Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 11 September 2024

TB2024.75

Title:	**Oxford University Foundation Trust (OUHFT) Safeguarding (Children and Adults) Annual Report 2023-2024**

Status:	**For Information**
History:	**The previous Safeguarding Children and Adults Annual Report was presented at the OUH Trust Board on 18th January 2023**

Board Lead:	**Chief Nursing Officer**
Author:	**Tracy Toohey, Head of Safeguarding**
Confidential:	**No**
Key Purpose:	Assurance, Policy, Performance

Executive Summary

1. The Oxford University Foundation Trust (OUHFT) Safeguarding Annual Report 2023-2024 highlights the trust's efforts and achievements in safeguarding children and adults. It details increased activity, multi-agency collaboration, training compliance, key challenges, and recommendations for future improvements.
2. Safeguarding activities increased in all areas, adults, children and maternity averaging an activity of 1,064 a month across the service. Themes of domestic abuse, emotional abuse, neglect, self-neglect, substance misuse and mental health continue with additional issues of fabricated induced illness in children safeguarding. Adolescent complex mental health and eating disorders continued to require significant liaison and planning. In maternity delays in discharge due to placement and housing issues increased from 6 to 65 days.
3. There were three section 42 investigations issued relating to neglect and discharge concerns, all have been closed and no additional learning points raised to the Trust from the Local Authority (LA).
4. There were 1210 Deprivation of Liberty Safeguards (DoLS) applications made during the year, an increase of 600 applications. A process is in place with the LA to escalate any urgent applications that need authorising when behaviours escalate.
5. There continues to be significant multi-agency working to ensure risks and safety plans are in place and participation in multi-agency case reviews.
6. Partnership Working continues to be strong across the system with participation at multi-agency meetings, working in the MASH 2 days a week, involvement in Oxfordshire Children and Adult Safeguarding Board (OSAB) and subgroups, participating in audits and there are good systems in place to share relevant information of risks to protect children and adults.
7. Training compliance levels varied, with Adult Level 3 at 88%, Children Level 3 at 85%, and Mental Capacity Act training at 78%. The correct mapping of adult level 3 training dropped levels of compliance and has now been rectified and all levels have improved.
8. There have been several key achievements over the year that have evidence improved safeguarding and partnership working.
9. Challenges are around increased activity and complexity and the increased number of safeguarding multi agency reviews requiring information and participation at panel.

Recommendations

The Trust Board is asked to note and approve the content of this report.

Contents

Oxford University Foundation Trust (OUHFT) Safeguarding (Children and Adults) Annual Report 2023-2024

1. Introduction

1.1 This report provides a comprehensive overview of the Trust's safeguarding activities and initiatives between April 2023 and March 2024 and includes both Child and Adult Safeguarding.

1.2 Throughout the year, the Trust has worked diligently to enhance safeguarding practices, address emerging challenges, and promote a culture of safety and vigilance. The report highlights key achievements, areas for improvement, and future goals in ongoing efforts to protect vulnerable individuals.

2. Purpose

2.1. The Trust Annual Safeguarding report provides an overview of the safeguarding activities and progress made over the past year. It aims are to:

2.1.1 Assure the Board that the Trust has met its statutory responsibilities for safeguarding children and adults.

2.1.2 Highlight key achievements and developments in safeguarding practices and identify areas for improvement and set priorities for the coming year.

3. Background

3.1. The Trust is committed to ensure safeguarding is part of core business and has a responsibility to safeguard children, young people, and adults in its care. This is a legislative requirement set out in:

3.1.2 The Children Act (1989), the Children Act (2004)

3.1.3 The Care Act (2014) and Health and Social Care Act (2022)

3.1.4 The Mental Capacity Act (2005

3.2. in addition, the Trust is committed to ensuring safeguarding is part of core business, complies by the responsibilities in CQC Regulation 13: Safeguarding service users from abuse and improper treatment.

3.3. The Trust is monitored by the Berkshire, Oxfordshire Buckinghamshire Integrated Care Board (BOB ICB) to ensure that the Trust is compliant with the Safeguarding in the NHS Contract to demonstrated compliance with

safeguarding duties as set out in the Safeguarding Accountability and Assurance Framework (July 2022).

