Islington Safeguarding Adults Board

Islington local appendices to the London safeguarding adults policy and procedure

The Care Act 2014 ("the Care Act") together with Chapter 14 of the Care and Support Statutory Guidance issued under the Care Act, have introduced a clear framework for safeguarding adults.

A London-wide safeguarding adults policy and procedure has been developed and adopted by the Islington Safeguarding Adults Board. These appendices are supplementary to the London Safeguarding Adults policy and should be read together with them.

This document contains additional information and guidance specific to Islington.

Please also refer to the Islington Safeguarding Adults Partnership Board's Constitution and Information sharing policy, which can be found on Islington Council's website.

Appendix A: Local contact details

This appendix only includes contact numbers relevant to the reporting and investigating of abuse. Many more organisations have a role to play in protecting adults.

SOCIAL SERVICES	
Access and Advice Team: This is the first point of contact. This team takes initial details and refers on to the most appropriate team.	***Tel:*** 0207 527 2299 ***Fax:*** 020 7527 5114 ***Email****:* access.service@islington.gov.uk accessservicesecure@islington.gcsx.gov.uk
Emergency Duty Team Weekdays- 5pm-9am Weekends and Bank Holidays- 24 hours	***Tel:*** 0207 226 0992
CHILDREN'S SOCIAL SERVICES	
Children's Services Contact Team (Monday to Friday 9am to 5pm)	***Tel:*** 020 7527 7400
Emergency Duty Team (5pm to 9am, Weekends and Bank Holidays)	***Tel:*** 020 7226 0992
POLICE	
Islington Police Station	***Address:*** 2 Tolpuddle Street, N1 0YY Central Switchboard: 0300 123 1212
Community Safety Team/Officer	***Tel:*** 020 7421 0174
Useful links http://cms.met.police.uk/met/boroughs/islington/06advice_and_support/community_safety_unit_csu http://content.met.police.uk/Site/reportingcrime	

INSPECTION	
Care Quality Commission	***Address:*** Finsbury Tower 103 – 105 Bunhill Row London EC1Y 8TG ***Helpline***: 0300 061 6161
Disclosure and Barring Service (replaced the Independent Safeguarding Authority)	
For referrals to the Employment Barring Service	**Address:** PO Box 110 Liverpool, L69 3JD ***Tel:*** 0870 90 90 811 ***Email***: info@vbs-info.org.uk

Appendix B: Contact details of local and national support organisations

Local

Islington Victim Support www.vslondon.org 1 Highbury Crescent London N5 1RN	Helpline: 0845 303 0990 (24 hours) or 020 7700 6014 vs.islington@vslondon.org

Local (domestic violence)

Home Safe (children & families)	020 7527 5778
Independent Domestic Violence Advocacy Service (for professionals only 10-4 Mon –Fri)	020 7281 9284
Women's Aid advice and support following violence	0808 2000 247 020 8269 2121
Single Homeless Project	referral line: 020 7520 8660 client support line: 0800 783 8993
Criminal Injuries Compensation Authority (CICA) www.cica.gov.uk	(claims) 0300 003 3601 020 7842 6800
Women's Therapy Centre (individual & group psychotherapy)	020 7263 6200 020 7263 7860
Women's Alcohol Centre	020 7226 4581
IMECE Women's Centre (Turkish, Kurdish and women of other ethnic minorities)	0207 354 1359
KMEWO Women's organisation (Kurdish, Middle Eastern Women's Organisations)	0207 263 1027
Latin American Women's Aid	0208 275 0321

National (for victims)

Criminal Injuries Compensation Authority	0800 358 3601
Women's Aid Domestic Violence Helpline (24 hour)	0808 2000247
Men's Advice Line & Enquiries	0808 801 0327
Rights of Women (family law advice line)	020 7251 6577
Samaritans www.samaritans.org	0845 790 9090

National (for agencies)

Homeless Link (hostel advice to agencies)	020 7840 4430
Forced Marriage Unit British Nationals	020 7008 0151

National (for people causing harm)

Respect Help for perpetrators of domestic violence	0808 801 0327
Respond For victims or perpetrators of sexual abuse & other trauma, who have learning disabilities.	Helpline: 0808 808 0700

National (for agencies and victims)

Modern Slavery Helpline 0800 0121 700

For advice to professionals and victims who have been force to work illegally against their will in any sector, including brothels, cannabis farms, nail bars, agriculture and domestic servitude.

