haringey strategic partnership

NOTICE OF MEETING

Well-Being Partnership Board

TUESDAY, 4TH MARCH, 2008 at 19:00 HRS – CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

MEMBERS: Judy Allfrey, Tracey Baldwin (Haringey Teaching Primary Care Trust), Councillor Gideon Bull (Haringey Council), Stephen Clarke (Homes for Haringey), Councillor Isidoros Diakides (Haringey Council), Councillor Dilek Dogus (Haringey Council), Robert Edmonds (Haringey Association of Voluntary and Community Organisations (HAVCO)), Christina Gradowski (Haringey Teaching Primary Care Trust), Councillor Bob Harris (Haringey Council) (Vice-Chair), Cathy Herman (Haringey Teaching Primary Care Trust), Sue Hessel (Haringey Federation of Residents Associations), Cecilia Hitchen (Haringey Council), Vicky Hobart (Haringey Teaching Primary Care Trust), David Hooper (North Middlesex Hospital Trust), Carl Lammy (BEH Mental Health Trust), Narendra Makanji (Whittington Hospital Trust), Lesley Misrahi (Haringey Teaching Primary Care Trust), John Morris (Haringey Council), Marion Morris (Haringey Council, DAAT), Simon O'Brien (Haringey Metropolitan Police Service), Mun Thong Phung (Haringey Council), Naeem Sheikh (HAVCO), Richard Sumray (Haringey Teaching Primary Care Trust) (Chair) and Mary Pilgrim (Haringey Probation Service), Cathy Walsh (CoNEL)

AGENDA

1. WELCOME, APOLOGIES AND SUBSTITUTIONS

To welcome those present to the meeting and receive any apologies for absence.

2. MINUTES (PAGES 1 - 10)

To confirm the minutes of the 13 December 2007 as a correct record of the meeting.

3. URGENT BUSINESS

The Chair will consider the admission of any late items of urgent business. (Late items will be considered under the agenda item where they appear. New items will be dealt with under Item 13 below).

4. DECLARATIONS OF INTEREST

Members of the Board must declare any personal and/or prejudicial interests with respect to agenda items and must not take part in any decision with respect to these items.

5. PRIMARY CARE STRATEGY NEXT STEPS (PAGES 11 - 26)

6. WELFARE TO WORK FOR DISABLED STRATEGY 2005/15

The report will be sent to follow.

7. SAFEGUARDING VULNERABLE ADULTS POLICY AND PROCEDURES (PAGES 27 - 150)

8. DEVELOPMENT OF TOBACCO CONTROL STRATEGY FOR HARINGEY (PAGES 151 - 154)

9. UPDATE ON THE DEVELOPMENT OF THE NEW STYLE LOCAL AREA AGREEMENT (PAGES 155 - 162)

10. AREA BASED GRANT

Report to follow.

11. MOVE ON STRATEGY

A verbal update will be provided.

12. NORTHUMBERLAND PARK UPDATE (PAGES 163 - 168)

13. NEW ITEMS OF URGENT BUSINESS

To consider any new items of Urgent Business admitted under Item 3.

14. WELL BEING SCORECARD (PAGES 169 - 186)

15. NEIGHBOURHOOD RENEWAL FUNDING UPDATE (PAGES 187 - 192)

16. COMMUNITIES FUNDING UPDATE (PAGES 193 - 194)

17. BARNET, ENFIELD, AND HARINGEY CLINICAL STRATEGY UPDATE

A verbal update will be provided.

18. ANY OTHER BUSINESS

To raise any items of AOB.

19. DATES OF FUTURE MEETINGS

Please note that the Council's Calendar of meetings has yet to be finalised.

Dates have been provisionally set for:

10 June
20 October
8 December
2 March

Once dates have been confirmed the Board will be contacted.

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Agenda Item 2

MINUTES OF THE HARINGEY WELL-BEING PARTNERSHIP BOARD (HSP)
THURSDAY, 13 DECEMBER 2007

Present: Richard Sumray (Chair), Councillor Isidoros Diakides, Judy Allfrey, Helen Brown, Tom Brown, Robert Edmonds, Cathy Herman, Vicky Hobart, John Morris, Mun Thong Phung,

In Attendance: Helena Pugh, Andrew Wright

MINUTE NO.	SUBJECT/DECISION	ACTON BY
OBHC18.	**WELCOME, APOLOGIES AND SUBSTITUTIONS** The Chair welcomed those present to the meeting and noted that apologies had been received from the following people: Tracey Baldwin –Helen Brown substituted Councillor Bob Harris Sue Hessel David Hooper Aiden Gibson Naeem Sheik	
OBHC19.	**MINUTES** When asked if the minutes of the previous meeting were a correct record, Councillor Bevan noted that he had raised concerns regarding the inefficient use of space at The Laurels and that this had not been recorded in the minutes. Councillor Bevan also noted that he had contacted Keith Gardner at the PCT via email regarding this issue and that his email had not been responded to. In response to Councillor Bevan's concerns, Helen Brown of the PCT agreed to take this issue forward and offered to arrange a visit of The Laurels for Councillor Bevan. The Chair reminded the Board that at the previous meeting it had been agreed that a meeting should be arranged between the Council and the PCT in order to clarify how often the Chair of the Board should be rotated between the bodies. He advised that Board that it had been agreed that this would be rotated on an annual basis. At the same meeting it had been agreed that the Haringey federation would have an observer place on the Board. **RESOLVED:** That, subject to the inclusion of the above, the minutes of the meeting held on 22 October 2007, be confirmed as a correct record.	PCT (HB) ALL TO NOTE

OBHC20.	**URGENT BUSINESS** No items of Urgent Business were raised.	
OBHC21.	**MENTAL HEALTH TRUST: UPDATE ON ST ANN'S** The Board was provided with a verbal update on the position in relation to St Ann's Hospital. An Options Appraisal for the site had been submitted to NHS London. As consultation exercises were still under way in relation to the PCT Primary Care Strategy and the BEH Clinical Strategy, the Options Appraisal would not be finalised until the results from these consultation exercises were available. In order to draw the this piece of work together the Mental Health Trust Board had met to appoint a project director who would oversee the development of an Outline Business Case. The Board was advised that the timescales around the project were dependent upon the results of the consultation exercises. However, it was envisaged that an Outline Business Case would be finalised by the end of 2008 and a Commercial Business Case would be compiled following this in early 2009. The Chair requested that, once the public consultation exercise had taken place, the document be brought back to the Board for discussion and that a presentation should be made. It was suggested that the MH Trust should meet with the Director of the Urban Environment and the Cabinet Portfolio holder in order to discuss planning issues. **RESOLVED:** i. To note the verbal update provided. ii. That, following consultation with the public, the Mental Health Trust should make a presentation to the Board on how this would inform the Outline Business Case.	MHT MHT/ COUNCIL MHT
OBHC22.	**PRESENTATION FROM BARNET, ENFIELD AND HARINGEY MENTAL TRUST: APPLICATION FOR FOUNDATION TRUST STATUS** The Board received a presentation from Andy Wright of the Mental Health Trust (MHT) on its application for Foundation Trust status. The Board was advised that formal consultation on the Trusts application for Foundation Trust status had begun in October and as part of that process a number of presentations had been given to partners.	

Due to the large and diverse population of the area covered by the Trust, ways of improving links to other organisations, including the voluntary sector, Councils and the PCTs within the area, were being looked at.

It was noted that the Trust had achieved a 'Good' rating for the Quality of Services and a 'Fair' rating for its Use of Resources. In addition to this there were ongoing improvements to the services provided to Service Users and Carers.

The Board was advised that Foundation Trust status would allow greater financial freedom and would mean that the Trust was more accountable to local people. It would also provide greater scope for involvement and influence by the local community and to develop partnership working.

It was noted that the consultation exercise would end in January 2008 and in March the Secretary of State would determine whether Foundation Trust status should be awarded. A monitoring assessment would be carried out between April and July 2008 and, if approved, confirmation of Foundation Trust status would be given in the Autumn.

It was noted that the PCT and Council had met with the MHT to discuss the application and at this meeting concerns had been raised over the Trust's capacity to take the project forward and to address operational issues. These concerns had been set out in more detail in a letter to the MHT.

The Board was advised that an Operational Director had been appointed, with the intention of developing a more consistent approach across the three Boroughs and that the Operational Director would liaise with each of the Local Authorities to achieve this once in post. It was envisaged that this appointment would also help to build better relationships across all the partner organisations. In addition to this the MHT's existing Director for Barnet was moving across to Haringey; he had experience in a Borough where a similar re-organisation had taken place.

The Chair noted that reference would need to be made to the PCT's Primary Care Strategy and that full consideration should be given to this. It was also noted that both the Council and the PCT had expressed concerns regarding the MHT's capacity to deliver both this piece of work and operational issues, given the changes to the its senior management team. MHT

There was a general consensus that it would be useful if a further presentation could be given to the Board following the consultation process. MHT

RESOLVED:

i. To note the presentation.

	ii. That the MHT should be asked to make a further presentation to the Board following the conclusion of the consultation process.	MHT
OBHC23.	**UPDATE ON BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY** This provided under the previous item.	
OBHC24.	**DEVELOPMENT OF JOINT STRATEGIC NEEDS ASSESSMENT** The Board received a presentation on the development of Haringey's Joint Strategic Needs Assessment (JSNA's). The Board was advised that a JSNA was being undertaken with the aim of developing a more effective commissioning process. It was noted that there was a duty upon the Council and the PCT to carry out the Assessment and the new LAA and local targets for both bodies would be based on evidence gathered as part of the JSNA. The JSNA would provide the evidence and information to support the commissioning process. The responsibility for delivering this would rest with the jointly appointed Director of Public Health, in conjunction with the Council's Directors for Adult and Children Services. It was noted that a scoping workshop would be held early in the new year and that the new Director of Public Health would be in post on 21 January 2008. The Board was advised that a range of partner organisations had been invited to attend the workshop and that the voluntary sector would be represented by HAVCO. It was noted that consideration should be given to how links could be better developed with other NHS partners. **RESOLVED:** To note the content of the presentation.	
OBHC25.	**HARINGEY GREENEST BOROUGH STRATEGY** The Board received a presentation on the Greenest Borough Strategy. The Board was advised of the national and regional context within which	

	the Strategy had been formed. It was noted that the Strategy would address Government targets in relation to the reduction of emissions and the targets within the Mayor's London Plan and supporting strategies. In addition to the broader national and regional targets, the Strategy was also informed by the local context, including the Sustainable Community Strategy, the Haringey Council Plan and the Strategic Framework for Improving Adults' Well-Being 2007/10. In order to develop the Strategy, a Better Haringey Working Group and Stream Board had been formed and an Away Day was being held in the new year. In terms of linkage to the Well-Being Framework, it was noted that Priority 2 Improved Quality of Life and Priority 6 Economic Well-Being, were strongly linked to the Strategy and were addressed within it. The Board was advised that the consultation process had included a 'vox pop', presentations to the Council's Area Assemblies and to young people via schools and that there had been consultation with Council staff. It was noted that the consultation period would end on 31 January 2008. The Council's Cabinet would consider the Strategy in April 2008 and it would be submitted to Council in July 2008. The Board discussed housing issues and the need to ensure that private landlords were included in any drive to raise the quality of homes and to make homes more energy efficient. The Board was advised that there were strategies in place to address the need to reduce poverty and improve heating in homes. A thermal mapping exercise had recently been undertaken to identify where there was energy wastage in the Borough and this had been made available online to enable residents to see how energy efficient their home was. The Chair underlined the need to take a holistic approach and to work in partnership to achieve the goals contained within the Strategy. It was noted that at present the document referred only to the Council as the body responsible for delivering the Strategy and suggested that it should be redrafted to reflect the role of partners and to recognise that the Strategy would need to be 'owned' by all of the partner bodies in order to be successful. There was agreement that a letter should be sent to the PCT and the MHT requesting their views on the Strategy and how they might be able to contribute towards their achievement. **RESOLVED:** i. To note the content of the presentation. ii. That the final version of the Strategy should be written in a way	COUNCIL COUNCIL

	that reflected the Strategy was jointly owned by all partners. iii. That a letter should be written to the PCT and MHT regarding the Strategy in order to ensure that their views were incorporated.	COUNCIL COUNCIL
OBHC26.	**LOCAL AREA AGREEMENT (LAA) UPDATE** The Board considered a report that set out progress in relation to the new style Local Area Agreement (LAA) and the initial work that was being undertaken in preparation for further negotiation with the Government Office for London (GoL). Prior to consideration of the report, the Board was advised of two factual errors within the report. Recommendation (iii) should have read as follows: 'To consider whether current Neighbourhood Renewal Funding (NRF) and Communities for Health funded Well-Being projects could achieve the outcomes of the new LAA and so be eligible for future funding.' Paragraph 4.7 of the report should have read as follows: 'The Board also needs to consider whether current NRF and Communities for Health (CfH) projects meet the proposed priorities. By reviewing the list of proposed 35 priorities the Board will be able to ascertain whether current projects can achieve the outcomes for the new LAA and so be eligible for future funding.' The Board was advised that in developing and negotiating the new LAA the HSP and Thematic Boards were required to form a 'Story of Place'. This would provide an evidence based narrative for the demonstrating why the indicative targets selected had been chosen. It was noted that the Government Office for London (GoL) acted as the link between central and Local Government and that meetings would be held with GoL throughout the process. At the initial meeting held between GoL and the Council; GoL had commented that the indicative targets presented formed a strong starting point and following this the partnership had made significant progress in forming the context for the final thirty-five indicators. An Editorial Group had been set up to produce the Story of Place and the Acting Director of Public Health and the Interim Head of Policy from	

	the Adult, Culture and Community Services team had been nominated to represent the Board. There would be liaison between with the Chair and Vice-Chair of the Board throughout the process. It was noted that the section of the narrative, which was based on the Well-Being Boards priorities, would be based on the Sustainable Community Strategy priorities and the Well-Being Strategic Framework. The text and prioritised targets would need to be drafted prior to Christmas for discussion at the HSP Performance Management Group (PMG) meeting on 7 January 2008. The Board discussed the targets set out in the report and there was agreement that prominence should be given to addressing mental health issues. It was noted that reference was made to this within the Children and Young People's Strategic Partnership Boards indicators and that this would need to be taken into consideration when forming the Board's indicators. It was noted that the Supporting People Programme would end next year and that this would have a significant impact upon many of the programmes the Board supported. Consideration would need to be given to this and the pooling of existing budgets. The Board discussed transport and whether reference should be made to this within the Board's priorities. It was agreed that the use of public transport should be encouraged. Walking should also be promoted and should be referred to as part of increasing physical activity. There was agreement that the following alterations should be suggested to the list of Proposed Target Areas: i) Priorities 20 and 34, which belonged to the Integrated Housing Board and Well-Being Board respectively, should be combined. ii) A priority around Mental Health, which could be shared with the Children and Young People's Strategic Partnership Board, should be developed. With clarification being sought as to which Board would lead on this. iii) A local indicator should be considered in relation to encouraging the use of public transport and promoting walking as a way of increasing physical activity. It was noted that a report detailing progress on the new LAA would be received by the Board at its next meeting. **RESOLVED:** i. To note the recommendations agreed at the HSP on 13 November. ii. To note the timescales for producing a draft narrative and prioritised targets.	COUNCIL

	iii. That the alterations to the Proposed Target Areas for the LAA be suggested as set out above. iv. That the Boards representatives, sitting on the Editorial Group, should determine whether the projects currently funded by the NRF and CfH would be eligible for funding under the new LAA and incorporate this within the Story of Place if appropriate.	
OBHC27.	**UPDATE ON RESTRUCTURING OF SUB-GROUPS** The Board considered a report that provided an update on the restructuring of the Sub-Groups that supported the Board. It was noted that the development of the Sub-Groups should include measures to ensure that they addressed targets effectively. **RESOLVED:** To note the progress made in relation to the restructuring of the Sub-Groups.	
OBHC28.	**ITEMS OF URGENT BUSINESS** No items of Urgent Business were raised.	
OBHC29.	**NEIGHBOURHOOD RENEWAL FUNDING AND COMMUNITIES AND HEALTH UPDATE** The Board received an update on Neighbourhood Renewal Funding and Communities and Health budgets and spending. **RESOLVED:** To note the content of the report.	
OBHC30.	**WELL-BEING BALANCED SCORECARD: SEPTEMBER 2007** The Board received a report that presented the balanced scorecard, which had been developed against the objectives of the Well-Being Partnership Theme Board. **RESOLVED:**	

	To noted the content of the report.	
OBHC31.	**DRUGS: OUR COMMUNITY, YOUR SAY** The Board considered a report that provided an update on the Council's response to the consultation document 'Our Community, Your Say' on the National Drugs Strategy. **RESOLVED:** To note the report.	
OBHC32.	**WELL LONDON/ NOEL PARK: PROGRESS REPORT** The Board received a verbal update on the Well London/ Noel Park project. It was noted that a workshop had been held in order to identify how the project should be taken forward. There had been good engagement at the meeting and a report was being pulled together based on this and a Programme of Actions would be completed by the end of January. **RESOLVED:** To note the report.	
OBHC33.	**FAMILIES INTO WORK NORTHUMBERLAND PARK: PROGRESS REPORT** The Board received a verbal update on the Families into Work Northumberland Park project. It was noted that an initial meeting had been held with GoL (the body responsible for ensuring that the work of the partners involved in the project was joined up) and a second meeting was currently being arranged where the framework for the project would be agreed. **RESOLVED:** To noted the update provided.	
OBHC34.	**HEALTH INEQUALITIES AND AUDIT** The Board received a verbal update on the Health and Inequalities Audit. It was noted that external auditors Grant and Thornton had been appointed carry out the audit. The guidance issued was broad at present, but following initial discussion, it was likely that there would be a	

	focus on deaths resulting from cardiovascular disease and reducing obesity. **RESLOVED:** To note the update provided.	
OBHC35.	**ANY OTHER BUSINESS** None.	
OBHC36.	**FUTURE AGENDA ITEMS** The Board noted that items for the next agenda should be emailed to Xanthe Barker, at the address below, no later than 4 February, 2008. xanthe.barker@haringey.gov.uk	
OBHC37.	**DATES OF FUTURE MEETINGS** The Board noted that the next meeting was due to be held on 2 March 2008, at 7pm, at the Civic Centre.	

Richard Sumray

Chair

Well-Being Partnership Theme Board

Date: **4 March 2008**

Report Title: **Primary Care Strategy Next Steps**

Report of: **Helen Brown, Acting Deputy Chief Executive.**

Summary

This paper sets out the next steps for the development of the primary care strategy for Haringey, taking into account the outcome of the recent consultation and equalities impact assessment (EIA). Full reports of the consultation and the EIA are now available at http://www.haringey.nhs.uk/publications/primary_care_strategy/index.shtm

Recommendations

- To note the report.

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Final version of primary care strategy

We will be producing a final version of the primary care strategy. The full list of recommendations (previously circulated and attached for ease of reference at Appendix A) will also need to be reflected in the changes made to the final strategy document.

Case for change

- Restate the case for change to respond to those who during the consultation did not want any change, and add further reasons for change noted during the consultation (e.g. current problems with access to primary care services).

The model of service delivery

- Set out an adapted model of primary care service provision that will comprise 4 super health centres based in each of the collaborative areas each networked with a number of other larger general practices in that area as follows:

  North East – Lordship Lane/Tynemouth Road (plus further consideration of provision in Northumberland Park)
  South East – Laurels/St Ann's
  West – Hornsey Central
  Central – Wood Green/Turnpike Lane (new development)

- Proposed centres based at the Whittington and North Middlesex hospitals to be focused on the provision of urgent care. We will need to set out clearly how these hospital-based urgent care centres would operate differently from community based super health centres and to explain how they will fit into the broader context of urgent care provision across the borough in future.

- The development of the model to be based broadly around and jointly led by the existing 4 PBC collaborative groups. This will include developing a local approach to needs assessment and engagement alongside the PCT-wide work on these areas. The intention remains to significantly reduce the number of small GP practices (ie with less than 4,000 patients) over time and phase out sub-standard premises. Whilst it is recognised that some small GP practices perform well, this mode of service delivery will not provide a sustainable model for Haringey in the future. The name "super health centre" could also be reviewed.

- Criteria will be developed to select the practices that will remain or need to be developed in addition to the super health centres, to include:
  - Minimum list size
  - Standard of premises
  - Standards of quality of care
  - Ability to work within networked model
  - Ability to offer extended opening hours
  - Location (ensuring appropriate geographical spread to assist with access and transport issues and ensure appropriate coverage especially in North East of the borough).

- Greater detail to be provided of how services will be delivered in this new model to include for example sexual health/family planning, foot health, diabetes, phlebotomy, physiotherapy, dietetics.

Health inequalities

- More information to be provided on how the primary care strategy can help tackle health inequalities through targeting resources and improving access, especially in the deprived areas of Haringey.

Workforce

- Plans for developing a workforce strategy including engagement with staff side and clinicians. This is potentially wide-ranging as it could pick up on issues as diverse as GPs and PBC to extended opening hours to role and function of receptionists.

Access

- We should provide some detail as to how we will be taking forward the recommendations of the EIA in order to improve access especially for groups experiencing discrimination and disadvantage, and developing indicators for measuring how successful the strategy is at doing this.

Transport

- The final version of the strategy should provide illustrations of how travel time will be affected (based on real life examples/illustrative case studies), this will be informed by the criteria relating to location noted above and the detail of how services might be delivered.
- A joint review of transport issues to be instigated, the outcome of this to include recommendations as to how transport difficulties can be minimised.

Governance and engagement

- Include options for governance arrangements of super health centres and principles of stakeholder engagement

Pharmacy

- Set out the parameters for developing a strategy on the role of community pharmacy.

Clinical quality

- Information on how the PCT will approach monitoring and managing performance during transitional periods to ensure that the primary care strategy supports GPs to maintain good practice and over time deliver measurable improvements in quality.

Levers for change

- Further clarification if possible on the incentives and drivers that will result in independent contractors adopting the new model proposed.

Table 1 below summarises the original proposals, the consultation and EIA outcomes and how the final strategy has taken these into account.

Next steps

Once the board has considered this paper, the final strategy will be produced, taking into account the outcome of Healthcare for London (consultation ends on 7 March) as noted above, and brought back to the board for their final decision in May.

We are in discussion with LBH Overview and Scrutiny Committee about the detailed planning of services in each area and in particular engagement with the public, GPs and other key stakeholders and the phasing of those planning/engagement processes, ie should we draw up detailed plans for each super health centre network before engagement with stakeholders or would it be more appropriate to phase this so that we develop plans in one area and consult before moving on to the next.

The TPCT will also endeavour to learn from similar developments in other areas throughout the next stages of the strategy development and implementation.

Table 1: Brief summary of how the strategy will change in response to the consultation and EIA

Primary care strategy consultation document – key points and questions posed	**Views expressed during consultation**	**Related outcome from EIA**	**How PCT proposes to take this forward**
Clear case for change: outdated model	- Some wanted to see no change – happy with way things are - Some welcomed changes - OSC were convinced of need to develop and improve services. - Some wanted to see improvements in addition to existing services (e.g. add super health centres/DGH at St Ann's to current provision)	EIA highlighted existing issues re access e.g. current problems with transport to health services	No change is not an option, current model not sustainable, some current premises not fit for purpose. However need to acknowledge what people currently appreciate about their services e.g. continuity of care and that some single handed practices do perform well.
Outcome statements	Support for greater access to promotion/prevention services Continuity of care important	Suggestions for additions made by PHAST	Consider amending outcome statements as proposed by PHAST[1]

[1] (Add to 4.) That even if I have no regular or permanent address, I can still easily access screening programmes.

i. (Add to 13.) In my general practice consultation, I feel comfortable and receive respect for my cultural identity.
ii. In all services staff are aware of and sensitive to the way in which gender may affect accessing health care.
iii. That I can receive health care with the minimum of organizational barriers, in particular without an appointment even for non-urgent care, if that is a barrier for me.
iv. That general practice consultation times will be flexible to allow more time if I have difficulty understanding advice, gaps in knowledge about how to access services or the need to be more involved with decision making.
v. That services will be planned mindful of the work that users of each service will need to do, to access them.
vi. That services will seek to comply with recommendations of the Children & Young Persons and Older People NSFs, and in particular listen to and respect my concerns even if they seem to be inappropriate for the consultation.

Extended opening hours	Welcomed by some	Of particular benefit to those in employment and welcomed by young people	Aim to offer 12 hour and weekend opening hours (Aim to achieve extended opening hours in 2 sites during 0809)
Bringing wider range of services together more locally	Support for 1-stop-shop approach although concerns re waiting times and impersonal service from some Others welcomed idea of not needing to go to hospital	Flexible appointment systems can improve access for different groups Language services can be provided more effectively	Illustrate what services might be available and how organised in the new model
Need to continue to improve quality/clinical standards	Some satisfaction with current quality of care	Workforce competency around diversity and equality needed as well as clinical skill	Ongoing development of performance monitoring and management of primary care to ensure standards are maintained during transition period and improved as the strategy is implemented
Ensuring equity of access including vulnerable people	Concerns that there would be reduced continuity of care and increased travel which would disadvantage older and disabled people Concerns that people from deprived communities would not be served well	Range of recommendations made in relation to this including for example develop performance indicators that will measure progress on inequalities	Incorporate indicators around equalities in primary care strategy implementation and assign senior leader to oversee implementation of EIA recommendations.
Integrating services better, co-location and joint working e.g. with VCS	Support for this especially in relation to mental health and enthusiasm from VCS	Potential to improve access to a range of services	Include VCS and other providers in governance and stakeholder engagement arrangements.
Trade off between further to	No clear consensus although	Currently people experience	Propose that the trade off is

travel and more and better services	many concerns about increased travel distance	travel problems. Any worsening of the situation would adversely affect certain groups more	worth while and take steps to mitigate against greatest difficulties around travelling further
Acknowledging contribution of workforce	Need to ensure workforce have right skills including new skills needed to work in new model	As noted above competency around diversity needed as well as clinical skills, importance of role of receptionists and other non-clinical staff noted in promoting access to services	Develop detailed workforce strategy with involvement of staffside, clinicians etc
Links to other strategies	VCS noted need to link with wellbeing strategic framework Also to ensure needs of specific groups e.g. children and young people, mental health and people with learning disabilities are taken into account and services planned in conjunction with the strategic work underway in these and other areas	Key link needs to be between the primary care strategy and the strategic work to address health inequalities	Review other related strategies to identify common ground and how the primary care strategy can help deliver on these
6 super health centres proposed in Haringey	Queries raised as to if 6 would be enough (especially given that 2 are located outside the borough). Wish to retain other practices in addition to the new super health centres including concerns re Hornsey Central being sole provision in West of borough	Need to better understand travel issues and to mitigate against any particular difficulties faced by different groups	Go ahead with model of 4 super health centres within Haringey, 2 hospital-based, supported by network of other larger practices meeting set of agreed criteria.
Specific locations	Generally accepted locations	Need to ensure NE of borough	Developments to be focused

	specified with proviso regarding coverage/transport noted above	has sufficient provision	around the 4 collaborative areas, with the super centres sited broadly as set out in the original strategy but with networked practices providing “spokes” to these hubs to ensure appropriate coverage across the borough
Reduction to number of GP practices	Mixed views, concerns re reduction of service and travel	Transport issues raised	Number of single-handed GPs to reduce and substandard premises to be phased out over time, but retain networked practices as noted above
PBC	Few comments made	Not covered in detail	Strategy to be delivered through the PBC collaborative localities
Primary care contracting	Queries as to how GPs and pharmacists will be moved – concerns that they will not want to move and will be forced to do so	Not covered in detail	Further detail to be provided on contracting mechanisms likely to be used. Also further consideration of local governance arrangements for the networked super health centres
Role of community pharmacy	Concerns re affect on businesses, and potential loss of local pharmacies		Further work with LPC/local pharmacists to inform a pharmacy strategy
Transport	Biggest single area of concern	Big area of concern and will affect some groups more than others	A transport review to be carried out.
Premises	Some welcomed improvements to premises, comments made as to how to improve premises e.g.	Need to improve premises are not accessible. Design of new premises can help access	As noted above, substandard premises to be phased out. New build to be designed to high

	accessibility and comfort	especially for disabled people.	standard including in terms of accessibility
Financial strategy	Queries of the financial modelling and affordability, some concerns of LIFT and some opposition to privatisation/use of private providers	Reducing unplanned variations in services can help address inequalities. The financial strategy wasn't commented on in detail in the EIA process but the equity audit shows lack of link between need and resource allocation	All options to be explored in terms of financing new developments including ongoing liaison with the local authority Consider target re resource distribution more closely related to need
Engagement with stakeholders	Desire to influence the strategy	Need to engage range of stakeholders	Ongoing engagement in the overall strategy and in locality developments

Appendix A

DRAFT

Recommendations for primary care strategy from consultation report and equalities impact assessment

This paper sets out the main themes identified in the primary care strategy consultation and suggests how these issues might be responded to in the next version of the primary care strategy or other responses that might be required. We have also set out below where we cannot respond in the way people wanted us to in the consultation and the reasons for this.

1. No change – keep things as they are

The primary care strategy clearly sets out a case for change that we feel is compelling, we cannot continue with the current model of service provision. Although we understand that there is lots of good work underway already and many people are satisfied with their primary care service, our current model is not sustainable and does not provide the opportunities for delivering improved services to Haringey residents. In particular it is not possible for us to keep some of our current premises as they are not fit for purpose and cannot be developed to an acceptable level. This is not an option for us.

2. Develop a networked model of super health centres and retain some existing primary care premises

The consultation documentation set out an approach focusing on six super health centres with a small number of additional GP practices. Concerns about this approach were expressed in the consultation and, although further work will need to be done on the financial implications to ensure it is affordable, a greater emphasis on a networked model is suggested. This would seem to answer many of the concerns raised during the consultation, including those in relation to transport, and would allow the improvements in opening hours and range of services available that people would like to see.
The adapted model would include the development of super health centres (in a phased way) at:

- Lordship Lane and Tottenham Hale (or environs)
- Hornsey Central
- Wood Green/Turnpike Lane
- St Ann's, The Laurels and Tynemouth Road.

Development of super health centres at the Whittington and North Middlesex to be taken forward as well, but with a different emphasis around better management of urgent care than the community based services that would develop in the four super health centres listed above.

In addition, a number of existing primary care practices would be retained and developed as appropriate. These practices would be linked with the super health centres to provide a network of primary care that would be accessible to all Haringey residents and most importantly would work together in an integrated way. Small/single-handed GPs in unsuitable premises would not fit

with our model of service delivery, and over time, we would like to see these GPs move to provide services as part of the new model.

In order to identify those primary care practices that are likely to be retained and/or developed as part of our networked model of primary care, it would be helpful to develop some criteria that they would need to meet, taking into account the population needs of the area they serve. This is likely to include for example:

- Minimum list size
- Premises meeting certain standards
- Minimum standards of quality of care
- Ability to work with local super health centre
- Ability to offer extended opening hours.
- Location which ensures appropriate geographical spread to assist with access/transport.

A number of other PCTs have already done some work in this area (including Heart of Birmingham PCT) and we would look to learn from their experiences.

It may or may not be desirable at this stage to identify those practices that are likely to meet these criteria and hence to be retained, or to respond to the particular calls for certain practices to be retained that were made in the consultation.

We may also wish to respond to the calls from a small but vocal group who want to see a fully functioning DGH on St Ann's site. The BEH Clinical Strategy sets out the options for acute provision in Barnet Enfield and Haringey. That detailed process did not identify a need for another acute provider based at St Ann's. However, we are clear that the sort of community based access to a much wider range of specialist services called for could be met through the super health centre model we are proposing.

3. Amount of provision/coverage especially in the North East

The proposal above should address this issue, however in addition it is recommended that there is a clear statement that we will look again at the north east of the borough and undertake further modelling to identify how best to meet the challenges of need and access posed by that area. Also we need to do more to either counter the perception that we are under-doctored or to take specific action to improve distribution of primary care services/increase establishment if necessary.

4. Transport

We should acknowledge the difficulties that people currently face in travelling to health services and consider undertaking a review of this and the PCT's role in providing/facilitating transport to health services and the role of other key partners e.g. the local authority, Transport for London. Many people responding to the consultation said they would have to travel further if they were to go to a super health centre instead of their current GP practice. However, most did not take into account the potential for reducing journeys to hospital by having services currently only provided in hospital available in the

super health centres, and organised in such a way as to have a one-stop shop type approach. We have drafted some illustrative case studies that attempt to show how travel might be affected. These need to be finalised. If the networked model outlined above is accepted, further work should be undertaken to see what kinds of journeys people would need to take. If a review is carried out, a transport strategy could be devised that would clarify what transport can be provided/commissioned by the PCT and what other partners can do to improve travelling to health services and how we would work together to influence Transport for London. This strategy should be informed by the expertise of local disability groups.

We should acknowledge that any increase in difficulties in travelling will adversely affect people with disabilities and mobility problems including older people, as well as those on lower incomes more than other people.

The issue of freedom passes not being valid before 9.30 a.m. and therefore older people not being able to access early appointments came up on several occasions in the consultation – this may be something we want to comment on. However, this is presumably something that can be addressed between the patient and the practice – as patients could simply ask for appointments after this time, unless there are other issues here that need to be addressed.

5. Access

A series of actions need to be taken to ensure that the primary care strategy will not reduce access especially for vulnerable groups. This includes considering the issues related to transport outlined above but also issues around workforce training and development, language services, appointment systems, building design and supporting people to access primary care.

Suggestions for improving the outcome statements for patients in the primary care strategy are made in the PHAST report carried out as part of the EIA. These could be incorporated into the next version of the strategy, and linked to key indicators which should be developed to monitor issues around access over time e.g. ‘did not attends’ by specific groups, ethnicity recording.

6. Working with GPs and Practice-based Commissioning Collaboratives

More description of how the PBC collaboratives will implement and support the developments should be included in the next version of the strategy. However, it is clear that the Practice Based Commissioning (PBC) collaboratives will be instrumental in developing and refining the networked care pathway and responsible for commissioning care for the super health centre network populations along those pathways.

7. Implementation, governance and performance monitoring

In order to benefit from the wealth of ideas from the voluntary and community sector organisations in relation to improving primary care, and to continue to involve public, patients and other key stakeholders in the development and

implementation of the primary care strategy, ongoing stakeholder involvement is recommended. Service users and other stakeholders should be integral to the implementation process for each super health centre. This should be through representation of proposed patient and public involvement structures linked to PBC collaboratives with collaboratives taking a lead in the development of health centres for their locality. This structure will need to feed into HTPCT's commissioning structures as well as into its governance and performance structures.

8. Organisation of services including continuity of care, appointment systems

It needs to be clearly stated that patients will be able to continue to see their same GP if that GP moves to a super health centre, and that they will be able to make appointments with that same GP for planned care. However, for urgent care, as at present, patients might need to see another professional. The feasibility of having different types of appointment systems should be explored e.g. some drop-in non-urgent sessions as well as booked appointments in order to address some of the issues about access. Concerns about waiting times will be difficult to allay, but should be noted and taken into account in appointment systems.

9. Services provided in super health centres

Foot care and blood testing should be priorities for inclusion in super health centres and reference to the full list of services required should be made in terms of service planning, as well as full local needs assessments and greater involvement of local stakeholders in planning/commissioning services.

10. Workforce

A workforce strategy needs to be developed to ensure that the right staff are in the right place to deliver the strategy and to address some of the issues in relation to access that have arisen during the consultation. This should include raising awareness of the specific needs of vulnerable people and of other specific groups such as carers, children/young people, older people and those with mental health problems and include all of the workforce.

11. Hospital based model

Further work needs to be done to define how the super health centres might work that would be located at the acute hospital sites, and how they might work differently to those within the community/primary care settings and focus on urgent care.

12. Health inequalities

The development of the individual super health centre networks should be informed by a clear understanding of the needs of the populations they serve. This should underpin what services are commissioned and what performance measures are used to monitor the implementation and success of the super health centre model in addressing health inequalities.

It would also be helpful to raise awareness of what the PCT is currently doing to address health inequalities. The issues in relation to the distribution of services noted above also need to be addressed. More widespread access should be given to preventative interventions and health information as part of the strategy.

13. Pharmacy

Further work to be undertaken with pharmacists to develop an approach that would support the new model.

14. Children and Young People

The primary care strategy should include more detail as to how it will help implement the children and young people's agenda and work with children's services.

15. Older People

Action related to concerns raised about transport will be particularly important for older people; other issues for older people could be specifically addressed in the next version of the primary care strategy.

16. Mental health

Further work to be carried out to plan how people with mental health problems might benefit from the primary care strategy and how mental health services might work alongside primary care.

17. Learning disabilities

The work that has been done to date to identify the needs of people with learning disabilities needs to be incorporated into the implementation of the strategy. This to include the recent review and recommendations by the Overview and Scrutiny Committee

18. Carers

The specific needs of carers in relation to primary care services could be considered further, and included in workforce training and development.

19. St Ann's site

As noted above, there were some calls for a hospital on St Ann's, the mental health trust were also keen to work together on proposals for this site. It might be helpful to have a position paper on proposals/options for the site.

20. Privatisation concerns

We need to be clear that the super health centre model is not about privatisation but about quality. We will look to commission services from a range of providers including local NHS providers, 3rd sector providers as well working with private providers. This will be in line with Department of Health policy that the TPCT is expected to develop and work with a range of providers to deliver the best possible services for its population.

haringey strategic partnership

Well-Being Partnership Theme Board

Date: **4 March 2008**

Report Title: **Safeguarding Vulnerable Adults Policy and Procedures**

Report of: **Director Adults, Culture and Community Services**

Summary

To update Well-Being Partnership Board on The Multi-Agency Safeguarding Policy.

Recommendations

- That Well-Being Partnership Board endorse the revised policy and procedures and commend them across all stakeholders for implementation
- That stakeholders across the Borough review internal procedures to ensure that they are aligned to the revised policy and procedures.

For more information contact:
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Strategic Implications

- Haringey has had a multi-agency policy in place since 2002 to protect vulnerable adults. This has been implemented across the Council and partner agencies with varying degrees of success. Over the last three years significant progress has been made in implementing robust procedures across all adult service user groups to ensure that we do all we can to protect vulnerable adults from abuse.

- Building upon work undertaken following the publication of “No Secrets” in 2000, the ADSS have drawn up a National Framework of standards for good practice. The focus of the new guidance seeks to be more proactive in looking to ensure that anyone who may require community care services is able to retain independence, well-being and choice and do so free from risk of abuse or neglect.

- In the light of the change of focus and developments, the Council and partners have reviewed and revised the Haringey Multi-Agency Policy and Procedures to reflect best practice.

