Older People's Commissioner for Wales
Comisiynydd Pobl Hŷn Cymru

Safeguarding in Hospitals in Wales

Review of the Actions which Health Boards are taking to ensure that older people who are hospital in-patients are safeguarded from harm in line with the requirements of the Social Services and Wellbeing (Wales) Act 2014 Sections 7 and 10.

March 2018

The Older People's Commissioner for Wales

The Older People's Commissioner for Wales is an independent voice and champion for older people across Wales. The Commissioner and her team work to ensure that older people have a voice that is heard, that they have choice and control, that they don't feel isolated or discriminated against and that they receive the support and services that they need.

The Commissioner and her team work to ensure that Wales is a good place to grow older, not just for some but for everyone.

How to contact the Commissioner:

The Older People's Commissioner for Wales
Cambrian Buildings
Mount Stuart Square
Cardiff
CF10 5FL

Phone: 03442 640 670
Email: ask@olderpeoplewales.com
Website: www.olderpeoplewales.com
Twitter: @talkolderpeople

Accessible Formats

If you would like this publication in an alternative format and/or language, please contact us. All publications are also available to download and order in a variety of formats from our website.

Contents

Background

Ensuring that older people are safeguarded and protected has been a key focus of my work as Commissioner, and I have worked with professionals across our public services to grow their knowledge and understanding of safeguarding issues and how these can be addressed.

However, more still needs to be done across our public services to safeguard older people. Much of the assistance and support I provide to older people through my casework team relates to issues relating to safeguarding, something I highlighted in my Casebook, which was published in October 2017[1]:

- The most complex cases my team and I receive are adult safeguarding matters. Many older people who contact me are extremely distressed as a result of their experiences, particularly in cases where the harm could have been prevented. They often feel that their concerns have not been taken seriously and consistently tell me that they do not want anyone else to have a similar experience.
- The circumstances of every individual … are unique to them, but most experience significant distress, and are worried, anxious and disillusioned. Many of them have fought hard to have their concerns resolved, but often with little success.
- Public bodies are not good enough at learning from their mistakes or using people's voices and experience to underpin and drive continuous service improvement.
- Many cases where older people and their families have raised concerns about safeguarding cases are in relation to hospitals.

I have welcomed the aspiration of the Social Services and Wellbeing (Wales) Act 2014[2] to improve the safeguarding of adults at risk of abuse and neglect by placing safeguarding on a statutory footing and placing new duties on statutory agencies, and wanted to review the difference the Act is making to the safeguarding work of Health Boards.

I therefore wrote to Health Boards in June 2017, asking them to participate in a review to determine how effectively they are responding to their new duties relating to adult safeguarding arising from the Act, specifically the requirements under Sections 7 and 10.

Specifically, this work has focused on:

- Changes made by Health Boards to the composition and organisation of their safeguarding teams.

- Changes to safeguarding policies and procedures to reflect the new duties.
- Training of staff to ensure that they are aware of and equipped to fulfil their safeguarding responsibilities.
- The extent to which Health Boards have taken more ownership of Adult Safeguarding and work as full partners with other agencies.
- Any increase in the rates of identification and referral to Social Services of older people at risk who meet the criteria for safeguarding.
- The extent to which, and how, Health Boards are 'making enquiries' in the context of safeguarding as requested by Social Services Departments and are subsequently contributing to safeguarding case work (including how well alleged victims of abuse and neglect are being engaged in the safeguarding process and are enabled to access advocacy).
- Whether alleged victims of abuse and neglect are being treated as full and equal partners in the safeguarding process and are enabled to access advocacy.
- The arrangements Health Boards have for learning from individual cases, case reviews and Adult Practice Reviews and the extent to which this informs future practice (i.e. the extent to which there is a learning culture).
- The engagement of Health Boards in the recognition of and prevention of abuse and neglect, and their quality assurance arrangements.

All seven of the Health Boards in Wales, as well as the Velindre NHS Trust, participated and contributed very positively to this review. They are referred to collectively as 'Health Boards' in the report. The review focuses on the safeguarding of older people and it does not include other aspects of safeguarding with which Health Board safeguarding teams are also concerned (child safeguarding, violence against women, domestic abuse and sexual violence, hate crime, modern slavery, counter-terrorism and Deprivation of Liberty Safeguards).

The review methodology was straightforward: an analysis framework (Appendix 1) was developed, which was used to assess the responses provided by Health Boards to a questionnaire (Appendix 3) and follow-up interviews undertaken with safeguarding staff. Colleagues with detailed knowledge and experience from Social Services Departments and Public Health Wales were also consulted and their views informed this review report.

Summary of Findings

Health Boards engaged positively with this review and were able to identify a range of initiatives they have taken to address the requirements of the Social Services and Well-being (Wales) Act. They have generally responded constructively to the Act and the statutory duties it has introduced. Adult safeguarding, now within the ambit of new, generic Safeguarding Teams, has clearer leadership, is somewhat better resourced and increasingly embedded within Health Boards' core work. There are, however, significant factors that are weakening their approach.

The introduction of the Social Services and Well-being (Wales) Act by the Welsh Government was not supported by the timely provision of up-to-date and detailed national policies and procedures which Health Boards need to support its implementation. Whilst the Welsh Government has now commissioned the writing of national policies and procedures, it is understood that these are not due to be completed until December 2018, leaving those responsible for meeting the requirements of the Act without the necessary guidance. This has resulted in the perpetuation of a range of differing approaches by Health Boards to adult safeguarding, as well as variations in practice. Some Health Boards are continuing to use the out of date Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse, which were published in 2013, whilst others have produced their own versions or updates. Until adult safeguarding is underpinned by one Wales policy and a single set of procedures, the implementation of duties created by the Act by Health Boards is likely to remain patchy and inconsistent.

The introduction of a new Duty to Report by the Act requires engagement by Health Board staff at all levels. The distinctions between poor practice and abusive and neglectful practice are subtle and complex. Detailed guidance is therefore required to support staff to understand these distinctions in the context of the Act, but this guidance has not been issued. With respect to the new Duty to Report, there is considerable variation in the level of reporting of adult safeguarding concerns across Health Boards. Similarly, there is much variation in the activity levels of Health Boards in undertaking enquiries and investigations.

Training and on-going support is required for staff to underpin their practice. As a consequence of the lack of up to date guidance from the Welsh Government, trainers have generally been left to draw upon the out of date 2013 Wales Interim Guidance. The safeguarding training available for all Health Board staff (Levels 1 and 2) does not equip staff to address complexities in adult safeguarding such as distinguishing poor practice from abusive and neglectful practice in exercising their duty to report. The e-learning training approach also does not lend itself to explaining such complexity and is not multi-agency. The training for staff with specific responsibilities for adult safeguarding – Level 3 training, Investigator

training and Designated Lead Manager training – vary considerably in content and duration, and are generally weakened by the lack of a multi-agency approach.

Fundamental to the objectives of the Act is the opportunity for full engagement in the adult safeguarding process of patients and their families. One Health Board has recently begun to audit the effectiveness of the key person in the process of facilitating their engagement, the Designated Lead Manager. However, some Health Boards chose not to appoint Designated Lead Managers and to rely upon Social Services to undertake the role. They do not have arrangements to check on the effectiveness of the Social Services Designated Lead Managers in promoting the engagement of their patients and their families in adult safeguarding cases. Even where Health Boards are providing Designated Lead Managers, there was no conviction from some Health Boards – or from Social Services contributors to this review or the case workers of the Older People's Commissioner – that significant progress has been made in improving the engagement in the safeguarding process of patients and their families by Health Boards.

Part 10 of the Act identifies the importance of assessing and enabling people at risk to access advocacy. This duty in adult safeguarding falls to Social Services and, in practice, to the Designated Lead Manager. If the Social Services Department has delegated a case to the Health Board, a Health Board Designated Lead Manager (if there is one in place) must exercise this responsibility. No specific guidance has been issued by the Welsh Government to make this explicit and some Health Boards appear to be unaware of this duty. In addition, Health Boards are not recording referrals to Independent Professional Advocates and could identify very little activity. This means that some older people and their families who should be receiving the support of an Independent Professional Advocate are unlikely to be receiving this. The opportunity afforded by the Act to commission Independent Professional Advocacy jointly with Social Services Departments also does not seem to have been recognised by Health Boards.

As a consequence of the Act, the task of adult safeguarding data collection and reporting can no longer be left by Health Boards to Social Services Departments. Health Boards need to have information systems in place that are fit for purpose and enable them to learn from their adult safeguarding work, both from individual cases and preventative work. Whilst all Health Boards have introduced arrangements to monitor, learn from and share data, some of which are sophisticated, not all Health Boards are yet able to report routine activities such as levels of enquiries undertaken on behalf of Social Services Departments.

A consistent data collection approach is required regionally and nationally so that it becomes possible to track whether older people are becoming less at risk from abuse and neglect in hospital settings, and to ensure that cases are managed effectively, with the full involvement of the patient, their family and advocates as appropriate where abuse or neglect occurs. In order for initial and longer term

progress on the implementation of the Act to be tracked and analysed, it must become possible to benchmark progress in adult safeguarding across Health Boards in Wales.

Adult safeguarding will benefit from its recent inclusion in the safeguarding work of Public Health Wales and the supportive, developmental role that Public Health Wales has begun to play. The work planned by Public Health Wales to create a Safeguarding Quality Assurance and Improvement Tool will provide Health Boards with one data capture tool and one consistent Wales reporting framework, enabling essential benchmarking and the tracking of improvements. Public Health Wales also plans to facilitate the development of a competency-based training framework in safeguarding for use across Wales.

In summary, in spite of evident commitment, leadership and progress, adult safeguarding by Health Boards remains inconsistent across Wales. It lacks the essential underpinning of up-to-date Wales policies and procedures, a national competency-based training framework and a national data capture tool.

The Impact of the Social Services and Well-being (Wales) Act 2014

Changes made by Health Boards to the composition and organisation of their safeguarding teams

All Health Boards reported that they have restructured their safeguarding teams during the last few years. In some cases, the restructuring took place in advance of the Social Services and Well-being (Wales) Act. Cwm Taf University Health Board undertook a restructure in 2010 to combine children and adult safeguarding, and subsequently to meet the requirements of a new model of service, a Multi-Agency Safeguarding Hub (MASH). Some Health Boards have restructured as a direct response to the Act. The common features of the restructuring have been:

- Merging separate children and adult safeguarding teams into single entities – corporate safeguarding teams – which embrace all safeguarding functions.
- New Heads of Safeguarding posts.
- Most or all posts are now generic for children and adult safeguarding.
- Additional posts created, strengthening new generic safeguarding teams.
- Training has generally been provided for the specialist safeguarding staff who have moved from children and adult posts to generic posts.

One consequence of the Act and the restructuring reported by Health Boards has been an increase in the status of adult safeguarding. All Health Boards described the way in which safeguarding now has a higher profile within their Boards.

The level of resourcing and composition of the new teams vary considerably and do not appear to be a reflection of the very different sizes of populations served. One of the larger Health Boards has made only a modest increase to its adult safeguarding capacity and reported that it is seeking additional resources as the new adult safeguarding agenda has “grown like topsy” and “can seem overwhelming”.

Another common feature of the new adult safeguarding services described by Health Boards is a commitment to effective leadership and clear lines of accountability. Most of the Heads of Safeguarding appointed were formerly Heads of Children’s Safeguarding. However, whilst generally the Boards recognise the importance of having some specialist safeguarding team members who have a background in adult nursing and specialist knowledge of adult safeguarding, the

seniority of specialists in adult safeguarding within the generic safeguarding teams varies considerably.

One Health Board has created six new regional posts to manage its adult safeguarding and has recruited social workers and nurses to these posts. It is also recruiting a doctor to lead on adult safeguarding, but no other Health Boards reported plans to do so. This approach – in line with children's safeguarding, where doctors provide clinical leadership – is commended by Public Health Wales.

Prior to the Act, adult safeguarding was undertaken in Wales in accordance with the Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse, 2013[3] (hereafter referred to as the 2013 Interim Guidance); all of the HBs were signatories. The Interim Guidance set out a key role for Designated Lead Managers to manage cases. The lead agencies for adult safeguarding, Social Services Departments, all appointed Designated Lead Managers but not all Health Boards did so. It is important to note that the Act has not resulted in a change to these different arrangements – some but not all Health Boards continue to have Designated Lead Managers. Unhelpfully, the Act and its guidance[5] have not set out any expectations about Designated Lead Managers. Whether or not Health Boards provide Designated Lead Managers to oversee the management of adult safeguarding cases has implications for the way in which they can ensure that they are meeting the requirements of the Act.