4. Safeguarding System Data

4.1. Safeguarding activity is divided into three main areas, children, maternity and adult safeguarding.

Children

4.2. Safeguarding children and maternity joint activity saw a 45% increase over the year (Figure 1). There were 8,467 contacts in total which is an increase of 2,678 (average of 715 per month). Children activity was 4,821 and maternity activity was 3,646.

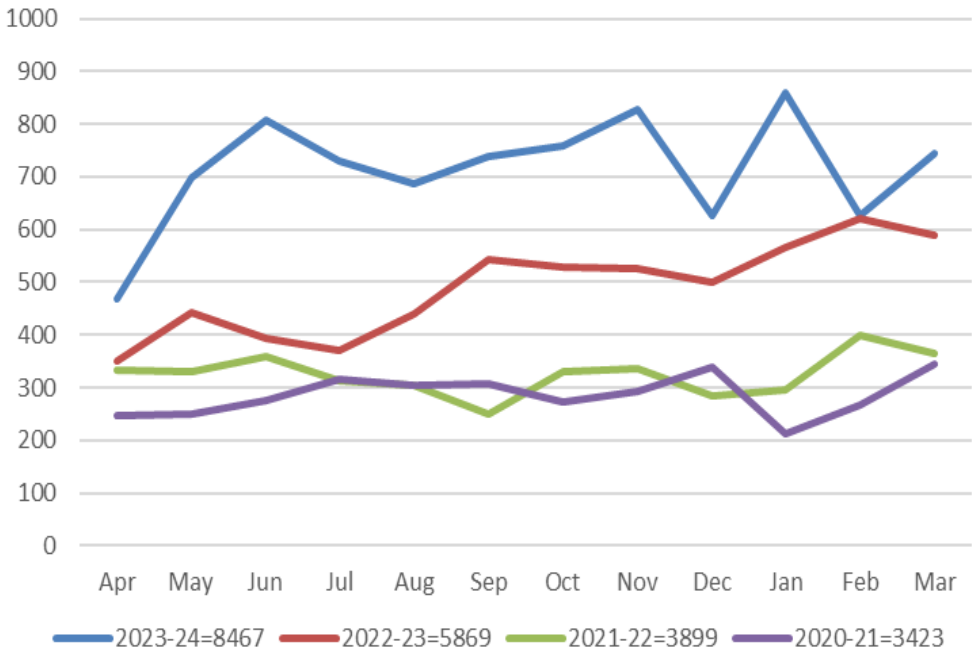

Figure 1:Children and Maternity Activity 2020-2024

4.3 Themes for children safeguarding related to cases of neglect, emotional and physical abuse, fabricated induced illness, and issues around adolescent mental health including eating disorders. Issues around complex cases over the year that led to delays in discharge due to insufficient residential or mental health placements needing escalations and increased joint working with the local authority and Oxford Health.

4.4 Adolescent complex mental health and eating disorders have continued to require significant liaison and planning. Attendances to ED's have stabilised; there were 829 attendances in 2023/24 which is a decrease of 2% from 22/23 (n=848), however this is a 41% increase in attendances since 20/21 (n=588)

(Fig.2). The complexity of the cases continues to increase and can often require escalation; partnership working with the LA and CAMHS that reduced discharge delays. Attendances continue to be analysed monthly and shared with primary care, CAMHS, school health nursing service, children social care and education. The county self-harm forum restarted at the start of 2024, OUH share themes, patterns or trends to escalate concerns to ensure support is in place for families, schools, and professionals. This includes any themes around locations,clusters of abuse, age groups (figure 3.) and methods of self harm to escalte to the locality to consider the need for a Communitiy Around School Offer (CASO) with partner agencies to ensure robust plans are put in place to support the young person, family, community and professionals working with young people.

