IMPROVING THE SAFEGUARDING OF VULNERABLE ADULTS IN THE NORTH EAST:

Report to

NORTH EAST IMPROVEMENT AND EFFICIENCY PARTNERSHIP

&

ASSOCIATION OF DIRECTORS OF ADULT SOCIAL SERVICES NORTH EAST BRANCH

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EXECUTIVE SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS

This project was commissioned by the North East Improvement and Efficiency Partnership (NEIEP) following discussions with the North East branch of the Association of Directors of Adult Social Services (NE ADASS). Richard Corkhill and Caron Walker were commissioned to undertake this work between June and September 2010.

The aim of this project was to consider how the safeguarding of vulnerable adults across the north east region could be improved, through the development of recommendations for enhanced, regionally consistent safeguarding arrangements. The focus of the project included the following elements:

- analysis of current arrangements for Safeguarding Adults Boards (SABs);
- review of safeguarding teams, highlighting areas of best practice;
- analysis of recent Care Quality Commission (CQC) inspections to share lessons;
- consideration of the practice and policy around safeguarding thresholds.

THEME ONE: SAFEGUARDING ADULTS BOARDS AND INTER-AGENCY ARRANGEMENTS

Theme 1: Key Findings

SAB structures in the North East
- The four Teesside local authorities have recently adopted a sub regional SAB, which offers a number of possible benefits, particularly for partner agencies which work across local authority boundaries. This could potentially provide a model for other parts of the region.

SAB Chairpersons
- It is increasingly common for SABs in this region and elsewhere to appoint independent Chairs, but potential costs and benefits of this approach will vary, according to local factors.

SAB Membership and engagement
- The quality of multi-agency engagement with SAB arrangements in the region is variable. Some partner agencies, though listed as SAB members, do not engage effectively. This is evidenced by non-attendance at SAB meetings or repeatedly delegating attendance to staff who do not have sufficient authority to represent the organisation and hold it to account.
User engagement and SAB membership
- Only one SAB in this region has individual service users as a board members. All of the others have representation from voluntary sector organisations.
- SAB sub-groups also lack membership from people who would be defined as ‘vulnerable adults’ under No Secrets guidance.
- Some sub-groups have made efforts to engage with local user-led organisations.

Inter-agency work and financial abuse
- There are pockets of excellent practice in joint work with DWP and the Benefits Agency to deal with alleged financial abuse.
- But there is a lack of strategic engagement with these agencies on issues including inter-agency working and information sharing.
- As a result, it seems likely that cases of financial abuse of vulnerable adults, which may otherwise have been prevented or identified earlier, will go undetected.

Involvement of Health in Safeguarding Adults Boards and Inter-Agency arrangements
- All SABs in the region have at least one health partner member, but their level of involvement is variable.
- However, at operational levels, health colleagues do actively participate in individual investigations around possible harm to vulnerable adults.
- There is currently little GP involvement in adult safeguarding at strategic or operational levels.
- The current white paper, *Equity and Excellence: Liberating the NHS*, may be a useful lever to encourage more active participation of GPs as part of their consortia development.
- Locally, the Strategic Health Authority (SHA) has recently established a regional group of commissioning adult safeguarding leads to develop approaches to adult safeguarding. This group is conducting a baseline audit of the current position on health sector safeguarding in the the North East.
- However, with current plans to remove SHAs from the NHS management structure, it is unclear how this work will be developed in future.
- There is a need for more open information sharing on adult safeguarding issues, between NHS providers and Safeguarding Adults services. This needs to be addressed through a strong national lead.

An optimum model for multi – agency arrangements
- An optimum model for Safeguarding arrangements in the region would include multi-professional safeguarding adults teams, resourced jointly between local authorities, PCTs and other statutory sector partners.
- Some safeguarding related activities such as professional training could be commissioned regionally or sub-regionally, which could deliver economies of scale whilst improving consistency across the region.
Theme 1: Recommendations

Recommendation 1 (page 16 of main report)
There should be a regionally coordinated approach to consultation on the White Paper, with particular reference to potential impacts of NHS reforms on multi-agency approaches to safeguarding vulnerable adults. This could be led by NE ADASS, collecting and collating views, issues and practice examples from each of the SABs in the region.

Recommendation 2 (page 21 of main report)
There should be a focused evaluation of the outcomes of the new Teeswide SAB arrangements, including analysis of potential costs and benefits of introducing similar sub-regional arrangements in other locations in the North East. This evaluation should be started in approximately 12 months time (September 2011) to allow sufficient time for the Teeswide arrangements to generate evidence of outcomes.

Recommendation 3 (page 24 of main report)
There should be a regionally coordinated drive to improve levels of engagement of those SAB partnership agencies which currently do not engage effectively with SAB arrangements. This may include some targeted work to better understand barriers to engagement; regional or sub regional awareness raising events and lobbying of regulatory and inspection bodies.

Recommendation 4 (page 26 of main report)
As a minimum requirement, every SAB in the region should have a nominated member with an explicit role of monitoring performance against standard 11 (user engagement) of the ADASS framework. This member should ideally be a person who could be defined as a vulnerable adult, using the No Secrets definition. Alternatively they may be a representative of a service user led organisation.

Recommendation 5 (page 26 of main report)
Standard 11 of this ADASS framework should be a standard agenda item at SAB meetings and at the regional Safeguarding Leads meetings.

Recommendation 6 (page 26 of main report)
There should be a regional focus on user engagement, coordinated by the regional Safeguarding Leads network. This regional approach should include:
1) Establishing regional or sub-regional support and training networks for service user representatives on SABs or SAB sub-groups.
2) Ensuring that SAB service user representatives are actively encouraged to take part in relevant mainstream training opportunities organised by SAB member organisations.
3) Collecting and sharing examples of good practice which enables individual service users to be supported and effectively informed, engaged and involved in formal safeguarding processes.

**Recommendation 7 (page 28 of main report)**
There should be a regionally coordinated approach to senior officers of the DWP and the Benefits Agency, to re-affirm the importance of active engagement in relation to vulnerable adults at risk from financial abuse. A good starting point would be to try and ensure the presence of senior regional lead from each of these agencies at the conference on 16 Nov.

**Recommendation 8 (page 28 of main report)**
Examples of effective joint working between services for vulnerable adults and statutory pensions and benefits agencies should be collated and circulated as good practice examples.

**Recommendation 9 (page 29 of main report)**
The local adult safeguarding network should make approaches to Local Medical Committees to begin a dialogue around how SABs and safeguarding units can work more closely with GP consortia.

**Recommendation 10 (page 30 of main report)**
The establishment of a regional group, comprising local authority and health leads, to facilitate an open dialogue around how they would like adult safeguarding to look in the future, after the white paper reforms have been implemented.

**Recommendation 11 (page 36 of main report)**
There should be multi-agency discussion at regional, sub-regional and local levels, on joint resourcing of Safeguarding Adults teams. The aims of these discussions should be
1) To agree an optimum model, using the model described in this report as a baseline for discussion.
2) Establish joint funding arrangements for Safeguarding Adults Teams, which will deliver the agreed optimum model; maximum value for money; and the best possible outcomes for vulnerable adults.

**Recommendation 12 (page 36 of main report)**
This multi-agency discussion on the optimum model and resourcing issues should include consideration of sub-regional or regional funding partnerships, if such arrangements can deliver economies of scale, or more consistency of approach within the sub-region or region.
THEME 2: LESSONS FROM CQC INSPECTIONS

Theme 2: Key Findings

Use of Independent Mental Capacity Advocates (IMCAs)
- Under utilisation of IMCAs, combined with poor recording of decision making processes on whether or not to refer for IMCA services, is a recurring issue highlighted by CQC inspections in this region and nationally.
- Another North East regional study by Action for Advocacy (commissioned by Social Care North East) is looking specifically at the role of IMCAs in safeguarding vulnerable adults and is due to report in November 2010.

Recording systems and standards / data collection and analysis
- CQC inspections in this region and elsewhere have frequently highlighted poor recording systems and / or poor quality practice in recording of safeguarding referrals, responses and outcomes as an area in need of urgent improvement.

Service User Engagement
- CQC commonly engage ‘Experts by Experience’, who form part of the inspection team.
- CQC have also noted the value of service user influence at board level.
- CQC have also highlighted the importance of SABs having effective communication systems and working arrangements with the wider strategic framework for adults with social care and health related needs, including Partnership Boards.

Community safety initiatives
- Wider community safety initiatives such as the work of Crime Reduction Partnerships contribute significantly to positive CQC inspection findings.

Theme 2: Recommendations

Recommendation 13 (page 39 of main report)
Each SAB in the region and the regional leads group should carefully consider findings and recommendations from the regional Advocacy in Action report on IMCAs, due for publication in November 2010. In the meantime policy procedure and practice across all SAB areas should ensure that:
1) Every safeguarding assessment systematically considers whether or not referral to an IMCA is appropriate.
2) Reasoning behind each decision on whether or not to use an IMCA service is clearly recorded.
Recommendation 14 (page 39 of main report)
Each SAB should, through their performance and quality sub-group, review systems and practice on recording, data collection and analysis. Outcomes from these reviews should be shared by the regional safeguarding leads group, in order to identify common issues and build on good practice in the region.

Recommendation 15 (page 41 of main report)
All SABs should review their working relationships and communication with Community Safety Partnerships and ensure that corporate and multi-agency initiatives meet the specific safeguarding needs of vulnerable adults.

THEME 3: THRESHOLDS

Theme 3: Key Findings

What is a threshold?
- lack of clarity about the purpose of a threshold

Consistency
- thresholds should have flexibility for practitioners to use professional judgment

Managing alerts and referrals
- disagreement about whether a threshold should be high or low

Harm
- ‘significant harm’ is the most commonly used threshold in the region

Threshold continuum
- different thresholds depending on the setting may be a way forward

Setting a threshold
- Several adult safeguarding leads acknowledged that the issue of thresholds was something this had not addressed.

Theme 3: Recommendations

Recommendation 16 (page 43 of main report)
That SABs across the region agree a common set of overarching principles around thresholds for all partner agencies.

Recommendation 17 (page 45 of main report)
Partners across the region need to formulate a view about their preferred definition of safeguarding and vulnerability in anticipation of the Law Commission’s findings.

**Recommendation 18 (page 45 of main report)**
Guidance around thresholds should also identify an approach for those individuals who do not reach the safeguarding threshold.

**Recommendation 19 (page 46 of main report)**
NE ADASS should provide clear guidance around what type of consistency around thresholds they are aiming for in adult safeguarding. Part of this also needs to consider the impact of thresholds on equity and inequality.

**Recommendation 20 (page 47 of main report)**
The concept of a ‘threshold continuum’ should be explored further.

**Recommendation 21 (page 48 of main report)**
If ‘significant harm’ becomes the favoured threshold, guidance should be developed that assists decision makers to make an assessment around how ‘significant’ might be interpreted, with reference to seriousness and risk.

**Recommendation 22 (page 49 of main report)**
Developing a risk enablement approach may help inform decisions around risk and risk management.

**Recommendation 23 (page 50 of main report)**
SABs need to consider how they quality assure that all providers have policies and procedures for addressing poor practice.

**Recommendation 24 (page 50 of main report)**
For incidents that involve a possible poor practice issue, the following questions should be considered:
- has it caused the victim significant and/or permanent harm?
- is it deliberate or premeditated?
- is it part of a pattern or culture?
- what is the duration and frequency of the poor practice of concern?
- what is the victim’s perception about whether they are being abused or harmed?

**Recommendation 25 (page 50 of main report)**
Providers should be supported to develop their own training programmes, linked to recognised accredited training providers.

**Recommendation 26 (page 51 of main report)**
A regional information sharing agreement should be developed. It should be based on the good practice principles of a ‘need to know’ basis and informed consent.
**Recommendation 27 (page 52 of main report)**
Develop a regional glossary of common language for use by all SABs.

**Recommendation 28 (page 53 of main report)**
Any threshold should be tiered but must allow for practitioners to use their professional judgment in reaching a decision about whether to pursue an investigation.
BACKGROUND

Project Brief

This project was commissioned by the North East Improvement and Efficiency Partnership (NEIEP) following discussions with the North East branch of the Association of Directors of Adult Social Services (NE ADASS). Richard Corkhill and Caron Walker were commissioned to undertake this work for a period of four months from 1 June to 30 September 2010, including a presentation to the NE ADASS branch on 16 September 2010.

The aim of this project was to consider how the safeguarding of vulnerable adults across the north east region could be improved, through the development of recommendations for enhanced, regionally consistent safeguarding arrangements. The focus of the project included the following elements:

- analysis of recent inspection experience in the region to share the lessons learnt and to understand the approach to user/carer involvement in the process;
- analysis of current arrangements for Safeguarding Adults Boards (SABs) particularly around stakeholder participation and the resourcing of the safeguarding team to identify an optimum model for discussion with partners;
- a regional review to identify how safeguarding teams are currently commissioned and utilised, and highlighting areas of best practice;
- consideration of the practice and policy around safeguarding thresholds and the development of a consistent regional approach. This will be linked to the new safeguarding health networks being established by the Strategic Health Authority.

The project brief also set out the following target outcomes:

- Common approaches to participation in and contribution toward safeguarding.
- Consistent level of representation on and resourcing of SABs from partner organisations.
- Development of a regional model of what good safeguarding looks like.
- A clear regional understanding of the threshold between poor quality service provision and safeguarding issues.
- Consistent participation of relevant public sector organisations to tackling aspects of safeguarding, e.g. DWP work regarding financial abuse.
- Consistent level of understanding of safeguarding across health and police partners.

Report Themes

The following 3 sections of the report are divided into 3 themes, in line with the project brief. These themes provide a helpful report structure, but it is acknowledged that each of these areas are closely inter-connected, with many cross-cutting issues. Consequently, each set of themed findings and recommendations contributes to a
number of the project target outcomes. We have not added a separate theme of user involvement and engagement, as we see this as an underpinning issue, which is integral to all three themes.

- **Theme 1:** Safeguarding Adults Boards
- **Theme 2:** Lessons from Care Quality Commission (CQC) inspections
- **Theme 3:** Thresholds

These themes are discussed at a regional level, where appropriate drawing on policy / practice / procedural examples from specific locations within the region. Examples have been highlighted through local document reviews, CQC inspection reports and consultation interviews. We have also cross referenced regional findings with national guidance and good practice examples from other regions.

**Methodology**

The project was divided into five main stages:

- project inception and project management arrangements;
- review and analysis of strategy, policy and guidance documents;
- review of safeguarding adults Care Quality Commission inspection reports;
- consultation meetings and discussions at local, sub-regional and regional levels;
- drafting of final written report, with key findings and recommendations presented to the NEIEP and ADASS in September 2010.

In addition, a further stage was agreed that would incorporate a multi-agency conference in November for all SAB members to further disseminate key findings and recommendations. It will also be used to consult more widely on the policy, practice and resource implications for organisations with adult safeguarding responsibilities.

For consistency, Caron Walker focused on the geographical areas of Tyne, Wear and Northumberland, while Richard Corkhill focused on Durham, Darlington and Tees Valley. Each consultant worked closely together to analyse data, compare findings and share learning from across the whole of the North East region.

Summaries were also produced for each of the 12 local authority areas using a standard format (see appendix 1) covering the following aspects of local safeguarding arrangements:

- Safeguarding Adults Board arrangements;
- Safeguarding policy / procedures;
- Service delivery arrangements;
- Approaches to thresholds;
- User involvement.
In addition, we identified good practice examples from other regions, looking particularly at CQC inspections; different approaches to thresholds; and service user involvement.

Consultation meetings have taken place with a wide range of organisations, including each of the local authority lead officers for safeguarding and many key partner organisations, including the Strategic Health Authority, PCTs, NHS provider services, police, voluntary sector and user led organisations. A full list of organisations and individuals who have contributed to the consultation exercise is included at appendix 2.

We acknowledge there are many organisations in the region which we have not directly consulted with, although they play important roles in helping to safeguard vulnerable adults. This is because the time available to complete the project could not allow for any wider consultation. We would emphasise, however, that the findings and recommendations are intended to form the basis for further regional consultation, including at the regional conference on 16 November.

A Project Board met on a monthly basis throughout the project, to receive progress update reports and provide ongoing coordination, support and professional advice. The Board included the NEIEP project manager and a number of local authority safeguarding leads from this region (see appendix 3 for membership details).

We would like to take this opportunity to thank the members of the Project Board for their professional support and advice. We would also thank all the people who have engaged with the project by sharing a wealth of knowledge, experience and ideas on safeguarding vulnerable adults in this region. Without their cooperation and goodwill this project would not have been possible.
Regional and national contexts

Regional
The rationale for this work is underpinned by a number of common safeguarding issues identified by the NE ADASS. These included:

- no commonality in terms of participation and contribution to safeguarding from PCT partners, e.g. Safeguarding Boards;
- lack of understanding of how to effectively engage users, carers and local communities in safeguarding responsibilities and to evidence this involvement;
- lack of clarity surrounding evidence of user/carer involvement for inspection purposes;
- inconsistent level of representation on and resourcing of Safeguarding Boards from partner organisations which is concerning as they become a statutory requirement. This needs to be linked to the new SHA Safeguarding networks for health agencies;
- no single model of what good safeguarding looks like;
- lack of clarity around the threshold between poor quality service provision e.g. in care homes and a safeguarding issue;
- inconsistency of activity or involvement of other public sector organisations to tackle other aspects of safeguarding, e.g. is the DWP doing any work to look at financial abuse? Are Job Centre Plus and DWP engaged sufficiently in safeguarding? What are the links to the Personalisation agenda?
- need to understand the links between Safeguarding, the Mental Capacity Act and Deprivation of Liberty Safeguards and to identify which is the most appropriate referral process to utilise dependent on circumstances. This applies to all Managing Authorities, but in particular to Acute Trusts/Mental Health Trusts/independent hospitals;
- involvement of Safeguarding Boards in areas that are not within their jurisdiction to investigate.

National and policy context
The national context for safeguarding vulnerable adults has been driven to a large extent by the 'No Secrets'\(^1\) guidance published by the Department of Health in 2000. This was followed in 2005 by the ADASS publication, *Safeguarding Adults: A National Framework for Good Practice and Outcomes in Adult Protection Work*\(^2\), which recognised a need to place more emphasis on wider preventative strategies; in addition to effective multi agency policy, procedures; and systems to identify and respond to individual cases of abuse or neglect.

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\(^1\) Department of Health (2000) No Secrets: Guidance on developing and implementing multiagency policies and procedures to protect vulnerable adults from abuse

\(^2\) ADASS (2005) Safeguarding Adults: A National Framework for Good Practice and Outcomes in Adult Protection Work
In 2008-09 the (then) government carried out a wide ranging consultation exercise around ‘No Secrets’. Key messages reported from this exercise included:

- a need for stronger national leadership;
- local arrangements should be placed on a statutory basis;
- the ‘No Secrets’ guidance is in need of revision and updating;
- the voice of vulnerable people needs to be heard much more clearly than it currently is: vulnerable people want to be heard in safeguarding policy and practice and in situations where they are victims of harm.

In January 2010, a ministerial statement was published, which made a number of commitments in response to the consultation exercise:

- formation of an inter-departmental ministerial group on safeguarding vulnerable adults;
- introduction of new legislation which would put Safeguarding Adults Boards on a statutory footing;

A Law Commission consultation paper on adult social care, published in February 2010, also set out proposals that future social care legislation should place safeguarding adults arrangements on a formal statutory footing.

Since publication of the ministerial statement and the Law Commission paper there has been a change of government, resulting in reviews of all aspects of government policy, including those relating to adult social care and the safeguarding adults agenda. Consequently, it is unclear whether the new government will bring forward further legislation around the safeguarding of adults. At the time of writing, the government has yet to set out a policy framework on the safeguarding agenda, but informal indications from the Department of Health are that ‘No Secrets 2’ guidance will be published in due course.