In summary, Health Boards have accorded to the requirements of the Social Services and Well-being (Wales) Act in establishing generic safeguarding teams and affording adult safeguarding greater status. However, the new teams vary in size and composition and only one Health Board is planning to recruit a doctor to provide clinical leadership for adult safeguarding. Generally, Health Boards have recognised the importance of retaining or recruiting staff in their safeguarding teams who have backgrounds in work with adults and an understanding of the specific requirements of adult safeguarding, although some Health Boards have chosen to continue to rely upon Social Services Departments to provide Designated Lead Managers, which may be reducing their ability to ensure that they are meeting the expectations of the Act.

Changes to safeguarding policies and procedures to reflect the new duties

Agencies with safeguarding responsibilities under the Social Services and Well-being (Wales) Act need up to date guidance as the basis for training their staff and guiding their work. The Welsh Government has published a suite of general guidance on Section 7 of the Act[4] and in 2017 issued draft guidance – Handling Individual Cases to Protect Adults at Risk – for consultation, which states that there should be 'national protection procedures for practitioners which are accessible, easily understood and used by all relevant partners' (para 4). However, the Welsh Government did not issue procedures to support the implementation of the Act. Instead, it belatedly commissioned their production in 2017 (to be completed by December 2018), which meant that up-to-date guidance would not be available to support the initial implementation of the Act.

This lack of new national procedures has created a dilemma for Health Boards (and Social Services Departments). The most current Wales policies and procedures for adult Safeguarding are the 2013 Interim Guidance, interim because the Act was pending when they were issued. Whilst most Health Boards indicated that they are still working to the 2013 guidance, this is out of date is out of date and there is not yet anything to replace it with.

Some Health Boards have developed their own interim guidance, generally based on the 2013 guidance but with additions and revisions to reflect the Act (e.g. Betsi Cadwaladr University Health Board and Hywel Dda University Health Board), which demonstrates a commitment to meet the new requirements of the Act. All Health Boards suggested that they are eagerly awaiting the new guidance, although this is not due to be issued until December 2018 and, assuming that a final consultation will be required, the final guidance may not be available until 2019. However, consultation by the working group that is developing the new guidance has commenced and Health Boards and Public Health Wales are actively participating in regional consultation meetings.

In summary, it has been unhelpful for Health Boards that detailed procedures for adult safeguarding, compliant with the Social Services and Well-being (Wales) Act, have not been issued. Some Health Boards have committed staff resources to produce their own interim guidance and keep them up to date. It is recommended that these are shared at the NHS Wales Safeguarding Network and those without up-to-date guidance adapt one from another Health Board. However, the perpetuation of a fragmented approach to adult safeguarding seems to be the inevitable consequence of the lack of timely, detailed Welsh Government guidance.

Training of staff to ensure that they are aware of and equipped to fulfil their safeguarding responsibilities

The lack of up-to-date, national procedures for adult safeguarding is a complication for training providers. However, most Health Boards reported that they have provided some update training on the Social Services and Well-being (Wales) Act for their staff.

Generic safeguarding Level 1 and 2 training courses that use e-learning have been made available nationally to all Health Boards through Public Health Wales. Given the large numbers of staff employed by Health Boards, the use of e-learning for basic awareness training is understandable. However, the 2013 interim guidance sets out an expectation that, wherever possible, training should be multi-agency, to reinforce the message that adult safeguarding should be undertaken jointly by the key agencies. Furthermore, the Duty to Report in adult safeguarding needs to be understood by front-line staff and the complexities of distinguishing poor and neglectful and abusive practice cannot be dealt with effectively through short e-learning courses.

Level 3 adult safeguarding training is being provided within most Health Boards; in some Health Boards it is open to all clinical staff, whilst others provide it for nurses who are Band 6 or 7 and above. The content of the training described seems to be varied, as does the target audience. Generally, Level 3 training is not multi-agency but one Health Board has invited staff from the Social Services Department and Police.

Some Health Boards provide their own Adult Safeguarding Investigator training, usually as an add-on to their Root Cause Analysis and HR investigative training. Others send staff on Social Services Investigator training courses or arrange no Investigator training.

Whilst the Designated Lead Manager role is critical and unique to adult safeguarding, not all Health Boards have Designated Lead Managers. This creates a potential risk that child safeguarding procedures will be followed for older people and issues could be missed. It is important to note, however, that two Health Boards have commissioned their own Designated Lead Manager training and have invited participation from the local Social Services Department. Furthermore, most Health Boards arrange for their staff to participate on Social Services Designated Lead Manager training courses, the duration of which varies from three days to half a day

In summary, there appears to be little consistency across Wales in the approaches of Health Boards to training at levels above Level 2. It is understood that Public Health Wales is supporting the development of competency based training in safeguarding for use across Wales. This needs to accord with the requirements of

the new procedures once issued. Social Care Wales is also working on standards for safeguarding training and it is recommended that Public Health Wales and Social Care Wales work jointly to develop national competency based training which will be delivered on multi-agency courses.

The extent to which Health Boards have taken more ownership of Adult Safeguarding and work as full partners with other agencies

Historically, adult safeguarding has been the responsibility of Social Services Departments, the lead agencies with responsibility to manage adult safeguarding and accountability for the effectiveness of its management to the Welsh Government. As generally much larger organisations, but in this context junior partners, Health Boards did not have any statutory imperative to engage fully with adult safeguarding until the Social Services and Well-being (Wales) Act. Furthermore, there is no comfortable fit between Health Boards' clinical approach to concerns and incidents and what may be characterised as the Social Services Department adult safeguarding approach or the approach taken when the police are leading investigations. It also seems that it has not always been clear to Health Boards that adult safeguarding provides added value to their own clinical processes – such as using Serious Incident and Root Cause Analysis methodology – and that adult safeguarding issues can bring potentially uncomfortable external scrutiny.

The Social Services and Well-being (Wales) Act, which places statutory duties upon Health Boards with respect to adult safeguarding for the first time, has been challenging for the Boards. However, there is considerable evidence of ways in which Health Boards have increasingly taken ownership of adult safeguarding, including new leadership, additional posts, additional training, policy work, new data-capture and analysis systems, strategic plans and network meetings. Adult safeguarding being placed on a statutory footing seems to have had the intended effect of increasing its status within Health Boards; Public Health Wales has identified that steady progress is being made by Health Boards and that a leadership programme for succession planning needs to be part of its future agenda to ensure that development continues.

All Health Boards expressed a commitment to joint work with partner safeguarding agencies. Those which have signed up to a MASH or are in the process of doing so are particularly well placed to demonstrate this. Similarly, Health Boards report that they have become committed members of the new regional Safeguarding Boards established by the Act.

Health Boards generally seem to have embraced their new duty under the Act to report adult safeguarding issues to their Social Services Department partners (see Section 5 below). Most are able to report the extent to which they are undertaking enquiries on behalf of Social Services Departments. Some Health Boards noted the variation in the ways that Social Services Departments work, highlighting different levels of requesting enquiries and the way that cases are subsequently managed.. Also reported by Health Boards were the different cultures of the police

and Social Services Departments and frustratingly long time-scales, especially for police led cases.

As highlighted in Section 1 above, some Health Boards do not appoint any of their staff to undertake the role of Designated Lead Manager and therefore work closely with their Social Services Department partners on all cases involving hospital patients. Referral patterns suggest that handing over Health Board cases to Social Services Departments to manage does not seem to have impacted upon the willingness of these Health Boards to make referrals. Furthermore, it was reported that Health Boards continue to undertake joint investigations where complex cases have health care related elements.

Although, as reported in Section 3 above, much training of Health Board staff is not multi-agency, Health Boards were able to provide some examples of joint training courses, for investigators and for Designated Lead Managers. Multi-agency learning events are also being organised by Regional Safeguarding Boards.

The safeguarding work of Health Boards has become better supported and coordinated by the inclusion of adult safeguarding within the brief of the Wales Safeguarding NHS Network, supported by the Public Health Wales national safeguarding team. However, there is a potential risk that the NHS finds its own solutions to some of the challenges posed by adult safeguarding without doing so in the multi-agency context of the Regional Safeguarding Boards and the National Independent Safeguarding Board. An example of this is Health Boards developing their own interim policies and procedures independently of their local Social Services Departments. Health Boards expressed a commitment to the work of the Regional Boards, and some of the interim documentation such as the new interim referral forms are multi-agency. On the other hand, one Health Board highlighted that it now has three different Social Services Department referral forms to work with.

In summary, it would seem that Health Boards have increasingly embraced the adult safeguarding agenda in response to the Social Services and Well-being (Wales) Act and have not done so to the detriment of joint work with their partner agencies. However, there is a lack of national consistency in terms of approach.

Rates of identification and referral to Social Services of older people at risk who meet the criteria for safeguarding

Health Boards reported an overall increase in the number of referrals to Social Services since the Social Services and Well-being (Wales) Act was enacted. Most considered that the increase was probably a consequence of the Act, arising from factors such as an increase in staff awareness training and a cultural change in staff perception of adult safeguarding. However, not all Health Boards were convinced that the increase was necessarily correlated to the Act and one Health Board pointed to a steady rise in referrals which pre-dated the new duty to report. Some thought that the Act might "open the flood gates" for adult safeguarding cases and expressed relief that this has not happened.

The reported rates of referral of hospital in-patients by HBs varied considerably in 2016/17: four Health Boards reported less than 2 referrals per 10,000 population, two Health Boards made between 3 and 5 referrals per 10,000 and one Health Board made 14 referrals per 10,000. The Health Board with the highest rate, Betsi Cadwaladr University Health Board also reported an extensive level of adult safeguarding awareness training for all staff, a substantial increase in adult safeguarding resources, recruitment of social workers and nurses to their safeguarding posts, and changes in culture and perception of adult safeguarding.

A number of Health Boards identified as significant the fact that the Social Services and Well-being (Wales) Act has changed the working definition of harm from "significant harm" to "potential for harm" (i.e. if the person is at risk of harm) and considered that this change in the "threshold" for adult safeguarding may be giving rise to the increase in referral rates and the new duty to report. They identified that the available guidance on thresholds (2013 interim guidance) needs to be revised in the light of the Act. They now refer cases into adult safeguarding that might previously have been dealt with (only) as a "Significant Incident" within the Health Boards' internal procedures. Healthcare Inspectorate Wales established a working group that produced an NHS Adult Safeguarding Flowchart (known as the Decision Tree), but a number of Health Boards and Public Health Wales suggest that this is not suitable to assist Health Boards with the complex decision making around adult safeguarding thresholds.

National guidance on pressure ulcers[5] and an agreement to refer into adult safeguarding all grade 3 and grade 4 pressure ulcers was also cited by some Health Boards as causing a significant increase in their referral rates. Some Health Boards screen grade 3 and 4 ulcers to check if they were preventable and only refer those that might have been prevented. Others argue that the screening through a Root Cause Analysis, which can take weeks, inappropriately delays referrals to adult safeguarding and they refer all grade 3 and grade 4 pressure

ulcers. The variation in referral rates by Health Boards may partly be explained by such different working arrangements.

One Health Board reported the tension they have experienced in managing cases with respect to the duty to report included in the Social Services and Well-being (Wales) Actand the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015, which places greater emphasis on respecting capacitated victims' preferences. The dilemma of whether or not to refer into adult safeguarding is described as being significantly compounded by different and inconsistent responses to referrals from Social Services Departments.

In summary, the Social Services and Well-being (Wales) Act seems to have led to some increase in the reporting of adult safeguarding concerns to Social Services Departments, but there is a considerable variation in the rates of referring. This, in part, may relate to the need for new, national guidance on adult safeguarding thresholds. It may reflect different levels of engagement by Health Boards with their new duties. It is not possible to determine how effective Health Boards have become in identifying possible abuse and neglect and referring these cases into adult safeguarding, but the increase in referral rates suggests that Health Boards are seeking to comply with this new duty.