Appendix C: Quick guide for alerters

What is 'safeguarding adults'?

'Safeguarding Adults' means making sure that adults at risk live free from abuse and neglect. This used to be called 'Adult Protection'. Everyone working in public services has a legal responsibility to report suspicions or allegations of abuse of adults at risk and children.

Who is at risk?

An 'adult at risk' is someone who is 18 years or over who has care and support needs (whether or not the local authority is meeting any of those needs).

As a result of their mental or other disability, age or illness, they may find it difficult to protect themselves from abuse. Children can also be at particular risk of abuse and neglect.

What is abuse?

There are many different types of abuse; some examples are:

- Physical
- Sexual
- Emotional/psychological
- Financial/material
- Neglect/acts of omission
- Discriminatory
- Organisational
- Modern Slavery
- Exploitation
- Domestic abuse
- Self-neglect

Lots of different people may abuse adults with care and support needs. Some examples are:

- People who deliberately target adults with care and support needs
- Members of the adult's own family and friends
- People who are employed to care for adults with care and support needs

Sometimes people are not actually aware that they are abusing someone. Carers of adults at risk may become abusive because they are stressed and tired. It is still important that you report these situations, as Social Services can help to reduce pressure on stressed carers. Carers can also be at risk of harm from the person they care for.

What are the signs of abuse?

There are many signs of abuse – ask if you are not sure! Some examples are:

- The person looks dirty or is not dressed properly
- The person never seems to have money
- The person has an injury that is difficult to explain
- The person seems frightened

There may be other explanations but these are often signs of abuse.

What should I do if I suspect abuse?

- If there is a risk of immediate harm to the adult and/or others:
  - Take yourself out of danger
  - Call 999

- If there is no immediate risk but you think abuse or neglect may be a problem:
  - Call the Islington Access and Advice Service Tel: 020 7527 2299

- If you think another colleague or professional person is abusing an adult at risk:
  - Report this to your line manager.
  - If you are unhappy with their response or do not feel you can approach them then call the Islington Access and Advice Service (Tel: 020 7527 2299).
  - You might feel worried about reporting your colleagues. Remember that it is difficult for adults at risk to report abuse and they rely on you to help them.

- If you think a child is at risk, and it is an emergency, call 999.

- If you think a child is at risk, but it is not an emergency, call the Referral and Advice Team (Monday to Friday 9am to 5pm) on 020 7527 7400, or the Emergency Duty Team (5pm to 9am, Weekends and Bank Holidays) on 020 7226 0992.

What happens next?

We will look into your concern.

Depending on what we find, we may take action to safeguard the adult from harm.

Do you suspect abuse? Tell us now.

Islington Adult Access and Advice Service
Tel: 020 7527 2299 | Email: access.service@islington.gov.uk | Fax: 020 7527 5114

Appendix D: The legislative framework

The introduction of the Care Act 2014 and Chapter 14 of the Care and Support Statutory Guidance places a new legal framework around safeguarding adults.

For the first time, there's now a clear legal framework for how local authorities and other parts of the health and care system should protect adults at risk of abuse or neglect. Key organisations and individuals with responsibilities for adult safeguarding now have clear roles to play in keeping adults at risk from harm.

