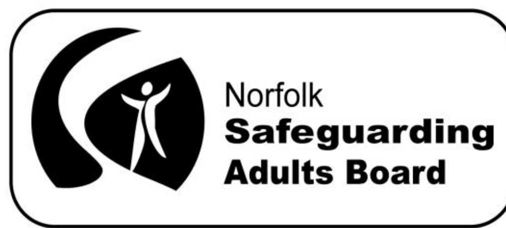


Norfolk Safeguarding Adults Board

Complex Case Management - Multi-agency Guidance

FINAL

Issue Number	4 – FINAL
Document Owner	Norfolk Safeguarding Adults Board
Date Approved	12 July 2022
Date Published on NSAB website	3 October 2022 V2 14 Feb 2023 V3 10 July 2023 V4 05 Mar 2024
Review Date	March 2026

Norfolk Safeguarding Adults Board

1. Complex case management: Introduction
    1.1. Standard multi-agency approaches
    1.2. Convening a multi-agency meeting
    1.3. Identifying a lead professional
    1.4. Coordinating a multi-agency meeting
    1.5. Holding a multi-agency meeting
    1.6. Information sharing
2. Circumstances where there is a need to escalate to senior management level for review
    2.1. Criteria for escalation
    2.2. The process
    2.3. Detail of senior management review process
3. Flowchart
4. Case example
5. Notes for completing the referral form

1. Complex case management: Introduction

This guidance has been developed by the Norfolk Safeguarding Adults Board (NSAB) to promote a joined-up approach by all agencies involved in the assessment and management of risk to adults with care and support needs.

It provides an overview of **standard through to complex approaches** where there are concerns about individuals, safeguarding prevention as well as s42 duties.

In the specific context of complex cases, it describes how to escalate to senior management review where significant risk remains unmitigated, despite best efforts of agencies involved and the use of existing multi-agency forums.

This is not a new process – it simply makes clearer how we should support people in complex situations or who have complex needs, using our existing multi-agency pathways.

This does not replace or negate the responsibility of individual organisations to maintain their own standard operating procedures around risk and multi-agency working but provides additional guidance.

This guidance is intended to:

- ensure all possible pathways to resolution have been explored effectively
- clarify the role of agencies and professionals in multi-agency approaches
- identify the circumstances in which there is a need for a complex case discussion at senior management level
- set out a clear process for escalation, risk assessment and review

1.1 Standard Multi-agency approaches

In Norfolk we have a wide range of existing options to support joint and multi-agency working, including in complex cases:

- General concerns about safety, health, environment, care needs – contact relevant agencies individually; use collaboration hubs or meetings in the local area, including primary care; police-led Vulnerable Adults Risk Assessment Conference (VARAC)
- Safeguarding concerns – follow the local authority safeguarding process, which may lead to s42 enquiry
- Mental incapacity – use processes within the Mental Capacity Act including the Court of Protection
- High risk domestic abuse cases – police will lead, including Multi Agency Public Protection Arrangements (MAPPA) or Domestic Abuse Partnership Perpetrator Arrangements (DAPPA) as appropriate.
- Self-neglect/hoarding - use collaboration / early help hubs to facilitate a multi-agency discussion, as described in Norfolk's Self Neglect and Hoarding Strategy.

Using these options would be the expected way to progress any situation where you have been unable to meet the need / mitigate the risk as a single agency.

Be clear from the outset and regularly review the following:

- What exactly is your concern?
- What risks have you identified? Have they changed, have new risks been identified?
- What are the views of the individual, or their representative if appropriate?
- Do you have any concerns about the mental capacity of the individual?
- Which agencies do you need input from and why?

Often, discussion and collaboration at this level will support the need identified.

Where it does not, and where the risks identified are higher (to the individual or wider) consider if a specific meeting would be more effective.

1.2 Convening a multi-agency meeting

Be clear about the purpose of any multi-agency meeting, and make sure the right people are there. There may be parallel multi-agency meetings happening as well, especially where there is concern around high risk of serious harm e.g. from domestic abuse.

