2020

# HARINGEY ADULTS SAFEGUARDING PRACTITIONER MANUAL

BETTER OUTCOMES BETTER LIVES

REVIEW DECEMBER 2020

HARINGEY COUNCIL | River Park House, 225 High Road, Wood Green, N22 8HQ

## Contents

**SAFEGUARDING PRACTITIONER MANUAL**

## 1. Adult Safeguarding – what it is and why it matters

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

Organisations should always promote the adult's wellbeing in their safeguarding arrangements. People have complex lives and being safe is only one of the things they want for themselves. Professionals should work with the adult to establish what being safe means to them and how that can be best achieved. Professionals and other staff should not be advocating 'safety' measures that do not take account of individual well-being, as defined in Section 1 of the Care Act.

The following 6 principles apply to all sectors and settings including care and support services, further education colleges, commissioning, regulation and provision of health and care services, social work, healthcare, welfare benefits, housing, wider Haringey functions and the criminal justice system. The principles should inform the ways in which professionals and other staff work with adults. The principles can also help SABs, and organisations more widely, by using them to examine and improve their local arrangements.

## 2. Six key principles underpin all adult safeguarding work

**Empowerment**

People being supported and encouraged to make their own decisions and informed consent.

I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens.

**Prevention**

It is better to take action before harm occurs.

I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.

**Proportionality**

The least intrusive response appropriate to the risk presented.

I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed.

**Protection**

Support and representation for those in greatest need.

I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want.

**Partnership**

Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me.

**Accountability**

Accountability and transparency in delivering safeguarding.

I understand the role of everyone involved in my life and so do they.

## 3. What constitutes abuse and neglect?

Practitioners should not limit their view of what constitutes abuse or neglect, as they can take many forms and the circumstances of the individual case should always be considered; although the criteria at paragraph 14.2 will need to be met before the issue is considered as a safeguarding concern. Exploitation, in particular, is a common theme in the following list of the types of abuse and neglect.

**Physical abuse including:**

- Assault
- Hitting
- Slapping
- Pushing
- misuse of medication
- restraint
- inappropriate physical sanctions

**Domestic violence including:**

- psychological
- physical
- sexual
- financial
- emotional abuse
- so called 'honour' based violence

**Sexual abuse including:**

- rape
- indecent exposure
- sexual harassment
- inappropriate looking or touching
- sexual teasing or innuendo
- sexual photography
- subjection to pornography or witnessing sexual acts
- indecent exposure
- sexual assault

- sexual acts to which the adult has not consented or was pressured into consenting

**Psychological abuse including:**

- emotional abuse
- threats of harm or abandonment
- deprivation of contact
- humiliation
- blaming
- controlling
- intimidation
- coercion
- harassment
- verbal abuse
- cyber bullying
- isolation
- unreasonable and unjustified withdrawal of services or supportive networks

**Financial or material abuse including:**

- theft
- fraud
- internet scamming
- coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions
- the misuse or misappropriation of property, possessions or benefits

**Modern slavery encompasses:**

- Slavery
- human trafficking
- forced labour and domestic servitude.
- traffickers and slave masters using whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment

**Discriminatory abuse including forms of:**

- harassment
- slurs or similar treatment:
- because of race
- gender and gender identity
- age
- disability
- sexual orientation
- religion

**Organisational abuse**

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

**Neglect and acts of omission including:**

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

**Self-neglect**

This covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. It should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support.

Incidents of abuse may be one-off or multiple, and affect one person or more. Professionals and others should look beyond single incidents or individuals to identify patterns of harm. Repeated instances of poor care may be an indication of more serious problems and of what we now describe as organisational abuse. In order to see these patterns, it is important that information is recorded and appropriately shared. **Further information relating to self-neglect can be found in the Haringey Multi-Agency Self Neglect and Hoarding Procedure 2016-19.**

Patterns of abuse vary and include:

- serial abuse, in which the perpetrator seeks out and 'grooms' individuals. Sexual abuse sometimes falls into this pattern as do some forms of financial abuse
- long-term abuse, in the context of an ongoing family relationship such as domestic violence between spouses or generations or persistent psychological abuse
- opportunistic abuse, such as theft occurring because money or jewellery has been left lying around

**Domestic abuse**

The cross-government definition of domestic violence and abuse is: any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- psychological
- sexual
- financial
- emotional

A new offence of coercive and controlling behaviour in intimate and familial relationships was introduced into the Serious Crime Act 2015. The offence will impose a maximum 5 years imprisonment, a fine or both.

