

This document is currently being revised and updated to reflect the statutory duties from the implementation of the Care Act 2014.

Adult Safeguarding

Policy Guidance and Procedures

Part 2

Practice

April 2012

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Document Control Sheet

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Review	To be reviewed by the Cambridgeshire Adult Safeguarding Board.
Equality and Diversity	These guidance and procedures are to support all vulnerable adults in Cambridgeshire.

Please check the end of this document for the latest revisions made in April 2012

IMPORTANT:

This document is in two parts, which should be read in conjunction.

Part 1 contains Contents, Introductions, Standards, Partner Agencies, Legal Reference and Guidance.

Part 2 contains Contents, Procedures, Practice Guidance and Appendices.

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PROCEDURES

Xxxxx (For Cambridgeshire County Council, Cambridgeshire Community Services NHS Trust, Cambridgeshire and Peterborough NHS Foundation Trust, Cambridgeshire Physical Disability and Sensory Services and Cambridgeshire Learning Disability Partnership).

Timescale for safeguarding process see Appendix 4.

Initial Contact and Responsibilities

Safeguarding alerts can be received via:

- Cambridgeshire Direct Contact Centre, or
- from professional to professional within health and social care services.

Unknown people - referrals must be sent via Cambridgeshire Direct Contact Centre for the attention of the Adult Safeguarding Lead for the area in which the incident took place.

On receiving a referral from Cambridgeshire Direct, the Locality Team is responsible for designating a person to check Oneserve and for receiving and checking referrals. For other referral routes within or to services, the services own general referral routes should be followed.

Known people - referrals between professionals on open cases should be passed directly to the relevant team, who must designate a person to receive and check SWIFT to see if the alleged victim is known to the service.

If there is team involvement, designated person to complete new Contact on Swift with the reason as Adult Safeguarding Concern (if Swift is used), or record the referral using usual processes.

If there is no worker or team allocated to the person (if using Swift, complete Contact with the reason "Adult Safeguarding Concern") agree allocation with Line Manager, if serious, immediately or within 24 hours.

Where the Adult Safeguarding Lead is unavailable, it is a Team Manager's responsibility to allocate the case based upon the nature and urgency of the stated issues, if serious, immediately or within 24 hours.

If the Safeguarding concern relates to a person currently open to the Safeguarding Lead, then it will be good practice, if possible, for another Safeguarding Lead to lead on the investigation and Chair any strategy meetings. If it is not possible for another Lead to take on this work, then it is essential that the team manager is involved in the safeguarding process and attends any strategy meetings.

The locality team where the abuse occurs will have the overall responsibility for coordinating the adult safeguarding arrangements, this is particularly important if the incident relates to a service user from another County.

For further information see Practice Guidance 16, Inter-Authority Investigations.

If the allegation relates to the activities of a contracted provider then Cambridgeshire County Council Procurement (Social Care) Department (Contracts) must be informed.

Within care home settings, the team whose area the service user is residing in, takes full responsibility for the whole process – investigation, discussion and strategy meeting. This would reduce the need for a number of other workers from around the county to get involved if there are several service users affected, unless they have information about people funded by their area that should be included in the discussion/meeting.

If the allegation relates to any permanent resident in a DEE nursing care home, then the referral should be passed to the relevant older person's team within Cambridgeshire and Peterborough NHS Foundation Trust.

The team who takes lead responsibility can request additional help from neighbouring teams in the case of a large number of residents having to be reviewed simultaneously, or when another team has information about the residents that would be beneficial i.e. if they are the funding team.

For issues that need further investigation regarding the conduct of domiciliary service providers, team managers must:-

- collectively identify the team who would be most appropriate to take the responsibility for leading the investigation and Chairing any strategy meetings,
- assist and support each other and take an active part in decision making
- care management concerns must be managed by the team involved with the service user, unless they are clearly safeguarding issues, in which case,
- the team member working with the person must be part of the discussion, and send information to and/or attend the strategy meeting.

In all safeguarding situations, one Team/SOVA Lead will lead on the case, this could include:

- Requesting support from other teams/workers who have knowledge of the person,
- Chairing meetings for their colleagues, to facilitate the discussion, but not lead on all the actions that come out of the meeting.

This method of managing work works very well - supporting each other has the benefit of sharing information across teams and services, reaching decisions collectively. This supporting role spans all adult social care services.

Information Gathering

The person carrying out the investigation will:

- make an assessment of what immediate steps need to be taken to protect the vulnerable adult
- in cases involving high risk to the vulnerable adult, aim to make contact immediately

- gather information from a variety of sources to provide comprehensive background information
- identify any risks for employees visiting
- make sure that the information is gathered in such a way, that where possible, the perpetrator is not alerted, sensitivity to the needs and wishes of the vulnerable adult should be maintained at all times
- if there are concerns that a child or young person living in the same household as the vulnerable adult could also be at risk, they must immediately inform the appropriate safeguarding children's team
- record all action taken on relevant forms, such as all adult social care SOC forms and CPA documentation and in Swift/Wisdom or appropriate recording systems.

Responsibility of Individual Agencies:

- it is the responsibility of each agency that is committed to the multi-agency policy and procedures to ensure that it has in place internal policies and procedures that will enable it to interact appropriately with colleague agencies in the protection of vulnerable adults
- it is the responsibility of each agency that is committed to the multi-agency policy and procedures to ensure that its staff are appropriately trained in both this and their own policy and procedure.

Responsibility of the Member of Staff:

- it is the responsibility of all staff in all health and social care settings to be alert to the possibility of abuse occurring, if they have any concerns or suspicions that abuse may have taken place, they must bring them to the attention of their immediate line manager as soon as possible or to the next senior manager in their line management structure on the same day if their own line manager is not available
- if this is not appropriate, for example where their manager is, in any way, implicated in the possible or alleged abuse, they must report the matter to the next senior manager of their manager in their line management structure
- concerns about the possible abuse of vulnerable adults should be dealt with as a priority, just as child protection issues are recognised as a priority
- it is also open to staff to use their agency's "whistle-blowing" procedure

The manager will collate information from within their own agency only to assess whether abuse may have occurred. While doing so, they will pay attention to the need to ensure that:

- the person is safe
- medical attention is provided if necessary
- any physical evidence of abuse is left undisturbed in case it is needed for forensic purposes
- details about the incident are fully recorded
- decisions (with reasons) and subsequent actions related to the incident are fully recorded as appropriate

Assessment of Immediate Risk and Response Times

(See Safeguarding Process Checklist, Appendix 4)

If the person is at great risk of harm or in need of immediate medical attention contact should be made directly with the emergency services.

If the (alleged) perpetrator is also a service user, consideration must be given to their safety and well-being and to their needs as a vulnerable adult. An Advocate or an Appropriate Adult should be provided for the (alleged) perpetrator so that their rights can be safeguarded.

In all instances the needs of the vulnerable adult for protection, support and redress must be assessed. This will be dealt with through a Strategy Discussion which should start immediately in order to decide on any urgent action that may be needed and a multi agency plan must be devised within five working days.

Strategy Discussions

Strategy discussions can be held by telephone/face to face or a mixture of both, to gather information about what is alleged to have happened and determine the course of action.

The safeguarding lead or line manager must:

- be involved in the decisions made during the Strategy Discussion, and must ensure that decisions and actions are recorded on the SOC1434
- consider who else should be informed or involved at this stage, e.g. Procurement (Social Care) Department, police, Care Quality Commission, Service Provider, GP and District Nurses
- consider confidentiality and information sharing together with the wishes of the service user taken into account (see Sharing of Information, Practice Guidance 24)
- decide whether the Adult Safeguarding Policy, Guidance and Procedures are the most appropriate response to the situation
- assess the degree of risk at this stage and to identify any immediate need for protection (see Risk Assessment, Practice Guidance 22)
- assess whether other vulnerable adults might be at risk
- make a referral to the Safeguarding Children's Team if there is concern that a child's needs are not being met or that a child is at risk of harm
- must address the needs of the alleged perpetrator if they are also a vulnerable adult and allocate responsibility for this
- decide whether there is a need for medical examination or other specialist assessments
- decide whether the most appropriate intervention is an investigation, active or passive monitoring or the referral should be no further action
- decide who will be involved in the intervention and the purpose of their involvement (this to include where applicable a representative to address Human Resources/Disciplinary/Capability issues)

- decide who will be the key person to whom all information will be passed and who will co-ordinate the intervention on an ongoing basis
- plan for any particular communication needs during the intervention
- assess whether there is any potential risk to those involved in the intervention
- assess the potential for use of legal powers at any stage now or in the future
- determine the best way to move forward based on incident evidence. (See Four Levels of Response, Practice Guidance 10)

If the allegation relates to an employee of a care service provider, following discussion and agreement with the police, the provider should be informed by the police or the Safeguarding Lead of the concern, to enable them to start their own internal investigation.

Police involvement

The police need to be informed of all allegations, to be able to make their own decision as to whether to be involved in discussions/meetings.

Where a criminal offence is suspected, ensure that:

- care is taken not to contaminate anything, which may be used as evidence; (see Preserving Evidence, Practice Guidance 20)
- if the allegation is against a relative, friend, or employed carer, the police should be contacted for their advice and course of action, prior to informing them
- if the allegation involves a member of health or social care staff it must be brought to the immediate attention of their line manager, it may be necessary to inform the police before discussing it with the employee, if so the appropriate authorised manager will do this
- if the allegation involves a member of staff from any agency other than health or social care, it will be necessary to seek guidance from the police before discussing it with the agency concerned
- counselling or questioning, either the alleged victim or the alleged abuser, must not be undertaken by staff unless instructed by the police

Feedback to People Involved

The person who makes a referral should have their referral acknowledged.

The alleged perpetrator will need to be informed of the allegation - how this is done will be guided during the initial strategy discussion. When there is a criminal investigation, the police will manage how the alleged perpetrator is informed and will guide on how information is shared.

The informal carer will normally be kept informed but what they are told may depend on the wishes of the vulnerable adult and whether or not they are the alleged perpetrator – the police will guide on this.

Informing relatives: where a person is deemed not to have capacity, a decision should be made whether relatives should be told of the allegations. When making this decision, a best interest decision should be made, and information should be provided that is relevant, without breaching Article 8 of the Human Rights Act.

Where the discussion does not lead to a strategy meeting

Agreement should be made about how the abused person (and where appropriate their relative/advocate) will be involved in drawing together an Adult Safeguarding Action Plan. This should include any action to be taken regarding protection or investigation (and may include a referral to the advocacy service), together with the monitoring and review arrangements.

Note - at any part of the process a discussion or meeting can be held as required.

Professional Meetings

Professionals Meetings have a place in the safeguarding process: they should be used for professionals to inform each other of their professional views regarding a particular issue or case and to share differing opinions, when other methods such as telephone calls do not aid communication. When there is multi-agency involvement, they assist with the sharing of information, without intent of withholding information from the person/family/carer, who may know that the meeting is taking place, and/or the outcomes of the meeting. A professional meeting is not an alternative to a strategy meeting.

The safeguarding lead or line manager must:

- be involved in the decisions made during the Professionals Meeting
- ensure that decisions and actions are recorded on the SOC1434 – a separate one per meeting
- consider who else should be involved, e.g. Procurement (Social Care) Department, Police, Care Quality Commission, GP and District Nurses.

The outcome of a professional meeting, for example, could be that it is not safeguarding or to move forward to a strategy meeting, or to address care issues.

Decisions that Indicate the Holding of a Strategy Meeting:

- it is unclear what sort of investigation is needed
- to decide which agency will conduct the investigation
- whether the investigation should be single or multi agency
- to identify the best person to lead the process
- to gather any additional information on the allegation
- to assess the degree of risk
- to decide how the vulnerable adult should be protected during the investigation
- to clarify what information can be shared with the family
- to establish what legal powers may be appropriate and any need for legal advice or opinion
- to clarify issues of mental capacity
- find out the need for an independent advocate to represent the views and wishes of the vulnerable adult and ensure that suitable arrangements are made

- some other assessment under care management or the care programme approach or action under complaints procedures may be a more appropriate response
- to clarify what additional investigations may be triggered by the particular incident, including a police investigation or disciplinary procedures
- if the perpetrator is also a vulnerable adult, to make a decision about how their needs will be addressed, who will be responsible for ensuring there is a care plan and that they have access to appropriate support
- identification and arrangement of an appropriate adult if the alleged perpetrator is a vulnerable adult and is to be interviewed by the police
- identify what special measures are needed if the vulnerable adult who has been abused is to provide evidence in a criminal prosecution, this may lead to a decision that interviews will take place in a video suite
- to discuss issues of preservation of evidence where this is relevant

Other factors to be considered:

- the potential seriousness of the incident
- several agencies have concerns and the sharing and pooling of information is desirable
- several individuals are or could be at risk
- there are indications that a number of different investigations are being undertaken (or could be)
- a criminal prosecution could be under consideration
- the alleged perpetrator is another service user
- other legal or regulatory actions are indicated
- the allegation or suspicion involves a member of staff or volunteer
- the issue could attract media attention

In considering the above a decision will be made whether or not a strategy meeting is held.

If it is decided to move to a Strategy Meeting this should be held within 28 days from the referral/alert.

If the case is serious or complex contact the Adult Safeguarding Operational Manager or Adult Safeguarding and Quality Manager and notify your senior managers.

Examples of this are:

- contentious or complex cases
- suspicious or unexplained deaths of service users
- large-scale enquiries
- threat of media attention

The following contact information must be entered on SWIFT:

- date of strategy meeting/discussion
- summary of Adult Safeguarding Action Plan

- summary of monitoring arrangements
- provide information for duty/fellow worker (bear in mind that at this stage it is only an allegation)
- enter hazard warning indicator – adult safeguarding concerns

Strategy Meeting Attendees

Attendance at a strategy meeting should be limited to those who need to know and can contribute to the decision making process, such as:

- Care Manager, if the case is known
- Care Coordinator, if the case is known to a Community Mental Health Team
- The police, if there are concerns that a crime has been committed
- The person making a referral, if they are a professional
- Care Quality Commission
- Health Care Professional
- Emergency Duty Social Worker
- The manager or member of staff of the provider service
- Legal representative if agreed
- Safeguarding Children's Worker, if there are also child protection concerns
- CCC Contracts/Procurement Team
- Commissioning Manager
- HR Manager
- Senior Manager of the employing agency
- Customer Care Manager
- IMCA Service
- Advocate
- Appropriate adult
- Environmental Health services
- Service User
- Carer
- Emergency Services

Clarify issues of communication and information sharing: what can be shared with whom.

Identify needs for language interpreters, or address the communication needs of vulnerable person with sensory or learning disabilities or dementia.

Any agency requested to attend a strategy meeting should regard the request as a **priority** and if they are unable to attend should provide information as requested and ensure that it is available at the meeting.

Specific Decisions to be taken at the Strategy Meeting

How the action in relation to the vulnerable adult who is the perpetrator will be coordinated:

- identification of, and allocation to a separate care manager, in order to ensure that their needs are met and that a support plan is devised to ensure that other vulnerable adults are not also put at risk
- identification of who should be involved in the investigation and support plan
- whether there is likely to be a criminal prosecution
- what information needs to be shared and with whom

The Adult Safeguarding Lead will maintain communication with those concerned with the care of the vulnerable adult who is also alleged to be the perpetrator.

Holding the Strategy Meeting

Minute taking - it is the Chair's responsibility to source a minute taker for the meeting - whether from their team or as offered by another team.

See Practice Guidance 4 Chairing of Strategy Meetings and Strategy Meeting Checklist, Appendix 5.

The Strategy Meeting will:

- be Chaired by an Adult Safeguarding Lead or a Manager trained in Chairing Strategy Meetings
- assess risks, decide agency to lead in any investigation, what needs doing, by whom and timescales
- include representatives from appropriate agencies
- agree an Adult Safeguarding Action Plan, which will include an assessment of risk
- determine the timescales for monitoring and review
- determine the sharing of minutes and action plan

Record the outcome of the meeting in the Adult Safeguarding Action Plan SOC1434, use a new SOC1434 form for each strategy meeting. Original minute notes must be kept securely.

Hazard/Warning Indicators must also be entered on SWIFT by the Adult Safeguarding Lead or the Chairs of Strategy Meetings where 'Substantiated', 'Not Determined/Inconclusive' and 'On-Going' outcomes to meetings have been agreed. The only occasion when it is not necessary to record Hazard/Warning Indicators is where 'Not Substantiated' outcomes to meetings have been agreed.

If the outcome of the meeting is that sanctions need to be imposed on a particular service – for example, that no further placements are made until an improvement in the service is confirmed or existing service users being moved to a different service – then this must be agreed with Cambridgeshire County Council Procurement (Social Care) Department, the Assistant Directors of the Cambridgeshire Community Services, Cambridgeshire County Council's Adult Safeguarding Team and the Cambridgeshire and Peterborough Mental Health NHS Partnership Trust. See Flow Charts, Appendices 8 and 9.

Possible Outcomes of the Strategy Meeting

- adult safeguarding action plan
- proceed on the basis of a criminal investigation
- work within the usual individual or care planning and review process
- use the care programme approach (CPA) for service users with ongoing mental health needs
- conduct an inspection or quality review where the whole establishment is in focus
- the decisions of the strategy meeting must be recorded and circulated to attendees
- that based on the evidence, there is no specifically identifiable issue of abuse but there are concerns about quality of care that could lead to abuse occurring if not addressed, therefore, for example CQC or contracts should be involved.
- there are adult safeguarding concerns but the vulnerable adult has mental capacity and has expressed a wish that no action should be taken and there are no public interest reasons for taking action against their wishes; in this case, the vulnerable adult should be told of the decision and given information about who to contact should they change their mind. A date could be fixed to review the above decision with the vulnerable adult, if a concern persists and their refusal to consent to action being taken has resulted from fear, loyalty or disempowerment as the result of long-term abuse

In all cases, the decision and reasons for closing the concern must be recorded and a copy sent to attendees, as agreed during the meeting.

Action to be taken where the Alleged Perpetrator is also a Vulnerable Adult

A vulnerable adult may be the perpetrator of abuse. The identification of indicators that a vulnerable adult may be a potential abuser should be included as part of any risk assessment of the service user.

Where a vulnerable adult is identified as a potential abuser this should be addressed as part of their support plan including:

- devising a protection plan
- devising a treatment plan
- having in place a contingency plan
- making arrangements for monitoring and reviewing arrangements

Plans should involve all relevant professionals as well as family and carers where appropriate.

An allegation of abuse perpetrated by a vulnerable adult will be dealt with in the same way as all other adult safeguarding concerns.

Immediate action should be taken to protect other vulnerable adults from harm.

Consideration should be given to inviting the alleged perpetrator to the strategy meeting, but only if agreed by the alleged victim (support must be given to ensure

that no coercion or intimidation has been involved in this decision which should be documented).

Where the police are the lead agency, consideration will also need to be given to the appropriateness of the alleged perpetrator being present.

Review of the Needs of Service Users as Part of the Investigation

- the decision to review all service users needs should be made by the relevant social care team regardless of who funds the placement because this would be in the best interests of the vulnerable service users
- balance the risk to service users with the need to avoid causing any unnecessary concern
- following the review it may be sufficient to give some general observations about quality of care
- where reviews cannot be completed for several weeks consideration must be given to what information should be disclosed

The Adult Safeguarding Action Plan

It may be necessary to establish some form of adult safeguarding plan before the full investigation concludes and if appropriate prior to the reconvened strategy meeting, at which the plan should be further reviewed.

An action plan should include:

- action to ensure the safety of the vulnerable adult/s
- action to ensure the continued involvement of the vulnerable adult and where appropriate their carer or advocate
- details of support services, treatment or therapy available either in the immediate or the longer term to the vulnerable adult

Reviewing the Intervention

The first review should be agreed as part of the action plan and should link to any support plan following which frequency of reviews will subsequently be decided, bearing in mind all the facts and the level of risk to the individual:

- the current situation and the level of risk to the individual and to the public interest
- have the outcomes for the service user been achieved
- to agree reporting/monitoring and reviewing arrangements
- if needed further investigation by a named agency or agencies
- a decision that no further action is required under safeguarding adults procedures

Medical Examination

It may be necessary, as part of the investigation, to arrange for a medical examination to be conducted. If so, the following points should be considered:

- the rights of the vulnerable adult
- issues of consent and ability to consent

- the need to preserve any forensic evidence
- the involvement of any family members and/or carers
- the need to accompany and support the vulnerable adult and provide reassurance

Complex or High Risk concerns

In the case of adult safeguarding concerns that are complex or involve high risks due to:

- contentious or complex issues
- a large-scale enquiry involving multiple service users
- a police investigation into a serious crime
- the likelihood of an Inquest
- interest from the press
- or there maybe suspicious or unexplained deaths of service users

Then contact must be made with the senior manager with safeguarding responsibilities within your organisation to discuss how the case should be managed. This should include consideration of the appointment of a suitably senior and experienced member of staff to Chair any strategy meeting and to support the Adult Safeguarding Lead.

Contact should also be made with the Adult Safeguarding and Quality Manager or the Adult Safeguarding Operational Manager to ensure that they are aware of the concerns.

Cambridgeshire County Council Procurement (Social Care) Department (Contracts) with responsibility for commissioning the service subject to the safeguarding investigation should also be informed and will be expected to co-ordinate any compliance action in line with the relevant Terms and Conditions of contract applicable to the service.

In terms of an inquest then the General Manager for the Service or relevant senior manager with safeguarding responsibilities must be made aware of any staff that are to be called to give evidence and anything that might be relevant to the case, guidance must also be sought from the communication managers.

Not Safeguarding

This would apply to situations where discussions and/or meetings take place, when it is found that the allegation made did not relate to an action that is considered to be a form of abuse, and there is clear evidence to support this decision. Most of these types of situations are identified before the investigation gets to the point of using safeguarding processes, but sometimes they are not, which is why it is important to summarise work completed to reach that decision on the SOC1434, then end the investigation, or move on appropriately using another process, such as care management or CPA.

If you make a decision that it is not safeguarding, you need to record Unsubstantiated on the SOC1434 and SOC388 in the usual way, to demonstrate that the allegation was not proven.

Definitions

Unsubstantiated

This would apply to cases where any allegations of abuse are unsubstantiated/not agreed on the balance of probabilities i.e. most likely from evidence that it did not happen.

Partly substantiated

This would apply to cases where it has been possible to substantiate some but not all of the allegations made on the balance of probabilities. For example 'it was possible to substantiate the physical abuse but it was not possible to substantiate the allegation of financial abuse'.

Substantiated

This would apply to cases where any allegations of abuse are substantiated on the balance of probabilities.

Not determined/inconclusive

This would apply to cases where it is not possible to record an outcome against any of the categories.

Ongoing

This would apply to cases when the safeguarding work has not been finalised and further discussions or meetings are required.

Commissioners of Services and Contract Monitoring

A representative from the Procurement (Social Care) Department should be invited to attend any strategy or planning meetings, if required to do so and carry out actions agreed to at the meetings. He/she will then monitor to ensure that any changes required in the management, staffing or practice of the service is undertaken.

Monitoring and Review

The allocated worker will be responsible for monitoring and reviewing the Adult Safeguarding Action Plan.

If during monitoring further concerns are raised:

- discuss with Line Manager/Adult Safeguarding Lead
- consider the purpose of reconvening a strategy meeting

Case Records

The Adult Safeguarding Action Plan **SOC1434** must be used for **Strategy Discussions, Professionals Meetings and Strategy Meetings** to record the

decisions taken, together with their qualifying reasons, actions to be taken and by whom. Where only a **Strategy Discussion** has taken place the Adult Safeguarding Lead should sign the SOC1434 and for **Professionals Meetings and Strategy Meetings** the Chair should sign it.

The SOC1434 should also be used to record information even when no further action is taken. Use a separate SOC1434 for each meeting.

Copies of the Adult Safeguarding Action Plan should be sent to all those involved in the Strategy Discussion/Meetings within **five working days**.

The SOC388 must be completed and signed off by a Manager.

Safeguarding notes/information other than those recorded on the Adult Safeguarding Action Plan SOC1434 should be recorded on the Detailed Record Form SOC902 and filed in the SOVA file in Wisdom. All other SOC902s should be filed in the usual SOC902 section.

All original documents relating to the abuse must be filed in the adult safeguarding section of the case file in Wisdom, except the initial referrals, which should be filed in the appropriate sections in Wisdom.

Keeping an Overview

A copy of the SOC388 should also be held by the Adult Safeguarding Lead to enable them to keep a central record of all the incidents of abuse, take an **overview** of monitoring arrangements and decide when Hazard/Warning Indicators should be removed from SWIFT.

Closing the Adult Safeguarding Investigation

Prior to closing an investigation, the Adult Safeguarding Lead should ensure that:

- the investigation has been completed and reached an outcome
- the case file contains all the necessary information and forms
- agencies who are involved in the Adult Safeguarding Action Plan are aware of their responsibility to re-refer the vulnerable adult should circumstances change or risks increase significantly
- the person has been informed of the outcome (and their carers/family or advocate if appropriate)
- all decisions have been recorded in writing with evidence to support the decisions clearly documented using the appropriate form
- the reasons for closing the case are recorded
- a record is made that the investigation has been formally signed off and noted as closed on SWIFT
- if appropriate, information about organisations which assist victims of crime should be made available to the vulnerable adult, victim support schemes play an important role in this, for more information see the Victim Support website on www.victimsupport.org.uk

- the outcome of the investigation has been agreed as unsubstantiated, substantiated, likely on balance of probability, unlikely on balance of probability, inconclusive, insufficient evidence or allegation withdrawn
- if the person or a vulnerable witness wishes to seek justice or redress through the criminal justice system, consideration has been given to contacting the local Court Witness Service
- the initial referrer should receive feedback with the permission of the person and given reassurance that the concerns expressed have been thoroughly investigated
- all individuals who have been involved in the investigation are notified as appropriate of the outcomes and conclusions of the investigation
- commissioning specialist health assessments if required
- determining the format of (post-interview) risk assessments
- achieving good communication between professionals/agencies
- considering what measures are needed to ensure that service users continue to be safe
- advising senior managers of any resource issues relevant to undertaking the investigation and maintaining the safety of service users
- ensuring appropriate communication with the press office

The case may remain open to Care Management or Care Programme Approach, in which case future reviews will be conducted under those procedures.

Glossary of Terms

ACPO	Association of Chief police Officers
ADASS	Association of Directors Adult Social Services
AAIU	Adult Abuse Investigation Unit
CPA	Care Programme Approach
CPS	Crown Prosecution Service
DeE	Dementia Elderly
DOL Safeguards	Deprivation of Liberty Safeguards
DWP	Department of Work and Pensions
EPUAP	European Pressure Ulcer Advisory Panel
IMCA	Independent Mental Capacity Advocates
LDAF	Learning Disabilities Awards Framework
LPA	Lasting Power of Attorney
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MARU	Multi-Agency Referral Unit
MCA	Mental Capacity Act 2005
MHA	Mental Health Act
MOJ	Ministry of Justice
NHS	National Health Service
NMC	National Midwifery Council
NQF	National Qualifications Framework
PQSW	Post Qualifying Award in Social Work
SOC1434	Adult Safeguarding Action Plan
SOC388	Adult Safeguarding Monitoring Form
SWIFT	Adult Social Care Services Client Database

Practice Guidance 1

Adult Safeguarding Action Plan SOC1434 – Completion

The Adult Safeguarding Action Plan SOC1434 should be used for Strategy Discussions, Professionals Meetings and Strategy Meetings. It should also be used to record information even when no further action is taken.

Using the SOC1434 in Strategy Discussions

The SOC1434 is used by the named worker – whether safeguarding lead or other designated worker.

- People involved in discussions – Adult Safeguarding Lead, or a social work trained Manager and others involved - names, agency, or relationship to service user.
- Record events to date, including nature of suspected abuse.
- List reports that have been referred to – type of report and author.
- Summarise the discussion, use bullet points to separate issues.
- List risks – refer to risk assessments – SOC311, CPA etc.
- Record decisions.
- If it has been decided that it is not safeguarding, with evidence to show this, summarise work completed in the decisions box then end the investigation, and/or record alternative support options in the action plan.
- Action plan – record what has happened and what is planned to happen, with names of who will be completing the actions, how and by when.
- Monitoring - how, by who and when and frequency if appropriate – link to the needs of the service user and risks still apparent.
- Review date – set to meet the needs of the service user, so may be sooner than the next scheduled review.
- Referral to other agencies as appropriate e.g. ISA – by employer if agency employee, by Lead or Manager if no other route identified, MARAC, MAPPA.
- Outcome – complete when situation resolved and cross reference with SOC388.
- Record the lead agency.
- Adult Safeguarding Lead signs the SOC1434.

Using the SOC1434 in Professionals Meetings and Strategy Meetings

Professionals meetings may take place at any time during the safeguarding process and to maintain adequate and appropriate records should be recorded on the SOC1434.

All Professional and Strategy Meetings must be recorded on a new SOC1434. The first Strategy Meeting must take place within 28 days of the original alert/referral. The SOC1434 is used as a template for the meeting minutes, with the Chair having over all responsibility for its completion.

- List people present at the strategy meeting.

- Record events to date, including nature of suspected abuse and discussions previously held.
- List reports attached – type of report and author.
- Summarise the discussion during the meeting – link to individuals where possible, verbatim recording is not needed.
- List risks – these may have changed from those first identified, new ones may have been identified and some may now be resolved. Refer to risk assessments – SOC311, CPA etc.
- Some risks may relate to the delivery of a social care service – if the service provider is regulated by CQC, information may be available to demonstrate whether the provider is compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010:
 - A report by CQC following an inspection could provide detail of compliance linked to the specific Regulations and Outcomes that were the focus of the inspection.
 - CQC’s Judgement Framework can also be referred to, to provide background information and examples of compliance and non compliance for all outcomes, at minor, moderate or major levels of concern.
- Record decisions reached during the meeting.
- If it has been decided that it is not safeguarding, with evidence to show this, summarise work completed in the decisions box then end the investigation, and/or record alternative support options in the action plan.
- Action plan – the group identifies what needs to be done, by whom and by when, with the Chair leading and ensuring agreement.
- Monitoring - how, by who, when and frequency – link to the needs of the service user and any actions identified to reduce risks.
- Review date – set by the group at a time scale to meet the needs of the service user and to reflect the actions to be taken, but should not be so long that risks are prolonged. The review could be linked to a care management review, or CPA review, depending on levels of risk and actions, or may be set as a reconvened strategy meeting if the situation has not been resolved and is ongoing – if ongoing, record this in the outcomes box.
- Referral to other agencies as appropriate e.g. ISA – by employer if agency employee, by Chair if no other route identified, MARAC, MAPPA.
- Outcome – complete when last meeting held and cross reference with SOC388.
- Record the lead agency – this should be agreed by the group.
- Chair signs the SOC1434.

Copies of the meeting minutes, which include the Action Plan should be sent to all agencies involved in the Strategy Meeting, or part minutes, covering the part of the meeting the person attended.

Practice Guidance 2

Adult Safeguarding Monitoring Form SOC388 – Completion

Return form in a sealed envelope marked 'STRICTLY CONFIDENTIAL ADDRESSEE ONLY' to: Adult Safeguarding Administrator, Cambridgeshire County Council, Box No: CC1310, Castle Court, Castle Hill, Cambridge CB3 0AP

All fields should have an entry

FRONT DESK/FRONT SHEET

First field - complete all boxes – Name, date of birth, gender, Swift ID.
Ethnicity – check one box

MAIN CLIENT CATEGORY (FRONT SHEET/FURTHER DETAILS/CATEG.)

