

GLA Rough Sleepers' Services Safeguarding and Serious Incident Policy

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1 Introduction

- 1.1 This document sets out the GLA's policies on safeguarding adults at risk and the handling of serious incidents within services commissioned by the GLA's Rough Sleeping Commissioning Team.
- 1.2 The GLA does not have the same role and statutory responsibility as local authorities with regard to safeguarding so services should be aware of and always follow the safeguarding procedures of the local authority in which the individual resides and the safeguarding policies and procedures of any local authority whose residents are in their care. Local authorities in London have adopted a common set of policies and procedures to which service providers should have regard –
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/197402/Statement_of_Gov_Policy.pdf
- 1.3 The GLA does not have the same duty of investigation in respect to safeguarding referrals as local authorities and safeguarding alerts should not be made to the GLA for this reason.
- 1.4 However, the GLA does have a duty as a commissioner to ensure that the services we commission have safeguarding procedures in place and are able to correctly and expediently respond to safeguarding concerns. The GLA also has a duty to ensure its services are safe and well run and that the services we commission have procedures and policies for minimising, handling, investigating and learning from serious incidents.
- 1.5 The GLA also has a duty as a service commissioner to investigate patterns of safeguarding incidents and serious incidents that occur in or in relation to the services it commissions in order:
 - To enable the GLA to monitor the incidence and types of safeguarding incidents and serious incidents reported and to identify any trends so that learning can take place across commissioned services.
 - To enable the GLA to monitor the outcomes and action plan implementation from the investigation of safeguarding incidents and serious incidents in commissioned services in order to share the learning locally and ensure the services it funds are performing well.
 - To ensure that safeguarding incidents and serious incidents are handled appropriately.

2 Glossary and useful acronyms

Abuse includes physical, sexual, emotional, psychological, financial, material, neglect, acts of omission, discriminatory and institutional abuse.

ADASS (Association of Directors of Adult Social Services) is the national association for directors of local authority adult social care services.

Adult at risk means adults who are eligible for community care services because of mental or other disability, age or illness and who are, or may be unable, to guard themselves against significant harm or exploitation. The term replaced 'vulnerable adult'.

Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need.

Alert is a concern that an adult at risk is or may be a victim of abuse or neglect. An alert may be a result of a disclosure, an incident, or other signs or indicators. Where these are accepted by the social services team within a local authority that is responsible for undertaking safeguarding work they become a **Safeguarding Referral**.

Alerter is the person who raises a concern that an adult is being, has been, or is at risk of being abused or neglected. This could be the person themselves, a member of their family, a carer, a friend or neighbour or could be a member of staff or a volunteer.

Alerting manager is the person within an organisation to whom the alerter is expected to report their concerns. This may be a specified Safeguarding Adults lead within an organisation or it may be the service manager. It is the alerting manager who will in most cases make the safeguarding referral and take part in the investigation of the referral.

Capacity is an individual's ability to make a decision about a particular matter at the time the decision needs to be made (as detailed in the Mental Capacity Act 2005 Code of Practice).

Care setting/services includes health care, nursing care, social care, domiciliary care, social activities, support setting, emotional support, housing support, emergency housing, befriending and advice services and services provided in someone's own home or other setting for a person by means of a personal budget.

Case conference is a multi-agency meeting held to discuss the outcome of the investigation and to put in place a protection or safety plan.

GLA the Greater London Authority.

SAPB (Safeguarding Adults Partnership Board) represents various organisations in a local borough who are involved in safeguarding adults and sets the local strategic approach to safeguarding adults at risk in the area.

Serious case review (adults) is undertaken by a Safeguarding Adults Partnership Board (SAPB) when a serious case of adult abuse takes place. The aim is for agencies and individuals to learn lessons to improve the way in which they work.

SI (Serious Incident) is a term defined as an incident that occurred in relation to services resulting in significant harm or unexpected or avoidable death of one or more patients, staff, visitors or members of the public.

Significant harm is not only ill treatment (including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable deterioration in, physical or mental health, and the impairment of physical, intellectual, emotional, social or behavioural development.

Staff, for the purposes of this protocol, relates to staff in services commissioned by the GLA as well as staff working directly for the GLA. Unless specifically excluded, staff will also include volunteers used by commissioned services and the GLA.



Vital interest is a term used in the Data Protection Act 1998 to permit sharing of information where it is critical to prevent serious harm or distress or in life threatening situations.

Wilful neglect is an intentional or deliberate omission or failure to carry out an act of care by someone who is responsible for the care of a person who lacks capacity to care for themselves.