Equalities Implications

- This policy and attached procedures are aimed at safeguarding some of the most vulnerable people in the borough. They will be applied on the basis of identified risk, targeting those deemed to be at the most significant and imminent risk. Equalities monitoring of the use of the policy and procedures will take place at least annually (more often if patterns of abuse are suspected).

Consultation

- These policies and procedures have been taken via the Safeguarding Board to all stakeholders.

Background

- Since the Multi-Agency protocol was implemented in Haringey in 2002, there have been significant improvements in training, awareness, reporting and investigating concerns of abuse of vulnerable adults. In 2006/07 there were 172 alerts raised that resulted in 158 formal investigations under the protocol. This was markedly increased from the 78 in the previous year. The figures for 2007/08 to January 25th are 157 alerts (including four serious institutional investigations with many individuals at risk).

- In the light of the increasing awareness of Safeguarding issues and the consequent increase in referrals and investigations, Haringey Council has made a decision to increase it's investment in this area and has created a new post to support the current Adult Protection Manager – now to be re-designated Safeguarding Manager, Adults. This will increase our capacity across the Borough to support all stakeholders in raising awareness, identifying potential abuse and ensuring appropriate investigation and support for those who are at risk. Resources for the new post have been identified in budget proposals for next year and we are in the process of recruiting to this post.

- Haringey Safeguarding Adults Partnership has a Zero-Tolerance Policy to abuse. In no circumstance is abuse accepted or tolerated. All agencies across Haringey seek to work in collaboration to ensure that we implement this policy. The primary aim of all partners is to prevent abuse, but where preventative strategies fail; partners will initiate and follow the revised policies and procedures.

Conclusion

- All stakeholders have improved awareness and performance in Safeguarding vulnerable adults. The Well-Being Partnership Board is asked to endorse the proposed revised policy and procedure and commend them for implementation over all partners within Haringey.

Use of Appendices / Tables / Photographs

- Haringey Multi-Agency Safeguarding Adults Policy and Procedures

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HARINGEY MULTI-AGENCY

SAFEGUARDING ADULTS

POLICY AND PROCEDURES

Adult, Culture & Community Services

Version V3	**Status** Final Draft	**Author** Olive Komba-Kono Safeguarding Adults Manager Adult Services Denise Sourris Interim Business manager Adult Services

Document objectives: Sets out the multi agency framework for with regards to Safeguarding Adults, in line with government legislation and up to date guidance	
Intended Recipients: All staff in Adults, Culture, Community Services; Partner Agencies across Haringey	
Group/Persons Consulted: Safeguarding Adults Board	
Monitoring Arrangements: The Safeguarding Adults Manager will ensure that policy and procedures are kept in line with new legislations and guidelines.	
Equalities Impact Assessment: The assessment was completed in December 07 and recommendations accepted.	
Training/Resource Implications: Ongoing training is in place with regards to safe guarding adults, the new policy and procedure should be incorporated into that training	
Approving Body and Date Approved	
Date of Issue	March 2008
Schedule Review Date	March 2010
Lead Officer	Safeguarding Adults Manager
Path and File Name	

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10.2.5 Does consent need to be given by the vulnerable adult for the referral to be made

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Appendix 1: Safeguarding Adults Board: Terms of Reference
Appendix 2: Mental Capacity Guidance Notes
Appendix 3: Commissioning, Contracts and the Tender Process
Appendix 4: Learning from Cornwall: CSCI recommendations
Appendix 5: Haringey Multi-Agency Safeguarding Adults Procedures Workflow chart.

17 References

Gloucestershire Safeguarding Adults Multi-Agency Policy and Procedures, 7/6/2007
Ealing Safeguarding Vulnerable Adults (multi-agency policy and procedures, Aug 2006
Protection of vulnerable adults from abuse in Haringey, Policy and Procedures, December 2005
No Secrets, Department of Health, 2000
Safeguarding Adults, A National Framework of Standards, ADSS, 2005

1. Foreword

"Abuse is a violation of an individual's human and civil rights by any other person or persons." [1]

People living in Haringey have the right to live a life free from abuse and neglect. It is the responsibility of each agency in Haringey working with vulnerable adults to ensure that these adults are protected from any type of abuse. Each agency has a responsibility to assess when a vulnerable adult may be at possible risk of harm and to work and to work with them, their families and any carers to reduce this risk.

This document represents a collaboration between the agencies in the Borough with a responsibility for working with vulnerable adults: statutory, health, the policy the voluntary sector and the private sector, to provide a joint policy framework by which we work in partnership to safeguard vulnerable adults from abuse. The policy and procedures are based on 'No Secrets'[2] and 'A National Framework of Standards for good practice and outcomes in Adult Protection work.'[3]

Haringey Adult Services are responsible for the co-ordination and development of the policy and procedures for safeguarding vulnerable adults in their local community. This policy would however be ineffective without input and ownership from all partner agencies.

Haringey's multi-agency safeguarding adults policy and procedures represents the commitment across the agencies in Haringey to promote a safer Haringey.

2. Policy

[1] No Secrets – Department of Health (2000)
[2] No Secrets – Department of Health (2000
[3] A National Framework of Standards for good practice and outcomes in Adult Protection work.'[3] ADSS 2005

2.1 Introduction:

This document sets out the policies and procedures Haringey Council staff need to adhere to with relation to Safeguarding Vulnerable adults from abuse. The policies have been developed to promote good practice requirements across the different agencies in the Borough.

Effective communication and an understanding of each agencies roles and responsibilities are crucial to the implementation of this policy. These policies and procedures have not been developed in isolation; they represent a unified approach to safeguarding adults across Haringey.

As a statutory organisation Haringey Council has a duty of care to promote the best interest of all the Adults it supports. Haringey's Multi-Agency Safeguarding Adults Policy and Procedures exist so that any suspected abuse of a vulnerable adult is reported; vulnerable adults at risk are protected from further abuse; clear guidance and support is provided to those reporting abuse; procedures and guidance are in place for those investigating alleged abuse; ensure that effective monitoring and recording systems are in place to collect evidence; promote the rights of vulnerable adults and protect them from abuse and ensure that there is a robust assessment process in place that will safeguard adults from abuse.

2.2 Vulnerable Adults Statement of the Rights

Abuse exists in various forms and can be perpetuated by one or more people. Whatever the abuse or the setting, abuse is not acceptable and a violation of a persons basic human right.

There are people living in Haringey who may be at greater risk of abuse because of their age, the nature of their disability or circumstances. Some adults are unable to live their life without the assistance of others. Each Adult living in Haringey has the right to receive support and live a life free of abuse and neglect.

Haringey Safeguarding Adults Partnership has a Zero-Tolerance Policy to abuse. In no circumstance is abuse accepted or tolerated. All agencies across Haringey will work in collaboration to ensure that this policy is adhered to.

Vulnerable Adults in Haringey have the right to:

- Safety and the provision of adequate care and support. Including protection from all forms of violence including physical punishment, intimidation, belittling, lack of respect, harassment and sexual assault.
- Independence.
- Make decisions about their own life, even if this may involve activities where there is an element of risk.
- The protection of the law, including the right to money and property that is legally theirs.

- Lead a life free from discrimination and have their own rights upheld regardless of ethnic origin, sexuality, impairment or disability, age and religion or cultural background.
- Privacy.
- Appropriate information about keeping themselves safe and exercising their rights.
- Advocacy and assistance in making decisions regarding their abuse, where their Mental Capacity would prevent them from fully participating in the investigations.
- Be involved in all necessary decision making in the event of abuse, including the right to decide how to proceed and who they decide to confide in.
- Decline the intervention of statutory organisations after having made an informed decision regarding their circumstances, where risk has been identified.
- Report any abuse and/or neglect and for that allegation to be recorded and taken seriously, including the right to call the police in circumstances where a crime has been committed.
- Bring a formal complaint under the relevant complaints procedures if they are not satisfied with the initial investigations.

2.3 Multi-agency statement of Commitment:

All agencies and organisations that worked in partnership to develop the Multi-agency Safeguarding Adults Policy and Procedure in Haringey are committed to making sure it is effective by:

- Raising awareness that vulnerable adults can be subjected to abuse.
- Giving a clear message that preventing abuse from happening, or **protecting a vulnerable adult from further abuse if abuse has taken place is everyone's responsibility**.
- Making sure that Safeguarding Adults policies and procedures are widely available and easily understood, especially by those people they are designed to help.
- Promoting best practice to minimise abuse through the collaboration of all agencies/organisations.
- Making sure that all staff have sufficient knowledge and understanding of their roles and responsibilities in regard to Haringey's Multi-agency Safeguarding Adults Policy and Procedures through the relevant training for implementing the procedures in their work.
- Promoting the early recognition of abuse and prevention of further abuse.
- Making sure that there is consistent and effective response to any concerns, allegations or disclosure of abuse. Supporting staff in reporting and investigating allegations of adult abuse.
- Contributing towards Safeguarding adult's investigations, Strategy Meetings and Safeguarding plans.
- Making sure that, where intervention is necessary, staff pursue action in a way that causes the least disruption to the vulnerable adult's way of life.

- Preventing the risk of the abuse reoccurring.
- Recognising that adults identified as vulnerable have a right to confidentiality.
- Working in a preventative manner to protect vulnerable adults from abuse and/or neglect.
- Making sure that if during a Safeguarding Adults Referral or Investigation, any concerns about the safety and well-being of a child or young person arise these concerns should be referred immediately to Haringey Councils Children and Young People's Service.

3 Scope

This policy and procedure applies to staff working in: Haringey Council Adult, Culture and Community Services, Haringey Primary Care Trust, Haringey Mental Health Trust, Haringey Police, Haringey Legal Services, Commission for Social Care Inspection, The Probation Service, The Crown Prosecution Service, London Ambulance Service NHS Trust, the Fire and Rescue Service and contracted and independent providers of care.

This policy and procedures applies to all vulnerable adults, resident in the London Borough of Haringey, aged 18 and over.

4 Policy Framework

The Department of Health and Home Office issued the publication "No Secrets: Guidance on developing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse" in March 2000. Haringey's Safeguarding Adults Policy adheres to the contents of "No Secrets".

Haringey is currently working towards meeting the 11 standards set out in the Association of Director of Adult Social Services (ADASS): "A National Framework of standards for good practice and outcomes in Adult Protection work". The 11 standards are:

Standard 1: Each local authority has established a multi-agency partnership to lead Safeguarding Adults work.

Standard 2: Accountability for and ownership of Safeguarding Adults work is recognised by each partner organisation's executive body.

Standard 3: The Safeguarding Adults policy includes a clear statement of every person's right to live free from abuse and neglect, and this message is actively promoted to the public by the Local Strategic Partnership, the Safeguarding Adults Partnership, and its member organisations.

Standard 4: Each partner agency has a clear, well-publicised policy of Zero Tolerance of abuse within the organisation.

Standard 5: The "Safeguarding Adults" partnership oversees a multi-agency workforce development/training sub-group. The partnership has a workforce development/training strategy and ensures that it is appropriately resourced.

Standard 6: All citizens can access information about how to gain safety from abuse and violence, including information about the local Safeguarding Adults procedures.

Standard 7: There is a local multi-agency Safeguarding Adults policy and procedure describing the framework for responding to all adults "who is or may be eligible for community care services" and who may be at risk of abuse or neglect.

Standard 8: Each partner agency has an internal set of guidelines, consistent with the local multi-agency "Safeguarding Adults" policy and procedures, which set out the responsibilities of all workers to operate within it.

Standard 9: The multi-agency Safeguarding Adults procedures detail the following stages: Alert, Referral, Decision, Safeguarding Assessment Strategy, Safeguarding Assessment, Safeguarding Plan, Review, Recording and Monitoring.

Standard 10: The safeguarding procedures are accessible to all adults covered by the policy.

Standard 11: The partnership explicitly includes service users as key partners in all aspects of the work. This includes building service-user participation into its membership, monitoring, development and implementation of its work; training strategy, planning and the implementation of their individual safeguarding assessment and plans.

5 Aims of the Policy

In Haringey, the Haringey Safeguarding Adults Board is tasked with the responsibility of ensuring that vulnerable adults are free from abuse and neglect. This multi-agency policy and procedure is the framework by which the Board's strategies are implemented across the borough. This policy does not stand alone and should be read in the context of other local operational procedures, the legislative framework and good practice requirements set out by regulators. The framework provides good practice guidance to local agencies that have a responsibility to investigate and take action when a vulnerable adult is believed to be suffering abuse.[4]

[4] No Secrets": DOH 2000- Section 1.5

This policy and procedure should provide all staff working in voluntary, community, statutory and private agencies/organisation throughout the Borough the means to identify incidences of abuse and be able to respond in a way that safeguards that adult, in line with the good practice requirements. Each agency has a responsibility to respond sensitively and coherently to reported incidents or allegations of abuse/neglect. It is imperative that there is a consistent approach across the Borough.

The primary aim for all agencies is to prevent abuse. Where preventative strategies fail, agencies should ensure that robust procedures are in place and are closely followed in dealing with incidents of abuse.

6. What is the definition of a Vulnerable Adult?

A Vulnerable Adult is any adult over the age of 18 "who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation". [5]

The term "community care services" in this document includes all social and health care services in any context. This includes adults with Mental Disability, Physical Disability, Learning Disability, Illness and Frailty. [6]

The term "harm" should be taken to include not only ill treatment (including sexual abuse and forms of ill treatment that are not physical), but also the impairment of, or an avoidable deterioration in, physical or mental health. It should also be taken to include the impairment of physical, intellectual, emotional, social or behavioural development. [7]

For young people or children under the age of 18, who may be at risk of abuse, or significant harm, Haringey's Safeguarding Children Procedures should be referred to.

There will be certain circumstances when it will be appropriate for the Children and Young People's Directorate to work jointly with Adult Services to safeguard a young person, for example a young person who is aged 17 years old and is in transition.

6.1 What Constitutes Abuse?

[5] No Secrets": DOH 2000: Section 2.3

[6] ("No Secrets": DOH 2000: Section 2.4)

[7] No Secrets": DOH 2000 Section 2.18

Abuse can take place in a number of different ways and in any setting. Fundamentally, abuse violates an individual's human and civil rights. [8]

Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it. [9]

Abuse can constitute "a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust, which causes harm or distress to a vulnerable adult". [10]

Abuse of a vulnerable adult may be obvious for example, where this is a visible injury, but in many instances the evidence may be subtle.

Abuse is an ill treatment that causes significant harm and can result in the deterioration of a person's physical, emotional, social or behavioural development. Neglect and poor professional practice can be considered abuse. This may take the form of isolated incidents of poor practice through to ill treatment or gross misconduct.

6.2 Risks Arising From Self Neglect

In cases where there is risk arising from significant neglect due to capacity then the Haringey Multi-agency Safeguarding Adult Policy and Procedure should be applied. In particular, if a vulnerable adult does not have the capacity to meet their needs, or consent to services/care that will ensure those needs are met due to: mental health, a brain injury or learning disability. The procedure should also be followed if a vulnerable adult does have mental capacity but has refused essential services, without which their health and safety needs cannot be met.

In cases where a vulnerable adult does have capacity, then that adult has the right to make their own choice about the care they wish to receive or not receive. All endeavours should be made to provide that person with as much relevant information as possible to assist them in making an informed choice.

Where agencies are unable to implement services to reduce or remove risks the reasons for this should be fully recorded and maintained on the person's file, with a full record of the efforts and actions taken by the agencies to assist and help the vulnerable adult.

The vulnerable adult, carer or advocate should be fully informed of the services offered and the reasons why the services were not implemented. There is a need to make clear that the person can contact the relevant agency at any time in the future for services. In cases of high risk, consideration should be given to

[8] ("No Secrets": DOH 2000- Section 2.5)
[9] ("No Secrets": DOH 2000- Section 2.6)
[10] ("No Secrets": DOH 2000- Section 2.6)

arrangements for monitoring and where appropriate making proactive contact to ensure that circumstances do not deteriorate to an unacceptable degree.

If an individual does not have mental capacity due to the state of their mental health or a brain injury, the Mental Capacity Act 2005 protocols need to be followed. In Haringey Council, these protocols set out the steps that a professional needs to take in relation to the legislation. The key action is a referral to an Independent Mental Capacity Advisor (IMCA) Service. Haringey Council currently uses Rethink as it IMCA service. The IMCA will act as the individual's independent advocate throughout the safeguarding investigation to promote the individuals wellbeing and safety.

6.3 Types of Abuse:

The types of Abuse found in this policy are in accordance with "No Secrets" definitions.

Physical Abuse: includes hitting, slapping, pushing, kicking, misuse of medication or inappropriate sanctions or restraint.

Sexual Abuse: includes rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured in to consenting.

Psychological Abuse: includes emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.

Financial or material abuse: includes theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

Neglect and acts of omission: includes ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating;

Discriminatory abuse: includes racist, sexist, that based on a person's disability, and other forms of harassment, slurs or similar treatment.

6.4 Other types of abuse could include:

Institutional Abuse: includes neglect and poor professional practice: this can range from isolated incidents of poor or unsatisfactory professional practice to pervasive ill treatment or gross misconduct. It includes the mistreatment or abuse by a regime or individual/s within an institution e.g. a hospital, care home or day centre. It occurs where the individual's wishes or dignity are consistently or

repeatedly compromised to ensure the smooth running of an institution or organisation. Any types of the abuse mentioned above can occur within institutions and could include poor care standards, misuse of medication, inappropriate restraint, lack of privacy etc.

Peer Abuse: including abuse of one vulnerable adult by another vulnerable adult, both of whom are service users within a care setting.

6.5 Indicators of Abuse:

An indicator of abuse should not be taken to mean that abuse is or has occurred. Indicators of abuse should act as a trigger for a robust assessment of the individual's circumstances and situation. Allegations of abuse need to be substantiated with evidence. It is therefore essential that care is taken not to entirely depend upon these indicators. Missing these indicators on the other hand could have serious consequences for the vulnerable adult. Indicators of possible abuse need to be used as tools to support professional practice and judgement.
The following warning signs are good indicators of abuse:

- Bruises, falls and injuries
- Signs of neglect such as clothes being dirty, malnutrition
- Poor care either at home or in residential or nursing home or hospital
- Changes in someone's financial situation: problems with their finances, depletion of funds, change in ownership etc.
- Changes in behaviour such as, loss of confidence, anxiety, aggression.

6.6 Who can be a Perpetrator?

Anyone potentially could be a perpetrator of abuse. Anybody in any relationship with a vulnerable adult, who exploits their position of trust, could be the perpetrator of abuse.

Vulnerable Adults are abused by a wide range of people such as:

- Family
- Friends
- Neighbours
- Professional staff
- Paid carers
- Informal carers
- Volunteers
- Other Service Users
- Associates
- People who deliberately exploit vulnerable people
- Strangers.

The roles, powers and duties of the various agencies in relation to the alleged perpetrator will vary.[11]

6.7 The Carer as Alleged Perpetrator:

Carers provide support to sick and disabled people that saves the state approximately £57 billion every year.[12] However, it is also important to recognise that a carer may also be a perpetrator of abuse. Raising an awareness will help to ensure that carers will receive assistance and support to reduce the likelihood of them committing an abusive act.

It may be that the carer's response or attitudes indicate that something is the matter. The abusive behaviour may stem from an individual response to a given situation rather than because of the situation itself.

There are various factors that could affect the relationship to breakdown between a carer and the vulnerable adult. The factors include:

- Dependency on the vulnerable adult (e.g. financial)
- Alcohol/substance misuse
- Conflicting responsibilities
- Poor family relationships over the years
- Low income/ poor housing/ financial difficulties
- Carer had to change his/her lifestyle
- Isolation/ no family support/ no support from other agency/ no social life
- No personal private space
- Caring responsibility has been imposed
- Carer has abused in the past or has been abused
- Personal ambition is affected
- Carer under extreme stress
- History of Mental health problems

Abuse can manifest in various ways and include:

- Silence in the home
- Lack of consideration of vulnerable adult's needs
- Refusing the vulnerable adult to have an opinion
- Aggression or volatile behaviour
- Carer rejecting other help
- Carer shows apathy, withdrawal, depression, hopelessness or suspicion
- Not allowing the vulnerable adult to be visited without the carer present;
- Any of the other types of abuse already listed

Aggravating factors could include:

- Reversal of the usual parent/child roles
- Incontinence or difficult behaviour, especially if perceived as deliberate
- Communication problems e.g. hearing, speech or memory
- Violence is the norm

[11] No Secrets: DOH 2000- Section 2.12
[12] Carers UK 2002, Without Us: Calculating the value of carers' support

- Vulnerable person is rejecting or ungrateful;
- Disturbed sleep
- Carer feels exploited
- Carer feels guilty about expressing their feelings around the caring role
- Carer experiences a cultural conflict in their caring role
- Carer lacks the knowledge required to provide appropriate care

6.8 Where can a Vulnerable Adult be Abused:

Abuse can take place in any context[13] and can occur in the following settings:

- Nursing Home
- Residential Care Home
- In Hospital
- Day care centre
- In a custodial situation
- In their own home
- In other places assumed as being safe
- In public places
- Living alone or with a relative.

6.9 When abuse constitutes a crime:

Various definitions of abuse are actions that may constitute a criminal offence. Such actions include: assault (whether physical or psychological), sexual assault (including rape), theft, fraud or other forms of financial exploitation, discrimination on grounds of race, gender or disability and false imprisonment. In this respect, vulnerable adults are entitled to the protection of the law in the same way as other members of the public.

Criminal acts carried out by strangers are not usually defined as abuse but in some cases it may be appropriate to use Haringey's Multi-agency Safeguarding Adults Policy and Procedures to ensure that the vulnerable adult receives the services and support that they need.

In addition to this the Mental Capacity Act 2005, which came in to force in April 2007, introduces a new criminal offence of ill treatment or neglect of a person who lacks Mental Capacity (e.g. Adults suffering from dementia)

When reports about alleged abuse suggest that a criminal offence has been committed, it is important as part of Haringey's Safeguarding Adults procedures, to immediately refer the incident to the police as a matter of urgency. The police will advise on the necessary further action, level of urgency and the process for undertaking any subsequent criminal investigation.

Criminal Investigation by the Police must be prioritised. Through the Safeguarding Adults process, liaison with the police may allow other action to

[13] No secrets: DOH 2000- section 2.14)

take place whilst the criminal investigation continues. However, it may be that the Council takes no action because the police need to complete their own investigation and any action could jeopardise that investigation. The decision must be made in liaison with the police, who will advise what action should be taken.

Criminal Offences are dealt with by the State - the Police investigate and then in liaison with the Crown Prosecution Service decisions are made whether or not to prosecute. The Crown Prosecution Service has to apply two tests - whether there is a realistic prospect of conviction, and if so, whether it is in the public interest to proceed.

6.10 Prevention of Abuse: The Responsibility of all agencies.

The primary aim of all the care agencies/organisations within Haringey (Police, Adult Services, Commission for Social Care Inspection, Day Centres, care homes, private and voluntary organisations and any other care provider) is to prevent abuse. Each agency has a duty to ensure that policies and procedures are based on a strategies for prevention as much a possible.

Each agency must provide accessible information available to users, carers and the general public on how to raise a concern or make a complaint.

Staff need to be aware of safeguarding adults procedures. Safeguarding Adults should feature in induction and training packs for staff at a level that is commensurate with their role in the Safeguarding Adults process. Safeguarding Adult training must be mandatory training across each agency. All staff should be made aware that abuse can occur and what processes are in place to keep vulnerable adults safe.

Procedures need to be in place across each agency, that deal with disclosure of abuse by a vulnerable adult. These procedures need to be compatible with this Haringey Multi-Agency Safeguarding Adults Policy and Procedures.

Assessing vulnerability and identifying possible risks relating to abuse should be integrated into each agencies assessment and risk assessment framework. This should not be seen as a separate exercise but as part of a holistic assessment process. Good communication should be fostered, to promote an open culture in an organisation. Staff must communicate effectively with service users, carers and ensure that managers and senior managers are made aware of any concerns.

Staff across all the agencies should have access to all relevant policies and procedures which will enable them to carry out their work to the best interest of the service user and carer. It is essential that staff are made aware of the importance of keeping accurate, factual and contemporaneous records. All information should be recorded in a sensitive non judgemental manner keeping in mind service users and carers have access to their records under the Freedom of

Information Act 2000. Any record kept about a service user may be also be used in the court arena as a legal document.

Safe recruitment procedures and practices need to be in place for all staff across each agency. This should include agency staff, staff bank, sessional staff, student volunteers and any other staff/people working with vulnerable adults or children. Work references should be obtained prior to the employment commencing, candidates should be subject to an enhance Criminal Record Bureau (CRB) check, that is cross referenced with the Protection of Vulnerable Adults (POVA) register. Where a profession is regulated, for example social workers are regulated through the General Social Care Council (GSCC) and nurses are regulated via the Nursing and Midwifery Council (NMC), agencies should ensure that candidates are properly registered with their respective regulators and are not subject to any conduct proceedings or suspended from the register.

Clear procedures should be in place for 'whistle blowing' or addressing allegations or concerns against staff, volunteers or any other person working on behalf of that agency. These procedures should be accessible to all staff and the public. They must promote the safety and welfare of vulnerable adults. Furthermore, agencies must guarantee that staff and service users, using these procedures appropriately, will not prejudice their own positions and prospects.

Agencies must have robust systems to evidence the Safeguarding Adults guidance and must apply them when staff are suspended or dismissed. Professional bodies must be informed of the suspension or dismissal. Codes of Conduct for all staff must be in place setting out what is expected of all staff and the minimum standards that should be upheld at all stages. There must also be clear guidance in place informing staff about what is not acceptable and how the agency will deal with such behaviour/ lapse in standards.

6.11 Failure to Investigate

If a statutory agency (Police, Adult Services or Health), does not investigate an allegation of abuse, other agencies or concerned parties (i.e. family, friends etc) have the right to make a formal complaint using the complaints procedures in place within those statutory organisations.

Such complaints should always be brought to the attention of the Haringey Multi-Agency Safeguarding Adults Board. The complaint should be followed up in writing, outlining how the complaint is being investigated. There should also be an appropriate plan of action in place to ensure that support is provided to the Vulnerable Adult and these procedures are being correctly implemented.

There may be cases where one organisation or agency does not believe another organisation is fulfilling its obligations to investigate or contribute to the investigation. In such instances, a complaint or discussion should initially be made with the manager of that team or section.

If a satisfactory reply is not received the complainant should:

- Consult with their own manager

- Consider with him/her addressing the complaint to a more senior manager until a more satisfactory outcome is received.
- Inform the Haringey Safeguarding Adults Co-ordinator of the difficulties faced in completing a full investigation.

Any failure of an agency to investigate or contribute effectively to an investigation of alleged abuse may have serious consequences for a vulnerable adult. In the worst case scenario it may even result in the death of that vulnerable adult, which may lead to a criminal investigation.

It is therefore always imperative to escalate any concerns to a senior manager in the organisation, if there is no response from a team or unit manager.

6.12 What is considered an inappropriate relationship between a paid carer/ professional and service user?

As a professional employed to provide care and support to a service user or carer, there is a duty of care to promote the welfare and safety of that service user/carer. It is therefore appropriate to maintain a professional boundary at all times.

Having a sexual or close personal relationship with a service user is not acceptable behaviour. This is because of the inherent power imbalance that is present in a professional support relationship. The Sexual Offences Act 2003 recognises this imbalance and makes it illegal for a paid carer to have a sexual relationship with a service user who may have a mental health condition or is in a care setting. Other offences may be committed even if the professional thinks that the relationship is “consensual”.

In order to safeguard vulnerable adults from this potential abuse each agency should have clear procedures in place for staff to report their concerns about interactions with a service user before it progresses.

There may be cases where a service user or carer makes sexual advances or would like to have an intimate relationship with the professional. As a professional, there is a duty to maintain boundaries and to report any such advances directly to a line manager. The relationship should be managed so as not to alienate the service user/carer. It is the professional’s responsibility to ensure that the relationship remains within the boundaries professionalism.

Any such incidences must be accurately and clearly recorded; evidencing what action has been taken to safeguard the vulnerable adult. It may be appropriate to offer the member of staff or the service user additional counselling and support.

6.13 When can intervention be justified?

When an alert outlining an allegation of abuse is first received, the extent or seriousness of the abuse may not always be clear. It is therefore important when

considering appropriateness of intervention to approach reports or allegations with an open mind. When assessing risks involved in the case, the following factors should be considered:

- the vulnerability of the individual
- the Mental Capacity of the individual
- the nature and extent of the abuse
- the length of time it has been occurring
- the impact on the individual
- the risk of repeated or increasingly serious acts involving this or other vulnerable adults.[14]

Once the assessment has highlighted the level of risk involved in the case and a decision has been made that professional intervention is required in order to safeguard that vulnerable adult, the intervention should be based on the following principles:

- Once an individual makes an informed decision about his or her circumstances, where risk has been identified, and a choice is made to decline the intervention of a statutory authority, then his or her wishes must be respected. The decision to override such a decision can only be made once a statutory obligation exists to intervene.
- Intervention is necessary to reduce the risk and the intervention is accepted by the individual, the professional should pursue a course of action that reduces the risk in the least disruptive way to the individual.
- The vulnerable adult must be given relevant information and advice that will assist that individual in making an informed decision. The information should always be presented in a format that is appropriate to that individuals needs.
- Staff will document their decisions that must take in to account the welfare of the vulnerable adult and their civil liberties.
- The needs of the carer must be considered.
- If possible, a link will be maintained with that vulnerable adult in case the situation becomes intolerable and swift action is needed.

The degree of abuse that would justify intervention builds on the concept of ‘significant harm’ introduced in The Children Act 1989.

[14] No Secrets Section 2.19

7 Other Related Policies

7.1 Domestic Violence

Although not formally classified as a type of abuse, all staff must be aware that adult abuse can occur within a domestic context. There can be overlap between Safeguarding Adults incidents and cases of domestic violence.

Domestic violence has been defined as "any incident threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been in a relationship together, or between family members, regardless of gender or sexuality"[15]

"Causing or allowing the death of a child or vulnerable adult" has now become a criminal offence. The perpetrator and victim do not need to co-habit in order for an allegation of domestic violence to be made because: "a person is to be regarded as a "member" of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it." [16]

7.2 Child Protection

There will be cases where Domestic Violence or abuse of a vulnerable adult also involves a child, or puts a child at risk of significant harm. In these situations a referral must be made to the:

Haringey Child Protection Referral and Assessment Team on 020 8489 1856/1805/1806 (Hornsey)
or
02084895402/5403/5404 (Tottenham).

If there are children in a household and there is concern/evidence of Domestic Violence, the welfare of the child must always be paramount. That child or children may themselves be subject to violence or other forms of harm. Children who witness Domestic violence are at risk of significant harm, in that this is a form of psychological abuse and should be logged via a referral to the Children and Young People's directorate on the afore mentioned telephone numbers. Should a referral be made concerning the welfare of a child or children it is good practice to inform the parents/carers that a referral has been made. There are circumstances where that information may put the child at greater risk of harm, or in some instances of Domestic Violence could further harm the adult. Extra care should be taken in these cases and a professional judgement should be made about the best interest of the child and safety of the adult. For further information on such circumstances it may be useful to consult the London Child Protection Procedures which can be found at **www.londonscb.gov.uk.**

[15] Metropolitan Police Racial and Violent Crimes Task Force
[16] Domestic Violence, Crime and Victims Act, 2004

Young people in transition who are considered to be at risk of significant harm will be supported through the Children and Young Peoples service via the Safeguarding Children Protocols. Adult Services will work jointly with the Children and Young People's Service to ensure that the young person is safeguarded and effective transition plans are in place.

Where a Child is Looked After by the Local Authority, and is in transition to Adult Services, The Looked After Children Procedures will run in parallel to the Transition planning. Any safeguarding issues will be worked jointly via the Children and Young People's Service and Adult Services. The young person (s) will be subject to children safeguarding protocols until that young person (s) is made safe. Once a child is over the age of 18 this procedure should then be followed. It should not be assumed that if a child or young person has been subject to child protection concerns they will automatically be considered as subject to safeguarding adult's procedures. Each case should be assessed in line with these procedures and risk properly identified and recorded with actions planned.

7.3 Confidentiality

The Data Protection Act 1998 sets out the guidelines by which each agency should maintain confidential information.

Each agency will have a set of protocols and procedures on how staff should handle confidential information that is sensitive and not in the public domain.

There are circumstances in which it is imperative that staff share and exchange relevant information in order to progress a vulnerable adult enquiry or investigation. The information shared is done so in order to safeguard a vulnerable adult from potential abuse. That information is however shared between agencies that are involved in that persons care, or involved in safeguarding that individual. The information should still be treated as confidential and is still covered by data protection.

Whenever possible, it is good practice to obtain the consent of the individual concerned before sharing any information about that person. This should preferably be in writing and is dependant on that individual having the mental capacity to consent to disclosure. There are circumstances in which it is necessary to disclose information without consent of the individual concerned. This may be necessary in the public interest, where a failure to disclose information may expose an individual or others to significant risk of serious harm or to prevent criminal activity.

All those providing information should take care to distinguish between fact, observation, allegation and opinion. It is important that should any information exchange be challenged, in respect of a breach of confidentiality or, for example, as a breach of the Human rights Act, the information can be supported by evidence.

7.4 Information Sharing:

As outlined above, confidential information can be shared with the consent from the person providing it, or to whom it relates. Confidential information can be shared without consent if this can be justified to be in the public interest. A clear record should be maintained whenever information is shared, outlining the reasons the information was shared.

It is good practice to share concerns that may arise with the individual concerned and their carer(s), and to obtain the consent of the individual to share the information with other agency pertinent to that individuals care. There will be exceptions, where sharing that information may further jeopardise that individuals safety, or place them or other individuals at risk. If informing or sharing the concerns with the individual impedes the investigation, then it is appropriate not to share that information. A decision not to share information or obtain consent from an individual to share information that is about them, should not be taken lightly and must done to safeguard that adult or in the interest of public protection. Such a decision should be agreed with a manager/senior manager in the agency and must always be recorded and evidenced on the service user's records.

The Data Protection Act 1998, allows personal data to be processed without the consent of the individual, when the processing is for the prevention or detection of a crime. "No Secrets" also suggests that sharing personal or sensitive information regarding a service user, ideally informed consent should be sought, but if this is not possible and other vulnerable adults are at risk, it may be necessary to override this requirement.

A public interest to share information can arise in cases:

- Where there is evidence that a child, young person or adult is suffering, or at risk of, significant harm.
- Where there is reasonable cause to believe that a child, young person or adult is suffering, or at risk of significant harm.
- To prevent significant harm to children and young people or serious harm to adults.
- With legal staff for court proceedings
- With the T police in the detection or prevention of crime.

Shared information must be adequate, relevant and not excessive in relation to the purpose for which it is held and must be held no longer than is necessary for that purpose.

Each Haringey agency/ organisation (Police, The Council, Care Homes, Care Agencies, Day Centres, NHS, and PCT etc.) is responsible for maintaining their own records on work with Safeguarding Adult cases. Each agency must also have a policy stating the purpose and format for keeping the records and for their destruction.

This policy seeks to set out the proper level and line of communication to be adhered to when any partner agency seeks to obtain from another agency confidential information concerning clients and records

7.5 Consent:

The Mental Health Act 1983 defines consent as:

"The voluntary and continuing permission of the adult to agree a course of action or inaction, based on an adequate knowledge of the purpose, nature, likely effects and risks of the proposed action or inaction including the likelihood of its success and any alternatives to it. "

Permission given under unfair or undue pressure is not 'consent'.

Staff should wherever possible seek the consent of an individual before sharing any information about them. There will be circumstances when it is not possible to seek consent or may place the individual or other individuals at risk by doing so.

Practitioners should not seek consent if by doing this they might:

- ☒ Place a child, young person or adult at increased risk of serious harm
- ☒ Prejudice the prevention or detection of a serious crime
- ☒ Prejudice the safeguarding investigation
- ☒ Lead to unjustified delay in making enquiries about allegations of significant harm

7.6 Capacity

Capacity is related to the ability of an individual to make decisions. In order to be capable of making a decision the individual should be able to demonstrate the ability to:

- ☑ understand the information relevant to the decision
- ☑ retain that information
- ☑ use or weigh that information as part of the decision making process
- ☑ communicate that decision (using whatever form of communication is appropriate to that individual)

All adults are presumed to have legal capacity unless there is clear evidence to the contrary: "A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success."[17]

Capacity should be considered throughout any assessment process. It should also be noted that an individual's needs, circumstances and capacity may change and are not fixed. Therefore where a person may assume to have capacity and the beginning of a safeguarding investigation, there may be occasions where that

[17] Mental Capacity Act 2005: Section 1(3)

capacity may be diminished at various stages throughout the process. If this is the case, a re-assessment/review should take place taking into account any changes to that individuals overall needs and wellbeing.

See Appendix 2: Capacity guidance for more information on Mental Capacity

7.7 Lack of Capacity

In the case that an individual is unable to make an informed decision or lacks the capacity to recognise or acknowledge risk, then statutory authorities may need to be involved in accordance with these procedures. It is however important to remember that in any case where mental capacity is in question; the Haringey Multi-agency Safeguarding Policy and Procedures should be followed in parallel with the Mental Capacity Act protocols. A referral to IMCA should always be made if there is a question around an individual's mental capacity.

Any intervention must be proportionate to the risk and must be carried out in a way that is least disruptive to the individual's way of life. Before proceeding with statutory intervention the safeguards that may be provided by carers and other significant people must be explored. The decision about assessing risk is a joint responsibility between the relevant agencies involved.

In some cases A Mental Health Act assessment may need to be considered .

7.8 Best Interest

Where a vulnerable adult is judged to lack capacity in relation to a specific decision, this decision should then be made in that individual's 'best interest'.

When making a 'best interest' decision the following factors must be considered:

- Any past and current wishes and feelings of the individual concerned; including any written statement or choice directives.
- The individuals' beliefs and values, including: any religious or cultural beliefs likely to influence that individual if they had capacity.
- Other factors that the individual would be likely to consider if they were able to do so, e.g. a sense of family obligation.
- The views of others considered appropriate to approach e.g. carers
- The recommendation of the IMCA

8 Equal Opportunities Policy Statement

Haringey Council is committed to reflecting the full diversity of the community it serves and to promoting equality for everyone. We accept that the Council is not free of unintended institutional discrimination. We will work to eradicate it.

We aim to ensure equal access to our services by all citizens on the basis of need and to provide services in a manner that is sensitive to the individual

whatever their background. We will represent the needs of our diverse communities to other agencies and make equal opportunities a key guiding principle in all of our work with our partners. We will ensure that our workforce reflects the community it serves. We will take positive action to realise our equality our equality of opportunity policy.