- choose whether Adult or Elderly
- choose which client group

HAZARD - record in Swift - FRONT SHEET/FURTHER DETAILS/HAZS

Is the client known to Cambridgeshire Adult Support Services?

- choose yes or no

RELATIONSHIPS – record in Swift - FRONT SHEET/FURTHER DETAILS/RELAT

- in the box, record if the perpetrator has
 - a relationship with the vulnerable adult and
 - if they are the main carer and
 - if they live with them

CONTACT (FRONT SHEET/CONTACT TAB)

- record the date of initial contact and
- contact reason – SOVA or other local authority placement SOVA
- record contact source type
- record the team who received the contact
- record the name of the worker who received the contact
- record whether it is a new SOVA contact, or
- a SOVA contact on an existing investigation – this option means whether it is a new concern about a person who already has another SOVA investigation running and the two concerns are unrelated

INVOLVEMENTS (FRONT SHEET/INVOLVEMENTS TAB)

- record name of Adult Safeguarding Lead and
- name of team

- record whether the person is funded by Cambridgeshire, OR another
- authority/PCT – if another Authority/PCT,
 - record details – create person/LA/PCT on Swift if not known – (seek IT Helpdesk’s help if needed)

SERVICES TAB (or INDEPENDENT SECTOR PROVIDER (ISP) SPREADSHEET)

Record if the person receives a service following the investigation, yes or no and which agency commissions/funds.

FRONT DESK/NAVIGATE TO ADULT PROTECTION MODULE INCIDENTS TAB

- record start date, **and**
- end date of incident
- record location of incident
- record whether the main perpetrator is a named person, or an organisation
 - record details – create person/organisation Swift if not known – (seek IT Helpdesk’s help if needed)
- record relationship of alleged perpetrator with the person
- record if the alleged perpetrator is:
 - vulnerable themselves
 - aware of the allegation
 - are others at risk
 - does the alleged perpetrator care for others
 - choose yes, no, or unknown for each point

INCIDENTS/FURTHER DETAILS/CATEGORY

- record the nature of the abuse – check all that apply and
- if there are multiple types of abuse and
- if the abuse is domestic violence – this is if it occurred within a close domestic relationship on more than one occasion
- indicate which is the main type of abuse

DISCUSS TAB

- choose incident date (there must be a main type of abuse recorded)
- record date of initial discussion and location of discussion
- record coordinator – lead practitioner/worker leading on the case and
- name of team
- record level of risk, low medium or high – this links to the DoH definition for the AVA mandatory returns needed for DoH - see practice guidance 22 for more information
- record outcome of discussion – this must be checked for any investigation to be counted
- record whether this is a repeat referral for the same person – if yes, give date of most recent previous concern

DISCUSS TAB/FURTHER DETAILS

Add all involvements that were involved with discussions creating contact if necessary (Insert in Notes Section – Look at SOC1434 for full details).

INVEST TAB

- choose linked incident date
- choose whether single or joint investigation
- record lead agency
- record worker and team
- record priority – check one box
- record start date of investigation
- record end date of investigation
- record outcome of investigation – chose whether there will be a
 - strategy meeting, or
 - the case has concluded following the discussion

STRATEGY MEETING (ADULT PROTECTION/STRATEG TAB)

- choose linked investigation date

The following boxes may be used as many times as needed – one set for each strategy meeting, but note that the whole form does not need repeating, just this section.

- choose strategy meeting type – choose whether it is the
 - first initial meeting
 - a reconvened meeting
 - or a review meeting – this is when things have settled and you go back after a set time to check all ok
- record:
 - due date
 - planned date
 - actual date
 - delay reason
 - location
 - Chairperson
 - worker and team
 - date minutes sent out
- decision – choose whether ongoing or concluded
- has the referral led to a serious case review – choose yes or no

CASE CONCLUSIONS (Record in the Investigation or Strategy Meetings/Further Details/Outcomes)

- record the date the case concluded
- record the C1 outcome and
- record one C2 outcome – see ‘Definitions’ in the Procedures Section of the Adult Safeguarding Policy Guidance and Procedures, for guidance on the terms, Not Substantiated, Partly Substantiated, Substantiated, Not Determined/ Inconclusive.

- record perpetrator outcomes as relevant, at least one and
- record victim outcomes as relevant, at least one, link to the appropriate person

PLANS

- record the start date
- record the plan type – whether a:
 - final plan, or
 - an interim or emergency plan
- record the date of a linked strategy meeting
- record whether the person has accepted the action plan put in place – choose from yes, no, or could not give consent
- record if the persons care/support plan has been affected/changed by the action plan

PLANS/FURTHER DETAILS/OBJECTIVES

- check the box to 'safeguard the service user'
- check the box if referral passed to children's services
- check the box if Feedback Form provided

REMEMBER TO RECORD OTHER LA IF NECESSARY

- sign and record your name and date
- team leader/manager sign and record name and date

Practice Guidance 3

Advocacy

Advocacy aims to support people who need assistance to express their views and to have their own stories heard and to safeguard people in situations where they are vulnerable.

Advocacy is about standing up for and sticking with a person or a group, taking their side, helping them to get their point across. Advocacy adds weight to people's views, concerns, rights and aspirations. Independent advocacy reduces any possibility of conflict of interest ensuring loyalty to the individual or group and no one else.

There are a number of models of advocacy to support people:-

Peer or Collective Advocacy - people come together to explore ways to get their voices and stories heard.

Independent Professional Advocacy - the advocate, usually provided through an agency with expertise, represents a person's interests to assist the person to put their point over more effectively. The advocate can be a paid or volunteer worker as part of an advocacy service.

Citizen Advocacy - an unpaid citizen gets to know a person in a vulnerable situation and promotes the person's interests over a long period of time. A citizen advocate will receive initial support from an advocacy service but this will reduce as the partnership develops. Citizen advocacy can help break the cycle of a very dependent person relying totally on paid support.

Advocacy services in Cambridgeshire are:

Age UK AICH (Advice, Information, Counselling In Hunts) Andrew Holman (Independent Advocate) Adult Services Consortium - Advice Advocacy & Representation Service Cambridge Independent Advice Centre Cambridge Independent Advocacy Service Cambridge Council for Voluntary Services Cambridge Refugee Support Group Cambridge Women's Resources Centre Cambridgeshire Deaf Association Cam Sight Carers' Centre Carers Huntingdonshire Centre 33 The Children's Legal Centre Citizen's Advice Bureaux Directions Plus Dial/Druglink	Disability Information Service Hunts Ethnic Community Forum Cambridge Family Rights Group Grandparents' Federation Huntingdonshire Mental Health Association Hunts Forum Hunts Society for the Blind The Information Shop Lifecraft One Parent Families Our Voice Pensioners' Voice People First Sense Advocacy Development Network Shield Values into Action VoiceAbility The Who Cares? Trust Women's Aid
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This list is not exhaustive.

Practice Guidance 4

Chairing Strategy Meetings

See Appendix 5 - Strategy Meeting Checklist - Chair and Admin and Practice Guidance 1 – Completing the Adult Safeguarding Action Plan SOC1434.

Introduction

All comments and questions should be directed through the Chair.

Pass around an attendance list for all to sign.

Consider having name of person and organisation in front of each person on the table, the participants can write their own name and organisation on the card.

Chairperson's Introduction

“This is an adult safeguarding strategy meeting/discussion held under the Cambridgeshire Adult Safeguarding Board Policy Guidance and Procedures regarding (Insert name of vulnerable person/service)”.

Confidentiality Statement – read out by Chair

To be confirmed at the start and on the attendance list and minutes, of each meeting held under these procedures.

“The issues discussed are confidential to the members of the strategy discussion/meeting and the agencies they represent. They will only be shared in the best interests of the vulnerable adult and with explicit agreement by the Chair.

Minutes of the strategy discussion/meeting are circulated on the strict understanding that they will be kept confidential and stored securely.

In certain circumstances it may be necessary to make the minutes of the meeting available to the civil and criminal courts, solicitors, psychiatrists, other local authority social workers or other professionals involved in the care of the vulnerable adult/s.

Please note that you are signing up to the above confidentiality statement when you sign the attendance sheet.”

The Purpose of the Meeting:

It is worth spending time on this especially if people attending have not been part of a strategy meeting/discussion before to:

- determine a course of action
- consider the assessed risks
- agree responsibilities
- establish facts

Assess the needs of the victim for:

- protection
- support
- redress

Make decisions regarding follow up action for the:

- perpetrator
- service
- service manager (if they have been culpable, ineffective or negligent)

A SOC1434 will be agreed and produced to include any action taken regarding protection and investigation, together with the monitoring and review arrangements.

Actions must be read out and agreed, with each participant making a note of their allocated actions and time scales.

The action plan part of the SOC1434, if needed urgently as identified by the group, may be sent out prior to the full set of minutes being ready.

The minutes should be sent out in 14 days if possible.

A copy of the SOC1434 will be sent to everyone involved in the meeting and those who gave their apologies.

People who attend part of the meeting will be eligible to receive minutes covering the part attended only – this should be agreed by the Chair and main group of attendees.

The SOC1434 should be used as a structure and format for the meeting.

Remember to agree and record why the victim/vulnerable person has not attended the meeting.

Reconvened Meeting:

Start by going through the risks involved, decisions and actions from the previous meeting:

- monitoring and review arrangements
- date of next meeting

Attendees List

The issues discussed are confidential to those present and the agencies you represent and should only be shared in the person's best interests. Minutes of the meeting are circulated on the strict understanding they are kept confidential and are stored appropriately. Please note that if you sign the attendance list you are signing to this confidential statement.

Attendees At:.....(Held Under Cambridgeshire County Council Adult Safeguarding Procedures) On At Concerning DOB:

Name (Print)	Designation & Agency	Address (For Minutes)	Tel No	E-Mail	Report Received	Report To Follow	Signature

Template - Invitation Letter

Your ref:
My ref:
Date:
Contact:
Direct
E Mail:

Dear

Adult Safeguarding Strategy Meeting

Regarding: (Insert Name of vulnerable adult)

Venue:

Date:

Please confirm your attendance, or attendance of your representative, by phone or e-mail. If no one is able to attend and you have information to share, please send a report and indicate whether it can be shared with all those attending the meeting. It is important that reports are received at least 3 days prior to the date of the meeting.

We encourage all attendees to keep a record of their actions as discussed in the meeting. Minutes will be forwarded to you, please let us know if you do not receive your copy.

For your information, invitations have also been sent to the following people, who may take part in some or all of the meeting, according to the Chair's agenda.

.....
.....
.....

Yours sincerely

Insert your name
Your contact details

Provider Invitation Letter

Your ref:
My ref:
Date:
Contact:
Direct
E Mail:

Dear

Re: (Insert service user's name and address or service*)

You have been invited to attend an Adult Safeguarding Strategy Meeting held under Cambridgeshire Adult Safeguarding Policy, Guidance and Procedures regarding the above service user/service* (*delete as appropriate).

The meeting will be held on _____ (date and time) at
_____ (place)

The aim of the strategy meeting will be to:

- establish facts
- consider the assessed risks
- determine the course of action
- agree responsibilities

The meeting will address the needs of the victim for:

- protection
- support
- redress

The meeting will also make decisions regarding follow up action for:

- perpetrator
- service

To help with the process of the meeting it would be helpful if you brought with you the following information (delete as appropriate).

- details of client (e.g. date of birth, disabilities, capacity)
- current living situation

Continued . . .

- chronological order of incidents or events (past to present)
- any records of clients (to be determined by the Chair prior to the meeting)
- up to date client care plans and risk assessments
- any significant events
- changes in family and environmental factors

Prior to the meeting a decision will be made regarding the attendance of the service user at the strategy meeting, if the service user or their representative are not involved in the strategy meeting then this decision will be recorded on the strategy meeting minutes.

Please advise me of your attendance by returning the attached reply form or by telephone.

If you are not able to attend please let me know as soon as possible who will be attending the meeting on your behalf. If no one from your organisation is able to attend on the day then the Chair should receive a written report before the date of the meeting.

I would strongly urge you to attend the above meeting so you can participate in the decision making process.

Please don't hesitate to contact me should you require any further information.

Yours sincerely

Adult Safeguarding Lead (Chair)

Other professionals invited to this meeting are:

STRICTLY CONFIDENTIAL

Adult Safeguarding Strategy Meeting Reply Form

Strategy Meeting regarding _____ (insert clients name or service)

on _____ (date)

I will/will not* be able to attend the above meeting. (* Please delete as applicable).

My replacements name is: _____

Their contact details are:

Signed: _____

Name: _____ (Please print)

Date: _____

Please return this slip to the address below and mark Confidential.

Chair's contact details below:

Name: _____ (Chair)

Address:

Telephone Number: _____

Fax Number: _____

Email: _____

Practice Guidance 4a

Adult Safeguarding Minute Taking

Introduction

This guidance is for a person to consider when asked to minute a strategy meeting.

The Chairperson should identify the minute taker in consultation with their line manager. It is not appropriate for the same person to Chair and take minutes at the same time.

Preparation

Following discussions with the Chair, compile details of those to be invited to attend (Name/Agency/Contact details).

Send invitations with sufficient notice of strategy meeting date. Liaise with the Chair or Team Manager before sending an invitation to the Service User or Carer. Mark letters with "Private and Confidential" and use the standard letter template.

- collate a participant list
- obtain background of case with Chair or read through previous minutes
- collate and photocopy reports to be presented at the meeting
- plan your time and your Chair's time to ensure a pre-briefing, debriefing and time to produce 'first draft' soon after the meeting, try to book a quiet office for typing up the notes
- pre-briefing – meet with the Chair prior to meeting to agree the structure of the meeting and anticipate content
- clarify with the Chair arrangements in place to ensure you are able to keep track of the discussion and maintain accurate notes (e.g. can you interrupt or 'signal' to the Chair you need a moment to clarify issues or catch up if falling behind)

You may need to consider:

- waiting room/area
- pens/paper for participants
- seating arrangements/name labels on tables
- refreshments (NB: once the meeting begins the minute taker should not leave the meeting)

During the Meeting

At the beginning of the meeting pass around attendance sheet and make a note of acceptances, apologies and those not replied and pass to Chair.

Familiarise yourself with the names/details of those that attend.

Follow the Strategy Meeting/Action Plan SOC1434 Template for the meeting Agenda.

Sit in such a way as to ensure you can communicate with the Chair (ideally next to them).

Introductions should include the Minute Taker, the role you fulfil and any considerations you (or the Chair) have made to help keep a good record of the meeting.

Your task will be made easier by a Chair who:

- provides structure/time limits
- summarises information and points
- acknowledges the needs of the minute taker
- follows the SOC1434 form
- allows time for the actions to be written
- helps the minute taker after the meeting to clarify issues and provides feedback
- follows the guidelines for writing your report when taking notes of the meeting
- makes use of reports provided to the strategy meeting (you won't need to repeat this information)

Don't be afraid to ask "Do you want that recorded?" If you get lost or confused, let the Chair know you are having some difficulty. Try not to get distracted or involved in the discussions

Ensure that any additional papers circulated at the meeting are forwarded to you the Minute Taker electronically if possible, for further circulation.

Ensure that any follow up meetings are agreed and that a note is made of any date, time and likely venue mentioned for clarity with the Chair.

After the Meeting

Debrief with the Chair – check and clarify your notes. Make sure you both agree and are clear about the discussions and any actions that are to be taken. It is also an opportunity to discuss any emotional impact the strategy meeting may have had for you.

Produce a first draft for the Chair as soon as possible after the meeting (ideally within 1 working day no more than 7 days) using the SOC1434.

Liaise with the Chair regarding circulation of notes to Service User and/or Carer, ensuring any information not shared at the meeting is not included in the minutes.

Chair agrees the minutes are to be circulated. Protect the final version of documents against changes before sending out electronically or hard copy.

For part attendees, provide them with minutes of the part of the meeting they attended - this should be agreed by the Chair and main attendees during the meeting.

Original hand written notes of the meeting must be kept.

What the Minutes Should Include

The SOC1434 used will give guidance on the areas to be recorded and give prompts for the information required. The information must include the following:

- record of attendance
- apologies and details of any reports submitted in lieu of attendance
- those not present but that were invited
- factual information provided by participants (don't need to duplicate information in reports)
- information linked to source (who said what)
- agreed level of investigation if appropriate (Level 1, 2, 3 or 4)
- summary
- recommendations and reasons for recommendations (if there are any disagreements note these)
- conclusions/actions to be taken forward
- outcomes
- review date

Amending Minutes

- If an attendee of the meeting wants the minutes amending, the Chair may make the amendments if they agree with the suggested changes.
- If the Chair does not agree with the suggestions, the person wishing to make the changes should provide the Chair with their comments in writing, to then be shared with attendees of the meeting and attached as an appendix to the minutes, making it clear who the comments are from.
- The person making the comments should agree that their comments will be shared, otherwise, they cannot be included in this way.
- Non-attendees cannot request changes to the minutes.
- Changes cannot be made if a person does not agree with meeting arrangements, information provided, recommendations or outcomes.
- Minutes can only be changed if they do not reflect what was said.

Practice Guidance 5

Colleges - Residents of other local authorities attending colleges in Cambridgeshire

These placements are different to those relating to students attending local colleges on a residential basis, as these are made on a self-funding basis, and establish the residency of the service user in Cambridgeshire and therefore their eligibility for Community Care Services from Cambridgeshire County Council.

Student placements, whether at the university in Cambridge or at a specialist college for adults with disabilities, do not establish 'Residency' in the same way.

Although the Government has instituted nationally applicable eligibility criteria for Community Care Services, it remains the fact that each local authority can establish its own threshold at which it will begin to provide services. It could therefore be the case that there will be students attending colleges in Cambridgeshire who are eligible for Community Care Services in their placing authority who would not be eligible if they had established 'Residency' in Cambridge.

The Care Quality Commission may register the residential unit in a college as a "Care Home" but this does not mean that all students will necessarily be "vulnerable adults" as defined in "No Secrets".

Unlike cases of child protection, there is no legal requirement of a local authority to investigate allegations of adult abuse. The responsibility is on the local authority with whom the service user has established 'Residency' to assess their needs under the NHS and Community Care Act 1990. This would require the placing authority to assess the level of risk to the service user and to agree a relevant and appropriate protection/support package.

Good practice would require the placing authority to be part of any intervention under the Safeguarding Adults Procedures of the host authority, the responsibility of the host authority being to coordinate that intervention.

The placing authority therefore has to be part of any intervention in an active not a passive role. The Cambridgeshire Adult Safeguarding Policy, Guidance and Procedures requires the involvement of both the victim's and the perpetrator's placing authority in the intervention.

The coordination role relates to three distinct policies: that of the host authority, the placing authority and the college.

It appears likely that the majority of cases that will fall under this guidance will relate to adults with a disability. Cambridgeshire County Council may fulfil the role of the investigating authority for the placing authority and then charge that authority for its services.

This Guidance does not impact on the responsibilities of the placing authority or the college to implement their own Complaint and Disciplinary Procedures as appropriate. These should be implemented in conjunction with any intervention under Cambridgeshire County Council Adult Safeguarding Policy, Guidance and Procedures.

Practice Guidance 6

Communicating with the Media

The growth of the 24-hour media over the last few years means stories become news almost as soon as they happen. Communications teams within agencies have evolved to handle this increased demand and meet the requirements of the media.

Process

In the main, the media know to contact communications teams first for any enquiry. However, there are occasions when they may go direct to whoever they think may give them the answers they need.

The first point to identify if you are contacted by someone from the press or other media is whether they have spoken to the press office in your agency.

If they have, stop the conversation and seek advice from your communications department before answering.

If they haven't you should take the following next steps:

- take the name of the person and the media
- find out their contact details
- find out the full details of their enquiry
- at this point you should not divulge any information

Then contact your communications team for further advice – if you are unsure of who to contact, pass the information to your line manager.

Remember, if you are contacted, do not ever feel pressured into giving an answer to a question. Reporters may have deadlines but you also have a duty to ensure the answer you can give is right. A journalist will understand if you tell them you can't give them an answer there and then.

You may be the right person for the media to speak to but your communications team or your manager should make that decision and provide you with guidance. Be sure of the answers you may give and those that you may not – this may be for confidential, data protection or legal reasons.

If you ultimately do find yourself in appropriate dialogue with the media be sure to always set realistic expectations for when you or the communications team can answer their questions and the degree of information that may be shared.

Practice Guidance 7

Court Proceedings

It may be the case that a prosecution results from the Investigation. If this is the case, the following issues will need to be addressed with the active involvement, as far as possible of the vulnerable adult:

- ensuring that the investigation and the ongoing involvement with the vulnerable adult is managed and implemented in line with “best evidence”
- informing the vulnerable adult that they may be required to give evidence and be cross-examined in court
- preparing the vulnerable adult and their carers for the practical issues of a court appearance and its possible ramifications
- enabling the vulnerable adult to read their witness statement or view the video of their evidence
- record who is the responsible adult in relation to the witness
- the timing of any therapeutic input to the vulnerable adult as this may dilute the impact of the prosecution case
- building the above into the protection plan for the vulnerable adult

Practice Guidance 8

Domestic Abuse and Violence

Introduction

Domestic abuse and violence is best described as the use of physical and/or emotional abuse or violence including undermining of self-confidence, sexual violence or the threat of violence, by a person who is or has been in a close relationship.

Domestic abuse can go beyond actual physical violence. It can also involve emotional abuse, the destruction of a spouse or partner's property, their isolation from friends, family or other potential sources of support, threats to others including children, control over access to money, personal items, food, transportation, telephone and stalking.

It can also include violence perpetrated by a son, daughter or any other person who has a close or blood relationship with the victim. It can also include violence inflicted on, or witnessed by children. The wide adverse effects of living with domestic violence for children must be recognised as a child protection issue. It may link to poor educational achievement, social exclusion and to juvenile crime, substance abuse, mental health problems and homelessness from running away.

Domestic violence is not a 'one-off' occurrence but is frequent and persistently aimed at instilling fear into and compliance from, the victim.

Reference: Department of Constitutional Affairs Domestic Violence Guide to Civil Remedies & Criminal Sanctions.

Although domestic abuse is significantly under-reported, research estimates that it:

- accounts for 16% of all violent crime (source: Crime in England & Wales 04/05 report)
- has more repeat victims than any other crime (on average there will have been 35 assaults before a victim calls the police)
- costs in excess of £23 billion a year
- claims the lives of two women each week and thirty men per year
- is the largest cause of morbidity world wide in women aged 19-44, greater than war, cancer or motor vehicle accidents
- accounts for 51% of rape and serious sexual assault by a partner or former partner and thus domestic violence

Whatever form it takes, domestic abuse is rarely a one-off incident. It is more commonly a pattern of controlling or abusive behaviour through which the abuser seeks power over their victim. It occurs across all sectors of society, regardless of class, ethnicity, sexuality or geography but figures show however, that it consists mostly of violence by men against women.

One woman in four experiences domestic abuse at some stage in her life and it is estimated that one in ten women experience domestic abuse in any one year (Home Office, 2000).

During the British Crime Survey of 1996, fifteen percent of men aged 16 to 59 said they had been physically assaulted by a current or former partner at some point in their lives (one in six men also suffer domestic abuse). A deeper analysis of the data, however, revealed some important differences in the abuse used by women and men in their intimate relationships. Women's abuse against men was reported to be largely reactive and protective rather than proactive and offensive.

The victims of domestic abuse suffer on many levels such as health, housing and education and they lose the freedom to live their lives with self determination and without fear.

In 2004 a new piece of legislation was introduced to increase the protection, support and rights of victims of domestic abuse and their witnesses. This is the Domestic Violence Crimes and Victims Act 2004 and it gives police and other agencies the tools to get to the heart of domestic abuse and violent crimes. The Act is seen as a key part of the Government's aim to put victims of domestic abuse at the heart of the criminal justice system.

This Act gives police and courts new powers to deal with domestic abuse and violence, including:

- common assault which is an arrestable offence
- courts can impose restraining orders when sentencing
- the law applies to couples who have never married or lived together

Section 5 of the Domestic Violence, Crime and Victims Act 2004: causing or allowing the death of a vulnerable adult (or child) in a household - states that it is an offence to cause the death and also to have stood by and not taken reasonable steps to safeguard the victim.

Domestic Abuse and Violence and Safeguarding Adults from Abuse

On some occasions, the domestic abuse issues outlined above may need to be considered under the adult safeguarding framework because they overlap into the criteria for this procedure.

It is important that social care and health care professionals identify those cases where alleged abuse involves family members, so that they can also be recognised as domestic abuse.

For those issues of domestic abuse that do fit within the adult safeguarding procedures, a Detective Sergeant from Cambridgeshire Constabulary Domestic Abuse Unit must be contacted immediately for advice particularly in relation to risk assessment and possible referral to the Multi Agency Risk Assessment Conference (MARAC) and the advocacy service.

Police and Domestic Violence Advocates will be invited by the Adult Safeguarding Lead/Chair of the meeting, to attend the strategy meeting to offer advice and guidance in dealing with the adult safeguarding concern.

There may be occasions where the police or DV advocacy worker has uncovered the domestic abuse that has overlapped into the adult safeguarding procedures.

In such cases, it would be the responsibility of the police or DV advocacy worker to alert the relevant social care service via Cambridgeshire Direct.

As outlined within the Adult Safeguarding Policy Guidance and Procedures, the involvement of the victim is of paramount importance and where possible, victims should be encouraged to participate and be present at meetings. This is of particular resonance in domestic abuse cases as it is crucial that the alleged victim is aware of the support available to them and that their input, views, evidence and perspectives are valued.

Many domestic abuse cases coming under the adult safeguarding procedures will have police involvement and as such, appropriate information sharing and communication with the police is imperative to the protection process.

There may be cases where the alleged perpetrator is also under Multi Agency Public Protection Arrangements (MAPPA) or already known to the MARAC system, again liaison with the police will be crucial to ensure the smooth and effective co-ordination of both processes.

Vulnerable Adults tool kit – ACPO CAADA DASH RIC Risk Assessment - for MARAC can be found on www.caada.org.uk

Practice Guidance 9

Emergency Duty Team

The Emergency Duty Team (EDT) provides an emergency service outside of office hours, during the weekend and on statutory holidays.

The role of the EDT is to take any emergency action necessary to ensure the vulnerable adult's immediate safety and to protect any evidence that may be needed in either a criminal or an adult safeguarding investigation.

All actions taken by the EDT will be recorded using their standard recording formats. These will be sent to the appropriate team at the end of each duty session.

All actions will be made in accordance with the Cambridgeshire Adult Safeguarding Policy Guidance and Procedures.

EDT staff will be invited to attend any meetings that are held as a result of a referral they receive. They will not be involved in the procedures beyond that point.

The EDT is contactable outside of office hours, during the weekend and on statutory holidays on 01733 234724.

Practice Guidance 10

Four Levels of Response

All actions should be recorded using the Adult Safeguarding Monitoring Form SOC388 and Adult Safeguarding Action Plan SOC1434.

For an incident or allegation to be considered as a safeguarding referral, these 'Four Principles' need to be met:

1. The person is a vulnerable adult as defined as someone aged 18 years or over, who meets the criteria for a community care service
2. There is an alleged perpetrator – a third party/person/agency/unknown
3. There is abusive behaviour by the alleged perpetrator
4. There is harm, or a risk of harm to the vulnerable adult

If the referral does not meet the four principles, this needs to be evidenced and documented as not safeguarding using the normal reporting processes. If this decision comes out of a SOVA activity i.e. a strategy meeting, it should be recorded on the usual SOVA documentation such as the SOC1434. Further action could be for example providing information, care management, CPA, complaints, redirect.

Level One Investigation

The following will apply:

- one-off, isolated incident that has not adversely affected the vulnerable adult
- no previous history of similar incidents recorded for the vulnerable adult
- no previous history of similar incidents recorded for the service provider
- no previous history of abuse by the person alleged responsible
- not part of a pattern of abuse
- no clear criminal offence described in referral
- no clear intent to harm or exploit the vulnerable person

This will mostly apply in health and social care settings and where the perpetrator is another vulnerable adult and where all the above applies. Level one investigation would never be undertaken where the capability of the provider to investigate is in doubt or any staff are implicated in the abuse.

Examples of Actions and Outcomes at this Level (this list is not exhaustive)

- Strategy discussions and professional meetings to identify that where the abuse occurred in a service, the Service Provider Manager is the most appropriate person to investigate.
- Investigation by Service Provider.
- The provider will prepare a report for the Adult Safeguarding Lead.
- The report will record whether abuse was substantiated or not.

- The report will indicate the steps taken to address concerns to prevent further harm and ensure the wellbeing of the persons involved.
- The investigation may lead to minor alterations in the way service is provided to a person and/or alterations to the way staff or other resources are deployed in the delivery of health and social care.
- These changes will be included in the person's support plan.
- The Adult Safeguarding Lead and any other agencies involved in the strategy discussions and professional meetings are satisfied that there is no ongoing risk to the vulnerable adult or other vulnerable people.

Level Two Investigations

The following will apply:

- the wellbeing of the vulnerable adult may be being adversely affected
- the concerns reflect difficulties and tension in the way current health and social care services are provided to the vulnerable adult
- the concerns reflect difficulties and tensions within the network of informal support provided to the vulnerable adult (e.g. family/friends)
- concerns have occurred in the past, but at lengthy and infrequent intervals

Examples of Actions and Outcomes at this Level (this list is not exhaustive)

- Concerns are investigated by strategy discussions and professionals meetings if needed.
- The most relevant person to investigate will be identified by the Adult Safeguarding Lead.
- The needs of the vulnerable adult and/or alleged perpetrator of abuse are formally assessed or reviewed.
- Another person may be identified to assess or review the needs of the alleged perpetrator, if this person is also a vulnerable adult.
- Improvements may be made to the way health and social care services are provided to the vulnerable adult and/or alleged perpetrator.
- Support may be provided to enable the vulnerable adult to explore and negotiate relationships with 'significant others' in their support network.
- Current and future risks of harm or exploitation are significantly reduced or eradicated by changes to the person's care plan or adjustments with more informal support networks or personal relationships.
- The Adult Safeguarding Lead and any other agencies involved in the strategy discussion and or professionals meeting are satisfied that there is no ongoing risk to the vulnerable adult or other vulnerable people.

Level Three Investigations

The following will apply:

- the wellbeing of the vulnerable adult may be being adversely affected
- a criminal offence may have been committed
- possible breach of regulations provided by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
- possible breach of Professional Codes of Conduct
- there is an actual or potential risk of harm or exploitation to other vulnerable people
- there is a deliberate intent to exploit or harm a vulnerable adult
- there is significant breach in the duty of care between vulnerable adults and the person alleged responsible
- the referral forms part of a pattern of abuse either against a particular individual, by a particular individual or by a health or social care service

Examples of Actions and Outcomes at this Level (this list is not exhaustive)

- Concerns are investigated in strategy discussions and professionals meetings if needed.
- The most relevant person to investigate will be identified by the Adult Safeguarding Lead.
- Strategy meeting held and all parties agree the action plan.
- The designated investigation officer/s carry out their investigation/s and compile a report which outlines the process and outcome of the investigation, the evidence they found to substantiate, or refute the allegation and recommendations for providing safeguards that will reduce the risk to the person/s affected by the abuse.
- The evidence in the report is evaluated at the strategy meeting and is used to develop the safeguarding action plan to reduce risk of further abuse.
- The action plan will be incorporated into the person's support plan and monitored through support planning and review processes.
- The Adult Safeguarding Operational Manager and agencies involved with the vulnerable adult are satisfied that risk of abuse to the vulnerable adult or other vulnerable people is removed, reduced or being closely monitored.