The extent to which, and how, Health Boards are 'making enquiries' in the context of safeguarding as requested by Social Services Departments and are subsequently contributing to safeguarding case work

The extent to which Health Boards have embraced the new duty to make enquiries seems varied. Whilst some Health Boards have provided their staff with written guidance about undertaking enquiries with clear time frames, describing what is required to "establish the facts", and have created new recording forms including chronologies (Betsi Cadwaladr University Health Board, Hywel Dda University Health Board and Aneurin Bevan University Health Board), no Health Boards reported specific training to help staff to undertake the task. In some Health Boards, the enquiries are undertaken by members of their headquarters safeguarding teams, whilst others rely upon Level 3 trained ward nurses.

Two Health Boards were unable to provide data about making enquiries on behalf of SSDs; one of these explaining that the data is not required for Welsh Government. It is of note that it was not considered information which the HB itself might need.

Of the HBs which reported their activity levels for the last two years, all showed a rise in the number of requests received. For 2016/17, Health Boards reported very different activity levels, corresponding to some extent to their contrasting reporting rates. There is a significant range in terms of the number of requests: two Health Boards reported 14 requests per 10,000 population and 11 per 10,000 respectively, and two others reported 0.9 and 0.7 per 10,000. Some Health Boards have very different request rates from the Social Services Departments within their catchment areas.

In summary, Health Boards undertake enquiries when asked by Social Services Departments and the number of requests in relation to hospital in-patients varies very considerably. As identified in section 5 above, so do referral rates by Health Boards. Some Health Boards have produced helpful written guidance and documentation for their staff and those which have not done so may benefit from adapting and using their material. Health Boards that have not provided training to support their staff in this new duty should make this available.

Are alleged victims of abuse and neglect are being treated as full and equal partners in the safeguarding process and are they then enabled to access advocacy?

Patients and their families

Effective partnership work with patients and their families is a cornerstone of the Social Services and Well-being (Wales) Act and of subsequent policy development around prudent health care. The procedural guidance currently available that is specific to adult safeguarding is the 2013 Interim Guidance. This specifies that the responsibility for ensuring that patients and their families are fully informed and involved as equal partners throughout the process lies with the Designated Lead Manager for each case.

The Health Boards that have appointed staff to the Designated Lead Manager role acknowledge that their Designated Lead Managers have this responsibility and one of the Health Boards that has commissioned its own Designated Lead Manager training confirmed that this part of the Designated Lead Manager role is emphasised on the training course (Powys Teaching Health Board). However, one Health Board described the pressures on their Designated Lead Managers, busy senior nurses for whom the Designated Lead Manager task is a difficult additional responsibility, and suggested that they are not confident that their Designated Lead Managers are consistent and effective in ensuring that patients and families are fully engaged throughout the adult safeguarding process. Their arrangements were described as neither formalised nor recorded.

One Health Board described how it has adopted a proactive approach to addressing patient and family involvement, whilst another has instigated audits of their engagement at each stage of the process to inform the work which is does in supporting and mentoring its Designated Lead Managers to increase their awareness and effectiveness in this key aspect of their work.

One of the Health Boards that does not have its own Designated Lead Managers suggested that it was the responsibility of the Social Services Department to manage this task. No evidence was provided that this Health Board has arrangements to assure itself that their patients and families have been fully involved by Social Services Department Designated Lead Managers.

In addition to the key role of the Designated Lead Manager, Health Boards identified some ways in which they are currently endeavouring to engage patients and their families in adult safeguarding. These include case conferences with patients and families to complete the adult safeguarding process. However, this was an expectation of the 2013 procedures.

One Health Board identified that their processes for "dealing with families, complaints and the clinical governance issues have not changed since the implementation of the Act". The implication seems to be that they have nothing to improve. However, not all Health Boards considered this to be the case. Whilst not specific to adult safeguarding, Health Boards identified a number of recently instigated initiatives which they see as a positive response to the expectations of the Act of endeavouring to engage patients and their families, such as What Matters to Me[6] conversations, Implementation of Putting Things Right[7], the PALS service[8], Introduction of the Friends and Family test, using The Alzheimer's Society tool 'This is me'[9], open visiting across all wards, patient Safety Champions on all in-patient wards, annual patient experience surveys and a liaison person appointed for all Serious Incidents (unlike adult safeguarding).

Colleagues from Social Services Departments reported that they were aware of improving practice by Health Boards, but cited recent cases where an older, inappropriate culture still operates during the adult safeguarding process and patients and their families were not involved. Examples were described where Health Boards remain unwilling to offer an apology to a patient or family even when an adult safeguarding investigation has confirmed that a Health Board has been at fault. This evidence reflects the current experience of the Older People's Commissioner's own case workers.

Advocacy

The Social Services and Well-being (Wales) Act sets out a requirement that patients who need safeguarding are offered an opportunity to receive the support of an advocate; Guidance on Section 10 of the Act[10] specifies:

'The local authority in partnership with the individual, **must** (emphasis added) consider and reach a conclusion on arrangements to appoint an independent professional advocate to support and represent an individual who is the subject of a safeguarding enquiry under section 126 of the Act. If a safeguarding enquiry needs to start urgently, it can begin before an advocate is appointed but one must be appointed as soon as possible. **All safeguarding agencies need to know how advocacy services can be accessed and what their role is** (emphasis added). It is critical in this particularly sensitive area that the individual is supported in what may feel a daunting process which may lead to some very difficult decisions. An individual who is thought to have been abused or neglected may be so demoralised, frightened, embarrassed or upset that independent advocacy provided under the Act to enable them to express their views, wishes and feelings and participate fully will be crucial.'

Health Boards reported that they were familiar with their responsibilities with respect to the appointment of IMCAs and IMHAs, but it was not evident that they have recognised the requirement under the Act for an Independent Professional

Advocate to be made available when a patient is subject to a safeguarding enquiry that they have been asked to undertake by a Social Services Department. If the Social Services Department is not involved with the patient, the health practitioner needs to be able to recognise if the patient would benefit from advocacy and they need to be able to refer the patient for Independent Professional Advocacy.

It would seem that Health Boards are not collecting any data on their referrals for Independent Professional Advocacy, which means they will not be able to assure themselves of their compliance with this aspect of the Act. The new responsibilities in respect of advocacy, and opportunities which include joint commissioning of advocacy services that have been created by the Act, do not as yet seem to have been embraced by some Health Boards. However, two Health Boards (Cardiff and Vale University Health Board and Aneurin Bevan University Health Board) were able to provide anecdotal information about referrals to Independent Professional Advocacy. Another Health Board (Powys Teaching Health Board) has added advocacy as a new field in its referral form so that those making referrals are prompted to consider advocacy and have available good legal advice for potential their use of advocacy. Another Health Board, (Hywel Dda University Health Board), has mandatory training which encompasses advocacy with regular updates, awareness days and global emails and tweets to keep staff up to date on the need to identify when advocacy is required.

In summary, there is evidence to suggest that some Health Boards have recognised the appropriateness of engaging patients and their families and are supporting them to access advocacy in the adult safeguarding process. However, it would seem that an inappropriate and defensive culture still prevails at times. Furthermore, some Health Boards do not seem to have recognised their role with respect to Independent Professional Advocates, none record referral rates to Independent Professional Advocates and none seem to have considered joint commissioning of advocacy services to reduce its current fragmentation.

The arrangement(s) which Health Boards have for learning from individual cases, case reviews and Adult Practice Reviews and the extent to which this informs future practice i.e. the extent to which there is a learning culture

Health Boards identified a range of ways in which they learn from individual cases so that they can manage generic risks, such as the creation of new Safeguarding Teams and the increase in the resourcing of adult safeguarding, which seem to have had a significant impact. The Teams are providing an overview of individual cases, concerning themselves not only with the effective conduct of each case but checking for any wider implications and/or generic risks. Two examples included recognising an inappropriate procedure and checking if this was a one-off event or more serious, and identifying inappropriate staff conduct and checking if this was a rogue staff member or a ward cultural issue.

As well as the regular Safeguarding Team case review meetings which Health Boards described, Betsi Cadwaladr University Health Board has standard operating procedures for responding if there have been two safeguarding incidents within six months, or three such incidents within 12 months.

Health Boards made reference in their responses to this review to a number of high profile safeguarding cases that have attracted national media attention and were at pains to illustrate how they have endeavoured to learn and act upon findings from these. The All Wales Safeguarding NHS Network, facilitated by Public Health Wales, has broadened its remit to encompass adult safeguarding in line with the Social Services and Well-being (Wales) Act. This was cited by Health Boards, together with the regular meetings of Heads of Safeguarding, as having a significant impact upon the way in which learning is now shared across Wales. It was also suggested that the National Independent Safeguarding Board will be playing a role in pulling together and disseminating the findings of Adult Practice Reviews.

As yet, there seem to have been few Adult Practice Reviews (APRs) completed or commenced concerning in-patient care of older people. This may change, given the new guidance and criteria on APRs provided by the Social Services and Well-being (Wales) Act. However, some Health Boards cited their frequent involvement in Domestic Homicide Reviews and highly relevant learning from these, which has been shared and cascaded.

Many examples were provided of the ways in which learning about adult safeguarding is now shared within Boards, with arrangements for cascaded learning and also with multi-disciplinary groups and events: Adult Safeguarding Team Panel meetings to review and learn from current cases together with invited experts, regional conferences, local Safeguarding networks using anonymised

recent cases, feedback systems for trainers on recent cases so that adult safeguarding training can be kept up to date, frequently updated intranet pages, quarterly adult safeguarding newsletters, global emails and use of patients' stories.

The engagement of Health Boards in the recognition of and prevention of abuse and neglect and their quality assurance arrangements

This review identified that all of Health Boards have the expected raft of policies, procedures and protocols for guiding their staff in situations where there may be particular risk of neglect or abuse, including prevention and management of incontinence and pressure damage, management of medication, prevention and management of falls, management of nutrition and hydration, dementia care, mental capacity awareness and restraint. Significant work has been undertaken in Wales to identify when pressure ulcers should be referred into adult safeguarding. The policies and procedures identify the point at which referral into adult safeguarding should be made.

Typically, however, the other policies and procedures listed above do not flag up the possibility that there may have been neglectful or wilful actions that should trigger adult safeguarding referrals and may even require criminal investigation. This is a significant omission that may reflect the way in which adult safeguarding has not yet become embedded as part of Health Boards' culture and practice.

Whilst adult safeguarding was not identified as a possible outcome within policies and procedures, some Health Boards provided lists of settings and activities which they had documented as presenting greatest risk, for example falls, failed discharges, pressure damage, agency nurses practices and ward staff attitudes.

Historically, Health Board seem to have noted that Social Services Departments have the lead for adult safeguarding, which has included gathering and reporting detailed adult safeguarding data to Welsh Government, and have not collected or used their own data. As reported above, this culture may not entirely have changed since some Health Boards are not recording their own activity levels around numbers of enquiries requested and undertaken or referrals to Independent Professional Advocates. However, generally there seems to have been a major shift in approach by the Health Boards to collecting and using their own data to learn, to understand and manage risk and to improve practice. Health Boards were able to provide examples of very recent initiatives which included features such as a strategic information hub with analysts and a dash-board system for obtaining, triangulating and continuously analysing a range of ward level data, ward level access to their own dashboard reports and generating ward action plans.

The crucial next step that is required is the work planned by Public Health Wales to create a Safeguarding Quality Assurance and Improvement Tool (replacing Health and Care Standard 2.7[11])will provide Health Boards with one data capture tool and with one consistent Wales reporting framework, enabling benchmarking

and the tracking of improvements.

There are also encouraging examples of the ways that Health Boards are increasingly "thinking safeguarding". Whilst these are insufficient in themselves to drive cultural change, the initiatives of some Health Boards provide helpful practice examples for other Boards and include:

- Standard operating procedures for responding to 2 and to 3 adult safeguarding incidents occurring in the same ward within 6 and 12 months
- Joint auditing of adult safeguarding cases with SSD partners
- Multi-agency Safeguarding Hub 'learning from cases' methodology
- The quarterly Adult Safeguarding group reviewing practice using trackers, looking for themes and patterns
- Patient Care Standards Learning and Improvement groups prompting thematic monitoring of patients' experiences
- Clinical audits and risk assessments on wards then targeted for extra support
- Senior nurses undertaking HIW type inspections of each other's wards
- Patient Watch: 1 :1 monitoring of patients identified as at risk
- Safe Care Rostering with 3 x per day checks
- Use of ward level general safeguarding plans
- Ward safety briefings on safeguarding
- Targeted staff supervision relating to safeguarding
- Multi-agency peer reviews on safeguarding work
- Increased use of internal announced and unannounced inspections, in one HB supported by nursing college tutors
- Patient Care Standards Groups using patient experience data
- All falls having a full Concerns Investigation and Root Cause Analysis
- Pharmacists undertaking targeted medication reviews, reviewing poly-pharmacy and use of anti-psychotics
- Operational Root Cause Analysis group reviewing patterns of pressure ulcer referrals
- A whistleblowing policy which starts with: "Our commitment to support those who raise a concern" (some other HB policies were comparatively weak on this)
- A whistleblowing pathway for student nurses
- An emphasis to staff on their duty of candour, and refresher training on their

professional codes of conduct

- Champions for Patient Safety, dementia care, falls and pressure damage prevention and care
- A ‘Board to Floor’ approach of ‘walk-abouts’ by a committed Board Chair and Deputy and by independent board members

In summary, whilst adult safeguarding needs to be more clearly embedded through the policy and procedures which govern staff actions, Health Boards were able to provide descriptions of ways in which they have become smarter, from obtaining, analysing and using data, to a range of examples of specific approaches and initiatives to promote continuous improvement. They describe bottom to top reporting structures, new(ish) structures with Heads of Safeguarding, and safeguarding teams providing leadership and committed Board ownership of adult safeguarding.

