

**Multi-agency Policy, Procedures
and Practice Guidelines for**

**Safeguarding
Vulnerable
Adults**

In Hull and the East Riding of Yorkshire

**Safeguarding Adults Boards
(Hull and East Riding of Yorkshire)**

This policy, procedures and guidance notes are applicable to all agencies and have been developed and agreed by:

 <p>Hull City Council</p>	<p>Signed </p> <p>Position Head of Community Care</p> <p>Dated October 2009</p>
 <p>EAST RIDING OF YORKSHIRE COUNCIL</p>	<p>Signed. </p> <p>Position Director Children, Family and Adult Services</p> <p>Dated October 2009</p>
<p>Humber Mental Health  Teaching NHS Trust</p>	<p>Signed </p> <p>Position Chief Executive</p> <p>Dated October 2009</p>
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	<p>Signed </p> <p>Position Chief Superintendent Divisional Commander</p> <p>Dated October 2009</p>

Supported by representatives from Independent Providers of Care and Voluntary sector

Background

There is a history of joint working in Hull and the East Riding of Yorkshire to promote good practice agreed policies and procedures that seek to protect and empower vulnerable adults.

New 'Multi-agency Policy, Procedures and Practice Guidelines' were introduced across Hull and the East Riding of Yorkshire on the 1st October 2001, following the guidance contained in the publication 'No Secrets' (Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse).

This document is the revised edition based on current research, evidence based practice and local and national developments, and reflects new legislation including the Mental Capacity Act 2005 and Deprivation of Liberty standards.

Geographical area covered

The policy and procedures covers all vulnerable adults (as defined in the 'No Secrets' guidelines) living in Hull and the East Riding of Yorkshire who are at risk of abuse. It includes those residents living outside the area in residential homes supported by either Hull City Council or the East Riding of Yorkshire Council. Should an investigation be required in these circumstances following an allegation of abuse then negotiation must take place with the Local Authority in whose area the Residential Home is situated in order to agree which authority is best placed to undertake the investigation. Liaison must also take place with the relevant inspection and regulatory bodies.

Safeguarding Vulnerable Adults

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Safeguarding Vulnerable Adults

in

Hull and the East Riding of Yorkshire

CONTENTS

	Page
PART ONE - POLICY AND KEY PRINCIPLES	
1. Introduction	1
2. Policy Statement	3
3. Definitions: Vulnerable Adult, Abuse, Types of Abuse and Predisposing Factors	6
4. Intervention	11
PART TWO - Procedures for all Agencies	
1. Introduction	15
2. Alerting	16
PART THREE - Action after a Referral	
1. Introduction	22
2. Social Services Procedures	22-23
3. Police Procedures.....	24
PART FOUR - Appendices	
Appendix 1 Forms	
Alerter/Initial Referral Form - Sections 1 to 4.....	27-30
Section 5 - Decision Making.....	31
Section 6 - Result of Investigation.....	32
Section 7 - Monitoring Form Vunerable Adults	33-34
Investigation - Guidance Template	35-36
Referral Progress Checklist.....	37
Form 3A - Consent to information sharing with other agencies.....	38-39
Form for Adults who are unable to consent	40-44
Appendix 2	
Local Points of Referral and Other Statutory Agencies	45

Appendix 3

Guidance Notes on Consent, Confidentiality and Information 47
Sharing

Appendix 4

Key Categories of Abuse and Indicators 53

Appendix 5

Safeguarding Adults Arrangements (Hull and East Riding)..... 61

Appendix 6 - Protocols

(i) Inter-authority investigations..... 69
(ii) CQC protocol..... 72
(iii) Case Review protocol 77
(iv) Multi-agency information sharing protocol..... 80

Appendix 7

Whistleblowing Policy Template 95

Appendix 8

POVA Guidance and Referral Form and Independent..... 97
Safeguarding Authority - Vetting and Barring

Appendix 9

Staff Training Notes110

Appendix 10

Mental Capacity Act and Deprivation of Liberty Standards112

1. INTRODUCTION

This multi-agency document outlines the policy and principles that underpin the protection of vulnerable adults. It defines the roles and responsibilities of professionals, staff and volunteers who may detect or suspect abuse of a vulnerable person.

The document includes procedures to be followed by all agencies when abuse is suspected, including statutory, independent and voluntary agencies.

It comprises 5 parts, as follows:

1. **Policy and Key Principles:** a general introduction including definitions etc
2. **Procedures for all Agencies:** procedures on referring suspected abuse to appropriate agencies, to be followed by all staff working with vulnerable adults
3. **Procedures for Social Services and Police:** Brief detail procedures on investigating suspected abuse to be followed by the responsible agencies, Police and Social Services
4. **Paperwork:** Copies of all the paperwork developed to record actions, decisions etc in connection with adult protection
5. **Appendices:** includes detailed guidance on definitions, the law and details of agencies that can be contacted for advice and information by anyone involved in working with vulnerable adults.

This document has been developed by a group of people working with vulnerable adults in statutory, independent and voluntary settings. It is based on the Government guidelines in “No Secrets”, published by the Department of Health in 2000. It aims to:

- prevent and reduce the incidence of abuse by better informing those who work with vulnerable adults, by raising awareness of adult abuse in conjunction with staff training;
- improve the response by individual agencies to allegations of abuse;
- improve the quality of life of vulnerable adults by providing better protection, encouraging service user empowerment, and identifying and improving bad practice.

This policy, procedure and practice guidance is concerned with vulnerable adults, aged 18 or over, who are unable to protect themselves without support, in a range of settings.

Definitions of vulnerable adult and abuse are given in section 2.

There are procedures concerned with the protection of children and young people aged under 18, and advice on child protection may be sought from social services or the Local Safeguarding Children's Boards. Details of how to contact them are included in Appendix 2 within these procedures.

Agencies may already have their own procedures on Safeguarding Adults and these should be checked to ensure they are consistent with the procedures and guidelines outlined within this document. They may also have additional and associated procedures e.g. whistle blowing, disciplinary procedures that are necessary in addition to vulnerable adult procedures. Where they do not, they may wish to develop them following models used by statutory agencies.

2. POLICY STATEMENT

The agencies that have developed these procedures have agreed to co-operate in an inter-agency approach aimed at protecting vulnerable adults from abuse. The organisations or agencies that formally agree to this Multi-agency Policy, Procedures and Practice Guidelines for the Protection of Vulnerable Adults in Hull and the East Riding of Yorkshire recognise that:

- vulnerable adults can be at risk of mistreatment and abuse;
- the abuse of vulnerable adults constitutes a clear infringement of human and civil rights and in many cases may be a criminal offence;
- each agency has an obligation to work in partnership to protect vulnerable adults.

2.1 Responsibility of Agencies

All agencies concerned with vulnerable adults have responsibilities, either statutory (Social Services, NHS Trust and the Police) or contractually (the independent sector) or have a duty of care (the voluntary sector).

The agencies involved will work to the following key areas and principles (taken from the Safeguarding Adults Board Strategy and Development Plan);

- **Prevention:** prevent abuse, respect the rights of the individual, prevent a re-occurrence of abuse by the use of clear systems and appropriate measures;
- **Participation:** responsible agencies to commit to participation in joint working aimed at preventing abuse and protecting vulnerable adults;
- **Partnerships:** agencies will identify working levels of responsibility and representation, channels of communication and information sharing will be established, and there will be commitment to best practice and learning from experience;
- **Guidance and Procedures:** policy, guidance and procedures will be developed from legislation, research, review, experience and best practice. Agencies will commit to ownership, will use, update and ensure they are accessible to staff. This will ensure a continued level of understanding and promotion of the protection of vulnerable adults. Agencies will develop their own protocols when necessary;

- **Education:** prevention, protection and practice is underpinned by education which is multi-agency in involvement and accessible to those needing it, raising awareness and standards;
- **Commissioning:** standards are to be laid down, demonstrating the importance of clear, open and focused protection of vulnerable adults which includes dignity and respect.

More details on specific responsibilities can be found within Part Two, Procedures for all Agencies.

2.2 The Rights of Vulnerable Adults

All people have human rights in accordance with the Human Rights Act 1998. In this context the rights of vulnerable adults should be acknowledged and respected during the course of an investigation into abuse.

These rights include:

- the right to be left alone, undisturbed and free from intrusion into their affairs;
- to be able to move freely about the community without fear of violence or harassment;
- to be empowered through education and counselling where appropriate, to make choices about their lives and their relationships, including sexual relationships;
- to engage in relationships and sexual activities that are wanted and understood by the person and that do not expose them to exploitation and/or sexual violence;
- to live safely in the home of their choice without fear of domestic violence from caregivers or other service users;
- to be given appropriate and accessible information about keeping themselves safe and exercising their human rights;
- to have their money, goods and possessions treated with respect;
- to be given the same respect and support as any other adult regardless of age, ability, gender, religion, sexual orientation or cultural background, when making a complaint or seeking help as a consequence of abuse;

- the right to bring a formal complaint under the relevant agency procedure if they are not satisfied with the outcome of a vulnerable adult investigation;
- to be supported in making their own decisions about how they wish to proceed in the event of abuse, to whom they wish to confide, and to know that their wishes will be followed unless it was considered necessary for their safety or the safety of others not to follow those wishes;
- to receive appropriate support following abuse, which may include advice, support, education, counselling, therapy, treatment, access to redress etc.

3 DEFINITIONS: VULNERABLE ADULT, ABUSE, TYPES OF ABUSE AND PREDISPOSING FACTORS

All adults are potential victims of crime or abuse, but not all adults are vulnerable - the majority of adults are capable of protecting themselves, only a proportion would be considered as being in need of protective intervention.

3.1 Vulnerable Adult

A vulnerable adult is defined as a person aged 18 years or over:

“who is or may be in need of community care services by reason of mental or other disability, age or illness; and

who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation”

(Department of Health Guidance “No Secrets” March 2000)

Significant harm refers to:

“ill-treatment (including sexual abuse and forms of ill-treatment that are not physical):

the impairment of, or an avoidable deterioration in, physical or mental health and

the impairment of physical, emotional, social or behavioural development”.

(Law Commission 1995 and quoted in “No Secrets”).

It can include people who are elderly or frail, suffer from a mental disorder, have a physical, sensory or learning disability, or have a debilitating illness.

The definition contained in ‘No Secrets’ relates to abuse or neglect experienced by vulnerable adults no matter their age or living arrangements. The current definition is wide and includes individuals in receipt of Social Care services such as health care and those who may not be in receipt of care services.

(The Government’s response to the recommendations and conclusions of the Health Select Committee’s Inquiry into Elder Abuse - April 2004).

This definition may be used as a guide. It does however exclude a number of adults who may have mild or moderate learning disabilities and who manage their lives relatively independently but remain exposed to risks of exploitation within their communities. It should include adults who may only be temporarily vulnerable, for example due to mental ill health that is transient.

3.2 Abuse

There have been many definitions of adult abuse. Most stress a number of common elements even if they frequently vary in emphasis and scope. The Department of Health - No Secrets Guidance, March 2000 on the protection of vulnerable adults, defines abuse as:

“a violation of an individual’s human and civil rights by another person or persons”

This global definition reflects the implementation of the Human Rights Act 1988.

The Council of Europe definition is given:

“any act, or failure to act, which results in significant breach of a vulnerable person’s human rights, civil liberties, bodily integrity, dignity or well-being; including exploitative sexual relationships and financial transactions to which the person has not, or cannot validly consent.

Abuse, whether intended or inadvertent, may be perpetrated by any person, (including another person with disabilities) and raises particular concern within a relationship based on,

- *a position of trust such as one with legal, professional or authority status*
- *unequal physical, economic or social power*
- *inequalities of gender, race, religion or sexual orientation*
- *responsibility for, and control over, day to day care*

It may arise out of poor or ill-informed practice; individual cruelty, negligence or neglect; inadequate and/or under-resourced service provision; public hostility or society’s indifference. It requires a proportional and equivalent response, one which recognises exploitation without cutting across autonomy, and which assures equitable access to support, justice and redress”.

For the purpose of these procedures and practice guidance, abuse is defined as the physical, sexual, financial, emotional or psychological harm or neglect of a vulnerable adult.

Such harm or neglect would constitute a violation of an individual's human and civil rights.

A vulnerable adult may be abused by a wide range of people including relatives, family members, professional staff, paid care workers, volunteers, other service users, neighbours, friends etc - in other words, anyone!

Abuse can take place within any context - if a person lives alone, with family, in nursing or care settings, in support services etc.

3.3 Types of Abuse

For ease of understanding, abuse is often viewed in terms of types or categories. However, it must be emphasised that abusive situations are rarely as tidy or straightforward as putting them into types or categories might suggest. Abuse may consist of a single or repeated acts over time, of one particular type or of several types. It may be physical, verbal, psychological, or an act of neglect or omission. It may occur when a vulnerable person is persuaded to enter into a transaction (sexual or financial) to which he or she has not consented or is unable to consent to. Abuse can occur in any relationship and it may result in harm to, or exploitation of, the person exposed to it.

Although some abuse comes to light through disclosure by the vulnerable adult to someone whom they trust, there are times when abuse only comes to light through situations or events that may indicate to professionals involved that all is not well.

Listed below in brief are types of abuse and some definitions.

- **Abuse in Care Settings:** Care settings include residential and nursing homes, hospitals, day centres, sheltered housing schemes, group or supported housing projects
- **Physical Abuse:** includes hitting, slapping, pushing, kicking, misuse of medication, restraint or inappropriate sanctions
- **Sexual Abuse:** includes rape and sexual assault or sexual acts to which the vulnerable adult has not consented, could not consent to, or was pressured into consenting

- **Psychological or Emotional Abuse:** includes threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks
- **Financial and/or Material Abuse:** includes theft, fraud, exploitation, pressure in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits
- **Neglect/Acts of Omission:** includes ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition or heating
- **Discriminatory Abuse:** includes racism, sexism, abuse based on a person's disability and other forms of harassment, slurs or similar treatment.

Appendix 4 contains more detail of these types and provides some indicators of abuse. If staff are uncertain they should refer to the information in the appendix, or consult with more experienced or senior staff. Training should also provide further information.

3.4 Predisposing Factors

Abuse occurs for many reasons and the causes are not always understood. Some risk factors have been identified, to include:

- environmental problems - overcrowding, poor housing, lack of facilities
- financial problems - low income, dependent vulnerable adult adding to financial problems, person unable to work due to caring role, debt arrears, low uptake on benefits
- social Isolation (those abused usually have fewer social outlets than those who are not)
- history of a poor quality long term relationship between abused and abuser, a pattern of family violence may exist

- high levels of stress due to dependency issues e.g. increased dependency of the vulnerable adult, changes in personality and behaviour, unwanted changes in lifestyle for carer, lack of practical and emotional support to carer, multiple dependents to care for, lack of free time and space for carer, personal problems of carer, role reversal where for example domineering parent becomes dependent
- person who abuses has a history of mental health problems or a personality disorder or a drug or alcohol problem
- care settings where staff are inadequately trained or supervised, work in isolation or have little support from managers, where there is high staff turnover, or where staff do not interact with other professionals.

Patterns of abuse vary greatly, and may include the following:

- Serial abuse where perpetrator seeks out and grooms vulnerable adults - sexual abuse and some forms of financial abuse fall into this pattern
- Long term abuse in context of family relationships e.g. domestic violence
- Opportunist abuse e.g. theft of property left lying about
- Situational abuse resulting from build up of stress or because of challenging behaviour
- Neglect if carer cannot respond to care needs
- Institutional abuse (see above 'abuse in care settings')
- Unacceptable 'treatments' or programmes which may include sanctions or punishments such as withholding food and drink, seclusion, inappropriate use of control and restraint, misuse of medication
- Failure of agencies to ensure staff receive appropriate training and guidance on anti-discriminatory and anti-racist practice
- Misappropriation of benefits or misuse of vulnerable adult's money, fraud or intimidation with respect to finance, property, wills etc

4 INTERVENTION

4.1 Role of Social Services and the Police

Generally Social Services will lead the investigation unless there is a criminal investigation, in which case the Police will lead. However, if the investigation demands criminal intervention and social care then it will be a joint responsibility. The role of the lead agency is to:

- co-ordinate the investigations of any allegation or suspicions of abuse of a vulnerable adult;
- act as the contact point for collating information about the victim, the perpetrator and circumstances surrounding the alleged abuse incident(s); and
- lead the consultation process, in deciding who should be interviewed, at what time and how.

Social Services will always be responsible for organising relevant planning meetings or case conferences. Referrals of adult abuse will normally be made to Social Services in the first instance unless there is clear evidence of a criminal offence having been committed when a direct report should be made to the Police.

The police will investigate possible criminal offences, but this will not prevent Social Services carrying out its duty to identify and meet the needs of vulnerable adults.

It is the role of Social Services to ensure that the investigation takes place through these agreed Multi-agency Policy, Procedures and Practice Guidelines.

The role of investigation is primarily the responsibility of the Police and Social Services although other agencies ie. such as Care Quality Commission, may be requested to assist in an investigation, where appropriate.

4.2 Role of other Agencies including non statutory sector

Generally if a member of staff within an establishment or an agency suspects or is informed of an incident or incidents of adult abuse, they should consult with their line manager and decide whether a referral should be made to Social Services or Police. Dependent on the circumstances there may be issues about the vulnerable adult consenting to a referral and what to do if the

vulnerable adult does not consent. There is a section relating to this in appendix 3 with more detail. If unsure, staff should discuss with their line manager, who should consult with Social Services for advice. Advice may be sought without giving any details of the vulnerable adult that would breach confidentiality.

The establishment/agency making the referral should give as much information as possible using the Alerter Form (see appendix 1) following up any verbal referrals in writing. The referring agency will be informed as to the decision and outcome of the referral. Depending on the extent of their involvement with the vulnerable adult, the alerting agency may have a role in the investigation, which will be determined by Social Services and/or Police e.g. as an advocate, or translator if the vulnerable adult has communication difficulties etc.

The Care Quality Commission has a monitoring role and there are certain circumstances when they should be informed of an incident (when the incident takes place in a registered environment e.g. residential care/domiciliary care setting).

4.3 General Guidance on Intervention for all Agencies and Staff

Abuse can take many forms and staff working with vulnerable adults may need to consider whether something may be abusive. It is often difficult for staff working with adults to know when a situation is one of abuse or not, especially if the person is not able or willing to explain what is happening to them. Quite often the seriousness or extent of abuse is not clear when concerns are first raised or expressed. It is very important therefore to approach reports or incidents of abuse with an open mind. Advice should always be sought from line managers who may wish to take advice from Social Services or Legal Services. An assessment of the significance of the incident or allegation needs to be made. Some factors that may be considered to aid decision-making might be:

- how **vulnerable** is the person?
- what is the **nature and extent** of the abuse?
- how long has it been happening?
- what is the **impact** on the person?
- is there a risk of this being **repeated** on either this person or others, and is it likely to get more **significant** as time goes on?
- what are the **wishes and feelings** of the person?

The multi-agency procedures should be used to ensure appropriate action is considered and taken. This should complement professional judgement of the situation. See Part Two of this multi-agency guidance for detail on alerting and referring alleged abuse.

The rights and welfare of the person must always take priority during an investigation, however when the alleged abuser is also a vulnerable adult, their rights and welfare should also be promoted. If the alleged abuser is a parent or carer, consideration must be given to their right to have their needs assessed and receive support.

Generally, the wishes and feelings of the vulnerable adult are central to the application of these procedures. If the vulnerable adult is not felt to have the capacity to make this decision, then the investigating team may need to take other appropriate action to make a decision on their behalf. If the vulnerable adult does not wish the matter to be taken further, providing they have the capacity to make this decision, it should be respected, however difficult this may be to accept. There are exceptions to this, in respect of capacity and public interest and further advice should be sought before taking action. Risk taking has a positive side in that it allows adults to maintain greater independence, but those professionals involved with the individual concerned should identify the risk(s), manage such risk taking, and ensure that all decisions are recorded appropriately.

Staff may find that they have no power to:

- gain access to a particular adult;
- to remove the adult or the alleged perpetrator from a risk situation;
- to investigate the financial affairs of a vulnerable adult;
- otherwise intervene positively.

The respect given to the rights and wishes of vulnerable adults and the actions taken to promote their quality of life inevitably means that Public and Independent Sector Bodies must at times accept that individuals can choose to live without services or in circumstances where they remain at risk.

In these circumstances, staff should continue, to monitor levels of risk and support the vulnerable adult as far as possible. Agencies should have followed these guidelines as far as possible, have made every effort, along with other agencies, to positively intervene to protect the vulnerable adult, and have sought legal advice.

At some stage an acceptable risk may become an unacceptable risk and action may be required to protect the vulnerable adult. These decisions must be made in conjunction with appropriate line managers and with the vulnerable adult concerned, where appropriate. Any decision to refer to Social Services must be recorded, especially if this is against the wishes and feelings of the vulnerable adult involved. Agencies should refer to their own risk assessment and management procedures, and seek legal advice if necessary, especially if considering making a referral against the wishes of the vulnerable adult involved.

4.4 Investigation Process/ Outcome-dissatisfaction

If at any stage after having made a referral in respect of a vulnerable adult you are dissatisfied with either the process of the investigation or the outcome, please report your concerns to the relevant local authority or Police to whom the referral was made.

Any report will be if required dealt with through individual agencies complaints process and if necessary referred to the Safeguarding Adults Board Case Review Protocol.