Level Four Investigations

The following will apply:

- there are indications of institutional abuse
- the health and well-being of a number of vulnerable adults are being adversely affected
- criminal offences may have been committed
- evidence of multiple breaches of regulations issued under Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Examples of Actions and Outcomes at this Level (this list is not exhaustive)

- Concerns are investigated in strategy discussions and professional meetings if needed.
- Strategy meeting held involving the Providers, Care Quality Commission and other relevant agencies, to assess the risks to service users and agree a detailed action plan with clear roles, responsibilities and timescales.
- Relevant senior managers are notified of concerns and agreement is given for proposed actions to be taken.
- The meeting identifies the investigating officer/s with the relevant skills and seniority to undertake and co-ordinate the investigation.
- The Adult Safeguarding Lead ensures that the investigation progresses and is monitored and updated through further strategy meetings as appropriate.
- If the abuse is substantiated, the Adult Safeguarding Lead will liaise with the Procurement (Social Care) Department to alert all placing authorities for them to determine their further actions.
- All agencies involved monitor the implementation of the improvement plans through quality assurance systems i.e. inspection, contract monitoring, care management review, complaints and service user satisfaction surveys.
- Further professional meetings and strategy meetings may be arranged as necessary to monitor the progress of the action plan.

Practice Guidance 11

Good Practice Examples

Adult Safeguarding Concern - An Adult with Limited Capacity in a Domestic Setting

Mr Myrcha is 82 years of age. His short-term memory is poor; he is lonely and anxious about money. He has a twice weekly visit from a domiciliary care agency contracted by Adult Social Care Services. Mr Myrcha told one of the care workers that he feared he had been robbed. His friend Anne manages his money for him.

Referral

Care worker tells her manager who contacts Cambridgeshire Direct and an Adult Safeguarding Lead is informed.

Strategy Discussion

Adult Safeguarding Policy, Guidance and Procedures are appropriate. Mr Myrcha says £800 is unaccounted for. An “old friend” had visited him but he could not recall why. He has a safe but it is broken and he leaves his curtains open at night to make use of the street lighting and save money. He trusts Anne.

police Vulnerable Victims Coordinator contacted – agrees to visit Mr Myrcha together with a care manager.

Action Plan

- Door entry system installed.
- Vetted handyperson scheme employed to carry out gardening and maintenance work.
- Mr Myrcha signs Lasting Power of Attorney with Anne as attorney. Anne asked to keep full record of all transactions.
- Mr Myrcha starts attending day care.

Review

Mr Myrcha is still anxious but less lonely. No reports of alleged theft received since safeguarding action plan introduced. Day care to monitor and will call a review if needed.

Adult Safeguarding Concern - An Adult Without Capacity in a Domestic Setting

When Mrs Begum (born approx 1928) attended day care, a doctor observed severe bruising to her upper arms and face, thought to be of a non-accidental origin. Mrs Begum is very demanding but her husband refuses help, insisting he can cope. He is described as “attentive and caring”.

Referral

Day care made referral to Cambridgeshire Direct who passed referral to an Adult Safeguarding Lead.

Strategy Discussion

Adult Safeguarding Lead decides that the Adult Safeguarding Procedures should be followed. police informed. Agreed police will lead investigation. Mrs Begum admitted to respite care until police investigation complete.

Strategy Meeting

police photograph Mrs Begum’s injuries and carry out interviews with her husband. Mrs Begum is very unsettled in respite placement. Family involved in strategy meetings. They are unhappy and want her home. At a strategy meeting her husband states, “He might have slapped her”. police caution him.

Action Plan

Changed medication makes Mrs Begum more settled. Mr Begum agrees to accept support from home care and planned respite. He has started to attend a support group for carers at the local community centre. His son is visiting more often and doing more of the shopping and helps with lifting his mother for example, at bedtimes.

Review

Mrs Begum returns home. She is calm most of the time and Mr Begum is not so stressed. Family is happy to talk through issues with allocated social worker. police take no further action. Further review date set – 6 months.

Adult Safeguarding Concern - An Adult With Capacity in a Domestic Setting

Thomas' sister rings Cambridgeshire Direct. Thomas had a road traffic accident and now uses a wheelchair. After he received compensation his estranged wife Melanie moved back to live with him and told him she would "look after" him. Thomas has told his sister that Melanie does not provide personal assistance, shop, or cook food. He can't get out of his flat without assistance. Yesterday she pushed him down the stairs. He is hungry.

Referral

Cambridgeshire Direct refers to the Adult Safeguarding Lead who rings the referrer.

Decision

The Adult Safeguarding Lead agrees this is a situation covered by the Adult Safeguarding Procedures.

Strategy Discussion

Thomas' sister and brother-in-law bring him to their house. A care manager speaks to Thomas on the phone and to the sister and arranges to visit. He is adamant that he does not want the police involved.

Thomas says that Melanie is clearly only interested in spending his compensation money and does not want to care for him. He rings the bank and finds out that there is only £416 in his account. He wants help to gain adapted housing so he can be independent.

Action Plan

Thomas reluctantly agrees to live in a nursing home for disabled adults whilst his housing application is considered. He contacts the bank, takes Melanie's name off his account and changes his pin number.

Reviews

Six weeks later Thomas has an offer for a property that will need further adaptation. He has advertised for a personal assistant who he will pay through direct payments. He is keen to move and happy that he has made a good friend in the home and found out from other residents about local resources for disabled people. Melanie came to visit to "make up" but he told her that he did not want to see her.

Practice Guidance 12

Health Outcome Assessment for Service Users in Residential Homes, for Health Professionals

Service User's Name: D.O.B:
 Name of Care Home:

"This tool should be is used to aid the professional to assess if the health needs of a service user are being met in the care planning implemented by a care home. The tool has both an assessment and review section. The tool can then be used to identify areas of each care domain that require the care home to improve on and a section to review that the changes have been implemented. It is not an exhaustive list and decision making should remain founded in clinical judgement and best practice."

No.	Behaviour- (Non Complex)	Need met	Need not met	N/A
1.	Management of Challenging Behaviour that is of a physical and/ or verbal nature.			
2.	If ABC charts are use the information gathered should be utilised to improve the care given in the care plan.			
3.	Management of Noisy Behaviour, including trigger responses.			
4.	Management of Agitated/ Unsettled Behaviour (e.g. tendency to wander, invade the personal space of others, tendency to abscond or attempt to abscond).			
5.	Management of Inappropriate/ Unsocial Behaviour (e.g. sexually inappropriate behaviour, faecal smearing, inappropriate urination, undressing).			
6.	Management of Thought Content/ Behaviour (e.g. hallucinations or delusions that may affect behaviour or lifestyle).			
7.	Management of Cognitive Impairment in relation to retrieving short-term memory, lack of awareness of needs and risks, disorientation, lack of perception, reasoning and ability to problem solve.			
8.	Management of Psychological and Emotional Needs which are having an impact on individual health and well-being, including displaying mood disturbances (e.g. individuals who are withdrawn, low in mood/ tearful or elated). Management also includes the results of engagement in support and reassurance; to include the inclusion, planning and implementation of meaningful life activities/ occupations individualised to the service user's experience of themselves.			
9.	Management of Communication (verbal and non verbal) needs including understanding, speech and gesture and the ability or inability to reliably express their needs (+/- interpreting, visual or auditory needs).			
10.	Referral to GP for specialist services (CMHT)			
11.	Management of behavioural changes that may be as a result of a physical problem e.g. constipation, pain, low blood glucose levels.			
12.	Unwanted evidence of normalisation of challenging behaviour/ capacity issues			
	<i>Further information:</i>			
No.	Mobility	Need met	Need not met	N/A
13.	Transfers			
14.	Mobilising			
15.	Moving and handling matrix			
16.	Mobility Equipment needs			
17.	Documented sling size			
18.	Falls management/ prevention/ risk assessment			
19.	Management of Bed rails and bumpers			
20.	Referral to specialist services (Physiotherapist / OT/ Falls prevention team)			
21.	Promotion of independence			
	<i>Further information:</i>			

No.	Nutrition- Food and Drink	Need met	Need not met	N/A
22.	Swallowing difficulties			
23.	Weight and BMI monitoring			
24.	Special diets/ supplements. Kitchens notified of special requirements and provision of.			
25.	Food intake monitoring			
26.	Dehydration- Fluid input monitoring			
27.	Dehydration- promotion of fluids/ management and prevention of urinary tract infection			
28.	Dehydration- prevention of constipation			
29.	Risk prevention/ risk assessments/ Nutritional screening tools/ MUST			
30.	Referral to specialist services (Dietician/ Speech and Language Therapist)			
	<i>Further information:</i>			
No.	Continance (urinary and faecal)	Need met	Need not met	N/A
31.	Toilet regime			
32.	Catheter management			
33.	Infection management (urinary tract)			
34.	Infectious disease management, MRSA/ C-DIF/ Diarrhoea			
35.	Constipation risk			
36.	Fluid balance monitoring			
37.	Stoma care management			
38.	Preventative Care			
39.	Referral to specialist services (Continance Team)			
	<i>Further information:</i>			
No.	Tissue Viability	Need met	Need not met	N/A
40.	Wound care monitoring (including pressure sores) REFERAL TO DISTRICT NURSING TEAM			
41.	Infection management			
42.	Nutrition to promote healing			
43.	Pressure Area Care - preventative management/ risk assessments			
44.	Pressure relieving equipment- referral to DN's			
45.	Turning programme			
46.	Diabetic Neuropathy risk/foot care			
	<i>Further information:</i>			
No.	Breathing	Need met	Need not met	N/A
47.	Shortness of breath including preventative measures			
48.	Infection management (chest infection)			
49.	Prevention of infection			
50.	Management of inhalers, nebulisers			
51.	Choking concerns			
52.	Referral to specialist services			
	<i>Further information:</i>			

No.	Drug Therapies and Medication	Need met	Need not met	N/A
53.	Administration of medication			
54.	Administration of medication specifically for the management of mental health issues including "as required" medications.			
55.	Non-concordance/ compliance management			
56.	Appropriate management of side effects (non complex)- appropriate onward referral to GP or DN.			
	<i>Further information:</i>			
No.	Pain Control Management	Need met	Need not met	N/A
57.	Appropriate acknowledgement of pain including frequency and severity (non complex).			
58.	Referral to appropriate professional e.g. GP or District Nurse.			
59.	Appropriate use of non-therapeutic pain relief measures (e.g. comfortable positioning etc)			
60.	Medication administration including as required medication (non complex) e.g. Paracetamol			
	<i>Further information:</i>			
No.	Altered States of consciousness (ASC)	Need met	Need not met	N/A
61.	Management of ASC acute event (including epileptic attack and hypo/hyperglycaemia)			
62.	Appropriate preventative management to reduce the risk of harm to service user and others			
	<i>Further information:</i>			
No.	Long Term Conditions (non complex)	Need met	Need not met	N/A
63.	Management of diabetes (non complex) Including diabetic foot care Management of hypoglycaemic attack			
64.	Management of epilepsy (non complex)			
65.	Management of heart failure/ COPD (non complex)			
66.	Management of asthma (non complex)			
67.	Referral to GP, DN or other involved specialist service.			
68.	Information following hospital/clinic/ GP/ Health Professional visits included within the care plans where necessary.			
	<i>Further information:</i>			
No.	Other issues	Need met	Need not met	N/A
69.	Dependency Assessment			
70.	Management of sexuality and desire			
71.	Management of Personal Care/ dressing			
72.	Management of Washing and bathing			
73.	Management of Oral/ Dental Care			

74.	Promotion and Management of Privacy and dignity			
75.	Service User confidentiality			
76.	Evidence of service user and family involvement in care planning			
77.	Evidence that plans are preventative rather than reactive			
78.	Appropriate manual handling techniques witnessed			
79.	Evidence of multidisciplinary team working			
80.	Evidence that the service users needs are understood			
81.	Tools completed accurately/ results used to adjust, improve or adapt care.			
<i>Further information:</i>				

SECTION 1 - ASSESSMENT

Name of person these concerns were reported to at the Care Home:	
Role:	
Have they been given a copy of the concerns raised: Yes/No	
Assessment completed by:	Designation:
Signed by:	Date:

SECTION 2 - REVIEW

No.	Review finding	Health Outcome achieved	Date reviewed	Date concluded

Continue on another sheet if required.

Review completed by:	Designation:
Signed by:	Date:

Practice Guidance 13

Independent Mental Capacity Advocacy Service (IMCA) in Adult Safeguarding Cases

Consideration should be given as to the most appropriate time to instruct an IMCA in the adult safeguarding case. This will be dependent on the decisions to be made and the risks to those involved. In some cases it will be appropriate to involve an IMCA at the Strategy Discussion/Meeting stage. This would need to happen for cases where the wishes/decisions made by the individual would have a significant impact on the investigative process or where immediate actions need to be taken to safeguard the individual prior to further investigations taking place.

Where an IMCA has been involved at any stage of the process, they should be invited to attend strategy meetings, as appropriate, including any subsequent reviews. The involvement of the IMCA should be reviewed once the specific decisions that prompted the referral have been resolved.

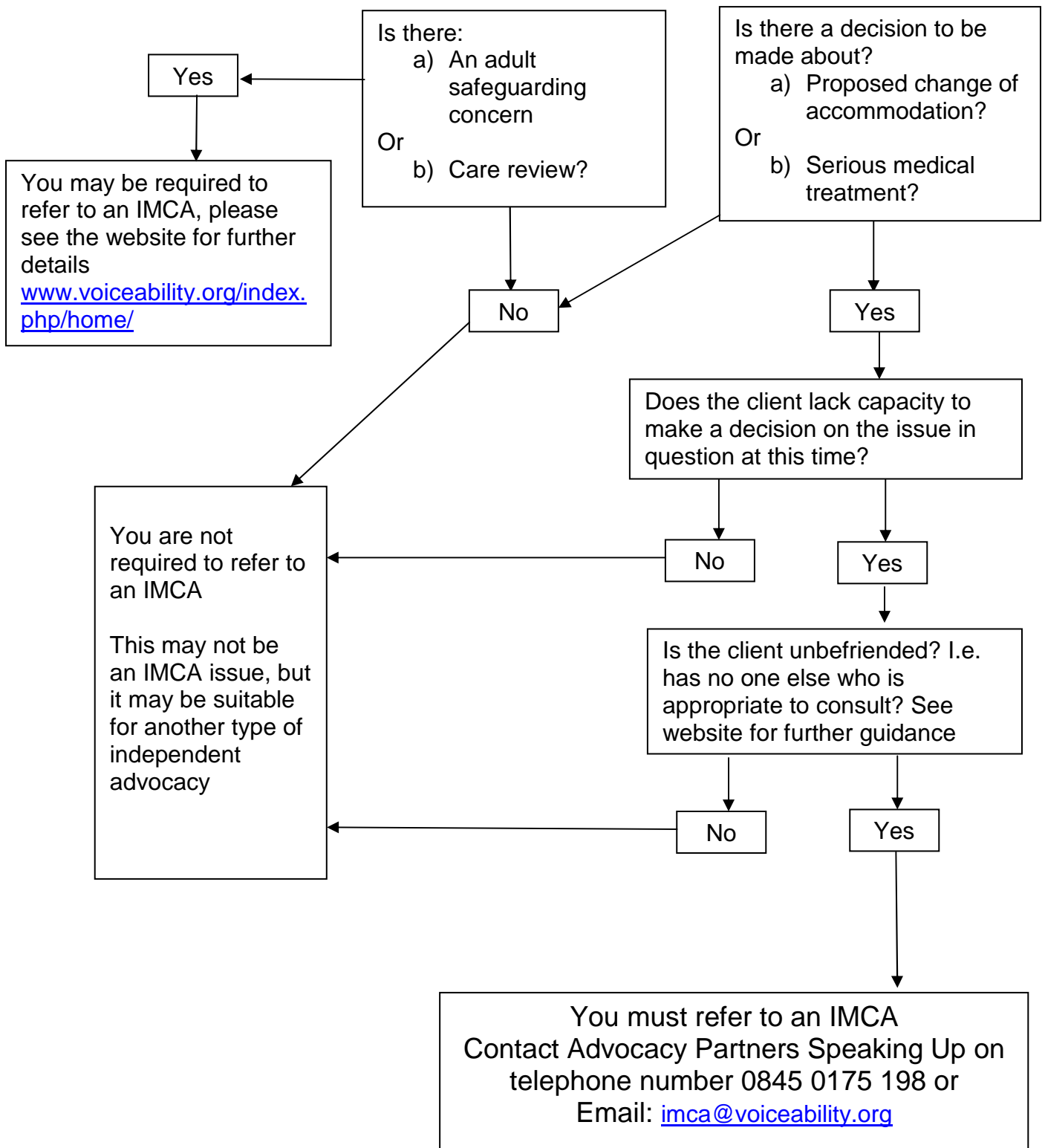
In some situations, a case may start out as an adult safeguarding case, where consideration is given whether or not to involve an IMCA under the set criteria – but this subsequently becomes a case where the allegations or evidence give rise to the question of whether the person should be moved in their best interests. The case then becomes one where an IMCA must be involved if there is no one else appropriate to support and represent the person in this decision.

In those cases involving Lasting Powers of Attorney, where there is reasonable belief that the person holding the LPA is not acting in the best interests of the person lacking capacity, an application should be made to the court of protection for either a best interest decision or to displace the LPA before an IMCA is considered.

What are the criteria for referring someone to the IMCA Service?

- Where a life-changing decision is involved and consulting family or friends is compromised by the reasonable belief that they would not have the person's best interests at heart.
- Where there is a conflict of views between the decision makers regarding the best interests of the person.
- What are the criteria for not involving IMCA in an adult safeguarding case?
- There are family or friends or another advocate who are not involved in the allegations of abuse who are willing and able to support the person.

Should I refer my client to an Independent Mental Capacity Advocate (IMCA)?



Practice Guidance 14

Independent Safeguarding Authority (ISA) Overview

ISA Registration

The scheme was officially launched in October 2009 but does not start for new workers or those moving jobs until July 2010. ISA-registration does not become mandatory for these workers until November 2010.

All other staff will be phased into the scheme from 2011. (Put on hold by government June 2010, until a review and redefinition of ISA is carried out).

However, important changes came into effect on 12 October 2009. These are outlined below.

The ISA will now administer two single barring lists:

- for those barred from working with children
- for those barred from working with vulnerable adults

There is a new statutory duty to share information – employers, social services and professional regulators have to notify the ISA of relevant information so that the ISA can give consideration to the suitability of individuals to work with vulnerable groups and bar them if necessary.

It is a criminal offence for a barred individual to seek or undertake work or volunteer with vulnerable groups, punishable by imprisonment for up to five years or a fine of up to £5,000.

It is a criminal offence for an employer to knowingly recruit a barred individual to undertake regulated activity, punishable by imprisonment of up to five years or a fine of up to £5,000.

Barring provisions under the Safeguarding Vulnerable Groups Act 2006 have come into force, extending the range of activities and workplaces which individuals may be barred to include all regulated activities as defined by the Act.

Regulated Activity

Regulated activity includes any activity that involves or allows contact with children or vulnerable adults and is of a specified nature, such as teaching, or in a specified place, such as nursing homes. It also covers some defined positions of responsibility, such as school governors.

Employers who provide regulated activities are termed a RAP – Regulated Activity Provider.

Regulated activity is when the activity is undertaken 'frequently' (once a month or more often), 'intensively' (at any time on three or more days in a 30-day period) or overnight (between 2am and 6am).

Those employed in domestic situations, such as home carers, or self-employed people working in regulated activity, should register with the Scheme, although it will not be mandatory for domestic employers to check ISA status.

Controlled Activity

Controlled activity is described as 'frequent' or 'intensive' support work in settings such as further education, social care or health or where individuals have access to sensitive records about children or vulnerable adults.

Employers will be under the same obligation to check the ISA status of applicants for both regulated and controlled activity and it will be a criminal offence to fail to do so. An employer can, however, permit a barred individual to work in controlled activity provided that sufficient safeguards are put in place to protect children and/or vulnerable adults.

The ISA and the Department for Children, Schools and Families (DCSF) have stressed that employers will retain their responsibilities for ensuring safe recruitment and employment practices; ISA registration is an additional safeguarding mechanism.

Relevant Conduct

Relevant conduct is defined in the Safeguarding Vulnerable Groups Act 2006 and is any conduct:

- that endangers a child or vulnerable adult or is likely to endanger a child or vulnerable adult
- that if repeated against or in relation to a child or vulnerable adult would endanger them or would be likely to endanger them
- involving sexual material relating to children (including possession of such material)
- involving sexually explicit images depicting violence against human beings (including possession of such images), if it appears to the ISA that the conduct is inappropriate
- of a sexual nature involving a child or vulnerable adult, if it appears to the ISA that the conduct is inappropriate

The Harm Test

The harm test is satisfied if the RAP believes that an individual may:

- harm a child or vulnerable adult
- cause a child or vulnerable adult to be harmed

- put a child or vulnerable adult at risk of harm
- attempt to harm a child or vulnerable adult; or
- incite another to harm a child or vulnerable adult

Relevant Offence

A relevant offence for the purpose of referral to the ISA is an automatic inclusion offence, which is set out in the Safeguarding Vulnerable Groups Act 2006.

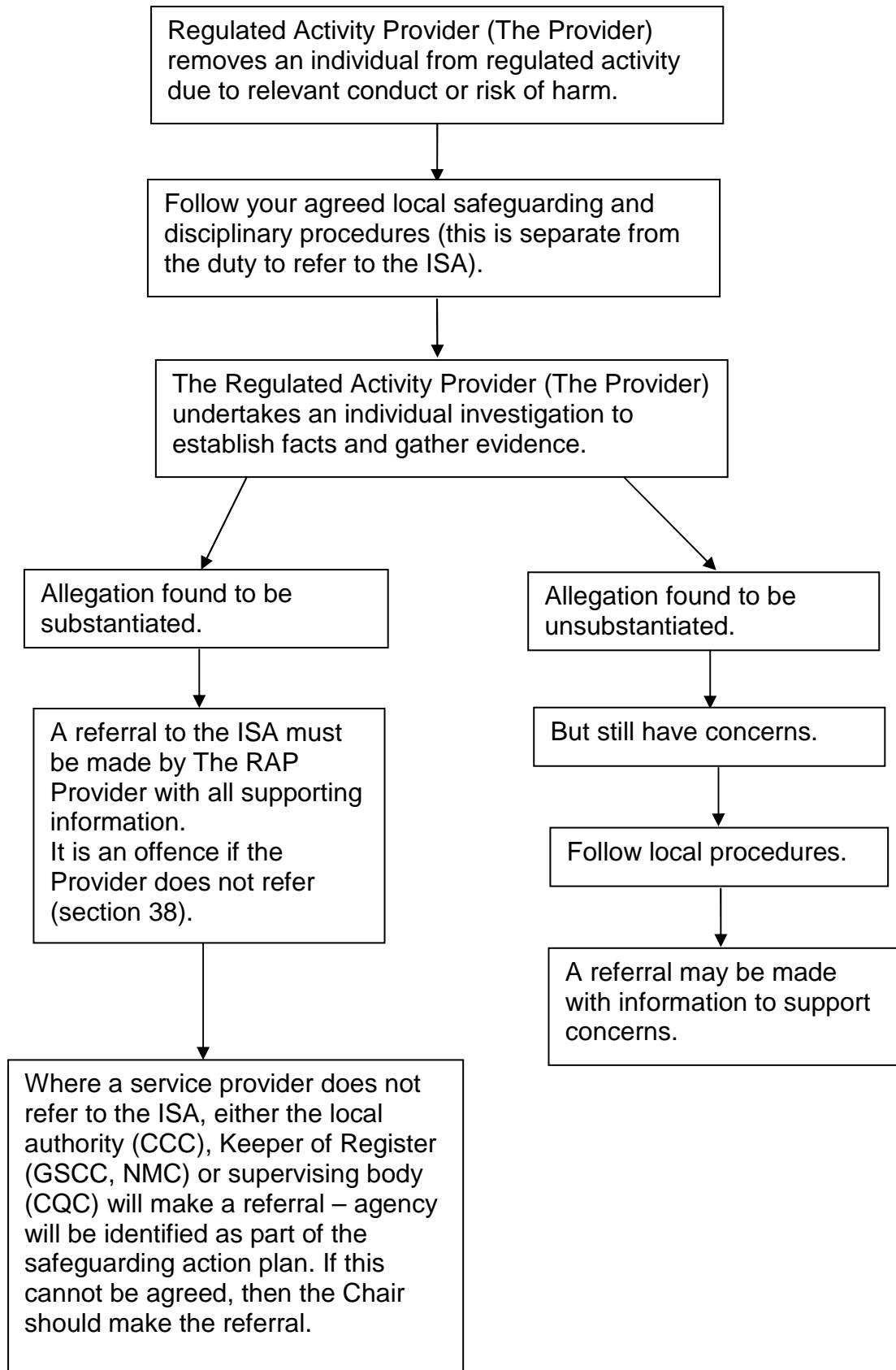
It is important to note that suspension without prejudice can take place and does not mean the person is liable, until the RAP has gathered sufficient evidence to suggest that, on the balance of probabilities, relevant conduct did occur or the harm test is satisfied.

However, it is not necessary for the individual to be permanently removed from their post. If, on balance, an allegation is found to be true but it is deemed that a formal warning is sufficient and the employee is able to return to regulated activity, the RAP is still under a duty to refer that individual to the ISA.

Referral to ISA

The RAP (Provider) employer of the employee, who has demonstrated harmful or potentially harmful behaviour to a vulnerable adult, has the responsibility for referring the person to the ISA, as they have the employee's employment history and details of their conduct. The employer can still make a referral if the person has left their employment, as they will have the details of the individual's conduct whilst working for them. Section 38 of the Act makes it an offence if the RAP (The Provider) does not refer as required to do so under section 35 (RAP) and 36 (personal supplier).

When the employer does not have the information about the employee, for example when the employer is no longer in business, the local authority (CCC), Keeper of Register (GSCC, NMC) or supervising body (CQC) will make the referral. The decision regarding which agency will be responsible for making the referral will be part of the safeguarding action plan - this will be based on knowledge held by each agency. If this cannot be agreed, then the Safeguarding Lead or Chair of the Strategy Meeting should make the referral.



Practice Guidance 15

Inter Agency Serious Case Review Practice Guidance and Procedure (ADASS)

The purpose of this document is:

- to provide guidance to the Cambridgeshire Adult Safeguarding Board (CASB)
- to facilitate the development of practice guidance and procedures in undertaking a serious case review
- to acknowledge that there is no statutory requirement for agencies to cooperate with such reviews, however where voluntary involvement has been achieved the outcome has led to good practice development

The document 'No Secrets'¹ (March 2000) issued by the Department of Health and Home Office under section 7 of the Local Authority Social Services Act 1970, gave guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.

The guidance states that local agencies should collaborate and work together to achieve effective inter-agency working through the formation of multi-agency management committees.

The document Safeguarding Adults published by the Association of Directors for Social Services (ADSS) published in (October 2005) provides a National Framework of Standards for good practice and outcomes in adult safeguarding work. One of the standards in this document states that as good practice Adult Safeguarding Boards have in place a serious case review protocol.

Relevant Standards: 1.22 - 9.10.15²

It is recommended that:

There is an adult safeguarding serious case review protocol. This is agreed, on a multi-agency basis and endorsed by the Coroner's Office and details the circumstances in which a serious case review will be undertaken. For example: when an adult experiencing abuse or neglect dies, or when there has been a serious incident, or in circumstances involving the abuse or neglect of one or more adults. The links between this protocol and a domestic violence homicide review should be clear.

¹ No Secrets Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse Department of Health 2000.

² Safeguarding Adults – A National Framework of Standards for good practice in and outcomes in adult safeguarding work ADSS 2005.

Purpose

The purpose of having a case review is not to reinvestigate or to apportion blame. It is:

- to establish whether there are lessons to be learnt from the circumstances of the case and the way in which local professionals and agencies work together to safeguard vulnerable adults
- to review the effectiveness of procedures
- to inform and improve local inter-agency practice
- to improve practice by acting on learning (developing best practice)
- to prepare or commission an overview report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action^{3 4}

It is acknowledged that all agencies will have their own internal/statutory review procedures to investigate serious incidents: this protocol is not intended to duplicate or replace these. Agencies may also have their own mechanisms for reflective practice.

Criteria for Inter Agency Serious Case Reviews

The CASB has the lead responsibility for commissioning an inter agency serious case review. A serious case review should be considered when:

- a vulnerable adult dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death
- a vulnerable adult has sustained a potentially life-threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect and the case gives rise to concerns about the way in which local professionals and services work together to protect vulnerable adults from abuse
- serious abuse takes place in an institution, or multiple abusers are involved, the same principles of review apply, they are, however, likely to be more complex, on a larger scale and may require more time, terms of reference need to be carefully constructed to explore the issues relevant to this specific case
- the case suggests that the CASB may need to consider making changes to its guidance and procedures, or that protocols are not being understood or acted upon

³ The Secretary of State also has authority under the Local Authority Social Services Act 1970 to cause an enquiry to be held where he considers advisable.

⁴ Note – Consultation Document Guidance for Domestic Homicide Reviews under Domestic Violence, Crime and Victims Act 2004

Process for Commissioning and Carrying Out an Inter Agency Serious Case Review

The Cambridgeshire Adult Safeguarding Board will be the only body, which commissions an inter agency serious case review. The Board will publicise the terms of reference under which each serious case review will be considered and the process under which an application might be made. There must also be mechanisms for the consideration of requests from the Coroner, MPs and Elected Members.

Applications must attract the support of the quorum of the Board and that they must be made in writing to the Chair.

In the event of an application being turned down, the reasons need to be recorded in writing and given back to the applicant.

Initiating an Inter Agency Serious Case Review

The case for review will be passed to the Chair of the CASB to initiate a discussion/decision, by the quorate Board. If it is agreed, an Inter Agency Serious Case Review Panel will be set up.

The Chair of the Board will be responsible for the appointment of an Independent Panel Chair. The CASB will ensure the Serious Case Review Panel Chair receives adequate support.

The Chair of the panel will be responsible for establishing individual terms of reference and setting timescales for the review in agreement with the CASB. They will also be responsible for ensuring administrative arrangements are completed and that the review process is conducted according to the terms of reference.

The Chair of the CASB will write to the Chief Officers of all the agencies involved for nominations to the Serious Case Review Panel.

Membership of the Serious Case Review Panel will be comprised from appropriate representatives of the agencies. Each agency will nominate a representative who has appropriate levels of experience.

Conduct of the Inter Agency Serious Case Review

The initial meeting will agree:

- the detailed terms of reference
- the “evidence” required from each participant
- the support and other resources needed (any perceived deficits to be referred to Chair of the CASB)
- timescales within which the review process should be completed
- dates, times and venues of meetings
- the nature and extent of legal requirements, in particular: Data Protection, Freedom of Information and the Human Rights Act

Inter Agency Serious Case Review - Receipt of Evidence

This stage of the meeting is a relatively formal “information sharing” session and all agencies will be encouraged to query and comment on the reports presented by all agencies.

