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The Road

I've been on the road many a day
Since I got into trouble and lost my way
I walk sometimes til' my feet do blister
My mind envisions my brother and sister

It was my decision to leave I know
For I had nowhere else to go
I couldn't go home, it wouldn't be fair
The police searched for me everywhere

I didn't want my mother troubled
So I left on my own, on the double
They'll all get by, I had no doubt
They'd no need for me, a common lout

I walked the length of each road I met
Stopping only to seek a room to let
With money earned along the way
Helping farmers bailing hay

The days were long and arduous
I kept my head down and made no fuss
Painting fences, feeding hens
Before moving on, yet again

Years later, I lost my way
Once again, I was led astray
I was in trouble with the law
Just the same as I was before

I lost my mind
I was twenty-nine
I counted with a life of crime
And was sent to prison to serve my time

Fifteen years later I was free
And twice the man, a whole new me
I'd spent my time in prison well
Learnt many crafts from that dark, cold cell

The road still long but I was tough
I kept on going through the rough
I met a man who gave me a chance
Not like others who didn't give me a second glance

I worked hard in the knacker's yard
Glad to have a brand new start
Every day new treasures delivered
Another man's scrap by to me gold and silver

I crafted, created and made the metal shine
Fashioned figurines, then redesigned
All my pieces, works of art
Made with love from my heart

Then came those who appreciated
The intricate pieces I created
They offered me money for my creations
I was left with feelings of pure elation

Success was swift after that
Demand was high, I earned a lot
Soon, I was a wealthy man
Helping others because I can

I may have had a rocky start
But I could teach others my precious art
Many young men came to my gate
I taught them well.
THE ROAD WON'T BE THEIR FATE

By MG – Beechvalley Community Wellbeing Service, Dungannon

I have struggled with depression and anxiety for many years. I've had times when I've felt so afraid, lost, lonely and isolated, fearing I would never recover. It was during my darkest days – there were many and still are – that I found writing about my feelings in poetry form not only cleared my mind but also brought me a sense of achievement and pride with each poem or story that I completed. Putting my thoughts and emotions down on paper became a lifeline. Gradually, I found I began to enjoy writing – creating poems not only about my illness but a wide range of subjects, some serious, some even comedic. Putting my innermost thoughts, worries and fears onto paper gave me a little release, an outlet. I could express myself, explain to myself and teach myself. Almost every day, whether good or bad, I record my mood, my thoughts and my feelings and use them for some of my poetry. Some I am able to share, while others are raw and private.

Ministerial foreword

Mental ill health is one of the greatest challenges facing us today. It is accepted that the COVID-19 pandemic and restrictions to everyday life have had, and continue to have, a significant impact on our population's mental health. Too many people in our communities are struggling with mental ill health, which is impacting on their life choices and outcomes.

This is at a time when our mental health services are under considerable pressure. Such pressures were present before the pandemic and unfortunately they have only increased over the past 15 months. Inpatient services are under extreme pressure, with HSC Trusts consistently operating above 100% bed occupancy levels in adult mental health inpatient units and the regional child and adolescent unit at full capacity. Our community services are seeing increased referrals and a heightened acuity of patients. It is heart breaking to hear about people as young as 8 needing specialist mental health support with eating disorders and to hear stories about people desperately seeking help without being able to receive what they need.

Since becoming Health Minister, I have repeatedly noted that mental health is one of my top priorities. I am determined to reduce the number of people who struggle with mental ill health and I want to ensure that people get the help they need when they need it. I have therefore put a focus on mental health, which has included the publication of a Mental Health Action Plan and a COVID-19 Mental Health Response Plan on 19 May 2020 and the appointment of Northern Ireland's first ever Mental Health Champion. I have also approved the creation of a perinatal mental health service, established a £10m Mental Health Charities Support Fund and initiated change across mental health services.

I am very pleased to continue this drive for reform in mental health services by publishing this Mental Health Strategy. The Strategy sets out a clear direction of travel to support and promote good mental health, provide early intervention to prevent serious mental illness, provide the right response when a person needs specialist help and support, as well as outlining how the system will work to implement these changes.

To drive the strategic reform needed, the Strategy sets out 35 actions under three overarching themes. The first – promoting mental wellbeing, resilience and good mental health across society – is key to ensure that we reduce the stigma around mental health, provide early intervention and prevention and provide support across the lifespan and to those caring for people with mental ill health. The second – providing the right support at the right time – covers a range of service improvements, including improvements in child and adolescent mental health services, integration of old age psychiatry and psychology into mainstream mental health services, community mental health and in-patient services and specialist services.

This theme outlines a number of service improvements that ensure better access to support when it is needed, putting the person's needs at the centre. The third theme – new ways of working – sets out the changes that will support the improvements needed across the systems, including a single mental health service, data and outcomes, workforce planning and research.

Of the 35 actions, five stand out. Firstly, I am creating an action plan for promoting mental health through early intervention and prevention, with year-on-year actions covering a whole life approach from infancy to older age. The action plan will consider groups disproportionally affected by mental ill health who often struggle to access early intervention services and seek to reduce stigma associated with mental ill health. Secondly, I am creating an action to increase the funding for Child and Adolescent Mental Health Services to 10% of the funding for adult mental health services. This will allow improvement in the delivery of the stepped care model for children and young people to ensure services meet the needs of young people, their families and their support networks. Thirdly, I am changing how mental health services are structured, with a greater focus on the community. This means reorganising mental health services around the community, with an increased focus on our GPs. This will involve increasing the availability of therapy hubs to meet local needs and will ensure a focus is maintained on people and not on systems, thus improving outcomes for individuals. Fourthly, I am intending to improve the integration between the statutory and community and voluntary sectors by fully integrating the community and voluntary sector in mental health services delivery, including the development of a protocol to make maximum use of the sector's expertise. Finally, I am creating a single mental health service. I will do so, not by changing organisational boundaries to create new silos, but by creating enhanced regional co-operation and consistency. Implementing these five actions, together with the other 30 actions in the Strategy, will provide the reform our mental health services need.

The need for reform is particularly important in the current context of the COVID-19 pandemic. However, it is important to note that we are not starting from a zero base, and our mental health professionals already are providing high quality, dedicated services to enhance mental health outcomes. By providing the professionals with the right tools as outlined in this Strategy, we can further enhance the good work that they do.

I would like to thank all those who have been involved in drafting this Strategy. Your voice and continued support in the process has been highly valued and we could not have created what we have without your support! Going forward, we will continue working together to implement the vision of this Strategy. In so doing, we can collectively ensure that Northern Ireland has world-class and leading mental health services that deliver the best outcomes for everyone in society.

Robin Swann, MLA

Summary of actions

Theme 1 – Promoting mental wellbeing, resilience and good mental health across society

Promotion and prevention

ACTION 1. Increase public awareness of the distinction between mental wellbeing, mental ill health and mental illness, encouraging public understanding and acceptance of how life can impact upon mental wellbeing, and recognition of the signs of mental ill health and mental illness. Using public mental health education and effective awareness raising methods, increase public knowledge of the key measures that can be taken to look after mental wellbeing, increase understanding of mental ill health, and encourage public discourse and dialogue to reduce stigma.

ACTION 2. Create an action plan for promoting mental health through early intervention and prevention, with year on year actions covering a whole life approach, reaching from infancy to older age. The action plan must consider groups disproportionally affected by mental ill health who often struggle to access early intervention services and seek to reduce stigma associated with mental ill health.

Social determinants and mental health

ACTION 3. Increase the supports available to individuals, families and communities to address the social factors that impact on their mental health.

ACTION 4. Work with delivery partners across Government and the health and social care system, to maximise the availability and use of a range of social wellbeing supports, including social prescribing, to encourage and support mental wellbeing and positive mental health.

Early intervention

ACTION 5. Expand therapy hubs, which are resourced sustainably, to ensure Northern Ireland wide coverage. The hubs should be managed by primary care and link with the wider work on establishing mental health as an integral part of the primary care multi-disciplinary team.

Promoting positive mental health across a person's whole life

ACTION 6. Further promote positive social and emotional development throughout the period of infancy and childhood, including in pre-school and school settings, and provide new evidence-informed interventions and support for families and support to ensure that children and young people get the best start in life.

ACTION 7. Provide enhanced and accessible mental health services for those who need specialist mental health services, including children and young people with disabilities. The services must be able to cater for those with disabilities, including physical and sensory disabilities, ASD and intellectual disabilities. This must include help and support for parents and families.

ACTION 8. Create dedicated resource for student mental health across tertiary education through the existing delivery of mental health services.

ACTION 9. Embed unpaid carers, families and others in the help and support provided to people with mental ill health and also in the development of mental health policy and wider decision making.

Theme 2: Providing the right support at the right time

Child and adolescent mental health

ACTION 10. Increase the funding for CAMHS to 10% of adult mental health funding and improve the delivery of the stepped care model to ensure it meets the needs of young people, their families and their support networks.

ACTION 11. Ensure that the needs of infants are met in mental health services, and meet the needs of vulnerable children and young people when developing and improving CAMHS, putting in place a 'no wrong door' approach.

ACTION 12. Create clear and regionally consistent urgent, emergency and crisis services for children and young people that will work together with crisis services for adult mental health.

ACTION 13. Develop proposals for transitions between CAMHS and adult mental health services, engaging widely with all relevant stakeholders.

Mental health and older adults

ACTION 14. Ensure mental health services continue to meet the mental health needs of an ageing population and those with dementia through specialist Old Age services. These will be needs based rather than solely dependent on age. The quality of care provided must be equal to that provided to other service users and must be open to younger people when necessary.

Community mental health

ACTION 15. Refocus and reorganise primary and secondary care mental health services and support services around the community to ensure a person-centred approach, working with statutory and Community and Voluntary partners to create local pathways within a regional system, engaging all actors who can help and support a healthy local population.

ACTION 16. Create a recovery model, and further develop and embed the work of Recovery Colleges, to ensure that a recovery focus and approach is embedded across the entire mental health system.

ACTION 17. Fully integrate community and voluntary sector in mental health service delivery with a lifespan approach including the development of a protocol to make maximum use of the sector's expertise.

Medicines in mental health

ACTION 18. Fully integrate the Medicines Optimisation Quality Framework and the Northern Ireland Medicines Optimisation Model into mental health service delivery by integrating pharmacy teams into all care pathways that involve the use of medicines to ensure appropriate help and support is provided to people who are in receipt of medication for their mental ill health.

Psychological therapies

ACTION 19. Embed psychological services into mainstream mental health services and ensure psychological therapies are available across all steps of care.

Physical health and mental illness

ACTION 20. Develop an agreed framework between mental health services and primary care services for the physical health monitoring of people with a severe and enduring mental illness, as well as other people with mental disorders.

ACTION 21. Ensure that all mental health patients are offered and encouraged to take up screening for physical health issues. Provide help and support across all mental health services to encourage positive physical health and healthy living.

ACTION 22. Create effective pathways from physical healthcare into mental health services to ensure those with a physical illness that causes mental ill health can receive the care and treatment they need.

Severe and enduring mental ill health

ACTION 23. Provide people with severe and enduring mental ill health the right care and treatment at the right time. They, together with their support networks, are to be included in the decision making around their care and in the development of services and new ways of working.

In-patient mental health services

ACTION 24. Continue the capital works programme to ensure an up to date in-patient infrastructure. Consider alternative options to hospital detentions in line with legislative changes to ensure the best outcomes for patients and that those who need in-patient care can receive the best care available.

ACTION 25. Create a regional structure for a mental health rehabilitation service, including specialist community teams and appropriate facilities for long-term care.

ACTION 26. Develop regional low secure in-patient care for the patients who need it.

Crisis services

ACTION 27. Create a Regional Mental Health Crisis Service that is fully integrated in mental health services and which will provide help and support for persons in mental health or suicidal crisis.

Co-current mental health issues and substance use (dual diagnosis)

ACTION 28. Create a managed care network with experts in dual diagnosis, supporting and building capacity in both mental health and substance use services, to ensure that these services meet the full needs of those with co-occurring issues.

Specialist interventions

ACTION 29. Ensure there are specialist interventions available to those who need it. In particular:

a. Continue the rollout of specialist perinatal mental health services.

b. Ensure access to evidence based treatments and interventions for people presenting with a first episode psychosis and develop a regional psychosis network.

c. Enhance the provision of personality disorder services regionally through the formation of a Personality Disorder Managed Care Network.

d. Enhance the regional eating disorder service.

e. Further develop specialist interventions with a lifespan approach to ensure that those who require specialist interventions will receive them when needed.

Theme 3: New ways of working

Digital mental health

ACTION 30. Develop and implement a comprehensive digital mental health model that provides digital delivery of mental health services at all steps of care.

A regional mental health service

ACTION 31. Develop a regional mental health service, operating across the five HSC Trusts, with regional professional leadership that is responsible for consistency in service delivery and development.

Workforce for the future

ACTION 32. Undertake a comprehensive workforce review considering existing workforce need, training and development of new workforce, such as allied health professions, therapists and physician associates.

ACTION 33. Create a peer support and advocacy model across mental health services.

Data and outcomes

ACTION 34. Develop a regional Outcomes Framework in collaboration with service users and professionals, to underpin and drive service development and delivery.

Innovation and research

ACTION 35. Create a centre of excellence for mental health research.

The current state of mental health in Northern Ireland

Mental health problems

1. Northern Ireland has the highest prevalence of mental health problems in the UK, with a 25% higher overall prevalence of mental health problems than England.

2. Mental health is shaped by the wide-ranging characteristics (including inequalities) of the social, economic and physical environments in which people live. People on low incomes have higher rates of mental health conditions, particularly severe and enduring problems, than high-income groups.[1] People with mental ill health have a higher risk of economic hardship.

3. The legacy of the Troubles is also recognised as having a significant impact on mental health in Northern Ireland. In 2008, 39% of the population in Northern Ireland reported experiencing a traumatic event relating to the Troubles. Deprivation and high rates of mental and physical illness co-occur in the areas most impacted by the violence.[2] It is important to recognise and address the specific context of this trauma on people in Northern Ireland. The impact of the violence, fear, bereavement, political unrest and the associated economic hardship has had a significant and long term effect on our population's collective wellbeing. The trauma can be seen across generations, and continues to impact on both individuals and communities today.

39% OF THE POPULATION IN NORTHERN IRELAND HAS REPORTED EXPERIENCING A TRAUMATIC EVENT RELATING TO THE TROUBLES

1 Boardman et al, 2010, *Social exclusion and mental health - How people with mental health problems are disadvantaged: An overview.*
2 Ulster University, 2019, *Review of Mental Health Policies in Northern Ireland: Making Parity a Reality.*

4. According to the Youth Wellbeing Child and Adolescent Prevalence Study, among children and young people, one in ten (11.9%) experienced emotional problems, with significantly higher rates in deprived areas. One in six have a pattern of eating disorder, and almost one in ten of 11-19 year olds reported self-injurious behaviours. The prevalence study found that anxiety and depression is 25% more common in children and young people in Northern Ireland compared to other parts of the UK.[3]

1 IN 10 CHILDREN AND YOUNG PERSONS EXPERIENCED EMOTIONAL PROBLEMS AND 1 IN 6 HAVE A PATTERN OF EATING DISORDER

5. The advent of the COVID-19 pandemic has also significantly impacted mental health in Northern Ireland. Lockdown, shielding and social distancing, the closure of schools, working from home, increased deaths, a reduction in face-to-face services, as well as the restrictions on funeral rites have all had an impact on the emotional wellbeing of many, including those with existing mental health conditions. In addition, evidence has shown increased levels of acuity presenting to acute mental health services. It is highly likely that we will see increased levels of need for a number of years due to the ongoing impact of the pandemic on our society's mental health.

6. Loneliness affects all ages and all backgrounds. 1 in 5 people in Northern Ireland report feeling lonely always or often, which represents 380,000 people. Recent surveys conducted by NISRA show that loneliness is higher in urban areas at 40% compared to 33% in rural areas. The COVID-19 pandemic has exacerbated this issue due to the restrictions to everyday life.

1 IN 5 PEOPLE IN NORTHERN IRELAND REPORT FEELING LONELY

7. The mental health impact of these restrictions on everyday life has been widely documented and discussed. The older and frailer tend to experience social isolation and loneliness for longer periods of time and may not have resources to keep in touch with anyone. While loneliness is not a mental health problem in itself, it can contribute to mental health difficulties; likewise, mental health difficulties can cause loneliness.

3 Bunting et al, 2020, *Youth Wellbeing Child and Adolescent Prevalence Study.*

8. Loneliness is both a cause and contributor to depression and can lead to increased mortality. People who are lonely are more likely to develop mental ill health than those with strong social connections. We also know that loneliness is associated with an increased risk of dementia. For children, loneliness can exacerbate mental ill health, affecting their development, education and long term outcomes.

Strategic context

9. There has been a transformation in mental health services over the last 20 years. The Bamford Review was established by the Minister of Health, Social Services and Public Safety in October 2002. The Review provided a forward plan for mental health and learning disability policy and services and also focused on the existing provisions of the Mental Health (Northern Ireland) Order 1986, and directed that in future, particular account be taken of issues relating to incapacity, human rights, discrimination and equality of opportunity.

10. The Bamford Review led to important improvements in care for people with mental health problems, including a significant reduction in long stays in mental health hospitals – meaning more people living well in our communities. We have also made significant improvements in the involvement of people with lived experience in the commissioning and delivery of services. The establishment of Recovery Colleges has embedded a recovery-oriented practice in mental health services and ensured a greater number of peer support workers.

11. The You in Mind – Regional Mental Health Care Pathway launched in 2014 provides a care pathway for people who require mental health care and support. The pathway recognises that all treatment and care needs to be highly personalised and recovery orientated. The Working Together: A Pathway for Children and Young People through CAMHS launched in 2018 and provides a similar pathway for children and young people who require mental health care and support.

12. Other recent reviews, including Lord Crisp's report on acute psychiatric care and the Bengoa review Systems not Structures, have driven further improvement and additional investment. The Department of Health's 2016 response to the Bengoa review, Health and Wellbeing 2026: Delivering Together, set out a ten year plan to transform health and social care in Northern Ireland. Delivering Together promotes a model of person-centred care focused on early intervention, prevention and supporting independence and wellbeing. It identified mental health as a priority area and committed to building capacity in communities, developing services to deal with trauma, and achieving parity of esteem with physical health.

13. In recent years, public attitudes towards mental health have improved, an ethos of co-production and co-design has been promoted, and a greater focus on human rights has improved the lives of many suffering from mental ill health. The cross-Departmental policies Making Life Better and Protect Life 2 have driven extensive work on health promotion and suicide prevention by addressing health inequalities and risk factors for suicide and self-harm. We have also seen additional investment in mental health through the establishment of, for example, Multi-Disciplinary Teams and mental health primary care workers in some areas, as well as mental health liaison services in Emergency Departments. The mental health response to the COVID-19 pandemic has also helped to promote and encourage the use of digital resources to support mental wellbeing and mental health.

14. However, gaps in provision remain. Services are coming under increasing pressure due to increasing demand and staffing issues, and there remains a stigma attached to mental health. Mental health is still not viewed or treated in the same way as physical health, and despite the injection of additional resources, is still underfunded when compared with other UK jurisdictions. In 2018/19 approximately £300m was allocated to mental health in Northern Ireland, representing around £160 per person. During the same period, spend in England was £12.2bn, or £220 per person, whilst in Ireland investment equated to over £200 per person.[4]

MENTAL HEALTH SPEND IS 27% LESS THAN ENGLAND AND 20% LESS THAN IRELAND

15. In addition, barriers to access mental health services remain, particularly for some marginalised groups who are considered to be at higher risk of mental ill health. This may be due to social exclusion or isolation, communication needs and barriers, or they may be in some way stigmatised by society.

16. To tackle some of these issues in the short to medium term, and put the foundations in place for longer term strategic change, the Department of Health published a new Mental Health Action Plan in May 2020. The 38 actions in the Action Plan fall into three broad categories: immediate service developments; longer term strategic objectives; and preparatory work for future strategic decisions. With the publication of this Strategy, the Action Plan will stop, and remaining actions are subsumed into the actions in this Strategy.

4 There are differences in how mental health spend is calculated. However, even considering such factors there is a significant under investment in Northern Ireland.

17. There are also a number of other strategic documents already in place or under development by the Department of Health which complement this Mental Health Strategy. It is important to note the linkages between these policies and this Strategy to ensure the broader picture of support is coherent and reflective of the needs of our communities.

18. The Protect Life 2 Strategy to prevent suicide and self-harm will continue to work in tandem with this Mental Health Strategy and ensure synchronized service delivery. A wide number of actions, services and initiatives delivered under Protect Life 2 complement our mental health work. This includes services such as Multi Agency Triage Team, Lifeline, Towards Zero Suicide programme, bereavement support services, self harm services and stigma reduction.

19. Northern Ireland's new Substance Use Strategy Preventing Harm & Empowering Recovery: A Strategic Framework to Tackle Substance Use has been co-produced by the Department of Health, working in partnership with key stakeholders, both inside and outside government, including service users. The new strategy issued for public consultation on 30 October 2020. 78 formal responses were received from a wide spectrum of stakeholders, in addition to significant feedback from the formal facilitated consultation events and the individual meetings groups had with Departmental officials. Underscored by five population-level outcomes, the proposed vision of the new strategy is that people in Northern Ireland: are supported in the prevention and reduction of harm and stigma related to the use of alcohol and other drugs; have access to high quality treatment and support services; and will be empowered to maintain recovery. The strategy is expected to be published during summer 2021. As part of this process, consideration is being given to the investment required to deliver the new strategy, including funding for alcohol and drug services.

20. An interim Autism Strategy has recently been launched and the development of a fully co-produced longer term strategy is about to commence. In addition, a Learning Disability Service Model is also being developed by the Health and Social Care Board. These are important strategic drivers that aim to bring about improvements to services for people with autism/learning disability beyond mental health. It is therefore important that this Strategy dovetails with these other strategies.

21. There are also a wide range of policies in place or under development by other government departments which have an impact on the mental health of our communities. Some of these are highlighted in Theme 1 as of particular relevance and a more comprehensive list is provided in Annex A. It is important to recognise the links between these policies, and it is essential that government departments and other agencies continue to collaborate and communicate to ensure their work is joined up and in line with the high level ambition to ensure good mental health across Northern Ireland.

What needs to change

22. Despite the improvements we have seen in mental health services in recent years and the positive experiences of many people accessing support, there remains much to be done to achieve real, meaningful and lasting change for all.

23. We consistently hear the same messages from people using mental health services: waiting lists are too long for psychological therapies, crisis support is not available when it is needed, those with specific needs often find themselves outside of service criteria and therefore unable to access the right type of help and support, and that earlier intervention is needed to prevent or delay the onset of more serious mental health problems.

24. Across Northern Ireland, targets for access to services are regularly missed, with almost 2,000 people waiting more than 9 weeks for access to adult mental health services, 170 children and young people waiting more than 9 weeks for core CAMHS and more than 1,800 people waiting more than 13 weeks for psychological therapies.[5]

2,000 PEOPLE ARE WAITING MORE THAN 9 WEEKS FOR ADULT MENTAL HEALTH SERVICES

170 CHILDREN AND YOUNG PEOPLE ARE WAITING MORE THAN 9 WEEKS FOR CORE CAMHS

1,800 PEOPLE ARE WAITING MORE THAN 13 WEEKS FOR PSYCHOLOGICAL THERAPIES

5 Correct as of 28 February 2021.

25. We know that if we can provide effective mental health interventions early, the outcomes for individuals, unpaid carers and families are much better. Care and treatment must therefore be available when and where they are needed. We must create systems that work together to reduce waiting lists and that support people at their time of crisis, including a reduction of the use of Emergency Departments as a crisis response. This will help people in their recovery and promote full participation in society. Our mental health system needs to be family focused to ensure that individual recovery also supports family recovery.

26. In the same way as ensuring there is a continued strategic focus on parity of esteem between mental and physical health, attention must also be given to parity within mental health services themselves, to ensure equality and equity of access for all, with a focus on recognising and meeting the individual's specific needs.

27. It is vital that we recognise the ongoing impact of the COVID-19 pandemic on our population's emotional wellbeing and mental health and that we build our response to it into the long term strategic direction. We must use the learning from the pandemic to ensure we have a system that works to prevent or delay the onset of mental health problems and which truly meets the needs of its users.

28. Leaders across the system must take decisive steps to break down barriers in the way services are provided, reshaping how care is delivered, increasing access to the right care at the right time, and improving outcomes. This requires a culture change with better outcomes as the core focus and accountable leadership embedded in our workforce. This will mean regionality of services to ensure consistency of delivery. This will avoid unwarranted variation for patients and ensure better treatment outcomes.

29. And we need to focus on putting the right foundations in place to support our workforce, by increasing training numbers, having well trained staff and ensuring we are using the workforce in the best way possible.

30. By learning from our experience to date, by listening to the views and suggestions of people with lived experience, unpaid carers and other experts across organisations and sectors, we can ensure that the future for mental health in Northern Ireland is brighter, more positive and reflective of the needs of our population.

31. The changes proposed in this Strategy are the result of co-design and co-production with people with lived experience, unpaid carers, professionals, managers and academics. The work started with the development of the Mental Health Action Plan in 2018 through 2019, and has continued throughout 2020 during the Strategy development process. A large number of people with wide experience have told us that much good has been done over the last decade, but that much more needs to be done.

THIS STRATEGY IS CO-DESIGNED AND CO-PRODUCED WITH SERVICE USERS, CARERS, PEOPLE WITH LIVED EXPERIENCE, PROFESSIONALS, MANAGERS AND ACADEMICS

32. During the development process, people have told us we need to focus on mental health promotion, early intervention, prevention and family focussed recovery. We have been told that this should include: ensuring a good start in life; providing effective support early through primary care and accessible treatment; and ensuring that people who are usually difficult to reach are targeted.

33. We have also been told that we need to focus on putting the person and the family at the centre and model services around their needs; that we need to ensure that the same services are available across Northern Ireland, regardless of where a person lives; and that services and interventions must be based on clear evidence.

Vision for the future

34. We have listened to stakeholders through the process of co-producing this Strategy, and we recognise the key issues that matter to them: consistency and equity of access to services, support with a lifespan approach, choice, a focus on quality of life, and the need to put the person right at the centre of every decision. We have also heard how co-production and co-design must become the standard at every stage of policy and service design, and individual care planning.

35. We have translated the views shared with us into a vision which sets out what we want to achieve for mental health in Northern Ireland over the next decade.

Our vision for Northern Ireland is a society which promotes emotional wellbeing and positive mental health for everyone with a lifespan approach, which supports recovery, and seeks to reduce stigma and mental health inequalities.

We want a system that ensures consistency and equity of access to services, regardless of where a person lives, and that offers real choice.

We want to break down barriers so that the individual and their needs are placed right at the centre, respecting diversity, equality and human rights, and ensuring people have access to the most appropriate, high-quality help and treatment at the right time, and in the right place.

And we aspire to have mental health services that are compassionate and able to recognise and address the effects of trauma, that are built on real evidence of what works, and which focus on improving quality of life and enabling people to achieve their potential.