We are committed to eliminating discrimination on the grounds of:

- Age
- Disability
- Colour, ethnic origin, nationality national origin or race
- Gender
- HIV status
- Marital status
- Religion or belief
- Responsibility for dependants
- Sexual orientation
- Unrelated criminal convictions

It is the responsibility of every employee of the council to uphold and implement the policy.

It is the responsibility of each individual manager, at all levels, to plan and provide their services to realise this policy.

9 Roles and Responsibilities

9.1 The Haringey Safeguarding Adults Board MUST:

- Include representatives from Haringey Adult Services, Haringey PCT, the Police, the Voluntary and Private Sectors and The Probation Service.
- Meet quarterly. The meeting must be chaired by the Assistant Director, Adult Services Haringey Council.
- Oversee the development and approval of multi-agency policies and procedures in respect of Safeguarding Adults.
- Establish systems to monitor and review Safeguarding Adults policies and procedures and ensure these are promoted across all Haringey agencies.
- Ensure the publication and distribution of documentation to support the Vulnerable Adult Process and increase public awareness of abuse and neglect of Vulnerable Adults.
- Identify and secure funding to support the implementation of the Vulnerable Adult Process.
- Ensure that the Safeguarding Adults Policies and Procedures reflect the needs of all communities in Haringey.
- Ensure links with other areas of policy and good practice guidance, both locally and nationally.
- Ensure the development and implementation of the training strategy.

- Oversee the development of research links to ensure that information is available on current practice and trends which can support service improvements.
- Oversee and be informed by the monitoring of referrals and outcomes of allegations of abuse to the Department of Adult Social Care. To ensure that this information is used to promote good practice and to respond to government and other bodies requests for reports on activities.
- Ensure the development and implementation of serious cases Multi-agency review system and to ensure that agencies implement all recommendations arising from these reviews.
- Produce an annual report on Safeguarding Adults work in Haringey.

9.2 Statutory Agencies **(which include the Services provided by: Haringey Council, the Police, the Mental Health Trust, Primary Care Trust, and other government services with a statutory responsibility to vulnerable adults) MUST:**

- Have clear guidelines in place that set out the roles and responsibilities for all staff in relation to Safeguarding Adults.
- Supervise and monitor staff working with vulnerable adults to ensure that best practices are being adhered to.
- Raise public awareness regarding the abuse of vulnerable adults. A clear message should also be given that this is everyone's responsibility.
- Make sure that all staff and volunteers are appropriately trained in Safeguarding Adults. The training should be correlated to people's roles.
- Ensure that the relevant reports and information are prepared for Strategy Meetings, Case Conferences and Review Meetings as set out in these procedures.
- Maintain clear, accurate records of any safeguarding adult concerns. Any action taken should be clearly outlined and monitored.
- Share information in accordance with the local and national agreement on a need-to-know basis, when it is in the best interest of the vulnerable adult.
- Contribute to investigations acknowledging the requirements of confidentiality and data protection.
- Participate in the joint working arrangements as defined in this policy.
- Implement preventative and/or supportive action to vulnerable adults in accordance with this policy and within their role.
- Establish and implement robust and consistent practises in relation to employing staff and in the selection of volunteers by ensuring that an enhanced CRB check is done and that this is then cross-referenced with the Protection of Vulnerable Adult register.
- Attend the Safeguarding Adults Board Meetings, where appropriate
- Provide an annual report to their own Management Board.

9.3 Haringey Adult Services MUST:

- Investigate allegations of abuse

- Liaise with advocacy services
- Complete needs assessments for vulnerable people and their carers.
- Contribute to Strategy Meetings and Case Conferences as per these procedures as lead agency, where appropriate.

9.4 The Haringey Safeguarding Co-ordinator within Adult Services MUST:

- Co-ordinate the Safeguarding Adults Policy
- Contribute to Safeguarding Adult investigations and casework as per these procedures
- Monitor and record the outcome of each Safeguarding Adults referral
- Maintain the Safeguarding Adults Register
- Co-ordinate Serious Case Reviews
- Co-ordinate the Multi Agency Risk Management and Assessment Procedures (MARMAP)
- Collate and report to the Department of Health, CSCI and other national policy makers all relevant information monitored under this policy.
- Produce an annual report.

9.5 Haringey Adults Contracts Team MUST

- Participate in investigation when they occur setting where services have been purchased or commissioned.
- Focus their investigation on the standards required in the provision of services outlined in the contract.
- Attend Multi-agency Strategy Meetings and Strategy Review Meetings prior to any investigation and must carry out any actions agreed to at the meeting.

9.6 It is the responsibility of the Placing Authorities to:

- Provide support to the vulnerable adult and plan their future care needs.
- Nominate a link person for liaison purposes during the investigation.
- To attend any Safeguarding adults Strategy Meeting and/or may be required to submit a written report.

9.7 The Police MUST:

- Pursue criminal proceedings where appropriate.
- Protect people in vulnerable situations.
- Contribute to Safeguarding Adult investigations and casework as per these procedures.
- Allocate a named Safeguarding Adults Link Officer for each division.

- Provide advice and possible action throughout the whole Safeguarding Adults process.

9.8 National Health Service Professionals (Including hospitals, GPs, Primary Care Trust and the Mental Health Trust) MUST:

- Ensure evidential investigations of medical examinations are undertaken, with the consent of the person involved.
- Ensure services are delivered in line with these procedures.
- Contribute to Safeguarding Adults investigations and casework as per these procedures.
- Investigate any allegation of abuse in a health based service under the Serious Untoward Incident Procedures.
- Contact the Director of Haringey Adult, Culture and Community Services in such cases whether they occur in the community or on a Haringey Hospital Site to discuss how the investigation will be conducted. This contact must be made by the Director of Clinical Governance or such equivalent.
- Contact Director of Clinical Governance or equivalent if an allegation of abuse in a hospital comes to the attention of Adult Services. The contact must be made by the Assistant Director of Adult Services or equivalent.

9.9 The Commission for Social Care Inspection (CSCI) MUST:

- Regulate care services
- Contribute any knowledge of services and regulatory standards for the Multi-agency assessment.
- Investigate all allegations relating to residential or nursing homes or regulated domiciliary care agencies in Haringey.
- Examine any general issues concerning the care of residents in a care home rather than just the particular circumstances and needs of the individual adult who is the focus of concern of Adult Services and other agencies.
- Be responsible for registering and inspecting nursing agencies.
- Inform Adult Services when reports are received that one or more service users may be or are at risk of abuse or neglect within registered establishments or their own homes.
- Carry out investigations independent of those carried out by Adult Services or the Police.
- Work jointly with Adult Services or National Health Services where service users require a response under these procedures.
- Work in partnership with other agencies. CSCI will however not suspend its own statutory enforcement responsibilities pending the outcome of another (e.g. criminal) process where to do so would run counter to the safety and well-being of the people who use the service. In such

circumstances the CSCI will aim wherever possible to coordinate actions to preserve evidence and avoid impeding each other investigations or enforcement action.
- Attend Strategy Meetings and Case Conferences in respect of regulated services.
- Keep other agencies informed of any enforcement action taken by the CSCI on any regulated service.

9.10 Independent Providers (Domiciliary, Day Care, Residential Care, Nursing Care and Hospital Care) MUST:

- Have established procedures in place for safeguarding Vulnerable Adults in line with those outlined in the appropriate Care Standards Act, Regulations and National Minimum Standards. These must comply with this Multi-agency Safeguarding Adults Policy and Procedures.
- Report incidents of abuse to either the CSCI or the Health Care Commission, where appropriate. (These agencies will be joint in 2008)
- Notify their local CSCI area office of any allegation of abuse or any other significant incidents under the Care Standards Act 2000.
- Provide information and assistance to investigating officers
- Contribute to Safeguarding Adult investigations and casework as per these procedures
- Deliver services in line with these procedures.

9.11 Supporting People and Supported Housing MUST:

- Receive reporting forms from service providers for each incident or allegation of abuse at their services (be it accommodation or floating support services based)
- Inform the Safeguarding Adults Coordinator of each reported incident (including incidents or suspicions of abuse identified by Supporting People Team members)
- Attend Strategy Meetings and Case Conference where necessary
- Inform the Safeguarding Adults Co-ordinator of any enforcement actions taken on any Supporting People Service.
- Contribute to Safeguarding Adults investigations and casework as per these procedures.
- Monitor cases of abuse within Supporting People services
- Ensure all service provides comply with Supporting People standards regarding protection from abuse.
- Provide or Commission support services to meet eligible needs as identified through completing assessments and through following these procedures.

9.12 Complaints Officers must:

- Inform a relevant manager that a complaint has been received which may indicate that a vulnerable adult is subject to abuse. This should be done in line with operational policies in place within the agency and this procedure. Local Authorities and Health Trusts have statutory Complaints Procedures in place.
- Inform the relevant regulatory body (i.e. CSCI or Health Care Commission) if a complaint is received indicating the abuse of one or more vulnerable adults concerning a service subject to regulation.
- Notify the relevant contract or commissioning manager if a complaint is received that indicates abuse of one or more vulnerable adults has taken place in commissioned or contracted service.
- Ensure that action under the Haringey Multi-agency Safeguarding Adults procedure takes precedence in the event of a complaint leading to a Safeguarding Adults enquiry.
- Attend Multi-Agency Strategy Meetings or discussions prior to any investigation and will be expected to carry out any actions agreed at the meeting.
- Inform the complainant of the suspension of the complaints procedures until the outcome of the Safeguarding Adults investigation has been decided.
- Ensure that the complainant can receives a response to the original complaint through the statutory complaint procedure after the Safeguarding Adults Enquiry.

9.13 Lead Roles for Agencies relating to Safeguarding Procedures

The Haringey Multi-Agency policy identifies distinct roles in the Safeguarding of Vulnerable Adults in each individual organisation and their roles in the procedures. This is a role all statutory agencies should identify.

- The lead should be responsible for ensuring the agency has an up to date Safeguarding Adults Policy and that it is accessible to staff and is in line with Haringey's Multi-Agency Policy and Procedures.
- Ensure that training is available at the different levels for relevant staff.
- Co-operate with the audit process and participate fully in the Safeguarding Adults Board Meetings.
- Produce an annual report for their agency's own management Board.
- Be at a Senior level in their respective organisation to ensure that Safeguarding Adults policy and practice is owned at the highest level within each organisation.

9.13.1 The lead investigating agency (which is usually Haringey Council, Adult Services) is responsible for:

- Organising any Strategy Meetings, Review Meeting or Safeguarding Plan Meetings

- Co-ordinating the investigation of any allegation or suspicion that a vulnerable adult is subject to abuse
- Acting as the contact point for collating any information about the victim and the perpetrator of abuse and the circumstance surrounding the alleged incident (s) of abuse.
- Taking the lead in deciding who should be interviewed, at what time and how, ensuring Achieving Best Evidence protocols are followed.
- Deciding who would be the most appropriate person to carry out the investigations at the Strategy Meeting. It is the role of Adult Services to ensure that the process of the investigations follows the agreed Multi-Agency Policy and Procedures.
- Sharing information with other relevant agencies within legal and professional restraints where investigations are carried out by other agencies.
- **NO** Agency should take action (except in an emergency) without first consulting the lead agency.

9.13.2 When the Police are the Lead Agency it is important to remember that:

- Where the police decide to investigate a crime in relation to the alleged abuse of an adult, the police shall act as the lead agency in the conduct of the investigation.
- No action should be taken in relation to the investigation without their agreement. This applies to all other investigations, including disciplinaries and investigations carried out by CSCI or Adult Services.
- All investigations involving the police are governed by the legal requirements of PACE (the Police and Evidence Act, 1984). This means that all police enquiries have to conform to certain standards in terms of interviewing practice, the involvement of appropriate adults and the collection and analysis of evidence.
- The Police can advise other agencies on the likely impact of PACE requirements.
- It is crucial to the success of the criminal prosecution of an abuser that the Police are involved at the earliest possible stage.
- Where the Police are involved in the investigation in view of a possible prosecution they will take responsibility for leading their own investigation and all activities linked to the collection of evidence. Where this is the case, it will be important for the Social Worker/ Care Manager, Team Manager and the police officer to work together to co-ordinate the overall investigation.
- In the case of the Police being the Lead Agency the responsibility of setting up Strategy Meetings and Case Conferences should fall with the Police.

9.13.3 When another agency is the lead agency it may be:

- Appropriate for an agency that is outside of Adult Services to carry out the investigation because:
  - The alleged abuse occurred in a health-based service or on a hospital site and an Assistant Director (or equivalent) has agreed that the allegation is investigated by hospital or health staff under their Serious Untoward Incident Procedures.
  - The incident of abuse requires specialist knowledge for example identification of non-accidental injury or allegations of financial abuse by a council employee.

- The level of abuse is minor and can be properly addressed by staff from another agency e.g. a domiciliary care provider investigating a minor allegation against a care worker.
- The vulnerable adult is more likely to confide in other professionals who they trust.

9.14 Management Roles and Responsibilities:

9.14.1 What are the duties and responsibilities of Service Managers in care settings?

Where a concern is raised that a person is being abused or neglected within the same service you manage, you have the primary responsibility to safeguard that person. This responsibility includes working with all other agencies that may have a role or responsibilities in the situation. Take any immediate actions to safeguard people that fall within the remit and remember that:

- You should normally be a key person within the planning of any safeguarding assessment.
- That the agreed safeguarding assessment strategy may:
  - Involve another agency taking the lead. The most common scenario is where the police may lead the safeguarding assessment with a criminal investigation. On other occasions, it could be a regulatory or commissioning body, where they may decide that the concerns are so serious they will investigate within their remit.
  - Include one or more strands of actions within your remit, for example, it may include a complaints investigation or a disciplinary investigation.
  - Takes precedence over any other internal investigations.

9.14.2 An allegation is made against a member of his/her own staff?

The manager will need to balance:

- supporting the abused person
- supporting all the staff
- supporting the investigation of the event
- being fair to the alleged staff member

Allegations must always be taken seriously however, they should always be treated as such, an allegation. Evidence is required to substantiate that which was alleged to have taken place, actually did.

It is important to take relevant immediate action and consideration should be given to an organisation's disciplinary procedures where this will protect service users, the alleged perpetrator and allow a fair investigation to be conducted.

Disciplinary action on staff is the responsibility of the employing agency or organisation. Suspension is a neutral act that may be necessary as an immediate protection plan. The member of staff is innocent until proven otherwise. The suspension of the staff member is to ensure that he/she is protected, while still enabling a full investigation or safeguarding assessment to take place.

Staff subject to disciplinary procedures must be made aware of their rights, and, if suspended, should be given an outline of the reasons for that action in line with those procedures. However, the details of the allegation should not be discussed with them until the multi-agency assessment strategy has been agreed.

The staff member must be advised to seek union or legal advice and should have access to support networks. Even if another agency, such as the police, is leading the investigation, it is important to try to ensure that you meet your responsibilities as an employer and keep the member of staff or their representative informed in accordance with confidentiality.

A manager could also seek advice from their relevant regulatory body or legal services as appropriate.

9.14.3 What is the duty and responsibility of Registered Managers in Regulated Care settings?

Regulated services are required to report concerns about the welfare of a vulnerable adult to the CSCI **within 24 hours** of the incident.

Senior Managers must be informed of any concerns reported as per local procedures.

Regulation of The Care Homes regulations 2001 requires the registered person to inform CSCI without delay of:

- The death of any service user
- The outbreak in the care home of any infectious disease
- Any serious injury to a service user
- Serious illness of a service user at a care home at which nursing is not provided.
- Any event in the care home which adversely affects the well-being or safety of any service user.
- Any theft, burglary or accident in the care home.

- Any allegation of misconduct by the registered person or any person who works at the care home.

This report should be made by fax to CSCI **within 24 hours** of the incident to: ***020 8420 0119*.**

9.14.4 The duty of a member of staff or volunteer when suspicions or allegations of abuse are reported to them?

Staff and volunteers all have a duty of care to report any allegations or suspicions of abuse to their line manager as soon as possible. These concerns must be reported to a line manager, even if the service user is reluctant for them to do this, or asks them not to do so. The service user must be made aware that the member of staff or volunteer is not able to maintain information regarding alleged abuse a secret.

There will be occasions when a member of staff is unable to go directly to their line manager because that line manager may be implicated in the allegations. In such situations, members of staff or volunteers may need to use their organisations whistle blowing procedures, or inform a senior manager in that organisation about the alleged abuse. Staff or volunteers should not disclose this information directly to their line manager if the allegation of abuse implicates their line manager.

Any concerns about abuse occurring in a regulated care setting must be directed to a regulatory body such as the Commission for Social Care Inspection or the Health Care Commission independently. In parallel if there are suspicions that a crime has taken place the police should be notified.

This may be take place when:

- They have concerns that their manager or proprietor/tress may be implicated.
- They have grounds for thinking that the manager or proprietor/tress will not take the matter seriously or act appropriately to protect service users.
- They fear intimidation or have immediate concerns for their own or for a service user's safety.

10. Procedures

This section of Haringey's Multi-agency Safeguarding Adult's Policy and Procedures refers to the actions that should be taken by staff in all organisations within Haringey that are signatories to this document and provide a service to vulnerable adults over the age of 18.

10.1 Raising the Alert

10.1.1 Who can raise the Alert?

An alert can be raised by anyone who has witnessed abuse taking place, has been told about abuse or neglect taking place, or suspects that abuse or neglect is taking place. It is that individual's duty to report the allegation to the relevant agency. The alert can be raised by any individual in any agency.

The alleged victim themselves may make a disclosure outlining the abuse they have been subjected to. Or a referral may come from another service user, relative or carer.

A paid care worker, volunteer or other visitor may observe behaviour that causes concern. It may be that the standard of care that a particular organisation provides may be putting people at risk or a service users challenging behaviour or actions may themselves be a concern for the safety of other service users.

All partner organisations should use the Haringey Multi-agency Safeguarding Adults Alert Form to report and record any concerns about the safety of a vulnerable adult. In certain circumstances an agency may be required to use their own internal form, for example where a crime has been committed the police will report it using the appropriate forms.

Members of the public can contact the Initial Contact Service on 020 8489 1400 to report any concerns or allegations of abuse concerning a vulnerable adult.
Alerts raised by staff that may concern a service or other staff in an organisation, about suspected abuse of a vulnerable adult or adults, must always be examined. It may be necessary to use other procedures such as disciplinary or whistle blowing procedures in parallel with the Multi-agency safeguarding Adult procedures.

10.1.2 How should you respond to an Alert

If a vulnerable adult discloses allegations that they are being abused, as a professional, you must always listen carefully in a non judgemental manner. Don't interrupt or stop that individual telling their story. You must not question them directly on the details, as this may jeopardise gathering evidence at a later stage in line with "Achieving Best Evidence"[18]

All allegations of abuse should be taken seriously. It is important that you try and not to show shock or disbelief and that you remain calm. Be empathetic; assure the person that the complaint or allegation will be taken seriously. Assure the person that it was not their fault and that they did the right thing by disclosing what happened to them.

You should also be aware that the vulnerable adult may not realise they are being abused and therefore not realise the significance of what they are saying.

[18] Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses including Children Home office 2002

In some instances a person may make an allegation of abuse some years after the abuse had taken place. This could be due to the trauma of the abuse or simply the person may be blaming themselves, whatever the reason, it should not cast doubt on the reliability of the allegation.

You should not promise complete confidentiality. Explain that you have a duty of care to report what you have been told to a line manager and that the concerns may be shared, especially if other vulnerable adults are at risk.

One of the products of abuse, in many cases is a lack of control. It is therefore important that the alleged victim is given some of that control back. Ways in which you can do that is by keeping them informed of the actions you will be taking to protect and support that individual. If appropriate refer that individual to this procedure, which will outline what they can expect from a Haringey Agency.

10.1.3 How to raise an Alert?

An Alert can be raised by telephone, visit, email or fax.

A Haringey Alert Safeguarding Adults Multi-agency Alert form must be completed and sent back to the relevant agency (as shown on the form).

10.1.4 Where to find a copy of the Alert form?

A copy of the Haringey Multi-agency Safeguarding Adults Alert Form can be found at http://www.haringey.gov.uk/alert_form-november_2006.doc or can be requested from the Initial Contact Service by telephoning 020 8489 1400.

10.1.5 How to complete the Alert Form?

- You **must** complete all parts of the Alert form
- If any part is left incomplete you **must** be able to justify the reason for it

Personal Information of vulnerable Adult:

- Personal details
- The current situation in which they are living
- Details of their family or significant other people
- Mental capacity/disability/ sensory impairment
- Whether the vulnerable adult has been informed that a referral has been made.
- Services received/ agencies that have contact with the vulnerable adult including their GP.

Details of alleged abuse:

- What is the actual allegation or cause of concern or suspicion
- Where and when the alleged incident took place and who witnessed it and/or provided the information

- The details of what occurred including the actions and words used by the alleged perpetrator of abuse and the person being abused
- The extent of the abuse and the degree of immediate danger that the referrer perceives the vulnerable person to be in.

The alleged perpetrator of abuse:

- The alleged perpetrators relationship to the vulnerable adult
- The alleged perpetrators mental capacity/disability/ sensory impairment
- The alleged perpetrators whereabouts and the likelihood of contact or the risk to other people if known
- Services received/agencies that have contact with the alleged perpetrator including the GP

The referrer's judgement of the situation:

- Action already taken, e.g. have the Police been informed
- Any immediate action that the referrer thinks should be taken
- Identify anyone else at risk e.g. Children or other vulnerable adults.

Other agencies already involved:

- Information about any police involvement including Crime reference number if available
- Other agencies that have been involved in the identification of abuse.
- Always make sure that you have provided sufficient information in order for the allegations to be efficiently investigated.
- Always ensure that all personal details are completed
- Make sure that the Alert form is legible and that it is filled out either in pen or typed
- Ensure that the Alert form is always signed and dated.
- Any opinions need to be identified as opinion and not as fact; assumptions are not always based on concrete evidence

10.1.7 What is the timeframe for completing an Alert form?

An Alert form **must** be completed **immediately.** The referral **must** be made to the relevant organisation **within the same working day** as receiving the Alert.

10.1.8 Summary of action that should be taken once a disclosure of alleged abuse has been made:

- ☑ If the vulnerable adult is at risk of immediate harm contact the Police on 999
- ☑ The Police should also be contacted if there is evidence that a crime has been committed and evidence needs to be collected immediately otherwise it will contaminated
- ☑ Ensure that the person who has made the alert is made aware how their concerns are being dealt with
- ☑ Only share the information within the framework of the safeguarding adults information sharing protocol
- ☑ If the allegation was made by a member of the public who wanted to remain anonymous or wished to have their details kept confidential then this should be respected and the referral should still be progressed.

☑ Ensure that the correct steps are in place to safeguard the vulnerable adult from further abuse as outlined in this procedure

Do Not:

☒ Create the impression that the vulnerable adult is not believed.
☒ Risk contaminating the evidence
☒ Inform the alleged perpetrator of the allegations against them
☒ Put the vulnerable adult at further risk

It is the responsibility of whoever raises the Alert to ensure that the Vulnerable Adult is safeguarded from immediate danger, be it by contacting the Police or relevant Social or Health Service department.

10.2 The Referral

10.2.1 When must a referral be made and where is it sent?

A referral **must** be made **within the same working day** as raising the Alert. The Alert should be directed to ICS who will signpost to appropriate teams.

10.2.2 What must ICS do with the referral?

- ICS will direct referrals to the relevant Social Services duty team that is, Learning Disabilities, Physical Disabilities, Older People Services, PCT or CMHT
- ICS duty team is only responsible for the initial investigation/interview if service user is an older person not known to service previously or a closed case.
- The referral **must** be recorded on the POVA Spreadsheet **immediately**, even if after initial investigation it is decided that no further action is to be taken. The purpose of this recording is for monitoring referrals and outcomes. This system will be replaced by an electronic version on Framework I shortly.

10.2.3 What happens if the referral is made out of hours?

If a referral is made out of normal office hours, the Emergency Duty Team will be responsible for undertaking an initial assessment of risk and take steps f to ensure that the vulnerable person is safe, (Interim Safeguarding Plan).

If immediate action is not required, the emergency Duty Team will refer the case to the appropriate teams at the beginning of the next working day for them to proceed with the Safeguarding Adults process.
Haringey Social Services Out of Hours:
Tel: 020 8348 3148 / Fax: 020 8489 2388

10.2.4 What happens if the concerns arise using the Single Assessment Process (SAP) or during a current Assessment of care?

If the concern arises during an assessment using the Single Assessment Process then the action to be taken will depend on who is undertaking the assessment.

If the assessment is being undertaken by another agency then a referral should be made to the Initial Contact Services using the Alert form to Haringey Adult Services (see contact details above) who will be able to redirect the referrer to the appropriate team.

If the concerns of abuse are raised during a current assessment e.g. an Overview Assessment, review or as part of ongoing support, or monitoring of care provided, the Social Worker / Care Manager who is already working with the person should complete the Alert form and send copies to ICS and Safeguarding Adults Co-ordinator.

10.2.5 Does consent need to be given by the vulnerable adult for the referral to be made?

Consent **must** be gained from a mentally capable adult who is thought to be experiencing abuse or neglect unless there are overriding public duties to act. Such circumstances include:

- The prevention or detection of a crime
- In order to protect the vital interests of another person in a case where consent by or on behalf of the service user has been unreasonably withheld.
- Where it is necessary for the purpose of, or in connection with, any legal proceedings
- Where there is a significant risk of suicide.
- Where there is a significant risk to a third party.

If there are overriding duties, the person is **always** to be informed that the referral will take place, except where this could jeopardise the safety of others who may be at risk.

10.3 Notification

10.3.1 To what other agency must abuse of a criminal nature be reported?

The police **must** always be contacted if the allegation is of a criminal nature, e.g. physical injury, sexual abuse and/or financial abuse.

Call 999 if the Vulnerable Adult is in immediate danger, otherwise contact the Community Service Unit on: 020 8345 1939/1941
Send the Alert Form to: yrmailbox-csu@met.pnn.police.uk

or by Fax to: 020 8345 1946.

The Police must be informed of alleged/suspected financial abuse, prior to any action being taken e.g. interviewing/ suspending staff or interviewing vulnerable adults. This is necessary to ensure best evidence is achieved in respect of any investigation undertaken. An offence of financial abuse involving the theft of personal cash or funds from accounts, which may also involve false entries in financial records, is often difficult to prove. This could be further complicated if the abused adult is cognitively impaired.

Forensic evidence **must** be collected **within 24 hours** of the crime being committed. Only the Police can collect such specimens to avoid contamination. Do not interfere with the crime scene.

10.3.2 Who do you contact if abuse occurs in a regulated care provision

You must immediately contact CSCI or the Healthcare Commission.
You must send your Alert Form to enquires.harrow@csci.gsi.gov.uk or by fax to 020 8420 0119 when a Social Care regulated service, be it a Care agency or Care home are involved.

You must send the Alert form to feedback@healthcarecommission.org.uk or by Fax to 020 7448 9391 where a Health service (NHS hospital, PCT, GPs, Nurses, Midwives, etc.) is involved.

For professions that are regulated such as Doctors, nurses, midwives, social workers and care home workers (as of 2008) etc a referral may need to be made their respective regulatory body, which may carry out an investigation into that professional's conduct or temporarily suspend them from the relevant register. This will only be done if the alleged perpetrator is in a profession that is regulated and there is a threat to public safety. The decision to suspend or remove a person from a professional register lies with the professional regulatory body. For further information or to make a referral please contact

General Social Care Council (GSCC)
02073975120
Email: conduct@gscc.org.uk

Nursing and Midwifery Council (NMC)
02073336564/6572
Email: fitness.to.practice@nmc-uk.org

General Medical Council (GMC)
0845 357 0022
Email: practise@gmc-uk.org

10.3. Who must you always notify regardless of the of the source of the referral

The Initial Contac Services (ICS) Adult Services must be contacted on **0208 489 1400** if there are concerns that a vulnerable adult is the subject of abuse. This team receives all alerts and co-ordinates all referrals.

Send alert form to over65@haringey.gov.uk or by fax to 0208 489 1993

You must also send copy of alert to the Safeguarding Adults Co-ordinator Olive Komba-Kono
Send alert to form to Olive.Komba-Kono@haringey.gov.uk or by fax to 0208 489 3977

10.4 Allocations

10.4.1 Who is allocated the referral when the decision is made to proceed with an investigation?

When the referral is received by the ICS team, the referral will be forwarded to the appropriate duty-team for processing. The team that meets the client group classification or is providing services would be deemed appropriate.

A Safeguarding Manager is allocated to the case after the decision is made to proceed with an investigation. The safeguarding manager is responsible for assessing the level of risk and what the response will be. A Safeguarding Manager can be any Unit, Team or Practice Manager. Safeguarding Managers must be of Practice Manager's level and above

If the Service User is already allocated to a **specific** Social Worker/Care Manager/Care Coordinator then the case is allocated to that worker's Practise or Team Manager who will become the Safeguarding Manager for that case..

If the Vulnerable Adult is known to Adult Services, the case **must** be designated **within the same working day** as receiving the referral.

If the Vulnerable Adult is not known, a background information and Contact Assessment **must** be done by the appropriate Adult Services Duty-Team. The Safeguarding Adults Referral needs to be made for the client **within the same working day** as receiving the alert.

10.4.2 What is the role of the Safeguarding Manager?

The role of the Safeguarding Manager is to decide if referral meets the criteria of abuse and to co-ordinate the strategy of the investigation.

The Safeguarding Manager ensures that staff who support the service user, and others affected by the incident, have guidance and access to support.

The Safeguarding Manager should remind his/her staff that their role is to support the service user. Staff should not however question the service user or any witness on the abuse, especially by asking any leading question which may contaminate evidence.

Staff should be reminded about the importance of confidentiality (not to discuss details with other staff or clients, or people outside the workplace).

Ensure all written material which may be needed as evidence has been completed, for example, written reports, diary records, client files, staff files etc. Ensure you ask for written reports from any witness.

10.4.3 What are the responsibilities of the Safeguarding Manager?

The Safeguarding Manager is responsible for recording the decision about the level of risk in a case. He/ She **must** appoint an Investigative Officer, a Social Worker/ Care Manager/care coordinator to go out and do an initial investigation.

The Safeguarding Manager **is responsible** for chairing the Strategy Meeting. It is good practice for the sake of continuity that the same person chairs all following meetings in an investigation.

IF the Safeguarding Manager is different to the one from the Initial investigation then the replacement Safeguarding Manager must be fully informed of the facts of the case so that they are able to effectively chair the Strategy Meeting or Discussion

- In the case of an emergency, either ill health or a duty emergency, whereby a Safeguarding Manager is unable to chair a follow-up meeting it is the **responsibility of the Team Manager** to allocate a Chair.

10.4.4 What is the role of the Investigative Officer?

The Initial Investigating Officer **must** go out and visit the Vulnerable Adult within the timescale stated for each level of risk. The initial investigation includes an interview with alleged victim and a discussion among involved care providers to determine risk and response. This is an essential part of the investigation which must happen as soon as the referral is received.

This discussion with involved others is called a strategy discussion. The essence of the discussion is to assess level of risk and response requirement. It can suffice as an investigation in very low levels of risks.

DO NOT at this stage contact the alleged perpetrator. There must be a different interviewer for the alleged perpetrator.

The investigative officer must discuss the outcome of the interview with the safeguarding manager that same day. If the officer can not return to the office this discussion could take place over the phone, keeping in mind confidentiality requirements.

They **must** write up their report on Framework-I of the visit in a timely manner.

Other investigating officers may be appointed at the Strategy Meeting and the numbers would be determined by the lines of enquiry.

The Initial Investigating Officer in conjunction with the Safeguarding Manager must:

- Complete a risk assessment identifying what the immediate risk to the vulnerable adult is and what immediate action is needed e.g. removing the vulnerable adult from their current environment. This must be clearly recorded on the service user's case file.
- If it is an alleged criminal offence, ensure the incident has been reported to the police and a crime number recorded. If the police decide to 'lead' the investigation, then no further action, including preliminary enquiries, informing agencies, or interviewing parties are to take place without their approval. A Strategy Meeting must be convened within the necessary timescales depending on the level of risk possible in order to co-ordinate activity and ensure that the welfare of the vulnerable adult(s) are addressed while the investigation is being conducted.
- In the event of physical/sexual assault, ensure the vulnerable adult has been seen by the GP. The examining medical practitioner and General Practitioner, must be involved of the alleged/suspected abuse and a request be made that a written record be kept, which could be made available to the investigation. Generally a medical examination can only be carried out with the consent of the vulnerable adult.
- In the event of the abuse involving a registered care provider, either in the community or in a residential/nursing setting, ensure the CSCI has been notified.

10.5 Decisions

10.5.1 What decisions must the Safeguarding Manager make?

- The Safeguarding Manager **must** decide whether the referral meets the criteria as stated in the policy and procedures. This decision is reached after an informal consultation with involved care providers, this could be by telephone or email and after the initial interview with the vulnerable adult.
- The level of risk and response time
- The Safeguarding Manager must also decide the most appropriate agency to conduct the initial interview.

10.5.2 What happens if consent is not given by the vulnerable adult to proceed with the investigation?

Consent is always sought in the case of a criminal investigation and the service user has the right to proceed or decline that line of enquiry. However, an internal investigation relating to staff and the safeguarding process can continue irrespective of consent.

A vulnerable adult who is able to make an informed decision, but refuses assistance or who feels unable to make a decision about this, is considered to be placing themselves at risk.

In this instance, the Social Worker/Care Manager/Care coordinator should communicate with appropriate parties (e.g. independent advocates, other professionals, carers, friends etc.) to inform them of the decision and to identify another person who might be able to help the vulnerable adult understand the risks and the choices available to them to remove that risk.

In the case where the vulnerable adult is not capable of making an informed decision, then, the Social Worker/Care Manager must consult with the Safeguarding Manager and appropriate parties (e.g. independent advocate, other professionals, carers, friends etc.) to agree on action which will ensure the safety of the vulnerable adults.

10.5.3 What happens if the criteria for an investigation is not met?

If the outcome of the initial investigation does not indicate abuse, the Safeguarding Manager needs to consider the following options:

- Does the vulnerable adult meets the criteria for a Community Care Assessment if not currently receiving services

- Is there a need for a review or a re-assessment of care plans? The client must be referred to the correct team within Adult Services, for an overview assessment.

- Did not meet the criteria but in need of other services – refer to other agencies.

- Inappropriate referral – No Further Action.

10.6 Risk Assessment

10.6.1 What must be considered when assessing Level of Urgency and Risk?

- Level of threat to the Vulnerable adult's physical well-being.
- The nature extent of the abusive acts.
- Whether the abuse was a one off event or part of a long standing relationship or pattern.
- The impact of the abuse on the vulnerable adult and their independence.
- The impact of the abuse on other vulnerable adults and children.
- The intent of the person allegedly responsible for the abuse.
- The illegality of the alleged perpetrators actions.
- The risk of the abuse being repeated against this vulnerable adult.
- The risk of the abuse being repeated against other vulnerable adults and children.
- The risk that serious harm would result if no action is taken,
- The illegality of the acts or acts.
- Risk can be assessed and managed but outcomes cannot be guaranteed.

10.6.2 What is considered a High Level of Risk?

- Physical abuse which causes severe injury or is life threatening.
- Sexual abuse where penetrative sex or insertion of objects has occurred without Vulnerable Adults.
- Severe neglect where the Vulnerable Adult is imprisoned.
- If life threatening immediately call 999 or 020 8345 1939

10.6.3 What must be done if the allegation has a High Level of risk?

A visit **must** be done **within the same working day** of the referral being made.
Where assault of any kind has occurred, or could occur, the police must be asked to accompany the Social Worker/Care Manager/care coordinator to assist in achieving a assessment in safety.
Where necessary the vulnerable adult should be offered the opportunity to move to a place of safety and if necessary be given assistance to obtain legal advice.

10.6.4 What is considered to be Medium Level of Risk?

- Emotional/psychological abuse, e.g. intimidation
- Financial Abuse, e.g. theft, fraud or exploitation (not burglary or robbery, these are criminal offences and must be reported to the Police immediately).
- Physical abuse which causes mild bruising.

10.6.5 What must be done if the allegation has a medium level of risk?

A visit **must** be made to the Vulnerable Adult **within two working days** of the referral being made.

10.6.6 What is considered to be Low level of Risk?

- Verbal Abuse where the Vulnerable Adult is being spoken to in an inappropriate manner or ignoring requests.
- Verbal Abuse that is not physically threatening or causing stress and anxiety.

10.6.7 What action must be taken if the allegation has a low level of risk?
A visit **must** be made to the Vulnerable Adult **within three working days** of the referral being made.

10.7 Safeguarding Assessment Strategy

10.7.1 Who must co-ordinate the Safeguarding Assessment Strategy process?
It is the responsibility of the Safeguarding Manager to co-ordinate the Strategy assessment process.

10.7.2 What is the difference between a Strategy Meeting and a Strategy Discussion?
A Strategy Meeting is the face-to-face meeting of all relevant agencies to discuss the referral and the outcome of the initial investigation and to form a plan of action and an Interim Safeguarding Plan. Regardless of whether a Strategy Meeting or Discussion is held, the outcomes, Interim Safeguarding Plan and assigned agency tasks **must** be recorded in the minutes correctly.

10.7.3 When must you have a Strategy Meeting?
A Strategy Meeting **must** be convened if the allegation has been judged as either of High or Medium Risk. In these cases the Strategy Discussion will **not** be sufficient and so a Meeting in person must always take place.
A Strategy Meeting will always be required when:

- The investigation and intervention requires careful planning.
- The vulnerable adult has given consent for information to be shared with other agencies.
- Public interest issues appear to outweigh the vulnerable adult's wishes.
- The best interest of the vulnerable adult may be contentious.
- The situation is extremely complex/ or serious.
- A Serious Case Review investigation.
- An investigation is required under the "Untoward Incident Procedures" of the Barnet, Enfield and Haringey Mental Health NHS Trust.
- Information must be shared between agencies to protect the vulnerable adult while the allegation is being investigated.

- In High Risk cases a Strategy Meeting **must** be convened **within 4 working days**.
- In Medium Risk cases a Strategy Meeting **must** be convened **within 5 working days**.
- In Low Risk cases a Strategy Meeting/Discussion **must** be convened **within 5 working days**.

10.7.4 When can you have a Strategy Discussion?
A Strategy Discussion is required after a referral has been received to determine abuse and to agree on an Interim Safeguarding Plan.

A Strategy Discussion **must only** take the place of a Strategy Meeting if the case is Low Risk and issues raised can be addressed adequately.