1. INTRODUCTION

This part of the procedure sets out what is expected of those who come into contact with vulnerable adults so that each person knows what their responsibilities are and to whom they should report. In this context it could include for example, care staff, volunteers or anyone who may be involved in the care provision for vulnerable adults.

This section of the procedures should form the basis for guidelines and procedures which Care Agencies need to have in place in order to protect and safeguard the service users to whom they provide a service.

This section should provide a basis for induction and ongoing training and awareness and be available for staff to refer to at all times.

Appendix 4, Key categories of Abuse and the process of dealing with an allegation or suspicion of abuse of a vulnerable adult goes through a number of distinct stages. The process has been divided into the stages of:

- Alerting
 - Referring
 - Decision making
 - Investigating
 - Monitoring
- } Summarised only as they are the responsibility of Police and Social Services - appropriate Adult Services Team.

The first two stages are examined in the following sections.

The procedures inevitably concentrate on the early stages of responding to allegations of abuse and the process of making decisions.

The protection of vulnerable adults from abuse should always receive high priority from all agencies involved. Concerns or allegations about abuse should be reported without delay.

2. ALERTING

The aim of this procedure is to **prevent** the abuse of vulnerable adults and **support** individuals to come forward to report any suspected abuse. It is important that all concerns about possible abuse, however trivial, should be reported. Particular awareness should be paid to those adults where concerns have been expressed previously or where the service user has been assessed as being at risk of abuse.

Managers need to ensure that a policy and guidelines on Whistle Blowing are in place. A template is provided for guidance (see appendix 6)

Staff need to be aware of this policy and be confident that the reporting of abuse/bad practice of any other worker in the agency made in good faith will be treated seriously and be investigated.

Staff also need to be confident that they will be supported by the relevant agency following the reporting of any incident made in good faith.

It is essential that managers have in place individual service user plans drawn up in conjunction with service users if possible, which highlight and identify other potential risk factors.

All staff have a duty to recognise abusive situations and should report concerns to their relevant manager, to allow a discussion to take place around whether a referral should be made and by whom.

The first priority is to ensure the safety and protection of vulnerable adults. It is the responsibility of all staff to act on any suspicion or evidence of abuse or neglect and to pass on concerns.

Staff should:

- **know and recognise all types of abuse (see appendix 4.)**
- **be alert to and aware of signs of abuse at all times**
- **inform their line manager immediately if they suspect abuse has or is taking place**
- **inform another senior manager immediately if they suspect that the abuser is their line manager**
- **use the “Whistle Blowing” procedure**

Action that should be taken if someone reports that there has been or suspects there may have been instances of abuse or in the event of a service user disclosing that they are being abused:

STEPS

DELEGATION

STEP 1

- Remain calm and non-judgemental
- Take whatever action is required to ensure the immediate safety or medical welfare of the adult
- Do not discourage from disclosure
- Use active listening skills
- Remain sympathetic and attentive
- Give reassurance but do not,
 - press for more detail
 - make promises that cannot be kept

Person discovering or informed of actual or suspected abuse

STEP 2

- Clarify main facts, summarising what has been disclosed to you
- Explain that you cannot keep information about alleged or suspected abuse confidential
- Remain sensitive
- Explain that a line manager must be informed
- Seek the person's consent to share this information (see appendix 3)
- Offer future support from yourself or others (keyworker or advocate)

Person discovering or informed of actual or suspected abuse

STEP 3

- Take all reasonable steps to ensure that the adult is in no immediate danger of further harm
- Make a complete and accurate record of events as soon as possible
- Record facts not opinions. Use person's own words, record date, time and sign
- Preserve evidence
- Line Manager or other appropriate manager must be informed as soon as possible
- Remember "duty of care"

Person discovering actual or suspected abuse

STEPS

STEP 4

- Relatives of the victim should not automatically be informed if the victim is able to consent unless they so wish
- If the victim lacks capacity the decision to share information with family, friends or significant others should be made by the relevant manager following consultation with the lead agency ie Social Services or Police
- Informed consent should be obtained but it may be necessary to override this if there are other vulnerable adults at risk eg in a residential setting/hospital ward
- Information must always be shared on a need to know basis (see appendix 3)
- It is inappropriate for agencies to give assurances of confidentiality where there are concerns of alleged or suspected abuse
- If the alleged abuser is a family member or friend they should NOT be contacted at this stage.

STEP 5

The line manager must on receiving information regarding an allegation or suspicion of abuse, check that:

- The adults immediate needs are being met, and that there is no risk of further harm
- If necessary, medical assistance has been sought
- The facts and circumstances are clear, but avoid unnecessary discussion with the victim
- A report has been made to the Police if a criminal offence is suspected or alleged,

DELEGATION

*Line Manager/
Relevant Manager
according to agency
procedures*

*Line Manager/
Relevant Manager
according to agency
procedures*

STEPS

The manager must:

- Assess whether the victim is able to give consent (see appendix 3)
- Make a referral. If there are several victims, a separate referral must be completed for each one
- Report the alleged abuse within 24 hours to Social Services or the Police when appropriate or out of hours to the Social Services Emergency Duty Team
- Ensure that a clear, accurate and factual record is kept
- Consider implementing the agency's disciplinary procedure if appropriate, when the alleged abuser is a staff member. You must follow previous steps and inform the Care Management Team as soon as possible.

Subsequently:

- Consider making referral to POVA register, (see appendix 8)
- For Regulated Care Settings complete Regulation 37 form and send to Care Quality Commission.
- Complete Accident form (if applicable)

Note: In cases where particular difficulties are experienced in communicating with the adult, steps must be taken to overcome these, eg by ensuring the adult has access to appropriate assistance (translation services/interpreter/ intermediary). It should be made clear to any person providing assistance at this stage that their role is supportive and not investigative.

DELEGATION

Relevant manager

All agencies to complete alerter form

EXCEPT *Social Services and the Police*

STEPS

STEP 6

Procedure following the submission of the alerter form:

- Upon receipt of the alerter/referral form, the Care Management Team Leader or Safeguarding Team Leader will, after discussion with the Police, decide on the appropriate action, ie NFA, Social Services alone (social care issues only) investigation or Police alone (criminal offence apparent only) investigation, or a joint Social Services and Police (both elements) investigation.
- The Safeguarding Adult investigation will involve an initial Strategy Meeting and the appropriate agencies/workers will be invited.
- For a Social Services led investigation, a Social Services worker will be assigned to investigate the alleged abuse, and this may be done in partnership with Care Quality Commission.

The result of any investigation will be given to the person/agency who made the initial referral. This will include the agreed Safeguarding Protection Plan if appropriate.

**ACTION TO BE TAKEN IF SOMEONE REPORTS/DISCLOSES ABUSE OF
A VULNERABLE ADULT**

ENSURE THE PERSONS IMMEDIATE SAFETY AND MEDICAL WELFARE

**LISTEN, BE ATTENTIVE AND SYMPATHETIC BUT DO NOT DISCOURAGE
OR PRESS FOR MORE DETAIL.**

**CLARIFY AND SUMMARISE
REMAIN SENSITIVE – DON'T MAKE PROMISES THAT CANNOT BE KEPT**

**EXPLAIN THAT A MANAGER MUST BE INFORMED (UNLESS THEY ARE
THE ALLEGED ABUSER).**

**MAKE A COMPLETE, FACTUAL AND ACCURATE RECORD OF WHAT YOU
HAVE BEEN TOLD – RECORD TIME, DATE, THEN SIGN.**

PASS TO A MANAGER IMMEDIATELY OR AS SOON AS POSSIBLE



MANAGER WILL:

- **ENSURE THE SAFETY AND WELFARE OF THE PERSON WHO HAS DISCLOSED THE ALLEGED ABUSE.**
- **REPORT THE ALLEGED ABUSE TO THE POLICE OR SOCIAL SERVICES CARE MANAGEMENT TEAM (WITHIN 24 HOURS) OR EMERGENCY DUTY TEAM.**
- **SEND 'ALERTER FORM' TO CARE MANAGEMENT AND DISCUSS WITH THEM THE INTENTION TO IMPLEMENT THE AGENCIES DISCIPLINARY PROCESS IF APPROPRIATE**
- **INFORM CARE QUALITY COMMISSION (REG 37)**
- **CONSIDER A REFERRAL TO POVA LIST (See appendix 8)**
- **COMPLETE ACCIDENT RECORD IF APPROPRIATE**
- **LIAISE WITH FAMILY/OTHER AGENCIES ETC AS APPROPRIATE.**
- **CONSIDER ISSUES OF CONSENT.**

REMEMBER "DUTY OF CARE"

SOCIAL SERVICES AND POLICE: WHAT HAPPENS NEXT?

1. INTRODUCTION

The following gives brief details as to what happens after a referral is made to social services concerning an allegation of abuse against a vulnerable adult. The purpose is to inform Health Trusts, independent providers of care (residential/domiciliary), the voluntary sector including other professionals involved in the care of the process and their role within it.

The forms to be used by Social Services and Police are in appendix 1, Form 1. Their detailed procedures are available within their own in-house procedure manuals.

2. SOCIAL SERVICES PROCEDURES

Stage 1



Referral to Customer Services Centre
(See Part Two “Procedures for All Agencies” above)
Social Services complete Form 1

Stage 2



Social Services and Police liaise to agree action to be taken, involving others as necessary and possibly the referrer
(Commence Progress Checklist & Form 2)
Decision made at an Safeguarding Strategy Meeting
(in person or by phone)

Stage 3



Action may include:

- No action if vulnerable adult does not consent or allegation appears unfounded
- Safeguarding vulnerable adult and others
- Changing vulnerable adult's service
- Medical attention if necessary
- Investigation either by Police or Social Services together or separately. This may include video interviewing
- Referral to Care Quality Commission if the allegation takes place in a regulated setting
- Disciplinary proceedings if employees are involved

Form 3 should be completed

Stage 4



Following the action or investigation, Social Services and Police, with relevant others, will consult as to any further action needed.

This may include:

- criminal prosecution of alleged abuser, and/or
- disciplinary action, if a staff member,
- referral to POVA list.

For the victim it may include a protection plan, change of service, or ongoing support. This may be agreed at an Safeguarding Conference.

Stage 5



All parties must be informed of the outcome

Form 4 (or electronic equivalent) and Progress Checklist must be completed

3. POLICE PROCEDURES

1. The purpose is to provide guidance for Police Staff in relation to their responsibilities relative to the 'Safeguarding of Vulnerable Adults - Multi-agency Policy, Procedures and Practice Guidelines for the Protection of Vulnerable Adults'.

2. The intention is to ensure that vulnerable adults, that is, a person aged 18 years or over;

'Who is or may be in need of community care services by reason of mental or other disability, age or illness, and

Who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'

Who become victims of crime, are protected and able to fully participate in the justice system.

3. Whilst the Police are one of the key players in these procedures eg. in relation to the investigation of any alleged criminal offence the lead agency is the Local Authority Social Services, Adult Care Management.

4. Decision making in relation to referrals will be the Duty Inspector in their absence/unavailability - any inspector (referral decision maker)..

5. The Duty Inspector will perform the referral procedure.

If a member of the public/residential home staff/relative etc reports an incident where the victim is as defined above or an officer attends to such an incident and there is no immediate response requirements eg lives at risk, risk of serious injury or loss to property, then the matter should be referred to a referral decision maker.

In cases where serious crime is suspected (for example rape of an elderly female resident whilst in a nursing home) the Duty Detective Inspector will be informed without delay with all efforts made in terms of evidence.

6. If an incident of this nature is initially dealt with by another agency and the decision is to seek a referral with the Police they will contact a decision maker directly or will make contact with the appropriate command centre.

7. In the latter instance an incident log will be created and if immediate resourcing is required then appropriate action will be taken. In other cases the matter will be referred, as soon as practicable to a relevant referral decision maker.

The Officer receiving and completing the referral will be responsible for ensuring appropriate initial action is taken without delay:

All processes surrounding such a transfer should be recorded on the file and the referring agency updated.

Full guidance for Police Officers can be obtained from the force intranet site practice direction/crime/victim care.

APPENDICES

- APPENDIX 1** **FORMS**
- Alerter/Initial Referral form - sections 1 to 4
 - Section 5 - Decision Making
 - Section 6 - Result of Investigation
 - Section 7 - Monitoring Form Vulnerable Adults
 - Investigation - Guidance Template
 - Referral Progress Checklist
 - Form 3A - Consent to information sharing with other agencies
- APPENDIX 2** Local Points of Referral and Other Statutory Agencies
- APPENDIX 3** Guidance Notes on Consent, Confidentiality and Information Sharing
- APPENDIX 4** Key Categories of Abuse and Indicators
- APPENDIX 5** Safeguarding Adult Arrangements (Hull and East Riding)
- APPENDIX 6** Protocols
- (i) Inter-authority investigations*
 - (ii) Care Quality Commission protocol*
 - (iii) Case Review protocol*
 - (iv) Multi-agency information sharing protocol*
- APPENDIX 7** Whistleblowing Policy Template
- APPENDIX 8** POVA Guidance and Referral form
- APPENDIX 9** Staff Training Notes
- APPENDIX 10** Mental Capacity Act and Deprivation of Liberty Standards
- (i) MCA Assessment of Capacity form*
 - (ii) MCA Best Interests form*
 - (iii) DoL Assessment of Capacity form*
 - (iv) DoL Best Interests form*

SAFEGUARDING ADULTS - ALERTER / INITIAL REFERRAL FORM
Please complete ALL details in Sections 1 - 2 and 3 - 4 as fully as possible

Section 1 - Details of Adult being referred

Name:		Age/Date of Birth:		
Usual address:		Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>		
Tel:		Ethnicity:		
Current location: (if different from above)		<input type="checkbox"/> White/ White British		
		<input type="checkbox"/> Mixed		
		<input type="checkbox"/> Asian /Asian British		
		<input type="checkbox"/> Black or Black British		
		<input type="checkbox"/> Chinese		
		<input type="checkbox"/> Other Ethnic group		
		<input type="checkbox"/>		
Known to LA Adult Care Services		GP name:		
<input type="checkbox"/> Yes <input type="checkbox"/> No		Address:		
LA: <input type="checkbox"/> Hull <input type="checkbox"/> East Riding of Yorkshire			
LA Team/worker		Tel:		
LA Subject ID/ PID				
Care Services provided:				
Service User Group (tick all which apply)	Learning Disability	Physical Disability	Older Person	
	Mental Health	Substance Misuse	Sensory Impairment	
	Temporary Illness	Frailty	Other	
Type of Abuse (tick all which apply)	Physical	Sexual	Financial	Neglect
	Psychological	Institutional	Discriminatory	Other
Referring Agency/ Person	LA - Adult Care Services	LA – Emergency Duty Team	Police	CSCI
	Health - PCT	Health - MHT	Health – Acute Trust	Independent Provider
	Voluntary Sector	Family/ Friend	Housing	Other/ specify

Section 3 - Details of Alleged Perpetrator

Name:		Age/Date of Birth:		
Address:		Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>		
Tel:		Ethnicity:		
Known to LA Adult Care Services <input type="checkbox"/> Yes <input type="checkbox"/> No LA: <input type="checkbox"/> Hull <input type="checkbox"/> East Riding of Yorkshire LA Team/worker LA Subject ID/ PID Care Services provided:		<input type="checkbox"/> White/ White British <input type="checkbox"/> Mixed <input type="checkbox"/> Asian /Asian British <input type="checkbox"/> Black or Black British <input type="checkbox"/> Chinese <input type="checkbox"/> Other Ethnic group <input type="checkbox"/>		
Relationship of victim to alleged perpetrator	Husband/Wife/ Partner	Son/Daughter	Friend/ Neighbour	Stranger
	Paid carer	Practitioner	Volunteer	Other (specify)
Does the alleged perpetrator provide care to the victim or to any other person(s)? If so, please give details:				
Do you have any concerns about other adults or children being at risk from the alleged perpetrator? If so, please give details:				
Is the alleged perpetrator aware of the allegations? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is the alleged perpetrator thought to be vulnerable? If so, please give details:				

Section 4 – Consent and Actions taken

Consent to referral	
Is the victim aware of a referral being made?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the victim consented to a referral to Social Services / Police?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Victim does not have capacity to consent	<input type="checkbox"/>
(Attach Assessment of Capacity Form if completed)	
Please give reasons for any decisions to refer without consent:	
Summary of Actions taken by Referring Agency	
Action taken (including details of disciplinary action if appropriate)	
Immediate safety – details of any measures taken to secure the alleged victim's immediate safety, including new or changes to existing service provision	
Medical - details of any medical attention provided or required by the alleged victim	
Any other information	

Section 5 - Decision Making

Has the alleged victim or perpetrator been the subject of previous adult protection referrals?		
Victim	No <input type="checkbox"/>	Yes <input type="checkbox"/> Not Known <input type="checkbox"/>
Details:		
Perpetrator		
No <input type="checkbox"/>	Yes <input type="checkbox"/>	Not Known <input type="checkbox"/>
Details:		
Have previous referrals been made in respect of this care setting?		
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Known <input type="checkbox"/>
Details:		
Summary of consultations / strategy discussion		
Outcomes		
Summary of action: by whom and time scales		
Strategy meeting to be held		
Immediate investigation		
No further action (reason)		
IMCA referral?	YES/NO	Advocate:
Information Sharing		
Agency advised	Date contacted	Comments
Decision Makers		
Adult Care Services Manager		
Adult CMT/contact number		
Police Officer		
Location/contact number		

Section 6 - Result of Investigation

Summary to be completed by investigator(s) and sent or relevant Adult Care Services manager after appropriate level decision concerning prosecution or otherwise

Section 7**CONFIDENTIAL - SAFEGUARDING ADULTS PERFORMANCE / DATA
COLLECTION MONITORING FORM**

(To be completed by Local Authority Adult Care Services and submitted to the Manager, Safeguarding Adults Board as soon as outcome of investigation is known)

Name		Date of Birth			
Address		Age Banding			
		18 - 64	65 - 74	75 - 84	85+
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Initial Referral			
Contact/PID Number		Police Reference			
Client Group (tick as many as apply)	Learning Disability	Physical Disability		Older Person	
	Mental Health	Substance Misuse		Sensory Impairment	
	Temporary Illness	Frailty		Other	
Ethnicity	White (British, Irish, any other white background)				
	Mixed (White and black Caribbean, white and black African, white and Asian, any other mixed background)				
	Asian or Asian British (Indian, Pakistani, Bangladeshi, any other Asian background).				
	Black or Black British (Caribbean, African, any other black background)				
	Chinese				
	Other Ethnic Group				
Religion					
Referring Agency / Person	LA - Adult Care Services	LA - Emergency Duty Team	Police	CSCI	
	Health – PCT	Health – MHT	Health – Acute Trust	Independent Provider	
	Voluntary Sector	Family/Friend	Housing	Other (please specify)	
Type of Abuse (tick as many as apply)	Physical	Sexual	Financial	Neglect	
	Psychological	Institutional	Discriminatory	Other	

Relationship of Victim/ Perpetrator	Husband/Wife Partner	Son/ Daughter	Friend/ Neighbour	Stranger
	Paid Carer	Practitioner	Volunteer	Other (please specify)
Location of Abuse	Own Home	Residential Home	Hospital	Nursing Home
	Day Service	College/Adult Education/Work	Leisure/Social Activity	Other (please specify)
Services Provided	Residential Care	Nursing Care	Home Care	Respite Care
	Day Services	Direct Payments	Supported Living	Other (please specify)
Agencies involved in Investigation	LA Adult Care Services	Police	CSCI	Housing
	Independent Sector	Voluntary Sector	Health	Other (please specify)
OUTCOME OF INVESTIGATION				
Result of investigation	NFA		Abuse founded	
	Abuse Unfounded		Inconclusive	
Outcome for Victim/Perpetrator (eg) increased services, criminal prosecution, case conference etc				
Additional Comments:				
DECISION MAKERS				
Adult Care Services Manager				
Adult CMT/contact number				
Police Officer				
Location/contact number				

SAFEGUARDING ADULTS INVESTIGATION - GUIDANCE TEMPLATE

Name of person referred: _____ **Date of Birth:** _____
Address: _____

Significant Family Members and Other Significant Contacts (please indicate any alleged perpetrator)

Name	Address	Age/Date of Birth	Relationship/Legal Responsibilities

Lead Agency: LA Adult Care Services Police Joint

Name of Investigating Officer(s)	Agency	Time/Date Allocated(s)

Interviews – who will be interviewed, by whom and when? What arrangements will be made to take account of any special needs of interviewees?

Medical – is any examination required? Yes No
 What arrangements will be made?

Legal – details of any legal action that needs to be taken.