If you are having difficulty getting people to your meeting, try these tips:

- in your invitation set out why the person is being asked, particularly if there is a specific risk relating to their specialism / service
- make direct contact to explain the importance of their contribution
- escalate where necessary through your line management, using the Managing Professional Difficulties process if required
- State clearly how multi-agency approaches seek to prevent harm and mitigate risk
- Ask for them to provide an alternative contact / deputy if they cannot make the meeting

If you have been asked to participate in such a meeting, make sure that you understand why you have been invited - if you do not believe you are the right person explain why and help to identify an alternative. If you cannot make the date / time, send a representative who is briefed with the right information.

It's important for all relevant agencies to attend these meetings, in order for the strongest possible collaborative response to be achieved (as set out in the Care Act 2014).

In safeguarding cases, the first stage of the multi-agency process is the *Safeguarding Planning Discussion* (previously known as a strategy discussion). These are mandatory in any safeguarding concern where a Section 42 enquiry has been started by the local authority. These must involve the police and an adult social care manager / practice consultant / safeguarding adults practice consultant as a minimum. This discussion agrees which agencies are going to take which agreed action.

In more complex safeguarding cases, a *Safeguarding Planning Meeting* (previously known as a strategy meeting) is held. These are formal meetings (with a minute taker) which include a robust multi-agency identification of risk and clear plans to address the concerns. These meetings offer opportunity for regular review and set out who is responsible for what.

1.3 Identifying a lead professional

If the person is known to have an allocated worker within health or social care agencies, the practitioner concerned should contact them and request that a multi-agency meeting is considered. There may be reasons why it will not be appropriate for that worker to continue to lead (e.g. an assistant practitioner or

newly qualified worker) in which case they should discuss with their line manager in the first instance.

If the person is on a waiting/holding list for an agency, the agency must arrange to allocate a worker or send a suitably qualified and informed representative who can speak about the case from the agency's perspective.

If no allocated worker exists, the lead professional will vary from case to case, depending on the circumstances. The lead professional is someone from the agency with the **most significant involvement with the individual** / most aware of their primary needs and concerns. For example, if the primary concerns are related to a health condition, the lead professional should be the most appropriate healthcare professional involved; if the primary concerns are around housing (social housing), the lead professional should be from the housing provider, and so on.

If there is no identified lead professional, the practitioner concerned will need to take responsibility for coordinating a multi-agency meeting. A decision as to who will be the ongoing lead professional can be agreed at the meeting.

1.4 Coordinating a multi-agency meeting

If relevant agencies are not already involved, the identified lead professional should contact the reception service for each required, to secure their attendance at a meeting.

If you need to escalate a concern, here are some of the main organisations' points of contact

There may be other agencies, including voluntary sector, involved and these should be contacted via their local office.

If there is a formal advocate involved with the person, they should be invited to the meeting.

1.5 Holding a multi-agency meeting

The meeting should be chaired by a manager from the agency of the lead professional.

The person's capacity (in relation to the decision to be made) should be confirmed at the beginning of the meeting, evidencing why this is thought to be the case. Mental capacity & safeguarding | Norfolk Safeguarding Adults Board

An overview of the person's views and wishes, or those of their family/representative, should be available at the meeting, wherever possible.

Risks must be clearly identified and assessed in terms of actual and potential harm. **Action plans** for addressing these risks must be clear, including interventions that have been offered in the past / not been effective. Actions need to be written in a SMART way (**S**pecific – **M**easurable - **A**chievable – **R**elevant – **T**ime-bound) with mutually agreed timescales for implementation and review by the individual(s) responsible for the action.

The meeting should have minutes (taken and stored by the agency chairing the meeting), and further meetings held as required. The minutes and any associated records, including actions should be saved by each agency using their own recording systems. There should be an agreed process to ensure that actions have value and are completed / monitored.

It is highly likely that in complex cases there may be regular multi-agency meetings required, and that work with some individuals can be lengthy (months / years). The need for escalation will always depend on the level of risk in each individual case, which is why it **must** be considered on a regular basis and well documented.

1.6 Information-sharing

Some agencies, including statutory ones, may already have consent to share information from the person.

If consent has not already been obtained, this is not necessarily a barrier to information-sharing. Information can be shared in the public interest and for the prevention and detection of crime, provided it is shared in accordance with the data protection principles.

Anyone can take a concern to an open forum such as a collaboration meeting. Be mindful of confidentiality, ideally get consent from the person at the centre of your concern, but if you are not sure, simply describe the situation without identifying detail, so you can still get initial support.

