Safeguarding adults at risk
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Full Procedures Review due: January 2020
Safeguarding adults at risk

The multi-agency policy, procedure and practice for working with adults at risk of abuse or neglect in Hertfordshire
Foreword
Everybody has the right to live a life that is free from harm and abuse; the Hertfordshire Safeguarding Adults Board (HSAB) is committed to working together to ensure that all adults at risk of abuse or neglect are enabled to live and work, be cared for and be supported in an environment free from abuse, harassment, violence or aggression.

Safeguarding adults at risk of abuse or neglect is everybody’s business, and as such Hertfordshire Safeguarding Adults Board has developed a multi-agency policy and procedure for working with adults at risk of abuse or neglect; this should be read alongside Chapter 14 of the Care and Support Statutory Guidance.

When abuse or neglect occurs or is suspected, it needs to be responded to swiftly, effectively and proportionately to enable the adult in need of safeguarding to remain in control of their life as much as possible. ‘Safeguarding Adults at Risk’ policy, procedure and practice guide will provide front-line staff, their managers and crucially adults at risk themselves with a framework within which to work together to reduce the incidence and impact of abuse and neglect across Hertfordshire.

The Board members have all signed up to working together to put the policy into operation and to raise the awareness of safeguarding adults with our staff, our service users or patients, their families and carers, elected members and the general public. We need to remember that not all abuse and neglect happens in care and support services and is not always committed by members of staff. It occurs in people’s own homes and can be committed by families, ‘friends’ and neighbours. Not all abuse or neglect is malicious and the person who may cause harm or abuse and neglect may themselves need care and support. Most importantly, ‘Safeguarding Adults at Risk’ is not an end in itself, but a means to an end – enhancing the quality of life of adults at risk.

I would like to express my appreciation of the hard work and commitment of the individuals and agencies who have contributed to the development of ‘Safeguarding Adults at Risk’. It ensures that Hertfordshire is well positioned to implement the Care Act 2014 and to continue to raise the quality of safeguarding adult services across the county.

Liz Hanlon
Independent Chair
Hertfordshire Safeguarding Adults Board
Glossary and acronyms

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

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

Adult at risk means adults who need community care services because of mental or other disability, age or illness and who are, or may be unable, to take care of themselves against significant harm or exploitation. The term replaces ‘vulnerable adult’.

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

Concern is a worry that an adult at risk is or may be a victim of abuse or neglect. A concern may be a result of a disclosure, an incident, or other signs or indicators.

Capacity is the ability to make a decision about a particular matter at the time the decision needs to be made.

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.

Carer refers to unpaid carers, for example, relatives or friends of the adult at risk. Paid workers, including personal assistants, whose job title may be ‘carer’, are called ‘staff’.

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.

Clinical governance is the framework through which the National Health Service (NHS) improves the quality of its services and ensures high standards of care.

CMHTs (community mental health teams) are made up of professionals and support staff that provide specialist mental health services to people within their community.

Consent is the voluntary and continuing permission of the person to the intervention based on an adequate knowledge of the purpose, nature, likely effects and risks of that intervention, including the likelihood of its success and any alternatives to it.

CPA (Care Programme Approach) was introduced in England in the joint Health and Social Services Circular HC(90)23/LASSL(90)11, ‘The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services’, published by the Department of Health in 1990. This requires health authorities, in collaboration with social services
departments, to put in place specified arrangements for the care and treatment of people with mental ill health in the community.

**CPS (Crown Prosecution Service)** is the government department responsible for prosecuting criminal cases investigated by the police in England and Wales.

**CQC (Care Quality Commission)** is responsible for the registration and regulation of health and social care in England.

**CQUIN** – Commissioning for Innovation and Improvement. A payments framework introduced by the Department of Health so that a proportion of health and care providers income is based on demonstrating improvements in patient care. Areas of action are set nationally by the Department of Health and by CCGs.

**DASH (domestic abuse, stalking and harassment and honour-based violence)** risk identification checklist (RIC) is a tool used to help front-line practitioners identify high-risk cases of domestic abuse, stalking and harassment and honour-based violence.

**DAISU (Domestic Abuse, Investigation and Safeguarding Unit)** – Herts Police Team investigation allegations of domestic abuse where there is an intimate relationship.

**DoLS (Deprivation of Liberty Safeguards)** are measures to protect people who lack the mental capacity to make certain decisions for themselves. They came into effect in April 2009 using the principles of the Mental Capacity Act 2005, and apply to people in care homes or hospitals where they may be deprived of their liberty.

**DBS (Disclosure and Barring Service)** The Disclosure and Barring Service helps employers make safer recruitment decisions and prevent unsuitable people from working with at risk groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA).

**Enquiry** establishes whether any action needs to be taken to stop or prevent abuse or neglect, and if so, what action and by whom the action is taken.

**Enquiry Lead** is the agency who leads the enquiry described above.

**Enquiry Officer** is the member of staff who undertakes and co-ordinates the actions under s42 enquiries.

**HSE (Health and Safety Executive)** is a national independent regulator that aims to reduce work-related death and serious injury across workplaces in the UK.

**Independent Domestic Violence Advisor** - Adults who are the subject of domestic violence may be supported by an Independent Domestic Violence Advisor (IDVA). IDVA’s provide practical and emotional support to people who are at the highest levels of risk. Practitioners
should consult with the adult at risk to consider if the IDVA is the most appropriate person to support them and ensure their eligibility for the service.

**IMCA (Independent Mental Capacity Advocate)** established by the Mental Capacity Act (MCA) 2005 IMCAs are mainly instructed to represent people where there is no one independent of services, such as family or friend, who is able to represent them. IMCAs are a legal safeguard for people who lack the mental capacity to make specific important decisions about where they live, serious medical treatment options, care reviews or adult safeguarding concerns.

**Independent Mental Health Advocate** - under the Mental Health Act 1983 certain people known as ‘qualifying patients’ are entitled to the help and support from an Independent Mental Health Advocate. If there is a safeguarding matter whilst the IMHA is working with the adult at risk, consideration for that person to be supported by the same advocate should be given.

**Independent Sexual Violence Advocate (ISVA)** - is trained to provide support to people in rape or sexual assault cases. They help victims to understand how the criminal justice process works and explain processes, for example, what will happen following a report to the police and the importance of forensic DNA retrieval.

**Intermediary** is someone appointed by the courts to help an at risk witness give their evidence either in a police interview or in court.

**LGBT (lesbian, gay, bisexual and transgender)** is an acronym used to refer collectively to lesbian, gay, bisexual and transgender people.

**MAPPA (Multi-agency Public Protection Arrangements)** are statutory arrangements for managing sexual and violent offenders.

**MARAC (Multi-agency Risk Assessment Conference)** is the multi-agency forum of organisations that manage high-risk cases of domestic abuse, stalking and 'honour'-based violence.

**Making Safeguarding Personal** is about person centred and outcome focussed practice. It is how professionals are assured by adults at risk that they have made a difference to people by taking action on what matters to people, and is personal and meaningful to them.

**Mental Capacity** refers to whether someone has the mental capacity to make a decision or not.

**Modern Slavery** encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

**NHS (National Health Service)** is the publicly funded healthcare system in the UK.
OPG (Office of the Public Guardian), established in October 2007, supports the Public Guardian in registering enduring powers of attorney, lasting powers of attorney and supervising Court of Protection appointed deputies.

PALS (Patient Advice and Liaison Service) is an NHS body created to provide advice and support to NHS patients and their relatives and carers. **Person alleged to cause the harm** is the person or adult who is alleged to have caused the abuse or harm.

Public interest – a decision about what is in the public interest needs to be made by balancing the rights of the individual to privacy with the rights of others to protection.

Safeguarding adults is used to describe all work to help adults at risk stay safe from significant harm. It replaces the term ‘adult protection’.

Safeguarding adults lead is the title given to the member of staff in an organisation who is given the lead for Safeguarding Adults. The role may be combined with that of manager, depending on the size of the organisation.

Safeguarding adult’s process refers to the decisions and subsequent actions taken on receipt of a referral. This process can include a strategy meeting or discussion, an investigation, a case conference, a care/protection/safety plan and monitoring and review arrangements.

Safeguarding adults review is undertaken by Hertfordshire Safeguarding Adult Board when a serious case of adult abuse takes place. This is a requirement of the Care Act 2014 and the aim is that agencies and individuals to learn lessons to improve the way in which they work.

SafeLives is a national charity supporting a strong multi agency response to domestic violence. They were originally known as CADDA.

SI (Serious Incident) is a term used by the National Patient Safety Agency (NPSA) in its national framework for serious incidents in the NHS requiring investigation. It is defined as an incident that occurred in relation to NHS-funded services resulting in serious 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.

SOCA (Serious Organised Crime Agency) is a non-departmental public body of the government and law enforcement agency with a remit to tackle serious organised crime.
Enquiry Planning/ Strategy/ Meeting or discussion is a multi-agency discussion between relevant organisations involved with the adult at risk to agree how to proceed with the referral. It can be face to face, by telephone or by email.

Vital interest is a term used in the Data Protection Act (DPA) 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 has care of a person who lacks capacity to care for themselves.
Contents

PART ONE – POLICY

1. CONTEXT PRINCIPLES AND VALUES ................................................................. 13
   1.1 Hertfordshire Safeguarding Adults Board (HSAB) .............................................. 13
   1.2 Principles and Values ....................................................................................... 14
   1.3 Information Sharing and Cooperation .............................................................. 15
   1.4 Making Safeguarding Personal ....................................................................... 16
   1.5 Core standards ............................................................................................... 16
   1.6 Advocacy ......................................................................................................... 18
   1.7 Risk Assessment ............................................................................................ 19

2. SAFEGUARDING POLICY .................................................................................. 20
   2.1 What is Safeguarding? ................................................................................. 20
       2.1.1 The aims of Adult Safeguarding are to: ................................................... 20
   2.2 Who do adult safeguarding duties apply to? .................................................. 20
       2.2.1 Out of area safeguarding enquiries ........................................................ 21
       2.2.3 Transition arrangements and safeguarding young people ................. 22
       2.2.4 Carers and safeguarding ................................................................. 22
       2.2.5 Personal budgets and self-directed care ....................................... 23
       2.2.6 Complaints ....................................................................................... 23
   2.3 Types and indicators of abuse and neglect ................................................. 24
       2.3.1 Pressure Ulcers .................................................................................. 25
       2.3.2 Medication errors and neglect ......................................................... 25
       2.3.3 Radicalisation .................................................................................... 25
   2.4 When would an enquiry take place? .............................................................. 26
   2.5 Who abuses and neglects adults? ................................................................. 26
   2.6 Safeguarding Adults Review (Appendix 17) .................................................. 27
   2.7 Hertfordshire Provider Serious Concerns Process (Appendix 16) ............... 28

PART TWO – PROCEDURES ................................................................................. 29

3. CONTEXT ........................................................................................................... 30
   3.1 The Four Stage Process ................................................................................ 30
   3.2 Roles and Responsibilities ............................................................................ 32
       3.2.1 Health and Community Services Hertfordshire County Council (HCC) 32
       3.2.2 Hertfordshire Constabulary ............................................................... 32
       3.2.3 Clinical Commissioning Groups (CCG’s) ........................................... 32

STAGE 1: CONCERNS ....................................................................................... 34

1.1 What is an adult safeguarding concern? ......................................................... 34
1.2 Receiving/ Responding to a Disclosure ......................................................... 34
1.3 Immediate Actions ......................................................................................... 35
1.4 Raising a concern .......................................................................................... 36
1.5 Reporting a Concern ....................................................................................... 36
3.8 Health organisations and links to clinical governance ................................................................. 58
3.9 Pressure ulcers................................................................................................................................ 58

Appendix 1: Advocacy ............................................................................................................................ 59
Appendix 2 Risk assessment and risk management .................................................................................. 62
Appendix 3 Information sharing ............................................................................................................. 64
Appendix 4 Pressure ulcers and neglect: making a decision whether to refer to adult safeguarding .......... 69
Appendix 5 Medication errors and safeguarding ..................................................................................... 76
Appendix 6: Allegation of abuse against staff and/or volunteers ............................................................ 77
Appendix 7: Mental capacity and Consent ............................................................................................... 78
Appendix 8: Deprivation of Liberty Safeguarding (DoLS) ....................................................................... 81
Appendix 9: Hate crime ........................................................................................................................... 83
Appendix 10: Cyber abuse and cyber bullying ......................................................................................... 84
Appendix 11: Domestic violence and abuse ............................................................................................ 85
Appendix 12: Multi-Agency Public Protection Arrangements (MAPPA) .............................................. 86
Appendix 13: Prevent .............................................................................................................................. 92
Appendix 14: NHS Risk Summits .......................................................................................................... 93
Appendix 15: Safety & Improvement process .......................................................................................... 95
Appendix 16: Safeguarding Adults Review Protocol ............................................................................... 126
PURPOSE AND HOW TO USE THIS DOCUMENT

Safeguarding Adults at Risk is the inter-agency policy, procedure and practice guidance for safeguarding adults from abuse in Hertfordshire. It must be followed by all organisations and staff working with adults at risk in Hertfordshire. This includes managers, professionals, volunteers and staff working in public, voluntary and private sector organisations.

The document is structured into the following sections and appendices:

a. **Policy framework:**
   The policy framework sets out the strategic aims, the strategic roles and responsibilities of the Hertfordshire Safeguarding Adults Board and the responsibilities of the agencies in Hertfordshire.

b. **Safeguarding Procedures:**
   The procedures which must be followed to report and conduct an enquiry when actual or suspected abuse against an adult at risk occurs.

c. **Safeguarding Practice guidance:**
   Practice guides to support good practice and decision making in adult safeguarding.

**Review and audit**

This document will be reviewed every three years and will be kept under review by the Policy & Procedure sub group of the HSAB. In line with government policy, the objective of the HSAB is to prevent and reduce the risk of significant harm to adults from abuse or other types of exploitation, while supporting individuals to maintain control over their lives and to make informed choices without coercion.
Safeguarding adults at risk – the multi-agency policy, procedure and practice for working with adults at risk of abuse or neglect in Hertfordshire

Part one – Policy
1. Context Principles and Values

The **Care Act 2014** puts adult safeguarding on a legal footing and requires each Local Authority to set up a Safeguarding Adults Board (HSAB) with core membership from the Local Authority, the Police and the NHS (specifically the local Clinical Commissioning Group/s) and has the power to include other relevant bodies. One of the key functions of the HSAB is to ensure that the policies and procedures governing adult safeguarding are fit for purpose and can be translated into effective adult safeguarding practice.

1.1 Hertfordshire Safeguarding Adults Board (HSAB)

The Hertfordshire Safeguarding Adults Board is the strategic partnership which works together to safeguard and promote the welfare of adults at risk in Hertfordshire.

HSAB believes that all adults at risk have a right to live and work, be cared for, and be supported in an environment free from abuse, harassment, violence or aggression.

HSAB has set out strategic objectives to support its vision that all adults at risk, live and work, are cared for, and supported in an environment free from abuse, harassment, violence or aggression.

All organisations working with adults at risk in Hertfordshire are required to have policies and processes in place to meet these objectives. The HSAB expects each partner agency to ensure it has effective safeguarding arrangements in place within their organisations.

Further information about the HSAB can be found on the Hertfordshire County Council (HCC) website: [http://www.hertfordshire.gov.uk/HSAB](http://www.hertfordshire.gov.uk/HSAB)

*Safeguarding Adults at Risk* aims to ensure that organisations work together to prevent abuse occurring and when abuse does occur adults at risk are protected from further harm. It makes sure that:

- the needs and interests of adults at risk are always respected and upheld;
- the human rights of adults at risk are respected and upheld;
- a proportionate, timely, professional and ethical response is made to any adult at risk who may be experiencing abuse;
- all decisions and actions are taken in line with the Mental Capacity Act 2005;
- each adult at risk maintains:
  - choice and control;
  - safety;
  - health;
  - quality of life;
  - dignity and respect.
The document represents the commitment of all organisations to:
- work together to prevent abuse;
- protect adults at risk from abuse;
- empower and support people to make their own choices;
- conduct an enquiry into actual or suspected abuse and neglect;
- support adults and provide a service to adults at risk who are experiencing abuse, neglect and exploitation.

_The Hertfordshire Safeguarding Adults at Risk policy and procedure_ has been revised in line with the legislative changes set in the **Care Act 2014** and the principles set out in the government policy on adult safeguarding¹ which must be applied to all safeguarding activity.

**The Care Act 2014 section 42** requires local authorities to make enquiries, or to ask others to make enquiries, where they reasonably suspect that an adult in their area with care and support needs is at risk of abuse or neglect and is unable to protect himself/herself. The purpose of the enquiry will be to establish what, if any, action is required in relation to the case.

### 1.2 Principles and Values

The policy and procedures are based on **The Six Principles of Safeguarding** that underpin all adult safeguarding work.

<table>
<thead>
<tr>
<th>Empowerment</th>
<th>Protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults are encouraged to make their own decisions and are provided with support and information.</td>
<td>I am consulted about the outcomes I want from the safeguarding process and these directly inform what happens</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Proportionate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategies are developed to prevent abuse and neglect that promotes resilience and self – determination.</td>
<td>A proportionate and lease intrusive response is made balanced with the level of risk.</td>
</tr>
<tr>
<td>I am provided with easily understood information about what abuse is, how to recognise the signs and what I can do to seek help</td>
<td>I am confident that the professionals will work in my interest and only get involved as much as needed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Protection</th>
<th>Partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults are offered ways to protect themselves, and there is a co-ordinated response to adult safeguarding</td>
<td>Local Solutions through services working together within their communities</td>
</tr>
<tr>
<td>I am provided with help and support to report abuse. I am supported to take part in the safeguarding process to the extent to which I want and to which I am able.</td>
<td>I am confident that the information will be appropriately shared in a way that takes into account its personal and sensitive nature. I am confident that agencies will work together to find the most effective responses for my own situation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accountability</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountability and transparency in delivering a safeguarding response.</td>
<td>I am clear about the roles and responsibilities of all those involved in the solution to the problem</td>
</tr>
</tbody>
</table>

¹ Statement of Government Policy on Adult Safeguarding: Department of Health: May 2013
This means that:

- individuals have the right to make choices about their care and treatment – this includes making decisions about their safety, even where those decisions may seem to others to be unwise;
- individuals are enabled to control decisions about their care to the extent they are able;
- any actions that do not have the person’s full and informed consent must have a clear justification, be permissible in law and the least restrictive of the person’s rights to meet the justifiable outcome.

The HSAB aims to include adults at risk as key partners in all aspects of its work. This includes building service-user participation into its membership; the monitoring, development and implementation of its work; its training strategy; and the planning and implementation of their individual safeguarding assessment and plans.

1.3 Information Sharing and Cooperation

Information sharing between all agencies and organisations is essential to safeguard adults at risk. This includes all HSAB partners including CCGs, Health and Community Services, Hertfordshire Partnership Foundation Trust, Housing, Hertfordshire Constabulary, Hertfordshire Fire and Rescue Service, Probation and all private and voluntary health and social care providers.

The Care Act 2014 section 6 outlines a general duty to co-operate between the Local Authority and other organisations providing care and support. This includes a duty on the Local Authority itself to ensure co-operation between its adult care and support, housing, public health and children's services.

The Care Act 2014 section 7 provides a new ability to request co-operation from a relevant partner or another local authority, in relation to an individual case. The local authority or relevant partner must co-operate as requested, unless doing so would be incompatible with their own duties or have an adverse effect on the exercise of their functions.

The Care Act 2014 Section 45 ‘supply of information duty’ covers the responsibilities of others to comply with requests for the right information to be shared, with the right people at the right time.

Information must be shared on a need to know basis and in line with the confidentiality and information sharing policies of the individual organisations.

The duty to share personal confidential data can be as important as the duty to respect adult at risk confidentiality. Whether information is shared with or without the consent of the adult at risk, the information sharing process must comply with the Data Protection Act 1998. In some instances where the person lacks capacity to consent to information sharing, the requirements of the Mental Capacity Act 2005 must be considered and information shared in the person’s best interest if necessary. Wherever possible, informed consent to sharing information should be obtained.
However:

- emergency or life-threatening situations may warrant the sharing of relevant information with the relevant emergency services without consent;
- the law does not prevent the sharing of sensitive, personal information within organisations. If the information is confidential, but there is a safeguarding concern, sharing it may be justified;
- the law does not prevent the sharing of sensitive, personal information between organisations where the public interest served outweighs the public interest served by protecting confidentiality – for example, where a serious crime may be prevented.

The Department of Health Caldicott principles are to be adhered to at all times when professionals consider whether to share or not to share information and can be found in Appendix 3 along with further guidance on information sharing.

1.4 Making Safeguarding Personal

HSAB is committed to the principles of Making Safeguarding Personal, a project developed by the Local Government Association and the Association of Directors of Adults Social Services (ADASS). The aim of Making Safeguarding Personal is to ensure that safeguarding is person-led and focused on the outcomes that they want to achieve. It engages the person in a conversation about how best to respond to their safeguarding situation in a timely way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

We will:

- work with people (and their advocates or representatives if they lack capacity) at the beginning to identify the outcomes they want to achieve;
- include adults in the enquiry process as appropriate throughout;
- review with the person at the end of safeguarding activity to what extent their desired outcomes have been achieved;
- record and monitor the results in a way that can be used to inform practice and account to the HSAB;
- develop a range of social work and other responses that focus on supporting people to meet their desired outcomes and reduce the risk of or recurrence of abuse.

1.5 Core standards

All organisations working with adults at risk must have:

- A clear, well-publicised policy of zero-tolerance of abuse within the organisation;
- Internal policies and procedures must be consistent with Safeguarding Adults at Risk and include policies on:
  - safeguarding;
  - reporting concerns in the workplace/whistle blowing.
- Robust recruiting and safer staffing policies in place to make sure that their staff are fit to work with adults at risk and are compliant with national safe recruitment and employment practices, including the requirements of the Disclosure and Barring Service;
• A learning and development strategy which specifically addresses adult safeguarding and demonstrates that:
  ▪ staff receive induction and training appropriate to their levels of responsibility;
  ▪ staff and volunteers in contact with adults at risk recognise abuse and the internal reporting procedures;
  ▪ staff and volunteers know how to raise safeguarding concerns and to contribute to the safeguarding investigation and safeguarding plan;
  ▪ A named safeguarding lead that is responsible for embedding safeguarding practice and improving practice in line with national and local developments.