Appendix 1: Analysis Framework

KEY ISSUE 1: DEMONSTRATION OF COMMITMENT TO ADULT SAFEGUARDING BY LHBs

The areas for evaluation are:

- Appropriate **policies**, providing clarity about duties and responsibilities
- Commitment of **staff resources** which are adequate to fulfil duties and responsibilities
- Appropriate **procedures**, providing clarity about how adult safeguarding must be achieved in a multi-agency context
- Staff **training** which addresses the training needs of all LHB staff and Board members, given their respective duties, and which is regularly updated

Appropriate **policies**, providing clarity about duties and responsibilities **(Question 2)**

Key criteria:

- LHB has maintained commitment to the policies set out in the Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse (November 2010, updated 2013) to which all LHBs made a commitment **or**
- Equivalent written policies which demonstrate a commitment to the principles and values in the above document **and**
- Supplementary written acknowledgement of the requirements of the SS&WB Act

Commitment of staff **resources** which are adequate to fulfil duties and responsibilities **(Question 1)**

Key criteria:

- A lead manager specialising in and with overall responsibility for adult safeguarding
- Sufficient appropriately skilled, specialist staff to undertake adult safeguarding enquiries and contribute to adult safeguarding investigations as requested by SSDs in a timely fashion.

Appropriate procedures, providing clarity about how adult safeguarding must be achieved in a multi-agency context (Question 2)

Key criteria:

- LHB has maintained commitment to the procedures set out in the Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse (November 2010, updated 2013) to which all LHBs made a commitment **or**
- Equivalent written procedures which demonstrate a commitment to the multi-agency framework and processes which the above contains **and**
- Supplementary written acknowledgement of the requirements of the SS&WB Act

Staff **training** which addresses the training needs of all LHB staff, given their respective duties, and which is regularly updated **(Question 3)**

Key criteria:

- Awareness training provided for all LHB staff and Board members enabling them to recognise possible abuse and neglect and know how this must be reported, and which is updated regularly (eg 3 yearly)
- Specialist training provided and updated for LHB staff who have specific adult safeguarding responsibilities, including the lead manager, staff undertaking enquiries and joint investigations, ward managers, managers of specialisms e.g. OTs, and other staff requiring specific knowledge e.g. HR staff.

KEY ISSUE 2: EFFECTIVENESS OF LHBs IN THE IDENTIFICATION AND REPORTING OF POSSIBLE ABUSE AND NEGLECT IN HOSPITAL SETTINGS

The areas for evaluation are:

- New arrangements introduced by the LHB in response to their duties under the SS & WB Act
- Appropriate and consistent use of threshold criteria
- Recognition and reporting of all types of possible abuse and neglect
- Use of adult safeguarding procedures in addition to other procedures (e.g. complaints) when both can / should be triggered

Any **new arrangements** introduced by the LHB in response to their duties under the SS & WB **(Question 4)**

Key criteria:

- New LHB policy statement
- New LHB written procedure
- Changes in staff duties and responsibilities

Appropriate and consistent use of **threshold criteria (Question 4)**

Key criteria:

- LHB uses threshold guidance from the Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse or its own equivalent written criteria on thresholds
- These are referred to in all awareness training and are used consistently by staff
- Welsh Govt statistics show levels of referral by LHBs

Recognition and reporting of **all types** of possible abuse and neglect

Key criteria:

- Welsh Govt statistics may be available which show referral by LHBs by types of possible abuse and neglect

Use of adult safeguarding procedures **in addition** to other procedures (e.g. complaints) when both can and should be triggered

Key criteria:

- LHB has a system for checking whether or not complaints and clinical incidents should and do also trigger adult safeguarding referrals
- LHB has clarity in written policy and procedures identifying how parallel procedures should be followed (eg homicide reviews)

KEY ISSUE 3: EFFECTIVENESS OF LHBs IN MAKING ENQUIRIES CONCERNING POSSIBLE ABUSE AND NEGLECT IN HOSPITAL SETTINGS

The areas for evaluation are:

- The extent to which the LHB undertakes enquiries on behalf of SSDs
- How the LHB ensures the independence of staff who undertake enquiries

- Any changes in the level and nature of joint work with other agencies

The **extent** to which the LHB undertakes enquiries on behalf of SSDs (Question 5)

Key criterion:

- Activity patterns reported by the LHB may reflect the level of confidence of SSDs in the independence of LHB staff designated to make enquiries

How the LHB ensures the **independence** of staff who undertake enquiries (Questions 5 and 1)

Key criterion:

- The arrangements and capacity of the LHB to appoint from amongst its staff trained and independent investigators

Any changes in the level and nature of **joint work** with other agencies **(Question 5 and 1)**

Key criterion:

- Joint enquiries and investigations have been identified as the ideal in adult safeguarding. The extent to which this is reflected in current practice.

KEY ISSUE 4: EFFECTIVENESS OF LHBs IN COMMUNICATING WITH AND ENGAGING WITH VICTIMS OF ABUSE AND NEGLECT AND THEIR FAMILIES

The areas for evaluation are:

- Responses by the LHB to the recommendations in **Trusted to Care** such as guidance which the LHB has issued to staff in relation to listening to, recording and responding to concerns of victims and their families
- The extent to which **advocacy** services are recommended and are used by victims and families
- The extent to which possible abuse and neglect are **recognised and reported** by the LHB (key issue 2 above) "at least the abuse was acknowledged"
- The extent to which the LHB recognises the potential for **generic risks** from individual cases (key issue 5, below) "at least it may help others"

Responses by the LHB to the recommendations in **Trusted to Care** such as guidance which the LHB has issued to staff in relation to listening to, recording and responding to concerns of victims and their families **(Questions 7 and 8)**

Key criteria:

- Some LHBs should be able to provide their written responses to Trusted to Care
- LHBs may have issued guidance
- LHBs may have evidence of compliance

The extent to which **advocacy** services are recommended and are used by victims and families

Key criteria:

- Written policy and procedures encouraging use and promoting access to advocacy services
- Evidence of take-up

KEY ISSUE 5: EFFECTIVENESS OF LHBs IN RECOGNISING THE POTENTIAL FOR GENERIC RISKS FROM SINGLE CASES, AND USE OF RISK MANAGEMENT

The areas for evaluation are:

- **Risk management** policies and procedures (key issue 1 above)
- **Early recognition** of potential risks

Risk management policies and procedures (Question 1)

Key criterion:

LHB has written risk management P&Ps in key areas where neglect is known to occur in hospital settings, including:

- Dementia care
- Nutrition and hydration
- Falls prevention
- Management of medication
- Management of incontinence
- Prevention of pressure sores

Early recognition of potential risks

Key criterion:

- LHB has a system for flagging generic risks from single cases

KEY ISSUE 6: ABILITY OF LHBs TO LEARN FROM ADULT SAFEGUARDING, DISSEMINATE LEARNING AND CHANGE WARD CULTURES

The areas for evaluation are:

- Robust **quality assurance** and audit processes
- Commitment to encourage and support **whistle blowers**
- Learning from individual **cases** and from large scale investigations
- Learning from **Adult Practice Reviews**

Robust quality assurance and audit processes **(Question 6)**

Key criteria:

- QA and audit reports on adult safeguarding are regularly submitted to the Board of the LHB
- There is evidence of actions by the LHB in response to the reports

Commitment to encourage and support whistle blowers **(Question 8)**

Key criteria:

- There is a whistle blowing policy which encourages open reporting
- There is evidence that staff feel supported if they report concerns

Learning from individual **cases** and from large scale investigations **(Questions 6 & 8)**

Key criteria:

- There is evidence of sharing of learning such as staff seminars
- There are arrangements to update trainers about learning from cases and this informs their training

Learning from **Adult Practice Reviews (Question 8)**

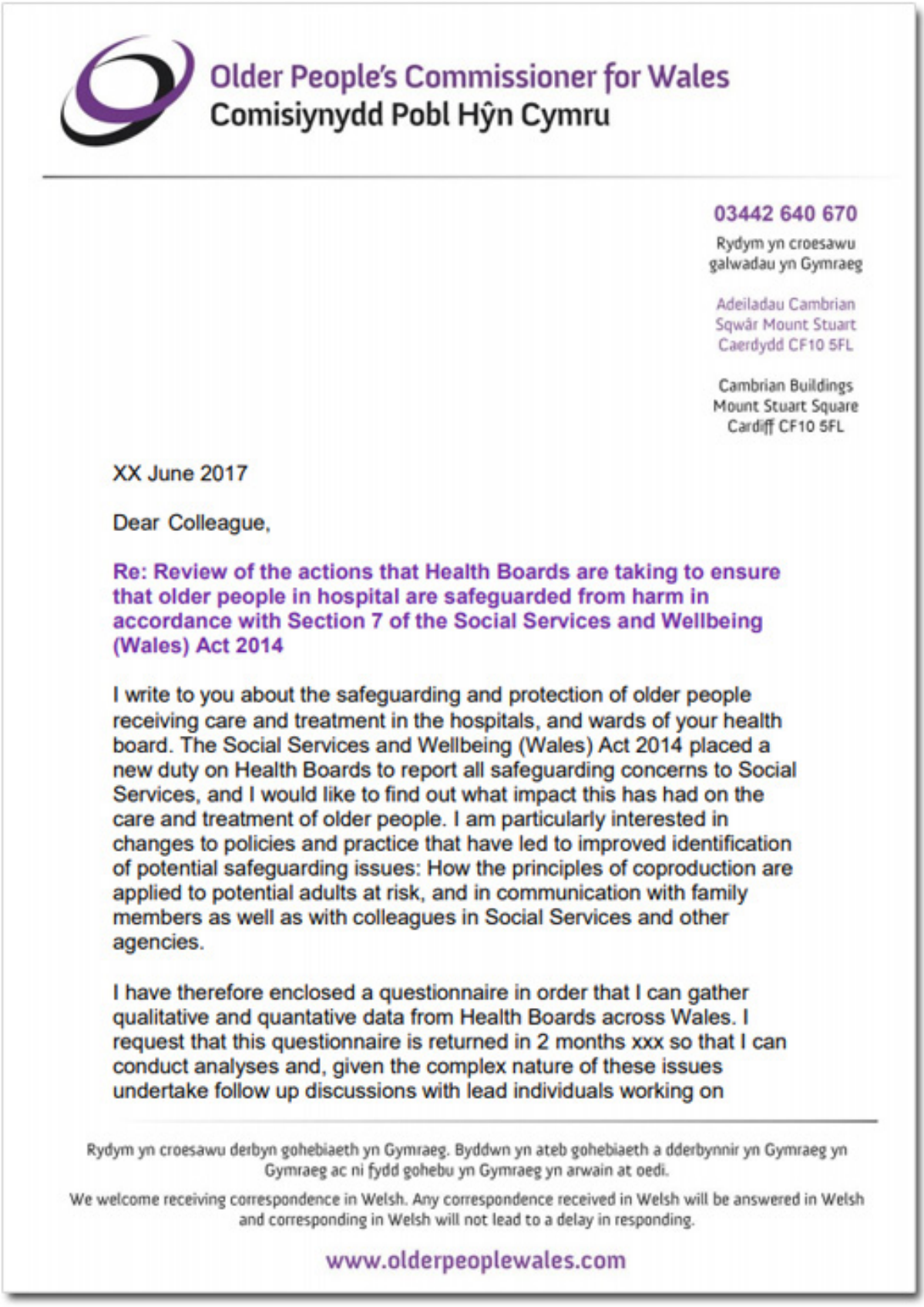
Key criteria:

- The LHB has commissioned APRs and there is evidence of actions

commensurate with Review recommendations

- APRs from other parts of Wales are disseminated and arrangements made to apply lessons learnt

Appendix 2: Letter circulated to Health Boards



Older People's Commissioner for Wales
Comisiynydd Pobl Hŷn Cymru

03442 640 670
Rydym yn croesawu galwadau yn Gymraeg

Adeiladau Cambrian
Sqwâr Mount Stuart
Caerdydd CF10 5FL

Cambrian Buildings
Mount Stuart Square
Cardiff CF10 5FL

XX June 2017

Dear Colleague,

Re: Review of the actions that Health Boards are taking to ensure that older people in hospital are safeguarded from harm in accordance with Section 7 of the Social Services and Wellbeing (Wales) Act 2014

I write to you about the safeguarding and protection of older people receiving care and treatment in the hospitals, and wards of your health board. The Social Services and Wellbeing (Wales) Act 2014 placed a new duty on Health Boards to report all safeguarding concerns to Social Services, and I would like to find out what impact this has had on the care and treatment of older people. I am particularly interested in changes to policies and practice that have led to improved identification of potential safeguarding issues: How the principles of coproduction are applied to potential adults at risk, and in communication with family members as well as with colleagues in Social Services and other agencies.