Decisions about **consent** and what information is shared and with who, should be taken on a case-by-case basis.

Practitioners can share information if they believe:

- the person lacks capacity about the concern, and they believe it would be in the person's best interests to share
- there is a risk to others
- for the 'prevention or detection of crime'
- sharing information is in the 'public interest' which may include if they believe the person is being controlled or coerced

You must be able to evidence what your rationale was for sharing information to make the decision to share defensible.

See also 7 golden rules for information sharing and NSAB guidance on information sharing in safeguarding adults.

If you are not sure if information could be legitimately shared or action taken without the consent of the individual, further advice should be sought from your manager who can also seek legal advice.

2. Circumstances in which there is a need to escalate to senior management level

The steps above may involve necessary longer term single and / or multi-agency working, particularly in relation to complex needs, where relationships of trust need building, and risk management may need to focus on small wins to begin with. Where a situation continues (over a lengthy period) to involve complex issues and **very high risk** to the individual, despite positive multi-agency working at local level as described above, it can be escalated for a senior level review.

This may include cases involving people with complex mental health issues including dementia, learning difficulties/disabilities, long term physical health needs and people with chronic self-neglecting behaviour.

Practitioners need to carry out a mental capacity assessment in the first instance, centred around the **specific decision** that needs to be made in relation to the high-level risk identified.

If it is deemed that the person lacks mental capacity, this escalation guidance will not apply and procedures for best interests decision-making need to be followed (which may also include a senior management discussion, but not through this route).

2.1 Criteria for escalation (multi-agency senior management level review)

Please note – **all of these** must be met**:**

- An adult with care and support needs has been identified as being at risk of significant harm, is well known to one or more agencies with repeated concerns or presentation, but there is no established plan to manage ongoing needs

- The person has the mental capacity to make relevant decisions but has **consistently** refused essential services or interventions, which could result in significant harm

- Current multi-agency approaches have not been able to mitigate the risk of this significant harm

- There is concern about the individual's ability to manage their care and support needs (in 2 or more areas below)

  - Managing and maintaining nutrition
  - Maintaining personal hygiene
  - Managing toilet needs
  - Being appropriately clothed
  - Being able to make use of the home safely
  - Maintaining a habitable home environment
  - Developing and maintaining family or other personal relationships
  - Accessing and engaging in work, training, education or volunteering
  - Making use of necessary facilities or services in the local community, including public transport, and recreational facilities or services
  - Carrying out any caring responsibilities the adult has for a child.

- One or more of the partners in the established multi-agency meetings has concerns about the individual and believe a senior manager review would be of benefit.

The purpose of the review is to:

- acknowledge and reflect on the interventions of the multi-agency group used to date; what has been working / not working with the individual to minimise risk / harm
- ensure that all relevant partners have been active and engaged
- consider the risk remaining from an organisational partnership perspective
- ensure that decision-making in relation to those risks has been properly documented, including what risks have little or no available mitigation at that point
- agree who will continue to monitor, and how

2.2 The process

As part of the standard multi-agency approaches described above, **line managers should already be aware / involved in any complex risk management scenario**. Where the above criteria have been met, it could be a decision of the multi-agency group to raise it for senior review.

Important to note: this is **not a forum to address professional disagreements** – please follow the NSAB Managing Professional Difficulties guidance instead, which sets out the escalation process between agencies who have conflicting views.

Using the referral form you must set out in detail:

- the situation of concern
- the detail of the specific risk(s)
  - what's working well
  - what the group is worried about
  - what actions have been taken
  - likelihood and impact scores before and after mitigating actions
- why the multi-agency group feel they have no further interventions to offer

Relevant managers involved in standard multi-agency meetings / aware of the situation must then present this to their senior operational managers. Senior operational managers also have responsibility for notifying their executive leads about cases where there is high and sustained risk.

On receipt, the senior manager will review the information, ensuring that **all possible interventions by that agency have taken place**, and that the case meets the criteria above.

