

Multi Agency Safeguarding Escalation & Risk Process Guide

1. Introduction

- 1.1 The Safeguarding Adult Review 'George' commissioned by the Barking and Dagenham Safeguarding Adult Board recommended:

The Safeguarding Adult Board are asked to review the approaches and guidance currently available relating to multi-agency working within the workforce. The SAB is asked to develop an overarching 'Complex Safeguarding Strategy' which will define a multi-agency pathway approach and take into account other multiagency pathways in the wider system.

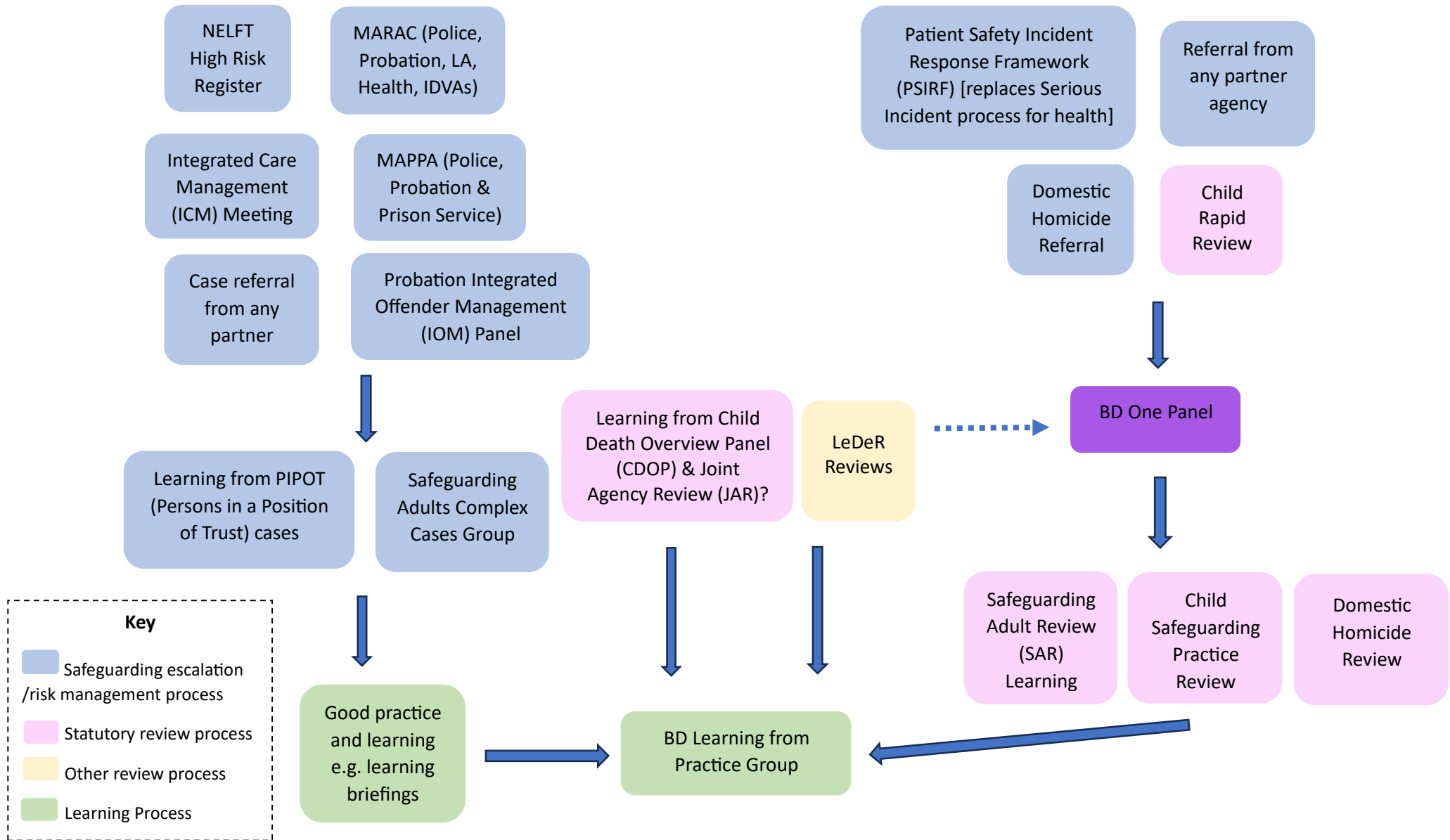
The full SAR 'George' report can be found here

<https://www.lbbd.gov.uk/adult-health-and-social-care/barking-and-dagenham-safeguarding-adults-board/safeguarding-adult>

This document aims to set out the various multi agency safeguarding escalation and risk processes that are available to professional working with complex cases, across Barking and Dagenham.

The diagram overleaf shows the relevant and current processes and pathways and available and how they interact with each other within the safeguarding partnership context.