The offence closes a gap in the law around patterns of coercive and controlling behaviour during a relationship between intimate partners, former partners who still live together, or family members, sending a clear message that it is wrong to violate the trust of those closest to you, providing better

protection to victims experiencing continuous abuse and allowing for earlier identification, intervention and prevention.

**Financial abuse**

Financial abuse is the main form of abuse investigated by the Office of the Public Guardian both amongst adults and children at risk. Financial recorded abuse can occur in isolation, but as research has shown, where there are other forms of abuse, there is likely to be financial abuse occurring. Although this is not always the case, everyone should also be aware of this possibility.

Potential indicators of financial abuse include:

- change in living conditions
- lack of heating, clothing or food
- inability to pay bills/unexplained shortage of money
- unexplained withdrawals from an account
- unexplained loss/misplacement of financial documents
- the recent addition of authorised signers on a client or donor's signature card
- sudden or unexpected changes in a will or other financial documents

This is not an exhaustive list, nor do these examples prove that there is actual abuse occurring. However, they do indicate that a closer look and possible investigation may be needed.

## 4. Making Safeguarding Personal (MSP)

It is important that all safeguarding partners take a broad community approach to establishing safeguarding arrangements. It is vital that all organisations recognise that adult safeguarding arrangements are there to protect individuals. We all have different preferences, histories, circumstances and life-styles, so it is unhelpful to prescribe a process that must be followed whenever a concern is raised.

Making safeguarding personal means it should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

We have changed and updated our Mosaic system to ensure that the aims and objectives of the person to whom the safeguarding relates is captured from the beginning to the end of the process. This means we are able to measure how effective the intervention has been and whether the outcomes have been met through the work that has been undertaken.

Making safeguarding personal is a central focus for all safeguarding undertaken in the borough and workers should be ensuring that the service user voice is central throughout the process. However, consideration must be given to the person's ability to understand the safeguarding process and as such, the capacity of the person to be engaged in the process and provide their views must always be ascertained.

If the service user lacks capacity, then the outcomes of the safeguarding process must be determined by the individual's representative or advocate. If there is no suitable family member or friend to act in this role, then an advocate from HAIL must be provided. There might be need for there to be no outcomes recorded however this must only be done in exceptional circumstances. All practical steps to engage the service user or/and the advocate to ensure that there is clarity about what outcome(s) from the safeguarding intervention should be sought and accurately recorded. Making Safeguarding Personal is a key performance indicator in Haringey for how effective our safeguarding interventions are.

Once the enquiry is completed the practitioners must consider whether the outcomes that had been identified have been met. This will be recorded within the planning meeting document but it is essential that the outcomes have been clearly documented throughout the safeguarding process.
The below extract and table is from the Local Government Association 'Making safeguarding personal: A toolkit for responses'

*In Making Safeguarding Personal there are two outcomes measures:*
*1. The number and percentage of people referred for services who define the outcomes they want (or outcomes that are defined through a Best Interest decision making process or with representatives or advocates if people lack capacity)*
*2. The number and percentage of people whose expressed outcomes are*
*fully or partly met.*
*These measures are not without their challenges in terms of implementation.*

*Consideration needs to be given as to how this information is gathered, their use as potential indicators of "good" or "poor", the impact of benchmarking, and other unintended consequences.*

*Other potential measures are outlined below:*

| Desired Outcomes |
| --- |
| **What difference is wanted or desired** |
| **o People are safe from continuing harm and / or abuse**<br>**o People feel that they have recovered from the abuse or neglect**<br>**o People are empowered and able to manage their situations**<br>**o People are aware of services and options to meet their needs.**<br>**o People have their stated objectives and desired results met.**<br>**o People have access to independent advice and support**<br>**o The person believes that their views, worries and wishes are taken seriously**<br>**o The person reports that they haven't had to compromise their safety and wellbeing at the cost of having relationships with other people**<br>**o The person develops stronger networks that are also protective**<br>**o The person knows how to take precautions against harm and how to keep safe**<br>**o The person knows who to contact to find out information**<br>**o The person feels in control and not driven or controlled by the adult safeguarding process**<br>**o The person can get help from someone who is independent** |