If so:

1. The referral form will then be sent via email to the NSAB mailbox; initial triage will be completed by NSAB business team, to check that the criteria have been met.
2. The information will be shared with the NSAB Statutory Partners group via email who will review and agree if a multi-agency senior management level review meeting should be convened
3. The multi-agency senior management level review will be chaired by the lead agency involved in the case, who will also be responsible for arranging and minuting the meeting

Reviews will be held as required rather than on a set / panel basis. Feedback will be shared back to the original multi-agency group working the case.

2.3 Detail of senior management review process

1. **Referral is received in the NSAB mailbox** – top line detail logged on spreadsheet and deputy board manager (DBM) alerted (NB: in absence of DBM, NSAB board coordinators will log top line detail and share directly to Statutory Partners with a note that initial triage has not been completed)
   a. Triage –

        i. Person has identified care and support needs, even if these are not being met
        ii. Specific risks have been identified but no services or approaches have been successful in mitigating those risks to date
        iii. The person has been assessed to have capacity to make the decisions required
        iv. Multi-agency approaches have been evidenced, within a timescale proportionate to the level of risk
        v. Senior manager has reviewed and is named on referral
    b. *Criteria not met*: form returned via email to sender with note of where criteria have not been evidenced; decision logged
    c. *Criteria met*: form emailed to Statutory Partners group; decision logged

2. **Statutory Partners receive email**
    a. Individually review and decide:
        i. email review / further single agency work required
        ii. meeting required
    b. Share view with group via email (within 5 working days)
    c. Final decision made (within 10 working days) – majority view

3. **Referral Outcome**
    a. No meeting required – partners agree a response back with rationale and any further actions identified - decision and rationale emailed back to NSAB mailbox and logged by DBM or board coordinators who will feedback to referrer
    b. Meeting required – if lead will **not** be one of Statutory Partners, then group agrees who will contact most appropriate lead to arrange review

4. **Senior management review meeting** held by lead agency representative
    a. acknowledge and reflect on the interventions of the multi-agency group used to date; what has been working / not working with the individual to minimise risk / harm
    b. ensure that all relevant partners have been active and engaged
    c. consider the risk remaining from an organisational partnership perspective
    d. ensure that decision-making in relation to those risks has been properly documented, including what risks have little or no available mitigation at that point
    e. agree who will continue to monitor and how, including if a further review meeting at senior level is required
    f. lead agency records key points and any agreed actions
    g. provide feedback to referrer

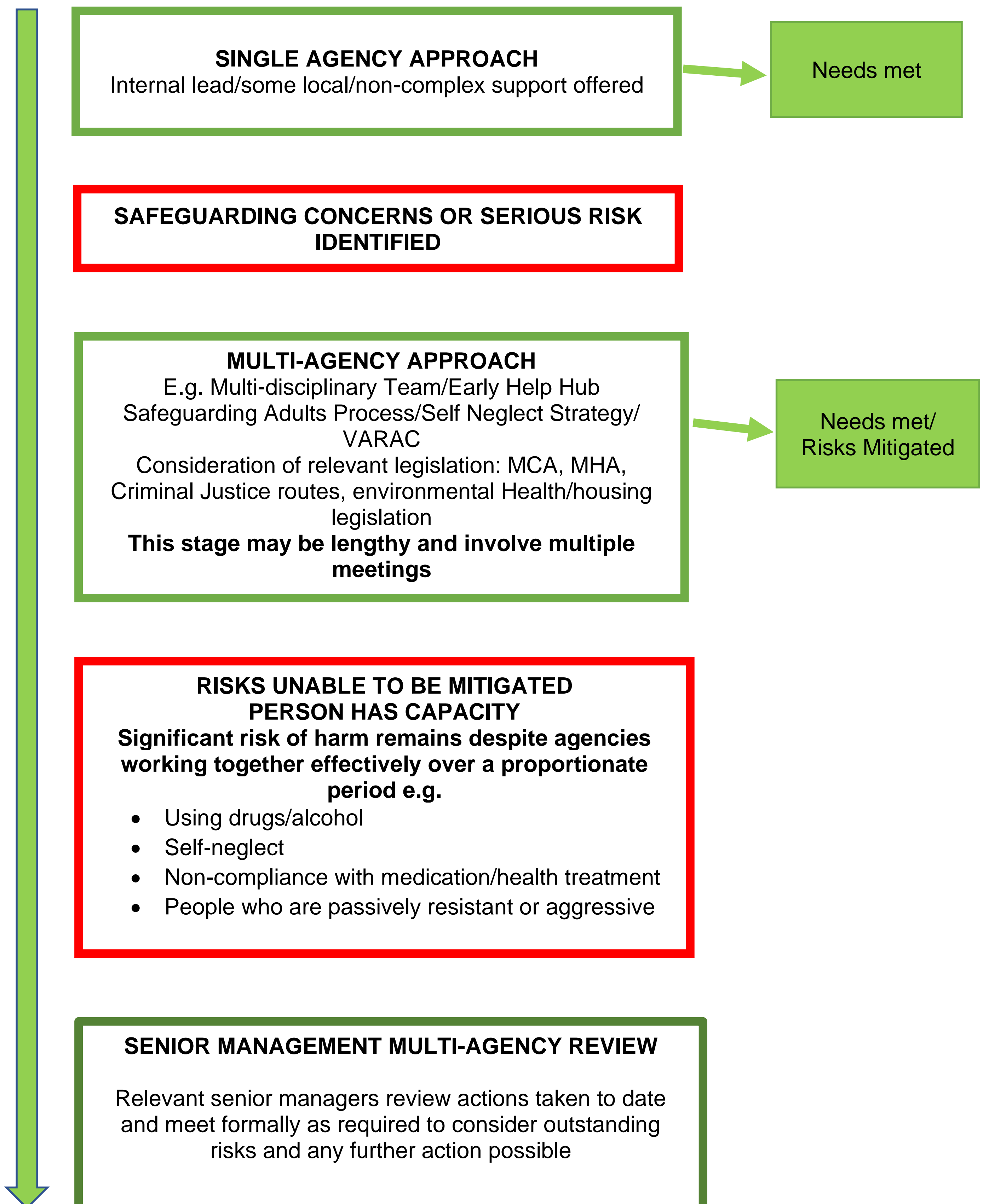
Case log spreadsheet (held by NSAB) to cover:

- Date received
- Date triaged
- Basic info
- Outcome of triage – eligible yes / no
- Date returned / date sent to SP
- SP decision – meeting required yes / no
    - If no, rational and feedback sent
- Date meeting held and feedback sent
- Further meeting required
    - Date set (loops back to above)

If a case is particularly urgent then it is more appropriate to be escalated independently of this process, which is designed for **longer term chronic concerns**

Norfolk Safeguarding Adults Board

3. Flowchart



4. Case Example

A housing officer was very concerned about Mr Dixon who had struggled to look after himself for a long time but refused help. They had been alerted by the police that Mr Dixon's neighbours had contacted them worried about his welfare. He had open sores on his legs and was clearly not managing his personal care.

Mr Dixon said he didn't want any help from the GP or social services as he didn't like the authorities. The sores had got worse since her last visit and looked infected, and Mr Dixon seemed to have lost weight. He was hardly moving from his chair and was using a bucket as a toilet and the housing officer had noticed a mouse infestation had developed in the property. Mr Dixon had a friend who dropped off some food once a week.

The housing officer discussed the case with her manager who visited with her and explained to Mr Dixon how worried about him they were and discussed the risks of having an untreated infection with him. Mr Dixon said he knew it wasn't good but still refused a referral to the GP or adult social care. He also declined support to remove the mice as he didn't want the disruption.

Believing Mr Dixon's condition to be very serious, the housing officer consulted NSAB's information sharing guidance and decided to share information on the basis that "the risk is unreasonably high and needs a multi-agency discussion" and also "other people are or may be at risk" due to the mouse problem which could impact on the neighbours.

The housing officer convened a **multi-agency meeting** involving Mr Dixon's GP and she requested attendance from adult social care, the police and the environmental health department. The meeting was **chaired by the housing manager** as the lead agency.

The group developed a **risk identification and risk management plan** and agreed that Mr Dixon needed to be seen by a medical professional in the first instance as the sores could potentially be life threatening. The group agreed that the housing officer would visit with a district nurse who Mr Dixon might perceive as less threatening than a GP, to see if he would let the district nurse in. They agreed to prioritise this action and meet again after the visit had taken place. Believing Mr Dixon may be suffering from a mental health condition, the GP agreed to refer to mental health services and that they would be invited to the next meeting.