**Hull & East Riding Adult Protection RESULT OF INVESTIGATION
Summary to be completed by investigator(s) and sent to relevant LA Adult
Care Services Manager after appropriate level decision concerning
prosecution or otherwise**

VULNERABLE ADULTS REFERRAL PROGRESS CHECKLIST

	Name of Client	LA Subject ID/PID	Team
		Date	Notes
1	Alerter /Initial referral form received (Sections 1-4)		
2	Consent issues considered and obtained -'Assessment of Capacity' form if required		
3	Decision Maker decides what further action is needed Section 5 to be completed		
4	If decision is not to progress investigation then give brief reason why in writing. (consider the need for a formal risk management meeting)		Within 24 hours of receiving the referral
4a	Update the alerter		
5	Section 5 – preliminary checks/previous history to be completed. Strategy discussion or meeting with the Police. Decision: Joint Investigation Y / N Police only Y / N Adult Care Management only Y / N No Further Action Y / N		Within 24 hours of receiving the referral
6	Investigation Plan to be drawn up. (see Safeguarding Adults Investigation Guidance/Template) Investigating Officer(s) appointed: Name(s) & Agency:		ASAP within 3 days (within 24 hours if urgent response is required)
6A	Investigation commenced including interview of vulnerable adult		
6B	Investigating Officer writes report with recommendations.		
7	Decision Maker(s) considers report and decides further action to be taken.		Within 10 days (where applicable)
8	Adult Protection Case Conference arranged (where applicable)		
9	Adult Protection Plan produced (if agreed at Case Conference)		
10	Outcomes to be completed. ALL parties involved informed of outcome of investigation including Service User/ Alerter, other agencies etc		Indicate which: In person/ Letter/phone for each
14	Section 7 - Performance /Data Collection Monitoring Form Complete and send to the Manager, Safeguarding Adults Board		
Signature of Decision Maker: Signature of Investigating Officer: Team: Copy of the form to be kept on the case file			

Section 2 - Form 3(A)
Hull & East Riding Safeguarding Adults
CONSENT TO INFORMATION SHARING WITH OTHER AGENCIES
Consent to the Disclosure and Sharing of Information

The Safeguarding Adults Procedures require that statutory agencies (e.g. social services, police, and health services) and anybody caring for you work closely together in order to ensure that your welfare and safety are safeguarded.

In order to do this effectively, information held about you by one agency or organisation may need to be shared with one or more other agencies/organisations. It may also be necessary to contact other organisations/agencies for information about you.

Information will only be shared with those people who need to know for the purpose of deciding what action should be taken under these procedures to protect you, or other people. All information shared in connection with these procedures will be kept confidential and not used for any other purpose. Similarly we will contact only those agencies necessary for information about you needed in order to protect you or others.

In general the Data Protection Act 1998 protects your right to privacy and requires that your permission is needed before confidential information about you held by a statutory agency or other organisation is disclosed to a third party. However, you should be aware that the Act allows that confidential information can be disclosed in limited circumstances, for example to protect the vital interests of an individual.

You are asked to sign the declaration below to confirm that you understand about the need to give/share information, and whether or not you agree to this being done.

Please tick appropriate box:

- I agree that statutory agencies and people/organisations who provide services that I use can share information that they have about me in order to help with the Safeguarding adult enquiry.
- I agree that information about me can be requested from other agencies in order to help with the safeguarding adult enquiry.
- I agree to the above but with the following restrictions:

- I do not consent to any information being obtained about me or shared with others.

Name:

Signed:

Date:

If this decision is to be overridden. full notes of reasons why should be given on form.
If the person is unable to give consent, use "Assessment of capacity form" instead

APPENDIX 2 LOCAL POINTS OF REFERRAL AND OTHER STATUTORY AGENCIES

1. POINTS OF REFERRAL

1.1 East Riding of Yorkshire Council

SINGLE POINT OF ACCESS

Social Services	‘Duty officer’	01482 861103 (Tel) 01482 866265 (Fax)
Safeguardingadultsteam@eastriding.gov.uk Address: 65 Keldgate, Beverley, HU17 8HU		
Emergency Duty Team		01482 880826
Call Centre		01482 393939
Humberside Police/Public Protection Unit (East Riding)		01430 80840 808405/416/417

Customer Care Centres

Anlaby (17 Hull Road, HU10 6SP)	Tel: 01482 883150
Beverley (Cross Street, HU17 9BA)	Tel: 01482 883400
Bridlington (Town Hall, Quay Road, YO16 4LP)	Tel: 01262 422500
Cottingham (Civic Hall, Market Green, HU16 5QQ)	Tel: 01482 883500
Driffield (Council Offices, West Garth, YO25 7TP)	Tel: 01377 255536
Goole (Council Offices, Church Street, DN14 5BG)	Tel: 01405 722000
Hessle (Peeler House, Ferriby Road, HU13 0RQ)	Tel: 01482 883130
Hornsea (75 Newbegin, HU18 1PA)	Tel: 01964 537060
Pocklington (Burnby Hall, YO42 2QQ)	Tel: 01759 302298
Withernsea (243 Queen Street, HU19 2HH)	Tel: 01964 614477

Children, Family and Adult Services

West - District 1 (Wolds/Dale Adults Care Management Team (Burnby Hall, The Balk, Pocklington YO42 2QF)	Tel: 01759 304699
West - District 2 (Goole/Howden) (Council Offices Church Street, Goole DN14 5BG)	Tel: 01482 396842 396861
East - District 3 (Beverley Rural/Haltemprice (3 Eastgate, Hessle HU13 9NA)	Tel: 01482 640131
East - District 4 (Beverley Minster/South Holderness) (Council Offices, Skirlaugh HU11 5HN)	Tel: 01482 396532
North - District 5 (Driffield/Bridlington North) (Council Offices, Westgarth, Driffield YO25 6YP)	Tel: 01482 396791

Adult Protection Policy, Procedures and Practice Guidelines for Hull and the East Riding of Yorkshire

(Bayle View, Long Lane, Bridlington YO16 4LP Tel: 01262 401488
North - District 6 (Bridlington South/North Holderness) Tel: 01482 396761
(Town Hall, Quay Road, Bridlington YO16 4LP)
Castle Hill Hospital - Social Services Hospital Team Tel: 01482 623056
(Castle Hill Hospital, Cottingham HU16 5JQ)

Hull City Council

SINGLE POINT OF ACCESS

Social Services 01482 374137 (Tel)
01482 708447 (Fax)

Socialservicesafeguardingserviceadults@hullcc.gov.uk

Address: Pashby House, 69 James Reckitt Avenue, HU8 7TH

Emergency Duty Team 01482 788080

Call Centre 01482 300300

Humberside Police/Public Protection Unit (Hull) 01482 307220

Care Management - Adult Services

Central Hull (*48 Pearson Park, HU5 2TG*) Tel: 01482 493164

East Hull (*including Longhill and Stoneferry*) Tel: 01482 374137

(*Pashby House, 69 James Reckitt Avenue, HU8 7TH*)

North Hull (*including OPE, North Hull, Bransholme*) Tel: 01482 822819

and Sutton) (*49 Kinloss Garth, Bransholme, HU7 4LY*)

West Hull (*Lindsey Place, Arcon Drive*) Tel: 01482 572911

Anlaby Road, HU4 6AJ)

Hull Royal Infirmary (*including Princess Royal Hospital*) Tel: 01482 605220

(*Anlaby Road, HU3 2JZ*)

1.3 Humberside Police

Northern Communications Centre Tel: 0845 6060222

1.4 Care Quality Commission

National Contact Centre 03000 616161

1.5 Safeguarding Adults Board (Hull & East Riding of Yorkshire)

Room BF54A, County Hall, Cross Street, Beverley, HU17 9BA

Manager: Steve Clay 01482 396410

APPENDIX 3 GUIDANCE NOTES ON CONSENT, CONFIDENTIALITY AND INFORMATION SHARING

General

Generally and also within procedures for the protection of vulnerable adults, most actions require the consent of the individual concerned.

The types of consent within vulnerable adults procedures may include consent to the investigation being initiated (person is agreeing to needs being assessed or circumstances being identified), to information being shared (an agreement for personal information to be given to third parties), and to intervention or treatment (to agree that physical actions can take place), if medical then the consent of a medical practitioner is also needed.

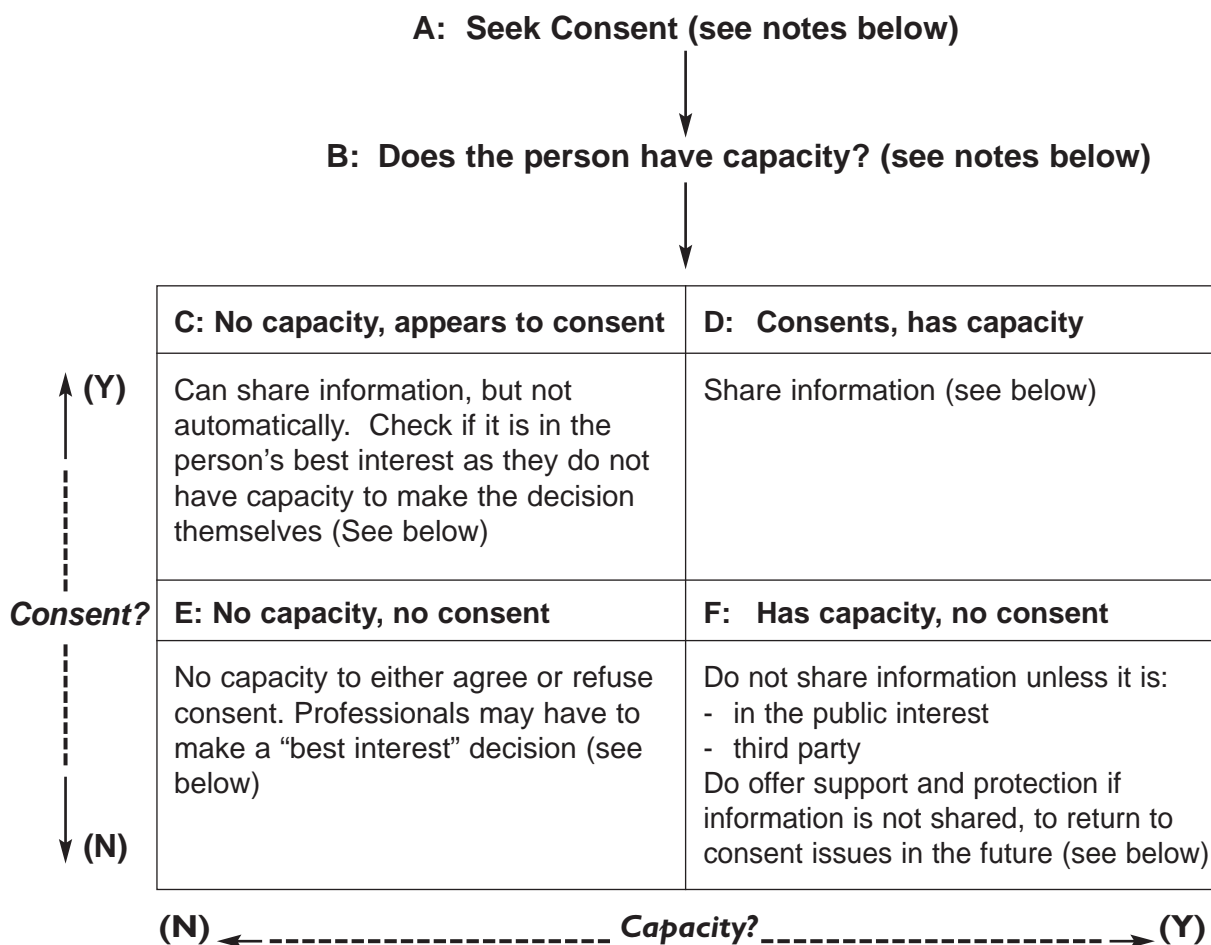
If you suspect abuse, or a person has told you about abuse, you must always seek their consent to refer or report the incident. If the person agrees that you may share information about them with others, they have given consent. If they do not agree, there are occasions when you must accept this and occasions where their wishes may be overridden. It may be that sometimes they are not able to give informed consent because they lack capacity and further information about this is detailed below.

The key principles of confidentiality are:

- information should only be shared on a need to know basis when it is in the best interest of the service user
- confidentiality should not be confused with secrecy
- informed consent should be obtained but if this is not possible and other vulnerable adults are at risk it may be necessary to override consent
- it is not appropriate to reassure absolute confidentiality where there are concerns about abuse, especially in situations where other people may be at risk.

The following notes outline general issues around consent and capacity and apply anywhere within these procedures where the consent of the vulnerable adult is required in order to pursue a course of action, be it concerning making a referral, sharing or gathering information, or planning for the individual.

FLOW CHART TO ASSIST DECISION MAKING ON CONSENT AND CAPACITY



A Seek consent

Consent should generally always be sought. Consent is a process and should be informed - this means giving the person sufficient information at a level and in a way appropriate to their needs such that they can choose whether or not to consent. Consent should be sought for a specific action or act of information sharing, and the person should always know what is being shared, when and with whom in order to make the right choice.

There are different levels of consent, as follows:

- Overall: agreement to share information freely with relevant parties
- Restricted: requests to withhold some information or information from some parties
- Withheld: refusal to share information
- Unobtainable: person cannot give consent due to issues of capacity

Sometimes it might not be appropriate to gain consent immediately, being too detrimental to the health or wellbeing of the person, for example if the incident has just happened, or if treatment is the main priority, or if the person is in shock. If that is the case it should be noted with reasons why consent was not obtained, and it should then be sought retrospectively.

THE ISSUE OF OBTAINING CONSENT SHOULD NEVER BE IGNORED.

B Does person have capacity?

ALL ADULTS ARE PRESUMED TO HAVE LEGAL CAPACITY UNLESS THERE IS CLEAR EVIDENCE TO THE CONTRARY

Capacity can be transient, it may depend on the decision being made - for example, some people can make simple decisions but not complex ones.

If there is any doubt, there should be an assessment of capacity - this is required to help professionals decide whether or not to make a decision on someone else's behalf.

Generally, the professional there at the time must make a decision as to the capacity of the person at that particular time and in relation to that specific issue. The professional may well be either the police officer or social worker. This decision does not require a General Practitioner or psychiatrist to be there. There are 4 stages to the decision-making:

- (1) Can the person absorb information, communicated simply and appropriately, about the pros and cons of the specific issue?
- (2) Can the person retain the information long enough to process it? For example, if they have forgotten information communicated appropriately and simply by the end of the conversation, they cannot retain it long enough to process or think about it
- (3) Can the person weigh up the pros and cons and come to a decision?
- (4) Can they communicate the decision? This means that the worker must make available whatever is necessary for the person to communicate e.g. translator, symbolic methods etc. There may be issues here for people who may have capacity but are unable to communicate them. In a very few cases, for example, people with "locked in" syndrome.

If it is thought the person lacks capacity, the form “Form for Adults who are Unable to Consent” should be used. This form evidences the decision making process, who was consulted, who was involved in the decision etc. It can be found within appendix 1 of these guidelines.

C The Person does not have capacity but appears to consent to sharing information

The person does not have capacity, so even if they consent, the professionals involved must decide whether sharing information is in the best interest of the person or not.

Others may be consulted about consent, including family and carers where appropriate, but it should be noted that NO-ONE may legally consent on behalf of another person - See Appendix 10 Mental Capacity Act 2005

In some situations the person may have made decisions at a time when they were able to do so in the form of an Advance Directive or a Living Will, and it would be good practice to observe such directions where they exist. These decisions are usually made about treatment, or accommodation or care decisions and may not be appropriate to decisions about sharing personal information.

Decisions about what action to take when a person lacks capacity should be taken in a multi agency setting, usually a Strategy Meeting. The views of relevant others including non-abusing carers should be taken into account. If a consensus of opinion cannot be reached then legal remedies via the Court may be sought.

D The person has capacity and consents

If a person clearly has the capacity to give agreement and they do so, then information may be shared as agreed with that person within the remit of that consent, and the Safeguarding Adult procedures followed.

It must be noted that consent freely given can also be withdrawn and if this is the case further decision-making may have to be made by the professionals involved (see “F” below).

Consent may be taken verbally but if possible, it is best to have it evidenced, either with the signature of the person or if this is not possible by any witnesses.

E The person does not have capacity and does not consent

As with “C” above, the very fact that the person does not have capacity means that they are unable to neither give consent or not. The decision to share information/follow vulnerable adult procedures must be made on their behalf. Such decisions must be recorded, and should take into account whether a criminal offence may have been committed and possible public interest issues.

F The person does have capacity but does not consent

This can be the most difficult position for professionals to be in. Article 8 of the Human Rights Act states that “everyone has the right to respect for his private and family life, his home and his correspondence”. This means people may make decisions that involve them risking further abuse, or that the professionals feel uncomfortable with.

It may help to consider why a person may refuse to agree to a referral and to sharing information about themselves. Information may come about through a third party, say a friend who thought the alleged victim was being physically abused by the victim’s partner. The alleged victim might not want to take it further because s/he is afraid of the partner, and it may be in time that with support the victim might change their mind.

The victim themselves might refer abuse and not want to take it further because the alleged abuser might also be vulnerable, or dependent on them, say a husband or wife with dementia. Again, professionals can advise people of their rights and give support to that person to prevent further abuse happening. For example by providing services for the victim or abuser without taking it down a vulnerable adult route. Not wanting to make a referral as a vulnerable adult does not stop someone from receiving support and care from the local authority. A rights based approach would see a vulnerable adult investigation as just one or part of other options that could be put into place to protect the victim from further harm.

If there is a link between victim and abuser that is leading the victim to refuse to consent, it may be possible to break those links in order to intervene. It is also worth considering that it is dangerous to allow the perpetrator to believe that the victim alone, controls the vulnerable adult process, and that it may be necessary for them to realise that decisions may well lie with others, for example, the police.

The consequences of not consenting should be explored with the person, as should acceptable, alternative support. They should not be left at risk or unsupported simply because they do not want to explore legal remedies to their abuse.

In such cases, the person's decision NOT to share information/make a referral/accept treatment, can only be overridden if professionals can demonstrate that to do so, would either be in that person's best interests, in the interests of others (third parties) or to prevent a crime. For example, if a person did not want to pursue the fact that their son was taking money from them any further and if they had also said that their son was taking money from their elderly neighbour, then the person's decision not to take the matter further could be overridden in the best interest of the neighbour. It is a balance between rights and risks - is the individual or anyone else at risk of harm - is a criminal activity taking place? - is there a legal obligation or power to act?

Any decision to override consent should be taken within a meeting involving people relevant to the decision - it should be part of a case conference or strategy meeting. Details of those involved should also be recorded, and the person themselves told that their decision was being overridden and why.

Such a decision to override consent is not illegal, it is made within a common law framework in the public interest of vulnerable people. It is good practice to seek consent, but not essential when local authorities are carrying out statutory functions.

On occasions it has to be accepted that a person making a bad decision is not enough justification to override that decision.

TO SUMMARISE:

- Obtaining consent demonstrates a clear respect for choice, encourages trust and enhances service delivery
- Decisions to take actions without consent should be based on assessment of risk and can be supported by relevant evidence
- Capacity to consent must be based on a case by case, decision by decision basis
- Be clear about the requirements of the law and be confident about the wishes of the client

APPENDIX 4 KEY CATEGORIES OF ABUSE AND INDICATORS

For ease of understanding, adult abuse is often viewed in terms of a number of key categories. However, it needs to be emphasised that abusive situations are rarely as tidy or straightforward as the categories suggest, (see below for definitions and indicators of abuse). Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.

Abuse usually comes to light through disclosure by the person who, sensing they are safe, confides in a trusted person. However, there are situations or events that might indicate that all is not well. Below are lists of indicators under each category of abuse. These highlight situations or events that may require closer attention. They are merely indicators - the presence of one or more does not confirm abuse and they are no substitute for a thorough assessment. However, a number of indicators may identify the potential for abuse and a need for an assessment. Typically, an abusive situation may comprise indicators from a number of key categories of abuse.

1. Physical Abuse

Physical injuries can occur where there is no satisfactory explanation, definite knowledge, or a reasonable suspicion that injury was inflicted with intent, caused through lack of care by the person having custody, charge or care of that person. This could include hitting, slapping, pushing, misuse of or lack of medication, restraint or inappropriate sanctions.

Possible indicators

Some common signs are:

- history of unexplained falls or minor injuries;
- unexplained bruising - in well protected areas, on the soft parts of the body or clustered as from repeated striking;
- unexplained burns on unusual locations or of an unusual type;

- unexplained fractures to any part of the body that may be at various stages in the healing process;
- unexplained lacerations or abrasions;
- slap, kick, pinch or finger marks;
- injuries/bruises found at different stages of healing or such that is difficult to suggest an accidental cause;
- injury, shape similar to an object;
- untreated medical problems;
- weight loss - due to malnutrition or dehydration, complaints of hunger.

2. Sexual Abuse

Sexual abuse is the involvement of vulnerable adults in sexual activities which they do not fully comprehend, to which they are unable to give consent either verbally or by their behaviour, to which they object or which may cause them harm. This may include rape, buggery, incest, indecent assault, sexual assault, acts of gross indecency or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting. Sexual acts which might be abuse include 'non-contact abuse' such as viewing pornographic material, indecent exposure, harassment (including looking), unwarranted teasing or innuendo, also 'contact abuse' such as touching breasts, genitals or anus, masturbation, penetration or attempted penetration of vagina, anus or mouth with or by penis, fingers or other objects.

Sexual abuse is very difficult to identify.

Possible indicators

Some common signs are:

- a change in their usual behaviour for no apparent or obvious reason;
- sudden onset of confusion, wetting or soiling;
- withdrawal, choosing to spend the majority of time alone;
- overt sexual behaviour/language by the vulnerable person;
- self-inflicted injury;
- disturbed sleep pattern and poor concentration;
- difficulty in walking or sitting;
- torn, stained, bloody underclothes;

- love bites;
- pain or itching, bruising or bleeding in the genital area;
- sexually transmitted disease/urinary tract/vaginal infections;
- bruising to the thighs and upper arms;
- frequent infections;
- severe upset or agitation when being bathed/dressed/undressed/medically examined;
- pregnancy in a person not able to consent.