36. To achieve this vision, we need to invigorate and energise our communities and organisations, to promote a culture change that will bring about real improvements for the population in Northern Ireland. We need to focus on learning from our experiences and supporting each other. We need to stop people falling through gaps in services by putting the foundations in place for true collaboration and integration, working together with and supporting our partners in the Community and Voluntary sector to provide high quality support and services on the ground. We need to work hard to reduce the "silo" mentality, and create a holistic system where all partners are valued and respected for the important role they play, including families, unpaid carers and wider support networks. We need to ensure that people get care and support when they need it and most fundamental of all, we need to prevent avoidable deaths.

37. In addition to the vision, we have developed seven core principles, which represent the foundations upon which each of the actions set out in this Strategy are based:

    I. *Meaningful and effective co-production and co-design at every stage, involving all partners equally.*

    II. *Person-centred care and a whole life approach – a system that meets the needs of the person and their family and support network, rather than expecting the person to fit into a rigid system.*

    III. *Care that considers and acknowledges the impact of trauma – where staff have the appropriate knowledge and skills and are aware of the impact of trauma, particularly in the context of Northern Ireland.*

    IV. *Choice in treatment to fit the needs and preferences of the person.*

    V. *Early intervention, prevention and recovery as a key focus – all decisions should be made with this in mind.*

    VI. *Evidence informed decisions - services and interventions built upon sound evidence of what works.*

    VII. *The specific needs of particularly at risk groups of people, and the barriers they face in accessing mental health services, should be recognised and supported.*

38. This Strategy builds upon this vision and core principles to set out 35 actions to bring about change to mental health services in Northern Ireland. The actions are set out under three overarching themes:

    - **Theme 1: Promoting mental wellbeing, resilience and good mental health across society**
    - **Theme 2: Providing the right support at the right time**
    - **Theme 3: New ways of working**

Theme 1

Promoting mental wellbeing, resilience and good mental health across society

40. Health is closely linked to the conditions in which people are born, grow, live, work and age, and inequities in power, money and resources – the social determinants of health.[6] The mental health and wellbeing of the population in Northern Ireland is therefore not just a health and social care issue, it is societal. The Northern Ireland Executive has recognised that promoting and maintaining good mental health cuts across all Departments and all aspects of life. The establishment of the Executive Working Group on Mental Wellbeing, Resilience and Suicide Prevention, and the appointment of the NI Mental Health Champion, demonstrates the clear commitment across the Northern Ireland Executive to joint working to improve society's mental health and wellbeing.

Mental Health Champion

In April 2020, cross-Departmental support was secured, through the Northern Ireland Executive, to formally establish a Northern Ireland Mental Health Champion role. The creation of such a role was in response to wide ranging calls from across the mental health sector for the creation of a strong, effective and independent voice to advocate on their behalf. The Mental Health Champion is therefore a joint initiative across the NI Executive and is fully supported by all Executive Ministers. As a signal of the collaborative will for the role to succeed, funding for the role is shared across Departments.

The purpose of the Mental Health Champion is to integrate a mental health friendly ethos into all policies and services developed and delivered by the NI Executive and to enhance the level of collaborative working on, and awareness of, psychological wellbeing, mental health, suicide and recovery in Government Departments. The role is also to be a voice for people with lived experience, who are often not heard in the public debate.

41. If we want a system that promotes positive mental health and seeks to enable people to achieve their potential, it is critical to invest in societal measures to promote and support mental wellbeing and resilience, raise awareness of mental health and reduce the stigma associated with it and prevent and delay the onset of mental health problems as far as possible.

6 World Health Organization *Social determinants of health* https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Promotion and prevention

42. Outcomes:
    - Better mental health among the wider population, evidenced by a reduction of % of population with GHQ12 scores ≥4 (signifying possible mental health problem).
    - Greater public understanding of the differences between mental wellbeing, mental ill health and mental illness.
    - A reduction in the stigma associated with mental ill health and mental illness.
    - Better inter-agency cooperation to promote wellbeing and resilience.
    - Wider awareness of mental health within the health and social care sector outside the mental health profession.
    - Wider awareness of how mental health can be impacted by every day decisions and strategic policy directions outside the health and social care sector.

43. Good mental health is linked to good physical health and positive relations with families, friends, and colleagues. It enables us to fulfil our potential, engage in community life, and lead full and rewarding lives. The natural and built environments in which we live, work, visit and play can impact profoundly on our wellbeing. Surroundings that are well-planned, designed and maintained may help prevent, and support recovery from, mental illness.

The Healthy Wigan Partnership

A partnership between primary care, community services, Start Well (early years), mental health and public health is driving reform in Wigan, a deprived area of Greater Manchester. This has resulted in Wigan's Deal for Health and Wellness, which communicates the actions the NHS and residents can take across the life span to improve all aspects of health. The citizen-led, asset-based approach to health adopted by this partnership has seen tangible outcomes and is regarded as an effective way to build and sustain communities and system-wide commitments.

44. As a society, we need to continue to provide opportunities for individuals and communities to look after their own emotional wellbeing and mental health, for example, by providing access to green and blue spaces, opportunities for exercise, leisure activity and social interaction, volunteering opportunities, tackling loneliness and access to housing and employment, all of which are proven to have an impact on emotional and mental wellbeing.

Connswater Community Greenway

This £40 million project in East Belfast was developed by EastSide Partnership and delivered by Belfast City Council. Funded by the Big Lottery Fund, Belfast City Council, the Department for Communities and the Department for Infrastructure, the Connswater Community Greenway opened in September 2017. It provides vibrant, attractive, safe and accessible green and blue spaces for leisure, recreation, community events and activities.

Among the wide range of facilities it has created are a 9km linear park making provision for walking, wheeling and cycling along the course of three rivers; 16km of foot and cycle paths, hubs for education, interpretation points and tourism and heritage trails, a wildlife corridor from Belfast Lough to the Castlereagh Hills, and C.S. Lewis Square – an events and activities space.

The route links with the Comber Greenway which is also is improving the quality of life for the people of east Belfast, including the 40,000 residents and pupils and students attending 23 local schools and colleges. A whole new greener environment has emerged to link local residents to parks, leisure facilities, businesses, shopping centres, schools and colleges.

Greenways promote active travel, connect people and communities, create green safe spaces, and encourage community members to volunteer to keep them clear and looking great for everyone to enjoy. In all of these ways, they help to enhance both our physical and mental health.

45. A key part of this as we move forward has to be about ensuring that mental health remains high on the public agenda, to encourage open dialogue, understanding and acceptance. This is a key element in addressing the stigma that still shadows mental health and those who suffer from mental ill health, in particular, individuals with severe mental illness. Severe mental illness, such as schizophrenia, psychosis and Bi-polar affective disorder, often commence when a person is young, and are associated with long-term disabilities or recurrent episodes throughout the lifespan. Early intervention and effective treatments have improved outcomes, and it is important to ensure people are aware of this.

46. By ensuring mental health remains part of everyday conversation, it will also support and encourage people to seek help when they need it, and will ensure we as individuals, families, friends, employers and colleagues are better equipped to recognise and understand mental health problems in ourselves and others, and skilled to access or provide help, support and guidance in an appropriate and considerate manner.

47. We must also work across the whole of the population to promote a better understanding of what good mental health is, and clarify the distinction between mental wellbeing, mental ill health and mental illness. We need to encourage open dialogue and public discourse around how the many challenges life presents can impact on our mental wellbeing, but recognising that this does not necessarily lead to mental ill health. We need to encourage public recognition that "it's ok not to feel ok", that while life's ups and downs can have an impact on our wellbeing, this is normal, especially in the context of pandemic which has affected everyone across the globe. We also need to continue to promote the important steps that everyone can take to look after their own mental health and mental wellbeing.

WE MUST CONTINUE THE DISCUSSION AROUND MENTAL HEALTH ACROSS SOCIETY

48. This could be achieved through public awareness campaigns that increase people's mental health literacy, and may also include targeting specific groups of people who may be vulnerable to mental ill health, for example, peer support programmes for LGBT+ young people, debt advice for people on low incomes, or outreach programmes for ethnic minorities, refugees and asylum-seekers.

Sport Wellbeing Hub

The Sport Wellbeing Hub is an online resource which Sport NI launched in April 2020. It offers the sports sector and communities wellbeing support during the Covid-19 pandemic. The Hub was developed in partnership with the PHA and Inspire to help sports users to create their own wellbeing care-plan, as well as giving guidance on support through a guided self-assessment. The Hub is for everyone across the sporting community, at all levels and all abilities. It provides a range of innovative tools and resources, including a guided self-assessment via 'chatbot'; self-help programmes and digital intervention tools; a searchable '5 ways to wellbeing' map; a wellbeing information library; and video content featuring some of our sporting heroes talking about mental health.

ACTION 1. Increase public awareness of the distinction between mental wellbeing, mental ill health and mental illness, encouraging public understanding and acceptance of how life can impact upon mental wellbeing, and recognition of the signs of mental ill health and mental illness. Using public mental health education and effective awareness raising methods, increase public knowledge of the key measures that can be taken to look after mental wellbeing, increase understanding of mental ill health, and encourage public discourse and dialogue to reduce stigma.

49. Prevention of mental health problems in the workplace is of particular importance, both in terms of its impact on economic productivity, but also in light of the impact of the COVID-19 pandemic on working practices. Increased isolation due to home working, coupled with increased stress, particularly for those working on the front line or in public facing roles, means that it is more important than ever to invest in strategies and measures to support the wider workforce in staying mentally well. This involves demonstrating commitment at the highest levels of the organisation to mental wellbeing, reducing stigmatising attitudes and discrimination, tackling the causes of workplace stress, providing training and support to managers, and providing early intervention supports for employees.

Buy Social - mental health in procurement

Buy Social works to maximise the social benefits delivered through public investment. This includes social considerations on public contracts, which require Public Sector Contractors to deliver certain initiatives as part of the contract. Work is ongoing by the Department of Finance to consider the possibility of including Buy Social on relevant public sector contracts to benefit the mental health of employees working on these contracts, through for example, employment opportunities for those that are disadvantaged from the labour market, work experience and business in education opportunities, digital skills training for people at risk of digital exclusion and a requirement that contractors have a health and well-being policy in place in for staff.

50. For certain sectors, for example, the rural and farming community, mental health is a particular concern. This can be due to physical isolation from communities, worries about livelihood, or anxiety regarding personal and family safety. Research by the Farm Safety Foundation revealed that 84% of farmers under the age of 40 believe that mental health is the biggest hidden problem facing farmers (up from 81% in 2018).[7] It is important to reach out to harder to reach groups to intervene early and prevent the onset of mental health problems.

7 Farm Safety Foundation *Mental Health in Agriculture*, https://www.yellowwellies.org/mind-your-head/.

Tackling Rural Poverty and Social Isolation Framework

The Tackling Rural Poverty and Social Isolation (TRPSI) Framework supports the development and delivery of initiatives to address the Framework's three priority areas of financial poverty, access poverty and social isolation. Through this Framework, the Department for Agriculture, Environment and Rural Affairs supports a range of initiatives to promote better mental health and wellbeing amongst farmers.

The Rural Support charity operates a telephone Helpline and signposting service for farmers and rural dwellers in stress. Their volunteers support clients with a range of issues pertaining to farming matters and stress. Rural Support are currently delivering mental health awareness training workshops entitled 'Coping With The Pressures of Farming', covering mental wellbeing and suicide awareness and prevention funded by Farm Family Key Skills Programme.

Through the Farm Families Health Checks Programme, 2,600 rural dwellers per annum avail of a comprehensive physical and mental health screening service.

51. Prevention actions in later life should focus on promoting active and healthy ageing, as well as addressing the living conditions and environments that support wellbeing and allow people to lead a healthy life.[8] For many older adults, social contact is key to building emotional resilience and staying mentally well. For others, staying active, both physically and mentally, contributes to their mental wellbeing. As a society, we must continue to value the contribution older adults make to our communities and provide opportunities and support for them to look after their mental health, whether through social groups or befriending schemes, access to physical activity, or other advice and support. The Executive's Active Ageing Strategy, which has been extended to May 2022, includes a number of actions which contribute to positive mental health among our older population.

8 Policy direction for aging and older people can be found in the Department for Communities' *Active Ageing Strategy*. https://www.communities-ni.gov.uk/publications/active-ageing-strategy-2016-2022

Arts Council and NI Screen

There has been much research into the powerful contribution that engaging with arts and creativity can make to mental health. The Arts Council plans to reopen its Arts and Older People programme in 2021, which funds projects addressing social and mental health issues in older people. This is particularly welcome given the impact that lockdown and other aspects of the COVID-19 pandemic may have had on older people.

Northern Ireland Screen's Digital Film Archive outreach programme delivers free themed presentations based on the content of the archive to audiences, including community groups, charities and care homes. Recent collaborative projects include PLACE EE, a transnational inter-generational project, which works with older people in sparsely populated rural areas to improve wellbeing.

52. For those with a recognised mental disorder in Northern Ireland, mental health promotion, prevention and early intervention is often secondary to the delivery of specific mental health services. Often, this is not in the patient's best interests.

53. To improve this, we need to ensure that promotion, prevention and early intervention is mainstreamed in service delivery and across different sectors.

WE WILL CREATE AN ACTION PLAN TO PROMOTE MENTAL HEALTH FOR THE WHOLE POPULATION

54. Going forward, this will require a renewed focus to ensure that mental health promotion meets the needs of those who need early intervention. This can include targeted approaches to groups more likely to be adversely affected by mental ill health, such as BAME groups, refugees and asylum seekers, people with a specific trauma exposure, LGBT+ people, people with a physical or sensory disability and persons with an intellectual disability.

ACTION 2. Create an action plan for promoting mental health through early intervention and prevention, with year on year actions covering a whole life approach, reaching from infancy to older age. The action plan must consider groups disproportionally affected by mental ill health who often struggle to access early intervention services and seek to reduce stigma associated with mental ill health.

Social determinants and mental health

55. Outcomes:
    - Increase in the number of people who receive help and support to improve their lives in difficult social circumstances.
    - Greater ability in the population to access easy to use social support, including social prescribing.

56. A person's mental health is shaped by a range of social, economic, cultural and environmental factors. Evidence shows that poverty and mental ill-health are closely associated, and disadvantage can have long-term consequences.[9] We also know that the Troubles has had a lasting impact on both social deprivation and levels of mental ill health. In Northern Ireland, we need to continue to work together across government, sectors and the whole of society to implement existing policies designed to address deprivation, poverty, loneliness and social cohesion issues, and other social determinants of mental ill health. The four new social inclusion strategies that are currently being developed by the Department for Communities in relation to Disability, Anti-Poverty, Gender and Sexual Orientation, are likely to include interventions from across Government Departments that will contribute to improving our population's mental health and wellbeing.

57. Poor housing and unemployment are particularly relevant when considering mental health outcomes. Again, action across government to provide financial and emotional support to those who have become unemployed, and to help people back into work where possible, plays an essential role in preventing the occurrence of mental health problems.

9 Mental health and poverty in the UK – time for change? (Jed Boardman et al, May 2015)

Employment Support

Through Work Coaches, the Department for Communities (DfC) works in collaboration with contracted and specialist local providers to support people with physical and mental health conditions. Support is provided through the Workable (NI), Access to Work (NI), European Social Fund projects and the Condition Management Programme (CMP) to help people realise the ambition to work and achieve mental health improvement and stability. DfC delivers CMP in collaboration with the Department of Health. It is a work-focused, rehabilitation programme, aimed at improving the employability of our people by supporting them to understand and manage their health condition(s), including mental health, to enable them to progress towards, move into and stay in employment.

DfC is in the process of standing up a suite of new programmes to improve the employment prospects of those impacted by the COVID-19 pandemic. This will include a specific focus on our youth and those with health and disability support needs who are particularly vulnerable in the labour market and subsequently at risk for longer term health and wellbeing issues. The Department also has a team of Work Psychologists who are responsible for leading on the work and health agenda and developing the capacity of our front line teams to support people with mental ill-health.

58. For many of these issues, the solutions lie in tackling root causes and the impact of root causes and the responses need to sit across a range of Government departments and agencies. However within health and social care, an acknowledgement of the psycho-social aspects of the needs of individuals, families and communities is also very important. In addition to the more clinically orientated interventions, mental health services should also offer help and support with the social context of people's lives where this is impacting upon their mental health. Social work and social care services are important in this regard.

THERE WILL BE INCREASED SOCIAL SUPPORT FOR INDIVIDUALS, FAMILIES AND COMMUNITIES

59. Going forward we will increase the social support available and work across government to improve the outcomes for those in difficult situations.

Improving Social Wellbeing

Social wellbeing is a broad concept encompassing the quality of people's relationships, their sense of belonging and the choice and control people have about decisions affecting them and their lives. It also includes having purpose and meaning in life as well as feeling safe and secure.

The purpose of social work is to improve and safeguard people's social wellbeing. In this case study, Paula, a young mother who is experiencing severe anxiety and panic attacks, has been referred to a social worker in a primary mental health team with the suggestion that she would benefit from relaxation and mindfulness teaching. When the social worker visits, she finds that Paula is caring for two young children on her own, that she has fallen out with her mother who was her main source of support, that she is working two low-paid part-time jobs to make ends meet, that the flat is cold and damp and that Paula is tortured by noise and nuisance from drug dealing taking place in the hall of the apartment block she lives in.

The social worker feels that Paula is not in a place at the minute to benefit from relaxation and mindfulness teaching, and that the source of her anxiety and panic is most probably her current life circumstances. She therefore suggests to Paula that they work together on relieving some of those stressors.

The social worker refers Paula to the Make the Call service to see if she can increase her income in any way and she offers her a sponsored day-care placement for her youngest child, where support groups for parents are also involved. The social worker spends time talking Paula through the relationship with her mother, how complicated it can be and the very mixed emotions it can evoke. She helps Paula to prepare for a conversation with her mother to lay the ground for a reconciliation. The social worker also supports Paula to make a complaint to the landlord responsible for the apartment block about the damp in her flat and the lack of security in the entrance hall.

ACTION 3. Increase the supports available to individuals, families and communities to address the social factors that impact on their mental health.

ACTION 4. Work with delivery partners across Government and the health and social care system, to maximise the availability and use of a range of social wellbeing supports, including social prescribing, to encourage and support mental wellbeing and positive mental health.

Early intervention

60. Outcomes:
    - Increased access to early intervention services.
    - More people being seen early, with a long term reduction in people requiring higher intensity interventions.

61. Early intervention can prevent the escalation of mental health problems. This can, for example, be through providing therapy in primary care to prevent depression and ensuring fast access to psychological therapies. This means providing primary care with the tools to provide mental health early intervention services. In Northern Ireland, the roll out of primary care multi-disciplinary teams, including mental health workers, provides better access to mental health support in an easily accessible format where people need it. Social workers in the primary care multi-disciplinary team also have a role in responding to the social determinants of health, including mental health, and in the promotion of social wellbeing interventions. This support is now available for an increasing part of the population.

62. The Department of Health, Social Services and Public Safety's 2010 Psychological Therapies Strategy recommended integration of psychological therapies across all steps of mental health services. In practice, this has led to the establishment of talking therapy hubs, managed by Trusts. Effective talking therapy hubs can provide early intervention and prevent a deterioration of mental health. However, the availability of talking therapy hubs varies across Northern Ireland, with services unavailable to significant parts of the population.

63. Going forward, we also need to consider other methods of providing therapy, such as art or music therapy and use this in our every day delivery models. The talking therapy hubs should therefore be considered more widely as mental health therapy hubs which encompass a wide range of different interventions that are focused on the needs of individuals.

Music therapy

Music Therapy is a low-cost, low-risk, and high-impact intervention that can be used in isolation or together with other interventions. It requires minimal equipment and is flexible in terms of settings, timing and length of intervention, making it highly adaptable to meet a range of service user needs. It can add value through: improving clinical outcomes for service users; enhancing the services of other healthcare colleagues; reducing demand for medication; and avoiding future costs to the system through prevention-based services..

64. By expanding the availability of therapy through local Hubs, we can ensure early intervention services are available to the whole population. This needs to happen together with primary care. In that context, the Hubs should therefore become part of primary care services and be developed in conjunction with the development of the primary care multi-disciplinary teams.

65. In practice, this means ownership of the therapy hubs would be transferred to primary care, with further integration with the multi-disciplinary teams and with the community and voluntary sector.

66. Expansion of therapy hubs with involvement from the community and voluntary sector will increase the availability of psychological interventions and other interventions that will help and support good mental health. This means waiting times can be reduced and people will have easier access to therapies when they need it.

THERAPY HUBS WILL EXPAND AND WILL SEE FURTHER INVESTMENT

ACTION 5. **Expand therapy hubs, which are resourced sustainably, to ensure Northern Ireland wide coverage. The hubs should be managed by primary care and link with the wider work on establishing mental health as an integral part of the primary care multi-disciplinary team.**

Promoting positive mental health across a person's whole life

67. Outcomes:

- Improved mental health among children and young people using key indicators from the 2020 Youth Wellbeing Child and Adolescent Prevalence Study.
- Increased access to specialist mental health provisions, including for those with underlying disabilities.
- Improved mental health outcomes for students.
- Increased engagement with support for families and carers, including unpaid carers, and a greater involvement of families and carers in decision making processes.

68. We have already noted the importance of focusing on the promotion of prevention, early intervention and wellbeing throughout a person's whole life. However, if we can give every child a good start in life, and support them and their families throughout their childhood, we can significantly reduce the likelihood of future mental health problems occurring.

69. Positive social and emotional development in infancy helps children feel safe and better able to develop cognitively and prepares them more fully for transitions into education. Children and young people who have strong attachments with parents and caregivers have an increased likelihood of experiencing good mental health throughout their lifetime.

70. Children's mental health and emotional wellbeing is nurtured primarily in the family. Therefore a key priority for all services is to support parents and carers. Across mental health services, a Think Family approach is therefore expected.

71. A secure parent/child relationship is a key building block for the development of positive attachment and helps to build emotional resilience in children. This support needs to continue into childhood and adolescence. Like cognitive capabilities, resilience, social and emotional skills can be taught and developed throughout childhood, adolescence and beyond.

72. Work needs to continue across sectors to promote positive social and emotional development throughout the period of childhood and adolescence. This means building on existing good practice and areas of collaboration, for example between the health and education sectors, and seeking new, innovative ways of working to ensure children have the best start to improve their chances of a happy, healthy life.

73. As adverse childhood experiences (ACEs) have been found to account for 29.8% of mental disorders,[10] prevention of ACEs is key to preventing mental ill health among children and in later life. For children, a key focal point for prevention is in connection with schools. Evidence shows that school-based programmes for children and adolescents have achieved a reduction in depressive symptom levels of 50% or more a year after the intervention; and anxiety disorders can successfully be prevented by strengthening emotional resilience, self-confidence and cognitive problem-solving skills in schools.[11]

10 Kessler et al, 2010, *Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys,* British Journal of Psychiatry 197(5).

11 Scott, S. (2005). *Do parenting programmes for severe child antisocial behaviour work over the longer term, and for whom? 1 year follow up of a multicenter controlled trial.* Behavioural and Cognitive Psychotherapy, 33(4), 403-421. https://doi.org/10.1017/S135246580500233X

Mental health in schools

The Department for Education recognises the importance of embedding mental health and wellbeing into all educational settings, and has been working collaboratively with other agencies to develop a Framework for Children & Young People's Emotional Health and Wellbeing in Education.

The main emphasis of this work is to support schools to promote emotional health and wellbeing at a universal level, through a holistic, multi-disciplinary approach, providing early and enhanced support for those children and young people who may be at risk or showing signs of needing further help. £5m has been made available by the Department for Education to enable the implementation of this Framework in 2020/21 and subsequent years. The Department of Health has agreed to provide an additional £1.5m from 2021/22 onwards. A range of proposals are currently being considered, all of which have a focus on promotion, prevention and early intervention, through which Education, Health and Community services can work together in an integrated way.

ACTION 6. Further promote positive social and emotional development throughout the period of infancy and childhood, including in pre-school and school settings, and provide new evidence-informed interventions and support for families and support to ensure that children and young people get the best start in life.

74. Children with global developmental delay or neurodevelopmental disorders can present with particular behavioural challenges which require specialist support for the child and their parents. Seven out of ten people with autism also have a condition such as anxiety, depression, Attention Deficit Hyperactivity Disorder or Obsessive Compulsive Disorder. One helpful way of supporting children and young people with an intellectual disability is to provide specialised parenting education and support programmes. Services must also adapt to ensure that their provisions are suitable and available for children with such needs.

75. In Northern Ireland, the approach to children with developmental delays or neurodevelopmental disorders is often characterised by approaches where the education and support needed is not always provided. In addition, mental health services are not always accessible due the setting of thresholds which often don't allow services to be based around the individual.

76. We need to ensure that the needs of these children and young people are considered as part of a whole system approach, where their needs come first. This means working across service boundaries.

77. We must also consider specific psychological interventions in services for infants, children and young people living with persistent physical symptoms or who have been hospitalised for medical reasons. Evidence suggests that while the majority of children with a medical condition or chronic illness do not have a psychiatric disorder, a significant minority do have difficulties with adjustment or symptoms of psychological distress. Their needs are therefore often best met by a paediatric clinical psychology intervention rather than a psychiatric intervention.

78. Dedicated programmes are also required to help parents understand the function of their child's behaviours of concern and to teach the child new skills that can be used to replace behaviours of concern. Parents should also be taught strategies to promote positive behaviour and positive mental health. It is vital that specialist mental health and well-being services are available for families caring for children and young people with neurodevelopmental disorders such as Attention Deficit Hyperactivity Disorder (ADHD), intellectual disability or Autism Spectrum Disorder (ASD) and for the young people themselves. These services should work in partnership with other child health services including paediatrics and health visiting.

ACTION 7. Provide enhanced and accessible mental health services for those who need specialist mental health services, including children and young people with disabilities. The services must be able to cater for those with disabilities, including physical and sensory disabilities, ASD and intellectual disabilities. This must include help and support for parents and families.

Mental Health of Students

79. Mental health among students is also an area that has come into increasing focus, particularly in the context of the COVID-19 pandemic. There is clear evidence that the student population in Northern Ireland is vulnerable to mental ill health. An NUS-USI survey in 2017 identified that 78% of students were struggling with their mental health, with many living away from home.[12] Anxiety and stress about exams, money worries, housing and social interactions can all contribute to poor mental health among students. It is important that we continue to work across government and sectors to intervene early to provide support to help students stay emotionally well and build resilience to support them in their learning journeys and lives beyond.

12 NUS-USI Northern Ireland (2017) *Student Wellbeing Research Report 2017*, https://www.nusconnect.org.uk/resources/nus-usi-student-wellbeing-research-report-2017

Mood Matters for Students

The Mood Matters for Students programme is a free online Student Mental Health Programme which has been designed especially for students to deal with the impact on mental health arising from the COVID-19 pandemic. The programme, which is delivered by Aware NI, is based on the Mood Matters for Adults programme commissioned by PHA and gives participants knowledge and skills which can be used to maintain or regain good mental health and build resilience to deal with life's challenges.