10.7.5 What is the purpose of a Strategy Meeting?

The purpose of a Strategy Meeting is to:

- Decide how any needs for immediate protection will be met.
- Consider all available information regarding the service user's background and the alleged incident.
- Provide information about the setting in which the abuse or neglect took place.
- Decide the allegations to be investigated.
- Consider the wishes, if known, of the vulnerable adult.
- Decide who will co-ordinate the investigation and conduct the interviews.
- Decide the time frame for the assessment.
- Consider the needs of the vulnerable adult and who is best suited to support the vulnerable adult through the investigation.
- Agree a communications strategy.
- Agree action set out in safeguarding adults procedures.
- Put an Interim Safeguarding Plan into place to immediately safeguard the vulnerable adult. .
- Agree a date for a Case Conference to review the action agreed at the Strategy Meeting.

During the Meeting, all information known about the situation is shared in accordance with the information-sharing protocol with the appropriate consent sought. Each organisation is proactive in offering resources within their remit to enable the risk of abuse to be assessed.

10.7.6 Who is to be involved and invited to a Strategy meeting?

All relevant agencies and organisations are to be involved in a Strategy Meetings e.g. Care agencies, police (where a crime is committed), legal services (if necessary), relevant Social Services departments.

Strategy Meetings may include any of the following agencies where necessary:

- Safeguarding Manager
- The Safeguarding Adult's Co-ordinator.
- A designated minute-taker.
- Police
- GP
- The individual at risk, or their carer, or their advocate.
- The adult's Social Worker/Care Manager.
- The adult's Key Worker or Care Co-ordinator
- .A representative from the line management of the service provider.
- CSCI
- Health representative: hospital or PCT.
- A representative from the Department of Work and Pensions, bank or building society, the receivership officer (if there is suspicion of financial abuse).
- A legal advisor (in appropriate cases only)

- Supporting People
- Home Care
- Community Learning Disabilities Nurse
- District Nurse
- Community Mental Health Nurse
- Community Psychiatric Nurse
- Environmental Health Officer
- Health Visitor
- Housing Officer
- OT
- Probation Officer
- Psychologist

CSCI are always to be invited to a Strategy Meeting when there is a regulated Care agency or regulated Care Home implicated in the Abuse.

Haringey Contracts Team is **always** to be invited to a meeting if a regulated service is implicated in the Abuse/Neglect. Where a member of the team is unable to attend the meeting a copy of the minutes **must** always be sent to them.

The Police are **always** invited to a Strategy Meeting where a crime has allegedly been committed or suspicion of crime. The Police **must** decide whether they intend to investigate the case further or not.

10.7.7 Is the Service User included at this stage?

Haringey Social Services **must** always keep the Vulnerable Adult informed of all investigation taking place, unless this places them at further risk.
An Adult with Mental Capacity **must** be a full partner in the discussions, unless they are prevented by other considerations, like their own safety. At the discretion of the chair they **should** be invited to the Strategy Meeting.
An Adult without Mental Capacity can not participate fully and so the use of an advocate is necessary at this stage.

If a client meets the following criteria, they should be referred to Rethink, which is Haringey Councils commissioned IMCA Service:
A decision is being made about either:

a) a serious medical condition or
b) long term care and health moves (more than days in hospital/ 8 weeks in a care home)

and

i) it is believed they do not have the capacity to make that decision

and

ii) they have no appropriate family or friends to represent them.

If in doubt that a referral is appropriate to IMCA, a discussion should take place with a line manager or senior manager for an appropriate decision.

For Adults with Hearing or Speech Impairments a Signer **must** be provided. If the Adult is in need of an interpreter they **must also** be provided to ensure that the Vulnerable Adult is able to participate fully in the Strategy process.

10.78 Would the alleged perpetrator be invited to the Strategy Meeting?
No, the alleged perpetrator would **never** be invited to the Strategy Meeting.
If for extremely exceptional circumstances the alleged perpetrator is to be involved, consent **must** be given by the victim if they have Mental Capacity. This decision **must** then be approved by the Safeguarding Manager and a Senior Manager.

10.7.9 When is the perpetrator interviewed?
The perpetrator also has rights. A different investigating officer must interview s/he during the investigation. The officer must report to the Case Conference/Safeguarding Assessment Plan Meeting of findings. Information shared will influence Safeguarding Plan. The agency dealing with the investigation of the perpetrator **must** ensure that confidentiality is maintained at all times to safeguard the victims, witnesses and 'whistleblowers'.
As little information as possible is given to the alleged perpetrator. Information is given on a **'need to know'** basis. Names of witnesses and 'whistleblowers' are **not** to be discloses to the perpetrators. The location of the Vulnerable adult, if changed due to an allegation, **must** not be disclosed also. The Chair will determine the level of information that could be shared.
If the investigation is criminal in nature, the Police will comply with own guidelines.

10.7.10 Who else would not be invited to a Strategy Meeting?
If a Residential Home or any other Service of Care is implicated in neglect or abuse, a strategy discussion is to take place before the Strategy Meeting so that all other involved parties, including Regulatory bodies and Service Commissioners decide whether the manager of the home should be involved in the Strategy process or not.
A judgement **must** be made and agreed by all involved agencies as to whether the proprietor is judged 'fit' or not. Once they have been judged fit they are to be involved as full partners in the Strategy process.
Ensure that clear investigations are done so that the evidence is not contaminated and that somebody who may have been implicated in the abuse/neglect is **never** involved in the Strategy Meetings.

10.7.11 What needs to be agreed at a Strategy Meeting or Strategy Discussion?

- ☑ A Multi-agency assessment of the current level of risk and to whom.
- ☑ A plan for actions to investigate and assess the nature, level and lines of enquiry to pursue:
  - Who is to lead the investigation
  - Who is to be interviewed or assessed; when and by whom
  - A plan to meet any needs arising from gender, sexuality, ethnicity, or disability of any alleged victims, perpetrators or witnesses, including special measures available to "achieve best evidence".

- A plan to meet any needs arising from potential harassment or intimidation of any alleged victims, witnesses or whistleblowers.

☑ Co-ordination between different strands of the assessment, for example, any criminal or disciplinary action or investigation of a complaint or community care assessment, so that they complement and inform each other and do not interfere with each other.
☑ An explicit statement of roles and responsibilities with actions designated to named individuals
☑ Ongoing communication with the adults at risk and others concerned and who will undertake this.
☑ Consider the need and method to manage any media interest or set up a helpline.
☑ There may be need to hold a separate meeting about the service needs of an alleged perpetrator who is a service user themselves.
☑ An agreed Interim Safeguarding Plan

10.7.12 What should the interim Safeguarding Plan include?
The Interim Safeguarding Plan should adhere to the following principles:

- The safety of the vulnerable adult and others at risk is the overriding consideration.
- Action is planned to minimise the risk to victims, witnesses and 'whistleblowers'.
- Actions concerning people alleged to have perpetrated abuse are co-ordinated.

10.7.13 How is the meeting to be recorded?
The discussion at the meeting is recorded, using the Initial Strategy Meeting Minutes Template. It is the responsibility of the Safeguarding Manager who has chaired the meeting to approve the minutes and to ensure that they are distributed **within five working days**. Once approved, the minutes must be distributed to all attendees. It is also very important to find out whether the minutes are to be sent to anyone who was unable to attend, although invited.

10.7.14 When is the next meeting to be convened for?
A Safeguarding Plan Meeting is to be convened within **28 days** of the referral. A Safeguarding Strategy Review Meeting can be called any time before then if the Interim Safeguarding Plan appears to break down.

10.8 Safeguarding Assessment

10.8.1 What is the purpose of the assessment?

- To analyse all the information gathered by the investigating officer(s) in order to draw up a Safeguarding Plan.
- To protect the vulnerable adult from serious harm and ensuring the safety of staff
- To establish and record the facts and other issues that relate to the allegation of abuse.

- To decide the likelihood of the vulnerable adult having been abused.
- To assess the level of risk to the vulnerable adult.
- To assess to what extent the vulnerable adult has mental capacity to understand the degree of risk to which they may be exposed.
- To establish what the vulnerable wants to happen to ensure their safety.
- To ensure appropriate action is taken with regard to the perpetrator.
- To decide if action needs to be taken to protect other people.
- To decide if legal action should be sought.

10.8.2 Type of abuse determines other agencies involvement

Adult Services should always be involved in Safeguarding Adults investigations, however, when there are any of the following types of cases other agencies/organisations need to be contacted and involved to:

Reason for Investigation/ Type of Investigation.	**Agency responsible for Investigation**
Criminal Act (including Sexual or physical assault, theft, fraud, hate crime and domestic violence	Police
Fitness of a registered provider or manager under the Care Standards Act 2000	CSCI
Breach of Regulations relevant to a regulated residential, nursing home or accredited care agency.	CSCI
Breach of Rights of person detained under the Mental Health Act.	Mental Health Act Commissioner
Unresolved serious complaint in a health care setting	Health Care Commission
An investigation in to the care standards and contracts compliance	Haringey Contracts Team
A disciplinary investigation of staff alleged to have abused a service user. Breach of terms of employment procedures.	Employer
Alleged Abuse towards a vulnerable adult	Haringey Social Services
Untoward Incident Procedure	Barnet, Enfield and Haringey Mental Health NHS Trust
Breach of Professional code of conduct	Professional Regulatory Body.
Breach of Health and safety Legislation	Health and Safety Executive

Complaint regarding failure of service provision (including neglect of provision of care and failure to protect one service user from the actions of another)	Service Provider: Manager and Proprietor of Service or Complaints Department.
Breach of Contract to provide care	Service Commissioner (for example, Social Services, PCT, Supporting People)
Bogus Callers or Rogue Traders	Trading Standards Officers
Misuse of Public Money	Local Authority Audit
Anti-social behaviour (for example, harassment and nuisance by neighbours)	ASBAT Team (Anti-Social Behaviour Team)
Breach of Tenancy Agreement (for example, harassment of landlord or registered Social and nuisance by neighbours	Housing Trust
Misuse of Enduring power of attorney or power of a deputy.	Public Guardianship Office.
Misuse of appointee-ship or agency	Department of Work and Pensions
Inappropriate person or person making decisions about the care and wellbeing of an adult without Mental Capacity which are not in the adult's best interest	Court of Protection

All staff have the right to be accompanied by another worker if it is deemed appropriate and agreed by the Safeguarding Manager.

If circumstances indicate there may be violence or a breach of the peace at the interview, staff must request Police to accompany them to the interview. Interviews can be conducted also outside of the home. For instance, it might be safer to interview a service user at the day centre if s/he attends.

10.8.3 How much information should be shared?

- There is an Information-Sharing protocol in place.
- It is the responsibility of the relevant agencies to report their findings, without the confidentiality or safety of the Victim being jeopardised.
- All information **must** be shared where someone else other than the alleged victim is at risk, e.g., a child or another Vulnerable Adult.
- Information **must** be shared but only where necessary and permission had been sought to disclose it.

10.8.4 What is the role of the Police at this stage if a crime has been committed?

In cases where criminal proceedings may be a possible outcome, a formal interview should always take place with the police. This could involve the alleged victim being interviewed under the Achieving Best Evidence (ABE) Proceedings i.e. being videotaped, etc. Police officers are specially trained in A.B.E and conducting disclosure interviews. Forensic evidence **must** be collected and preserved. Police **must** decide **within five working days** of receiving the referral whether an Achieving Best Evidence Interview is necessary or not.

10.8.5 What is the role of the Safeguarding Manager at this stage?

It is the responsibility of the Safeguarding Manager to support and supervise the work of their Social Worker/Care Manager /Care coordinator during the investigation.

Where a worker from a different agency is investigating, it is the responsibility of their manager to supervise and support them during this assessment stage.

10.8.6 What is the role of the Relevant Agency Investigating Officers at this stage?

The investigating officer must carry out any tasks assigned to them at the Strategy Meeting.

Any new information that comes to lights should be shared with the Safeguarding Manager immediately, who will decide if a Strategy Review Meeting is necessary to update the Interim Safeguarding Plan.
Each worker **must** keep comprehensive records of all findings and be able to produce a report of them at the Safeguarding Plan Meeting.

10.8.7 What are the possible outcomes of the Assessment/Investigation?

The assessment will lead to the development of a Safeguarding Plan with time scales for implementation.

The decision on whether or not to proceed to a Case Conference/ Safeguarding Plan Meeting in order to agree to the plan should be taken in consultation with the line manager and all the involved agencies.

It is important to remember that at this stage it is paramount to investigate without putting the vulnerable adult at further risk.

10.8.8 What is the difference between a Strategy Meeting and a Case Conference?

- A Strategy Meeting is:
    - For the purpose of planning an investigation
    - Identify investigating officers and allocate tasks.
    - Agree and implement an Interim Safeguarding Plan.
- A Case Conference:

- Should make decisions based on the facts revealed by the investigations.
- Shares the outcome of the investigation.
- Should decide either abuse happened as alleged or not.
- The allegation was disproved or there is not enough information to decide whether the abuse happened or not.
- Should agree a care plan that will provide protection and support the vulnerable adult.
- Should agree when and by whom the protection plan will be monitored.

10.9 Safeguarding Plan/Case Conference

10.9.1 When should the Safeguarding Plan Meeting/Case Conference be convened?

The Safeguarding Plan Meeting/Case Conference **must** be convened **within 28 days** of the referral being received.

10.9.2 What is the aim of the meeting?

- Information Gathering:
  - This will include the information gathered through the investigation. Good practice would be for the investigating officer to produce a written report for the purpose of the Case Conference.
  - To provide a forum for the exchange of information between multi-agency and multi-disciplinary colleagues involved with the individual deemed to be at risk.
- Assessing Risk:
  - The meeting will assess the risks to the service user and if necessary other service users.
- Weigh up the evidence, on the balance of probabilities that the allegation can be sustained
- Agree on further action needed and by whom
- Devise and agree a multi-agency Safeguarding Adults Plan that addresses the medium and long term protection needs of the vulnerable adults.
- Continue to enable the views and wishes of the vulnerable adult, and if appropriate their carers, members of their family and friends to be taken in to consideration.
- To consider whether the alleged perpetrator, if a worker, should be referred to the Safeguarding Adults Register.
- To clarify the role and responsibilities of professionals and the legal context of intervention.

10.9.3 Who is invited to the meeting?

All the relevant agencies that have carried out investigations must attend the meeting with written reports explaining the results of their findings.
Any other relevant agencies that may need to be involved in the case, e.g. legal services should also be invited to the Meeting.

The Safeguarding Manager will ensure that the vulnerable adult is informed of any forthcoming Safeguarding Plan Meeting/ Case Conference , invited to attend and given an explanation of the Meeting and its format. However this must be discussed with the Chair if this raises the level of risk that the vulnerable adult is subject to, or if there are other compelling reasons why this is inappropriate.

When a vulnerable adult lacks mental capacity and regardless of whether they have their family or care representation the need for an IMCA must always be explored. The best interest of the service user should always be the paramount objective.

Separate advocates can represent the carer(s) and the vulnerable adult. The Chair must be aware that the interests of the vulnerable adult and the carer(s) will not necessarily be the same.

If the vulnerable adult and/or carer(s) have communication needs, which have to be met in order to enable his/her participation in the Meeting, the Safeguarding manager should ensure that appropriate arrangements for meeting these needs have been made.

10.9.4 What happens if an important involved professional can not attend the meeting?

Should any professional with direct knowledge of the vulnerable adult or his/her situation not be able to attend the Meeting, he/she must submit a written report giving details of his/her knowledge and expressing his/her opinion regarding possible action.

10.9.5 Who should chair a Case Conference/Safeguarding plan Meeting?

The Chair must be the Safeguarding Manager that chaired the Initial Strategy Meeting, unless for reasons of unavoidable absences or because of the complexity of the case, it has been passed on to the Practice Manager's Team Manager.

The Chair will also provide the minute-taker.

10.9.6 Where should a Safeguarding Adults Plan Meeting/Case Conference be held?

When deciding the venue for the Safeguarding Plan Meeting/Case Conference the needs of the Vulnerable Adult and his/her interpreter and/or advocate must be considered and accommodated, where possible. Appropriate transport and care support must be sought.

The Safeguarding Manager is responsible for ensuring an appropriate venue is booked and for meeting any special needs such as ensuring the venue is wheelchair accessible if the service user is in a wheelchair.

10.9.7 How freely can information be shared in a Safeguarding Plan Meeting/ Case Conference?

Information should be shared freely between the participants. Participants have a responsibility to protect the confidentiality of the information that has been

exchanged in reference to the proper management of the case and the legal responsibility and accountability of each agency.

The deliberate withholding of information is indefensible on the grounds of confidentiality. Non-disclosure may impact upon the future safety of the vulnerable adult.

Where a non-professional is invited to attend the Safeguarding Plan Meeting because of his/her personal knowledge of the case, the Chairperson should ensure he/she is briefed properly beforehand about the purpose of the meeting and the duty of confidentiality.

If any professional feels he/she is unable to divulge confidential information to the Safeguarding Plan Meeting because of the presence of the non-professional, he/she should communicate his/her concern to the Chair. The Chair will then make suitable arrangements to allow the information to be shared with the professionals involved in the Safeguarding Plan Meeting.

10.9.8 What is on the agenda of a Safeguarding Plan Meeting?

The agenda for the Safeguarding Plan Meeting will cover the following:

- All attending will identify themselves and their role in the specific case.
- The aim of the meeting will be explained.
- Summaries will be given from other professional, including any previous involvement with the case, any recent updates, a copy of the written report of their investigation and any action currently being taken or planned.
- Chair's summary of the significant details thus far. The Chair will reconfirm the exact nature of the risk(s) pertinent to the case concerned.
- Discussion to confirm, or otherwise, that the case falls within the "Safeguarding Adults Registration Criteria" and a decision shall be taken as to whether registration is appropriate.
- Discussion about the availability of statutory powers to intervene.
- Agree a plan of action, identifying specific actions for each agency and delegates with time scales.
- Key Worker (Safeguarding Manager) nominated.
- Set date to review progress within six months of this meeting whether further action will be taken or not.
- If the Case is not being closed here, then a Strategy Review Meeting will be convened when necessary.

10.9.9 What happens if abuse is substantiated?

If after the investigation it becomes clear that abuse/neglect did take place appropriate legal or police services are involved in the potential use of relevant legislation and prosecution.

Where a person is entitled to 'Special Measures' under 'Achieving Best Evidence', they are given the relevant support from Witness Support services.

10.9.10 What action is to be taken against the perpetrator if abuse is proven?

If the perpetrator is in a paid regulated service a referral should be made for their inclusion on the POVA (Protection of Vulnerable Adults) register. The person should be suspended under the relevant disciplinary procedures until a full investigation under those procedures takes place. The person should not be in a position where they are working with vulnerable adults or children.

Positive action **must** be taken by the participating agencies to ensure that the perpetrator is not allowed to abuse/neglect ever again.

Action **must** be taken to ensure that the victim is protected from the perpetrator and not at any further risk.

10.9.11 What is the purpose of a Safeguarding Plan?

The Safeguarding Plan must clearly state its objectives and the intended outcomes with respect to each action that is planned.
It ensures that the vulnerable adults' health and social care needs are being addressed.

The Plan needs to outline how the recommendations and actions of each agency, following an investigation are monitored. Ensuring that any support the service user requires in relation to therapy, community services or seeking justice is in place. Any future risks should be identified, with clear mechanisms in place for sharing information and taking agreed action.

The views of the vulnerable adult must be represented always.

If it has not been possible to put in measures in place to protect the vulnerable adults, this must be clearly be stated with the reasons this was not possible.

A contact person should be identified on the Safeguarding Adults Plan who will have responsibility for taking appropriate action to monitor the safety and well-being of the vulnerable person and to convene a strategy review meeting if necessary.

10.9.12 What is the role of Community Care Services in the Safeguarding Plan?

Fair Access to Care Services (FACS) criteria should be used to assess eligibility to care services from Haringey Council. This will determine whether the risk to the person's independence is critical, substantial, moderate or low and therefore, whether or not the person is eligible to receive community care services.

A vulnerable adult not in receipt of community care services but has become a victim of abuse will automatically meet the criteria for a Community Care Assessment.

Community Care Services must be considered as part of the Safeguarding Plan.

10.9.13 What are the possible outcomes of the Meeting?

The outcome of the investigation could be:
- The investigation could be inconclusive
- Partially substantiated
- Wholly substantiated
- Unsubstantiated

For the vulnerable adult, the investigation could be closed, when no further action is necessary. In this case, a review will be booked for six months following this meeting, during which regular monitoring and the frequency determined in the Safeguarding Plan will take place to ensure the Vulnerable Adult is at no further risk.
Where further investigation is needed another Meeting will be convened to allow for this assessment to take place. All relevant agencies need to remain involved and undertake the tasks assigned to them. The Safeguarding Manager will remain in charge of the case lead until its conclusion.
A Safeguarding Plan must be modified to meet changes in circumstances. For example, Police arrest the alleged perpetrator and hold them in custody or the vulnerable adult is moved to a place of safety.
The Safeguarding Plan and situation are continually monitored. Counselling is offered to those requiring it.
The safeguarding plan becomes part of the care plan.

For the alleged perpetrator
- Criminal charges could be pursued
- The alleged abuser if a paid worker in a regulated service is referred to the POVA list under the Care Standards Act 2000.

How will the outcomes be documented?

- The Case Conference/Safeguarding Plan Meeting must be recorded by an allocated Minute-Taker.
- It is the responsibility of the Safeguarding Manager to identify the Minute-Taker
- A copy of the Safeguarding Adults Plan Meeting/Case Conference must be sent to all attendees and to anyone else that should have attended but must have a copy of the minutes.
- The contents of minutes are highly confidential and must not be reproduced, divulged or copied in any way. Information obtained at a Case Conference/Safeguarding Plan Meeting is not to be discussed or revealed to persons not present without first obtaining written permission from the source of that information and the Chair.

10.9.14 What is the role of the Safeguarding Adults Key Worker?

Where the Case Conference/Safeguarding Plan Meeting concludes that a vulnerable adult's name shall be placed on the 'Safeguarding Adults register' a professional delegate shall be identified as the Key Worker.

The Key Worker will be the person who in the view of the Case Conference/Safeguarding Plan Meeting can best perform the role. The identified person will act as a focus for communications between agencies and co-ordinate the inter-agency work of those concerned.

The Key Worker will ensure as far as possible that the recommendations from the Case Conference/Safeguarding Plan Meeting are implemented accordingly. If there are any difficulties that threaten the effectiveness of the safeguarding plan and/ or any other significant developments following the case conference the key worker has a duty to alert the Safeguarding Adults Co-ordinator. The alert should include notification of how the Key Worker intends to address the situation in question. They will almost inevitably involve other members of the core group who attended the Case Conference/Safeguarding Plan Meeting being requested to take appropriate action. It is advisable that the vulnerable adult is in agreement with the choice of Key Worker.

If for any reason the Key Worker believes that he/she is no longer able to fulfil their responsibilities of the role they must inform the Safeguarding Adult Co-ordinator immediately. It is their organisation's responsibility to provide interim Key Worker cover until such time as the next Review is held.
The Safeguarding Adults Co-ordinator will provide the Key Worker with the contact details of all other delegates at the Case Conference/Safeguarding Plan Meeting.

10.9.15 What happens after the meeting?

Following this meeting, remember to inform the person who raised the concern that the investigation is completed. Sharing details of the outcome with the alerter is with the consent of the vulnerable adult or their advocate.
The Safeguarding Manager is to remain allocated in their role until the Review has taken place six months after the Safeguarding Plan Meeting. This is so that if further concern is raised the case can automatically be sent to this Manager who has prior knowledge.

Between this Case Conference/Safeguarding Plan meeting and the review, it is imperative that the Vulnerable Adult is monitored. The frequency and type of contact will be agreed at the Safeguarding Plan Meeting.

10.10 Review

10.10.1 When must a Review be held?

Six months after the Safeguarding Meeting a review is to be undertaken.

The time scale for reviewing the Safeguarding Adults Plan must have been set at the Case Conference/ Safeguarding Plan Meeting.
If any concerns or changes in circumstances might increase the risk of further abuse occurring before the date set, these should be brought to the attention of the Safeguarding Manager and the date for the review brought forward.

The date of the Review will only be delayed in exceptional circumstances e.g. if the vulnerable adult is resident in hospital and it is judged that to delay the review until the moment of planning for discharge better protects that person.

Members of the Core group may meet formally between meetings if this will assist in the management of risk pertaining to the vulnerable adult in question. It is highly advisable that some form of Minutes (however brief) is taken of such meetings. Any minutes gathered from this meeting must be provided to the Key Worker and the Safeguarding Adults Co-ordinator **within 5 working days** of the meeting.

10.10.2 What is the purpose of the Review?

The Review is to ensure that the actions agreed in the Safeguarding Adults Plan have been complied with and included into the care plan to further protect the vulnerable adult.

The vulnerable adult should, if possible, be consulted about the way arrangements for their care and protection are working.

10.10.3 What happens if the review reveals a serious concern?

If the review reveals any serious concerns it may be appropriate to carry out a further Safeguarding Adults Investigation or to update the Safeguarding Adults Plan.

If the Safeguarding Adults Plan needs to be amended then a copy of this plan should be sent to all the organisations providing a service for the vulnerable adult.

The vulnerable adult will remain an open case allocated to a Care Manager, who would have the responsibility of monitoring the case and completing a further review of the Safeguarding adults Plan.

If new allegations or suspicions with respect to abuse are identified, then consideration needs to be given as to whether it would be appropriate to begin a new Safeguarding Adults Investigation.

10.11 Recording and Monitoring

Comprehensive records **must** be kept of any ‘Safeguarding Adults’ work.

Multi-agency work carried out under the procedures is to be stored on Framework-I under the 'Safeguarding Adults' workflow process. All documents must be scanned and saved in appropriate folders.
In order to identify repeat victimisation when a case is closed and a review is completed the Framework-I warning is changed from a **WARNING** to a **GENERAL NOTE** so that a previous POVA allegation can be immediately recognized.

Each Alert is be dealt with, with the same severity and diligence.

10.12 Post Intervention Work and Debrief

For the purpose of this document, the term 'debrief' refers to positive and constructive feedback that may highlight both examples of good practice and areas in need of improvement. The process of debrief will enable staff to be provided with support and feedback on their role in the process.

The specific objectives of post-intervention work and debrief are:
- To confirm the outcome of the process with the vulnerable adult and appropriate carers.
- To offer effective post intervention support for staff.
- To share and learn from experience.
- To raise awareness of Safeguarding Adults issues
- To act as a reporting mechanism that records outcomes to inform future strategic policy and procedural planning, training developments and good practice.
- To review the effectiveness of these procedures.

Those who may require debrief are:
- The original Alerter
- The vulnerable adult
- The family/carers
- Any agencies/individuals/group involved
- CSCI
- The Police
- The Safeguarding Adults Board
- The investigating Worker.

It is the responsibility of Safeguarding Managers to ensure that staff receive quality support during and after investigations and to identify and meet any training needs. Where appropriate, support may involve a referral to occupational Health or a Professional Counselling Service.

It is the responsibility of Safeguarding Managers who may have made an alert on behalf of one of their workers, to ensure that the alert is discussed in supervision and to provide appropriate feedback.

Safeguarding Managers must be supported, given access to appropriate training and enabled to fulfil their supporting role by their manager.

The level of debrief and information provided to each group or individual will be proportionate to their involvement. They will be debriefed on a need to know basis. The Key Worker will confirm with their Safeguarding Manager or the Safeguarding Adults Co-ordinator what level of information should be given to each group or individual.

10.13 Support for Staff

A case of adult abuse causes stress for all the individuals involved. In the case of staff members, whilst supervision and support provided by the Safeguarding Manager is important, a range of other options should be available.

The options that should be made available for all individuals involved in an abuse case include:

- Access to the Multi-Agency Safeguarding Adults from Abuse Panel.
- Training within and between agencies
- Information on an appropriate telephone advice line
- Access to the Safeguarding Adults Co-ordinator.

10.14 Institution Concerns Investigations

This section of Haringey's Multi-agency procedures describes the way in which a Safeguarding Adults Investigation should be carried out when a group of people are at risk from the same abuser e.g. an employee of a regulated service provider, or as a result of delivery of poor standards of care by a service provider.

The purpose of this process is to ensure a co-ordinated approach at senior management level, to a complex situation that may involve a number of Haringey Safeguarding Adults partner organisations/agencies, including Adult Services, Health, CSCI, Police and possibly other agencies outside the borough.

For the purpose of this section the word "institution" refers to regulated providers of services to vulnerable adults and includes:

- Residential care home
- Nursing care home
- Hospital including day hospital
- Day care services including luncheon clubs
- Home care provision

When a group of people have been abused or are at risk it may be appropriate to carry out an Institution Concerns Investigation rather than an individual series of Safeguarding Adults Investigations. The decision to initiate an Institution Concerns investigation will be made by the Haringey Safeguarding Adults Co-ordinator when concerns about a provider of service to vulnerable adults become wide-ranging and serious.

The prompt leading to a decision by the Safeguarding Adults Co-ordinator to proceed with a larger scale investigation can come from various sources including the following:

- The nature and type of abuse referred under the Safeguarding Adults procedures in relation to an individual service user which may highlight broader serious concerns about provision of care to vulnerable adults by the provider agency involved.
- An ongoing Safeguarding Adults Investigation about an individual service user which may highlight serious concerns about the provider of services to the vulnerable adult. Where it becomes apparent to a team manager that accumulated concerns should be followed up, they will notify the Safeguarding Adults Co-ordinator.
- Complaints monitoring by Haringey Council Contracts Team and the Complaints Unit highlighting wider concerns that have arisen from accumulated complaints about a service provider. In this case the Contract Team or relevant Commissioning Manager should contact the Safeguarding Adults Co-ordinator.

It remains important to ensure the safety and well-being of those individuals who have been affected is addressed in terms of their individual care needs and therefore individual Safeguarding Adults Investigations will complement Institution Concerns Investigations.

The usual starting point for this process is a Multi-agency Institution Concerns Strategy Meeting which will be arranged and chaired by the Safeguarding Adults Co-ordinator or a Team Manager, who will take responsibility for co-ordinating these investigations. A decision will be made at the Institution Concerns Strategy Meeting with respect to the structure of the investigation, the boundaries with regards to what is and what is not to be covered by the investigation and the timing of subsequent meetings, including an Institution Concerns Case Conference.

It needs to be clear who is leading the Institution Concerns Investigations, who should be involved, which actions to take and systems to follow. The type of investigation would normally involve the CSCI, Social Services Team Managers, representatives from the Provider agency, Haringey Contracts team, Customer care Unit or Haringey Commissioning Teams, other teams with service users placed in the establishment or who are receiving care from the provider agency. It may become necessary to involve Haringey Legal Services, Haringey PCT and hospitals.

Likely elements of an investigation would be a review of all Haringey service users within the service and recommendations to other local authorities and Health providers to do the same. While CSCI cannot volunteer information on concerns they have about a service, they are able to share information about risks to individual service users.

CSCI should themselves be informed of any concerns they have about a service that is registered under the Care Standards Act 2000. CSCI must be kept

informed of developments at all stages of the Institution Concerns Investigation in order to ensure that they are able to carry out their statutory duties and responsibilities.

If it is apparent that a crime has been committed, a senior Police Officer from the CSU should be consulted at the outset of the Investigation to ensure that the investigation is planned in a way that does not compromise any Police Investigation.

There may be service-users of other authorities receiving a service about which there are concerns. There is a tension between wanting to act responsibly and notify these other authorities of our concerns, and the need to act within the law in terms of not injuring the proprietor's ability to trade by expressing general concerns. It is the responsibility of the Safeguarding Adults Co-ordinator to make the decision to inform other placing authorities of Haringey's concerns.

At the close of an Institution Concerns Investigation, an Institution Case conference meeting should be held to enable all parties to meet to summarise the outcome and recommendations arising from the investigation. The action plan will be summarised in an Institution Concern Action Plan.

With respect to recommendations concerning individual service users, it is the responsibility of their Care Manager/Social Worker to ensure that these are being met. Where recommendations are made in relation to provision of care by a provider agency, the Safeguarding Adults Co-ordinator in partnership with the CSCI will monitor that these are carried out.

The Safeguarding Adults Co-ordinator may decide to set an Institution Concerns Review Meeting to check that appropriate actions have been taken. The Safeguarding Adults Co-ordinator will also be the appointed contact for other placing authorities to ensure prompt dissemination of information.

11 Serious Case Review

11.1 What is a Serious Case Review?

Serious case reviews were established following the revised "Working Together" child protection guidance (Home Office et al 1991). A serious case review is a process of investigation, re-evaluation, analysing, scrutinising and making recommendations:

- When a vulnerable adult who is receiving community care services dies
- When a vulnerable adult is subject to a serious injury when there is suspected or actual abuse
- When there is a safeguarding adults issue with major public concern.

Serious Case Review used to be known as Part 8 or Section 8 and the process is co-ordinated by the Chair of the Haringey's Safeguarding Adults Board (HSAB) through the Case Review Sub Committee.

The guidance is issued under Section 7 of the Local Authority Social Services Act 1970. It does not have the full force of the law but, according to the Department of Health, 'should be complied with unless local circumstances indicate exceptional reasons which justify a variation'.

Relevant Standards: 1.22-9.10.15

It is recommended that:

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

There is a clear process for commissioning and carrying out of a serious case review by the partnership.

11.2 The Purpose of a Serious Case Review

The purpose of the serious case review is to:

- Identify involved professional(s)
- Establish the facts
- Establish whether there are lessons to be learnt from the case about the way in which local professionals and agencies worked together to safeguard adults
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and as a consequence
- To improve inter agency working and better safeguarding of adults.

It is acknowledged that all agencies will have their own internal statutory review procedures to investigate serious incidents; e.g. an Untoward Incident.

This protocol is not intended to duplicate or replace these. Agencies may also have their own mechanisms for reflective practice.

Where there are possible grounds for both a Serious case Review and a Domestic Violence Homicide Review then the two decision makers as to which process is to lead and who is to chair with a final joint report taken to both commissioning bodies. This process will be of specific benefit when the case involves a victim aged between 16-18.

11.3 Criteria for Convening Serious Case Reviews

A serious case review **must always** be held when an adult who is being provided with services by the local authority dies due to an actual, suspected or alleged abuse.

In cases where an adult has not died it is appropriate to hold a serious case review if **any** of the following criteria is met:

- There was a significant risk of harm to an adult which was unrecognised by agencies or professionals in contact with the adult or alleged perpetrator
- Risk(s) not shared with others or not acted upon properly
- The adult was abused in an institutional setting, for example, residential/nursing homes, day-centres
- Agencies or professionals consider that their concerns and suspicions were not taken sufficiently seriously or acted upon appropriately by another agency when the concern and suspicions were a determining factor.
- The case indicates that there may be failings in one or more aspect of the local operation of formal safeguarding adults procedures which extend beyond the handling of the case.
- The adult had previously been subjected to a Protection Plan
- The case appears to have implications for a range of agencies or professionals.
- The case suggests that there may be a need for the HSAB to change its protocols or procedures or that they need to be more effectively promoted, understood or acted upon.

11.4 Process for commissioning and carrying out of a serious case review

The HSAB will be the only body which commissions any serious case reviews. The Board will publicise both the process under which applications for reviews may be made and the terms of reference for each serious case review.

There must also be mechanisms for the consideration of requests from the Coroner, MPs, Elected Members and other interested parties.

Applications must attract the support of the quorum of the Board be made in writing.

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

11.5 Initiating a Serious Case Review

The case for review will be passed to the Chair of the HSAB to initiate a discussion/decision by the Board. If it is agreed, a multi-agency Serious Case Review Panel will be set up:

- The HSAB will be responsible for the appointment of an Independent Panel Chair.

- The HSAB will ensure the Serious Case Review Panel Chair receives adequate support.

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

- Any professional or agency working within the local safeguarding adults network who concludes that a case review may be required must immediately notify the Chair of the HSAB.

- Within a month of any such notification, the HSAB Chair should convene a Case Review Sub-Committee.

- It is the duty and responsibility of the HSAB Chair to instruct the case Review Sub-Committee to undertake a Serious Case Review.

- Members of this sub-committee may determine that a full case review is not justified and that internal management review/s might be more helpful. The results of any such internal enquiries within member agencies must be fed back to this sub-committee.

- It is the responsibility of both the lead agency and the Case Review Sub-Committee to ensure feedback is undertaken.

- If the Case Review Sub-Committee does not conclude that a serious case review is required, it should make this recommendation to the Chair of the HSAB who has the final responsibility for making the decision.

11.6 When the HSAB instigates a case review, they will be responsible for:

- Identifying the agencies/service providers whose part in the case is to be examined
- Make arrangements for each participating agencies Chief Officer to be written to informing them of the details of the process, and that they need to arrange an internal/management case chronology and review.

11.7 Immediate Conduct

As soon as the HSAB Chair has decided that a Serious Case Review is required, s/he must immediately inform the relevant Service Manager or comparable officer who must then within 1 working day complete the following tasks:

- Convene an emergency Strategy Meeting to make arrangements for the safety of other vulnerable adults, for instance, in a care setting or in a domestic environment where there are other vulnerable adults.
- Check the electronic database to establish if service user is/was known and to identify involved professionals.
- Freeze and seal paper files: a senior manager in the agency must take possession of the file and ensures that a suitable member of staff numbers and initials both sides of each paper

- Limit access of all electronic database to approved person/s from the Case Review Sub Committee
- All agencies must make a photocopy of the file(s) so as to allow ongoing work and the original is held by a senior manager
- Files should not be entrusted to the postal service and must be delivered in person or by courier
- Inform The Director of Adults, Culture and Community Services or comparable equivalent and the Press Office
- Define those agencies which have been involved with the adult and alert them via a letter from the HSAB to Chief Executive/Officer, to their obligation to undertake an internal enquiry as a contribution to the overall case review
- Inform CSCI

Within 2 further working days, the manager who has taken possession of the active files must:

- Complete a briefing report for the Director of Adults, Culture and Community Services, equivalent in Health ,HSAB and Serious Case Review Sub-Committee, the Social Services Cabinet/Committee Member and Press Office

11.8 Individual Agency Internal Management Reviews

The Main objectives of each agency review are to:

- Look openly and critically at organisational and individual practice
- Establish if the case indicates that changes could and should be made
- Identify how any such changes may be introduced
- Propose any other action required

To achieve these objectives, the following will need to be completed:

- Files need to identified and read
- Relevant practitioners and managers need to be interviewed
- A chronology needs to be established
- Establish the service provided as a result of the decisions made
- An analysis of involvement
- A summary of 'lessons learnt'
- Recommendations for practical action

11.9 Individual Agency Response to HSAB Notification and Internal Management Reviews

The HSAB case review notification will be received usually by the agency's Chief Executive. If it is received by someone else in the agency, the Chief Executive or equivalent should be informed as soon as possible. The Chief Executive will inform the agency lead for safeguarding adults.