3 Aims of this policy

- 3.1 The aims of this policy are twofold:
- To ensure that GLA-funded service providers are clear about how to manage safeguarding referrals for adults at risk.
 - To ensure that other serious incidents that take place within or in relation to services are well handled, reported, learnt from and their occurrence reduced. It should be noted that an event can be both a serious incident and a safeguarding concern.
- 3.2 This policy is not intended to replace safeguarding and serious incident policies already held by agencies, nor does it replace any specific requirements outlined in contractual service specifications or in any way affect the providers' need to act within the law. This policy is designed to supplement existing policies and procedures.

4 Objectives of the policy

- 4.1 The GLA has a duty to ensure that service users receive a safe, secure and appropriate service. This policy aims to ensure that:
- Commissioned services take steps to minimise the risk of serious incidents and/or abuse of adults at risk.
 - Staff in services are fully aware of the service's serious incidents policy and safeguarding procedures, and also this policy.
 - Where incidents or abuse does occur that services take immediate remedial action and draw lessons from the subsequent reporting and investigation which will enable them to prevent such incidents or abuse in future and share these conclusions with other services
 - The GLA and all commissioned services comply with legislation and partnership policies.
- 4.2 The service, or its parent organisation must have, its own serious incidents policy and procedures and be able to demonstrate this to the GLA Rough Sleeping Team on request.
- 4.3 The service must also keep accurate records of all serious incidents to enable review and audit to take place. These records must be open to review and audit by the GLA Rough Sleeping Team on request.
- 4.4 It is expected that service providers will provide their staff with appropriate training so they will be able to identify and respond to serious incidents in the manner set out in this policy and the service's own policies and procedures.

5 Definitions

- 5.1 The definition of a serious incident is broad and is expected to be covered within the service provider's own policies and procedures. It is expected that this will include all incidents involving the following:
- serious crime or violence to service users, staff or members of the public
 - serious threats to service users, staff or members of the public
 - unexpected death or serious injury within the service

- unexpected emergency admission to hospital
- incidents that lead to a serious disruption of a funded service e.g.. fire, flood, power failure, bomb threats
- any incident that leads to a Safeguarding Adults/Children Alert being raised

5.2 An adult at risk, formerly described as a vulnerable adult, is described as:

A person aged 18 years or over who may be in need of community care services by reason of mental or other disability, age or illness

AND

who is not/or may not be able, to take care of himself or herself or unable to protect him or herself against significant harm or exploitation

5.3 For the services commissioned by the GLA the most likely people to be assessed as at risk are:

- those suffering from mental illness
- those who lack capacity (this may be caused by impairment related to alcohol or drugs).
- elderly or frail
- from different cultural backgrounds with limited English
- those who have physical or sensory disability
- those who have a learning disability
- those who suffer from a severe and incapacitating physical illness.

5.4 Abuse is defined as:

- Physical abuse - includes, hitting, slapping, punching, pushing, kicking, other physical assault, misuse of medication, restraint or other inappropriate sanctions.
- Sexual abuse - includes rape, sexual assault or sexual acts that a vulnerable person has not given consent to take part in, or who was pressurised into consenting; verbal and the inappropriate use of sexual language.
- Psychological abuse - includes emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supporting networks.
- Financial abuse - includes theft, fraud, exploitation, pressure in relation to wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.
- Neglect and acts of omission - includes 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.
- Discriminatory Abuse - includes racist and sexist abuse; abuse based on a Safeguarding Adults Policy person's impairment; and any other forms of harassment, slurs or similar treatment.
- Institutional abuse - includes neglect and poor professional practice. This may take the form of isolated incidents of poor and unsatisfactory professional practice, through to pervasive ill treatment or gross misconduct.

6 Relevant policies and guidance

- 6.1 It is intended that this policy should be used in conjunction with the London multi agency policies and procedures to safeguarding adults from abuse (*Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse*)¹ and any additional policies and or guidance of the local authority in which the service is based. It may also be necessary to follow the reporting requirements of any authority outside London whose resident is using a GLA commissioned service.
- 6.2 Providers of services commissioned by the GLA should also have regard to the following national guidance:
- Safeguarding Adults (2005, ADASS)
 - No Secrets (2000, Department of Health and Home Office)
 - (for charitable organisations) Reporting Serious Incidents (2010, Charity Commission).
 - Disclosure and Barring Service: Criminal Records Checks and Referrals (2013 Home Office).
- 6.3 Providers of services commissioned by the GLA should also have regard to the following legislation:
- Mental Capacity Act (2005)
 - Human Rights Act (1998)
 - Mental Health Act (1998)
 - Safeguarding Vulnerable Groups Act (2006)
 - Equality Act (2010)
 - Data Protection Act (1998).