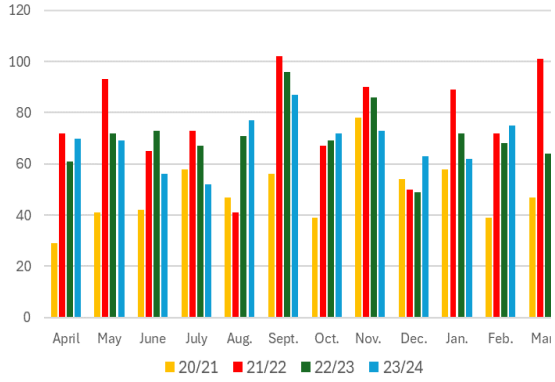

Figure 2: OUH ED attendances over 4 years

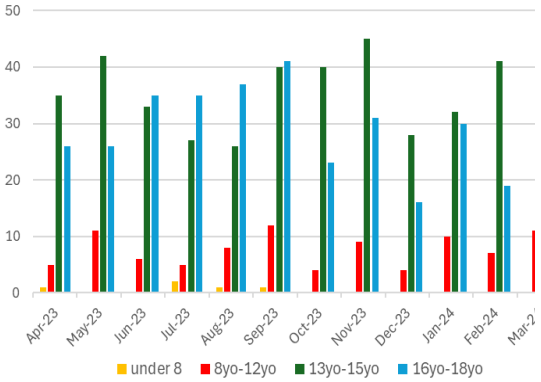

Figure 3: Age of attendances with DSH, OD and MH

4.5 The safeguarding liaison service is contracted to share information with primary care and children social care for open cases when children present to the Emergency Department (ED). The three areas are children with safeguarding presentations, babies under 1-year due to vulnerability of age, and parent or carer attendances to ED where their presentation raises a safeguarding concern and potential risk to a child (Figure 2). There was a small reduction of 42 over the year to 13,186 (Figure 3).

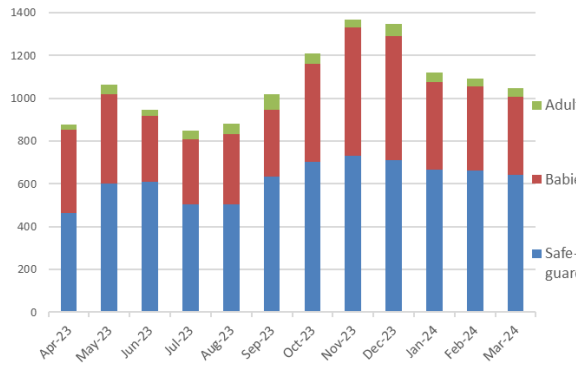

Figure 4: Safeguarding Liaison Service year attendance

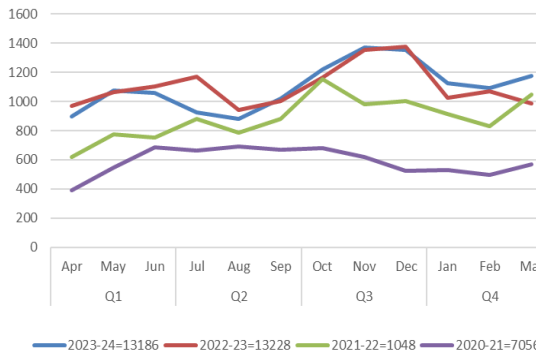

Figure 5: Safeguarding Liaison Service over 4 years

4.6 The Home Office funded Thames Valley Hospital Navigator project for the JR ED stalled in 2023 when the provider ended their contract. A new provider will be continuing this project during 2024. The aim of the Thames Valley ED project in is to support the police Violence Reduction Unit (VRU) working with children and young adults attending hospital with injury from violent or criminal activity to reduce reattendances and support.

A Brookes University evaluation of the whole project showed that there is a cost benefit of 5% across health services, police, and the criminal justice system.

Violence is an increasing international public health concern. Consequences of violence have implications for the individual, community, and society. These include anxiety, depression, drug and alcohol use, the likelihood of reactive perpetration, and hospital reattendance. Wider impacts include the financial cost for community health and rehabilitation services. A focus on vulnerable young people is an opportunity for early intervention and support to prevent or interrupt the cycle of violence and promote positive pathways into adulthood.

Maternity

4.7 Maternity safeguarding activity increased by 62.8% (n=3646) (figure 6) from 2022/23 data (n=2289). Themes relate to complex cases of substance misuse, mental health, and domestic abuse. Delays in discharge have increased from 6 days in 2022/23 to 65 days this year. This has mainly been due to a shortage of residential mother and baby units or foster placements and in some cases appropriate housing to discharge a baby to. There has been close working with the local authority and the senior team within Oxfordshire Children's Social Care who contributed to supporting the maternity unit financially with room costs and staffing for supervising families that required an enhanced level of support where discharge plans were delayed.