The key changes that the Care Act has brought are:

- Safeguarding Adults Boards (SABs) are now statutory bodies
- Local authorities have a duty to make enquiries, or ask others to make enquiries, when they think an adult with care and support needs may be at risk of abuse or neglect in their area
- SABs must arrange for a Safeguarding Adults Review where an adult with care and support needs dies and there is a concern about how one of the members of the SAB acted.
- The local authority must arrange for an independent advocate to represent and support a person who is the subject of a safeguarding enquiry of Safeguarding Adult Review, if they need help to understand and take part in the enquiry or review and to express their views, wishes or feelings.
- If an SAB requests information from an organisation or individual who is likely to have information which is relevant to the SAB's functions, they must share what they know to any problems can be tackled quickly.

The safeguarding provisions in the Care Act are supplemented by the Care and Support Statutory Guidance which is issued under the Care Act. Section 14 of the statutory guidance replaces the previous 'No Secrets' guidance.

Change in language and terminology

The Care Act has brought about a change in language and terminology and introduced some new definitions.

The change in terminology and language signals the new way of working to safeguard adults at risk of abuse or neglect.

People have complex lives and being safe is only one of the things they want for themselves. The language around safeguarding adults has been changed to reflect this. Words such as 'perpetrator' have very negative and criminal associations. There is a move away from this kind of language to easier to understand, more neutral, constructive language.

The changes are summarised below:

Care Act terminology	Replaces (where relevant)	Comment
Safeguarding concern	Safeguarding alert/referral	Safeguarding duties apply to an adult who meets the 'three part test': 1. Has needs for care and support (whether or not the local authority is meeting any of those needs); **and** 2. is experiencing, or is at risk of, abuse or neglect; **and** 3. as a result of those care and support needs is unable to protect themselves from the risk or experience of abuse or neglect
Safeguarding enquiry		A safeguarding enquiry is any first action taken in response to a safeguarding concern to establish whether the local authority's Section 42 duty has been triggered i.e. the three part test in the Care Act have been met. There is a move away from investigations (except criminal investigations by the police and where disciplinary investigations are undertaken by employers).
Section 42 enquiry	Safeguarding investigation	The local authority must make or cause other agencies or organisations to make enquiries when the Section 42 duty is triggered i.e. when it has reasonable cause to believe that the Care Act 3 part test has been met.
Non-statutory enquiry		There is no legal obligation on the Local Authority to undertake non-statutory safeguarding enquiries. Ordinarily, such adults would be signposted to sources of support instead. However, there is scope to for the local authority to undertake a non-statutory safeguarding enquiry if agreed. An example would be where the adult does not meet the 'three part test' but it is agreed that the risks are too high not to continue to take action.
Initial actions	Immediate actions and Information gathering	Any first responses made under the local authority's Section 42 duty to make enquiries / cause enquiries to be made. Note: A conversation with the adult should always be one of the first responses if the adult has not already been spoken with.

Care Act terminology	Replaces (where relevant)	Comment
Safeguarding meeting / Core group meeting	Strategy meeting / Case conference	In line with London Policy & Procedure, where Section 42 is to continue further, safeguarding planning should be discussed with all relevant parties' participation. In drawing up and implementing actions, a Core Group of key people should be identified. Membership of a Core Group will always include the adult at risk and/or advocate, Enquiry Officer and SAM. The core group professionals will be dependent on the complexity and nature of the enquiry. Note: The Care Act refers to Core Group meetings. However, the London Policy & Procedure has adopted the term 'safeguarding meetings', because it is easier for people to understand.
Safeguarding plan	Protection plan	Actions / arrangements agreed with the adult to support them in maintaining their safety. These should be incorporated into the adult's support / care plan where they have one. It should include clear information regarding roles and responsibilities or all those involved and the arrangements for monitoring and reviewing the effectiveness of the plan. While the local authority's Section 42 duty will be discharged once it has determined the adult has been safeguarded and/or the actions required have been taken, it must ensure that any action taken as a result of this process are monitored and kept under review.
Conclusion of an enquiry	N/a	The local authority's Section 42 duty of enquiry continues until it has been decided what action is necessary to safeguard the adult, and by whom, and has ensured that this action has been taken.
Further actions (enquiries)	N/a	If the issue cannot be resolved through the actions taken in the initial response to the safeguarding concern, the local authority's duty under Section 42 continues until it decides what action is necessary to protect the adult, and by whom and ensures itself that this action has been taken.
Enquiry Manager (EM)	Safeguarding Adults Manager (SAM)	A suitably trained and experienced practitioner employed by the local authority and with responsibility for decision making in relation to Section 42 enquiries.
Enquiry Officer (EO)	Investigating Officer	A suitably trained and experienced practitioner undertaking an enquiry or aspects of an enquiry