Each agency involved will be asked to:

- present and examine the chronology of events, highlighting any discrepancies
- present a comprehensive report on their agencies actions in the case
- ensure any other management reports, plus any other relevant information is made available

Inter Agency Serious Care Review - Discussion of Evidence/Adjudication

This stage is where the assessment of what might have been done differently takes place.

The review panel will:

- review and cross-reference all agency management reports and reports commissioned from any other source
- examine and identify relevant action points
- form a view on practice and procedural issues
- agree the key points to be included in the report and the proposals for action

Issues Arising

If at any stage of this procedure, information is received which requires notification to a statutory body regarding significant omission by individual/s or organisations this should be done without delay.

The Chair of the review panel should report back to the Chair of the CASB and a decision made as to whether the Inter Agency Serious Case Review process is suspended.

Report Stage

The review panel will complete the review of agency management reports and those commissioned from any other source, advising the Chair on the production of an Overview Report, which brings together information, analyses findings and recommendations for future action.

Acting on the Recommendations of the Serious Case Review

On completion, the Overview Report will be presented to the CASB which will:

- ensure contributing agencies are satisfied that their information is fully and fairly represented in the Overview Report
- ensure that the overview report contains an executive summary that can be made public
- translate recommendations from the overview into an action plan, which should be endorsed at senior level by each agency
- pass the action plan to the serious case review monitoring group for review of implementation

The action plan will indicate:

- who will be responsible for various actions
- timescales for completion of actions
- the intended outcome of the various actions and recommendations
- the means of monitoring and reviewing intended improvements in practice and/or systems
- clarify to whom the report or parts of the report should be made available and agree the means by which this will be carried out

Disseminate the report or key findings to interested parties as agreed and provide feedback and debriefing to staff, family members and where appropriate media.

Recommendations

The CASB will ensure that all recommendations are actioned and will request updates from agencies.

The action plan will remain on the Board agenda until such time that all recommendations have been implemented.

Annual Report

All Serious Case Reviews conducted within the year should be referenced within the annual report along with relevant service improvements.

Other Considerations to the Inter Agency Serious Case Review

- The right under the Freedom of Information Act and the Environmental Information Regulations to request information held by public authorities, known as the 'right to know', came into force in January 2005.
- There are 'absolute' and 'qualified' exemptions under the Act. Where information falls under 'absolute exemption', the harm to the public interest that would result from its disclosure is already established.

- If a public authority believes that the information is covered by a 'qualified exemption' or 'exception' it must apply the 'public interest test'.
- The public interest test favours disclosure where a qualified exemption or an exception applies. In such cases, the information may be withheld only if the public authority considers that the public interest in withholding the information is greater than the public interest in disclosing it.
- The Data Protection Act 1998, Children Act 1989 – updated 2004.
- There will be a need to address the budgetary requirements for undertaking Serious Case Reviews.
- Timescales for the completion of Serious Case Reviews will need to be put in place to ensure that the process is driven within a timely and specific framework.
- There may be need for the completion and implementation of media and communication strategies.

Practice Guidance 16

Inter-Authority Investigation of Vulnerable Adults

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.

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) 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 safeguarding
- 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

Procedure

The authority where the abuse occurs will have overall responsibility for coordinating the adult safeguarding 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 in 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 adult safeguarding concern.

Responsibilities of Host Authorities

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. The host authority will also coordinate initial information gathering and background checks and ensure a prompt notification to the placing authority and other relevant agencies.

It is the responsibility of the host authority to coordinate 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.

The Care Quality Commission (CQC) should always be included in investigations involving regulated care providers and enquiries should make reference to national guidance regarding arrangements for adult safeguarding.

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 so that the placing authority undertakes certain aspects of the investigation. However, the host authority should retain the overall coordinating role throughout the investigation.

Responsibilities of Placing Authorities

The placing authority will be responsible for providing support to the vulnerable adult and planning their future care needs.

The placing authority should nominate a link person for liaison purposes during the investigation. They will be invited to attend any adult safeguarding strategy meeting and/or may be required to submit a written report.

Responsibilities of Provider Agencies

Provider agencies should have in place suitable adult safeguarding procedures to prevent and respond to abuse, which link with the local inter-agency policy and procedures set out by the host authority.

Providers should ensure that any allegation or complaint about abuse is brought promptly to the attention of Cambridgeshire County Council, the police and/or the CQC in accordance with local inter-agency policy and procedures.

Provider agencies have responsibilities under the Health and Social Care Act 2008, to notify their local Care Quality Commission contact of any allegations of abuse or any other significant incidents.

Provider agencies who have services registered in more than one local authority area will defer to the CQC contact relevant to the area in which the abuse took place.

Practice Guidance 17

National (Training) Standards for Good Practice (ADASS)

Introduction

This document collects best practice and aspirations together into a set of good practice standards, which is intended to be used as an audit tool and guide by all those implementing adult safeguarding work.

There are eleven standards within the document, which are reflected within these guidance and procedures.

The training partnership has endorsed these standard principles and will use them to audit all future adult safeguarding training in Cambridgeshire.

It is the responsibility of each organisation to ensure that it has a workforce development plan that includes appropriate competencies of staff and volunteers in relation to adult safeguarding work. Staff will need different competencies depending on whether, for example, they are frontline staff or managers. All people working in the organisation must be able to recognise abuse and neglect and know how to make effective reports.

Whilst this is an individual organisational responsibility, adult safeguarding is a multi-agency task. It is therefore of great benefit if staff who will be liaising with colleagues in other agencies can take part in multi-agency courses that promote understanding of the roles of other partners.

The training partnership will play a key role in enabling organisations to plan and commission such training together.

Standards

- The training partnership oversees a multi-agency workforce development.
- The training partnership has a workforce development/training strategy and ensures that it is appropriately resourced.
- The training partnership has established standards and agreed competencies for the delivery of all adult safeguarding training which is delivered locally.
- Partner organisations jointly commission multi-agency training to meet common needs. This must include training for those undertaking specific roles within the procedures.
- Equality and diversity issues and the role of discrimination in supporting abuse and neglect is integrated into training courses.

- The partnership's training strategy includes training that is accessible to and/or specifically tailored for service users and carers e.g. 'how to make a complaint about abuse or neglect'.
- Multi-agency training meets the relevant national occupational standards for all of the target audience (e.g. NQF/Skills for Care, LDAF, PQSW).
- There is a central database of everyone who has attended adult safeguarding training; this is audited to plan and target training courses e.g. at particular staff groups.
- Each organisation ensures that staff and volunteers at all levels have appropriate knowledge of and competencies in relation to the:
 - potential for occurrence of abuse or neglect
 - identification of abuse and neglect
 - adult safeguarding policy, guidance and procedures
 - requirement to report any concerns of abuse or neglect
 - internal reporting structure for such concerns
- Each organisation has a workforce development plan that includes competencies in relation to safeguarding adults and audits the plan for reporting to the partnership on an annual basis.
- Each organisation has established safeguarding adults competencies for each staff role and enables staff to access successive levels of training in line with their personal and professional development. Where appropriate this training is mandatory.
- Every member of staff is made aware of how they can use their routine processes (e.g. single assessment, risk assessments, care planning, triage) to enable people to acknowledge that they are at risk of abuse and signpost them to effective support.
- All training delivered 'in-house' (or commissioned by external providers for partner organisations) is consistent with the local Adult Safeguarding Policy, Guidance and Procedures, as well as with relevant national standards.
- Local providers of further and higher education courses to criminal justice, health and social care professionals include safeguarding adults in their curriculum.

Practice Guidance 18

Partner Agencies - Roles and Responsibilities

A number of agencies including police, Social Care and Health have a key role in adult safeguarding.

They may take a lead responsibility in a range of situations; police do so in respect of criminal matters and Health and Independent Care Sector bodies in the course of looking after people in both community and institutional settings.

Organisations have a prime role in ensuring their staff act with probity in serving the people they care for, including patients and residents who are likely to require treatment or care for a short period.

It is clear that the County Council and its partners have a duty to meet the requirements of the operation of the multi-agency guidance and procedures to safeguard adults from abuse, each agency in a range of situations will have in place policies to guarantee safe practices, be it medical treatment, social care or management of a patient or service user's money and possessions. Equally all agencies will operate sanctions should the required standard not be achieved.

Even where these agencies recognise the need to alert the safeguarding services, or for example are obliged to report an incident in a residential placement because it is funded by the County Council, the agency will retain a prime role in taking action in respect of its own responsibilities, for example investigating the actions of its staff.

In some cases it may be clear to that agency, for example a hospital in respect of a patient who is at this time dependent but can expect to recover and resume control of their own life, that it can take the necessary steps within its own procedures and there is no added value in involving the adult safeguarding services, however, it may be appropriate to keep the Adult Safeguarding Leads informed of such events.

NHS Cambridgeshire and Cambridgeshire Community Services (CCS) NHS Trust

CCS has a responsibility for providing and commissioning health services in the community and employs a range of staff who will come into contact with vulnerable adults in the course of their normal duties. Staff will be trained to be alert to potential indicators of abuse and know how to act upon their concerns in line with the adult safeguarding procedures.

CCS has Adult Safeguarding Leads within their locality teams and a professional lead within CCS who will take on a professional lead in conjunction with the CCC Adult Safeguarding Operational Manager. The named individual will provide advice to colleagues and act as a link with other agencies.

Cambridgeshire and Peterborough NHS Foundation Trust

CPFT has a responsibility for providing Mental Health services. Staff, who will come into contact with vulnerable adults in the course of their normal duties, will be trained to be alert to potential indicators of abuse and know how to act upon their concerns in line with the adult safeguarding procedures.

CPFT has Adult Safeguarding Leads within their teams and a professional lead. The named individual will provide advice to colleagues and act as a link with other agencies.

Addenbrookes Hospital Cambridge University Hospitals NHS Foundation Trust and Hinchingsbrooke Health Care NHS Trust

The Trusts will ensure all staff are aware of their responsibilities for adult safeguarding and will provide training to support staff execute their duties in accordance with national best practice guidance.

Advice can be accessed via the named lead for each Trust, if the immediate line manager is unable to provide local resolution.

Interface between Hospital Discharge Planning Teams and Locality Teams

While the person is in hospital, the Discharge Planning Team deals with hospital based SOVA issues and if they return to the community without hospital team involvement, then the locality team deals with them.

When a person is admitted to hospital and there is a concern that they have been subject to harm prior to admission, it is the responsibility of the SOVA lead in the Discharge Planning Team to initiate a response, safeguard the person while in hospital and ensure a safe discharge destination is offered, and work collaboratively with ward staff, and the SOVA Lead in the locality team who will lead on the investigation. If the person is not known to the locality team prior to admission, the Lead in the Discharge Planning Team will lead on the investigation, and liaise with the locality team to be part of the discussion if support is required post discharge, following the usual transfer process.

When the concern is reported after discharge, the locality team will have responsibility for applying the SOVA procedures wherever the incident occurred, on the basis that they are most likely to know the service user, their care and care setting and will have already requested information about the service users care needs and concerns after discharge.

If the incident occurred in hospital, this part of the investigation should be led by a senior clinical member of health staff, who will have responsibility for the hospital part of the investigation, and will report their findings to the locality team Safeguarding Lead.

If there is an ongoing safeguarding situation being managed by the locality team prior to the person being admitted to hospital, the locality Lead should inform the discharge planning team/safeguarding Lead or appropriate person in the hospital.

Cambridgeshire Constabulary

The police will take the lead in conducting all investigations into suspected adult safeguarding cases where indications suggest that a criminal offence may have been committed.

Vulnerable adults are entitled to the protection of the law in the same way as all members of the public. Some instances of abuse will constitute a criminal offence. Examples of actions which may constitute an offence are assault, whether physical or psychological, sexual assault and rape, theft, fraud or other forms of financial exploitation, and certain forms of discrimination, for example racial discrimination. Accordingly, when complaints of alleged abuse suggest that a criminal offence may have been committed it is imperative that the police are contacted as a matter of urgency.

The National Probation Service

The Probation Service has a clear, unambiguous remit to be a public service that protects the public. To do so it must be effective in taking steps necessary to reduce re-offending and harm. The service has a history of working jointly with other public services and voluntary agencies in order to identify, assess and manage the risk in the community of offenders who have the potential to do harm. Alongside this role the service has a remit to be involved with victims of serious sexual and other violent crimes.

Offenders and non-criminal persons come into contact with the Probation Service in a number of ways. At each point of entry whether statutory or voluntary, staff are aware of the need to assess the level of risk that person may offer, to the public, to themselves and to staff, or what risk that person may be subject to from others.

To assist in this process the Cambridgeshire Probation Service is a signatory to the Sharing of Information Protocol, the principles of which guide its staff in its work with other agencies. This protocol, together with the Cambridgeshire Adult Safeguarding Policy, Guidance and Procedures will ensure that Probation staff respond appropriately should the care and wellbeing of a vulnerable adult come to their attention.

Care Quality Commission (CQC)

The Care Quality Commission is responsible for regulating a range of care services, including care homes, nursing homes, domiciliary care and nurse agencies. Services are regulated in accordance with the Health and Social Care Act 2008 and, specifically; the Care Quality Commission (Registration) Regulations 2009.

Providers should refer to CQC's: Guidance about Compliance: Essential Standards of Quality and Safety March 2010. The essential standards of quality and safety consist of 28 regulations, and associated outcomes. For each regulation, there is an associated outcome – the experiences the commission expects people to have as a result of the care they receive. When the commission checks providers' compliance with the essential standards, they focus on the 16 regulations (out of the 28) that come within Part 4 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – these are the ones that most directly relate to the quality and safety of care. Providers must have evidence that they meet the outcomes.

The Commission has an important role in working with other agencies to prevent and respond to concerns about actual or suspected abuse. This will include sharing information, in accordance with agreed Sharing of Information Protocol's and where appropriate, joint working in accordance with the Cambridgeshire Adult Safeguarding Policy, Guidance and Procedures.

The Commission must be contacted if there is any information indicating actual or potential abuse in any regulated care setting. Where allegations have been substantiated, the Commission will take appropriate action in accordance with its legal powers and enforcement protocol.

Department of Work and Pensions (DWP)

The Department for Work and Pensions (DWP) is the government department responsible for welfare. It works with people of working age, employers, disabled people, pensioners, families and children, providing services through a number of executive agencies and non-departmental public bodies.

The DWP will take the lead for concerns relating to vulnerable adults of pension age. The Pensions Service will contribute to the investigation of abuse where appropriate and can be effective in supporting and facilitating exchange of information during investigations. This is likely to involve benefit/financial and material abuse. The Pensions Service will attend strategy meetings where appropriate.

The DWP may be able to assist in cases of financial abuse against vulnerable adults of working age where social security benefits are in payment, in particular where appointees are alleged to be failing to carry out their responsibilities. In these cases action can be taken to prevent further abuse. Job Centre Plus can advise on payment methods and will attend strategy meetings where appropriate.

The Disability and Carers Service is part of the Pension, Disability and Carers Service (PDCCS) which is an executive agency of the Department for Work and Pensions (DWP). It provides financial support for customers claiming disability benefits and their carers – for example, Disability Living Allowance and Carer's Allowance. We aim to provide a high quality and efficient service to all our customers. The DWP Customer Charter sets out the standards you can expect from us and what your responsibilities are in return.

Practice Guidance 19

police Referrals

In all cases where a crime has, or is suspected to have taken place it is imperative that the police are informed at the earliest possible opportunity so that the needs of any investigation can be considered alongside the need to keep the victim safe from further harm.

In an emergency, the 999 system should be used. The operator will need to know the precise location of the emergency and the nature of it.

The most likely response will be uniformed, non-specialist officers who will have only a limited knowledge of adult safeguarding investigations.

This is most likely to be appropriate where:

- There is an immediate danger of injury to a person, especially if that person is vulnerable.
- There is a risk of serious harm to or loss of property.
- The crime is particularly serious and has just been discovered.
- The victim is still at risk from the suspect even though the risk is not physical as described above.

If the above criteria do not apply, or if the case is less serious overall, it may be more appropriate to use the force non-emergency number to arrange a scheduled response to the incident.

Depending on what has occurred it may be that the attending officers will have a greater understanding of adult safeguarding or will have received a more thorough briefing before attending.

The police non-emergency number is 101.

Formalising the referral system

In all cases, a referral to the Multi Agency Referral Unit Safeguarding of Vulnerable Adults (SOVA) desk must be initiated by using the constabulary's form 102.

At the time of receipt of the referral, it will be scrutinised by the SOVA team, who will respond as soon as possible, depending on prioritisation. The SOVA desk will be staffed at all times.

Adult Safeguarding Leads may wish to follow the referral with a telephone conversation with one of the SOVA team on 01480 847728, if an urgent response is required.

The email address for referrals and information requests are: -

va.multiagency@cambs.pnn.police.uk

Fax number for referrals and information requests

- 01480 425909

police attendance at meetings

Where a criminal investigation has been undertaken or is ongoing police officers leading the investigation should attend all professional/strategy meetings, supported where possible, by the Safeguarding Vulnerable Adult Constable (SVAC). Cases meeting the threshold of serious abuse or serious incidents should be attended by a Senior Investigating Officer (SIO).

In cases where a criminal investigation has not yet been launched, police officers will attend professional/strategy meetings either if it is expected that there will be offences disclosed at the meeting which will necessitate a criminal investigation, or if the meeting will require a decision to be made as to whether or not the threshold of criminality has been reached. They will also attend, at the discretion of the Adult Abuse Investigation Unit (AAIU) or Safeguarding Detective Sergeant, if there is no expectation of a criminal offence being launched but there is a need for the police to carry out an urgent safeguarding action using their warranted powers.

There is no expectation that Police Officers will attend meetings if there is no prospect of a criminal investigation being launched or of the police being required to assist in immediate safeguarding of vulnerable adults.

When the investigating officer is unable to attend the reasons should be documented and a written report of police actions, progress of the investigation and other relevant information should be sent to the Chair of the meeting. All those providing information should take care to distinguish between fact, observation, allegation and opinion. Prior to attending a meeting the police should ensure that all databases are searched again immediately prior to the meeting so that any new relevant information in relation to the vulnerable adult can be shared.

CAMBRIDGESHIRE CONSTABULARY
Vulnerable Adult referral form. (102)

A vulnerable adult is a person 18 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.

Division:		SOVA Ref:		Date and time of referral:		Crime/Incident Number:	
Name & contact details of person completing form (including collar number)							
Details of supervisor informed of the incident to include a summary of their involvement:							
Vulnerable Person Details:				Male/Female	DOB		
Home Address: Phone no: Previous Address?							
Present Location: (If different from above)							
Ethnic Origin		Religion		Language			
Reason considered vulnerable Tick as appropriate	Mental Health		Physical disability/illness		Learning disability	Other	
GP – details							
Supported by other agencies Details (Name of agency and name of key worker)							
Identified Risk Factors Please give signs & symptoms Is person able to protect themselves? Is there any supporting documentation?							
Name and Address of: Carer/Next of Kin or other relevant person (relative, friend, neighbour)							

Children(s) Details: Name, DOB and gender (If applicable. If children are present a separate 101 will need to be completed)					
Name of original referrer E.g. on CC3					
Address:					
Contact Phone No:					
Incident Day:		Incident Date:		Incident Time:	
Offenders name		Age/DOB		Address	

Circumstances:

Include any views of the victim, including whether they have given consent for the information to be shared, details of any other action taken by police or other agencies and results of relevant intelligence checks.

When complete please send to:

Email: va.multiagency@cambs.pnn.police.uk

Fax: 01480 425909

Practice Guidance 20

Preserving Evidence

Introduction

When dealing with any allegation of abuse, due regard should be given as to whether the police should be involved and whether it is necessary to preserve evidence relating to the incident.

Consider the following:

- the wellbeing of the victim must be your first priority
- when the police are involved following an alleged crime, they are likely to respond quickly
- to enable the police to investigate effectively it is crucial that evidence is preserved, if in doubt consult the police on the telephone prior to their arrival
- what is done or not done, in the time prior to the police arriving on the scene, may make all the difference to their investigation
- when dealing with allegations of financial abuse or other irregularities, documentation should not be removed or altered in any way

Practical Guidelines

The following points may help you preserve evidence:

- secure the scene and do not allow anyone to enter until the police arrive, with the exception of medical staff if the victim requires medical attention
- obtain consent before examining the victim
- examination should only be necessary to determine the extent of injury, provide first aid or arrange for transfer to hospital
- ensure that the victim and the alleged perpetrator do not come into contact with each other once the allegation has been made, this should prevent any cross contamination of evidence
- remember that the welfare of the alleged victim is paramount and you will not be held accountable if you inadvertently destroy or invalidate evidence
- where possible, leave things as they are, if anything has to be handled, keep this to a minimum, do not clean up, do not touch anything you do not have to
- leave weapons where they are unless they are handed to you, if a weapon is handed to you, take care not to destroy fingerprints
- do not wash anything or in any way remove blood, fibres etc
- preserve the clothing and footwear of the victim, handle them as little as possible
- note in writing the state of the clothing of both the alleged victim and the alleged perpetrator, note injuries in writing, make written notes on

the conditions and attitudes of the people involved in the incident, this should be done as soon as practicably possible

- discuss with the police how to preserve any obvious evidence such as footprints or fingerprints or any other evidence, which may have been left behind by the suspect
- preserve any videotape if security cameras are present

Cross Contamination

Whenever two objects meet there is an exchange of material from each to the other. In other words every contact leaves a trace.

Evidence in Cases of Sexual Abuse

The following should be considered in cases of sexual abuse:

- in serious cases, an examination of the victim by an appropriately trained forensic medical examiner will need to take place, if permission is granted
- an examination of the alleged perpetrator should also be carried out after arrest
- try not to have any person in physical contact with both the victim or the alleged perpetrator as cross-contamination can destroy evidence
- preserve bedding where appropriate and any items that might contain evidence e.g. used condoms
- in any instance where a victim is seriously injured and is taken to hospital, the police should ask for a sample of blood to be taken before any transfusion is given, as a transfusion will invalidate evidence in relation to blood
- health care staff should endeavour to work in conjunction with the police at the scene and to co-operate with the investigating officer during the subsequent investigation
- if an allegation of sexual abuse is disclosed days after the alleged offence, it may still be possible to collect forensic evidence, do not assume that it is too late, let the police decide

Practice Guidance 21

Pressure Ulcer(s)

For guidance on the Prevention and Treatment of Pressure Ulcers refer to the National Institute for Health and Clinical Excellence (NICE) Pressure Ulcer Policies.

Issues to Support Decision

Review information already gathered about the patient then consider the pressure ulcer history. Any grade 3 ulcer (EPUAP - European Pressure Ulcer Advisory Panel Scale) should be considered as possible neglect.

Neglect is described in the adult safeguarding procedures as: ignoring medical or physical care needs, persons physical condition/appearance is poor e.g. ulcers, pressure ulcers, soiled or wet clothing, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating and undermining personal beliefs.

If a patient presents with pressure ulcers, which are assessed as grade 3 or 4 on the EPUAP Scale, the following assessment should be done by a qualified nurse and the decision reviewed by a second clinical trained person.

Use the following criteria to assess the patient and the history of the development of the pressure ulcer.

To compile the report use the attached format. Review the standard and detail of documentation and evidence of the care regime against the criteria.

Patient History

- whether rapid onset and deterioration to a severe ulcer
- patient compliance/behaviour
- whether extensive damage in a low risk patient

Co-morbidity

- medical history
- chronic disease
- palliative care
- mental health issues

Care Regime

- poor quality care: standard of assessment and use of relevant policy and procedures to support care and appropriate documentation with a plan of care

- whether appropriate equipment has been provided
- evidence of implementation of the plan of care
- continence management
- hygiene
- deterioration of appearance
- general indicators of care – e.g. clean nails, oral care
- inappropriate prevention and treatment regimes
- recurrent pressure ulcers
- evidence of risk management

Hydration and Nutrition

- evidence of intake monitoring
- fluid balance
- regular weighing

Under/Over use of Medication

- note use of sedation if patient is immobile for extended periods
- is pain assessed and managed

Contributory Circumstances of Pressure Ulcers

- detailed history of patient journey - e.g. environmental changes
- change(s) in care setting(s)
- history of falls – has patient been on floor for extended period
- previous history of pressure ulcers
- carer involvement
- health and social care involvement

The information should be documented in the recommended format of a report and the case reviewed by a second clinical person to support the decision.

Where appropriate photographic evidence to support the case may be useful.

Recommended format of report

Name of Patient	
DOB	
Hospital number/NHS number	
Place of current care	
Previous place of care (if appropriate)	
GP or Consultant	

Documentation available at time of reporting:

Patient relevant past history should include factual information of pre-injury status highlighting medical diagnosis.	
Include the detailed patient journey and events recording documented dates/times of assessments and action taken.	
Record risk factors and other details that would impact on the subsequent care and injury.	

This section should not contain any opinion or subjective data.

Recent events and description of incident

This should include detailed recent events that caused the situation to raise concern.	
Raise issues that could contribute to injury or response to patient assessment.	

This section should not contain any opinion or subjective data.

Examination of patient

Describe patient's current status include the date of examination. Include photos if possible or details of wound assessment e.g. size (using grid) colour, position etc.	
---	--

Management

Report subsequent treatment and care including equipment specialist care and investigations.	
--	--

Opinion based on above information

This section could contain opinion but must be supported by above information or evidence and references (in the form of policy/guidelines, standard practice).	
If you have insufficient information to form an opinion record as such ensure the opinion is objective and can withstand scrutiny and questioning.	

Conclusion

This must be objective and accurate.	
--------------------------------------	--

Recommendations

Your opinion as to whether this case needs further information or investigation perhaps second opinion second examination.	
--	--

Author's details

Name	
Title	
Place of work	
Qualifications that make you an expert able to comment on this case	
Signed	

Second Reviewer

Name	
Title	
Place of work	
Qualifications that make you an expert able to comment on this case	
Signed	

Conclusions

Agree/disagree add comments	
-----------------------------	--

Recommendations

Agree/disagree add comments	
-----------------------------	--

Appendices

E.G. Photographic image and dates.

Ensure information is marked confidential.

Practice Guidance 22

Risk Assessment

Introduction

Social care staff working within Cambridgeshire Community Services NHS Trust and Cambridgeshire County Council Adult Social Care should refer to and use the usual Cambridgeshire Care Management Procedures and Forms i.e. the Specialist Social Care Assessment SOC311.

Cambridgeshire and Peterborough NHS Foundation Trust employees should follow their own recording processes and CPA documentation for risk assessment. Other health professionals should follow their own risk reporting procedures as usual.

The rest of this guidance may be used to support your practice as required.

Safeguarding Vulnerable Adults Risk Assessment

Name of alleged victim:	Completed by:
DOB:	Date:
Address:	Identifying numbers: NHS/NI/Swift etc

Summary of issues

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

The Alleged Abuse

What is the nature of the alleged abuse?

Evidence of abuse	
Harm/potential harm	

Risk Assessment

Are there factors that may mean the alleged victim could be more vulnerable to abuse?

Mental Capacity or Deprivation of Liberty issues	
They are frail or have a disability	
They appear to be emotionally dependent	
They may be socially isolated	
They may have communication needs	
They may be financially dependent	
Their carer may be under stress	

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

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

Wishes of the alleged victim

Are they aware of the abuse?	
What is their view? Do they understand the risk?	

Do they wish to remain in the same situation?	
Does the person wish involvement from other agencies? Do they consent to information being shared?	

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

The person's own: Coping abilities and strengths? Awareness of security in own home? Awareness of own rights? Awareness of what is abuse?	
Supportive informal networks – family/friends/social contacts etc	
Support services – arranged care	

What is the immediate safeguarding plan?

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

Who needs to be informed: Family carers, direct payments arrangements, other agencies involved etc?	
Are other referrals needed: Health, support for alleged perpetrator, emergency services, police etc?	
How quickly should this be dealt with? Refer to Appendix 4 of the Adult Safeguarding Policy, Guidance and Procedures – Adult Safeguarding Process Checklist	

What is the ongoing safeguarding plan?

Who will lead on the process? and who will carry out any actions needed?	
Are assessments needed, such as: community care assessment, mental capacity assessment, health care assessments, CPA, OT, etc?	
Is a meeting needed: Adult safeguarding professional meeting? Adult safeguarding strategy meeting? Who should be contacted regarding meetings?	
How will people be kept informed?	

Summary

Action to be taken	Who Involved

Assessment completed by:

Date:

Practice Guidance 23

Safer Recruitment Guidance - Resignations and Compromise Agreements

The fact that a person tenders his or her resignation or ceases to provide their service must not prevent an allegation being followed up in accordance with the service's human resources procedures. It is important that every effort is made to reach a conclusion in all cases of allegations bearing on the safety of a vulnerable adult, including any which the person concerned refuses to cooperate with the process. A full investigation should be carried out and the person should be given the opportunity to answer the allegations and make representation about it. In the event that someone refuses to cooperate with the investigation they should be advised that the process will continue and the facts will be considered as they are represented, therefore they should always be encouraged to participate in the process. They should also be advised that should the outcome of any disciplinary action be dismissal, the Independent Safeguarding Authority (ISA) would be notified.

If a person's period of notice expires before the process is complete, s/he should be advised that any reference requested by a future employer would have to state that the person left pending the outcome of an investigation into the specific allegations that were raised. However, it is important to reach and record a conclusion wherever possible.

By the same token so called compromise agreements by which a person agrees to resign and the service agrees not to pursue disciplinary action and both parties agree a form of words to be used in any future reference, must not be used in these cases. In any event, such an agreement will not prevent a thorough police investigation where that is appropriate. Nor can it override the statutory duty to make a referral to the ISA where circumstances require it.

See [Safer Recruitment Guidance](#)

Practice Guidance 24

Sharing of Information

Sharing personal and confidential information lawfully between agencies is essential when protecting vulnerable adults from abuse.

The general principles for achieving this are:

- the informed consent of the vulnerable person should be obtained whenever possible
- sharing information should be on a 'need to know basis' only
- vulnerable adults should be informed from the outset what the limits and boundaries of confidentiality are
- where possible, the vulnerable adult should be kept informed of what personal information about them is being shared with other agencies or individuals

Practitioners and Managers should always remember:

That the promise of complete confidentiality should not be given to the person reporting the referral or raising the 'concern' this includes the vulnerable adult.

When such information is passed to Adult Social Care Services, Health, CQC or the police, these agencies are likely to take positive action. This applies even if consent has not been given in circumstances such as:

- the vulnerable adult is believed to lack capacity to make informed choice
- a criminal investigation by the police is warranted
- a wider public interest exists

In furtherance of this, each partner agency must have their own policies and procedures for ensuring that vulnerable adults receive a confidential service.

It is therefore important that staff have due regard to their own agency's policies when dealing with issues of confidentiality in the context of their work regarding the abuse of vulnerable adults.

The question of sharing or disclosing information with a view to protecting vulnerable adults presents a number of professional, ethical, practical and legal dilemmas. Any disclosure of information must be bound to both common and statute law, for example the common law Duty of Confidence, the Data Protection Act 1998, the Public Interest Disclosure Act 1998, the Human Rights Act 1998 and the Health and Social Care Act 2008. (For further details of these provisions, see the Legal Section).

It will always be difficult to make decisions about whether to share (or not to share) information about risk, particularly where the issue is about disclosing to individuals or voluntary bodies. It will always be crucial to gather the best information possible about the risk posed, assess the risk and consult thoroughly before reaching a decision.