Safeguarding adults must be included in all appropriate HR strategies, systems, policies and procedures.

**Organisations that commission care and support services**
Organisations that commission services must have robust safeguarding adults' standards in place and monitor the ability of the contracted provider to meet this standard through quality review and contact/compliance monitoring processes.

They have a responsibility to make sure that:
• organisations from which services are commissioned know about and adhere to relevant registration requirements and guidance;
• all documents such as service specifications, invitations to tender, service contracts and service-level agreements adhere to *Safeguarding Adults at Risk*;
• they (and regulators) regularly audit reports of risk of harm and require providers to address any issues identified;
• senior managers of commissioned services are clear about their leadership role in safeguarding adults in ensuring the quality of the service, the supervision and support of staff, and responding to and investigating a concern about an adult at risk;
• services routinely provide service users and carers with information in an accessible form about how to make a complaint and how complaints will be dealt with;
• service providers give information to service users and their carers about abuse, how to recognise it and how and to whom they can raise a concern;
• contract monitoring includes compliance with safeguarding adults' procedures, the requirements of the Mental Capacity Act and the Deprivation of Liberty Safeguards (where commissioned services are managing authorities).

Where commissioners identify safeguarding concerns these must be reported in line with the procedures set out in part two of this document.

**Commissioned services**
In order to meet the core standards set out above all commissioned provider organisations should produce their own policies, procedures and guidelines that are consistent with *Safeguarding Adults at Risk*. These should set out the responsibilities of staff, clear internal reporting procedures and clear procedures for reporting possible or actual abuse of adults at risk as set out in part two of this document.
Provider organisations should routinely provide users and their carers with information about how to make a complaint about the service and how to raise safeguarding concerns as set out in *Safeguarding Adults at Risk*.

**All staff and volunteers working with adults at risk**

All staff and volunteers from any service or setting who have contact with adults at risk have a responsibility to be aware of issues of abuse, neglect or exploitation. This includes personal assistants paid for from direct payments or personal budgets.

All staff and volunteers have a *responsibility to act* in a timely manner on any concern or suspicion that an adult at risk of is being abused, neglected or exploited and to ensure that the situation is assessed and investigated.

The minimum standard for all organisations is that staff and volunteers know how to:

- recognise, record and report abuse;
- take any immediate action to protect further harm;
- access help and advice for the adult at risk.

### 1.6 Advocacy

At every stage of the safeguarding process consideration must be given to whether the person at risk would benefit from the support of an independent advocate, including an Independent Mental Capacity advocate to express their views. There are two types of non-statutory advocacy than can be commissioned:

- **Instructed advocates** take instructions directly from the person and can support at meetings and with communication. If the person decides they do not require the support of an advocate then support will be withdrawn.

- **Non-instructed advocates** work with people who may lack capacity or have severe communication challenges. A non-instructed advocate will work with the person and those around them. An independent report will be produced that will ask relevant questions and can support the safeguarding decision-making process.

Throughout the safeguarding procedure the decision to instruct an advocate must be considered and recorded.

It is important that people involved in the safeguarding adult’s process are aware of which type of advocate is representing the person and supporting them to express their views. Refer to Appendix 1.
1.7 Risk Assessment

A risk assessment must be undertaken when a concern is raised to clarify the degree of risk to the individual and others including other vulnerable people for example in a residential home or supported living environment. Risks to children must be considered and addressed appropriately.

It should be constantly reviewed throughout the procedure to ensure adults at risk and all others involved are appropriately protected.

The risk assessment may be evidenced in a safeguarding plan, which is put in place to remove or minimise risk to the person, and others who may be affected or be a separate assessment. The vulnerability of the person alleged to cause harm must be considered and any identified support needs addressed.

The risk assessment and/or safeguarding plan must be monitored, reviewed and amended/revised as circumstances arise and develop.

The risk assessment will seek to determine:

- what the actual risks are – the harm that has been caused, the level of severity of the harm, and the views and wishes of the adult at risk;
- the person’s ability to protect themselves;
- who or what is causing the harm;
- factors that contribute to the risk, for example, personal, environmental, relationships, resulting in an increase or decrease to the risk;
- the risk of future harm from the same source;

and

- balance the above against the perceived benefit or value to the person of the risk.

The risk assessment should also take into account wider risk factors, such as the risk of fire in the person’s home.

Organisations will have a range of risk assessment tools in paper and IT formats to assist staff in risk assessment. Refer to appendix 2.
2. Safeguarding Policy

2.1 What is Safeguarding?

The Care Act 2014 and supporting statutory guidance describes safeguarding as protecting an adult’s right to live safely, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adults’ wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.

2.1.1 The aims of Adult Safeguarding are to:
- stop abuse or neglect wherever possible;
- prevent harm and reduce the risk of abuse or neglect to adults with care and support needs;
- safeguard adults in a way that supports them in making choices and having control about how they want to live;
- promote an approach that concentrates on improving life for the adults concerned;
- raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect;
- provide information and support in accessible ways to help adults understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult; and
- address what has caused the abuse.

2.2 Who do adult safeguarding duties apply to?

In the context of the Care Act 2014 section 42 an enquiry will be carried out under the safeguarding adults at risk procedures when an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Within the scope of this definition are:

- all adults who meet the above criteria regardless of their mental capacity to make decisions about their own safety or other decisions relating to safeguarding processes and activities;
• adults with care and support needs regardless of whether those needs are being met;
• adults who manage their own care and support through personal or health budgets;
• adults whose needs for care and support have not been assessed;
• adults who fund their own care and support;
• children and young people in specific circumstances as detailed below.

Concerns regarding adults at risk with so-called ‘low level needs’ are not excluded from action under the procedures where there are risks that the harm to the person puts their independence and well-being at risk and leads to a deterioration in their ability to protect themselves. Such adults include:

• adults with low-level mental health problems/borderline personality disorder;
• older people living independently in the community;
• adults with low-level learning disabilities;
• adults with substance misuse problems.

Outside of scope of this policy and procedures.

• The Care Act 2014 section 76 states that: Sections 42 and 47 (safeguarding enquiry by local authority and protection of property) do not apply in the case of an adult who is- (a) Detained in prison, or (b) Residing in approved premises. The HSAB’s objective under section 43(2) does not include helping and protecting adults who are detailed in prison or residing in approved premises; but the HSAB may nonetheless provide advice or assistance to any person for the purpose of helping and protecting such adults in its area in cases there the adults has needs for care and support and are at risk of abuse or neglect.

2.2.1 Out of area safeguarding enquiries
There is an increased risk to adults at risk from abuse or neglect whose care arrangements are complicated by cross boundary considerations. These arise where funding/commissioning responsibilities lie with an authority in one area and the concerns about potential abuse arise in another area.

HSAB will work in accordance with the Association of Directors of Adult Social Services guidance\(^2\) which states that the responsibility for co-ordinating the investigation is with the local authority in the area where the abuse occurred (the host authority). The local authority or NHS body that has commissioned the service for the adult at risk (the placing authority) has a continuing duty of care to the individual and will contribute to the investigation and maintain overall responsibility for the individual they have placed.
It is recognised that a safeguarding concern could be raised with either the host or placing authority. Each must inform each other at the earliest opportunity.

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\(^2\) Out of Area Safeguarding Adults Arrangements
Once a safeguarding concern has been raised with the host authority it is the host authority’s responsibility to lead the initial response to the referral in consultation with the placing authority. Funding responsibilities remain with the placing authority.

2.2.3 Transition arrangements and safeguarding young people.
The **Children Act 1989** and safeguarding children’s procedures cover children and young adults up to the age of 18. Safeguarding adults’ procedures apply to adults from the age of 18 years. However when the person at risk is over 18 years by the time the incident is reported, but the alleged incident occurred prior to the individual reaching 18 years, the investigation will be led by children’s services.

The **Children and Families Act 2014** and **Care Act 2014** state that protection arrangements, however, may be the responsibility of either children or adults services, where the following criteria apply:
- if a young person is supported by children’s services under ‘leaving care’ arrangements, their protection is the responsibility of that service until they are 21 (25 if they are a disabled person);
- if the responsibility for care management of a service user lies with transition services **within** children and young people’s services when the safeguarding concern is made, responsibility for protection will remain with this service throughout the investigation. Any discussion or agreement to transfer responsibility should be made subsequent to and not as part of the investigation;
- in all other cases, the protection arrangements would be the responsibility of adult services.

Abuse within families reflects a diverse range of relationship and power dynamics which may affect the causes and impact of the abuse. Professionals will work across multi-disciplinary teams in order to protect all those identified as at risk within a family. Staff providing services to adults, children and families must have appropriate training to ‘Think family’ identifying risks and abuse to both adults and children.

2.2.4 Carers and safeguarding.
Circumstances in which a carer could be involved in a situation that may require a safeguarding response includes when:
- a carer may witness or speak up about abuse or neglect
- a carer may experience intentional or unintentional harm from the adult they are trying to support or from professionals and organisations they are in contact with; or,
- a carer may unintentionally or intentionally harm or neglect the adult they support on their own or with others.

Where there is intentional abuse, adult safeguarding under **Care Act 2014 Section 42**, should always be considered. Work developed by ADASS, carers groups, commissioners
and organisations working with carers, identify six distinct areas related to carers and safeguarding:

- Partnership working
- Prevention
- Support
- Information and Advice
- Advocacy
- Role of carers in strategic planning

2.2.5 Personal budgets and self-directed care.
People who direct their own care have a responsibility to consider, through their support plan, how to manage any risks to their safety. In particular, they need to consider their responsibility to use safe recruitment and employment practices.

The County Council’s Health and Community Services and Clinical Commissioning Group have responsibilities around the provision of personal budgets. They retain responsibility to make sure that:

- people who commission their own care are given the right information and support to do so from providers who engage with safeguarding adults principles and protocols;
- the commissioning of services such as brokerage includes information on safeguarding and dignity;
- services are commissioned in a way that raises service users’ and carers’ expectations in relation to quality of services;
- commissioners develop links with front-line staff to review performance of providers in relation to complaints, standards of care and safeguarding.

Organisations that support individuals to recruit personal assistants should ensure that they provide sufficient information to enable the individual to make an informed decision to safeguard them from harm.

2.2.6 Complaints.
All partners must have procedures in place to manage complaints that are received by their organisation. If a complaint is made about a service and there are concerns that an adult at risk is or may be abused the safeguarding adults from abuse procedure must be followed.

Where the complaint requires a multi-agency approach, this should be coordinated by the agency receiving the complaint and a joint response provided to the complainant.

**Complaints about the safeguarding practice or process**
Complaints received from any source about the safeguarding adults practice and arising from the safeguarding adult’s process should be handled by the relevant complaints procedures of the organisation about which the complaint has been made. If more than one organisation has been named or is implicated in the complaint, the complaints officers from the named
organisations must reach joint agreement with the complainant about how the complaint investigation will be taken forward.

If the complaint results from the experience of the safeguarding process by the adult at risk, their carer, family member or personal representative and / or from a breakdown of inter-agency working, the relevant investigating team manager must be notified of the complaint and the findings.

2.3 Types and indicators of abuse and neglect
The Care Act 2014 and the Care and Support Statutory Guidance define the categories of abuse but emphasises that organisations should not limit their view on what constitutes abuse.

The main forms of abuse are set out in the Statutory Guidance chapter 14 which is not an exhaustive list but an illustration as to the sort of behaviour that could give rise to a Safeguarding concern.

<table>
<thead>
<tr>
<th>Type of Abuse</th>
<th>Description of Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse</td>
<td>Including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions</td>
</tr>
<tr>
<td>Domestic violence/ abuse</td>
<td>Including psychological, physical, sexual, financial, emotional abuse; so called ‘honour’ based violence.</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>Including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting</td>
</tr>
<tr>
<td>Psychological abuse</td>
<td>Including emotional abuse, threats of harm or abandonment, radicalisation, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.</td>
</tr>
<tr>
<td>Financial or material abuse</td>
<td>Including theft, fraud, internet scamming, coercion in relation to an adult’s financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits</td>
</tr>
<tr>
<td>Modern slavery</td>
<td>Encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.</td>
</tr>
<tr>
<td>Discriminatory abuse</td>
<td>Including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.</td>
</tr>
<tr>
<td>Organisational abuse</td>
<td>Including neglect and poor care practice within an institution or</td>
</tr>
</tbody>
</table>
specific care setting such as a hospital or care home, for example, or in relation to care provided in one’s own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation

<table>
<thead>
<tr>
<th>Neglect and acts of omission</th>
<th>Including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-neglect</td>
<td>This covers a wide range of behaviour; neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding</td>
</tr>
<tr>
<td>Sexual Exploitation</td>
<td>Involves exploitative situations, contexts and relationships which can be face to face or online, where adults at risk (or a third person or persons) receive ‘something’ (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. It affects men as well as women. People who are sexually exploited do not always perceive that they are being exploited.</td>
</tr>
</tbody>
</table>

2.3.1 Pressure Ulcers
The purpose of specific guidance is to protect adults at risk by providing a framework to guide health and social care agencies on whether safeguarding procedures should be instigated when concerns have been raised that a pressure ulcer may have developed as a result of neglect. Refer to Appendix 4.

2.3.2 Medication errors and neglect
‘A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, product labelling, packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.’
National Coordinating Council for Medication Error reporting and Prevention.
Refer to appendix 5 for guidance on responding to a medication error.

2.3.3 Radicalisation
Radicalisation is comparable to other forms of exploitation, such as grooming and Child Sexual Exploitation. The aim of radicalisation is to attract people to their reasoning, inspire new recruits and embed their extreme views and persuade vulnerable individuals of the legitimacy of their cause. This may be direct through a relationship, or through social media.
Prevent is part of the Government's counter-terrorism strategy CONTEST and aims to
provide support and re-direction to vulnerable individuals at risk of being groomed into terrorist activity before any crimes are committed. Refer to Appendix 14.

Seriousness of harm or the extent of the abuse is not always clear at the point of the concern or referral. All reports of suspicions or concerns should be approached with an open mind and could give rise to action under Safeguarding Adults at Risk policy and procedures.

2.4 When would an enquiry take place?
Hertfordshire must make enquiries whenever abuse or neglect are suspected in relation to an adult in order to decide what, if any, action is needed to help and protect the adult.

Reference should be made to Part 2 Procedures.

The Care Act 2014 Statutory guidance puts forward the following factors to be taken into account when considering the management of an enquiry:

- the adult’s needs for care and support; the adult’s risk of abuse or neglect;
- the adult’s ability to protect themselves or the ability of their networks to increase the support they offer;
- the impact on the adult, their wishes;
- the possible impact on important relationships;
- potential of action and increasing risk to the adult;
- the risk of repeated or increasingly serious acts involving children, or another adult at risk of abuse or neglect;
- the responsibility of the person or organisation that has caused the abuse or neglect;
- research evidence to support any intervention.

2.5 Who abuses and neglects adults?
Adults at risk can experience abuse by a wide range of people both known and unknown to them. Throughout this document the term person alleged to cause harm is used to describe the individual who is alleged or known to have abused an adult at risk. Anyone can carry out abuse or neglect including:

- spouses/partners;
- other family members;
- neighbours;
- friends;
- acquaintances;
- local residents;
- people who deliberately exploit adults they perceive as vulnerable;
- paid staff or professionals;
- volunteers or strangers;
- other people with care and support needs.
Abuse can happen anywhere: for example in someone’s own home, in a public place, in hospital, in a care home or college. It can take place when an adult lives alone or with others.

2.6 Safeguarding Adults Review (Appendix 17)
The Care Act 2014, Section 44 makes it a duty for HSAB to 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. HSAB must also arrange a SAR if an adult with care and support needs, in its area has not died, but the HSAB knows or suspects that the adult has experienced serious abuse or neglect.

In the context of SARs, something can be considered serious abuse or neglect where, for example the individual was likely to have died but for an intervention, or suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

The criteria are met when:

- An adult in its area who has care and support needs dies (including death by suicide), and the Board knows or suspects that the death resulted from abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult.

  or

- An adult in its area who has care and support needs has not died, but the Board knows or suspects that the adult has experienced serious abuse or neglect and there is concern that partner agencies could have worked more effectively to protect the adult.

HSAB will consider conducting a MASIR when the above criteria for a SAR is not met but when a review into the circumstances of a death or serious abuse or neglect can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults who are at risk of, or experiencing, abuse and neglect.

There is an expectation that individuals, agencies, organisations, cooperate with the review but the Care Act 2014 Section 45 also gives SABs the power to require information from relevant parties. HSAB may also commission a SAR in other circumstances where it feels it would be useful, including learning from ‘near misses’ and situations where the arrangements worked especially well. HSAB should decide when a SAR is necessary, arrange for its conduct and if it so decides, implement the findings. Refer to Appendix 17 for SAR process.
2.7 Hertfordshire Provider Serious Concerns Process (Appendix 16)

A key objective of HSAB is to promote, implement and maintain high quality multi-agency Safeguarding Adult at Risk practice across Hertfordshire. This includes the commitment of all partner organisations to ensure that all adults at risk are cared for in a safe environment and protected from avoidable harm. This is irrespective of how and where their care and support is funded and delivered.

The serious concerns process will be triggered when the care and support being delivered by a specific provider is, or may be, causing a service user, or a number of service users, abuse or neglect. Refer to Appendix 16 for Serious Concerns process.
Safeguarding adults at risk – the multi-agency policy, procedure and practice for working with adults at risk of abuse or neglect in Hertfordshire

Part two – Procedures
3. Context

*Safeguarding Adults at Risk* is the inter-agency policy, procedure and guidance for safeguarding adults from abuse in Hertfordshire and must be followed by all organisations working with adults at risk and individuals involved in safeguarding adults.

The procedures are a means for staff to combine principles of protection and prevention with individuals’ self-determination, respecting their views, wishes and preferences in accordance with Making Safeguarding Personal. They are a framework for managing safeguarding interventions that are fair and just, through strong multi-agency partnerships that provide timely and effective prevention of and responses to abuse and neglect. All organisations who work with or support adults experiencing, or who are at risk of, abuse and neglect may be called upon to lead or contribute to a safeguarding concern and need to be prepared to take on this responsibility.

HCC has lead responsibility to ensure the safeguarding adult’s procedure is followed and to coordinate the investigation of cases of possible or actual abuse. This responsibility is carried out by HCC’s Health and Community Services, the Hertfordshire Partnership University NHS Foundation Trust (*HPFT*) and other strategic partners as part of their delegated social care duties.

Safeguarding enquiries can involve more than one procedure that need to be coordinated. In fact many procedures may run concurrently, for example, disciplinary processes, complaints investigation or a criminal investigation. However, all such procedures need to be discussed, agreed and coordinated at a strategy meeting or discussion.

The organisation responsible for undertaking their part of the enquiry should have regard to their other responsibilities or the legal powers, for example, employment law, criminal law and clinical governance.

Risk assessment and risk management are central to the safeguarding of adults from abuse or neglect.

In all safeguarding cases the mental capacity of the adult at risk must be continually reviewed, including balancing the right of an adult to make unwise decisions against the duty to safeguard and protect. Refer to Appendix 7.

3.1 The Four Stage Process

The safeguarding process has been updated to be complaint with the Care Act 2014 statutory guidance. The timescales are indicative. In compliance with Making safeguarding Personal, these will vary from case to case depending on the adult’s individual wishes and circumstances.
<table>
<thead>
<tr>
<th>Stage</th>
<th>Action</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concern</td>
<td>Raise concern with HCC or HPFT</td>
<td>Immediate action in emergency</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Within 24 hours if non urgent</td>
</tr>
<tr>
<td>Enquiry</td>
<td>Decision on how to proceed</td>
<td>Within 2 working days</td>
</tr>
<tr>
<td></td>
<td>Initial conversation with adult</td>
<td>Within 2 working days</td>
</tr>
<tr>
<td></td>
<td>Strategy meeting/ discussion</td>
<td>Within 5 working days from decision to proceed</td>
</tr>
<tr>
<td></td>
<td>Investigation</td>
<td>Agreed at strategy stage</td>
</tr>
<tr>
<td></td>
<td>1st Case conference</td>
<td>Agreed at Strategy (within 3 months)</td>
</tr>
<tr>
<td></td>
<td>Subsequent Case Conferences</td>
<td>Maximum time between case conferences</td>
</tr>
<tr>
<td></td>
<td>Distribution of approved minutes</td>
<td>4 months.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Within 10 working days of meeting.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If draft minutes are sent out an additional 5 days can be added to ensure accuracy.</td>
</tr>
<tr>
<td>Closure</td>
<td>Closing the enquiry</td>
<td>On completion of enquiry.</td>
</tr>
<tr>
<td>Review of Safeguarding Plan</td>
<td>Review of Safeguarding plan</td>
<td>Within 3 months of closure.</td>
</tr>
</tbody>
</table>

During each of these four stages, key considerations are:

- supporting and enabling the adult at risk to achieve outcomes that they see as the best for them, where possible;
- assessing and addressing risk;
- taking action to protect and support the adult at risk;
- whether a formal mental capacity assessment is needed in regard to specific decisions;
- whether the adult at risk should be represented by an advocate and/or an independent mental capacity advocate (IMCA) Refer to Appendix 1;
- taking appropriate action for the person causing harm;
- giving timely feedback to the referrer;
- taking appropriate action with a service and/or its management if they have been culpable, ineffective or negligent;
- identifying any lessons to be learnt for the future, including recommendations for any changes to the organisation and service delivery;
- whether there are concerns about a provider which need investigation under the serious concerns procedures.
3.2 Roles and Responsibilities

3.2.1 Health and Community Services Hertfordshire County Council (HCC)
HCC has the lead responsibility for ensuring effective arrangements are in place for the safeguarding of adults at risk across the county. Health and Community Services (HCS) leads this work, reporting to the county council’s chief executive. HCS ensures the safeguarding adults’ procedures are followed and coordinates the investigation of cases of possible or actual abuse. This responsibility is undertaken by the social care teams in HCS and Hertfordshire Partnership University NHS Foundation Trust (HPFT) as part of their delegated social care duties.