I have therefore enclosed a questionnaire in order that I can gather qualitative and quantative data from Health Boards across Wales. I request that this questionnaire is returned in 2 months xxx so that I can conduct analyses and, given the complex nature of these issues undertake follow up discussions with lead individuals working on

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

www.olderpeoplewales.com

safeguarding issues within the Board. I will then produce a final report, with recommendations for Health Boards, Welsh Government and HIW as well as evidence of good practice in Spring 2018.

The principles of the Social Services and Wellbeing (Wales) Act have the potential to make meaningful change in the lives of older people, the importance of retaining voice and control, (with the support of an independent advocate or family member) being actively involved in decisions about their lives and being supported to sustain, improve and maintain their wellbeing in Wales for as long as possible. I want to understand how and where the Health Boards have embedded these principles within their safeguarding responsibilities alongside existing legal responsibilities such as the Mental Capacity Act and Mental Health Act.

My aim is not only to share good practice across Wales, but also to drive change in collaborative working with older people, family members and existing statutory partners through exploring key actions that could have a positive impact on the lives of older people at risk identified in Health Boards across Wales.

From discussions with Health Boards across Wales I am aware that this is a shared agenda, and one where clear commitments have been made to ensure the protection, safeguarding and care of older patients are in place and subject to continual improvement.

Should you have any further questions about this review then please do not hesitate to contact my office.

Best wishes,

Sarah Rochira

Sarah Rochira
Older People's Commissioner for Wales

Appendix 3: Self-Evaluation Questionnaire for Health Boards

Older People's Commissioner for Wales
Comisiynydd Pobl Hŷn Cymru

What actions are Health Boards taking to ensure that older people in hospital are safeguarded from harm in accordance with Section 7 of the Social Services and Well-being (Wales) Act 2014?

Organisation	
Name and job title of officer accountable for adult safeguarding	
E-mail	
Telephone	
Date	
Signed	

Chief Executive Officer	**Chair**
Name:	Name:
Date:	Date:
Signed:	Signed:

Deadline for responses: 28th July 2017

Please email responses to: review.adolygiad@olderpeoplewales.com

May 2017 1

Additional Information (Optional)

Name and job title of other officer nominated to contribute to review	
E-mail	
Telephone	
Date	

Name and job title of other officer nominated to contribute to review	
E-mail	
Telephone	
Date	

Question 1

List the adult safeguarding roles in your Health Board (with a % of time allocated to adult safeguarding). Identify which posts have changed since 2014 (e.g. are they new posts or have additional adult safeguarding responsibilities been added).

Role	% Adult Safeguarding	Changes

Comment on any changes made or planned

(500 words)

Question 2

What policies, procedures and guidance are being used by Health Board staff specifically for their adult safeguarding work, including Adult Practice Reviews?

With respect to prevention of potential abuse and neglect, provide copies of the Board's risk management documentation for:

- Dementia care
- Nutrition and hydration
- Falls prevention
- Management of medication
- Management of incontinence
- Prevention of pressure sores

Provide copies or links to the documents.

Name of document	Type of document	Date introduced

Comment on any changes made and on any changes planned (500 words)

Question 3 What training courses has the Health Board provided or commissioned specifically on adult safeguarding since 2014, and for whom? (e.g. Awareness training; Designated Lead Manager training; Investigator/ Enquirer training; requirements of the Social Services and Well-being (Wales) Act 2014)		
Course name and target group(s)	Dates course run	Number of attendees

May 2017 5

Question 4

What has been the impact on the work of the Health Board of the new duty to report adults at risk to local authorities?

Is there a specific procedure in place for Health Board staff to follow that specifies arrangements 'to establish the facts' prior to reporting safeguarding concerns to local authorities?

Yes / No

If yes, attach a copy or reference where it is located in documents supplied for question 2.

Provide data on the total number of referrals made to Social Services Departments by the Health Board concerning adults at risk in hospital, where the abuse or neglect may have taken place within the hospital indicating whether or not the alleged perpetrators were Health Board employees, for the following years:

Year	Number of referrals	Alleged employee perpetrators
2013/14		
2014/15		
2015/16		

Comment on any identification of trends at ward or hospital level (500 words)
How does the Health Board ensure that concerns about adults at risk are referred to local authorities as adult safeguarding concerns even though other procedures may also have been triggered (e.g. clinical governance, complaints, HR investigations, Mental Health Homicide Investigations and Domestic Abuse Homicide Case Reviews)? (500 words)
Comment on the impact of the new duty to report on the work of the Health Board and any changes planned. (1000 words)

Question 5 Has the Board been requested by Local Authorities to "make enquiries on their behalf" concerning adults at risk who are hospital-in-patients, to inform adult safeguarding decisions and decide whether any actions should be taken?	
Provide the data for 2015/16 and 2016/17 for all of the enquiries which the Board undertook with respect to hospital in-patients as follows:	
Local authorities	Number of enquiries requested
xxxxx 2015/16 2016/17	
xxxxx 2015/16 2016/17	
xxxxx 2015/16 2016/17	
Have the new arrangements for Health Boards to make enquiries on behalf of local authorities changed the way in which the Health Board and local authorities are working together? Specify if joint work on cases increased or decreased? (1000 words)	

Question 6

What quality assurance and audit processes does the Health Board have in place to ensure that it is meeting its duty to inform local authorities about hospital in-patients who are adults at risk and to undertake enquiries when requested to do so?

Provide a copy of the quality assurance policy and audit procedures which cover adult safeguarding (if these are part of large document extract and provide the relevant sections only).

Provide copies of all of the quality assurance reports on adult safeguarding which have been submitted to the senior management team and to the Board for 2014/15, 2015/16 and 2016/17 (if these are parts of larger reports extract and provide the relevant adult safeguarding sections only).

What has been the key learning for the Board from the above quality assurance and audit reports?

Are written plans in place to effect any changes and improvements in current practice? If so, submit copies.

For example: Has the Board been able to identify specific trends that may/ or have indicated wider safeguarding issues about older people that the Health Board are exploring further or currently addressing?

(1000 words)

Question 7 Describe any changes in the work of the Health Board in safeguarding adults arising from the implementation of the Social Services and Well-being (Wales) Act 2014 in respect of: (Max 850 words per answer)
Working with adults at risk that are hospital in-patients, including ensuring the availability of independent advocacy to adults at risk as described under the Social Services And Well-Being (Wales) Act 2014 as well as current legislative duties under the Mental Capacity Act and Mental Health Act.

Working with the families of adults at risk utilising the principles of co-production and ensuring that when family members raise safeguarding concerns that these are acted upon in line with the Social Services And Well-Being (Wales) Act 2014.

- Responses to this answer must include reference to the procedures and quality assurance that the Health Board has put in place to ensure that the concerns of family members are heard, recorded and acted upon.
- Reference is also expected in regard to how on-going oral and written communication is and has been managed with family members since the Social Services And Well-Being (Wales) Act 2014 came into force in relation to case conferences, independent advocacy and when a decision has been reached that the issues raised are not safeguarding concerns but need to be treated as a formal complaint or clinical governance issue.

Working with local authorities
Working with the Police
Early identification and / or prevention of abuse and neglect

Question 8

Provide examples of good practice and of learning by the Health Board in the safeguarding of adults at risk since 2014.

These might include:

- Identification of adults at risk
- Independent Advocacy
- Learning from Adult Practice Reviews
- Managed change of an inappropriate ward culture
- Learning from large scale investigations
- Whistleblowing
- Individual work with victims and their families (anonymised)
- Joint work with other agencies
- Innovative staff training
- Disseminating learning

Indicate, for each example provided, if and how the learning has already been shared within and beyond the Health Board to drive cultural change and positive outcomes for older people across Wales.

(500 words each)

Appendix 4: Guidance under Part 7 Section 131(1) of the Social Services and Well-being (Wales) Act 2014

INTRODUCTION

2. The Social Services and Well-being (Wales) Act 2014 (the Act) has 11 parts. Part 7 of the Act relates to safeguarding. The Act 2014 is available at:

http://www.legislation.gov.uk/anaw/2014/4/enacted

3. Part 7 is intended to be read in the context of the Act as a whole.

4. Part 1 of the Act provides an overview and some key terms:

- section 2 provides the meaning of the term "well-being";
- section 3 defines for the purposes of the Act who is an "adult", a "child", a "carer" and who is to be regarded as "disabled";
- section 4 provides the meaning to be given to the term "care and support".

5. Part 2 of the Act sets out the overarching duties with which a person exercising functions under the Act **must** comply.

- section 5 provides that any person exercising functions under the Act **must** seek to promote the well-being of people who need care and support, and carers who need support;
- section 6 imposes overarching duties on those exercising functions under the Act in relation to persons who need or may need care and support, carers who need or may need support, or persons in respect of whom functions are exercisable under part 6 of the Act (looked after and accommodated children);
- section 7(1) provides that where a person is exercising functions under the Act in relation to an adult who has, or may have, a need for care and support or who is a carer who has, or may have, needs for support, that person **must** have due regard to the United Nations Principles for Older Persons adopted by the General Assembly of the United Nations on 16 December 1991;
- section 7(2) provides that where a person is exercising functions in relation to a child who has or may have needs for care and support or who is a carer who has, or may have, needs for support or who is a "looked after child", that

person must have due regard to Part 1 of the United Nations Conventions on the rights of the child adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989 ("the convention");

- section 15 requires that local authorities arrange preventative services, including in relation to contributing towards preventing people from suffering abuse or neglect.
- The code of practice in relation to Part 2 provides further guidance on preventative services.

6. The provision in Part 7:

- requires local authorities to investigate where they suspect that an adult with care and support needs is at risk of abuse or neglect (section 126);
- provides for adult protection and support orders to authorise entry to premises (if necessary by force) for the purpose of enabling an authorised officer to assess whether an adult is at risk of abuse or neglect and, if so, what if any action should be taken (section 127);
- requires local authorities and their relevant partners to report to the appropriate local authority where they suspect that people may be at risk of abuse or neglect (sections 128 and 130);
- disapplies section 47 of the National Assistance Act 1948 (which enables local authorities to apply for a court order to remove people in need of care and attention from their homes to hospitals and other places) (section 129);
- establishes a National Independent Safeguarding Board to provide support and advice to ensure the effectiveness of Safeguarding Boards (sections 132 and 133);
- provides for Safeguarding Boards for adults and children and for combining such boards (sections 134 to 141).

7. Part 7 provides the Welsh Ministers with various regulation making powers to underpin this part of the Act. The relevant regulations made in relation to Part 7 of the Act are:

- The Adult Protection and Support Orders (Authorised Officer) (Wales) Regulations 2015;
- the National Independent Safeguarding Board (Wales) (No.2) Regulations 2015; the

- Safeguarding Boards (General) (Wales) Regulations 2015; and the Safeguarding Boards
- (Functions and Procedures) (Wales) Regulations 2015.

These Regulations are reproduced at annex 1 of this Guidance.