The programme is based on cognitive behavioural concepts and introduces the 'Five Areas Approach', which participants use to challenge and change unhelpful thinking and behaviour in order to make a positive difference to their lives. It also features the 'Take5 for Your Emotional Wellbeing' which focuses on the five most evidenced ways of looking after our mental health (Connect, Be Active, Take Notice, Keep Learning and Give) and highlights how we can build these into our everyday lives.

80. Going forward, the unique position of students is identified as crucial for prevention and early intervention. In addition, the student population is very mobile, moving between home, university campuses and work placements, which provides challenges for students who need to be seen by secondary care mental health services. Research has found that 75% of people with both common and serious mental health conditions first experience symptoms before the age of 25.[13] As approximately two-thirds of third level students are between the ages of 18 and 25, we must ensure this group is targeted for preventative work and early intervention.

ACTION 8. Create dedicated resource for student mental health across tertiary education through the existing delivery of mental health services.

Unpaid carers and families

81. Unpaid/informal carers and families are in a unique position to help and support people with their mental health. A good support network can help prevent mental ill health, provide help during mental health difficulties and assist with recovery.

13 Kessler, R. C., et. al. (2007). *Age of Onset of Mental Disorders: A Review of Recent Literature*. Current Opinion in Psychiatry 20(4), 359-364.

82. At all times, mental health services should be taking a Think Family approach, which considers the wider family, unpaid carers and others close to the person with mental health problems in the decision making.

83. Promoting and developing the involvement of families and unpaid carers is relevant across the whole lifespan. Structured advocacy services, peer support and other support platforms to inform, educate and support carers in their caring role are invaluable. These should be in place and accessible as part of the proposed reconfiguration of early intervention and prevention services.

GOING FORWARD THINK FAMILY SHOULD BE AN ADOPTED APPROACH ACROSS ALL MENTAL HEALTH SERVICES

84. On occasions, the person with mental ill health does not want the involvement of family or particular people around them. When such a decision is capacitous and made by an adult, it must at all times be respected, to ensure the privacy and autonomy of the person.

ACTION 9. Embed unpaid carers, families and others in the help and support provided to people with mental ill health and also in the development of mental health policy and wider decision making.

Learning Disability / Autism

85. It is accepted that people with a learning disability or autism are at higher risk of having negative mental health outcomes. While it is vital that such individuals have good and equitable access to mental health services, and that those services are able to cope with their specific needs, it is not considered appropriate to develop dedicated mental health services designed to treat those individuals. Doing so would mean people are treated primarily according to their underlying disability or circumstance, as a homogenous group, rather than receiving the most appropriate intervention they need for their mental ill health- which is different for everyone. Instead, this Strategy aims to put in place a truly person-centred service that is focused on the presenting mental health needs of the individual, with consideration of how best to meet those needs given their underlying disabilities and/or circumstances.

86. However, it is acknowledged that often interactions with general mental health services are more difficult than they should be for this client group.

87. This Strategy recognises that there are barriers currently preventing this client group, and other marginalised groups, from accessing mental health services and support. It therefore actively seeks to reduce barriers and to implement a "no wrong door" approach to access to services, ensuring staff are appropriately trained to identify and address the specific needs of particular marginalised or at risk groups, and ensuring that services can be flexible to meet individual needs at the point of contact. In many cases, this can be addressed by the provision of appropriate social support, rather than dedicated mental health interventions. In other cases, information sharing and close working between teams can alleviate some of the challenges faced by such groups in accessing appropriate mental health support.

88. It is important that mental health services are fully equipped to identify the specific needs of individuals and address these appropriately, whether through engagement with support services such as social work teams, speech and language therapy or interpreting services, onward referral to specialist services or interventions if required, or by the employment of innovative solutions such as digital mental health interventions.

Theme 2

Providing the right support at the right time

89. In Theme 1 we have set out the importance of promoting positive mental health and resilience, and of intervening early to prevent the onset of mental health problems. However, for some individuals, more targeted mental health support may be required.

90. Our vision for mental health services is about putting the person and their needs at the centre and ensuring people have access to the support that they need, at the right time and in the right place.

91. This theme therefore focuses on ensuring access to a broad range of services with a lifespan approach and covering the spectrum of need, from Children and Adolescent Mental Health Services through to support for older people with mental ill health, and covering the range of services provided from community to inpatient and specialist services. Providing services at the right time means that support has to be available when people need it. That might be through appropriate crisis support, but it also means ensuring quicker access to appropriate services without multiple onward referral processes – a "no wrong door" approach. We also need to consider support for individuals with mental health needs holistically, to ensure that they do not fall between gaps in services if they have a dual diagnosis of mental ill health and an addiction, and to ensure they receive support for their physical health as well as mental health.

Child and adolescent mental health

92. Outcomes:

- Support for infants in child and adolescent mental health services.
- Children and young people should receive the care and treatment they need, when they need it, without barriers or limitations. This should be evident through shorter waiting lists.
- Reduction in difficult transitions for children and young people, by improved outcomes in 10,000 more voices and similar user surveys.
- A regional approach to the delivery of child and adolescent mental health services.

93. The 2020 Youth Wellbeing Child and Adolescent Prevalence Study[14] provides estimates of common mental health problems in children and young people in Northern Ireland. At any time, one in ten children and young people are experiencing anxiety or depression, which is approximately 25% higher when compared to the other UK jurisdictions. One in 20 young people aged 11-19 years display symptoms of post-traumatic stress disorder. One in six children and young people in Northern Ireland engaged in a pattern of disordered eating and associated behaviours. About one in ten of 11-19 year olds reported self-injurious behaviour, with nearly one in eight reporting thinking about or attempting suicide.

1 IN 20 - POST-TRAUMATIC STRESS DISORDER

1 IN 10 - ANXIETY OR DEPRESSION

1 IN 6 - PATTERNS OF EATING DISORDER

1 IN 10 - SELF-INJUROUS BEHAVIOUR

94. Child and Adolescent Mental Health Services (CAMHS) provide services to children and young people and are organised according to a stepped care model. This is aimed at delivering the appropriate level of care, at the earliest point, that best meets the assessed needs of the child or young person. This is delivered through the CAMHS Integrated Care Pathway, which sets out quality service standards across the different steps of care.

95. The stepped care model with its recovery ethos has provided a foundation which has facilitated improvements to the delivery of CAMHS. However, this model has become a system which tends to define itself in terms of services, meaning that young people with complex needs, or who do not meet narrow criteria for a particular service, may have difficulty accessing treatment. Combined with resource limitations, this has led to long waiting times, with 170 children and young people waiting longer than 9 weeks for core step 3 CAMHS, with over 15 waiting longer than 26 weeks.[15]

14 Bunting et al, 2020, *Youth Wellbeing Child and Adolescent Prevalence Study.*
15 Correct as of 28 February 2021.

96. To help overcome this, we need to focus on the needs of the young person and see them as individuals with a unique set of needs. This must involve improving our system so that service users and families can navigate it easily and it is adaptable to the way that symptoms and needs fluctuate. In practice, this means improving the flexibility in the system and providing increased advice and support to young people and their families/support networks.

97. Currently CAMHS funding is approximately £20-25m per year, which is between 6.5% and 8.5% of the total mental health budget. This must increase to 10% of the overall mental health budget. This will allow meaningful investment to ensure the stepped care model can be flexible and meet the needs of young people.

CAMHS FUNDING WILL INCREASE TO 10% OF THE OVERALL MENTAL HEALTH BUDGET

98. The structures of CAMHS need to change to ensure that the needs of young people are met. The focus of CAMHS needs to shift towards a model where the steps provide an indication of the level of care modelled on the individual child or young person's needs.

ACTION 10. Increase the funding for CAMHS to 10% of adult mental health funding and improve the delivery of the stepped care model to ensure it meets the needs of young people, their families and their support networks.

99. Children between 0-3 regularly do not have access to CAMHS. Such a position does not recognise that the path to good mental health starts in infancy. Infants should therefore also be part of our mental health services approach. This will require clear and committed leadership across CAMHS services and inter-agency working with the Community and Voluntary sector to help and support the full age spectrum in CAMHS.

100. Going forward, we will ensure that infants' mental health is on the agenda, and that the needs of children under 3 are included in the development of mental health services and in the delivery of CAMHS.

INFANTS MENTAL HEALTH WILL BE PART OF THE DEVELOPMENT AND DELIVERY OF CAMHS

101. Improved delivery of the Stepped Care Model in CAMHS should incorporate an inclusive health approach. This acknowledges that some groups are disadvantaged when it comes to access to services, or more likely to experience mental ill health. These groups include looked after children, children in immigrant or minority ethnic populations, substance use populations, children with physical health problems and physical and sensory disabilities, children of parents with mental health problems or with parents in prison, young people in the LGBT+ population, travellers, those at the transition juncture to adult services and children and young people with intellectual disabilities.

Co-located mental health services for young people in contact with the justice system

As part of the review of CAMHS and the introduction of the new Stepped Care Model in the Southern Health and Social Care Trust, it was identified that young people within the justice system, although they appeared to have considerable levels of mental health needs, struggled to engage with CAMHS. From this, the concept of a pilot mental health worker, co-located within CAMHS and the Youth Justice Agency (YJA), was developed.

Commencing in March 2019, a Senior Mental Health Practitioner worked collaboratively across the CAMHS and the YJA teams in Banbridge and Portadown respectively. The service was established and sought to determine more clearly the level of mental health need within the youth justice population.

The service has enabled children coming into contact with the YJA to be assessed and supported directly, with referrals made to CAMHS where appropriate, including the promotion of services available within their multi-disciplinary team. Mental health assessment tools have also been developed for use by YJA to support early intervention with children and their families. The co-location of these services is delivering improved outcomes for children involved with the youth justice system and has been positively received from the children involved, their families, CAMHS and YJA alike. The pilot has resulted in more children having better access to mental health services, which in turn, contributes to their desistance from offending. This pilot has been co-funded by SHSCT and YJA in 2020 and, such has been its success to date, consideration is now being given to rolling it out across Northern Ireland.

102. Whilst policy direction in Northern Ireland is based on equality of access, CAMHS services vary from Trust to Trust in terms of their organisation and remit. In that context, it is possible for children to be 'bounced around' or to 'fall through gaps' and to face barriers to accessing CAMHS.

Equal Access to services

In 2014, the Southern Health and Social Care Trust reorganised its services to ensure children and young people with an intellectual disability had equal access specialist CAMHS. A 'no wrong door' approach, with timely access to specialist assessment and therapeutic intervention, has led to improved outcomes for children and young people. The Trust has fewer children and young people with an intellectual disability prescribed psychotropic medication and has reduced the need for, and duration of, inpatient assessment and treatment. This service has been recognised for its innovation, child-centred approaches and clinical excellence across the UK and Ireland.

103. Going forward, there must be particular consideration of these vulnerable groups when developing and improving services for children and young people. This will incorporate a 'no wrong door' approach, meaning that children and young people from vulnerable groups will no longer be passed from service to service and should mean fewer hospitalisations and less use of medication.

CAMHS WILL HAVE A NO WRONG DOOR APPROACH

ACTION 11. **Ensure that the needs of infants are met in mental health services, and meet the needs of vulnerable children and young people when developing and improving CAMHS, putting in place a 'no wrong door' approach.**

104. The regional care pathway and Stepped Care Model has improved the consistency in acute and crisis care for children and young people across Trusts. However, there are still significant variations across Trusts, with reports of some young people waiting too long in Emergency Departments.

105. A quarter of CAMHS referrals in Northern Ireland are emergency or urgent, compared to the UK average of just over one in ten. On average, 40% of children assessed in crisis do not need CAMHS treatment, so having highly skilled staff at crisis points is essential to ensure that children and families get the best and most appropriate care, including within the community and voluntary sector.

106. The recently established CAMHS managed care network and partnership board provides a platform for improving urgent, emergency and crisis CAMHS services in Northern Ireland. We will, through this network, develop regionally consistent urgent, emergency and crisis services to children and young people.

WE WILL CREATE CRISIS SERVICES FOR CHILDREN AND YOUNG PEOPLE

107. This means we will have a better response to children and young people in crisis, with the right provisions at the right time to prevent further escalation and provide timely interventions.

ACTION 12. Create clear and regionally consistent urgent, emergency and crisis services for children and young people that will work together with crisis services for adult mental health.

108. Young people who continue to need mental health treatment and care transition from CAMHS to adult mental health services with the aim of completing the transition around their 18th birthday. There is no regional protocol in Northern Ireland for the transition of young people from CAMHS to adult mental health services, and transition pathways vary across the Trusts.

109. While Trusts have worked to establish and improve transition pathways, there continues to be reports of poor service user experience. The IMPACT study on transitions in Northern Ireland found that none of the young people transitioning experienced an “optimum transition”. The study also identified inequities, with those prescribed medication and those with psychotic disorders most likely to transfer, whereas service users with autism are generally transferred back to primary care.

TRANSITIONS FOR CHILDREN AND YOUNG PEOPLE WILL BE IMPROVED

110. The transitions process therefore needs to be improved to ensure that the impact on the young person is minimised.

ACTION 13. Develop proposals for transitions between CAMHS and adult mental health services, engaging widely with all relevant stakeholders.

Mental health and older adults

111. Outcomes:

- All older adults who need mental health services will receive the care and treatment they need.
- Old age psychiatry services are no longer based on an age threshold but on the needs of the person.

112. The world's population has been growing exponentially in the past century and correspondingly, the proportion of older adults is increasing rapidly. Mental ill health is common among older adults and in Northern Ireland, it is estimated that a mental health problem is present in 40% of older adults seeing their GP, 50% of older adults in general hospitals and 60% of care home residents. Under-diagnosis is reported as a chronic problem. Older adults with mental illness are more likely to require domiciliary or institutional care. They are more prone to physical co-morbidity and have higher rates of frailty and vulnerability.

40% OF OLDER ADULTS ATTENDING GP

50% OF OLDER ADULTS IN GENERAL HOSPTAL

60% OF CARE HOME RESIDENTS HAVE MENTAL HEALTH PROBLEMS

113. Older adults are vulnerable to the full spectrum of mental illness seen in younger adults, with anxiety disorders particularly prevalent. In addition, they typically have higher rates of mental illness associated with physical illness, frailty and dementia. Social challenges include isolation, bereavement and economic poverty. Despite this, evidence suggests older adults receive proportionally less help than other age groups. Depression affects around 22% of men and 28% of women aged 65 years and over, yet it is estimated that 85% of older adults with depression receive no help at all from statutory services.

114. The legacy of trauma related to the Troubles poses a particular challenge in Northern Ireland. A person who was 18 at the beginning of the conflict will be 68 years old in 2020 and may present to older adults' services, where there is an under provision of psychologically informed, recovery focused interventions.

18 YEAR OLDS AT THE START OF THE TROUBLES TURNED 68 IN 2020

115. Mental health services for older adults in Northern Ireland have not kept up with the changing demand. Old age psychiatry still largely operates on an outdated concept of health and aging, with a cut-off at the age of 65. The increasing number of people over 65 who are relatively physically well, may have their needs met by working-age services. However, the physically frail older adult (including those under 65 with chronic illness) may have needs that result from the physical effects of ageing – needs which are better addressed in specialist old age services.

Ageility NI

Ageility NI (2020 – 2023) is a social circus project designed to engage with older adults across Northern Ireland The project is funded by the Lottery's 'People and Communities' fund and designed and delivered by Streetwise Community Circus. The project provides circus skills workshops that address specific areas of need relevant to older people, with a particular focus on loneliness, social isolation and other aspects of wellbeing. The proposed impacts for this project are based on academic research into the arts as a therapeutic tool, and in particular, the efficacy of using circus skills. Social circus is based on the belief that learning new skills – such as juggling, acrobatics, balancing or aerial skills – can have positive effects on those who participate in the programme. The positive benefits that participants generally experience are not restricted to the acquisition of a new skill; instead, social circus practitioners refer to concepts of improved wellbeing – physically, emotionally, cognitively and socially. As such, social circus is distinct from other forms of circus, such as traditional tented or theatre-based circus shows; or hobbyist organisations such as juggling clubs or fitness acrobatic classes.

116. Safeguarding the rights of people living with frailty and older adults will require identification of needs and planning of systems that deliver the right service, in the right way at the right time. Going forward, we will recognise that age alone is not sufficient to determine what services are needed and how they are best delivered.

117. Respect for personal autonomy and human rights should be central tenets in ensuring the needs of older people are identified and met. When circumstances arise whereby older people require treatment or assessment for mental health, they themselves should play an active role in the decision-making process. Including people over 65 in adult mental health services should not mean a reduction of services, but rather it will ensure that they will be able to access the same expertise as those under 65.

MENTAL HEALTH SERVICES TO OLDER PEOPLE WILL BE NEEDS BASED AND NOT AGED BASED

118. That means we need to plan services based on the needs of the person, rather than their age.

ACTION 14. Ensure mental health services continue to meet the mental health needs of an ageing population and those with dementia through specialist Old Age services. These will be needs based rather than solely dependent on age. The quality of care provided must be equal to that provided to other service users and must be open to younger people when necessary.

Community mental health

119. Outcomes:

- A mental health system that is person centred, where the system adapts to the need of the person.
- Reduction in waiting lists.
- Increase in service user satisfaction through methods such as 10,000 voices.

120. According to the Mental Health Foundation, it is estimated that only 40% of those with mental health problems in Northern Ireland were able to access effective mental healthcare. 79% of those with a mental disorder who sought treatment felt they had not received the service they need.[16]

16 Mental Health Foundation (2016). *Mental Health in Northern Ireland: Fundamental Facts 2016.* https://www.mentalhealth.org.uk/sites/default/files/FF16%20Northern%20ireland.pdf

ONLY 40% OF THOSE WITH MENTAL ILL HEALTH WERE ABLE TO ACCESS MENTAL HEALTHCARE

121. Going forward, community based services will be evidence based, organised on a Stepped Care Model, the core principle of which is that people are matched to interventions that are appropriate to their level of need and preference. At all times, the services must be adaptable to people and their needs. This includes understanding and responding to the underlying factors, such as social factors, trauma and addictions, including gaming and gambling.

122. Secondary care and community mental health services must therefore be focused on and integrated with the community, with primary care as the hub for mental health care. This will involve a fundamental change in the operation of secondary care mental health, moving away from current service structures towards joined-up locality based approaches that are based on populations in GP Federation areas. Services will be organised to work collectively in responding to the spectrum of need of the population, including those with more severe mental health problems, through collaborative and consultative models of care across primary, secondary and community care. This will put professionals where the people are to ensure the system fits the needs of the people.

GOING FORWARD MENTAL HEALTH SERVICES WILL BE FOCUSSED AROUND THE COMMUNITY TO ENABLE ACCESS FOR THOSE WHO NEED HELP

123. In practice, this means co-designing local pathways of care across primary and secondary care and across the range of available Community and Voluntary sector resources in local areas. It will mean involvement of all actors in the delivery of mental health: GPs, Trusts, the Community and Voluntary sector and other services such as community pharmacists. It will also mean including people with lived experience, their family and carers in the co-design process.

124. At the heart of this is the primary care multi-disciplinary team, which will include mental health workers. We already have mental health practitioners in primary care covering five GP Federation areas. Over the next few years, we will seek to improve access to mental health workers and other professions who can provide mental health support in the primary care multi-disciplinary team.

125. The GP with the primary care multi-disciplinary team will be the first port of call in the newly structured mental health system. In conjunction with greater accessibility of a wider range of therapies through new mental health therapy hubs, many people will have their needs met without requiring further escalation. This will lead to quicker access to services, less referrals and better outcomes for people.

126. The reorganisation of mental health services towards the community will also mean fully involving those who deliver wider health and social care functions across Northern Ireland. The accessibility of community pharmacy and their relationship with their local populations, including individuals suffering from mental ill health, means that they can play a vital role in providing accessible services to support people's mental health. Not only can they help people to get the most from their medicines, they also help people look after their general health and wellbeing, using preventative approaches and behavioural interventions. Whether it is spotting early signs of mental health problems, managing long-term conditions, providing expert medicines advice to patients or signposting to other forms of support, pharmacists working across the health service are ideally placed to ensure people get the support they need. Going forward, pharmacy teams in all settings, including community pharmacy, primary care and hospitals, must be included as key partners in mental health service development to ensure the best outcomes for those with mental health support needs.

127. The effect of this will be noticeable for all. It is expected that this will reduce waiting times, that it will ensure timely access to services from primary and secondary care and the community and voluntary sector and that it will improve user satisfaction with access to services.

ACTION 15. Refocus and reorganise primary and secondary care mental health services and support services around the community to ensure a person-centred approach, working with statutory and Community and Voluntary partners to create local pathways within a regional system, engaging all actors who can help and support a healthy local population.

128. The new models of service delivery across mental health will be based on a principle of recovery based care. This will ensure that all those with mental ill health receive the support they need. We will therefore create a recovery model where care is provided using a person centred approach with continuous involvement with the service user throughout the recovery period.

129. As part of this model, Recovery Colleges represent a valuable resource that could be better used and valued. However, a more comprehensive roll out of the recovery and wellness agenda will require time and resources. Currently, staff engagement in co-production activities through Recovery Colleges has largely been optional. A truly recovery-focused service will view involvement with Recovery Colleges as integral to practitioners' professional development. Existing expertise within the Community and Voluntary sector will be part of this, in particular their valuable experience in training and pathways to employment.

WE WILL CREATE A RECOVERY MODEL WHERE THE RECOVERY COLLEGES ARE IDENTIFIED AS CORE ASSETS

130. In practice, that means creating a recovery model and consolidating the role of Recovery Colleges, ensuring they are accessible to those who need it, wherever they are in Northern Ireland.

ACTION 16. Create a recovery model, and further develop and embed the work of Recovery Colleges, to ensure that a recovery focus and approach is embedded across the entire mental health system.

131. The effective delivery of a community based model of mental health is not possible without the full integration of the community and voluntary sector.

132. Historically, work with the Community and Voluntary sector has developed incrementally and whilst essential, availability of services, focus and configuration is not consistent across Northern Ireland. It is important that support from this sector is available to those who need it, wherever they are. We must harness the skills and experience that exist in this sector to ensure that this is used to benefit people with mental ill health.

Impact of the Community and Voluntary Sector

Kourtnie: "I feel like my life was all a bad dream before I joined The Prince's Trust, with the help of the Team programme I grew into the confident, bubbly person I am today."

Kourtnie, 23 from Belfast, was just 13 when her 17-year-old sister died by suicide. The death had a profound impact on Kourtnie, and she became emotionally withdrawn from her friends and family. She became pregnant aged 16 and left school without the qualifications she wanted. By 17 she was a single parent and moved out of the family home. She was very isolated and rarely left her house other than to go shopping or visit her Grandmother. When her Grandmother sadly passed away, Kourtnie became even more depressed and lonely. She was put in touch with the leader of The Prince's Trust Team programme in East Belfast.

Team is a 12-week personal development programme for young people to gain new skills, take a qualification and meet new people. "When I first met the Team Leader, I confessed to him that it was the first time I'd spoken to anyone in months. None of my friends had children so our friendships faded away after I had my daughter. When I started on Team my confidence was very low and I had no idea what I wanted to do. But around the fifth week it was like a light went on within me, my confidence started to grow, and I even put myself forward as the leader for a community project we were working on."

After the Team programme Kourtnie secured a job in a restaurant where she worked happily until she had a bad experience with another employee. The situation caused her to seek counselling where she finally began to deal with the impact her sister's death had on her. With the help of her counsellor and her own determination, she was able to face the issues head on. Kourtnie went on achieve her English and Maths GCSEs and met a new partner, who she is now engaged to.

"I've always wanted to work as a receptionist. Last year I saw my ideal job advertised working in an admin and reception role, I applied and was delighted to get the job! After that, my fiancée and I bought our first house. I'm now happy and enjoying life, constantly setting new goals and planning a future with my family."

133. In practice, this means seeing the community and voluntary sector as true partners who are fully integrated in ensuring improved outcomes for the population. This means fully including the sector in the planning, development and delivery of mental health services. Going forward, all service delivery mechanisms must include consideration of the role of the community and voluntary sector.

GOING FORWARD THE COMMUNITY AND VOLUNTARY SECTOR WILL BE FULLY INTEGRATED IN DEVELOPMENT AND DELIVERY OF MENTAL HEALTH SERVICES

134. This will mean the development of protocols for formal involvement and integration of the sector in the development of mental health services.

ACTION 17. Fully integrate community and voluntary sector in mental health service delivery with a lifespan approach including the development of a protocol to make maximum use of the sector's expertise.

Medicines in mental health

135. Outcomes:

- Better understanding of the use of medication in mental health services.
- More help and support to professionals prescribing mental health medication.
- Improved outcomes for people on mental health medication.

136. For many people with mental ill health, the help and treatment they receive involves medication. Medicines when carefully selected and used appropriately are an important factor in the sustainability of treatment for those with long term mental ill health and can play a pivotal role in the recovery process. The Medicines Optimisation Quality Framework (2016) sets out a Regional Model for Medicines Optimisation that outlines what patients can expect when medicines are included in their treatment.

137. When a person receives medication for their mental ill health, it is vital that they have access to the necessary level of expertise, especially for those people with severe mental health problems, including those who have coexisting physical health problems and are on complex medication regimes. Specialist mental health pharmacists not only link with their relevant mental health teams, but also with Health and Social Care Board and pharmacists in general practice and community pharmacies by facilitating training and providing medicines advice on complex cases.

STAMP STOMP

The STAMP STOMP initiative was launched in December 2018 by NHS England and The Royal College of Paediatrics and Child Health, pledging to ensure that children and young people with a learning disability, autism or both are able to access appropriate medication (in line with NICE guidance,) but are not prescribed inappropriate psychotropic medication. Regular and timely reviews should be undertaken so that the effectiveness of the medication is evident and balanced against potential side effects. This will mean that children and young people are getting the right medication, at the right time, for the right reason.

138. Community and GP practice pharmacists are ideally placed to initiate medication review for children and young people who are prescribed psychotropic medication. However, systems for referring complex cases for specialist mental health pharmacist review are also required.

139. Many of the medicines used to treat mental health problems are associated with health risks, some of which can be severe. As experts in medicines and their use, pharmacists can ensure people get the best outcomes from their medicines, reduce adverse events, minimise avoidable harm and unplanned admissions to hospital, while ensuring resources are used more efficiently to deliver the level of care that people with mental health conditions deserve.

140. The World Health Organisation's third Global Patient Safety Challenge "Medication without Harm" focuses on strengthening the systems for reducing medication errors and avoidable medication related harm, with priority given to actions to reduce harm from inappropriate polypharmacy, high risk situations and transitions of care. "Transforming medication safety in Northern Ireland" is the HSC response to the WHO Challenge, and this recognises that utilising the knowledge and skills of pharmacy teams in all settings is essential to minimising avoidable medication related harm. This is particularly important in mental health service delivery models, with many medicines used for mental health conditions having the potential to cause serious harm if used incorrectly.

WE WILL INCREASE THE USE OF PHARMACISTS IN MENTAL HEALTH SERVICES TO HELP ENSURE THE BEST USE OF MENTAL HEALTH MEDICATION

141. Going forward we will continue to work to ensure that specialist medication is available to those who need it and that the usage of medication is in accordance with best practice. This means integrating the medicines Optimisation Quality Framework and better usage of pharmacists across mental health services.