The Care Act 2014 Section 42 requires local authorities to make enquiries, or to ask others to make enquiries, where they reasonably suspect that an adult in their area with care and support needs is at risk of abuse or neglect and unable to protect himself/herself.

3.2.2 Hertfordshire Constabulary
Hertfordshire Constabulary has the lead responsibility for investigating any criminal offences committed against adults at risk. A dedicated team of officers and staff specialise in safeguarding adults from abuse (SAFA). The SAFA team investigates all offences against adults at risk committed by persons in a position of trust – this includes family members. In investigating these offences the police work very closely with partnership organisations. Throughout these investigations the police use a number of methods to achieve the best evidence whilst supporting the person at risk throughout the investigative and criminal justice process. Additionally, where police officers or staff have concerns over the welfare of an adult at risk that falls short of a criminal investigation, they refer these concerns to the appropriate organisation recognising their wider safeguarding responsibilities.

The Care Act 2014 places a legal obligation on the Chief Officer of Police to be a core member of the HSAB.

3.2.3 Clinical Commissioning Groups (CCG’s)
Herts Valleys Clinical Commissioning Group and East & North Clinical Commissioning Group are statutory NHS bodies with a responsibility for commissioning many local healthcare services. The CCG’s are statutorily responsible for ensuring that the organisations from which they commission services provide safe care which protects all patients, including those recognised to be particularly at risk, from avoidable harm or abuse. The CCG’s also ensure that all aspects of safeguarding adults are fully integrated into the commissioning and contract management processes.

The CCG’s have a statutory duty to be members of the HSAB and are accountable to NHS England.
Safeguarding concern received

Does the concern meet criteria for Section 42 enquiry?

Are there grounds for an Other Safeguarding enquiry?

Stage 2 - Enquiry

Start section 42 enquiry

Conversation with Adult at Risk (or representative) about Consent and Desired outcomes

Can the enquiry be closed?

Start Other Safeguarding enquiry

Stage 3 – Closure

Are other actions required?

Agree other actions required

Close Safeguarding Episode

Stage 4- Review

Is review required?

Review date set

Review takes place and record outcome

Case conference Outcome/evaluation of enquiry and update Safeguarding Plan

Undertake planned investigation/enquiry actions

Strategy Discussion or Strategy Meeting to plan further enquiry and create Safeguarding Plan

Yes

No

Yes

No

Yes

No
SAFEGUARDING CONCERN

Stage 1: Concerns

1.1 What is an adult safeguarding concern?
A concern may be:

Any worry about an adult who has or appears to have care and support needs, who is subjected to or may be at risk of, abuse or neglect and who may be unable to protect themselves from the abuse or neglect or risk of it.

A concern may be raised by anyone, and can be:

- a direct or passive disclosure by the adult at risk
- a concern raised by staff, volunteers, others using the service, a carer or a member of the public
- an observation of the behaviour of the adult at risk, of the behaviour of another person(s) towards the adult at risk, or of one service user towards another
- patterns of concerns or risks that emerge through reviews, audits and complaints or regulatory inspections or monitoring visits

1.2 Receiving/ Responding to a Disclosure

<table>
<thead>
<tr>
<th>Good Practice Guidance – Disclosure</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Speak to the adult in a private and safe place;</td>
</tr>
<tr>
<td>- Don’t interview the person, but establish basic facts;</td>
</tr>
<tr>
<td>- Do not promise to keep a secret/ keep information confidential; explain who you will tell and why;</td>
</tr>
<tr>
<td>- Ask the adult what they would like to happen;</td>
</tr>
<tr>
<td>- Explain how the adult will be kept informed;</td>
</tr>
<tr>
<td>- Identify an immediate safeguarding plan with the adult at risk;</td>
</tr>
<tr>
<td>- Where appropriate make a best interest decision about the risks and the immediate protection plan needed if the adult is unable to provide informed consent.</td>
</tr>
</tbody>
</table>

Key Information to establish where possible:

- Basic facts such as what happened, when and by who;
- What the immediate risks are;
- Mental capacity of the adult to understand the risks and consent to safeguarding enquiry.

If not all the facts can be established initially this MUST NOT prevent you from raising a safeguarding concern.
1.3 Immediate Actions

**Immediate Action by Person Raising the Concern**

The person raising the concern must first and foremost ensure that immediate safety of the adult.

- Make an immediate evaluation of the risk and take steps to ensure that the adult is in no immediate danger;
- Ensure others are not in immediate danger;
- If a crime has been committed or life is in danger or at risk dial 999;
- In situations where there has been or may have been a crime and the police have been called it is important that forensic and other evidence is collected and preserved. Evidence may be present even if you cannot actually see anything. Try not to disturb the scene, clothing or adult at risk if at all possible;
- Arrange any medical treatment (note if the allegation is of a sexual nature this will require expert advice from the police);
- In most cases unless the situation is urgent and an immediate referral to the police and/or the investigating team is needed, staff should follow their organisations internal safeguarding procedures, reporting immediately to their line manager;
- Record the details of the concerns as soon as possible after the disclosure or suspicion, using the organisations internal recording procedures.

* The responsibilities of other adults with care and support needs, carers and members of the public are different from those of staff and volunteers directly involved in the care of adults at risk: their responsibility is just to bring the concern to the attention of the latter.

**Responsibilities of the organisation/line manager of the person raising the concern (manager)**

The Manager should review actions taken in line with your organisations safeguarding policy and procedures. Ensure that the following has been clearly addressed and recorded.

- Evaluate the risk to the adult at risk;
- Take reasonable and practical steps to safeguard the adult at risk as appropriate;
- Refer to the police if the abuse suspected is a crime;
- Arrange any necessary emergency medical treatment (note offences of a sexual nature will require expert advice from the police);
- If the person alleged to have caused the harm is also an adult at risk, arrange for a member of staff to attend to their needs;
- Ensure that any staff or volunteer who has caused risk or harm is not in contact with service users and others who may be at risk, for example, the person who has reported the concern;
- If the person alleged to have caused the harm is a member of staff, decide whether any action is required under the organisation’s disciplinary procedures;
- Make sure that other service users are not at risk;
- If your service is registered with the Care Quality Commission, and the incident constitutes a notifiable event, complete and send notification to CQC.
1.4 Raising a concern

If on the information available the following three criteria are met a referral **MUST** be made to the Local Authority.

1. A person has care and support needs
2. They may be experiencing or at risk of abuse and neglect
3. They are unable to protect themselves from neglect because of those care and support needs

1.5 Reporting a Concern

Concerns from adult at risk, carers or members of the public should always include the following:
- what the adult wants to happen;
- details of the referrer;
- details of the adult at risk;
- information about the abuse or neglect;
- details of the person who may be causing the harm (if known);
- any immediate actions that have been taken.

Anonymous concerns will be accepted and acted on. However, the individual raising the concern should be encouraged to give contact details.

<table>
<thead>
<tr>
<th>Referral Point</th>
<th>Risk to Adult</th>
<th>Email</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Community Services</td>
<td>Adults at risk of abuse or neglect</td>
<td><a href="mailto:Adult.Safeguarding@hertfordshire.gov.uk">Adult.Safeguarding@hertfordshire.gov.uk</a></td>
<td>0300 123 4042</td>
</tr>
<tr>
<td>HPFT</td>
<td>Adult receiving mental health services who is at risk of abuse or neglect</td>
<td></td>
<td>0300 777 0707</td>
</tr>
<tr>
<td>Police</td>
<td>Immediate risk to life or limb, risk of injury or crime being committed</td>
<td></td>
<td>999</td>
</tr>
<tr>
<td>Police</td>
<td>For incidents taking place against an adult at risk where there is NO immediate risk to life or property but a police response is required as soon as practicable due to the seriousness of the incident and/or potential loss of evidence</td>
<td></td>
<td>101</td>
</tr>
<tr>
<td>Police SAFA Team</td>
<td>Partner agencies can make a referral to the police SAFA team.</td>
<td>hq <a href="mailto:safeguarding@herts.pnn.police.uk">safeguarding@herts.pnn.police.uk</a></td>
<td>01707 354556</td>
</tr>
</tbody>
</table>
SAFEGUARDING ENQUIRY

Stage 2: Enquiry

When the Local Authority becomes aware of a situation that meets the criteria described abuse, it must arrange for a Care Act 2014 section 42 enquiry. ‘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 whom.’

2.1 Decision to initiate an enquiry

It is the responsibility of the investigating team manager to decide whether to initiate an enquiry under these procedures. This decision must be made within 2 working days of the concern being received and recorded, including the reasons for the decision. The person raising the concern must also be informed of the decision in a timely way, the reasons for it and information given about any alternative services which have been offered, as long as this does not breach the adult at risk’s confidentiality.

It may be decided not to use the safeguarding adult’s procedures when there is enough information to decide that:

- the adult is not covered by these procedures;
- the situation does not involve abuse, neglect or exploitation;

or

- the adult at risk has the mental capacity to make an informed choice about their own safety, they choose to live in a situation in which there is risk or potential risk and there are no public interest or vital interest considerations.

2.1.1 Criminal Investigations

Although the Local Authority has the lead role in making enquiries or requesting others to do so, where criminal activity is suspected, early involvement of the police is essential. Police investigations should be coordinated with the Local Authority who may support other actions, but they should always be police led.

2.1.2 Initial Visit/ Discussion with Adult

In the majority of cases where it is safe to do so the enquiry will start with a conversation with the adult at risk. In the event that it is known that the adult does not have capacity to consent to the enquiry, but they have an appropriate individual to support them, the appropriate individual should be included in the initial discussion. This initial discussion should take place within the first 48 hours of receipt of the concern unless there are circumstances to prevent the discussion
such as the adult being acutely unwell and unable to be spoken to. At all times the immediate safety of the adult must be considered. Enquiry officers must conduct enquiry discussions/ visits in line with the principles of the **Mental Capacity Act 2005**. The enquiry officer conducting the conversation with the adult at risk needs to be sensitive to the needs of the adult, causing minimal distress.

### Areas to Cover at Initial Visit/ Discussion with Adult at risk and/ or Representative

- Basic facts of the concern
- Identified risks and safety of the adult and others
- Capacity to understand risks and protection measures
- Adults desired outcome/ wishes regarding the safeguarding concern; these views may change throughout the safeguarding enquiry so there will be an ongoing dialogue throughout the enquiry to ensure their views and wishes are gained.
- Consent:
  - to proceed with the enquiry
  - to share information with professionals
  - to share information with lay people such as advocates and friends
  - to give a statement to the police if a criminal offence
  - to protection measures

### Initial Decisions to be made following conversation with adult

- Establish whether the adult and others are safe and devise a safeguarding plan including immediate protection measures;
- Decide whether the adult needs an advocate to support them through the safeguarding enquiry. Refer to appendix 1;
- Who needs to participate in the safeguarding enquiry?;
- If the adult has capacity and does not wish to proceed, are there any vital or public interest reasons to override their wishes. If yes explain them to the adult if it is safe to do so;
- If the adult does not have capacity to consent to the enquiry but it is in their best interest to pursue, ensure advocacy is instructed or the appropriate individual to support the adult through the enquiry is agreed. Appendix ;
- If the adult has capacity and refuses a further enquiry and there are no vital or public interests ensure any support identified with the adult at the initial visit, has been provided;
- If the Adult has capacity and has consented to the further safeguarding enquiry; agree ongoing support and engagement throughout the process;
- The person raising the concern must also be informed of the decision in a timely way, the reasons for it and information given about any alternative services which have been offered, as long as this does not breach the adult at risk’s confidentiality.
2.2  Gaining the consent of the adult at risk

2.2.1 Adults who lack Mental Capacity to consent
The mental capacity of the adult at risk and their ability to give their informed consent for an enquiry to be taken under these procedures is a significant but not the only factor in deciding what action to take.

The test of capacity in this case is to find out if the adult at risk has the mental capacity to make informed decisions about:

- actions which may be taken under safeguarding adults at risk;
- their own safety, including an understanding of longer-term harm as well as immediate effects;

and

- their ability to take action to protect themselves from future harm.

If the Adult lacks capacity to consent, a best interest decision under the Mental Capacity Act 2005 can be made. Refer to Appendix 7.

2.2.2 Adults who have capacity but refuse consent
Where there is a risk to other adults, children or young people or there is a public interest to take action because a criminal offence had occurred and the view is that it is a safeguarding matter, the wishes of the individual may be overridden. Where the sharing of information to prevent harm is necessary, lack of consent to information sharing can also be overridden.

If the adult at risk has capacity and does not consent to an enquiry continuing and there are no public or vital interest considerations, they should be given information about where to get help if they change their mind or if the abuse or neglect continues and they subsequently want support to promote their safety.

The enquiry officer must be clear that the decision to withhold consent is not made under undue influence, coercion or intimidation.

A record must be made of the concern, the adult at risk’s decision and of the decision not to continue, with reasons.

2.2  Strategy Meeting/ Discussion
If the manager decides to initiate an enquiry, they must ensure that a multi-agency strategy discussion or meeting takes place within 5 working days of the decision being made. The purpose of the strategy meeting/discussion is to plan and co-ordinate the enquiry ensuring repeated interviews of the adult at risk and the person who may cause harm are avoided and organisations work together.
It is the responsibility of the investigating team manager to convene and chair the strategy discussion or meeting and ensure the minutes are taken and circulated. Investigations conducted as part of the safeguarding enquiry must be outcome focused and best suit the circumstances to achieve the desired outcomes for the adult at risk.

**Decisions and Actions to be taken at Strategy Meeting/Discussion:**

- share the information currently available about the adult at risk and their situation;
- consider whether a mental capacity assessment is required to ensure the adult understands the type of enquiry, the outcomes and the effect on their safety now and in the future. This may involve more than one separate mental capacity assessment;
- evaluate the risk faced by the adult at risk and or others;
- consider the adults wishes and desired outcome from the safeguarding enquiry;
- consider the adults own strengths and support networks;
- consider the impact of the abuse on the adult;
- agree a safeguarding plan;
- coordinate the collection of information about the alleged abuse or neglect;
- agree whether to continue with the safeguarding enquiry and coordinate the investigation or close;
- if an enquiry is not required identify an alternative and appropriate response to the concern.

If it is agreed to continue the enquiry by conducting an investigation:

- identify individual(s) to liaise/support the adult at risk and family/carer during the investigations (this could be a worker from the investigating team or someone who knows the adult well, (for example, care or support staff);
- identify the lead agency to conduct the investigation: link different types of investigations; there are a number of different types of investigations that contribute to an enquiry. It is important to ensure that where there is more than one investigation that information is dovetailed to avoid delays, interviewing staff more than once, making people repeat their story;
- agree the multi-agency enquiry plan actions including a timely response with named people accountable for actions to be addressed.

**Involving the Adult at Risk in Safeguarding Meetings and Decisions**

Adults at risk should be invited to attend and participate in all strategy discussions or subsequent safeguarding meetings including the case conference. To support adults at risk engagement professionals must consider:

- How to prepare the adult to actively engage in the meeting/discussion;
- Where the meeting should be held;
- How long the meeting should last;
- Who the adult wishes to have attend to support them e.g. an advocate or appropriate individual.
Consider Adult at Risk Support Networks
Risk should be assessed with the adult throughout the enquiry. Identifying the risk with the adult and highlighting their support networks strengths may reduce the risks sufficiently that the adult does not wish to continue to the enquiry as they feel safe.

The identification of risk must aim to:
- Prevent further risk of abuse or neglect
- Keep the risk at a level that is acceptable to the adult
- Support the adult to continue in the risky situation if it is their choice and they have capacity but empower them to take action to safeguard themselves from abuse or neglect

2.2.1 Agreed outcome of Strategy discussion or meeting
All strategy discussions and meetings must have one of the following outcomes:

<table>
<thead>
<tr>
<th>Care Act 2014 Section 42 enquiry to continue</th>
<th>The safeguarding adults process will continue and an investigation/joint investigation and review of the safeguarding plan will take place. This requires identifying who will co-ordinate and lead the investigation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No further action under the safeguarding adults procedures</td>
<td>There are no safeguarding adult concerns, or there are safeguarding concerns but the adult at risk has mental capacity, and they do not wish any action to be taken under the procedures or there is sufficient evidence to conclude the safeguarding enquiry without further investigation.</td>
</tr>
<tr>
<td>Continuing action through other procedures</td>
<td>There is no need to conduct a safeguarding adult’s enquiry/investigation, but there is need for action through other procedures (for example, care management or referral to other services).</td>
</tr>
</tbody>
</table>

2.3 Formal Section 42 Enquiry continued: Investigation

2.3.1 Roles and responsibilities
Agreement will be reached at the strategy meeting about respective roles and responsibilities of organisations during the investigation/enquiry, including agreement on lead responsibilities, specific tasks, cooperation, communication and the best use of skills.

If there are going to be a number of investigations, the meeting or discussion will decide in what order the various investigations, assessments and enquiries should take place. Any criminal investigation will take precedence over other investigations, provided this doesn’t compromise the legal responsibilities and duties of other agencies.

Where joint investigations or assessments are planned, there should be clear agreement between the organisations concerned as to their respective roles and responsibilities.
2.3.2 Undertaking the investigation

An investigation under these procedures can be very intrusive and, because of the relationship that often exists between the adult at risk and the person alleged to cause harm, touch on very sensitive issues. It is therefore important, in order for the adult at risk to gain the outcomes they want, for the investigation to be handled in a manner that respects their dignity. It is also important to respect the dignity of any alleged person who may cause harm or, who may themselves be an adult at risk or carer.

2.3.3 Types of investigations as part of Care Act 2014 Section 42 Enquiry

Below is a list of possible investigations and agencies who might lead or take part in the safeguarding enquiry. For further guidance refer to Local Government Association website for Making Safeguarding Personal.

<table>
<thead>
<tr>
<th>Types of enquiries/ investigations</th>
<th>Who might lead/take part</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal (including assault, theft, fraud, hate crime, domestic violence and abuse or willful neglect.)</td>
<td>Police</td>
</tr>
<tr>
<td>Domestic violence (serious risk of harm)</td>
<td>Police, MARAC process, IDVA</td>
</tr>
<tr>
<td>Anti-social behaviour (e.g. harassment, nuisance by neighbours)</td>
<td>Community safety services/local Policing (e.g. Safer Neighborhood Teams).</td>
</tr>
<tr>
<td>Breach of tenancy agreement (e.g. harassment, nuisance by neighbours)</td>
<td>Landlord/registered social landlord/housing trust/community safety services</td>
</tr>
<tr>
<td>Bogus callers or rogue traders</td>
<td>Trading/Standards/Police</td>
</tr>
<tr>
<td>Complaint regarding failure of service provision (including neglect of provision of care and failure to protect one service user from the actions of another)</td>
<td>Manager/proprietor of service/complaints department Ombudsman (if unresolved through complaints procedure)</td>
</tr>
<tr>
<td>Breach of contract to provide care and support</td>
<td>Service commissioner (e.g. Local Authority, NHS CCG)</td>
</tr>
<tr>
<td>Fitness of registered service provider</td>
<td>CQC</td>
</tr>
<tr>
<td>Serious Incident (SI) in NHS settings</td>
<td>Root cause analysis investigation by relevant NHS Provider</td>
</tr>
<tr>
<td>Unresolved serious complaint in health care setting</td>
<td>CQC, Health Service Ombudsman</td>
</tr>
<tr>
<td>Breach of rights of person detained under the MCA 2007 Deprivation of Liberty Safeguards (DoLS)</td>
<td>CQC, Local Authority, OPG/Court of Protection</td>
</tr>
<tr>
<td>Breach of terms of employment/disciplinary procedures</td>
<td>Employer</td>
</tr>
<tr>
<td>Breach of professional code of conduct</td>
<td>Professional regulatory body</td>
</tr>
<tr>
<td>Breach of health and safety legislation and regulations</td>
<td>HSE/CQC/Local Authority</td>
</tr>
<tr>
<td>Misuse of enduring or lasting power of attorney or misconduct of a court-appointed deputy</td>
<td>OPG/Court of Protection/Police</td>
</tr>
</tbody>
</table>
2.3.4 Responsibility of all organisations taking part in the enquiry/investigation

Each organisation must designate a suitably trained and experienced member of staff to ensure that the organisation carries out its role and responsibilities in the plan agreed at the strategy meeting stage. This will include ensuring that the organisation carries out agreed actions including conducting an investigation, carrying out a risk assessment and implementing their part of the safeguarding plan. In addition, the manager of the organisation will ensure that:

- actions to safeguard adults at risk are given top priority and they are supported throughout the process;
- clear records are kept of any contact with, or actions taken to support or care for, the adult at risk;
- there is support and supervision for staff carrying out this work;
- the organisation actively cooperates with other organisations taking part in the investigation, risk assessment and safeguarding adults enquiry;
- the investigating team manager is kept up to date and informed of any new information or changes in the situation or the plan as soon as possible;
- any agreed enquiries are conducted without delay;
- clear records are kept of any enquiries or investigation findings which emerge about the circumstances of the safeguarding adults concerns.

2.4 Enquiry Reports

On the conclusion of the enquiry the safeguarding manager should consider whether a report should be collated and drawn up by the HCC/ HFPT enquiry coordinator, overseen by the Team Manager. These reports should be used in more complex enquiries, where there may be a number of actions taken by other staff that supports the enquiry. Where there are contributions from other agencies/staff, these should be forwarded within agreed formats and timeframes, so that there is one comprehensive report that includes all sources of information.

Reports need to be concise, factual and accurate. Reports should be drafted and discussed with the adult at risk/representative. Reports need to address general and specific personalized issues. They should cover:

- Views of the adult at risk;
- Whether the adults at risks desired outcomes were achieved;
- Whether any further action is required and if so by whom;
- Who supported the adult and if this is an on-going requirement.
In some enquiries, there will be an investigation for example, a disciplinary investigation; these might be appended to the report. In drawing up the report, the safeguarding plan should be reviewed and any recommendations for adjustments made as appropriate.