8. This Guidance is given in relation to Part 7 of the Act. Except where stated otherwise it is statutory guidance.

9. The Guidance given in relation to sections 126-128 and section 130 of the Act is issued under section 131(1) of the Social Services and Well-being (Wales) Act 2014. Guidance issued under section 131 applies to the following persons:

(a) local authorities;

(b) Local Health Boards;

(c) NHS Trusts;

(d) the local policing body and the chief officer of police for a police area any part of which falls within the area of a local authority in Wales;

(e) the Secretary of State to the extent that the Secretary of State is discharging functions under sections 2 and 3 of the Offender Management Act 2007 in relation to Wales;

(f) any provider of probation services that is required by arrangements under section 3(2) of the Offender Management Act 2007 to act as a relevant partner of a Welsh local authority;

(g) the Welsh Ministers to the extent that they are discharging functions under Part 2 of the Learning and Skills Act 2000;

(h) such a person, or a person of such description, as regulations under section 162(4) may specify;

(i) a youth offending team for an area any part of which falls within the area of a local authority in Wales;

(j) a person who is an authorised officer for the purposes of section 127;

(k) a constable or other specified person accompanying an authorised officer in accordance with an adult protection and support order made under section 127;

10. The Guidance given to Safeguarding Board Partners in relation to sections 134-138 of the Act is issued under section 139(3) of the Social Services and

Well-being (Wales) Act 2014. Guidance issued under section 139 applies to the following persons:

(a) local authorities;

(b) the chief officer of police for a police area, any part of which falls within a Safeguarding Board area;

(c) Local Health Boards;

(d) NHS Trusts;

(e) the Secretary of State to the extent that the Secretary of State is discharging functions under sections 2 and 3 of the Offender Management Act 2007 in relation to Wales;

(f) any provider of probation services that is required by arrangements under section 3(2) of the Offender Management Act 2007 to act as a Safeguarding Board partner in relation to a Safeguarding Board area.

11. Statutory guidance does not have the full force of statute, but Safeguarding Board partners and other relevant individuals or organisations **must** have regard to it unless local circumstances indicate exceptional reasons justifying a variation.

12. This guidance also includes non-statutory guidance which is intended to provide information to assist Safeguarding Boards. Whilst it does not have the force of statutory guidance, it represents good practice.

13. This guidance takes into account:

a) The European Convention of Human Rights, particularly Articles 2,3,5 6 and 8;

b) The United Nations Principles for Older Persons; and

c) The United Nations Convention on the Rights of the Child.

14. Section 7 of the Act places duties on persons exercising functions under the Act to have due regard to the United Nations Principles for Older Persons and the United Nations Convention on the Rights of the Child.

15. When exercising functions under the Act in relation to adults who need care and support and carers who need support, local authorities **must** have due regard to the United Nations Principles for Older Persons as adopted by the General Assembly of the United Nations on 16th December 1991. The UN Principles for Older Persons can be seen at: http://www.un.org/documents/ga/res/46/a46r091.htm. There are 18 principles, grouped into 5 themes: independence, participation, self-fulfillment, care and dignity.

16. When exercising functions under the Act in relation to children who need care and support and child carers who need support and persons in respect of which functions are carried out under Part 6 (looked after and accommodated children), local authorities **must** have due regard to Part 1 of the United Nations Convention on the Rights of the Child. This duty does not apply to Welsh Ministers as they already have a duty to have due regard to the UNCRC in accordance with the Rights of Children and Young Persons (Wales) Measure 2011. Information about the UNCRC and the Children's Rights Scheme published by the Welsh Government can be accessed at:

http://wales.gov.uk/topics/childrenyoungpeople/rights/uncrc/?lang=en

Advocacy

17. An individual **must** feel that they are an equal partner in their relationship with professionals. It is open to any individual to invite someone of their choice to support them to participate fully and express their views wishes and feelings. This support can be provided by someone's friends, family or wider support network.

18. The dedicated code of practice on advocacy under Part 10 of the Act sets out the functions in relation to which a local authority, in partnership with the individual, **must** reach a judgement on how advocacy could support the determination and delivery of an individual's personal outcomes; together with the circumstances when a local authority **must** arrange an independent professional advocate. Professionals and individuals **must** ensure that judgements about the needs for advocacy are integral to the relevant duties under this statutory guidance.

Chapter One

GUIDANCE UNDER PART 7 SECTION 131(1) OF THE SOCIAL SERVICES AND WELLBEING (WALES) ACT 2014 (THE ACT)

19. This part of the guidance relates to the following:

- section 126, which defines "adult at risk", imposes a duty on local authorities to make, or cause to be made, such enquiries as it considers necessary to decide whether a person is an adult at risk; and to decide what action, if any, should be taken;
- section 127, which introduces adult protection and support orders (APSOs). Regulations made under section 127(9) restrict the persons or categories of persons who can act as an 'authorised officer';
- section 128, which introduces a statutory duty on 'relevant partners' as defined by section 162(4) to inform the local authority of an adult at risk in specified circumstances;

- section 130, which contains a duty on 'relevant partners' and the relevant youth offending team to inform a local authority of a child at risk in specified circumstances.

20. Relevant partners are defined by section 162(4) as:

(a) the local policing body and the chief officer of police for a police area any part of which falls within the area of the local authority;

(b) any other local authority with which the authority agrees that it would be appropriate to co-operate under this section;

(c) the Secretary of State to the extent that the Secretary of State is discharging functions under sections 2 and 3 of the Offender Management Act 2007 in relation to Wales;

(d) any provider of probation services that is required by arrangements under section 3(2) of the Offender Management Act 2007 to act as a relevant partner of the authority;

(e) a Local Health Board for an area any part of which falls within the area of the authority;

(f) an NHS Trust providing services in the area of the authority;

(g) the Welsh Ministers to the extent that they are discharging functions under Part 2 of the Learning and Skills Act 2000;

(h) such a person, or a person of such description, as regulations may specify[1].

Human rights

21. Practitioners will note the duty on public authorities under section 6 of the Human Rights Act 1998 not to act in a way that is incompatible with rights under the European Convention of Human Rights. Part 7 of the Social Services and Well-being (Wales) Act 2014 engages a number of rights included in the Convention:

Article 2 – right to have life protected;

Article 3 – right not to be subjected to inhuman or degrading treatment;

Article 5 – right to liberty and security;

Article 6 – right to a fair hearing;

1 No other persons are currently or proposed to be prescribed.

Article 8 – right to respect for private and family life, home, and correspondence.

Adults at risk

22. Section 126(1) defines an adult at risk.

An "adult at risk", for the purposes of this Part, is an adult who:-

(a) is experiencing or is at risk of abuse or neglect;

(b) has needs for care and support (whether or not the authority is meeting any of those needs); and

(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it."

23. This definition of an "adult at risk" applies in relation to the statutory powers and duties included in Part 7 of the Act and, for those purposes, replaces the definition of a "vulnerable adult" included within In Safe Hands (Welsh Assembly Government 2000).

24. Section 197(1) of the Act provides definitions of "abuse" and "neglect": "abuse" means physical, sexual, psychological, emotional or financial abuse (and includes abuse taking place in any setting, whether in a private dwelling, an institution or any other place), and "financial abuse" includes:-

- having money or other property stolen;
- being defrauded;
- being put under pressure in relation to money or other property;
- having money or other property misused.

"neglect" means a failure to meet a person's basic physical, emotional, social or psychological needs, which is likely to result in an impairment of the person's well-being (for example, an impairment of the person's health or, in the case of a child, an impairment of the child's development).

25. These definitions are familiar to practitioners. When assessing a situation regard should be had to the:

- frailty or vulnerability of the adult at risk;
- extent of abuse or neglect;
- length of time and frequency of the occurrence;
- impact on the individual;

- risk of repeated or escalating acts involving this or other adults at risk.

26. The following is a non-exhaustive list of examples for each of the categories of abuse and neglect:

- physical abuse - hitting, slapping, over or misuse of medication, undue restraint, or inappropriate sanctions;
- sexual abuse - rape and sexual assault or sexual acts to which the vulnerable adult has not or could not consent and/or was pressured into consenting;
- psychological abuse - threats of harm or abandonment, coercive control, humiliation, verbal or racial abuse, isolation or withdrawal from services or supportive networks (coercive control is an act or pattern of acts of assault, threats, humiliation, intimidation or other abuse that is used to harm, punish or frighten the victim);
- neglect - failure to access medical care or services, negligence in the face of risk taking, failure to give prescribed medication, failure to assist in personal hygiene or the provision of food, shelter, clothing; emotional neglect
- financial abuse in relation to people who may have needs for care and support. Possible indicators of this include:
    - unexpected change to their will.;
    - sudden sale or transfer of the home;
    - unusual activity in a bank account;
    - sudden inclusion of additional names on a bank account;
    - signature does not resemble the person's normal signature;
    - reluctance or anxiety by the person when discussing their financial affairs;
    - giving a substantial gift to a carer or other third party;
    - a sudden interest by a relative or other third party in the welfare of the person;
    - bills remaining unpaid;
    - complaints that personal property is missing;
    - a decline in personal appearance that may indicate that diet and personal requirements are being ignored;
    - deliberate isolation from friends and family giving another person total

control of their decision-making.

27. Any of the above forms of abuse could be motivated by the personal characteristics of the victim. This may make it a hate crime. These involve a criminal offence perceived by the victim or any other person, to be motivated by hostility or prejudice based on a person's actual or perceived disability, race, religion and belief, sexual orientation and transgender.

28. Practitioners **must** share information in accordance with the Data Protection Act 1998 and the common law duty of confidentiality. Both allow for the sharing of information and should not be automatically used as a reason for not doing so. In exceptional circumstances, personal information can be lawfully shared without consent where there is a legal requirement or the professional deems it to be in the public interest. One of the exceptional circumstances is in order to prevent abuse or serious harm to others.

29. Any personally identifiable information should be shared in accordance with the Wales Accord on the Sharing of Personal Information (WASPI). WASPI is a framework for all Welsh public, independent and third sector organisations. It underpins effective collaboration across organisations, helps overcome perceived barriers and enables staff to share information safely and legally. More information on WASPI can be found via the following link: http://www.waspi.org/. HM Government – Information Sharing: guidance for practitioners and managers highlights:-

3.41 It is not possible to give guidance to cover every circumstance in which sharing of confidential information without consent will be justified. You must make a judgement on the facts of the individual case. Where there is a clear risk of significant harm to a child or serious harm to an adult, the public interest test will almost certainly be satisfied (except as described in 3.43). There will be other cases where you will be justified in sharing limited confidential information in order to make decisions on sharing further information or taking action - the information shared should be necessary for the purpose and be proportionate.

3.42 There are some circumstances in which sharing confidential information without consent will normally be justified in the public interest. These are:

- when there is evidence or reasonable cause to believe that a child is suffering, or is at risk of suffering, significant harm; or
- when there is evidence or reasonable cause to believe that an adult is suffering, or is at risk of suffering, serious harm; or
- to prevent significant harm to a child or serious harm to an adult, including through the prevention, detection and prosecution of serious crime.

3.43 An exception to this would be where an adult with capacity to make

decisions (see paragraph 3.30 [of Information Sharing: guidance for practitioners and managers]) puts them self at risk but presents no risk of significant harm to children or serious harm to other adults. In this case it may not be justifiable to share information without consent. You should seek advice if you are unsure.

30. The definition of an "adult at risk" refers to the person experiencing abuse or neglect, or 'at risk' of doing so. The inclusion of "at risk" enables early intervention to protect an adult at risk. The decision to act does not require actual abuse or neglect to have taken place.

31. Abuse and neglect often constitute a criminal offence. The following is a non-exhaustive list of the types of criminal offences that may be committed:-

- offences against the person – assault, grievous bodily harm, actual bodily harm;
- sexual offences – rape, offences under the Sexual Offences Act 2003 (including sexual activity with a person with a mental disorder impeding choice);
- property offences – theft, fraud, criminal damage.

Duty of a local authority to make enquiries

32. Section 126 (2) sets out that:-

"If a local authority has reasonable cause to suspect that a person within its area (whether or not ordinarily resident there) is an adult at risk, it **must**:-

(a) make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken (whether under this Act or otherwise) and, if so, what and by whom; and

(b) decide whether any such action should be taken."

33. There are three separate components:

- a reasonable cause to suspect;
- the making of enquiries; and
- recording the outcome of the enquiries

34. The decision to initiate enquiries should be recorded to identify the point when the duty is engaged and for the purpose of ensuring enquiries are completed in a timely manner.