Further information relating to Making Safeguarding Personal can be found through the link to the local government association 'Making Safeguarding Personal' resource.
https://www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/making-safeguarding-person

5. **The Mental Capacity Act 2005**

People must be assumed to have capacity to make their own decisions and be given all practicable help before anyone treats them as not being able to make their own decisions. Where an adult is

found to lack capacity to make a decision then any action taken, or any decision made for, or on their behalf, must be made in their best interests.

Practitioners need to understand and always work in line with the Mental Capacity Act 2005 (MCA). Practitioners should use the Haringey Mental Capacity Assessment (embedded in Mosaic) in circumstances where there is reason to think that the person may lack the capacity to engage in the process. Best practice must be followed and the 5 principles of the MCA should be central and evidenced through the assessment process.

The recent *'Learning from SARS: A Report for the London Safeguarding Adults Board'* (2017) highlighted the most common learning theme was that mental capacity assessments and best interest decision making were often missing or poorly performed. It is therefore vital that practitioners ensure their practice is this area is robust and informed.

The MCA created the criminal offences of ill-treatment and wilful neglect in respect of people who lack the ability to make decisions. The offences can be committed by anyone responsible for that adult's care and support – paid staff but also family carers as well as people who have the legal authority to act on that adult's behalf (for example, persons with power of attorney or Court-appointed deputies).

These offences are punishable by fines or imprisonment. Ill-treatment covers both deliberate acts of ill-treatment and also those acts which are reckless which results in ill-treatment. Wilful neglect requires a serious departure from the required standards of treatment and usually means that a person has deliberately failed to carry out an act that they knew they were under a duty to perform.

## 6. Preventing abuse and neglect

The provisions of the Care Act are intended to promote and secure wellbeing. Under the definition of wellbeing, it is made clear that protection from abuse and neglect is a fundamental part of that. Identification and management of risk is an essential part of the assessment process; the risk to an adult of abuse or neglect should be considered at this point.

Haringey must cooperate with each of their relevant partners, as described in section 6(7) of the Care Act, and those partners must also cooperate with Haringey, in the exercise of our functions relevant to care and support including those to protect adults.

Relevant partners of Haringey include any other local authorities with whom we agree it would be appropriate to co-operate (for example, neighbouring authorities with whom they provide joint shared services) and the following agencies or bodies who operate within Haringey's area including:

- NHS England
- CCGs
- NHS trusts and NHS foundation trusts
- Department for Work and Pensions
- the police
- prisons
- probation services

Haringey must also co-operate with such other agencies or bodies as it considers appropriate in the exercise of its adult safeguarding functions, including (but not limited to) those listed in section 6(3):

- general practitioners
- dentists
- pharmacists
- NHS hospitals
- housing, health and care providers

Agencies should stress the need for preventing abuse and neglect wherever possible. Observant professionals and other staff making early, positive interventions with individuals and families can make a huge difference to their lives, preventing the deterioration of a situation or breakdown of a support network. It is often when people become increasingly isolated and cut off from families and friends that they become extremely vulnerable to abuse and neglect. Partners and providers should implement robust risk management processes in order to prevent concerns escalating to a crisis point and requiring intervention under safeguarding adult procedures.

## 7. Practitioner role in carrying out enquiries

An enquiry is the action taken or instigated by Haringey in response to a concern that abuse or neglect may be taking place. An enquiry could range from a conversation with the adult, or if they lack capacity, or have substantial difficulty in understanding the enquiry their representative or advocate, prior to initiating a formal enquiry under section 42, right through to a much more formal multi-agency plan or course of action. Whatever the course of subsequent action, the practitioner concerned should record the concern, the adult's views, wishes, and any immediate action they have taken and the reasons for those actions.