However, it is clear that the national spending review, due for publication this autumn, is likely to present some serious challenges to most areas of public expenditure, including those related to safeguarding of vulnerable adults.

The recent White Paper, Equity and Excellence: Liberating the NHS sets out plans for major structural reforms including the removal of strategic health authorities and primary care trusts from regional and local NHS management structures. As regional and local NHS organisations have key responsibilities for safeguarding vulnerable adults, it will be essential for Safeguarding Adults Boards (SABs) and regional

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safeguarding leads to take every opportunity to contribute to the White Paper consultations. The objective should be to ensure that the needs of vulnerable adults are prioritised within the revised NHS management and commissioning arrangements.

In summary, the national context is one of considerable uncertainty, with inevitable pressure on sectors with adult safeguarding responsibilities to reduce expenditure and find efficiency savings. It is very probable that there will be significant changes in policy, guidance and legislation over the next two or three years, but the precise timing, nature and impact of these changes is not yet known.

In the meantime, it will be important for safeguarding policy, guidance and practice to have a strong regional lead. This will help ensure that work to safeguard vulnerable adults in this region continues to develop and improve. It should also help to form a base of good practice from which North East partner agencies with adult safeguarding roles and responsibilities can positively influence the national agenda.

**Recommendation 1**

There should be a regionally coordinated approach to consultation on the White Paper, with particular reference to potential impacts of NHS reforms on multi-agency approaches to safeguarding vulnerable adults. This could be led by NE ADASS, collecting and collating views, issues and practice examples from each of the SABs in the region.
THEME 1: SAFEGUARDING ADULTS BOARDS AND INTER-AGENCY ARRANGEMENTS

SUMMARY OF KEY FINDINGS

SAB structures in the North East
- The four Teesside local authorities have recently adopted a sub regional SAB, which offers a number of possible benefits, particularly for partner agencies which work across local authority boundaries. This could potentially provide a model for other parts of the region.

SAB Chairpersons
- It is increasingly common for SABs in this region and elsewhere to appoint independent Chairs, but potential costs and benefits of this approach will vary, according to local factors.

SAB Membership and engagement
- The quality of multi-agency engagement with SAB arrangements in the region is variable. Some partner agencies, though listed as SAB members, do not engage effectively. This is evidenced by non-attendance at SAB meetings or repeatedly delegating attendance to staff who do not have sufficient authority to represent the organisation and hold it to account.

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- Only one SAB in this region has individual service users as a board members. All of the others have representation from voluntary sector organisations.
- SAB sub-groups also lack membership from people who would be defined as ‘vulnerable adults’ under No Secrets guidance.
- Some sub-groups have made efforts to engage with local user-led organisations.

Inter-agency work and financial abuse
- There are pockets of excellent practice in joint work with DWP and the Benefits Agency to deal with alleged financial abuse.
- But there is a lack of strategic engagement with these agencies on issues including inter-agency working and information sharing.
- As a result, it seems likely that cases of financial abuse of vulnerable adults, which may otherwise have been prevented or identified earlier, will go undetected.

Involvement of Health in Safeguarding Adults Boards and Inter-Agency arrangements
- All SABs in the region have at least one health partner member, but their level of involvement is variable.
However, at operational levels, health colleagues do actively participate in individual investigations around possible harm to vulnerable adults.

There is currently little GP involvement in adult safeguarding at strategic or operational levels.

The current white paper may be a useful lever to encourage more active participation of GPs as part of their consortia development.

Locally, the Strategic Health Authority (SHA) has recently established a regional group of commissioning adult safeguarding leads to develop work around adult safeguarding. This group is conducting a baseline audit of the current position around health sector safeguarding in the in the North East.

However, with current plans to remove SHAs from the NHS management structure, it is unclear how this work will be developed in future.

There is a need for more open information sharing on adult safeguarding issues, between NHS providers and Safeguarding Adults services. This needs to be addressed through a strong national lead.

**An optimum model for multi-agency arrangements**

An optimum model for safeguarding arrangements in the region would include multi-professional safeguarding adults teams, resourced jointly between local authorities, PCTs and other statutory sector partners.

Some safeguarding related activities such as professional training could be commissioned regionally or sub-regionally, which could deliver economies of scale whilst improving consistency across the region.

**Introduction**

This section of the report provides an analysis of current arrangements for SABs and inter-agency arrangements in this region, with reference to the No Secrets Guidance; the ADASS Safeguarding National Framework document and examples of good practice in the North East and other regions. In particular we have examined stakeholder participation and resourcing of safeguarding adults teams.

Drawing on findings from this analysis, we have made a number of recommendations for developing an ‘optimum model’ for multi-agency arrangements, as required by the project brief. These recommendations are intended as a basis for discussion between all of the key partner agencies. We have sought to accommodate the fact that the North East is a highly diverse region (for example in terms of urban and rural communities; existing organisational structures and resources; and population demography) On this basis, we recognise that a model which can be usefully applied to the region as a whole will need to be flexible and adaptable to each SAB locality.

**National guidance on inter-agency arrangements**

‘No Secrets’ establishes local authorities as having lead responsibility to co-ordinate and monitor multi-agency arrangements and ensure that vulnerable adults are safeguarded effectively by all agencies working with them. However, in the absence of a statutory duty to co-operate, local authorities have the responsibility to deliver effective adult protection arrangements but may not have the necessary authority to do
so. It is, therefore, important that a wide range of different agencies, at the right level of seniority, must be engaged in local multi-agency arrangements - across statutory, voluntary, community and independent sectors.

‘No Secrets’ includes guidance on setting up inter-agency administrative frameworks, suggesting that these should include:

- Commissioners of health and social care services
- Providers of health and social care services
- Providers of sheltered and supported housing
- Regulators of services
- Police and other relevant law enforcement agencies (including the Crown Prosecution Service)
- Voluntary and private sector agencies
- Other local authority departments, e.g. housing and education
- Probation departments
- DSS Benefit Agencies
- Carer support groups
- User groups and user-led services
- Advocacy and advisory services
- Community safety partnerships
- Services meeting the needs of specific groups experiencing violence
- Agencies offering legal advice and representation.

‘No Secrets’ also suggests that agencies ‘may consider the merits of’ setting up adult protection management committees, with representation from lead officers of key partner agencies.

Standards 1 (The Partnership) and 2 (Joint Planning and Capability) of the ADASS National Framework of Standards for Good Practice and Outcomes in Adult Protection Work are rather less equivocal on the fundamental importance of establishing formal inter-agency committees (which have since been commonly referred to as SABs) and making effective connections with other relevant strategic networks, including Community Safety Partnerships. The ADASS standards also include a useful ‘checklist’ of the agencies which should be represented on SABs, making it clear that members need to be sufficiently senior to represent their organisation and reach multi-agency agreements. For ease of reference, we have reproduced ADASS standards 1 and 2 in full (see appendix 4).

SAB structures in the North East

All local authorities in the region are operating within the No Secrets guidance and ADASS standards, at least to the extent that they each have a functioning SAB which meets on a regular basis and has multi agency input.

The four Teesside authorities (Hartlepool, Stockton, Middlesbrough, Redcar and Cleveland) differ from the rest of the region, as they have a sub-regional Teeswide
SAB, with all agencies in the sub-region working to a single multi-agency safeguarding adults procedure. Each of the Teesside local authorities also has a local safeguarding committee, with sub groups focusing on local issues including training and support, quality and performance, policy and implementation. The sub groups feed into their local committees, which in turn are represented at the Teeswide SAB.

The Teeswide SAB was launched in November 2009, and a new role of SAB Coordinator has been jointly funded by the four local authorities. The new Coordinator has only been in post since July 2010. It is obviously too early to draw firm conclusions about the impact of this new sub-regional structure, but we have received generally positive feedback in our consultation meetings across Teesside. Potential benefits of a sub regional SAB include:

- Agencies working across 4 LA boundaries - including particularly Police and NHS commissioners and providers - are operating to single multi agency policy and procedure.

- Senior officers from partner agencies which operate across LA boundaries are members of one SAB, instead of four. This may result in better attendance from those officers, with less delegation to more junior staff or non-attendance.

- There is potential for economies of scale in relation to SAB coordination, administration and support services.

- There may also be economies of scale in purchasing other services, including multi-agency, post qualification training.

One potential problem with the Teeswide model is the possibility that the four local committees may duplicate the work of the sub-regional SAB, which would be an inefficient use of time and lead to confusion around roles, responsibilities and lines of communication.

Another concern with this approach was highlighted by Middlesbrough’s CQC inspection report, which observed:

'It was not intended that the new safeguarding governance arrangements would result in a published Middlesbrough-focused annual report but that Middlesbrough specific data would feature in a Tees-wide report. This gave some cause for concern. Local arrangements needed to be secured by clear work plans that reflected local issues, which were themselves well profiled.'

This observation emphasises that sub-regional SAB arrangements must support effective planning and good practice at constituent local authority levels, as this is where lead responsibility for delivery and outcomes is located. Having said this, the Teeswide arrangements do retain local authority located committees, so it should be possible to produce an annual Teeswide SAB report encompassing performance reports and business plans for each of the four local authority areas.
The remaining 8 North East local authorities each have separate SABs, and separate sets of multi agency policies and procedures for safeguarding adults. They also each have working sub-groups which focus on issues including quality and performance management; training and support; policy and procedure implementation; and communication. All of the policies and procedures in these eight areas are based on national guidance from No Secrets and the ADASS standards and as a result are broadly similar in structure and content. But, in contrast to Teesside, partner agencies which work across LA boundaries are often represented on several SABs and need to be familiar with several different sets of local policy and procedure. A possible longer term option would be to develop a regional policy statement. But there would still be a need for local guidance and procedures, to reflect differences in inter-organisational structures, resource distribution and locally identified priorities.

The possibility of introducing the Teeswide model in other parts of the region was raised by some health agencies. As PCTs are increasingly working in clusters such as North of Tyne and South of Tyne and Wear, they have voiced the view that they do not have the capacity to be adequately involved with several SABs. A sub regional approach is favoured by them as a way of promoting more coordinated intervention. Some even suggested that adult and children’s boards could be brought together but the general view is that this would be unwieldy and dilute the board’s role.

**Recommendation 2**

There should be a focused evaluation of the outcomes of the new Teeswide SAB arrangements, including analysis of potential costs and benefits of introducing similar sub-regional arrangements in other locations in the North East. This evaluation should be started in approximately 12 months time (September 2011) to allow sufficient time for the Teeswide arrangements to generate evidence of outcomes.

**SAB Chairpersons**

SAB Chairs play a pivotal role as the lead public representative of the multi-agency arrangements, as well as chairing regular SAB meetings. The following table summarises Chair arrangements in the North East:

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Chair person</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darlington</td>
<td>Director Community Services (LA)</td>
<td>Considering Independent Chair</td>
</tr>
<tr>
<td>Durham</td>
<td>Head Adult Services (LA)</td>
<td></td>
</tr>
<tr>
<td>Gateshead</td>
<td>Director Adult Services (LA)</td>
<td></td>
</tr>
<tr>
<td>Newcastle</td>
<td>Independent</td>
<td></td>
</tr>
<tr>
<td>North Tyneside</td>
<td>Independent</td>
<td></td>
</tr>
<tr>
<td>Northumberland</td>
<td>Independent</td>
<td></td>
</tr>
<tr>
<td>South Tyneside</td>
<td>Executive Director (LA)</td>
<td>Plan to appoint Independent Chair</td>
</tr>
<tr>
<td>Sunderland</td>
<td>Independent</td>
<td></td>
</tr>
</tbody>
</table>
As the above table shows, there is no consistent regional approach on the issue of independent chairs, although the region is following the national trend, which is increasingly towards having an independent Chair. Potential benefits of this approach are:

- It may help emphasise that all SAB partners have equal ownership of adult safeguarding arrangements, and thus tackle any perception that ownership and responsibility for adult safeguarding arrangements and outcomes lies solely or mainly with the LA.
- It enables the Chair to independently challenge and criticise any of the member organisations, without being seen to be compromised by allegiance to a specific organisation (usually the LA adult social care department).
- It provides an opportunity to bring in additional specialist expertise and skills to SAB strategic planning activities.
- It may reduce senior managers’ workloads, allowing them to focus more on managing their own agency’s performance on safeguarding.

On the other hand, some organisations and individuals we have consulted with have questioned the potential benefits in their own locations, citing the following disadvantages:

- Financial cost of independent Chairs fees (usually in the region of £500 per day plus expenses) and recruitment costs.
- Difficulty in recruiting people with the necessary skills and experience, partly because safeguarding adults is a relatively new specialist area.
- Although they may be independent in the sense that they are not directly employed by any of the partners, they will usually have a specific professional background, which means they may not be perceived as completely independent.
- An alternative model would be to rotate the role of Chair among the partner organisations. There is no requirement that a Chair must be a senior LA adult social care manager.

A recent CQC inspection report on Safeguarding in Salford did cite the presence of a ‘robust and effective SAB with an independent Chair’ as one of a number of factors which resulted in a performance rating of excellent. This should not be taken as evidence that robustness and effectiveness depend entirely on having an independent chair, but it reflects a growing trend towards this approach.

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Published CQC reports can be accessed on their website: [www.cqc.org.uk](http://www.cqc.org.uk)
In summary, we have reached the conclusion that whether or not to appoint an independent Chair is one which should be based upon local factors, and as such does not lend itself to a regional recommendation.

**SAB Membership and engagement**

*Good practice example*

**Teeswide SAB & Crown Prosecution Service:**
A number of organisations represented on the SAB have had concerns that only a very small proportion of safeguarding incidents have resulted in criminal prosecutions, even where there appears to have been strong evidence that identified perpetrators have committed criminal offences.

The SAB and CPS have agreed to jointly review some sample cases where these concerns have been highlighted.

It is intended that this review will improve multi-agency understanding of why particular cases have not resulted in criminal prosecutions. This will then help to inform future multi-agency safeguarding policy and procedure (e.g. on joint investigations; use of court intermediaries for vulnerable victims or witnesses) with the aim of increasing the future rate of successful prosecutions.

The written membership lists of North East SABs (see appendix 1) indicate that there is a reasonably good level of multi-agency involvement, as most of the key statutory agencies identified in the ADASS standards are listed. However, our regional consultations confirm that, in practice, levels of engagement are not consistently satisfactory across all of the partner agencies. This is reflected by poor attendance by some agencies at SAB meetings, or frequent delegation to less senior employees who do not have sufficient authority within their organisation. This is recognised as a problem nationally and there is no evidence that the North East is particularly unusual in this respect. If multi-agency cooperation does eventually become a statutory requirement, as is already the case for children’s safeguarding arrangements, it is commonly expected that this will significantly improve levels of engagement with SABs.

However, in the meantime, we would suggest some possible regional strategies which may help to address this issue:

- Some targeted work with those SAB member organisations which consistently fail to effectively engage. This may include a regional survey to establish barriers to engagement.
- A series of regional or sub regional awareness raising events on safeguarding, targeting senior executive officers of all SAB membership organisations. These could include sessions to highlight examples of excellent multi-agency working.

- Lobbying of national regulatory and inspection bodies to ensure that they consider engagement with adult safeguarding arrangements, as part of their regulation and inspection processes.

**Recommendation 3**

There should be a regionally coordinated drive to improve levels of engagement of those SAB partnership agencies which currently do not engage effectively with SAB arrangements. This may include some targeted work to better understand barriers to engagement; regional or sub regional awareness raising events and lobbying of regulatory and inspection bodies.

**User engagement and SAB membership**

Standard 11 of the ADASS framework states that safeguarding adults partnerships should explicitly include service users as key partners in all aspects of their work, including:

- Membership
- Monitoring, development and implementation of its work
- Training strategy
- Planning and implementation of their individual safeguarding assessment and plans.

We have identified only one SAB in the region which has individual service users as a full member of the board, as outlined in the following good practice example:

**Good Practice Example:**

**Service User Engagement with Northumberland SAB**

There are two service users represented on the Northumberland SAB. Both are active participants in one of the network of Service User Forums currently operated by Northumberland Care Trust across the county.

There is recognition that, for service users to actively participate, factors such as language / jargon / timing and chairing style are important, as is ongoing support. Having two service users means that they can also support each other.

They participate as regular Board members and are sent the same papers and agenda as everyone else. They contribute as they feel appropriate, and are ‘experts by experience’. They have attended the same training sessions.
They have brought additional value to the work of the SAB. Some of the benefits noted include:

- Bringing a valuable perspective on important issues for service users.
- Providing the board with timely ‘reality checks’ and keeping meetings focussed on outcomes for service users (‘why we are here’).

All but one of the remaining SABs have representatives of voluntary sector organisations, including LINks, Victim Support, voluntary sector providers and umbrella organisations. For a number of SABs, the involvement of non-statutory partners has been a very recent development and there is so far very little evidence of any significant impacts from this, on safeguarding strategies, policies practice, or outcomes for service users.

Discussions with stakeholders identified a number of barriers to direct service user membership of SABs:

- Lack of a shared definition or clarity on who may constitute a ‘service user’. For example, some thought this should be a vulnerable adult who has been through a formal safeguarding process. Others suggested that a person who meets the No Secrets definition of a vulnerable adult may be a suitable candidate for Board membership, even though they may not have experience of any safeguarding interventions.
- There was concern that an individual service user can not be expected to represent the views of all service user groups and there was therefore a danger of their membership being perceived as a tokenistic gesture.
- Service users are likely to require additional support, in order to ensure that they can contribute on an equal basis to SAB business. The main concern here was that providing such support may have significant resource implications.

At sub group level, there was slightly more evidence of attempts to involve service users, but even here the level of involvement was very limited. The most usual approach was to contact service user led organisations and request input on an ad-hoc basis, with specific work streams. This has included using existing fora such as Older Peoples Assemblies (Gateshead) and Area Fora (North Tyneside). In recognition of their need to encourage greater involvement of service users, Newcastle Safeguarding Adults Team have arranged for IDeA to undertake some work around this issue.

Attempts have been made to seek individual user views around their experience of the safeguarding process. Questionnaires, telephone interviews and audits have all been used locally to obtain feedback on the process. However as a number of stakeholders
recognise, the safeguarding process can be a traumatic and stressful event and sensitivity in seeking feedback is important.

It is worth noting that safeguarding processes in the region do involve individual service users in the safeguarding after the strategy meeting has taken place; but only one local area has started to involve users in the strategy meeting.

In summary, the quantity and quality of service user input and influence at the strategic planning level is generally poor. Where attempts have been made, service users have often not been given sufficient training or support to be able to engage effectively.

The picture in terms involvement in individual safeguarding incidents / investigations is more variable. But our consultations with all of the L.A. leads and partner organisations across the region revealed a strong consensus that current attempts to keep service users at the centre of adult safeguarding processes are generally inadequate.

**Recommendation 4**

As a minimum requirement, every SAB in the region should have a nominated member with an explicit role of monitoring performance against standard 11 of the ADASS framework. This member should ideally be a person who could be defined as a vulnerable adult, using the no secrets definition. Alternatively they may be a representative of a service user led organisation.

**Recommendation 5**

Standard 11 of this ADASS framework should be a standard agenda item at SAB meetings and at the regional Safeguarding Leads meetings.

**Recommendation 6**

There should be a regional focus on user engagement, coordinated by the regional Safeguarding leads network. This regional approach should include:

1) Establishing regional or sub-regional support and training networks for service user representatives on SABs or SAB sub-groups.

2) Ensuring that SAB service user representatives are actively encouraged to take part in relevant mainstream training opportunities organised by SAB member organisations.