ACTION 18. Fully integrate the Medicines Optimisation Quality Framework and the Northern Ireland Medicines Optimisation Model into mental health service delivery by integrating pharmacy teams into all care pathways that involve the use of medicines to ensure appropriate help and support is provided to people who are in receipt of medication for their mental ill health.

Psychological therapies

142. Outcomes:

- Availability of psychological services at the time when people need it.
- Reduction in waiting times to access psychological services.
- Integrated psychological therapies in mainstream mental health services.
- Use of all available methods and technology to meet the needs of the people.

143. An important part of community mental health services is the use of psychological therapies. However, there are currently inequalities in the provision of and access to these services across Northern Ireland. Waiting lists for psychological therapies are long, with over 2,400 adults and over 260 children and young people waiting longer than 13 weeks and over 700 adults and over 90 children and young people waiting longer than a year.[17]

OVER 700 ADULTS AND OVER 90 CHILDREN AND YOUNG PEOPLE HAVE WAITED OVER A YEAR FOR PSYCHOLOGICAL THERAPIES

144. Improving access to effective psychological therapies is therefore a fundamental component to improving the mental health of the population.

145. In practice, to ensure improved access to effective psychological interventions, it is essential to match the right level of intervention to the individual seeking support, at the right time. This will require having a sufficient workforce with the right knowledge, skills and competencies to meet demand and deliver psychologically informed interventions to a high quality.

146. Improving access must encompass a whole life approach, be evidence-based and trauma informed, placing the service user at the centre such that they are equal partners in their own self defined and self-directed care. Beyond increasing access to high quality interventions, there is also a need to fully integrate psychological therapies pathways within mental health services. Existing regional variations in service delivery means that in some areas people have to wait excessively long for psychological therapies.

WE WILL INCREASE ACCESS TO PSYCHOLOGY ACROSS MENTAL HEALTH SERVICES BY EMBEDDING PSYCHOLICAL SERVICES IN MAINSTREAM MENTAL HEALTH SERVICES

17 Correct as of 28 February 2021.

147. This means embedding psychological services into mainstream mental health services, both in primary and secondary care. In primary care, this means further rollout of therapy hubs. In secondary care, this means integrated community mental health teams where psychology is one of the tools for the successful outcomes for the patients. This will ensure that psychological therapies are available across all steps in the stepped care model.

148. This will reduce the time people have to wait for psychological therapies.

ACTION 19. Embed psychological services into mainstream mental health services and ensure psychological therapies are available across all steps of care.

Physical health and mental illness

149. Outcomes:

- People with mental health difficulties will be supported to enjoy the same quality of life as the general population and have the same life expectancy.
- People with Serious Mental Illness will be offered, and encouraged to participate in, an annual health check.
- Reduction in % of mental health patients who are smoking.
- People with a physical illness will receive appropriate help and support to deal with mental ill health.

150. In Northern Ireland, people with severe and enduring mental illness have a reduced life expectancy of 15 to 20 years because of poor physical health. Addressing this requires a cultural change and systematic approach across our communities, primary care, secondary care and specialist acute services. Every part of the mental health system should take all appropriate opportunities to support people with mental health problems where they have difficulties with smoking, weight, alcohol or drug use and exercise – the physical healthcare of people with mental health problems is everybody's responsibility.

LIFE EXPECTANCY OF PEOPLE WITH SEVERE AND ENDURING MENTAL ILLNESS IS 15 - 20 YEARS LESS THAN THE GENERAL POPULATION

151. The main responsibility for the physical monitoring of mental health patients receiving treatment in secondary care rests with secondary care. However, often patients with severe and enduring mental health issues see their GP more frequently than secondary care teams. Given the poor physical health outcomes of those with a long term mental illness, we believe there is a need to increase the focus on monitoring the physical health of those with a mental illness. That will mean using every interaction with patients to monitor and seek to improve their physical health.

152. The physical wellbeing of mental health patients must continue to be a priority for secondary care mental health services, particularly in relation to patients who are cared for in acute settings.

WE WILL INCREASE THE PHYSICAL HEALTH OUTCOMES FOR PEOPLE WITH MENTAL ILL HEALTH

153. In practice, this means that all mental health patients should be offered and encouraged to take up physical health screening where appropriate. All patients should also have a combined healthy eating and physical activity programme as part of medication initiation and as part of their recovery plan.

ACTION 20. **Develop an agreed framework between mental health services and primary care services for the physical health monitoring of people with a severe and enduring mental illness, as well as other people with mental disorders.**

ACTION 21. **Ensure that all mental health patients are offered and encouraged to take up screening for physical health issues. Provide help and support across all mental health services to encourage positive physical health and healthy living.**

154. It is accepted that many people with physical health problems experience mental ill health, often as result of their physical illness. This is particularly relevant for those with serious and chronic physical health diagnoses. The needs among these groups of people are wide and varied, however, many experience difficulties accessing appropriate mental health help and support.

155. Going forward, we will ensure that those with physical health problems that lead to mental ill health will be provided with the care and treatment they need. In practice, this will mean further integration of psychology in multi-disciplinary teams, to ensure that psychological support is mainstreamed across physical health. It also means that those working in physical health teams where mental ill health is common among clients, should be trained in identifying mental health needs and in responding to such needs. This may also include providing counselling or therapies within physical health services.

GOING FORWARD THOSE WITH PHYSICAL ILL HEALTH THAT LEAD TO MENTAL ILL HEALTH WILL RECEIVE THE CARE AND TREATMENT THEY NEED

156. For those with more specialist mental health needs, access to mental health specialist support must be available. This does not mean the provision of dedicated mental health resources within physical health services; instead, it requires the creation of efficient pathways to allow individuals to access this specialist support, thereby ensuring patients get the care and treatment they need, when they need it.

Our Hearts Our Minds

Our Hearts Our Minds (OHOM) is a model of high quality preventative cardiology care. It is a nurse-led programme delivered under the Department of Health's Transformation agenda that supports patients after a cardiovascular event helping them to achieve healthier lifestyles, manage their blood pressure and cholesterol, as well as making sure that they are on the right cardioprotective medications.

The multi-disciplinary team is the first of its kind in Northern Ireland, as it has psychology practitioners as integral members of the team and also comprises a Specialist Clinical Psychologist and a Psychological Wellbeing Practitioner. Dedicated psychology provision is an integral and critical aspect of the programme.

The Psychology service, along with all the OHOM team, reconfigured service provision to meet issues which have arisen due to COVID-19 - individual sessions were conducted virtually by either phone or video call as per patient preference. Analysis shows statistically significant improvements in anxiety and depression levels for patients who have completed their cardiac rehabilitation through this programme.

ACTION 22. Create effective pathways from physical healthcare into mental health services to ensure those with a physical illness that causes mental ill health can receive the care and treatment they need.

Severe and enduring mental ill health

157. Outcomes:
    - Increased user satisfaction for people with severe and enduring mental ill health.
    - Increase in % of people with severe and enduring ill health that are actively engaged with society.
    - Improved engagement with service users, families and carers in the development and delivery of services and personal care plans.

158. It is important to recognise that there are some individuals who will always need specialist help and support that is often long term. All practicable help and support will be provided to people with severe and enduring mental ill health, in line with the vision of person-centred care and a "no wrong door" approach.

159. It is accepted best practice that a partnership approach should be employed for those living with severe and enduring mental ill health. This recognises informal carers and families as having informed experience in the needs of the service user and in identifying potential person-centred solutions. This approach should be based on the Triangle of Care, which encourages joined-up working between the informal carer/family, the person using services and professionals.

A PARTNERSHIP APPROACH TOGETHER WITH PEOPLE WITH SEVERE AND ENDURING MENTAL ILL HEALTH SHOULD BE ADOPTED ACROSS MENTAL HEALTH SERVICES

160. Service developments relating to people with severe and enduring mental ill health should value and include the expertise of the user, as well as informal carers and family members. This would mean a cultural change, where users with severe mental ill health and their support networks are not just valued, but are sought out and identified for their input.

ACTION 23. Provide people with severe and enduring mental ill health the right care and treatment at the right time. They, together with their support networks, are to be included in the decision making around their care and in the development of services and new ways of working.

In-patient mental health services

161. Outcomes:
    - Acute in-patient bed occupancy levels in line with the Royal College of Psychiatrists recommendations.
    - Regional consistency in length of stay.
    - Decrease in average length of stay across acute in-patient settings.
    - Better life outcomes for patients with a long term intensive mental health need.

162. Whilst community mental health services provide the best outcomes for most people who experience a mental illness, inpatient services are required for those where an effective community intervention is not possible.

163. In Northern Ireland, the acute inpatient care system has for many years been under extreme pressure. Bed occupancy has consistently been around 100%, even though the Royal College of Psychiatrist's recommended occupancy level is 85%.

AVERAGE ADULT ACUTE MENTAL HEALTH IN-PATIENT BED OCCUPANCY BETWEEN 1 JUNE 2020 AND 21 MAY WAS 101%

164. This has led to an in-patient system that operates in crisis mode, where it is not possible to provide therapeutic intervention as required. Due to the pressures on the system, the focus is often on patient maintenance rather than recovery.

165. The provision of therapeutic improvements in an in-patient setting is further hampered by an old in-patient infrastructure. About half the acute in-patient beds are in facilities that have not seen significant upgrades for decades and do not meet recognised best practice standards, including the routine availability of single-bed bedrooms.

166. Over the last decade, the Department has invested significantly in new mental health units across Northern Ireland. This has provided state of the art, single bed bedroom units where the physical infrastructure is helping in the recovery journey of the patient.

WE HAVE INVESTED IN NEW MENTAL HEALTH UNITS AND WILL INVEST A FURTHER £206M

167. The capital works programme to replace the existing in-patient units will continue over the next decade, with a further £206m to invest in a further three new units. When continuing this programme, it is important that new inpatient developments meet the changing needs of the population. This means considering how to get the best outcomes for patients, and not remain in old ways of thinking. It also means considering how to integrate learning disability wards in mental health units, considering the need and design of a specialist perinatal mother and baby unit and provisions of other specialist in-patient care.

168. Across Northern Ireland, there are also significant variations in average patient length of stay (varying from 12 days in one Trust to 42 days in another). While there are demographic and geographic differences between the Trusts, we must get a better understanding of the regional variations to ensure consistent quality services will be provided.

169. The new Mental Health units have single bed bedrooms, and will be built to help deliver state of the art therapeutic options. We expect this to lead to a reduction in the length of in-patient stay, with less incidents and problems on the wards.

170. For the small cohort of detained patients, the recent first phase commencement of the Mental Capacity Act provides a framework for deprivation of liberty in the community. This allows us to consider new ways of responding to patients who require detention. Going forward, we will use this change in legislation to consider if these patients can be cared for safely in the community. This will allow for greater community integration and a more normal life for patients.

Different ways of working in in-patient care

When I lived in Germany, we had access to "recovery rehab centres". I would spend up to eight weeks there when I felt I couldn't cope with my illness but was not severely unwell. This was very different from an in-patient stay in hospital. I received support with all areas of my life. A holistic approach was used. We did mindfulness, art therapy, horse therapy, one-to-one and group counselling, emotional testing. I developed some great relationships there. It is badly needed in Northern Ireland, away from acute hospital.

ACTION 24. Continue the capital works programme to ensure an up to date in-patient infrastructure. Consider alternative options to hospital detentions in line with legislative changes to ensure the best outcomes for patients and that those who need in-patient care can receive the best care available.

171. Across the in-patient units in Northern Ireland, there are a number of patients who have a high level of need who require a longer period of time to respond to treatment. This patient group are often detained under the Mental Health Order and are often in hospital for a very long time.

172. This patient group, usually consisting of people with complex psychosis who are at risk of being unable to achieve or sustain successful community living, are not in need of acute mental health inpatient beds, but still comprise up to 20% of the acute in-patient population.

173. Acute in-patient services do not provide the best outcomes for this patient group and are often less effective. A better approach to meet their needs would be a dedicated rehabilitation service based on a recovery model. Rehabilitation services form part of a pathway to recovery for people with schizophrenia and related psychoses. Rehabilitation can be provided in a variety of settings, accepting referrals from acute wards and delivered through inpatient rehabilitation, community based rehabilitation services and various levels of care and support in the community, including supported living, nursing and residential care home options.

WE WILL CREATE A SUSTAINABLE REHABILITATION SERVICE ACROSS NORTHERN IRELAND

174. In Northern Ireland, we will create a sustainable rehabilitation service that meets the needs of the patients. In practice, that means creating a regional structure for mental health rehabilitation with specialist community teams and a recovery ethos.

Community Mental Health Rehabilitation Team (CMHRT)

The Southern Health and Social Care Trust has spearheaded the introduction of a multi-disciplinary Community Mental Health Rehabilitation Team, the first dedicated tertiary service of its kind in Northern Ireland.

Occupational therapists working in the area of Resettlement and Rehabilitation holistically look at all areas of a person's life and functioning, including activities of daily living, cognition, meaningful education and employment opportunities, with the desire to develop and maintain skills, promote social inclusion, community integration and enable service users to achieve maximum independence.

For example, Aiden is a young man with a psychotic disorder which has resulted in several lengthy admissions for acute inpatient care. Living in a supported living facility, he faced problems with motivation, looking after himself and his space, social isolation and low confidence. He wanted to make friends again while avoiding anti-social behaviours and misuse of substances.

The occupational therapists in the CMHRT worked with Aiden using the Recovery Star outcome measure tool, which helped prioritise goals for Interventions. These included improved home management skills, healthy eating habits, daily routines and social activities with others. The team led a combined effort to help him achieve his goals which initially focused on a personalised weight management programme, making healthy food choices and increased physical exercise activities, including engagement in graded exercise sessions such as weekly walking, cycling and gym activities. The occupational therapists also introduced him to new skills in the kitchen to help with his goal of healthy eating.

The result of these interventions is that Aiden's life and skills have improved to the point where he can successfully live in his own flat within his local home town. He has maintained his new living arrangements for a substantial period of time, with significant reduction for the need of CMHRT support. He has identified his next goals as gaining paid employment and his driver's licence which would help promote the quality of his life.

ACTION 25. Create a regional structure for a mental health rehabilitation service, including specialist community teams and appropriate facilities for long-term care.

175. A number of mental health patients in hospital have needs which are greater than what can ordinarily be provided in mental health in-patient units. Low secure services are for people detained within a legislative framework that cannot be treated in other settings because of the level of risk or challenge they present. They do not require the provisions of medium secure care as provided by the Shannon Clinic. Such patients may have been in contact with the criminal justice system but others may present other risks.

176. The mixing of patients who have low secure needs with the general mental health population, including those detained under the Mental Health Order but not deemed low secure risk, increases the risk of conflict and reduces recovery times for both patient groups. Specialist low secure services will help in the provision of the accurate assessment and management of risk.

WE WILL PROVIDE LOW SECURE SERVICES

177. We will therefore provide regional specialist in-patient services for patients with a higher need in dedicated low secure settings. This will support patients with severe presentations that are gravitating towards the criminal justice system, which could ultimately result in a lost opportunity for recovery. It will also lead to less conflict on existing mental health wards and overall shorter patient stays in hospital.

ACTION 26. Develop regional low secure in-patient care for the patients who need it.

Crisis services

178. Outcomes:
    - A regional mental health crisis service.
    - Effective help and support for people in crisis, through a regional crisis service, with a resultant reduction in Emergency Department attendance for mental health patients.

179. A recent report by the Royal College of Psychiatrists found that 40% of mental health patients have been forced to resort to emergency or crisis services and one in ten people in distress end up in Emergency Departments.[18] People in crisis require help and support and no-one should have to wait for that help.

180. Crisis services exist to provide support to some of the most vulnerable patients in a very difficult time of their lives. Over recent years, a number of pilots of new crisis services have been tried in Northern Ireland, including cooperation between the PSNI, the ambulance service and HSC Trusts (Multi Agency Triage Team), and the community crisis intervention service in Derry/Londonderry. Other improvements to crisis and urgent care services include the creation of mental health liaison in Emergency Departments.

Multi Agency Triage Team

The Multi Agency Triage Team (MATT) pilot commenced in July 2018 as a collaborative project involving two Police Officers, a Community Mental Health Practitioner and a paramedic working together to respond to people experiencing a mental health crisis, aged 18 and over, who have accessed the 999 or 101 system. The pilot was initially established as a two year initiative in the South Eastern Health and Social Care Trust. However, following positive feedback from service users and MATT staff, the service was extended to cover Belfast Health and Social Care Trust in August 2019.

MATT has successfully assisted in the de-escalation of crisis with signposting to appropriate services and through reducing presentations at Emergency Departments.

181. Going forward, we need to improve crisis services, which will include the use of new delivery methods such as MATT. We will establish a Regional Mental Health Crisis Service, that will help to integrate practitioners trained in Distress Brief Intervention, or similar, into existing mental health crisis pathways. These pathways will include primary care multi-disciplinary teams, out of hours primary care, Emergency Departments, MATT, Lifeline, 999, PSNI, the Ambulance Service and the Regional Emergency Social Work Service.

WE WILL CREATE A REGIONAL CRISIS SERVICE

18 Royal College of Psychiatrists (2020). *Two-fifths of Patients Waiting for Mental Health Treatment Forced to Resort to Emergency or Crisis Services.* https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2020/10/06/two-fifths-of-patients-waiting-for-mental-health-treatment-forced-to-resort-to-emergency-or-crisis-services

182. It is anticipated that the crisis services will have four strands, including crisis resolution home treatment, mental health liaison, community crisis support and primary care and interagency partnership. The crisis service will be developed on a regional basis and will provide consistency for those with crisis needs.

ACTION 27. Create a Regional Mental Health Crisis Service that is fully integrated in mental health services and which will provide help and support for persons in mental health or suicidal crisis.

Co-current mental health issues and substance use (dual diagnosis)

183. Outcomes:

- A reduction of patients with a co-current mental health and substance use issue that are non-compliant with mental health treatment
- A person centred approach to care that focusses on the person, rather than expecting the person to fit the system.
- Better health and social outcomes for those with co-current mental health and substance use issues.
- People with co-occurring mental health and substance use issues receive high quality, holistic and person-centred care.

184. Access to services for people who have a co-occurring mental health and substance use problem, often called "dual diagnosis", has been an ongoing concern. For some individuals, their drug use and mental health issues are interrelated. Both general mental health difficulties and symptoms associated with psychological trauma can lead people to "self-medicate" with alcohol and drugs to manage these aversive feelings. However, this heightened level of alcohol and drug use can, in turn, result in an exacerbation of these mental health issues.

185. The guidelines are clear: no matter where the individual with co-occurring issues is first referred to, whether mental health or substance use services, clinicians and services users must work collectively together to address the issues and people should not be referred back and forward between different services unnecessarily.

DUAL DIAGNOSIS GUIDELINES ARE CLEAR - SERVICES SHOULD WORK COLLECTIVELY TO ADDRESS THE NEEDS OF THE PERSON

186. Service users often report difficulties in accessing services and unclear lines of referral. The response must therefore ensure that mental health services and substance use services consider the patient first, and adjust the systems to fit the patient, rather than expect the patient to fit the system.

187. However, the creation of a dedicated dual diagnosis service is not the answer. Such a service would be at risk of receiving "difficult" referrals that mental health and substance use services do not feel able to treat. Instead, the most effective approach is likely to be one where mental health and substance use services work together.

A MANAGED CARE NETWORK WILL BE CREATED TO ENSURE A NO WRONG DOOR APPROACH

188. In practice, support will need to be provided to ensure services work collaboratively and that existing pathways are followed. This will take the form of a managed care network with experts in dual diagnosis, to ensure capacity building and appropriate pathways.

ACTION 28. Create a managed care network with experts in dual diagnosis, supporting and building capacity in both mental health and substance use services, to ensure that these services meet the full needs of those with co-occurring issues.

Specialist interventions

189. Outcomes:

- Effective specialist interventions that meet the needs of the people, when they need it.
- A person-centred service that avoids silos and where people are treated as individuals.
- The right specialist interventions when needed, with quicker outcomes thus reducing the time people require mental health interventions.

190. Mental health services in Northern Ireland are normally provided through generalist services. Such a system allows a wide approach to mental health that can capture a large group of people without unnecessary onward referrals. However, generalist services do not always cater for the needs of specific groups.

191. Evidence from other countries is clear: specialist interventions provide better outcomes for patients and shorter recovery times when they have been set up correctly within a wider generalist mental health system. Going forward, we will address the shortfall in specialist services and will provide specialist interventions where they are needed.

WE WILL CREATE SPECIALIST INTERVENTIONS WHEN THEY ARE NEEDED

192. When developing specialist interventions, we must remember that we have a relatively small population. It will not be possible to provide some specialist interventions in Northern Ireland as they cannot be provided safely.

193. Currently, approximately 12-15 patients per annum who are detained under the Mental Health Order, are sent for specialist treatment in England and Scotland. These patients often stay away from family and friends for a long time. We will, where possible, develop specialist in-patient provisions to avoid sending these people to England and Scotland.

Perinatal mental health

194. Perinatal mental health is a priority for prevention and early intervention. Poor perinatal mental health affects not only mothers but also increases the risk of poorer outcomes in health, educational and social outcomes for children. This potentially creates a cycle of poorer mental health in subsequent generations.

195. Northern Ireland currently lags behind the rest of the UK in relation to specialist perinatal mental health care, with Belfast being the only Trust currently having a specialist consultant-led perinatal mental health service. For mothers requiring inpatient mental health care, there is no mother and baby unit in Northern Ireland, and mothers requiring admission are cared for on general adult mental health wards, with no opportunity for their child to be accommodated alongside them.

196. We have started the work to develop a regional specialist perinatal community mental health service. This will play a key role in: helping expectant and new mothers who are experiencing mental ill health; reducing in-patient care; and promoting strong, secure, attachments with their children. We will continue to roll out specialist perinatal mental health services, including in-patient services.

WE WILL CONTINUE TO ROLL OUT SPECIALIST

PERINATAL MENTAL HEALTH SERVICES

Psychosis

197. Early intervention in the treatment of psychosis has been shown to reduce the severity of symptoms, improve relapse rates and significantly decrease the use of inpatient care. A recent meta- analysis of outcomes at 6 to 24 months concluded that an early intervention in psychosis approach was associated with better outcomes compared with standard treatment, including hospitalisation risk, bed-days, symptoms, and global functioning.[19]

198. NICE guidance on psychosis and schizophrenia states that early intervention services in psychosis should aim to provide a full range of pharmacological, psychological, social, occupational and educational interventions for people with psychosis, irrespective of age or illness duration. Treatment with an oral antipsychotic, combined with psychological interventions, is the recommended first line choice. The Medicines Optimisation Quality Framework domains of patient/client focus, safety and effectiveness must be incorporated into first episode services.

The STEP service

The STEP service (Service, Treatment, Education and Prevention) in the Northern Health and Social Care Trust is made up of psychology and psychiatry staff, and has been developed to identify young people (14-34 years) that have an increased risk of developing psychosis. The service uses evidence-based assessment procedures and offers a range of treatment packages aimed at delaying / preventing psychosis from occurring. Most people seen by the STEP service never develop a psychotic disorder.

199. In Northern Ireland, psychosis interventions are provided within community mental health teams, home treatment and throughout in-patient services. However, they are not as integrated as they could be and do not always help patient recovery. To overcome this, we will create a psychosis network to ensure early intervention psychosis care, access to evidence-based treatments and interventions.

WE WILL CREATE A PSYCHOSIS NETWORK

19 Correll, C. U. et. al. (2018) *Comparison of Early Intervention Services vs Treatment as Usual for Early-Phase Psychosis* JAMA Psychiatry 75(6): 555-565

Personality disorders

200. Up to 50% of those attending psychiatric outpatient clinics, 50% of those in psychiatric inpatient services and 80% of the prison population, meet the criteria for a personality disorder. 45% of those presenting at Emergency Departments with self-harm have a personality disorder and 9%-10% of those with a personality disorder die by suicide.[20] The ethos of the 2010 'Personality Disorder Strategy: Diagnosis of Inclusion' will be retained and people considered to have a personality disorder will have access to mental health services in a way that is equitable with all other patients who access treatment.

201. Specialist psychological treatments are often needed for people with a personality disorder and this sits closely alongside the vital role of community mental health teams. Personality disorder services will be further developed on a regional basis in a tiered approach to enhance both community mental health team expertise and the provision by specialist services, alongside an integrated approach with the community and voluntary sector.

SPECIALIST PERSONALITY DISORDER SERVICES WILL BE FURTHER DEVELOPED

202. In making best efforts to reduce the transfer of patients to England and Scotland for the specialist in-patient treatment of personality disorders, there needs to be a focus on increasing day treatment services and providing therapeutically-informed supported accommodation regionally. In addition, people with personality disorder will be considered in the development of general in-patient settings and of low-secure provisions in order to access inpatient treatment locally when appropriate.

Eating disorders

203. While Northern Ireland already has a regional network for the provision of services for people with an eating disorder, outcomes for these patients could be improved. In particular, evidence suggests that early intervention is key. This means supporting services to offer specialist treatment to all those who are presenting with eating disorders, including mild to moderate cases, without delay.

20 RCPsych, 20220 (PS 01/20 Services for People Diagnosable with Personality Disorder. https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps01_20.pdf?sfvrsn=85af7fbc_2 last accessed 9.4.2021)

204. We will provide further investment so that eating disorder services can achieve optimum staffing levels and skill mix to deliver effective care across the pathways. In practice, this will include additional medical, nursing, dietetic, psychology, occupational therapy and social work staff working in the community, and providing in-reach to medical and mental health wards. It may also involve other therapies and allied health professions.

EATING DISORDER SERVICES WILL BE IMPROVED WITH AN ENHANCED SKILL MIX TO DELIVER MORE EFFECTIVE CARE

205. Additional investment will allow for the development of intensive day treatment facilities in line with National Institute for Health and Care Excellence (NICE) guidance.

206. The future of in-patient services will involve adequately supporting our local in-patient units, medical and mental health, with in-reach and clinical consultation. We need to ensure that there are sufficient staffing levels for the management of high-risk patients with eating disorders. Support includes facilitating the development of Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) groups.

Other specialist interventions

207. We acknowledge that there are many other specialist interventions required across mental health services. Going forward, we will continue to develop our understanding of specialisms within a general mental health service.

208. For example, this includes consideration of neuropsychiatry or services for those with ADHD. Such services provide a contribution to assessment and treatment for people with cognitive, behavioral or psychiatric symptoms associated with neurological disorders, such as Parkinson's Disease, epilepsy and acquired brain injury (including alcohol and drug related brain injuries); those with functional neurological symptoms such as dissociative seizures or conversion disorders; as well as for other neuropsychiatric conditions which may include sleep disorders or complex neurodevelopmental disorders. Such conditions must be considered across the whole course of human development from birth to old age.

209. Interventions across mental health focused on specialist areas should be delivered through multi-disciplinary teams including psychiatric specialists, clinical psychologists, occupational therapists, speech and language therapists, nurses and social workers.