The purpose of the enquiry is to decide whether or not Haringey or another organisation, or person, should do something to help and protect the adult. If Haringey decides that another organisation should make the enquiry, for example a care provider, then Haringey will set timescales, the need to know the outcomes of the enquiry and what action will follow if this is not done.

What happens as a result of an enquiry should reflect the adult's wishes wherever possible, as stated by them or by their representative or advocate. If they lack capacity it should be in their best interests if they are not able to make the decision, and be proportionate to the level of concern.

The adult should always be involved from the beginning of the enquiry unless there are exceptional circumstances that would increase the risk of abuse. If the adult has substantial difficulty in being involved, and where there is no one appropriate to support them, then Haringey must arrange for an independent advocate to represent them for the purpose of facilitating their involvement.

Professionals and other staff need to handle enquiries in a sensitive and skilled way to ensure distress to the adult is minimised.

**Criminal offences and adult safeguarding**

Everyone is entitled to the protection of the law and access to justice. Behaviour which amounts to abuse and neglect, for example physical or sexual assault or rape, psychological abuse or hate crime, wilful neglect, unlawful imprisonment, theft and fraud and certain forms of discrimination also often constitute specific criminal offences under various pieces of legislation. Although Haringey has the lead role in making enquiries, where criminal activity is suspected, then the early involvement of the police is essential to ensure the safety of the individual.

**When should an enquiry take place?**

Haringey must make enquiries, or cause another agency to do so, whenever abuse or neglect are suspected. The scope of that enquiry, who leads it and its nature, and how long it takes, will depend on the particular circumstances. It will usually start with asking the adult their view and wishes which will often determine what next steps to take. Everyone involved in an enquiry must focus on improving the adult's well-being and work together to that shared aim. At this stage, Haringey also has a duty to consider whether the adult requires an independent advocate to represent and support the adult in the enquiry.

The safeguarding concern, when raised, will be triaged by the safeguarding team. During the triage stage the safeguarding social worker will ensure that, where practical and appropriate, contact is made with the service user. They will ensure that any immediate danger is mitigated and a decision will be made as to who is best placed to undertake the s.42 enquiry. In most cases where the case is already allocated to a practitioner the s.42 will be allocated to that worker. If not allocated, then the case will be passed to the most appropriate team to undertake the enquiry and the manager of that team will be responsible for prioritising the allocation of the enquiry. Where there are cases that are considered to contain high levels of risk to the service user or high levels of complexity then those cases will be retained by the safeguarding team to undertake the s.42 enquiry.

**Objectives of an enquiry**

The objectives of an enquiry into abuse or neglect are to:

- establish facts
- ascertain the adult's views and wishes
- assess the needs of the adult for protection, support and redress and how they might be met
- protect from the abuse and neglect, in accordance with the wishes of the adult;
- make decisions as to what follow-up action should be taken with regard to the person or organisation responsible for the abuse or neglect
- enable the adult to achieve resolution and recovery

The first priority should always be to ensure the safety and well-being of the adult. The adult should experience the safeguarding process as empowering and supportive. Practitioners should wherever practicable seek the consent of the adult before taking action. However, there may be circumstances