3) Collecting and sharing examples of good practice which enables individual service users to be supported and effectively informed, engaged and involved in formal safeguarding processes.
Inter-agency work and financial abuse

Good practice example: North Tyneside SAB & Department of Work and Pensions (DWP)
In North Tyneside, a DWP representative attends the SAB’s Finance Panel. As this is a multi-agency group, it is much easier and quicker for the DWP to share information across agencies because there are no barriers at a high level. There is a good working relationship between the DWP and the safeguarding team and it is possible for the DWP to undertake background checks prior to meetings. It also means that a fuller picture can be put together quickly and can be progressed quickly with, for example, a visit by the DWP.

Prior to this, staff in safeguarding were unclear about who to contact within the DWP. For the DWP, by the time they were involved, the abuse was often long standing with a large amount of financial loss to an individual. Now, they pursue successfully civil prosecutions and there is a perception that the public are more aware of the DWP’s involvement in safeguarding. Anecdotally the DWP representative believes that appointees who may be undertaking financial abuse are increasingly “throwing in the towel” before they reach them. It has also led to a reduction in the number of cases seen by the DWP. The DWP involvement is seen as an example of good practice which is being recognised and explored by other SABs.

From this greater involvement of the DWP in safeguarding, awareness within the DWP has increased. Their representative regularly raises the issue of safeguarding with colleagues doing visits and they are encouraged to discuss issues with the representative or consider a referral.

Discussions with stakeholders confirm that inter-agency work to prevent and detect financial abuse is an area where there is very significant room for improvement, although there are pockets of excellent practice, as described in the above example. We found that, while some SABs have the DWP and / or the Benefits Agency named as members, there was often very limited engagement with these agencies at a strategic planning level. Consequently, responses to suspected financial abuse of vulnerable adults in receipt of benefits or pensions are often dependent upon informal relationships at local practitioner level. This raises a number of concerns, including:

- there is a lack of jointly developed and agreed strategies with pensions and benefits agencies, to prevent financial abuse of vulnerable adults in receipt of pensions or benefits, or to identify abuse when it occurs;
- there is also a lack of clear inter-agency agreement on issues of confidentiality and information sharing around suspected financial abuse. This means that local staff of safeguarding and benefits or pensions services may be unable to share...
relevant information, even in cases where there is a substantive reason to suspect financial abuse.

**Recommendation 7**
There should be a regionally coordinated approach to senior officers of the DWP and the Benefits Agency, to re-affirm the importance of active engagement in relation to vulnerable adults at risk from financial abuse. A good starting point would be to try and ensure the presence of senior regional lead from each of these agencies at the conference on 16 November.

**Recommendation 8**
Examples of effective joint working between services for vulnerable adults and statutory pensions and benefits agencies, should be collated and circulated as good practice examples.

**Involvement of Health in Safeguarding Adults Boards and Inter-Agency arrangements**

Document reviews and stakeholder consultations confirm that all SABs in the region have at least one health partner member, but their level of involvement is variable. In some areas the representative plays an active role, but in others attendance is sporadic and strategic engagement inconsistent. Reasons given for this most often relate to lack of sufficient resource in terms of not having the time to attend and participate in SAB meetings. Generally, however, health colleagues do actively participate in individual investigations around possible harm to vulnerable adults.

The recent NHS White Paper sets out plans for major reform of the NHS, most notably announcing the abolition of Primary Care Trusts and placing the responsibility for commissioning services to GP consortia. ADASS has broadly welcomed these proposals on the grounds that GP consortia will have a duty to work in partnership with local authorities, with their stated aim to:

> “strengthen democratic legitimacy at local level, local authorities will promote the joining up of local NHS services, social care and health improvement.” (p.4)

Specifically with regard to safeguarding, the white paper states,

> “GP consortia will have a duty to promote equalities and to work in partnership with local authorities, for instance in relation to health and adult social care, early years services, public health, safeguarding, and the wellbeing of local populations. (p.29)

From our discussions, it is clear that there is currently little GP involvement in adult safeguarding at strategic or operational levels, particularly with GPs not being prepared to share information around individual cases. The BMA is in the process of producing guidance around safeguarding and the Department of Health (DH) are drafting an adult
safeguarding toolkit for GPs. It is hoped that these documents and legislation arising from the white paper may lead GPs to begin engaging with the adult safeguarding agenda but a concern is that although consortia will have a duty to work in partnership, individual GPs may still be reluctant to take part. The proposed white papers on public health and adult social care may provide more detail around how this will work in practice. Nevertheless, the current white paper may be a useful lever to encourage more active participation of GPs as part of their consortia development. There remains a danger that during this intense period of change from PCTs to GP consortia, a vacuum around the planning and involvement of health could occur and this would impact negatively on inter-agency arrangements.

**Recommendation 9**
The local adult safeguarding network should make approaches to Local Medical Committees to begin a dialogue around how SABs and safeguarding units can work more closely with GP consortia.

Consideration also needs to be given to the impact of the white paper on those in the NHS who currently have an adult safeguarding role. With the abolition of PCTs the reforms could be viewed either as a threat or an opportunity to become more closely aligned to local authority safeguarding functions. Discussions with NHS safeguarding adult leads in PCTs suggest a common view that much of their work in this area is based on goodwill, but is clear that the health professionals involved are strongly committed to the safeguarding agenda. Their view is that their relationships with local authority safeguarding units and SABs are improving whilst acknowledging that resources for this work are limited. If, as expected, PCT commissioning adult safeguarding leads move into GP consortia, they could positively influence consortia approaches to safeguarding adults. Similarly, those leads in NHS providers and Foundation Trusts may see it as beneficial to work more closely with local authorities as part of a wider quality agenda of protecting their patients.

Locally, the Strategic Health Authority (SHA) has recently established a regional group of commissioning adult safeguarding leads to develop work around adult safeguarding. Acknowledging that the NHS is further behind local authorities in developing the adult safeguarding agenda - for example few NHS managers are trained in adult safeguarding issues - the SHA are undertaking a baseline audit of the current position in the north east, culminating in a regional conference. Their initial discussions have focused on process indicators including:

- Whether organisations have a policy on safeguarding;
- Whether they have identified lead personnel for safeguarding;
- Whether commissioners have clear and monitored safeguarding standards in contracts;
- The number of adult safeguarding incidents reports and action plans following investigations.
However, another proposal in the white paper is to abolish SHAs and it is currently unclear who will take on these development and performance monitoring roles from the SHA.

This SHA work is also being supported by the DH nationally, who have developed a number of documents including a guide for commissioners, a draft toolkit for GPs and a draft assessment toolkit – all around adult safeguarding. The North East SHA has offered to pilot the assessment toolkit. DH also has on-going work on the following areas that impact on adult safeguarding:

- R&D on Safeguarding Adults Boards
- A guide to current law
- Guidance for NHS Boards
- Guidance on Clinical Governance and Adult Safeguarding.

**Recommendation 10**

The establishment of a regional group, comprising local authority and health leads, to facilitate an open dialogue around how they would like adult safeguarding to look in the future, after the white paper reforms have been implemented.

The issue of accountability, both in acute trusts and other NHS providers, highlights a tension between local authorities and the NHS. On the one hand, local authorities want to ensure they are discharging their responsibility for adult safeguarding and are keen to know about adult safeguarding issues that arise in the NHS. On the other hand, there is a prevailing culture within NHS provider organisations which regards incidents that could be adult safeguarding issues (for example, medication errors and pressure sores) as internal clinical management issues. To acknowledge these incidents openly is often regarded by senior NHS leaders as somehow admitting publicly to failure – and something that they are not prepared to undertake. Some have said that this results in a lack of a level playing field because private residential care and nursing homes are closely monitored and expected to account in detail, issues like these. However, most safeguarding adult’s teams do not have expertise or the necessary resource capacity to be involved with the detail of these types of incident in NHS provider services.

Funding is another issue that could impact on the capacity of health to be involved with adult safeguarding. In the white paper, it is planned that by 2014 the NHS reforms will release up to £20 billion of efficiency savings. The intention is that this will be reinvested to support improvements in quality and outcomes. However, the level of management savings on which this is predicated may affect detrimentally the involvement of NHS people at a senior level – it may be the case that there are insufficient individuals to be involved with SABs and investigations.

**An optimum model for multi – agency arrangements**

Part of the brief for this project was to develop an ‘optimum model’, which would consider stakeholder participation in SAB arrangements and the resourcing of
safeguarding teams. **We would emphasise that the purpose of the model described below is to provide a basis for further discussion between partner agencies and not to suggest that there is a simple ‘blue-print’ solution which should be rigidly applied across the region.** There will inevitably be many local factors which would impact on how such a model may be implemented in different locations.

In developing this model, we have made the following assumptions:

- For the foreseeable future, there is unlikely to be any significant new government funding specifically for development of adult safeguarding services. In this context, an ‘optimum’ model needs to be broadly deliverable within the existing regional resource base.
- Until any new national guidance or legislation is published, there is a regional commitment to work within the existing No Secrets guidance and the ADASS standards as a base-line for safeguarding policy, procedure and practice.

We have made the latter assumption, because our stakeholder consultations have highlighted an ongoing and active debate on whether or not adult safeguarding as a specialism can realistically deliver on the wider prevention agendas (e.g. driving up basic standards in residential care establishments and NHS acute trusts) at the same time as delivering high quality and effective responses to protect vulnerable adults at immediate risk of significant harm. One of the challenges here is that work to raise general standards and awareness of potential harm to vulnerable adults, has led to large increases in numbers of referrals into formal safeguarding procedures. There is therefore an argument that the current ‘two pronged’ approach of wider prevention work and offering a specialist response to safeguarding incidents is unsustainable within existing resource levels.

This line of argument could suggest an approach similar to that developed under national legislation and guidance for children and young people, where strategic planning, policy and service delivery responsibilities and structures are defined more clearly between a broad welfare agenda (Children’s Trust Boards / Every Child Matters) and a specific framework for child protection policy, procedure and practice (Local Safeguarding Children Boards and specialist child protection services).

On the other hand, there is a strong body of opinion that an integrated and preventative approach to safeguarding adults; with a strong focus on issues of service quality, human rights and dignity; will ultimately result in fewer incidents of significant harm and better outcomes for the whole population of vulnerable adults.

We have not made any findings on the relative merits of either side of this complex debate, because this is a national policy issue and well beyond the remit or scope of this regional study. On this basis, our proposed optimum model is intended to deliver adult safeguarding in line with existing national guidance, frameworks and standards offered by No Secrets and the ADASS document. The ADASS document in particular would suggest that adult safeguarding services should retain a strong emphasis on
prevention work, as opposed to focusing exclusively on responses to specific safeguarding concerns.

The diagram on the following page illustrates our proposed optimum model:
AN OPTIMUM MODEL FOR SABs & INTER-AGENCY WORK

**SAB MEMBERSHIP**
- (Senior Strategic Leads)
  - Adult Social Care
  - Council Member
  - PCT
  - Police
  - CPS
  - DWP & Benefits Agency
  - Probation
  - Service user led organisation
  - Expert by Experience
  - Community Safety Team
  - Housing Strategy
  - NHS Trusts
  - CQC
  - Others as relevant to locality

**SAB SUB GROUPS**
- Community and User Engagement
- Training
- Policy & procedure implementation
- Performance & outcome monitoring and information management
- Other sub groups or short term working groups tasked by SAB in response to local issues

Memberships drawn from strategic & operational partners, voluntary / user led orgs & Safeguarding Team, as appropriate

**User led and vol sector organisations / groups**
For example:
- LiNK; Victim Support; Age Concern;
- CAB; Other user groups & providers for Older people / Learning disability / Physical disability / Mental health / Carers; Community groups

**Safeguarding Adults Team:**
- Strategic Lead
- Operational manager
- Senior practitioner (health focus)
- Senior practitioner (social care focus)
- Training officer
- User & Community engagement lead
- Administrative support

Sub group workstreams directed by SAB.

Feedback loop on policy & procedure impacts on local outcomes

**Core Functions of Safeguarding Adults Team**
- Coordinating SAB directed workstreams in line with annual business plan
- Progress reports to each SAB, against business plan
- Collecting, collating and analysing data on safeguarding alerts / referrals and outcomes. Reporting findings to SAB
- Coordinating complex and high risk investigations – chairing strategy meetings
- Providing professional guidance on adult safeguarding, including MCA & DoLS
- Delivery / coordination / commissioning of multi agency vulnerable adults training
- Promoting and supporting user engagement at service delivery and strategic levels
- Promoting wider community awareness of adult safeguarding issues
- Prevention and awareness raising

Improving the Safeguarding of Adults in the North East
Richard Corkhill & Caron Walker, September 2010.

www.richardcorkhill.org.uk
Optimum SAB membership and sub-group arrangements

As already stated, the structure outlined above is intended to illustrate a possible ‘optimum model’, but the precise details of such a model are likely to vary according to local factors, including pre-existing resources, inter-agency structures and working arrangements. However, our findings from consultation within the region and recognised good practice nationally, suggest that the following factors are prerequisites for successful inter-agency safeguarding arrangements across the region as whole:

- Nominated SAB members are sufficiently senior to commit their organisation to multi-agency agreements and strategies – and ensure their organisation delivers on these commitments.
- Delegation of attendance at SAB meetings to less senior staff is the exception, not common practice.
- Each member organisation achieves at least a 75% attendance rate by the primary nominated member.
- All of the key statutory partner organisations are represented. This includes L.A. Adult Social Care; PCT; Police; CPS; Benefits Agency; Probation; CQC; DWP.
- SAB membership includes at least one ‘Expert by Experience’. This person is a ‘vulnerable adult’, in line with the currently recognised definition (No Secrets). They may also have had direct experience of being involved in a formal safeguarding process.
- Additional support, if needed, is provided to enable the Expert by Experience to be fully engaged and involved with the SAB.
- SAB membership also includes at least one non-statutory and user led organisation which works with vulnerable adults.
- SABs meet at least on a quarterly basis.
- Sub-group membership is drawn from a wide range statutory and non-statutory partners, utilising local knowledge and expertise of operational managers and practitioners.
- SABs and Sub Groups have clearly defined terms of reference which are complementary and do not lead to confusion of roles or duplication of work.
- There are clear lines of responsibility and communication with the SAB directing sub-group work streams and sub groups advising the SAB on local impacts of policy / procedure implementation on real outcomes for vulnerable adults and the wider community (i.e. an effective ‘feedback loop’).

An optimum Safeguarding Adults Team

We have suggested that an optimum safeguarding adults team would, as a minimum, include the following staff resources:

- Strategic manager
- Operational manager
- Senior Practitioner (health focus)
- Senior Practitioner (social care focus)
- Training officer
- User and Community engagement lead
- Administrative support

The team would have clearly defined functions, as outlined by the above illustration:

- Coordinating SAB directed work streams in line with annual business plan.
- Progress reports against business plan to each SAB meeting.
- Coordinating complex and high risk investigations – chairing strategy meetings.
- Providing professional guidance on adult safeguarding, MCA and DoLS.
- Collecting, collating and analysing data on safeguarding alerts / referrals and outcomes.
- Delivery / coordination / commissioning of multi agency vulnerable adults training.
- Promoting and supporting user engagement at service delivery and strategic levels.
- Promoting wider community awareness of adult safeguarding issues.

We have proposed these defined functions, in recognition of a need to develop a more consistent regional approach. Currently, there are major variations within the region, both in terms of resource levels and remits.

In some localities there is an expectation that relatively less well resourced teams will be actively involved in all safeguarding investigations, leaving little capacity for any strategic or preventative work.

Other teams are relatively well resourced, but are only actively involved in the most complex or high risk safeguarding investigations. In such investigations, the role of the Safeguarding team is one of coordination and ensuring investigations operate within local policy and procedure, rather than having direct ‘hands on’ involvement. Typically, direct investigative work may be led by an adult care social work team leader, in partnership with other agencies (e.g. police vulnerability unit), but this will depend on the specific circumstances and the nature of allegations / suspicions concerning abuse, neglect or poor practice. The safeguarding team is also responsible for monitoring outcomes and ensuring that, where necessary, action is taken to address wider organisational systems issues (e.g. staff training needs) which may have contributed to the original safeguarding referral and thus mean that other vulnerable adults remain at risk. We are proposing that the optimum model should be based on this approach.

This model will raise significant resource issues, especially for those areas which currently have less well resourced safeguarding teams. We also recognise that
expected reductions in public expenditure in the immediate future will create additional challenges for all of the partners with safeguarding responsibilities.

In this challenging financial climate, it is essential that these resource issues should be discussed on a multi-agency basis, with the objective of ensuring that resources are utilised efficiently, to achieve the best possible outcomes for vulnerable adults. Possible options for consideration would include:

- Opportunities for joint funding or secondment arrangements, to create integrated teams of health and social care professionals. This may include, for example, NHS funding of the Senior Practitioner (health focus). The Durham Safeguarding Adults Team provides an example where such arrangements have already achieved positive outcomes. (See good practice example below)
- Similarly, there may well be a case for joint funding arrangements for other posts which have clear multi-agency remits, including those of safeguarding strategic lead and the training officer.
- Sub regional or regional partnership arrangements to deliver economies of scale and regional consistency. This is already being achieved by the Teeswide arrangements, including commissioning of a sub-regional training programme.

**Good Practice example: Durham Safeguarding Adults Team**

The Durham Safeguarding Adults team is a jointly resourced and integrated service, made up of health and social care professionals. The current team structure is:

- Safeguarding Practice & Development Manager.
- Safeguarding Communication and Training Officer
- Safeguarding Practice Officer
- 2 Social Workers at senior practitioner level
- 2 Nurses employed by PCT, seconded to LA
- O.T. senior practitioner (funded 50% PCT / 50% L.A.)
- Dedicated administrative support

This integrated model enables the team to work pro-actively across sectors, with a strong preventative agenda.

**Good Practice example: Salford Adult Safeguarding Unit**

Salford Council’s performance on safeguarding adults was rated as excellent by CQC. Among other areas of good practice, CQC reported that:

“The Adult Safeguarding Unit was a joint unit between the Council and the PCT. Two co-ordinators were employed, one from each..."
agency. They ensured that all alerts were actively managed, timescales were adhered to and advice was freely available.” (June 2010, www.cqc.org.uk)

Recommendation 11
There should be multi-agency discussion at regional, sub-regional and local levels, on joint resourcing of Safeguarding Adults teams. The aims of these discussions should be:
1) To agree an optimum model, using the model described in this report as a baseline for discussion.
2) Establish joint funding arrangements for Safeguarding Adults Teams, which will deliver the agreed optimum model; maximum value for money; and the best possible outcomes for vulnerable adults.

Recommendation 12
This multi-agency discussion on the optimum model and resourcing issues should include consideration of sub-regional or regional funding partnerships, if such arrangements can deliver economies of scale, or more consistency of approach within the sub-region or region.
THEME 2: LESSONS FROM CQC INSPECTIONS

SUMMARY OF KEY FINDINGS

Use of Independent Mental Capacity Advocates (IMCAs)
- Under utilisation of IMCAs, combined with poor recording of decision making processes on whether or not to refer for IMCA services, is a recurring issue highlighted by CQC inspections in this region and nationally.
- Another North East regional study by Action for Advocacy (commissioned by Social Care North East) is looking specifically at the role of IMCAs in safeguarding vulnerable adults and is due to report in November 2010.

Recording systems and standards / data collection and analysis
- CQC inspections in this region and elsewhere have frequently highlighted poor recording systems and / or poor quality practice in recording of safeguarding referrals, responses and outcomes as an area in need of urgent improvement.

Service User Engagement
- CQC commonly engage ‘Experts by Experience’, who form part of the inspection team.
- CQC have also noted value of service user influence at board level.
- CQC have also highlighted the value of SABs having effective communication systems and working arrangements with the wider strategic framework for adults with social care and health related needs, including Partnership Boards.

Community safety initiatives
- Wider community safety initiatives such as the work of Crime Reduction Partnerships contribute significantly to positive CQC inspection findings.