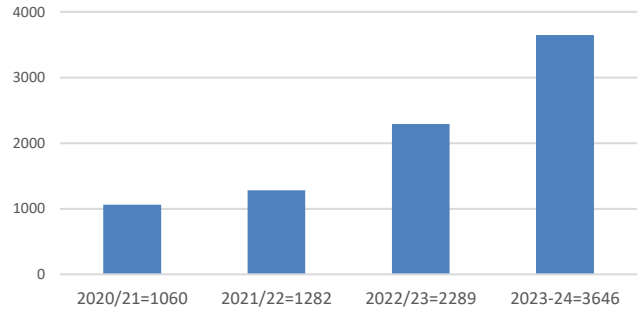

Figure 6: Maternity Consultations

4.8 There were 243 unborn babies with Children's Social Care involvement and 24 Interim Care Orders granted in court following birth for the separation of Mother and Baby. Collaborative working with the PAUSE[1] project has enabled successful engagements with women who have been through the maternity service resulting in a baby being removed from their care.

4.9 Virtual court hearings when seeking Interim Care Orders (ICOs) have continued since COVID by the request of the maternity safeguarding team to enable parents to attend court without leaving their babies and for the process to experience minimal delays following birth. Courts now request reports from the safeguarding midwives directly rather than being included in the social workers reports.

4.10 Housing issues and homelessness at birth has been a theme that led to an improved pathway with the LA homeless team to identify antenatally women who may present as homeless at birth. This is often related to multi-occupancy housing and not allowing babies in the residence. Cases also included women that have no recourse to public funds who are homeless on admission.

4.11 Close multi-disciplinary working continues, the mental health midwives and the substance misues midwife became integratedand into the maternity safeguarding team. This has improved joint working and reduced duplication.

4.12 Badgernet has been implemented as the maternity electronic patient record system in January, this works alongside the Cerner EPR system to ensure safeguarding concerns are documented on both systems. Prior to the change EPR reports identified 33% of pregnancy bookings had a social or safeguarding concern. This level was the highest reported and safeguarding reports are being developed in Badgernet.

4.13 Due to the significant amount of domestic abuse cases within maternity, a Hospital Independent Domestic Abuse Advocate (HIDVA) was funded by

[1] PAUSE model to create Space for Change for women at risk of having a child removed from their care.

Standing Together charity, NHS England, alongside Oxfordshire County Council and A2Dominion. The HIDVA will support victim-survivors of domestic abuse in many aspects including housing, finances, court applications, emotional support, and police involvement until the specialist service allocates a support worker. The feedback has been positive, and the funding will be reviewed after the 12-month pilot has finished. Many Trusts have a HIDVA in place and funding will need to be sought to continue after the year. Dolmestic abuse is the main theme across maternity and adult safegaurding.

4.14 Maternity Safeguarding have been involved with Oxfordshire Children's Social Care in the generation of the new pre-birth assessment guidance to strengthen the knowledge front line practitioners have when assessing the safeguarding risk to an unborn baby.

Adult

4.15 Safeguarding adult activity is divided into three main areas:

- Safeguarding consultation activity
- Section 42 (Care Act 2014) investigations of safeguarding concerns Trust services including investigations and Safeguarding Adult Reviews (SARS)
- Deprivation of Liberty Safeguards (DoLS) applications for the Trust

4.16 The team received 5,295 safeguarding adult consultations, an increase of 1,310, 33% from 2022-23 (see Figure 8). This is an average of 441 per month. Figure 9 shows additional sources of activity of EPR referrals and Ulysses reports, this totals 9,724.