3. Psychological or Emotional Abuse

Psychological or emotional abuse includes the use of threats, fears or bribes to:

- negate a vulnerable adult's choices, independent wishes and self esteem;
- cause isolation or over-dependence (as might be signalled by impairment of development or performance);
- prevent a vulnerable adult from using services which would provide help.

Psychological abuse includes intimidation, humiliation, a calm but very destructive attitude towards the individual, shouting, swearing, emotional blackmail and the denial of basic human and civil rights (including choice and opinion, privacy and dignity and allowing people to follow their own spiritual or cultural beliefs or choice about their own sexuality). It also covers racial abuse and harassment and/or the neglect of the cultural needs of the individual.

There are psychological consequences of any form of abuse, be it physical, financial, sexual, institutional or professional. The abused person may suffer feelings of insecurity, fear, rejection, hopelessness and loss of self-respect and self worth. Such damaging emotions inevitably affect the individual's physical and mental health.

Possible Indicators

- ambivalence about carer;
- fearfulness expressed in the eyes, avoids looking at the carer, flinching on approach;
- deference;

- insomnia/sleep deprivation or need for excessive sleep;
- change in appetite;
- unusual weight gain/loss;
- tearfulness;
- unexplained paranoia;
- low self-esteem;
- excessive fears;
- confusion;
- agitation.

In the above list, a number of the indicators present would lead one to consider whether abuse has occurred.

Possible Rights Violation Indicators

- coercion;
- causing distress by locking a person in a home or car etc;
- no visitors or telephone calls allowed;
- inappropriate clothing;
- sensory deprivation, not allowed to have hearing aid, glasses etc;
- restricted access to personal hygiene and toilet;
- lack of respect for the dependent person as an individual or because of their illness;
- carer does not offer personal hygiene, medical care, regular food and drinks;
- use of furniture and other equipment to restrict movement.

4. Financial or Material Abuse

Financial abuse of vulnerable adults can occur whenever the individual circumstances forces dependence on others. The position of dependence make a person extremely vulnerable, despite the legislation which exists to offer protection to vulnerable adults against the unscrupulous.

It involves an individual's funds or resources being inappropriately used by a third person. It includes the withholding of money or the inappropriate or unsanctioned use of a person's money or property or the entry of the vulnerable adult into financial contracts or transactions that they do not understand, to their disadvantage.

Possible indicators

- unexplained or sudden inability to pay bills;
- unexplained or sudden withdrawal of money from accounts;
- person lacks belongings or services which they can clearly afford, eg: empty fridges, new furnishings;
- lack of receptivity by the person or relative to any necessary assistance requiring expenditure, when finances are not a problem. (The natural thriftiness of some people should be borne in mind);
- extraordinary interest by family members and other people in the vulnerable person's assets;
- power of Attorney obtained when the vulnerable adult is not able to understand the purpose of the document they are signing;
- recent change of deeds or title to house;
- carer only asks questions of the worker about the user's financial affairs and does not appear to be concerned about the physical or emotional care of the person;
- the person who manages the financial affairs is evasive or uncooperative;
- a reluctance or refusal to take up care assessed as being needed;
- a high level of expenditure without evidence of the person benefiting;
- the purchase of items which the person does not require or use;
- personal items going missing from the home;
- unreasonable and inappropriate gifts.

5. Neglect and Acts of Omission

Neglect can be both physical and emotional and includes:

- the deprivation of help to perform activities of daily living;
- the failure to keep a vulnerable adult clean, warm and in as apparent good health as possible;

- the failure to provide adequate nutrition;
- the wilful failure to seek appropriate medical or health care;
- failure to adequately review and monitor the effects of prescribed medication and seek medical advice;
- under or over medication;
- refusal to abide by approved treatment on the part of the staff or carer;
- the wilful failure to intervene or consider the implications of non-intervention in behaviour which is dangerous to the individual concerned;
- allowing a person judged to lack capacity to make decisions concerning their safety or to take unwarranted and unreasonable risks.

Neglect may also occur as a result of unintentional actions by caregivers not responding as adequately to the needs of the vulnerable person as could be reasonably expected. This can occur where the caregiver lacks the physical, financial and/or mental resources to provide sufficient care, or lacks knowledge about their dependant's illness or disability and has not received guidance or support on how to care.

Possible indicators

This does not cover situations caused by self-neglect or people refusing help.

- neglect of accommodation;
- inadequate heating and/or lighting;
- poor physical condition of person, eg: ulcers, pressure sores etc;
- person's clothing in poor condition eg: unclean, wet etc;
- malnutrition;
- failure to give prescribed medication or inappropriate medical care;
- failure to ensure appropriate privacy and dignity;
- inconsistent or reluctant contact with health and social agencies;
- refusal of access to callers/visitors.

6. Abuse in Care Settings

Institutional abuse is different from other categories because it is about who abuses and how that abuse comes to pass rather than about types of harm. Abuse occurs in a relationship, family, service or institution and it can be perpetrated by an individual or more collectively by a regime.

Institutional abuse occurs when the rituals and routines in use force residents or service users to sacrifice their own needs, wishes or preferred lifestyle to the needs of the institution or service provider. Abuse may be perpetrated by an individual or by a group of staff embroiled in the accepted custom, subculture and practice of the institution or service. Abuse by professionals within the regimes of the setting is an abuse of the vulnerable person's citizenship. It is as serious as personal abuse and should be treated with the same concern. It may be reflected in an enforced schedule of activities, the curtailment of personal freedom, the control of personal finances, a lack of adequate clothing, poor personal hygiene, a lack of stimulating activities or a low quality diet - in fact, anything which treats service users as not being entitled to a 'normal' life.

Institutions may include residential and nursing homes, hospitals, day centres, sheltered housing schemes, group or supported housing projects. However, the distinction between abuse in institutions and poor care standards is not easily made and judgements about whether an incident or situation is abusive should be made with advice from appropriate professionals (eg: Care Quality Commission).

Possible indicators

- no flexibility in bed time and/or deliberate waking;
- people left on commode or toilet for long periods;
- inappropriate care of personal clothing and bedrooms;
- lack of personal clothing and possessions;
- unhomely, stark living areas;
- deprived environmental conditions and lack of stimulation;
- inappropriate use of nursing or medical procedures (eg: enemas or catheterisation);
- 'batch care' - lack of individual care plans;
- illegal confinement or restriction;
- inappropriate use of power or control;
- people referred to or spoken to with disrespect;
- inflexible services based on the convenience of the provider rather than the person receiving the services;

- undue or inappropriate physical interventions;
- service user removed from home or establishment without discussion with other appropriate people or agencies because staff are unable to manage their behaviour.

7. Discriminatory Abuse

Discriminatory abuse may be used to describe serious, repeated or pervasive discrimination which leads to:

- significant harm or exclusion from mainstream opportunities;
- provision of poor standards of health care and/or which represents a failure to protect or provide redress through the criminal or civil justice system.

APPENDIX 5 SAFEGUARDING ADULTS ARRANGEMENTS - HULL & EAST RIDING OF YORKSHIRE

Multi-agency Safeguarding Adult Board (Hull and East Riding of Yorkshire)

Introduction

'No Secrets' in its guidance advises that to achieve effective inter-agency working, agencies may consider that there are merits in establishing a multi-agency management committee, which is a standing committee of lead officers. Such a body should have a clearly defined remit, lines of accountability, and identify agreed objectives and priorities for its work.

Such committees should determine policy, co-ordinate activity between agencies, facilitate joint training and monitor and review progress.

Experience in other areas of practice has shown that such committees are often most effective where agency boundaries are coterminous.

Multi-agency framework

Will cover those statutory, voluntary and independent organisations working in Hull and the East Riding of Yorkshire who have a responsibility for adult protection. The area is that defined by the boundaries of the two local authorities.

Responsible Organisations

The responsible and relevant agencies will include those which have a key statutory role, namely, Social Services, Health Services, Police and regulatory bodies.

Also included will be those with a direct involvement, knowledge and interest such as voluntary and independent agencies, housing providers, carer support services and user groups. Advocacy and advice services will also be involved.

Objectives of the Multi-agency Framework

The overall objective of the framework is to enhance the quality of life of the vulnerable adults who are at risk of abuse and to progressively improve the services of those in need of protection.

This will be achieved by:

- improving the identification of adult abuse and the support for people who have been abused;
- ensuring an appropriate and consistent response to abuse through the adoption of multi-agency policies and procedures;
- ensuring that all the relevant agencies contribute to the multi-agency framework;
- encouraging the development of services that contribute to the prevention of adult abuse and to promote good practice.

The Safeguarding Adults Board - Terms of Reference

The board will form the focus of the multi-agency framework in Hull and the East Riding of Yorkshire. The Safeguarding Adults Board will have responsibility for:

- developing inter-agency policies and procedures and ensuring they are reviewed;
- submitting an annual report on its work to member organisations and the public;
- monitoring the incidence of adult abuse in the area;
- developing a dissemination plan to ensure users, carers and staff are aware of adult protection issues;
- preparing a training strategy in conjunction with member organisations;
- developing user and carer involvement as appropriate;
- ensure that best practice is disseminated and lessons are learnt from practice;
- ensuring that a multi-agency information sharing protocol is in place which conforms to the requirement of the Data Protection Act;
- ensuring that all partner agencies have management arrangements in place to ensure the implementation of the jointly agreed policy and procedures;
- undertaking the specific review of cases where an individual or a group of people have suffered harm and it appears that the issues raised would lead to the strengthening of multi-agency procedures;

- advising organisations on how commissioning arrangements can contribute to the protection of vulnerable adults;
- developing practice guidelines eg: on the conduct of interviews;
- receiving reports from and supporting the work of the Safeguarding Board Manager and staff;
- co-ordinating the work of agencies in Hull & East Riding in respect of safeguarding adults and the prevention of abuse.

Membership

There will be core representation from the key statutory and other relevant agencies, namely:

Humberside Police

Hull Social Care and Health

East Riding of Yorkshire Children, Families & Adult Services

Primary Care Trust representatives (Hull/East Yorkshire)

Hull and East Riding Hospitals NHS Trust

Humber Mental Health NHS Trust

Legal Advisor (local authority)

The regulatory authorities representative (Care Quality Commission)

The voluntary sector representative (North Bank Forum)

The independent sector representative

Users and Carers representative

Crown Prosecution Service

Representatives should be at a sufficiently senior level in their organisation to commit resources and make decisions on behalf of their organisations.

Other agencies will be invited to become members by the Board if it is identified that their representation would assist the Board in its objectives and there is an agreement of the members.

The Chair

The Chair, who will be determined by the SAB members, will be independent of the key statutory agencies and will have a background and interest in the field of adult protection.

Review

The Safeguarding Adults Board will keep the entire multi-agency framework under review. It will review its work against the objectives set out in pages 65 and 66, in light of changing regulations and guidance issued by Government and against research findings and best practice.

Accountability

The Safeguarding Adults Board will be a stand-alone board and it will publish an annual report. This will be distributed to all partner and affiliate agencies and be presented to an annual general meeting. Representatives will be responsible for reporting to their own organisation. It is suggested that in the case of the Local Authorities that an annual report to both the Cabinet and the Scrutiny Committees may be appropriate,

Frequency of Meetings

It is anticipated that the SAB will meet quarterly.

Safeguarding Adults Board - Staffing

A post of **Safeguarding Adults Board Manager** will be hosted and managed by East Riding of Yorkshire Council on behalf of the partner agencies. A protocol will be drawn up to formalize this arrangement. The Manager on behalf of the Board will co-ordinate the development work being undertaken in line with terms of reference. A briefing update will be given out at the quarterly Board meeting and an update report to the monthly management meeting.

The Manager will be supported by a **Safeguarding Adults Board Training Officer** and a **Safeguarding Adults Board Administrator**. Both posts will be hosted by East Riding of Yorkshire Council on behalf of the partner agencies and line managed by the Manager.

The Training Officer will develop multi-agency training in line with the agreed training strategy and act as deputy to the Manager as required.

The Administrator will provide administrative support to the Board, Manager and Training Officer.

Further posts will be created where a need is identified, funding is available and Board members are in agreement.

Budget

The work of the Board will be financed by individual multi-agency contributions to a pooled budget. The budget will be administered by the East Riding Council on behalf of the contributing agencies. The level of contribution and period of funding for each of the contributors will be contained in a service level agreement. The main base line costs within the budget will be:

Staffing (including on-cost, travelling expenses)

Consumables and equipment

Providing multi-agency training

Any costs of appointing the Chair,

Publicity,

Publishing an annual report,

User/carer participation costs,

Revisions to the procedures

This base line expenditure will be required in each financial year on a recurring basis.

Other individual development projects will be subject to any monies being available in the pooled budget or through additional contributions.

Supporting Groups

The Safeguarding Adults Board will be supported by a Management Group of lead officers from the key statutory agencies plus other relevant agencies known as the Multi-agency Steering Group. It is anticipated that this group will take forward the responsibility for developing the multi-agency framework, the development being co-ordinated by the Safeguarding Adults Board Manager.

The Management Group will be supported and advised by a Training Sub-Group comprising training staff from the relevant agencies. The Training Sub-Group will report to the Management Group and hence to the Safeguarding Adults Board.

The Safeguarding Adults Board will keep the status composition and membership of these sub-groups under review. Other sub-groups will be decided upon if need is identified.

Multi-agency Steering Group

The role of the 'Multi-agency Steering Group' will be to develop the strategic decisions of the Safeguarding Adults Board.

A core representative membership will be as follows:

'Chair' Hull City Council Social Care and Health / East Riding of Yorkshire Council Social Services

Mencap

Humber Mental Health NHS Trust

Quest

Humberside Police

Safe Communities East Riding of Yorkshire Council

Care Quality Commission

Hull and East Yorkshire Hospitals NHS Trust

MIND

Hull Primary Care Trust

East Riding of Yorkshire Primary Care Trust

Age Concern (Hull/East Riding)

Hull City Council Community Safety Unit

Choices and Rights (physical disability)

Terms of Reference

On a multi-agency basis implement the strategic decisions made by the Safeguarding Adults Board.

To alert the Safeguarding Adults Board to any problems identified in local practices or in the implementation of the strategy.

Monitor and review the multi-agency policy, procedures and practice guidelines for the protection of vulnerable adults.

Ensure that data collection systems are in place, which enable adult abuse cases to be accurately recorded and trends identified.

Monitoring agencies response in respect of adult protection in terms of individual agency responsibilities in relation to care issues and criminal investigation.

Identify good and bad practice through case reviews and instigate action to strengthen multi-agency working.

Develop links with authorities who have a responsibility for the commissioning, regulation and inspection of care provision.

Providing evidence and information for an annual report.

Position of Chair

To be filled by the Social Services representative(s) and rotated by agreement or absence.

Frequency of Meetings

The group will seek to meet monthly.

The Steering Group is supported by additional sub-groups to develop particular aspects of adult protection. The groups can be either long or short-term dependant on the nature of the activity.

There will be standing sub-groups for training and budget matters.

Other standing short-term sub-groups will be created when required.

Standing Sub-Groups

Training Sub-Group

'No Secrets' outlines that in implementing a strategy for the protection of vulnerable adults there should be a training strategy for all levels of staff. This is in place locally and seeks to direct the basis of the training programme. The membership of this group is still not as consistent as would be ideal but now that a full-time training officer is in post there can be more of a focus to this work. The main elements of the strategy are to:

- produce information on safeguarding adults, which is available to the public and raises awareness in the community.
- to produce information on safeguarding for vulnerable adults and oversee its dissemination.
- monitoring of training provided against the training strategy and identifies areas for development.

- ensure that there is appropriate representation on the group from the user and carer groups together with relevant agencies and sectors.
- identify best practice, disseminate to practitioners and monitor outcomes.
- ensure that the requirements of the multi-agency information sharing protocol are monitored and staff are aware of their responsibilities.

Budget Sub-Group

As monies become available through agency contributions it was felt that there had to be a mechanism in place to apportion amounts to projects on a priority basis. This enabled amounts to be allocated to the Safeguarding Adults Board Trainer's post, the Education Awareness Project and the publication of a poster for public information. This group meets as required.

Monitoring the Effectiveness of Policy, Procedures and Practice

Monitoring is aimed at ensuring that:

- the Policy, Procedures and Practice Guidelines are appropriate and helpful in meeting the challenges of responding to the abuse of vulnerable adults in Hull and the East Riding of Yorkshire.
- the number and type of referrals are measured so that there are sufficient resources to respond.

APPENDIX 6
(i) ADSS PROTOCOL FOR INTER-AUTHORITY
INVESTIGATION OF VULNERABLE ADULT ABUSE

Leaders in social care



This agreement was ratified by the ADSS on 20th February, 2004 and is intended for adoption by all Local Authorities and Safeguarding Adults Board

1. Introduction

These arrangements recognise the increased risk to vulnerable adults whose care arrangements are complicated by cross boundary considerations. These may arise, for instance, where funding/commissioning responsibility lies with one authority and where concerns about potential abuse and/or exploitation subsequently arise in another. This would apply where the individual lives or otherwise receives services in another local authority area

2. Aims

This protocol aims to clarify the responsibilities and actions to be taken by local authorities with respect to people who live in one area, but for whom some responsibility remains with the area from which they originated.

This protocol should be read in conjunction with Section 3.8 of 'No Secrets' (DoH 2000) and LAC (93) 7 Ordinary Residence - which identifies these responsibilities in terms of:

- The authority where the abuse occurred in respect of the monitoring and review of services and overall responsibility for adult protection;
- The registering body in fulfilling its regulatory function with regard to regulated establishments; and
- The placing authority's continuing duty of care to the abused person.

3. Principles

- The authority where the abuse occurs will have overall responsibility for co-ordinating the adult protection arrangements (and, for the purposes of this protocol, be referred to as the host authority)

- The placing authority (i.e. the authority with funding/commissioning responsibility) will have a continuing duty of care to the vulnerable adult.
- The placing authority should ensure that the provider, in service specifications, has arrangements in place for protecting vulnerable adults and for managing concerns, which in turn link with local policy and procedures set out by the host authority.
- The placing authority will provide any necessary support and information to the host authority in order for a prompt and thorough investigation to take place.
- The host authority will make provision in service contracts, which refer to this protocol, outlining the responsibilities of the provider to notify the host authority of any safeguarding adult concern.

4. Responsibilities of Host Authorities

- 4.1 The authority where the abuse occurred should always take the initial lead on referral. This may include taking immediate action to protect the adult, if appropriate, and arranging an early discussion with the police if a criminal offence may have been committed.
- 4.2 The host authority will also co-ordinate initial information gathering, background checks and ensure a prompt notification to the placing authority and other relevant agencies.
- 4.3 It is the responsibility of the host authority to co-ordinate any investigation of institutional abuse. If the alleged abuse took place in a residential or nursing home, other people could potentially be at risk and enquiries should be carried out with this in mind.
- 4.4 The Care Quality Commission Inspection should always be included in investigations involving regulated care providers and enquiries should make reference to national guidance regarding arrangements for safeguarding adults.
- 4.5 There will be instances where allegations relate to one individual only and in these cases it may be appropriate to negotiate with the placing authority their undertaking certain aspects of the investigation. However, the host authority should retain the overall co-ordinating role throughout the investigation.

5. Responsibilities of Placing Authorities

- 5.1 The placing authority will be responsible for providing support to the vulnerable adult and planning their future care needs.
- 5.2 The placing authority should nominate a link person for liaison purposes during the investigation. They will be invited to attend any Safeguarding strategy meeting and/or may be required to submit a written report.

6. Responsibilities of Provider Agencies

- 6.1 Provider agencies should have in place suitable adult protection procedures to prevent and respond to abuse which link with the local inter-agency policy and procedures set out by the host authority.
- 6.2 Providers should ensure that any allegation or complaint about abuse is brought promptly to the attention of Social Services, the Police, and/or the Care Quality Commission Inspection in accordance with local inter-agency policy and procedures
- 6.3 Provider agencies will have responsibilities under the Care Standards Act 2000 to notify their local Care Quality Commission area office of any allegations of abuse or any other significant incidents.
- 6.4. Provider agencies who have services registered in more than one local authority area will defer to the Care Quality Commission area office relevant to the area in which the abuse took place.

APPENDIX 6

(ii) VULNERABLE ADULTS PROTOCOL (AGREED BETWEEN THE LEEDS AND NEWCASTLE AREA OFFICES OF CARE QUALITY COMMISSION AND THE SAFEGUARDING ADULTS BOARD OF HULL AND EAST RIDING OF YORKSHIRE) MARCH 2005

1 Introduction

1.1 This is an interim protocol to be used in conjunction with the existing Hull and East Riding of Yorkshire Safeguarding Adults Board (SAB) Procedures which are available from the SAB Office telephone (01482) 396409

1.2 This protocol outlines:

- The arrangements for Care Quality Commission regarding exchange of information with Social Services as the lead agency on adult protection matters.
- The role of the Care Quality Commission in the investigation of any allegation relating to adult service users in any regulated service.
- The need to ensure that local Care Quality Commission staff are invited to be involved in strategy discussions/meetings relating to any regulated care service.
- The actions that local Care Quality Commission staff must take if they receive an allegation that a vulnerable adult is suffering or is likely to suffer significant harm.

1.3 The protocol does not outline:

- The definitions of abuse - please refer to the relevant Safeguarding Adults Board Procedures.
- Agency roles and responsibilities - please refer to relevant Safeguarding Adults Board Procedures.