Overview of recent CQC inspection outcomes in the North East
The following table summarises inspection findings for each of the 6 North East local authorities which have been subject to a CQC inspection of adult safeguarding arrangements:

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Inspection date</th>
<th>Report date</th>
<th>Findings on safeguarding:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Performing</td>
</tr>
<tr>
<td>Darlington</td>
<td>Aug 2009</td>
<td>Dec 09</td>
<td>Adequately</td>
</tr>
<tr>
<td>Gateshead</td>
<td>Nov 2009</td>
<td>Apr 2010</td>
<td>Poorly</td>
</tr>
<tr>
<td>Middlesbrough</td>
<td>Feb 2010</td>
<td>May 2010</td>
<td>Well</td>
</tr>
<tr>
<td>Redcar &amp; Cleveland</td>
<td>July 2010</td>
<td>Pending</td>
<td>Pending</td>
</tr>
<tr>
<td>Stockton</td>
<td>July 2010</td>
<td>Pending</td>
<td>Pending</td>
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<tr>
<td>South Tyneside</td>
<td>May 2009</td>
<td>May 2009</td>
<td>Adequately</td>
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<tr>
<td>Sunderland</td>
<td>Jan 2010</td>
<td>Apr 2010</td>
<td>Adequately</td>
</tr>
</tbody>
</table>
Seven out of 12 NE local authorities have received CQC inspections, although two of these (Redcar & Cleveland and Stockton) have been completed very recently and inspection findings have yet to be published. Of those five which have published reports, Gateshead was found to be performing poorly; S. Tyneside, Sunderland and Darlington adequately; while Middlesbrough was found to be performing well. So far no local authorities in this region have received an ‘excellent’ CQC performance rating for safeguarding vulnerable adults.

Reviews of inspection report findings and interviews with local authority leads have helped us to identify some of the most common factors which significantly impact on CQC ratings.

**Use of Independent Mental Capacity Advocates (IMCAs)**

Another North East regional study by *Action for Advocacy* (Commissioned by Social Care North East) is looking specifically at the role of IMCAs in safeguarding vulnerable adults and is due to report in November 2010. Following discussion with the NEIEP project board, it was agreed that we would not carry out detailed enquiries on the use of IMCAs, as this would duplicate the Action for Advocacy study.

However, as CQC inspection reports in this region and elsewhere have repeatedly referred to under-utilisation of IMCAs as an area of concern, we would highlight this as an important learning point for SABs this region. For example, in Middlesbrough use of IMCAs was noted as an example of good practice:

‘Appropriate use was made of IMCAs and capacity testing, in cases we saw’

But, in the same report, CQC questioned why IMCAs were not being used more frequently:

‘….use of IMCAs was not well embedded in safeguarding practice. Referral rates were low with two adult safeguarding referrals reported to have been made to the IMCA service in nine months.’

Our discussions with LA leads indicate a degree of consensus that IMCA services could be more frequently and effectively utilised. But there are a number of factors, including IMCA referral routes and referral criteria, which have prevented more widespread use of IMCAs. It is anticipated that the Action for Advocacy report referred to above will provide a more detailed analysis of these issues.

In the meantime, it is essential that safeguarding procedures should, as a minimum requirement, ensure the following:

- Every safeguarding assessment considers whether or not referral to an IMCA is appropriate.

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6 Contact info@actionforadvocacy.org.uk. Project lead Martin Coyle.
Reasoning behind each decision on whether or not to use an IMCA service is clearly recorded.

**Recommendation 13**

Each SAB in the region and the regional leads group should carefully consider findings and recommendations from the regional Advocacy in Action report on IMCAs, due for publication in November 2010. In the meantime policy procedure and practice across all SAB areas should ensure that:

1) Every safeguarding assessment systematically considers whether or not referral to an IMCA is appropriate.
2) Reasoning behind each decision on whether or not to use an IMCA service is clearly recorded.

**Recording systems and standards / data collection and analysis**

CQC inspections in this region and elsewhere have frequently highlighted poor recording systems and/or poor quality practice in recording of safeguarding referrals, responses and outcomes as an area in need of urgent improvement. A related issue is poor collection and utilisation of data which could otherwise help to inform strategic planning processes at SAB levels. Example CQC recommendations for improvement in three different localities this region include:

“....Improve standards of record keeping to ensure they are an accurate representation of events, actions, decisions, monitoring and formal determination of the outcomes”

“Implement a robust quality management system to ensure that records are an accurate representation of events, actions, monitoring and formal determination of outcomes.”

“The council and partners should ensure that.....the safeguarding Committee is supported by robust performance and management information”

Similarly, CQC recommended that Westminster council and partners should:

“Improve analysis of safeguarding activity reported to the Safeguarding Adults Board, with more focus on trends in activity and outcomes for individuals”

**Recommendation 14**

Each SAB should, through their performance and quality sub-group, review systems and practice on recording, data collection and analysis. Outcomes from these reviews should be shared by the regional safeguarding leads group, in order to identify common issues and build on good practice in the region.

**Service User Engagement**

One learning opportunity from CQC inspections arises from their own approaches to service user involvement in the inspection process itself. CQC commonly engage ‘Experts by Experience’, who form part of the inspection team. These experts are recruited from areas outside of that being inspected, usually from voluntary sector or user led organisations such as Age Concern or LINks networks. From recent
inspections which have been conducted in this region, we understand that the role of Experts by Experience is relatively unstructured, but they talk informally with individual service users during inspection visits to local services for vulnerable adults. Other methods used by CQC include individual and group meetings with service users.

CQC have also noted value of service user influence at board level. A recent CQC report on adult safeguarding in Wirral made the following positive observation:

“Representatives of people who used services made a good contribution to shaping the priorities of the Safeguarding Adults Partnership Board. This was positive and supported a more inclusive and challenging approach to service developments”.

Salford, which received a CQC performance rating of excellent, was similarly praised for representation of service user views on their SAB:

“Lay representatives on all Partnership Boards were able to feed information and views to the SASB and told us that they felt able to influence policy. The carers centre was represented on the board”.

This observation confirms the value of SABs having effective communication systems and working arrangements with the wider strategic framework for adults with social care and health related needs.

**Recommendations**

Refer to recommendations under Theme 1 on user engagement (particularly Recommendation 6).

**Community safety initiatives**

Our review of CQC inspection reports from this region and elsewhere has highlighted that wider community safety initiatives contribute significantly to positive CQC inspection findings. Examples include:

- **Essex County Council** (rated excellent, June 2010) were praised by CQC for effective partnership with local Crime and Disorder Reduction Partnerships, with a corporate plan setting out priorities to reduce levels of domestic violence, tackle anti-social behaviour, increase citizen’s feelings of safety, reduce assaults and reduce re-offending behaviour.
- **Brighton & Hove City Council** (rated as performing well, August 2010) were praised for giving a high profile to anti-discrimination, with some positive initiatives to tackle harassment and hate crime.
- **Sunderland City Council** (rated as performing adequately, April 2010) were particularly commended for an initiative in which people with learning disabilities had been instrumental in developing a new programme of support with a strong focus on anti bullying and awareness raising about how to keep safe.

**Recommendation 15**
All SABs should review their working relationships and communication with Community Safety Partnerships and ensure that corporate and multi-agency initiatives meet the specific safeguarding needs of vulnerable adults.

New CQC standards for provider services
CQC are currently developing a new information system, to report on the quality of adult social care provider services. It is intended that this system will roll out from May 2011, subject to consultation. It is expected that this new system will also impact on CQC inspections of adult safeguarding performance at local authority levels. A particular area of focus is likely to be on the extent to which contracting teams and safeguarding leads are working effectively together, to ensure that all providers are meeting the new CQC standards. These will build on the current compliance standards that are already in place for Foundation Trusts and Mental Health trusts.
THEME 3: THRESHOLDS IN SAFEGUARDING ADULTS WORK

SUMMARY OF KEY FINDINGS

What is a threshold?
- Lack of clarity about the purpose of a threshold

Consistency
- Thresholds should have flexibility for practitioners to use professional judgment

Managing alerts and referrals
- Disagreement about whether a threshold should be high or low

Harm
- ‘Significant harm’ is the most commonly used threshold in the region

Threshold continuum
- Different thresholds depending on the setting may be a way forward

Setting a threshold
Several adult safeguarding leads acknowledged that the issue of thresholds was something this had not addressed.

Introduction
NE ADASS has highlighted the lack of clarity around the threshold between poor quality service provision and circumstances which should trigger referrals into adult safeguarding systems. This section draws on existing practice in other areas and the views of key partners involved with safeguarding adults locally. It aims to provide some recommendations around principles and common definitions that should be common across partnerships in the North East.

In our document review it became clear that there are no commonly agreed and understood thresholds for determining what factors should result in a vulnerable adult being referred into formal multi-agency safeguarding procedures. This was borne out through our discussions with adult safeguarding leads in the region as different interpretations on the issue of thresholds were evident. This, however, is not surprising as the complex - and individual - nature of safeguarding does not easily allow for prescribed rules in setting thresholds. That said, we consider having some common understanding across all partnerships around thresholds could improve consistency and enhance the effectiveness of joint working.
Overarching principles

The safeguarding of adults in our community should begin from the premise that harm and abuse must be prevented. Notwithstanding this, where this fails all agencies should ensure they have robust procedures in place to promptly deal with incidents of abuse.

The Law Commission consultation has suggested that a future adult social care statute should include a statement of principles and we would support this. Similarly, to improve consistency across the region, we consider it would be beneficial to have some overarching safeguarding principles that all agencies could adopt. This would assist partners from a wide range of agencies to ensure that they have high level commitment for their involvement in adult safeguarding. Promisingly, some inter-agency safeguarding agreements do have stated principles and these could be extended to include both the protection and prevention aspects of safeguarding. Such principles could include, for example:

Prevention
- a commitment that all partner agencies are responsible for improving the quality of services;
- an acknowledgement that commissioning and contracting teams can have a critical role in ensuring that failing services improve and that standards are met;
- supporting staff to be confident about exercising their professional judgment through regular training opportunities.

Protection
- a recognition that safeguarding is not the only way of addressing issues that arise;
- any safeguarding response should be proportionate to the concern;
- investigation under inter-agency safeguarding procedures should be reserved for individuals at highest level of risk;
- safeguarding teams should determine the level of vulnerability to establish guidelines around where an alert or notification should best be dealt with.

Any principles would be best discussed at a regional level. However, whichever regional forum takes this forward they would need to be mindful that all SABs would need to contribute fully to the debate. This could be a topic for discussion at our regional conference to disseminate our findings.

Recommendation 16
That SABs across the region agree a common set of overarching principles around thresholds for all partner agencies.

Who should be safeguarded?
In this report we have been guided by the ADASS definition around safeguarding adults,
“all work which enables an adult ‘who is or may be eligible for community care services’ to retain independence, wellbeing and choice and to access their human right to live a life that is free from abuse and neglect.”7

This definition specifically includes people who are assessed as being able to purchase all or part of their community care services, as well as those who are eligible for community care services but whose need is for access to mainstream services, such as housing, health services or the police.

Adult safeguarding work focuses on neglect, harm and abuse. It is also the duty of all agencies to protect the human rights of all citizens, regardless of whether or not they fit any safeguarding criteria. This includes, for example, ‘Article 3: the right not to be subjected to torture or to inhuman or degrading treatment or punishment’.8 Under this article there is a positive duty on the state to protect all people from abuse and approaches would indicate the threshold for this breach is lower for those who are vulnerable.

The Law Commission consultation proposes that the term ‘vulnerable adults’ should be replaced by ‘adults at risk’ to reflect the need to focus on the risks that a person faces rather than the characteristics of the person concerned. However on further analysis, the Law Commission’s proposals are, in effect, setting a two stage threshold in defining who needs to be safeguarded. They explain,

“In our view, an adult at risk should be defined by adopting a two-limbed approach. The first limb needs to describe in general terms who would fall within the remit of the definition. In our view, the first limb should be based on a person’s social care needs, rather than having eligible needs, being in receipt of services or diagnosed with a particular condition or disability. This would ensure that the duty to investigate would be wide ranging (and would include self-funders), while also ensuring that local social services responsibilities do not extend to, for example, those with health needs…..

The second limb of the definition would need to set out what the person is at risk from. Our view is that the threshold significant harm, which is currently used in No Secrets, In Safe Hands and the Children Act 1989, should be retained. Harm could be defined as ill-treatment or the impairment of health or development, or unlawful conduct, including specifically financial abuse. Significant should continue to be left undefined and left to interpretation.”9

In view of these proposals, partners across the region need to formulate a view about their preferred definition of safeguarding and vulnerability to anticipate the findings of the Law Commission’s consultation.

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7 ADASS (2005) Safeguarding Adults: A National Framework for Good Practice and Outcomes in Adult Protection Work
8 The Human Rights Act (1998)
Recommendation 17
Partners across the region need to formulate a view about their preferred definition of safeguarding and vulnerability in anticipation of the Law Commission’s findings.

What is a threshold?
Defining what might be meant by a ‘threshold’ is not an easy task. The Oxford Concise Dictionary (1995) provides five different definitions and in particular two merit consideration. The first definition describes a threshold as ‘a point of entry or beginning’ and this would seem to be a useful explanation. Using this definition, a threshold could be regarded as the point at which an individual or group of individuals enter the safeguarding adults process and signifies the boundary where the decision is made about whether or not to proceed further along the formal safeguarding process. This is, in effect, the approach that a number of safeguarding units take locally.

The second definition of threshold also provides a helpful clarification. This definition refers to, ‘a limit below which no reaction occurs’. Regardless of where a threshold is drawn, there should be no acceptance in the safeguarding arena that below any threshold no action (or reaction) should occur. Any decision about thresholds needs to consider not only the process once a threshold is reached, but conversely, what processes are required to support those adults who do not reach the threshold. All agencies still have a duty to protect all its citizens and consideration needs to be made about the processes on both sides of any threshold.

Recommendation 18
Guidance around thresholds should also identify an approach for those individuals who do not reach the safeguarding threshold.

This may seem a straightforward way forward. However, this fails to take account of the complexity of the practicalities of trying to determine whether or not a vulnerable adult is at risk of significant harm. There is also a view that by setting a threshold it takes away the context under which the alleged incident(s) have taken place. The issues posed in deciding if an incident should be reported as a safeguarding issue is rarely clear cut and so assessments will include multiple, and often conflicting, considerations.

Purpose of a threshold?
It is useful to consider what the purpose of a threshold might be because it is difficult to make an assessment of what a threshold should look like if its purpose is unclear.

A number of reasons are provided to support the need for a threshold. These include:
- a benchmark to assess the level of vulnerability of an individual;
- a measure of consistency;
- managing the demand around alerts and referrals;
- framework to allow agencies to manage risk.
Benchmark

The contention is that it without a benchmark or threshold it would be difficult to assess whether any action or intervention is required. Others, however, argue that these deliberations are primarily a matter of professional judgment and that an arbitrary line or threshold is of limited value.

Consistency

Most agree that there needs to be more consistency in the approach to safeguarding; appropriate thresholds are seen as a good way of achieving this. Is consistency of paramount importance? It is assumed that by having a threshold that is clearly explained in all policies and procedures, all agencies are able to act in a similar way in similar situations. Yet practitioners skilled in using their professional judgment may feel restricted by thresholds and be unable to consider issues of equity or inequality if they feel bound to act in a similar way to similar situations. For example, evidence suggests that men are less likely to report abuse or seek help from social services at an early stage so additional processes may need to be considered for some sections of the community.

An alternative approach might be to aim for consistency of decision-making. This would combine the need for consistency within the framework of professional judgment. This would need to be supported with a comprehensive training programme to ensure that staff are appropriately trained and skilled to be able to use their professional judgment.

Recommendation 19

NE ADASS should provide clear guidance around what type of consistency around thresholds they are aiming for adult safeguarding. Part of this also needs to consider the impact of thresholds on equity and inequality.

Managing alerts and referrals

Evidence suggests that setting a low threshold tends to open the gates to increased referrals, sometimes inappropriate ones. In our interviews in localities where thresholds are low, their experience suggests that a significant number of alerts or notifications are care management issues rather than safeguarding issues, for example, an alert about the cleanliness of a particular residential establishment needs to be addressed but it would not usually be appropriate for adult safeguarding to investigate. This said, those with low thresholds take the view that they prefer to keep thresholds low so they can be alerted to low level and repeated incidents. They do acknowledge, however, that having a low threshold does encourage alerts that are subsequently not processed through the safeguarding process.

Threshold continuum

It has been suggested that there may be justification for having a different threshold depending on the setting. Whether it is nursing or residential care, day care, paid staff in domiciliary settings, sheltered and supported housing or personal and family relationships some have made the point that the threshold needs to be lower...
depending on the likelihood and risk of abuse. This is based on the premise that a
decision to intervene will be determined partly by the context and environment where
the alleged abuse has occurred. Some would suggest that thresholds are already
different, e.g. the threshold for determining a safeguarding issue can be lower within
local authorities than NHS organisations and other partner organizations.

The complexity of safeguarding may be such that a threshold itself needs to be part of
a continuum. At one end there could be a very low threshold where all notifications are
encouraged whilst at the other end it is akin to the ‘Fair Access to Care’ thresholds.
Different sections of the continuum could relate to different environments and contexts.

**Recommendation 20**
The concept of a ‘threshold continuum’ should be explored further.

**Harm**
The two main definitions of harm, from ‘No Secrets’ and the Law Commission are:

“*harm* should be taken to include not only ill treatment (including sexual abuse
and forms of ill treatment which are not physical), but also the impairment of, or
an avoidable deterioration in, physical or mental health; and the impairment of
physical, intellectual, emotional, social or behavioural development*” \(^{10}\)

“*Harm could be defined as ill-treatment or the impairment of health or
development, or unlawful conduct, including specifically financial abuse.
Significant should continue to be left undefined and left to interpretation.*” \(^{11}\)

Although this may seem clear, most areas in the region use ‘significant harm’ in
deciding whether a threshold of abuse or neglect has been reached, rather than ‘harm’.
There needs to be a clear approach to the consideration of harm within the context of
adult safeguarding. Given that ‘significant’ is notoriously difficult to define, if ‘significant
harm’ is the preferred threshold, those working in safeguarding would benefit from
guidance around interpreting this, such as ensuring that any consideration also
includes the assessment of seriousness and risk.

**Seriousness**
Assessing the level of seriousness is a fundamental component of any threshold. In
determining the level of seriousness of the extent of harm or abuse, the ‘No Secrets’
guidance suggests that in making any assessment of seriousness the following factors
need to be considered:

- vulnerability of the individual;
- nature and extent of the abuse;
- length of time it has been occurring;

\(^{10}\) Department of Health (2000) No Secrets: Guidance on developing and implementing multiagency
policies and procedures to protect vulnerable adults from abuse

\(^{11}\) Law Commission
- impact on the individual;
- risk of repeated or increasingly serious acts to the individual or third party;
- wishes and feelings of the individual.

These factors are not contentious and most areas locally use these considerations when considering whether to investigate an incident.

Risk

Risk is an inevitable consequence of people taking decisions about their lives and different views of risk will be held between an individual, their family, supporters or carers and professionals. Risk has to be assessed both in terms of the likelihood of something happening as well as the impact which arises if it does actually happen.

Some have explained that this is about managing the risk for an individual. It is unclear, however, to what extent this is also seen as a quality assurance indicator for agencies involved with adult safeguarding. An alternative view is that the importance of managing risk for an organisation stems more from their risk averseness rather than encouraging informed risk taking.

A 2006 Government report\(^\text{12}\) called for a redefinition of society’s approach to risk management. This is relevant to the debates around adult safeguarding because it stressed the need for balancing necessary levels of protection with preserving levels of choice and control. Most agencies working within adult safeguarding would agree that the emphasis should not be on reducing risk to a minimum but is about striking a balance between empowering people to make choices while supporting them to take informed, everyday risks. This is often referred to as ‘reasonable’ risk.