The agency lead (or a member of staff appointed by them) will then:

- Ensure that the agency Serious Case Review policy has been instigated
- Read all the secured records and establish a chronology of the history of the agency's involvement
- Interview appropriate staff
- Complete an initial report which will include a chronology and an analysis of our services involvement
- Any initial recommendations made at this time will be in addition to recommendations and implementation/action plans made by the HSAB Serious Case Review Panel
- The completed report will be made available to the agency and senior management as outlined within the Serious Case Review Procedure
- The completed report will be sent to the case review panel

11.10 HSAB Action on Receiving Reports

11.11 Ongoing Conduct and Timescales

The conduct of the review should be overseen by a Serious Case Review Sub Committee to be briefed at a session convened by the HSAB Chair. The overall time limit for submission of a Serious Case Review Report to the Department of Health is 4 months from the decision that such a review is required unless, as a result of complexity of a case or other circumstance, an alternative has been negotiated with CSCI.

The HSAB Chair must also notify each member agency of the need to conduct and submit to the Chair of the Serious Case Review Sub Committee (within 3 months unless otherwise agreed), its individual agency review.

The HSAB is responsible for forming an Inter-Agency Case Review Panel with a clear term of reference

11.12 Responsibilities of Serious Case Review Panel

- The Inter-Agency Case Review Panel will usually draw its members from the HSAB Serious case Review Sub Committee, with other professionals co-opted for their specific skills/insight as required
- The Serious Case Review Panel is responsible for compiling an inter-agency chronology, carefully analysing all the information available and completing a final unnamed report.
- The Serious Case Review Panel may decide to re-examine case notes and agency based evidence, as well as interview staff to aid their analysis
- They will ensure that contributing agencies and individuals are satisfied that their information is fully and fairly represented in the overview report
- They will translate recommendations into an action plan which should be endorsed and adopted at a senior level by each of the agencies involved. The plan should set out individual task, timescale with intended outcomes. It should set out also the means of improvements to be made in practice and systems for monitoring and reviewing

- Identify person(s) to whom the report or any part of it should be made available
- Disseminate report or key findings to interested parties as agreed
- Make arrangements to provide feedback and de-briefing to staff, family members of the vulnerable adult and the media as appropriate
- Provide a copy of the overview report, executive summary action plan and individual management report to the HSAB, CSCI and Health Care Commission

11.13 Overview Report and Follow-up

The Serious Case Review Sub Committee is responsible for the production of a composite report (prepared by a nominated senior manager or an independent person) to the full HSAB which will:

- Provide an overview and include all relevant facts
- Offer an integrated chronology, using the template for internal agency chronologies
- Make recommendations for action by the HSAB and individual agencies

The format of the composite report should be as follows:

An introduction - which summarises the circumstances leading to the review. The introduction should also set out the terms of reference for the review, outline the contributors and who contributed to the review and clarify the Serious Case Review Sub Committee members and author of the report

Facts - including an integrated chronology showing involvement of all agencies and an overview of what relevant information was known to each involved agency and professional, about the parent/carer/spouse, any perpetrator, and the home circumstances

An analysis, - which considers how and why events occurred. What decisions were made and the actions taken or not. This section of the report should also consider that if a different decision or action had been taken the outcome may have differed. Any exampled of good practice can also be included wherever useful.

Conclusions and recommendations, - summing up what lessons should be drawn from this case and any proposals that the agencies involved should progress as a result. The conclusion and recommendations should be explicit, simple and realistic. This section should be seen as an opportunity to improve good practice requirements in the safe guarding adults process.

A process must be put in place in advance of formal submission of the overview report to the HSAB which enables feedback and de-briefing of staff involved.

The overview report should be submitted to the Chair of the HSAB within 1 month of the internal reviews being received.

12 Dispute resolution for complex cases involving more than one specialist area

12.1 What is the Purpose of the dispute resolution for complex cases Involving more than one specialist area?

This procedure helps assists managers in Adult Services with their decision-making in relation to their funding responsibilities to service users with multiple care needs. This procedure aims to avoid disputes, where the vulnerable adults' needs are neglected as a result.

12.2 When this procedure should be used

This procedure should be referred to when:

- There is more than one service area, which may be involved in the joint assessment of need.
- For service users with multiple care needs requiring complex care packages.
- More than one service area is providing services.
- Where there is concern that an adequate level of care to support needs is not being provided. Where there is risk that the appropriate level of care to support needs is not been provided
- Where there is a risk that the appropriate level of care is dependent on funding approval/criteria
- Where service user is unable to complain or has access to an independent advocacy service

12.3 What should be done?

- ☑ Agreed care plans must be needs led and not service led.
- ☑ A person centred approach to care management should be followed especially when there is more than one team involved
- ☑ The same duty of care and the principle of acting in the service user's best interest applies to all professionals irrespective of the task
- ☑ All service providers are equally responsible for the well-being of the service user.
- ☑ Multiple care needs must be jointly assessed
- ☑ The service user should be involved in the decision-making process as much as possible. Where the service user is not able to do so then an advocate or carer should be approached.
- ☑ Relevant service managers must sign off the outcome of any assessments
- ☑ Relevant service managers to have a discussion about proposed care package
- ☑ Service managers are responsible for the funding of such care packages.
- ☑ If funding is a problem, service managers to escalate the situation to the Assistant Director of Adult Services for a resolution

- ☑ The Care package needs to be closely monitored for effectiveness
- ☑ Care packages should be reviewed as soon as any concerns arise about the quality of the service

13 Guidance Notes on Referral to the Protection of Vulnerable Adults Register (POVA)

13.1 What is the POVA register?
The POVA register is a list of names of employees who have been found to have abused a vulnerable adult. The registers overarching aim is to prevent professionals in a health or social care setting found guilty of abusing a vulnerable adult from providing direct care is such a setting again.

There are two parts to the register: the provisional list which holds the names of those currently under investigation and the permanent list for when the allegations have been substantiated. A request must be made by the person who made the referral to the provisional list to transfer a name from the provisional to the permanent or to remove a name from the provisional if the allegation could not be substantiated or is inconclusive.

13.2 Who can make a referral to the register?
It is the employer's responsibility to refer. If the worker is employed by an agency, it is the agency's responsibility.

Human Resources will make the referral if an allegation of abuse has been received about a Haringey Council employee.

The only other agencies that can refer to the register are the Commission for Social Care Inspection (CSCI), the Care Standards Inspectorate of Wales and the Secretary of State of Health.

13.3 Who can be referred?
Care workers (any worker who provides care from social workers to care assistants), volunteers and approved carers who have regular contacts with vulnerable adults in registered care and nursing homes, adult placements or service users' homes when they are receiving care.

13.4 When is a referral made?
The worker must be informed of the decision to refer. A referral is made when there is reasonable consideration that an individual is guilty of misconduct that has caused harm or risk of harm to a vulnerable adult**.** The harm or potential harm should have been because of certain action or inaction on the part of the individual. Harm is defined in law as "ill treatment or the impairment or health or development.

The misconduct could have been at work or outside of work. When disciplinary action leading to a dismissal is taken and exceptionally when the individual has been suspended pending further investigation

When a carer's approval to provide adult placement has been withdrawn/terminated

13.5 Referral to regulatory bodies
As soon as the worker is provisionally included on the POVA list there must be a prompt referral to appropriate regulatory body for instance the General Social care Council, the Commission for Social Care Inspection (CSCI), Nursing and Midwifery Council (NMC) or the Care Standards Inspectorate of Wales

The worker must be notified of this action

13.6 Supporting the referred worker
Management has an obligation to support the referred person who has been suspended while the investigation continues. The Personnel Manager should be prepared to answer questions about procedures but will not be able to comment on the allegation

13.7 Confidentiality
Only the senior manager(s), the relevant personnel manager or advisor, the individual's manager, and the individual himself or herself will know of the referral to POVA.

New employers will be told by the Criminal Records Bureau (CRB) that an individual's name is on the register or list

13.8 The worker's right to appeal
If an individual is provisionally included on the POVA list, the Secretary of State of Health will confirm this in writing to the individual sent by "Special Delivery."

The individual will have the opportunity to make written representations direct to the Secretary of State as to why s/he should not be not be confirmed on the list.

The individual will be given 28 days in which to make written observations or to indicate that s/he intends to make observations within a reasonable period. If observations are not received, the Secretary of State will take a decision based on all available evidence.

All representations made by the individual will be passed on to the manager as the referring manager for comment. Similarly the Secretary of State will provide the individual concerned with copies of all papers submitted to him from the employers

13.9 How does the referral affect the individual worker?
If a referral is withdrawn from the provisional list, that individual will the be able to continue to work with vulnerable adults. It should however lead to improved monitoring and supervision of practices by managers

Individuals who are included on the provisional list will not be employed in a care position working with vulnerable adults.

It is a criminal offence for an individual who has been transferred to the permanent register to try to obtain employment in a vulnerable adult care setting. This offence is punishable with imprisonment.

13.10 Form for referral

This can be obtained from the DOH website
http://www.elderabuse.org.uk/Media%20and%20Resources/Useful%20downloads/POVA/pova%20referral%20form.rtf

The Safeguarding Vulnerable Groups Act 2006.

The Safeguarding Vulnerable Groups Acts 2006 was introduced in the House of Lords on 28 February 2006 and received Royal Assent on 8 November 2006. A new will be introduced requiring those who intend to work with children, or vulnerable adults, to be registered. The register would confirm that there is no known reason why an individual should not work with these client. The implementation timetable is from the autumn of 2008.

Once the scheme is fully implemented, an individual who is working or volunteering, or seeking to work or volunteer, with children or vulnerable adults must apply to join the scheme. If the individual is considered unsuitable by the Independent safeguarding Authority (ISA), they are barred from working in regulated activity with children or vulnerable adults.

The new scheme will be based on two barred lists: one of people barred from working with children which replaces List 99, POCA(these two are for children) and the POVA list(a list of those barred from the care workforce). All barring decisions will be taken by the new ISA.

For further information, please visit the ISA website: http://www.isa-gov.org/

14 Related Policies and Procedures

The Safeguarding Adults procedures do not exist in isolation. Existing organisational policies and protocols provide the structure for actions taken as part of the Safeguarding process.

Concerns of abuse or neglect reported through those processes should be referred to the Safeguarding Adults procedures. Examples Include:

- Health and safety
- Untoward incident reporting procedures
- Bullying and Harassment
- Recruitment and selection
- Complaints and representation

- Disciplinary procedures
- Information sharing protocols
- Whistle Blowing policy
- Equal Opportunities

Whistle-blowers should know how to access support and to protect their own interests. Even if they decide that they wish to make an anonymous report, the information they provide will be taken in to account and treated seriously.

All requests for anonymity by the referrer will be fully respected. It cannot however be guaranteed, especially if the referrer's information becomes an essential element in any subsequent legal proceedings. In addition, the Data Protection Act 1998 removes the blanket confidentiality of third party information.

15 Haringey Safeguarding Legal Framework

15.1 Introduction

This section outlines the main legal provisions that are relevant to Safeguarding adults from abuse. It is a guide and provides information about supportive legislation linked to Safeguarding Adults policy and procedures
.
The legislative issues relating to protection and safeguarding of vulnerable adults are complex because the existing legal framework is not completely effective in safeguarding vulnerable adults. It is not always very helpful in balancing the issues of autonomy, individual rights and protection.

Legal action may provide a solution to problems being encountered when working with vulnerable adults. That nature will depend on the circumstances of each case and the type of abuse.

The law in respect of vulnerable adults is to be found in various sections of separate acts of parliament.

It is advisable that in cases where legislative issues need to be considered the agencies legal department/advisor are contacted.

15.2 Criminal Law

Vulnerable adults may be the subject of criminal acts e.g. Physical or sexual assault and theft.

Witnesses to crimes are usually interviewed under 'Achieving Best Evidence in Criminal Proceedings" procedures. If the witness is vulnerable as defined under

these procedures they may be offered special measures. That is an appropriate adult (advocate etc) may be appointed to partake in the interview process.

In any criminal investigation joint work with the police becomes extremely important, as any action may prejudice the outcome of the criminal investigation as evidence may be lost or contaminated. It is therefore essential that the police are contacted and advice is sought as soon as there is a suggestion that a crime has been committed or may be committed.

Staff may be a potential witness to a crime and any records kept used as evidence. It is therefore of the utmost importance that such records are accurate, and up to date.

15.3 Police Powers and Criminal Investigations

The police should be informed of situations where a criminal investigation is warranted under criminal law. The standard of evidence required for a successful prosecution will be “proof beyond reasonable doubt”. The police will therefore need to obtain all possible evidence and include statements from both the victim and witnesses if available.

The ultimate decision whether to prosecute lies with the Crown Prosecution Service. They will have to take in to account the weight of the evidence and the potential for a prosecution going ahead.

15.4 Police and Criminal Evidence Act 1984

Section 17: Allows a police officer to search and enter any premises without a warrant for the purpose of saving life or limb or preventing serious damage to property.

Section 24: Allows a police officer to arrest any person who is suspected of having committed, or is about to commit an arrestable offence.

Section 25: Allows a police officer, where there are reasonable grounds to make an arrest or someone to prevent them causing physical injury to another person, or to protect a child or other vulnerable person.

Codes of Practice:
Code C: A vulnerable adult taken in to police custody will be supported or represented. In exceptional cases, the person in custody may not be afforded this right in police custody.

Provide for an appropriate adult to be in attendance at police interviews involving mentally disordered or mentally handicapped person.

15.5 Youth Justice and Criminal Evidence Act 1999

This Act gives the police and the courts the ability to offer 'Special Measures' to vulnerable victims and witnesses of crimes. The act fundamentally affects the way in which evidence is gathered and presented in court in respect of children and other vulnerable groups.

The 'Special Measures' apply to:

15.5.1 Under Section 16:

- All children under 17 years of age at the time of the hearing.
- Persons suffering from mental disorder within the meaning of the Mental Health Act 1983.
- Persons suffering from significant impairment or intelligence or social functioning.
- Person with a physical disability or other physical disorder.

15.5.2 Under Section 17:

- Persons suffering fear or distress in connection with testifying in the proceedings
- Complainants in sexual offence cases.

15.5.3 Special Measures: Other 'Special Measures' provisions include:

- Video recorded evidence
- Evidence presented in court by live link
- Evidence in private
- Screening witness from the accused
- Removal of wigs and gowns
- Aides to communication
- Support from an intermediary.

In considering the use of 'special measures' the court must consider whether or not the quality of evidence given by the witness is likely to be diminished by reason of their belonging to one of the categories of vulnerable or intimidated witnesses.

Under **Section 17**, a person suffering fear or distress, the court must take account of the following in reaching a determination of the use of special measures:

- The nature and alleged circumstance of the offence.
- The age of the witness.
- Social, cultural and ethnic origins.
- Domestic and employment circumstances
- Religious or political opinions
- Behaviour of accused, his or her family or other associates towards the witness.

15.6 National Guidance Document 'Achieving Best Evidence in Criminal Proceedings' 2001

The national guidance provides a framework by which the police and social services gather services gather evidence from children and vulnerable adults in criminal investigations. Only those trained in this guidance should interview victims of and witnesses to suspected crimes. The guidance is extended beyond criminal proceedings and used as the basis for interviewing witnesses in civil and quasi legal proceedings.

15.7 Sexual Offences Act 2003

This Act repeals all previous legislation on sexual offences. Consent is a key issue in the Act and the freedom to make choices. The main sexual offences are rape (now including penile penetration of the mouth, anus or vagina), assault by penetration, and a sexual assault by touching and causing sexual activity without consent. Sexual relations with certain relatives have been clarified.

The Act introduced new offences to protect vulnerable persons with a mental disorder or a learning disability from sexual abuse. These include where they are unable to refuse because of a lack of understanding, where they are offered inducements or subject to threats or are deceived and where there is a breach of relationship of care, by care workers.

Section 30- Sexual Activity with a person with a mental disorder impeding choice

A person (A) commits an offence if-
(a) he intentionally touches another person (B)
(b) the touching is sexual
(c) B is unable to refuse because of or reason related to mental disorder, and
(d) A knows or could reasonably be expected to know that B has a mental disorder and that because of if or for a reason related to it B, is likely to be unable to refuse.

B is unable to refuse if-
(a) he lacks the capacity to choose whether to agree to the touching (whether because he lacks sufficient understanding of the nature or reasonably foreseeable consequences of what is being done, or for any other reason), or
(b) he is unable to communicate such a choice.

Section 31- Causing or inciting a person, with a mental disorder impeding choice, to engage in sexual activity

Section 32- Engaging in sexual activity in the presence of a person with a mental disorder impeding choice.

Section 33- Causing a person with a mental disorder impeding choice, to watch a sexual act.

The Sexual Offences act 2003 also contains specific sexual offences that can be committed by a care worker against a person with a mental disorder or learning disability:

Section 38- Care workers: sexual activity with a person with a mental disorder.

Section 39- Care Workers: causing or inciting sexual activity.

Section 40- Care Workers: sexual activity in the presence of a person with a mental disorder.

Section 41- Care Workers: causing a person with a person with a mental disorder to watch a sexual act.

For further information please go to www.legislation.hmso.gov.uk

15.8 Civil Law

Protection from Harassment Act 1997
This piece of legislation is a civil law but creates the offence of harassment. It can be used when a matter falls short of a physical attack but the vulnerable adult is being intimidated or harassed by an abuser. In such situations an injunction can be sought.

15.9 Domestic Violence Legislation

Family Law Act 1996 Part 4

In relation to domestic violence, there are several relevant sections within criminal law pertaining to assault. The police should take a proactive approach to domestic violence between partners and have the powers to arrest an alleged perpetrator, even where the victim has not decided to press charges.

The Family Law Act provides for the making of non-molestation and occupation orders and these can include powers of arrest. These can be obtained against "associated persons" which include cohabiters, spouses and persons who live together in the same household and relatives. It does not include employees, tenants, lodges and boarders.

Domestic Violence, Crime and Victims Act 2004

This Act broadens the relationships covered by domestic violence legislation to include same sex and couples who have never lived together. It makes common assault an arrestable offence. There are significant Police powers including making it an arrestable, criminal offence to breach a non-molestation order.

The victim is given stronger legal protection as the legislation enables the courts to impose restraining orders when sentencing for any offence, or on acquittal for any offence of causing or allowing the death of a child or vulnerable adult. This places a new offence of causing or allowing the death of a child or vulnerable adult who is at significant risk of serious harm. The Act set up an Independent Commissioner for Victims to give them a voice nationally.

15.10 Mental Capacity Act 2005

The Issue of mental capacity is critical in deciding action in adult protection. English law presumes that everyone has mental capacity until it is proven otherwise. In undertaking investigations, capacity to consent is a key issue. There are two key issues and the first is the capacity of the adult to consent to a sexual act or other act about which there is concern. If the adult has capacity and consented to the 'abusive' act, it is unlikely that any prosecution can take place although the Police should be consulted. A vulnerable adult's capacity may fluctuate over time. This can be critical in determining whether an act is abusive or consensual.

The second key area where capacity is significant is consent to the process of the investigation- active involvement of the Police, interviews and medical assessment. If the vulnerable adult lacks capacity for this function, it is inappropriate for their consent to the process to be sought. However, they should be engaged with the process in any way possible. If the adult has capacity and declines assistance and refuses an investigation, actions will be limited. Such situations should be discussed at a Safeguarding Adult Conference to ensure all agencies are aware of the risks and the danger signals.

In assessing capacity, it is important to distinguish between capacity to make the decision and the ability to communicate the decision. The Mental Capacity Act 2005 makes clear that a functional approach to capacity must be taken and the adult must be assessed in relation to their capacity for this specific decision, not a general assessment. The test is whether the person is capable of understanding the particular decision. If a particular decision is trivial, a low degree of understanding will suffice. The more complex the decision the greater the understanding is needed.

If an adult lacks capacity, professionals involved need to act in the vulnerable adult's best interests. Capacity must have been carefully assessed and recorded. Legal advice should be sought. In the context of medical decisions, best interests is defined as where medical treatment is *"necessary to save life or prevent a deterioration or ensure an improvement in the patient's physical or mental health; in accordance with a practice accepted at the time by a responsible body of medical opinion skilled in the particular form of treatment in question"*: [19]

[19] Code of Practice Mental Health Act 1983.

This Act is underpinned by a set of five principles which make it clear that a person should be seen as having capacity unless proved otherwise. These are:

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

What does the Act do?

- Enshrines current best practice and common law principles concerning people who lack capacity.
- Replaces current statutory schemes for Enduring Powers of Attorney and the appointment of Court of Protection Receivers
- Sets out single clear test for assessing whether a person lacks capacity to make a particular decision at a particular time.
- Everything done on behalf of a person who lacks capacity must be in that person's best interest.
- Clarifies that where a person is providing treatment or care for someone who lacks capacity, then the person can provide the care without incurring legal liability.

Someone is unable to make a decision for himself if he/she is unable:

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

There is a best interest's checklist for people acting on behalf of others. This includes the following:

- Consider whether it is likely that the person will at some time have capacity in relation to the matter in question and if so when.
- Must permit and encourage the person to participate as fully as possible in any act and decision.
- Must consider the person's past and present wishes and feelings, the beliefs and values that would be likely to influence his decision if he had capacity and the other factors he would be likely to consider if he were able to do so.
- He must take account if it is practical and appropriate to consult them, the views of anyone named by the person for consultation, carers, donees of lasting power of attorney or court appointed deputies.

Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the incapacitated person and if the restraint is proportionate to the likelihood and seriousness of harm.

The Act has extended the Court of Protection's role to cover welfare matters not just financial matters. A lasting Power of Attorney can specify other decisions on wider welfare matters as well as finance. Most day to day informal decisions should be able to be taken without interference of the court, with a general authority resting on the carer.
A Court can appoint a deputy to help with healthcare, welfare and financial decisions, where a person lacks capacity, without appointing a Lasting Power of Attorney. This replaces the current system of receivership covering financial decision making and extends it to include health and welfare.
The Act has also made three new provisions

- The creation of the Independent Mental Capacity Advocates (IMCAs) to support those lacking capacity who have no one else to speak for them when decisions are taken about serious medical treatment or long term residential care.
- Advance decisions to refuse treatment – statutory rules with clear safeguards confirm that people may make a decision in advance to refuse treatment if they should lose capacity in the future. It is made clear in the Act that an advance decision will have no application to any treatment which a doctor considers necessary to sustain life unless strict formalities have been complied with. These formalities are that the decision must be in writing, signed and witnessed. In addition, there must be an express statement that the decision stands "even if life is at risk".
- The Act creates a new criminal offence of ill treatment or neglect of an adult who lacks mental capacity. A person found guilty of such an offence may be liable to imprisonment for a term of up to five years.

15.11 Financial Protection

The prevention of financial abuse can be difficult. It is important to remember that such abuse may be a crime so consult the police. The Mental Capacity Act 2005 also provides some safeguards.

Court Appointed Deputies

Under the Mental Capacity Act 2005, the Court of Protection has replaced receivers with Deputies.

- Deputies can be appointed to make decisions on financial matters
- Will only be appointed if the Court cannot make a one-off decision to resolve issues.
-

Power of Attorney
The adult can, through a legal process, empower someone else to act on their behalf in relation to all their financial affairs. Unless any restrictions or conditions are placed on the Attorney this person will be able to do almost anything that the adult would have done, for example sign cheques, or withdraw money from

savings accounts. The adult granting the Power Of Attorney must be mentally capable at the time and can appoint almost anyone who is over 18 years of age. An ordinary Power of Attorney lasts only so long as the person who grants it is mentally capable whereas a Lasting Power of Attorney allows for incapacity.

Lasting Power of Attorney (LPA)

It is similar to the previous system of Enduring Power of Attorney which it replaces under the Mental Capacity Act 2005.
A Lasting Power of Attorney continues after the adult becomes mentally incapable of managing their own affairs. An attorney can be appointed to make decisions on financial matters LPAs must be registered with the Public Guardian Office (PGO) before it can be used.

Appointee
The Department of Works and Pension (DWP) can appoint someone else to receive the adult's benefits and to use that money to pay expenses such as household bills, food and personal items. An appointee should be a close relative or friend or someone who is regularly in contact with the adult. The person who is willing to act as the appointee must contact the local Benefits Agency office, who will arrange to interview the adult to decide whether they are mentally or physically incapable of acting on their own behalf. Where an adult has no one who can take this on, it is technically possible for someone from the Council to do so but is not generally considered appropriate.

Agent
If the adult cannot go to the Post Office because of a physical disability or incapacity they could either fill in the back of the payment order or they could arrange for a suitable person to be made their Agent. The adult will need to contact the local Benefits Agency office and the adult can cancel this arrangement at any time they see fit. The Attorney and Agent assume that the adult is able to make the decision. An attorney is in fact under a legal duty not to misuse the power granted to them. If they do so, they can be sued in the Civil Courts.

Inherent Jurisdiction

The High Court may use its inherent jurisdiction to make a declaration as to whether action which is proposed to be taken is in the best interests for a person or is unlawful. The High Court can make decisions as to appropriate place of residence with someone who does not have capacity to make decisions by themselves and can also make injunctions to back up any residents and to stop removal.

15.12 Mental Health Act (MHA) 1983

This Act provides for the detention and treatment of mentally disordered individuals and if use is being considered an Approved Social Worker should advise.

Section 115: Powers of Entry and Inspection:

An Approved Social Worker may at reasonable times enter and inspect any premises in which a mentally disordered adult is living, if he/she has reasonable cause to believe that the patient is not under proper care.
Section 115 does not allow an approved social worker to force entry, although obstruction may be offence under Section 129, and the approved social worker can apply for a warrant under Section 135. The adult need not be named in this warrant, so this allows for investigation of suspected maltreatment of people whose identity is unknown but whose whereabouts are known. The evidence used to obtain the warrant can be about mistreatment in the past and therefore allows for accumulation of evidence over a period of time.

Section 135 allows an Approved Social Worker to apply for a warrant to search for and remove adults where there is a reasonable cause to suspect that an adult believed to be suffering from a mental disorder has been, or is being, ill-treated or neglected and not kept under proper control, or is unable to care for himself or herself and is living alone.

Section 136 allows for a police officer to intervene if the adult is in a public place (for example wandering outside their home).

Section 13(4): Duty to make application for admission
This places a duty on Social Services Department to direct an Approved Social Worker to consider making an application for admission under the Act, if requested to do so by the nearest relative. This power could be used if the nearest relative of a mentally disordered adult complains of mistreatment by a third party, provided grounds exist under the MHA.

Section 2, 3 and 4: Admission to hospital
These sections give power to an Approved Social Worker based on the recommendation of one or two doctors to authorise the admission to hospital of a mentally disordered adult, if she/he is satisfied the criteria for compulsory admission are met as per the provisions of the MHA.

Section 7: Guardianship
A vulnerable adult can be received in to guardianship by the local authority if she/he has a mental illness, severe mental impairment or mental impairment associated with “abnormally aggressive or seriously irresponsible conduct”. The Guardianship must also “be necessary in the interests of the welfare of the adult or for the protection of other persons”. The “welfare of the patient” is interpreted broadly.

Guardianship gives the guardian 3 basic powers:
1. Accommodation: to say where someone is to live.

2. Attendance: to require the adult to attend somewhere for the purpose of medical treatment, occupation, education or housing.
3. Access: to gain access to the patient at the place where they are living.
There is a necessity to consult the nearest relative when considering guardianship. Consideration to displacing the requested relative should be given if any of the statutory grounds set out in Section 29 (3) are met. Legal advice must be sought.

Section 127: Ill-treatment of patients
This section makes it an offence for an officer on the staff or otherwise an employee or a manager of a mental nursing home or hospital, to ill-treat or wilfully neglect" a patient who is either:

- currently receiving treatment for mental disorder as an in-patient in that hospital or home;
- a patient receiving treatment as an out-patient

Furthermore under subsection (2) "it shall be an offence for any individual to ill-treat or wilfully neglect a mentally disordered patient who is for the time being subject to his guardianship under this Act or otherwise in his custody or care (whether by virtue of any legal or moral obligation or otherwise)". This sub section has rarely been used but potentially could include the mistreatment of a mentally disordered adult by any carer- informal or otherwise.

15.13 Powers to act without Consent

A person with mental capacity is entitled to refuse the provision of services even though the professional opinion is that this will cause deterioration, abuse, or neglect. In such situations, a multi-agency conference is recommended. One situation allows for intervention without consent where the Mental Capacity Act and the Mental Health Act are not relevant or helpful.

15.14 The Rights of the Vulnerable Adult

The vulnerable adult who is being abused is very likely to have their own legal remedy and should seek their own legal advice where possible. The worker should support this.

Human Rights Act 1998
All public authorities have to comply with the Act which gives legal force to the rights enshrined in the European Convention of Human Rights. There is a positive duty on local authorities, approved social workers; health authorities, NHS, PCT and the Police to uphold these rights. It is not enough for public authorities not to go against these rights; they also have a positive duty for example, a duty to ensure that someone is not subject to torture of inhuman or degrading treatment. These rights can be limited but the limit on these rights must be proportional.

The main rights that apply include:

Article 2: right to Life
Article 3: Prohibition of Torture and Inhuman or Degrading Treatment
Article 5: Right to Liberty and Security
Article 6: Right to a Fair Trial and Determination of Civil Rights
Article 8: Right to Respect for Private and Family Life including home and correspondence
Article 9: Freedom of Thought, Conscience and Religion.
Article 10: Freedom of Expression.
Article 11: Freedom of Assembly and Association
Article 12: Right to Marry
Article 13: Right to redress at a national level
Article 14: Prohibition of Discrimination (this only prevents discrimination in relation to the other rights and applies to ground such as sex, race, colour, language etc or other status)
Article 17: Prohibition of Abuse of Rights
Article 18: Limitations on use of restrictions on rights
First Protocol Article 1: Property of Property
First Protocol Article 2: Right to Education

Disability Discrimination Act 1995
This Act provides positive protection for disabled people from discrimination in relation to services and employment.

15.15 Local Authority Adult Services

Local authorities have a number of statutory powers and duties to provide services for adults who need them. Some of the important powers and duties are covered in the legislation below:

The National Assistance Act 1948

Whenever you consider the use of Section 47, seek legal advice as you will need to consider Article 5 of the European Convention of Human Rights which states that:
“Everyone has the right to liberty and security of the person. No one shall be deprived of his liberty save in the following cases and in accordance with the procedure prescribed by law but also allows for:
(e) “the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants”.

Therefore, not only do you have to fulfil the requirements of Section 47 of the 1948 Act, you also have to fulfil the requirements of Article 5 (e) of the Human Right Act.

Section 47:
This section of the 1948 Act gives power to a district council to apply a Magistrate Court to remove a person from his/her home on the grounds:

- that the person from grave chronic disease or, being aged, infirm or physically incapacitated, is living in unsanitary conditions; and
- that the person is unable to devote to himself, and is not receiving from other persons, proper care and attention; and
- that his/her removal from home is necessary, wither in his own interests or for preventing injury to the health of, or serious nuisance to, other persons.

In practice this section of the National Assistance Act is rarely used. However, its use could be considered if there is no alternative and the risk is considered to be very grave. An order will last for up to three months depending on the circumstances in which it is obtained.

A modification of the Section 46 procedure is provided by the national Assistance (Amendment) Act 1951 to deal with situations in which it is necessary to remove the adult without delay. An order can be made which lasts for up to 21 days.

As far as financial abuse is concerned the position is complicated. One of the following sections allows vulnerable adults to be protected.

Section 21: Places either a power, or duty on local authorities to provide accommodation for persons by reason of age, illness, disability, or any other circumstance are in need of care and attention which is not otherwise available for them.

Section 29: Places either a power, or duty on local authorities to make arrangements for promoting the welfare of persons aged 18, or over who have a sight or hearing impairment, or who suffer from mental disorder of any description and other persons aged 19 or over who are substantially and permanently disabled by illness. Injury or congenital deformity, or such other disability as may be prescribed.

15.16 Public Health Act 1936:

District Councils have power under this Act to give notice to owners or occupiers if those premises are “in such a filthy or unwholesome condition as to be prejudicial to health”. The notice can require the owner or occupier to clean the premises or the Council can carry out the work itself.

The Health Services and Public Health Act 1968
Section 45 (1) allows local authorities with a Social Services responsibility to promote the welfare of old people (subject to the approvals and directions contained in Circular LAC (93) (10).

Chronically Sick and Disabled Persons Act 1970
Section 2:

This provision extends the provisions of Section 29 of the National Assistance Act 1948 and places a duty on local authorities to make arrangements in respect of all, or any of the welfare services set out in Section 2(1) (a) to (h) as to any disabled person ordinarily resident in their area and the local authority is satisfied that the welfare service (s) is necessary to meet the needs of the person.

The National Health Service and Community Care Act 1990
Section 47: requires local authorities with a Social Services responsibility to carry out an assessment of need where people appear to them to be in need of community care services.

The Housing Act 1985 Part III (Homelessness)
Local authorities have a preventative duty (under section 66) to take reasonable steps to ensure that accommodation does not cease to become available for people threatened with homelessness (para.10.1 Code of Guidance). The Code of Guidance stresses that much can be done to prevent homelessness. It mentions special reasons for considering people as a priority, one is "Men and Women without children who have suffered violence at home or who are at risk of further violence if they return home"

Section 72 of the Act says that a housing authority may seek help from another authority (Housing association, Housing Authority or Social Services Department) to discharge their duties. The authority asked for help shall co-operate as is reasonable in the circumstances. This will help, for example, a woman fleeing violence who cannot be referred because of having a local connection with an area but feels she would not be safe living in the area.

Disabled Persons (Services Consultation and Representation) Act 1986
Duty to access the needs of disabled people and to assess the ability of carers to continue caring.

15.17 Residential Care and the Law

Care Standards Act 2000
The Care Standards Act set national minimum standards for care settings and set up new inspection arrangements. The Act requires homes providing personal care and accommodation to be registered and brought in registration and inspection of requirements for domiciliary care, day care and nursing agencies. The quality of residential provision is assured through this Act.

The Care Standards Act requires people and organisations providing care to be registered as "fit", running services, according to regulations and standards.

Regulation 13(6) requires the registered person to "make arrangements by training of staff or other measure to prevent service users being harmed or suffering abuse or being placed at risk of harm or abuse". The standards state

that homes must have robust procedures for responding to suspicion or evidence of abuse and neglect and ensure the safety and protection of service users. All allegations and incidents of abuse and action taken must be recorded.

Section 31 of the Act empowers inspectors to enter a home at any time and interview the manager, staff or persons accommodated, to inspect and take copies of documents.

Regulation 13(7) requires no physical restraint unless "restraint of the kind employed is the only practicable means of securing the welfare of that or any other service user and there are exceptional circumstances".

There are restrictions on acting for service users and Regulation 20 states a registered person cannot pay money belonging to a service user into a bank account is in the name of the service user. There is a requirement for a clear complaint policy.

Regulation 37 requires the registered person to notify CSCI without delay of any event which adversely affects the well being of a service user and any allegation of misconduct by the registered person or staff. Failure to notify is an offence.

The POVA list was set out in the Care Standards Act. Through referrals to and checks against the list, care workers who have harmed a vulnerable adult or placed a vulnerable adult at risk of harm will be banned from working in a care position with vulnerable adults. The scheme is currently implemented within care homes and domiciliary care but will be extended in the future. Employers and CSCI can refer people to POVA and checks are made on it for relevant posts as part of CRB checks.

Registered Homes Act 1984 and the Registered Homes (Amendment) Act 1991

This Act contains provisions for the registration, conduct and inspection of "residential care homes" (including small homes) which are establishments providing both board and personal care for persons in need of care by reason of old age, disablement, dependence on alcohol or drugs, or mental disorder. Similar provisions are contained in respect of nursing homes and mental nursing homes. Part 1 of the act relates to residential care homes, whilst Part 2 relates to nursing homes and mental nursing homes.

This Act gives powers to authorised staff of registration and inspection units to enter and inspect premises where vulnerable adults are living.

All such homes must be registered with either the local Social Services Department (residential care homes) or the health authority (nursing homes and mental nursing homes) for the area in which the respective home is situated.

Section 10: Provides the grounds upon which the registration of a person in respect of a residential care home can be cancelled by a registration authority (local Social Services authority)

Section 20: Provides the grounds upon which the registration of a person in respect of a nursing home, or a mental nursing home can be cancelled by a registration authority (health authority)

Section 11: Details the urgent procedure for cancellation of registration of a person in respect of residential care home by a registration authority (local Social Services authority) if officers consider there will be a serious risk to the life or well-being of the residents in the home.

15.18 Legislation Relevant to Carers

Carers Recognition and Services Act 1995
This Act places a duty on local authority Social Services Departments to assess, on request, the ability of a carer to provide and continue to provide care and a duty for them to take this into account when deciding which services to provide to the person in need of care.

Carers and Disabled Children Act 2000
This Act gives carers the right to services in their own right

15.19 Disclosure of Personal Information

The Local Authority may hold personal information about individuals and some of that information will relate to risk posed to vulnerable adults. This may indicate the likely risk of abuse as a result of allegations made. It may include information of a sensitive nature about alleged and actual incidents of abuse. Legal advice should be sought if there is any uncertainty about the sharing of information. Generally, if consent is given by the vulnerable adult there is no difficulty. The challenge arise in situations where seeking consent would put the adult at increased risk of harm or where consent is not given.

Principles in Information Sharing:

- The Local Authority Social Services Department has the power to disclose to a 3rd party and where appropriate the vulnerable adult information relating to an individual if it genuinely and reasonably believes that it is desirable to protect vulnerable adults.
- Each case must be decided on its own facts
- Disclosure without consent should only be made if there is a pressing need and should be the exception not the rule.
- In deciding whether there is a pressing need, the following factors will be considered:

- The Local Authority's own belief about the truth of the allegations will be a factor.
- The greater the conviction that the allegation is true, the more pressing the need.
- The level of involvement of the third party to whom the information would be disclosed.
- The degree of risk posed if disclosure is not made- previous history of allegations, level of continuing contact with vulnerable adult, seriousness of alleged abuse.

Crime and Disorder Act 1998
Section 115: This legislation allows for the sharing of information between agencies to prevent a crime being committed. This is relevant to the many abuse situations which constitute a crime.