ACTION 29. Ensure there are specialist interventions available to those who need it. In particular:

a. Continue the rollout of specialist perinatal mental health services.

b. Ensure access to evidence based treatments and interventions for people presenting with a first episode psychosis and develop a regional psychosis network.

c. Enhance the provision of personality disorder services regionally through the formation of a Personality Disorder Managed Care Network.

d. Enhance the regional eating disorder service.

e. Further develop specialist interventions with a lifespan approach to ensure that those who require specialist interventions will receive them when needed.

Theme 3

New ways of working

210. We have set out in this Strategy the strategic changes to mental health services that can support individuals throughout their lives. But we need to ensure we have the right framework, structures and support in place to make these changes happen and improve outcomes for individuals.

211. Our vision sets out our desire to ensure consistency and equity of access across Northern Ireland, and to provide a choice of services that are based on evidence of what works. And we need to find a way of measuring how these changes are positively impacting people on an individual level.

212. Having a skilled, compassionate and trauma informed workforce is key to achieving the change required. Our mental health workforce is dedicated and committed to supporting the people they work with, but the system too often hampers their best efforts. It is important to provide the right environment that enables support staff to do their utmost to meet the needs of the people they work with.

213. We also need to build on existing and new evidence to allow us to be ambitious and innovative as we seek to bring about lasting change.

Digital mental health

214. Outcomes:

- Increase access to digital mental health solutions.
- Support the traditional delivery of mental health services with new digital methods.

215. Since the outbreak of COVID-19, individuals attending mental health services have received support in innovative and alternative ways using digital technology (e.g. tele-therapy sessions). While these supports should not be viewed as replacements or proxy versions of traditional psychological therapies modalities, they represent an important new avenue of support by providing additional stand-alone treatment models.

216. In Northern Ireland, new initiatives have been developed rapidly throughout 2020, including an Apps Library, on-line Stress Control classes and the usage of virtual platforms to deliver group and individual psychological interventions.

THE PANDEMIC HAS HELPED US FIND NEW WAYS OF DELIVERING SERVICES

217. Going forward, we must build on our experiences from the pandemic and bring in the many good new practices that have been developed into the ongoing delivery of services. This means further developing and providing digital delivery of mental health services. We recognise that digital services are not the most suitable option for some individuals, and traditional therapy options should and will remain available for those who need them. However, by increasing access to digital options we will increase choice, availability and access across a broader range of services, leading to improved outcomes for all.

ACTION 30. Develop and implement a comprehensive digital mental health model that provides digital delivery of mental health services at all steps of care.

A regional mental health service

218. Outcomes:

- A regional approach to mental health with regional consistency in service delivery.
- Less confusion for patients using services across Trusts measured through service user satisfaction surveys.
- Improved experience for those transitioning between Trusts.
- People have access to high quality, regionally consistent but locality-based services within local communities.

219. In Northern Ireland, mental health services are delivered through the Health and Social Care Trusts. The integrated structures between health and social care have significant advantages, including a single employer and budgets, integrated management (which fosters inter-professional working) and integrated approaches to hospital discharges.

220. However, Lord Crisp's report into mental health services in Northern Ireland noted that whilst there are significant strengths in this system, there are also weaknesses around commissioning arrangements and that the organisational boundaries get in the way of improving quality and efficiency. Mental health does not always get the same attention as physical health, which can offset the positive impact of an integrated health and social care system across physical and mental health.

221. To overcome the current challenges, we will create regional structures to provide oversight of service development and delivery. This will ensure greater consistency, overcoming the sometimes confusing range of different types of service provision in different Trust areas. The regionality that is needed will extend to service models, service delivery and service structures, including service names and language.

222. In practice, that means we will create a regional mental health service network which will include professional leadership responsible for consistency in service models and development. This includes ensuring consistency in the services offered across Northern Ireland. The Encompass programme offers us a significant opportunity to start to build this regional consistency. As we roll out new, digitally enabled ways of working this will drive regional discussions on consistent care pathways, data collection, nomenclature and standards.

A REGIONAL MENTAL HEALTH SERVICE WILL ENSURE CONSISTENCY IN SERVICE PROVISIONS

The Regional Eating Disorder Network Group

When developing a regional mental health service, it is important to recognise those existing structures that already exemplify regionalisation and equity in service planning with local delivery. The Regional Eating Disorders Network Group is one such example. This group has been meeting for many years involving: multi-disciplinary clinicians from each Eating Disorder Service within Adult and CAMHS; individuals from Community and Voluntary sector user and carer groups (EDANI); representation from the HSCB; and the Department of Health, when required. The work of the group has revolved around the collation and interpretation of data, sharing best practice and ensuring a collective vision for the future direction of Eating Disorder Services across the region. It has also created a culture of good working relationships and open, honest communication. The group is empowering, inclusive and takes proud ownership of steering its chosen specialist field of work.

223. It is not the intention to limit local areas' ability to respond to the needs of their communities. Trusts will still be responsible for service delivery in their area, and patients will interact with the Trusts. Even so, a regional mental health service will directly benefit patients by removing variations in service availability, ensuring everyone in Northern Ireland has access to similar types of services regardless of where they live. It will improve the movement of patients across Trust boundaries and will aid understanding of the system among users.

ACTION 31. Develop a regional mental health service, operating across the five HSC Trusts, with regional professional leadership that is responsible for consistency in service delivery and development.

Workforce for the future

224. Outcomes:

- A well supported workforce that is fit for the future and meets the needs of those who are mentally ill.
- An increase in the number of training places for mental health professionals.
- An increase in the number of staff employed in mental health services and a development of new professions and practices across services.
- A workforce who have training in meeting the needs of particular high risk groups, suicide prevention skills and trauma informed practice.

225. The significant and enduring mental health needs of Northern Ireland's population have been repeatedly demonstrated and have clear links to well-established socioeconomic determinants of health and the legacy of the Troubles. For staff in mental health services, there appears to be an ever increasing demand, more complexity in presentation, and recruitment and retention challenges.

226. Across Northern Ireland, mental health services are struggling with high vacancy rates, with some Trusts reporting mental health nurse vacancy rates of over 20%. Over the last few years, we have increased training places at local universities for mental health nurses by 85%. Going forward, we will continue to train more mental health nurses.

OVER 20% OF MENTAL HEALTH NURSING POSTS IN HSC TRUSTS ARE VACANT

227. While the number of vacant psychiatry posts is not higher than the rest of the UK, the use of locums to fill vacant posts is very high, with a combined locum and vacant posts rate at 22%. Whilst locums can fulfil the duties of a permanent psychiatrist, the effectiveness is often reduced due to lack of stability and lack of patient knowledge. We will work with the relevant bodies to ensure that the psychiatry workforce is sufficient to meet the demand.

22% OF PSYCHIATRIST POSTS ARE EITHER VACANT OR FILLED BY LOCUM STAFF

228. The number of approved social workers in Northern Ireland has increased over the last few years. However, it is estimated that at least a further 25% are required in order to meet demand.

229. Occupational Therapy vacancy rates across Northern Ireland are approximately 10% and in the past ten years, there has been a decrease of 16.6% in undergraduate commissioned places. National shortages mean that Occupational Therapy has recently been added to the Priority Immigration Shortage Occupation List.

230. We have significantly increased the training places in clinical psychology, but there is still a shortfall in the availability of clinical psychologists and fewer training places per head than other parts of the UK.

231. Going forward, multidisciplinary working – with a skilled, supported workforce that is equipped to meet the demands – is central to the future provision of mental health services, as it provides the strength of the biopsychosocial approach and creates an effective working environment that enables each professional and group of professionals to use their own unique skills, knowledge, and abilities. Teams with wide skillsets can better meet the individual's needs by creating a tailored blend of personalised interventions that provide consistency, cohesion, and choice. Strong, well-trained multidisciplinary teams therefore can deliver safer, more effective services that can meet the depth and breadth of the challenges faced during the individual's recovery journey by developing and implementing a shared intervention plan from each profession's unique perspective.

232. Going forward, this also means investing in areas of the health and social care workforce that have often not been included. Development and improvement of the mental health workforce must include the full range of allied health professionals, counsellors and therapists.

Speech and Language Therapy - Children with disabilities

The speech and language therapy community paediatric service in the Southern Health and Social Care Trust, works with children with special educational needs in Child Development Clinics and Special Schools. The children supported by the service also experience a range of mental health needs and difficulties.

Speech and language therapists work alongside occupational therapy, physiotherapy and education staff in special schools to help understand any behaviours of concern, adopting a trauma informed approach. Speech and language therapists have started working with intellectual disability CAMHS and are supporting the completion of assessments. Speech and language therapists have also joined with multi-disciplinary team therapeutic planning meetings, provide recommendations to the therapeutic plan and set goals.

Challenging behaviour is often communicating an unmet need or a distress particularly if a child is feeling unsafe, insecure and disconnected. Speech and language therapists, as part of the multidisciplinary team, can provide important information on speech, language and communication needs, training and advice on alternative communication tools and strategies, as well as contributing to the development of a more comprehensive plan and effective practice across all aspects care. This can help the child's feeling of safety and security and therefore lead to better outcomes.

233. In practice, this means considering the existing workforce and new models of working in a comprehensive workforce review. This will allow informed decision making as to where the focus on training, recruitment and retention needs to be, and help us create a workforce for the future that will meet the needs of our population. This may include bringing in new professions and skillsets to the mental health workforce, ensuring such skills and expertise are available across Northern Ireland, and normalising new care and treatment options.

WE WILL COMPLETE A COMPREHENSIVE WORKFORCE REVIEW TO ENSURE WE HAVE A WORKFORCE FOR THE FUTURE

234. The current definition of the mental health workforce needs to be broadened to capitalise on all of the specialist skills available. This will help to ensure equity of access for people and will enable them to make an informed choice of the service which best meets their needs. Flexibility and innovative thinking will be required in the workforce review. Its scope will need to incorporate all professions that are trained and equipped to meet the needs of the whole population, including those professions whose services are not currently provided within the health service or whose skills are currently underutilised. This could also help to address the current recruitment and retainment issues, staff vacancies and workforce pressures which are so critical in mental health services at the present time.

ACTION 32. **Undertake a comprehensive workforce review considering existing workforce need and training, and the development of a new workforce, such as allied health professions, therapists and physician associates.**

235. Greater engagement and support for the peer support worker role and advocacy is critical to the development of mental health services now and into the future. Peer support workers and advocates use their own lived experience and knowledge to help and support individuals in their recovery journey. In Northern Ireland, peer support workers have been partially rolled out, but there is uneven coverage across the Trusts. Clearer regional guidance, a consistent approach and job descriptions across all Trusts will help improve the impact that peer support and advocates can have.

WE WILL CREATE A REGIONAL PEER SUPPORT AND ADVOCACY MODEL

236. Going forward, we will create clear roles and guidance for peer support workers and advocates and integrate peer support fully in the multi-disciplinary team.

ACTION 33. **Create a peer support and advocacy model across mental health services.**

Data and outcomes

237. Outcomes:

- A clear, evidence based outcome framework which allows evidence to be the foundation for decision making.

- A robust data set which is comparable across Trusts to measure performance and to determine what works.

238. To ensure we have the right services that meet the needs of the population, we must have data to measure outcomes. In Northern Ireland, only a small number of mental health services have adopted successful outcomes frameworks.

239. Going forward, we will create a new regional Outcomes Framework together with professionals and service users. In overall terms, this framework should include areas such as patient safety, accessibility (timely access, appropriate demand, demographics), acceptability (person-centred, service-user views on intervention), efficiency, equitability (geographical parity), and integration (inter-service interfaces). This will help in the evaluation of what works and will ensure services are provided that deliver good outcomes for people while providing value for money. The Encompass programme, which will be replacing a number of existing software systems, provides us with the opportunity to access a much richer pool of data and information to help inform and improve practice. We will need to work together regionally to exploit this opportunity.

240. Development of outcomes will also be part of the implementation of each action in this Strategy to ensure we can measure what works and where we can improve.

ACTION 34. Develop a regional Outcomes Framework in collaboration with service users and professionals, to underpin and drive service development and delivery.

Innovation and research

241. Outcomes:
    - A regional approach to mental health research which produces quality outcomes.
    - Increase in mental health related research across Northern Ireland.

242. To ensure that mental health in Northern Ireland benefits from innovation and research, we will seek to create a more innovative and research focussed culture. This will allow us to shape research to include our specific needs, including the legacy of the Troubles, and the use of technology, particularly given the experience during the COVID-19 pandemic.

243. In practice, there needs to be a renewed emphasis on mental health research and innovation through increased research funding and by establishing a centre of excellence which supports research and innovation. This will act as an exemplar and a point of reference for clinical staff and Community and Voluntary sector providers seeking to innovate, test ideas, or implement emerging knowledge. It is important to note that the Centre would not replace the existing research that is conducted at the local Universities. Rather, it is envisaged it would help and support the research carried out at these institutions.

WE WILL HELP AND IMPROVE MENTAL HEALTH RESEARCH ACROSS NORTHERN IRELAND

244. It is also important that we avoid duplication of research effort and we learn from other places, rather than seeking to answer questions locally which have already been answered elsewhere. A central centre of excellence will ensure effective working and tangible outcomes. It will also ensure that mental health patients in Northern Ireland can be at the forefront of experiencing new and innovative ideas.

ACTION 35. Create a centre of excellence for mental health research.

Funding of the Strategy and next steps

245. As we move forward, it is important that we acknowledge the difficult financial context in which this strategy is being issued. At the time of publication, all actions are subject to confirmation of funding and will therefore require prioritisation, workforce mapping and planning to ensure realistic delivery. The investment required to deliver the Strategy is significant, and is in addition to existing expenditure in mental health services. It is not possible to fund implementation from within the Department's existing resources and delivery is therefore dependent on the provision of significant additional funding for the Department. Where it is possible, the Department will also seek to release resources through service efficiencies and reconfiguration, however, this in itself will not be sufficient to fund implementation. The pace of change outlined in this strategy will also be considered in the context of other service priorities and with regard to the Department's overall financial settlement.

246. Implementation of the Strategy will require significant work. A number of workstreams will be required and the support of all stakeholders will be essential. The Department is fully committed to implementing the Strategy based on the core principles set out above, with the overall aim of making the vision a reality. As such, it is expected that implementation will be fully co-designed and co-produced.

Annex A: Other Government Strategies

Published Strategies			
Title	**Timeframe**	**Headline Objective**	**Owner**
Improving Health within Criminal Justice Strategy and Action Plan	Published 2019 (5 year lifespan)	The joint Strategy and Action Plan seeks to address the health and social care needs of children, young people and adults at all stages of the criminal justice journey (as suspects, defendants and serving sentences) in Northern Ireland. In doing so, it aims to ensure that children, young people and adults in contact with the criminal justice system are healthier, safer and less likely to be involved in offending behaviour.	DoJ & DoH
Community Safety Framework	Published October 2020	The Framework provides a model for multi-agency collaborative working and aims to link the strategic and operational response to community safety issues, including addressing harm and vulnerability which may lead to risk taking behaviours, for example mental health.	DoJ
Stopping Domestic and Sexual Violence and Abuse	2016 - 2023	The strategy is a cross Executive strategy led jointly by Health and Justice, including Education, Finance, Communities. Potential to cut across issues of mental health in relation to: prevention; protection; support for offenders; and at the point of reviewing cases of domestic homicide to learn lessons (Domestic Homicide Reviews).	DoJ & DoH
Suicide and Self-Harm Prevention Policy 2011 (revised 2013)	Published 2011 (revised 2013)	Support for those at risk of suicide or serious self-harm.	NIPS - DoJ

Special Educational Needs (SEN) Framework	Phased implementation commencing late 2021	A new SEN Framework which focuses on early identification and assessment of children who have, or may have, SEN and making special educational provision for those children with SEN, so that they get the support they need, when they need it in order to help them make progress and improve outcomes.	DE
Children & Young People's Emotional Health & Wellbeing in Education Framework	Published February 2021 Implementation ongoing	To ensure that children & young people are empowered and assisted to understand and manage their emotional health & wellbeing; identify and address need early; establishing an integrated model of support which will ultimately result in fewer numbers of children & young people will require specialist intervention from mental health services.	DE & DoH
A Life Deserved: "Caring" for Children & Young People in Northern Ireland	2021-2025	To improve the wellbeing of looked after children & young people.	DE & DoH
Nurture provision	Ongoing	To continue to support 46 Nurture Groups in primary schools; the development of a Nurture in Education Programme which will be available to all educational settings, including Education Otherwise Than at School (EOTAS); and establish a Nurture Advisory & Support Service within the Education Authority.	DE
Active Ageing Strategy	2016-2022	The purpose of the Strategy is to transform attitudes to, and services for, older people. It aims to increase the understanding of the issues affecting older people and promote an emphasis on rights, value and contribution.	DfC

Executive's Child Poverty Strategy	2016-2022	Children in poverty are more likely to suffer from poor mental health and contains actions to promote good health and wellbeing.	DfC
NI Wellbeing in Sport Action Plan	2019-2025	To encourage a positive mental health culture to the National Governing bodies of Sport and their clubs and to help raise awareness of mental health.	DfC
Uniting Communities and Creativity Programme	Ongoing	Uniting communities through leadership, community activity and building capacity.	DfC
People and Place – a strategy for Neighbourhood Renewal	Ongoing	Supports delivery of projects in most deprived urban areas.	DfC
Social Inclusion Strategies	2020-2025	Anti-Poverty, Disability, Gender and Sexual Orientation/LGBTQI+ – aim to tackle inequalities and obstacles that directly affect the everyday lives of most vulnerable people in society.	DfC
Strategic Planning Policy Statement for Northern Ireland 2015 'Planning for Sustainable Development' (SPPS)	ongoing	To secure the orderly and consistent development of land whilst furthering sustainable development and improving well-being - the SPPS includes '*Improving Health and Well-being*' as one of five core planning principles of the two-tier planning system.	DfI
Exercise – Explore – Enjoy: a Strategic Plan for Greenways	2016-2026	By 2026 75% of Primary Network delivered 25% of secondary network delivered 50 million journeys on the greenways and NCN	DfI

NI Changing Gear - a Bicycle Strategy	2015-2040	By 2040 40% of all journeys less than 1 mile, to be cycled 20% of all journeys between 1 and 2 miles, to be cycled 10% of all journeys between 2 and 5 miles, to be cycled	DfI

Published Strategies

Title	Timeframe	Headline Objective	Owner
Empowering Change in Women's Lives' Draft Framework for supporting and challenging women and girls in contact with the justice system	Currently subject to development. Publication is due in Autumn.	The framework relates to those who offend or those who are at risk of offending. Research and evidence available suggests that the needs of women and girls are complex including a high risk of alcohol and substance misuse, mental health issues, and self-harm.	DoJ
Adult Restorative Justice Strategy	The final strategy and action plan will be published by March 2022.	The proposed strategy will provide a strategic approach to restorative practices at all stages of the criminal justice system, from early intervention in the community, formal diversion by statutory agencies, court-ordered disposals, custody and reintegration. The use of restorative justice provides an opportunity to focus on repairing harm and minimising the impact of offending on victims as well as finding positive ways of dealing with children, young people and adults. The use of restorative practices can only impact positively on mental health outcomes, whether those concerned are victims of crime or offenders.	DoJ

Victim and Witness Strategy for Northern Ireland	Planned July 2021	The Victim and Witness Action Plan is intended to give effect to the specific recommendations made by CJINI. However in doing so it lays a foundation for further work by the Department, in partnership with criminal justice organisations and victim and witness support providers, to develop a revised Victim and Witness Strategy. This will include strengthening cross-departmental collaboration and identifying solutions that will improve health and justice outcomes for victims and witnesses.	- DoJ
Interdepartmental Homelessness Action Plan	Planned May 2021	Priority is to focus on non-accommodation services such as health and wellbeing including mental health and substance abuse.	DfC
Disability Employment Strategy	2021-2026	To Support those with disabilities and heath conditions to move closer, find, remain and progress within employment.	DfC
New Strategy for Sport and Physical Activity (S2020)	To be published by 31 March 2022 (subject to Ministerial and Executive approval)	The aim is to provide a flexible strategic framework for a cross-departmental, ambitious, and comprehensive approach to promoting participation and excellence in sport and physical activity.	DfC
NI Debt Respite Scheme/ Breathing Space	Early planning stage	DfC is bringing forward plans for a Debt Respite Scheme in the next NI Assembly mandate. This will include consideration for a Breathing Space for those receiving mental health crisis treatment.	DfC

Delivery of the UK Financial Wellbeing Strategy and Development of NI Financial Wellbeing Strategy	2020-2030 for the UK Financial Strategy NI Financial Wellbeing Strategy planned publication August 2021	The UK Strategy for Financial Wellbeing, through close collaboration with industry and stakeholders, is to build a financial wellbeing movement in the UK - to collectively improve financial wellbeing in the UK. DfC will bring forward plans for a post Covid 2021 Financial Wellbeing strategy. There is a strong relationship between Financial Wellbeing indicators and Mental Health Wellbeing.	DfC
Culture, Arts and Heritage Strategy	To be published by end 2022	Includes activity to raise aspirations, build skills and inspire people.	DfC
New Rural Policy Framework	In development	Includes a theme 'to reduce loneliness and social exclusion in rural areas, to minimise the impacts of rural isolation and to promote the health and well-being of rural dwellers'.	DAERA

Mental Health Strategy 2021-2031

Department of Health
An Roinn Sláinte
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Protocol For Joint Investigation

of Alleged and Suspected Cases of Abuse of Vulnerable Adults

December 2003

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FOREWORD

In recent years, significant efforts have been made within Health and Social Services and the Police Service to establish procedural and operational arrangements in order to respond effectively to the abuse or exploitation of vulnerable adults. This has involved a considerable degree of interagency liaison in order to develop effective partnership working which will help to prevent abuse and respond appropriately and sensitively when it occurs.

New measures designed to support vulnerable and intimidated witnesses will result in even closer working arrangements between police officers and Health and Social Services staff.

This protocol is an important aspect of these changes in attempting to outline the roles and responsibilities of the respective agencies and providing guidance about joint working arrangements and investigation. It has been developed in partnership between the Police Service of Northern Ireland, DHSS&PS, Health and Social Services Boards and Trusts in Northern Ireland. It is based on the recognition of the need for more coordinated interagency working to ensure that vulnerable adults, who are at risk of abuse, receive protection, support and equitable access to the criminal justice system.

The protocol was underpinned by local research, and has taken cognisance of the most recent guidance issued in Great Britain by the Home Office and Department of Health.[1] [2] This requires agencies to investigate and take action when a vulnerable adult is believed to be at risk of abuse, to develop interagency policies, procedures and joint protocols that draw on good practice.

Although other agencies will be involved in aspects of the investigative process, the PSNI, Trusts and Boards, through their Registration and Inspection Units, have traditionally taken the lead roles in investigating abuse and reporting crimes. The protocol has

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[1] Bailey A (2001) 'Factors influencing police investigation of sexual crimes committed against people who have a learning disability and implications for public policy'. Dphil Thesis. (University of Ulster)

[2] 'No Secrets: Guidance on developing and implementing multi agency policies and procedures to protect vulnerable adults from abuse'. Home Office/DOH 2000.

been designed as a basis for improved inter agency working and will need to be closely monitored, reviewed and revised in the light of experience. It is supported by an ongoing programme of interagency training.

We commend this protocol to all who are involved in this critical and demanding area of work and would like to place on record our thanks to all who contributed to its development.

Leslie Frew
Director of Community Care
DHSS&PS

Judith Gilllespie
Assistant Chief Constable
Criminal Justice Department
PSNI

1 Introduction

1.1 The PSNI, Boards and Trusts are committed to the development of collaborative working which will enhance arrangements for the protection and support of vulnerable individuals and groups. This will include responding to the specific needs of vulnerable and intimidated victims of crime. In 1998 the Home Office published a report prepared by an Interdepartmental Working Group on the treatment of vulnerable victims and witnesses, entitled 'Speaking Up for Justice'.[3] The report recommended that the existing special measures introduced for children, e.g. live CCTV links and video recorded evidence-in-chief, be extended to include vulnerable adults.

1.2 The subsequent enactment of the Criminal Evidence (NI) Order in 1999 made provision for these arrangements, or 'special measures' to be introduced locally. Guidance on the application of special measures can be found in 'Achieving Best Evidence in Criminal Proceedings: Guidance for Intimidated Witnesses, including Children'.[4]

1.3 Although other agencies, statutory and voluntary, may be involved in aspects of the investigative process, the PSNI, Trust and R & I Unit staff have been primarily responsible for the investigation of abuse and the protection of vulnerable adults. This Protocol is designed to ensure staff from these agencies work together in a way that ensures the well-being and rights of vulnerable adults are paramount. It also helps to ensure that people receive equitable access to justice.

1.4 This Protocol sets out a framework for joint working in a complex area of practice and emphasises the need to involve all other relevant agencies in information sharing, early assessment and the planning process. It is important that Trust, R & I Unit and PSNI staff read this Protocol in conjunction with the Policy and Procedures presently in use within each of the four Health and

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[3] 'Speaking up for Justice' - Home Office (1998)

[4] 'Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses, including Children' - Home Office Communication Directorate (2002)

Social Services Boards. Police officers should be mindful of relevant PSNI General Orders. This Protocol extends to suspected crimes in domiciliary, community and hospital care if the victim is a vulnerable adult as defined in Section 2.

2 Definition

Definition of a Vulnerable Adult

2.1 For the purposes of this Protocol the definition of a vulnerable adult has been taken from 'No Secrets'. It therefore applies to adults:

a) **who are 18 years old and over; and**
b) **who are, or may be, in need of community care services by reason of mental or other disability, age or illness and who are, or may be, unable to take care of themselves, or unable to protect themselves against significant harm or exploitation.**

2.2 This definition is more inclusive than the definition of vulnerability contained in the Criminal Evidence (NI) Order 1999. It is likely that some cases of alleged or suspected abuse against vulnerable adults will require a joint approach to investigation but will not qualify for the special measures outlined in the Order in relation to accessing the criminal justice system. It should also be borne in mind that the human and civil rights of the individual may have been breached.

2.3 'No Secrets' also offered a brief definition of abuse as being:
'The violation of an individual's human and civil rights by any other person'.
The original DHSS guidance, which was produced in 1996 as a basis for the development of Board and Trust adult protection policies, offered a more detailed definition of abuse as being:
'The physical, psychological, emotional, financial or sexual maltreatment, or neglect of a vulnerable adult by another person. The abuse may be a single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is the expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependent, whether they be informal or formal carers, staff or family members or others. It can occur outside such a relationship'.

3 Aims and Objectives

3.1 The overall aim of the Protocol is to prevent abuse by promoting a multi-agency approach to the protection of vulnerable adults, and to ensure that they receive equitable access to justice in a way that promotes their rights and well-being.