35. Enquiries should not be rushed, but timescales should be set. An enquiry should normally be completed within SEVEN working days of the referral. This will not prevent immediate action being taken when necessary to protect an adult at risk. If an enquiry takes longer than seven days, the reasons should be recorded. The local authority should monitor compliance with timescales and the reasons given for exceeding the seven working day timescale. Local authorities will share their data with the Safeguarding Adults Board for the purpose of the Board's responsibility to monitor improvement.

36. Enquiries embrace a range of activity and are not necessarily identical. The form that the enquiries take is at the local authority's discretion, based on the information and evidence that it has available and the circumstances of the individual case. Local authorities should record in writing why they consider the enquiries they are making, and the form that they are taking, to be necessary. Enquiries are information gathering in nature rather than a formal commissioned investigation as part of the Protection of Vulnerable Adult process. Enquiries may lead up to the strategy meeting stage; they are not the investigative part of the Protection of Vulnerable Adult process. Enquiries do not include formal investigations involving the police although that may be the outcome.

37. The local authority may make the enquiries itself, or may cause them to be made by another body. The duty to determine the nature of the enquiries required remains with the local authority even where another body is carrying out the enquiries. Relevant partners may be asked to undertake enquiries on behalf of the local authority, and are required to comply with such requests unless to do so is incompatible with their own duties. There may be circumstances where others could assist, for example a third sector organisation supporting the person.

38. In deciding on the nature of enquiries, the local authority should consider a number of factors:

- the right of the person thought to be an adult at risk to refuse to participate. Refusal to participate does not automatically relieve the local authority of its duty, but may reduce the effectiveness of the enquiry. The enduring nature of the duty will assist in enquiries where coercion or undue influence are present;
- the wishes and feelings of the adult at risk;
- the possibility that the adult thought to be at risk is not making decisions freely;
- whether there is a need to involve an advocate under any statutory or voluntary advocacy scheme;
- the need to carry out the enquiry sensitively and with the minimum distress to the person and others (for example, carers and family members);

- whether the perpetrator has any needs for care and support;
- whether the perpetrator is providing care or support for another adult at risk or child who may be at risk;
- the need for the local authority to work closely with and involve other agencies who may be able to assist with the enquiries and contribute to achieving the identified outcomes of the enquiries;
- the need to be aware of contaminating any evidence that might be used in any current or future criminal investigation;
- the importance of recognising that any enquiries are proportionate and compatible with the European Convention on Human Rights and sections 2, 5, 6, and 7 of the Social Services and Well-being (Wales) Act 2014.

39. In broad terms, enquiries should have three phases:

i. Screening: to check general factual accuracy of any referral.

ii. Initial evaluation: This will involve collecting, reviewing and collating information.

iii. Determination: Given the outcome of the screening/initial evaluation what, if anything, should be done? This may include initiating a single or multi agency investigation.

40. If it is determined at an early stage that the adult is not an adult at risk, the enquiries should end. However, the person may need to be signposted to other agencies or services if appropriate or may require an assessment under section 19 or 24 of the Act. Section 17 of the Act requires the local authority to provide Information, Advice and Assistance services to help all people access relevant, accurate and timely advice and assistance about ways to meet their care and support needs to achieve their personal well-being outcomes. The code of practice in relation to Part 2 sets out all the requirements on local authorities in relation to an Information Advice and Assistance service.

41. Relevant partners **must** share information as part of exercising this duty in line with paragraph 28 and 29 above, unless to do would be unlawful.

42. The following information should be included in a report of an enquiry which is likely to be held in the individual case record of the person suspected to be an adult at risk:

- identities of the individual who identified the concern and the individual who took the decision to initiate the enquiry;
- the identity and relevant details of the person who is the subject of the enquiries;

- a summary of the evidence on which the 'reasonable cause to suspect' was founded;
- the identity of the person or persons and, if relevant, the agency who conducted the enquiries;
- the chronology of the enquiries;
- a list of people who provided information during the enquiries;
- a list of people interviewed during the enquiries;
- a list of documentary evidence reviewed during the enquiries;
- a statement that those making the enquiries consider that the person is or is not an adult at risk. Where the finding is that the adult is not an adult at risk, a statement should be included stating why this conclusion was reached. Consideration should be given to identifying any possible future concerns that may arise and the need for Information, Advice and Assistance;
- a statement on whether an assessment under the Mental Capacity Act 2005 or the Mental Health Act 1983 has been, or should be carried out. If such an assessment has been carried out, the outcome should be included in the record;
- a statement of the findings of the enquiries that led to the conclusion (if that is the case) that the adult is an adult at risk;
- a record of any abuse that the person may be experiencing together with any supporting evidence including the following:
    - the nature of the abuse;
    - the length of time the person has been subjected to abuse;
    - the wishes and feelings of the adult at risk;
    - the frequency and intensity of the abuse;
    - the alleged perpetrator of the abuse and the relationship, if any, to the adult at risk;
    - the impact of the abuse on the adult at risk;
    - the presence of any other person in the household who may be an adult at risk or a child;
    - whether the alleged perpetrator provides care and support for the adult at risk or for any other known adult at risk. If so, the nature and intensity of such care;
    - the nature of any support and assistance the adult at risk may be

receiving from a carer or relative other than the alleged perpetrator;

- the identity of any other agencies or third sector organisations who are aware or involved in working with the adult at risk;
- such other matters as those making the enquiries consider should be included in the care and support plan.

43. Section 54 provides that a local authority **must** prepare and maintain a care and support plan for a person whose needs it is required to meet. This includes needs which the local authority considers it necessary to meet in order to protect an adult from abuse or neglect or a risk of abuse or neglect. The conclusions of any enquiries made when an adult is suspected to be an adult at risk **must** be recorded in this care and support plan. A care and support plan may incorporate any adult protection plan that is in place.

44. The conclusion should include whether the person is or is not an adult at risk and, what action should be taken and by whom.

45. Where an adult at risk has refused a care and support plan the findings of enquiries should be recorded in the individual case record. The record should be accessible. It is important that the record is not lost simply because it is not attached to the care and support plan.

Adult Protection and Support Orders (APSOs)

Purposes

46. The purposes of an APSO are:

(a) to enable the authorised officer and any other person accompanying the officer to speak in private with a person suspected of being an adult at risk

(b) to enable the authorised officer to ascertain whether that person is making decisions freely, and

(c) to enable the authorised officer properly to assess whether the person is an adult at risk and to make a decision as required by section 126(2) on what, if any, action should be taken.

47. Regulations set restrictions on persons or categories of persons who can act as an authorised officer. The restrictions set out in Regulation 3[2] provide for an officer of the local authority where the adult at risk resides to act as an authorised

2 Adult Protection and Support Orders (Authorised Officer) (Wales) Regulations 2015

officer. Where this is not practical the authorised officer should be an officer from

a local authority in the Safeguarding Board area and if this is not practical, the authorised officer must be an officer from a local authority in Wales.

The role of the authorised officer

48. An authorised officer is the person that may apply to a justice of the peace for an APSO. The authorised officer should prepare the information required to be included in the order as set out at section 127(5&6) of the Act. The role includes liaison with the local authority legal service to make the application to the court and possible attendance to give evidence about the need in particular cases. The APSO allows the authorised officer, a police constable and any other specified person accompanying the authorised officer to enter the premises to implement the order.

49. An authorised officer requires a complex set of skills and **must** undergo appropriate training (subject to exemption provided by Regulation 3(3)) and be required to keep their skills up to date. It is essential that the authorised officer has a degree of autonomy from his or her employer and is able to perform the functions independently of the day-to-day management of the particular case. Only in very exceptional circumstances should anybody other than a trained authorised officer be eligible to make an application for an APSO and the reasons should be recorded. Following this event the local authority will review the effectiveness of its arrangements in relation to APSOs.

50. The authorised officer should have:

- the ability to assess any risk to the person suspected of being an adult at risk prior to making the application and, if an APSO is made, once it has been executed. This
- may include the use of standardised risk assessment tools;
- a high level of understanding of the context of abuse, abusive situations and neglect;
- an ability to identify coercive control and its effects on adults at risk;
- effective communication skills and the ability to identify any special communication needs that the person suspected of being at risk may have and how their ability to communicate their wishes may be enhanced;
- an ability to be assertive and exercise control in difficult and challenging situations;
- an ability and willingness to challenge their own local authority and other agencies when necessary;
- an awareness of when an advocate is required and how to support the adult

to secure an advocate;

- the ability to prepare and present, with legal assistance, an APSO application clearly and confidently to a justice of the peace;
- an understanding of the legal framework within which APSOs operate including the implications of the Human Rights Act 1998, Equality Act 2010 and the need to respect diversity;
- a clear understanding of the provisions of the Mental Capacity Act 2005 in relation to assessments of capacity, best interests assessment and the role of the Independent Mental Capacity Advocate.

Definitions

51. For the purposes of this statutory guidance:

'A person is "living" in any premises if he or she resides there for a period of time either permanently or temporarily regardless of whether they have a legal or other interest in the premises.'

52. 'Premises' include

- domestic premises;
- a residential care home or a nursing home;
- a hospital;
- any other building, structure, mobile home or caravan in which the person is living.

An APSO cannot be used within premises of the secure estate; Prisons or Youth Detention Centres. (see 185(6) of the Act).

53. The assessment **must** be undertaken in private. Where the premises are large enough for the person to be interviewed without fear of being overheard, fewer problems are encountered. However, in a small flat or house the adult suspected of being at risk may fear speaking frankly. The use of police powers may be necessary in such circumstances for example to require any other occupier to leave the premises for the duration of the assessment interview.

54. The nature of the powers available to the police officer under statute include,

- section 17(1)(e) Police and Criminal Evidence Act 1984; and
- section 24 Police and Criminal Evidence Act 1984;
- common law powers such as arrest for breach of the peace;
- Domestic Violence Protection Order, Crime and Security Act 2010

55. The extent of the powers of a constable accompanying the authorised officer goes further than obtaining entry to the premises. The officer may use reasonable force 'in order to fulfil the purposes of an adult protection and support order'. This includes ensuring that it is possible to speak to the person in private.

Making decisions freely

56. The purpose of the APSO is to ensure that the adult suspected of being at risk is 'making decisions freely'. Practitioners should consider indicators of undue influence including:

- is the person allegedly exercising undue influence in a position of trust? For example, care home staff, carer or relative;
- in cases of financial abuse, has the person been offered independent advice?
- is the person allegedly exercising undue influence preventing the interview in private from taking place?
- is the particular decision the person is taking untypical and out of character based on what the authorised officers and those accompanying him or her know or have been told about them?

57. Those involved in the execution of the APSO should ensure that they do not exercise undue influence. They should be aware that the adult suspected of being at risk may feel intimidated by the use of statutory powers and the presence of a number of strangers in their home, including a police officer. An advocate may be necessary to ensure that the person is able to challenge the views of practitioners.

58. It is important to note that the powers of the police under section 127(7) of the Act include the power to assist in enabling the adult at risk to make decisions freely.

Planning

59. Good planning is essential for an APSO; in preparing an application and planning the entry and, importantly, the exit. The authorised officer **must** work in collaboration throughout the process to the extent necessary in the particular case and invite relevant agencies to be involved. Such planning will enable the authorised officer to ensure that other options have been explored, perhaps through adult safeguarding procedures, which may potentially avoid the need to apply for an APSO.

60. Authorised officers should liaise with the police, as they will be able to assist in identifying potential risk. It is also important to anticipate, as far as is possible, the nature and level of the police involvement in implementing the APSO in any particular case. For example, authorised officers should agree with the police

whether it is necessary for the police to be present in the premises, or whether it would be sufficient if they were outside or nearby.

61. Those involved in considering the need for an APSO **must** discuss the application to ensure that it will lead to a structured implementation, to ensure that the authorised officer has all the relevant information, and that there is adequate consideration of the next steps once the APSO has expired. Those involved may include relevant partners, other agencies or the third sector. However, the authorised officer is responsible for the application and ensuring execution if the order is obtained.

62. In preparing an application for an APSO regard should be had to the following:

- everyone involved **must** understand the purpose of an APSO and their role in theprocess;
- identifying what the police officer can do in the event of non-compliance by the occupier – in particular what common law or statutory powers may be used;
- there **must** be discussion and agreement on who will do what; this cannot be left until the execution of the APSO. Of course, the agreement may need revising depending upon what is discovered upon obtaining access to the person suspected of being at risk.