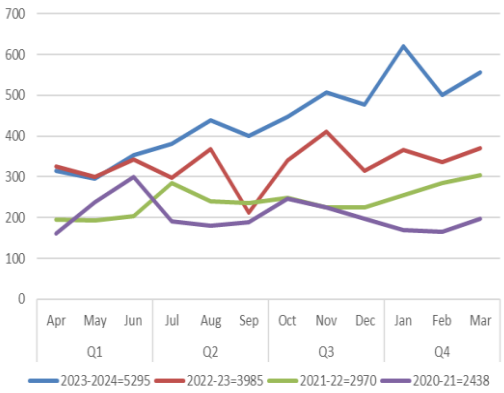

Figure 2: Adult Safeguarding Consultations

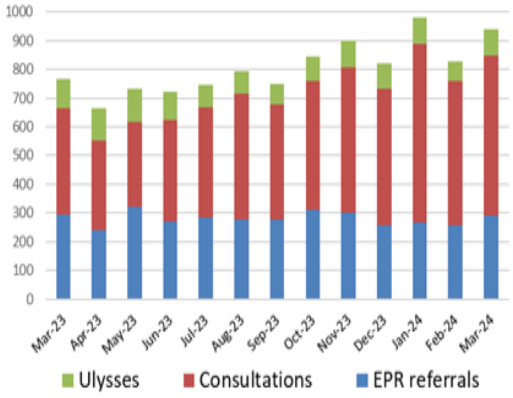

Figure 3: Adult Combined Activity 2022-23

4.17 Domestic abuse, neglect, and self-neglect continue this year to be the main themes of activity. Complex discharges and close working with the learning

disability team on cases have been a significant theme often requiring Best Interest meetings and multi-agency involvement to ensure support in the community to meet health needs.

4.18 The team attend Harm Free meetings when incidents are reviewed, and it is evidenced that mental capacity is well embedded when reviewing cases.

4.19 The Trust were issued with three section 42 investigations over the year, these were related to neglect and discharge concerns. This was a reduction of 8 from the previous year. No additional learning was raised to the Trust by Local Authorities (LA) following their investigations. The Trust reported to the LA three SIRI investigation reports when referring a safeguarding concern that did not result in being issued a s.42 as learning and action plans had been implemented.

4.20 Thames Valley Police (TVP) implemented Right Care Right Person (RCRP) operating model designed to ensure that when there are concerns for a person's welfare linked to mental health, medical or social care issues, the right person with the right skills, training and experience will respond. This has led to OUH guidelines being produced to ensure concerns around missing patients are appropately responded to. The Trust has participated in the implementation group to work in partnership with Oxford Health and TVP to ensure the appropriate response is applied. Initial concerns about this process have not led to significant issues. This process is for adults and not for chidlren.

4.21 The adult safeguarding team manages the DoLS process for the Trust. Each application is reviewed for accuracy then sent to relevant LA and notifies the Care Quality Commission (CQC). The review process, prior to submission ensures:

- a documented relevant mental capacity assessment
- accurate, appropriate, and comprehensive DoLS application
- the appropriate use of Sections 5 and 6 of the Mental Capacity Act

4.22 There were 1210 DoLS applications made during the year, an increase of 600 from the previous year (Figure 10). Figure. 11 shows the DoLS applications per division varied over the year. MRC division submit the majority of DoLS applications. Training, awareness, and audits to ensure clinical areas compete mental capacity assessments and quality documentation has continued to be a focus; alongside an increase in acuity of complex admissions has resulted in the increase in DoLS applications. There is close working with the Local Authority (LA) to request urgent authorisations are undertaken. There was one authorisation escalation during the year.