Key principles for managing information:

There are a number of key principles for managing information concerning service users in multi-disciplinary work with vulnerable adults:

- information given to an individual member of staff or agency representative belongs to the agency and not the individual employee, therefore, decisions to share information about a service user with other agencies, without the consent of the service user in question, must be made by the agency and not one individual acting on their own
- decisions made to share information concerning the service user with other agencies can normally only be made with the expressed consent of the service user
- although the views and wishes of the service user will normally be respected when sharing information they give us, agencies cannot guarantee a fully confidential service, there will always be exceptional circumstances when a duty to protect the wider public interest will outweigh the responsibility to any one individual
- information given to an agency must only be used for the purposes for which it was intended
- service users and where appropriate carers, must be advised as early as possible why and with whom information will be shared, best practice should encourage service user and carer participation in the process of information sharing
- information about service users and carers must only be shared within an agency on a need to know basis to support the effective delivery of services of that user
- decisions about who needs to know and what needs to be known should be taken on a case by case basis, within agency policies and the constraints of the legal framework
- staff have a clear duty to report any concerns they may have relating to the abuse or suspected abuse of a vulnerable adult to their line manager at the earliest opportunity

Confidentiality:

Principles of confidentiality designed to safeguard and promote the interests of service users and patients are paramount. These should never be secondary or confused to protect the management interests of an organisation. Whilst these have a legitimate role, they must never be allowed to conflict with the interests of service users and patients.

If it appears to an employee or person in a similar role that such confidentiality may be operating against the interests of vulnerable adults then a duty exists to make full disclosure in the public interest.

Confidentiality must never be confused with secrecy. Whilst it will be the responsibility of participating staff to protect the confidentiality of the information that may be exchanged, in cases where non-disclosure of

information may have a significant influence on the future safety of an individual or the wider public, the intentional withholding of information cannot be defended on the grounds of confidentiality.

Where it is necessary to disclose or exchange personal/patient identifiable information, the exchange/disclosure must always be undertaken in accordance with the principles of the Data Protection Act 1998.

These state that the information/data must be:

- processed fairly and lawfully
- processed for limited purposes and in an appropriate way
- relevant and sufficient for the purpose
- accurate
- kept for as long as is necessary and no longer
- processed in line with individual's rights
- secure

The Information Commissioner's Office has issued general guidance on the preparation and use of information sharing protocols.

Patient-Identifiable Information:

Patients have a right to expect that personal and sensitive information will be held in confidence by their doctors. Confidentiality is central to trust between doctors and patients. Without assurances about confidentiality, patients may be reluctant to give doctors the information they need in order to provide good care.

Following a formal review of the ways in which the NHS handled and shared patient information with other organisations, the review committee Chaired by Dame Fiona Caldicott, made 16 recommendations, one of which was the appointment of a Caldicott Guardian in every NHS organisation to safeguard the confidentiality of patient identifiable information.

The recommendations were translated into guidance for NHS organisations in 'Protecting and Using Patient Information: A Manual for Caldicott Guardians'. The manual and all other work on confidentiality is underpinned by the Caldicott Principles of good practice.

The Caldicott Principles summarised:

- justify the purpose(s) for using confidential information
- only use patient identifiable information when absolutely necessary (for some purposes aggregated data or non-personalised data may be sufficient)
- use the minimum data required - e.g. the NHS number, or post-code may be sufficient without name, address, date of birth etc

- access should be on a need to know basis that means that only those who need to know should have access - e.g. managers may need to know less than their staff
- everyone must understand their responsibilities with regard to confidentiality – e.g. ensuring that patient identifiable information is kept secure by using password protection on computers
- understand and comply with the law

Obtaining personal information from the Department of Work and Pensions

The Department of Work and Pensions (DWP) is an umbrella organisation which includes the executive agencies of the Pension Service and Jobcentre Plus – both of which are regulated by the Social Security Administration Act 1992.

The manner in which the DWP protects personal information and allows it to make disclosure of personal information to third party organisations is regulated by the Data Protection Act, Human Rights Act and common law. Currently, formal arrangements exist at a national level between the DWP and all Adult Social Care Authorities to exchange confidential information relating to vulnerable adults – these data sharing powers being underpinned by Social Security legislation.

Additionally, a memorandum of understanding between DWP and the Association of Chief Police Officers sets out the ways in which the disclosure of personal information between the DWP and the police can be achieved.

Whilst current arrangements imposes constraints on the disclosure of personal information to any agency other than Adult Social Care Services and the police, those agencies involved in the strategic process relating to an alleged/potential abuse of a vulnerable adult should be able to access this information through either Adult Social Care Services and/or the police. This will be on a 'need to know' basis and subject to security constraints imposed by the DWP.

Security of Information:

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

- manual and computer records containing such information is kept secure and care is taken to avoid any unintentional breach of confidence to third parties
- any breach of confidentiality is considered to be a serious matter and will be dealt with under each organisations relevant personnel policy

- one of the offences under the Data Protection Act 1998 which has particular significance for staff is that it is an offence to knowingly or recklessly obtain or disclose personal or patient identifiable information without the consent of the data controller, this covers unauthorised access to and disclosure of personal/patient identifiable information

If there is any doubt as to whether confidential information about any individual should be disclosed to a third party, then you should seek legal advice.

Practice Guidance 25

Suspension of Placements relating to Safeguarding Concerns

Introduction

Definition of a Suspension

Where Cambridgeshire County Council, in consultation with partner agencies establish serious concerns relating to the quality of service delivery and the safety of service users, the authority has a duty of care not to commission any new services.

Background

There are many ways in which the quality of care provided or commissioned can be influenced. Examples of these include: specific contractual conditions, routine monitoring of care providers, supporting the provision of training for care staff encouraging advocacy services and ensuring that service users and their families are aware of their rights and how to complain.

Additionally, the Care Quality Commission has a regulatory responsibility to register, inspect and report on Adult Social Care Services and Councils who arrange these services.

There are however occasions when some care providers continually fail to meet the Care Quality Commission Essential Standards and Cambridgeshire's County Council contractual obligations and may as a consequence, affect the welfare and safety of service users. It is anticipated that with support these concerns can be successfully addressed with increased monitoring and support by Cambridgeshire County Council in partnership with the partner agencies and regulatory bodies.

Where any care provider continues to fall short of their duty of care, despite the increased intervention by the various inspection/monitoring bodies and service users may still be at risk, enforcement conditions may be considered.

This guidance provides a clear procedure to be followed in the event of any care provider who has been consistently unable or unwilling to make the required improvements in the quality of care to which their service users have a right to expect.

The guidance formalises roles and responsibilities in the event of a safeguarding concern being raised and the need for a suspension of new placements/care packages to be considered.

It should be recognised that there will be circumstances such as concerns about the safety of service users which require an urgent response. On these occasions it may not be appropriate to apply this protocol as the circumstances indicate a more immediate escalation.

Purpose of the Guidance

- To establish an approach to collective decision making.
- To ensure a standardised response to all circumstances.
- To identify responsibility for co-ordinating the response.

Types of Suspension:

Temporary Suspension:

For a specified period of time to allow for the action plan to be met and which may result in the suspension being lifted or made a full suspension.

Full Suspension:

Will refer to situations where the Procurement (Social Care) Department has terminated contracts, alternative care provision has been sourced and service users have been relocated to a different care provider. Even though contracts have been terminated the full suspension will remain to prevent further placements/contracting arrangements.

Partner Agencies Responsibilities:

Cambridgeshire County Council

The Chair of the Adult Safeguarding Strategy Meeting will make a recommendation, agreed by the meeting participants to Cambridgeshire County Council, Cambridgeshire Community Services NHS Trust or the Cambridgeshire and Peterborough NHS Foundation Trust to suspend/or lift placements. The aim is to ensure that risks are identified and a robust action plan is put in place to safeguard service users from abuse.

The information from the Strategy Meeting will be passed through either of the management groups below, dependant on which service is managing the safeguarding process.

CCC Manager confirms with Service Director, Strategy & Commissioning (Adult Social Care) and Service Director, Operations (Adult Social Care) and CPFT.

Or,

The CCS Locality Manager confirms with County Manager of Planned Care, who then confirms with Service Director, Strategy & Commissioning (Adult Social Care) and CCS Director of Clinical Delivery and CPFT.

A decision whether to suspend, or not, will be agreed by either of the above management groups. The decision will be passed back to the Chair of the strategy meeting, and other service managers will be informed by Head of Procurement (Adult Social Care and Supporting People) – see flowchart.

Procurement (Social Care), CCC

Contract Managers support decision making with independent service providers, in relation to meeting their contractual requirements.

Social Care Commissioners

Adult services social care commissioners, in older people, disability and mental health services, who directly commission and arrange services from providers to meet the needs of service users, should act on safeguarding issues, using the safeguarding process.

Health Commissioners and Providers

The Chair of the adult safeguarding strategy meeting will make a recommendation, agreed by the meeting participants to Cambridgeshire County Council, Cambridgeshire Community Services NHS Trust or the Cambridgeshire and Peterborough NHS Foundation Trust to suspend/or lift placements. The aim is to ensure that risks are identified and a robust action plan is put in place to safeguard service users from abuse.

Acute Trusts

Acute Trusts have a responsibility to contribute and agree inter-agency local policies and procedures to safeguarding vulnerable adults.

Care Providers

It is the care provider's duty to ensure that safe care is delivered to all service users, inline with appropriate regulations, contractual and legal requirements and specific needs and outcomes outlined in individual support plans.

Out of County Placements

Cambridgeshire County Council commissions placements in residential and nursing homes within other Local Authorities throughout the Country. In these cases, where the host Local Authority places a suspension on a home Cambridgeshire County Council will also place a temporary suspension.

Care Quality Commission (CQC)

There are occasions when the Care Quality Commission has identified significant failures in terms of standards they inspect in the case of individual registered services. There are a range of regulatory conditions which they can sanction, one of which includes a suspension on new placements/new work on the care provider in question. In most cases, these concerns will have been known to Cambridgeshire County Council and therefore will have been subject to the Cambridgeshire County Council Adult Safeguarding Procedures.

Independent Safeguard Authority

Any provider that dismisses a member of staff or has a member of staff arrested and charged by the police has a duty to report that member of staff to the Independent Safeguards Authority and make an application to have that person placed on the Vetting and Barring List.

Lifting of a Suspension

Once the decision to lift a suspension has been agreed inline with the adult safeguarding action plan a letter confirming the lifting of the suspension will be made by the relevant manager.

Gradual Removal of a Suspension

Where it is evidenced that the care provider has made significant progress lifting a suspension in full could put the care service under pressure to achieve full delivery before they have the required infrastructure in place. Therefore stakeholders with the care provider's agreement may agree to lift the suspension gradually. This may be done by agreeing that referrals may still go ahead but limit the number of support packages that may be accepted over an agreed period of time.

Informing Service Users, Relatives and Carers

Where a suspension of placements is being considered, a decision should be made, in consultation with the relevant partners on what information should be provided to the service users, relatives and carers and when, how and who should deliver this. A decision should be made in each individual situation.

Relocation of Service Users due to Safeguarding Concerns

It is not always in the best interests of a service user to be relocated, however, there may be times when this option may be preferred. If a move of accommodation is to be arranged, staff from the agencies will work closely with service users and relatives to ensure a smooth transition. The authority will be fully reliant on the co-operation of the care provider to give full support through the transition period and to ensure it is completed as quickly and with as least disruption as possible for the service users.

If service users remain in their current accommodation, the authority will support the current provider by offering help and advice and support through training and development to assist them to improve their services to be able to provide a good quality service and meet their contractual obligations.

A record of staff involvement/work implications and extra costs of new services should be kept.

Conclusion

This guidance only covers those circumstances relating to safeguarding concerns, in which providers have demonstrated a consistent inability or unwillingness to meet the requirements of safeguarding recommendations, to the point where contractual remedies need to be escalated.

Appendix A

Cambridgeshire County Council

Your ref:
My ref:

Date:

Contact:
Direct Dial:
E Mail:

Dear

Temporary suspension of new care provision arrangements

I write to confirm our conversation of (Insert Date) during which you were advised of our concerns relating to (Insert Concerns) by (Insert Care Provider).

As a consequence of these concerns, Cambridgeshire County Council and its Partners will place a temporary suspension of new care provision arrangements while the adult safeguarding investigation and remedial action takes place.

The adult safeguarding investigation may find that the suspension can be lifted without further action. This would be actioned without undue delay. However the investigation may establish serious concerns which as a result may lead to a full suspension.

For your information the investigation may involve the following actions:

- Cambridgeshire County Council's Procurement (Social Care) Department to undertake Quality Monitoring visits and activities and/or complete observational reports.
- Contact and/or visits from health colleagues to ensure the appropriate care service is delivered
- Contact and/or visits from safeguarding staff to discuss concerns
- Assessment and Care Management activities to complete a review of care for Service Users.
- An action plan from yourselves to address safeguarding and breach of contract issues.

Please be aware that during this time the teams are available to offer advice and support to assist you to improve the quality of your services and address any issues.

If further investigation is required, you/your representative will be invited to attend a meeting to discuss the concerns and provide a response.

Continued

For full details please refer to the Suspension of Placements relating to Safeguarding Concerns guidance which can be found on the adult safeguarding web page at www.cambridgeshire.gov.uk/social/adultprot/
Or if you require a hard copy please do not hesitate to contact Cambridgeshire County Council.

Please note that you will be informed of progress, however should you wish to discuss please do not hesitate to contact the Adult Safeguarding Lead via Cambridgeshire Direct on 0345 045 5202.

Yours sincerely

Head of Procurement
(Adult Social Care & Supporting People)

Appendix B

Cambridgeshire County Council

Your ref:
My ref:
Date:
Contact:
Direct Dial:
E Mail:

Dear

Lifting of temporary suspension

I refer to my letter dated (insert date) with respect to the suspension of new care provision arrangements agreed at the safeguarding meeting (Insert date) with representatives from your company, which discussed the safeguarding concerns and actions needed to remedy them.

At the safeguarding strategy meeting it was agreed that an action plan should be prepared and submitted to the reconvened strategy meeting on the (insert date).

It is noted from the strategy meeting (insert date) that all aspects of the action plan have been completed.

In light of this I can confirm that new referrals may commence with effect from (insert date)

Yours sincerely

Head of Procurement
(Adult Social Care & Supporting People)

Appendix C

Cambridgeshire County Council

Your ref:
My ref:
Date:
Contact:
Direct Dial:
E Mail:

Dear

Advice for members of the public with private arrangements with (insert care provider name), regarding suspension of Cambridgeshire County Council care arrangements

I write to inform you that Cambridgeshire County Council and its Partners have taken the decision to place a suspension on new care provision arrangements with (insert care provider name). I would like to assure you that this decision has not been taken lightly and is as a result of concerns that have been brought to our attention in relation to the safety and wellbeing of vulnerable adults.

The suspension means that Cambridgeshire County Council and its Partners will not refer any new service users to this care provider, however I can assure you that the situation is being closely monitored and that Cambridgeshire County Council and its partners are willing to work with (care provider name) to support improvements and address any poor practice issues.

If you wish to discuss any aspects of this letter please do not hesitate to contact me.

Yours sincerely

Head of Procurement
(Adult Social Care & Supporting People)

Appendix D

Cambridgeshire County Council

Your ref:
My ref:
Date:
Contact:
Direct Dial:
E Mail:

Dear

Advice for members of the public with private arrangements with (insert care provider name), regarding suspension of Cambridgeshire County Council care arrangements

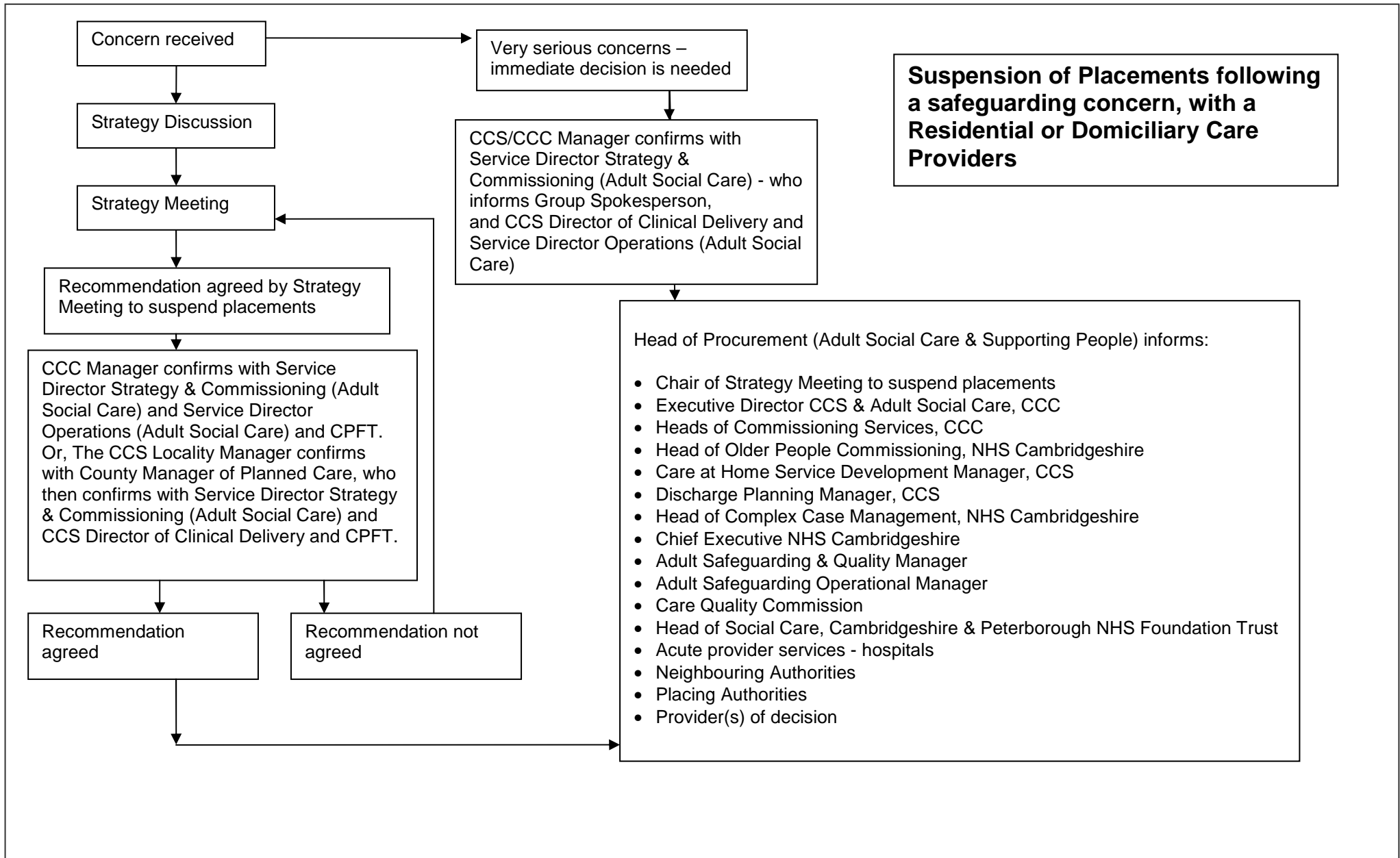
As you are aware I wrote to you on the (insert date) to advise that Cambridgeshire County Council and its Partners had placed a suspension on new care provision arrangements with (insert care provider name) due to concerns that have been brought to our attention in relation to the safety and wellbeing of vulnerable adults.

I can confirm that (care provider name) has made good progress by addressing the concerns which were brought to the attention of Cambridgeshire County Council; therefore I am pleased to inform you that with immediate effect the suspension has been removed.

If you need further information, please contact me.

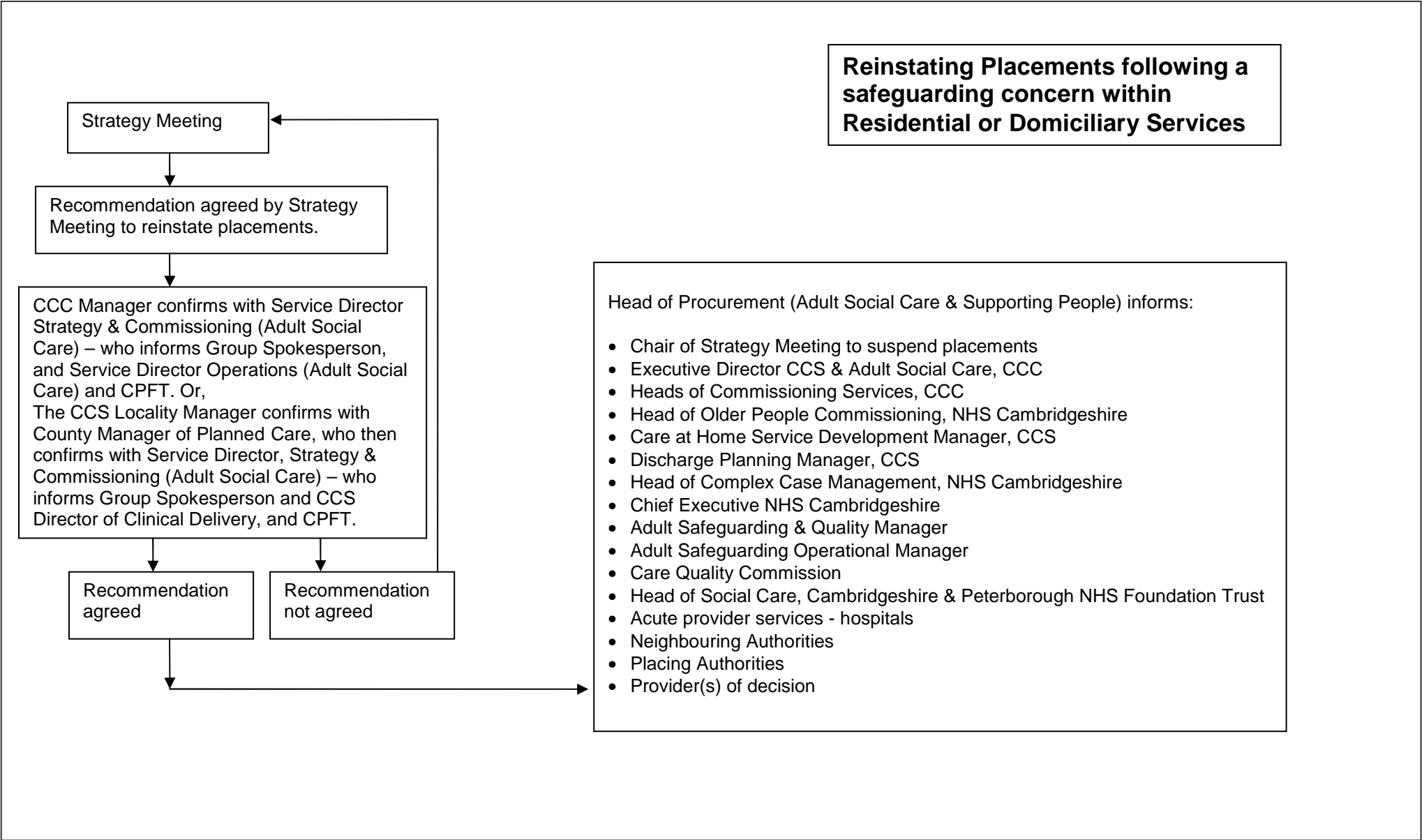
Yours sincerely

Head of Procurement
(Adult Social Care & Supporting People)



Reinstating Placements following a safeguarding concern within Residential or Domiciliary Services

- Head of Procurement (Adult Social Care & Supporting People) informs:
- Chair of Strategy Meeting to suspend placements
 - Executive Director CCS & Adult Social Care, CCC
 - Heads of Commissioning Services, CCC
 - Head of Older People Commissioning, NHS Cambridgeshire
 - Care at Home Service Development Manager, CCS
 - Discharge Planning Manager, CCS
 - Head of Complex Case Management, NHS Cambridgeshire
 - Chief Executive NHS Cambridgeshire
 - Adult Safeguarding & Quality Manager
 - Adult Safeguarding Operational Manager
 - Care Quality Commission
 - Head of Social Care, Cambridgeshire & Peterborough NHS Foundation Trust
 - Acute provider services - hospitals
 - Neighbouring Authorities
 - Placing Authorities
 - Provider(s) of decision



Practice Guidance 26

Therapy for Vulnerable or Intimidated Adult Witnesses Prior to a Criminal Trial

Introduction

There has for some time, been concerns that witnesses, including vulnerable or intimidated adult witnesses, have been denied therapy pending the outcome of a criminal trial for fear that evidence could be tainted and the prosecution lost. This fear may conflict with the need to ensure that vulnerable or intimidated adult victims are able to receive, as soon as possible, immediate and effective treatment to assist their recovery.

In the context of this potential conflict, the following matters are relevant:

- Many victims express the wish to see the alleged offender convicted and punished.
- There is wider public interest in ensuring that offenders are brought to justice to prevent further offences.
- All accused persons are entitled to a fair trial.

It follows, therefore, that victims, service provision professionals and forensic investigators have a mutual interest in ensuring, wherever possible, that those who receive therapy prior to a criminal trial are regarded as witnesses who are able to give a reliable testimony.

The national practice guidance – “Provision of Therapy for Vulnerable or Intimidated Adult Witnesses prior to a Criminal Trial” - 2001 seeks to provide a framework for good practice in relation to the provision of therapy and advises the development of local protocols setting out the approach to be followed.

This document sets out the procedure to be followed and points to be considered by the Crown Prosecution Service (CPS), Cambridgeshire Adult Social Care, Health and the Police and have been produced to strengthen the existing arrangements and to meet the needs of No Secrets and Action for Justice in the provision of therapy for a vulnerable or intimidated adult witness prior to a criminal trial.

The protocol takes into account current guidelines on the topic, common law and legislation relating to disclosure issues. Further information on confidentiality can be found within Cambridgeshire County Council's procedures General 5.2: Confidentiality which sets out the procedure to be followed and points to be considered in relation to preserving the confidentiality of shared material in their possession in so far as they are able to do so and making the necessary arrangements for public interest immunity hearings at which the agency which originally supplied the material may attend and make representations regarding disclosure issues.

What is Therapy?

The term “therapy” covers a range of treatment approaches, including counselling, but in this context it does not include any physical treatments.

A precise definition of psychotherapy is not straightforward but Kazdin (1990) defined it in the following way:

- psychotherapy includes interventions designed to decrease distress, psychological symptoms and maladaptive behaviour, or to improve adaptive and personal functioning through the use of interpersonal interaction, counselling or activities following a specific treatment plan, treatment focuses on some facet of how clients feel (affect), think (cognition) and act (behaviour)
- psychotherapies and counselling can be grouped in a number of ways (for example, psychodynamic, cognitive behavioural, systemic, experiential), they are underpinned by different models of understanding and techniques and they vary in the context in which they are given (individual, family, group etc) and frequency of sessions

Types of Therapeutic Work Undertaken Prior to a Criminal Trial

Two broad categories of therapeutic work undertaken prior to a criminal trial can be identified:

Counselling - This will address a number of issues, including:

- the impact of the incident on the adult
- improving the self-esteem and confidence of the adult
- providing the vulnerable or intimidated adult with information with regard to dealing with and avoiding abusive situations, the purpose of this is to help the adult to protect him/herself and to access appropriate help

Psychotherapy - This will address a number of issues, including:

- treatment of emotional and behavioural disturbance, for example post-traumatic stress disorder
- treatment of an adult who has been highly traumatised and shows symptoms which give rise to concern for the adult’s mental health

Both counselling and psychotherapy may require long term involvement with the vulnerable or intimidated adult.

Preparation for Court

A vulnerable or intimidated adult witness may have no previous experience of giving evidence in court and some preparation work prior to the criminal trial is likely to be of considerable value.

The purpose of this work will be to:

- provide information about the legal process, for example the respective roles of judge, advocates, jury
- address any particular concerns or fears, which the adult may have in relation to giving evidence
- reduce anxiety

Any information provided will need to be available in forms accessible for the particular witness taking account of such issues as language, literacy, communication (including British Sign Language, use of Braille etc.) cultural understanding and disability.

Decision Making

Who makes the decisions about the provision of therapy where there are criminal proceedings? The Crown Prosecution Service is responsible for reviewing and conducting the majority of criminal cases involving vulnerable adults or intimidated witnesses. Once a crown prosecutor considers that there is a realistic prospect of conviction, the public interest must be considered.

The prosecution in these criminal cases must do what it can to:

- identify cases in which the provision of therapy before the criminal trial might be thought to have some material impact on the evidence
- assess the likely consequences for the criminal trial in these cases
- ensure that these are dealt with as quickly as possible
- safeguard the confidentiality of therapy sessions wherever possible whilst ensuring that the defence and the court are aware of the existence of information, which might undermine the prosecution case or assist the defence

These questions are not unique to therapy, which takes place before the criminal trial, but the ethical, medical, welfare, and legal issues are of particular importance in these cases.

Whether a vulnerable or intimidated witness should receive therapy before the criminal trial is not a decision for the Police or the Crown Prosecution Service (CPS). Such decisions can only be taken by the vulnerable or intimidated witness, in conjunction with the professionals from the agencies providing the service to the witness.

The best interest of the vulnerable or intimidated witness are the paramount consideration in decisions about the provision of therapy before the criminal trial. In determining what is in the best interests of the vulnerable or intimidated witness, it will be essential to consider the wishes and feelings of the witness and, where appropriate, of those who are emotionally significant to the witness. The witness will need to be given information on the nature of the therapy proposed in a form, which is accessible. Account should be taken of issues associated with gender, race, culture, religion, language, disability and communication difficulties both in initial discussions about the proposed therapy and in the provision of the therapy itself.

Whilst some forms of therapy may undermine the evidence given by a witness, this will not automatically be the case. The Crown Prosecution Service will offer advice, as requested in individual cases, on the likely impact on the evidence of the vulnerable or intimidated person receiving therapy.

If there is a demonstrable need for the provision of therapy and it is possible that the therapy will prejudice the criminal proceedings, consideration may need to be given to abandoning those proceedings in the interests of the wellbeing of the vulnerable or intimidated witness. In order that such consideration can be given, it is essential that information regarding therapy is communicated to the prosecutor.

Process

The Chair of the Adult Safeguarding Strategy Meeting will be responsible for ensuring that a discussion is had regarding the appropriateness of therapy. If it is agreed that therapy is appropriate, then this must be reflected in the adult safeguarding action plan.

Prior to the case being allocated to a therapist, the lead person will liaise with the officer from the Action for Justice Unit who is in charge of the investigation. The purpose of this liaison is to establish that there are no investigative matters outstanding and/or that there are no other issues that might militate against the advisability of commencing therapy.

The nature of the therapy should be explained by the lead person and/or the proposed therapist so that consideration can be given to whether or not the provision of such therapy is likely to impact on the criminal case.

The officer involved in the case informs the lawyer in charge of the case from the Crown Prosecution Service that the vulnerable or intimidated adult is able to commence therapy and ascertains if there are any reasons why this should not occur.

Communication between professionals involved maybe desirable in some circumstances especially if the CPS are considering advising against the commencement of any therapy session during criminal proceedings. Records of the discussion and decisions made on the case should be recorded by the lead person and the officer in the case and submitted to the CPS together with an MG6D form with details of the notes disclosed on that form.

The officer in the case informs the lead person that there are no perceived outstanding issues to prevent therapy commencing after receiving confirmation from the CPS. Any written statement or video interview with the adult witness should be provided to the therapist by the lead person/officer in the case. In exceptional circumstances, further details maybe required to be disclosed, for example, expert evidence. A detailed record of all information provided to the therapist must be maintained by the lead person and the officer in the case. Details of the information supplied to the therapist must also be agreed with the CPS.