The report will be completed prior to the case conference and shared at the case conference for discussion.

2.5 Case Conference

The purpose of the case conference is to review the progress of the enquiry and the safeguarding plan for the adult at risk.

A case conference will be held in circumstances where it would benefit the adult from attending a meeting with all professionals to discuss the outcome of the agreed investigation plan, where the enquiry is complex and has involved a number of agencies contributing to the enquiry. The adult and their representative must be included in the meeting unless there are exceptional circumstances such as they have chosen not to attend or a best interest decision has been made as they do not have capacity to participate in the meeting.

It is the responsibility of the investigating team manager to convene and chair the case conference and ensure the minutes are taken and circulated. Safeguarding meetings conducted as part of the safeguarding enquiry Care Act 2014 Section 42 must be outcome focused and best suit the circumstances to achieve the desired outcomes for the adult at risk.

<table>
<thead>
<tr>
<th>Decisions and Actions to be Taken at Case Conference</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. receive and consider the information from all agencies participating in the investigation and the enquiry report and decide what further action is/may be needed;</td>
</tr>
<tr>
<td>b. review the evidence found by the investigation;</td>
</tr>
<tr>
<td>c. make a decision about current levels of risk and make decisions about the reduction and management of future risks;</td>
</tr>
<tr>
<td>d. decide what action is appropriate when the allegation was not proved or was unfounded but concerns remain about standards of care;</td>
</tr>
<tr>
<td>e. agree the outcome of the enquiry;</td>
</tr>
<tr>
<td>f. identify whether the adult at risks desired outcomes have been met through the safeguarding process and if they feel safer;</td>
</tr>
<tr>
<td>g. decide whether the enquiry is complete or whether further actions are needed to complete the enquiry;</td>
</tr>
<tr>
<td>h. review and revise the safeguarding plan;</td>
</tr>
<tr>
<td>i. recommend to agencies with statutory powers any statutory actions that need to be taken;</td>
</tr>
<tr>
<td>j. decide if a further case conference is required and set a date.</td>
</tr>
</tbody>
</table>

2.6 Outcome of the Care Act 2014 Section 42 Enquiry

Following the evaluation of the evidence presented, the outcome of the investigation of the Care Act 2014 Section 42 enquiry will be determined. It is important that the findings are used to consider future protection measures for the adult at risk and others as appropriate.
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantiated</td>
<td>Refers to cases where ‘on the balance of probabilities’ it was concluded that all the allegations made against the individual or organisation believed to be the source of the harm or neglect were founded</td>
</tr>
<tr>
<td>Unsubstantiated</td>
<td>Refers to cases where, on the balance of probabilities, the allegations are unfounded, unsupported or disproved</td>
</tr>
<tr>
<td>Inconclusive</td>
<td>Refers to cases where there is insufficient evidence to allow a conclusion to be reached</td>
</tr>
<tr>
<td>Partially Substantiated</td>
<td>Refers to cases where there are allegations of multiple types of abuse being considered against an individual or organisation. Verification will be partial where ‘on the balance of probabilities’ it was concluded that one or more, but not all, of the alleged types of abuse were found. For example, a referral that includes allegations of physical abuse and neglect, where the physical abuse can be found on the balance of probabilities, but there is not enough evidence to support the allegation of neglect will be partially substantiated</td>
</tr>
<tr>
<td>Investigation ceased at individual’s request</td>
<td>Refers to cases where the individual at risk does not wish for an investigation to proceed for whatever reason and so preclude a conclusion being reached. Referrals which proceed despite this, for example where a local authority has duty of care, will not come under this definition.</td>
</tr>
</tbody>
</table>

2.7 **Outcome for the Adult at risk**

The adult at risk’s views regarding the outcome of the safeguarding enquiry should be sought at the case conference. If the adult is not in attendance or their representative then their views should be sought prior to the case conference. The key questions asked should be:

1. Were the desired outcomes met? (In exploring this, there is a need to clarify whether they were):
   a. Fully met
   b. Partially met
   c. Not met

2. Do they feel safer
   a. Yes
   b. Partially - in some areas but not others
   c. No

The evaluation is that of the adult, and not of other parties. Whilst professionals may consider that enquiry and actions already taken have made the adult safe, and that their outcomes were met, the important factor is how actions have impacted on the adult. Adults at risk may change their desired outcomes through the safeguarding enquiry process. All actions must reflect the change in their desired outcomes.
2.8 Outcome for the person(s) alleged to cause harm
To ensure the safety and wellbeing of other people, it may be necessary to take action against the person/organisation alleged to have caused harm. Where this may involve a prosecution, the police and the Crown Prosecution Service lead sharing information within statutory guidance.

The police may also consider action under the Common Law Police Disclosure (CLPD) which is the name for the system that has replaced the ‘Notifiable Occupations Scheme’. The CLPD addresses risk of harm regardless of the employer or regulatory body and there are no lists of specific occupations. The CLPD focusses on:

- Disclosure where there is a public protection risk
- Disclosures are subject to thresholds of ‘pressing social need’.
- The ‘pressing social need’ threshold for making a disclosure under common law powers is considered to be the same as that required for the disclosure of non-conviction information by the Disclosure and Barring Service under Part V of the Police Act 1997 (as amended).

2.9 Referrals to Professional Bodies
Where it is considered that a referral should be made to the DBS careful consideration should be given to the type of information needed. This is particularly pertinent for people in a position of trust. Where appropriate, employers should report workers to the statutory and other bodies responsible for professional regulation such as the General Medical Council the Nursing and Midwifery Council and the Health & Care Professions Council. The legal duty to refer to the Disclosure and Barring Service may apply regardless of a referral to other bodies.

2.10 Support for people who are alleged to have caused harm
Where the person is also an adult who has care and support needs, organisations should consider what support and actions may help them not to abuse others. For example, enquiries may indicate that abuse was caused because the adult’s needs were not met and therefore a review of their needs should be made.

Where the person alleged to have caused harm is a carer, consideration should be given to whether they are themselves in need of care and support.

Checks might be made whether staff were provided with the right training, supervision and support and prevention strategies to reduce the risk of it occurring again to the adult or other people should be considered.
### 2.11 Agreed outcome of Case Conference

| **Care Act 2014 Section 42 enquiry to continue** | The safeguarding adult’s process will continue and further investigation/joint investigation and risk assessment will take place. |
| **Care Act Section 42 Enquiry to close** | There are no safeguarding adults concerns, or there are safeguarding concerns but the adult at risk has mental capacity, and they are confident that they can protect themselves from further harm and they do not wish any action to be taken under the procedures. Enquiry concluded no evidence of abuse or neglect. |
| **Continuing action through other procedures** | There is no need to conduct further safeguarding actions, but there is need for action through other procedures (for example, care management or referral to other services). |
| **Safeguarding Plan and Review** | Actions agreed as an outcome of the safeguarding enquiry will be formulated into a safeguarding plan and reviewed as appropriate. |
Stage 3: Closing the enquiry

3.1 When to close the safeguarding adult’s enquiry?

The safeguarding adults process may be closed at any stage if it is agreed that an ongoing enquiry is not needed or if the enquiry has been completed and a safeguarding plan agreed and put in place.

The investigating team manager must reach agreement to close the process with all organisations that have been involved in the enquiry and safeguarding plan. The closing process must be signed off by the investigating team manager and/or a senior manager.

3.2 When other processes continue

The safeguarding enquiry can be closed when an agreed outcome has been achieved as described in section 2.5.1 above. After closure other processes may continue for example, a disciplinary or professional body investigation, criminal investigation or the outcome of a court case.

3.3 If the person causing the harm is an adult who uses the service and is also an adult at risk

The information about that person’s involvement in a safeguarding adult’s investigation, including the outcome of the enquiry, should be included in their records. If an assessment is made that the individual still poses a threat to other service users, this must be included in any information passed on to service providers.

Where the person causing harm is living within a care setting or supported living unit, the impact of their actions on the environment for other residents should be taken into account.

<table>
<thead>
<tr>
<th>Actions to close safeguarding enquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>The investigating team manager should ensure that, on conclusion of the process:</td>
</tr>
<tr>
<td>• all actions are completed or are in progress and transferred to alternative procedures for monitoring</td>
</tr>
<tr>
<td>• case records contain all relevant information and satisfactorily completed forms</td>
</tr>
<tr>
<td>• the person at risk knows that the process is concluded and where/who to contact if they have any future concerns about abuse</td>
</tr>
<tr>
<td>• all those involved with the person know how to re-refer if there are renewed or additional concerns</td>
</tr>
<tr>
<td>• if substantiated, action to remove a member of staff from a professional register or refer</td>
</tr>
</tbody>
</table>
to the Disclosure and Barring Service (DBS) has been taken by the employer
• referral is made to appropriate professional bodies where necessary
• the referrer is notified of completion
• all relevant partner organisations are informed about the closure
• the necessary monitoring forms and all data monitoring systems are completed
• Feedback must routinely be sought from the adult at risk about their experience of the
  process and whether they are satisfied with the measures that have been put in place
  and if they feel safer.
• If the adult disagrees with the decision to close safeguarding, their reasons have been
  fully explored and alternatives offered.
• Set a date to review the safeguarding plan or any other actions agreed as part of the
  enquiry.
SAFEGUARDING REVIEW

Stage 4: Safeguarding Review

4.1 Review of the enquiry (optional)

The identified lead should review the safeguarding plan within agreed timescales. The purpose of the review is to:

- evaluate the effectiveness of the adult safeguarding plan
- evaluate whether the plan is meeting/achieving outcomes
- establish new or changed risks

Reviews of adult safeguarding plans, and decisions about plans should be communicated and agreed with the adult at risk.

Following the review process, it may be determined that:

- the adult safeguarding plan is no longer required;
- or
- the adult safeguarding plan needs to continue.

Any changes or revisions to the plan should be made, new review timescales set (if needed) and agreement reached regarding the lead professional who will continue monitoring and reviewing; or, it may also be agreed, if needed, to instigate a new adult safeguarding Care Act 2014 Section 42 enquiry. New safeguarding enquiries will only be needed when the Local Authority determines it is necessary. If the decision is that further enquiries would be a disproportionate response to new or changed risks, further review and monitoring may continue.
### Hertfordshire safeguarding adult concern form

#### Personal details of adult at risk

<table>
<thead>
<tr>
<th>Name:</th>
<th>Mr/Mrs/Ms</th>
<th>Dob:</th>
<th>Gender:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Address:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postcode:</td>
<td>Home address (if different):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tel no:</td>
<td>Postcode:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tel no:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS no (if known):</td>
<td></td>
<td>Ethnic origin:</td>
<td>preferred language/communication needs?</td>
</tr>
<tr>
<td>Police URN:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other ref no:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Allegation

| Date alleged abuse took place: | | Time (if known): |
| Where did the abuse happen: | | |

**What type of abuse is suspected?**

Please check all appropriate

<table>
<thead>
<tr>
<th>Neglect/acts of omission</th>
<th>Sexual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-neglect</td>
<td>Modern Slavery</td>
</tr>
<tr>
<td>Domestic Abuse</td>
<td>Discriminatory (including hate crime)</td>
</tr>
<tr>
<td>Psychological/emotional (including radicalisation)</td>
<td>Physical</td>
</tr>
<tr>
<td>Financial/Material</td>
<td>Organisational</td>
</tr>
</tbody>
</table>

Please provide a brief, factual summary of the concerns leading to the referral.
This should include what harm/injury or potential harm was caused?
## Is anyone else at risk of harm?

*Please state*

## Vulnerability of the adult at risk

<table>
<thead>
<tr>
<th>Physical disability</th>
<th>Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning disability</td>
<td>Sensory impairment</td>
</tr>
<tr>
<td>Mental health</td>
<td>Older person, frailty, temp illness</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>Terminal illness</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

## Confidentiality and consent

<table>
<thead>
<tr>
<th>Has this referral been discussed with the service user?</th>
<th>Yes or No?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the service user given permission to share the concerns with appropriate others?</td>
<td>Yes or No?</td>
</tr>
</tbody>
</table>

If the answer either/both of the above questions is No, please state the reasons for proceeding without consent?

What are the service user's views and what outcome do they expect?

Does the service user have mental capacity to be involved in the enquiry and protection plan?

*Yes/no/unknown*

Or, has a diagnosis or presents in such a way that indicates that a capacity assessment is required?

*please state*

Has a capacity assessment been arranged or taken place?

*please state*

## Details of the people involved in the incident

<table>
<thead>
<tr>
<th>Name:</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Occupation:</td>
</tr>
<tr>
<td>Relationship to service user?</td>
<td></td>
</tr>
</tbody>
</table>
**Immediate actions**  
( Including any emergency medical treatment provided, evidence preserved, actions taken to prevent further abuse)

**Safeguarding plan**

<table>
<thead>
<tr>
<th>Please indicate other agencies alerted</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; Community Services</td>
<td>HPFT</td>
</tr>
<tr>
<td>Police</td>
<td>CLDT</td>
</tr>
<tr>
<td>Acute hospital</td>
<td>Hertfordshire Community NHS Trust</td>
</tr>
<tr>
<td>GP</td>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Details of person completing the referral</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Organisation:</td>
</tr>
<tr>
<td>Contact number:</td>
<td>Date referral form completed:</td>
</tr>
</tbody>
</table>

Please return form to:  [Adult.Safeguarding@hertfordshire.gov.uk](mailto:Adult.Safeguarding@hertfordshire.gov.uk)

*NB This e-mail account is only monitored within office hours*  
9am – 5.30pm        Mon – Thurs  
9am – 4.30pm        Friday  

Telephone number for HCS emergency, out of hours service - 0300 123 4042
Safeguarding adults at risk – multi-agency policy, procedure and practice for working with adults at risk of abuse or neglect in Hertfordshire

Part three – Practice guidance
3. Practice Guidance

Safeguarding adults at risk of harm is everybody’s business. Adult abuse can happen to anyone, anywhere, and responsibility for dealing with it lies with us all.

*Safeguarding Adults at Risk* is the inter-agency policy for safeguarding adults from abuse in Hertfordshire and must be followed by all organisations working with adults at risk and individuals involved in safeguarding adults. This includes managers, professionals, volunteers and staff working in public, voluntary and private sector organisations.

3.1 Supporting the adult at risk throughout the safeguarding process

- clarify the key issues of risk faced by the adult at risk;
- decide who will interview and record the account of the adult at risk;
- decide who will ensure the adult at risk is involved in the process to the maximum of their willingness and ability, and how this will be achieved;
- decide who will support the adult at risk in a formal investigation and ensure that their needs for support and protection are met;
- clarify the mental capacity of the adult at risk to make decisions about their own safety - arrange for an assessment by the most appropriate person, if required;
- if the person does not have mental capacity, decide how they will be supported to be involved as much as they are able, who is a suitable person to act in the person’s best interests and whether an IMCA should be instructed;
- identify if the person needs advice, support, assistance or services under community care legislation;
- identify any communication needs of the adult at risk;
- identify any equality issues that need to be addressed;
- identify who will keep the adult at risk informed and what information can be shared with them;
- where the adult has capacity, ensure their wishes are respected as to sharing of information with relatives and/or carers (unless there is a duty to override their decision).

3.2 Supporting the adult at risk – when also the person who caused harm

If the person allegedly causing harm is also an adult at risk, a decision must be made about how their needs are to be met during the investigation. For example;
- If they lack capacity, they will need someone who can support their views and this must be considered and provided. This could be a family member or advocate.
- If the person needs advice, support, assistance or services under community care legislation.

3.3 Support for at Risk Witnesses

If there is a police investigation, the police will ensure that interviews with a victim who is a vulnerable or intimidated witness are conducted in accordance with ‘Achieving Best Evidence in Criminal Proceedings’.

Special measures are those specified in the Youth Justice and Criminal Evidence Act 1999 and will be used to assist eligible witnesses.
The Witness Service provides practical and emotional support to victims of crime and witnesses (either for the defence or for the prosecution). The support is available before, during and after a court case to enable them and their family and friends to have information about the court proceedings, and could include arrangements to visit the court in advance of the trial.

3.4 Responsibilities to those who are alleged to have caused the harm
Adults who are alleged to have harmed an adult at risk have the right to be assumed innocent until the allegations against them are proved on the evidence. Whether they are a member of staff, a volunteer, a relative or a carer they also have the right to be treated fairly and their confidentiality respected. What information is shared with them and when should be decided at the strategy discussion or meeting. They have a right to know in broad terms what the allegations are that have been made against them, unless the police advise otherwise. They should be provided with appropriate support throughout the process.

3.5 Record keeping and confidentiality
Organisations should have their own recording systems for keeping comprehensive records whenever a concern is made/arises/occurs, and of any work undertaken under the safeguarding adults procedures, including all concerns received and all referrals made. Organisations should refer to their own internal policies and procedures for additional guidance on recording and storage of records.

Throughout the safeguarding adult’s process, detailed factual records must be kept. This includes the date and circumstances in which conversations and interviews are held and a record of all decisions taken relating to the process.

Records may be disclosed in court as part of the evidence in a criminal action/case or may be required if the regulatory CQC authority decides to take legal action against a provider.

Records kept by providers of services should be available to service commissioners and to regulatory authorities.

Organisations should identify arrangements, consistent with the principle of fairness for making records available to those affected by, and subject to, investigation with due regard to confidentiality.

3.6 Role of the police
Hertfordshire Constabulary has lead responsibility for investigating any criminal offences committed against adults at risk.

If the police decide to investigate, their investigation usually takes primacy to ensure:

- preservation of evidence;
- interviews are conducted correctly and due process is followed.

The police investigate the whole crime including:

- interviewing the adult at risk using achieving best evidence (ABE) guidelines where appropriate;
• interviewing witnesses;
• interviewing the person alleged to have caused harm.

Depending on the nature and seriousness of the abuse, police officers from different teams may be involved with the investigation, for example:

• safer neighbourhood team (adults at risk from individuals in the community, incidents of service user upon service user or staff);
• harm reduction unit (domestic violence, forced marriage/HBV and missing persons);
• hate crime (crimes motivated by hostility or prejudice upon an individual’s disability/vulnerability);
• Safeguarding adults from abuse (SAFA) team. This is a specialist team of officers and staff who investigate all offences against adults at risk committed by persons in a position of trust – this includes family members who have a care responsibility. In investigating these offences the police work very closely with partnership organisations.

3.6.1 Preserving evidence
The police are responsible for the gathering and preservation of evidence to pursue criminal allegations against people causing harm.

In situations where there has been or may have been a crime and the police have been called it is important that forensic and other evidence is collected and preserved. Other organisations and individuals can play a vital role in the preservation of evidence to ensure that vital information or forensics is not lost.

The first concern must be to ensure the safety and well-being of the alleged victim. But where possible:

• try not to disturb the scene, clothing or adult at risk if at all possible;
• secure the scene, for example, lock the door;
• preserve all containers, documents, locations, etc.

Remember evidence may be present even if you cannot actually see anything. If in doubt contact the police and ask for advice.

If forensic evidence needs to be collected, the police should always be contacted and they will normally arrange for a police surgeon (forensic medical examiner) to be involved.

3.6.2 Standard of Proof
The standard of proof for a criminal prosecution is higher as the case has to be proved beyond reasonable doubt.

For civil, disciplinary or regulatory investigations the standard of proof is based on the balance of probability.

For safeguarding investigations the standard of proof is based on the balance of probability. This means a safeguarding investigation the allegation can be substantiated on the balance of probability where there is insufficient evidence for a criminal prosecution.
3.7 Medical treatment, examination and advice
If it is necessary as part of the investigation to arrange for a medical examination to be conducted, the following points must be considered:

- the rights of the adult at risk;
- issues of consent and ability to consent;
- the need to preserve forensic evidence;
- the involvement of any family members or carers;
- the need to accompany and support the adult at risk and provide reassurance.

It may be unclear whether the alleged abuse or neglect has a reasonable explanation. For example it could be the result of an accident or unpreventable because of a medical condition. In such cases specialist clinical or medical advice should be sought. Careful consideration should be given as to who will make Best Interest decisions and consideration should be given to using an IMCA.

3.8 Health organisations and links to clinical governance
All health organisations should have robust processes in place to report events and clinical incidents that occur within their premises or on premises where NHS staff are delivering care.

This will include a locally agreed process that will ensure all reports are reviewed within 24 hours to identify if harm has occurred that requires a safeguarding referral. (Clinical Governance and Adult Safeguarding, DH, 2010).
Safeguarding adults, (the Role of Health Practitioners, DH, 2011) guidance sets out the actions that health staff need to take when considering patient safety and clinical governance so that safeguarding concerns are considered and managed appropriately.

3.9 Pressure ulcers
Pressure ulcers are costly in terms of both patient suffering and the use of resources. It is widely accepted that pressure ulcers are, for the most part, preventable if:

- the circumstances which are likely to result in pressure ulcers are recognised
- those at risk are identified early
- appropriate prevention measures are implemented without delay

It is recognised however, that there are situations where the development of a pressure ulcer is unavoidable. If the pressure ulcer is believed to have been caused by neglect it should be reported as an adult safeguarding concern whether the pressure ulcer was acquired in a hospital, care setting or the person’s own home.

Further information on pressure ulcers can be found in Appendix four.
Appendix 1: Advocacy

The Care Act 2014 Section 68 requires that a Local Authority must arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or SAR where the adult has ‘substantial difficulty’ in being involved in the process and where there is no other appropriate individual to help them.

There are distinct differences between an Independent Mental Capacity Advocate (IMCA) introduced under the Mental Capacity Act 2005, and an Independent Advocate introduced under the Care Act 2014. Independent advocates cannot undertake advocacy services under the Mental Capacity Act 2005, however where there is an appointed IMCA they may also take on the role of Independent Advocate under the Care Act 2014.

1.1 Independent mental capacity advocates (IMCAs)
IMCAs provide one type of non-instructed advocacy. Their role was established by the Mental Capacity Act 2005 to provide a statutory safeguard mainly for people who lack capacity to make important decisions and who do not have family or friends who can represent them to do so. IMCAs have a statutory role in the safeguarding adult’s process.