At the next meeting, the housing officer explained that Mr Dixon had refused to let the district nurse in but had spoken to him through the window. The district nurse could see the sores were very serious and managed to **make an assessment of his capacity** through the window, concluding that Mr Dixon did have capacity to understand that if left untreated, the sores could be life-threatening. It was apparent that the mouse problem had got worse, and the bucket was overflowing onto the floor. The housing officer and the district

nurse did their best to engage Mr Dixon, but he told them to go away, he didn't want to see the district nurse again. The mental health team representative had shared that Mr Dixon was previously unknown to them, but it was possible he could be suffering from depression. They offered to visit with the housing officer if Mr Dixon would agree to this.

The group agreed that as the housing officer had a relationship with Mr Dixon, she would continue to visit him to **maintain a relationship and monitor the situation** and the group would meet again. Over the coming weeks, Mr Dixon did on one occasion agree that the housing officer could arrange for a commode to be delivered which the adult social care practitioner was able to arrange.

Each time that she visited, the housing officer **checked Mr Dixon's capacity** by asking questions to establish if he understood the risks he was under.

Each time the group met **the risk identification and risk management plan was updated**. The police had done some work with the neighbour who repeatedly raised concerns with both the police and adult social services.

6 months later, the situation had further deteriorated, and Mr Dixon had lost more weight. The local authority had **applied to the Court of Protection with a request to use the inherent jurisdiction of the court** to remove Mr Dixon from his home, but this had been declined by the court.

At this point, the group's concerns were such that they submitted a **referral for a multi-agency senior management level review** to consider whether all actions had been carried out to engage Mr Dixon, that ongoing monitoring was in place with plans to intervene if and when possible and to accept that the partnership must jointly carry this risk. The senior manager in housing agreed to this referral and to chair a partnership meeting.

5. Notes for completing the referral form

Section 1 – ensure that eligible care and support needs, and the harm / abuse identified are clearly set out.

The Care and Support (Eligibility Criteria) Regulations 2014 describe the eligibility threshold for adults with care and support needs. The threshold is based on identifying how a person's needs affect their ability to achieve relevant outcomes, and how this impacts on their wellbeing. To have needs which are eligible for support, the following must apply:

• The needs must **arise from or be related to a physical or mental impairment or illness.**

• Because of the needs, the adult must be unable to achieve **two or more** of the following outcomes:

- managing and maintaining nutrition
- maintaining personal hygiene
- managing toilet needs
- being appropriately clothed
- being able to make use of the adult's home safely
- maintaining a habitable home environment
- developing and maintaining family or other personal relationships
- accessing and engaging in work, training, education or volunteering
- making use of necessary facilities or services in the local community including public transport, and recreational facilities or services
- carrying out any caring responsibilities the adult has for a child

By of not achieving these outcomes, there is likely to be a significant impact on the adult's wellbeing.

Set out the most significant harm or abuse – there are 10 categories of abuse under the Care Act:

- Physical
- Emotional / psychological
- Financial
- Sexual
- Organisational
- Neglect and acts of omission
- Discriminatory
- Domestic
- Modern slavery and human trafficking
- Self-neglect and hoarding

Section 2 – consideration of the person's mental capacity **must** have been made through the process to date, as it will be integral to any proposed intervention / support offered and should be evidenced.

Section 3 – there is an expectation that for the individual case to be escalated up for this level of review, that significant work will already have taken place within a multi-agency framework. If this has not been relevant, please explain why.

Difficulties convening multi-agency meetings are not a reason to escalate using this review process, instead please refer to the NSAB 'Managing Professional Difficulties' guidance linked in section 2.2.

There is also an expectation that **robust risk assessment** using an agreed tool(s) has taken place (either single or multi-agency) to achieve a clear understanding of exactly what any risk is and the impact on the individual or others. This should include, but is not limited to, thinking about actual and potential risk, degree and impact as well as levels of mitigation.

Please **attach the most up to date risk assessment** with the referral.

Section 4 – sets out some specific areas to help identify where the concerns are impacting day to day

Section 5 – as set out above, there is an expectation that multi-agency discussion / joint working is in place, and involvement to date (which may have been lengthy) has been unable to mitigate certain high level risks. This questions helps us to see where there is more than one agency with this level of concern.