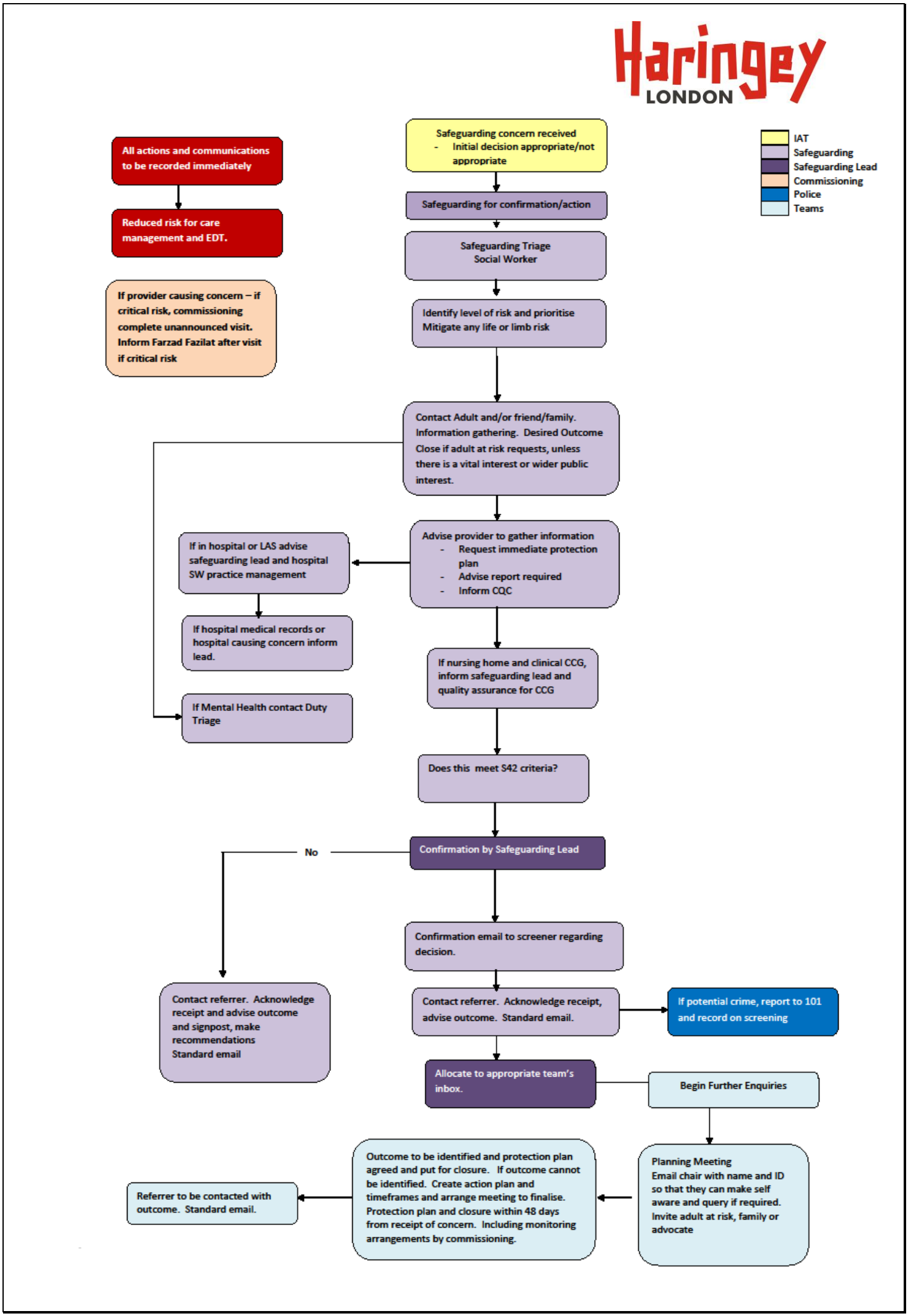
when consent cannot be obtained because the adult lacks the capacity to give it, but it is in their best interests to undertake an enquiry. Whether or not the adult has capacity to give consent, action may need to be taken if others are or will be put at risk if nothing is done or where it is in the public interest to take action because a criminal offence has occurred. It is the responsibility of all staff and members of the public to act on any suspicion or evidence of abuse or neglect and to pass on their concerns to a responsible person or agency.

**Who can carry out an enquiry?**

Although Haringey is the lead agency for making enquiries, it may require others to undertake them. The specific circumstances will often determine who the right person is to begin an enquiry. In many cases a professional who already knows the adult will be the best person. They may be a social worker, a housing support worker, a GP or other health worker such as a community nurse. Haringey retains the responsibility for ensuring that the enquiry is referred to the right place and is acted upon. Haringey, in its lead and coordinating role, should assure itself that the enquiry satisfies its duty under section 42 to decide what action (if any) is necessary to help and protect the adult and by whom and to ensure that such action is taken when necessary. In this role if the safeguarding team has asked someone else to make enquiries, it is able to challenge the body making the enquiry if it considers that the process and/or outcome is unsatisfactory.

Where a crime is suspected and referred to the police, then the police must lead the criminal investigations, with Haringey's support where appropriate, for example by providing information and assistance. Haringey has an ongoing duty to promote the wellbeing of the adult in these circumstances.