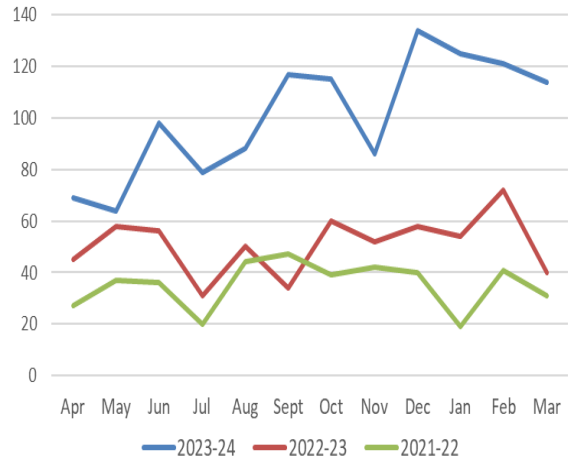

Figure 10: DoLS Applications over 3 years

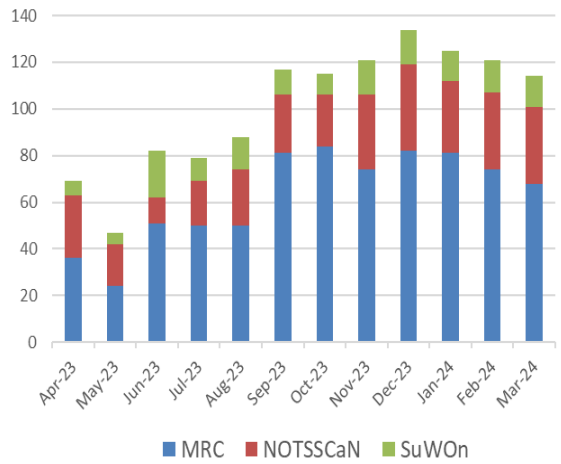

Figure 11: Divisional DOLS Applications 2023/24

5 Partnership working to improve outcomes for children and adults

5.3 The Head of Safeguarding represents the Chief Nursing Officer on both Oxfordshire Children and Adult Safeguarding Boards. The Trust is represented at 13 sub-groups for the OSCB and OSAB (see Table 1).

OSCB subgroups	OSAB subgroups
Joint Adult and Children Training subgroup (OUH/OH Share the Chair)	
Performance Audit and Quality Assurance (PAQA)	Performance Information and Quality Assurance (PIQA)
Child Safeguarding Practice Review (CSPR)	Safeguarding Adults Review (SAR)
Policies and Procedures	Procedure Subgroup
Child Exploitation Subgroup	Vulnerable Adult Mortality Group (VAM)
Neglect Subgroup	Homelessness Mortality Review Group (HMR)
Child Death Overview Panel (CDOP)	Engagement Group
Health Advisory Group	Mental Capacity Forum
OSCB Business Group	

Table 1: Membership of OSCB/OSAB sub-groups

5.4 The Multi-Agency Safeguarding Hub (MASH) health desk is managed by both OUH and Oxford Health safeguarding teams to share the health information as part of the assessment to ensure risks are identified. MASH contacts had increased every year since 2020 between 35% and 18%. Over the last year

this had started to reduce with targeted triage and Family Support early help involvement.

5.5 Information requests from the LA to inform decision making for Initial Child Protection Case Conference (ICPCC) under section 47 of the Children Act (1989) dropped by 65 (n=339). This involved sharing information for 665 children and 51 unborn babies. Information recorded on all children's EPR records.

5.6 The team attended most of the three-area monthly Multi-Agency Risk Assessment Conferences (MARAC) to share relevant information in high-risk domestic abuse cases. Where the team were unable to attend due to capacity, relevant information was shared. Information documented on the electronic patient record to inform practitioners involved with patients of when they attend the Trust. The team also attended most of the three county Multi-Agency Task and Coordination (MATAC) group to share information and support perpetrators of domestic abuse to reduce risk.

5.7 The Head of Safeguarding is the Trust Prevent lead and attended the Prevent Board. There were 14 requests from the Oxfordshire Channel panel to share relevant information to inform risk assessments, this is an increase of five this year.

6 Designated Safeguarding Officer (HR)

6.3 The HR Designated Safeguarding Officer (DSO) works closely with the safeguarding team with allegations and liaising with the Local Authority Designated officer (LADO) to manage risks and ensure support for staff and managers is in place.

6.4 The Trust signed up to the Sexual Safety at Work Charter in September 2023 to eradicate sexual harassment and abuse in the workplace. This became embedded in the Managing Allegations against Staff and Persons in a Position of Trust, Respected and Dignity at Work, Disciplinary Procedure policy and included the Freedom to Speak Up team.

6.5 From April 2023 to March 2024 the DSOs were involved in 56 safeguarding cases involving members of OUHFT staff, including our third-party contractors and NHSP staff members.

6.6 There were seven cases that required Local Authority Designated Officer (LADO) discussion or involvement.

7 Case Reviews

7.3 Child Safeguarding Practice Reviews (CSPR) and, are commissioned by the OSCB when a child or young person dies or experiences serious harm or injuries and there is interagency learning.

7.4 There were four Practice Learning Reviews over the year related to risks in pregnancy, adolescent drug and alcohol use, disability, and safeguarding.

7.5 Learning is disseminated through learning events, learning summaries and lessons are included on safeguarding training:

7.5.1 Improve the pre-birth assessment documentation and safety planning to include the period between birth and court proceedings. The maternity safeguarding team has been involved in updating the OSCB pre-birth procedures.