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2. Multi Agency Safeguarding Escalation and Risk Management Processes

2.1 Safeguarding Adult Complex Cases Group

The Barking and Dagenham Safeguarding Adults Complex Cases Group (SACCG) is sub-committee of the Safeguarding Adults Board (SAB). It is a meeting where information is shared on cases presenting with the highest risk and or complexity.

The group is made up of representatives of the Local Authority, the Police, mental health services, housing services, safeguarding officers, officers from the fire service, and other professionals as and when required.

The SACCG will consider cases in respect of adults aged 18 years and over, as well as transitional cases of people aged 17 years and over to ensure a well-managed, transitioning into adult services where care and support needs are likely under the Care Act 2014. This will be where existing mechanisms within agencies, for resolving or minimising risk, have not achieved this outcome.

[Safeguarding Adults Complex Cases Group | London Borough of Barking and Dagenham \(lbbd.gov.uk\)](http://lbbd.gov.uk)

2.2 Patient Safety Incident Response Framework (PSIRF)

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The PSIRF replaces the Serious Incident Framework.

[NHS England » Patient Safety Incident Response Framework](#)

2.3 Integrated Care Management (ICM) Meeting

The ICM is a multi-disciplinary team of professionals who work together to ensure patients with long term conditions and complex needs receive good quality co-ordinated care.

The aim of the meeting is to:

- Improve quality and coordination of care across the whole system of primary, community and social care, with care pathways designed around service user assessed need
- Improve access to care for vulnerable adults, reducing the inequalities currently experienced by certain groups of adults
- Reduce avoidable hospital admissions

- Improve patient experience of care and demonstrate this through patient survey outcomes
- Improve patient confidence in managing their own condition.

Cases for discussion will be put forward by one of the professionals involved in the case such as the GP, Named District Nurse, the Community Matron, a Social Worker or Care Liaison Officer.

2.4 MARAC

The MARAC stands for Multi Agency Risk Assessment Conference. It is a regular conference/meeting, which focuses on helping victims at high risk of murder or serious harm.

www.lbbd.gov.uk/take-action/refer-marac

Email: MARACReferrals@lbbd.gov.uk

2.5 MAPPA

Multi-Agency Public Protection Arrangements (MAPPA) are a set of statutory arrangements to assess and manage the risk posed by certain sexual and violent offenders.

<https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance>

2.6 NELFT High Risk Register

NELFT operate an internal high risk register process where cases are risk assessed and monitored. These cases may be referred into the Safeguarding Adult Complex Cases Group for multi agency discussion. Any queries about this process should be directed to the relevant clinician who will discuss with the wider team.

2.7 Integrated Offender Management Panel

Integrated Offender Management (IOM) is a national framework for managing persistent and high harm offenders.

<https://www.justiceinspectorates.gov.uk/hmiprobation/research/the-evidence-base-probation/specific-types-of-delivery/integrated-offender-management/>

For further information contact: Devina.ford@justice.gov.uk

3. Statutory Safeguarding and Partnership Review Processes

3.1 BD One Panel

The One Panel is a multi-agency group which receives referrals on cases in Barking and Dagenham that may meet statutory review criteria, such as a Safeguarding Adults Review (SARs), Child Safeguarding Practice Reviews (CSPRs) or Domestic Homicide Reviews (DHRs).

<https://www.lbbd.gov.uk/adult-health-and-social-care/barking-and-dagenham-safeguarding-adults-board/barking-and-dagenham>

Email: bdonepanel@lbbd.gov.uk

3.2 Safeguarding Adult Reviews (SARs)

The Care Act 2014 stipulates that Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult in its area with care and support needs 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. SABs must also arrange a SAR if an adult with care and support needs, in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

Published Barking and Dagenham SARs can be accessed here

<https://www.lbbd.gov.uk/adult-health-and-social-care/barking-and-dagenham-safeguarding-adults-board/safeguarding-adult>

3.3 Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)

Integrated Care Systems are responsible for ensuring that LeDeR reviews are completed based on the health and social care received by people with a learning disability and autistic people (aged four years and over) who have died, using the standardised review process.

<https://www.england.nhs.uk/learning-disabilities/improving-health/learning-from-lives-and-deaths/>

To report the death of someone with a learning disability or an autistic person click here <https://leder.nhs.uk/report>

3.4 Rapid Reviews & Child Safeguarding Practice Reviews

The purpose of a Safeguarding Child Practice Review (SCPR) is for organisations and individuals to learn lessons to improve the way in which they work both individually and

collectively to safeguard and promote the welfare of children. It is not an inquiry into how a child died or was seriously harmed or into who is to blame.

<https://www.lbbd.gov.uk/childrens-safeguarding-partnership/multi-agency-safeguarding-partnership-arrangements/child>

3.5 Domestic Homicide Review

Domestic Homicide Reviews are carried out to ensure that lessons are learnt when a person has been killed as a result of domestic violence.

<https://www.lbbd.gov.uk/adult-social-care/health-and-wellbeing/domestic-abuse-and-sexual-violence/domestic-homicide-review>