Care Act terminology	Replaces (where relevant)	Comment
Designated Adult Safeguarding Manager (DASM)	N/a (this is a new role)	Each statutory member of the SAB (i.e. local authority, CCG and police) should have a DASM responsible for the management and oversight of individual complex cases, providing advice and guidance, liaising with other agencies as necessary, monitoring the progress of cases to ensure they are dealt with as quickly as possible.
Safeguarding adults review (SAR)	Serious case reviews	Safeguarding Adults Boards must arrange a SAR when an adult in its area dies as a result of, or has experienced serious abuse or neglect and there is a concern that partner agencies could have worked together more effectively. The aim of a SAR is to learn lessons.
'Cause of risk'	Alleged perpetrator	A person, organisation or service who may have some relationship to the cause of risk or issue of concern for the adult.
Adult	Adult at Risk	Note that although the statutory guidance has moved away from the term 'adult at risk', the London Safeguarding Adults Policy and Procedure uses the term 'adult at risk'.
Well-being		Wellbeing' is a broad concept. It is described as relating to the following areas in particular: • personal dignity • physical and mental health and emotional wellbeing • protection from abuse and neglect • control by the individual over their day-to-day life (including over care and support provided and the way they are provided) • participation in work, education, training or recreation • social and economic wellbeing • domestic, family and personal domains • suitability of the individual's living accommodation • the individual's contribution to society There is no hierarchy in the areas of wellbeing listed above – all are equally important. There is also no single definition of wellbeing, as how this is interpreted will depend on the individual, their circumstances and their priorities. Wellbeing is a broad concept applying to several areas of life, not only to one or two. Therefore, using a holistic approach to ensure a clear understanding of the individual's views is vital to identifying and defining wellbeing in each case.

Care Act terminology	Replaces (where relevant)	Comment
Making safeguarding personal (MSP)	N/a	Person-led and outcomes focused safeguarding practice. MSP engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, well-being and safety.
Organisational abuse	Institutional abuse	Includes neglect and poor practice within an institution or specific care setting
Modern slavery	N/a	Includes slavery, human trafficking, forced labour, domestic servitude.
Domestic violence	N/a	The Care Act guidance uses the term 'violence' in the widest sense of the word to include psychological, physical, sexual, financial, emotional abuse and 'honour' based violence.
Self-neglect	N/a	Self-neglect is now included as a type of abuse.

References: Sussex Multi-Agency Safeguarding Adults Policy and Procedures 2015

Appendix E: Local implementation

The Islington Safeguarding Adults Board (ISAB) has agreed to adopt the entire London Multi-Agency Policy and Procedures.

What's new in the London policy and procedures?

- Reflects the principles of the Care Act 2014
- Develops the key ideas in the Care Act (such as personalisation, prevention, positive risk management)
- Sets out the requirements of individual services to safeguard adults
- The London Policy sets out a 4-stage process for enquiries
- There are indicative timescales for the safeguarding process
- Choosing the right type of enquiry

However, there are a few procedures which have been implemented to support local implementation in Islington. These are listed below:

1. Provider Concerns Process

The Provider Concerns process is set out in the London Multi-Agency Policy and Procedures Section 5 'Working with Care Providers'

In Islington, care provision and trends in care delivery issues are monitored at monthly multi-agency RADAR meetings. These meetings are attended by commissioners from Islington Council, the CCG, and the Safeguarding Adults team.

If you have concerns about a Care Provider, you should raise your concerns with either your line manager, or the Access Team (See Appendix 1 above).