7 Confidentiality

- 7.1 Staff must be aware that information concerning an allegation of abuse and any client details must be shared on a 'need to know' basis only, taking care to protect client confidentiality. Staff must also be aware of how decisions on breaching client confidentiality when it is in the best interest of a client or in the wider public interest are made by the commissioned service provider. Commissioned services must be able to demonstrate they have the processes in place to make decisions regarding safeguarding and client confidentiality fairly and appropriately.
- 7.2 When in doubt over whether a safeguarding referral is necessary alerting managers should refer to section 2.3.2.4 of *Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse* which details when a safeguarding referral should be made when:
- the person is an adult at risk and there is a concern that they are being or at risk of being abused or neglected, and at risk of significant harm,

¹ The Care Act (April 2014) suggests this guidance is now out of date. However, at the time of writing, the new guidance is currently being written. Commissioned services should maintain their knowledge of guidance changes.

- the adult at risk has capacity to make decisions about their own safety and wants this to happen,
- the adult at risk has been assessed as not having capacity to make a decision about their own safety, but a decision has been made in their best interests to make a referral,
- a crime has been or may have been committed against an adult at risk without mental capacity to report a crime and a 'best interests' decision is made,
- the abuse or neglect has been caused by a member of staff or a volunteer,
- other people or children are at risk from the person causing the harm,
- the concern is about institutional or systemic abuse,
- the person causing the harm is also an adult at risk.

7.3 All staff should also be aware of the circumstances under which they should make a safeguarding alert, referenced in section 2.3.1.4 of *Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse* which states:

- "If you are concerned that a member of staff has abused an adult at risk, you have a duty to report these concerns. You must inform your line manager
- If you are concerned that your line manager has abused an adult at risk, you must inform a senior manager in your organisation, or another designated manager for Safeguarding Adults.
- If you are concerned that an adult at risk may have abused another adult at risk, inform your line manager."

7.4 Staff should also refer to the GLA's Rough Sleepers' Services Information Sharing Policy.

8 Responsibilities

8.a Responsibilities of the GLA

- 8.1 The GLA as a service commissioner will ensure that safeguarding requirements and expectations are included in all contracts, funding agreements and service specifications for services that it commissions or otherwise funds.
- 8.2 The GLA will also ensure that safeguarding is integrated into contract monitoring and contract management processes. The GLA will also have procedures in place to carry out audits of the safeguarding procedures, policies and any incidents which have occurred in relation to services it commissions and from time to time will carry out an audit of services its commissions and report on this audit.
- 8.3 The GLA will ensure that safeguarding issues reported to it through the contract monitoring of services are also being reported to the relevant local authority/Safeguarding Adults Board.
- 8.4 The GLA will attend when required relevant local Safeguarding Adults Boards in its role as a commissioner of support services. The GLA will also require commissioned services to attend or otherwise support Safeguarding Adults Boards as required and participate in Serious Case Reviews commissioned by Safeguarding Adult Partnership Boards
- 8.5 The GLA will promote learning and best practice on safeguarding amongst all the services it commissions or otherwise funds.

8.b Responsibilities of commissioned services

- 8.6 Commissioned services will ensure that they have their own internal safeguarding and serious incidents and safe recruitment policies and procedures and that these are compatible with this policy and all the policies referenced above. If these policies are reviewed and updated, new versions should be sent the GLA's Rough Sleeping Commissioning Team.
- 8.7 Commissioned services will ensure their staff, including temporary staff employed either by an agency or directly by the service provider, and volunteers are fully trained on safeguarding and serious incident policies and procedures and that staff and volunteers regularly attend refresher training. The training staff or volunteers receive should be appropriate to their job role.
- 8.8 Staff, including temporary staff employed either by an agency or directly by the service provider, and volunteers will be appropriately vetted and commissioned services will have safe recruitment practices.
- 8.9 Commissioned services will make service users aware of their safeguarding and serious incidents policies and procedures, in particular in relation to alerting the service or an independent organisation of a safeguarding concern.
- 8.10 Commissioned services will report safeguarding alerts to the relevant local authority using that local authority's policies and procedures. Commissioned services will also report safeguarding alerts to the GLA using the procedures in the section 9 of this document.
- 8.11 Commissioned services will attend Safeguarding Adults Boards where appropriate and support them in their work when required; commissioned services will support Serious Case Reviews.
- 8.12 Commissioned services will support all multi agency safeguarding investigations regarding their clients or service led by local authorities and will carry out their own investigation as agreed as part of the multi agency investigation.
- 8.13 Commissioned services will keep clear local records on all serious incidents and safeguarding alerts/referrals and ensure that these are reviewed to identify all key learning and action points at an appropriately senior level at least annually.
- 8.14 Regularly review and audit their safeguarding and serious incidents policies and procedures at a high level within the organisation and report the findings of these reviews to the GLA and any relevant local authority.
- 8.15 Support the GLA in its conduct of any review or audit of safeguarding or serious incidents policies and procedures.
- 8.16 Commissioned services will have a whistle blowing policy and ensure that staff and volunteers are aware of when and how to use it.
- 8.17 Commissioned services will refer staff and volunteers to the Independent Safeguarding Authority and/or Professional Regulatory Body when appropriate.