1.4 The protocol contains basic safeguarding adult principles and procedures only.

For more detailed information refer to the Safeguarding Adults Board Procedures.

1.5 This protocol has been agreed and remains in place until it is superseded by a replacement agreed Protocol.

2 Role of Care Quality Commission

- 2.1 The Care Quality Commission is the new regulatory body incorporating the old Commission for Social Care Inspection, Mental Health Act Commission and Healthcare Commission. It independently regulates health and social care in England
- 2.2 Care Quality Commission is responsible for regulation of the following adult services throughout England.
 - Care homes for Older People and Younger Adults
 - Domiciliary Care Agencies
 - Nurse Agencies
 - Adult Placement Schemes
 - Residential Family Centres
- 2.3 As a regulator, Care Quality Commission has a primary role in monitoring compliance of regulated provision for adults, with good adult protection practice, and in particular with specific safeguarding issues and staff recruitment. The protocol relates to responses to allegations and concerns, and liaison with Social Services.

3 Responding to Safeguarding Enquiries

- 3.1 The statutory regulations and National Minimum Standards for adult settings require those **providing** services to notify the Care Quality Commission of any adult protection allegations/concerns and the initiation and the outcome of adult protection enquiries affecting these settings.
- 3.2 Inspectors may also become aware of adult protection matters via inspections, complaints made or other notifications.
- 3.3 An allegation of abuse can be made by a variety of agencies and by many different individuals.
- 3.4 Whenever an allegation is received or an adult protection concern is noted, the inspector receiving the allegation/noting the concern must:
 - Log all details (by completing agreed local procedures referral paperwork) e.g. name, address and telephone number of referrer, full details of regulated service where the alleged abuse has taken place, full details of the service user(s) involved, full details of the concern/allegation.

- Information must be passed immediately to the relevant Regulation Manager for the service.
 - The manager and inspector will assess whether the providers immediate adult protection measures, both to prevent abuse, obtain necessary medical assistance and to respond promptly are satisfactory to protect service users and if not require action to be taken.
 - The inspector/manager must immediately contact the appropriate Social Services Department to report the allegation if not already reported, or the police if a criminal offence is readily evident.
- 3.5 The notification to the relevant agency and the outcome of any investigation will be recorded in writing in the Care Quality Commission provider file. Any additional monitoring or enforcement action needed, will be taken subject to relevant procedures.

4 Safeguarding Enquiries

- 4.1 Care Quality Commission and Social Services will consult each other on actions following a report of an allegation of abuse in a registered service and will aim to work together to agree an appropriate investigation process.
- 4.2 This will be done within safeguarding adult procedures by a strategy discussion or the convening of a strategy meeting, case conference and subsequent reviews. Social Services or a lead agency nominated by them will convene the meetings. It is likely that a number of agencies and processes will be involved after a report of actual or likely harm. These potentially include safeguarding adult enquiry, by Social Services, police investigation, disciplinary action by the service provider and investigation and monitoring of the service by the Care Quality Commission. All of these processes will be agreed within the safeguarding adult process as set out in the relevant adult protection procedures.
- 4.3 Care Quality Commission will share relevant information with other agencies within the adult protection process. The role of Care Quality Commission in relation to future monitoring and possible enforcement action will be discussed within the Safeguarding Adult Process.
- 4.4 Depending on the content of the allegation, the strategy meeting may decide that the regulated service's owner or manager should assist with the investigation. If the manager/owner is the subject of the

allegation, such involvement would not be appropriate and the Care Quality Commission will consider the appropriateness of the management arrangements.

- 4.5 Agreements reached as to each agencies role in the investigation will be recorded and must be sent to participants with a clear timescale for reporting back to the re-convened strategy meeting or the Safeguarding Adult Case Conference.
- 4.6 Social Services will take the lead in co-ordinating the investigation process unless another lead agency is identified.
- 4.7 In particular circumstances an inspector's powers of entry and seizing of documents may be required, plus the power to require the production of relevant information. Such action will usually be coordinated within the adult protection process.

5 Participation in Strategy Meetings, Conferences and Reviews

- 5.1 Care Quality Commission Inspectors and or Regulation Managers will participate in strategy meetings, safeguarding adult conferences, and reviews where this will assist the enquiry. Reports will be provided to case conferences.
- 5.2 The role of Care Quality Commission staff in such meetings is:
 - Provision of information from Care Quality Commission regulation work regarding the setting concerned, which will assist the enquiry.
 - To seek views and agree on respective roles of the agencies involved.
 - To seek & receive information pertinent to the Care Quality Commission decision-making processes regarding monitoring the home or enforcement action.
 - To advise on pertinent regulations, national minimum standards.

6 Following Safeguarding Adult Enquiries

- 6.1 Where an allegation or suspicion of abuse is substantiated wholly or partially, the Care Quality Commission lead inspector in conjunction with Regulation Managers must assess the outcome of the adult protection investigations, making statutory requirements or recommend enforcement action as necessary.

6.2 Following a Safeguarding Adult enquiry, Social Services may make recommendations to the Care Quality Commission for possible conditions of registration. Care Quality Commission will give serious considerations to any such recommendations.

6.3 The lead inspector must check that the registered person/responsible individual has taken appropriate action against any member of staff who has been found to have been involved in an abusive act and that where appropriate referral has been made to the POVA List.

7 Accumulation of Concerns

7.1 Where an agency receives an accumulation of concerns, which could indicate there is an safeguarding adult issue, consultation should take place between Care Quality Commission and Social Services, with the aim of agreeing a strategy for investigating the situation.

8 Safeguarding Adults Board

8.1 Care Quality Commission staff are willing to contribute to local policy and practice development with other agencies and a Regulation Manager will attend Safeguarding Adults Board Meetings when agenda items relate to the work of the Care Quality Commission.

9 Inspections

9.1 The Care Quality Commission will report in an inspection report that there are shortcomings in the regulated services adult protection policies and practice and make relevant requirements.

9.2 Care Quality Commission inspection reports must state if:

- an allegation has been referred to safeguarding adult procedures;
- any safeguarding adult enquiries have taken place since the previous inspection;
- the outcome of the enquiry and details if any requirements/enforcement action to be taken;

9.3 The above must be reported as factual statements, without giving any details of:

- the alleged abuse in a public report;
- any unsubstantiated allegation;
- identities of any individuals.

APPENDIX 6

(iii) CASE REVIEW PROTOCOL

1. Background

The Safeguarding Adult Board (Hull and East Riding of Yorkshire) (SAB) have agreed to a list of core responsibilities. One of these is cited as follows;

Undertaking the specific review of cases where an individual or a group of people have suffered harm and it appears that the issues raised would lead to the strengthening of the multi-agency procedures.

This protocol is to provide guidance on why, when and how the review process should be implemented.

2. The purpose of reviews

- to protect vulnerable adults
- to strengthen multi-agency procedures
- to improve multi-agency arrangements
- to improve inter-agency working
- to develop practice by lessons learned

3. Identification of cases

There is nothing in the guidance contained in the Department of Health document 'No Secrets' that require case reviews to be carried out, although individual agencies may have their own statutory responsibility. However to accord with the core responsibilities of the SAB there is an expectation that member agencies will support this process. Also that agencies will have in-house systems in place which will identify cases which met the criteria for review.

4. Criteria for review

- death of a vulnerable adult where abuse or neglect are known or suspected to be a factor;
- serious injury to a vulnerable adult or group of adults where abuse or neglect are known or suspected to be a factor;
- any case where there are public interest issues;
- any case where SAB members agree that there is a specific need to carry out a review.

(Vulnerable adult is as defined in 'No Secrets')

5. Process of review

- 5.1 Any member of the SAB or the SAB Manager can nominate cases for a review.
- 5.2 A decision to review a case will be made by the SAB members based on the criteria for reviews.
- 5.3 Cases for review will normally be ones that have been subject to a referral under the multi-agency procedures unless there are stated reasons why a case was not referred.
- 5.4 All agencies who have had involvement with the case will be asked to carry out an initial management review and prepare a report based on their findings. An aide-memoir will accompany the request as to what the agreed parameters of the review should include.
- 5.5 A separate chronology should be completed with the report.
- 5.6 Agencies reports and chronologies should be forwarded to the SAB Manager who will produce a composite overview report for SAB members.
- 5.7 Once submitted to the Board, members will decide whether and what actions should be instigated as a result of the report content.
- 5.8 Action plan(s) will be sent to the relevant agencies who will be asked to address the points raised and implement further action(s) required, within their own agencies.

5.9 Realistic time-scales will be set in conjunction with the agencies concerned with a request for a final update when actions are complete.

5.10 The progress/completion of action plans will be subject of agenda items at the SAB Committee Meetings.

6. Principle of review

The purpose of the review is to find out what happened and learn from the lesson, not to attach blame. However, if during a review an agency identifies conduct or practice which may amount to criminal / disciplinary offence, that should be treated as singular and separate to the case review carried out under this protocol.

Although it is recognised that agencies do not have a requirement to undertake any action(s) emanating from case reviews, it is hoped that as all the relevant agencies are involved in the decision making process they will see it as a corporate responsibility within the framework of SAB membership.

APPENDIX 6
(iv) GENERAL PROTOCOL FOR SHARING INFORMATION BETWEEN
AGENCIES IN KINGSTON UPON HULL AND THE
EAST RIDING OF YORKSHIRE

CONTENTS

SECTION	PARAGRAPHS
1. INTRODUCTION	
Purpose of this document	1 - 4
2. KEY LEGISLATION AND GUIDANCE	
The Data Protection Act 1998 - Introduction	5 & 6
The Data Protection Act Principles	7
The Lawful Use of Information	8 - 13
Individuals' Rights under the Act	14
Individuals' Rights of Access to Information	15
The Common Law Duty of Confidentiality	16 & 17
The Human Rights Act 1998	18 & 19
The Crime & Disorder Act 1998	20
3. PRINCIPLES GOVERNING THE SHARING OF INFORMATION	21 - 34
4. PROCEDURES FOR THE DISCLOSURE OF PERSONAL INFORMATION	
Obtaining Consent	35 - 42
Disclosure without Consent	43 - 46
5. ACCESS AND SECURITY PROCEDURES	47 - 49
6. MONITORING AND REVIEWING PROCEDURES	50 - 55
7. PARTNERSHIP UNDERTAKING	56 - 58
8. APPENDIX A - Parties to the Protocol	59
9. APPENDIX B - Operations Procedures for Information Sharing Template	60

SECTION 1

INTRODUCTION

Purpose of this document

1. This document is the information sharing protocol for agencies working in Kingston upon Hull and the East Riding of Yorkshire. It provides guidance for sharing personalised information between these agencies, which are listed in Appendix A
2. It is accepted from practice, experience and research that the sharing of information between professionals helps to ensure that adults and children in need receive the care, protection and support they need. Sharing personal information between partner agencies is vital to the provision of co-ordinated and seamless care to individuals. In addition the sharing of information can help achieve statutory and local initiatives designed to prevent crime and disorder. Legislation does not prevent the sharing of information between agencies delivering services, although there are important rules and safeguards to be observed.
3. All professionals who are party to this agreement accept their continuing obligation to comply with their professional codes of conduct.
4. It is expected that individual agencies will prepare their own operational procedures specific to particular purposes. However, all agencies that are party to this general protocol agree to ensure that operational procedures are compliant and consistent with this document.

SECTION 2

KEY LEGISLATION AND GUIDANCE

The Data Protection Act 1998 - Introduction

5. Since the 1st March, 2000, the key legislation governing the obtaining, protection and use of identifiable personal information has been the Data Protection Act 1998 (the DPA). The DPA does not apply to information relating to the deceased.
6. The key difference between the DPA and the previous legislation is that it applies not only to automatically processed personal data but also to manual personal data.

The Data Protection Act Principles

7. The DPA sets out eight principles which must be complied with when obtaining and using personal data. These principles are as follows:-

First Principle

Obtain and process personal data fairly and lawfully.

Second Principle

Hold data only for the lawful and specified purposes.

Third Principle

Personal data shall be adequate, relevant and not excessive in relation to the purposes for which it is processed.

Fourth Principle

Personal data must be accurate and where necessary, kept up to date.

Fifth Principle

Hold data for no longer than necessary.

Sixth Principle

Personal data shall be processed in accordance with the rights of data subjects under the Act.

Seventh Principle

Measures should be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction or damage to personal data.

Eighth Principle

Personal data shall not be transferred to a country outside the European Economic Area unless that country ensures an adequate level of protection for the rights and freedoms of data subjects regarding the processing of personal data.

The use of personal information by agencies must therefore comply with these principles.

The Lawful Use of Information

8. When sharing information, compliance with the first DPA principle is crucial to ensuring the sharing of information is carried out lawfully.

9. To ensure personal information is processed in a lawful manner, one of several specified conditions, which are set out in Schedule 2 of the DPA , must be complied with. These conditions are as follows:-
- the individual has given his/her consent to the processing
 - the processing is necessary to comply with a legal obligation
 - the processing is necessary to carry out public functions
 - the processing is necessary in order to protect the vital interests of the individual (this is envisaged to be a life and death scenario)
 - the processing is necessary in order to pursue the legitimate interests of the organisation or certain third parties (unless prejudicial to the interests of the individual)
 - the processing is necessary for the entering into a contract at the request of the individual or performance of a contract to which the individual is a party.
10. Therefore, as a general rule, if one of the above conditions are satisfied, the processing of information is likely to be lawful. However, if the information to be processed is what is described as “sensitive personal data”, then there are extra conditions that must be satisfied before the processing of information is lawful.
11. Sensitive personal data is information as to:-
- the racial or ethnic origin of the individual
 - their political opinions
 - their religious beliefs or beliefs of a similar nature
 - whether they are a member of a trade union
 - their physical or mental health or condition
 - their sexual life
 - the commission or alleged commission by them of any offence
 - any proceedings for any offence committed or alleged to have been committed by them, the disposal of such proceedings or the sentence of any Court in such proceedings
12. Therefore, should the information processed come within one of the categories of sensitive personal data, then one of the following conditions, which are contained in Schedule 3 of the DPA, must be satisfied before processing that information. The main conditions are as follows:

- that the individual has given their explicit consent to the processing of the personal information
 - that the processing is necessary to perform any legal right or obligations imposed on the organisation in connection with employment
 - the processing is necessary to protect the vital interests of the individual or another person, where consent cannot be given by the individual, or the organisation cannot be reasonably expected to obtain consent or consent is being unreasonably withheld where it is necessary to protect the vital interests of another
 - the information contained in the personal information has been made public as a result of steps deliberately taken by the individual
 - the processing is necessary in connection with legal proceedings, dealings with legal rights or taking legal advice
 - the processing is necessary for the administration of justice or carrying out legal or public functions
 - the processing is necessary for medical purposes
13. Where information is given to professionals in confidence, then in addition the common law duty of confidentiality must also be considered. This is summarised at paragraph 16 below.

Individuals' Rights under the Act

14. The DPA gives seven rights to individuals in respect of their own personal data held by others. They are:-
- right of subject access
 - right to prevent processing likely to cause damage or distress
 - right to prevent processing for the purposes of direct marketing
 - rights in relation to automated decision making
 - right to take action for compensation if the individual suffers damage
 - right to take action to rectify, block, erase or destroy inaccurate data
 - right to make a request to the Commissioner for an assessment to be made as to whether any provision of the Act has been contravened

Individuals' Rights of Access to Information

15. Subject to certain exceptions, any living person who is the subject of information held and processed by an organisation has a right of access to that information. Where access is refused, the individual may appeal. There are certain statutory exemptions which may limit access rights. These include for example where access would prejudice the prevention or detection of crime.

The Common Law Duty of Confidentiality

16. Information has a necessary quality of confidence when it is of a confidential character. This does not mean that the information need be particularly sensitive, but simply that it must not be publicly or generally available. Information is not confidential if it is in the public domain. To decide whether an obligation of confidence exists, the following must be considered:-

- whether the information has a necessary quality of confidence
- whether the circumstances of the disclosure have imposed an obligation on the confidant to respect the confidence. This usually means considering whether the information was imparted for a limited purpose.

17. Most of the information used by the parties to this agreement will be of a confidential nature. Therefore, as a general rule this confidential information should not be disclosed without the consent of the subject. However, the law permits the disclosure of confidential information where there is an overriding public interest or justification for doing so. Examples of this might be child protection or the protection of vulnerable adults or the prevention and detection of crime or public safety.

The Human Rights Act 1998

18. Article 8(1) provides that:.

Everyone has the right to respect for his private and family life, his home and his correspondence.

However, this is a qualified right and Article 8 (2) states that:

There should be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interest of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

19. Therefore, disclosure of information will need to take Article 8 into consideration. The sharing of information may be necessary, for example, for the protection of health or morals, for the prevention of the rights and freedoms of others or for the protection of disorder or crime.

The Crime and Disorder Act 1998

20. This Act was introduced to provide measures to prevent crime and disorder and anti-social behaviour in the community. Section 115 of the Act provides that any person can lawfully disclose information, where necessary or expedient for the purposes of any provision of the Act, to a chief officer of police, a police authority, a local authority, a probation service or a health authority, even if they do not otherwise have this power. This power also covers disclosure to people acting on behalf of any of the named bodies. The “purposes” of the Act include a range of measures such as local crime audits, youth offending teams, anti-social behaviour orders, sex offender orders and local child curfew schemes. However, the use of Section 115 must be considered on a case by case basis, and must still be compliant with the principles of the DPA.

SECTION 3

PRINCIPLES GOVERNING THE SHARING OF INFORMATION

21. The agencies who are party to this document recognise that they work in a multi-agency environment and initiatives cannot be achieved without the exchange of information about individual service users, levels of activity, the level and nature of resources and about their approach to addressing the issues. Their adoption of a multi-agency approach to address the issues therefore, includes a commitment to ensure such information is shared, albeit in a manner which is compliant with their statutory responsibilities.
22. The majority of information provided by service users is confidential in nature. All agencies therefore accept that this information will not be disclosed without the consent of the individual concerned, unless there are statutory grounds and, in the case of confidential personal information, an overriding public interest or justification to disclose.
23. When seeking information from other parties to this agreement, staff in all agencies will respect the responsibility of confidentiality and will not seek to override the procedures which each agency has in place to ensure information is not disclosed illegally or inappropriately.

24. Each agency accepts that information received under this protocol is only to be used for a specified purpose(s). The secondary use of personal information is not permitted unless the consent of the disclosing party to that secondary use is sought and granted, but having regard to the provisions of paragraph 22.
25. Each agency agrees always to give consideration as to whether it is possible to use depersonalised information (namely information presented in such a way that individuals cannot be identified) to achieve the purpose.
26. Each agency agrees to ensure that the information shared is purposeful, justified and specifically geared to the task it is intended to serve. The information should be sufficient and sharing should exclude unnecessary material.
27. All agencies agree that they will each comply with the various statutory timescales relating to how long particular types of information are retained. Internal procedures will be put into place to ensure compliance with this. Where there are no statutory guidelines, information will be held in accordance with the fourth and fifth principles of the DPA.
28. Subject to certain exemptions, each agency is obliged to notify the Data Protection Commissioner of all purposes for which they process personal data by automated means.
29. The parties agree to ensure compliance with the notification requirements of the DPA and ensure that their notification is accurate and kept up to date.
30. Each agency agrees to make every reasonable effort to ensure that the information they hold is accurate and up to date. Any errors identified in the information held will be corrected or erased as soon as reasonably practicable.
31. Each agency agrees to make reasonable efforts to ensure that the recipients of personal information are kept informed of changes in the personal information which they have received, so that records can be kept up to date.
32. Each agency will ensure efficient and effective procedures are put in place to address complaints relating to the disclosure of information.
33. Each agency agrees that appropriate training will be given to staff to ensure they are aware of their responsibilities to ensure information is shared lawfully.

34. Should information be disclosed without legal justification, each agency agrees to ensure that a manager at the appropriate level of the organisation reviews the incident and considers ways in which the repetition of the error can be avoided in the future, and take other such action as may be appropriate in the circumstances.

SECTION 4

PROCEDURES FOR THE DISCLOSURE OF PERSONAL INFORMATION

Obtaining Consent

35. The general principle is that service users should be as fully informed as possible. Therefore, as a general rule, in every practical circumstance, the individual's consent should be obtained for sharing identifiable information.
36. In most cases the consent to share information will be sought at the first contact with an individual. The member of staff should inform the service user who their employer is, why the information being sought is to be shared, and which agencies the information might be shared with. If, in the professional judgement of the staff member concerned, it would be detrimental to the person concerned to address these issues at the time of first contact, then the reason for not doing so should be recorded and arrangements agreed to complete this task at the first available opportunity.
37. Should it become necessary to share information with other agencies other than as originally agreed with the service user, or to share information for other purposes other than originally agreed, then the renewed consent of the individual will be obtained unless disclosure can otherwise be justified as being in the public interest where the information is of a confidential nature, and within the conditions permitted in Schedule 2 and Schedule 3 of the DPA.
38. Each agency agrees to work towards a situation whereby in most cases, where practically possible, especially in the case of sensitive information, the consent of the individual is given in writing. If consent can only be taken verbally, then the details of this consent should be recorded on an individual's file. An individual should be given a copy of any written consent given by them, and a further copy placed on the individual's file. Any refusal of consent or limited consent should also be recorded on the file.