2. Requesting another organisation to carry out a Section 42 safeguarding enquiry

Under the Care Act, the local authority can ask another organisation to carry out a S42 safeguarding enquiry. The London procedures give some pointers on how to implement this, but a local procedure specific to Islington is currently being developed.

In the interim, seek guidance from the Safeguarding Adults Unit before asking another organisation to carry out a S42 enquiry on behalf of Islington Council.

3. Safeguarding Adults Reviews

The London Policy sets out the general procedure for carrying out Safeguarding Adults Reviews.

Islington Safeguarding Adults Board has adopted a new approach to learning from serious cases. This is set out in Appendix F below.

4. Protocol for Inter-authority safeguarding adults enquiries

In the past, protocols for inter-authority safeguarding concerns varied across London and the country. However, the Care Act has clarified this situation. It is now clear from section 42 of the Care Act that a local authority has a duty to make safeguarding enquiries when it suspects abuse or neglect of an adult in its area, whether or not that adult is ordinarily resident there.
For further information, see Cross Boundary and Inter-Authority Enquiries of the London Policy.

5. Pressure ulcers

The London Policy sets out a general decision pathway for pressure ulcers. However, the process in that flowchart is based on the assumption that a local pressure ulcer pathway and Pressure Ulcer Decision Guide have been agreed through the local Safeguarding Adults Board.

In Islington, the NHS England (London Region) Good Practice for Pressure Ulcers sets out the expectations for NHS organisations, but has been adopted locally for all partner organisations. See Appendix G below.

Further guidance

Whittington Health NHS Trust has issued clinical management guidance on safeguarding adults and pressure ulcers and deciding whether to refer to the safeguarding adults procedures. For a copy of the guidance, contact the Tissue Viability Service.

Whittington Health Tissue Viability Service
River Place
Essex Road
London
N1 2DE
Tel: 0203 316 8393
Fax: 0203 316 8405

Appendix F: A New Approach to Learning from Serious Safeguarding Cases

The Islington Safeguarding Adult Board believes that when service users experience poor outcomes it is important that all services reflect on the quality of their services both internally and collaboratively, so that they are able to learn from their practice and that of others in order to improve local safeguarding practice. This Framework is designed to support these processes.

The Islington Safeguarding Adults Board is committed to promoting a culture which values and facilitates learning and in which the lessons learned are used to improve future practice and partnership working to safeguard adults at risk. The Islington Safeguarding Adults Board (ISAB) has developed a multi-agency Learning and Review Framework to support this approach. It has been developed for use by all partner agencies and local organisations which work with adults at risk across the Islington Local Safeguarding Adults Board area. The ISAB is confident that the approaches outlined in the Learning and Review Framework will drive improvements in the wider safeguarding system as well as in the outcomes experienced by users of services.

Overview

The Learning and Review Framework recognises that ISAB member agencies and organisations have their own internal governance and learning structures. This Framework therefore, seeks to complement and build on single agency arrangements by adding a multi- agency approach to enable partner agencies to work collaboratively to learn lessons from cases where there may have been multi agency failings and to use this learning to improve future joint working. The Learning and Review Framework is designed to support decision making regarding the use of multi agency review processes and outlines the pathway for commissioning reviews and the governance arrangements underpinning these arrangements.

Guiding Principles

The review and audit processes referenced in the Learning and Review Framework are underpinned by the following principles:

❖ Learning and review activities should be proportionate according to the scale, significance and level of complexity of the issues and concerns highlighted.

- Adults at risk and their families should always be offered the opportunity to contribute to the learning review and receive feedback on the learning outcomes achieved.

- Professionals from the range of agencies involved in the case should be fully engaged in the learning review and be invited to contribute their perspectives.

- The central focus of any learning review will be to gain insight and understanding of how effectively agencies were working together to support and safeguard the person at risk and to identify any actions needed to improve future practice and partnership working.

- The learning review should be fair and balanced and not used to apportion blame. It should take account of what practitioners knew or could have reasonably have been expected to have known at the time. Consideration should also be given to the capacity of the person at risk and their views and choices at the time.

