings (as needed)
Case conference
Agree care and Support
Part 4 Care and Support Protection Plan (as needed)
Review and Closure
Determination 2: Adult not at risk but may have other needs for care and support services
Advise individual that duties under section 126 of the Act come to end
Assessment under Part 3 of the Act 2014 (as appropriate)
Part 4 Care and Support Plan
Review
Determination 3: Adult at risk and action to protect needed
Further strategy meetings (as needed)
Case Conference
Agree care and Support
Part 4 Care and Support Protection Plan (as needed)
Review and Closure
Review Part 4 Care and Support Protection Plan
(Regularly to ensure all risks are removed)
Close

7. Revision History

Author	Summary	Date
Adam Greenow	Few minor additions and syntax errors	23-10-2017
Local Authority Leads & Health Board	Revised document to reflect multi-agency.	20-04-2018