There is a legal requirement to make a decision about instructing an IMCA for an adult at risk who is the focus of safeguarding adult’s processes where they lack capacity to make decisions about their safety. IMCA instruction may be unnecessary if the adult at risk has adequate alternative independent representation. This could be from another advocate, or from family or friends.

It should be remembered that where the adult does not want support from family or friends that their wishes should be respected and an independent advocate provided.

There are two distinct types of advocacy – instructed and non-instructed.

Instructed advocates take their instructions from the person they are representing. For example, they will only attend meetings or express views with the permission of that person.

Non-instructed advocates work with people who lack capacity to make decisions about how the advocate should represent them. Non-instructed advocates independently decide how best to represent the person.

Advocates should be invited to the strategy meeting or case conference, either accompanying the adult at risk, or attending on their behalf to represent the person’s views and wishes. Instructed advocates would attend only with the permission of the adult at risk.

2. Support to adults
A requirement under the Equality Act 2010 is for provision and adjustments to enable disabled people equal access to information and advice. Ensuring equality may reduce or remove substantial difficulty. Access to other services for example, translators should always be considered to ensure that the adults are afforded every opportunity to participate and be involved.

2.1 Support for vulnerable witnesses in the criminal justice process
Research has found that sometimes evidence from victims and witnesses with learning disabilities is discounted. This may also be true of others such as people with dementia. It is crucial that reasonable adjustments are made and appropriate support given, so people can get equal access to justice. Guidance should include reference to support relating to criminal justice matters which is
available locally from such organisations as Victim Support and court preparation schemes; Some witnesses will need protection; and the police may be able to get victim support in place.

Special Measures were introduced through legislation in the Youth Justice and Criminal Evidence Act 1999 (YJCEA) and include a range of measures to support witnesses to give their best evidence and to help reduce some of the anxiety when attending court. Measures in place include the use of screens around the witness box, the use of live-link or recorded evidence-in-chief and the use of an intermediary to help witnesses understand the questions they are being asked and to give their answers accurately.

Vulnerable Adult Witnesses (Section 16 YJCEA) have a:

- Mental disorder
- Learning disability, or
- Physical disability

These witnesses are only eligible for special measures if the quality of evidence that is given by them is likely to be diminished by reason of the disorder or disability.

Intimidated Witnesses (Section 17 YJCEA): Intimidated witnesses are defined by Section 17 of the Act as those whose quality of evidence is likely to be diminished by reason of fear or distress. In determining whether a witness falls into this category the court takes account of:

- the nature and alleged circumstances of the offence;
- the age of the witness;
- the social and cultural background and ethnic origins of the witness;
- the domestic and employment circumstances of the witness;
- any religious beliefs or political opinions of the witness;
- any behaviour towards the witness by the accused or third party.

Also falling into this category are:

- complainants in cases of sexual assault;
- witnesses to specified gun and knife offences;
- victims of and witnesses to domestic violence, racially motivated crime, crime motivated by reasons relating to religion, homophobic crime, gang related violence and repeat victimization;
- those who are older and frail;
- the families of homicide victims.

Registered Intermediaries (RIs) have been facilitating communication with vulnerable witnesses in the criminal justice system in England and Wales since 2004.

Special measure include practical and emotional support to victims and witnesses (either for the defence or for the prosecution) provided by the Witness Service. Support is available before, during and after a court case to enable adults and their family and friends to have information about court proceedings and could include arrangements to:

- visit the court in advance of the trial;
- consider the use of screens in court proceedings;
- the removal of wigs and gowns;
- the sharing of use of intermediaries and aids to communication.
If the person alleged to have caused harm is a young person or has a mental disorder, including a learning disability, and they are interviewed at the police station, they are entitled to the support of an 'appropriate adult' under the provisions of the Police and Criminal Evidence Act 1984 Code of Practice.

There is an automatic referral to Victim Support services for all victims of crime whether they are deemed vulnerable or not.
Appendix 2 Risk assessment and risk management

The risk management plan is the safeguarding plan. It is put in place to remove or minimise risk to the person, and others who may be affected. This assessment must always consider the balance between risk and the perceived benefit to the adult at risk. It will need to be monitored, reviewed and amended/revised as circumstances arise and develop.

A risk assessment must be undertaken when a concern is raised. This should clarify the degree of risk to the adult at risk, other adults and/or children.

Risk should be constantly re-evaluated throughout the process to ensure adults at risk and all others involved are appropriately protected.

Organisations will have a range of risk assessment tools in paper and IT formats to assist staff in risk assessment.

Risk assessments will seek to determine the following facts:

A summary of the presenting concerns:

- Who is saying that the person is at risk (professional/relatives/informal carer)?
- What are they saying and what information leads them to this conclusion?
- Does the person agree with what is being said?
- What is their view of the situation?
- What is known about their mental capacity?
- Should other professionals be involved in a multidisciplinary assessment? If so, who?

The alleged abuse:

What is the nature of the alleged abuse?
- evidence of abuse;
- harm/potential harm.

Risk assessment:

Are there factors that may mean the adult at risk could be more vulnerable to abuse?

- Mental capacity or deprivation of liberty issues;
- They are frail or have a disability;
- They appear to be emotionally dependent;
- They may be socially isolated;
- They may have communication needs;
- They may be financially dependent;
- Their carer may be under stress;
- Wider environmental issues.

Assessment of the seriousness of the alleged abuse and the risk of abuse reoccurring.

- How long has the abuse been occurring?
- Are the incidences increasing?
• Could significant harm/major injury result?
• What could be the worst possible outcome?
• What is the impact on the individual/others/children?
• Is the abusive behaviour deliberate?
• Does the abuser still have access to the adult at risk?
• What is the attitude of the alleged person alleged to cause harm now?
• What monitoring options are available?
• Are supportive measures in place, or can they be put in place?

Wishes of the alleged adult at risk.

• Are they aware of the abuse?
• What is their view /do they understand the risk?
• Do they wish to remain in the same situation?
• Does the person wish involvement from other agencies?
• Do they consent to information being shared?

Are there factors that mitigate (provide some protection against) the risk?

Consider the person’s own:

• coping abilities and strengths;
• awareness of security in own home;
• awareness of own rights;
• awareness of what is abuse;
• supportive informal networks – family/friends/social contacts etc;
• support services – arranged care.

What is the immediate safeguarding plan?

• Does the person need to move from their environment to be safeguarded?
• If so, what alternative arrangements need to be made? Who will do this?
• Do other people also need support or safeguarding?
• Does the alleged person alleged to cause harm also have support needs?
• Do supportive measures need to be put in place in the current environment?

Who needs to be informed?

• Family carers, direct payments arrangements, other agencies involved etc.

Are other referrals or assessments needed, for example:

• Health, support for alleged person alleged to cause harm, emergency services, police, community care assessment.
• What are the contingency arrangements should this plan not deliver the desired outcomes?
• What are the arrangements for review of the safeguarding plan and how does this link with the ongoing safeguarding adults from abuse investigation.
Appendix 3 Information sharing

The policy of Hertfordshire Safeguarding Adults Board is that information to safeguard and promote the welfare of individuals will be shared between agencies on a need to know basis in line with both the statutory guidance and the Information Sharing Agreement and Protocol for HSAB. It is important to identify any potentially abusive situation as early as possible so that the individual can be protected. Withholding information may lead to abuse not being dealt with in a timely manner. Confidentiality must never be confused with secrecy.

In seeking to share information for the purposes of protecting adults at risk, agencies are committed to the following principles:

- personal information will be shared in a manner that is compliant with agencies statutory responsibilities;
- adults at risk will be fully informed about information that is recorded about them and as a general rule, be asked for their permission before information about them is shared with colleagues or another agency. However there may be justifications to override this principle if the adult or others are at risk;
- staff will receive appropriate training on service users/patient confidentiality and secure data sharing;
- the principles of confidentiality designed to protect the management interests of an organisation must never be allowed to conflict with those designed to promote the interests of the adult at risk.

Aggregated/statistical data may also be shared between agencies to:

- coordinate partnership working and improve delivery of services;
- train staff and set professional standards;
- manage, plan, commission and contract services;
- develop inter-agency strategies;
- improve performance management and audit;
- inform local and national research initiatives.

However this data will not identify any individual.

Procedure

There is an Information Sharing Agreement in place which identifies the purposes and statutory basis for the work of the Hertfordshire Safeguarding Adults Board. All agencies will also have internal policies and procedures in respect of information sharing and data security in compliance with the Data Protection Act and Caldicott principles which staff should follow when they are sharing information.

Caldicott principles

**Principle 1. Justify the purpose(s) for using confidential information**
Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.
Principle 2. Don’t use personal confidential data unless it is absolutely necessary
Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

Principle 3. Use the minimum necessary personal confidential data
Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data is transferred or accessible as is necessary for a given function to be carried out.

Principle 4. Access to personal confidential data should be on a strict need-to-know basis
Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.

Principle 5. Everyone with access to personal confidential data should be aware of their responsibilities
Action should be taken to ensure that those handling personal confidential data - both clinical and non-clinical staff - are made fully aware of their responsibilities and obligations to respect patient confidentiality.

Principle 6. Comply with the law
Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.

Principle 7. The duty to share information can be as important as the duty to protect patient confidentiality
Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.

Principles guiding the sharing of information

The three main sources of law on confidentiality which allow for information to be disclosed in certain circumstances, even if consent has been refused, are set out in the section ‘relevant legislation and guidance’:

- safeguarding and promoting the welfare of individuals is the prime consideration in all decision making about information sharing;
- safeguarding adults work requires the sharing of personal information, both about an adult at risk and a person who (may have) caused harm;
- workers should share as much information as is required to address the safeguarding issue;
- withholding information may lead to abuse not being dealt with in a timely manner.

Explicit consent is not always necessary to share personal and sensitive personal information as there are circumstances when information can be shared even if consent is explicitly withheld. For example:

- a serious crime may have been committed;
- where the person who caused harm may harm other adults at risk;
other adults are at risk;
the adult is deemed to be at serious risk of harm;
there is a statutory requirement e.g. Children’s Act 1989, Mental Health Act 1983, Care Standards Act 2000;
the public interest in sharing the information overrides the interest of the individual.

It is best practice to gain the permission of the adult at risk before sharing information about them where capacity and security is not a concern. It is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other adults may be at risk.

If a practitioner considers that an adult may not have the capacity to give permission for their information to be shared, the Mental Capacity Act 2005 and its Code of Practice must be followed. When requesting/providing information workers and managers should clearly record:

- why the information is being sought and that the request is part of the safeguarding adults from abuse procedure;
- why it cannot be accessed in another way or by consent and the exact nature of the information that has been disclosed.

Consideration should be given to the following questions before making a decision on whether to disclose information without the consent of the adult at risk:

- what risks will others face if the information is not disclosed, including the risk of self-harm to the adult at risk;
- will the rights and freedoms of the public be affected if it isn’t disclosed;
- will a crime be committed;
- will the investigation of a crime be hampered;
- is there another, equally effective way, of achieving the same aim without disclosing personal information without consent;
- what is the impact of the disclosure likely to be on the person who is the subject of the information? Is this out of proportion to the benefit of disclosing the information.

If there is any doubt as to whether confidential information about an adult at risk should be disclosed to a third party, then legal advice should be obtained.

All partner agencies should also ensure that any information that they obtain /share is held securely and destroyed after use or other appropriate retention period.

Security of information

Ensuring the security and accuracy of confidential information is the responsibility of management and staff at all levels. Partner agencies must ensure that they have in place methods of accurately recording information and that:

- manual and computer records containing such information is kept secure and care is taken to avoid any unintentional breach of confidentiality;
- any breach of confidentiality is considered to be a serious matter and will be dealt with under each a relevant personnel policy;
- one of the offences under the Data Protection Act 1998 which has particular significance for staff is that it is an offence to knowingly or recklessly obtain or disclose personal or patient identifiable
information without the consent of the data controller, this covers unauthorised access to and disclosure of personal/patient identifiable information.

**Relevant legislation and guidance**

The law allows for information to be disclosed in certain circumstances even if consent has been refused.

**Common Law**

The starting position is that personal information provided in confidence can only be disclosed without consent when it is in the public interest to do so and there must also be a pressing need for the disclosure to occur.

Public interest includes the protection of ‘at risk’ members of the community and maintaining public safety.

The main pieces of legislation which set this out are:

- Human Rights Act 1998 – namely Article 2 [The Right to Life] and 8 [ The right to respect for Private and Family Life]
- Data Protection Act 1998
- Common Law duty of confidentiality
- Care Act 2014

Other relevant legislation and guidance can also be found in:

- Care and Support Statutory Guidance Crime and Disorder Act 1998 – Section 115
- The 1997 Caldicott Report.
- The 2013 Caldicott Report *Information: to share or not to share* also known as Caldicott 2.

**The Data Protection Act 1998**

The Data Protection Act 1998 allows for the disclosure of personal and sensitive personal information without the consent of the individual concerned if it is necessary for:

- the performance of a contract to which the data subject is a party
- to comply with any legal obligation other than one imposed by contract
- to protect the vital interests of the data subject
- for the administration of justice/for the exercise of any functions conferred by or under an enactment/for the exercise of a function by the Crown, a Minister of the Crown or a government department or for the exercise of any other function of a public nature exercised in the public interest by any person
- for the purposes of legitimate interests pursued by the controller of the data or to any third party to which it is disclosed
- for the purposes of legal proceedings, obtaining legal advice or exercising/defending legal rights
- for medical purposes.

Personal data must be:

- processed lawfully
- processed for specific purposes
- adequate, relevant, not excessive
- accurate and up to date
- not kept for longer than necessary
- processed in accordance with the rights of the data subject
- protected by appropriate security
- not transferred outside the EEA (European Economic Area) without adequate protection

The Human Rights Act 1998, Article 2 [Right to Life]

The Human Rights Act 1998, Article 2 states that “everyone’s right to life shall be protected by law”. Case law has developed to a point where a positive obligation has been placed on public authorities to actively protect the vulnerable from the risk of self-harm. In light of this, depending on the circumstances of the case, we could have a duty to share information to protect life.

The Human Rights Act 1998, Article 8

The Human Rights Act 1998, Article 8 allows a public authority to interfere with the privacy of an individual if the interference is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health and morals, or for the protection of the rights and freedoms of others

Record keeping and confidentiality

Organisations will have their own recording systems for keeping comprehensive records whenever a concern is made/arises/occurs, and of any work undertaken under the safeguarding adult’s procedures, including all concerns received and all referrals made. Organisations should refer to their own internal policies and procedures for additional guidance on recording and storage of records.

Throughout the safeguarding adult’s process, detailed factual records must be kept. This includes the date and circumstances in which conversations and interviews are held and a record of all decisions taken relating to the process. Records may be disclosed in court as part of the evidence in a criminal action/case or may be required if the regulatory CQC authority decides to take legal action against a provider.

Records kept by providers of services should be available to service commissioners and to regulatory authorities.

Agencies should identify arrangements, consistent with the principle of fairness, for making records available to those affected by, and subject to, investigation with due regard to confidentiality.
Appendix 4 Pressure ulcers and neglect: making a decision whether to refer to adult safeguarding

The purpose of specific guidance is to protect adults at risk by providing a framework to guide health and social care staff and agencies on whether safeguarding procedures should be instigated when concerns have been raised that a pressure ulcer may have developed as a result of neglect or poor care practice.

This guidance will enable health and social care staff to identify if it is likely the pressure ulcer was caused as a result of neglect, or poor care practice and whether an investigation under the safeguarding procedures should take place. It will provide a focus on thresholds for referral through the safeguarding adult process.

This guidance applies to all health and social care staff in Hertfordshire who work with adults at risk and develop a pressure ulcer or are at risk of developing a pressure ulcer.

Pressure ulcers

‘A pressure ulcer is defined as a localised injury to the skin and or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear’ (NPUAP, EPUAP, PPPIA 2014).

‘All patients (or those people with care needs) are potentially at risk of developing a pressure ulcer. However, PU are more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, impaired nutrition, or poor posture or a deformity. Also, the use of equipment such as seating or beds which are not specifically designed to provide pressure relief can cause pressure ulcers. As pressure ulcers can arise in a number of ways, interventions for prevention and treatment need to be applicable across a wide range of settings including community and secondary care’ (NICE 2014).

Pressure ulcers are often preventable (NICE 2014) and their prevention and reducing the risk of avoidable harm to patients is an important part of health and social care, as detailed in Domain 5 of the NHS outcome framework 2016/17 (DH 2016).

It should also be recognised, however, that not all tissue/skin damage is a pressure ulcer and there may be other explanations for the tissue/skin damage e.g friction damage, moisture lesion, ischaemic ulcers. It is important therefore to obtain clinical opinion on the nature and causation of the tissue/skin damage to clarify the type of wound which is present.

Specific guidance on neglect or poor care practice relating to pressure ulcers

Pressure ulcers are costly in terms of both patient suffering and the use of resources. It is widely accepted that pressure ulcers are, for the most part, preventable if:

- the circumstances which are likely to result in pressure ulcers are recognised
- those at risk are identified early
- appropriate prevention measures are implemented without delay

Pressure ulcers can occur in any individual but are more likely in high risk groups. To consider whether the pressure ulcer has developed in terms of neglect/acts of omission or poor practice from
care providers requires an understanding that the pressure ulcer was avoidable. NHS England has defined unavoidable and avoidable PU as follows: (NHS England 2016):

**Unavoidable**
A pressure ulcer developed despite the care provider evaluating the patient’s clinical condition and pressure ulcer risk factors and developing an appropriate preventative plan of care

- Monitoring and evaluating the impact of the interventions and revising the intervention as appropriate
- The patient (or person) chose not to adhere to the prevention strategies despite being fully informed of the possible consequences

**Avoidable**
The person providing care did not:
- Evaluate the patient’s clinical condition and identify pressure ulcer risk factors
- Plan and implement interventions consistent with the patients’ needs and goals and recognised standards of practice
- Monitor and evaluate the impact of the interventions and revise the interventions as appropriate
- Reasons for refusing care have not been explored and risks not adequately explained

If the pressure ulcer (or other skin/tissue damage) is believed to have been caused by neglect, or organisational abuse, it should be reported as an adult safeguarding concern.

Care homes regulated by the CQC are required to inform CQC, via a regulation 18 notification, of a category 3 or 4 pressure ulcer which has developed after the resident started to use their service (CQC 2015).

NHS commissioned organisations are required to investigate category 3 and 4 pressure ulcers under the policy/framework agreed by the CCG with an NHS organisation and, if appropriate, consider or undertake investigations within the NHS serious incident framework (NHS England 2015).

**Neglect, poor care practice and organisational abuse**

In the context of adult safeguarding and pressure ulcers neglect or organisational abuse refers to:

**Organisational abuse**

Including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one’s own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

**Neglect and acts of omission including:**
- ignoring medical, emotional or physical care needs
- failure to provide access to appropriate health, care and support or educational services
- the withholding of the necessities of life, such as medication, adequate nutrition and

The Care Act statutory guidance indicates that the circumstances surrounding any actual or suspected case of abuse or neglect will inform the response to be taken and who is best placed to lead on the response or the investigation. For example, with pressure ulcers it may be more appropriate for the NHS service or care organisation to investigate the circumstances or undertake a Root Cause Analysis to establish if the PU was unavoidable or avoidable and consider what response is required. This may include taking actions to improve care practice or address the practice deficits.
of individual staff. It may also include actions being taken with organisations by the commissioning or regulatory bodies (DH 2016).

**Current tools used to identify ‘at risk’ individuals and categorise the severity of pressure ulcers**

There are various validated assessment tools which organisations should utilise as part of developing a person's care plan to assist with the identification and management of those people at risk of developing pressure ulcers (NICE 2014). These include:

- Pressure ulcer prevention and management guidelines. These may require reference and an escalation process to a NHS organisation e.g. from residential care homes to the District Nursing Service
- A risk assessment tool e.g. Waterlow Score, Braden Scale or Norton Risk assessment scale
- Categorisation of ulcers should be recorded using the European Pressure Ulcer Classification System (EPUAP 2014)
- The Malnutrition Universal Screening Tool (MUST)

Where an adult at risk requires transfer into another health or social care establishment staff will be expected to complete a skin condition transfer form, body map or ‘Nursing Transfer’ letter.

**Mental Capacity Act and pressure ulcer prevention**

Where the person, or patient, lacks mental capacity to consent to or comply with pressure ulcer preventative measures care providers will need to develop preventative care plans to minimise the risk of harm occurring. In care planning care providers will need to take account of the Mental Capacity Act and, where appropriate, Deprivation of Liberty Safeguards (UK 2007 & 2009).

**Procedure**

**Five steps to determine if a pressure ulcer is due to neglect of an adult at risk**

**Step one:**

**Assess if there is a problem**

Where there are concerns regarding potential or actual pressure ulcers the adult at risk will require an assessment and treatment from a health professional to identify skin care issues.

**Step two:**

a) **The questions for the health or care professional to ask and which apply to all settings are:**

- Should the illness, behaviour or disability of the adult at risk have reasonably required the monitoring of skin condition (where no monitoring has taken place prior to serious pressure ulcers occurring)?

- If the treatment of the skin condition was then refused by the adult at risk was it reasonable for specialist advice to be sought i.e. HPFT seeking specialist advice from HCT.

- If monitoring was then refused by the adult at risk/family was it reasonable for advice to be sought? The adults at risk consent to monitoring should always be sought but if the person
lacks mental capacity to make a decision regarding this, a decision will need to be taken in their best interests. The family has no right to refuse monitoring.