- Learning reviews are not disciplinary proceedings and should be conducted in a manner which facilitates learning and allows for reflection.

- The Care Act 2014 provides a statutory basis for undertaking the learning and review processes described in the Framework.

- The Framework recognises that there are other forms of statutory reviews (such as domestic homicide reviews, mental health homicide reviews, MAPPA reviews, children's serious case reviews, etc.) and the importance of managing the interface between these.

- Where the ISAB is satisfied that other review processes have adequately identified learning it may not be necessary to conduct a multi agency review under this Framework in order to avoid duplication of activity.

- Where necessary, an independent advocate will be arranged to support and represent an adult who is the subject of a multi agency review.

The 4 approaches

A. Safeguarding Adults Reviews
B. Multi-agency Partnership Reviews
C. Multi-agency Reflective Workshops
D. Multi-agency Themed Audits

The following considerations should be made when deciding whether to make a referral for a multi agency review:

- The concerns must relate to a person with needs of care and support – whether or not in receipt of services.
- Abuse, neglect or acts of omission is known or strongly suspected to have contributed to the harm caused.
- There are concerns about systemic failings relating to multiple organisations and so there is potential to identify to improve multi agency practice and partnership working.

Safeguarding Adults Review

The Safeguarding Adults Board is the only body that can commission a safeguarding adult Review. Under section 44 of the Care Act 2014, the SAB must arrange a SAR when an adult in its area dies as a result of abuse or neglect (whether known or suspected) and there is concern that partner agencies could have worked more effectively to protect the adult.

The SAB must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. The adult who is the subject of any SAR need not have been in receipt of care and support services at the time.

Purpose

The purpose of a safeguarding adult review is to:

- ❖ Determine what might have done differently that could have prevented harm or death.
- ❖ Identify lessons and apply these to future cases to prevent similar harm occurring again.
- ❖ Review the effectiveness of multi agency safeguarding arrangements and procedures.
- ❖ Inform and improve future practice and partnership working.
- ❖ Improve practice by acting on learning (developing best practice).
- ❖ Highlight any good practice identified.

Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

Criteria for a Safeguarding Adult Review

The ISAB must arrange a safeguarding adult review of a case of an adult in its area with needs of care and support (whether or not the local authority was meeting those needs) if:

1) The case involves an adult with care and support needs (whether or not the local authority was meeting those needs)
2) There is reasonable cause for concern about how the SAB, its members or organisations worked together to safeguard the adult

   AND

3) The person died (including death by suicide) and the SAB knows/suspects this resulted from abuse or neglect (whether or not it knew about this before the person died)

   OR

4) The person is still alive but the SAB knows/suspects they've experienced serious abuse/neglect, sustained potentially life threatening injury, serious sexual abuse or serious/permanent impairment of health or development.

Process

- The Review and Learning Subgroup will be responsible for establishing an independently chaired Safeguarding Adult Review Panel to undertake the review and will maintain an oversight and co-ordination role throughout the process.
- The Safeguarding Adult Review (SAR) will be undertaken by people who are independent of the case under review and of the organisations whose actions are being reviewed. The Review and Learning Sub Group will ensure appropriately experienced and skilled people undertake this role.
- The SAR will reflect the six safeguarding principles.
- The ISAB Review and Learning Subgroup will agree a terms of reference and these will be openly available
- If the SAB requests information from an organisation or individual who is likely to have information which is relevant to SAB's functions, they must share what they know with the SAB.
- When undertaking the SAR, the records will either be anonymised through redaction or consent should be sought.
- Where necessary, an independent advocate will be arranged to support and

represent an adult who is the subject of a safeguarding adult review.

- Recommendations and action plans arising from the safeguarding adult review will be monitored by the ISAB Review and Learning and reported to the Quality Assurance and Audit Subgroup as appropriate for further assurance purposes.