63. Very little may be known about the person suspected of being at risk. The lack of reliable information on the person, coupled with concerns about their safety, may be the reason why an APSO is sought. In preparing an application, an authorised officer should:

- be able to provide evidence that alternative and less interventionist approaches have been considered, but judged insufficient. Given the human rights implications, an APSO **must** be the last resort and the authorised officer **must** demonstrate that this is the case;
- consider drawing up a 'balance sheet' assessing the risks and benefits of applying/not applying for an order. This will assist the authorised officer when considering whether to make the application, and will be of assistance to justices of the peace if an application is made.

64. Authorised officers do not have to prove to the justice of the peace the need for the APSO beyond all reasonable doubt. The APSO may be sought because there is insufficient information about the adult suspected of being at risk. The responsibilities of the justice of the peace are found in section 127(4) of the Act.

65. The justice of the peace may make an APSO if satisfied that:

(a) The authorised officer has reasonable cause to suspect that the person is an adult at risk;

(b) It is necessary for the authorised officer to gain access to the person in order properly to assess whether the person is an adult at risk and to make a decision as required by section 126(2) on what, if any, action should be taken;

(c) Making an order is necessary to fulfil the purposes set out in subsection (2); and

(d) exercising the power of entry conferred will not result in the person being at greater risk of abuse or neglect.

66. The justice of the peace needs to be satisfied as to the matters outlined in the section above. The following points should be noted:

- 'reasonable cause to suspect';
- 'necessary'– this requires something more than merely desirable – it should be unavoidable or essential;
- 'exercising the power of entry….will not result in the person being at greater risk of abuse or neglect' - It will not be possible in all cases to demonstrate conclusively that this will be the case. The evidence presented **must** be sufficient to satisfy the justice of the peace.

67. The authorised officer will be responsible for developing an exit strategy to use once the APSO entry has taken place. There is concern that to exit without explaining to the adult suspected of being at risk and the occupier what happens next, may increase the level of risk. All those affected by the APSO must be made aware of the next steps.

68. An APSO may include a condition that notice is given to the occupier of the premises and to the person suspected of being an adult at risk. The preparation of the application should address a number of matters:

- what form of 'notice' is required? Does it have to be written notice, or will telephone notice suffice?
- how does the authorised officer assist the justice of the peace to assess whether notice would expose the adult suspected of being at risk to further harm or disrupt the assessment? What factors should be considered?
- consideration should be given to the need to inform other persons affected by the order – for example, where there is shared living within a domestic

setting such as supported accommodation.

69. More than one order in respect of the same person is not possible, unless circumstances have changed. Where it is unlikely that one visit will be sufficient, the application **must** include the period for which the order is to be in force to enable more than one visit to be possible under a single APSO. Where multiple visits are included in the order it **must** be clear that this is to complete the assessment and not as a means to monitor the situation.

70. The purpose of the APSO is to enable the authorised officer to assess whether the person is an adult at risk and to make a decision on what, if any, action should be taken. The assessment should include consideration of risk, health status, capacity, and the ability of the person to protect his or herself and the level of risk before and after the intervention. The person's own understanding of what is happening and what their wishes are and giving them appropriate weight, bearing in mind the possibility of undue influence should also be included in the assessment.

71. APSOs do not give a general power of entry; they are focussed on the specific purposes outlined in section 127 (2) of the Act. Once those purposes are satisfied, an APSO will lapse and should be recorded as having done so. The power cannot be continued unreasonably as some kind of deterrent. The use of an APSO is subject to the general principle of proportionality. This applies to the number of visits and the number of people who accompany the authorised officer.

72. Conditions may be attached as to the time at which the order may be exercised. Other than in a case that requires immediate action, careful consideration should be given to the time of entry, regardless of whether a condition is included. Timing of the entry may be particularly important where an assessment of mental capacity is required.

73. An APSO may include a condition providing for the authorised officer to be accompanied by another specified person. So far as is possible, such a person or persons are identified as part of the application. Examples of such a person are:

- the key worker (social worker or health care worker);
- domiciliary care worker;
- advocate (statutory or non-statutory);
- family member or close friend;
- best interest assessor;
- General Practitioner;
- Approved Mental Health Professional under the Mental Health Act 1983;
- Court of Protection Visitor, Office of the Public Guardian.

74. When seeking to include a condition as to who should accompany the authorised officer, the rationale for their inclusion should be provided in the application.

75. It may not be possible to identify ahead of time the nature of any expertise or assistance that may be required in assessing the person suspected of being at risk. Often this will only be ascertainable once an assessment visit has been completed. An appropriate person may accompany the authorised officer on a subsequent visit even though they were not included in a condition under section 127 (6) (b). The reasons for their involvement should be fully recorded.

76. The anticipated roles of those who accompany the authorised officer will vary. They include:

- ensuring that any interview with the person suspected of being at risk is conducted fairly;
- assisting communication;
- to provide expert knowledge and experience on specific matters (e.g. mental capacity);
- to advocate on behalf of the person;
- to share their existing knowledge of the person;
- building rapport with the person.

77. Authorised officers should consider whether an advocate should accompany them. Authorised officers should record why they consider an advocate should not be used. If an advocate is considered necessary, authorised officers need to be clear what type of advocate is required – Independent Mental Capacity Advocate (IMCA), Independent Mental Health Advocate (IMHA), Independent Domestic Violence Advocate (IDVA) or a non-statutory advocate.

78. Note that under section 127 (5)(b) of the Act an APSO **must** include a provision that a constable may accompany the authorised officer. This reflects that although it is included in the order, there is discretion whether or not a constable should accompany the authorised officer. Those involved in the preparation for the APSO should discuss, based on their knowledge of the situation, whether a constable should be present and record the reason for the decision.

79. The APSO should include details of measures to minimise the risk of a forced or highly confrontational entry to the premises. The role of the police will depend upon individual circumstances. In some situations, their presence will be in the background, whereas in others they will be central to obtaining access to the person. A key principle is that the police will use the minimum amount of force necessary and that the impact of their presence should contribute to and not

compromise achieving the purposes of the APSO.

80. As noted above, under section 127 (7) of the Act the constable's powers under an APSO extend beyond achieving entry and include ensuring that the purposes of an APSO are achieved. The constable may use his or her powers to arrest if they suspect that certain criminal offences have been committed.

81. Given the sensitive nature of this power it is essential that the authorised officer states clearly to the adult suspected of being at risk and any other occupier of the premises what is happening, and what will happen once the visit is completed. There should be agreement by those involved on the form of words to describe the purpose of the visit and the statutory power under which it is made. Similarly, the occupier of the premises is entitled to information about their right to complain.

Duty to report adults at risk

82. The Act imposes a new duty on relevant partners to report to a local authority if it is suspected that an adult is an adult at risk. The Act also imposes a duty on a local authority to report to another local authority if an adult suspected of being an adult at risk is living in or moving to another area. Section 128 provides as follows:

a) If a relevant partner of a local authority has reasonable cause to suspect that a person is an adult at risk and appears to be within the authority's area, it **must** inform the local authority of that fact.

b) If the person that the relevant partner has reasonable cause to suspect is an adult at risk appears to be within the area of a local authority other than one of which it is a relevant partner, it **must** inform that other local authority.

c) If a local authority has reasonable cause to suspect that a person within its area at any time is an adult at risk and is living or proposing to live in the area of another local authority (or a local authority in England), it **must** inform that other authority.

d) For the purpose of this section a relevant partner of a local authority is a person who is a relevant partner of the authority for the purposes of section 162 of the Act.

83. A key issue under this section (as with sections 126, 127, 128 and 130) is the meaning of 'reasonable cause to suspect'. The person upon whom the duty is imposed **must** have 'reasonable cause to suspect'. The following factors should be noted:

- it is unnecessary to establish on a balance of probabilities that a particular fact is established;

- it is a relatively low standard when compared with ‘reasonable cause to believe’;
- it is not the subjective opinion of the decision maker;
- reasonable suspicion exists when there is information which would satisfy an objective observer that the particular circumstances exist.

84. Practitioners should record in writing the evidence they rely on in making the decision, thus providing a structure for decision-making:

- a summary of information upon which the decision is based;
- why it is that the decision maker considers objectively that action is required;
- a short statement of the potential risks for the adult if nothing is done.

85. The duty to make enquiries in section 126 (2) of the Act applies whether or not the person is ordinarily resident with the local authority area.

86. There should be clearly identifiable points of contact within the local authority and the relevant partners to ensure that a relevant partner can report any concerns to the local authority in line with the duty set out at section 128 of the Act. There should be a single point of contact within each of the organisations.

87. Local authorities **must** ensure that the appropriate person(s) acts upon any concerns identified in a report under this section in a timely manner. Such reports will inform the decision whether to make enquiries under section 126(2).

88. Relevant partners should make staff in their organisations aware of this new duty to report and the requirement that they report any concerns they have to the appropriate officer who has responsibility for making decisions.

89. Local authorities should put in place parallel arrangements to enable reporting from across the local authority.

Social Services and Well-being (Wales) Act 2014 Part 10 Code of Practice (Advocacy)

Safeguarding

67. Local authorities **must** have regard to the need to help protect adults and children from abuse and neglect. Local authorities are experienced in supporting adults in deciding how much risk they are able to manage. Chapter 11 identifies circumstances where it is inappropriate sor someone to act as an advocate.

68. The local authority in partnership with the individual, **must** consider and reach a conclusion on arrangements to appoint an independent professional advocate to support and represent an individual who is the subject of a safeguarding enquiry under section 126 of the Act or section 47 of the Children Act 1989 or who is subject to arrangements for an adult protection and support order under section 127 of the Act. Where an independent professional advocate has already been arranged under this Act or under the Mental Capacity Act 2005 then, unless inappropriate, the same advocate may be used.

69. If a safeguarding enquiry needs to start urgently, it can begin before an advocate is appointed but one must be appointed as soon as possible. All safeguarding agencies need to know how advocacy services can be accessed and what their role is.

70. It is critical in this particularly sensitive area that the individual is supported in what may feel a daunting process which may lead to some very difficult decisions. An individual who is thought to have been abused or neglected may be so demoralised, frightened, embarrassed or upset that independent advocacy provided under the Act to enable them to express their views, wishes and feelings and participate fully will be crucial.

References

1. Older Peoples Commissioner for Wales (2017) Commissioner's Casebook <http://www.olderpeoplewales.com/Libraries/Publications_E/Casebook_2017_English.sflb.ashx>

2 Social Services and Well-being (Wales) Act 2014 <https://www.legislation.gov.uk/anaw/2014/4/contents>

3 Commissioned by the four Adult Protection Fora (2013) Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse <https://socialcare.wales/resources/wales-interim-policy-and-procedures-for-the-protection-of-vulnerable-adults-from-abuse>

4 Welsh Government Statutory guidance in relation to part 7 (Safeguarding) of the Social Services and Well-being (Wales) Act 2014 <http://dera.ioe.ac.uk/21361/7/141027pt7statguideen.pdf>

5 NHS Wales (2014) Pressure Ulcer Reporting and Investigation, All Wales Guidance <http://www.welshwoundnetwork.org/files/1914/1076/7223/Pressure_Ulcer_Reporting_Investigation_All_Wales_Guide__2014_-_Approved-1.pdf>

6 'What Matters to Me' conversations – mentioned throughout the code of practice in the Social Services and Well-being Wales Act 2014, Part 2 Code of Practice (General Functions) <http://gov.wales/docs/dhss/publications/151218part2en.pdf>

7 Welsh Government and NHS Wales (updated 2017) Putting Things Right Raising a concern about the NHS in Wales <http://www.wales.nhs.uk/sites3/home.cfm?orgid=932>

8 Every Health Board has its own Patient Advice and Liaison Service <http://www.search.wales.nhs.uk/search/?q=Patient+Advice+and+Liaison+Service+%28PALS%29+>

9 Alzheimer's Society (2017) This is me <https://www.alzheimers.org.uk/info/20033/publications_and_factsheets/680/this_is_me>

10 Social Services and Well-being (Wales) Act 2014, Section 10 <https://www.legislation.gov.uk/anaw/2014/4/contents>

11 NHS Wales (2015) Health and Care Standard 2.7, Safeguarding Children and Safeguarding Adults at Risk <http://www.wales.nhs.uk/governance-emanual/standard-2-7-safeguarding-children-and-s