If a vulnerable or intimidated adult witness is referred to a therapist the lead person will contact the officer in the case to inform them that therapy is commencing.

The officer in the case will enter details off form A on the MG6D sensitive unused material form and send a copy of that form and form A to the CPS reviewing prosecutor.

Therapy may then commence, subject to this procedure being accepted by the vulnerable or intimidated adult witness and the following conditions are applied:

- the Adult receives individual sessions with the same therapist
- the Adult is not involved in any group sessions prior to giving evidence
- the therapist makes immediate factual, concise and accurate recording of the session following its cessation

The therapist must complete records of therapy after each session, this will include date and location of the session, names of anyone else present, length of session and confirmation whether records were made and if applicable sign the form to confirm that the vulnerable adult did not disclose anything during the session which was inconsistent with the statement made by the vulnerable adult to the police/or any other information supplied to the therapist about the criminal case.

The therapeutic process follows the practice guidance provided in the document "Provision of Therapy for Adult Witnesses to a Criminal Trial", so for example there should be no direct questioning of the Adult about his/her experiences and the session should take place at the Adults pace.

When/if an Adult chooses to talk about his/her abusive experiences for which the perpetrator is awaiting trial, the therapist should acknowledge what the Adult has said and make appropriate generalised comments but should not ask probing, investigative questions. It is recognised that the disclosure by adults of a traumatic event rarely occurs as a one off event and is seen, in practice, as a process in which facts and details evolve over a period of time.

At the completion of each therapy session the therapist must give a written assurance that the adult did not say anything inconsistent with the statements made by the witness to the police and any other information supplied to the therapist in relation to the case. If the Adult discloses further abuse experiences or inconsistent statements the therapist should disclose this information to the lead person and officer in the case in accordance with the procedure set out below.

The prosecutor may need to be made aware of the contents of therapy sessions as well as other details when considering whether or not to prosecute and their duties of disclosure. If requested the therapist should provide a copy of the records of the therapy session which the police and the CPS will treat as sensitive material.

In cases where an adult safeguarding strategy meeting is not held and Adult Social Care Services have no involvement in the case, the police Officer in charge of the investigation will be responsible for ascertaining if therapy is proposed for any adult witness. If therapy is proposed, the police Officer (or any other officer delegated with the task) will also be responsible for carrying out the procedures set out above, which would normally be carried out by the lead person in relation to communication with the therapist and the subsequent handling of records of the therapy sessions.

Records of Therapy

The administration of justice and the need to ensure a fair trial demand that any information and evidence, which could have an impact on the decision to prosecute; the conduct of the case, or the outcome of proceedings is made available to the police and prosecution.

The rules of disclosure place certain responsibilities on the investigator, prosecutor and also the third parties, that is to say individuals or bodies who are not part of the prosecution. Therapists will generally be third parties for this purpose. Those responsibilities mean that all material that may be relevant to the issues disputed in the case must be preserved.

At some stage during the trial process the prosecution must provide the defence with such information and evidence as may undermine the prosecution case or assist the defence case. In this way, all of the material that is relevant to the outcome of the trial is put before the jury or magistrate's relevant material is that which may tend to prove or disprove the issues disputed by the prosecution.

Disclosure should not be viewed as a tool to enable the prosecution or defence to satisfy their curiosity. It is a principle designed to ensure that information that is of genuine relevance to a criminal case is available to the parties and the court.

This document does not set out the detailed provisions relating to disclosure but aims to highlight some of the issues that may affect the handling of those cases. Local arrangements exist to facilitate handling requests for disclosure of material in the hands of third parties.

Requests for information to be obtained from third parties may be made at various states in a criminal case by:

- the police
- the Prosecutor
- the Defence
- the Court

The requests should explain the issues in the case, so far as they are known and be reasonably precise. Speculative inquiries are discouraged. The purpose should be to elicit a genuine and focused search for relevant documents or information. Careful maintenance of records of therapy will facilitate this focused approach. Where a therapist receives a request for information or documents, legal advice should be obtained before complying with the request. If for example the therapist is employed by an Adult Social Care Department or NHS, the legal department of such department should provide advice.

In addition to informal requests for information, if there are real grounds to believe that material which could affect the outcome of the prosecution is being withheld, an application may be made to the court for a witness summons to obtain the material. If, as will usually be the case a therapist having taken appropriate legal advice, believes that the material should not be disclosed, he or she may oppose the witness summons application. In that case the court may hold a hearing at which the therapist's employer may be legally represented. The court having heard representation from advocate for the therapists employer, will decide whether or not to issue a summons requiring the disclosure of the material.

Because of the recognition that maintaining trust is central to the provision of therapy it will be usually only appropriate to breach confidentiality in compliance with a court order as outlined above. Those aspects of the therapy that have no material relevance to criminal proceedings should not have to be disclosed. However, the issues of relevance may need to be reviewed at different stages of the criminal case, as more becomes known about the prosecution and defence cases.

Confidentiality cannot, therefore be guaranteed in advance. Bearing in mind, it is important that an understanding is reached with the vulnerable or intimidated adult witness (and where appropriate, any other emotionally significant person) at the outset of any therapy undertaken

of circumstances under which material obtained during treatment may be required to be disclosed.

Confidentiality and Disclosure

The CPS has a primary duty to make sure that the right person is prosecuted for the right offence and that all relevant facts are given to the court.

The information contained in the records maintained by the therapist may have a positive impact on any prosecution of an alleged offender if the vulnerable or intimidated adult witness has provided material, which is capable of supporting a particular allegation.

Equally such information may have a negative impact on any prosecution if it reveals material, which casts doubt on the reliability of the evidence contained within the prosecution file.

If a case goes to criminal trial then any relevant material which comes into the possession of the prosecution (i.e. the police and CPS) during the investigation but which does not form part of the prosecution case falls to be considered for disclosure to the defence as unused material.

The CPS has a duty within criminal proceedings to disclose any such information which:

- might undermine the prosecution case (primary disclosure)
- might reasonably be expected to assist the accused person's defence if disclosed in his defence statement (secondary disclosure)

Unless in either case the material is classed as sensitive, in that case the criminal courts will be asked to rule on disclosure.

Because of the recognition that maintaining the trust of the vulnerable or intimidated witness is central to the provision of therapy, it is accepted that the records and information maintained by the therapists will be confidential and should thus be treated as "sensitive" material by the prosecution.

Those aspects of therapy that have no material relevance to criminal proceedings should not have to be disclosed. However the issue of relevance may need to be reviewed at different stages of the criminal case, as more becomes known about the prosecution and defence cases.

The CPS and the police undertake to treat all "therapy" records and information provided to them as sensitive third party material.

Primary prosecution disclosure is normally made to the defence at the point of transfer or committal of criminal proceeding to the Crown Court or in indictable only cases at the point of service of the Crown's case.

If the CPS lawyer considers that the "therapy" material provided contains no material satisfying the test for primary disclosure then no application to the court to assert public interest immunity over it will be made.

However, the CPS will write to the defence, preferably before the plea and directions hearing confirming the following information:

- the fact that the adult witness has received or is receiving therapy
- the name and address of the Health Department or Adult Social Care Department responsible

It is recognised that in respect of the Department of Health or Adult Social Care material which has not been disclosed to the prosecution the right exists for either the prosecution or the defence to bring the issue of disclosure thereof before the Crown Court Judge by means of the issue of a witness summons against them.

If the CPS lawyer considers that any of the therapists material in its possession does satisfy the test for primary disclosure then before any discovery of it is made to the defence the CPS will make an application to the Crown Court for a Public Interest Immunity hearing at which the relevant authority has the right to appear and make representations as an interested party pursuant to Section 16 Criminal Procedure and Investigations Act 1996. This hearing should take place at or before the date fixed for Plea and Directions in the criminal proceedings.

Pursuant to Section 6(1) Criminal Procedure and Investigations Act 1996 the CPS will give both relevant departments and the police at least 5 working days notice where practicable of any Public Interest Immunity hearing, preferably more. At the same time the CPS will also identify to the relevant department and the police which documents the CPS considers should be disclosed to the defence and why.

Copies of the relevant documents will be submitted to the Judge in order that the Judge may conduct the appropriate balancing exercise.

If the CPS wishes to rely on public interest immunity to justify non-disclosure then, in the majority of cases, it will notify the defence that they are applying for a ruling by the court and indicate to the defence at least the category of the material which they hold. The defence must then have the opportunity of making representations to the court at an inter parties' hearing.

In any case where some material is provided to the prosecution the fact that the Local Authority or Health Department is in possession of additional material will be disclosed by the CPS to the defence unless the circumstances are wholly exceptional and a Judge has ruled that such disclosure need not be made. Whether or not to make an application for third party disclosure then becomes a matter for the defence.

By virtue of Section 5 Criminal Procedure and Investigations Act 1996 once primary disclosure has taken place in Crown Court proceedings the accused must give a defence statement to the prosecutor. The defence statement is a written document setting out in general terms the nature of the defence and the matters on which the accused takes issue with the prosecution, with reasons.

Once the accused has served a defence statement the prosecutor must apply the test for secondary disclosure. The obligation is complemented by the duty placed on the investigator and disclosure officer who are required to look again at the material retained and draw the prosecutor's attention to any material, which satisfies the test for secondary disclosure.

If any Adult Social Care or Health Department material in the possession of the prosecution satisfies the test for secondary disclosure then the same procedures will be adopted by the

CPS for determining Public Interest Immunity issues as set out in the paragraphs above save that any Public Interest Immunity hearing should be obtained as soon as reasonably practicable which may be after plea and directions.

Under Section 9 Criminal Procedure and Investigations Act 1996 the CPS remains under a continuing duty to review questions of disclosure. Similarly where the court has ruled against disclosure in relation to a matter, which is being tried on indictment, it must keep under review the question whether it is still in the public interest not to disclose the material affected by its order. The procedure in the paragraphs above will be followed. It is recognised that such issues can arise rapidly during a trial. In such cases the CPS will use its best endeavours to notify the relevant authority in advance.

Where the Judge rules that material must be disclosed the CPS will seek the following undertakings through the Court.

The documents will be kept secure at all times including when in transit to counsel and expert witnesses.

All copies of the documents provided to and subsequently made by the defence will be accounted for, recovered at the end of the case and returned by them to the relevant department.

The documents' content will only be revealed to the legal representatives, their client and such expert witnesses as are necessary to the defence case. Copies shall not be supplied to the client.

The documents will only be used for the purposes of the criminal trial in line with the defendant's rights and duties as set out in Section 17 Criminal Procedure and Investigation Act 1996.

Before any disclosure is made of a document's contents to a witness that witness shall be informed of their statutory obligations with regard to the information and shall be required to undertake to treat copies in the same way as set out above.

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Training for Staff and Volunteers

In response to Section 5.2 of No Secrets, Cambridgeshire County Council's Adult Safeguarding Training Team provides a comprehensive adult safeguarding training programme.

Training opportunities are open to staff and volunteers (commensurate with their responsibilities in the safeguarding adult's process) and provide opportunities to learn about and carry out their responsibilities as outlined in these guidance and procedures and to develop their professional practice in relation to safeguarding adults.

The programmes include:

- e-learning packages for Adult Safeguarding and Mental Capacity Act
- basic induction training with respect to awareness that abuse can take place and duty to report
- more detailed awareness training, including training on recognition of abuse and responsibilities with respect to the procedures in their particular agency
- specialist training for investigators
- specialist training for Safeguarding Adults Lead Practitioners, including Chairing multi-agency meetings
- training for managers in their role of providing support and guidance to front-line staff carrying out their safeguarding adults responsibilities
- training on domestic abuse and vulnerable adults and MARAC (Multi-Agency Risk Assessment Conference)
- training for administrators responsible for preparing for and taking minutes of strategy meetings
- 'training for safeguarding trainers' recall days

No Secrets states that adult safeguarding training should take place at all levels in an organisation and within specified time scales and all partner agencies have a responsibility to ensure that this is built into their agency's workforce development plan.

The safeguarding adults training programme is available to all staff groups and is a rolling programme which is reviewed and improved through monitoring and evaluation of content and presentation.

Safeguarding adults is referenced in most training courses offered to health and social care staff in Cambridgeshire.

Partner agencies need to demonstrate a strong commitment to safeguarding adults by underpinning good practice through development, training and learning opportunities for all staff at all levels of their organisation particularly if employees are covered by the Health and Social Care Act 2008.

Partner agencies should integrate training on safeguarding adults where appropriate with other areas of training such as risk assessment, care planning, physical intervention, health and safety and assisting people to move. Adult safeguarding training needs to be integrated into any induction training.

The local authority has a responsibility to ensure that adult safeguarding training provided in-house by providers under contract complies with the requirements of these guidance and procedures.

Support for Service Users

Guidance for Professionals Working in Health and Social Care Services regarding how to involve and empower people who use services, and their families.

There is much guidance and research available suggesting the benefits of working with people who use health and social care services around keeping safe and the preventative aspects that this work plays in reducing cases of abuse and crime to Vulnerable Adults (SCIE - Report 41, CQC Essential Standards, RiPFA - Personalisation and Safeguarding).

After recent findings from the European Human Rights Committee, BBC Panorama 'Undercover Care' and MENCAP's 'Death by Indifference', it is seen as best practice in Cambridgeshire that all health and social care services offer support, information and learning opportunities, accessible information and where appropriate training or sessions in services led by staff around what is abuse and how to report it.

When working with people who use services this work should be developed to meet the needs of the people you work with, and should only be undertaken by staff who have had training in adult safeguarding for example; have undertaken a Adult Safeguarding Raising Awareness, Professional Responsibilities or Management Responsibilities Session.

Best Practice Recommendations:

- To ensure information (also in accessible formats) is available in your service that explain your policy on abuse and complaints.
- That you have a clear and accessible reporting flowchart for reporting complaints or abuse. This should always include the contact details for Cambridgeshire Direct, the police and the Care Quality Commission.
- To ensure that where appropriate information and/or awareness sessions are also made available to families.
- That where appropriate people who use a service should have an opportunity to voice concerns or propose recommendations for services. This can often be achieved by setting up a forum involving the people who use or live in a service.
- That (where appropriate) all support plans and care plans reference or refer to keeping safe and safeguarding.

Practice Guidance 28

Forced Marriage and Honour Based Violence - Guidance for staff working with Vulnerable Adults

Introduction

This document has been produced to give guidance to professionals and volunteers from all agencies within Cambridgeshire working to safeguard adults.

The guidance should be read in conjunction the Practice Guidance for Professionals produced by the Forced Marriage Unit, Foreign and Commonwealth Office.

Domestic Abuse and Honour Based Violence

Incidents of HBV fall within the Home Office definition of domestic abuse, therefore staff taking HBV disclosures should contact their local specialist Domestic Abuse Team/Constabulary for guidance on risk assessment and risk management in all HBV cases.

Definitions

What is forced marriage?

Forced marriage is a term used when a marriage is conducted under the duress of a person and without their valid consent. A forced marriage maybe performed through pressure or abuse to both or one of the parties to be married. A marriage should be the choice of both parties involved.

Duress and pressure placed on an individual to enter into marriage could be the threat of physical violence, actual physical violence, emotional/psychological pressure, financial abuse and sexual harm.

The following definition is used by The Foreign and Commonwealth Office:

“A forced marriage is a marriage in which one or both spouses do not (or, in the case of some vulnerable adults, cannot) consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and emotional pressure.” ‘The Right to Choose: Multi-Agency Statutory Guidance for dealing with Forced Marriage’ (November 2008).

It is important that the distinction should be made between an arranged marriage and a forced marriage. An arranged marriage is one whereby a suitable husband or wife is found primarily by the person’s family and the marriage is entered into freely, with the consent of both individuals.

It is essential that with cases involving a vulnerable adult that the vulnerable adult’s capacity to consent is assessed under the guidance of the Mental Capacity Act 2005.

What is honour based violence?

“Honour based violence” or “honour” crime is a term used to describe violent acts primarily, although not exclusively, against women due to the perceived shame that a person has brought on the family or community.

Honour based violence includes acts of harassment, assault, imprisonment, unexplained death (suicide), forced pregnancy/abortion and in some cases murder. The family may perceive that

the person has acted inappropriately and dishonoured the family and community, the violence carried out is to punish them for this.

Background and Context

Incidence of forced marriage

Currently, the Foreign and Commonwealth Office have reported to them approximately 250 cases each year. Other cases are reported to other agencies such as health, education, social care services, voluntary agencies and the police. There are, of course, the other incidences of forced marriage that go undetected and unreported.

Cambridgeshire Choice Helpline (which covers Peterborough) was launched in June 2008 providing a 24hour helpline. It has received over 470 calls which have resulted in over 177 live cases of Forced Marriage (FM) and Honour Based Violence (HBV) of which 55% of these calls resulted in an intervention.

Forced marriage is an issue for all communities; however the occurrence is significantly higher in South Asian families. Other communities affected include those from East Asia, the Middle East, Europe and Africa. Although there is yet to be any studies regarding the prevalence of forced marriage with people with learning disabilities, the forced marriage unit has dealt with the majority of cases from the South Asian community and incidence of learning disability within this group is three times as high as the rest of the population.

Motives for forced marriage

There may be many reasons that parents give to justify their actions when people are forced into marriage. Religion and culture are often used as primary justifications alongside pressure from extended families.

Key motives include:

- controlling unwanted sexuality (including perceived promiscuity, or being lesbian, gay, transgender or bisexual)
- controlling unwanted behaviour perceived as westernised such as use of make up, alcohol, drug use and also displays of intimacy in public.
- preventing relationships outside of religious, caste or cultural group
- achieving financial gain
- stronger family ties
- protecting cultural ideals
- assisting claims for uk residence and citizenship
- control of a young person following their rejection of a marriage proposal

Additional motives in cases involving vulnerable adults include:

- Marriage can be seen as a means of providing a carer and continuing support. Parents may be primary carers and as they get older and less able to provide support, they may view marriage as a means of ensuring continuing care for their son or daughter.
- A forced marriage is also a way of improving the chances of getting a visa to the UK. A person with learning disabilities may be seen as easier to deceive or coerce into such a marriage and into then acting as a visa sponsor.
- Families may believe that marriage will “cure” an individual’s learning disability and/or allow a person with learning disabilities to lead a “normal” life.
- Every major religion condemns forced marriage, honour based violence and female genital mutilation.

The Victim

Victims of forced marriage often feel very isolated, they may be unable to speak English thus exacerbating their feelings of being trapped and alone.

These feelings can leave people who face or experience forced marriage at a higher risk of depression, self harm, low self esteem and suicide.

People with a learning disability, physical disability, mental health difficulty or sensory impairment who find themselves facing forced marriage are even more vulnerable than most. They may be unable to communicate with others what is happening or know where to go for help.

Case Study

KC & NNC v City of Westminster v IC – IC Neutral Citation Number: [2008] EWCA Civ 198

This court case concerned a young man with autism and severe learning disabilities referred to in court as IC. In September 2006, IC's parents arranged for him to be married to NK. The marriage took place over the telephone, while IC was in the UK and NK in Bangladesh. The parties to the case accepted that the marriage was recognised in Bangladeshi and Sharia law. IC does not have capacity in English law to enter into marriage or engage in sexual relations. The Court of Appeal ruled that the marriage was not entitled to recognition in UK law. It also ruled that the marriage was “potentially highly injurious” to IC and that consummating the marriage would constitute rape or indecent assault.

www.anncrafttrust.org/Forced_Marriage.php

The possible consequences of forced marriage

There are many possible consequences of forced marriage, one of which can be domestic abuse (physical, emotional, sexual and financial abuse).

Children can then subsequently be affected by the violence and abuse they witness.

Some victims consider that their only option is running away, this can, in turn, lead to people living in fear that they will be traced and lead to honour based violence.

For vulnerable adults the consequences are the same and more. Vulnerable adults forced to marry may not understand that there is an expectation that a marriage will be consummated and their understanding of sex and sexual relationship may be limited leaving them vulnerable to sexual abuse and rape.

There is also a risk that the spouse may not have a full understanding of the needs of the vulnerable adult leading to frustration and resentment that could, in turn, lead to domestic violence and abuse. Ultimately this could then lead to the abandonment of the vulnerable adult, leaving the vulnerable adult with feelings of rejection.

Potential Warning Signs and Indicators

The following example may indicate that a forced marriage has or is likely to take place:

- low self esteem or motivation
- history of siblings leaving education to marry early
- poor attendance in the workplace/day service
- poor performance in the workplace/day service
- parental control of income and limited career choices
- evidence of self harm

- treatment for depression or attempted suicide
- parental control/misuse of medication
- social isolation
- eating disorder
- substance abuse
- evidence of family disputes or conflict
- persistent running away from home or desire to run away
- unreasonable restriction i.e. house arrest

Most cases of forced marriage involve a British citizen being sent abroad (a vulnerable person may disclose that they are going overseas on a “family holiday and have concerns about this”) or a partner coming from overseas, some take place in the UK with no overseas element. The majority of the cases in the UK involve South Asian families but can also involve families from Middle East, Europe and Africa. Female Genital Mutilation (FGM) in some communities is required prior to a woman being married and although usually performed in young girls, it has been known of young women undergoing female circumcision.

FGM is illegal in the UK and it is a criminal offence to take someone overseas for the purpose of FGM.

Safeguarding Vulnerable Adults at risk of Forced Marriage and Honour Based Violence

It is very important to remember that some vulnerable adults do not have the capacity to consent to marriage. However, this does not stop people forcing vulnerable adults to marry. Sometimes the reason for this can be to ensure that they will have someone to care for them when their parents have died. Another motivation can be to ensure that the vulnerable adult follows cultural norms and is not identifiable as different.

The legal framework in relation to protecting vulnerable adults from forced marriage is the same as for those who are not vulnerable under the definition. However it is important for practitioners and agencies to remember that that additional support maybe required when supporting vulnerable adults.

Good Practice should include:

- Listening to vulnerable adults and making sure that their communication needs are met.
- Supporting vulnerable adults to extend their support network outside of the family so that they have people they can talk to.
- Ensure staff that work with vulnerable adults are aware and have relevant training.

Following a concern raised by a vulnerable adult:

- Always ensure an adult safeguarding referral is made via the Contact Centre.
- Assess the immediate vulnerability of the person and ensure their immediate safety.
- Contact the police if a criminal act has taken place.
- REMEMBER that these cases can be very complex and require handling with sensitivity.
- Do not ignore the allegations of forced marriage as a domestic issue.
- Do not contact the family or attempt any mediation with the family.
- Do not contact community leaders.
- Consider where to discuss the issues with them, i.e. a private secure place.
- Consider who they may wish to speak to, i.e. a practitioner of the same gender.
- Consider their communication needs and whether an interpreter is required.
- Stress the need for confidentiality to any persons supporting the vulnerable adult.
- Record all decisions and actions.

- Seek advice from the Forced Marriage Unit.
- Seek advice from Cambridgeshire County Council Legal Department.

Each case where a vulnerable adult has been forced into marriage will be overseen by the Adult Safeguarding and Quality Manager. It will be necessary to convene a strategy meeting as a matter of priority, keeping in mind the 'one chance' rule below.

The one chance rule

All Chief Executives, Directors and Senior Managers providing services to victims of forced marriage and honour based violence need to be aware of the 'one chance' rule, that is their staff may only have one chance to speak to a potential victim and thus staff may only have one chance to save a life.

This means that all professionals working within statutory organisations need to be aware of their role and responsibilities when they come across forced marriage and honour based violence.

In consideration of the 'one chance' rule, practitioners should also obtain the following information, if possible:

- Establish any family history of forced marriage and/or domestic violence (previous records can sometimes be helpful in this task).
- Nationality of vulnerable adult.
- Preferred language of vulnerable adult and family.
- Date and place of birth.
- Passport details.
- Recent photograph or with consent to take a photograph.
- Distinguishing marks or features of the vulnerable person.
- Ask the person's consent, if possible, to refer them to appropriate local or national support groups.

Management and recording of incidents

Confidentiality in all HBV cases is of paramount importance. Preventing "leakage" of incident/disclosure detail should be of the main consideration for the relevant staff member and failing to do this could lead to serious escalation of an incident and increase the risk of harm to the service user.

Subsequently, any disclosed incident of HBV should not be recorded on case management systems until a full discussion on risk has been had with relevant line management.

Where recorded, HBV issues should be cloaked/shielded from general viewing and safe addresses (refuge, etc) should never be recorded on case management systems. Warning flags/alerts clearing stating HBV should be made visible on all relevant client records.

Incidents of HBV should not be openly discussed in any case or management meeting. All care should be taken to restrict access to any information to only those who are actively involved in the case or the management of the caller/service user.

Use of interpreters

Where interpreters are required in HBV cases, staff should use Language Line. No other staff member should be used to interpret, nor should a caller/service user be left alone with any one from their community whilst arrangements are made for an interpreter.

When Language Line is used, the caller must be asked where he/she has family /relatives throughout the UK. Every effort should be made to ensure the interpreter does not live within the service delivery area or any other areas specified by the service user.

Legal Framework

It is important to know that there is not a criminal offence of 'forcing someone to marry'; however, there may have been other offences that have taken place. There are also protective measures that can be sought through civil and family courts.

Any criminal offence that has taken place whilst a person is being forced to marry or evidence of honour based violence should be reported to the police. These could include conspiracy, assault, kidnap, abduction, theft (passports), threats to kill, imprisonment, rape and murder.

A Forced Marriage Protection Order (FMPOs) can be sought under the Forced Marriage (Civil Protection) Act 2007, which came into force in November 2008. The Act enables courts to tailor the order so that it protects and meets the specific needs of the victim.

FMPOs can be used to:

- stop individuals entering into engagement or marriage arrangements
- confiscate passports to prevent a person from being taken abroad
- prevent intimidation and violence; and reveal the whereabouts of an individual

Those who do not comply with an FMPO could face a custodial sentence. From 2 November 2009, local authorities, as a relevant third party, have the power to seek a protection order for vulnerable adults and children at risk of a forced marriage without having to seek leave from the courts. The local authority may also wish to consider an application to the Court of Protection in cases where an adult lacks capacity to consent to marriage.

Case Study

M is a young woman with mental health difficulties and learning disabilities.

M uses limited verbal communication and Makaton. Professionals became concerned for M's health and well-being after reports of her arriving at day service looking dirty and unkempt.

Further contact with M by professionals also raised concern that M was living in squalid conditions and had limited access to food.

As the implementation of the Safeguarding Action Plan progressed M began to share information with the social worker that raised her concerns that M was at risk of being forced into marriage. M had told professionals that her mother had put her on a diet and that she was due to go on holiday. M had confirmed to professionals on a number of occasions that she did not wish to be married particularly to someone she had not met.

The local authority subsequently applied for a Forced Marriage Protection Order to prevent M's family members from forcing her to marry or remove her from the country. Simultaneously a Guardianship Order was also sought in order to dictate where M lived and M was moved to a place of safety.

Further Information

HM Government have published Multi-Agency Practice Guidelines for handling cases of Forced Marriage (Section 10 – Guidelines for Adult Social Care).

www.fco.gov.uk/resources/ur/pdf/FM-Guidelines

Referral Contact Details

Cambridgeshire Direct

Between 8am and 8pm Monday to Saturday **0345 045 5202**
If you urgently need to make contact outside office hours **01733 234724**

Cambridgeshire Constabulary

Employ staff trained in HBV issues and also run a specialist helpline for those affected (**CHOICES on 0800 5 999 818**).

Cambridgeshire Constabulary should be contacted by professionals following all HBV disclosures, and the relevant staff member/manager should state that the case is HBV from initial contact with the Constabulary.

For all police/HBV/DV inquiries, contact **0345 456 4564** and ask for the Multi-Agency Referral Unit (MARU) or Central Referral Unit (CRU).

Cambridgeshire and Peterborough NHS Foundation Trust

Huntingdon - Intake and Treatment Pathway Team Central **01480 415143**
(Monday Friday 09-00 -17.00)

Fenland duty number covering both Intake and Treatment **01945 482100**
and Rehab and Recovery

Cambridge North and South - Intake and Treatment **01223 533300**

Action on Elder Abuse Response Line **0808 808 8141**

Age UK Cambridgeshire **01354 696650**

Independent Mental Capacity Advocate Referral Line **0845 650 0081**

Other Useful Contacts

The Forced Marriage Unit

www.fco.gov.uk/forcedmarriage

9.00 am – 5.00 pm

0207 008 0135

0207 008 0230

0207 008 8706

Out of hours

0207 008 1500

Karma Nirvana – Honour Network Helpline Number www.karmanirvana.org.uk

9.30 am – 9.00 pm 7 days per week

0800 5999 247

Southall Black Sisters

www.southallblacksisters.org.uk/

020 8571 9595

The Honour Network

0800 5999 247

Practice Guidance 29

Photographic Evidence

Medical Examinations

A medical examination may be required for two reasons:

Immediate medical assessment and treatment may be needed

In cases where immediate medical assessment and treatment is required then this should be provided in the normal way through access to the usual primary and secondary health services.

For evidential purposes as part of a criminal investigation

The police take the lead in making decisions and arrangements of this nature. Only a Forensic Medical Examiner (FME) with specialist knowledge should undertake such medical examinations.

An examination would not be lawful if the person has capacity to understand the process but does not give informed consent. Issues such as the venue, the type of examination and who will undertake a medical examination should be decided by the police at the strategy discussion stage.

If there are doubts over capacity to give informed consent, an assessment of capacity should be made in line with the principles and guidance contained in the Mental Capacity Act 2005 Code of Practice.

Where a vulnerable adult is unable to give informed consent due to a lack of mental capacity a judgement must be made that the examination will be in the vulnerable adult's best interests.

The police can consult with the Crown Prosecution Service as to the need for medical evidence. All discussions regarding medical examinations and treatment must be consistent with the guidance given in the Mental Capacity Act 2005 Code of Practice and consideration should be given to whether it is appropriate to involve an Independent Mental Capacity Advocate (IMCA) in the process.

If there is any doubt about what the law allows then legal advice should be sought. It is ultimately the responsibility of the doctor to consult others, including relatives and carers when appropriate to determine whether an examination is in the service user's best interests.

Photography

The photographing of a vulnerable adult will follow the same principles as for any other individual:

- Consent should be sought from the person before any photograph is taken.
- The person's dignity must be preserved at all times.
- There must be clear evidential or clinical reasons for the use of photography.
- This guidance focuses on photographing individuals but it may also apply to premises or rooms.

If the vulnerable adult lacks the mental capacity to consent to being photographed then the principles of the Mental Capacity Act 2005 will apply and it will only be acceptable if photography is considered to be in the vulnerable adult's best interests following consultation with other people who may be able to advise (e.g. carers, relatives or professionals).

It is not possible for any individual to give consent on behalf of the vulnerable adult but it may be possible for others to inform a judgement as to whether photography would be in the person's best interests.

In the absence of appropriate people to consult, a decision will need to be made on the basis of the information available, the urgency of the situation and the anticipated effect that the act might have on the vulnerable adult.

Any photography undertaken must take account of all medical or nursing care that is being provided and of any clinical advice provided (e.g. removal of dressings).

In some cases (e.g. pressure areas) photography will be required also for clinical care reasons and such photographs may also be admissible as evidence where they indicate neglect or ill treatment.