Data Protection Act 1998
The Data Protection Act sets up suitable safeguards in sharing information that need to be abided by. E.g. fairly and lawfully processed, not kept longer than necessary, rights of access. However there are specific conditions in relation to access and sharing of information where there are situations of serious risk of physical harm or to mental health. Information can be disclosed without consent if it is for the protection of the "vital interests of the subject" or prevention or detection of serious crime or for legal purposes. Where information is shared without consent, it is essential for advice to be sought and a careful recording of the reasons for this decision.

Freedom of Information Act 2000
The Information Commissioner is now responsible for implementation and enforcement of this Act and the Data Protection Act. The Freedom of Information Act only applies to public authorities. The Act establishes the right of any person making a request to a public authority to be informed in writing whether or not the authority holds the information sought and if so to be supplied with the information subject to certain exemptions.

Public Interest Disclosure Act 1998
This is the legal protector for the whistleblower. It sets out a clear and simple framework for raising concerns about malpractice, guaranteeing full protection for the worker. The Act enables employees who make a protected disclosure to disclose information, confidential or otherwise, internally to prescribed regulators or to a wider audience. A "protected disclosure" is a disclosure of information which, in the reasonable belief of the worker, tends to show one of the following has occurred or is likely to occur:

- A criminal offence has been committed
- A person has failed to comply with a legal obligation
- A miscarriage of justice has occurred
- Health or Safety of an individual endangered
- Environment has been damaged
- Information about any of these has been concealed.

15.20 Other Civil Remedies

The Law of Tort
This is the civil law which allows one person to sue another complaining about a wrong that the other has committed vis-à-vis the complainant.

- Trespass to the person (assault and battery) and false imprisonment, i.e.: covering much of the same area as criminal law.
- Negligence- if a person is owed a duty of care by another, branch of that duty lays that other potentially open to a civil action. A person who takes on board the care of another owes her/him a duty of care. If the carer fails to act as a reasonable carer would have done, she/he has broken that duty of care. If the carer fails to act as a reasonable carer would have done, she/he has broken that duty of care. If this breach causes the injury of which the person is complaining, the negligence action has been established.

Common Law
Common Law allows for intervention, without consent. To save life or avoid serious physical harm based upon the principle that the action is reasonable and can be professionally justified as immediately necessary for the purpose of saving life or serious physical harm. Conversely, not to act under circumstances of the utmost gravity could be deemed negligent.

In high risk situations where both physical and mental disorders may be present (e.g. drug overdose, serious injury), if there is doubt concerning which of the two take precedence, then the Physical Disorder should be given priority. The relevant action would then be a Common Law intervention e.g. removing the individual to a Casualty Department. When it is physically safe to do so, the adult should then be assessed for treatment/admission under the Mental Health Act 1983 with respect to section 135/136.

Declaratory Relief is a common law remedy, which can be obtained in high court proceedings in the family division. It is a kind of wardship for adults who are mentally incapable of making or communicating a decision about specific issues. It results in a declaration that to do x, y or z in respect of an incapacitated person would not be lawful, since it has been found, on the evidence, by the judge, to be in the best interests of the person concerned. It derives from the jurisdiction which the courts have always claimed in respect of medical intervention, when doctor or Trust Hospitals were uncomfortable, as to whether they could properly act or cease to treat someone, whose capacity or condition was such as to make their wishes or confirmed consent unclear.

The Court of Appeal in Re F (2000) removed any doubts as to the use of this jurisdiction by local authorities and emphasised that it may be the duty, and not merely the power, of the local authority in some cases, to take the step of going to court. When considering whether to apply to the High Court for declaratory relief the following needs to be established:

- That it is believed that the adult lacks mental capacity in relation to the particular decision at the particular time. (Wherever possible this should be supported by professional evidence).
- The issue is of a "serious justifiable nature" relating to welfare e.g. sterilisation or placement and contact arrangements including supervised contact, where there are strong concerns/evidence of abuse, ill-treatment or neglect and lack of care.
- What is in the adult's "best interests" (as opposed to their carers, relatives etc.) which includes medical, emotional or all other welfare issues. This has to be determined by balancing all relevant factors and obtaining professional evidence e.g. consultant psychiatrist and social worker (if in doubt the judge will decide).
- That determined efforts have been made to agree what is in the best interests by working in partnership with relatives, carers and recording evidence on this file.

No Secrets: March 2000
'No Secrets' is a Department of Health guidance document requiring the development and implementation of local multi-agency policies and procedures to protect vulnerable adults from abuse. The guidance is supported by a range of other initiatives and is issued under Section 7 of the Local Authority Social Services Act 1970

A section of the document refers to record keeping and requires all agencies to keep clear and accurate records of all actions taken whenever a complaint or allegation of abuse is made. In the case of service providers the records should be available to service commissioners, regulatory authorities and to the nominated investigating officer. It provides points to consider when making records in the service user's file.

National Framework for Safeguarding Adults: October 2005
The National framework "Safeguarding Adults" was launched in October 2005 at the Association of Director of Social Services (ADSS) meeting. It is a guidance document collecting best practice examples and aspirations into a set of good practice standards. It is intended to be used as an audit tool by all those implementing protection work.

Appendices

Appendix 1

Haringey Safeguarding Adults Board: Terms of Reference

Introduction

The Haringey's Safeguarding Adults Board (HSAB) has been established as a sub-group of the Haringey's Well-Being Partnership Board, a sub-group of the Haringey Health and Social Care Partnership Board which reports to the Haringey Local Strategic Partnership. All local authorities and partner agencies are required to set up a Safeguarding Adult Board *('No Secrets' report of Department of Health 2000).*

A vulnerable adult is anyone aged 18 or over who, because of physical or mental disability or frailty is dependent on others for their care and /or support. Abuse is when a person or persons have caused harm, or may be likely to do so, and can be physical, sexual, emotional/psychological, or financial, or involve the denial of basic human rights.

Aims:

The aims of the HSAB are to:

- work in partnership with all relevant people and organisations to prevent abuse occurring wherever possible and to deal with it appropriately and effectively when it occurs
- draw attention to the issue of adult abuse and work towards its prevention
- make sure that services to support vulnerable people are provided within an anti-discriminatory framework.

Responsibilities:

- collate information gathered from responses to abuse
- identify trends, review research and suggest any policy reforms
- identify training needs and promote awareness raising and inter-agency training
- review procedures and promote best practice
- ensure that the work of all agencies involved is properly co-ordinated
- generally, through the above activities, to ensure that the needs of vulnerable adults who have been abused are appropriately met
- report annually to the Well-Being Partnership Board and Safer Communities Executive Board

Roles and Duties of the HSAB and its Members:

- To act as the lead body for the safeguarding adults policy implementation and to raise awareness within the local agencies and the wider community of the need to safeguard vulnerable adults and promote their wellbeing
- To develop and agree local policies and procedures for inter-agency working to safeguard adults, within the national framework , ensuring agreed operational definitions and thresholds for intervention
- To commission, implement and monitor an annual business plan based upon “No Secrets” and supported by the National Framework of Standards for good practice
- Responsibility and accountability for meeting national guidance and legal requirements for policy implementation, either when working in partnership or through individual actions
- To audit and evaluate how well local services work together to safeguard adults
- To use multi-agency information and knowledge gained from national and local experiences and research plus reports on trends and recommendations to enable performance management
- To ensure that training delivered meets the requirements of the annual business plan and safeguarding adults’ policies
- To ensure that any lessons learnt from case reviews are shared, understood and acted upon
- To identify and set up the subgroups
- To nominate chairs for the subgroups from within the Board
- To identify and allocate resources for the Board and subgroups
- To commission and monitor projects/work of any time-limited, task-focussed subgroups that are set up

Objectives of the HSAB:

- review the policy and procedure for protecting vulnerable adults from abuse (including identifying trends, reviewing research and suggesting any policy reforms)
- promote best practice (develop multi-agency information sharing protocols)
- develop multi-agency training (by working in partnership to identify training needs and deliver training courses)
- promote awareness of adult abuse (through training, producing information for staff, service users, carers and the public, establishing links with the client group specific partnership boards and engaging a high profile champion)
- ensure that the work of all agencies involved is properly co-ordinated (by appointing an Safeguarding adults Manager and working with all social care services to make sure no abuse is missed)

A meeting of the HSAB will be quorate when a minimum of five members are present, providing that three members are from the Local Authority and the Primary Care Trust.

Any member of the HSAB who fails to attend three consecutive meetings or any three from six meetings will have their membership formally reviewed by the Chair and Deputy Chair.
Members may arrange for a representative to attend on their behalf. This should be agreed with the Chair at least five working days before a meeting.

The roles of the members are to:

- Represent the key statutory stakeholders
- Have the authority and resources to meet the aims and objectives of the Terms of Reference
- Possess the relevant expertise to deliver the Terms of Reference
- Act with trust and probity at all times
- Be responsible for disseminating decisions and actions back to their own organisation and ensuring compliance.

Membership
The HSAB will comprise of the following members:

Agency	**Post holders**
Local Authority	Assistant Director Adults, Older People's Services Manager, Adults Learning Disabilities, Service Manager Adults Physical Disabilities, Service Manager Adults Mental Health, Service Manager Safeguarding adults Manager (Co-ordinator) Contracts Manager Head of Safer Communities
Primary Care Trust	Deputy Director of Operations
Mental Health Trust	Deputy Chief Executive / Director of Mental Health Services for Haringey
North Middlesex Hospital Whittington Hospital	Asst/Deputy Director level Asst/Deputy Director level
MetropolitanPolice Service	Detective Chief Inspector Operations
Commission for Social Care Inspection	Locality Manager
Voluntary Sector	Director of Age Concern
** The HSAB will, as appropriate, co-opt other members for specific pieces of work. (e.g. Legal Services, Housing, Supporting People Board, Department of Work and Pensions, Haringey Probation etc)*	

Service User and Carer Representation
Links with the client group specific partnership boards will be made to ensure that service users and carers will be represented on the HSAB. Training will be provided where necessary, to guarantee everyone's active participation and involvement in the HSAB including the planning and performance monitoring.

Chair and Deputy Chair
The Chair & Deputy Chair will be elected at the first meeting of each municipal year from the above membership. The Chair and Deputy Chair will serve a maximum of 3 years and must be from different organisations.

Meetings
Meetings will be held four times each year and one these meeting to be a general meeting. Additional meetings to be arranged if necessary. Attendance by non-members is at the invitation of the Chair.

Governance
- Decisions will be arrived at by consensus. by. Where there is conflict between members/agencies or an equal vote on a decision, the chair will take this to the Haringey's Well-Being Partnership Board, chair for a decision/resolution.
- Agendas and reports to be considered at meetings will be circulated at least five working days before the meeting, in accessible formats.
- Any documents that may involve the disclosure of exempt or confidential information will be amended prior to public access, with an explanation of the reason(s) for this censorship.
- Additional/late items will be at the discretion of the Chair.

Date Terms of Reference Agreed:

Signed by the Chair:

Date of next review:

Appendix 1.1 Quality Assurance Sub-Group

Role
The Quality Assurance Sub-Group is the forum for specifying, collecting and interrogating management information across the safeguarding agenda in order to enable the HSAB to monitor and scrutinise the effectiveness of local arrangements to safeguard adult. This Sub-Group will also closely monitor the work of the HSAB, ensuring that HSAB decisions are properly followed through and drawing issues of concern to the attention of the Board.

Responsibilities
1. **Performance Management**
   - To specify, collect and collate relevant performance data from all agencies;
   - To interrogate that data in order to:
   - Report on performance across partner agencies;
   - Identify areas of good practice;
   - Identify areas of performance that should be of concern to the HSAB; and

- Understand Haringey's performance in relation to comparator authorities
- To produce an annual report of current practice issues for inter-agency working and set out statements and priorities for the HSAB

2. Audit

- To commission multi-agency audits as necessary
- To develop an audit model for use by all agencies

3. Monitoring and Scrutiny

- To draw issues of concern to the attention of the HSAB and make recommendations for action in order that the HSAB meets it duty to monitor the effectiveness of local arrangements to safeguard adult;
- To perform a "challenge" function; ensuring that HSAB decisions are properly followed through;
- To actively seek out and highlight good practice in safeguarding across partner agencies and in other local authorities.

Proposed Membership

Learning Disabilities, Service Manager - chair
Commissioner/Contracts
Service manager - Adults Services
PCT
CMHT
Hospital
Police

Frequency of Meeting

It will meet 6 weekly initially until embedded then quarterly and will report to the HSAB at each HSAB meeting.

Appendix 1.2 Prevention Sub-Group

Role

The Prevention Sub-Group co-ordinates initiatives to raise awareness - across organisations, community groups and the general public - of the need to safeguard and promote the welfare of adult. It commissions task groups to address areas that present a risk both to the safety of and to operational effectiveness.

Responsibilities

- To improve partnership working in the borough;
- To initiate multi-agency preventative work as directed by Serious Case Review recommendations and the work of the Quality Assurance Sub-Group;
- To devise and update a communications strategy for the HSAB;
- To raise awareness of issues relating to the protection of adult among operational staff, community organisations and members of the public;

- To co-ordinate preventative work in relation to agreed priority areas;
- To raise the profile of the HSAB among operational staff, community organisations and members of the public;
- To identify training needs as a consequence of multi-agency initiatives, linking with the Training sub-group.

Linked Task Groups

- Training and Serious Case Review subgroups
- Champions Forum
- Housing
- MAPPA
- Anti-Social Behaviour Action Team (ASBAT)
- Safer Communities
- Domestic Violence Team
- Community Safety Unit

Priority Workstreams

- Mapping of voluntary agencies & community groups in conjunction with HAVCO;
- Review of information currently provided on safeguarding adult processes;
- Review publicity material which meets the needs of all the community;
- Monitor effectiveness of campaign to raise awareness in ethnic minority communities and disability groups

Membership

Asst Director of Operations, PCT – Chair
Service Manager, Adult Services
Vulnerable Adult leads- PCT
Vulnerable Adult Lead – Hospital
Vulnerable Adult Lead – CMHT
Vulnerable Adult lead – Housing
Vulnerable Adult lead – Police
Domestic Violence
Communicatons
Contracts

Frequency of Meetings

6 weekly initially and reviewed after 6 months

Appendix 1.3 Training & Development Sub-Group

Aims and Functions

The HSAB is responsible for taking a strategic overview of the planning, delivery and evaluation of the inter-agency training that is required in order to promote effective practice to safeguard the welfare of adults.

The HSAB Training Sub-Group is responsible for inter-agency training. The planning, design, delivery and evaluation of inter-agency training is managed through the HSAB Training Sub-Group. This training is provided to all professional staff who come into contact with vulnerable adults in order that they

should know the predisposing factors and signs and indicators of adult abuse. This should also include information on inter-agency working particularly referral process to key agencies involved in the safeguarding of vulnerable adults.

Terms of Reference:

- The Sub-Committee is responsible for the strategy, development and co-ordination of multi-agency safeguarding adults training provision. This will include the facilitation and commissioning of appropriate training resources and the regular review and evaluation of the training provision in line with the HSAB Business Plan
- The Sub-Group will carry out tasks as delegated by main body of HSAB and inform the HSAB of current trends, issues and practices within inter-agency training.
- The subgroup will encourage feedback from single agency representatives of current trends, issues and practices within their agency that impact on training provision and will expect agency representatives to take back issues identified in training to their individual agencies.
- The Sub-Group will devise a system for feedback from service managers about the effectiveness of training and adapt training programmes accordingly.
- Annual report and work plan of the Sub-Group to be provided to the HSAB.
- The Sub-Group will ensure quality assurance is carried out on both internal and external training. This will include ensuring that adequate training for trainers/facilitators is provided and attended by all HSAB adult safeguarding trainers, if and when needed as identified by individual members on a personal basis.
- The Sub-Group should review the terms of reference at least annually.

Quoracy:
To establish quoracy, 3 representatives out of 4 key agencies must be present. Key agencies are as follows:- Health, Police, Adult Services and CMHT. Quoracy must not include presence of Chair.

Membership
The Chair is a member of the HSAB and therefore will not act as a representative of their agency, but will have the casting vote.

- Combined Team, Learning Disabilities – Chair, ? Paul Knight
- Private Provider, Sevacare
- Training Consultant - Adult Services
- PCT
- CMHT
- Police
- Voluntary Sector

An annual review of Chair and Membership will take place. The group will co-opt new members as necessary, to address specific areas of expertise required

Frequency of Meeting
Frequency of meeting to occur no less than 6 weekly basis.

Appendix 1.4 Operational Sub-Group (Champions Forum)

Terms of Reference

Role
The Champions Forum is responsible for reviewing operational and practice issues. It is responsible for challenging practices across all adult provider services, identifying good and bad practices and sharing these with the Safeguarding Adults Board.

Responsibilities
- To collate practice issues in individual service areas/agencies for discussion
- Share experiences of good practice and outcomes
- Learn of new developments locally and nationally
- Disseminate learning and new developments in service areas/agencies
- Identify training needs
- Review systems and structures
- Develop procedures and practice guidance
- Identify gaps
- Make recommendations through the Chair to the Safeguarding Board

Links
- Training
- Quality Assurance

Membership
- Aimed at supervisory/first level management level.
- Mental Health - Chair
- Adult Services – Practice/Team Managers from each service area (Older People, Learning Disabilities, Physical Disabilities, Mental Health, DAT)
- PCT – (acute and long stay units), ambulance, PALS
- Voluntary Sector – HAVCO
- Police– CSU/Sapphire Unit/ASBAT (can rotate)
- Private Domiciliary Care Providers – Sevacare, London Care, Satellite Consortium
- Private Residential/Nursing Care Provider
- In-House Domiciliary Services
- Day Care Services
- Housing – sheltered, supported living, Vulnerable Adults Team
- Supporting People
- Direct Payment Scheme

- Carers Forums

Frequency
It will meet quarterly and report to Safeguarding Board after each meeting.

Appendix 1.5 Serious Case Review Sub Group

The Haringey's Safeguarding Adults Board (HSAB) should establish a Serious Case Review Sub-group to consider whether a case review should take place.
The HSAB should always undertake a case review when an adult dies and abuse or neglect is known or suspected to be a factor in the adult's death.

The HSAB should always consider whether to undertake a case review where an adult has sustained a potentially life-threatening injury through abuse or neglect and the case gives rise to concerns about the way in which local professionals and services work together.

Terms of Reference

- Following notification to any HSAB agency of an adult death or serious injury the Serious Case Review Sub-group should meet urgently to decide if a case should be subject to the HSAB Case Review. All cases that fall into two or more categories of guidance should be notified.

- The sub-group will ask involved agencies to conduct individual management reviews using the agreed proforma. The sub-group should hear/receive the outcome of these single agency reviews.

- The sub-group, within one month of a case coming to the attention of the HSAB, is responsible for making a recommendation to the Chair of the HSAB as to whether the HSAB should conduct a Case Review.

- For each case considered the sub-group should determine the scope of the case review, draw up clear terms of reference for the review and decide who should conduct it and who should be on the panel.

- During a case review the sub-group should continue to meet to monitor the progress of the review, ensuring that timescales are being met. The Review should take no more than four months. If the original timescales cannot be met, the sub-group is responsible for agreeing new timescales and informing the HSAB of these. The Commission for Social Care Inspection is also notified.

- Upon receiving an HSAB Case Review Report, the sub-group will ensure it meets the Terms of Reference originally agreed.

- **The sub-group and the Chair will provide copies of the composite report for consideration by the HSAB.**

- **Agencies conducting management reviews and the Chair of the Serious Case Review Sub Group will provide copies of these reports together with a summary to the HSAB and it will meet to consider the case.**

- The sub-group is responsible for translating the recommendations of the report into an Action Plan which determines who will do what, by when and with what intended outcome.

- The sub-group will monitor the progress of the Action Plan, ensuring that improvements are evaluated and reviewed.

- The sub-group is responsible, at all times, for informing the HSAB of any difficulties it encounters at any stage of the review process.

- The sub-group will provide advice to the HSAB about the report's availability; its dissemination and the feedback to involved staff, family members and the media.

- The sub-group is also responsible for conducting other case reviews at appropriate points.

Membership

- The Chair of the sub-group shall be nominated by the Chair of the HSAB
- The sub-group is chaired by the Assistant Director of Adult Service, Culture and Community.
- Members should include:
  PCT, CMHT, Adult, Culture and Community Services, Police, CSCI
- The sub-group can co-opt other members on a short-term basis to address specific areas of expertise.
- Quoracy: to be quorate, 3 representatives out of the 4 key agencies must be present. Key agencies are The Adult Culture and Community Services, CMHT, CSCI**,** PCT and the Police.

Core Function

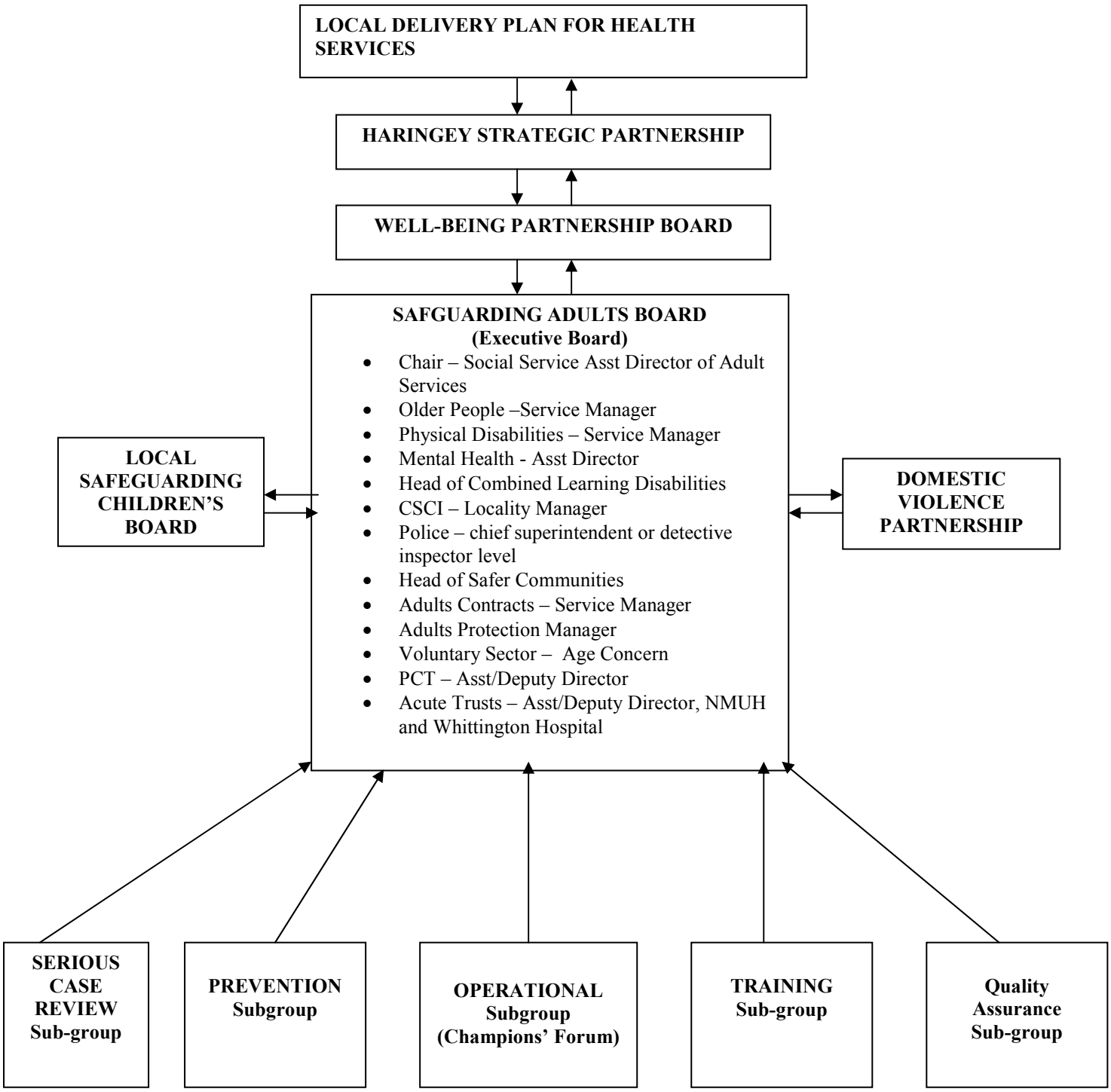
- To consider cases for review
- Make decisions on the process for review
- Facilitate and manage a panel to address the process.

Frequency

- The sub-group should meet as required to oversee and plan case reviews and in any event not less than 3 monthly.

Appendix 1.5

SAFEGUARDING ADULTS BOARD FLOWCHART



Appendix 2

Mental Capacity Act 2005 Key Messages

At some point in our lives, we are all likely to be affected by a lack of capacity to make decisions, either personally, or because someone close to us is unable to make decisions for themselves.

Millions of people lose their ability to make decisions that affect their lives through illness, disability or injury. And some people are born with disabilities that affect their capacity to make decisions. Millions of people also have caring responsibilities for people who lack capacity.

The Mental Capacity Act will improve all of their lives. We expect to implement the Act in April 2007.

Did you know…

- Did you know that there is no legal definition of next of kin and if your loved one is in hospital and unable to consent to treatment you have no legal right to give consent on their behalf or to be consulted about their treatment?
- Did you know that if you lose capacity in the future there is no statutory mechanism whereby you can state your wishes for your future care with confidence that your wishes will be taken into account?

The Act changes this by establishing a clear legal framework under which all decisions about people who lack capacity must be taken. This will be underpinned by a Code of Practice to guide and assist everyone who needs to make decisions for people who lack capacity.

The Act will:

- **Empower** people who may lack capacity
- Give them greater **protection**
- Give people the **choice** to plan for a time when they might lose capacity

Empowering

- Very few people are incapable of making any decisions at all. The Act makes it absolutely clear that everyone should be assumed to be able to take all their own decisions until it is shown that they can't.

All practicable steps must be taken to help people who lack capacity to participate in the decision making process. This includes assisting people who have communication difficulties.

Give protection

- The Act offers better protection because for the first time it tells everyone what the law expects. It makes it clear who can take decisions in which situations and how they should go about this.
- Where someone can't make a decision for themselves their best interests will be paramount when decisions are made on their behalf.

- The Act sets out how people who lack capacity can lawfully be cared for or treated.
- The Act provides for an Independent Mental Capacity Advocate (IMCA)

Give people more choice

- *The Act offers people who have capacity new choices to decide how they are cared for in the future by introducing new ways for them to plan ahead for a time when they might lose capacity.*
- People can make a Lasting Power of Attorney (LPA) appointing someone they trust who can take financial, welfare or health decisions on their behalf.
- It will also be possible to make an advance decision to refuse treatment, commonly known as a 'living will'. If doctors are satisfied the advance decision is valid and applicable they must respect your decision; if they don't think so doctors will be able to treat the person. If in doubt a doctor must continue to treat whilst seeking advice from the court.

Appendix 2.1 How the new law will benefit people

For those who lack mental capacity:

Will give vulnerable people the legal right:

- to have as much control as possible of decisions that affect them;
- to be involved in decisions about themselves; and
- not simply to be labelled 'mentally incapable'.

Will extend the current limited decision making process for financial matters to health and welfare decisions.

And people will have the chance to plan ahead for when they might lose capacity with confidence that their wishes would be respected.

For families and carers:

Will give families and carers of vulnerable people:

- a right to be consulted about the best interests of the person they care for;
- clarity about acts that they can legally do to, and on behalf of, the person they care for;
- a right to be consulted about a person being involved in research and a right to say no; and
- protection from liability for acts in connection with the care or treatment of that person, if he or she lacks capacity in relation to those acts, and they are in his or her best interests.

For professionals

Will give health and welfare professionals:

- a clear legal framework so that there is common understanding of how to care for and treat patients who lack mental capacity;

- clarity about the law on advance decisions to refuse treatment; and
- clarity about research involving people who lack capacity.

This means that vulnerable people will be protected from poor decision-making on important and sensitive issues.

The new law will also provide:
- a law to prosecute people who ill-treat or wilfully neglect people who lack capacity;
- a means of tackling financial abuse, as Lasting Powers of Attorney will have to be registered before they are used;
- for the appointment of a Public Guardian with responsibility for the registration of Lasting Powers of Attorney, to supervise deputies and to act as a signpost to other organisations; and
- a new Court of Protection to deal with particularly difficult decisions or difficult disputes which cannot be resolved in any other way.

Appendix 2.2 Creation of new public bodies

A new Court of Protection
- With the jurisdiction relating to the whole of the Act
- Will be the final arbiter for capacity issues
- Will deal with the end of life issues previously dealt with in the High Court
- The Court will have its own procedures and judges.

The Public Guardian Office (PGO)
- To register Lasting Power of Attorneys (LPAs)
- To maintain a register of LPAs and Deputies
- To supervise deputies appointed by the Court
- Responding to concerns regarding the way in which an attorney or deputy is operating
- Work with other agencies when dealing with complaints

Appendix 3

Commissioning, Contracts and the Tender Process

1 Tender Process:
Whenever tender processes are undertaken for services involving vulnerable adults, specific sections must be included that require confirmation that the organisation submitting the tender has an effective Safeguarding Adults Policy and Procedure that complies with this procedure. Tender specifications will stipulate that the Commissioners expect the provider to meet the requirements of Haringey's multi-agency Safeguarding Adults Policy and Procedure.

Tender validations and service reviews must include validation of the provider's Safeguarding Adults Policy and Procedure prior to any service users being placed with the provider.

2 Contracts:
Contracts will specify that all external providers have their own Safeguarding Adults policy and robust procedures for dealing with such complaints. Their policy and procedures should evidence links with the Multi-agency Safeguarding Adults Policy and Procedures. All policies should require that any allegation or complaint about abuse that may have occurred within a service, subject to contract specifications, must be brought to the attention of the Safeguarding Adults Co-ordinator.

Contracts must specify protocols surrounding reporting incidents, the sharing of information and confidentiality to comply with this policy.

Contract Monitoring:

The contract shall include a section on monitoring of services.

The provider will be required to meet with the Contract Monitoring Officer at least annually.

The contract must include a specific right for the relevant Contracts Monitoring Officer to audit any investigation of abuse undertaken by the external provider. Any such audits should be subject to a policy framework, including specific procedures and process forms. Serious infringements by the provider discovered by the audit would be subject to the due course of law or would be dealt with under the decommissioning section of the contract.

3 Contract Checklists to help prevent abuse of vulnerable adults:
All organisations that deliver Care and/or Support to vulnerable people on behalf of members of the Multi-agency partnership:

a. Have their own Safeguarding Policy with robust procedures on how to deal with alleged or suspected cases of abuse, regarding both the person experiencing the abuse and the perpetrator.

b. Include in their Safeguarding Policy an adherence to the Multi-agency Safeguarding Adults Policy and Procedure.
c. Include in their Safeguarding Policy a specification that any incidence of alleged or suspected abuse must be reported to the Adults at Risk Team and the specific department responsible for the contract.
d. Ensure that all members of staff cover Safeguarding Adults Code of Conduct and Professional Boundaries in their Induction Programme.
e. Ensure that members of staff involved with care/support delivery are adequately trained in Safeguarding Adult and have a schedule for receiving on-going training on a regular basis.
f. Have a Service User Handbook that includes a sections on Abuse, explaining the types of abuse and giving examples of what may constitute abuse, in an appropriate language and format for that particular client group.
g. Ensure that all Service Users have an up-to-date Care/Support Plan that incorporates views and aspirations and specifies the tasks required to be delivery by the Care/Support Worker.
h. Have a recruitment and Selection Policy and procedure that aims to eliminate discrimination and ensures fair treatment for all applicants.
i. Have procedures for ensuring all members of staff have a CRB check or enhanced CRB check and a POVA register check before taking up a position working with vulnerable people.
j. Have procedures for ensuring that references for all successful applicants are sought before acceptance into the post.
k. Have a Code of Conduct for the guidance of staff and processes for eliminating personal gain through position.

4 Prevention Care Planning

All organisations that deliver Care and/or support to vulnerable people on behalf of member of the Multi-Agency partnership must:

l. Have information on type of service they provide and their Statement of Purpose, available for all enquirers in a suitable format.
m. Ensure that, for those Protection registered with CSCI, the latest report should be made available for al enquirers or at least a signposting to the website or other access point.
n. Provide Service Users, or their legal representative, with a Service User Guide/Handbook that includes information on the organisation's Policy and Procedures, especially Safeguarding Adults and complaints.
o. Provide Service users, or their legal representative, with a copy of their Care/Support Plan.
p. Care Plans should be as detailed as possible in the tasks required by the Care/Support worker.

5 Early Detection of Abuse

All organisations that deliver Care and/or Support to vulnerable people on behalf of members of the Multi-Agency Partnership must:

q. Have an up-to-date Policy and procedure on risk Assessments, both on a personal and environmental basis. An Initial Risk Assessment should be completed prior to or as soon as possible after the Service User starts to receive the service.
r. Have Risk Assessments that highlight any potential risks or areas of vulnerability, identify the expected frequency and level of danger, any current measures in place and further measures required to adequately manage the risks.
s. Have procedures in place to review the Risk Assessments on a regular basis appropriate to the client group. Risk Assessments must be reviewed and updated after each significant incident or change.
t. Ensure that Staff, who have the responsibility for conducting Risk Assessments are adequately trained in Risk Assessment and have a schedule for receiving on-going training on a regular basis.
u. Ensure that Care/Support Plans are reviewed and updated on a regular basis. The delivery of Care/Support must be monitored on a regular basis by the contracting organisation.
v. Ensure that staff are fully supported and receive regular supervision, in order to highlight any areas of stress or lack of training that may compromise the delivery of Care/Support.
w. Have a Whistle-blowing Policy that enables Staff to address alleged or suspected cases of abuse without fear of reprisal or unfair treatment.

6 Protection from abuse: Care Planning

All organisations that deliver Care and/or support to Vulnerable people on behalf of members of the Multi-Agency Partnership must:

x. Ensure that Care/Support Plans include any assessed care/support needs identified in all areas of the individual's lifestyle. Care/Support Plans should include reference to any complementary services, delivery of which may impact on the Care/Support Plan.
y. Encourage networking between Providers of Care/Support involved with individual Service Users to ensure a Person Centred Approach. The involvement of other Providers will help to minimise the potential for abuse.
z. Ensure that Service Users are aware of the procedures for reporting alleged or suspected cases of abuse. The Service User Handbook should contain the reporting procedure in a format appropriate to the client group.
aa. Ensure that all alleged or suspected cases of abuse are documented on specifically designed forms. All incidents should be recorded separately from all other types of complaint, and filled securely so as to protect confidentiality. A note may be attached to a Service User's personal file to highlight the presence of an incident but no specific details should be kept on an individual's file.

7 Debrief/Post Intervention

All organisations that deliver Care and/or Support to Vulnerable people on behalf of members of the Multi-Agency partnership must:

bb. Have a Policy in place to review all alleged or suspected cases of abuse to ensure that the procedures for Staff to follow and the reporting process has been followed and is effective. Policy reviews should be scheduled every five years or less.

cc. Ensure that any improvements to procedures and processes are implemented as soon as practicable.

dd. Ensure that all new legislation relevant to Safeguarding Adults is incorporated in to Policies and Procedures.

ee. Ensure that all training and documentation takes in to account all changes resulting from the Policy review.

8 Supporting People Service Providers will:

ff. Meet at least minimum standards in the core objective "Safeguarding Adults" (including informing Service Users of the scope and nature of abuse, their right to be free from abuse and how to report abuse)

gg. Report each incident or allegation of abuse to the Supporting People Team and maintain relevant records of each case.

hh. Report each incident, which concerns a vulnerable adult to the Safeguarding Adults Co-ordinator.

ii. Investigate each incident in accordance with their Safeguarding Adults Procedures (in line with Haringey's Multi-Agency Safeguarding Adults Policy and Procedures.)

jj. Provide appropriate training in Safeguarding Adults to all relevant Staff.

Appendix 4:

Learning from Cornwall- CSCI Recommendations:

A recent CSCI report in 2006 detailed the findings of a joint investigation in to services for people with Learning Disabilities at Cornwall Partnership NHS Trust:

1 Some of the Key Issues highlighted from the Cornwall Investigation were:

- The low awareness of what constitutes, including abuse by service users.
- Isolation among the staff group and recognition that in Cornwall, the Learning disability Service was a 'minority' service within a large organisation.
- A low understanding of the 'Valuing People' agenda among staff.
- A lack of access to advocacy
- The low expectations of service users.
- A need for clear roles and responsibilities in partnership working
- A lack of awareness by police of criminal nature of cases referred to them.
- The lack of ability of the Local Authority to challenge the NHS Service.
- Lack of effective scrutiny and lack of registration of 'care services'.
- People raising complaints were not effectively dealt with but were deemed 'vexatious'.

2 National Recommendations made in the report are:

- "Services for people with Learning Disabilities must be redesigned by the Local Health and Social Care organisations, taking in to account the individual needs assessments of every Learning Disability Service User."
- "All providers of personal care, including the NHS, must register those services with the CSCI in accordance with the Care Standards Act 2000".
- "Best practice in medical, nursing and therapeutic care must be provided throughout the Learning Disability Services"
- "Regular reports on all matters relating to the protection of adults with learning disabilities must be provided to the Learning Disability Partnership Board and the strategic health authority to ensure that sufficient action is taken to address individual and systematic problems."
- "Interagency arrangements and planning for Learning disabled people must be clearly identified in the Local Development Plan"
- "Nationally, the Department of Health should strengthen processes for protecting adults, in accordance with provisions of the Safeguarding Vulnerable Groups Bill before parliament."
- "All local authorities, in their role as lead agency for the Protection of Vulnerable Adults, must ensure that arrangements for investigating allegations of abuse are robust."

3 For the full CSCI report please click on to this hyperlink:
http://www.healthcarecommission.org.uk/_db/_documents/cornwall_investigation_report.pdf

Appendix 5

HARINGEY MULTI-AGENCY SAFEGUARDING ADULTS WORKFLOW PROCESS

ALERT:
- **Raise alert within 24hrs of allegation, suspicion or concern by telephone, visit or email**
- **Complete Alert form**
- **Refer to ICS team and copy Safeguarding Co-ordinator**

WITHIN WORKING SAME DAY

Refer to Police:
If of criminal nature – sexual, physical causing injury and financial abuse

Refer to ICS:
All alerts and referrals copied to ICS and logged on monitoring database and signpost referrals

Refer to Regulatory Bodies:
- To CSCI if a social care registered provider
- Health Commission if a health provider

NOTIFY THE SAFEGUARDING CO-ORDINATOR:
Send copy of Alert form to: olive.komba-kono@haringey.gov.uk

DECISIONS:
- **Is this abuse?**
- **If it is abuse**
- Is the person and or others in the household in danger
- Are the Police involved
- **What is the level of risk**

Action - Make Safe

HIGH RISK: VISIT ON SAME DAY

MEDIUM RISK: VISIT WITHIN 2 DAYS

LOW RISK: VISIT WITHIN 3 DAYS

IF ABUSE
Convene Strategy Meeting
Within 4 working days if high risk and 5 working days if medium and low risks

IF NOT ABUSE
- Is there a need for Community Care Assessment
- Is review or re-assessment needed
- Inappropriate –refer to other agencies
- Inappropriate – No Further Action

SAFEGUARDING ASSESSMENT
Information gathered from involved agencies
Ensure safety of staff as well as the vulnerable adult when conducting interviews

SAFEGUARDING PLAN MEETING WITHIN 28 DAYS OF REFERRAL
All allocated investigators give feedback.
A Safeguarding Plan including a Monitoring System and frequency agreed

REVIEW:
If Safeguarding Plan is working well, review in **6months.**
The Safeguarding Plan can be reviewed at any time sooner if it breaks down or circumstances change.