3.2 The Protocol aims to:

- ensure effective communication and collaboration between Trusts/R & I Unit and PSNI to protect vulnerable adults;
- involve Trusts/R & I Unit and PSNI in determining whether a single agency or a joint agency investigation is required;
- provide a framework for early consultation, cross referral of appropriate cases and joint working arrangements for investigation and interviewing;
- define the roles and responsibilities of PSNI and Trust/R & I Unit staff in the joint investigation;
- minimise the number of interviews conducted with the victim,
- ensure that protective measures are paramount and run in parallel with the criminal inquiry or any other lines of enquiry, such as civil action or disciplinary proceedings.

4 Principles

4.1 The Protocol aims to promote the following principles in protecting vulnerable adults from abuse and the investigation of alleged or suspected crimes:

- the well-being and rights of the vulnerable adult are paramount;
- the processes should minimise distress to the vulnerable adult by maximising co-operation between agencies;
- Adult Protection Procedures must be properly followed;
- mechanisms should be available to resolve differences of opinion amongst staff through appropriate management structures.

5 Rights and Responsibilities

5.1 The Protocol is also committed to ensuring that the rights of vulnerable adults are upheld. These include the right to:

- receive protection for themselves and their property under the law;
- be supported in reporting the circumstances of any abuse;
- have alleged, suspected or confirmed cases of abuse thoroughly investigated as a matter of urgency;
- have options for resolution and the appropriate processes explained to them;
- be supported in making decisions about how they wish to proceed in the event of abuse and to be kept informed of progress;
- have issues of consent and capacity considered;
- be given information in accessible formats on how to protect themselves;
- be given practical help in protecting themselves;
- be supported when deciding whether to pursue a formal complaint;
- be subjected to the minimum degree of disruption;
- receive support on a longer-term basis, following the abuse.

5.2 In order to promote these rights effectively PSNI, Trust and R & I Unit staff must be aware of their responsibilities in this very difficult area of work. If an allegation of abuse does not appear to relate to criminal conduct, there is no statutory duty to report the matter to the Police and the decision about whether or not to investigate should be judged on the 'best interest' test. In the case of non-criminal matters it may not be in the best interests of the vulnerable adult to investigate if the person has specifically indicated a preference for no investigation. However, in reaching this conclusion, it is necessary to take into account the competence of the person making the decision and any other regulatory or personnel arrangements, e.g. disciplinary procedures, referral to NISCC.

5.3 Although all members of society are duty bound to report arrestable offences (those criminal offences which carry five years imprisonment or more), this Protocol requires staff to consider the cross-referral of suspected crimes whether they are arrestable or

not. In general, the Police are authorised to investigate alleged or suspected criminal abuse against the vulnerable adult where this is agreed to be in the best interests of the person. In the majority of cases, in particular where the vulnerable adult is deemed to have capacity, the Police will only proceed with the consent of the vulnerable adult. In practice this means that the vulnerable adult should be willing to make a complaint to the Police. However, there are some exceptions to this eg; where the vulnerable adult is deemed not to have capacity, is subject to undue influence or where others may be at risk. In some circumstances the Police may also intervene to prevent a crime being committed.

5.4 Where criminal abuse may have been committed then, a referral between the agencies should be made and an agreed strategy should be developed which takes account of the wishes of the alleged victim. The PSNI and Trust/R & I Unit should work sensitively in these enquiries and must secure the co-operation and consent of the victim unless there may be issues in relation to capacity and/or the potential for abuse to third parties. After referral between agencies the agreed strategy should take account of the wishes of the alleged victim. When there are concerns, but no real grounds to suspect that an offence may have been committed, there is a duty on Trust or R & I Unit staff to investigate and report any criminal offences or grounds that may emerge.

5.5 When judging whether the individual has capacity to give or withhold consent the policies of the relevant Board should be followed. This should take into account professional opinion as appropriate eg. Psychiatrists, Psychologists, GPs, Nurses, Social Workers.

6.0 Reporting

6.1 This Protocol is designed to be compatible with current Adult Protection Procedures in requiring all staff to report suspected, alleged or confirmed instances of abuse. It is not intended to replace professional judgements made by Trust or R & I Unit staff. It does however make sure that all cases are given appropriate consideration and are not screened out inappropriately. Added safeguards to prevent this include the necessity to report cases, in line with current policies and procedures, to a designated adult protection officer ('designated officer') and to consult, if necessary, with the relevant Police Liaison Officer. Where a crime is suspected or alleged and the vulnerable adult does not wish to make a formal complaint the agencies should consider the following factors:

- The individual's capacity to provide consent to a formal complaint;
- The extent to which other vulnerable persons, including children, are likely to be at risk;
- The vulnerable adult is subject to undue influence or coercion.

6.2 A referral to the PSNI does not automatically mean that a joint investigation will be initiated. This may involve seeking the views of the Police Liaison Officer. Where the PSNI is informed of suspected abuse which is clearly non-criminal the individual should be made aware of other sources of support and options to have the matter resolved and his/her agreement should be sought to refer to Trust or R & I Unit.

6.3 Alleged or suspected instances of abuse occurring in residential or nursing facilities must be reported to the local R & I Unit, which has a statutory duty to make sure an investigation is undertaken.

6.4 Reports of alleged or suspected abuse, which may be a criminal offence, will be categorised as:

(a) **Sexual** (e.g. rape, indecent assault)
(b) **Non-sexual** (e.g. physical assault, theft).

The PSNI will be responsible for determining the category of offence.

6.5 Where alleged or suspected crimes are reported to the PSNI they have a duty to conduct criminal investigations. The decision to investigate will be made at a Strategy Discussion and will be informed by the views of the victim, Trust or R & I Unit colleagues.

Referral to Police from Health and Social Service Trusts

6.6 a) In all cases of alleged or suspected criminal abuse the designated officer for the Trust should discuss the case with the relevant Police Liaison Officer. It will be the responsibility of the Police Liaison Officer to help determine whether the matter may involve criminal abuse and thereby to inform the decision concerning what level of enquiry/investigation is necessary.

b) Alleged or suspected sexual abuse should be reported to the Detective Inspector (CARE) who holds the role of Police Liaison Officer for sexual crimes.

c) Alleged or suspected non-sexual abuse should be reported to the Police District Command Unit (Crime Manager) who holds the role of Police Liaison Officer for non-sexual crimes. The Crime Manager will allocate any investigation to uniform or CID as appropriate.

d) For referral purposes, where more than one form of abuse is alleged or suspected, sexual offences will take precedence and these cases should be referred in the first instance to the Detective Inspector (CARE). The police will then decide if a criminal investigation is required and which branch of the Police should carry out the investigation.

Referral to Trusts by PSNI

6.7 Police officers who encounter vulnerable adults who may have been the subject of abuse, whether criminal or not, should contact the relevant designated officer to establish whether the vulnerable adult is known or should be referred to the Trust.

Referrals Outside Normal Working Hours

6.8 Where concerns are raised in relation to the care or treatment, which may involve criminal abuse, of a vulnerable adult outside normal working hours (9.00 am - 5.00 pm Monday to Friday), these concerns should be referred immediately to the Out of Hours Social Work Co-ordinator. A list of contact points for Co-ordinators can be found in **Appendix A.**

6.9 The Co-ordinator will take whatever action is necessary to ensure the protection of the vulnerable adult. Depending on the scale of the concern this may involve referral to other agencies. The Co-ordinator will make the relevant designated officer for the Trust aware of the referral details and any action taken/required, as a matter of urgency on the first working day following the date of the referral being made.

Alleged or Suspected Criminal Abuse in Residential or Nursing Facilities

6.10 When criminal abuse is alleged or suspected to have occurred in residential or nursing homes and is reported to, or comes to the attention of the R & I Unit, the Unit manager should ensure that the matter is referred to the Police Liaison Officer and to the relevant Trust. (see 6.6). If an incident of suspected or alleged criminal abuse in a home comes to the attention of Trust staff the R & I Unit must be informed by the designated officer as soon as is practicable.

Referrals from PSNI to R & I Units

6.11 Police officers, who encounter a vulnerable adult who is a resident of a residential or nursing home and who may have been subjected to abuse, whether criminal or not, should contact the manager of the R & I Unit. This will enable them to establish whether the Unit can investigate the matter or whether referral needs to be made directly to the local Trust. Where the need for the R & I Unit to initiate an investigation is indicated the relevant Board/Trust/R & I Unit procedures must be followed.

Inappropriate Referrals

6.12 In any event where a referral is made inappropriately between agencies the receiving agency will have responsibility for referring the matter to the appropriate agency.

7 Initial Assessment – Consultation – Planning and Investigation

Clarification of Roles

7.1 The PSNI, Trust and R & I Unit staff have specialist and complementary skills in terms of assessing and investigating allegations of abuse of vulnerable adults. The process is outlined in **Figure 1**. In appropriate cases it is necessary to combine these skills to provide maximum protection and support for those individuals who have been the subject of, or are at risk of, harm. This Protocol recognises that the various agencies may have different priorities or emphases in relation to adult protection work.

7.2 It is not designed to make Trust, R & I Unit or PSNI personnel undertake roles which are at variance with their primary professional responsibilities. It is however intended to provide a basis for maximising co-operation and a shared understanding of the issues involved. Differences of opinion, or approach, amongst staff should be resolved in a manner that does not hinder the protection of the vulnerable adult. Protection of the individual is paramount and staff should not inappropriately screen out cases by failure to follow this Protocol.

7.3 The strategy to be adopted must be informed by the professional views of PSNI, Trust and R & I Unit staff. The strategy for investigation should always be influenced by information gained from professionals or other persons who may have knowledge of the vulnerable adult, his/her family or circumstances.

7.4 The primary objective of PSNI, Trust and R & I Unit is the protection of the vulnerable adult. In addressing this shared objective the primary role of PSNI personnel is determined by their statutory responsibility to protect life and property, preserve order, prevent crime and, where a criminal offence has been committed, bring offenders to justice.

7.5 The primary role of Trust and R & I Unit staff is determined by their statutory responsibility and Duty of Care, to promote the care and well-being of vulnerable adults in situations of alleged or confirmed abuse.

7.6 Assaults (including minor assaults), thefts, criminal damage, sexual assaults and threats of force or violence are all likely to be criminal offences. PSNI, Trust and R & I staff must recognise that the non co-operation of the victim does not always preclude a prosecution. However, the views of the victim are vital elements in the decision to prosecute.

Joint Agency Consultation

7.7 When either Trust/R & I Unit or PSNI personnel identify the need for a Joint Agency approach, a staff member from the referring agency will take responsibility for instigating a Joint Agency Consultation. The designated officer will take responsibility for co-ordinating the practical arrangements associated with this action. This should be the person within the Trust/R & I Unit deemed to be responsible for the decision to proceed under the Adult Protection Procedures, in cases of alleged or confirmed abuse.

7.8 The purpose of the consultation is to discuss the case with the other agencies and to reach a decision on the need for a Joint Investigation involving Trust/R & I Unit and PSNI. This communication may be by telephone or direct contact and should occur within 24 hours of the decision that consultation with the other agency is necessary.

7.9 The outcome of this consultation may be:

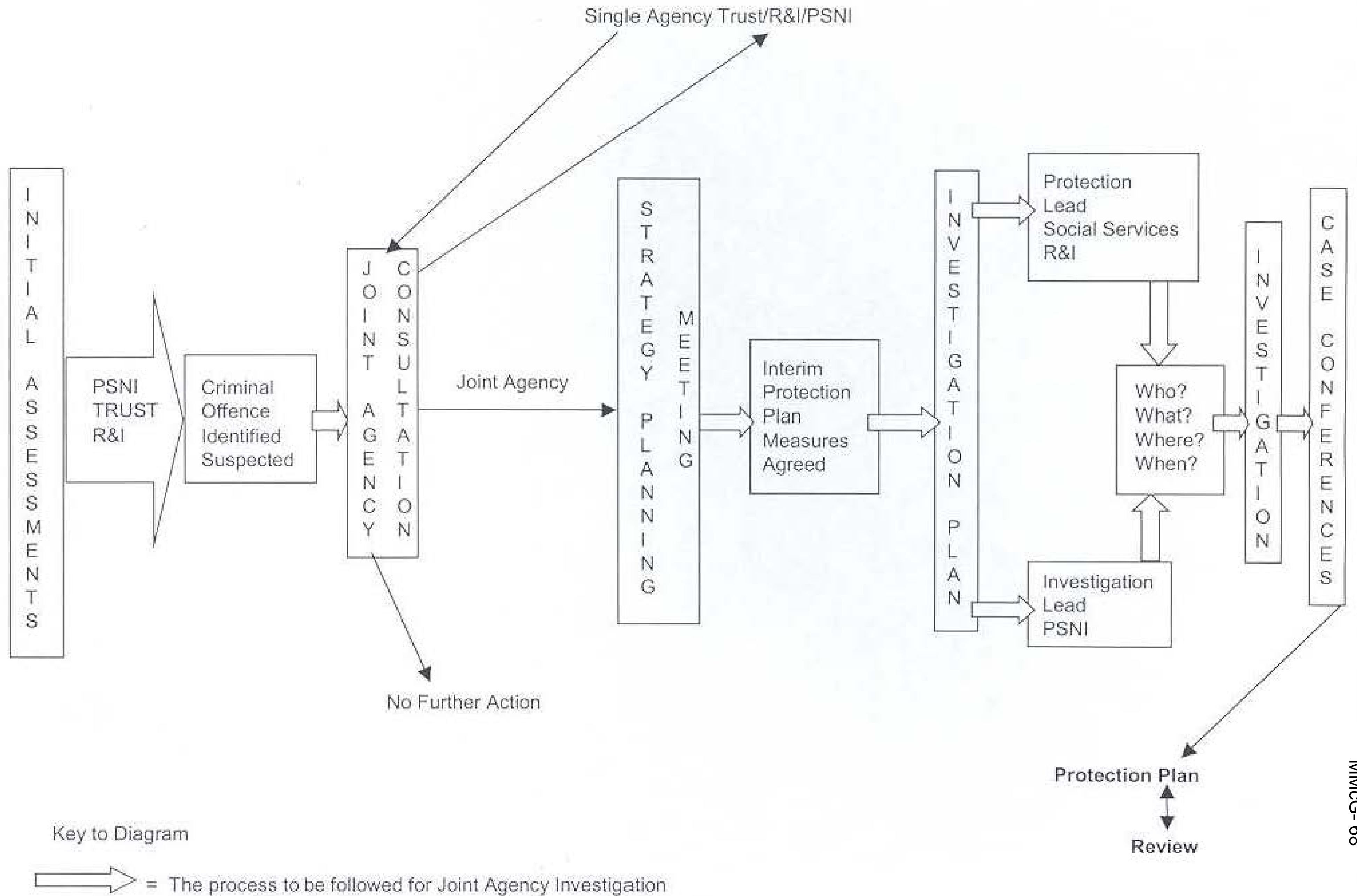
- No further action.
- A Trust/R&I Unit single agency investigation.
- A Criminal Investigation by Police.
- A Joint Investigation involving Trust/R&I Unit and Police.

The results of this consultation must be clearly recorded and shared between agencies. **(Appendix B).** Where it is agreed that a Trust/R & I Unit single agency investigation is appropriate, the procedures for the Protection of Vulnerable Adults will be followed.

Criteria for Joint Investigation by Trust/R & I Unit and PSNI

7.10 A detailed consideration of the need for a joint investigation will be triggered when there is an allegation or suspicion that one of the criminal offences described below has been committed against a vulnerable adult. The likelihood or otherwise of a prosecution is not a criterion for a joint investigation.

- A sexual offence committed against a vulnerable adult.
- Physical abuse or ill treatment amounting to a criminal offence.
- Financial abuse involving a criminal offence, e.g. fraud, theft.
- Abuse which involves a criminal offence e.g. blackmail.



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Preliminary Information Gathering

7.11 Following the decision of the Joint Agency consultation, to initiate a Joint Investigation, each agency will nominate a staff member to gather information for the Strategy Planning Meeting which will be the basis for planning any subsequent investigation. The nominated officer will carry out checks on internal systems for information that may be of use in deciding the strategy to be employed.

Strategy Planning Meeting

7.12 When sufficient preliminary information is available to facilitate the development of a strategy for dealing with the case, a Strategy Planning Meeting should be convened. This should occur as soon as is practicable. The responsibility for convening this meeting lies with the designated staff member who initiated the Joint Agency Consultation.

7.13 The purpose of the Strategy Planning Meeting is to ensure an early exchange of information and to clarify what action needs to be taken jointly or separately in the investigation. It is an action orientated discussion, which should be convened to plan the investigation and agree any necessary interim protection measures.

7.14 A Strategy Planning Meeting will always include Police and Trust and/or R & I staff where appropriate. Other professionals, agency representatives and persons with specialist knowledge/skills may also be included to ensure the protection of the vulnerable adult.

7.15 Where the Strategy Planning Meeting concludes that a vulnerable adult has been the victim of criminal abuse or may be at risk of a serious criminal abuse and that issues arise about the protection of the individual, the Strategy Planning Meeting should address the following points:

- whether action is needed to protect the vulnerable adult and who will be responsible for such action;
- the need to consider the issue of capacity to consent and the most appropriate person to deal with it;
- the requirement for a medical examination to be undertaken and if so, by whom;

- what issues of special needs, race, culture, gender, or religion are raised in the case, how and by whom they are to be addressed and what advice needs to be sought;
- what specialist support or advice might be needed and who will obtain it;
- what other information is needed to complete the investigation and who will seek it;
- the order in which the interviews will take place and who will carry out the interview; and
- practical arrangements for reporting back to those involved in the investigation.

7.16 It is the responsibility of the person who convenes the meeting to ensure that a record of the Strategy Planning Meeting is made and shared between agencies. **(Appendix C).** Although strategy planning will generally take place in a formally constituted meeting there may be occasions where this may need to be conducted by telephone.

8 Joint Investigation Interviews

8.1 Interviews with vulnerable adults will be conducted in accordance with the guidelines contained in 'Achieving Best Evidence in Criminal Proceedings'.

Joint Interviews by Police Officers and Social Workers

8.2 Where it is agreed in the Strategy Planning Meeting that interviews should be conducted jointly by a police officer and social worker the following procedures will apply. It must be emphasised that the decision about which interviews should be conducted jointly, and the sequence of interviews, is a matter for the group planning the investigation at the Strategy Planning Meeting. These procedures should be applied accordingly and the involvement of the R & I Unit should be considered when the alleged abuse has occurred in a nursing or residential home.

Selection of Interviewers

8.3 Only PSNI and Trust personnel, who have received specialist training in Joint Interviewing, should be appointed to the task. Where a vulnerable adult has requested the interviewer to be of a specific gender all reasonable steps must be taken to facilitate this request.

Supervision of Interviewers

8.4 It will be the responsibility of each agency to ensure that the interview and investigation process is properly supervised and supported by relevant managers who have been trained in these procedures.

Clarification Discussion

8.5 In making decisions about the method of interviewing vulnerable adults it may be necessary to have a short clarification discussion. This should normally be undertaken by the persons who will conduct any subsequent interview. However where this is not possible the clarification discussion may be carried out by other staff who have received Joint Protocol training. Once a decision has been made that an interview of a vulnerable adult should be conducted on video, a specialist investigative interviewer will be tasked to carry out the interview.

8.6 The purpose of the Clarification Discussion is:

- To establish whether or not the vulnerable adult has made an allegation or raised suspicions which have led to the referral. The substance and detail of the allegation or disclosure should not be part of the Clarification Discussion.
- To assess the vulnerable adult's willingness and ability to pursue the matter to court.
- To inform the police decision about which format should be used for the interview, eg; videotape, statement or question and answer. Videotaping is the preferred method of interviewing vulnerable adults, statements are the alternative and questions and answers should only be used when neither videotaping or statement are possible.
- Whether the use of video in the interview is likely to maximise the quality of that particular vulnerable adult's evidence.

8.7 The Clarification Discussion must be recorded and responsibility for this will lie with the investigator conducting it. The Clarification Discussion is not an investigative interview and should never replace or over-shadow the joint investigative interview with the vulnerable adult. Strictly no further examination of the allegation should take place beyond that which has been disclosed. It is important not to coach the interviewee in respect of the interview. If the discussion includes the disclosure of a criminal offence, that part must be recorded verbatim and contemporaneously, or at the very least as soon as possible after the contact. Even if no criminal disclosure is made, accurate recording is essential as decisions about risk may be made on the strength of the Clarification Discussion. The proforma at **Appendix D** must be completed in respect of every Clarification Discussion.

Preparation for a Joint Interview

8.8 The following should be taken into account when preparing for a Joint Interview:

- The needs and circumstances of the vulnerable adult (eg; development, impairments, degree of trauma experienced, whether he/she is now in a safe environment);
- The vulnerable adult's state of mind (eg; likely distress, and/or shock);
- Perceived fears about intimidation and recrimination;

- The circumstances of the suspected offence (eg; relationship of the individual to the alleged offender);
- Location of interview;
- Time of interview;
- Preferred gender of interviewer; and
- Special requirements.

Purpose of the Joint Interview

8.9 The purposes of the Joint Interview are:

- to promote the well-being and protection of the vulnerable adult;
- to validate or negate allegations or suspicions of abuse by helping the vulnerable adult to give as much information as possible;
- to avoid multiple interviews where possible;
- to identify the suspected abuser;
- to ensure that all decisions are made based on the experience of the vulnerable adult and not the influence or beliefs of the interviewer;
- to provide a record of the vulnerable adult's evidence-in-chief which may be used at a consequent criminal hearing.

Persons Present at Joint Interview

8.10 Normally no one else should be in the interview room apart from the vulnerable adult and the interviewers. Limiting the number of people present at the interview should lessen the possibility of the vulnerable adult feeling overwhelmed by the situation and uncomfortable about revealing information. It is recognised that other persons with specialist skills may be needed to assist the interviewer conduct the interview. This might include, specialist communicators using sign language, etc.

8.11 If it is the vulnerable adult's wish to have a supportive person present in the interview room it should be made clear to that person that he or she must take no part in the interview. It is good practice for the vulnerable adult to know that a supportive person is available in an adjoining room. A suspected offender should never be present in an interview.

Recording Information that is not Video Recorded

8.12 When a Joint Interview with a vulnerable adult is not video recorded a written account of the information given should be

made. If it is assessed by the interviewers, or on the basis of consultation with other expert opinion, that the vulnerable adult is capable of giving an account of relevant matters the PSNI officer may invite the adult to make a signed, written statement on Form 38/36. The evidence of a vulnerable adult who is not capable of making a statement should be recorded as questions and answers and certified by them and any other person present.

The Video Interview

8.13 The Criminal Evidence (NI) Order 1999 provides for the video recording of interviews with vulnerable adults to be admitted as evidence-in-chief at Criminal Proceedings. The guidance accompanying the legislation is designed to help those police officers and any Trust staff involved in making a video recording of an interview with a vulnerable adult, where it is intended that the result should be admissible in Criminal Proceedings.

8.14 The Order is "Permissive" legislation. There should be a general assumption that a video interview will be conducted where the criteria are met (eg an eligible witness in an Indictable [Crown Court] case). Use of a video for all interviews is not necessary in all cases and, on occasions, might add to the interviewee's trauma unnecessarily. The decision as to whether the interview will be videotaped will be taken by the investigating police officer in consultation with Trust staff following the Clarification Discussion.

Planning the Joint Interview

8.15 In order to be fully and properly prepared for an interview the joint investigation team of PSNI and Trust staff should normally plan the interview in line with the 'four phased' approach set out in 'Achieving Best Evidence in Criminal Proceedings' and adhere to the criteria which it has identified. The four phases are:

- **Rapport**
- **Free Narrative**
- **Questioning**
- **Closure**

8.16 Planning should include deciding whether PSNI and Trust team members should take the role of lead interviewer, the proposed time scale, any special arrangements/allowances which are required to take account of the vulnerable adult's individual

difficulties, agreed signals on when to take breaks or terminate the interview. As video recording of investigative interviews is aimed at providing evidence-in-chief at criminal courts, planning must include coverage of the 'points-to-prove' in criminal offences.

8.17 Where it appears, before interviewing a vulnerable adult, that the history of the case indicates a considerable amount of information is likely to be forthcoming, a series of interviews may be planned. The second, third, etc. interviews in this series will be considered part of the original interview without any automatic need to consult with the Department of the Director of Public Prosecutions/Public Prosecution Service.

8.18 The joint investigation team must be given sufficient time to carry out this planning process, prior to a joint investigative interview. Failure to allow this time may limit the effectiveness of the process and thereby do a disservice to the vulnerable adult. Preparation for the interview will include the following activities.

Technical Preparation

8.19 The joint investigation team will need to carefully prepare for the interview, ensure that the equipment is in working order, test for vision and sound quality and to ensure that tapes are correctly prepared, checked and inserted. Consideration should also be given to whether other equipment will be needed, e.g. hearing aids, communication boards, etc.

Consultation with Specialists

8.20 The joint investigation team should consider the conclusions of the Clarification Discussion about the need to involve staff with specialist skills in the joint investigative interview and any role they should take in it. Due to the nature of this type of investigative interviewing it will often be necessary to seek specialist assistance with issues such as communication difficulties, mental ill-health or learning disability. If a specialist is asked to facilitate the joint interview, he/she should be informed of the purpose of the interview and the limitations placed on his/her role. He/she should not be asked to undertake the role of "appropriate adult".

8.21 If an interpreter is required to assist in criminal proceedings involving a vulnerable adult who uses sign language the person

must have attained at least Stage 3 British Sign Language or Irish Sign Language qualification.

Consideration of Communicative Competency of Vulnerable Adult and Interviewer

8.22 The vulnerable adult and interviewers need to be able to achieve the minimum requirements for communication. The joint investigation team must establish whether a vulnerable adult has a reliable method of communication which he/she can use intentionally and that the interviewers can understand either directly or via a suitable interpreter.

8.23 If the vulnerable adult has specific difficulties with comprehension or use of language (vocabulary, ideas and grammar) associated with physical or intellectual impairment careful consideration must be given to how these could be overcome. Speech and language therapists, sign language interpreters or facilitators in augmentative communication may be required.

8.24 The competency of the interviewers in communicating will be the single greatest factor in determining whether a vulnerable adult will be able to deal with, and participate effectively in, an interview situation. The interviewer will also require information about the vulnerable adult's knowledge and understanding of him/herself, about objects, about places and events and how these things may be affected by his/her impairment or disability.

Conduct of the interview

8.25 The interviewers need to provide the vulnerable adult with information at a level which will help him/her to understand who and what will be involved. Initially they should cover:

- introduction of the social worker (or other professional) and the police officer with explanation of each of their roles;
- an explanation of the purpose of the interview in a sensitive way that the vulnerable adult can understand;
- an acknowledgement that it is a difficult situation for the vulnerable adult and that some things, particularly sexual assault, may be difficult to talk about;
- introduction of the video equipment and seeking consent to use it in the interview.

8.26 The following are categories of facts, which, if contained in the vulnerable adult's evidence, will enable properly informed decisions to be taken regarding the subsequent conduct of the investigation and ultimately whether or not to prosecute any person for any offence committed against them.

- Name/identity of the alleged abuser/offender, his/her present whereabouts, and the relationship of that individual to the vulnerable adult.
- The duration and extent of the abuse/offence.
- What happened in detail, when it happened, where, and how often, being mindful of the 'points-to-prove' for each offence.
- Date/time of last occurrence, likelihood of physical evidence.
- Names/identity of anyone else having knowledge of the abuse/offence.
- Names of anyone else involved in, or observing the abuse/offence.
- Identity of anyone the vulnerable adult has told about the abuse/offence.