39. Where it is necessary to seek the renewed consent of the service user, for example, because the purpose for which the information is to be shared has changed, or information is to be given to different agencies other than originally agreed with the service user, then the agencies agree to work towards obtaining a fresh written consent of the service user, where practical to do so.
40. Service users should be made aware that use of information is necessary to enable the organisation to meet its statutory obligations in relation to the particular service and the individual, to ensure the individual is not misled.
41. Reasonable steps should also be taken to ensure that service users are informed of their right to seek access to the information held about them. It is therefore important that staff having direct contact with service users ensure that the information they gather is accurate, coherent and as comprehensive as is needed, and properly recorded.
42. Where an individual does not have the capacity to make an informed decision, and are incapable of managing their own affairs, or where the individual is too young to understand, consent should be obtained from the person with legal authority to act on the person's behalf. Legal advice may be necessary in cases of uncertainty.

Disclosure without consent

43. Although it is regarded as good practice to seek the consent of service users, disclosure without the consent of the individual is lawful where the conditions set out in Schedule 2 of the DPA are met, and where the data is sensitive, where one of the conditions set out in Schedule 3 are met. Disclosure without consent of confidential information should only be made however, where it is in the public interest to do so. The information may, for example, need to be shared to ensure the performance of public functions or a legal obligation. Organisations will need to ensure that anyone who is given access to personal information is aware of the need to treat the information as confidential.
44. In other cases, consent should not be sought, at least initially, to the obtaining and sharing of information, provided the criteria under Schedules 2 and 3 are met, where it would be against the public interest to seek consent at that point. "Working Together to Safeguard Children" at paragraph 5.6 for example, indicates that:

“While professionals should seek, in general, to discuss any concerns with the family and, where possible, seek their agreement to make a referral to Social Services, this should only be done where such discussion and agreement seeking will not place a child at increased risk of significant harm”.

“No Secrets”, produced by the Department of Health in relation to adult protection states at Section 3.6 that the interagency framework must:

“... balance the requirements of confidentiality with the consideration that, to protect vulnerable adults, it may be necessary to share information” At Section 5.6, it goes on to say:

“Confidentiality must not be confused with secrecy; informed consent should be obtained but if this is not possible and vulnerable adults are at risk, it may be necessary to override this requirement”.

In other cases, disclosure might prejudice permitted objectives, such as the prevention or detection of crime or the apprehension or prosecution of offenders. Legal advice should be taken in cases of uncertainty.

45. In certain cases, the consent of an individual may be sought to disclose the information, but that consent is refused. That refusal of consent can be overridden provided the requirements of the DPA are met, and in the case of confidential information, where it is in the public interest to disclose. Taking into account the Human Rights Act, a balancing exercise needs to be carried out between the individual's right to confidentiality, and the public interest in disclosure. The refusal of consent and the reasons for overriding that refusal should be recorded on the client's file.
46. Each organisation should ensure that staff are trained on the need to seek consent, how to seek consent, recording consent and the circumstances under which information may be disclosed without consent.

SECTION 5

ACCESS AND SECURITY PROCEDURES

47. Each agency who is a party to this agreement will ensure procedures are prepared to enable service users to be given access to personal information held about them. In the case of joint records, either organisation can provide access to the joint record, provided the individual is informed that the information is held jointly. Agencies in joint record holding arrangements therefore agree to ensure they have in place

procedures to enable the individual to be made aware that he/she is not obliged to apply to all of the agencies for access, and to ensure that each agency is informed that access has been given.

48. Where information relating to an individual is shared between the agencies, each agency shall take all reasonable steps to ensure this information is transferred and shared in a secure manner.
49. Agencies shall ensure that appropriate security measures are taken to ensure that data is stored and held in a secure manner. These measures will ensure that access to the information can only be obtained by those with the need and the right to know.

SECTION 6

MONITORING AND REVIEWING PROCEDURES

50. This protocol will be subject to regular review. After the first twelve months of the operation of the protocol, this document will be reviewed by the agencies who are parties to this agreement. However, the day to day operation of the protocol will be reviewed at appropriate intervals.
51. There will be a Protocol Monitoring Group which will meet on a regular basis to discuss operational and policy issues arising from the implementation of policies and procedures in support of the protocol. Its membership will include:
 - the allocated Data Protection Officer for each agency
 - an operational/information representative for each agency

It will provide advice on the operational procedures developed by specific services. Attached as Appendix B is a template provided for this purpose.

52. Each agency should have an allocated person to respond to queries regarding the protocol, and take comments on the operation of the protocol. Members of staff of each organisation should be made aware of who the allocated person is and that comments on the operation of the protocol should be made to the allocated person. The presumption is that the allocated person responsible for dealing with queries regarding the protocol will be the allocated Data Protection Officer for each agency.
53. This protocol will be agreed by each signatory agency through its own appropriate mechanism for dealing with data protection and information sharing issues.

- 54. Each agency is aware that this protocol may need amending should there be further legislative changes. Legal advice will be sought before any major changes to the protocol are considered.
- 55. Copies of this protocol will be held by the allocated Data Protection Officer for each agency.

SECTION 7

PARTNERSHIP UNDERTAKING

Undertaking

- 56. The parties to the protocol accept that the principles laid down in this document will provide a secure framework for the sharing of information between their agencies in a manner compliant with their statutory and professional responsibilities.
- 57. As such they undertake to:
 - implement and adhere to the principles set out in this protocol.
 - ensure that all operational procedures established between their agencies for the sharing of information relating the population of Hull and East Riding are consistent with this General Protocol.
 - ensure that where these procedures are adopted then no restrictions will be placed on the sharing of information other than those specified within operational procedures.

58. Signatory

Name

Title

Organisation

Address

.....

.....

Signature

SECTION 8

APPENDIX A

Parties to the Protocol (Suggested)

59. • Connexions Humber
- Eastern Hull Primary Care Trust
 - East Riding and Hull Health Authority
 - East Riding of Yorkshire Council
 - East Riding of Yorkshire Council Schools
 - East Yorkshire Primary Care Trust
 - Hull and East Riding NHS Community Trust
 - Hull and East Yorkshire Hospital NHS Trust
 - Humberside Partnership
 - Humberside Police
 - Kingston upon Hull City Council
 - Kingston upon Hull City Council Schools
 - Kingston upon Hull Foster Carers
 - National Probation Service (Humberside)
 - Sure Start
 - Tees, East and North Yorkshire Ambulance Service NHS Direct
 - Voluntary and independent sector organisations with whom any of the other parties have a service level agreement or contract, in connection with work carried out under the contract or service level agreement with the other parties to this agreement
 - West Hull Primary Care Trust
 - Yorkshire Wolds and Coast Primary Care Trust
 - Youth Offending Team

SECTION 8

APPENDIX B

Operations Procedures for Information Sharing Template

60. The main headings for the framework were agreed as follows:

Introduction/objectives

- why a procedure is required and what is its purpose
- who's involved

Principles of Information Sharing

- refer to Hull and East Riding General Protocol

Client Consent

- details of how each organisation will gain consent

Parameters

- validation procedures e.g. verbal
- 'lead officer' for specific functions
- responsibilities including sub organisations

Defined Purposes

- reference to the principles of the Act.
- why? (justification - refer to other relevant documents)
- what information is covered and what is it used for?
- how will it be obtained?
- who will see it? (base on role/task)
- specific restrictions e.g. 3rd party

Access and Security

- physical/organisational
- procedure for dealing with requests

General

- review process (annual)
- procedure for handling disputes and complaints (ref. General Protocol)
- signature (level necessary to meet each organisation's compliance with data protection)

APPENDIX 7

WHISTLE BLOWING POLICY TEMPLATE

Each agency/care home/service provider should have in place a clear Whistle Blowing Policy and Procedure.

The aim of the policy is to:

- make clear to staff that there is a policy of zero tolerance to any form of abuse
- remind employees of their contractual responsibility to report poor practice
- point staff to the Procedure around Adult Safeguarding
- encourage individuals to feel confident in raising concerns and to question, and act upon concerns about the practice of others
- provide a clear procedure for individuals to raise concerns and receive feedback on any action taken
- assure employees that all concerns reported and made in good faith will be treated seriously
- assure employees that they will be protected from possible reprisals or victimisation

The Whistle Blowing Policy should support the Safeguarding Adult/Abuse Reporting Policy and Procedures and all staff must be aware of and have had training in this area in order to identify the different forms of abuse. Managers must make clear to staff and ensure understanding of the agency/home/service standards in order to recognise when practice has fallen below these standards.

The Registered Manager should use the Whistle Blowing Policy to encourage an open culture where poor practice is reported as a matter of course and where staff will not fear any form of retribution due to reporting a concern made in good faith.

Staff should also be aware that allegations made maliciously may mean that disciplinary procedures may be taken against them.

Managers should respect the wish for anonymity but make clear to staff that they must stand by any allegation made if it is felt that it will support a legal or disciplinary process.

The Policy should also identify other bodies to which employees may report abuse:

- Care Quality Commission
- Action on Elder Abuse
- Public Concern at work
- Age Concern
- Mencap
- Mind

APPENDIX 8 PROTECTION OF VULNERABLE ADULTS (POVA) SCHEME

1. Outline of Scheme

1.1 The POVA scheme was included as part of the Care Standards Act 2000 and was implemented in respect of regulated social care settings on the 26th July 2004. It will be introduced in respect of health care settings at a later date. It covers England and Wales and relates to the care of vulnerable adults aged 18 or over.

1.2 The scheme applies to:

- care workers employed by registered providers of care homes, including agency workers, who have regular contact in the course of their duties with care home residents,
- care workers employed by registered domiciliary care agencies, including agency workers, who provide personal care to vulnerable adults in their own homes,
- carers in adult placement schemes

1.3 The scheme will create a list of care workers who have :

- harmed a vulnerable adult or
- placed a vulnerable adult at risk of harm (whether or not in the course of their employment).

2. Key Definitions

2.1 'Harm' as defined in section 121 of the Act,

- in relation to an adult who is not mentally impaired, means ill treatment or the impairment of health; and
- in relation to an adult who is mentally impaired, or a child, means ill treatment or the impairment of health or development.

2.2 Regular contact, - not specifically defined, but to be interpreted as contact that has a constant or definite pattern or which recurs at short uniform intervals or on several occasions during short periods of time such as a week.

2.3 Personal care - as set out in the Domiciliary Care National Minimum Standards (Department of Health, 2003), the established, ordinary meaning of 'personal care' includes four main types of care, which are:

- assistance with bodily functions such as feeding, bathing and toileting;
- care which falls just short of assistance with bodily functions, but still involving physical and intimate touching, including activities such as helping a person get out of a bath and helping them get dressed;
- non-physical care, such as advice, encouragement and supervision relating to the foregoing, such as prompting a person to take a bath and supervising them during this;
- emotional and psychological support, including the promotion of social functioning, behaviour management, and assistance with cognitive functions.

3. Referring persons for inclusion on the POVA list

3.1 Current employees - a provider of care **must** refer a care worker to the Secretary of State for a possible inclusion on the POVA list are as follows:

- the provider has dismissed the worker on the grounds of misconduct (whether or not in the course of his employment) which harmed or placed at risk of harm a vulnerable adult as defined in subsections 80(6)(a) and 80(6)(b) of the Act;
- the worker has resigned, retired or been made redundant in circumstances such that the provider would have dismissed him, or would have considered dismissing him, on such grounds if he had not resigned, retired or been made redundant;
- the provider has, on such grounds, suspended the worker or provisionally transferred him to a position which is not a care position but has not yet decided whether to dismiss him or to confirm the transfer.

3.2 Suspended employees - if that suspension related to causing harm to a vulnerable adult and a decision has not been made to dismiss or permanently transfer the worker to a non-care position they should be referred to the POVA list. **BUT** the provider of care should (so far as possible) take steps to establish, as quickly as possible, that the

allegations of harm have some element of substance and a referral should only be made if the provider of care feels that those grounds exist.

3.3 Former employees - providers of care are under a duty to refer to the Secretary of State care workers who leave their care positions on or after this date, and where it is only later that information of misconduct on the part of the ex-care worker comes to light. The conditions relating to this requirement are:

- the provider has dismissed the worker, he has resigned or retired or the provider has transferred him to a position which is not a care position;
- information not available to the provider at the time of the dismissal, resignation, retirement or transfer, has since become available; and
- the provider has formed the opinion that if that information had been available at that time and if (where applicable) the worker had not resigned or retired, the provider would have dismissed him, or would have considered dismissing him on grounds of misconduct (whether or not in the course of his employment) which harmed or placed at risk of harm a vulnerable adult.

3.4 Retrospective referrals - providers of care may consider referring care workers who left their employment prior to the 26th July 04 if they consider that this course of action is in the interest of the protection of vulnerable adults. Note - dismissal in these instances should have been a real option.

3.5 Employment agencies - the conditions for referral where employment agencies are under a duty to refer supply workers to the Secretary of State for possible inclusion on the POVA list are:

- that the agency has decided not to do any further business with the worker on grounds of misconduct (whether or not in the course of his employment) which harmed or placed at risk of harm a vulnerable adult;
- that the agency has, on such grounds, decided not to find the worker further employment, or supply him for further employment, in a care position.

3.6 Employment businesses - must refer supply workers to the Secretary of State for consideration of inclusion on the POVA list are that:

- the business has dismissed the worker on the grounds of misconduct (whether or not in the course of his employment) which harmed or placed at risk of harm a vulnerable adult;
- the worker has resigned or retired in circumstances such that the business would have dismissed him, or would have considered dismissing, on such grounds if he had not resigned or retired; or
- the business has, on such grounds, decided not to supply the worker for further employment in a care position.

NOTE: agencies and businesses are not normally required to refer workers who left their care position before the 26th July 04 but in the interests of protection should carefully consider whether referrals should be made in the appropriate circumstances.

- 3.7 Referral of individuals from certain inquiries - the Secretary of State will consider such an inclusion where the person who held the inquiry found the individual was guilty of misconduct which harmed or placed at risk of harm a vulnerable adult (whether or not in the course of his employment) at a time when the individual was employed in a care position, and that the individual is unsuitable to work with vulnerable adults.

The individual shall be provisionally included on the list if:

- a relevant inquiry has been held;
- the report of the person who held the inquiry names an individual who is or has been employed in a care position; and
- it appears to the Secretary of State from the report that:
 - the person who held the inquiry found that the individual was guilty of relevant misconduct;
 - the individual is unsuitable to work with vulnerable adults.

- 3.8 Referral following police charges - referral to the Secretary of State should also be made in circumstances where a care worker has been suspended, dismissed or resigned after having been charged by the police with offences against vulnerable adults, and is awaiting the outcome of criminal investigation or trial.

- 3.9 Submission of referrals - the Department of Health referral form is included in this appendix.

4.0 Checking the POVA List

- 4.1 POVA checks must be carried out prior to appointment where an individual:
- applies for a care position with a new employer; or
 - moves, or is transferred, from a non-care position to a care position within his current employment. (Please note that a check against the POVA list is required if an individual moves from a regulated child care position to a care position working with vulnerable adults within his current employment).
- 4.2 Individuals in care positions on 26 July 2004 - POVA checks are not required for individuals already employed in care positions on 26 July 2004 and who remain in those same jobs thereafter, provided that a CRB Disclosure has been obtained on them.
- 4.3 Making checks against the POVA list - checks against the POVA list can only be made via the CRB as part of a Disclosure under the Police Act 1997. The check is requested by crossing the appropriate 'POVA' box (Y4) on the CRB Disclosure Application Form.

5. Further Information

- 5.1 Copies of the full guidance and related material can be accessed on the internet at www.dh.gov.uk
- 5.2 Advice - e-mail: pova.mail@dfes.gsi.gov.uk telephone 01325 391328

PROTECTION OF VULNERABLE ADULTS (PoVA) LIST

Independent Safeguarding Authority
PO box 181
Darlington
DL1 9FA



Phone 01325 953757 or 01325 953794

Private and Confidential

The Protection of Vulnerable Adults scheme acts as a workforce ban on care workers who have harmed or put at risk of harm vulnerable adults in their care. It adds an extra layer of protection to the pre-employment processes, including Criminal Records Bureau checks, which already take place and stop known abusers from entering the care workforce.

Independent Safeguarding Authority
PO BOX 181
Darlington
DL1 9FA

Phone 01325 953757 or 01325 953794

This form is for the referral to the Independent Safeguarding Authority (ISA) to consider whether a care worker should be placed on the adult's barred list. To be completed in line with:

- The Protection of Vulnerable Adults Scheme's 'A Practical Guide', and
- The Social Care Institute for Excellence's 'Practice guide 7: Making referrals to the PoVA List'.

These guides are available at www.dh.gov.uk/pova. Also see the ISA website at www.isa-gov.org.uk

Please note this is the maximum information required, therefore, please complete as much as possible but it is appreciated that a referral may only be at suspension stage. If any more information is required we will be in touch; we have no investigatory powers and are reliant on the information provided by referring organisations. Please also note that the text boxes can be expanded or you can add continuation sheets.

Note: If there are any documents you do not want the referred to see, clearly mark them. If these documents cannot be shared with the referred individual however the ISA may not be able to rely on them when reaching its barring decision.

1. Details of person being referred (“the person”):

Surname	
Forename(s)	
Maiden name or alias	
Title Mrs/Ms/Miss/Mr/Other:	
Date of birth	
National Insurance Number (if known)	
Position held Please include a copy of the job description, application form and references.	
Dismissed, suspended or resigned? If resigned or retired please state if the individual would have been dismissed or considered for dismissal.	<i>Please enclose a copy of the dismissal / suspension / resignation letter and the disciplinary procedures.</i>
Last Known Address	
Post Code	
Telephone Number	

Note: If there are any documents you do not want the referred to see, clearly mark them. If these documents cannot be shared with the referred individual however the ISA may not be able to rely on them when reaching its barring decision.

INCIDENT AND RELATED DETAILS

<p>2. Evidence attached of the person's employment in a care position, e.g. copy of letter of employment and/or application form. Include details of the person's normal duties (e.g. personal care of vulnerable adults).</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><u>Details:</u></p>
<p>3. Length of the person's employment with your organisation (including dates and positions held).</p>	
<p>4. Details of the person's employment history. Including details (post/length of service) of previous/other jobs (where known) and of any previous disciplinary action or complaints against the person.</p>	
<p>5. Details of any disciplinary action taken whilst with your organisation.</p>	
<p>6. Details of the person's relevant skills, qualifications and training received; e.g. RGN/NVQ Level 2 etc.</p> <p>Please confirm what the induction covered and provide any signed documents for training and supervisions.</p>	

Note: If there are any documents you do not want the referred to see, clearly mark them. If these documents cannot be shared with the referred individual however the ISA may not be able to rely on them when reaching its barring decision.

<p>7. Summary of alleged misconduct, to include the nature of the abuse (physical, sexual, financial, neglect etc).</p> <p>Please note you need to be specific with the allegations, ideally what, when, where and how.</p> <p>Please make it clear which misconduct was the reason for dismissal or would have led to dismissal if the carer left without dismissal.</p>	
<p>8. Explanation of how the person harmed, or put at risk of harm, the vulnerable adult(s), i.e. the conduct/misconduct.</p>	
<p>9. Impact of the alleged abuse on the victim(s).</p> <p>E.g. physical – injuries, STDs, pregnancy; emotional – changes in eating and sleeping patterns; or behavioural – dress or attitude.</p> <p>Give details of whether the victim(s) has given those details or whether it is based on an assessment of the impact - with details of who was involved in that assessment.</p>	

Note: If there are any documents you do not want the referred to see, clearly mark them. If these documents cannot be shared with the referred individual however the ISA may not be able to rely on them when reaching its barring decision.

<p>10. Background details on the victim(s), e.g. age; medical condition; level of care needed to assist his/her daily life; level of capacity; and, mobility.</p> <p>Where possible please provide a copy of the victim's care plan. If not, the dates these were sent and the signing-off officer details.</p>	
<p>11. Details of the care relationship between the person and the victim (e.g. personal/domiciliary carer, care assistant, adult placement carer, nurse, home manager, volunteer). Include details of the care usually provided (e.g. help with getting up, dressing, medication etc.)</p>	
<p>12. Evidence of alleged misconduct. List of documentation provided: e.g. Witness statement, hearing notes, etc</p> <p>Please number documentation according to the list and remember that the evidence has to be of specific incidents – what, when, where and how.</p>	<ol style="list-style-type: none"> 1. 2. 3.
<p>13. Witness Details.</p>	<p>Where possible, please keep an up-to-date list of these witnesses, their current addresses and whereabouts, in case we need to contact them.</p>

Note: If there are any documents you do not want the referred to see, clearly mark them. If these documents cannot be shared with the referred individual however the ISA may not be able to rely on them when reaching its barring decision.

<p>14. Details of investigations, and their conclusions, carried out to date. Include copies of relevant papers (statements, minutes of meetings, notes from disciplinary hearings), <u>signed</u> if possible.</p> <p>In the case of suspension pending investigation, describe planned investigation activities.</p>	<p>1.</p> <p>2.</p> <p>3.</p>
<p>15. Details of the action taken against the person, e.g. suspension, dismissal or transfer to alternative employment not involving contact with vulnerable service users.</p>	
<p>16. Information of Police Involvement.</p> <p>Please give details of current position of any civil or criminal proceedings.</p> <p>Please note we are reliant on you to inform us of the progress and conclusion of any proceedings.</p>	<p>Police Contact:</p> <p>Crime ref:</p> <p>Station and address:</p>
<p>17. Information of any other agency involvement, e.g. CQC, NMC, Local Safeguarding Team, Social Services, voluntary or independent sector agency.</p>	
<p>18. Details of proposed further action, e.g. give dates of any scheduled Safeguarding Adult investigations and/or disciplinary hearings.</p>	

Note: If there are any documents you do not want the referred to see, clearly mark them. If these documents cannot be shared with the referred individual however the ISA may not be able to rely on them when reaching its barring decision.