Reporting arrangements

The Review and Learning Subgroup will provide regular updates to ISAB on the progress of the review. The safeguarding adult review will report within six months of the SAR being established. Once competed, the report and recommendations will be presented to the ISAB for consideration. Once the report is approved, the Review and Learning Subgroup will produce a multi-agency action plan responding to any recommendations made.

A safeguarding adult review is a statutory process for cases meeting specific criteria. For cases not meeting these criteria, the ISAB Review and Learning Subgroup may consider commissioning another type of review.

Multi-Agency Partnership Reviews

A multi-agency partnership review will be commissioned by the ISAB Review and Learning Subgroup but will be led the organisations involved.

Purpose

The purpose of this type of review is to focus on the multi-agency organisational learning for the specific organisations involved in a case and to undertake these on a collaborative basis between the agencies involved.

Criteria

Multi-agency reviews will be considered where an adult at risk has died unexpectedly or sustained serious injury or harm and/or where there were safeguarding concerns identified prior to the incident or as a result. This may include circumstances where self neglect may have been a factor and also where an adult with needs of care and support has died as a result of fire and there may have been opportunities for the agencies involved to identify risk factors and to develop a risk management plan to manage these. This form of review can be used for cases falling short of SAR criteria and any of the following criteria can also be applied:

- The person was receiving services from more than one agency at the time of the incident
- The service user was under formal safeguarding procedures at the time of the incident
- Multi-agency concerns or learning has been identified
- The incident arose from or occurred during the delivery of care

Process

Supportive partnership working should be maintained throughout the process.

- A review team will be set up consisting of representatives of the agencies involved.
- The lead, co-ordinating agency will be agreed who will be responsible for arranging and chairing meetings as well as drafting the review report. Terms of reference will be agreed jointly at an initial scoping meeting.
- Each review team member will review their practice against expected organisational standards by interviewing staff, reviewing records and referring to organisational policies and procedures.
- The review team will share their own organisational findings with each other and will produce a report jointly agreed by agency representatives, covering both single agency and multi-agency responsibilities.

Reporting arrangements

Reporting will be via internal individual organisations usual governance arrangements.

In addition, reporting will be through ISAB Review and Learning Subgroup who will include collated findings in an annual learning report to the ISAB.

Multi-Agency Reflective Workshops

A multi-agency reflective workshop will be commissioned by the ISAB Review and Learning Subgroup but led by the organisations involved.

Purpose

The purpose of this type of review is for agencies involved with an incident to meet together and share their perspectives as a self assessment of the multi-agency safeguarding arrangements and practice and to identify improvements.

Criteria

A reflective workshop should be undertaken in the event of an adult at risk experiencing harm and where there are limited concerns about how organisations or professionals worked together but where the outcome for the adult(s) involved was poor. The issue may have come to attention due to a complaint or a concern raised. These reviews should be commissioned where it is believed there is potential learning and the possibility of improvements in the system to be made.

Process

The workshop will involve a one off facilitated event involving practitioners and managers directly involved in he case (or in some circumstances) other representatives such as those in policy or strategic roles who may be able to contribute to the learning process and/or in supporting implementation of learning into practice. The aim of the activity is to make a positive impact on frontline practice. The focus of the workshop will be to reflect

on the adult's journey through the system to identify any opportunities for improved interface between agencies. The workshop will be facilitated by a people independent of the case or the organisations involved. To support this, a multi agency pool of facilitators has been established to undertake reflective workshops.

Reporting arrangements

As an outcome of the workshop a series of actions or recommendations will be agreed by the attendees. Delegates will be responsible for providing feedback on generic areas of learning and to their respective senior management teams to relevant operational teams.

These will also be shared with the ISAB Review and Learning Subgroup. Partner agencies' ISAB representatives should be involved in any action planning within their organisation around the recommendations highlighted (as relevant to their organisation). The agencies involved in the review will be asked to provide ISAB with an impact analysis report outlining actions taken by their organisation to improve practice and partnership working in response to the case. Thematic findings from the reviews will be collated on an annual basis and summary included in the ISAB Annual Report.