8.27 After the interview, the vulnerable adult and/or their representative should be given as much information as possible about what will happen next including arrangements for his/her protection. If he/she is to be interviewed again, he/she should be informed of where and when it may take place.

8.28 If the interview or series of interviews has been completed and further information comes to light which makes it necessary to conduct another interview with the vulnerable adult, or where it is believed the vulnerable adult has more to tell, this should be considered a further or supplementary interview. In this case the matter should be discussed with the Department of the Director of Public Prosecutions/Public Prosecution Service. This will cover cases where, for example, conflicting evidence comes to light, a vulnerable adult makes further disclosures or names other suspects. 'Achieving Best Evidence' should be referred to when considering the further interview of a vulnerable adult.

8.29 Once the interview is complete, the joint investigation team should give consideration to the individual's need for any counselling or therapeutic requirements which this may have indicated. PSNI and the Department of the Director of Public Prosecutions/Public

Prosecution Service must be informed about the nature of such therapy in each case. This is to ensure that the evidence provided to a Court is not contaminated or contradicted by the vulnerable adult.

The Vulnerable Adult who becomes a Suspect

8.30 If a vulnerable adult becomes suspected of a crime during the course of an interview, a decision will have to be made on whether to proceed or terminate the interview. The interviewers should take a short break to consult, and if necessary seek advice, on the matter, in addition to being mindful of the need for sensitive handling of the situation. If it is concluded that the evidence of the vulnerable adult as a suspect is paramount in a particular case, the interview should be terminated so that any further questioning can be carried out in accordance with the Police and Criminal Evidence (NI) Order 1989, (PACE) at an appropriate location.

Further Interviews

8.31 Occasions may arise where a police officer or a social worker may wish to further interview a vulnerable adult who is the victim of some criminal offence. It will be the responsibility of that police officer or social worker to advise the other agency of the intention to further interview the individual. The same procedures will apply to a further interview as apply to the original interview. No agency should unilaterally conduct further interviews with the vulnerable adult who may be central to criminal proceedings.

Records of Joint Investigative Interviews

8.32 Police will retain a written statement, recorded as a Joint Interview, for evidential purposes. A copy may be provided to Trust and/or R & I Unit staff, provided that the vulnerable adult agrees. Where a Joint Investigative interview has been video recorded the original will be labelled and secured for Court purposes by the police. The working copy will be available for viewing by Trust or R & I Unit staff by arrangement with the officer in charge of the case. A log will be completed on each occasion that the tape is viewed by anyone and will detail the reasons for its having been viewed. This will be retained with the working copy of the tape.

8.33 Arrangements for viewing the tape by persons other than those identified above, e.g. defence or any subsequent court hearing, will

must be complied with. Where investigation involves police and health and social services participation, the police officer in the case will be responsible as the prime keeper of all exhibits, letters, drawings, notes, etc made.

Review of ongoing management of the case

8.34 When the formal joint interview process has been concluded there may be a need for further inter-agency discussions, outside of any judicial procedures, to agree a course of action to address the practical and emotional implications for the vulnerable adult, his/her carers and staff involved in the case. In the majority of cases this can be most comprehensively dealt with by convening a Case Conference, although other, less formalised, mechanisms should be considered to optimise client/family involvement in the process. This is the responsibility of the designated officer from the relevant Trust in consultation with PSNI colleagues. Consultation should also take place on an inter-agency basis to identify the need for any staff debriefing/counselling which may be required as a result of the work which has been undertaken.

Glossary

and Appendices

Glossary

'Achieving Best Evidence'

A voluntary code of practice for interviewing vulnerable witnesses for criminal proceedings and where video is used to record the witness's testimony.

Arrestable Offence

An offence which carries a penalty of five years or more imprisonment. Serious assaults, sexual assaults, dishonesty offences, criminal damage and threats to kill are all arrestable offences.

CARE (Child Abuse Rape Enquiry) Unit

Police team of detective officers with specific responsibility for the investigation of cases involving child abuse or sexual offence.

Case Conference

A meeting of those involved in a case which can include the client/victim. The purpose is to establish potential risk to the individual and what action, if any, would be required.

CID (Criminal Investigation Department)

Police team of detective officers based in each District Command Unit with responsibility for the investigation of crime other than sexual crime.

Cross Examination

The secondary stage of evidence giving in Court where the testimony that a witness has already given is examined by counsel for the defence.

Counsel for the Defence

The legal representative responsible for conducting the case for the defence.

Designated Officer

Person within the Trust responsible for managing the investigation. The title used can vary, for example in the NHSSB they are known as Adult Protection Co-ordinators.

DCU (District Command Unit)

Geographical police area based on local council boundaries and which has its own command and resource structure. There are presently 29 Police DCU's in Northern Ireland.

DCU Crime Manager

The detective officer responsible for the investigation of crime and in charge of CID within a DCU. Detective Chief Inspector or Detective Inspector rank.

Director of Public Prosecutions

A body of legal staff who work independently from the Police and who are responsible for directing on cases and conducting trials of defendants in more complex cases.

Evidence

The term 'evidence' in its legal sense embraces all matters exclusive of mere argument, which can be placed before a Court to prove or disprove any matter or fact, the truth of which is the subject of judicial investigation.

Evidence-In-Chief

The initial stage of giving evidence in Court where the witness is taken through their evidence by counsel for the prosecution.

Form 38/36

A form used for making a written record of a witness's evidence where video is not considered an appropriate form of recording. Generally known as a 'statement'.

Hearsay Evidence

Evidence of what a person has heard another person, not the accused, say. It is not admissible in criminal proceedings.

Investigating Officer

Professional, within the Trust, responsible for investigating the alleged abuse. Their role is to establish the facts, look at alternatives available and to provide counselling and support.

Line Manager

Management Grade within the Trust to whom an individual directly reports.

Live Television Link

A system allowed under the Police and Criminal Evidence (NI) Order 1989 whereby certain witnesses can give evidence from a television monitor in a room separate from the main body of the Court.

NISCC (Northern Ireland Social Care Council)

The Council was established in October 2002 as the body for accrediting, regulating and monitoring the social care workforce, in addition to the development of professional standards and training arrangements. The Council will eventually deal with issues of professional malpractices.

Nominated Officer

The Trust staff member who has been delegated the role of managing investigations of suspected, alleged or confirmed instances of abuse against vulnerable adults.

Points to Prove

The ingredients of a criminal offence, each of which must be satisfactorily proven in a criminal trial.

Police General Order

A written instruction, which is issued to the PSNI.

Protection Plan

This is a plan developed to clarify the protection measures put in place to protect the individual. Roles and responsibilities for protecting the individual are clearly identified.

Registered Facilities

Voluntary or private care facilities registered and inspected by Health and Social Services Board Registration & Inspection Units.

Third Party Material

Matters of potential relevance to a police investigation, which are not in possession of PSNI.

APPENDIX A

Out of Hours Emergency Social Work - Contact Numbers

Eastern Health and Social Services Board Knockbracken Healthcare Park	028 9056 5444
Northern Health and Social Services Board Holywell Hospital	028 9446 8833
Western Health and Social Services Board Altnagelvin Hospital	028 7134 5171
Southern Health and Social Services Board Daisy Hill Hospital	028 3083 5000

Police Service of Northern Ireland – Contact Number

Police Exchange for Northern Ireland Brooklyn	028 9065 0222

APPENDIX B
AJP1

ADULT PROTECTION - RECORD OF JOINT AGENCY CONSULTATION

Referral by telephone on _____/_____/_____
To: ______________________________ Designation: ____________________
Person referring: _________________ Designation: ____________________
Address: ____
___________________________________ Contact Tel No: __________________

Name of Vulnerable Adult: ___________________________ DOB: __/__/__
Home Address: ____
____
Present Location: ____
Gender*: M ☐ F ☐

Nature of Vulnerability*: ☐ Frail Older Person ☐ Dementia
☐ Learning Disability ☐ Physical/Sensory Disability ☐ Mental Illness
☐ Other (please specify) ____

Is the Vulnerable Adult subject to any legal/statutory status?*
(eg: Guardianship, Non Molestation Order) Yes ☐ No ☐
If yes please provide details: ____

Details of any current or past involvement with Social Services, Police and/or Registration and Inspection Unit: ____
____

Name of Carer/Next of Kin: ____
Address: ____
_______________________________________ Contact Tel No: ______________

WHAT IS THE MAIN FORM OF SUSPECTED, ADMITTED OR KNOWN ABUSE?*

☐ Physical ☐ Sexual ☐ Psychological/Emotional
☐ Financial ☐ Neglect ☐ Institutional Abuse
☐ Other (please specify) ____

HAS THERE BEEN PREVIOUS CONCERN OR EVIDENCE OF ABUSE?*

Yes ☐ No ☐ Don't know ☐
If yes, what was the nature of the concern and the outcome: ______________
____

* Please tick appropriate box/es.

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Outcome of Joint Agency Consultation*

Single Agency Investigation by:
Social Services ☐ Police ☐ Registration & Inspection ☐

Joint Investigation by:
Social Services ☐ Police ☐ Registration & Inspection ☐

OR

Protocol for joint investigation of alleged and suspected cases of abuse of vulnerable adults ☐
Please specify if any other follow up will take place.

____

____

Signature of person completing form: ____________________________

Designation: ____

Date: ______________________

* Please tick appropriate box/es.

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APPENDIX C
AJP2

ADULT PROTECTION - STRATEGY FOR INVESTIGATION

Name of Vulnerable Adult ______________________ DOB: __/__/__

(A) PEOPLE IN ATTENDANCE/INVOLVED (NAME & AGENCY):

____

____

OTHERS CONSULTED:

____

____

(B) INITIAL STRATEGY: Date: ___/___/___

____

____

____

Next of Kin/Carer to be informed: YES/NO By Whom: ___________

(i) Amendments to strategy Date: ___________

____

____

____

Telephone/Meeting*
Persons Involved/Designation:

____

____

(ii) Amendments to strategy Date: ___________

____

____

____

Telephone/Meeting*
Persons Involved/Designation:

____

____

(C) PERSONS TO BE INTERVIEWED

1 Person making the allegation to clarify all facts about referral

Name: ______________________________________

Address: ____________________________________

*Please delete as appropriate

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2 Next of kin or other carers:

Name: ________________ Relationship to Vulnerable Adult: ________

Address: ____

3 Significant others
(attach separate sheet if necessary)
Name: ______________________

Relationship: ____________________

Address: ______________________

____

Date & Time: ______________
Venue: __________________
Who will conduct:
SW: ____________________
PSNI: ___________________
Other: ___________________

4 The Vulnerable Adult

Name: ______________________

Address: ______________________

Date & Time: ______________
Venue: __________________
Who will conduct:
SW: ____________________
PSNI: ___________________
Other: ___________________

5 The Alleged Perpetrator

Name: ______________________

DOB: ______________________

Address: ______________________

____

Date & Time: ______________
Venue: __________________
Who will conduct:
SW: ____________________
PSNI: ___________________
Other: ___________________

Relationship to Vulnerable Adult: ______________________________

(D) Has a statement of complaint been made? YES/NO*

By whom: ______________________

Does the vulnerable adult have the capacity to:

(a) Consent to interview? YES/NO*

(b) Consent to medical examination? YES/NO*

Has the vulnerable adult consented to:

Interview? YES/NO*

Medical? YES/NO*

On what basis were these decisions made? ____________________

____

____

Signature of person completing form: __________________________

Designation: ____________________ Date: ________________

*Please delete as appropriate

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APPENDIX D
AJP3

ADULT PROTECTION - CLARIFICATION DISCUSSION

Name: ______________________________ DOB: ____/____/____

Address: ______________________________

____

Date: ______________________________ Time: ______________

Venue: ______________________________

Persons Present: ______________________________

____

CONSIDERATIONS:

1 Has the adult previously made a clear disclosure of abuse or are there substantive grounds for suspecting abuse has occurred?

Comment: ______________________________

____

2 Is the adult willing to engage in an interview?

Comment: ______________________________

____

3 Is the adult able to engage in an interview?

Comment: ______________________________

____

4 Has the purpose of the interview been explained to the adult?

Comment: ______________________________

____

5 Which format is the most suitable for the interview? If a video interview appears to be the most appropriate option assess the adult's willingness to be interviewed on videotape.

Comment: ______________________________

____

6 Decision: VIDEO STATEMENT QUESTION AND ANSWER

(Circle format to be used)

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NATURE OF DISCUSSION:

CONTEMPORANEOUS, VERBATIM RECORD OF DISCLOSURE:

(Please close with diagonal line)

PERSON MAKING NOTES: ______________________________

Responsibility for completion rests with either:
Police or Social Services

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Safeguarding Vulnerable Adults

Regional Adult Protection Policy & Procedural Guidance

SEPTEMBER 2006

You can access this document in English, in large print, $3^1/_2$ inch computer disk or CD and at the websites for each of the Health and Social Services Boards:

Eastern Health and Social Services Board
http://www.ehssb.n-i.nhs.uk

Northern Health and Social Services Board
http://www.nhssb.n-i.nhs.uk

Southern Health and Social Services Board
http://www.shssb.org

Western Health and Social Services Board
http://www.whssb.org

This document can also be made available in another language or alternative format. For further details and/or additional copies please contact:

Social Services Directorate
Northern Health and Social Services Board
County Hall
182 Galgorm Road
BALLYMENA
BT42 INQ

Telephone Number: 028 25 311216
E-mail: socialservices@nhssb.n-i.nhs.uk

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Department of
Health, Social Services
and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

Foreword

The abuse and exploitation of vulnerable adults is an issue that has become more prominent in recent years in terms of public awareness. It has also been increasingly reflected in the priorities of a wide range of organisations through the development of more effective responses and a great deal of progress has been made, as a result of local initiatives. This has resulted in a number of policies and procedures which are broadly similar but which do not allow for the degree of commonality and standardisation needed to underpin effective inter-agency endeavours in this complex area of work.

In 2002 the Department of Health, Social Services and Public Safety (the Department) supported the establishment of the Regional Adult Protection Forum to promote, develop and improve arrangements for the protection of vulnerable adults. It has become increasingly clear that a major contribution to effecting further significant progress lies in the production of regional policy and procedures. The need to address this issue has been brought into even sharper focus, and has been reinforced, by the degree of organisational change proposed by the Review of Public Administration.

In 2005 the Forum received Departmental endorsement to produce standardised, regional procedures. 'Safeguarding Vulnerable Adults', which is based on best practice, represents the outcome of that work and has been subject to widespread consultation. Whilst it marks a major step in improving

adult protection arrangements it has been produced at a time when further change is anticipated in areas such as legislation, governance and models of service delivery. Comparison with equivalent processes in child protection help to illustrate the potential for further amplification and development.
It is for these reasons that the Department is committed to reviewing the procedures when the initial phase of the organisational change referred to above has been completed. The Regional Forum will be asked to monitor and oversee this process.

The production of this document represents a major new phase in improving adult protection arrangements across the region. We do not underestimate the commitment that will be required to promote the effective operation of these procedures across the range of relevant organisations, but the Department is committed to ensuring that this happens. We would therefore commend the policy and procedures outlined in 'Safeguarding Vulnerable Adults' and expect it to be used as a framework within which we can effect major changes in this important area of work.

ANDREW HAMILTON
Deputy Secretary
Department of Health, Social Services and Public Safety

September 2006

PART I POLICY

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1.0 Policy - Introduction

1.1 Any adult at risk of abuse, exploitation or neglect should be able to access support to enable them to live a life free from violence and abuse. These procedures detail the processes that must be followed in the event of a suspicion or allegation that a vulnerable adult is at risk of abuse, exploitation or neglect. The procedures do not cover other responses to their needs. They are a vital part of a range of prevention, support and protection services offered to meet the needs of vulnerable adults, their families and carers.

1.2 The purpose of regional procedural guidance for Northern Ireland is to ensure a co-ordinated and standardised approach by all those who work with vulnerable adults and to establish the principles of good practice in this important area of work. This policy and the procedures which flow from it are derived from best practice in Northern Ireland and with reference to developments elsewhere in the UK.

1.3 The most recent guidance from the Department of Health has identified the need to establish a framework for action to ensure that there is:

'a coherent policy for the protection of vulnerable adults at risk of abuse and a consistent and effective response to any circumstances giving ground for concern or formal complaints or expressions of anxiety. The agencies' primary aim should be to prevent abuse where possible but, if the preventive strategy fails, agencies should ensure that robust procedures are in place for dealing with incidents of abuse '[1].

1.4 The following statements underpin the implementation of activities related to the protection and safeguarding of vulnerable adults:

- agencies and organisations will work co-operatively in the identification, investigation, treatment and prevention of abuse of vulnerable adults;

- a consistent response will be made to vulnerable adults when concerns are raised whether these are reported through complaints procedures, inspection or registration activity, as a result of whistle-blowing or as a result of disclosure on the part of vulnerable adults or their carers;
- action will be co-ordinated against alleged perpetrators to ensure that parallel processes are dovetailed including prosecution, disciplinary action and removal from, or notification to, professional registers and similar bodies;
- there is a responsibility to share information on a "need to know" basis so that effective decisions can be made and appropriate preventative action taken.

A co-ordinated approach in Northern Ireland will require the adoption and implementation of agreed regional procedures by Boards and Trusts. Such a process will need to include the strengthening of relationships with all providers of services and compatibility with the statutory responsibilities of other agencies and to policies already in force within them, in particular the Police Service of Northern Ireland (PSNI) and the Regulation and Quality Improvement Authority (RQIA).

2.0 Scope

2.1 This guidance is for all staff, regardless of employing organisation and sector, who provide health or personal social services to vulnerable adults in any setting or context. It is applicable to the protection from abuse of vulnerable people aged 18 or over and includes older people, people with a learning, physical or sensory disability and people with mental illness or dementia. It covers all types of abuse, including neglect and recognises that vulnerable people cannot always protect themselves.

2.2 The procedures within this guidance do not operate independently of other arrangements (see paragraph 1.4), such as complaints and disciplinary procedures, and should be implemented concurrently in order to ensure the protection of the vulnerable adult.

3.0 Definitions

Definition of Vulnerable Adult

3.1 The existing definition of 'vulnerable adult' varies across Boards and Trusts. It is important that there is a single, agreed definition of this term. The Regional Adult Protection Forum has adopted the Law Commission for England and Wales (1995) definition of a "vulnerable adult" as:

'a person aged 18 years or over who is, or may be, in need of community care services ***or*** *is resident in a continuing care facility by reason of mental or other disability, age or illness* ***or*** *who is, or may be, unable to take care of him or herself* ***or*** *unable to protect him or herself against significant harm or exploitation'*[2].

Adults who "may be eligible for community care services" are those whose independence and wellbeing would be at risk if they did not receive appropriate health and social care support. They include adults with physical, sensory and mental impairments and learning disabilities, howsoever those impairments have arisen; eg whether present from birth or due to advancing age, chronic illness or injury. They also include informal carers, family and friends who provide personal assistance and care to adults on an unpaid basis.

Definition of Abuse

3.2 The current definition of abuse is derived from regional guidance issued by the Management Executive, Department of Health and Social Services, in 1996, which states that abuse is:

'The physical, psychological, emotional, financial or sexual maltreatment, or neglect of a vulnerable adult by another person. The abuse may be a single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is an expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependant, whether they be formal or informal carers, staff or family members or others. It can also occur outside such a relationship' [3].

3.3 Forms of abuse can be categorised as follows:

- physical abuse (including inappropriate restraint or use of medication);
- sexual abuse;
- psychological abuse;
- financial or material abuse;
- neglect and acts of omission;
- institutional abuse; and
- discriminatory abuse.

3.4 Incidents of abuse may be multiple, either to one person in a continuing relationship or service context, or to more than one person at a time.

3.5 Any or all types of abuse may be perpetrated as the result of deliberate intent and targeting of vulnerable people, negligence or ignorance.

Significant Harm

3.6 The Law Commission in its 1995 report [2] makes use of the concept of significant harm as an important threshold when considering the nature of intervention and defines this as including not only ill-treatment

(including sexual abuse and forms of ill-treatment which are not physical), but also the impairment of physical, intellectual, emotional, social or behavioural development. Significant harm may include the degree, extent, duration and frequency of harm.

4.0 Guiding Principles

4.1 A set of commonly agreed principles underpins this regional procedural guidance. Such principles flow from respect for the rights of vulnerable adults who are entitled to:

- privacy;
- be treated with respect and dignity;
- lead an independent life and be enabled to do so;
- be able to choose how to lead their lives;
- the protection of the law;
- have their rights upheld regardless of ethnic origin, gender, sexuality, impairment or disability, age and religious or cultural background; and
- have the opportunity to fulfil personal aspirations and realise potential in all aspects of daily life.

This includes Human Rights considerations, particularly in relation to Article 2 “the Right to Life”, Article 3 “Freedom from Torture” (including humiliating and degrading treatment), and Article 8 “Right to Family Life” (one that sustains the individual).

Human Rights must be considered in all decision making processes, and due consideration given to concepts of proportionality and equality of arms.

5.0 Individual Rights

5.1 These principles assume that vulnerable adults have the right to:

- be accorded the same respect and dignity as any other adult, by recognising their uniqueness and personal needs;
- be given access to knowledge and information which they can understand to help them make informed choices;
- information about, and practical help in, keeping themselves safe and protecting themselves from abuse;
- live safely, without fear of violence or abuse in any form;
- have their money, goods and possessions treated with respect, and to receive equal protection for themselves and their property through the law;
- guidance and assistance in seeking help as a consequence of abuse;
- be supported in making their own decisions about how they wish to proceed in the event of abuse and to know that their wishes will only be over-ridden if it is considered necessary for their own safety or the safety of others;
- be supported in bringing a complaint under any existing complaints procedure;
- be supported in reporting the circumstances of any abuse to independent bodies;
- have alleged, suspected or confirmed cases of abuse investigated urgently;
- receive appropriate support, education, counselling, therapy and treatment following abuse;
- seek legal advice or representation on their own behalf;
- seek redress through appropriate agencies;
- have their rights respected and to have their family, informal carers or advocates act on their behalf as appropriate.

6.0 Inter-Agency Working

6.1 The principles and rights that have been identified can be further strengthened through the promotion of effective inter-agency co-operation, training and multi-disciplinary working. The operating principles which are needed to make this happen have already been specified as part of the recent work between HPSS and PSNI staff in developing procedures to improve co-operation in the field of adult protection[4].

6.2 These include the requirements for agencies to:

- actively work together within an identifiable inter-agency procedural framework encompassing effective communication, an appropriate risk management framework and clarity about agency and professional responsibility, authority and accountability;
- actively promote the empowerment and wellbeing of vulnerable adults through the services they provide;
- ensure the safety of vulnerable adults by integrating strategies, policies and services relevant to abuse within existing procedural frameworks;
- act in a way which supports the rights of the individual to lead an independent life based on self-determination and personal choice;
- ensure that when the right to an independent lifestyle and choice is at risk the individual concerned receives appropriate help, including advice, protection and support from relevant agencies;
- recognise that the right to self-determination can involve risk and ensure that such risk is recognised and understood by all concerned and minimised whenever possible; and
- ensure that the law and statutory requirements are known and used appropriately so that vulnerable adults receive the protection of the law and access to the judicial process.

7.0 Confidentiality

7.1 In normal circumstances observing the principle of confidentiality will mean that information is only passed on to others with the consent of the service user. However it should be recognised that in order to protect vulnerable adults, it may be necessary, in some circumstances, to share information that might normally be regarded as confidential.

7.2 All vulnerable adults and, where appropriate, their carers or representatives need to be made aware that the operation of multi-disciplinary and inter-agency procedures will, on occasion, require the sharing of information in order to protect a vulnerable adult or others, or to investigate an alleged or suspected criminal offence.

8.0 Consent and Capacity

8.1 One of the key challenges in relation to work with vulnerable adults relates to capacity and consent in considering what action should be taken about alleged or suspected abuse. Two key questions need to be addressed:

(i) did the vulnerable adult give meaningful consent to the act, relationship or situation which constitutes the alleged or suspected abuse?

(ii) does the person now give meaningful consent to any preventable action, investigation or report to the PSNI?

8.2 It is also necessary to determine both whether the person could consent and whether they did consent. Abuse may occur when any of the following conditions apply:

- the person does not consent;
- the person is unable to consent, either because of issues of capacity or because the law does not permit the vulnerable adult to give consent to a particular act or relationship;
- other barriers to consent exist for the vulnerable adult; eg where the person may be experiencing intimidation or coercion.

8.3 The principles contained in Good Practice in Consent (DHSSPS, 2003)[5] and enshrined in the legislation relating to mental incapacity which have been enacted in England and Wales[6], offer some useful guidelines for determining individual capacity and ability to consent. These include:

- a person must be assumed to have capacity unless it is clearly established that this is not so;
- a person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success;

- a person should not be considered as being unable to make a decision merely because he makes an unwise decision;
- an act done or decision made under this legislation for, or on behalf of, the person who lacks capacity, must be done, or made, in his best interests;
- before any action is taken, or decision made, regard must be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

8.4 Under this legislation a person is deemed to lack capacity in a matter if, at the same time, he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. It does not matter whether the impairment or disturbance is permanent or temporary. A person is deemed unable to make a decision for himself if he cannot:

- understand the information relevant to the decision;
- retain that information;
- use or weigh-up that information as part of the process of making that decision;
- communicate his decision (by speech, gesture, signing or any other means).

8.5 Where a person is deemed unable to make a decision every reasonable and practicable effort must be made to encourage and permit the person to participate, or to improve his ability to do so as fully as possible in any act done for him and decision affecting him. If it is decided that an adult does not have capacity, then staff should act in a way which is in that person's best interests; ie what is necessary to promote health or wellbeing or prevent deterioration, consistent with existing legislation.

PART II PROCEDURES

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9.0 Introduction

9.1 This part of the document outlines the core elements of adult protection procedures. It is important that they identify the responsibilities of different groups of staff, including reporting mechanisms.

9.2 The process of dealing with an allegation or suspicion of abuse of a vulnerable adult goes through a number of distinct stages. The following have been identified:

- alerting;
- referring;
- screening;
- planning the investigation;
- investigating;
- making decisions;
- monitoring and review.

9.3 Each stage is examined in turn and the roles and responsibilities of staff described. It will not be necessary to follow through all of these stages in every case. A decision may be reached at any stage to resolve the issue by providing care management or other services. At the other end of the spectrum, it may be necessary to reconvene a strategy meeting if new evidence comes to light which moves the focus of the investigation beyond its initial remit.

9.4 The protection of vulnerable adults from abuse should always receive high priority from all agencies involved. Concerns about abuse should be reported immediately.

10.0 Alerting

10.1 Alerting refers to the responsibility to recognise abusive situations and inform a nominated manager within the agency. It plays a major role in ensuring the protection of vulnerable adults and it is important that all concerns about possible abuse, however trivial, should be reported. An alert may come from any person who has knowledge or a reasonable suspicion that a vulnerable adult has been, or is at risk of, being abused.