Locally, several SABs have risk assessment tools that combine considerations around risk and seriousness. For example, Durham’s Risk Support Tool (see appendix 5) considers a range of factors including the vulnerability of the victim, the type of abuse, the impact on the individual and others as well as the extent of the abuse – very similar to the categories highlighted in ‘No Secrets’. Similarly, Newcastle’s Risk Assessment Management Plan (RAMP) is a risk assessment tool that serves a similar purpose. In Northumberland, the idea of positive risk taking has been explored as a way of taking a more proactive approach to risk.

Recommendation 21

If ‘significant harm’ becomes the favoured threshold, guidance should be developed that assists decision makers to make an assessment around how ‘significant’ might be interpreted, with reference to seriousness and risk.

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Risk enablement

Another approach gaining ground re-focuses risk around the concept of ‘Risk Enablement’.13 Risk enablement is about allowing people to make good choices, understand the consequences of their actions and take some responsibility for them. This involves a Risk Enablement Panel that explores the sharing of risk between a service user, their family, carers, professional care staff, third parties and the organisation. It can be used to resolve any issues about where the balance of risk should lie, explore how risk can be shared and support the resolution of disputes about risk sharing. It would also support the movement towards the personalisation agenda, encouraging greater control over their lives and making informed choices. It has also been suggested that an individual is less vulnerable if they are more in control.

**Recommendation 22**

Developing a risk enablement approach may help inform decisions around risk and risk management.

Poor practice or institutional abuse

Poor practice can cause harm and discomfort and can be a single or reoccurring act. Repeated instances of poor care may be an indication of more serious problems and was described in the ‘No Secrets’ guidance as institutional abuse. Poor care from unpaid supporters or relatives can be the result of ignorance, tiredness or stress. Nevertheless, all poor practice must be challenged and addressed, regardless of its source.

There is much existing guidance about what could constitute institutional abuse.14 It is more likely to occur where staff are inadequately trained, poorly supervised, not supported by management and have poor communication skills. Institutional abuse can involve more than one abuser and there might also be a number of people experiencing the same abuse e.g. hate crime against a particular group or several family members mistreating another family member.

The monitoring and management of poor practice from paid staff and organisations is the responsibility of the organisation or service provider, in particular the line manager of any staff member causing concern. Organisations and service providers should have procedures for identifying poor practice and for the management of poor practice. In addition, SABs need to consider how they assure themselves that all providers have policies and procedures for addressing poor practice.

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13 see Essex, Oldham and Newham as examples

14 Institutional abuse includes the mistreatment of people resulting from poor or inadequate care or support; it can also be systematic poor practice that affects the whole care setting. It can occur when an individual's wishes and need are overridden in favour of a service, an organisation or group. This may be manifested where there is a failure to respect or support a person or group's right to independence, dignity or choice. For example, a ritualised care routine, lack of flexibility in bed times or a lack of personal clothing or possessions could all be considered institutional abuse.
Recommendation 23
SABs need to consider how they quality assure that all providers have policies and procedures for addressing poor practice.

In relation to when poor practice becomes a safeguarding issue, Solihull NHS Care Trust\(^{15}\) gives useful guidance which suggests that poor practice becomes safeguarding if it:

- causes the victim significant and/or permanent harm;
- is deliberate or premeditated;
- is part of a pattern or culture;
- the duration and frequency of the poor practice is of concern;
- the victim’s perception is they are being abused or harmed.

Recommendation 24
For incidents that involve a possible poor practice issue, the following questions should be considered:

- has it caused the victim significant and/or permanent harm?
- is it deliberate or premeditated?
- is it part of a pattern or culture?
- what is the duration and frequency of the poor practice is of concern?
- what is the victim’s perception about whether they are being abused or harmed?

The provision of regular training is the best long term method of addressing the issues of poor performance. A number of safeguarding units have been good at providing extensive training for providers and other agencies. However, in the financial climate of public sector savings, providers need to be encouraged to develop their own training programmes, linked to recognised and accredited training providers to ensure quality.

Recommendation 25
Providers should be supported to develop their own training programmes linked to recognised accredited training providers.

Information sharing
The death of Steven Hoskin\(^{16}\) in 2006 prompted a serious case review, much of which focused on the need for good information sharing. It highlighted that although all agencies had legal responsibilities to prevent harm being by third parties, each agency dealing with Steven and his abuser focused on single issues within their own sectional remits. The review concluded that agencies did not make the connections required for the protection of vulnerable adults and by the No Secrets guidance.

\(^{15}\) http://www.solihull.nhs.uk/getmedia/a3cc2acd-6197-4d59-9216-7b5fd75b2001/Section-2--Principles---Definitions.aspx

\(^{16}\) http://www.cornwall.gov.uk/m_pdf/a_e_SCR_Executive_Summary1_Dec_2007_.pdf

Improving the Safeguarding of Adults in the North East
Richard Corkhill & Caron Walker, September 2010.

www.richardcorkhill.org.uk
The issue of information is crucial in the discussion around thresholds. In the consideration of whether a threshold is reached, it is essential that those making this decision have the full picture. As the Hoskin review clearly illustrated, it is difficult to assess the full picture if information is not being shared. It is for this reason that in considering thresholds, sharing of information across agencies must be integral. However, this can prove a difficult balance between sharing information and respecting a person’s right to confidentiality. For this reason it needs to be re-stated that information can only be shared on a ‘need to know’ basis when it is in the best interests of the vulnerable adult and that informed consent should be obtained whenever possible.

Many of the agencies involved in adult safeguarding, at an operational level, are good at sharing information between practitioners. However, not having formal information sharing agreements or protocols means that there is not a consistent regional approach. To improve information sharing, which sometimes needs to happen across geographical boundaries, a clear information sharing agreement across the region should be agreed.

**Recommendation 26**

A regional information sharing agreement should be developed that can be used across the region. It should be based on the good practice principles of a ‘need to know’ basis and informed consent.

**Language**

“It is inevitable that each agency has technical language, specific to their organisation or discipline. Terminology also develops as policy and practice develop and so meanings can change over time.”

From our review of policies and procedures used locally, it is clear that a number of different words are used to describe similar situations. In considering different SAB approaches even the basic terms ‘alert’ and ‘referral’ are accorded different meanings. For example, in relation to initial contacts around a possible safeguarding issue, some refer to this as an ‘alert’ whereas others immediately categorise this contact as a referral. In one SAB area, a ‘notification’ is used to describe a referral. SAB annual reports also reflect this variation as local activity around safeguarding is not uniformly reported; some count alerts, some count referrals and some count notifications.

This is also an issue in other parts of the country. The recent Northamptonshire Serious Case Review raised the issue of the confusing nature of language and that a lack of clarity can be confusing for those agencies at the centre of safeguarding procedures,

“There were a number of instances where terminology was not as clear as it could have been… The agencies need a better understanding of the language of priority that is being used in a multi agency setting. It can be confusing for
agency specific terms to be shared with partners, unless all parties are very clear on the meaning.”

As well as confusion for agencies who frequently work across local authority and health boundaries, the Northamptonshire report highlighted that it was unhelpful for members of the public who are encouraged to be mindful of safeguarding adults issues. In an attempt to address this, they concluded that,

“The agencies should, collectively, clarify …. use of language to express understandings of priority, risk and vulnerability”.¹⁹

Common language has been successfully used in some aspects of safeguarding adults. For example, in the No Secrets document there is a description of the different types of abuse and most SABs use these definitions in their documentation, namely,

- physical abuse
- sexual abuse
- psychological abuse
- financial or material abuse
- neglect and acts of omission
- discriminatory abuse.

A solution could be to develop a regional glossary of common language. For example, Liverpool has a glossary of common language around safeguarding children. A similar approach for the language around safeguarding adults could lead to more consistent understanding; improved inter-agency communication and cooperation; and - most importantly - better outcomes for vulnerable adults.

**Recommendation 27**

Develop a regional glossary of common language for use by all SABs.

**Setting a threshold**

Many attempts have been made to set appropriate thresholds for adult safeguarding (a number of examples can be seen in the appendix 6) but there is not one, uniform approach, so reflecting the difficulty in trying to achieve this. Several adult safeguarding leads acknowledged that the issue of thresholds was something they had not addressed. For example, although the Hoskin serious case review²⁰ highlighted the need for clear criteria and thresholds, the only thresholds identified were:

1. Any more than three presentations to accident and emergency or a minor injury unit by a vulnerable adult within a period of three months.
2. Any vulnerable adult who presents to accident and emergency or a minor injury unit having been assaulted or having taken an excess of drugs and/or alcohol.

¹⁹ Northamptonshire Safeguarding Adults (June 2010) Serious Case Review Executive Summary: Mr and Mrs Randall, p.12
²⁰ [http://www.cornwall.gov.uk/m_pdf/a_eSCR_Executive_Summary1_Dec_2007_.pdf](http://www.cornwall.gov.uk/m_pdf/a_eSCR_Executive_Summary1_Dec_2007_.pdf)
In Northamptonshire, their procedures stress the need for establishing clearer ‘thresholds’ and providing standardised screening with the express intention of reducing the numbers of cases investigated and managed under interagency safeguarding procedures. They have a screening toolkit but also acknowledge the need for professional judgments. As part of their decision making process they highlight the need for:

- greater distinction between a notification (alert) and the decision to take a case forward for investigation under safeguarding procedures;
- decision to proceed/not proceed as a safeguarding investigation, requires a clear risk assessment applying standardised criteria/thresholds.

Similarly, in Worcestershire they have built on work undertaken by children’s safeguarding and have constructed what they describe as thresholds guidance for practitioners. Like many authorities, they identify a number of tiers that increase in seriousness and level of harm. Their guidance around each tier of their thresholds (see appendix 6) can be described as follows:

<table>
<thead>
<tr>
<th>Tier 5</th>
<th>Serious Case Review</th>
<th>Very serious incident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 4</td>
<td>Adult protection level 2/3</td>
<td>Higher level of risk of significant harm</td>
</tr>
<tr>
<td>Tier 3</td>
<td>Adult protection level 1</td>
<td>Low to medium levels of harm</td>
</tr>
<tr>
<td>Tier 2</td>
<td>Complaints</td>
<td>About poor quality rather than abuse</td>
</tr>
<tr>
<td>Tier 1</td>
<td>Universal services</td>
<td>Internal investigation</td>
</tr>
</tbody>
</table>

Although these tiers seem fairly prescriptive, at the beginning of the Worcestershire guidance document they state,

“All staff must exercise their own professional judgment when using guidelines. However any decision to vary from the guideline should be documented on Framework to include the reason for variance and the subsequent action taken.”

Similarly, we would conclude that a tiered approach to thresholds is a reasonable approach, although this must be underpinned by the autonomy for practitioners to exercise their professional judgement.

**Recommendation 28**

Any threshold should be tiered but must allow for practitioners to use their professional judgment in reaching a decision about whether to pursue an investigation.

**Optimum model for thresholds**

In conclusion, we have not identified one approach to thresholds that would provide an optimum model for thresholds. However, we consider that any move towards a regional approach to thresholds requires the following elements:

- common set of overarching principles;
- a common definition of vulnerability;
- common approach to consistency;
- a consideration of a threshold continuum;
- an assessment of ‘harm’ or ‘significant harm’ and which should be used;
- a tiered approach to different levels of thresholds.

This also needs to be supported by:
- guidance around how to deal with those not meeting the threshold;
- a possible risk enablement approach;
- systems for identifying poor practice;
- accredited training programmes in provider agencies;
- regional information sharing agreement;
- glossary of common language.

We envisage this would be the starting point for discussion at the regional conference.
## APPENDIX 1: Summaries of Adult Safeguarding arrangements by area

### Local Authority: Gateshead

<table>
<thead>
<tr>
<th>1) Safeguarding Adults Board arrangements:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chair &amp; Membership:</strong></td>
<td>Director of Adult Services – no independent chair</td>
</tr>
<tr>
<td></td>
<td>Council Adult Care Assessment and Commissioning Services, Adult Provider Services, Community Safety and Drugs, the Housing Company, Northumbria Police, National Probation Service, NHS South of Tyne &amp; Wear and Northumberland, Tyne &amp; Wear Mental Health Trust, Gateshead Hospital NHS Trust, Carers Association, Tyne and Wear Care Alliance, Advocacy in Gateshead and Care Quality Commission.</td>
</tr>
<tr>
<td><strong>Frequency of meetings:</strong></td>
<td>?</td>
</tr>
<tr>
<td><strong>Service user representation:</strong></td>
<td>No individual representatives but voluntary sector reps on Board</td>
</tr>
<tr>
<td><strong>Other observations including good practice examples / key learning points:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2) Safeguarding policy / procedure:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date of latest revision:</strong></td>
<td>May 2010 (12 step guide)</td>
</tr>
<tr>
<td><strong>Other observations including good practice examples / key learning points:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3) Service delivery arrangements:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LA specialist adult safeguarding resources:</strong></td>
<td>Safeguarding Adults Manager</td>
</tr>
<tr>
<td></td>
<td>2 x senior practitioners + 2 temporary practitioners</td>
</tr>
<tr>
<td></td>
<td>2.5 x Admin (do minute taking)</td>
</tr>
<tr>
<td><strong>Other specialist resources:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Number of referrals:</strong></td>
<td>2007-8 264 alerts recorded (2006-7 213)</td>
</tr>
<tr>
<td></td>
<td>36% related to older people; 35% related to adults with a learning disability; 13% related to adults with mental health issues</td>
</tr>
<tr>
<td><strong>Other observations including good practice examples:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4) Approaches to thresholds:

<table>
<thead>
<tr>
<th>Any models / tools / protocols used:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- used narrow definition of vulnerable adult – used No Secrets definition</td>
</tr>
<tr>
<td>- since Partnership think of it as wider definition – broadened it out</td>
</tr>
</tbody>
</table>

**Other observations including good practice examples:**
- Need full picture to make a decision about whether or not a safeguarding issue – so need for information sharing
- About all processes
- Need to consider risk enablement aspects and empowerment
- Organisations not sufficiently skilled around prevention

5) User involvement:

<table>
<thead>
<tr>
<th>Approaches used to involve &amp; engage service users / user led organisations at a strategic planning level:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- good consultation with older people through the Older Peoples’ Assembly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Approaches used to involve service users at individual case level:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Beginning to involve in strategy and planning meetings</td>
</tr>
</tbody>
</table>

**Other observations including good practice examples:**
- Used Experts by Experience as part of CQC Inspection

6) CQC Inspections:

<table>
<thead>
<tr>
<th>Dates of last CQC adult safeguarding inspection and any follow up:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
</tr>
</tbody>
</table>

**Summary of inspection ratings:**
- Performing ‘poorly’ for safeguarding adults
- Performing ‘adequately’ in improving health and well being
- Capacity to improve ‘uncertain’
### Local Authority: Newcastle

#### 1) Safeguarding Adults Board arrangements:

| Chair & Membership: | Independent Chair  
| Newcastle City Council, NHS North of Tyne, Northumberland, Tyne and Wear NHS Trust, Northumbria Police, National Probation Service, NHS Newcastle and North Tyneside Community Health, Newcastle upon Tyne Hospitals Foundation NHS Trust, Age Concern, Victim Support, Skills for People, Care Quality Commission |
| Frequency of meetings: | Bi-monthly |
| Service user representation: | No service user rep on the Board – but Age Concern and Skills for People members of Board |

**Other observations including good practice examples / key learning points:**
- Have three sub groups: ① Learning & Development Committee ② Improving Practice and Service Review Committee ③ SCR Sub Committee
- Provides inter-agency training, including training for Durham and Northumbria Police forces
- Reports to Wellbeing and Health Partnership so brings people together and improve governance

#### 2) Safeguarding policy / procedure:

| Date of latest revision: | February 2009 |

**Other observations including good practice examples / key learning points:**
- Criteria used “all adults who are aged 18 and over, who are or may be eligible for receiving community care services, and whose independence and well-being would be at risk if they did not receive appropriate health and social care support.”
- Has agency step-by-step guide (February 2009)
- Use Risk Assessment & Management Plan (RAMP)
- Have inter-agency procedures that all partners and other agencies signed up with

#### 3) Service delivery arrangements:

| LA specialist adult safeguarding resources: | Safeguarding Adults Coordinator  
| 3 Safeguarding Adults Team Managers  
| Safeguarding Information Officer  
| 3 x Safeguarding Minute takers  
| Safeguarding Performance and Development Officer  
| Safeguarding Assistant Performance and Development Officer |
| Other specialist resources: | Have own learning and development officer  
| Have someone with a health background as part of specialist unit |
Part fund a lead nurse to support specialist safeguarding unit
Have dedicated sergeant and two other officers from Northumbria Police
Unit has good links with contracting and commissioning within the local authority

<table>
<thead>
<tr>
<th>Number of referrals: 2008-9</th>
<th>824 ‘alerts’ (2007-8 561)</th>
</tr>
</thead>
<tbody>
<tr>
<td>50% of alerts were relating to older people; 21% related to adults with a learning disability; 14% related to adults with mental health issues</td>
<td></td>
</tr>
<tr>
<td>Also 60 ‘cause for concern’ referrals</td>
<td></td>
</tr>
</tbody>
</table>

Other observations including good practice examples:
- Well resourced team
- Central point of contact
- Also responsible for Mental Capacity Act and Deprivation of Liberty Safeguards
- Support Newcastle Society for Blind People to develop awareness and support around elder abuse

4) Approaches to thresholds:

Any models / tools / protocols used:

Other observations including good practice examples:
- Strong emphasis on prevention, “It is far better to put in place strategies to minimise the likelihood of abuse occurring – preventative strategies – than to deal with abuse after it has happened. Therefore, each of the Newcastle Safeguarding Adults Board members will commit themselves to the prevention of abuse and neglect in the development of their own planning and commissioning processes, as well as within direct service delivery.” (Policy 2009)

5) User involvement:

Approaches used to involve & engage service users / user led organisations at a strategic planning level:
- IDeA coming in November to look at service user involvement

Approaches used to involve service users at individual case level:
- Not involved in strategy meeting but involved and supported at planning meetings and reviews

Other observations including good practice examples:
- Commissioned a media group of service users with a learning disability to produce a DVD to assist service users to understand forms of abuse and safeguarding process. Submitted it to DH as part of the ‘No Secrets’ consultation.
- Created pictorial chart of feedback for the ‘No Secrets’ consultation

6) CQC Inspections: Not been inspected
### Local Authority: North Tyneside

#### 1) Safeguarding Adults Board arrangements:

| Chair & Membership: | Independent Chair  
|                     | North Tyneside Adult Social Care, Lead Cabinet Member for Adult Social Care, North Tyneside Homes, Northumbria Health Care NHS Foundation Trust, Northumberland, Newcastle and North Tyneside Mental Health Trust, North Tyneside Primary Care Trust, Northumbria Police Protection Unit, Probation, VODA (voluntary sector), Care Quality Commission (CQC) |
| Frequency of meetings: | Bi-monthly |
| Service user representation: | No service user on Board |
| Other observations including good practice examples / key learning points: | ▪ Have three sub groups: ① Training Group ② Performance Monitoring Group ③ SCR Group  
   ▪ Reports into the Local Strategic Partnership, through the Health and Wellbeing Board and the Crime and Disorder Reduction Board, to ensure a clear focus in terms of the key roles of safeguarding and prevention |

#### 2) Safeguarding policy / procedure:

| Date of latest revision: | June 2008 |
| Other observations including good practice examples / key learning points: | ▪ criteria used: safeguard adults, aged 18 years and over, who are or “may be eligible for community care services”, whose independence and wellbeing would be at risk if they did not receive appropriate health and social care support, and who due to disability or illness may not be able to effectively protect themselves from abuse or neglect or seek support (adapted from Law Commission and DOH No Secrets). This definition will include all those who are funding their own care. |