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haringey strategic partnership

Well-Being Strategic Partnership Board

Date: **4 March 2008**

Report Title: **Development of a Tobacco Control Strategy for Haringey**

Report of: **Vicky Hobart, Head of Inequalities and Partnerships**

Summary

To update the Well-Being Partnership Theme Board on the Neighbourhood Renewal (NRF) funded project to support the development of an overarching Tobacco Control Strategy for Haringey.

Recommendations

That the Board:

i. Note the specification and timescales for this project.

ii. Identify key informants for the consultants delivering the project

For more information contact:

Name Vicky Hobart
Title Head of inequalities and partnerships
Tel: 020 8442 6668
Email address Vicky.Hobart@haringey.nhs.uk

Background

The 2007/8 £100k NRF Tobacco Control project included resources to commission a review of tobacco control initiatives in the Borough with a view to developing an overarching Tobacco Control Strategy for Haringey that would focus on reducing inequalities in health.

Tobacco is a major cause of ill health and premature mortality, and a significant contributor to health inequalities. There is a significant gap in life expectancy between populations living in the East and West of the Borough, driven largely by differences in socio-economic conditions, deprivation and population mobility. The Haringey Strategic Partnership adopted an action

plan to reduce this gap in life expectancy in March 2007, and Tobacco Control is a key part of this process.

The partnership has already undertaken a range of work on Tobacco Control including:

- An established Quit smoking service
- LAA stretch target to increase the number of smoking quitters from N17 (Tottenham)
- Enforcement of the ban on smoking in public places
- Health equity audit of utilisation of quit smoking services by BME communities
- Healthcare commission review
- Smokefree homes programme
- Life Expectancy Action Plan
- Infant Mortality Action Plan
- Children's Plan and Well-Being Strategic Framework

There is also new national guidance for quit smoking services that we would like to apply in a way that addresses health inequalities.

This project will pull together and review these areas of work, building on learning from implementation of the ban on smoking in public places over the summer 2007, and make recommendations as to how Tobacco Control initiatives focusing on reducing health inequalities can be strengthened.

Project specification

Aim: To develop an evidence-based strategy to reduce inequalities in health due to tobacco for Haringey.

Objectives:

1. Identify health inequalities due to tobacco in Haringey, and the population groups on which interventions should focus.

2. Review the effectiveness and cost-effectiveness of interventions currently in place in reducing health inequalities including quit smoking services, enforcement, licensing, maternity and health promotion services.

3. Review the literature to identify relevant guidance or good practice that could be applied in Haringey.

4. Consider how tobacco-related performance management arrangements could be used to support work to reduce health inequalities.

5. Produce:

    - a report outlining the review findings and recommendations,

- a draft tobacco control strategy for Haringey based on consultation with local stakeholders.

Key informants

The consultants will need to draw on a range of data and evidence sources to undertake this project. Key informants will include stakeholders from:

- Voluntary and community organisations
- Haringey TPCT and Haringey Council service commissioners
- The quit smoking service
- Haringey Enforcement Service
- Local employers/businesses
- Local Acute Trusts (North Middlesex and Whittington)
- Local Mental Health Trust
- Independent contractors (GPs, dentists, pharmacists)
- Children's service
- Public Health

Members of the WBPB have been asked to identify the relevant stakeholders to meet with the consultants.

Contract award

Expressions of interest were invited before Christmas from appropriately experienced individuals or organisations to undertake this review. One consultancy, Public Management Associates (PMA), responded and were invited to present their proposal to a panel comprising Vicky Hobart (head of inequalities and partnerships HTPCT, Keith Betts (enforcement service LBH) and Stephen Deitch (stop smoking service commissioner HTPCT). PMA developed a health inequalities toolkit for Birmingham, and have extensive experience in tobacco control including direct involvement in the Tobacco Control Collaborating Centre.

A contract has been awarded to PMA to deliver the above specification. The data collection and consultation aspects of the project should be completed by the end of March 2008. PMA have been asked to present their findings to the next WBPB and other forums as agreed.

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haringey strategic partnership

Well-Being Partnership Theme Board

Date: **4 March 2008**

Report Title: **Update on the Development of the New Style Local Area Agreement 2008-2011**

Report of: **Mun Thong Phung, Director of Adult, Culture and Community Services, Haringey Council**

Summary

This report sets out the progress towards agreeing the 35 targets for the new Local Area Agreement (LAA) and describes the next steps for preparing for the negotiation and final agreement of the LAA with Government Office for London and other Government Departments.

Recommendations

- That the WBPB notes the suggested changes by Government Office for London (GOL).
- That the WBPB reviews the suggested changes from GOL and finalise their selection by prioritising up to 35 improvement targets in total and a set of local indicators.
- That the WBPB notes that the Performance Management Group continues to oversee the development of the new LAA including the 'story of place' and supporting evidence.

For more information contact:

Name: Helena Pugh
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Name: Vicky Hobart
Title: Head of Health Inequalities and Partnerships, Haringey Teaching Primary Care Trust
Tel: 020 8442 6668
Email address: Vicky.hobart@haringey.nhs.uk

1. Background and progress

1.1 The Local Government and Public Involvement in Health Act 2007 requires Local Strategic Partnerships to have in place new Local Area Agreements by June 2008. These are to include up to 35 improvement targets negotiated with Government.

1.2 Haringey Strategic Partnership is well on its way in selecting the 35 targets. A positive second meeting between the Performance Management Group and Government Office for London took place on 25 January 2008 which confirmed that the HSP is on track to meet the June deadline and that the targets selected are on the whole the right ones for Haringey. However, GOL have made a number of suggestions on the thematic partnerships proposed indicators. These are listed in Appendix 1.

1.3 An early draft of the story of place was submitted to GOL and the Performance Management Group will oversee its completion.

2. Issues for consideration

2.1 On 11 February the HSP agreed that all thematic boards should consider the proposed changes and agree their final selections. For the WBPB this means the following comments need to be reviewed and recommendations made to the PMG immediately following this board:

i. The WBCE proposed NI 128 user reported measure of respect and dignity in their treatment to be replaced with NI 119 Self-reported measure of people's overall health and well-being.

ii. GOL proposed consideration be given to replacing NI 39 alcohol-harm related hospital admission rates with NI 20 assault with injury crime rate.

iii. GOL proposed consideration be given to moving NI 8 adult participation in sport to a local indicator

iv. There was discussion at the HSP about which board should take the lead responsibility of the following two targets:

- NI 187 Tackling fuel poverty - the Integrated Housing Board or the WBPB
- NI 198 Children travelling to school - the Better Places Partnership Board or the Children's and Young People's Strategic Partnership

It was decided that the decision on the leads for these and any other targets in a similar position would be made at the next meeting of the PMG.

2.2 In recognition that many of the 35 targets are cross-cutting and will need input of more than one thematic partnership it was agreed that a table will be drawn up to show the links.

2.3 It should be noted that there can only be a maximum of 35 improvement targets, therefore any indicators added to the list of 35 have to be balanced by the removal of others. However there is no limit to the number of local indicators within the LAA as no targets or negotiated stretch will need to be agreed with central government for these.

3. Next Steps

Activity	**By When**
Thematic Board finalise their selection of indicators	29 February 2008
Workshops to agree action plans linked to new Performance Management Framework Being held 17 March 2008.	28 March 2008
Agreement with GOL of 35 indicators	31 March 2008
Boroughs notified of DCSF statutory targets	April 2008
Negotiation on indicators and targets between partnership and GOL	April to June 2008
Final Ministerial sign off of Local Area Agreement	June 2008

Appendix 1 LAA Indicators, suggestions by thematic partnership and Well-being Strategic Framework outcomes

Better Places	**Suggested Changes**	**WBSF Outcomes**
1. NI 192 Household waste recycled and composted 2. NI 186 per capita CO2 emissions in the LAA area – domestic housing 3. NI 195 Improved street and environmental cleanliness (levels of graffiti, litter, detritus and fly-posting) ▪ Number of Green Flag parks – Local Indicator ▪ NI 175 Access to services and facilities by public transport (and other specified models) – Local indicator		Improved quality of life Increased choice and control
Safer Communities	**Suggested Changes**	**WBSF Outcomes**
4. NI 35 Building resilience to violent extremism 5. NI 40 Drug Users in effective treatment 6. NI 15 Serious violent crime rate 7. NI 16 Serious acquisitive crime rate 8. NI 111 First time entrants to the Youth Justice System aged 10-17 9. NI 21 Dealing with local concerns about anti-social behaviour and crime by the local council and police	PMG proposed NI 32 repeat incidents of domestic violence be considered as a local indicator The inclusion of re-offending measures were suggested by GOL: NI 18 adult re-offending rates for those under probation supervision NI 19 rate of proven re-offending by young offenders NI 38 drug-related (class A) offending rate NI 43 young people within the youth justice system receiving a conviction in court who are sentenced to custody. GOL proposed consideration be given to replacing NI 39 alcohol-harm related hospital admission rates with NI 20 assault with injury crime rate.	Improved quality of life

Children and Young People	Suggested Changes	WBSF Outcomes
10. NI 51 Effectiveness of CAMHS services 11. NI 54 Services for disabled children 12. NI 112 Under 18 conception rate 13. NI 198 Children travelling to school I- mode of transport usually used 14. NI 113 Prevalence of Chlamydia in under 20 years olds 15. NI 126 Early access for women to maternity services ▪ NI 60 Core assessments children's social care that were carried out within 35 working days of their commencement – Local Indicator ▪ NI 53 Prevalence of breastfeeding at 6-8 weeks from birth – Local Indicator ▪ Increase the % of children immunised by the 2nd birthday – Local Indicator ▪ Victim support services for children and young people – Local Indicator	GOL proposed NI 198 children travelling to school – mode of transport be moved to a local indicator and NI 56 obesity among primary school age children in Year 6 become the main indicator sitting above it GOL suggested NI 116 proportion of children in poverty be considered as a one of the 35 improvement targets	Improved health and emotional well-being Improved quality of life Increased choice and control
Integrated Housing Board	**Suggested Changes**	**WBSF Outcomes**
16. NI 154 Net additional homes provided 17. NI 158 % of decent Council homes 18. NI 156 Number of households living in temporary accommodation ▪ NI 155 Number of affordable homes delivered (gross) – Local Indicator	GOL proposed NI 158 % of decent council homes could be a local indicator	Economic well-being

Wellbeing	Suggested Changes	WBSF Outcomes
19. NI 8 Adult participation in sport 20. NI 123 16+ current smoking rate prevalence 21. NI 187 Tackling fuel poverty – people receiving income based benefits living in homes with a low energy efficiency rating 22. NI 39 Alcohol-harm related hospital admission rates 23. NI 121 Mortality rate from all circulatory diseases at ages under 75 24. NI 149 Adults in secondary mental health services in settled accommodation 25. NI 135 Carers receiving needs assessment or review and a specific carer's services, or advice and information 26. NI 141 Number of vulnerable people achieving independent living 27. NI 125 Achieving independence for older people through rehabilitation/intermediate care ▪ NI 128 User reported measure of respect and dignity in their treatment – Local Indicator ▪ NI 127 Self reported measure of respect and dignity in their treatment – Local Indicator % of HIV infected patients with CD4 count <200 cells per mm3 at diagnosis – Local Indicator	LA proposed NI 128 user reported measure of respect and dignity in their treatment to be replaced with NI 119 Self-reported measure of people's overall health and well-being GOL proposed consideration be given to replacing NI 39 alcohol-harm related hospital admission rates with NI 20 assault with injury crime rate. GOL proposed consideration be given to moving NI 8 adult participation in sport to a local indicator	Improved health and emotional well-being Improved quality of life Increased choice and control Maintaining personal dignity and respect
Enterprise	**Suggested Changes**	**WBSF**

		Outcomes
28. NI 153 Working age people claiming out of work benefits in the worst performing neighbourhoods 29. NI 117 16 to 18 year olds who are not in education, training or employment (NEET) 30. NI 79 Achievement of level 2 qualifications by aged 19 31. NI 171 VAT registration rate ▪ The number of in-work families claiming working families tax credit and child tax credit – Local Indicator	GOL proposed NI 180 changes in housing benefit/council tax benefit new claims and change events be considered as an improvement target	Economic well-being
HSP	**Suggested Changes**	**WBSF Outcomes**
32. NI 4 % of people who feel that they can influence decisions in their locality 33. NI 140 Fair treatment by local services 34. NI 6 Participation in regular volunteering 35. NI 1 % of people who believe people from different backgrounds get on well together in their local area	HAVCO proposed NI 7 environment for a thriving third sector to be included as one of the 35 improvement target	Making a positive contribution Freedom form discrimination and harassment Increased choice and control

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haringey strategic partnership

Well-Being Strategic Partnership Board

Date: **4 March 2008**

Report Title: **Families into Work in Northumberland Park**

Report of: **Martin Tucker, Regeneration Manager (Employment and Skills).**

Summary

The vision for the Families into Work (FIW) project is to improve the life chances of people in Northumberland Park by working with families to identify and provide the services they need for parents to become employed and for children to achieve success in education and develop the skills and desire to obtain work with career prospects.

Families into Work will be an innovative pilot project focussing on families in a specific neighbourhood which will test out an approach that is replicable and scaleable based on better use and co-ordination of neighbourhood features - schools, children's centres, community resources.

Families into Work will be a special project of the Haringey Guarantee - a special family focussed dimension to the Guarantee.

Recommendations

That the Board:

i. Note the specification and timescales for this project.

ii. Identify key informants for the consultants delivering the project

For more information contact:

Name: Martin Tucker
Title: Regeneration Manager (Employment and Skills)
Tel: 020 8489 2932
Email address: martin.tucker@haringey.gov.uk

Background

Approach

Although there are numerous services and projects delivering services in Northumberland Park these are not working well enough to achieve real change for families and a new approach needs to be developed to tackle long term Worklessness in the neighbourhood.

Families into Work will be a multi-agency approach in Northumberland Park to address wider social exclusion issues by working intensively with families to improve the life chances of all family members.

It will be a 3 year pilot with embedded evaluation. It is proposed that **a team of 4 is set up to work closely with some 100 families in Northumberland Park who have multiple barriers to taking up employment and training.**

It is proposed that the team work with 100 families, 50 recruited in year 1 and 50 in year 2, with each family being supported over a 2 year period.

It is not proposed that new services should be provided but that existing service and projects should be co-ordinated and targeted to the families on the project. Thus FIW will not duplicate existing services but seek to facilitate better use of them.

Project Design

The Families into Work project was designed as a way to work closely with whole families.

Thus the project team would work **with** families:

- to identify barriers to work for parents and older children
- to identify barriers to educational achievement for younger children
- to identify a family action plan, including a combination of services and projects, including ones already provided to the family, which would provide a rounded approach geared to that family's needs and barriers to work.
- to contact service providers to negotiate and agree access to the appropriate projects and services and shared action plans for the family which will support them into work.
- to ensure services are provided in a sensible way for the family
- to provide support to reduce drop out when things get tough and troubleshoot any problems which arise with service provision
- to monitor progress against each family action plan

Although the project focuses primarily on reducing Worklessness, it will need to help families deal with other issues in their lives which although not directly related to work, create problems for family members and become barriers to work.

The project is about co-ordination and partnership working and family support, rather than the provision of additional services.

Participation in the FIW scheme would be voluntary and require the family to be prepared for services to share information about them in order to identify the best package of services for that family's needs.

Possible indicators and targets will need to be agreed by the team and the steering group. However some ideas for monitoring data for each family are suggested here:

- Benefits received & for how long
- Qualifications / key stage school attainment for each family members
- Current employment / training status / whether previously held a job
- Barriers to training / employment for adults
- Barriers to educational attainment for children
- Family members NEET
- School attendance
- Whether registered with GP
- Household income

Targets would be for all families on the programme and cover such things as:

- Percentage / number on IB / SDA
- Percentage / number on JSA
- Percentage / number economically active
- Percentage / number NEET
- Percentage / number in permanent employment
- Percentage / number in temporary employment
- Percentage / number with job related qualifications
- Percentage / number with at least floor target level key stage attainment
- Average household income
- Percentage of days off school
- Percentage registered with GP

The steering and executive groups receive a quarterly report on progress and any issues which need resolution at a higher level.

Budget

3 years staff costs @ £165K pa (Co-ordinator PO6 £55K pa incl. on-costs 2 Support Workers PO3 £92K pa 0.5 SO2 Admin. £18K pa)	£495,000
Office Costs	£ 50,000

Leverage/added value projects (£75K yr1, £150K yr 2,£75K yr 3) (Childcare, training, placement expenses, added value small projects)	£400,000
Evaluation	£ 55,000
TOTAL	**£1,000,000**

Piloting the Approach

Northumberland Park Community School currently delivers a successful Tackling Worklessness project under the Haringey Guarantee. This project is aimed at increasing the scope of vocational subjects and retention rates for those year 11 (15/16 year olds) students who are most in danger of becoming workless. The aim is for 250 students to be engaged on the programme with 213 gaining an NVQ level 2 qualification (85 per cent pass rate), 192 progressing to further education and 40 (assessed as most at risk of becoming NEET) to be engaged on an enhanced information advice and guidance (IAG) programme leading to an NVQ qualification and the completion of a vocational training scheme.

Haringey Council have commissioned an extension of the project from January – April 2008 that will pilot the 'Families into Work' approach focussing on the employability skills needs of long term unemployed parents of primary and secondary school pupils. This project targets unemployed adults that are already attending seal classes at the school including parents of students supported through the current Guarantee intervention. The aim is to provide participants with quality training including employability skills, work placements and ultimately jobs. The aspiration is to provide at least 50% of the cohort the opportunity of sustainable employment within the Federation of the 3 secondary schools in Tottenham. The project will engage with 20 families, deliver employability skills training and work placements to 20 people with a minimum of 10 sustainable job outcomes. Currently there are 26 adults undertaking employability skills training.

Progress and Next Steps

The final Business Case was drafted and sent to Steering Group members on 19 December 2007 and agreed at the Steering Group meeting on 9 January 2008.

An allocation of Working Neighbourhoods Fund has been identified to fund the project in 2008/09 but this needs to be confirmed by the Enterprise Board on 5 March 2008.

In anticipation of Enterprise Board agreement work is progressing on drafting staff Job Descriptions and a draft delivery plan for the lifetime of the project.

It is planned that with agreement of the Partnership the project will go live by May/June to coincide with the start of the new LAA.

The 2007/8 £100k NRF Tobacco Control project included resources to commission a review of tobacco control initiatives in the Borough with a view to developing an overarching Tobacco Control Strategy for Haringey that would focus on reducing inequalities in health.

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Well-Being Partnership Theme Board

Date: **4 March 2008**

Report Title: **Well-Being Balanced Scorecard December 2007**

Report of: **Eve Pelekanos, Corporate Head of Performance and Policy.**

Summary

To present the balanced scorecard developed against the strategic objectives of the Well-Being Partnership Theme Board.

Recommendations

That the Well-Being Partnership note progress and key issues on performance as illustrated by the balanced scorecard.

For more information contact:

Margaret Gallagher/ Fiona Breen
LBH Performance Manager/ Performance analyst
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Development of a balanced scorecard

1.1 The Well-Being scorecard has been updated and aligned with the requirements of the new performance framework. It reflects the development of Haringey's Well-Being strategic framework and key priorities as identified in our Local Area Agreement. It is based around the seven outcomes in the Government's White Paper "Our Health, Our Care, Our Say" and includes a number of cross-cutting shared measures. These reflect the Choosing Health agenda and incorporate a range of joint priorities including the Health Care Commission's core standards and indicators.

1.2 The scorecard is designed to give an overview of performance and progress against key projects which contribute to health and Well-Being outcomes. It ensures that people who use social care services are at the heart of the work we do and monitors progress against the outcomes as set out in our well-being strategic framework.

1.3 The front page of the scorecard shows progress against each of the seven objectives in pie chart format. It illustrates the proportion of measures that are on target (green), close to target (amber) and not achieving target or below the expected level of performance (red). This approach relies on both the regular availability of data and targets having been set so as to enable the allocation of a traffic light. Progress on indicators continues to be tracked on a monthly and year to date position against the 2007/08 target using a traffic light annotation where:

- green: = target achieved / performance better than planned
- amber: = just below target (normally a 5% tolerance)
- red: = target not achieved / below expectation

1.3.1 In addition, trend arrows depict progress since the last financial year, so whilst an indicator may receive a red traffic light for not achieving target, it will show an upward trend arrow if performance had improved on the previous year's outturn. Between them, the lights and arrows indicate current progress and predict the likely annual position.

1.4 The report is based on Quarter 2 data from Health and Quarter 3 data from the Council. Performance data from Health will be available at the end of the month and will be updated into this report when made available.

2. Objective 1- Improved Health and Emotional Well Being

2.1 Sixteen out of 17 (94%) of the measures are on or close to target Performance on our LAA stretch target of smoking quitters in N17 has exceed the targets for Quarters 1 and 2, currently 97 smoking quitters have been achieved against a target of 67. 270 quitters are required for year 1. Quarter three figures will be available by the end of February 2008.

It is expected that there will be a higher number of smoking quitters in the last quarter of the year as the various projects progress. The assumption is that there will be 68 smoking quitters in Quarter 3 and an additional 135 in Quarter 4. There is an obvious risk attached to this assumption although the HTPCT are confident that this target will be met. Actions for 2007/08 include the recruitment of a stop smoking advisor and community advisors for the N17 area as well as increasing access to clinics and targeted marketing.

2.2 Quarter three shows good progress is being made on the Swim & Gym usage particularly in Park Road and The Health Walks Programme with 93 participants completing a 12 week programme and 162 referrals have been made to the Watch It programme (Childhood Obesity Programme)
The number of drug users sustained in treatment is making good progress with 24 over the LDP target and the Number of Delayed Transfer of Care has also exceeded the target.

2.3 The percentage of mothers known to be smoking has risen in quarter 2 and remains above the target of 5%

2.4 Performance has improved on mortality rates from cardiovascular disease from 116.5 per 100,000 in 2006/07 to 89.5 as at September ’07 and puts us on track to achieve our 2007/08 target.
The Reduction of obesity - mean body mass index of population (recorded as having a BMI of 30 or greater) September figure of 9% is a good improvement on last year’s figure of 14%.

2.5 Data is still not available for the breast cancer screening indicator due to the service being reinstated and dealing with a backlog of patients.

3. Objective 2- Improved Quality of Life

3.1 All 16 of the measures are on or close to target.
The number of physical visits to libraries increased in the 3rd quarter to over 9 visits per head of population and continues to better the target.
Summer enrolments has improved performance for the Silver Surfers (60+ educational take up) and the Adult Education take up indicators, if performance continues they will exceed their targets.

3.2 Third quarter figures show significant improvements on a number of social care indicators compared to last year – Number of people with learning disabilities helped to live at home has improved from 1.58 to 1.84 exceeding Haringey's target of 1.7. Adults with mental health problems, older people helped to live at home, Community equipment delivered within 7 days and Services for Carers have all improved considerably, placing these in the top PAF banding.

3.3 Performance has declined in quarter three on the number of physical disabled people helped to live at home remaining below the target of 5 per 1,000.

4. Objective 3- Make a Positive Contribution

4.1 Both measures are on target. Performance on the Out and About Project which measures volunteer hours secured for work with older people exceeded on last years year to date performance. 2,028 volunteer hours were recorded in the period April to December '07 compared to 1,832 hours for the previous period (April to December 06), a 10% increase.

5. Objective 4- Increased Choice and Control

5.1. All ten (100%) of the traffic lighted measures are on or close to target. Five indicators have made significant progress on last years performance and two have moved up on the Paf banding rating in this quarter

5.2 People receiving a statement of their needs improved from 89% in 06/07 to 97% in December, moving the indicator up to Paf banding 4. Adults and older people receiving direct payments improved from 138 per 100,000 in 06/07 to 153 in December, moving the indicator into the top Paf banding

5.3 Performance on Older people aged 65 or over admitted to residential or nursing care has moved from 85 per 10,000 in 2006/07 to 61.9 for the 3rd quarter of 2007/08: although good performance is generally low there may be a danger that a very low figure could suggest people in need of residential care are not receiving it. Current performance is within a reasonable range of our <67 target.

5.4 Excellent performance has been maintained on waiting times for assessment. This indicator is the average of new older clients receiving an assessment where time from initial contact to first contact with the client is less than or equal to 48 hours (part a) and the percentage where time from first contact to completion of assessment is less than or equal to 4 weeks (part b). The average of the two is 96.5% and remains within the top banding continuing to exceed our 90% target. (BV195/PAFD55)

6. Objective 5- Freedom from Discrimination or Harassment

6.1 Four of the five (80%) of the measures are on or close to target. Good progress has been made on the numbers of incidents of domestic violence which result in sanction detections. There have been 635 sanctioned detections (51.8%) in the year to December which scaled up equates to 847 in a year and would put us well on track to achieve the agreed stretch target. Performance is significantly better than 06/07 which had 652 detections in the whole year equating to a rate of 36.2%.

6.2 For the reduction of repeat domestic violence victimisation incidents, some progress has been made since 2005/06 with annual equivalent reports reducing from 339 in 05/06 to 230 as at January 2008. The target for 2007/08 is 191 which is at risk of not being met. Looking at the year three target of 523 (cumulative) it appears that this is extremely challenging: Key actions are being put in place which will help mitigate against this.

7. Objective 6- Economic Well-being

7.1 11 of the 13 (84%) of the indicators included under this objective have been assessed as on or close to target.

7.2 Progress continues to be good on putting in place energy efficiency homes measures. 890 energy efficiency measures have put in place in the year to date which is almost double that done the whole of last year.

7.3 The proportion of households accepted as homeless who have been previously accepted as homeless in the last two years has remained at 0% exceeding our 2.5% target for 2007/08.
The number of households for whom advice/intervention resolved their situation is a predicted 572 or 6% and places us in the top quartile nationally.

8. Objective 7- Maintaining personal dignity and respect

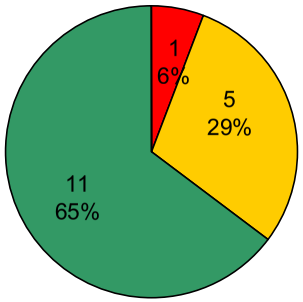
8.1 All 3 (100%) measures are on target.
Good performance maintained on the availability of single rooms continuing to meet its 100% target

9. Position on all objectives

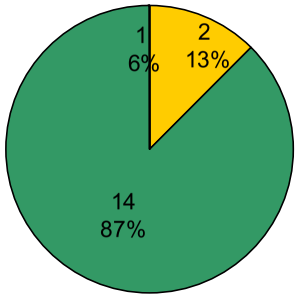
9.1 Overall 94% of the measures are on or close to target. 48 of the 66 indicators traffic lighted achieved green status with an additional 14 achieving amber status. Only 4 of the 66 measures fell short of the target.

Wellbeing Scorecard December 2007

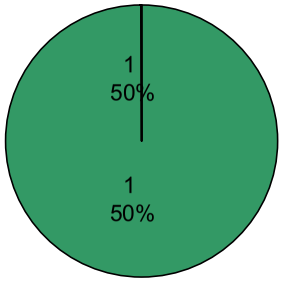
1 - Improved Health and Emotional Well-Being



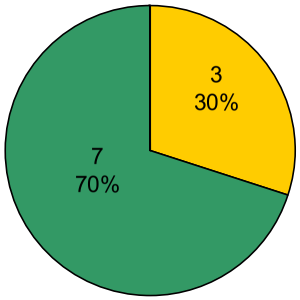
2 - Improved Quality of Life



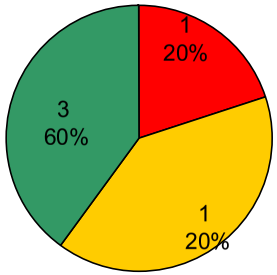
3 - Make a positive contribution



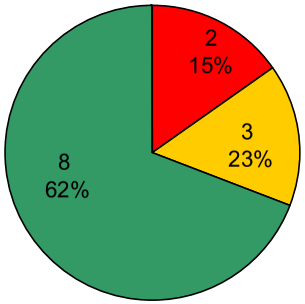
4 - Increased Choice and Control



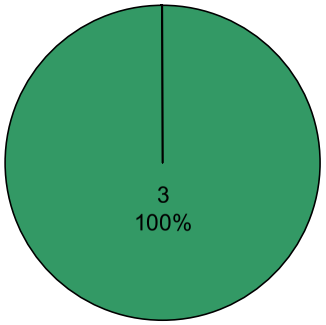
5 - Freedom from Discrimination or Harassment



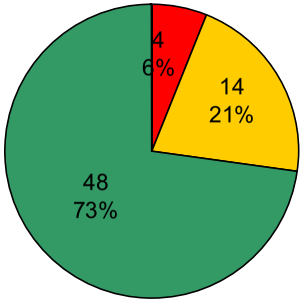
6 - Economic Well-being



7. Maintaining Personal Dignity and Respect



All objectives



Red	Well below target
Amber	Worse than, but within 5% of target
Green	On or better than target
New/Annual	
Blank	

Well-being Scorecard

Objective Name	Traffic light count					
	Red	Amber	Green	Annual or New	Blank	Total
Objective 1 - Improved Health and Emotional Well-being To promote healthy living and reduce health inequalities in Haringey	1	5	11	0	0	17
Objective 2 - Improved Quality of Life To promote opportunities for leisure, socialising and life long learning, and to ensure that people are able to get out and about and feel safe and confident inside and outside their homes	0	2	14	0	0	16
Objective 3 - Make a positive contribution To encorage opportunities for active living including getting involved, influencing decisions and volunteering	0	0	2	0	0	2
Objective 4 - Increased choice and control To enable people to live independently exercising choice and control over their lives	0	3	7	0	0	10
Objective 5 - Freedom from Discrimination or Harassment To ensure equitable access to services and freedom from discrimination or harassment	1	2	2	0	0	5
Objective 6 - Economic Well-being To create opportunities for employment and to enable people to maximise their income and secure accommodation which meets their needs	2	2	9	0	0	13
Objective 7 - Maintaining personal dignity and respect: To ensure good quality, culturally appropriate personal care and prevent abuse of service users occurring wherever possible and to deal with it appropriately and effectively if it does occur	0	0	3	0	0	3
Total	4	14	48	0	0	66
	6.1%	21.2%	72.7%	0.0%	0.0%	100.0%

Red	Well below target
Amber	Worse than, but within 5% of target
Green	On or better than target

Objective 1 - Improved Health and Emotional Well-being
To promote healthy living and reduce health inequalities in Haringey

	Description	Frequency	2006/07	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend Arrow	YTD Progress	Annual 2007/08 Target	Comments	Data Source/ Contact
1	Four week quitters	Monthly	1998	14	110	286	345	469	816							1998 (92.5%)	↑	✓	**2190 quitters.** Plan: Q1-274, Q2-274, Q3-547, Q4-1,095.	New data base in development to improve access to monthly data from community advisors. Revised plan to match NHSL's quarterly targets.	Catherine Brown (Health Report) Gerry Taylor gerry.taylor@haringey.nhs.uk
2	Smoking cessation: Increase the number of quitters living in N17	Quarterly	240			48 (Target 33)			49 (Target 34)							97	↑	✓	240 stretch 270	Profiles for Q3 and Q4 have targets of 68 and 135 quitters respectively. At present the targets are being met although there is a risk as the majority of work will need to be done in the final two quarters of the year.	Caroline Hulett (Caroline.Hulett@haringey.nhs.uk)
3	Number of drug users within treatment	Monthly	1435	822	872	922	958	983	1017	1051						1051	↑	✓	LDP target 1182 (stretched partnership target 1475)	Performance currently 24 over LDP target and 172 under the stretched partnership target . This is based on the NTA's expected progress trajectory.	Catherine Brown (Health Report) Adrian Hosken PCT
4	Percentage of problem drug misusers sustained in treatment	Quarterly	68.00%			72%			77%							77% (covers the period of Aug 06 to July 07 - the latest 12 month period where data	↑	✓	75% to be retained >12 weeks (local tgt. National is 82%)	2007/8 target is 75%. London performance is around 70%.	Adrian Hosken PCT
5	Mortality rate from Cancer in people under 75 per 100,000 people	Quarterly	111.5	108.03		105.9			109.2							109.2	↑	✓	117 per 100,000 in 2006 (age standardised) spearhead tgt	latest available data shows target is being achieved.	Graeme Walsh PCT
6	Cardiovascular disease mortality rates per 100,000 people	Quarterly	92.3			116.5			89.5							89.5	↑	✓	94 per 100,000 in 2007 (age standardised) spearhead tgt	latest available data shows target is being achieved.	Graeme Walsh PCT
7	Reduction of obesity- mean body mass index of population (recorded as having a BMI of 30 or greater)	6 monthly	14%						9.50%							9.50%	↑	✓	14% 2006/07		Vanessa Bogle/Catherine Browne PCT
8	Proportion of people 16+ taking 30 mins moderate physical activity on three or more days a week	Quarterly	72				76					93				93	↑	✓		Health Walks Programme 93 participants have completed a 12-week programme. Active for Life (Physical Activity Referral Scheme) 162 referrals made to the programme. Watch It! (Childhood Obesity Programme)	Vanessa Bogle PCT
9	Swim usuage as% of total usage in Tottenham Green Gym usuage as% of total usage In Tottenham Green	Quarterly	30% 13%	29% 5%	25% 6%	25% 5%	34% 6%	35% 4%	26% 4%	22% 4%	20% 4%	15% 4%				26% 5%	↓	–	2006/07 Cumulative % 30% 13%		Margaret Barzey LBH

Objective 1 - Improved Health and Emotional Well-being
To promote healthy living and reduce health inequalities in Haringey

	Description	Frequency	2006/07	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend Arrow	YTD Progress	Annual 2007/08 Target	Comments	Data Source/ Contact
10	Swim usuage as a % of total usuage in Park Road Gym usuage as a % of total usuage in Park Road	Quarterly	66% 11%	71% 6%	69% 6%	71% 5%	68% 7%	66% 9%	70% 12%	67% 13%	60% 9%	70% 9%				70% 8%	↑	–	2006/07 Cumulative % 66% 11%		Margaret Barzey LBH
11	CPA seven day follow up	Quarterly	90.60%			100%			100%							100.00%	↑	✓	100.00%		Janice Woodruff PCT
12	Number of Older People (aged 50+) participating in a healthier eating community based programme in Noel Park, Bruce Grove and Northumberland Park	4 Monthly	22 between Jan-Mar 07						32							32	↑	✓		Round 4 results below: Total number of both programmes completed to-date = 32 Total number of people attending Shape-Up programme to-date = 65. Total number of people attending Cook & Eat programme to-date = 93	Wilkins Debbie [Debbie.Wilkins@haringey.nhs.uk]
13	Infant Mortality: Smoking during pregnancy:% of mothers known to be smokers during pregnancy	Quarterly	12.41%			6.73%			9.10%							9.10%	↑	✗	4.99%		Vanessa Bogle/Catherine Browne PCT
14	Breast Cancer Screening for women aged 50-70 years	6 monthly	36.00%															–	70% of women beween 50-70	Data is not yet available for 2007/08 the service has been reinstated and backlog of Haringey patients is currently being screened. We are unlikely to be able to catch up this year, but expect that progress will be made towards meeting next year's target.	Vanessa Bogle/Catherine Browne PCT
15 Paf D40	Adults & Older clients receiving a review as a percentage of those receiving a service	Monthly	63%	133%	125%	113%	103%	97%	90%	80.00%	78.60%	74.60%				75%	↑	–	80%	Paf Top Banding 60>90% (3 blobs) Current Performance 2 Blobs	Paul Dryden LBH
16	Teenage Conception Rates (difference between 1998-2005)	Annual	62.5															–	41.3 conceptions/ 1000 15-17 year old females in calendar year 2006		Vanessa Bogle/Catherine Browne PCT
17 Paf D41	No of Delayed Transfers of Care- Adults & Older People per 100,000 (Social Services)	Monthly	65.5	44	50	49.91	42.90	39.93	35.05	32.67	33.01	36.07				36.07	↑	✓	39.78	Paf Top Banding 0<20.12 Current Performance 4 Blobs This is a cumulative figure across all services	Manisa Patel LBH

Objective 2 - Improved Quality of Life

To promote opportunities for leisure, socialising and life long learning, and to ensure that people are able to get out and about and feel safe and confident inside and outside their homes

	Description	Frequency	2006/07	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend Arrow	YTD Progress	Annual 2007/08 Target	Comments	Data Source/ Contact
1	The number of physical visits per 1,000 population to public libraries	Quarterly	9,585			9057			8,733			9,171				9003	↑	✓	8600	Still feeling impact of Hornsey and Stroud Green Library Closures	Erica Worth LBH
2	60+ Educational take up	4 Monthly	363				96					245				341	↑	✓	363	Performance data based on term times	George Szervanszky LBH
3	Adult (19+)education take up collected term time	4 Monthly	3149				690					2173				2863	↑	✓	3149 (787 qtr)		George Szervanszky LBH
4	BV119 - Increase in number of green flags award parks & public satisfaction	Annual	7 Flags 2 Pennants													8 Flags	↑	✓			
5 BV119e	% of residents satisfied with parks and open spaces	Quarterly	72% satisfied			72% (BVPI)			64%(W ave 2 track)			65%(residents survey)				65%	↓	–	72%	Latest residents survey show +8% rating the service as good/excellent	
6 BV119a	% of residents satisfied with sports and leisure facilities	Annual	48.70%															✓			
7	Residents Survey - Areas of personal concern % of sample mentioning concern with crime	Annual	54%									46%				46%	↑	✓		Latest residents survey show a 7% reduction in residents mentioning crime as an area of personal concern	
8 Paf C29	Younger physically disabled helped to live at home per 1,000 population aged 18-64.	Monthly	4.6			4.7	4.8	4.8	4.7	4.6	4.6	4.49				4.49	↓	–	5	Paf Top Banding 5+ Current Performance 4 Blobs	Paul Dryden LBH
9 Paf C30	Number of people with learning disabilities helped to live at home per 10,000 adults in population aged 18-64.	Monthly	1.58	1.57	1.56	1.57	1.54	1.54	1.56	1.55	1.65	1.84				1.84	↑	✓	1.7	Paf Top Banding 3+ Current Performance 2 Blobs	Paul Dryden LBH
10 Paf C31	Adults with mental health problems helped to live at home	Monthly	0.2	2.83	2.82	2.85	2.84	2.85	2.85	2.93	4.09	4.16				4.16	↑	✓	3	Paf Top Banding 2.3+ Current Performance 5 Blobs	Paul Dryden LBH
11 Paf C32	Older people helped to live at home per 1,000 aged 18-64	Monthly	94.00	89.00	89.00	88.00	88.00	87.00	93.00	104.64	103.30	101.56				101.56	↑	✓	101	Paf Top Banding 100+ Current Performance 4 Blobs	Paul Dryden LBH
12 PAF D54	Community equipment- social services items of equipment delivered in 7 days	Monthly	88%	94.6%	98.0%	93.0%	95.0%	96.0%	99.0%	99.00%	100.00%	99.80%				97.20%	↑	✓	88%	Paf Top Banding 85<100 Current Performance 5 Blobs	Paul Dryden LBH
13	Community equipment- health items of equipment delivered in 7 days	Monthly	96%	99%	99%	100%	100%	100%	100%							100%	↑	✓	100%		Catherine Brown - Health Report
14 Paf C62	Services for carers	Monthly	9.00%	9.00%	8.00%	8.80%	9.40%	9.70%	10.10%	13.5%	12.10%	12.1%				12.10%	↑	✓	9%	Paf Top Banding 12+ Current performance 5 Blobs	Paul Dryden LBH
15	Number of black and ethnic carers of who have received a breaks service - DIS 2.1 CS064	Annual	683															✓	600		Manisha Patel LBH
16	Number of active card users	Quarterly	23992	6074	6626	15008	9794	9781	8785	9056	8936	8316				82376	↑	✓	5264 (month)		Margaret Barzey LBH

Objective 3 - Make a positive contribution
To encorage opportunities for active living including getting involved, influencing decisions and volunteering

	Description	Frequency	2006/07	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend Arrow	YTD Progress	Annual 2007/08 Target	Comments	Data Source/ Contact
1	Out and About Project (Volunteer hours secured for work with older people) Visits and telephone	Monthly	2420	183	187	191	199	235	241	261	266	265	269			2297	↑	✓	06/07 2420		Ashraf Choudhury - Age Concern
2 Paf 30	Number of adults with learning disabilities helped to live at home per 1,000 population aged 18-64	Monthly	1.6	1.57	1.56	1.57	1.5	1.54	1.56	1.55	1.65	1.84				1.84	↑	✓	1.7	Paf Top Banding 3+ Current Performance 2 Blobs Professional support has been added which has been resulted in exceeding the 2007/08 target. However this indicator remains in Band 2.	