7.5.2 recognising parental difficulties and disabilities in care planning and assessments pre birth

7.5.3 transitions to adult services for adults when they have been in LA care as a child and for children with learning disabilities/difficulties.

7.5.4 reviewing agencies child protection conference reporting and participation

7.5.5 dissemination and awareness of the OSCB suicide prevention strategy and guidance

7.5.6 Critical thinking around cumulative concerns and not episodic/incident led.

7.6 Safeguarding adults team shared information for 10 Homeless Mortality Reviews (HMRs).

7.7 There have been 7 adult Serious Case Reviews (SARS) that the team have participated in over the last year. Learning includes:

- the need for clear documentation of mental capacity assessments.
- the need for professional curiosity to look wider than the presenting picture to identify abuse and neglect.
- no agency had a clear picture of the adult's life. Agencies recommended to consider how this can be improved to not see a person in isolation.
- agencies review their supervision processes and clear discussions for internal escalation and multi-agency working.

7.8 The team have participated in 5 Domestic Homicide Reviews and submitted information for three others where there was none or minimal involvement from the Trust so did not participate in the panel meetings.

8 Training

8.3 The adult and the children safeguarding training complies with the Intercollegiate guidance[2] [3]. Online safeguarding training is provided by e-Learning for Health (e-LFH) from Health Education England[4].

Safeguarding Level	KPI	Compliance % March 2024
Adults Level 1	90%	90%
Adults Level 2	90%	80%
Adults Level 3	90%	88%
Children Level 1	90%	92%
Children Level 2	90%	91%
Children Level 3	90%	85%
Prevent Level 1&2	85%	83%
Prevent Level 3,4&5	85%	90%
Mental Capacity Act	85%	78%
Identifying Victims of Mod. Slavery	85%	82%

Table 2: Trust Safeguarding Training Compliance

8.4 Online training is the mode of delivery for Level 1 and 2 safeguarding adult and children training. Adult Level 3 safeguarding training has been fully implemented and delivered via e-learning produced by the Trust. Compliance improved and is at 88%. Level 2 adult training is shown at 80%, this lower compliance level was due to staff mapping issues at year end, which have since been resolved. Level 3 children safeguarding training is delivered either face to face or via Microsoft Teams with compliance at 85%. Table 2 shows levels of compliance.

8.5 Prevent radicalisation online training is provided by the UK Home Office and was at 83% for awareness and 90% for the basic level of compliance at end of year (Table 2).

8.6 Mental capacity training is via e-LFH and additional bespoke training for teams delivered. Trust compliance was at 78%. The combination of training and raising awareness has in part led to the 100% increase in the DoLS applications and improved documentation of assessments.

8.7 Specific clinical services have been targeted to improve compliance and at the time of this report compliance had improved in each reported level of training.

[2] https://www.rcn.org.uk/professional-development/publications/pub-007069
[3] https://www.rcn.org.uk/professional-development/publications/pub-007366
[4] https://www.e-lfh.org.uk/

9 Audit

9.1 The Trust was compliant in all areas of the annual OSCB/OSAB self-assessment to meet the requirements set out in Section 11 of the Children Act 1989 and the Care Act 2014. This OSCB/OSAB partner agency peer review agreed compliance in all areas.

9.2 The NICE CG110 maternity audit of complex social factors in pregnancy was repeated and showed an improvement in the four areas of risk; substance misuse, domestic abuse, women who are recent migrants, asylum seekers or refugees who have language barriers and pregnant teenage women. The audit evidenced improvement in most areas with an updated action plan. This audit will be repeated each year to continue to evidence improvement.

9.3 Maternity audit as part of a master's dissertation around asking routine enquiries for DA across the multi-disciplinary team. This identified some barriers to asking routine questions on DA and an action plan that includes the need for specific training to include all disciplines.

9.4 An audit to review DoLS on two wards at the Horton over two separate periods showed an improvement in the number of capacity assessments and DoLS applications. This highlighted improved knowledge on mental capacity assessment and when to apply for a DoLS authorisation to protect vulnerable patients.