- If monitoring was agreed, was the frequency of monitoring appropriate for the condition as presented at the time?
- Would monitoring have shown changes in the presentation of the skin (e.g. persistent change in colour, temperature of skin etc.) that should have triggered the need for intervention or the seeking of more expert assistance that would have prevented serious harm or its high likelihood?
- Was the appropriate expert assistance sought? If so did that result in a care plan/equipment provision appropriate to address the pressure care needs of the adult at risk? Did the care plan address the management of risks that should have reasonably been identified? (E.g. the high risk of non-compliance by the service user or informal carer?)
- Was the care plan adhered to and revised appropriately? Was the equipment provided in a timely manner and used appropriately?

b) **Consider these three specific questions**

If the answer to the three specific questions below is yes, then a safeguarding adult concern should be made under the *Safeguarding Adults from Abuse* procedures [http://www.hertfordshire.gov.uk/your-council/hcc/healthcomservices/acs/policies/safeadults/](http://www.hertfordshire.gov.uk/your-council/hcc/healthcomservices/acs/policies/safeadults/)

<table>
<thead>
<tr>
<th>Question 1</th>
<th>Is there an adult safeguarding concern?</th>
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<tbody>
<tr>
<td>‘Safeguarding means protecting an adult’s right to live in safety, free from abuse and neglect’ Care Act 2014. This applies to adults who have care and support needs (whether or not the LA is meeting any of those needs) and is experiencing, or at risk of abuse or neglect, and as a result of those care and support needs is unable to protect themselves from either the risk of or the experience of abuse or neglect</td>
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<tr>
<th>Question 2</th>
<th>Is there evidence of neglect?</th>
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<tr>
<td>Relevant factors to consider:</td>
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<tr>
<td>• the individuals compliance / behaviour that might impact on appropriate care being given</td>
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</tr>
<tr>
<td>• other co-morbidities such as chronic disease and palliative care</td>
<td></td>
</tr>
<tr>
<td>• mental capacity to consent or decline treatment</td>
<td></td>
</tr>
<tr>
<td>• health and social care involvement</td>
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<tr>
<td>• carer involvement</td>
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<tr>
<td>• determining whether the pressure ulcer/damage is avoidable</td>
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<table>
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<tr>
<th>Question 3</th>
<th>Are there concerns that all reasonable steps have not been taken to prevent the pressure ulcer or tissue</th>
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<tbody>
<tr>
<td>• review the information already gathered</td>
<td></td>
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<tr>
<td>• circumstances of neglect should be considered</td>
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<tr>
<td>• a judgement maybe required about whether an act or an omission to act has caused significant harm</td>
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<td>• second opinion may be considered e.g. TVN or</td>
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| damage? | Safeguarding Adult Lead  
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<td>determining if pressure ulcer/damage was avoidable</td>
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| Guidance note  
The assessment should include |  
|---------------------------|-------------------------------------------------|  
|                           | When did the PU/tissue damage start to develop  
|                           | Patient’s/person’s clinical history  
|                           | history of compromised skin integrity  
|                           | co-morbidities  
|                           | indicators of neglect e.g. is the person’s physical appearance poor  
|                           | consider evidence of poor quality care  
|                           | standard of assessment and use of relevant policy/assessment tools  
|                           | evidence of identification and management of risk factors  
|                           | evidence of implementation of preventative care plan  
|                           | evidence that regular reassessment of care plan has been carried out and implemented  
|                           | evidence of a continence plan  
|                           | predisposing factors e.g moisture lesion, sheer or friction damage  
|                           | evidence of appropriate prevention and treatment plan including the consideration of appropriate pressure relieving equipment’ |
Skin Condition Transfer Form

<table>
<thead>
<tr>
<th>Surname</th>
<th>Forename</th>
<th>Date of Birth</th>
<th>Address</th>
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On the figures below identify and number any tissue damage, marks, or pressure ulcers present on the individual’s body and describe in the table. Please also check for any warmth or hardness of tissue over bony prominences.

<table>
<thead>
<tr>
<th>Pressure ulcer or marks</th>
<th>Description/Dimensions</th>
<th>How and where mark or ulcer developed if known</th>
<th>Details of any current treatment</th>
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<tbody>
<tr>
<td>1.</td>
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<td>5.</td>
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Please document here if the individual refuses assessment of any parts of the body:

Please document any relevant information regarding mental capacity:

Waterlow Score:
Transfer form completed by:
Name and contact number:
Designation:
Date:
References


Appendix 5 Medication errors and safeguarding
Currently under review.
Appendix 6: Allegation of abuse against staff and/or volunteers

All organisations should be proactive in reducing the risk of abuse taking place within the services they provide by:

- developing a safeguarding ethos in which adult at risk, volunteers and staff can express their concerns; where staff are encouraged to challenge constructively poor practice; and where ‘whistle-blowing’ procedures can be engaged without fear;
- adopting safe recruitment and effective safe termination of employment practices;
- ensuring that all staff receive appropriate training in adult safeguarding matters: signs, symptoms and referral procedures, which include how to recognise and respond to allegations against staff;
- ensuring that staff understand what is safe practice is and what is not. In particular, staff must be aware of behaviours that are likely to bring about criminal, adult protection or disciplinary action;
- ensuring that vulnerabilities expressed by staff are taken seriously and responded to at the earliest stage.

All agencies that provide services for adults at risk or provide staff or volunteers to work with or care for adults at risk should have an established policy for handling such allegations within their own organisation. Each agency should invoke its own disciplinary procedures as well as taking action under the HSAB procedures when it is known that a member of staff has:

- behaved in a way that has harmed, or may have harmed, an adult at risk;
- possibly committed a criminal offence against or related to an adult at risk;
- behaved towards any adult at risk in a way that indicates she is unsuitable to work with adult at risks.

These include concerns relating to inappropriate relationships between members of staff and adult at risks in their care e.g:

- having a sexual relationship with an adult at risk if in a position of trust even if the relationship appears consensual;
- the sending of inappropriate text/e-mail messages or images, providing gifts, socialising etc;
- possession of indecent photographs/pseudo-photographs of adults at risk.

If a crime is suspected a report must always be made to the police.

**The underlying principles of dealing with allegations are:**

The welfare of the adult at risk is paramount:

- Employees, subject of an allegation, should be listened to, treated fairly and honestly and should be provided with support.
- It is the responsibility of all employers to safeguard and promote the welfare of adults at risk. This responsibility extends to those employed, commissioned or contracted to work with adult at risk.

**Record-keeping**

Record keeping is an integral part of the management of allegations. Complete and accurate records will need to contain information which provides comprehensive details of:

- events leading to the allegation or concern about an adult’s behaviour
- the circumstances and context of the allegation
- professional opinion
- decisions made and their rationale
- action taken
- final outcome
Appendix 7: Mental capacity and Consent

The Mental Capacity Act 2005 (MCA) provides the statutory framework to empower and protect people who may lack capacity to make decisions for themselves and establishes a framework for making decisions on their behalf.

The Act states that a person lacks capacity in relation to a matter if at the material time he/she is unable to make a decision for him or herself in relation to the matter because of an impairment of, or disturbance in the functioning of the mind or brain.

The presumption is that adults have mental capacity to make informed choices about their own safety and how they live their lives.

All interventions need to take into account the ability of adults to make informed choices about the way they want to live and the risks they want to take.

Definition of lack of capacity

The MCA sets out a two stage test of capacity:

Stage 1 - There must be an impairment of, or disturbance in the functioning of, the mind or brain.

Stage 2 - There must be an inability to make the decision in question as a result of the impairment of, or disturbance in the functioning of, the mind or brain.

Further, a person is not able to make a decision if they are unable to:

- understand the information relevant to the decision or;
- retain that information long enough for them to make the decision or;
- use or weigh that information as part of the process of making the decision.

or

- communicate their decision (whether by talking, using sign language or by any other means such as muscle movements, blinking an eye or squeezing a hand).

Further information can be found in the Mental Capacity Act Code of Practice. [http://www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act](http://www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act)

Mental capacity and safeguarding

Issues of mental capacity and the ability to give informed consent are central to decisions and actions in the safeguarding adults’ procedure.

All decisions taken in the safeguarding adults’ process must comply with the five core principles of the Mental Capacity Act 2005:

- a person must be assumed to have capacity unless it is established that he lacks capacity;
- a person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success;
- a person is not to be treated as unable to make a decision merely because he makes an unwise decision;
• an act done or decision made, under this act for or on behalf of a person who lacks capacity must be done, or made, in his best interests;
• before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.

This means that:

• an adult at risk has the right to make their own decisions and must be assumed to have capacity to make decisions about their own safety unless it is shown otherwise;
• there should always be the assumption that an adult at risk has capacity to make the decision in question.

If there is evidence to suggest that a person may lack capacity then a formal assessment of capacity should be carried out. This includes their ability to:

• understand the implications of their situation
• take action themselves to prevent abuse or protect themselves from abuse
• participate to the fullest extent possible in decision making about interventions

If the adult at risk does not have capacity

If it is established though assessment that the adult at risk lacks capacity and they have no family or friend who can be consulted regarding their best interests, an advocate or an independent mental capacity advocate (IMCA) should be instructed in line with the local IMCA referral policy.

An IMCA should be instructed if it is felt that it will be beneficial to the adult at risk, even if they have family, friends and carers available to consult.

If the person has a lasting power of attorney, their attorney or court appointed deputy should be consulted unless they are implicated in the allegation.

If the adult at risk has capacity

If the adult at risk has mental capacity then they have the right to make decisions about their safety and the safeguarding investigation.

It is important to:

• ensure the adult at risk understands the risk and what help they may need to support them to reduce the risk if that is what they want;
• be satisfied that their ability to make an informed decision is not being undermined by the harm they are experiencing and is not affected by intimidation, misuse of authority or undue influence, pressure or exploitation if they decline assistance.

Consent

It is always essential in safeguarding to consider whether the adult at risk is capable of giving informed consent in relation to the investigation and safeguarding plan. If they are, their consent should be sought. This includes an awareness of the risks of disclosing that an investigation is being undertaken.
Where an adult at risk with capacity has made a decision that they do not want action to be taken and there are no public interest or vital interest considerations, their wishes must be respected.

The adult at risk must be given information and have the opportunity to consider all the risks and fully understand the likely consequences of that decision over the short and long term.

If, after discussion with the adult at risk who has mental capacity, they refuse any intervention, their wishes will be respected unless:

- there is a public interest, for example, not acting will put other adults or children at risk;
- there is a duty of care to intervene, for example, a crime has been or may be committed.

However consent may need to be considered in relation to the adult at risk’s participation in activity that may be abusive. If consent to abuse or neglect was given under duress, for example, as a result of exploitation, pressure, fear or intimidation, this apparent consent should be disregarded with a safeguarding adults investigation going ahead in response to the concern that has been raised.

**Ill treatment and wilful neglect**

Section 44 of the MCA makes it a specific criminal offence to wilfully ill-treat or neglect a person who lacks capacity.

An allegation of abuse or neglect of an adult at risk who does not have capacity to consent on issues about their own safety will always give rise to action under the safeguarding adults’ process and subsequent decisions made in their best interests in line with the MCA and Mental Capacity Act Code as outlined above.
Appendix 8: Deprivation of Liberty Safeguarding (DoLS)

Deprivation of liberty

A deprivation of liberty is a breach of the Article 5(1) right to liberty as set out in the European Convention on Human Rights. Following a Supreme Court judgement delivered in March 2014, what constitutes a deprivation of liberty was clarified in an "acid test". A person is considered to be deprived of their liberty, for the purposes Article 5 of the European Convention on Human Rights if they;

- Lack capacity to consent to their care/treatment arrangements
- Are under continuous supervision and control
- Are not free to leave

All three elements must be present for the acid test to be met. Detailed guidance on what is meant by 'continuous supervision and control' and 'not free to leave', can be found in the Law Society’s “Deprivation of Liberty: A Practical Guide" via the link below:

http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/

The Supreme Court ruling also clarified the factors which are NOT relevant to determining whether a person is deprived of their liberty, which are;

- The person’s compliance or lack of objection to the proposed care/treatment
- The reason or purpose behind a particular placement
- The relative normality of the placement given the person’s needs.

The Deprivation of Liberty Safeguards (DoLS) provide a legal framework for authorising, monitoring and challenging Deprivations of Liberty of people who lack capacity. DoLS will be applied to people who are, or may become deprived of their liberty within the meaning of Article 5 of the European Convention on Human Rights in a hospital, hospice, care home or nursing home, whether placed under public or private arrangements.

These safeguards provide protection to people in hospitals and care homes (managing authorities) who do not have mental capacity to decide whether or not they should be in the relevant care home or hospital to be given care or treatment. They do not provide the authority for care or treatment to be given.

It is the care home or hospital’s responsibility to identify those at risk of deprivation of liberty and request authorisation from the supervisory body.

The DoLS code of practice can be found at:

All decisions on care and treatment must comply with the Mental Capacity Act and the Mental Capacity Act code of practice.
http://www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act

Managing authorities must make requests to a local authority supervisory body for authorisation to deprive someone of their liberty.
The contact details for the Hertfordshire supervisory body are set out below:

**Phone**: 01438 843800  
**Fax**: 01438 844312  
**Email**: dolsteam@hertfordshire.gov.uk  
**Postal address**: SFAR 016 Ground Floor, Farnham House, Six Hills Way, Stevenage, Herts, SG1 2FQ

In the event that a Deprivation of Liberty is occurring in the community the Supreme Court Judgment on 19th March 2014 in the cases of *P v Cheshire West and Chester Council* and *P&Q v Surrey County Council* is clear that the Court of Protection must be approached for these to be authorised under Section 16 of the Mental Capacity Act. The judgment indicates that the “acid test” is that an individual is under constant control and supervision and is not free to leave and this is imputable to the State. In these circumstances legal advice must be sought regarding making an application to the Court.
Appendix 9: Hate crime

In Hertfordshire hate crime is defined as any incident that is perceived by the victim, or any other person, to be racist, homophobic, transphobic or due to a person’s religion, belief, gender identity or disability.

This definition is based on the perception of the adult at risk or anyone else and is not reliant on evidence. In addition it includes incidents that do not constitute a criminal offence.

Where adults at risk become a target for hate crime the police and other organisations should work together under the appropriate procedures to ensure a robust, coordinated and timely response to situations. Coordinated action will aim to ensure that adults at risk are offered support and protection, and action is taken to identify and prosecute those responsible.

In Hertfordshire hate crime is investigated by specially trained officers in the police harm reduction units. There are two harm reduction units in Hertfordshire Constabulary based at Watford and Stevenage police stations. Contact details and referral forms are available on the Hertfordshire Constabulary website.


• local guidance and reporting
• third party reporting centres - details
Appendix 10: Cyber abuse and cyber bullying

Cyber abuse and cyber bullying are generally defined as the use of internet, interactive or digital technologies by one or more people to exploit, deceive, bully, harass, intimidate, threaten, sexually abuse or steal from another individual. The term cyber-abuse and cyber bullying most commonly refers to the abuse and bullying of children or teenagers, however, in principle could also be against adults at risk.

Examples of abuse could include:
- tormenting, threatening, harassing, humiliating, embarrassing or targeting an individual;
- stalking/harassment/spy on/tracking an individual;
- 'trolling' which is the antisocial act of causing personal conflict or controversy on line;
- stealing passwords or hacking into computers - may be to impersonate the adult at risk or commit crime or fraudulent acts to the adult at risk;
- grooming or exploitation, including sexual;
- sending or using pornographic images or photos, including 'sexting' use of mobile phones/devices to take and send indecent or provocative images, or setting people up to receive emails from porn sites;
- sending malicious virus or spyware to PCs or devices;
- impersonation of the adult at risk to provoke attack/abuse - posing as the adult at risk and posting messages which would deliberately invite attack against the adult at risk.

In terms of safeguarding adults at risk, agencies in Hertfordshire should work together to raise awareness of the risks and how abuse may happen, how to stay safe when using the internet or interactive technologies, and how to report concerns and abuse.

Further useful information is available at:
Hertfordshire Constabulary website: www.herts.police.uk
UK National Crime Agency – Thinkuknow website: www.thinkuknow.co.uk
Bullying UK website: www.bullying.co.uk
NHS choices website: www.nhs.uk

Although bullying is not a specific criminal offence in UK law, criminal and civil laws can apply in terms of harassment or threatening behaviours and threatening and menacing communications. These include the Protection from Harassment Act 1997, the Malicious Communications Act 1988, Section 43 of the Telecommunications Act 1984, the Communications Act 2003 and Public Order Act 1986.
Appendix 11: Domestic violence and abuse

Domestic violence and abuse is defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

This definition, which is not a legal* definition, includes so called 'honour'-based Abuse, Female Genital Mutilation (FGM) and forced marriage, and is clear that adults at risk are not confined to one gender or ethnic group.

* meaning that the definition is not under-pinned by any Act of Parliament.

Domestic abuse knows no boundaries and affects every corner of society regardless of gender, class, age, race, religion, disability, sexual orientation or lifestyle. It can begin at any stage of a relationship and may continue after a relationship has ended.

Forming patterns of coercive and controlling behaviour impacts on all those directly or indirectly involved – including an estimated one million children each year in the UK.

Any incident reported to the police will be investigated by specially trained officers in the police harm reduction unit, based at Hatfield police station.

Reports can be made in a non-emergency by calling 101. In an emergency always dial 999.

Anyone can seek advice and support without contacting the police through the Herts Sunflower partnership and wider specialist services.

In Hertfordshire the Hertfordshire Domestic Abuse Partnership (HDAP) work together to drive forward the local strategic priorities and plan through its multi-agency arrangements. Governance is led by the HDAP Executive Board and related activity – including a number of sub-groups focussing on a number of priority areas – overseen by the operational HDAP Board.
Organisations and processes that support domestic abuse and safeguarding

Victim Support
Victim Support is a national charity which provides support for victims and witnesses of crime in England and Wales. It provides free and confidential help to family, friends and anyone else affected by crime, which includes information, emotional support and practical help. Help can be accessed either directly from local branches or through the Victim Support helpline. 0845 3030 900

http://victimsupporthertfordshire.org/about-us

Herts Sunflower
Herts Sunflower is the local partnership for the provision of information and support services for everyone affected or concerned by domestic abuse in Hertfordshire.

www.hertssunflower.org is the local ‘one stop’ shop of information about services and support available for victims, friends and families of victims, professionals and people who may have caused domestic violence and abuse. The website has a directory of services and provides an online reporting facility, so that incidents can be reported either directly to the police or to an independent domestic violence advisor (IDVA). It is also supported by the Hertfordshire Domestic Abuse Helpline - 08 088 088 088 - a charity providing a free, confidential and sensitive resource service to those affected by or concerned about domestic abuse. It is staffed by trained volunteers from 9am - 9pm, Monday to Friday, and 9am-4pm Saturday and Sunday.

Those with additional needs and vulnerabilities can also contact HertsHelp.

Independent domestic violence advisors (IDVAs)
IDVAs are trained support workers who provide assistance and advice to victims of domestic violence and abuse. They work closely with criminal justice and statutory partners, and are linked to other countywide services such as specialist domestic violence courts (SDVCs) and multi-agency risk assessment conferences (MARACs).

IDVAs work, independently from other agencies, with ‘high’ risk victims, to consider options and help access other support and legal services to ensure their safety.

Multi-agency risk assessment conferences (MARACs)
MARACs are meetings where information is shared on the highest risk domestic violence and abuse cases between representatives from local police, probation, health, child protection, housing practitioners, independent domestic violence advisors (IDVAs) and other specialists from the statutory and voluntary sectors.

The purpose of MARAC is:
• to share information to increase the safety, health and wellbeing of victims – adults and their children
• to determine whether the person alleged to cause harm poses a significant risk to any particular individual or to the general community
• to construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm
• to reduce repeat victimisation
• to improve agency accountability
• improve support for staff involved in high risk cases
After all relevant information is shared; representatives identify options for increasing the safety of the adult at risk and translate these into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult at risk. The MARAC also links with other processes to safeguard children and manage the behaviour of the person alleged to cause harm. At the heart of a MARAC is the principle that no single agency or individual can support and protect victims on their own, but that collectively the MARAC holds insights that are crucial to victim safety. The victim does not attend the meeting but is represented by an IDVA who speaks on their behalf. Any agency signed up to the local MARAC protocol can make a referral, and this can be without victim consent.

There are five MARACs in Hertfordshire, each held on a monthly basis, set up to cover all 10 local authority areas as follows:

- North Herts and Stevenage
- East Herts and Broxbourne
- Welwyn Hatfield and Hertsmere
- St Albans and Dacorum
- Watford and Three Rivers

All referrals must be accompanied by a full risk assessment (DASH RIC – Domestic Abuse, Stalking, Harassment and Honour Based Abuse Risk Identification Checklist). Please click here to download the risk assessment. Further advice and guidance on completing the risk assessment can be found in the MARAC Representatives Toolkit on the SafeLives website. The completed form should be emailed to the MARAC co-ordinator (details below) along with the completed referral form.

Cases may be referred to MARAC or to an emergency MARAC, by contacting the Hertfordshire MARAC Team at: HertsMARAC@herts.pnn.police.uk
For further information about referring to MARAC visit http://www.hertssunflower.org/multi-agency-risk-assessment-conferences-maracs

**Sexual Assault Referral Centre (SARC)**
SARC is a specialist centre providing centralised 24-hour professional and sensitive care and support for any victim of sexual assault and rape, including those not wishing to report the assault to the police. An independent sexual violence advisor (ISVA) is available to support victims, and works on the same principle as an IDVA.

For further information about the SARC, visit http://www.hertssunflower.org/victims-3/what-if-i-have-been-raped-or-sexually-abused

**Specialist Domestic Violence Courts (SDVCs)**
SDVCs are specially tailored to meet the needs of victims – including installation of special measures to protect and support victims. Magistrates and prosecutors are specially trained and cases are fast-tracked to avoid lengthy delays. There are two across Hertfordshire; St Albans and Stevenage.

**Herts Sunflower drop-in services** are currently being developed. Providing advice, information and support for anyone affected by domestic violence and abuse there is currently one; in the Welwyn Hatfield area.

To find out more about domestic violence and abuse, or how to contact services, call the Hertfordshire domestic abuse helpline on 08 088 088 088, or visit www.hertssunflower.org for further details.
Honour-Based violence/Abuse:
Reports of honour-based Abuse (HBA), or of suspected HBA, must be referred to the police; 999 for emergencies and 101 for non-emergencies. Specialist Domestic Abuse Officers within the police Domestic Abuse Safeguarding and Investigation Unit (DAISU) will respond to these referrals.