Objective 4 - Increased choice and contro

To enable people to live independently exercising choice and control over their lives

	Description	Frequency	2006/07	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend A	YTD Progress	Annual 2007/08 Target	Comments	Data Source/ Contact
1 Paf D39	% of people receiving a statement of their needs and how they will be met	Monthly	89%	89%	90%	93%	93%	93%	95%	94%	97.3%	97%				97.0%	↑	✓	98%	Paf Top Banding 100+ Current Performance 4 Blobs	Paul Dryden LBH
2 Paf C51	Adults and older people receiving direct payments per 100,000	Monthly	138	131	131	136	137	140	137	136	149	153				153	↑	✓	139	Paf Top Banding 150+ Current Performance 5 Blobs	Paul Dryden LBH
3 Paf D55	Assessments of older people which begin within 48 hours of first contact	Monthly	60%	97%	95%	96.50%	97%	97%	97%	97%	96.9%	97%				97.3%	↑	✓	90%	Paf Top Banding 90<100 Current Performance 5 blobs	Paul Dryden LBH
4 Paf D55b	Assessments of older people completed within 4 weeks	Monthly	73%	95%	94%	95.10%	95.00%	95.20%	95.30%	95.90%	95.50%	95.70%				95.70%	↑	✓	90%	Paf Top Banding 90<100 Current performance 5 blobs	Paul Dryden LBH
5 Paf D56	Social services for Older people provided within 4 weeks following assessment	Monthly	94%	82%	85.90%	85.30%	86%	91%	91%	91.20%	90.00%	89.90%				89.9%	↓	–	93%	Paf Top Banding 90<100 Current Performance 4 blobs	Paul Dryden LBH
6 Paf D71	% of respondents when asked " Do your care workers do the things that you want done" answered "they always do the things I want done	Annual	New																		Paul Dryden LBH
7 Paf C72 (Formerly C26)	Older people aged 65 or over admitted on a permanent basis in the year to residential or nursing care	Monthly	85	73	76	72	63	75	69	66.6	68.9	61.9				61.9	↑	✓	Local Target <67	Paf Top Banding 0<90 Current Performance 5 Blobs	Paul Dryden LBH
8 Paf C73 (Formerly C27)	Adults aged 18-64 admitted on a permanent basis in the year to residential or nursing care	Monthly	5.2	2.3	2.3	2.6	2.1	1.2	1.0	1.0	1.4	1.2				1.2	↑	✓	1	Paf Top Banding 0<1.5 Current Performance 5 Blobs	Paul Dryden LBH
9 Paf E82	Assessments of adults and older people leading to a provision of service	Monthly	67.00	71.00	72.00	72.00	72.00	70.00	71.00	69.50	67.60	67.90				67.90	↑	–	70	Paf Top Banding 68<77 Current Performance 4 Blobs	
10 KPI	Service users who are supported to establish and maintain independent living	Quarterly	97.90%			98.55%			98.00%							98.00%	↑	✓	98%	3rd quarter data not available until Feb	Carlos Bailey LBH

Objective 5 - Freedom from Discrimination or Harassment
To ensure equitable access to services and freedom from discrimination or harassment

	Description	Frequency	2006/07	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend Arrow	YTD Progress	Annual 2007/08 Target	Comments	Data Source/ Contact
1 DIS 2216 5.3LD 166	Ratio of the % of learning disabled adults receiving services that are from minority ethnic groups related to the % that are from minority ethnic groups	Annual	1.13															–	1.00		
2 Paf E47	Ethnicity of older people receiving an assessment	Quarterly	1.23			1.56			1.49	1.45	1.52	1.46				1.46	↑	–	1.3	Paf Top Banding1<2 (3 Blobs) Current Performance 3 Blobs	Paul Dryden LBH
3 Paf E48	Ethnicity of older people receiving services following an assessment	Quarterly	1.03			0.94			0.99	0.98	0.96	1.01				1.01	↔	✓	1	Paf Top Banding 0.9<1.1 (3 Blobs) Current Performance 3 Blobs	Paul Dryden LBH
4	An increase in the percentage rate of sanctioned detections of domestic violence	Monthly	487			223 or 53%	69 or 48%	69 or 51.9%	238 or 54.2%	61 or 50.4%	64 or 58%	75 or 46%				51.8	↑	✓	129 or 32% stretch 34%	The year to date position is 51.8% and we are on track to exceed the year 1 target of 770 sanction detections and performance is significantly better than last year. Previous issues with this indicator have been resolved with GOL through the mid-year review and we are now on track to meet the year three target.	
5	Reduction of repeat victimisation	Monthly	201			228			205	211	209	216	230			230	↑	✗	191	In January 2008 a domestic violence perpetrator programme has been set up and the Police held an Athena Day targeting and arresting DV perpetrators in January, 9 people were arrested. Two more Athena days will be held in February and March 2008. It should be noted that progress has been made since 2005/06	

Objective 6 - Economic Well-being
To create opportunities for employment and to enable people to maximise their income and secure accommodation which meets their needs

	Description	Frequency	2006/07	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend Arrow	YTD Progress	Annual 2007/08 Target	Comments	Data Source/ Contact
1	Reduction in worklessness/ people entering employment Employment in Haringey- data available by ward	Annual	66.2%(2005/06)															✗	England Avg 74.8%		Ambrose Quashie LBH -Floor Targets
2	Ethnic Minority employment rate- data available by ward	Annual	45.3% (2004/05)															✗	England Avg 58.9%		Ambrose Quashie LBH - Floor Targets
3	Number of LD people aged 18-64 in paid work per 1,000 (DIS 6.4 LD168)	Annual	45															—	60		Siobhan Harper/Chloe Rawlinson LBH
4	Number of supported employment placements for employees with disabilities via Jobcentre Plus "Workstep" achieved	4 Monthly	7					7					9			9	↑	✓	06/07 7	7 full time. Only 2 new sign ups; both job seekers.	Bill Slade LBH
5 New for 2006/07	Number of households with reduced fuel poverty in Noel Park, Bruce Grove & Northumberland Park	Annual	235															✓	235 2006/07		Lynn Sellars LBH
6 New for 2006/07	Number of properties that have received energy efficiency measures	Quarterly	461			307			429			154				890	↑	✓	461	Progress continues to be good on the proxy measures of putting in place energy efficiency and decent homes measures. 890 energy efficiency measures and 218 decent homes measures have put in place in the year to date which is almost double that done is the whole of last year.	LAA measure
7	Proportion of households accepted as homeless who have been previously accepted as homeless in the last two years (BV214)	Quarterly	2.50%			0.0%			0.0%			0%					↑	✓	2.5%		Greg Carter LBH
8	Number of households for whom advice/intervention resolved their situation per 1000 households (BV 213)	Monthly	380	15	37	70	56	69	28	77	44	33				572	↑	✓	500	The year to date of 572 is a prediction of year end by taking an average monthly figure from the data and multiplying by 12. The year end figure for this data is calculated by dividing the final number of cases by one thousandth of the total number of households in the borough (98). Therefore 594/98 = 6.06 which is currently top quartile national and local performance.	Greg Carter LBH
9	Delayed transfers of care to reduce to a minimal level by 2006 (Health)	Quarterly	2.64%			2.39%			0.75%							1.57%(current performance)	↑	✓	Local target 2%		Alex McTeare PCT
10 Paf E47	Ethnicity of Older people receiving assessment	Monthly	1.23	1.31	1.42	1.56	1.51	1.5	1.49	1.45	1.53	1.46				1.46	↑	—	1.3	Paf Top Banding1<2 (3 Blobs) Current Performance 3 Blobs	Paul Bryden LBH

Objective 6 - Economic Well-being

To create opportunities for employment and to enable people to maximise their income and secure accommodation which meets their needs

11 Paf E48	Ethnicity of Older people receiving services following assessment	Monthly	1.03	0.8	0.84	0.94	0.95	0.95	0.97	0.99	0.96	1.01				1.01	↔	✓	1	Paf Top Banding 0.9<1.1 (3 Blobs) Current Performance 3 Blobs	Paul Bryden LBH
12	Number of fire safety checks carried out by fire brigade	Annual	234			54			69	23	24	20				190	↓	✓	12 fewer fires over 3 years	The number of accidental dwelling fires was higher in quarter 2 than quarter 1 but fell slightly in quarter 3 to 67, scaled up for 07/08 will be 253, this is higher than last year and also higher than the year 3 target of 230.	LAA Agreement
13	Community Alarms	Monthly	342	29	22	38	44	22	35	42	34	21				266	↑	✓	06/07 342 (28 avg per month)		Yvette Husbands/ Maureen Smith LBH

Objective 7 - Maintaining personal dignity and respect:
To ensure good quality, culturally appropriate personal care and prevent abuse of service users occurring wherever possible and to deal with it appropriately and effectively if it does occur

	Description	Frequen	2006/07	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD Progress	Trend Arrow	YTD Progress	Annual 2007/08 Target	Comments	Data Source/ Contact
1 Paf D37	Availability of single rooms	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%	↔	✓	100.00%	Always be 100%	Paul Dryden LBH
2	To facilitate timely hospital discharge and/or effective rehabilitation Non-residential intermediate care schemes DIS 1.2 OP005	Annual	95															✓	115		Paul Dryden LBH
3	To facilitate timely hospital discharge and/or effective rehabilitation - DIS 1.2 OP007	Annual	629															✓	529		Paul Dryden LBH

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NRF Projects	Project Manager	Well-being Objectives					RAG Status					Finances			Project Objectives/Target 07/08	Year to date	Comments
		Achieve Economic Wb	Be Healthy	Positive Contribution	Be Independent	Stay Safe	Issues	Resources	Budget	Timescale	Overall Status	Total Budget 07/08	Spend Committed To Date	Budget Left to Spend			
Accessing Employment through Individual Budgets	Beverley Tarka	✔					G	G	G	G	G	£16,605	£16,263	**£342**	Increase the income of 15 households by an average of £10 per week	**10**	This is currently being sustained with a Job coach visiting the work place of all 10 Service Users in work and carrying out Job evaluations and booking training time. 10 people with learning disabilities supported into paid employment and 5 person in voluntary placement will be working towards paid employment.
															To support 15 people with a learning disability into paid employment.	**10**	
Appropriate Adult Training for B Tech Award (Crucial Steps)	Ify Adenuga	✔					G	G	G	G	G	£15,926	£13,144	**£2,782**	Recruitment target - 50 Training 25 to complete training	**40** **20**	Partnership with Mind in Haringey continues. A number of trainees expressed interest on training project by other local organisations prompting Crucial Steps to develop a criminal justice awareness seminar project. As many as three to four ex-trainees that moved into employment last year have joined Crucialsteps' management in order to boost the organsation's capacity in developing the sustainability strategies. Currently negotiating work experience positions for 6 trainees within local organisations and private legal firms.
Benefits Outreach (Age Concern)	Imelda Mullins	✔					G	G	G	G	G	£47,096	£34,765	**£12,331**	No of sessions to target is 100	**103**	Complimentary to the existing Community Legal Services Quality Marked benefits advice service. Enable a targeted information, advice and welfare rights outreach campaign toward those harder to reach communities.
															No of referrals to target is 280	**559**	
															No of people to train is 4	**1**	
Black and Minority Ethnic Carers Respite Service	Faiza Rizvi		✔	✔	✔		A	G	G	G	G	£20,000	£15,360	**£4,640**	Plan, develop and deliver 12 support group meetings.	**9**	Annual conference took place on the 15th June 07. Mun Thong Phung, the Director of Adult Culture & Community Services and cabinet member Bob Harris for Adult Social Care and Well-being addressed the audience. Plan to distribute Therapy Vouchers in December 07. The project has encouraged BME Carers to exchanged each others details and a number of carers have developed support mechanism for each other. Also BME Carers have been consulted and provided with information on Direct Payment systems, Breast Cancer Care, Carers Services in haringey, Children & young people services . Alternative Therapy planned from Jan-March 08.
															250 carers to attend group support meetings	**429**	
															One annual conference	**1**	
															75 Carers to receive alternative therapy treatment in support group	**12**	
															50 Carers to receive therapy vouchers	**50**	
Community Income (BME Carers Support Service)	Faiza Rizvi	✔					G	G	G	G	G	£32,000	£22,672	**£9,328**	150 families to be supported through advice and case work support	**130**	Approximately 10 clients have benefited from an increase in household income by an average of £10, this ranges from clients receiving Sure Start Maternity Grant, disability premium, housing benefit discretionary payment, Carers allowance, Milk and Healthy food tokens, Community care grant, Attendance Allowance etc
															Inform and support 150 families in applying for relevant benefits	**119**	
Cycling Club	Beverley Tarka	✔	✔				G	G	G	G	G	£10,000	£10,404	**£0**	200 people with Learning Difficulties, plus families, friends and volunteers to participate in cycling activities.	**133**	Cycle club launched on 22nd May 07 in partnership with Lordship Recreation and Lordship Users Forum at Broadwater Farm community centre. Approximately 150 people attended the launch and participated in cycling and other sports activities. The cycling club is successfully providing regular cycling sessions Mon-Fri, promoting mental well-being through regular exercise and promoting a healthy lifestyle for people with learning disabilities. The project has also provided employment opportunities for people with disabilities. The long term aim is for the club to be run and managed by people with learning disabilities.
Happy Opportunities (PHASCA)	Lena Hartley	✔	✔				G	G	G	G	G	£18,000	£12,545	**£5,455**	To improve the health outcome for 50 adults who are 50+	**79**	Flyers distributed and advertised on the internet/radio/library/local supermarket/ community centres and local newspapers. Tutors recruited for money management, healthy eating, life skills, one-to-one counselling. Sessions held to date in Self Esteem & Yoga. other sessions include A) Money management B) Streamline choice of utility provider, C) Looking at the shelf life of items in the supermarket before purchasing D) Teaching participants a skill to do with their hands so they can earn at least £10 a week extra, E) One-to-one and group counselling, F) Yoga & Slow movement and G) Back to work skills.
															To increase income opportunities in the local community especially from Noel Park, Bruce Grove and Northumberland Park for 30 adults	**18**	

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NRF Projects	Project Manager	Well-being Objectives					RAG Status					Finances			Project Objectives/Target 07/08	Year to date	Comments
		Achieve Economic Wb	Be Healthy	Positive Contribution	Be Independent	Stay Safe	Issues	Resources	Budget	Timescale	Overall Status	Total Budget 07/08	Spend Committed To Date	Budget Left to Spend			
Haringey Forum for Older People Age Concern Haringey	Manuela Toporowska				✔		G	G	G	G	G	£56,170	£41,324	**£14,846**	10 Executive Committee meetings;	**9**	New Committee elected, including honorary officers. Identified shadow volunteers to strengthen Committee. Maintained older people's involvment in Scrutiny Review of Access to Services for Older People. 5th AGM took place on 14 November 07 attended by 140 older people, with lively debate re Primary Care Strategy and information about Leisure opportunities for older people. Forum programme for 2008 discussed. Maintained older people's involvment in Scrutiny Review of Access to Services for Older People, including raising issue of footcare services accessible to older people. Forum programme for 2008 discussed. Maintained older people's involvment in Scrutiny Review of Access to Services for Older People, including raising issue of footcare services accessible to older people. Worked in partnership with Haringey Federation of Residents' Associations to raise Community Toilets Scheme at Better Places Partnership Board.
															Sustain membership at current (end of Mar 07) levels estimated at 550	**730**	
															3 Newsletters	**3**	
Health in Mind (HTPCT) Physical Activity	Vanessa Bogle Physical Activity	✔	✔				A	G	G	G	G	£88,984	£59,649	**£29,335**	Physical Activity Referral Scheme, (200 participants)	**200**	The Scheme has received 200 referrals to date (38 in January alone). 7 physical activity sessions are running on a weekly basis. The Scheme has been well received by the GP practices who strongly feel that this Scheme will assist them in helping their practice population to manage a range of long-term conditions including obesity, type II diabetes, high blood pressure, etc. Referrals are being received regularly on a weekly basis. Thirteen out of seventeen eligible practices have signed up to the Scheme and are making regular referrals.
															5 weekly Health Walks - 30 min moderate intensity walks (300 participants)	**97**	Predicting an increase in these figures as GP practices in the target wards are aware of the programme, and for those patients who do not meet the entry criteria for the Physical Activity Referral Scheme, practitioners are able to recommend the Group Health Walks as a physical activity option for them. ISSUE: Year to date targets lower than expected.
Health in Mind (HTPCT) Healthy Eating	Debbie Wilkins Healthy Eating	✔	✔				A	G	G	G	G	£148,306	£129,611	**£18,695**	Shape-Up Programme - Targets: 140 participants per year	**81**	There are some concerns with the numbers of participants registering for the shaoe up programme and therefore this month's status has been given an AMBER sign. This slight slippage is recoverable, main concerns lie with the numbers of people registering rather as previously mentioned in the last report, however despite outreach work it has still not been possible to get the target number of people to register on to the programme. Round 6 has now commenced.
															Cook and Eat Programme - Target: 60-90 participants per year	**99**	
Health in Mind (HTPCT) Mental Health	Dorian Cole Mental Health (Haringey Therapeutic Network)	✔	✔				A	G	G	G	G	£133,475	£122,157	**£11,318**	Haringey Therapeutic Network Groups, 146 new contacts.	**65**	The Mental Health Library service and the Haringey Therapeutic Network has promoted and now established a service for the three NRF areas Bruce Grove, Noel Park and Northumberland Park. Quantative data is collected including reason for referral, age, gender, ethnicity, type of intervention and outcome. 1. Physical Activity/Wellbeing Groups 317 people seen - 65 new contacts 2. Employment/Support Groups - 363 people seen - 145 new contacts 3. Health in Mind Library Service - 82 patients seen - 87 new contacts - 274 other contacts
															Employment Support Groups: 90 new contacts	**145**	
															Health in Mind Library Work, Graduate workers: 150 new contacts	**87**	
Home Support Workers & Outreach Street Drinkers (HAGA)	Damon Knight		✔	✔		✔	G	G	G	G	G	£78,400	£55,663	**£22,737**	Offer a service about alcohol misuse and service provision to 100 people with chaotic alcohol misuse problems	**125**	This has been providing advice and information about to chaotic drinkers or those affected by chaotic drinking. The service is currently averaging about eight new referrals a month. This has been boosted by us developing closer links with Haringey Housing Joint Assessment Team, formerly known as Vulnerable Adults Team. The Outreach element of the service has seen 125 clients since Aptil. The total amount of clients for the year so far if we include a conservative average of five per month from Apex House since May therefore would be 232 clients.
															Reduce alcohol problems and make positive lifestyle changes for 100 people in their own homes and/or on the street	**100+**	This has been done in engagement with local neighbourhood schemes, the police and community groups. There has been significant decreases in chaotic street drinking from the traditional client group. Concentrated this activity in Bruce Grove, Seven Sisters and St. Ann's wards and will develop this in other wards most notably Northumberland Park in the next quarter. Of the above 232 clients, around three quarters have made significant or better changes to their drinking behaviour.

Last Updated 25/02/08 16:20

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NRF Projects	Project Manager	Well-being Objectives					RAG Status					Finances			Project Objectives/Target 07/08	Year to date	Comments
		Achieve Economic Wb	Be Healthy	Positive Contribution	Be Independent	Stay Safe	Issues	Resources	Budget	Timescale	Overall Status	Total Budget 07/08	Spend Committed To Date	Budget Left to Spend			
Income Maximisation Strategy	David Hennings	✔					G	G	G	G	G	£30,000	£27,200	**£2,800**	The "final final" consultants' report was delivered on 31 May 2007. The report has already informed development work on the Income Maximisation Strategy; circulation of an initial first draft of the latter has been delayed, but will follow at a date to be decided following further consideration of the strategy's implementation at LBH Chief Executive's Management Board in late August 2007.	**Project Completed**	Urban Environment are now leading on this project, to deliver the*Economic Vitality and Prosperity Shared by All,* priority of the Sustainable Community Strategy through income maximisation. The approach is to: support residents into sustained employment where possible, improve take-up of in-work tax credits, and to improve benefit take-up and other support services for those who are not able to work. A position statement will be backed up by an action plan setting out 10 core projects to deliver income maximisation, built on existing work underway, for example, the Haringey Guarantee, and try to hit more than one objective of the Council, eg. improving advice services fits with the Excellent Services theme of Improving Customer Care, and driving up take up of Disability Living Allowance will reduce pressure on adult care package funding.
Libraries for Life	Diana Edmonds	✔	✔				G	G	G	G	G	£198,000	£145,204	**£52,796**	Reducing obesity and improving diet and nutrition - Dietary and nutritional advisory sessions = 300 people to have attended sessions	**890**	Stroud Green an event focusing specifically on encouraging healthy and fun eating for children was held on 9th August, attracting 24 attendees. The event involved information about the nutritional value of different fruits and vegetables, and provision of information o nutrition including quick and simple recipes for kids. We have recently engaged with Haringey PCT physical activity team who deliver the Watch It Programme from Marcus Garvey Library.
															Library Walker's programme = 40 people per week undertaking regular walks	**50 per week (avg)**	The Library Walkers programme continues to run weekly from five of our libraries, with trainer-led walks taking place on different days of the week. Numbers are increasing again as the wet weather recedes, and we are now averaging 9 people per session, per week. Planning a promotional walk around the borough in the coming months to give the programme a boost. Following the promotional walk which over 30 people attended, average numbers per week remained at a constant of 10 per session.
															Outreach programme to provide health information to 100 people by the mobile service per month by end of July	**24**	In conjunction with the Mobile Library Service, we are encouraging the provision of health information to those who are housebound or who may have difficulty accessing standard library facilities. Unfortunately, planning to expand this service has been put on hold due to lead officer away from work.
															Reducing the number of people who smoke, information and support sessions involving health-checks to 50 people.	**720**	These continue to be supported by monthly information and support sessions, involving health-checks and practical advice. 105 health checks have taken place from April - December 2007, these have been carried out in a range of libraries and mostly aimed at the older adult. Specifically they have been , biological lung age compared to chronological age , blood pressure checks , cardiovascular heart rate (where appropriate), lower back flexibility etc.
															Smoking cessation classes to 20 attendees per class	**25 per class (avg)**	We are continuing to run our smoking cessation classes, open to both Haringey Council staff and the general public, held within libraries in the Borough in partnership with Haringey NHS. An average of 25 people per class attended these sessions.
															Counselling advice to people with mild mental heath problems (3 sessions per week,10 people per session), help people with mental health issues gain employment (5 people per session, per week).	**31 per week**	Mental Health Suite operates from Wood Green Central Library, from which 2 trained counsellors provide advice to people with mild mental heath problems. The popularity of the service continues to increase, with each councillor now seeing an average of 15 people per session, per week. The programme was recently extended to Marcus Garvey and now attracts 10 people per session. Since PCT Mental Health Team has been delivering sessions via libraries, they have made contact with over 750 people from April to December 2007.
															Supporting people with alcohol and drug issues - Improve access and advice on alcohol and drug related issues (Monthly advisory sessions, 5 people per session, per week)	**11 per session (avg)**	

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		Achieve Economic Wb	Be Healthy	Positive Contribution	Be Independent	Stay Safe	Issues	Resources	Budget	Timescale	Overall Status	Total Budget 07/08	Spend Committed To Date	Budget Left to Spend			
Out and About: Befriending and Community Development	Ashraf Choudry		✔	✔	✔		G	G	G	G	G	£36,750	£29,102	**£7,648**	20 volunteers (240 for the year)	**239**	In October 2007, we celebrated the recruitment of our 100th active volunteer. In November 2007, we organised a 'Friends meet Befrienders' event. We took isolated older clients and their befriending volunteers to see a film at a cinema hall followed by lunch. In December 2007, hosted a volunteers festive get-together party which was well attended and very enjoyable. In January 2008, we hosted an induction evening for 18 new volunteers for placement in various projects across Age Concern Haringey.
															80 (960 for the year) older people befriended/home visits per month;	**781**	
															50 (600 for the year) telephone contacts per month.	**1219**	
Reaping the Benefits	Bernadette Riganti	✔					G	G	G	G	G	£98,000	£79,932	**£18,068**	400 people to be provided with detailed welfare benefits and/or debt advice and on going casework and support	**414**	Reaping The Benefits was launched in March 2007, following recruitment to our debt and welfare benefits coordinator posts. Regular weekly advice sessions are running in 6 locations in Noel Park, Northumberland Park and Bruce Grove. In addition over 4000 contacts already made through door to door leaflet drops, distribution through schools and attendance at community meetings. FINANCIAL OUTCOMES: The total money gains for clients to date is £190,867 (up £41,057 this month), which averages out at just over £10 per week gain per client - the LAA Well being target. In addition, residents are benefiting from more money in their pockets through renegotiatied debt repayment arrangement. TOTAL: 414 households provided with detailed advice and ongoing support since March 2007. These figures represent client numbers. Most clients require several repeat advice sessions. In addition, the project is assisting the client with several different types of enquiry (tax issues/benefit advice/debt).
Reducing smoking prevalence	Elisa Thompson		✔				G	G	A	G	G	£100,000	£31,400	**£68,600**	100% of employers of deprived and high-smoking prevalence communities identified and offered workplace-based smoking cessation support by March 2007	**On Target**	Stop Smoking Work Place Initiative, all businesses from the LA list have been contacted via either letter, e mail or in person regarding stop smoking treatments for thier employees. A comprehensive advertising and communications plan has been developed and will be implemented from beginning of November 2007 through to the end of March 2008. Resources for the 'protecting children from exposure to smoke in the home' project, have been printed, and a comprehensive distribution of these resources has taken place. All Children's centres have been visited. Additional work will take place over the coming months to promote the scheme in local schools. Leaflets will be provided to one large school in the area initially to gauge response
Salsa Club (Scorpion Salsa Group)	Natalia Blazina		✔				G	G	G	G	G	£9,200	£9,200	**£0**	Increase physical activity for at least 200 participants through 2-3 classes a week	**195**	Recently started working with the Haringey therapeutic centre in Wood Green who work with people with different mental problems. Project encourages them to get involved with the community and interact with others in fun, relaxing atmosphere. The most important questionnaires proof that 75% of participants are more aware of their health since taking part. 80% became confident to get involved in other activities available to them (art, yoga…). Fitness assessment in December to measure participants general health in order to compare with their general fitness from when first stared taking part in salsa classes. Feedback from the participants to help evaluate the project and make any necessary improvements in the future.

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		Achieve Economic Wb	Be Healthy	Positive Contribution	Be Independent	Stay Safe	Issues	Resources	Budget	Timescale	Overall Status	Total Budget 07/08	Spend Committed To Date	Budget Left to Spend			
Tackling Fuel Poverty	John Mathers	✔	✔				G	G	G	G	G	£55,000	£49,019	**£5,981**	1000 households to receive an energy efficiency survey.	**3000**	Out of 3000 surveys sent out 295 were returned and all indicated that residents were actively taking steps to reduce their carbon footprint. Between April 2006 and March 2007 it has been calculated that overall the borough has made a 3.6% improvement in energy efficiency.
															250 households living in properties losing the least amount of heat to receive advice and information.	**250**	Working together with Benefits and Local Taxation a list was obtained of all those residents in the borough likely to qualify for a Warm Front Grant. The list was then supplied to EAGA (administrators of the Warm Front Scheme in England) who sent out letters inviting residents to apply. EAGA generously agreed to include 8000 Housing Association tenants who, although not eligible for a Warm Front grant could apply to the 'here to HELP' scheme. The mailing resulted in over 1000 qualifying Warm Front applications being received in the first three weeks of October, making Haringey the top referring borough in London. Even prior to the mailing, as a result of our day to day promotional activities, Haringey was the top referring borough of all those which had not conducted a specific mailing
															250 households living in properties losing excessive amounts of heat to receive advice and information.	**250**	
															500 residents to receive heating and/or insulation measures via the Warm Front Scheme.	**500**	
															500 residents to receive heating and/or insulation measures.	**500**	
															500 energy efficient light bulbs to be given out at promotional events.	**500+**	A huge number of energy saving light bulbs, thermometer cards, water hippos and information booklets were given away at promotional events.
															250 residents to attend a promotional event.	**350+**	The first Energy Efficiency Roadshow of 2007 / 2008 was held at the Chestnuts Community Centre on 14th November 2007. Over 400 people attended and received advice and information in person from the various stall holders which included: The Metropolitan Police, Haringey Recycling Services, EAGA, Age Concern, The Energy Saving Trust and Homes for Haringey.
															100 households to receive a customer satisfaction survey.	**TBC**	Survey not yet ready to send out
															50 households to receive a benefit entitlement check.	**24**	Over 20 residents also received a detailed benefits entitlement check on the day and will be receiving follow up advice on the benefits that they were identified as being entitled to claim. Many more residents received general advice from the team.
															20 households without central heating to have a central heating system installed	**TBC**	Planned for Feb/March 08
The six8four Centre	Paul Knight	✔	✔				N	N	N	N	N	£78,823	£65,069	**£13,754**	250 referrals in a year. 90% participating in Physical Activity, 75% to undertake training/capacity building in preparation for college or employment.	**270**	Working in partnership with the NHS "Health in mind" walks with a qualified fitness instructor around the borough. Staff training in th e"Fit for life" council initiative to increase health awarness. Staff at the centre also training as "smoking cessation" instructors to help service users to give up smoking. In partnership with Street League there is an established mens and womens football team that train twice a week and play matches every month thus considerably increasing peoples physical activity. There is a qualified aeorobic instructor attending bi weekly to offer aerobics classes for women. There is a wel being group at the centre offering advice and information on diet, smoking, sexual awareness, exercise and fitness and guest speakers come to talk at these groups. there is a lifestyle group every week that focuses on exercise and health. There is a sounding out group that encourages service users to explore their mental distress.
															Increase household income to address fuel poverty in 100 households	**37**	There is a specialist housing officer who attends the centre every month to offer housing advice at a workshop at the centre. Service users at the centre are involved in groups and training activities and are paid incentive money for work carried out. 75% of service users who attend daily are in receipt of an extra £10 per week to carry out work or training (eg catering, cleaning and computing) via the centre. This helps build confidence and skills which enable people to return to paid or unpaid work

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		Achieve Economic Wb	Be Healthy	Positive Contribution	Be Independent	Stay Safe	Issues	Resources	Budget	Timescale	Overall Status	Total Budget 07/08	Spend Committed To Date	Budget Left to Spend			
Welfare to Work	Bill Slade	✔					G	G	G	G	G	£40,898	£40,898	**£0**	Deliver 40 sustainable jobs	**40+**	Across all provision we have 233 people engaged in various employment related programmes outside of statutory provision, most of which are mainstream. Currently we have 26 people on voluntary work programmes and 23 people supported in employment across provision. We are supporting the emergence of 3 social firms across the borough involving 25 people at present. We plan to link the emergence of social firms to mainstream efforts to tackle worklessness as a means of ensuring viability and extending the social interest base. We continue to influence the development of the day opportunities strategy in mental health and thereby increase the provision of relevant services. We have funded awareness training for local mainstream providers of employment related services,including mental health training to jobcentre Plus Specialist Incapacity Benefit Personal Advisers, as recommended in the ODPM document "Mental Health and Social Exclusion".
Total												**£1,311,633**	**£1,010,580**	**£301,457**			

Communities for Health Fund 07/08 (CfH) - Project as end of 31st January 2008

CfH Projects	Project Description	Project Manager	RAG Status					Finances			Project Objectives/Target 07/08	Year to date
			Issues	Resources	Budget	Timescale	Overall Status	Total Budget 07/08	Spend To Date	Budget Left to Spend		
Chlamydia Screening Media Campaign Exposure	A co-ordinated media campaign to promote and raise awareness of and to encourage the target group to take advantage of the Chlamydia Screening Programme (CSP). The media campaign will utilise a range of media to take the key messages to the target group. Funding for salaries, documentary & production costs, promotion & distribution, radio adverts, fliers and posters etc.	Aysha Tegally	G	G	G	G	G	£31,194	£24,774	**£6,420**	1 x 5 minute documentary-style film about Chlamydia and the CSP	**Completed**
											4 x 60- 90 second adverts, both the film and adverts will be uploaded to YouTube, MySpace and a specially created website, the film and advert can be downloaded to mobile phones	**2 adverts in final stages**
											A dedicated website to upload films and adverts to, the site will also link to the Enfield and Haringey CSP website	**Completed**
											A flier and poster campaign	**Completed**
											4 x 30-60 second radio adverts to be played on community radio stations	**1**
											1 x 8 page Under Exposure supplement in Exposure	**In progress**
Chlamydia Screening For Haringey Residents aged 15-24 years Ethiopian Community Centre - United Kingdom	The aim of the project is to increase the level of awareness of Chlamydia among young people and in particular BME males aged between 15 - 24 years to facilitate their engagement in the screening programme by taking a test. Other aims include the prevention of Sexually Transmitted Infections (STI) in young people through one to one, peer and small group discussions to initiate behavioural change in their sexual practice. Funding for salaries, training and development, travel expenses, publicity, monitoring and evaluation etc.	Alem Gebrehiwot	A	G	G	A	A	£33,500	£16,750	**£16,750**	Targets to be achieved will be to promote annual testing with these target groups through a range of community based outreach interventions, working towards reaching 4,800 young BME men who have been tested for Chlamydia in 2007/2008 in Haringey. This will be achieved through community outreach work which will involve networking with other service providers directly to inform them about the programme and seek their agreement for the engagement of their service users in the programme. It will also target local football teams, basket ball teams, athletic teams, fitness centres and other sport activities and other Community Based Organisations (CBOs).	**111**
Timebank Haringey Haringey Timebank	To develop a time bank initiative in LB Haringey. Groundwork will employ a time broker to develop a locally focused time bank for Haringey. The time broker will set up a steering group to help develop and manage the activities. The time bank will involve socially excluded groups, especially from deprived communities and take referrals from specialist mental health agencies. Funding for salaries, publicity materials, social events, travel costs, utilities, insurance, CRB check etc	Sandra Hoisz	G	G	G	G	G	£30,332	£16,001	**£14,331**	50 new people engaged in volunteering activity through time bank who will then benefit from help/support through time bank	**40**
Total	**Total budget available**	**£100,000**						**£95,026**	**£57,525**	**£37,501**		

Communities for Health Fund 07/08 (CfH) - Project as end of 31st January 2008

Comments/Updates
The Project officially launched first week of November. The project is well under way, the website has been completed and uploaded as has the myspace page. The documentary has been completed and is ready to be uploaded to the web. 2 of the filmed adverts are the final stages of editing and are due for completion at the end of this week. Work has started on the 2nd phase of filmed adverts. The first radio advert is completed and is being broadcast on community radio stations, the second advert is due for completion at the end of the month. Distribution will take place once they are recieved. Underexposure will be completed by the end of the month ready for distribution within the Feb issue of Exposure.
Progress of the programme is encouraging as links with different agencies, such as the Sixth Form College and community organisation has been established. From time to time, more young people are giving their urine to be sent for tests. ISSUES: The programme started late from the time expected for the following reasons, • Programme started late - started November 2007, 3 months and most time was spent on preparation • Screening kits were delayed • Identification of areas were not easy
• The steering group met in January. The following organisations are represented on the steering group: Havco, LBH Neighbourhood Management, Safer Neighbourhoods Team, Haringey Carers, Sustainable Haringey, a ward councillor, Somerford Grove Adventure Playground. • Working with the Vale resource centre providing volunteering opportunities for young people with mental and physical disabilities. • Working with social services to provide placements for social work students. • The Time Bank is committed to working with service providers who engage with people with a wide range of mental health issues. It is essential that we have the input of these providers at every stage of our planning process in order to ensure that we are meeting the needs of each client group. • One of the main areas we have identified at present where people need help is with respite care. Exchanges are expected to start in March.