8. The diagram below shows the process map of a safeguarding concern being raised and how that concern is then managed through the system.


Haringey
LONDON
IAT
Safeguarding
Safeguarding Lead
Commissioning
Police
Teams
All actions and communications to be recorded immediately
Reduced risk for care management and EDT.
If provider causing concern – if critical risk, commissioning complete unannounced visit. Inform Farzad Fazilat after visit if critical risk
Safeguarding concern received
- Initial decision appropriate/not appropriate
Safeguarding for confirmation/action
Safeguarding Triage
Social Worker
Identify level of risk and prioritise
Mitigate any life or limb risk
Contact Adult and/or friend/family. Information gathering. Desired Outcome
Close if adult at risk requests, unless there is a vital interest or wider public interest.
Advise provider to gather information
- Request immediate protection plan
- Advise report required
- Inform CQC
If in hospital or LAS advise safeguarding lead and hospital SW practice management
If hospital medical records or hospital causing concern inform lead.
If Mental Health contact Duty Triage
If nursing home and clinical CCG, inform safeguarding lead and quality assurance for CCG
Does this meet S42 criteria?
No
Confirmation by Safeguarding Lead
Confirmation email to screener regarding decision.
Contact referrer. Acknowledge receipt and advise outcome and signpost, make recommendations
Standard email
Contact referrer. Acknowledge receipt, advise outcome. Standard email.
If potential crime, report to 101 and record on screening
Allocate to appropriate team's inbox.
Begin Further Enquiries
Planning Meeting
Email chair with name and ID so that they can make self aware and query if required.
Invite adult at risk, family or advocate
Outcome to be identified and protection plan agreed and put for closure. If outcome cannot be identified. Create action plan and timeframes and arrange meeting to finalise. Protection plan and closure within 48 days from receipt of concern. Including monitoring arrangements by commissioning.
Referrer to be contacted with outcome. Standard email.

**Practitioners undertaking a s.42 enquiries**

Social care practitioners who are allocated s.42 enquiries must ensure that they follow the Haringey s.42 framework which can be found on the adults safeguarding intranet page along with other relevant Haringey Safeguarding policy.

## 9. What happens after an enquiry?

Once the wishes of the adult have been ascertained and an initial enquiry undertaken, discussions should be undertaken as to whether further enquiry is needed and what further action could be taken.

That action could take a number of courses: it could include disciplinary, complaints or criminal investigations or work by contracts managers and CQC to improve care standards. Those discussions should enable the adult to understand what their options might be and how their wishes might best be realised. Social workers must be able to set out both the civil and criminal justice approaches that are open and other approaches that might help to promote their wellbeing, such as therapeutic or family work, mediation and conflict resolution, peer or circles of support. In complex domestic circumstances, it may take the adult some time to gain the confidence and self-esteem to protect themselves and take action and their wishes may change. The police, health service and others may need to be involved to help ensure these wishes are realised.

## 10. Safeguarding plans

Once the s.42 enquiry has been completed there will be a requirement for a planning meeting to be initiated. The type of information gathered and what further action needs to be taken will determine the format and those required for the planning meeting. It might be appropriate for the planning meeting to be a discussion between the safeguarding manager responsible for chairing the planning meeting and practitioner who has undertaken the enquiry if it is felt that no further or limited action is required. However, equally it might be necessary for a number of partners to be involved and for more than one planning meeting to take place. Each case must be considered on its own merits and most importantly consideration has to be given to the best way to achieve the outcomes for the individual while ensuring safety and preventing further risks to individuals.

Once the facts have been established, a further discussion of the needs and wishes of the adult is likely to take place. This could be focused safeguarding planning to enable the adult to achieve resolution or recovery, or fuller assessments by health and social care agencies (for example, a needs assessment

under the Care Act). This will entail joint discussion, decision taking and planning with the adult for their future safety and well-being. This applies if it is concluded that the allegation is true or otherwise, as many enquiries may be inconclusive.