9.5 Audit of child protection medical assessments in community paediatrics against the Good Practice service delivery standards[5] (RCPCH 2020). Strengths identified seven areas of good practice that included timeliness, dissemination of reports, appropriate place, suitable for disabled children, appropriate staff training and supervision, process of clinical photography and investigations, good peer review process and support for staff. The six areas of improvement included additional resources for trained chaperones, developing a proforma for reports, ensuring written information for children to explain the process in age appropriate and different languages, access to dental services for assessment /referral for forensic dentistry and getting feedback from service users.

10 Key achievements

10.1 The Trust invested in two named adult safeguarding Drs who have made a significant contribution to the safeguarding team.

[5] https://www.rcpch.ac.uk/work-we-do/clinical-audits/child-protection-service-delivery-standards

10.2 The maternity safeguarding manager won the patient choice staff recognition award

10.3 This year saw a 100% increase in the number of DoLS applications and evidence of capacity assessments documented. The LA are processing DoLS when cases are escalated due to difficult behaviours in patients. There is more joint working with managers in adult social care to support this process.

10.4 Training and awareness to ensure appropriate referrals to the MASH has reduced the number of referrals that do not require statutory involvement from social care, this has meant the MASH health requests for information has been more manageable.

10.5 The Trust invested in the Ulysses safeguarding module to record all consultations and DoLS applications. This system will when fully developed will enable wards to access their DoLS data directly. This module will collate all safeguarding to provide automatic report. This commenced in April 2024.

10.6 The implementation and improved compliance of level 3 adult safeguarding training.

10.7 The HIDVA role funded for a year by charity and supported by the BOB ICB and Oxfordshire County Council to support victims of DA that come into the Trust.

10.8 Increased effective safeguarding advice to protect vulnerable adults and children and support to staff as demonstrated by activity.

10.9 Multiagency partnership working to evidence safeguarding.

10.10 Active participation at OSCB and OSAB board and subgroup meetings.

10.11 Safeguarding is further embedded across divisions and is demonstrated in the activity.

10.12 Evidence of good practice at the annual OSCB and OSAB self-assessment.

11 Key challenges

11.1 The activity continues to rise in all areas, alongside the level of complexity of cases, related to domestic abuse, mental health and substance misuse, neglect and self-neglect which is a challenge to manage going forward. There has been an average of 1,064 a month across the service.

11.2 Increased number of multi-agency safeguarding case reviews requiring information to be shared.

12 Conclusion

12.1 The Safeguarding Team continues to develop across the OUH and partner agencies to meet the requirements set out in section 11 of the Children Act 2004 and the Care Act 2014.

12.2 Significant multiagency joint working has demonstrated the Trust's commitment to work together to improve the identification of concerns, and to protect children and vulnerable adults within the Trust.

12.3 The work across the Trust and partnerships would not be possible without the commitment of our front-line staff and the safeguarding team who have the professional curiosity and commitment to safeguarding our patients. I would like to thank all of them for their professionalism, dedication, and continued support to safeguarding our patients across the Trust.

13 Recommendations

13.1 The Trust Management Executive is asked to note and approve the content of this report.

4.3.1.1. The Safeguarding Executive Lead during this period reported was Paula Gardner, the Interim Chief Nursing Director. The safeguarding team is led by the Head of Safeguarding (see updated structure in Appendix 2) to work across the Trust as one team to provide a family based safeguarding service.

1.2. The safeguarding team covers three domains, adults, children, and maternity.

Appendix 1 – Definition of vulnerable adults according to the Care Act 2014.

The Care Act 2014 describes an adult with care and support as:

- an older person
- a person with a physical disability, a learning difficulty, or a sensory impairment
- someone with mental health needs, including dementia or a personality disorder.
- a person with a long-term health condition
- someone who misuses substances or alcohol to the extent that it affects their ability to manage day-to-day living.

People with care and support needs are not inherently vulnerable, but they may come to be at risk of abuse or neglect at any point due to:

- physical or mental ill-health
- becoming disabled
- getting older
- not having support networks
- inappropriate accommodation
- financial circumstances or
- being socially isolated

Section 42: Section 42 Enquiries

A. When a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)
   i. has needs for care and support: (whether or not the authority is meeting any of those needs),
   ii. is experiencing, or is at risk of, abuse or neglect, and
   iii. as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

B. The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by who.

Appendix 2 – Safeguarding Team Structure.