Advice related to policy and procedure may be sought from the County Community Safety Unit.

Forced Marriage:
When responding to a potential victim of forced marriage, the Government’s Multi-agency Practice Guidelines: Handling Cases of Forced Marriage must be followed, with particular reference to Chapter 4 ‘Actions to be taken in all cases’ and the chapter relevant to the agency responding.

Cases may be referred to MARAC or to an emergency MARAC, by contacting The Hertfordshire MARAC Team at: HertsMARAC@herts.pnn.police.uk

The Forced Marriage Unit are contactable on 0207 008 0151 (0900 -1700 Monday to Friday and via their Global Response centre (in and out of hours emergency) on 0207 008 1500).
Advice related to policy and procedure may be sought from the County Community Safety Unit.

Female Genital Mutilation (FGM):
FGM is the term used to refer to the removal of part or all of the female genitalia for non-medical reasons. Any such procedure on a woman or girl is unlawful under the Female Genital Mutilation Act 2003. It is also an offence under the Act for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is legal.

All agencies need to be alert to the possibility of a girl or woman being at risk of FGM, or already having undergone FGM. The Government’s Multi-agency Practice Guidelines: Female Genital Mutilation must be followed. It is now a mandatory requirement to report all disclosures of FGM having been performed on anyone aged under 18 to the police. Referrals to social care should also be considered as per local Child Protection policies. The Joint Child Protection Investigation Team and/or the DAISU will respond.

The guidelines acknowledge that there have been reports of cases where individuals have been subjected to both FGM and forced marriage.

To find out more about domestic abuse, how to contact services or make referrals, call the Hertfordshire Domestic Abuse Helpline on 08 088 088 088, or visit www.hertssunflower.org for further details.
Appendix 12: Multi-Agency Public Protection Arrangements (MAPPA)

MAPPA stands for Multi-Agency Public Protection Arrangements. It is the process through which the Probation Service, Police and Prison Service work together with other agencies to manage the risks posed by violent and sexual offenders living in the community in order to protect the public.

MAPPA is delivered under the MAPPA Guidance 2012 Version 4.0. This document provides the framework for the MAPPA process in managing the risk of serious harm in Hertfordshire.

The strategic management board

The strategic management board [SMB] for MAPPA oversees how MAPPA functions in the county, prepares the MAPPA annual report and reviews MAPPA performance data. Meetings are held on a quarterly basis at Hertfordshire Probation Trust headquarters in Hertford.

The SMB consists of representatives from the three agencies making up the responsible authority, (probation, police and prison service), plus representatives from the duty to cooperate agencies and two lay advisers.

Offenders managed under MAPPA

There are three categories of offenders managed under MAPPA.

Category one – Those offenders with a current requirement to register with police as sex offenders.

Category two – Those offenders who have received a custodial term of 12 months or more for a sexual or violent offence and who are currently under probation supervision. It also includes some mental health orders imposed by the courts (for a full list see Appendix 1).

Category three – Those offenders who are currently deemed to be dangerous and a risk of serious harm to the public and who have a previous conviction or finding of an offence which supports that conclusion.

Levels of management/meetings and their operation

There are also three distinct levels of management and cases will rise and fall through the levels according to current level of risk and management needs

Level one - normal agency management, there being an expectation that agencies still communicate about offenders.

Level two - is active multi-agency management requiring active participation by several agencies. These cases are discussed on a monthly basis by a panel which meets at each of the probation centres. These meetings are attended by senior probation officers and police inspectors in addition to representatives from the duty to cooperate agencies.

Level three – These cases require senior officer management as a result of high media scrutiny, or a need for unusual resources such as high degree of police surveillance or specialist accommodation/placement. A county level three meeting is held once a month at police headquarters.
Young MAPPA - Hertfordshire is one of very few areas to have recognised a need for specialist Level two meetings for those relevant young offenders managed by the youth offending teams [YOTs]. A monthly county meeting is held at the central Hatfield YOT office to discuss those cases and attended by specialists from Children’s Services, the NSPCC, in addition to specialist placement and health professionals and representatives from police and YOT teams.

All above meetings are chaired by the MAPPA manager. In Hertfordshire the probation victim contact unit manager deputises for the MAPPA manager as required, although in most cases the local senior probation officer or police inspector will chair a Level two meeting in the MAPPA manager’s absence. The probation assistant chief officer public protection and offender management or the victim contact unit manager will deputise for the MAPPA manager at Level three meetings.

Referrals must be made on the MAPPA referral form and countersigned by a manager (senior probation officer in the case of probation).

Potentially dangerous persons

Inevitably, there will be some offenders who do not fit the criteria for MAPPA registration under any of the three categories, but who are still recognised as currently posing a risk of serious harm and a danger to the public.

Such offenders cannot be managed through the MAPPA process but can be designated by police as potentially dangerous persons (PDP). Information can then be exchanged and a Violent and Sex Offender Register (ViSOR) record maintained by police. In Hertfordshire such offenders are normally discussed on a multi-agency basis in conjunction with MAPPA meetings due to the presence and consequent availability of appropriate professionals. Although these meetings are minuted, it is important to distinguish them from official MAPPA meetings as such offenders cannot legally be managed under the MAPPA process.

What is ViSOR?

ViSOR stands for Violent and Sex Offender Register and is the shared national database maintained by police, probation and prison service containing information in relation to those offenders being managed under MAPPA.

The MAPPA Unit

The MAPPA manager - is accountable to the SMB for the functioning of the MAPPA process in accordance with the national MAPPA guidance. They maintain the national ViSOR system, which holds information on all MAPPA offenders managed at levels two and three and also all of the county’s registered sex offenders [RSOs] who are managed on the system by Police.
The MAPPA unit is located at Police HQ and can be contacted at:

Hertfordshire MAPPA
Police HQ, CMD Building
Stanborough Road
Welwyn Garden City
AL8 6XF
Tel: 01707 354831 / 354858
Fax: 01707 354740

Queries regarding referrals or questions about the MAPPA process, attending meetings or how MAPPA minutes should be stored should be directed to the MAPPA unit.

Police public protection units [PPUs]

All staff involved in this area of work will fall under central management through a detective chief inspector, based at Police HQ. Day to day management will be undertaken by police at inspector level supported by specialist detective sergeants. They will be assisted by a team of constables and support staff, who will deal with monitoring and visiting sex offenders resident in the county in addition to undertaking tasks agreed at MAPPA meetings.

In addition there will be an intelligence cell working with the PPU and specialist units such as the paedophile unit to develop intelligence and undertake enquiries into specific offenders.
Appendix 13: Prevent

Prevent
The purpose of the Prevent Strategy is to stop people becoming radicalised or supporting violent extremism.

Prevent is included in the performance framework for local authorities, the police and other partners. It forms part of a wider Government strategy to prevent terrorism.

Channel
The Channel project provides a mechanism for assessing and supporting people who may be targeted by violent extremists or drawn into violent extremism. It provides a multi-agency approach for identifying, assessing the nature and extent of risk and developing an appropriate support strategy for the individual concerned.

When concerns are raised about an adult at risk who is believed to be vulnerable to radicalisation a safeguarding referral should be raised. The referral should also be forwarded to the Hertfordshire police safeguarding adults from abuse team (SAFA). The referral will then be forwarded to the Channel co-ordinator and the Channel protocol will then be followed.

The SAFA team can be contacted on 01707-354556 for advice.

- A referral should be made on the agreed referral form and sent to saf@herts.pnn.police.uk.
- Out of office hours advice should be sought from the Hertfordshire Police Prevent Team, or Hertfordshire Police via the 101 system.

Information on factors which can leave a person more susceptible to exploitation by violent extremists can be found in Annex 1 of The Prevent Strategy: A Guide for Local Partners in England which can be found at: http://security.homeoffice.gov.uk/news-publications/publicationsearch/Prevent-strategy/
Appendix 14: NHS Risk Summits

Risk Summits are a reactive mechanism to bring together commissioners, regulators and often the provider, where a potential or actual serious quality failure has come to light.

All relevant parties share information, intelligence and their particular concerns about the provider in question to enable informed judgements to be made, particularly by the regulators.

Risk Summits allow for an aligned response between commissioners and regulators in support of the provider as far as possible to make the necessary improvements to provide a high quality, sustainable service to patients.

Serious incidents may sometimes trigger risk summits, but not all serious incidents will warrant a risk summit.

Commissioners
Commissioning is the process of arranging continuously improving services which deliver the best possible quality and outcomes for patients.

Commissioners are responsible for ensuring there is timely reporting of serious incidents by the providers they commission services from and for quality assuring the robustness of the serious incident investigation, learning and action plan implementation undertaken by their providers. They do this by evaluating the investigation and gaining assurance that the process and outcomes of the investigation including identification and implementation of improvements are consistent with principles outlined in this Serious Incident.

Framework
Commissioners should use the details of serious incident investigation reports, together with other information and intelligence achieved via day to day interactions with providers, to inform actions that continuously improve services. Commissioners must establish mechanisms for sharing intelligence with relevant regulatory and partner organisation.

Clinical Commissioning Groups
Each CCG is responsible for holding to account the providers of care they commission for the providers’ responses to serious incidents that occur in care commissioned by that CCG.

This means CCGs are responsible for managing providers’ responses to serious incidents in the majority of acute, community, mental health and ambulance services.

CCGs must also encourage and facilitate the sharing of learning as appropriate across the health community. CCGs also have a central role in supporting quality and safety development within local providers, including primary care services.

It is important that affected patients, victims, perpetrators, families and carers are involved and supported from the onset of an incident. An early meeting (which should not take place at the site of the incident) must be held to explain what action is being taken how they can be informed and what support processes have been put in place.

All staff involved in liaising with and supporting bereaved and distressed families must have the necessary skills, expertise, and knowledge of the incident in order to explain what went wrong promptly, fully and compassionately. The appropriate person must be identified for each case. Expert support must be sought to help facilitate such discussions where required.
Victims and families will want to know:

- What happened?
- Why it happened?
- How it happened?

What can be done to stop it happening again to someone else?
The victims, families and carer must have access to the necessary information and should:

- be made aware, orally and in writing, as soon as possible of the process of the investigation to be held, the rationale for the investigation and the purpose of the investigation (that is, to establish facts);
- have the opportunity to express any concerns.
Hertfordshire’s Safety and Improvement Process

Prevention and partnership working to improve standards of services and outcomes
Authors:
Tracey Cooper, Head of Adults Safeguarding East & North Herts and Herts Valleys Clinical Commissioning Group
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Kulbir Lalli, Head of Integrated Accommodation Commissioning
Edited by: Katherine Mead, Business Support Officer for Safeguarding
Contents
Introduction ........................................................................................................................................... 5
1. Context .............................................................................................................................................. 9
2. Scope of the Safety and Improvement Process ............................................................................... 9
3. Prevention ....................................................................................................................................... 10
   i) Quality Assurance processes .................................................................................................... 10
   ii) Quality Monitoring processes ................................................................................................. 10
   iii) Governance/Business Continuity ............................................................................................ 10
   iv) Role of HCPA ......................................................................................................................... 11
   v) Contract Compliance ................................................................................................................ 11
   vi) Duty of candour ....................................................................................................................... 11
   vii) Workforce Development ....................................................................................................... 12
4. Assurance ....................................................................................................................................... 12
   i) Care Provider led Improvements ............................................................................................. 12
   ii) Quality Assurance Meetings .................................................................................................... 12
   iii) QAM tools ............................................................................................................................... 12
   iv) Communications ..................................................................................................................... 13
   v) Multi-agency Decision Making Meeting ................................................................................. 13
5. Safety and Improvement Process .................................................................................................... 13
   i) Introduction ............................................................................................................................... 13
   ii) Purpose of the multi-agency decision making meeting (Replaces Professionals meeting & process) .................................................................................................................. 14
   iii) What constitutes multi-agency decision making meeting (Replaces Professionals meeting & process) .................................................................................................................. 14
   iv) Thresholds to support the decision making .......................................................................... 15
   v) Structure of the meeting ........................................................................................................... 15
   vi) Safeguarding investigations .................................................................................................... 17
   vii) Recovering Losses ................................................................................................................ 17
6. Reflection and Learning ................................................................................................................ 17
Appendices ......................................................................................................................................... 19
  Appendix One: Process Map ........................................................................................................... 19
  Appendix Two: CQC Information Pathway ................................................................................... 20
  Appendix Three: Observational Tool ............................................................................................. 21
  Appendix Four: Checklist of actions to be considered and or taken at meetings ......................... 24
  Appendix Five: Risk Assessment template ................................................................................... 25
  Appendix Six: Notification template ............................................................................................. 26
  Appendix Seven: GP Notification letters ....................................................................................... 28
Letter to self-funder ............................................................................................................................. 30
Introduction

The Care Act 2014 recognised that high quality, personalised care and support can only be achieved where there is a vibrant, responsive market of service providers. The role of the Local Authority in collaboration with key Partners is critical to achieving this, through its commissioning (joint or sole) services to meet needs, mindful of its overarching duties to facilitate and promote a dynamic market that benefits the wider system and people.

The Care Act 2014 places duties on local authorities to facilitate and shape their market for adult care and support as a whole, so that it meets the needs of all people in their area who need care and support, regardless of who funds the care. Local authorities are further expected to influence and drive the pace of change for their whole market, leading to a sustainable and diverse range of care and support care providers, continuously improving quality and choice and delivering better, innovative and cost effective outcomes that promote the wellbeing of people who need care and support.

Partners will work alongside the care providers and regulators to monitor and review individual and overarching care delivered that is compliant with contractual, safeguarding, quality and clinical practice. Care providers enter into contracts with Partners undertaking delegated responsibilities for the care and welfare of people and this, therefore, has to be of the highest standard. In undertaking these responsibilities, care providers will notify Partners at the earliest opportunity of any actual or potential failures to deliver safe, effective care and support. Where the care provider fails to meet expected standards of quality care, Partners will enact informal and formal processes to ensure rapid and sustainable improvements.

The Care Act 2014 sets out the requirements that statutory bodies such as local authorities and clinical commissioning groups (CCGs) should have in place to safeguard adults at risk ensuring that safeguarding adults is at the centre of every part of the commissioning cycle. Our responsibility is to safeguard and protect vulnerable people from risk or harm regardless of how and who commissioned the care provider services. Therefore, where appropriate people who pay for their own care will be contacted and offered assessment and care planning, including specialist health services as if their care was commissioned by ACS (See Appendix Eight).

Organisational abuse can occur in any setting providing health, care or support services. It occurs when the routines, systems and leadership of an establishment / service result in poor or inadequate care or practice, which affects the whole establishment / service and results in or puts adults at significant risk of abuse or neglect.

This Process has, at its heart, the wellbeing of people that access a range of services across Hertfordshire. This Process will link in with, and use information from, individual safeguarding concerns and enquiries, organisations that monitor, inspect or assess quality of services, the work of statutory or commissioned service delivery. The Process has changed since its last iteration to put greater focus on transparency, setting out clear requirements of the process itself, as well as clear roles and responsibilities for all organisations and setting out a clear multi-agency approach. No one organisation has the resources or expertise, and so decision making will need to be devolved and shared as appropriate.
It should be noted that a Safety and Improvement Process does not replace individual safeguarding adult investigations. There should be an individual safeguarding investigation for each separate adult at risk incident that reaches the threshold for an enquiry to be made.

The oversight for these relationships, their effectiveness and ability to deliver high quality standards sits with the Hertfordshire Strategic Quality Improvement Group (SQIG). This group will take a system wide approach, covering all elements of health and social care, to ensure all Partners and organisations are delivering in line with this policy and to have oversight of overall performance. SQIG will report into both the Hertfordshire Safeguarding Adult Board (HSAB) and the Market Shaping and Resilience Programme Board.

The specific areas that need to be explored in further detail and responded to as a system, given the variance between and across sectors are as follows:

i) Involvement and information

ii) Suitability of staffing, and appropriate training offered

iii) Quality of management

A key objective of the HSAB is to promote, implement and maintain high quality Multi-agency Safeguarding Adult at Risk practice across Hertfordshire. This includes the commitment of all Partner organisations to ensure that all adults at risk are cared for in a safe environment and protected from avoidable harm. This is irrespective of how and where their care and support is funded and delivered.

All organisations represented on the HSAB are expected to contribute to the Safety and Improvement process, including providing additional staff and resources to support the action plan to protect adults at risk of abuse. However, each organisation reserves the right to undertake unilateral action based on their own constitution and duty to safeguard service users and residents of Hertfordshire.

This Process formalises roles and responsibilities of different Partners. The Process has been produced to ensure clarity of each Partner’s roles and responsibilities, promoting consistency and fairness in approach and work in Partnership with care providers. The desire is to shift the focus to prevention and work with social care and health services to help raise and improve standards, while also ensuring that our customers receive high quality services that meet their needs and improve outcomes. Therefore the purpose of the policy is to:

i) Establish an approach for collective decision making

ii) Ensure a standardised response to all circumstances in which performance and enforcement measures are being escalated

iii) Identify responsibility for co-ordinating the response

iv) Agree a process which is meaningful and has measurable outcomes

v) Arrangements for managing quality issues

The following sections of this procedure describe a planned and unscheduled framework to secure immediate improvements in care and health provision and also to respond to intermediate or longer
term issues or concerns (see Appendix One). It is expected that most cases can be dealt with in the prevention or quality assurance stages. This procedure is set out in three sections.

- Stage 1: Prevention
- Stage 2: Quality Assurance
- Stage 3: Safeguarding

Integral to the effectiveness of managing a Safety and Improvement Process is the need for all Partners to work in a transparent and open way with care providers. It is not the intention of this procedure to be punitive in its dealings with care providers but to implement the Safeguarding Principles by supporting and providing guidance when concerns arise, to assist care providers in improving the standards of care that are sustainable. A shared goal should always be that people can expect and receive a safe, quality standard of care and support.

<table>
<thead>
<tr>
<th>Empowerment</th>
<th>People are encouraged to make their own decisions and are provided with support and information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td>Strategies are developed to prevent abuse and neglect that promotes resilience and self-determination</td>
</tr>
<tr>
<td>Proportionate</td>
<td>Proportionate and least intrusive/restricted response is made with people appropriate to the level of risk</td>
</tr>
<tr>
<td>Protection</td>
<td>People are offered ways to protect themselves, and there is a co-ordinated response to safeguarding concerns – protect people from harm</td>
</tr>
<tr>
<td>Partnership</td>
<td>Local solutions through services working with their communities</td>
</tr>
<tr>
<td>Accountability</td>
<td>Accountability and transparency in delivering safeguarding</td>
</tr>
</tbody>
</table>

Through this, care providers are aided to achieve and maintain the high standards of care expected from the organisations.

The following diagram sets out the processes described.
1. Context
Commissioners of health and social care have systems and processes in place to monitor quality and contract compliance and to support care provider improvement. Improving the quality of care needs to be addressed on four fronts.

i) **Personalisation:** to ensure care is delivered with regard to people’s choice and wellbeing

ii) **Prevention:** Developing a care and support market economy that delivers care to required standards

iii) **Quality assurance:** Supporting improvements and raising standards through identifying and tackling emerging concerns in the quality of care and support

iv) **Safeguarding:** Collaborative and assertive approaches to managing concerns when the care provided by a service to adults who are at risk of harm is causing them to experience, or be at risk of, abuse or neglect. This must include seeking the view of the individuals concerned at all times where possible.

2. Scope of the Safety and Improvement Process
When safeguarding concerns have been identified which cannot be addressed through the quality monitoring and/or contract monitoring processes. They will be managed through a formal process known as the Safety and Improvement Process.

The Process applies to both health and social care provision; it includes concerns about NHS providers, independent hospitals, and services directly delivered by HCC.

A Safety and Improvement Process will usually be triggered when the actions taken at prevention, quality assurance and safeguarding stages have failed to either address individual or overarching concerns about the delivery of safe effective care, which may be having an adverse impact on peoples care/support and wellbeing.

The Safety and Improvement Process provides an overarching framework which will ensure a coordinated response with:

- All aspects of the investigation planned;
- Organisations and individual professionals clear about their respective roles and responsibilities.

There may be cases where Partners including the regulator, through enquiries, investigations and inspections, identify concerns which are judged to place people at risk of harm. In such circumstance Partners could trigger a formal process.