<p>19. Any other information considered relevant to the referral.</p> <p>Include here brief details of any other employees involved in the abuse, and complete additional referral forms for them as appropriate.</p>	
--	--

20. Employer Details:

Contact Name	Mrs/Ms/Miss/Mr/Other:
Position	
Address	Post code:
CQC registration number	Note: Please enclose a copy of the certificate with referral
Type of Establishment, e.g. care home, adult placement. Include details of the number and nature of service users, and of the care provided.	
Contact Number	
Fax Number	
Email Address	
Signed	
Date	

Tick here to confirm CQC certificate enclosed with referral form Guidance for completion:

Note: If there are any documents you do not want the referred to see, clearly mark them. If these documents cannot be shared with the referred individual however the ISA may not be able to rely on them when reaching its barring decision.

Please provide as much information at this stage as you can as missing information may delay consideration of the case. Additional sheets may be used to provide extra information and/or supporting evidence, but must be clearly labelled as to which section it relates to on the form.

In addition to the above information, a referral to the POVA list from a provider of care should be accompanied by a copy of either:

- a. their registration certificate issued by the Care Quality Commission or the Care Standards Inspectorate for Wales; or
- b. the standard letter from the Care Quality Commission saying that the provider's application for registration has been received and is being processed.

Once completed, the form and all its supporting papers should be sent to:

Independent Safeguarding Authority
PO BOX 181
Darlington
DL1 9FA

Phone 01325 953757 or 01325 953794

Note: When sending material through the post, those making referrals should have due regard to the confidential nature of the material.

Note: If there are any documents you do not want the referred to see, clearly mark them. If these documents cannot be shared with the referred individual however the ISA may not be able to rely on them when reaching its barring decision.

APPENDIX 9 STAFF TRAINING NOTES

The 'No Secrets' guidance recommends that all staff should be trained in the protection of vulnerable adults for their appropriate job role.

The Safeguarding Adults Board has identified the following training pathways for health and social care staff who work with Vulnerable Adults.

BASIC AWARENESS - For all staff working with vulnerable adults. Basic awareness raising which includes definitions of a vulnerable adult and abuse, identification of types of abuse and potential indicators. Will also explore the alerting and referring process.

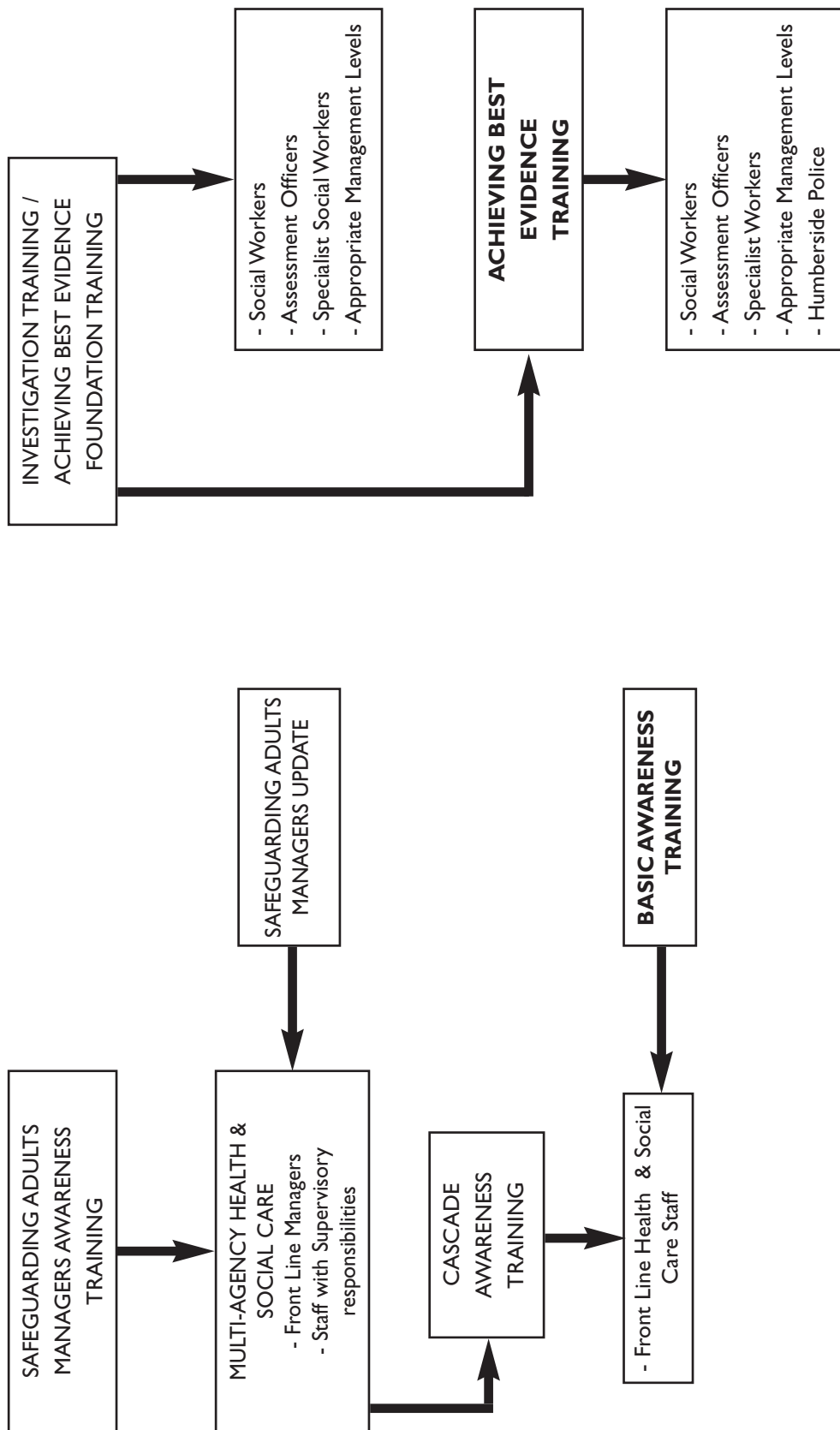
MANAGERS AWARENESS TRAINING - For front line managers and staff with supervisory responsibilities. As above and also includes the managers role, policy and training strategy to disseminate awareness to staff through a cascade process.

MANAGERS UPDATE - For experienced managers. Refresher briefing, updating knowledge, including the revised policy and the POVA Scheme.

INVESTIGATION PROCESS/INTRODUCTION TO ACHIEVING BEST EVIDENCE FOUNDATION TRAINING - For social workers, assessment officers and specialist social workers who will undertake vulnerable adult investigations. To inform investigators in the investigation process, gathering appropriate evidence and to provide an introduction to the legislative requirements and working practices of 'Achieving Best Evidence'.

JOINT ACHIEVING BEST EVIDENCE TRAINING - For social workers, assessment officers, and specialist social workers and police officers who, as part of the evidence gathering process will employ the measures available under Action for Justice.

**Safeguarding Adults Board
(Hull and East Riding of Yorkshire)**



TRAINING PATHWAYS

APPENDIX 10
THE MENTAL CAPACITY ACT 2005
DEPRIVATION OF LIBERTY SAFEGUARDS
INDEPENDENT MENTAL CAPACITY ADVOCATES.

Capacity, Consent and Decision Making

The consideration of capacity is crucial at all stages of Safeguarding Adults procedures. For example, determining the ability of a vulnerable adult, to make lifestyle choices, such as choosing to remain in a situation where they risk abuse; determining whether a particular act or transaction is abusive, or consensual; or determining how much a vulnerable adult can be involved in making decisions in a given situation.

The key development affecting this area of work is the implementation of the Mental Capacity Act 2005, which provides a statutory framework to empower and protect vulnerable people, who may not be able to make their own decisions. It makes it clear who can take decisions in which situations, and how they should go about this. It enables people to plan ahead for a time when they may lose capacity.

Guidance on the Act is provided in a statutory Code of Practice, and training provided as part of its implementation, see www.justice.gov.uk/guidance/mcacode-of-practice.htm further information on local arrangements can be found in this document.

The whole Act is underpinned by a set of five key principles:

1. **A presumption of capacity** - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
2. The right for individuals to be **supported to make their own decisions** - people must be given all appropriate help before anyone concludes that they cannot make their own decisions.
3. That individuals must retain the right to make what might be seen as eccentric or **unwise decisions**.
4. **Best interests** - anything done for or on behalf of people without capacity must be in their best interests.
5. **Least restrictive intervention** - anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.

Mental Capacity Act **section 2** (1), Code of Practice 4.11 – 4.13

Section 2 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 himself or herself in relation to the matter, because of an impairment of or a functioning of the mind or brain.

Mental Capacity Act 2005 **section 3**, Code of Practice 4.49 – 4.54 Section 3 states that a person is unable to make a decision if he/she is unable

- To understand the information relevant to the decision.
- To retain the information.
- To use or weigh that information as part of the process of making the decision.
- To communicate their decision by any means.

Every assessment of capacity must be undertaken in accordance with the Act and provisions of the Code of Practice. Where there is a reasonable belief that a person lacks capacity there is a statutory best interests checklist for people acting on behalf of others. The decision maker must work through the factors when deciding what is in the best interests of the individual.

The Act deals with two situations where a designated decision-maker can act on behalf of someone who lacks capacity:

- **Lasting Powers of Attorney (LPA)** - The Act allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future. This is similar to previously available Enduring Power of Attorney, but the Act also allows people to let an attorney make health and welfare decisions.
- **Court appointed deputies** - The Act provides for a system of court appointed deputies to replace the current system of receivership in the Court of Protection. Deputies will be able to take decisions on welfare, healthcare and financial matters as authorised by the court but will not be able to refuse consent to life-sustaining treatment. They will only be appointed if the court cannot make a one-off decision to resolve the issues.

The Act creates two new public bodies to support the statutory framework, both of which will be designed around the needs of those who lack capacity

- **A new Court of Protection** - The new Court has jurisdiction relating to the whole Act and will be the final arbiter for capacity matters. It has its own procedures and nominated judges.

- **A new Public Guardian** - The Public Guardian and his/her staff are the registering authority for LPAs and deputies. They supervise deputies appointed by the Court and provide information to help the Court makes decisions. They also work together with other agencies, such as the police and social services, to respond to any concerns raised about the way in which an attorney or deputy is operating

The Act also includes further key provisions to protect vulnerable people

- **Advance decisions to refuse treatment**

Statutory rules with clear safeguards confirm that people may make a decision in advance to refuse treatment if they should lose capacity in the future. It is made clear in the Act that an advance decision will have no application to any treatment, which a doctor considers necessary to sustain life unless strict formalities have been complied with. These formalities are that the decision must be in writing, signed and witnessed. In addition, there must be an express statement that the decision stands “even if life is at risk”.

- **A criminal offence**

The Act introduces a new criminal offence of ill treatment or neglect of a person who lacks capacity. A person found guilty of such an offence may be liable to imprisonment for a term of up to five years.

16.2 Independent Mental Capacity Advocate (IMCA)

The purpose of the Independent Mental Capacity Advocacy Service, is to help those who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends to consult about those decisions. The role of the Independent Mental Capacity Advocate (IMCA) is to work with and support people who lack capacity, and represent their views to those who are working out their best interests.

The Department of Health has extended the Act to cover circumstances where a safeguarding adults allegation has been made. In relation to safeguarding adults cases, the Regulations specify that Local Authorities and the NHS have powers to instruct an IMCA, if the following requirements are met

- where safeguarding measures are being put in place in relation to the protection of vulnerable adults from abuse.
- where the person lacks capacity.

In these circumstances the Local Authority or NHS body may instruct an IMCA, to represent the person concerned, if it is satisfied that it would be of benefit for the person to do so.

In safeguarding adults cases, access to IMCAs is not restricted to people who have no one else to support or represent them. People who lack capacity who have family and friends, can still have an IMCA to support them through the safeguarding process.

The regulations equally apply to a person who may have been abused, or neglected and a person who is alleged to be the perpetrator.

Where the qualifying criteria are met, it would be unlawful for the Local Authority or the NHS, not to consider the exercise of their power to instruct an IMCA for safeguarding adult's cases.

Restraint:

Section 5 of the Act permits the use of restraint, if the person using it reasonably believes that it is necessary to prevent harm to the incapacitated person and if the restraint is proportionate to the likelihood and seriousness of harm. However, section 6(5) confirms that there is no protection under the Act for actions that result in someone being deprived of their liberty, as defined by Article 5 (1) HRA 1998.

The Mental Capacity Act - deprivation of liberty safeguards (MCA / DoLS)

The MCA DOL safeguards were introduced into the Mental Capacity Act 2005 through the Mental Health Act 2007.

The Mental Capacity Act Deprivation of Liberty (MCA DOL) safeguards aims to protect people who cannot make decisions for themselves due to a learning disability or a mental health condition, for example Alzheimer's disease, or for any other reason. It provides clear guidelines for carers and professionals about who can take decisions in which situations.

The MCA DOL safeguards apply to anyone aged 18 and over who:

- Suffers from a mental disorder or disability of the mind - such as dementia or a profound learning disability
- Lacks the capacity to give informed consent to the arrangements made for their care and / or treatment
- For whom deprivation of liberty (within the meaning of Article 5 of the ECHR) is considered after an independent assessment to be necessary in their best interests to protect them from harm.

The safeguards cover patients in hospitals, and people in care homes registered under the Care Standards Act 2000, whether placed under public or private arrangements.

Mental Capacity Act 2005: Assessment of Capacity and Record of Best Interest Decision

Action/decision that needs to be made:

Name of person for whom a decision needs to be made:

Date of birth of person:

NHS No./Other Identifier:

Address and Contact details (permanent and temporary if different):

Date of decision:

Name of decision maker:

Is there a Lasting Power of Attorney or Deputy in place?

Yes (consider consultation) **No**

Consider any Advance Decision to refuse treatment/Statement if in place and applicable.

Consider if an assessment under the Mental Health Act 1983 is appropriate.

Mental Capacity Assessment:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Is there an impairment of or disturbance in the functioning of the person's mind or brain, either temporary or permanent? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. If yes, does that impairment or disturbance make the person unable to make the particular decision? | <input type="checkbox"/> | <input type="checkbox"/> |

If the answer to both questions is "Yes", determine whether they have capacity to make the particular decision by checking whether or not they meet the following 4 points:

- | | | |
|--|--------------------------|--------------------------|
| • Does the person understand the information relevant to the decision? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Can the person retain the information long enough to make a decision? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Can the person use or weigh the information in order to make a decision? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Can the person communicate their decision? | <input type="checkbox"/> | <input type="checkbox"/> |

If the answer to any of the above 4 points is "NO" the person lacks capacity for that particular decision at that particular time and a best interest decision needs to be made on their behalf.

Assessment of Capacity and Record of Best Interest Decision April 2007

Additional notes if any:

Note what steps have been taken to assist the person make this decision themselves – have all practicable steps been taken to ensure understanding?

Can the decision wait until the person has capacity, if so delay the decision and document evidence for this, if not arrange a best interest meeting/follow best interest checklist and document evidence for this.

Note what documents/records/people were consulted in assessing that the person did not have capacity to make this decision.

Details of the decision following an assessment that the person did not have capacity to make the decision himself or herself. Note also any actions taken following this decision, including amendments to care plans/treatment plans etc.

Guidance:

Use this form **when key decisions and actions are taken** on a person's behalf because they do not have the capacity to decide for themselves.

'Key decisions' means significant decisions that go beyond a person's daily routine or way of life. For example, decisions about:

- minor medical treatment or dentistry
- the use of person's money for more than their usual necessities
- obtaining or disposing of possessions of significant value
- spending short periods away from their home
- limiting activities (like smoking or drinking) that the person would normally choose to do
- bringing new people into the person's life (like an advocate or volunteer).

Also use this form for big, life-changing decisions, for example:

- moving to a different home
- having major medical treatment
- disposing of significant assets.

These decisions will usually involve a wider range of people in the decision-making process, sometimes at a Best Interest Meeting. This form should then be used in conjunction with the Best Interest Checklist and Decision Record.

Do not use this form with regard to small decisions that affect a person's daily routine, for example:

- what the person wears
- how they use their weekly benefits to buy necessities
- when they take their meals.

If you can't support the person to take their own decisions in these routine areas and you need to decide things for them, you should note what you have done and why in the person's support plan, service user plan or equivalent.

Do not use this form when there is someone empowered to make the decision, for example an attorney (appointed by the person when they had capacity) or a deputy appointed by the Court of Protection.

Best Interests Forum

If a person has been assessed as lacking capacity, then any action taken, or any decision made for, or on behalf of that person, must be made in his/her best interests – Principle 4

Date of Meeting:

Name of Person:

NHS Number:

Ward/Unit

Attendees at Meeting

Apologies (written feedback received)

Is it likely that the person may regain capacity, can the decision wait until that time, if not why not
(Give details) Yes No

What is the nature of proposed action or decision to be made ie examination and/or treatment or long term care provision?

Is there a least restrictive option (If yes, please explain this in full)
Yes No

What is the justification for proposed action, examination and/or treatment or long term care?

Are there any risks relating to proposed action, examination or treatment or long term care provision:

Yes No (Please give details)

What are the person past and present wishes and feelings? (Check if these have been written down anywhere or have been expressed in either emotional responses and or behaviours)

Is there an Advance Decision/Statement? (Does this relate to the decision in question as this will override the need to carry out best interests?)

Yes No

Are there any beliefs and or values that would be likely to influence the decision, if he/she had the capacity? (These could be religious, cultural or moral)

Yes No (Please give details)

Are there any other factors that need to be considered, factors that the person would be likely to consider if he/she were able to do so? (Emotional bonds or family obligations in deciding how to spend money or where to live)

Yes No

What are the views of the other relevant people in the person's life?

Have you consulted the Lasting Power of Attorney (L.P.A), deputy or person nominated by the person to consult?

Yes No

What are the views of the L.P.A, Deputy or person nominated by the person to consult?

Is there a need to involve an **Independent Mental Capacity Advocate (IMCA)**? What are their views? Yes No

(Please give details)

Is there a dispute about best interests?

Yes No (Please give details)

Outcome of discussions; reasonable belief as to best interests

(The decision maker must take the above steps, amongst others and weigh up the factors in order to determine what decision of course of action is in the best interests of the person concerned)

The undersigned believe this to be a fair representation of the discussions that took place. We have reasonable grounds for believing that what is being planned is in the best interests of the person concerned at this point in time.

Name: Designation: Signature: Date:	Name: Designation: Signature: Date:
Name: Designation: Signature: Date:	Name: Designation: Signature: Date:
Name: Designation: Signature: Date:	Name: Designation: Signature: Date:

CASE
NUMBER

Mental Capacity Act 2005

DEPRIVATION OF LIBERTY FORM No. 7

MENTAL CAPACITY ASSESSMENT**PART A — WHY THIS FORM IS BEING COMPLETED**Place a cross in **ONE** of the boxes below \emptyset

A1	This form is being completed in relation to a request for a standard authorisation.	<input type="checkbox"/>
A2	This form is being completed in relation to a review of an existing standard authorisation under Part 8 of Schedule A1 to the Mental Capacity Act 2005.	<input type="checkbox"/>

PART B — BASIC INFORMATION

Name, address and profession of the assessor	Name	
	Address	
	Profession	
Full name of the person being assessed	Name	
Name of the hospital or care home in which the person is, or may become, deprived of their liberty	Name	
Name of the PCT or local authority that is the supervisory body	Name	
The present address of the person being assessed (Place a cross in the relevant box and, where applicable, state the address)	As stated on the request for a standard authorisation	<input type="checkbox"/>
	As stated immediately below	<input type="checkbox"/>
	Address	
Address of the hospital or care home in which the person is, or may become, deprived of their liberty (Place a cross in the relevant box and, where applicable, state the address)	As stated on the request for a standard authorisation	<input type="checkbox"/>
	As stated immediately below	<input type="checkbox"/>
	Address	

PART C — RECORD OF THE ASSESSMENT

I have assessed whether the person meets the mental capacity requirement.

In carrying out this assessment, I have taken into account any information given to me, and any submissions made, by any of the following:

- (a) any relevant person's representative appointed for the person
- (b) any IMCA instructed for the person in relation to their deprivation of liberty.

The managing authority proposes to accommodate the person in the hospital or care home so that they can be given the care or treatment specified in their request for this standard authorisation.

In my opinion, all practicable steps have been taken to help the person to make their own decision in relation to this question.

I have assessed capacity in accordance with the principles and requirements of the Mental Capacity Act 2005.