#### 3) Service delivery arrangements:

| LA specialist adult safeguarding resources: | Strategic Lead for Safeguarding Adults  
|                                            | Safeguarding Coordinator  
|                                            | 3 x Senior Social Workers  
|                                            | Admin Worker  
| Other specialist resources: |  
| Number of referrals: | 2008-9 received 731 referrals. Dealt with 32% (234) at initial stages; remaining 68% (497) proceeded further within the safeguarding process.  
   - Highest proportion of concerns were for frail vulnerable adults 36% (262), and people with poor mental health 25% (185)  
   - 1 SCR and 2 Management Reviews |
- Provide training and support
- Part of commissioning service so work closely with them
- Work closely with NHS partners, including hospital trust
- 2 police who do safeguarding

**Other observations including good practice examples:**
- Member of safeguarding team chairs Finance Panel that investigates financial abuse
- Involved in preventative work around drugs and alcohol; also partner in the Integrated Care Pilot for Falls

### 4) Approaches to thresholds:

**Any models / tools / protocols used:** Strategic Lead considering issue of thresholds

**Other observations including good practice examples:**
- Subjective judgment – also depends on capacity of an individual
- When consideration whether to intervene, professional needs to take into consideration:
  - Does the individual meet the criteria of a vulnerable adult and what level of vulnerability that person is experiencing?
  - Is that person open to harm or exploitation and over what period of time has this been occurring?
  - Is intervention in that person’s best interests or in the interests of the public?
  - Is the person able to protect against significant harm or exploitation?
- Lead officer will also consider:
  - The level of threat to independence for the vulnerable adult
  - The impact on all areas of well being of the vulnerable adult
  - The duration and frequency of the alleged abuse
  - The level of support required in daily living and personal care and what is provided by the alleged perpetrator
  - The environment where the alleged abuse has taken place
  - Whether the alleged abuse was premeditated

### 5) User involvement:

**Approaches used to involve & engage service users / user led organisations at a strategic planning level:**
- Go out to area Fora and have a DVD that is used

**Approaches used to involve service users at individual case level:**
- Not involved in strategy meeting but supported at other stages to be involved
- System in place to obtain feedback from people who have experienced abuse
- More effectively monitor the outcomes for people through feedback

**Other observations including good practice examples:**
- Good examples of case studies in Annual Report

### 6) CQC Inspections:

Not been inspected
### Local Authority: Northumberland

#### 1) Safeguarding Adults Board arrangements:

<table>
<thead>
<tr>
<th>Chair &amp; Membership: Independent Chair Northumberland County Council (NCC), Community Safety NCC, Northumberland Care Trust (NCT), NHS North of Tyne, Northumbria Healthcare NHS Foundation Trust, Northumberland, Tyne &amp; Wear NHS Trust, Fire &amp; Rescue Service NCC, Supporting People, Housing NCC, Children’s Safeguarding NCT, Solicitor NCT, Contracts &amp; Safeguarding NCT, Northumbria Police, Probation Service, Age Concern, Victim Support, Spiral Skills Advocacy, independent providers (3), Care Quality Commission, Elected Member</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency of meetings:</strong> At least 6 times a year.</td>
</tr>
<tr>
<td><strong>Service user representation:</strong> 2 service users on Board – need to improve support for them</td>
</tr>
<tr>
<td><strong>Other observations including good practice examples / key learning points:</strong></td>
</tr>
<tr>
<td>▪ On Board have full and associate members</td>
</tr>
<tr>
<td>▪ Have four sub groups: ① Policy, Procedures &amp; Protocols ② Training ③ Communication and Publicity ④ SCR</td>
</tr>
</tbody>
</table>

#### 2) Safeguarding policy / procedure:

<table>
<thead>
<tr>
<th><strong>Date of latest revision:</strong> February 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other observations including good practice examples / key learning points:</strong></td>
</tr>
<tr>
<td>▪ Safeguarding given high profile in domestic violence awareness material</td>
</tr>
<tr>
<td>▪ Paper-free system for referrals via Swift – to assist data collection</td>
</tr>
</tbody>
</table>

#### 3) Service delivery arrangements:

<table>
<thead>
<tr>
<th><strong>LA specialist adult safeguarding resources:</strong> Strategic Manager Team Manager 4 x safeguarding officers (at practitioner level) Administrator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other specialist resources:</strong> 2 Learning Disability Partnership members who work alongside Safeguarding Adults officers</td>
</tr>
<tr>
<td><strong>Number of referrals:</strong> 2009-10 there were 830 alerts of which 61% were related to older people and 23% to people with learning disabilities. During this period there were 405 closures.</td>
</tr>
<tr>
<td>▪ No SCR but 1 management review</td>
</tr>
<tr>
<td><strong>Other observations including good practice examples:</strong></td>
</tr>
<tr>
<td>▪ primarily a support service</td>
</tr>
<tr>
<td>▪ deal with particularly complex cases</td>
</tr>
</tbody>
</table>
- well embedded in care management
- have early intervention approach with independent providers by providing support and advice - built trust

### 4) Approaches to thresholds:

**Any models / tools / protocols used:**
- Core position - use ADASS statement as this is a duty
- Also look at cases coming through and do use discretion depending on circumstances

**Other observations including good practice examples:**
- Criteria: ‘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 (‘No Secrets..’, DH 2000).
  
  Unpaid carers could themselves also be vulnerable adults.
- Developed a paper around positive risk taking

### 5) User involvement:

**Approaches used to involve & engage service users / user led organisations at a strategic planning level:**
- no routine feedback from service users but started to do this with people who have experienced safeguarding process

**Approaches used to involve service users at individual case level:**
- Supported to participate in process
- If individual not in attendance, reasons recorded

**Other observations including good practice examples:**

### 6) CQC Inspections: Not been inspected
**Local Authority:** South Tyneside

1) **Safeguarding Adults Board arrangements:**

**Chair & Membership:** Chaired by Executive Director – looking to appoint an independent chair
South Tyneside Adult Services, South Tyneside NHS Foundation Trust, NHS South of Tyne, North East Ambulance Service, South Tyneside Homes, Northumbria Police, South Tyneside Probation, South Tyneside Council Neighbourhood Services, South Tyneside Council Legal Services, Care Quality Commission, Bliss+ability

**Frequency of meetings:** Bi-monthly

**Service user representation:** No service user representation on Board but Bliss+ability on Board

**Other observations including good practice examples / key learning points:**
- Have four sub groups: ① Policy & Procedure Review ② Training ③ Reflective Practice ④ SCR
- Lead member on Board; also OSC done some work on safeguarding so pushed up elected members’ agenda

2) **Safeguarding policy / procedure:**

**Date of latest revision:** February 2009

**Other observations including good practice examples / key learning points:**
- Detailed policy framework
- Adoption of information protocol

3) **Service delivery arrangements:**

**LA specialist adult safeguarding resources:**
1 strategic safeguarding and risk manager
2 x safeguarding managers (chair meeting)
1 information officer
1 minute taker
1 admin staff
Hoping to secure manager

**Other specialist resources:**

**Number referrals:**
- 2008-9 received 294 referrals. Dealt with 32% (234) at initial stages; remaining 68% (497) proceeded further within the safeguarding process.
  - highest proportion of concerns were for older people 56% and people with learning disabilities 25%.
- 2 SCRs since 2007: 1st completed - recommendations included establishment of Unit; policies and processes strengthened
### 4) Approaches to thresholds:

**Any models / tools / protocols used:**

Criteria: 18 years and over and who are, or may be, eligible to receive support from social care or health services and who may be unable to take care of themselves, or be unable to protect themselves against serious harm or exploitation and whose independence and well-being would be, or is, at risk if they did not receive appropriate health or social care support.

**Other observations including good practice examples:**
- Has threshold guidance flowchart
- Use significant harm threshold
  - Use that to override right to choice
  - Would implement process

### 5) User involvement:

**Approaches used to involve & engage service users / user led organisations at a strategic planning level:**
- Service user representation on some sub-groups, e.g. Personalisation
- Reports regularly to Learning Disability Federation, Mental Health Local Implementation Team, Older Peoples Group

**Approaches used to involve service users at individual case level:**
- May let carer be involved in strategy meeting
- Very rarely have perpetrator in safeguarding meeting

**Other observations including good practice examples:**

### 6) CQC Inspections:

**Dates of last CQC adult safeguarding inspection and any follow up:** May 2009

**Summary of inspection ratings:**
- Performance 'adequate' for safeguarding adults
- Delivery of personalised services for older people 'good'
- Capacity to improve 'uncertain'
Local Authority: Sunderland

1) Safeguarding Adults Board arrangements:

<table>
<thead>
<tr>
<th>Chair &amp; Membership:</th>
<th>Just appointed Independent chair (formerly chaired by Head of Adult Services)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health, Housing and Adult Services, City Solicitors, Sunderland Housing Group, Safer Sunderland Partnership, Children’s Services, Community Mental Health Partnership, City Hospitals Sunderland, NHS South of Tyne and Wear, Northumberland Tyne &amp; Wear NHS Trust, Northumbria Police, Northumbria Probation, advocacy services, independent providers, Sunderland CVS, Care Quality Commission</td>
</tr>
<tr>
<td>Frequency of meetings:</td>
<td>?</td>
</tr>
<tr>
<td>Service user representation:</td>
<td>No service users on Board</td>
</tr>
<tr>
<td>Other observations including good practice examples / key learning points:</td>
<td>Have 5 sub groups (some new): ① Policies and Procedures ② Training ③ Quality Assurance (formerly Reflective Practice) ④ Marketing and Communications ⑤ SCR</td>
</tr>
</tbody>
</table>

2) Safeguarding policy / procedure:

| Date of latest revision: | April 2007 |
| Other observations including good practice examples / key learning points: | Model used was developed in 1998 – were ahead of the agenda – worked well at that time  |
|                        | All agencies deal with allegations of abuse and manage the investigation on a multi-agency basis |
|                        | - can provide an independent chair for investigations |

3) Service delivery arrangements:

| LA specialist adult safeguarding resources: | (new structure) Strategic Manager |
|                                            | Implementation Manager (currently vacant) |
|                                            | 3 x Safeguarding Practitioners (2 currently vacant) |
|                                            | 2 x Business Support Assistant |
| Other specialist resources: | PCT contribute 50% of costs of safeguarding team |
|                            | Joint Council / PCT training programme |
|                            | 24 hour safeguarding adults helpline |
| Number of referrals: | 2008-9 received 555 ‘notifications’ to the Safeguarding Adults Team; 473 for 2007-8 |
|                        | - highest proportion of notifications were for people with learning disabilities 42% and older people 34%.
About to start first SCR

Other observations including good practice examples:
- Central point of contact for advice
- Extensive training programme
- Have regular meetings with providers

4) Approaches to thresholds:

Any models / tools / protocols used:
- Comprehensive procedural framework

Other observations including good practice examples:
- Set threshold very low so that everyone would provide notifications
- Aim for consistency partly via threshold and partly through consistency of decision making (importance of training)

5) User involvement:

Approaches used to involve & engage service users / user led organisations at a strategic planning level:
- people with learning disabilities instrumental in developing new programme of support with strong focus on anti-bullying and awareness raising around keeping safe

Approaches used to involve service users at individual case level:
- recently undertaken an exercise to obtain feedback from a sample of people who have been through safeguarding process

Other observations including good practice examples:
- Have safeguarding adults complaints procedure

6) CQC Inspections:

Dates of last CQC adult safeguarding inspection and any follow up: January 2010

Summary of inspection ratings:
- Performance ‘adequate’ for safeguarding adults
- Performing ‘adequately’ in promoting choice and control for older people
- Capacity to improve ‘promising’
**Local Authority:** DURHAM

1) **Safeguarding Adults Board arrangements:**

<table>
<thead>
<tr>
<th>Chair &amp; Membership:</th>
<th>Chaired by Durham C.C. Head of Adult Services – no independent Chair.</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Council:</td>
<td>Safeguarding Practice &amp; Development Manager; Head of Safeguarding (Children’s Services); Senior Development Officer for Safeguarding Adults; Head of Housing; Elected Council Member.</td>
</tr>
<tr>
<td>Partner agencies:</td>
<td>Tees, Esk &amp; Wear Valley NHS Trust; Durham Age Concern &amp; LINk; Durham Tees Valley Probation Trust; Durham Police; Co Durham &amp; Darlington Community Health Services; Co Durham &amp; Darlington Foundation Trust; Victim Support; CQC</td>
</tr>
<tr>
<td>Frequency of meetings:</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Service user representation:</td>
<td>Via Age Concern; Victim Support; LINk</td>
</tr>
<tr>
<td>Other observations including good practice examples / key learning points:</td>
<td>The SAB has 4 sub-groups which focus on: Performance; Policy &amp; Practice; Training; Communications. Very clear terms of reference for the SAB and sub groups. SAB membership at appropriately senior level, though actual attendance is sometimes delegated. No representation from Benefits Agency.</td>
</tr>
</tbody>
</table>

2) **Safeguarding policy / procedure:**

| Date of latest revision: | Dec 2008 (policy statement and supplementary guidance. |
| Other observations including good practice examples / key learning points: | Policy and supplementary guidance documents each colour coded, which helps ensure clarity of purpose of respective documents. Dedicated Safeguarding Adults website, easily navigated for professional or public use. (www.safeguardingdurhamadults.info) |

3) **Service delivery arrangements:**

<table>
<thead>
<tr>
<th>LA specialist adult safeguarding resources:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Safeguarding Practice &amp; Development Manager (Lee)</td>
<td></td>
</tr>
<tr>
<td>▪ Dedicated Safeguarding Communication and Training Officer</td>
<td></td>
</tr>
<tr>
<td>▪ Safeguarding Practice Officer</td>
<td></td>
</tr>
<tr>
<td>▪ 2 Social Workers at senior practitioner level</td>
<td></td>
</tr>
<tr>
<td>▪ 2 Nurses employed by PCT, seconded to LA</td>
<td></td>
</tr>
<tr>
<td>▪ O.T. senior practitioner (currently temporary position)</td>
<td></td>
</tr>
<tr>
<td>▪ Dedicated admin</td>
<td></td>
</tr>
</tbody>
</table>

Team structure currently under review, to include possibility of making OT position permanent and re-defining roles / responsibilities of some other posts.

| Other specialist resources: | Durham Police have a 2 specialist Vulnerability Units (North and South areas) which include adult abuse investigation |

Improving the Safeguarding of Adults in the North East

Richard Corkhill & Caron Walker, September 2010.

www.richardcorkhill.org.uk
teams. They are each led by a Detective Inspector, with senior and strategic overview by a Chief Inspector who is a member of the SAB

- **County Durham & Darlington Community Health Services** (NHS provider – due to merge with Co Durham & Darlington Health Trust) employ a Lead Manager for Safeguarding who is a member of the SAB and has close working links with the Strategic Health Authority.
- **Tees, Esk & Wear Valley NHS Foundation Trust** employs a Lead Senior Nurse for Safeguarding, who is also a member of the SAB.

Other observations including good practice examples:
- The L.A. team is well resourced compared to other local authorities in this region and as result are able to work very pro-actively with a strong prevention agenda. This pro-active work is mainly with residential care services in the county.
- Also as a result of resource levels, safeguarding team can work pro-actively on wider adult care issues, including development of personalisation agenda – i.e. high level of integration of safeguarding as part of adult social care’s core business activity.
- Police Vulnerability Units and LA Safeguarding have good communication / links / joint agency working
- Dedicated Safeguarding website with easy access to policy / guidance documents for professionals and information for general public

4) Approaches to thresholds:

Any models / tools / protocols used: They use a standardised risk assessment tool, developed locally (See appendix 5)

Other observations including good practice examples:
The risk assessment tool includes guidance and practice examples which assist professional decision making, including guidance on circumstances which may indicate responses other than a formal safeguarding referral.

5) User involvement:

Approaches used to involve & engage service users / user led organisations at a strategic planning level: User representation on the SAB is from a manager employed by Age Concern who is also involved with the Voice Network and Durham LINk. But has only recently joined SAB, so impact so far is limited.

Approaches used to involve service users at individual case level: There is a target to carry out audit interviews with at least 50 service users / carers per year who have been part of formal safeguarding processes. Experiencing some challenges in getting high enough proportion of user to agree to engage with audit process. Also some concern that those who do agree may not be representative cross section.

6) CQC Inspections:

Dates of last CQC adult safeguarding inspection and any follow up: Have not had a CQC inspection
<table>
<thead>
<tr>
<th><strong>Local Authority:</strong> DARLINGTON</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1) Safeguarding Adults Board arrangements:</strong></td>
</tr>
<tr>
<td><strong>Chair &amp; Membership:</strong> Chaired by Director of Community Services. No independent Chair, but option under consideration. Darlington B.C Safeguarding Adults Team Manager; Darlington B.C. Children’s Services; Durham Police; Durham Tees Valley Probation Trust; Co. Durham &amp; Darlington PCT – Commissioning; Co Durham &amp; Darlington Community Health Service; County Durham &amp; Darlington NHS Foundation Trust; CQC.</td>
</tr>
<tr>
<td><strong>Frequency of meetings:</strong> Quarterly</td>
</tr>
<tr>
<td><strong>Service user representation:</strong> No representation at Board level</td>
</tr>
<tr>
<td><strong>Other observations including good practice examples / key learning points:</strong> There are 4 sub groups which report to the SAB: Policy &amp; Implementation; Support and Learning; Communication; Quality and Performance. Each sub group has written terms of reference. Learning from a Serious Case Review resulted in review of systems / communication / data recording</td>
</tr>
<tr>
<td><strong>2) Safeguarding policy / procedure:</strong></td>
</tr>
<tr>
<td><strong>Date of latest revision:</strong> 2008</td>
</tr>
<tr>
<td><strong>Other observations including good practice examples / key learning points:</strong></td>
</tr>
<tr>
<td><strong>3) Service delivery arrangements:</strong></td>
</tr>
<tr>
<td><strong>LA specialist adult safeguarding resources:</strong> Team Manager for safeguarding; MCA &amp; DoLS; Senior Practitioner; Support Worker (training) Support Worker (DoLS); Admin support.</td>
</tr>
<tr>
<td><strong>Other specialist resources:</strong></td>
</tr>
<tr>
<td>- Durham Police Vulnerability Unit</td>
</tr>
<tr>
<td>- County Durham &amp; Darlington Community Health Services (NHS provider – due to merge with Co Durham &amp; Darlington Health Trust) employ a Lead Manager for Safeguarding who is a member of the SAB and has close working links with the Strategic Health Authority.</td>
</tr>
<tr>
<td><strong>Other observations including good practice examples:</strong> Alerter Training provided for Council Members. Team developed key roles following CQC inspection findings in 09.</td>
</tr>
<tr>
<td><strong>4) Approaches to thresholds:</strong></td>
</tr>
<tr>
<td><strong>Any models / tools / protocols used:</strong> Standardised risk assessment tool, adapted from that used in Durham</td>
</tr>
<tr>
<td><strong>Other observations including good practice examples:</strong></td>
</tr>
</tbody>
</table>
### 5) User involvement:

**Approaches used to involve & engage service users / user led organisations at a strategic planning level:**
No user ongoing involvement at SAB level. Aiming to improve this through with sub group activity, but at early stages.