Multi-agency Themed Audits

Purpose

The purpose of multi-agency themed audits is to audit practice across agencies relating to a specific topics of interest. They yield qualitative information enabling the ISAB and partner agencies to test out the effectiveness of the system following changes in policy or guidance or it may be in order to understand why a particular group are more at risk or to evaluate the scale of an emerging problem area in order to seek to address it. These will be commissioned by the ISAB Review and Learning Subgroup but will be overseen by the ISAB Quality Assurance and Audit sub-group. Audit activities will form part of the ISAB Annual Audit Programme.

Criteria

Multi-agency themed audits can be undertaken on any topic or themes where concerns are identified that suggest a particular group may be more at risk. Examples might include undertaking a multi-agency audit on responses to financial abuse to test out any blockages in the system or check how agencies are working together.

Process

The programme will be agreed by the ISAB and will be coordinated and managed by the ISAB Quality Assurance and Audit Subgroup. The programme will be informed and influenced by an inter-play of five key factors:

- Issues and themes emerging from local safeguarding monitoring information
- Patterns and trends in local cases referred for learning and review
- Issues and themes emerging from Learning From the Learning Log
- ISAB priorities

- Response to national developments and events

The audits will normally be undertaken by a multi agency audit team working to agreed terms of reference. A report outlining findings and recommendations will be produced and a multi agency action plan developed to address these. The Quality Assurance and Audit Subgroup will be responsible for monitoring implementation.

Reporting and Monitoring arrangements

The audit report will be shared with the ISAB and more widely with partner agencies.

This framework will be monitored by the ISAB Review and Learning Subgroup and will be reviewed on an annual basis or sooner in response to the delivery of this framework or changes in national policy or guidance. The ISAB Review and Learning Subgroup will also produce an annual report for ISAB of collated findings and analysis of the range of review activities undertaken throughout the year.

Appendix G: NHS England (London Region) Good Practice Principles for Pressure Ulcers

9.5.2014

Pressure Ulcers

The broad principals of good practice in relation to Maintaining skin integrity

Preventing pressure ulcers should be a key priority for all agencies and may or may not be an indicator of abuse. They do however have a significantly adverse affect upon a person's quality of life and should be prevented.

If they do occur, irrespective of which investigation is being used, organisational learning has to occur.

- All care, support and explanation for patients who are at risk of developing pressure ulcers or who have pressure ulcers has to be done within: The principals of the MCA and the principals of duty of care and autonomy for those who have capacity.
- The engagement of, carers, paid and unpaid and legal representatives such as those holding LPOA for Health and welfare and relatives should be evident for those who lack capacity.
- Patients should receive an initial and on-going risk assessment within 6 hours of the first episode of care.
- Those assessed as at risk should be cared for as guidance suggests dependent upon the degree of risk.
- This should include a care plan that records the frequency of pressure area care required/skin care regime and the type of pressure relieving equipment required.
- An optimum environment should be created to maintain skin integrity or where compromised the ideal wound healing interventions. This will include satisfactory maintenance/referral/management of nutrition and Hydration; hygiene; continence care and maintaining mobility.
- Good communication is essential, which would include accurately recorded assessments; care/treatment plan; transfer/discharge forms and includes open/transparent and appropriate information sharing between agencies.

Safeguarding considerations

- All NHS organisations have a duty of candour and transparency in their outcomes.
- Any pressure ulcer may be an indicator of neglect/abuse; therefore all should be appropriately assessed to identify any possible safeguarding concerns.
- Not all grade 3 /4 pressure ulcers are indicative of abuse/neglect.
- Patients must be involved and empowered to engage with all stages of the safeguarding process and, their preferred outcome must be recorded.
- Once a safeguarding concern is identified, a safeguarding alert must be raised within the guidelines of the Local Policy and procedure timescales to safeguard adults from abuse.
- Keep up to date with best practice/evidence through learning the lessons from the investigation process.
- A duty of candour and openness is applicable and important for all concerned.