The MCA is clear that local authorities must presume that an adult has the capacity to make a decision until there is a reason to suspect that capacity is in some way compromised; the adult is best placed to make choices about their wellbeing which may involve taking certain risks. Of course, where the adult may lack capacity to make decisions about arrangements for enquiries or managing any abusive situation, then their capacity must always be assessed and any decision made in their best interests. If the adult has the capacity to make decisions in this area of their life and declines assistance, this can limit the intervention that organisations can make. The focus should therefore be, on harm reduction. It should not however limit the action that may be required to protect others who are at risk of harm. The potential for 'undue influence' will need to be considered if relevant. If the adult is thought to be refusing intervention on the grounds of duress, then action must be taken.

**Taking action**

It is for Haringey to determine the appropriateness of the outcome of the enquiry. One outcome of the enquiry may be the formulation of agreed action for the adult which should be recorded on their care plan. This will be the responsibility of the relevant agencies to implement.

In relation to the adult, this should set out:

- what steps are to be taken to assure their safety in future
- the provision of any support, treatment or therapy including on-going advocacy
- any modifications needed in the way services are provided (for example, same gender care or placement; appointment of an OPG deputy)
- how best to support the adult through any action they take to seek justice or redress;
- any on-going risk management strategy as appropriate
- any action to be taken in relation to the person or organisation that has caused the concern

**Person alleged to be responsible for abuse or neglect**

When a complaint or allegation has been made against a member of staff, including people employed by the adult, they should be made aware of their rights under employment legislation and any internal disciplinary procedures.

Where the person who is alleged to have carried out the abuse themselves has care and support needs and is unable to understand the significance of questions put to them or their replies, they should be assured of their right to the support of an 'appropriate' adult if they are questioned in relation to a suspected crime by the police under the Police and Criminal Evidence Act 1984 (PACE). Victims of crime and witnesses may also require the support of an 'appropriate' adult. Read government policy documents about helping victims of crime.

Under the MCA, people who lack capacity and are alleged to be responsible for abuse, are entitled to the help of an Independent Mental Capacity Advocate, to support and represent them in the enquiries that are taking place. This is separate from the decision whether or not to provide the victim of abuse with an independent advocate under the Care Act.

Employers who are also providers or commissioners of care and support not only have a duty to the adult, but also a responsibility to take action in relation to the employee when allegations of abuse are made against them. Employers should ensure that their disciplinary procedures are compatible with the responsibility to protect adults at risk of abuse or neglect.

With regard to abuse, neglect and misconduct within a professional relationship, codes of professional conduct and/or employment contracts should be followed and should determine the action that can be taken. Robust employment practices, with checkable references and recent DBS checks are important. Reports of abuse, neglect and misconduct should be investigated and evidence collected. Where appropriate, employers should report workers to the statutory and other bodies responsible for professional regulation such as the General Medical Council and the Nursing and Midwifery Council. If someone is removed from their role providing regulated activity following a safeguarding incident the regulated activity provider (or if the person has been provided by an agency or personnel supplier, the legal duty sits with them) has a legal duty to refer to the Disclosure and Barring Service. The legal duty to refer to the Disclosure and Barring Service also applies where a person leaves their role to avoid a disciplinary hearing following a safeguarding incident and the employer/volunteer organisation feels they would have dismissed the person based on the information they hold.

The standard of proof for prosecution is 'beyond reasonable doubt'. The standard of proof for internal disciplinary procedures and for discretionary barring consideration by the Disclosure and Barring Service (DBS) and the Vetting and Barring Board is usually the civil standard of 'on the balance of

probabilities'. This means that when criminal procedures are concluded without action being taken this does not automatically mean that regulatory or disciplinary procedures should cease or not be considered. In any event there is a legal duty to make a safeguarding referral to DBS if a person is dismissed or removed from their role due to harm to a child or a vulnerable adult.

## 11. Safeguarding Adults Boards

Each local authority must set up a Safeguarding Adults Board (SAB). The main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who meet the criteria set out at paragraph 14.2.

Haringey's SAB has a strategic role that is greater than the sum of the operational duties of the core partners. It oversees and leads adult safeguarding across the borough and will be involved in a range of activities that contribute to the prevention of abuse and neglect. These will include the safety of patients in our local health services and quality of local care and support service. The SAB will need intelligence on safeguarding in all providers of health and social care in our locality (not just those with whom its members commission or contract). It is important that SAB partners feel able to challenge each other and other organisations where it believes that their actions or inactions are increasing the risk of abuse or neglect. This will include commissioners, as well as providers of services.