**Approaches used to involve service users at individual case level:**
No specific approach or procedure

**Other observations including good practice examples:**

### 6) CQC Inspections:

**Dates of last CQC adult safeguarding inspection and any follow up:** August 09. (Followed up March 2010)

**Summary of inspection ratings:** Performing Adequately with promising capacity to improve. (Happy with progress at follow up)

**Key learning points from inspections:** Importance of good quality record keeping with robust management and oversight; partnership work with Police and effective referral / communication systems. Need for broad multi agency training delivery strategy;
### Local Authority: MIDDLESBOROUGH

#### 1) Safeguarding Adults Board arrangements:  
*Teeswide SAB (Middlesbrough, Redcar & Cleveland, Hartlepool, Stockton)*

**Teeswide Chair:** Currently, Hartlepool Director of Adult Services. (Rotates on annual basis between the adult care directors of the 4 local authorities)

**Teeswide Membership:** Hartlepool Council; Middlesbrough Council; Redcar & Cleveland Council; Stockton-on-Tees Council; Cleveland Police; Tees, Esk & Wear Valleys NHS Foundation Trust; South Tees Hospitals NHS Foundation Trust; North Tees & Hartlepool NHS Foundation Trust; Middlesbrough and Redcar and Cleveland Community Services; NHS Hartlepool; NHS Middlesbrough; NHS Redcar & Cleveland; NHS Stockton-on-Tees; Department of Work and Pensions; Teesside Probation Board; Care Quality Commission; Crown Prosecution Service

**Frequency of meetings:** Bi monthly

**Service user representation:** No User representation at Teeswide SAB level, to date. But LINk recently invited

**Other observations including good practice examples / key learning points:**

Teeswide SAB has only been operating since Nov 2009, so it is early to draw firm conclusions on benefits of sub-regional SAB arrangements. But early feedback is mostly positive. Benefits include: Consistency of policy, practice and training across 4 LA areas; Senior executives of SAB partner agencies which work across Teesside attend 1 SAB instead of 4; Economies of scale – e.g. purchase and delivery of multi-agency training.

Some concern expressed that the local committees in each LA may duplicate work of SAB, so it is important that the local committees focus on local implementation of Teeswide policy / procedure and provide feedback loop to enable the SAB to fulfil strategic functions.

#### 2) Safeguarding policy / procedure:

**Date of latest revision:** Teeswide procedure: November 08

**Other observations including good practice examples / key learning points:**

Teeswide procedure has major benefits from perspective of partner agencies including police / PCTs & NHS trusts which operate across the 4 LA boundaries but are dealing with only one multi-agency policy / procedure.

#### 3) Service delivery arrangements:

**LA specialist adult safeguarding resources:** 1 Full Time Safeguarding Strategic Lead plus 1 part time (4days) Adult Protection Coordinator. (Operational lead) and admin support. Safeguarding strategy meeting usually chaired / coordinated by adult care team managers, but Coordinator may take on role for more complex cases, or where there are capacity issues for adult care teams.

**Other specialist resources:** Cleveland Police Vulnerability units (Include Child Protection and Domestic Violence as well as Vulnerable Adults)
Other observations including good practice examples:
Middlesbrough commissioned an independent review of their approach to safeguarding vulnerable adults, about 3 years ago. This highlighted need for clearer definition and separation of strategic and operational roles/ responsibilities, leading to current structure. As a result, there is less “fire-fighting” and more pro-active safeguarding at operational end, plus more multi-agency involvement/ commitment.

4) Approaches to thresholds:
Any models/ tools/ protocols used: Standardised risk assessment tool, adapted from that used in Durham

5) User involvement:
Approaches used to involve & engage service users/ user led organisations at a strategic planning level:
- Mainly done through existing Partnership Boards for Older People and Learning Disability.
- Issue of how to ensure user representation on adult protection committee.
- LINks invited to be members of Teeswide SAB

Approaches used to involve service users at individual case level:
- Recognition of need for more work to promote support for service users to be more actively informed/ involved/ engaged with safeguarding procedures

6) CQC Inspections:
Dates of last CQC adult safeguarding inspection and any follow up: Report May 2010
Summary of inspection ratings: Performing well/ promising capacity to improve
Key learning points from inspections:
- Importance of wider community safety work on issues such as hate crime – indicates CQC take a very broad view on the concept of Safeguarding
- Importance of demonstrating not just process/ procedure, but outcomes – has the intervention resulted in prompt action which has protected the person from harm?
- Emphasis on issues of mental capacity and ability to deal with complex legal issues.
- Importance of sound foundation training for staff within council and delivered to provider agencies.
- Joint work with social care contracting functions is a key element of successful safeguarding for vulnerable in receipt of service commissioned by the local authority – both in terms of monitoring function and promotion of quality services.
### Local Authority: REDCAR & CLEVELAND

#### 1) Safeguarding Adults Board arrangements: Teeswide SAB (Middlesbrough, Redcar & Cleveland, Hartlepool, Stockton)

**Teeswide Chair:** Currently, Hartlepool Director of Adult Services. (Rotates on annual basis between the adult care directors of the 4 local authorities)

**Teeswide Membership:** Hartlepool Council; Middlesbrough Council; Redcar & Cleveland Council; Stockton-on-Tees Council; Cleveland Police; Tees, Esk & Wear Valleys NHS Foundation Trust; South Tees Hospitals NHS Foundation Trust; North Tees & Hartlepool NHS Foundation Trust; Middlesbrough and Redcar and Cleveland Community Services; NHS Hartlepool; NHS Middlesbrough; NHS Redcar & Cleveland; NHS Stockton-on-Tees; Department of Work and Pensions; Teesside Probation Board; Care Quality Commission; Crown Prosecution Service

**Frequency of meetings:** Bi monthly

**Service user representation:** No User representation at Teeswide SAB level, to date. But LINk recently invited

**Other observations including good practice examples / key learning points:**

#### 2) Safeguarding policy / procedure:

**Date of latest revision:** Teeswide procedure: November 08

**Other observations including good practice examples / key learning points:**

#### 3) Service delivery arrangements:

**LA specialist adult safeguarding resources:** Strategic Lead, Operational Lead

**Other specialist resources:** Cleveland Police Vulnerability units (Include Child Protection and Domestic Violence as well as Vulnerable Adults)

**Other observations including good practice examples:**

#### 4) Approaches to thresholds:

**Any models / tools / protocols used:** Standardised risk assessment tool, adapted from that used in Durham

**Other observations including good practice examples:**
5) User involvement:
Approaches used to involve & engage service users / user led organisations at a strategic planning level: The R&C local safeguarding committee includes representation from LINk & Disability Carers' Partnership

Approaches used to involve service users at individual case level:
There is recognition that more work needs to done on involving & supporting service users who are at the centre of safeguarding processes

Other observations including good practice examples:

6) CQC Inspections:
Dates of last CQC adult safeguarding inspection and any follow up: Inspected July 2010.
Summary of inspection ratings: Inspection report pending
**Local Authority:** HARTLEPOOL

1) **Safeguarding Adults Board arrangements:**

- **Teeswide Chair:** Currently, Middlesbrough Adult Services. (Rotates on annual basis between the adult care directors of the 4 local authorities)
- **Teeswide Membership:** Hartlepool Council; Middlesbrough Council; Redcar & Cleveland Council; Stockton-on-Tees Council; Cleveland Police; Tees, Esk & Wear Valleys NHS Foundation Trust; South Tees Hospitals NHS Foundation Trust; North Tees & Hartlepool NHS Foundation Trust; Middlesbrough and Redcar and Cleveland Community Services; NHS Hartlepool; NHS Middlesbrough; NHS Redcar & Cleveland; NHS Stockton-on-Tees; Department of Work and Pensions; Teesside Probation Board; Care Quality Commission; Crown Prosecution Service.

- **Frequency of meetings:** Bi monthly
- **Service user representation:** No User representation at Teeswide SAB level, to date. But LINk recently invited

2) **Safeguarding policy / procedure:**

- **Date of latest revision:** Teeswide procedure: November 08

3) **Service delivery arrangements:**

- **LA specialist adult safeguarding resources:** Strategic Lead for vulnerable adults, DoLS Lead (part PCT funded), Operational Officer for Safeguarding
- **Other specialist resources:** Cleveland Police Vulnerability units (Include Child Protection and Domestic Violence as well as Vulnerable Adults)

4) **Approaches to thresholds:**

- **Any models / tools / protocols used:** Standardised risk assessment tool, adapted from that used in Durham

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Richard Corkhill & Caron Walker, September 2010. www.richardcorkhill.org.uk
5) User involvement:

| Approaches used to involve & engage service users / user led organisations at a strategic planning level: | LINk are members of the local Hartlepool Adult Protection Committee. |
| Approaches used to involve service users at individual case level: | No specific approach or procedure |

Other observations including good practice examples:

6) CQC Inspections:

| Dates of last CQC adult safeguarding inspection and any follow up: | Have not received CQC inspection |
| Summary of inspection ratings: | |
| Key learning points from inspections: | |
Local Authority: STOCKTON

1) Safeguarding Adults Board arrangements:

Teeswide Chair: Currently, Hartlepool Director of Adult Services. (Rotates on annual basis between the adult care directors of the 4 local authorities)

Teeswide Membership: Hartlepool Council; Middlesbrough Council; Redcar & Cleveland Council; Stockton-on-Tees Council; Cleveland Police; Tees, Esk & Wear Valleys NHS Foundation Trust; South Tees Hospitals NHS Foundation Trust; North Tees & Hartlepool NHS Foundation Trust; Middlesbrough and Redcar and Cleveland Community Services; NHS Hartlepool; NHS Middlesbrough; NHS Redcar & Cleveland; NHS Stockton-on-Tees; Department of Work and Pensions; Teesside Probation Board; Care Quality Commission; Crown Prosecution Service.

Frequency of meetings: Bi monthly

Service user representation: No User representation at Teeswide SAB level, to date. But LINk recently invited

Other observations including good practice examples / key learning points:

2) Safeguarding policy / procedure:

Date of latest revision: Teeswide procedure: November 08

Other observations including good practice examples / key learning points:

3) Service delivery arrangements:

LA specialist adult safeguarding resources: 1 full time Safeguarding Coordinator with admin support. Currently also employ a temporary officer to deal with recent increase in referral numbers

Other specialist resources: Police Vulnerability Unit – deals with vulnerable adults, domestic violence and child protection

Other observations including good practice examples:

Strong links to Community Safety Partnership, resulting pro-active work on community prevention approaches with vulnerable adults. e.g. work with older residents to prevent doorstep crime / financial abuse

4) Approaches to thresholds:

Any models / tools / protocols used: Standardised risk assessment tool, adapted from that used in Durham
Other observations including good practice examples:

<table>
<thead>
<tr>
<th>5) User involvement:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approaches used to involve &amp; engage service users / user led organisations at a strategic planning level:</td>
</tr>
<tr>
<td>Currently no input at SAB level. Community based approaches to prevention –e.g. use of community service volunteers to raise awareness of doorstep scams. Also</td>
</tr>
</tbody>
</table>

| Approaches used to involve service users at individual case level: |
| No specific approach or procedure |

| Other observations including good practice examples: |
| Have 2 Council Members as members of the local Stockton Safeguarding Committee. One of these Councillors is additionally representative of the Home Safety Association |

<table>
<thead>
<tr>
<th>6) CQC Inspections:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dates of last CQC adult safeguarding inspection and any follow up:</td>
</tr>
<tr>
<td>Inspection completed July 2010</td>
</tr>
</tbody>
</table>

| Summary of inspection ratings: |
| Inspection report not yet published by CQC |

| Key learning points from inspections: |
### APPENDIX 2: People who contributed & meetings attended

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joy Akehurst</td>
<td>NHS South of Tyne and Wear</td>
</tr>
<tr>
<td>Lee Alexander</td>
<td>Durham County Council</td>
</tr>
<tr>
<td>Pat Amis</td>
<td>North Tyneside Primary Care Trust</td>
</tr>
<tr>
<td>D.S. Chris Ashford</td>
<td>Durham Police</td>
</tr>
<tr>
<td>Councillor Jim Beall</td>
<td>Stockton Borough Council</td>
</tr>
<tr>
<td>Jane Bowie</td>
<td>Northumberland Care Trust</td>
</tr>
<tr>
<td>Chris Brown</td>
<td>Middlesbrough Primary Care Trust</td>
</tr>
<tr>
<td>Mary Burns</td>
<td>Newcastle Primary Care Trust</td>
</tr>
<tr>
<td>Councillor Ann Cains</td>
<td>Stockton Borough Council</td>
</tr>
<tr>
<td>Heather Carmichael</td>
<td>Northumbria Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>Nonnie Crawford</td>
<td>Sunderland Teaching Primary Care Trust</td>
</tr>
<tr>
<td>Harry Cronin</td>
<td>NHS North East Strategic Health Authority</td>
</tr>
<tr>
<td>DCI Ron Cruikshanks</td>
<td>Northumbria Police</td>
</tr>
<tr>
<td>Kathryn Dilley</td>
<td>NHS South of Tyne and Wear</td>
</tr>
<tr>
<td>Carol Drummond</td>
<td>South Tyneside Primary Care Trust</td>
</tr>
<tr>
<td>Mike Egan</td>
<td>Durham &amp; Darlington Community Health Services</td>
</tr>
<tr>
<td>Bridget Farrand</td>
<td>Middlesbrough City Council</td>
</tr>
<tr>
<td>Chief Insp. Paul Goundry</td>
<td>Durham Police</td>
</tr>
<tr>
<td>Sheila Grant</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>Sue Grimes</td>
<td>Gateshead Council</td>
</tr>
<tr>
<td>Paul Green</td>
<td>Stockton Borough Council</td>
</tr>
<tr>
<td>Glynis Howie</td>
<td>Pensions Service</td>
</tr>
<tr>
<td>D.S. Ian Hudson</td>
<td>Cleveland Police</td>
</tr>
<tr>
<td>Jane Humphreys</td>
<td>Stockton Borough Council</td>
</tr>
<tr>
<td>Leslie Jeavons</td>
<td>Durham County Council</td>
</tr>
<tr>
<td>Deanna Lagan</td>
<td>NHS South of Tyne and Wear</td>
</tr>
<tr>
<td>Alyson Learmonth</td>
<td>Gateshead Primary Care Trust</td>
</tr>
<tr>
<td>Margaret Lester</td>
<td>Newcastle City Council</td>
</tr>
<tr>
<td>Deborah Lovatt</td>
<td>Hartlepool Borough Council</td>
</tr>
<tr>
<td>Susan Mackreth</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>Sheila Mottram</td>
<td>Darlington Borough Council</td>
</tr>
<tr>
<td>Joanne Pell</td>
<td>Sunderland City Council</td>
</tr>
<tr>
<td>Darren Ramshaw</td>
<td>South Tyneside Council</td>
</tr>
<tr>
<td>Kevin Robinson</td>
<td>Northumbria Probation Service</td>
</tr>
<tr>
<td>Suzanne Scott</td>
<td>Newcastle upon Tyne Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>Name</td>
<td>Organisation</td>
</tr>
<tr>
<td>--------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Lesley Scriven</td>
<td>Gateshead Council (now Northumberland Care Trust)</td>
</tr>
<tr>
<td>Mike Sharman</td>
<td>Middlesbrough City Council</td>
</tr>
<tr>
<td>Angela Sheen</td>
<td>Durham County Council</td>
</tr>
<tr>
<td>Pam Simpson</td>
<td>Hartlepool Borough Council</td>
</tr>
<tr>
<td>Pat Stewart</td>
<td>Government Office North East</td>
</tr>
<tr>
<td>Lesley Thirlwell</td>
<td>North East Ambulance Services</td>
</tr>
<tr>
<td>Lee Thompson</td>
<td>South Tyneside Council</td>
</tr>
<tr>
<td>Alison Tombs</td>
<td>North Tyneside Council</td>
</tr>
<tr>
<td>Wade Tovey</td>
<td>Teesside University / Tees Valley Alliance</td>
</tr>
<tr>
<td>Ian Waddle</td>
<td>Stockton Borough Council</td>
</tr>
<tr>
<td>Mick Walker</td>
<td>Teeswide Safeguarding Adults Board</td>
</tr>
<tr>
<td>Moira West</td>
<td>North Tyneside Council</td>
</tr>
<tr>
<td>Diane Whitehead</td>
<td>Hartlepool Borough Council</td>
</tr>
<tr>
<td>Andrea Wilson</td>
<td>NHS North of Tyne</td>
</tr>
</tbody>
</table>

**Meetings attended:**
- Durham Safeguarding Adults Board
- Gateshead Safeguarding Adults Board Development Day
- NHS North of Tyne Safeguarding Adults Meeting
- NHS South of Tyne and Wear Strategic Safeguarding Group
- Regional Safeguarding Leads Network
- Strategic Health Authority Safeguarding Adults Group
- Teeswide Safeguarding Adults Board
## APPENDIX 3: Project Board

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zoe Campbell</td>
<td>North East Improvement &amp; Efficiency Partnership</td>
</tr>
<tr>
<td>Sue Grimes</td>
<td>Gateshead Council</td>
</tr>
<tr>
<td>Margaret Lester</td>
<td>Newcastle City Council</td>
</tr>
<tr>
<td>Lesley Scriven</td>
<td>Gateshead Council (now Northumberland Care Trust)</td>
</tr>
<tr>
<td>Pat Stewart</td>
<td>Government Office North East</td>
</tr>
<tr>
<td>Moira West</td>
<td>North Tyneside Council</td>
</tr>
</tbody>
</table>
APPENDIX 4: ADASS Standards 1 & 2

Joint planning and capability
Standards 1 and 2
Standard 1 The Partnership

This Standard sets out the framework within which the planning, implementation and monitoring of 'Safeguarding Adults' work should take place. The key structure in this framework is a multi-agency partnership that leads the development of the work at a local level: the 'Safeguarding Adults' partnership.

The impetus for a multi-agency approach is the recognition that a plethora of organisations is involved in providing services to adults and may be involved in enabling them to access safety. In addition there are published inquiries into situations where abuse of adults has taken place and not been recognised or acted on in time to prevent harm. These include those examining the circumstances of deaths of adults in their own homes and the abuse and neglect of people living in care settings. (For example: Beverley Lewis, [Lamb L 2003] Independent Long Care Inquiry (Bergman T 1998), North Lakeland Healthcare NHS Trust (CHI November 2000) and Rowan ward, Manchester Mental Health and Social Care Trust (CHI September 2003). Each inquiry contains the theme that greater information-sharing and multi-agency working together may have placed organisations in a position to safeguard the adults concerned.

Strong partnerships are those whose work is based on an agreed policy and strategy, with common definitions and a good understanding of each other's roles and responsibilities. These underpin partnership working in response to instances of abuse and neglect, wherever they occur.

Local Crime and Disorder Partnerships have the lead role for delivering the Safer Communities agenda. The 'Safeguarding Adults' strategy should be included within the Crime and Disorder Reduction Strategy and be endorsed by the Local Strategic Partnership. It is also important that 'Safeguarding Adults' work is closely linked to other partnership initiatives - particularly those aimed at enabling all adults to have access to healthy, active and fulfilling lives - and is included within the Local Delivery Plan for health services.

Standard 2 Partner organisations

Working together is dependent on there being a clear framework for doing so. However, a successful partnership is built on the strength and capacity of individual organisations and is dependent on each partner being committed to engaging in the work.

'Safeguarding Adults' work is based on communication across agency boundaries. It is important that each partner has a good understanding of its role in the work of 'Safeguarding Adults' and making a clear commitment of resources appropriate to that role. Fundamental to this commitment is the implementation of good practice in the prevention of abuse and neglect within the service provided by the organisation (see Standard 4).

Each organisation is responsible and accountable for meeting national guidance and legal requirements in relation to implementing 'Safeguarding Adults' work, whether through working in partnership or through its own actions.