9 Reporting serious incidents to the GLA

9.a Reporting requirements

- 9.1 In process terms, all safeguarding events which lead to a safeguarding alert being issued should be reported to GLA commissioners as if they were serious incidents.
- 9.2 It is expected that all serious incidents are reported to the GLA's Rough Sleeping Commissioning Team as soon as practical following the event but at least within forty-eight hours, with a password protected incident report. Password to be provided by the GLA's Rough Sleeping Team.
- 9.3 This incident report should include all details that are known including:
- date of incident
 - description of incident
 - all parties involved
 - involvement of emergency services
 - immediate action taken
 - further action required
 - dates when further action required will be taken and/or completed
 - who reported/discovered the incident
 - who is managing the incident
 - where the incident was reported
- 9.4 The report should be completed within forty-eight hours and sent by e-mail to the GLA's Rough Sleeping Team. The support provider should inform the GLA's Rough Sleeping Team on subsequent progress against any actions required at contract monitoring meetings or upon specific request for this information at an earlier date.
- 9.5 The report should come on the service's own incident reporting forms as long as they include the information listed in 9.3 above.
- 9.6 If an incident is identified as exceptionally serious the service should contact the GLA Rough Sleeping Team immediately by telephone as well as preparing to report in the usual way.
- 9.7 Where a serious incident has occurred that is not a safeguarding incident the service should consider whether it would be appropriate to also report the incident to any relevant local authority. Cases where this might be appropriate would be:
- A member of staff has suffered a serious injury whilst operating on a local authority run housing estate or service.
 - An incident of arson or attempted arson at the service
 - A serious anti-social behaviour incident or a sustained period of anti-social behaviour.

9.b Additional reporting requirements where the serious incident is also a safeguarding alert

- 9.8 When the serious incident to be reported has also led to a safeguarding alert being raised the following information should also be included in the serious incident report:
- nature of the safeguarding concern
 - whether any children were directly or indirectly involved

- details of the safeguarding authority the alert was raised with.

- 9.9 The service must also report to the GLA's Rough Sleeping Team whether or not any safeguarding alert was accepted as a safeguarding referral as soon as possible after the decision has been made.
- 9.10 If the safeguarding alert is required to be sent on a local authority alert form then this will be an acceptable method of communicating the information to the GLA's Rough Sleeping Team – additional information should be appended if necessary.

10 Reporting safeguarding incidents to local authorities

- 10.1 In addition to the requirements to report to the GLA Rough Sleeping Team services must also report safeguarding alerts to the relevant team undertaking safeguarding adult work.
- 10.2 This will always include the local authority where the subject of the alert is currently residing, even in instances where another local authority is funding the subject of the alert's care and/or housing.
- 10.3 Where another local authority is funding the subject of the alert's care and/or housing in another local authority they must also be sent details of the safeguarding alert. However, the duty to ensure there is a response to the safeguarding alert remains with the local authority where the subject of the alert is currently residing. However, in some cases it may be more relevant for the placing authority to undertake this work – for instance, when it is abuse by family friends in the placing authority area
- 10.4 Reporting of alerts to the relevant local authorities should take precedence over reporting to the GLA Rough Sleeping Team. Ideally, reports should be made at the same time but reporting to the GLA should not impede the reporting of the safeguarding alert to the relevant local authority.

11 Reporting other incidents and 'near misses'

- 11.1 There may be times where it is identified that there was a substantial risk of a serious incident occurring even if one did not come to pass. These will be described here as 'near misses'.
- 11.2 When 'near misses' occur they should be recorded in the same way as serious incidents.
- 11.3 Services' serious incidents policies and procedures should also cover 'near misses' and the procedures for handling and learning from these events.
- 11.4 It is not required that 'near misses' are reported immediately to the GLA, although it would be considered good practice to do so. However, these must be reported at contract monitoring meetings to the GLA's Rough Sleeping Team within the performance monitoring narrative reports.
- 11.5 There may also be incidents that occur which do not in themselves constitute serious incidents or safeguarding alerts. Examples of this could be:
- minor accidental injuries sustained within the project
 - incidents causing a minor service disruption (ie: a flooded room, power outage).

- 11.6 Services should have their own policies and procedures for handling these incidents and they should be recorded in a way that makes them easy to report on and audit.
- 11.7 More significant examples of these incidents should be reported to the GLA's Rough Sleeping Team at contract monitoring meetings.
- 11.8 If a series of these more minor incidents of a similar type occur in quick succession, involving or affecting the same client for example, then the service should treat the series of incidents as a single serious incident and follow the reporting requirements outlined above.