Place a cross in EITHER box C1 OR box C2 below ∅

C1	In my opinion the person LACKS capacity to make their own decision about whether they should be accommodated in this hospital or care home for the purpose of being given the proposed care and/or treatment because of an impairment of, or a disturbance in the functioning of, the mind or brain.	<input type="checkbox"/>
C2	In my opinion the person HAS capacity to make their own decision about whether they should be accommodated in this hospital or care home for the purpose of being given the proposed care and/or treatment.	<input type="checkbox"/>

WHY THE PERSON LACKS CAPACITY TO MAKE THIS DECISION FOR THEMSELVES

If you placed a cross in box C1, also place a cross in ONE OR MORE of the boxes below (C3–C6) ∅

C3	The person is unable to understand the information relevant to the decision. <i>(The information relevant to a decision includes information about the reasonably foreseeable consequences of deciding one way or another, or failing to make the decision.)</i>	<input type="checkbox"/>
C4	The person is unable to retain the information relevant to the decision. <i>(The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent them from being regarded as able to make the decision.)</i>	<input type="checkbox"/>
C5	The person is unable to use or weigh that information as part of the process of making the decision.	<input type="checkbox"/>
C6	The person is unable to communicate their decision (whether by talking, using sign language or any other means).	<input type="checkbox"/>

REASONS FOR OPINION

Give your reasons for deciding that it has or has not been established that the person lacks capacity to make their own decision about whether to be accommodated in the hospital or care home for the purpose of being given the proposed care and/or treatment because of an impairment of, or a disturbance in the functioning of, the mind or brain.

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Signed	
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Dated	
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WHAT TO DO NOW

It is essential that you give a copy of this assessment to the supervisory body as soon as you have completed it. This is because the supervisory body may not give a standard authorisation unless and until it has written copies of all the assessments.

If you have placed a cross in box **C2**, to indicate that the person has capacity in relation to the relevant question, then the person does not meet the mental capacity qualifying requirement. As a result, a standard authorisation may not be given and all other on-going assessments should stop. You should immediately notify the supervisory body, and then provide them with a copy of this assessment as soon as practicable. You must keep a written record of the assessment.

Mental Capacity Act 2005

CASE
NUMBER

DEPRIVATION OF LIBERTY FORM No. 10

BEST INTERESTS ASSESSMENT**PART A — WHY THIS FORM IS BEING COMPLETED**Place a cross in **ONE** of the boxes below ☐

A1	This form is being completed in relation to a request for a standard authorisation. (If you place a cross in this box you must also take the person being assessed through the steps necessary to appoint a representative and complete Form 24.)	<input type="checkbox"/>
A2	This form is being completed in relation to a review of an existing standard authorisation under Part 8 of Schedule A1 to the Mental Capacity Act 2005. Note: Where the supervisory body decides that the best interests requirement should be reviewed solely because details of the conditions attached to the authorisation need to be changed, and the review request does not include evidence that there is a significant change in the person's overall circumstances, there is not need for a full reassessment of best interests. This form does not need to be completed in such a case, and the supervisory body can simply vary the conditions attached to the authorisation in such ways, if any, as it considers appropriate. In making any decision whether a change is significant, regard must be had to the nature of the change and the period that the change is likely to last for.	<input type="checkbox"/>

PART B — BASIC INFORMATION

Name, address and profession of the assessor	Name	
	Address	
	Profession	
Full name of the person being assessed	Name	
Their date of birth (or estimated age if unknown)	DOB	<input type="text" value="d"/> <input type="text" value="d"/> <input type="text" value="m"/> <input type="text" value="m"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/>
	Est. age	<input type="text"/> Years
Name of the hospital or care home in which the person is, or may become, deprived of their liberty	Name	
Name of the PCT or local authority that is the supervisory body	Name	

The present address of the person being assessed (Place a cross in the relevant box and, where applicable, state the address)	As stated on the request for a standard authorisation	<input type="checkbox"/>
	As stated immediately below	<input type="checkbox"/>
	Address	
Address of the hospital or care home in which the person is, or may become, deprived of their liberty (Place a cross in the relevant box and, where applicable, state the address)	As stated on the request for a standard authorisation	<input type="checkbox"/>
	As stated immediately below	<input type="checkbox"/>
	Address	
<p>PART C — PERSONS CONSULTED AND MATTERS TAKEN INTO ACCOUNT</p> <p>I have assessed whether the person meets the best interests requirement.</p> <p>C1 PERSONS WHO HAVE BEEN CONSULTED</p> <p>Note: before embarking on the full best interests assessment consultation process, the best interests assessor may first wish to check that there is <i>prima facie</i> evidence that a deprivation of liberty may be occurring, or is likely to occur, since, if it is apparent that there is no deprivation of liberty, the full best interests consultation process will be unnecessary.</p> <p style="text-align: center;">Place a cross in the boxes below to confirm the statements in A, B or C \emptyset</p>		
A	I have spoken to the person to whom this assessment relates, in accordance with section 4(6) of the Mental Capacity Act 2005.	<input type="checkbox"/>
B	I have consulted the managing authority of the hospital or care home and taken their views into account.	<input type="checkbox"/>
C	In carrying out this assessment, I have also consulted the following interested persons:	
<p>Note: before completing the rest of Part C, please read the notes at the end of the form, and in particular the definition of 'interested persons'.</p>		

	Name	Address
1		
2		
3		
4		
5		

If more than five interested persons were consulted, please give the names and addresses of any other individuals in Part G of this form.



D I have consulted the following additional individuals who were named by the person being assessed as people to be consulted in relation to the matters now under consideration, and have taken their views into account:

	Name	Address
1		
2		

If more than two people in this category were consulted, please give the names and addresses of any other individuals in Part G of this form.



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E	I have consulted the following additional individuals, who are engaged in caring for the person being assessed or are interested in their welfare, and have taken their views into account:	
	Name	Address
1		
2		
If more than two people in this category were consulted, please give the names and addresses of any other individuals in Part G of this form.		
<p>C2 MATTERS THAT I HAVE CONSIDERED AND TAKEN INTO ACCOUNT</p> <p>I have considered what I believe to be all of the relevant circumstances and, in particular, the matters referred to in section 4 of the Mental Capacity Act 2005. <input type="checkbox"/></p> <p>I have taken into account the conclusions of the mental health assessor as to how the person's mental health is likely to be affected by their being deprived of liberty. <input type="checkbox"/></p> <p>I have taken into account any assessment of the person's needs in connection with accommodating the person in the hospital or care home. <input type="checkbox"/></p> <p>I have taken into account any care plan that sets out how the person's needs are to be met while the person is accommodated in the hospital or care home. <input type="checkbox"/></p> <p>In carrying out this assessment, I have taken into account any information given to me, or submissions made, by any of the following:</p> <p>(a) any relevant person's representative appointed for the person</p> <p>(b) any IMCA instructed for the person in relation to their deprivation of liberty.</p> <p>Note: if this form is being used to record a Part 8 review assessment, and the best interests requirement is being reviewed solely because details of the conditions attached to the standard authorisation need to be changed in a situation in which there is a significant change in the person's overall circumstances, now proceed directly to Part F4 of this form.</p>		

PART D — WHETHER PERSON MEETS THE BEST INTERESTS REQUIREMENT

Note: if the answer to ANY of the questions D1 to D4 is No then the person is NOT eligible to be deprived of their liberty under the Mental Capacity Act 2005. Only if the answer to ALL of the questions below is Yes is the best interests requirement met.

In my opinion:

Place ONE cross in each row (no need to complete questions D2 to D4 if the answer to question D1 is No) ∅

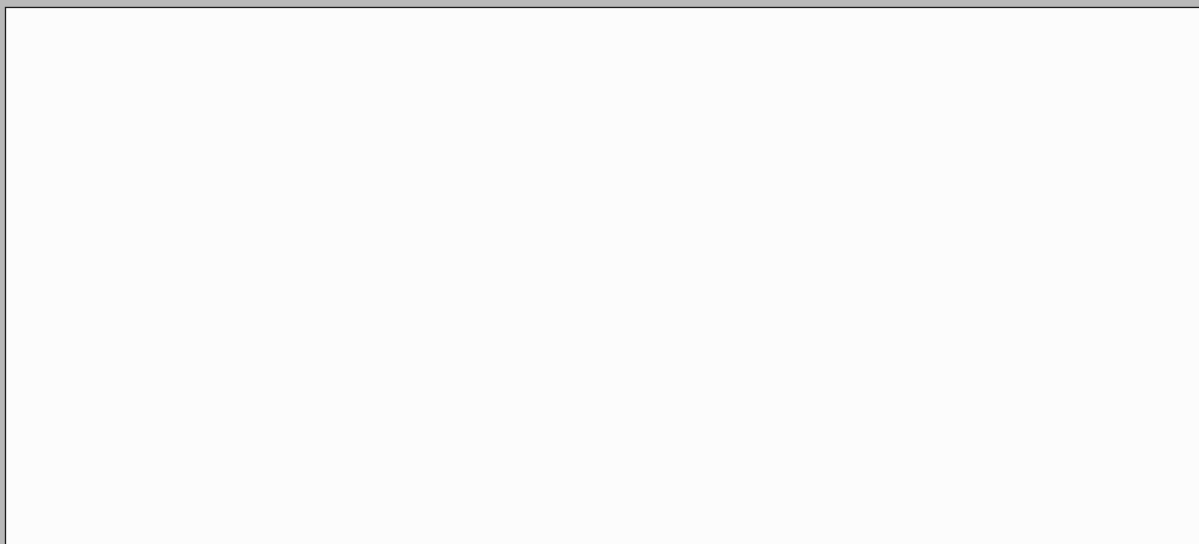
D1	The person is, or is to be, kept in the hospital or care home for the purpose of being given care or treatment in circumstances that amount to depriving them of their liberty.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
D2	This is in the person's best interests.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
D3	This is necessary in order to prevent harm to the person.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
D4	This is a proportionate response given the likelihood that the person will otherwise suffer harm and the seriousness of that harm.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Reasons for opinion

D5	The reasons for my opinion concerning whether or not the proposed arrangements for the person's care and/or treatment amount to depriving them of their liberty in the hospital or care home are:
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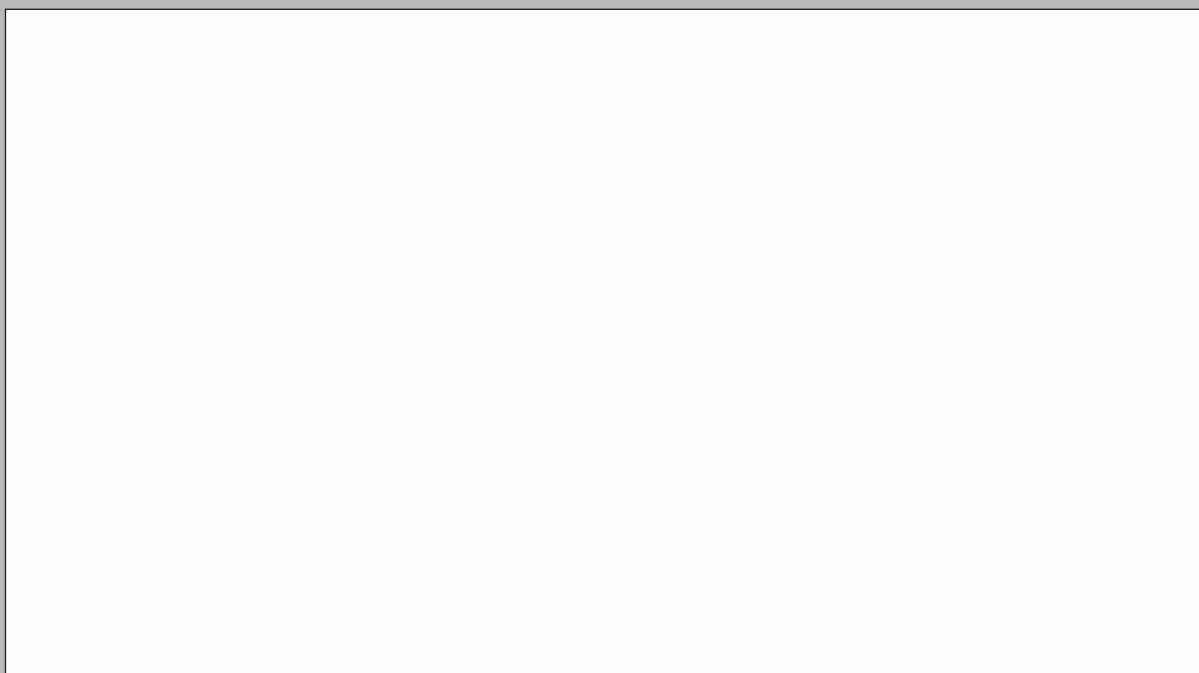
D6 If the proposed arrangements amount to depriving the person of their liberty, the reasons for my opinion that they are, or are not, in the person's best interests are:

Note: you should consider the provisions of section 4 of the Mental Capacity Act 2005, the additional factors referred to in paragraph 4.61 of the deprivation of liberty safeguards Code of Practice and all other relevant circumstances. Remember that the purpose of the person's deprivation of liberty must be to give them care or treatment. You must consider whether any care or treatment the person needs can be provided effectively in a way that is less restrictive of their rights and freedom of action.



D7 If the proposed arrangements amount to depriving the person of their liberty, the reasons for my opinion that they are, or are not, necessary in order to prevent harm to the person are:

Note: include particulars of the harm that will be avoided by depriving the person of their liberty.



D8	If the proposed arrangements amount to depriving the person of their liberty, the reasons for my opinion that they are, or are not, a proportionate response to the likelihood of the person otherwise suffering harm and the seriousness of that harm are:	
<p>Note: include why the risk of harm, and the seriousness of the harm, justifies deprivation of liberty.</p> <div style="border: 1px solid black; height: 250px; width: 100%;"></div> <p>Please go on to:</p> <ul style="list-style-type: none"> • Part E of the form if the best interests requirement is not met; OR • Part F of the form if the best interests requirement is met. 		
<p>PART E — BEST INTERESTS REQUIREMENT IS NOT MET</p> <p>Part E must be completed if you decided that the best interests requirement is not met.</p> <p style="text-align: right;">Place a cross in EITHER box E1 or E2 below Ø</p>		
E1	For the reasons given above, it appears to me that the person IS, OR IS LIKELY TO BE, deprived of their liberty. In my view, the deprivation of their liberty under the Mental Capacity Act 2005 is not appropriate. Consequently, unless the deprivation of liberty is authorised under other statute, the person is, or is likely to be, subject to an unauthorised deprivation of liberty.	<input type="checkbox"/>
E2	For the reasons given above, it appears to me that the person IS NOT, OR IS NOT LIKELY TO BE, deprived of their liberty. Consequently, the person is not, or is not likely to be, subject to an unauthorised deprivation of liberty.	<input type="checkbox"/>

If you have put a cross in box E1, please offer any suggestions that you have that may be beneficial to the commissioners and/or providers of services in deciding on their future action. This might, for example, include a recommendation about an alternative approach to care or treatment that would avoid deprivation of liberty:

PART F — BEST INTERESTS REQUIREMENT IS MET

F1 MAXIMUM AUTHORISATION PERIOD

State period in the box below. This must not exceed one year Ø

In my opinion, the maximum period it is appropriate for the person to be deprived of liberty under this standard authorisation is:

F2 DATE WHEN THE STANDARD AUTHORISATION SHOULD COME INTO FORCE

I recommend that the standard authorisation should come into force:

Place a cross in box A or enter the date in row B Ø

A	As soon as possible	<input type="checkbox"/>
B	On (date):	<input type="text" value="d"/> <input type="text" value="d"/> <input type="text" value="m"/> <input type="text" value="m"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/> <input type="text" value="y"/>

F3 RECOMMENDATIONS AS TO CONDITIONS

Complete F3 if you are completing this form in connection with a request for a standard authorisation.

Complete F4 INSTEAD if you are completing this form to record a Part 8 review assessment.

Do NOT complete both F3 and F4.

See the notes at the end of this form for guidance on imposing conditions.

Place a cross in box A or box B \emptyset

A	I have no recommendations to make as to the conditions to which any standard authorisation should or should not be subject (proceed to Part G of this form).	<input type="checkbox"/>
B	I recommend that the conditions specified immediately below should be attached to any standard authorisation that is given.	<input type="checkbox"/>

Any standard authorisation given should be subject to the following conditions:

(If more than six conditions are recommended, please add any additional conditions in Part G.)

1	
2	
3	
4	
5	
6	

Should any recommended conditions not be imposed:	
If you have made recommendations about conditions, place a cross in one of the boxes below Ø	
A	I would like to be consulted again, since this may affect some of the other conclusions that I have reached in my assessment. <input type="checkbox"/>
B	I do not need to be consulted again, since I do not think that the other conclusions reached in this assessment will be affected. <input type="checkbox"/>
<p>F4 RECOMMENDATIONS AS TO VARYING ANY CONDITIONS</p> <p>Only complete F4 if you are using this form to record a Part 8 review assessment. In all other cases, do not complete F4.</p> <p style="text-align: right;">Place a cross in EITHER box A OR box B Ø</p>	
A	I am of the opinion that the existing conditions to which the standard authorisation is subject are appropriate and should not be varied. <input type="checkbox"/>
B	I recommend that any existing conditions to which the standard authorisation is subject should be varied in the way shown immediately below. <input type="checkbox"/>
<p>The conditions to which the standard authorisation is subject should be varied so that the person is now subject to the following conditions and to no others:</p> <p>(If there are more than six conditions, please add any additional conditions in Part G of this form.)</p>	
1	
2	
3	
4	
5	

6

PART G — ANY OTHER RELEVANT INFORMATION

Please use the space below to record any other relevant information, including any additional conditions that should or should not be imposed and any other interested persons consulted by you.

PART H — THE AGE ASSESSMENT

Place a cross in ONE of the four boxes below Ø

H1	The person's date of birth is given on the first page of this form and this form also constitutes the age assessment that is required.	<input type="checkbox"/>
H2	I have not been able to ascertain the person's exact date of birth. However, I am satisfied that they are aged 18 or over, and this form also constitutes the age assessment that is required.	<input type="checkbox"/>
H3	It is not clear whether or not the person is aged 18 or over. In my opinion, a more detailed age assessment is required and Form 5 should be completed.	<input type="checkbox"/>
H4	In my opinion, an age assessment is not required. The current request is for a replacement standard authorisation and there is no reason to believe that the age assessment previously done is not accurate.	<input type="checkbox"/>

Signed	
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Dated	
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WHAT TO DO NOW

It is essential that you give a copy of this assessment to the supervisory body as soon as you have completed it. This is because the supervisory body may not give a standard authorisation unless and until it has written copies of all the assessments.

If the person does not meet the best interests qualifying requirement, a standard authorisation may not be given and all other on-going assessments should stop. You should immediately notify the supervisory body, and then provide them with a copy of this assessment as soon as practicable. You must keep a written record of the assessment.

Unauthorised deprivation of liberty

See below concerning the steps that must now be taken.

NOTES

Providing the eligibility assessor with relevant information

The eligibility assessor, if they are not also the best interests assessor, must ask the best interests assessor to provide them with any relevant eligibility information that the best interests assessor may have, and the best interests assessor must comply with the request. Relevant information might, for example, include:

- (a) whether the person is subject to guardianship under the Mental Health Act 1983¹ or meets the statutory criteria for being detained under section 2 or 3 of that Act; and, if so
- (b) whether they object to being accommodated in hospital in order to be given the treatment that it is proposed to give them there for their mental disorder; and, if they do
- (c) whether any donee of a lasting power of attorney or deputy appointed by the Court of Protection has consented to each matter to which they themselves object.

Definition of 'interested persons'

Any of the following is an interested person:

- (a) the relevant person's spouse or civil partner
- (b) where the relevant person and another person of the opposite sex are not married to each other but are living together as husband and wife: the other person
- (c) where the relevant person and another person of the same sex are not civil partners of each other but are living together as if they were civil partners: the other person
- (d) the relevant person's children and step-children
- (e) the relevant person's parents and step-parents
- (f) the relevant person's brothers and sisters, half-brothers and half-sisters, and stepbrothers and stepsisters
- (g) the relevant person's grandparents

- (h) a deputy appointed for the relevant person by the court
- (i) a donee of a lasting power of attorney granted by the relevant person.

One person is another's partner if the two of them (whether of different sexes or the same sex) live as partners in an enduring family relationship.

Recommending that conditions are or are not imposed

According to the law, the best interests assessor may recommend that conditions should be attached to a standard authorisation, but should not specify conditions that do not directly relate to the issue of deprivation of liberty. Conditions could, for example, deal with contact issues, issues relevant to the person's culture or other major issues related to the deprivation of liberty, without which deprivation of liberty would cease to be in the person's best interests. Conditions may also be recommended to work towards avoiding deprivation of liberty in future.

Unauthorised deprivation of liberty

The supervisory body and managing authority must address the situation urgently where there is an unauthorised deprivation of liberty. The possibility of legal proceedings may arise.

Paragraph 5.24 of the deprivation of liberty safeguards Code of Practice states as follows:

'Where the best interests assessor comes to the conclusion that the best interests requirement is not met, but it appears to the assessor that the person being assessed is already being deprived of their liberty, the assessor must inform the supervisory body and explain in their report why they have reached that conclusion. The supervisory body must then inform the managing authority to review the relevant person's care plan immediately so that unauthorised deprivation of liberty does not continue. Any necessary changes must be made urgently to stop what would be an unlawful deprivation of liberty. The steps taken to stop the deprivation of liberty should be recorded in the care plan. Where possible, family, friends and carers should be involved in deciding how to prevent the unauthorised deprivation of liberty from continuing. If the supervisory body has any doubts about whether the matter is being satisfactorily resolved within an appropriately urgent timescale it should alert the inspection body.'