The SAB is an important source of advice and assistance, for example in helping others improve their safeguarding mechanisms. It is important that the SAB has effective links with other key partnerships in the locality and share relevant information and work plans.

A SAB has 3 core duties:

- it must publish a strategic plan for each financial year that sets how it will meet its main objective and what the members will do to achieve this. The plan must be developed with local community involvement, and the SAB must consult the local Healthwatch organisation. The plan should be evidence based and make use of all available evidence and intelligence from partners to form and develop its plan
- it must publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any safeguarding adults reviews and subsequent action
- it must conduct any safeguarding adults review in accordance with Section 44 of the Act.

Safeguarding requires collaboration between partners in order to create a framework of inter-agency arrangements. Local authorities and their relevant partners must collaborate and work together as set out in the co-operation duties in the Care Act and, in doing so, must, where appropriate, also consider the wishes and feelings of the adult on whose behalf they are working.

Responsibilities of the SAB include:

- identify the role, responsibility, authority and accountability with regard to the action each agency and professional group should take to ensure the protection of adults
- establish ways of analysing and interrogating data on safeguarding notifications that increase the SAB's understanding of prevalence of abuse and neglect locally that builds up a picture over time
- establish how it will hold partners to account and gain assurance of the effectiveness of its arrangements
- determine its arrangements for peer review and self-audit
- establish mechanisms for developing policies and strategies for protecting adults which should be formulated, not only in collaboration and consultation with all relevant agencies but also take account of the views of adults who have needs for care and support, their families, advocates and carer representatives
- develop preventative strategies that aim to reduce instances of abuse and neglect in its area
- identify types of circumstances giving grounds for concern and when they should be considered as a referral to Haringey as an enquiry
- formulate guidance about the arrangements for managing adult safeguarding, and dealing with complaints, grievances and professional and administrative malpractice in relation to safeguarding adults
- develop strategies to deal with the impact of issues of race, ethnicity, religion, gender and gender orientation, sexual orientation, age, disadvantage and disability on abuse and neglect
- balance the requirements of confidentiality with the consideration that, to protect adults, it may be necessary to share information on a 'need-to-know basis'
- identify mechanisms for monitoring and reviewing the implementation and impact of policy and training
- carry out safeguarding adult reviews and determine any publication arrangements;
- produce a strategic plan and an annual report
- evidence how SAB members have challenged one another and held other boards to account

- promote multi-agency training and consider any specialist training that may be required. Consider any scope to jointly commission some training with other partnerships, such as the Community Safety Partnership

## 12. Safeguarding Adults Reviews (SARs)

SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

Early discussions need to take place with the adult, family and friends to agree how they wish to be involved. The adult who is the subject of any SAR need not have been in receipt of care and support services for the SAB to arrange a review in relation to them.

SARs should reflect the 6 safeguarding principles. SABs should agree Terms of Reference for any SAR they arrange and these should be published and openly available. When undertaking SARs the records should either be anonymised through redaction or consent should be sought.

The following principles should be applied by SABs and their partner organisations to all reviews:

- there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined
- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
- families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively

SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial.

The process for undertaking SARs should be determined locally according to the specific circumstances of individual circumstances. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected. The recommendations and action plans from a SAR need to be followed through by the SAB.

The SAB should ensure that there is appropriate involvement in the review process of professionals and organisations who were involved with the adult. The SAR should also communicate with the adult

and, or, their family. In some cases, it may be helpful to communicate with the person who caused the abuse or neglect.

It is expected that those undertaking a SAR will have appropriate skills and experience which should include:

- strong leadership and ability to motivate others
- expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics
- collaborative problem solving experience and knowledge of participative approaches
- good analytic skills and ability to manage qualitative data
- safeguarding knowledge
- inclined to promote an open, reflective learning culture

The SAB should aim for completion of a SAR within a reasonable period of time and in any event within 6 months of initiating it, unless there are good reasons for a longer period being required; for example, because of potential prejudice to related court proceedings. Every effort should be made while the SAR is in progress to capture points from the case about improvements needed; and to take corrective action.