Whenever photographic evidence of injuries has been obtained it will be advisable to obtain a medical opinion to provide expert interpretation of the images.

The purpose of photographic evidence will be to demonstrate the harm that has occurred to the vulnerable adult with a view to presenting this to a court or for regulatory or disciplinary processes.

The physical and mental well-being of the vulnerable adult will take priority over the need to gather evidence and investigating staff will always ensure that any plans to take photographs take account of the likely consequences that this will have.

Photography for a criminal investigation

Where the primary purpose of the photographs is to provide evidence for a criminal investigation the photographer will be a member of the police service and will have received appropriate training. If the photographs are being taken for clinical purposes then they will be taken by staff who are suitably trained and experienced in this area.

What is acceptable practice?

It will never be acceptable for any worker to take photographs of injuries on mobile telephones or on their personal cameras. Relatives and carers should also be discouraged from doing so in the interests of the dignity of the service user and wider confidentiality. Any photograph that is taken in accordance with the above guidance will be classed as confidential personal data and kept securely and subject to normal record retention procedures.

Practice Guidance 30

Review of Practice in Adult Safeguarding Cases

This is a template to be used as a tool for reviewing practice in safeguarding cases. The Adult Safeguarding Lead should decide when it should be used to review their own practice, for example following a strategy meeting, or when concerns have been raised, or in any 'debriefing' situation. It will also be used during supervision or appraisal with line manager, or with peers in development sessions. The template may be completed by the Adult Safeguarding Lead or Line Manager as relevant. This is primarily for Safeguarding Leads, but also may be used by other practitioners involved in safeguarding activities.

The Adult Safeguarding Lead should use this template at least 4 times a year to enable improvement in practice to be identified and maintained. Copies should be forwarded to the Adult Safeguarding Team Administrator in the Adult Safeguarding Team, to inform policy and service development.

The template consists of questions and spaces for evidence. Questions are formulated to consider whether: process was followed, decisions were evidenced, and recording was appropriate.

1	a Were the safeguarding procedures followed? b If not, what are the reasons for this? See Policy, Guidance & Procedures Part 2: 1) page 6 for procedures, 2) appendix 4 for time scales and whole process activities, 3) appendix 5 for meeting guidance, 4) appendix 1 - SOC388 for all situations to capture data (to be sent to CCC Safeguarding Administrator), 5) appendix 2 - SOC1434 adult safeguarding action plan to record decision making, risks and action plan, and outcomes, in discussions or meetings. 6) If necessary, were immediate steps taken to safeguard the person.
2	Were time scales followed?

3	<p>a Were the correct people involved in the discussion/meeting? b If not, reasons why not?</p>
4	<p>How is it evidenced that the service user was involved?</p>
5	<p>How were decisions evidenced i.e. risk assessments, reports, other supporting evidence?</p>
6	<p>a How were conclusions or outcomes reached? b Did you record the reasons for your decisions?</p>
7	<p>a Was there an action plan, and/or new/amended care/support plan? And b If so, were the outcomes of the action plan and care/support plan met?</p>

8	<ul style="list-style-type: none"> a Were the risks reduced to a manageable level? b If so, how is it evidenced that the service user/s has been safeguarded? c If not, why not?
9	<p>Is there evidence of quality assurance to monitor quality of the case recording, i.e. appropriate management oversight, and signing off of the documentation – did they agree the risk assessment and action plan?</p>
10	<ul style="list-style-type: none"> a How did the Lead/Chair in their role, manage confidentiality/data protection? b How is the justification for sharing information/not sharing information evidenced?
11	<p>Were the appropriate IT systems and correct documents used for performance management? Examples:– SOC388, SOC1434, SOC902, SOC311, CPA, CDL, Swift, Wisdom, Datix, System One</p>

12	<ul style="list-style-type: none"> a What did not go well? b What could have done better? c What has been learnt?

Lead name:

Signature

Date

Manager name:

Signature

Date

Practice Guidance 31

Adult Safeguarding Threshold Decisions Guidance for Adult Safeguarding Leads

Purpose

Information relating to possible abuse of vulnerable people can arise from a wide variety of sources including staff, the public, people who use health and care services, their carers, or managers of provider services.

All information relating to possible abuse will be brought to the attention of a member of staff responsible for making a decision as to whether to proceed with an investigation under SOVA procedures.

The purpose of this guidance is to aid staff in making such decisions as to whether an incident reported to statutory agencies should be subject to an **adult safeguarding investigation** or not.

Eligibility for Adult Safeguarding Service

For an **incident to be considered under SOVA procedures** there needs to be evidence or a strong suspicion that the four basic principles are met:

- a vulnerable adult as defined as someone aged 18 years or over, who meets the criteria for a community care service
- a perpetrator – a third party – person/agency/unknown
- abusive behaviour by the third party
- harm, or a risk of harm to the vulnerable adult

Investigation Threshold

The following factors should be taken into account when making a decision on whether any incident warrants an investigation under SOVA procedures.

- The length of time and the frequency with which the alleged abusive act(s) have taken place.
- A pattern of abuse.
- The degree of seriousness of the harm caused.
- The degree of vulnerability of the person.
- The vulnerable person's perception of the harm.
- The number of vulnerable people affected.

In any particular incident there may be a number of the above factors involved, and several of the factors may be interdependent. For example, two people experiencing a similar assault in physical terms may see the incident differently and may be emotionally affected in different ways.

A single incident of physical abuse which does not lead to serious injury may not warrant a SOVA investigation, but two or more of such incidents, or an increasing level of seriousness of the incidents, may do.

Each of these factors represents a continuum, and each incident needs to be placed within this continuum. SOVA decision makers will need to exercise their judgement as to where on each of the continua any particular incident would sit. The greater the frequency, seriousness of harm then the more likely it will be that a SOVA process will be required.

It is not necessary that all of the factors are rated as high. One factor taken individually may be sufficient to trigger the procedures.

The level of seriousness of the concern or allegation will determine the level of response. See table 1 below.

Mental Capacity

If a person is deemed to lack mental capacity in relation to an abusive act this will **usually** mean that the degree of their vulnerability will be greater.

However, if a person is deemed to have capacity, there will still be a possibility that they can suffer abuse. Not all vulnerable people lack the mental capacity to make decisions about their own protection. Those who have that mental capacity may still be subject to abusive acts and therefore should have the protection of the SOVA framework.

Best interests

Where a person lacks capacity a decision will need to be made as to whether it is in their interests to follow the SOVA procedures. It is envisaged that in the majority of cases this will be the case. Where it is not thought to be in their best interests clear reasoning for this must be recorded.

Criminal acts

Where the abuse of a vulnerable person is sufficiently serious to constitute a criminal act then it is likely that this will require a response under SOVA procedures.

Cases which do not reach the SOVA threshold

There will be a number of cases where there are concerns about the care and treatment of people that do not meet the threshold for a SOVA investigation.

Many of these cases will still require a response to the concerns raised. These will usually be dealt with through care management or care programme approach risk management processes. Where such a concern is the poor practice of a provider agency then this may be dealt with outside of the SOVA framework and the contracting processes may need to be utilised.

Table 1 Levels of Concern and Types of Response

The 4 Principles

For an incident or allegation to be considered as a safeguarding referral the four principles need to be met:

- a vulnerable adult as defined as someone aged 18 years or over, who meets the criteria for a community care service
- a perpetrator – a third party – person/agency/unknown
- abusive behaviour by the third party
- harm, or a risk of harm to the vulnerable adult

Level	Concerns	Response	Agencies involved
0	Concerns raised, but do not meet all 4 Principles, therefore, these are not classified as safeguarding concerns.	Provide information, care management, CPA, complaints, redirect. This will not be seen as requiring an adult safeguarding referral.	CCC, CPFT, CCS, PCS, health services, ISPs.
1	Low level concern, harm to service user is not thought to be serious e.g. isolated incident, no previous concerns. Vulnerable adult to vulnerable adult incident, not resulting in serious harm.	Strategy discussions, professionals meetings, investigation may be by provider, changes to support plan, Lead oversees response.	CCC, CPFT, CCS, PCS, Acute Health Trusts, ISPs, commissioners, police, GP or primary health care.
2	More serious concerns SU adversely effected, concerns re health/social care service delivery, tensions in family/support network, more than one incident/discernable pattern of abuse.	Strategy discussions, professionals meetings, Lead identifies person to lead investigation, changes to services, or informal networks, current & future risks reduced.	Will include: CCC, CPFT, CCS, PCS, May include: Acute Health Trusts, ISPs, commissioners, police, emergency services GP or primary health care.
3	Serious concerns SU seriously effected, risk to other vulnerable adults, possible criminal offence and/or breach of Health & Social Care Act regulations, deliberate intent, pattern of abuse.	Strategy discussions, professionals meetings, Lead identifies person to lead investigation, strategy meetings, investigation may be lead by police, action plans developed.	Will include: CCC, CPFT, CCS, PCS police, May include: Acute Health Trusts, ISPs, commissioners, CQC, emergency services, housing & community services, GP or primary health care.

4	<p>Institutional abuse, several vulnerable adults effected, criminal offence and/or breach of Health & Social Care Act regulations, deliberate intent, pattern of abuse.</p>	<p>Strategy discussions, professionals meetings, strategy meetings, Lead oversees or leads process, police may lead investigation, senior managers informed and agree actions.</p>	<p>Will include: CCC, CPFT, CCS, CQC, police. May include: Acute Health Trusts, ISPs, commissioners, emergency services, housing & community services, GP or primary health care.</p>
5	<p>Highest level concerns:</p> <p>A vulnerable adult dies (including by suicide) and abuse or neglect is known or suspected to be a factor in their death.</p> <p>A vulnerable adult sustained a potentially life-threatening injury, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect. There are concerns about the way in local professionals/services work together regarding safeguarding vulnerable adults from abuse.</p> <p>Serious abuse takes place in an institution, or multiple abusers are involved.</p>	<p>Serious Case Review (SCR).</p> <p>Individual Management reports from relevant agencies.</p> <p>The same principles of review apply, they are, however, likely to be more complex, on a larger scale and may require more time, terms of reference need to be carefully constructed to explore the issues relevant to this specific case.</p> <p>The Adult Safeguarding Board may need to consider making changes to its guidance and procedures, or that protocols are not being understood or acted upon.</p>	<p>SCR Panel, Adult Safeguarding Board</p>

Table 2 Examples – poor practice vs. Abuse

Poor Practice - not dealt with under safeguarding processes	Abuse - dealt with under safeguarding processes
<p>Patient/service user in a care home does not receive necessary help to have a drink/meal on one occasion. Explanation given that emergency with another resident held up staff.</p> <p>Rectified through discussion between resident/staff/manager.</p>	<p>Patient/service user in a care home does not receive necessary help to have drink/meal – this has happened on a regular basis. This has effected one or more residents.</p> <p>Abuse concerns: Neglect Institutional abuse</p>
<p>Patient/service user in a care home does not receive necessary help to get to toilet to maintain continence, or have appropriate assistance such as changed incontinence pads on one occasion. Explanation given that staff member was not aware of need.</p> <p>Rectified through staff training regarding care plans and staff meeting to highlight importance of meeting individual care needs.</p>	<p>Patient/service user in a care home does not receive necessary help to get to toilet to maintain continence, or have appropriate assistance such as changed incontinence pads – this has happened on a regular basis. This has effected one or more residents.</p> <p>Abuse concerns: Neglect Institutional abuse Physical abuse Emotional abuse Harm</p>
<p>Patient/service user in a care home has not been formally assessed with respect to pressure area management but no apparent harm has arisen. Explanation given that they were waiting for specific professional advice.</p> <p>Rectified by links being made with health care services. Local Authority Contracts Department advice sought for further guidance.</p>	<p>Patient/service user in a care home is physically frail and has been admitted without formal assessment with respect to pressure area management. Care provided with no reference to specialist advice re: diet, care or equipment. Pressure damage occurs, or is likely to occur.</p> <p>Breach of contract and CQC Regulated Activities Regulations.</p> <p>Abuse concerns: Neglect Institutional abuse (especially if more than one resident effected) Physical abuse Emotional abuse Harm</p>

<p>Patient/service user living in the community does not receive support with medication as prescribed on their CPA care plan on one occasion but no harm occurs. Explanation given that there was a new member of staff who had not been fully briefed.</p> <p>Rectified by internal investigation by the domiciliary agency and a staff briefing regarding care plans and medication management.</p>	<p>Patients/service user living in the community does not receive medication – this has happened on more than one occasion and regular and time specific administration is vital to their health. This may, or may not effect more than one person.</p> <p>Breach of contract and CQC Regulated Activities Regulations.</p> <p>Abuse concerns: Neglect Institutional abuse (especially if more than one patient/service user affected) Physical abuse Harm</p>
<p>Appropriate moving and handling procedures not followed but patient/service user does not experience harm. Explanation: Provider acknowledges departure from procedures and practice by identified care worker.</p> <p>Rectified though disciplinary procedures.</p>	<p>Failure to follow correct moving and handling procedures on more than one occasion, affecting one or more patient/service user, and involving one or more care workers. One or more patients/service users experience harm, or it is likely that harm will occur.</p> <p>Breach of contract and CQC Regulated Activities Regulations.</p> <p>Abuse concerns: Neglect Institutional abuse (especially if more than one patient/service user affected) Physical abuse Harm</p>
<p>Patient/service user is spoken to in a rude, insulting, belittling or other inappropriate way by a member of staff. They are not distressed by this isolated incident. Explanation given that the staff member did not realise their approach to be offensive.</p> <p>Rectified by staff supervision and appraisal</p>	<p>Patient/service user is spoken to in a rude, insulting, belittling or other inappropriate way, on a regular basis, and it may be happening to more than one patient/service user. They may or may not be mentally frail, and may or may not have capacity. Agency staff, which may include management, do not take it seriously. Patient/service user feels unable to complain and feels disempowered, or is unable to voice their views due to mental health frailty/lack of capacity.</p> <p>Breach of contract and CQC Regulated Activities Regulations.</p> <p>Abuse concerns: Emotional abuse Institutional abuse (especially if more than one patient/service user effected) Harm</p>

<p>Patient/service user reports money missing from their purse, but can't say how much and thinks they gave it to a family member to pay a bill. They may or may not have the ability to manage their financial affairs.</p> <p>Explanation – family member pays bills on a regular basis, so quite likely this has happened.</p> <p>Rectified by checking with care coordinator and family.</p>	<p>Patient/service user reports money missing, quite a lot, and money going missing has happened more than once. They have a lot of family and friends who visit, plus care workers call. The patient/service user may or may not have the ability to manage their financial affairs.</p> <p>Abuse concerns: Financial Professional abuse (if loss linked to care provider/agency worker) Harm</p>
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Practice Guidance 32

Cambridgeshire Safeguarding Adults Feedback Form

Advice to Adult Safeguarding Leads and Associated Practitioners

The purpose of the feedback form is to enable us to improve our practice, based upon feedback from service users or their representatives.

The form should be completed when a referral has resulted in an investigation and a plan to improve how the service user is safeguarded.

The completion of the form is optional. The Adult Safeguarding Lead should offer the form to the service user, their representative or advocate, when the process is concluded. It should be given by hand so that the purpose of the form can be explained.

Consideration should be given to whether the person needs assistance in completing the form. This may be assistance from the translation service, or specialist assistance as a consequence of sensory or cognitive impairments. The Adult Safeguarding Lead or associated worker may assist, but the appropriateness of providing support should be considered.

If the form is left with the service user or their representative, a pre-paid envelope should also be left for the form to be returned to the Adult Safeguarding Team Administrator.

The provision of the feedback form should be included on the Adult Safeguarding Action Plan SOC1434, and box ticked on SOC388 to show when the feedback form has been provided.

Cambridgeshire Safeguarding Adults Feedback Form

The Adult Safeguarding Team would like your comments

Information from this form will help us improve how we work with people who use our services, when there are concerns that they have been abused, exploited or neglected.

Please complete the sections that are relevant to you and your experience. Under each question there is space to say more, as well as giving a Yes/No answer or a score. Thank you for taking the time to complete this.

If you need help

If you have any difficulties in making your comments then please ask family, friends or an advocate to help you. This will not affect the way that we deal with your comments. In certain circumstances we will check with you that you agree with what has been written on your behalf.

Adult Safeguarding Feedback Form

Place a tick in the box to indicate your choice of answer, and if you wish, please add your comments.

Are you:

a) The person who was involved in the safeguarding concern? Yes No

Or,

b) A family member, friend, advocate completing the form on behalf of the person involved in the safeguarding concern? Yes No

Reporting

1. Are you the person reporting the abuse? If so, who did you report to? Yes No

If your answer is No, please go to 'What Happened Next'

Comments:
.....
.....

2. What was it like to report what had happened?

- Easy
- Fairly Easy
- Quite Difficult
- Difficult

Comments:
.....
.....

3. Did the person explain what action they would take?

Yes No

Comments:
.....
.....

4. Were things done to make you feel safe?

Yes No

If yes, what was done?
.....
.....

If no, what would have made you feel safer?
.....
.....

What Happened Next

1. Was the safeguarding process explained to you?

Yes No

Comments:
.....
.....

2. Did the person explain how long the process may take?

Yes No

Comments:
.....
.....

3. Were you kept informed of what was happening?

Yes No

Comments:
.....
.....

4. Were you involved in any discussions or meetings?

Yes No

Comments:
.....
.....

5. Do you feel you were listened to? Yes No

Comments:
.....
.....

6. Were you treated with respect? Yes No

Comments:
.....
.....

Would you like this followed up? If so, please give details:
.....
.....
.....

Outcome

1. How satisfied were you with the outcome? Very satisfied
Satisfied
If you were not satisfied, please say what could have been done differently: Not very satisfied
..... Dissatisfied
.....

2. Has the outcome made you feel safer? Yes No

Comments:
.....
.....

3. On a scale of 1 – 5 how safe do you feel? 1 Very Safe
2 Safer
Comments: 3 No Different
..... 4 Less Safe
..... 5 Unsafe

4. Were you involved in putting together a plan to keep you safe? Yes No

Comments:
.....
.....

5. Did you want to be involved in putting together a plan to keep you safe? Yes
No
Unsure

Comments:
.....
.....

6. If something like this happened again, would you report it? Yes
 No
 If no, please say why you wouldn't report it: Unsure

7. Do you know how to get help if you should need it in the future? Yes
 No
 Comments: Unsure

8. Would you encourage others to report concerns about abuse? Yes No
 Comments:

9. Is there anything else you want to say that could help us improve how we respond to reports of abuse?
 Comments:

Thank you for completing the form. There is a space below for a signature, or it can be returned anonymously.

Signed: Date:

Name and Relationship to service user.....

Name of service user (if not completing form).....

**Please return the form in the pre-paid envelope to the address to:
 Adult Safeguarding Administrator, Cambridgeshire County Council,
 Box no CC1310, Castle Court, Castle Hill, Cambridge, CB3 0AP**

Practice Guidance 32a

Template – Feedback Form Information Letter

Your ref:
My ref:
Date:
Contact:
Direct
E Mail:

Dear

The Adult Safeguarding Team would like your comments

This letter explains how you can use the Safeguarding Adults Feedback Form to comment about the support that you, or someone you know, received recently in relation to an Adult Safeguarding concern. You can use it to let us know when we have done things well and also where you feel things could have been better.

- If you feel that staff have done something particularly well, please let us know so that we can keep doing it.
- If you want to suggest how we could improve how we do things, please let us know so that we can take this into account when reviewing and planning our safeguarding services.

The information you provide will be stored securely. We will ensure we follow guidelines and policies on confidentiality and data protection and permissions will be sought before information is shared with other people.

You may complete the form anonymously and the information you give us will only be shared with those who need to know. If your answers indicate that there could still be risks to your safety or the safety of others, your concerns may be discussed with you, should you have directly or indirectly identified yourself in your comments and passed on for any further response.

If you have any difficulties in completing the form, please ask someone to help you. This will not affect the way that we deal with your comments. You can ask anyone to make a comment for you – although in some circumstances we will check that you agree with what has been written down. There are also groups or advocates that can help you. Please ask the person who gave you the form for advice.

We very much value the contribution you make by completing this feedback form and would like to thank you in anticipation, for the time you give in offering your feedback.

Yours sincerely

Insert name
Your contact details

Practice Guidance 33

Human trafficking and Radicalisation

Human trafficking

If an identified victim of human trafficking is also an adult at risk, adult safeguarding would be part of the coordinated response including organisations that have a role to play in dealing with victims of human trafficking, including the police, health trusts, immigrations officials and other relevant support services including those in the voluntary sector. The adult at risk should receive the support and advice they need and be safely repatriated if this is the future plan. If the victim is a child, the situation will be dealt with under the Children's Safeguarding Board Procedures.

The early identification of victims of human trafficking is key to ending the abuse they suffer and to providing the assistance necessary. Front-line staff need to be able to identify the signs that someone has been trafficked.

There is a national framework to assist in the formal identification and help to coordinate the referral of victims to appropriate services; this is called the National Referral Mechanism. The UK Human Trafficking Centre takes referrals of adults and children identified as being the victims of trafficking. Local authorities can provide a range of assistance on a discretionary basis. The Centre now comes under the Serious and Organised Crime Agency (SOCA).

The police are the lead agency in managing responses to adults who are the victims of human trafficking.

Exploitation by radicalisers who promote violence

Individuals may be susceptible to exploitation into violent extremism by radicalisers. Violent extremists often use a persuasive rationale and charismatic individuals to attract people to their cause. The aim is to attract people to their reasoning, inspire new recruits and embed their extreme views and persuade vulnerable individuals of the legitimacy of their cause.

There are a number of factors that may make the individual susceptible to exploitation by violent extremists. None of these factors should be considered in isolation but in conjunction with the particular circumstances of the individual: identity or personal crisis, particular personal circumstances, unemployment or underemployment and criminality. All of these may contribute to alienation from UK values and a decision to cause harm to symbols of the community or the state.

The Home Office leads on the anti-terrorism strategy, CONTEST, and PREVENT is part of the overall CONTEST strategy, aiming to stop people becoming terrorists or supporting violent extremism.

Adult safeguarding structures have a role to play for those eligible for safeguarding.

Appendix 1



**ADULT SAFEGUARDING MONITORING FORM
STRICTLY CONFIDENTIAL
SOC388 (Rev APR 2012)**

Please return this form in a sealed envelope marked 'STRICTLY CONFIDENTIAL/ADDRESSEE ONLY' to: Adult Safeguarding Administrator, Cambridgeshire County Council, Box No: CC1310, Castle Court, Castle Hill, Cambridge CB3 0AP

FRONT DESK/FRONT SHEET

Service User Name:	Date of Birth:	Gender: Female <input type="checkbox"/> Male: <input type="checkbox"/>	SWIFT ID:
---------------------------	-----------------------	--	------------------

Ethnicity: (Tick one only)	<input type="checkbox"/> Chinese	<input type="checkbox"/> Roma/Gypsy
<input type="checkbox"/> Any other ethnic group	<input type="checkbox"/> Client declines to answer	<input type="checkbox"/> White and Asian
<input type="checkbox"/> Asian other	<input type="checkbox"/> Indian	<input type="checkbox"/> White and Black-African
<input type="checkbox"/> Bangladeshi	<input type="checkbox"/> Irish Heritage Traveler	<input type="checkbox"/> White and Black-Caribbean
<input type="checkbox"/> Black-African	<input type="checkbox"/> Mixed Other	<input type="checkbox"/> White-British
<input type="checkbox"/> Black-Caribbean	<input type="checkbox"/> Not yet known	<input type="checkbox"/> White-Irish
<input type="checkbox"/> Black-Other	<input type="checkbox"/> Pakistani	<input type="checkbox"/> White-Other

MAIN CLIENT CATEGORY (FRONT SHEET/FURTHER DETAILS/CATEG.)

Primary Client Group:	Client is: Adult <input type="checkbox"/> Elderly <input type="checkbox"/>
<input type="checkbox"/> Alcohol misuse	<input type="checkbox"/> Dual sense loss
<input type="checkbox"/> Asylum seeker	<input type="checkbox"/> Learning disability
<input type="checkbox"/> Carer	<input type="checkbox"/> Mental health
<input type="checkbox"/> Deaf/hard of hearing	<input type="checkbox"/> Physical disability
<input type="checkbox"/> Dementia	<input type="checkbox"/> Physically frail
<input type="checkbox"/> Drug misuse	<input type="checkbox"/> Sensory disability
	<input type="checkbox"/> Temp ill
	<input type="checkbox"/> Terminal illness
	<input type="checkbox"/> Visual Impaired
	<input type="checkbox"/> Welfare benefits

HAZARD (FRONT SHEET/FURTHER DETAILS/HAZS (Remember to load hazard!))

Is the client known to Cambridgeshire Adult Support Services? Yes <input type="checkbox"/> No <input type="checkbox"/> (i.e. has the client got a key team (key responsibility) displaying or has the client had an adult assessment, service/provision or review in the same financial year as the contact date?)
--

RELATIONSHIPS (FRONT SHEET/FURTHER DETAILS/RELAT

If the alleged perpetrator lives with the vulnerable adult, or is the vulnerable adult's main carer, then they must be recorded in the Relationships tab:	
Name of alleged perpetrator:	
Address of alleged perpetrator:	
Relationship: (Detail family relationship or no relationship – DON'T use SOVA Prefix)	
Emerg Contact <input type="checkbox"/>	Next of Kin <input type="checkbox"/> Key Holder <input type="checkbox"/> Vuln Dependant <input type="checkbox"/>
Start Date:	End Date:
Principal Carer? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	
Does the alleged perpetrator live with the vulnerable adult?: Yes <input type="checkbox"/> No <input type="checkbox"/>	

CONTACT (FRONT SHEET/CONTACT TAB)

Date of Contact:	Contact Reason: <input type="checkbox"/> SOVA Investigation <input type="checkbox"/> SOVA Placed by OLA (Other Local Authority)
Contact Source Type:	
<input type="checkbox"/> Education/Training/Workplace Establishment <input type="checkbox"/> Family Member <input type="checkbox"/> Friend/Neighbour <input type="checkbox"/> Housing <input type="checkbox"/> NHS Staff: Mental Health <input type="checkbox"/> NHS Staff: Primary Health/Community Health <input type="checkbox"/> NHS Staff: Secondary Health <input type="checkbox"/> Other <input type="checkbox"/> Other Service User <input type="checkbox"/> police	<input type="checkbox"/> Regulator: CQC <input type="checkbox"/> Self Referral <input type="checkbox"/> Social Care Staff: Day Care <input type="checkbox"/> Social Care Staff: Domiciliary <input type="checkbox"/> Social Care Staff: Other <input type="checkbox"/> Social Care Staff: Residential Care <input type="checkbox"/> Social Care Staff: Self Directed Care <input type="checkbox"/> Social Care Staff: Social Worker/Care Manager
Contact Receiving Team:	Contact Receiving Worker:
Contact Outcome:	
<input type="checkbox"/> SoVA Investigation	<input type="checkbox"/> SoVA Contact on Existing Investigation

INVOLVEMENTS (FRONT SHEET/INVOLVEMENTS TAB)

Name of Adult Safeguarding Lead (Coordinator):
Name of Team:
Is the client placed in Cambridgeshire by another Authority/PCT?: Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please give details:
Other LA/PCT:
Contact name:
Contact job title:
Contact telephone number:
Create person/LA/PCT if not already in swift (help desk will need to create any LA or PCT). This information also needs to be recorded in the adult protection module/Other LA tab.

SERVICES TAB (or INDEPENDENT SECTOR PROVIDER (ISP) SPREADSHEET)

Is the client receiving a service? (at the date of the incident): Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, is it commissioned by/funded by: (tick all that apply)	
<input type="checkbox"/> Cambridgeshire County Council <input type="checkbox"/> Health Funded	<input type="checkbox"/> Other Local Authority <input type="checkbox"/> Self Funded

**FRONT DESK/NAVIGATE TO ADULT PROTECTION MODULE
INCIDENTS TAB**

Start date of incident:	End date of incident (if applicable):
Location of alleged abuse:	
<input type="checkbox"/> Acute Hospital <input type="checkbox"/> Alleged Perpetrators Home <input type="checkbox"/> Care Home - Permanent <input type="checkbox"/> Care Home with Nursing – Permanent <input type="checkbox"/> Care Home - Temporary <input type="checkbox"/> Care Home with Nursing – Temporary <input type="checkbox"/> Community Hospital <input type="checkbox"/> Day Centre/Service <input type="checkbox"/> Education/Training/Workplace Establishment	<input type="checkbox"/> Mental Health Inpatient Setting <input type="checkbox"/> Not Known <input type="checkbox"/> Other Health Setting <input type="checkbox"/> Other <input type="checkbox"/> Own Home <input type="checkbox"/> Public Place <input type="checkbox"/> Supported Accommodation Additional locations may be recorded in Incidents/Further Details/Locations
Name of (main) Alleged Perpetrator:	
Is the main perpetrator A person? <input type="checkbox"/> An organisation? <input type="checkbox"/> (create on SWIFT if required; Helpdesk will have to create organisations)	
Relationship of alleged perpetrator:	
<input type="checkbox"/> SOVA - Health Care Worker <input type="checkbox"/> SOVA - Neighbour/Friend <input type="checkbox"/> SOVA - Not Known <input type="checkbox"/> SOVA - Other <input type="checkbox"/> SOVA - Other Family Member <input type="checkbox"/> SOVA - Other Professional <input type="checkbox"/> SOVA - Other Vulnerable Adult <input type="checkbox"/> SOVA – Partner	<input type="checkbox"/> SOVA - Social Care Staff: Day Care Staff <input type="checkbox"/> SOVA - Social Care Staff: Domiciliary Care Staff <input type="checkbox"/> SOVA - Social Care Staff: Other <input type="checkbox"/> SOVA - Social Care Staff: Residential Care Staff <input type="checkbox"/> SOVA - Social Care Staff: Self Directed Care Staff <input type="checkbox"/> SOVA - Social Care Staff: Social Worker/Care Manager <input type="checkbox"/> SOVA - Stranger <input type="checkbox"/> SOVA - Volunteer/Befriender
Is Alleged Perpetrator Vulnerable: Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Is Alleged Perpetrator Aware: Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Are Others at Risk: Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Does the Alleg Perp Care for Others: Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	

INCIDENTS/FURTHER DETAILS/CATEGORY

Nature of alleged abuse: (tick all that apply)	Of which:
<input type="checkbox"/> Discriminatory <input type="checkbox"/> Emotional/psychological <input type="checkbox"/> Financial <input type="checkbox"/> Institutional <input type="checkbox"/> Neglect <input type="checkbox"/> Physical <input type="checkbox"/> Sexual	Included multiple types of abuse Yes <input type="checkbox"/> No <input type="checkbox"/> Included domestic violence Yes <input type="checkbox"/> No <input type="checkbox"/> If multiple types indicate which is the main category of abuse:

DISCUSS TAB

Select linked Incident date (N.B. the incident MUST have a main Nature of abuse recorded):

Additional related incidents may be linked in Further Details/Incidents

Date of Discussion:	Location of Discussion:
Coordinator:	Team:
Risk Level: Low <input type="checkbox"/> Medium <input type="checkbox"/> High <input type="checkbox"/>	
Outcome of Discussion: Initiate Investigation <input type="checkbox"/> (you must record an investigation for the referral to be counted)	
Is this a repeat referral? Yes <input type="checkbox"/> No <input type="checkbox"/> (i.e. has there been at any time a previous adult safeguarding investigation for this client) If yes, give date of the most recent discussion: Ensure that this discussion is recorded in SWIFT!	