This Process can be used for services that are regulated by the CQC and for care and support services that are not regulated but provide a service, where adults could potentially be at risk of harm, for example day services or where personal assistants (PA’s) are involved.
3. Prevention
A care provider’s contractual obligation is to have systems and processes in place to assure itself that the relevant checks and balances are in place to ensure safe delivery of services. This can range from staff supervision, delivery of training/mentoring (and measuring impact) and governance structures and processes. Care providers are expected to have undertaken a baseline of their own quality performance to assure itself it is meeting various compliance requirements; this should be done through regular auditing with evidence of mitigating actions in place to minimise any risks identified. For those care providers that are Hertfordshire Care Providers Association (HCPA) members, this MUST be through the Impartial Feedback Service (IFS).

i) Quality Assurance processes
To measure this, all care providers will be subject to an annual review process, from which all Partners will use and share relevant information across all care groups. The Care Quality Commission (CQC) has set up an information sharing protocol with Partners and individual reviews and themes from CQC will be used to work together to build a picture to assure the Partnership of quality (see Appendix Two). Partnerships have also been setup with Healthwatch to ensure information and themes from ‘Enter and View’ visits are factored in any intelligence considered. Partners from across the system will use an observational tool and key professional’s coming in and out of services will use this to feed back to the wider partnership. This may also include the police and their work through Police Community Support Officer’s (PCSO) engaging with care homes as part of their ‘beat’. The care concerns email system will also be used and receive completed observational tools (see Appendix Three).

ii) Quality Monitoring processes
Hertfordshire County Council (HCC), Clinical Commissioning Group’s (CCG) and Hertfordshire Partnership Foundation Trust (HPFT) use East of England Provider Assessment Market Monitoring System (PAMMS) tool, process and rationale. Monitoring visits are carried out jointly with the CCGs and experts by experience wherever possible. To provide evidence of contractual and clinical compliance, CCG’s will work with local authority officers to provide any relevant and appropriate support to the process of care homes that are not registered for nursing. Visits are prioritised based on the previous years’ scores, and other risk data. HPFT also has a role in monitoring services under their delegated secondary commissioning responsibility. On the understanding that safeguarding adults at risk is everybody’s business, any person visiting care homes or home care agencies as part of their work has a responsibility to highlight issues relating to service delivery. This work contributes to, and is delivered in partnership where necessary, the wider collection of intelligence.

iii) Governance/Business Continuity
It is the care provider’s responsibility to ensure that they are able to respond to and mitigate against factors that may have a direct impact on their ability to deliver a satisfactory quality of care. The contingency plan needs to be able to respond to
staffing and/or leadership issues and should be used to identify key risks across the system and to support services to maintain quality throughout various ‘disaster’ scenarios that could impact on the care of vulnerable people.

iv) Role of HCPA

Hertfordshire Care Providers Association can provide support in a number of ways, including, but not limited to:

- **Training** – covering a range of support, from activity programmes for services, train the trainer and formal qualifications
- **Quality improvement** – working with services experiencing issues by addressing key issues such as leadership and management, recruitment etc.
- **Impartial feedback service** – an innovative service that allows care services to seek anonymous feedback on their services, which is collated by HCPA and delivers an action plan for a service to follow

It is imperative that baselines by individual services make reference to and include HCPA, to ensure quality and continuity plans are robust. There is considerable value in asking independent third party partners to provide a critical friend role, even if it is to ‘accredit’ in-house training, or to be aware of good practice across the County. In addition, services can be signposted to other areas of support, such as the ‘Learning and Development Calendar’ of courses produced by the HCC’s Workforce Development and Partnership Team. To request a copy contact pvi.learning@hertfordshire.gov.uk

v) Contract Compliance

The vast majority of care providers deliver care under contract to HCC and/or one or both of the CCG’s. These contracts stipulate the minimum terms and service quality objectives that all services are required to meet. The quality objectives are measured through the 5 key domains under the PAMMS tool:

1. Involvement and Information
2. Personalised care and support
3. Safeguarding and safety
4. Suitability of staffing
5. Quality of management

Commissioners will utilise the contract to ensure quality and performance remain high.

vi) Duty of candour

In order to maintain the highest quality standards across Hertfordshire, there will be trust and transparency across all processes on quality improvement. The Partnership will be open with all levels of management within a service about any evidence we have, what is expected to remedy it and by when. In return, services should work with the Partnership in the spirit of quality improvement. This may mean highlighting issues
before they develop into something more serious or significant, raising appropriate alerts (Regulation 16 and/or 18) to HCC and delivering sustained quality. In addition, there would be expectation that services were open and honest with their service users and families.

vii) Workforce Development
A key factor in delivering high quality services is through effective recruitment, retention, training and Continuing Professional Development (CPD). Through HCC and HCPA, there are a number and range of opportunities for services and staff. Through HCPA’s recruitment portal and range of training opportunities and HCC’s ‘Learning and Development Calendar’ courses, we will be working with care providers to ensure all support is offered to ensure quality standards are raised.

4. Assurance
A care provider will retain any and all responsibility about the quality of its own service. The Partnership’s role, once concerns have been identified, and have been raised within the service for improvement and their success evaluated, are to escalate ongoing or unresolved concerns to the senior management/leadership within the service.

i) Care Provider led Improvements
The care provider will be responsible for setting the pace of improvements that are required. This should cover all appropriate levels within the service or across services. The role of the Partnership is to constructively challenge the care provider’s proposed actions plans, milestones and timescales, as well as proposed evidence for completion, to ensure improvements are deliverable and sustainable.

ii) Quality Assurance Meetings
Concerns that have not yet been remedied to the satisfaction of the Partnership will be escalated to the care provider’s senior management team and be discussed at a Quality Assurance Meeting (QAM). This level of management will be the tier that sits above the Registered Manager and has accountability for the Registered Business. It can include, but is not limited to, Quality Leads, Care Auditors, Finance Leads, Operational Leads/Directors, CEOs or Owners. These meetings will be time limited with the aim of ensuring service improvements in an effective and timely manner and to prevent concerns from escalating. There will be a minimum of two QAMs; the first to share and discuss the concerns ahead of agreeing an action plan and the second to close the process down following subsequent remedy of the concerns. The time between the two meetings will be dependent on the agreed timeframes as part of the action plan. Further QAMs may be required in some circumstances but this should be not the norm and in agreement between a care provider and the Partnership.

iii) QAM tools
a) Audits
Once concerns have been escalated to a QAM, the Partnership will request a care provider’s support in compiling a full as possible audit of the service to understand
risks, exposure to risks and liabilities, and whether these are shared across the Partnership and care provider. This will also include historical quality issues. This will be shared with the care provider during or after the QAM.

b) Targeted interventions
At the QAM, key targeted interventions by the Partnership will be agreed with a care provider, to ensure progress is checked in real time and that work can be adapted as things develop. This is to ensure an effective preventative response that delivers sustained improvements. The targeted interventions agreed will be delivered and supported by key professionals assigned by the Partnership.

iv) Communications

a) The Partnership will inform the senior management team of the decision to convene a QAM at least 2 weeks before any proposed dates, and will outline the quality issues that have not been remedied following preventative advice and support, and quantify the approaches taken and their success.

b) A care provider will develop an action plan ahead of the QAM based on these concerns and will share these with the Partnership no later than 48 hours before the QAM. A care provider will then share their approach with the Partnership at the QAM.

c) Agreed actions and timescales will be communicated by the Partnership to a care provider no later than one week following any QAM.

v) Multi-agency Decision Making Meeting
Concerns that have not yet been remedied, as agreed by a care provider’s senior management team at the QAM, to the satisfaction of the Partnership will be escalated to a Multi-agency Decision Making Meeting (MDMM). It will be the role of this meeting to gather all intelligence gathered throughout the preventative and assurance processes, to decide whether the concerns should be further escalated to a Safety and Improvement Process or whether they should continue to be managed within QAM.

5. Safety and Improvement Process

i) Introduction
There are five key stages in the Safety and Improvement Process when preventative and quality assurance have failed:

1) Drawing together information to include multi-agency discussion and decision taken as to whether the concerns meets the safety and improvement threshold
2) Safety and Improvement Process meeting takes place, agreeing timescales
3) Reconvened Safety and Improvement Process meeting
4) Closing the Safety and Improvement Process - placing emphasis on quality assurance and preventative measures and processes

5) Reflection and Learning
(See Appendix Four)

ii) **Purpose of the multi-agency decision making meeting (Replaces Professionals meeting & process)**

The purpose of the MDMM is to share intelligence to decide whether to proceed to the Safety and Improvement Process or whether the concerns should be managed within existing quality and/or contracting processes. It is also an opportunity to determine the level of risk to people receiving care and support and where necessary further develop the recovery actions. The expectation of the action plan is that they lead to tangible, measurable improvements in the quality of care.

All decisions must reflect a multi-agency approach, which is proportionate and based on the views of the professionals in attendance. The roles and responsibilities of all participants should be agreed with the chair and documented within the minutes. A risk template must be used at every professionals meeting to record the issues, risks, action plan and subsequent actions. (See Appendix Five).

If the **threshold** is not met to initiate the Safety and Improvement Process then quality monitoring arrangements will be led by commissioners and any further meetings arranged will be known as QAM; the findings of which will be shared with Partners via the Strategic Quality Improvement Group.

If it is decided that the **threshold** for a Safety and Improvement Process is met, the concerns, risk evaluation, discussion and decision must be documented. Planning and actions agreed for the investigation must also be documented. A formal notification (see Appendix Six) will be sent to the care provider outlining the reasons for triggering the process and the interim actions required to report on measures taken to assure Partners that people are being safeguarded and protected.

Where there are issues for safeguarding open dialogue and agreed actions for improvements can only be achieved where there is trust and willingness on all parties to work together.

iii) **What constitutes multi-agency decision making meeting (Replaces Professionals meeting & process)**

The responsibility for convening, chairing and minute-taking of the MDMM lies with Adult Care Services (ACS) or HPFT; this is considered part of their lead responsibility under the Care Act 2014 to make or cause others to make safeguarding enquiries.

The Chair of the Safety and Improvement Process meeting must be a Head of Service with delegated responsibility from the respective statutory Partners; to enable a decision to be made the following need to be present:
The relevant GP practice(s) must be notified by the CCG and ACS when a MDMM is taking place (see Appendix Seven); and the GP will be invited to contribute to the process and provide relevant information.

The care provider is not invited to this meeting but informed that it has taken place. (See Appendix Six).

It is the expectation that the Safety and Improvement process will last approximately three months, although there may be circumstances where this is managed on a case by case basis.

iv) Thresholds to support the decision making

In making a decision around triggering processes outside of the usual contract; Consideration of safeguarding, clinical and nursing practice and regulatory compliance will be given to the following list of indicators of safe, effective care. This is not an exhaustive list rather; it sets out the typical care scenarios that may trigger a formal process under the policy. There may be circumstances in which consideration will be given to overriding factors of public interest which in themselves may be sufficient to trigger a formal process.

Thresholds for convening a meeting include:

- A number of safeguarding concerns and/or referrals indicate that a significant number of adults are at risk of abuse or neglect;
- There is evidence or a credible concern that a number of adults at risk have been abused or neglected;
- There has been a death, serious injury or major impact on the health of an adult at risk and abuse or neglect is a contributory factor;
- Patterns or trends in care delivery where remedial action is not taken or has had no impact and there are indications that a number of adults are at risk of abuse or neglect;
- There has been a significant complaint;
- There has been significant whistleblowing;
- There is evidence from CQC inspection, CCG and/or local authority quality monitoring / contract monitoring visits indicating that a number of adults are at risk of abuse or neglect.

v) Structure of the meeting

The Safety and Improvement Process should last no more than six months, with the first multi-agency meeting with care provider to be arranged within 10 working days of the decision to trigger the Process. If the Process continues longer than six months from when it was triggered then it should be reported to SQiG and HSAB Board.
Meetings should be convened in two parts. The exception to this is when a criminal offence is believed to have occurred and/or where to include the care provider would compromise a police investigation.

Minutes and action points will be taken at the meeting by ACS Business Support Officer and will be circulated to all attendees within 5 working days. Any exception to this must be agreed by the Chair in consultation with the responsible board lead member.

Part one is for reports to be received from Partners around enquiries, investigation and reviews on individual or overarching care quality issues. The care provider is not present at this meeting. In order to enable effective, timely, evidence-based decisions, organisations are expected to provide written reports to be circulated with the agenda.

These must include, but not limited to:

- A summary of the most recent quality/contract monitoring visits (NHS/ACS/Commissioners);
- CQC inspection report (as published on CQC website);
- A summary of safeguarding alerts/ enquiries/ outcomes and themes (ACS/HPFT investigating teams);
- A summary of themes and trends from professional/ clinical observations/ reviews etc. (all organisations)

It is also to agree on the scope of further actions by the Partners and the agenda for part two of the meeting.

The purpose of part two of the meeting is for care providers to bring action plans to the meeting which should reflect action plans from CQC and PAMMS tool. The meeting should focus on:

- Summary of concerns;
- Obtaining the care provider response to concerns;
- Agree any immediate actions needed to protect adults at risk of harm;
- Agree a service improvement plan with the care provider;
- Decide whether any contracts should be suspended or terminated due to safeguarding issues;
- Agree a communications strategy, to include individuals using the service, their families and carers and other stakeholders;
- Agree a date to reconvene to review the action plan and service improvement plan; OR
- Decide that the Safety and Improvement Process can be concluded (this has to be a multi-agency decision).

Care providers will receive minutes for part two of the meeting only.

All other funding authorities must be informed via Commissioning that the Safety and Improvement Process has concluded.
vi) Safeguarding investigations

The Process does not exempt services from managing safeguarding adults at risk who are supported by care providers who are subject to single safeguarding concerns from the usual practice. In all cases, single concerns should ensure that there is an outcome to determine whether or not the safeguarding concern was substantiated through robust investigation and an effective protection plan is in place; it is not sufficient to state that the matter will be dealt with through an Safety and Improvement Process.

Where a Safety and Improvement Process is already taking place, the two processes should run in parallel with a possible outcome that the issues in the single concern is being addressed appropriately through the Safety and Improvement Process and there is no need for additional action. At the very least the single alert should be taken through both stage 2 – Referral and stage 3 – Safeguarding strategy discussion meeting and a decision recorded.

Roles and responsibilities in an investigation can overlap. It is important to be clear as to who is doing what within set timescales. This could include, but not limited to:

- Police investigation;
- Reviewing individual cases, including specialist clinical reviews;
- Monitoring visits by commissioners (both announced and unannounced);
- Monitoring visits by the regulator;
- Learning and development support;
- Informing other funding authorities;
- Professional’s advocacy.

vii) Recovering Losses

Commissioners on rare occasions will terminate individual contracts if people are deemed of imminent risk of harm or if there are not sustainable improvements to care which is resulting in risk or harm. It is important to note that CQC have ultimate jurisdiction and responsibility in removing registration and / or service closure falls outside the remit of this policy and procedure.

There may be resource invested by the Partnership to support a service, to ensure safe care is being delivered and/or providing specific training and/or support and guidance, in order to push the improvement process. In these cases, the Partnership will discuss with the care provider a number of options to ensure this investment doesn’t significantly disadvantage the Partnership.

6. Reflection and Learning

This is a multi-agency approach including the care provider as it is important that lessons learnt from each Safety and Improvement Process are identified and used to inform practice. The purpose is to:

- Celebrate good practice;
- Recognise areas where development is needed;
- Agree how learning should be disseminated across the Partnership.

The Chair of the Safety and Improvement Process should convene the Reflection and Learning meeting which should be held within one month of the conclusion of the process. The Chair of the session will not have been the Chair of the Safety and Improvement process and it is recommended that an independent chair is used as this will enable all participants to fully engage in the discussion. It will be concluded by a letter outlining the outcomes.
Appendices

Appendix One: Process Map

Preventative work

Quality Assurance Meetings

Multi-agency Decision Making

Safety and Improvement

Agreed timescales with Providers

Lessons Learned

Also see Diagram on Page 8.
Appendix Two: CQC Information Pathway

CQC have concerns

CQC make referral made to ACS by way of Safeguarding alert via SERCO GCSX email. This will then be triaged and passed to respected intake tray. Partner organisations will be notified

ACS log referral on Register and OPPD BSO Monitor (SERCO-authority under contract to work on behalf of HCC to deliver customer care and front end services)

Senior manager to have oversight and rationale of decision. Appropriate board member to be consulted

Consultation with Police, Contracts, CCG regarding information

Consider escalation to a MDMM Meeting

Disseminated to health and Social Care Partners for contribution to coordination of enquiries and safeguarding investigations

Quality Assurance undertaken
### Multi – Agency Observation Sheet

**Name of Home ......................................**

**Date of Visit.........................................**

**Visit completed by....................................**

<table>
<thead>
<tr>
<th>ENVIRONMENT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are your initial impressions?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Action/Comments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the establishment smell fresh and clean?</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td><strong>Action/Comments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are the staff aware of the reason for your visit?</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td><strong>Action/Comments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there drinks and snacks in the communal areas for people?</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td><strong>Action/Comments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does each person you visit have a drink within reach that they can manage?</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td><strong>Action/Comments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you look at a specific person, are fluid charts being completed fully where applicable?</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td><strong>Action/Comments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When observing an environment from a mental health perspective, is the layout of the furniture being used to restrict movement</td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td><strong>Action/Comments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td><strong>What is the quality of the information on notice boards especially with providers who cater for people with a functional illness and for EMI homes for families and carers?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Action/Comments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STAFFING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do staff make you welcome when you visit the home and are you asked to sign in?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Action/Comments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do the staff know who you are visiting and the reason for your visit?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Action/Comments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did staff ask permission to enter the person’s room?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Action/Comments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do the staff speak to people with respect?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Action/Comments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you hear call bells ringing constantly for long periods of time?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Action/Comments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you hear people calling out for any length of time and not being responded to?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Action/Comments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If people are sat in the lounges is there staff available to them or doing</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

---

**HCS 666 Safeguarding Procedure, Issue 12, Jan 2019** 116
any kind of activity with them? Within Care Homes for people with dementia, Care Home Staff should be with them.

<table>
<thead>
<tr>
<th>Action/Comments</th>
</tr>
</thead>
</table>

**MANAGEMENT**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you know who the Manager is and are they on site?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action/Comments</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>YES</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you aware of who is in charge of the shift?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action/Comments</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>YES</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you asked to see other people when you visit the Care Home?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action/Comments</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>YES</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there person identifiable information left lying around?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action/Comments</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>YES</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are care records available at your visit?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action/Comments</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>YES</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any other issues you wish to raise?</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix Four: Checklist of actions to be considered and or taken at meetings

<table>
<thead>
<tr>
<th>Action to be taken</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Management – Need to Know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategy decision on when to discuss matters direct with the Provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If a suspension on admissions is considered how this is communicated to front line staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alerting other local authorities who have made placements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alerting Health colleagues on any Continuing Care placements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information to the Provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Press release discussion to Communications Team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Briefing paper for Chief Executive and or Elected Members, Chair of HSAB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider how to consult with any other stakeholders, e.g. residents and relatives without raising anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree as part of strategy how to include self-funders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make recommendation on suspension of admission for contracted services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordinating service user/patient care reviews and reassessments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring care quality delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offering professional technical support and intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring service improvement plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree a multi-agency protection/action plan</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### MDMM Risk Assessment

**Provider:**

**Date of Meeting:**

<table>
<thead>
<tr>
<th>Date Agreed</th>
<th>Issues</th>
<th>Risks</th>
<th>Action Plan/ Actions Reviewed</th>
<th>Date Reviewed</th>
<th>Sign Off</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. 01/10/2017</td>
<td>Number of safeguarding issues</td>
<td>Residents mobilising without carers and falling</td>
<td>Review team to go out and complete review of care plans and identify risk assessments</td>
<td>01/11/2017</td>
<td>Chair signature</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reviews completed. Action for Home to update care plans</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Appendix Five: Risk Assessment template
Dear OWNER,

**RE: Safety and Improvement Process Meeting**

I am writing to inform you that Hertfordshire County Council would like to invite you to a multi-agency meeting to discuss how best to address some ongoing contractual and safeguarding concerns which have emerged from a number of residential homes registered to your organisation. These homes include; INSERT CARE HOMES.

The reasons why the decision was made to initiate this process, as well as the date of the meeting are detailed below. You may already be aware of and in the process of combating these concerns which have been noted by CQC, HCC operational safeguarding team and HCC contractual monitoring team.

Given the risk to the services being provided to the residents of the homes, we would want to prevent further deterioration and seek a speedy resolution to ensure improvements to the quality of your services. An overview of the concerns can be seen below:

**Reasons for initiating the Safety and Improvement Process:**

On DATE the Care Quality Commission (CQC) made an unannounced inspection in response to concerns that one or more of the essential standards of quality and safety were not being met. During this inspection they found that CARE HOME was non complaint in the following areas:

On the DATE the council received a Safeguarding concern pertaining to a resident that was potentially at risk. Following receipt of the SAFA concern, representatives from the council visited the home on DATE. The concerns noted at this visit included:
Date of Safety and Improvement Meeting
The Safety and Improvement meeting will be held on DATE at TIME at PLACE.
I would be grateful if you could please confirm your attendance at this meeting, and also inform me of
any other attendees you may bring with you.

To confirm your attendance please contact NAME OF BSO at EMAIL, or alternatively via telephone on
NUMBER.

Yours Sincerely,
Appendix Seven: GP Notification letters

Dear Practice Manager

Re: (CARE HOME)

According to the CCG records you are the practice providing medical services to NAME Care Home.

The County Council’s Adult Care Services (ACS) together with multi agency Partners has recently held a high level meeting through the Hertfordshire Safeguarding Adult Board Multi Agency Safeguarding Adult Procedures with the provider to discuss concerns regarding this home. These concerns relate to:

Our aim is to engage with the care home provider to ensure improvements and changes are made to care practices within the home.

In the course of the work you do within the Care Home please can you share any concerns with CARE HOME that you may have that will inform the improvement required.

The officer coordinating communication for this work is: NAME, TITLE

If you would like further information on the concerns ACS currently have at the home, please contact: NAME, Business Support Officer – Safeguarding on EMAIL AND PHONE
(These contact details are for the use of professionals only and must not be given out to members of the general public).

Your sincerely

Business Support Officer
Dear NAME,

RE: Your right to an assessment of your social care needs, including your residential care placement.

I have been given your name by NAME, Manager of CARE HOME. I am taking this opportunity to inform you that you have a right under law to have an assessment of your needs undertaken by a social care practitioner on behalf of the County Council.

This assessment (which is free of charge) will help to ensure that you are receiving the appropriate support for your care needs and make recommendations about any appropriate alternatives. It will also be able to identify if you are entitled to any financial support from the County Council.

If you would like to take up the offer of an assessment please contact NAME on 0300 123 4042, who will be able to assist arrange this.

Whilst writing I would like to take this opportunity to remind you that you can check and see how the Care Quality Commission rates local care home provision by visiting www.cqc.org.uk.

Yours sincerely

[Letter to self-funder]
Appendix Eight: NHS Legislative Framework

Protecting patients from avoidable harm and ensuring safe care is a requirement of all NHS organisations. National policies are in place which require all NHS organisations to have clinical governance processes in place including serious incident and never event reporting. These set out clearly defined processes and procedures, including root cause analysis to ensure learning from these incidents and to prevent reoccurrences.

http://www.nrls.npsa.nhs.uk/resources/?entryid45=75173

http://www.nrls.npsa.nhs.uk/resources/collections/never-events/

In Hertfordshire each NHS- commissioned organisation has a serious incident policy which includes reporting to the commissioning organisation. In addition the NHS has a risk summit procedure which will be followed when the concerns relate to NHS provider trusts.

Appendix 16: Safeguarding Adults Review Protocol
SAR protocol is under review (Dec 18).