Each organisation has a responsibility for working actively in partnership in order to implement 'Safeguarding Adults' work.
## APPENDIX 5: Thresholds guidance used in the north east

### Durham

#### Risk Support Tool

<table>
<thead>
<tr>
<th>Factors</th>
<th>Lower Risk (1)</th>
<th>Less Vulnerable (2)</th>
<th>More Vulnerable (3)</th>
<th>Higher Risk (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The vulnerability of the abuse</td>
<td>Extremity Serious</td>
<td>Extremity Serious</td>
<td>Extremity Serious</td>
<td>Extremity Serious</td>
</tr>
<tr>
<td>2. The extent of the abuse</td>
<td>Less Serious</td>
<td>More Serious</td>
<td>Extremely Serious</td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td></td>
<td></td>
<td></td>
<td></td>
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#### Guidance

- Can the adult protect themselves, and do they have the communication skills to raise an alert?
- Does the person lack access to resources?
- Is the person dependent on the alleged perpetrator?
- Refer to the table above (The Extent of the Abuse) for the relevant category of abuse.

### The extent of abuse

<table>
<thead>
<tr>
<th>Type of Abuse</th>
<th>Examples of abuse that might fall outside safeguarding procedures that should be addressed by other agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>- Unusual injury or unexplained medical conditions that are not obvious</td>
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<tr>
<td>Mental Health</td>
<td>- Psychological damage that is not obvious</td>
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Gateshead use a similar tool adapted from this.
### North Tyneside

**Evaluation of Seriousness of Risk - Example of Tool (source unknown)**

*(EXAMPLE ONLY)*

<table>
<thead>
<tr>
<th>Type of abuse</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>Physical</td>
<td>Isolated incident of bruising</td>
<td>Lesions, cut or grip marks on a number of occasions</td>
<td>Assault requiring attendance at A&amp;E or other medical treatment</td>
<td>Assault with a weapon leading to irreversible damage</td>
<td>Grievous bodily harm or attempted murder</td>
</tr>
<tr>
<td>Sexual</td>
<td>Non contact abuse including verbal harassment, teasing or watching pornography without consent</td>
<td>Sexual touching or masturbation without consent</td>
<td>Attempted penetration in a relationship without consent</td>
<td>Sex in a relationship characterised by authority, inequality or exploitation</td>
<td>Rape accompanied / not by violence or the threat of violence</td>
</tr>
<tr>
<td>Psychological</td>
<td>Occasional teasing, taunts or verbal outbursts</td>
<td>Frequent or frightening verbal outbursts</td>
<td>Humiliation and threats on a regular basis</td>
<td>Threats of abandonment and intimidation</td>
<td>Vicious and personalised attacks such as racial abuse and other forms of discriminatory abuse</td>
</tr>
<tr>
<td>Financial</td>
<td>Petty cash 'fiddled'</td>
<td>Personal belongings taken</td>
<td>Personal finances removed from person’s control without legal framework</td>
<td>Fraud relating to benefits, income, property or Will.</td>
<td>Fraud or theft to extent that person risks destitution</td>
</tr>
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<td>Neglect</td>
<td>Lack of care leading to discomfort or inconvenience</td>
<td>Lack of care leading to broken pressure areas or other medical complication</td>
<td>On going neglect with serious consequences such as malnutrition or other illness</td>
<td>Failure to access services or medical care</td>
<td>Neglect of medication or psychological needs leading to fears for survival.</td>
</tr>
<tr>
<td>Discriminatory</td>
<td>Occasional inappropriate language / jokes (e.g. racist, ageist, about disability)</td>
<td>Evidence that a less preferable service is being offered to this person</td>
<td>Failure to respect cultural preferences, customs and norms e.g. diet, religion</td>
<td>Systematic exclusion from rights / services of all citizens e.g. health, legal services</td>
<td>Violent abuse or harassment because of race, age, disability etc.</td>
</tr>
<tr>
<td>Institutional</td>
<td>Over – familiar patronising, derogatory forms of address tolerated</td>
<td>Substandard record keeping including that for client’s money / medication</td>
<td>Rigid, insensitive routines and regimes e.g. meal times, bed times</td>
<td>Denial of access to toilet or bathing facilities</td>
<td>V A confined / locked in. Inappropriate restraint either overt or covert.</td>
</tr>
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</table>

*Scale of 1 (serious) to 5 (extremely serious)*

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Improving the Safeguarding of Adults in the North East
Richard Corkhill & Caron Walker, September 2010.

www.richardcorkhill.org.uk
Gateshead

Safeguarding Adults Procedural Framework
Flowchart 1
Alert and Initial Contact with Adult Social Care Direct

Suspected/actual abuse?

In all cases, if the adult at risk is in immediate danger, take preventative steps and call 999. Preserve evidence.

All Alerts to be made immediately

Alert by service user or member of the public?
Report to Adult Social Care Direct on (0191) 4332700.

Alert by Adult Social Care worker?
Discuss with line manager and enter details onto CareFirst Initial Contact page. Workers who do not have access to CareFirst complete matrix form and email to ASCOC on adult safeguarding@northtyneside.gov.uk.

Alert by worker from Health *?
Follow your agency’s practice guidelines and then refer to Adult Social Care Direct on (0191) 4332700.
Described Persons in Health settings may use the ‘Safeguarding Adults Risk Support Tool’ to determine whether the concern constitutes a safeguarding matter. Where any doubt exists, refer.

Alert by CQC?
CQC fax alert form to Adult Social Care Direct on (0191) 4332700.
Follow your agency’s practice guidelines and then refer to Adult Social Care Direct on (0191) 4332700.
Described Persons may use the ‘Safeguarding Adults Risk Support Tool’ to determine whether the concern constitutes a safeguarding matter. Where any doubt exists, refer.

Alert by worker from any other organisation, including other Council departments?

If the alert concerns a health setting or health professional, ASCOC contacts the Council’s Safeguarding Adults Team on (0191) 4332700.
They advise on a single point of contact for health and give guidance about who will lead the safeguarding intervention.

If Adult Social Care staff are implicated, a senior manager may need to refer to the disciplinary procedures as an immediate protective measure.

Responsive Manager from Health leads the safeguarding process, with advice and support from the Safeguarding Adults Team.

Adult Social Care Direct logs allegation onto CareFirst safeguarding initial contact form and carries out screening function. Unless it is agreed that Health will be leading the safeguarding intervention, then ASCOC refers the case to an appropriate Community Based Services Team Manager for decision making (Responsive Manager) on the same day as initial contact.
Where ASCOC is in any doubt about how to proceed then they should ring the Council’s Safeguarding Adults Team on (0191) 4332701 for advice.

Remember to observe human resources policies and procedures in parallel with any safeguarding action

* Primary Care Trusts, Acute Trusts, Secondary Health Services, Foundation Trusts

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Alert stage

- Suspected or actual abuse
- Immediate threat or crime committed?
  - YES: Contact Police or Emergency Services
  - NO: Inform line manager or Adult Social Care Direct
- Safeguarding adults alert made to Adult Social Care Direct (within 24 hours using SAMA1 form)
- Inform regulatory body if registered service

Decision and strategy stage

- Alert to inter-agency procedures (within 24 hours of incident)
- Complete multi-agency alert form (SAMA1)
- Initial information gathering and safeguarding decision within 24 hours Complete SANA1 Form
- Protection issues resolved? Concern or allegation unfounded?
  - YES: Inter-agency procedures end
  - NO: Strategy meeting or discussion required?
- Strategy meeting/discussion within 7 days of alert
Northumberland
Procedural Flowchart

<table>
<thead>
<tr>
<th>TIMESCALE</th>
<th>STAGE</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate</td>
<td>Alert</td>
<td>Someone reports a concern that an adult may be experiencing abuse or neglect</td>
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<tr>
<td>Within same</td>
<td></td>
<td>Discussion to agree next step</td>
</tr>
<tr>
<td>working day</td>
<td></td>
<td>A referral is made to a Safeguarding Manager e.g. Team Manager</td>
</tr>
<tr>
<td></td>
<td>Referral</td>
<td>A decision is made as to whether the Safeguarding Adults Procedures are appropriate</td>
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<tr>
<td>By the end of the</td>
<td></td>
<td>The Safeguarding Assessment/Investigation Strategy is planned and an interim protection plan is put in place</td>
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<tr>
<td>working day</td>
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<td>within following</td>
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<td>The Safeguarding Assessment/Investigation Strategy is planned and an interim protection plan is put in place</td>
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<td>Multi-Agency</td>
<td>Carry out the necessary assessment/investigation about abuse or neglect that has occurred or might occur</td>
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## APPENDIX 6: Thresholds guidance from other areas

### Bedfordshire

| Thresholds |
|-----------------|---------------------------------------------------|
| **Level 1: Would not require alerting as safeguarding of a vulnerable adult:** |
| - A one off incident that has not been witnessed or its cause is not known. No more than three incidents involving the same person in a four week period would be an acceptable level of risk. |
| - A single incident where there is no previous history or a criminal offence that has been witnessed or cause known. |
| HOWEVER the above should be treated as no more than guidance and is not exclusive. These incidents **may be abusive.** |
| **Level 2: Would require alerting as safeguarding of a vulnerable adult:** |
| - Incidents that have caused significant harm and distress to one or more person(s) or where hospital treatment has been required. |
| - More than three incidents involving one person within a four week period. |
| - More than 5 incidents involving one person (victim or perpetrator) within a six months period. |
| **Level 3: Would automatically instigate the full safeguarding of a vulnerable adult procedures:** |
| - Incidents or allegations of a criminal offence. |
| - Incidents or services where there are known high risk concerns affecting one or more persons. |
| **Level 4:** |
| - Serious multiple allegations or concerns involving multiple vulnerable people or services. |
Doncaster

**THRESHOLD GUIDANCE FLOWCHART**

1. **Referral received**
   - Ensure immediate safety

2. **Does the alleged victim have**
   - YES
   - NO

3. **Does the alleged victim agree with the possible need for intervention?**
   - YES
   - NO

4. **Is the alleged victim making a free and informed choice about not wanting intervention?**
   - NO
   - YES
   - NO
   - YES

5. **Is the alleged victim at potential risk of significant harm, and/or are other vulnerable adults, workers or the**
   - NO
   - YES

6. **Does the allegation indicate that a crime may have been committed?**
   - NO
   - YES

7. **Consult with the Police before deciding: Safeguarding Strategy or No further action**
   - NO
   - Review Case Conference
   - Investigation
   - Safeguarding Case Conference

8. **Safeguarding Manager convenes a Strategy Meeting or Discussion**

9. **No further action**
### Hampshire

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level of response</th>
</tr>
</thead>
</table>
| **Case may include:**  
- Minor neglect  
- Concern for safety  

**and may also include:**  
- PPU Grade C or D cases  

| **and may also include:**  
- PPU Grade C or D cases  

| **The concern does fit with the definitions of abuse/vulnerable adult.**  
| **The level of seriousness should be assessed using the seriousness tool and is low in every aspect of the assessment.**  
| **The care manager/team manager believe that one individual or care provider is motivated and able to address the issue in its entirety and they are willing to work with the care manager to put in place measures to address the concerns and to monitor and communicate back the effectiveness of these measures to care managers.**  
| **This needs to be fully recorded and a satisfactory conclusion evident in those records.**  
| **If it cannot be concluded satisfactorily and the abuse continues, or if provider fails to implement actions then progress to level 2.**  
| **If multiple alerts arise progress to level 2** |

<table>
<thead>
<tr>
<th>Level 2</th>
<th>Level of response</th>
</tr>
</thead>
</table>
| **Case may include:**  
- neglect  
- assault  

**and may also include:**  
- PPU Grade B cases  

| **and may also include:**  
- PPU Grade B cases  

| **The concern does fit with the definitions of abuse/vulnerable adult.**  
| **The level of seriousness should be assessed using the seriousness tool and is substantial but perhaps not in the extremely serious category (see level 3). This will require following the formal safeguarding adults procedures in every aspect so that a multi-agency assessment/investigation is undertaken.**  
| **Information to be presented at local Quality Outcome Contract Monitoring meeting by Safeguarding Coordinators using Team Manager Tracking Sheet** |

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Level of response</th>
</tr>
</thead>
</table>
| **Case may include:**  
- a large number of vulnerable adults who may be adversely affected/ at risk and/or  
- more than one service or home/unit may be the focus of the investigation and/or  
- allegations indicate institutional abuse affecting a number of vulnerable adults and/or  
- other cases that due to their seriousness and complexity require input of senior managers  

**And may also include:**  
- PPU Grade A or B cases  

| **The concern does fit with definitions of abuse/vulnerable adult.**  
| **The level of seriousness should be assessed using the seriousness tool and is extremely serious in other words the risk to the individual(s)/department is very high.**  
| **For example, a service user may have died or be seriously ill/injured; there may be potential or actual press interest; the case may warrant a Critical Incident Review (see criteria: Incident Reporting & Investigation procedure, Appendix C)**  
<p>| <strong>Consider moving service users out of provider services due to the high level of risk.</strong> |</p>
<table>
<thead>
<tr>
<th>Poor practice which requires actions by a provider agency e.g. homes, ward or domiciliary care manager</th>
<th>Possible abuse which requires reporting as such, and the instigation of Safeguarding procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Patient/service user does not receive necessary help to have a drink/meal. If this happens once and a reasonable explanation is given e.g. unplanned staffing problem, emergency occurring elsewhere in the home, incident dealt with under staff disciplinary procedures; would not be referred under safeguarding adults procedures</td>
<td>Patient/service user does not receive necessary help to have drink/meal and this is a recurring event, or is happening to more than one vulnerable adult. This constitutes neglectful practice, may be evidence of institutional abuse and would prompt a safeguarding investigation</td>
</tr>
<tr>
<td><strong>2</strong> Patient/service user does not receive necessary help to get to toilet to maintain continence or have appropriate assistance such as changed incontinence pads. If this happens once and a reasonable explanation is given e.g. unplanned staffing problem, emergency occurring elsewhere in the home, dealt with under staff disciplinary procedures; would not be referred under safeguarding adults procedures</td>
<td>Patient/service user does not receive necessary help to get to toilet to maintain continence and this is a recurring event, or is happening to more than one vulnerable adult – neglectful practice, may be evidence of institutional abuse and would prompt a safeguarding investigation</td>
</tr>
<tr>
<td><strong>3</strong> Patient/service user has not been formally assessed with respect to pressure area management but no discernible harm has arisen. This may need to be dealt with under disciplinary procedures</td>
<td>Patient/service user is 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, neglectful practice, breach of regulations and contract, possible institutional abuse. Safeguarding procedures should be instigated</td>
</tr>
<tr>
<td><strong>4</strong> Patient/service user does not receive medication as prescribed on one occasion but no harm occurs. Internal investigation should be undertaken, possible disciplinary action depending on severity of situation including type of medication</td>
<td>Patients/service users do not receive medication as a recurring event, or it is happening to more than one vulnerable adult. Neglectful practice, regulatory breach, breach of professional code of conduct if nursing care provided. Depending on degree of harm, possible criminal offence. Safeguarding procedures should be implemented</td>
</tr>
<tr>
<td><strong>5</strong> Appropriate moving and handling procedures not followed but patient/service user does not experience harm. Provider acknowledges departure from procedures and inappropriate practice and deals with this appropriately under disciplinary procedures, to the satisfaction of the service user</td>
<td>One or more service users experience harm through failure to follow correct moving and handling procedures, or common faulting of moving &amp; handling procedures make this likely to happen. Neglectful practice – safeguarding procedures should be instigated</td>
</tr>
<tr>
<td><strong>6</strong> 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 the incidence and this is an isolated incident. Provider takes appropriate action, to the satisfaction of the service user</td>
<td>Patient/service user is frequently spoken to in a rude, insulting, belittling or other inappropriate way or it is happening to more than one vulnerable adult. Regime in the home doesn’t respect dignity of service users and staff frequently use derogatory terms and are abusive to service users. Regulatory breach Refer under safeguarding procedures</td>
</tr>
<tr>
<td><strong>7</strong> Service user does not receive a scheduled domiciliary care visit and no other contact is made to check on their well-being, but no harm occurs. Provider deals with this appropriately through internal investigation, to the satisfaction of the service user</td>
<td>Service user does not receive scheduled domiciliary care visit(s) and no other contact is made to check on their well-being resulting in harm or potentially serious risk to service user. Safeguarding procedures should be instigated</td>
</tr>
</tbody>
</table>
Northamptonshire

Thresholds for Interagency procedures

HIGH LEVEL CONCERN: SEVERE HARM URGENCY

CASE LEAD = SAFEGUARDING TEAM

HIGH LEVEL CONCERN CASE
MODERATE/SIGNIFICANT HARM LIKELIHOOD OF REPEAT OCCURRENCE IMPLICATIONS FOR OTHER VULNERABLE INDIVIDUALS REQUIRES MULTI AGENCY APPROACH BENEFITS FROM EXTERNAL INVESTIGATION

CASE LEAD = PC/MP/WS FROM RELEVANT TEAM

THRESHOLDS FOR INVESTIGATION UNDER INTERAGENCY PROCEDURES

LOW LEVEL CONCERN
MINIMAL RISK
ISOLATED INCIDENT + LOW HARM CONCERN CAN BE ADDRESSED BY SINGLE AGENCY APPROACH ACTION AGREED RECORDED BY NFA FOR SAFEGUARDING TEAM – MANAGED AS PART OF WIDER SERVICES CARE PLANS & MONITORING

CONCERN NOT SUBSTANTIATED OR WITHIN REMIT OF SAFEGUARDING ADULTS
NFA FOR SAFEGUARDING

SCREEN

ALERT & NOTIFICATION
South Yorkshire
### Surrey

<table>
<thead>
<tr>
<th>RESPONSE</th>
<th>PRESENTING INFORMATION</th>
</tr>
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</table>
| **Level 1**<br>Intervention by service providers | 'One-off' isolated incident – some of the factors to consider within the assessment of seriousness and decision making process:  
- Has there been a previous history of similar incidents recorded for the vulnerable adult?  
- Has there been a previous history of similar incidents recorded for the service provider?  
- Has there been previous history of abuse by the person alleged responsible?  
- Is this a pattern of abuse?  
- Is there a clear criminal offence described in the referral?  
- Is there a clear intent to harm or exploit the vulnerable person? |
| **Level 2**<br>Intervention by the appropriate Team to assess or review the needs of the vulnerable adult and/or the alleged perpetrator within the context of the presenting concern(s) | The physical, psychological or emotional well-being 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 (e.g. some perceived inadequacy in the services being provided)  
- The concerns reflect difficulties and tensions within the network of informal support provided to the vulnerable adult (e.g. some perceived difficulties between the vulnerable adult and family/friends)  
- Concerns have occurred in the past, but at lengthy and infrequent intervals |
| **Level 3**<br>Safeguarding Adults Enquiry Undertaken | The physical, psychological or emotional well-being of the adult has been adversely affected by the alleged incident  
- A criminal offence may have been committed  
- There is a breach of regulations provided by the Care Standards Act 2000  
- 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 a breach in an implied or actual ‘duty of care’ between vulnerable adults and the person alleged responsible  
- The referral forms parts of a pattern of abuse either against a particular individual or by a health or social care service |
| **Level 4**<br>Complex safeguarding adults enquiry undertaken with multiple service user/victims | Institutional abuse  
- Number of people adversely affected  
- A number of criminal offences may have been committed  
- Multiple breach of Care Standards Act 2000  
- Potential high profile due to seriousness/complexity |
CONCERN/INCIDENT REPORTED
SET SAF 1

RISK ASSESSMENT INITIATED

Is/was the relationship between the victim/alleged abuser any of the following?
Mother/Father
Grandparent/Great Grandparent
Children
Grandchildren/Great Grandchildren
Spouse/partner
In-laws or equivalent
Step-family

Yes

Complete domestic abuse risk indicator score card alongside SET SAF Risk.

No

Complete risk indicator check list
SET SAF Risk (Appendix 3)

If very high risk is identified consider referral to MARAC* and discuss with manager re police involvement if not already

Yes answers identified on scorecards

Risk Management Plan completed and reviewed at all stages of the process including closure and kept on Service User file

* Multi Agency Risk Assessment Conference
Worcestershire