DISCUSS TAB/FURTHER DETAILS – Add all involvements that were involved with discussions creating contact if necessary (Insert in Notes Section – Look at SOC1434 for full details).

INVEST TAB

Select linked Incident date: Additional related incidents may be linked in Further Details/Incidents	Investigation Method: (Tick one only) Joint Agency Investigation <input type="checkbox"/> Single Agency Investigation <input type="checkbox"/>
Lead Agency:	Worker & Team:
Priority: Immediate <input type="checkbox"/> Within 24 hours <input type="checkbox"/> Within 5 working days <input type="checkbox"/>	
Start date of investigation:	End date of investigation:
Outcome of Investigation: Initiate Strategy Meeting <input type="checkbox"/> Case concluded <input type="checkbox"/> (If Case concluded, record outcomes in Further Details)	

STRATEGY MEETING (ADULT PROTECTION/STRATEG TAB)

Select linked Investigation date	
Strategy Meeting Type: Initial: <input type="checkbox"/> Reconvened: <input type="checkbox"/> Review: <input type="checkbox"/>	
Due date of Meeting:	Planned date:
Actual date:	Delay reason (if applicable):
Location:	Chairperson:
Worker:	Team:
Date Minutes Sent Out:	
Decision: Ongoing <input type="checkbox"/> Case concluded <input type="checkbox"/>	
Has the referral led to a serious case review? Yes <input type="checkbox"/> No <input type="checkbox"/>	

CASE CONCLUSIONS (Record in the Investigation or Strategy Meetings/Further Details/Outcomes)

Record the C1 outcome AND only 1 C2 outcome. P and V outcomes are recorded as applicable; you must have at least 1 P and 1 V outcome, and they should be linked to the appropriate person.

Date of case conclusion: (= actual date of strategy meeting or investigation where case conclusion arrived at)	
Outcomes relating to the CASE CONCLUSION (mandatory when the strategy meeting is 'Case concluded': <input type="checkbox"/> C1: Case concluded	<input type="checkbox"/> C2: Not Determined/Inconclusive <input type="checkbox"/> C2: Not Substantiated <input type="checkbox"/> C2: Partly Substantiated <input type="checkbox"/> C2: Substantiated
Outcomes relating to the PERPETRATOR: <input type="checkbox"/> P: Action By Care Quality Commission <input type="checkbox"/> P: Action by Contract Compliance <input type="checkbox"/> P: Action under Mental Health Act <input type="checkbox"/> P: Community Care Assessment <input type="checkbox"/> P: Continued Monitoring <input type="checkbox"/> P: Counseling/Training/Treatment <input type="checkbox"/> P: Criminal Prosecution/Formal Caution <input type="checkbox"/> P: Disciplinary Action <input type="checkbox"/> P: Exoneration	<input type="checkbox"/> P: Management of access to the Vulnerable Adult <input type="checkbox"/> P: No Further Action <input type="checkbox"/> P: Not Known <input type="checkbox"/> P: police Action <input type="checkbox"/> P: Referral to Court Mandated Treatment <input type="checkbox"/> P: Referral to MAPPA <input type="checkbox"/> P: Referral to Registration Body <input type="checkbox"/> P: Referred to PoVA List/Independent Safeguarding Authority <input type="checkbox"/> P: Removal from property or Service
Outcomes relating to the VICTIM: <input type="checkbox"/> V: Application to change appointee-ship <input type="checkbox"/> V: Application to Court of Protection <input type="checkbox"/> V: Civil Action <input type="checkbox"/> V: Community Care Assessment and Services <input type="checkbox"/> V: Guardianship/Use of Mental Health act <input type="checkbox"/> V: Increased Monitoring <input type="checkbox"/> V: Management of access to finances <input type="checkbox"/> V: Moved to increase/Different Care	<input type="checkbox"/> V: No Further Action <input type="checkbox"/> V: Other <input type="checkbox"/> V: Referral to advocacy scheme <input type="checkbox"/> V: Referral to Counseling/Training <input type="checkbox"/> V: Referral to MARAC <input type="checkbox"/> V: Restriction/management of access to alleged perpetrator <input type="checkbox"/> V: Review of Self-Directed Support (IB) <input type="checkbox"/> V: Vulnerable Adult removed from property or service

PLANS

Start date:	Plan Type: <input type="checkbox"/> Final Plan <input type="checkbox"/> Interim/Emergency Plan
Linked conference date (i.e. Strategy Meeting):	Action Plan Accepted: Yes <input type="checkbox"/> No <input type="checkbox"/> Could not consent <input type="checkbox"/>
Care Plan Affected: Yes <input type="checkbox"/> No <input type="checkbox"/>	

PLANS/FURTHER DETAILS/OBJECTIVES

<input type="checkbox"/> Safeguard service user <input type="checkbox"/> Referral made to Children's services <input type="checkbox"/> Feedback form provided

REMEMBER TO RECORD OTHER LA IF NECESSARY

Signed:	Print Name:	Date:
Signed:	Print Name:	Team Leader/Manager Date:

Appendix 2

Adult Safeguarding Action Plan

SOC1434 (Rev April 2012)

Strategy Discussion <input type="checkbox"/> Strategy Meeting <input type="checkbox"/>	Professional Meeting <input type="checkbox"/> Re-Convened Strategy Meeting <input type="checkbox"/>
---	--

Name of Service User _____ **DOB** _____ **Swift Id** _____

Date of Discussion/Meeting _____

Incident Date _____

People Involved

Name	Agency

Summary of events to date and reason for Discussion/Meeting

Reports from Other Professionals (Please Attach)

Summary of Discussion

Assessment of Risk

List all risks to the vulnerable person/s

Decisions

Action Plan

Monitoring and Review Arrangements

Date of Review:

Referral to Independent Safeguarding Authority: Yes/No
Date of Referral:

Referral to MARAC: Yes/No
Date of Referral:

Referral to MAPPA: Yes/No
Date of Referral:

Outcomes:

Complete when Final Meeting has taken place:

Unsubstantiated	<input type="checkbox"/>	Partly Substantiated	<input type="checkbox"/>
Substantiated	<input type="checkbox"/>	Not determined/inconclusive	<input type="checkbox"/>
Ongoing	<input type="checkbox"/>		

Lead Agency:

Chaired/led
by:

Date:

Team:

Signed by
Chair/Lead:

Copies of
meeting
minutes to:

The contents of this document are confidential and should not be disclosed to a third party without prior permission from the Chair.

Note:

These notes are issued in the belief that they are an accurate representation of the discussion/meeting. Please make contact within 7 days of receipt to record inaccuracies or omissions.

This SOC1434 should be sent by secure email, or as a hard copy in a sealed envelope marked 'Strictly Confidential Addressee Only' to all those who took part in the discussion or meeting.

Appendix 3

Safeguarding of Vulnerable Adults Referral Form

Cambridgeshire County Council has in conjunction with its partner agencies procedures to safeguard vulnerable adults.

The procedure makes it clear what staff must do if abuse is disclosed, identified, suspected or alleged, it makes it clear that anyone who suspects abuse has a duty to report it so that the matter can be fully looked into and if necessary, appropriate steps taken to protect the vulnerable adult. Any report of abuse will be taken seriously and looked into in a fair and thorough manner. If you have concerns or you think someone may be being abused, don't assume that someone else is doing something about the situation.

Reporting Abuse: When receiving information that indicates that alleged abuse of a vulnerable adult may have taken place, it is imperative that prompt and effective action is taken as soon as possible.

Where abuse is ongoing or has just occurred, this action should be immediate.

In such cases, the process of referral to a 'line manager' should be completed as soon as possible and in any case within 24 hours.

If the line manager or any other member of staff is a potential suspect, then the local Human Resources reporting procedures must be used.

Where abuse occurs in a regulated setting, the Care Quality Commission must also be informed at the earliest opportunity.

Incidents involving criminal abuse must also be reported to the police at the earliest opportunity.

Sharing Confidential Information

Practitioners and Managers must always be mindful of the conditions imposed by the Data Protection Act 1998, the Caldicott Principles and other relevant legislation when sharing confidential information with outside agencies.

Abuse is defined in 'No Secrets' as a violation of an individual's human or civil rights by any other person or persons.

Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, 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. It may also occur through deliberate targeting or grooming of vulnerable people and may be carried out by individuals or groups of individuals. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.

Safeguarding of Vulnerable Adults Referral Form

Vulnerable Adult Details:

Name:

Address:

Date of Birth:

Gender: Male Female

Ethnicity:

GP Name & Address:

Responsible Authority:

Is the vulnerable adult self funding Yes No

Does the alleged victim/adult at risk have capacity to consent to this referral?

Yes No Not known

If the alleged victim/adult at risk does not have mental capacity there will be a need to consider the criteria for using an Independent Mental Capacity Advocate (IMCA), if appropriate.

Please describe any additional needs the vulnerable adult has (e.g. sensory loss, dementia, communication, language, physical disability, etc.) that should be taken account of:

Mental Capacity and Consent of the Vulnerable Adults

Consider mental capacity and consent – The mental capacity and wishes of the vulnerable person will always be a factor when deciding on the course of action you may take. In determining this action, consideration must be given to the likely risk to others and the potential for re-offending to take place if the matter is not formally dealt with.

Referral Details:

Name:

Designation:

Establishment:

Contact Number:

Time/Date 'Referral' form completed:

Incident Details:

Date of Incident:

Type of Alleged Abuse:

- | | |
|--|--|
| <input type="checkbox"/> Discriminatory | <input type="checkbox"/> Institutional |
| <input type="checkbox"/> Domestic Abuse & Violence | <input type="checkbox"/> Neglect |
| <input type="checkbox"/> Emotional/psychological | <input type="checkbox"/> Physical |
| <input type="checkbox"/> Financial | <input type="checkbox"/> Sexual |

For Completion by Line Manager/Supervisor:

Other Action Taken (To include any emergency medical treatment provided; evidence preserved; action taken to prevent further abuse)

Details of alleged perpetrator(s) involved if abuse is suspected:

(Please complete as much of this as is known)

Name:

Home Address including postcode: (if known)

Date of Birth:

Occupation/Position/Title (if known):

Is this person known/related to the individual who is the subject of this concern if so please describe relationship:

Are they aware of this alert? Yes No

Initial action taken:

Has a referral been made to Cambridgeshire Direct?

Yes No

If there is immediate danger/harm have the police been called?

Yes No

Has the Care Quality Commission been notified?
 Yes No

Has evidence been preserved? Yes No

Has a body map been filled out? Yes No

Please give details:

Additional Information and Comments *(For use of Line Manager and/or Supervisor ONLY)*
Fact and opinion should be clearly differentiated

Signed:

Position:

Date:

Please forward the completed form to Cambridgeshire Direct on
 Fax number: 01480 498066 or
 Email: referral.centre-adults@cambridgeshire.gov.uk
 Tel: 0345 045 5202

Where appropriate, please attach any additional information such as a body map, etc.
Details of this referral must be referred to your line manager without delay.

Appendix 4

Adult Safeguarding Process Checklist

Stage	Activities - examples	Responsibility	Time Frame
Initial referral	Record information and report to manager, record allegations and concerns of abuse or neglect, deal with immediate protection.	Everyone responsible for initial response.	Immediately on the same day.
Details sent to team	Refer allegation to the local team and Adult Safeguarding Lead.	Duty, locality team, Adult Safeguarding Lead, EDT.	Within 24 hours, including out of hours.
Strategy Discussion	Decide if safeguarding procedures are appropriate. If not, identify alternative responses. If yes, discuss with police whether a crime has been committed - if yes, refer to police. Appropriate manager to inform 'communications' if needed. SCR/SI instigation if appropriate	Adult Safeguarding Lead, in consultation with other organisations. Line Manager.	Within 24 hours.
Strategy discussion and/or professionals meetings	Formulate a multi-agency plan for assessing risk and addressing any intermediate protection needs.	Adult Safeguarding Lead, with other organisations.	Within 5 working days.
Investigation, assessments, professionals meetings and strategy meeting as required	Co-ordinate the collection of information about concerns - abuse or neglect that has, or may, occur. This may include an investigation, criminal, and/or disciplinary investigation.	Adult Safeguarding Lead and other organisations.	As decided through the strategy discussion, but within 4 weeks from the alert.
Safeguarding action plan – development, implementation and review.	Analyse concerns, investigation and decisions made in discussions and meetings. Develop Adult Safeguarding Action Plan at strategy meeting. Allocate actions to appropriate organisations. Identify timescales to monitor and review actions. Refer to MARAC if appropriate.	Safeguarding partner organisations as appropriate.	As identified from discussions, professionals meetings, strategy meeting.
Review	Review the Adult Safeguarding Action Plan.	Adult Safeguarding Lead, with other organisations as relevant.	First review as identified in the Adult Safeguarding Action Plan.
Recording, monitoring and reviewing.	Adult safeguarding process.	Adult Safeguarding Lead.	On-going as required.

Appendix 5

Strategy Meeting Checklist – Chair & Admin

Attendee list, as relevant:

Chair	GP/Consultants Etc	Providers
Care Manager	Legal Representative	Service User
Team Manager	police	Carer
Nurses	Housing	Commissioners of services
Therapists	Care Quality Commission	IMCA, Advocate
Procurement (Social Care)	Children's Services	Ambulance/Fire Services
Care Coordinator	Environmental Health	Others As Appropriate

Arrange prior to meeting (Chair & Admin):

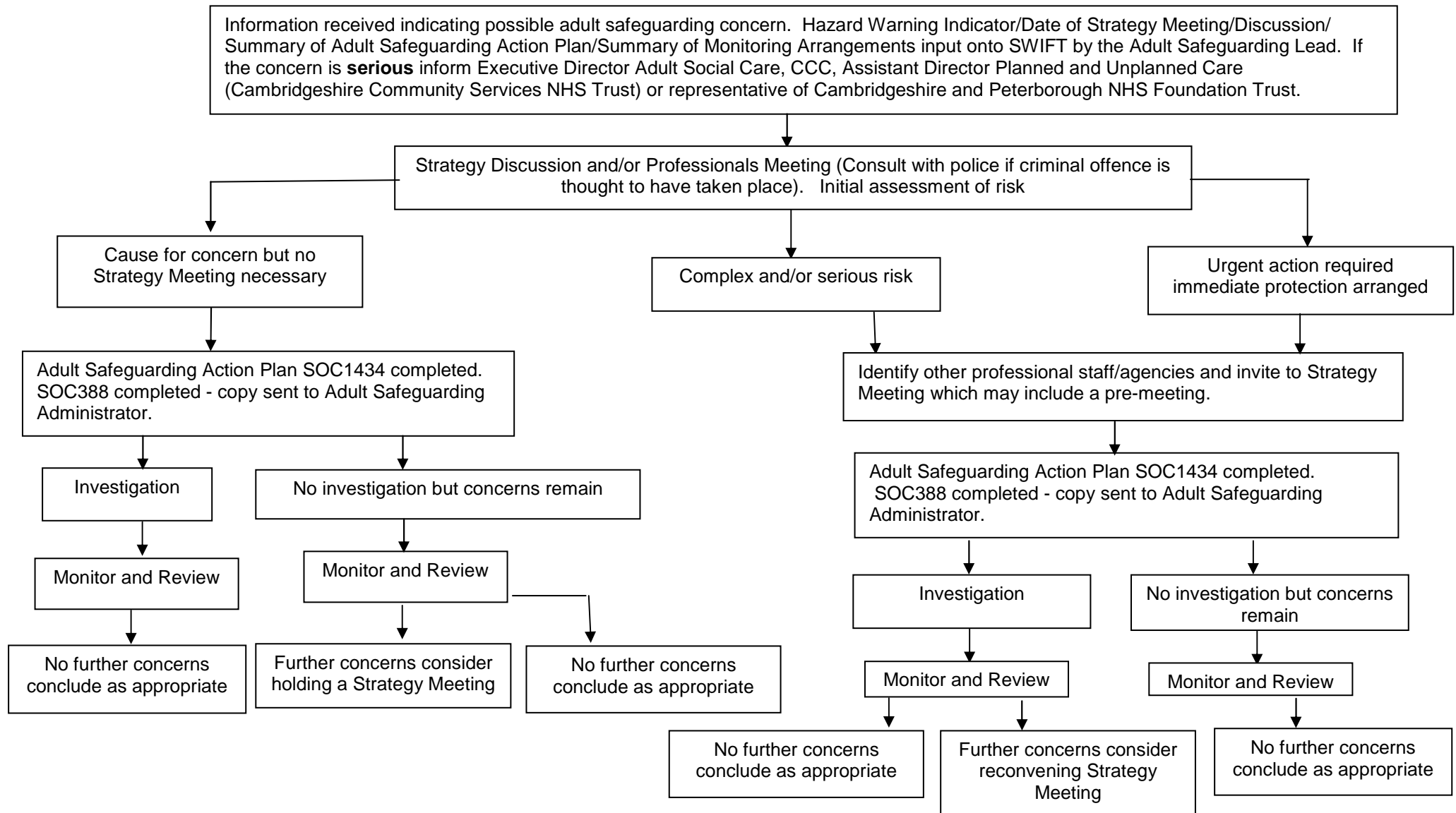
Tick

Strategy meeting date + time + venue	
Admin support/Minute Taker	
Invitations to the meeting – date/time/venue, request confirmation of attendance or provision of report and who should have access to report	
Set agenda – follow SOC1434, keep to time. Attendees to take part as previously arranged, at part or all of the meeting (e.g. family during second half)	

At meeting:

Minute Taker sits next to Chair – confer and clarify notes when needed - use SOC1434 to record meeting minutes	
Chair reads SOVA confidentiality and information sharing statement	
Circulate attendance list to sign	
Introductions	
Apologies	
Mobile phones, length of meeting, etc	
Purpose of the meeting – Chair sets the scene – initial concern, updates	
If this is not the first meeting, review minutes, decisions and actions from previous meeting	
Actions to date	
Reports – from attendees and non/attendees	
Service Users & Carers views	
Summary of discussion	
Risk assessment – compare risks with previous minutes if not first meeting	
Decisions reached	
Action plan – identify <i>Who, What, When</i>	
Monitoring and review arrangements, if/when to reconvene group, with timescales	
If service user not present, agree why not, and feedback if any	
Agree circulation of minutes & actions - ensure attendees take note of their own actions	
Agree feedback to - referrers etc, press	
Date & time of next meeting	

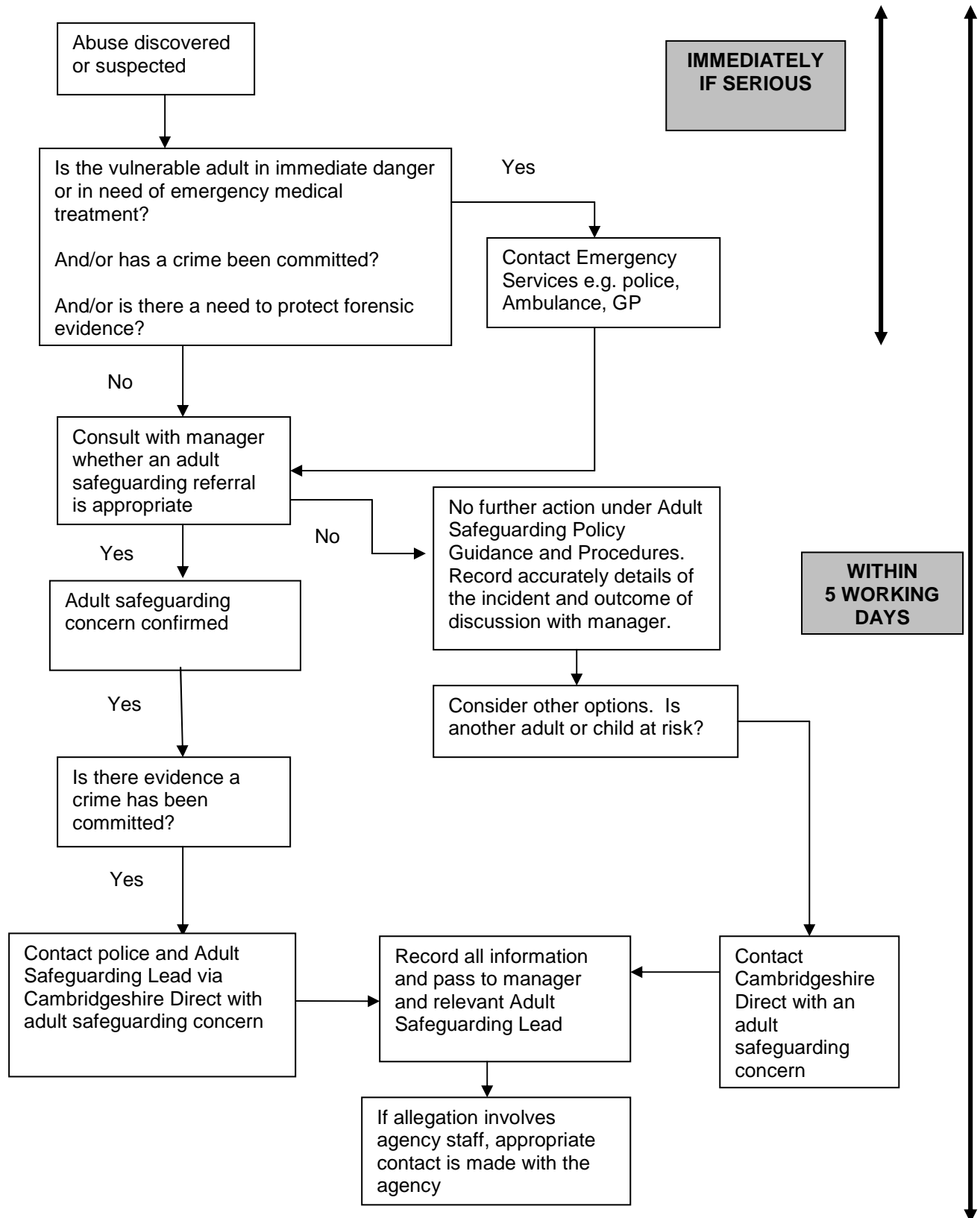
Appendix 6 - Adult Safeguarding Flow Chart



Appendix 7

Actions to be taken after becoming aware of an adult safeguarding concern

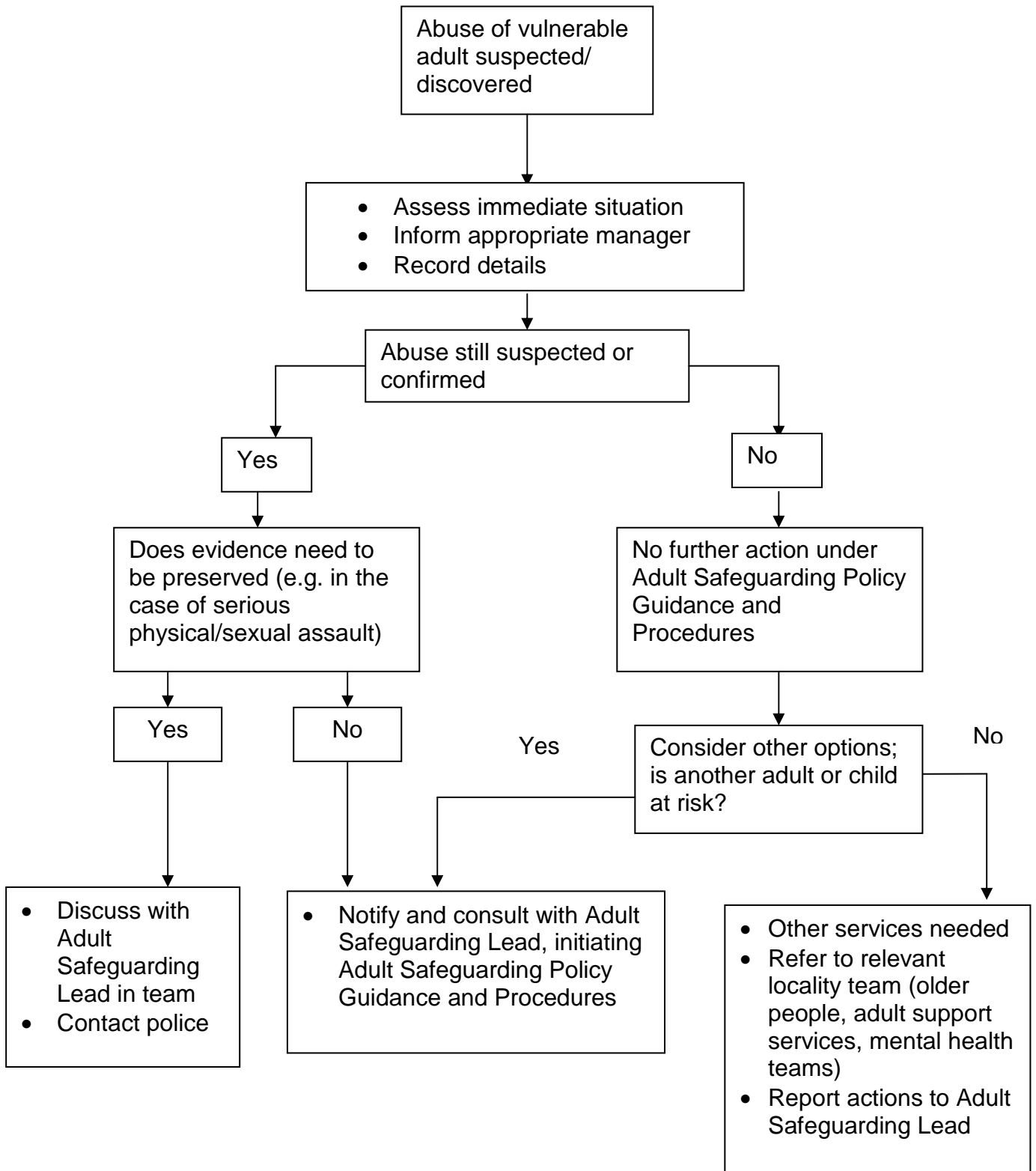
Flowchart for all agencies



Appendix 8

Adult Safeguarding Concern

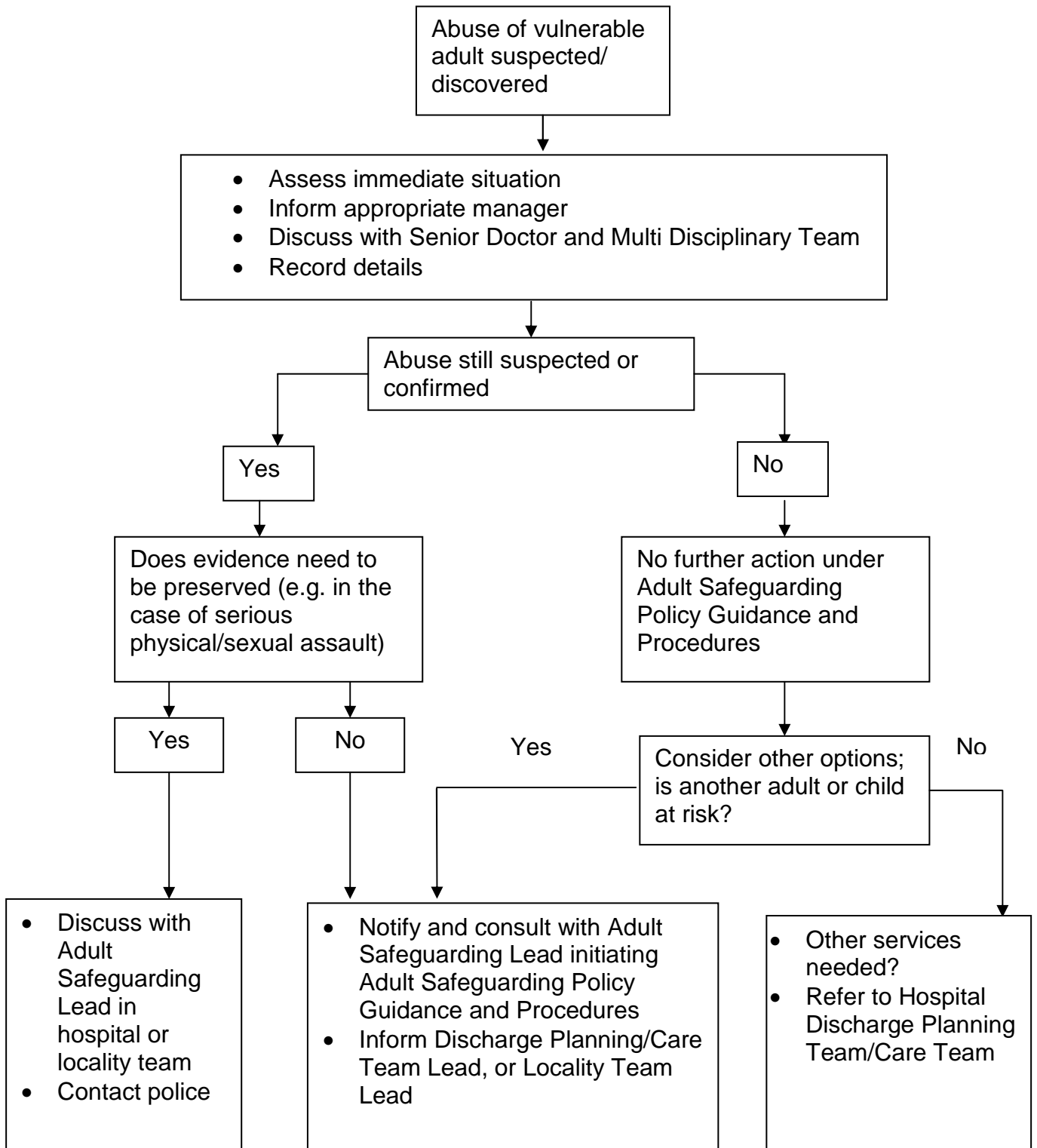
Flow chart for Cambridgeshire Community Services NHS Trust Staff



Appendix 9

Adult Safeguarding Concern

Flow chart for health staff (Hospital Settings)



Revisions made in April 2012:

Page	Description of change
3-5	Inclusion of specification to define who should follow the specific Guidance
7	Clarification of referral routes and recording
10	Removal of comment specifying the sharing of copies of strategy discussion notes
10	Inclusion of a reference to the needs of children
11	Inclusion of guidance regarding contacting a provider and the provider initiating their own internal investigation
11	Inclusion of guidance on feedback to people involved
18	Inclusion of guidance for the management of complex or high risk concerns
23	Inclusion of reference to CQC guidance and examples, related to compliancy of regulated provider services
27	Inclusion of reference to two new checkboxes on SOC388
38	Inclusion of guidance for amending professional/strategy meeting minutes
45	Inclusion of link to ACPO CAADA DASH RIC risk assessment
79	Inclusion of guidance regarding when police from the AAIU will attend professional/strategy meetings
89-93	General Adult Safeguarding Risk Assessment updated
103	Inclusion of guidance for informing service users, relatives and carers of suspension of a contracted service
121	Inclusion of guidance for empowering and informing service users and families of safeguarding matters
135	Inclusion of new Practice Guidance 31 – Adult Safeguarding Threshold Decisions Guidance
142	Inclusion of new Practice Guidance 32 - Cambridgeshire Safeguarding Adults Feedback form
147	Inclusion of new Practice Guidance 32a – Feedback Form Information letter
148	Inclusion of new Practice Guidance 33 – Human trafficking and Radicalisation
153	Insertion of two new checkboxes on SOC388
157	Updated Safeguarding of Adults Referral form