10.2 Everyone working with vulnerable adults has a duty to report suspected, alleged or confirmed incidents of abuse. In a situation where a staff member has concerns, they should report this immediately to their line manager or to a senior manager if consultation with their line manager would involve undue delay.

10.3 If the allegations relate to another employee, the staff member should alert their line manager. If the allegations relate to the line manager, the staff member should report the matter to a more senior manager. It should be noted that the Public Interest Disclosure (Northern Ireland) Order 1998 provides for the active safeguarding and protection of what are commonly known as 'whistle blowers'.

10.4 If the person who suspects abuse is employed within the voluntary, private or independent sector, they should report their concerns to their line manager whose responsibility it will be to refer to the appropriate Health and Social Services Trust Officer or Designated Officer.

10.5 Concerns about suspected abuse by staff should also be reported to the RQIA as outlined in the appropriate regulations. Staff providing assistance to the vulnerable adult at this stage will need to obtain as much information as possible pertaining to the allegation or suspicion of abuse, particularly if a criminal offence has been committed. Staff should only clarify the basic facts of the suspected abuse or grounds for suspicion. They should avoid asking leading questions and should not discuss the allegation with the victim or the alleged perpetrator. Staff should be clear that their role is primarily supportive rather than investigative.

10.6 Members of the public wishing to remain anonymous, or persons providing information who do not wish to be identified, should be aware that, while anonymity will be honoured as far as possible, it cannot be unconditionally guaranteed. They should be made aware that they may be required to give evidence, or their name may have to be disclosed in Court.

10.7 On receiving an alert of an allegation or suspicion of abuse, the line manager should check that the vulnerable adult's immediate needs are being met; ie that they are in no immediate danger and that medical assistance, if deemed necessary, has been sought.

11.0 Referral

11.1 All referrals should be made to the appropriate Designated Officer. This contact may be made by telephone in the first instance, but should be confirmed in writing within 2 working days. The Designated Officer should then acknowledge receipt of the referral within 2 working days.

11.2 When deciding the level of urgency of any referral, the degree of apparent risk should be the deciding factor. Some cases of abuse will require a rapid response and service provision must allow for this.

11.3 The first priority should always be to ensure the immediate safety and protection of the vulnerable adult. This may involve calling the relevant emergency service or considering, with the vulnerable adult, if they can move to a place where they feel safe. Life threatening situations, such as severe physical abuse, require an immediate response. In all other circumstances, allegations of abuse should be the subject of an initial investigation within 3 working days.

11.4 Situations arising outside of normal office hours and requiring immediate intervention should be passed on to the appropriate Out of Hours Social Work Service. The Duty Social Worker should give priority to the protection of the vulnerable person and report to the appropriate Designated Officer at the earliest opportunity when offices re-open.

Allegations against staff and paid carers

11.5 Disciplinary investigations of allegations against staff and paid carers will be undertaken within the disciplinary procedures of the employing agency. They should be conducted separately from any enquiry or investigation under Protection of Vulnerable Adult Policies and Procedures, although there may be a need for simultaneous action

and for the co-ordination and sharing of information. Where a criminal investigation is taking place, the disciplinary procedure may not be able to be concluded until this has been completed.

11.6 Employers should ensure that their disciplinary procedures are compatible with the responsibility to protect vulnerable adults. Where appropriate, they should report workers to the relevant statutory and other bodies responsible for professional regulation; eg Northern Ireland Social Care Council, Nursing and Midwifery Council, General Medical Council, Protection of Vulnerable Adults' lists.

12.0 Screening

12.1 Decisions around the threshold for intervention are questions of judgement.

The Designated Officer, along with fellow professionals and relevant others must:

- establish the substance of the suspected, alleged or known abuse;
- establish that the individual falls within the scope of the policy.

12.2 It is also important that the person's Human Rights are considered. Unnecessary or premature initiation of a vulnerable adult investigation should be avoided.

12.3 In deciding whether further investigation is necessary, the following factors need to be considered:

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

Consent and Capacity

12.4 It is important to consider issues of consent and capacity in order to establish the individual's ability to give meaningful consent to the abusive act or situation or to any further investigative process. The guiding principles in relation to these issues are outlined in Section 8 of this document.

Dispensing with Consent

12.5 When considering the vulnerable adult's ability to give meaningful consent, there should be full discussion and reference to legal and medical advice before any decision is made. In the context of adult protection, there will be some circumstances in which it will be necessary to over-ride the wishes of the individual even though they are deemed to be capable of giving meaningful consent. These will include situations:

- where there is an over-riding public interest; eg to prevent serious harm or injury to others; or
- where there is a requirement to investigate a criminal offence.

12.6 In all cases where the wishes of the individual are over-ridden, this should be fully explained both to them and their carer or advocate, where appropriate, and recorded in the service user's record.

Outcomes of Screening

12.7 Possible outcomes of initial screening may be that:

- no further action is required;
- referral for an appropriate assessment is made; eg for new or increased services; or
- further investigation under the Adult Protection Procedures is required.

Where there is a decision not to proceed

12.8 In all instances where an investigation is not pursued, the reasons for this decision, the personnel involved and any contrary advice should be noted. The file note should be countersigned by the line manager and Designated Officer and forwarded to the appropriate senior manager.

12.9 The decision not to proceed under the Adult Protection Procedures does not necessarily mean that there are no issues about the adult's welfare. These may be addressed by other types of intervention; eg referral for an assessment of the individual and/or their carer. It is important to record details of any intervention provided or offered on the service user's record.

13.0 Planning the Investigation

Identifying Roles

13.1 The appropriate agency to lead the investigation will be the HSS Trust. Where another possible lead agency, such as the PSNI, is involved the host Trust should take a lead in ensuring that a strategy discussion take place and in co-ordinating the arrangements for this.

The PSNI has a legal duty to investigate alleged criminal abuse. Where there is a possibility of a criminal prosecution, the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults[4] **must** be followed.

On receipt of a referral, the Designated Officer will convene a strategy discussion and will appoint an Investigating Officer.

Strategy Discussion

13.2 The purpose of the Strategy Discussion is to ensure an early exchange of information, to clarify what immediate action needs to be taken by whom and to determine the method of investigation. This should take place within one working day of referral to the Designated Officer unless good practice dictates otherwise. In most instances it will be appropriate for the Strategy Discussion to take place by telephone but, in a particularly complex referral, the telephone discussion may be extended to a meeting.

13.3 All relevant professionals and agencies should be involved in the discussion. The Regulation and Quality Improvement Authority (RQIA) must be notified in all situations where concerns have arisen in any registered establishment or agency as per the regulation. At this stage, in the case of allegations against staff members, consideration also has to be given to involving the relevant Human Resources Department.

13.4 The strategy for investigation should always be informed by information gained by those who have knowledge of the person and his or her circumstances. This may not be possible in a minority of cases; eg some referrals may require immediate action by the Trust or PSNI to ensure the protection of the person or the apprehension of a suspect.

Outcome of Strategy Discussion

13.5 The Strategy Discussion will make decisions on the following:

- the need for immediate protection;
- whether to proceed under the Adult Protection Procedures;
- the method of investigation; ie single or joint agency;
- who will co-ordinate the investigation and conduct any interviews;
- whom to interview;
- the roles and responsibilities of those involved;
- the need for protection of others viewed at risk;
- the need for medical/psychiatric/psychological assessment;
- what arrangements will be made for a person with a disability or special needs including the requirement for an interpreting service;
- what support the vulnerable adult, informal carers and family members will be offered during the investigation, as well as the alleged perpetrator if they are a vulnerable adult or service user;
- the wishes, if known, of the vulnerable adult involved;
- the rights of those involved in the investigation;

- the need to report to other bodies, such as RQIA, Mental Health Commission, Professional Bodies;
- arrangements for reporting back to the Designated Officer;
- a communication strategy/press statement (if appropriate).

13.6 A record of the Strategy Discussion must be completed by the Designated Officer or Chair of the Strategy Discussion Meeting.

Methods of Investigation

13.7 Depending on the decisions of the Strategy Discussion, the investigation may proceed through single agency investigations, joint investigations or joint investigations with the PSNI.

(a) Single Agency Investigations

These are investigations where intervention rests solely with one agency; eg Trust, PSNI.

(b) Joint Investigations

These are investigations which involve more than one agency or organisation but which lie outside the 'Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults' (eg Joint Investigations between Trust, RQIA, voluntary organisations, etc).

(c) Joint Investigations with the Police

A detailed consideration of the need for a joint investigation with the PSNI will be triggered when there is an allegation or suspicion that one of the following criminal offences has been committed against a vulnerable adult:

- a sexual offence committed against a vulnerable adult;
- physical abuse or ill-treatment amounting to a criminal offence;
- financial abuse involving a criminal offence such as fraud or theft; or
- abuse which involves a criminal offence; eg blackmail.

13.8 The vulnerable adult should be advised of their right to report the alleged or confirmed abuse to the PSNI at an early stage.

13.9 In all cases of alleged or suspected criminal abuse, the Designated Officer should consult with the relevant Police Liaison Officer. It will be the responsibility of the Police Liaison Officer to help determine whether the matter may involve criminal abuse and thereby inform the decision concerning what level of enquiry or investigation is necessary.

13.10 Alleged or suspected sexual abuse should be reported to the Detective Inspector - Child Abuse and Rape Enquiry (CARE) team who holds the role of Police Liaison Officer for sexual crimes.

13.11 Alleged or suspected non-sexual abuse should be reported to the Police District Command Unit (Crime Manager) who holds the role of Police Liaison Officer for non-sexual crimes.

13.12 Where more than one form of abuse is alleged or suspected, sexual offences will take precedence and these cases should be referred in the first instance to the Detective Inspector (CARE).

13.13 A referral to the PSNI does not automatically mean that a joint investigation will be initiated. In the majority of cases, the PSNI will only proceed with the consent of the vulnerable adult. In practice this means that the vulnerable adult should be willing to make a complaint to the PSNI. However there are some exceptions to this:

- where the vulnerable adult is deemed not to have capacity;
- where the vulnerable adult is subject to undue influence;
- where others may be at risk;
- to prevent a crime being committed;
- where the vulnerable adult has been the victim of a serious crime or a serious crime may take place.

13.14 Where a decision to proceed to joint investigation is taken, the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults **must** be followed.

13.15 Where the vulnerable adult receives a service from a registered establishment or agency, the Designated Officer must refer the matter immediately to the appropriate Inspector within RQIA. Close liaison and co-operation in relation to this will be essential in order to ensure an effective outcome. This procedure applies to statutory, private and independent sector provision.

The Manager of the registered facility or service also has a responsibility to inform RQIA of any ongoing investigations.

13.16 Where care is being purchased outside of the Board/Trust area, the Designated Officer of the host Trust should liaise with the Trust who has made the placement to satisfy themselves, of the individual's ongoing protection. They should also ensure that the allegation has been notified to the relevant Inspector within RQIA.

Accident and Emergency and Hospital In-Patients

13.17 When a vulnerable adult presents at an Accident and Emergency Unit or is a patient in a hospital facility and there is a concern or allegation of abuse, the hospital staff have a duty to alert their line manager. The

line manager should refer to the Designated Officer for the hospital who will, in turn, liaise with the appropriate Designated Officer in the community to determine who will take the lead role in the investigation.

13.18 It is essential that all professionals involved liaise effectively and that a Care and Protection Plan is in place before the patient is discharged. The Designated Officer for the hospital should inform the appropriate senior manager within Clinical Services and the RQIA of any investigation that takes place and its outcome.

13.19 Where the concern or allegation relates to a vulnerable adult who is known to Mental Health services or the Learning Disability Programme of Care, the Designated Officer for the hospital should inform the Mental Health Commission when an investigation is initiated and also of the eventual outcome.

Individuals who are in receipt of Direct Payments

13.20 People who are purchasing their own services through the Direct Payments scheme and their relatives should be made aware of the arrangements for the management of adult protection in their area. Such service users should receive the same level of support and protection as any other vulnerable adult if abuse occurs.

14.0 Investigating

14.1 The investigation strategy should be implemented as agreed at the Strategy Discussion. The Investigating Officer will take the lead role in undertaking the investigation and in keeping the Designated Officer informed. This role will require an experienced and suitably trained professional who will be responsible for direct contact with service users, informal carers or relatives involved in the case. In many instances, it will be appropriate to involve other staff in the investigation in order to ensure that an appropriate assessment is made.

14.2 The involvement of the vulnerable adult and significant others should be a primary consideration during the investigation.

14.3 The purpose of the investigation is to:

- establish the facts about the circumstances giving rise to the concern about the abuse or neglect;
- decide if there are grounds for concern;
- identify the sources and levels of risk;
- determine who is responsible and recommend what action or support may be necessary in relation to them;
- decide protective or other actions in relation to the persons concerned or any other vulnerable adult.

14.4 The Investigating Officer should ensure that the alleged victim is interviewed, if appropriate. The process of investigation may take several interviews. The needs of the vulnerable adult, informal carer or carers and, where appropriate, the alleged abuser should be considered. Investigations need to be handled with the utmost sensitivity, recognising that both parties may have a continuing relationship into the future. Where the individual makes a direct

disclosure of abuse, they should **NOT** be interviewed in the presence of the alleged perpetrator unless in exceptional circumstances.

14.5 The vulnerable adult may wish to have someone else present during the interview - a carer, friend, independent advocate or another member of staff. This should be facilitated where possible. There may also be the need to have an interpreter present where communication difficulties arise.

14.6 In instances of abuse that constitute a criminal offence and there is a decision that Social Services and PSNI will jointly interview the vulnerable adult this can **only** be undertaken by an interviewer who has been trained in the procedures specified in Achieving Best Evidence [7]. It will be the responsibility of each agency to ensure that the interview and investigation process is properly supervised and supported by relevant managers who have been trained in these procedures.

14.7 The Investigating Officer should keep the Designated Officer fully informed of developments throughout the investigation process.

14.8 When interviewing alleged perpetrators, agencies and staff should remain mindful of the potential for violence and aggression. They should adhere to agency risk management/health and safety policies to ensure staff are adequately protected in such circumstances.

14.9 If there are no significant indicators of risk or insufficient evidence to substantiate concern, a written record should be made by the Designated Officer which clearly sets out the reasons for taking a decision not to proceed to formal Case Discussion. Consideration should be given to whether:

- the vulnerable adult or significant others require counselling regarding the investigation;

- the person or others; eg their carers should be assessed for services;
- a multi-disciplinary care planning meeting should be convened.

Actions if there are indicators of continuing risk

14.10 When one of the following occurs:

- the abuse is confirmed;
- there is substantial risk of abuse;
- there are suspicions of abuse and doubt remains;
- the vulnerable adult refuses help;
- action is going to be required by more than one agency;

a Case Discussion should be convened and chaired by the Designated Officer as soon as possible and no later than 14 working days after the completion of the investigation. The purpose of the meeting is to identify risks and the actions necessary to manage those risks.

14.11 The Case Discussion may take the form of:

(a) a formal Case Discussion; eg when the individual is deemed not to have capacity to consent; in situations where there may be more than one victim of the abuse or where a multi-agency response is required;

(b) a Family Group Conference; eg where family relationship issues need to be addressed and family decisions are required;

(c) a Risk Management Meeting; eg where the focus of discussion is on the risks and the actions needed to alleviate them, for example in the case of medication misuse.

The Designated Officer will decide which meeting format is most appropriate and will both support the vulnerable person and secure commitment to any Care and Protection Plan.

Irrespective of which approach is adopted, the ongoing protection of the vulnerable adult must remain the key focus of the discussion.

15.0 Making Decisions

15.1 Regardless of the format adopted**,** the purpose of the Case Discussion is to consider the Investigating Officer's report and to formulate an agreed Care and Protection Plan for the individual. The tasks of the initial meeting are:

- to share and evaluate the information gathered in the investigation;
- to assess the level of risk to the vulnerable adult;
- to agree an inter-agency Care and Protection Plan;
- to appoint a key worker to oversee the implementation of the Care and Protection Plan;
- to identify any therapeutic interventions and follow-up work for the person who has been abused;
- where appropriate, to establish a Care Plan to work with the perpetrator if he or she is also a person who is vulnerable;
- to arrange appropriate follow-up support for carers if necessary;
- to agree a review date within 3 months;
- to inform RQIA of agreed action.

Attendance at Meeting

15.2 The circumstances will dictate who it is appropriate to invite to the meeting. All agencies and professionals who have been involved in the investigation or who may play a role in providing services to the vulnerable adult should be included as well as the vulnerable adult and their carer.

However, it may not be appropriate for the vulnerable adult and alleged perpetrator to be involved in these meetings when a PSNI investigation is in process.

15.3 The vulnerable adult may choose to attend with an advocate or other representative. Alternatively they may choose for an advocate or other person to attend the meeting on their behalf.

15.4 If the carer is the suspected abuser, the vulnerable adult's views should be taken into account concerning the carer's attendance. If the vulnerable adult's ability to understand the procedure makes their attendance inappropriate, the Designated Officer should ensure that their views are represented. The sequence of events in the meeting needs to be considered and the vulnerable adult or their carer should not be present when disciplinary matters or action to be taken in regard to another service user are being discussed.

15.5 If the alleged perpetrator is also a vulnerable adult, their needs may have to be considered in a separate meeting.

15.6 The following is a checklist of those who may be required to be in attendance at the meeting:

- staff members who can assist in clarifying what is known about the actual or potential abuse;
- professionals who have taken part in the adult protection investigation and any investigation in relation to other procedures and criminal matters, including the PSNI;
- staff who can contribute to the formulation of a Care and Protection Plan (Social Workers, Care Managers, Community Nurses, Health Visitors, Allied Health Professionals such as Occupational Therapists, Residential and Day Care staff);
- General Practitioner;

- Consultant/Accident and Emergency Staff;
- RQIA Representative;
- Professionals who can offer specialist advice; eg Psychiatrists, Psychologists, Legal Representative, Social Security Agency, Northern Ireland Housing Executive;
- the vulnerable adult and their carer, where appropriate;
- an advocate for the vulnerable adult, where appropriate;
- an interpreter for the vulnerable adult, where required.

15.7 Once a long-term plan has been formulated, a small group of staff from the various disciplines and agencies involved should be identified as the core group who will work together to implement and review the Care and Protection Plan.

Non Attendance at Case Discussion

15.8 Those who are invited to a formal Case Discussion meeting, but who are unable to attend, should ensure that their contribution is made through a written report to the Designated Officer. Particular attention should be paid to arranging the meeting so that those with a particular contribution and otherwise inflexible commitments can attend.

User and Carer Involvement

15.9 In deciding the appropriate meeting format, consideration should be given to ensuring that the views of the vulnerable adult and carers are heard or represented in what may be a potentially intimidating situation for them. Participation can be encouraged in the following ways:

- meetings should be held at a time and place which is convenient for the vulnerable adult and their carer(s);
- the procedures involved should be explained;
- the vulnerable adult and their carer(s) should be given help in preparing their views on the issues identified;
- the vulnerable adult should have access to an independent advocacy service;
- meetings should be service oriented and use jargon-free language.

Recording the Meeting

15.10 The Designated Officer should arrange for an accurate minute of the proceedings to be made, which clearly identifies decisions made, by whom actions are to be taken, and the agreed timescales for action and review. Any dissent should be recorded and resolution agreed. The minute should be signed by the Designated Officer and copied to all participants.

15.11 All agencies should identify arrangements, consistent with principles of fairness, for making records available to those affected by, and subject to investigation.

Agreeing the Care and Protection Plan

15.12 A Care and Protection Plan should be drawn-up in consultation with the vulnerable adult that sets out:

- what steps are to be taken to ensure their safety in the future;
- what service, treatment or therapy they can access;
- modifications in the way services are provided to them;
- how best to support them through any action they take to seek justice or redress;
- any ongoing risk management strategy, where this is deemed appropriate; and
- who is responsible for the implementation and ongoing management of the Care and Protection Plan. This may be the service user's key worker, the Investigating Officer, or other nominated person.

15.13 The Designated Officer must ensure that the Care and Protection Plan is circulated to all relevant parties, including the vulnerable adult and their carer, if appropriate, within 3 working days.

15.14 The Care and Protection Plan may also address the need to work with the perpetrator of the abuse. Where the perpetrator poses a risk to others, the Designated Officer should share this information with relevant others. (see Section 7).

15.15 Particular attention is needed in planning care which may be required in the future; for example, a vulnerable adult may be safe while the person who abused them is being held in custody or prison but protection may need to be reinstated when that person is released.

16.0 Monitoring and Review

16.1 Monitoring an individual case involves overseeing the services provided for the vulnerable adult to ensure that the individual's Care and Protection Plan is effective in protecting them from further abuse.

16.2 In situations where the vulnerable adult is considered to be still at risk, the case should be kept under review and further action taken within 24 hours or as considered necessary to safeguard them.

16.3 The Care and Protection Plan will have identified the person responsible for monitoring its operation. This should be reviewed with service providers, the vulnerable adult and carers within 10 working days of its implementation. Any concerns that arise about the operation of the Care and Protection Plan should be reported to the Designated Officer. If the responsible person is ceasing to work with the vulnerable adult, they must inform the Designated Officer immediately so that a replacement can be arranged.

16.4 The Care and Protection Plan should be further reviewed at a minimum of 3 monthly intervals, or more often if necessary.

16.5 The decision to cease reviews should normally be made following a formal Case Discussion. However there may be circumstances in which it is obvious that the vulnerable adult is no longer exposed to any risk, such as no further contact with the abuser or moving to a more protective environment. The Designated Officer must inform all relevant parties of the decision to end the review process in writing, and to ask for their views.

16.6 At the initial or review Case Discussion meeting, it may be decided that the case can be satisfactorily managed within existing line management arrangements. In these circumstances:

- the first meeting must take place within 6 weeks of the case conference;
- the line manager and the responsible person will address the concerns identified at the Case Discussion meeting.

16.7 Where a case remains open for other forms of intervention, the date of closure of adult protection reviews should be clearly recorded. The file note should be countersigned by the line manager and the Designated Officer and forwarded to the appropriate senior manager.

Monitoring for Statistical Purposes

16.8 Periodic audits of individual adult protection case records will enable strengths and weaknesses in current practice to be identified.

Standardised recording and monitoring systems should be agreed across agencies to assist such information gathering.

16.9 Accurate and consistent monitoring of vulnerable adult data will increasingly enable agencies across the region to base their policy and practice on sound and relevant evidence, highlighting trends and assisting in the planning process.

16.10 RQIA may not be directly involved in the investigation but reserve the right to monitor and conduct an overview of the investigation carried out by a HSS Trust.

PART III LEGAL FRAMEWORK

There is no specific legislation or body of common law relating to situations of risk or abuse of vulnerable adults. However there are pieces of legislation which seek to provide some protection and provide a potential framework for action. This list below is not finite:

- Criminal Law Amendment Act 1885;
- Offences Against the Person Act 1861;
- Marriages Act (Northern Ireland) 1954;
- Criminal Law Amendment Act (Northern Ireland) 1923;
- Public Health Act 1967;
- Health and Personal Social Services (Northern Ireland) Order 1972;
- Matrimonial Causes (Northern Ireland) Order 1978;
- Sexual Offences (Northern Ireland) Order 1978;
- Domestic Proceedings (Northern Ireland) Order 1980;
- County Courts (Northern Ireland) Order 1980;
- Mental Health (Northern Ireland) Order 1986;
- Marriage Act (Northern Ireland) 1983;
- Enduring Powers of Attorney (Northern Ireland) Order 1987;
- Prevention of Terrorism (Temporary Provisions) Act 1989;
- Police and Criminal Evidence (Northern Ireland) Order 1989;
- Northern Ireland (Emergency Provisions) Act 1996 and 1998;
- Homosexual Offences (Northern Ireland) Order 1982 as amended by Section 145(3) of the Criminal Justice and Public Order Act 1994;
- Human Rights Act 1998;

- Criminal Evidence (Northern Ireland) Order 1999;
- Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and Associated Regulations;
- Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003;
- Carers and Direct Payments Act (Northern Ireland) 2002.

Staff must interpret the rights, duties and powers available and apply them to individual circumstances. The following highlight some of these available to staff.

Human Rights

The Human Rights Act 1998 is an Act of the Westminster Parliament which makes the European Convention on Human Rights part of the law of all parts of the United Kingdom. Although passed in 1998, the Human Rights Act did not fully come into effect until 2nd October 2000. In making the European Convention part of the law of Northern Ireland, the Human Rights Act allows individuals and organisations to go to Court, or to a tribunal to, seek a remedy if they believe that the rights conferred on them by the European Convention have been violated by a public authority (Section 7).

There are three main areas of law which provide a legal framework for the protection of vulnerable adults.

Criminal Law

Vulnerable adults are protected in the same way as any other person against criminal acts. If a person commits theft, rape or assault against a vulnerable adult they should be dealt with through the criminal justice system, in the same way as in cases involving any other victim. Where there is a reasonable suspicion that a criminal offence may have occurred, it is the responsibility of the Police to investigate and make a decision about any subsequent action. The Police should therefore always be consulted about criminal matters. Failure to disclose to the Police any information about a suspected criminal offence as defined in Article 26 of the Police and Criminal Evidence (Northern Ireland) Order 1989 is itself a crime.

Under the above Order provision is made for 'an appropriate adult' to protect the interests of the mentally ill or impaired individual while in Police detention.

The Criminal Evidence (Northern Ireland) Order 1999 makes provision for special measures, previously introduced for children when giving evidence, such as CCTV links and video recorded evidence-in-chief, to be extended to include vulnerable adults.

Indecent assault on a female is contrary to Section 52 and on a male is contrary to Section 62 of Offences Against the Person Act 1861. For an act to be considered an indecent assault there has to be actual or apprehended physical contact in 'circumstances of indecency' to which one or other party does not consent. This offence can be committed by either a man or a woman. Since a person with a severe

learning disability cannot, in law, give consent, this means that any sexual contact between this person and someone who is not, may be construed as being indecent assault.

Article 3, Sexual Offences (Northern Ireland) Order 1978 states that a man commits rape if he has sexual intercourse with a woman whom he knows does not consent to it or where he is reckless as to whether she consents or not.

The Mental Health (Northern Ireland) Order 1986 gives power to an Approved Social Worker:

(i) to make an application for assessment in respect of a mentally disordered person;

(ii) to authorise admission to hospital of a mentally disordered person.

The assessment of risk is a critical element in the process of compulsory admission and all applications for assessment must be founded on the recommendation of a medical practitioner and made by an Approved Social Worker or nearest relative as defined by the Mental Health Order. In cases of dementia, it is the degree of impairment rather than the dementia itself which constitutes the mental disorder in terms of the legislation.

The purpose of Guardianship (Article 18) is primarily to ensure the welfare (rather than the medical treatment) of a person in a community setting where this cannot be achieved without the care of some or all of the powers vested in Guardianship. It provides a less restrictive means

of offering assistance to a person who, either, has a mental illness or severe learning disability and should be considered as an alternative to detention in hospital.

To be received into Guardianship, a person must meet two criteria:

(i) he or she must be suffering from 'mental illness or severe mental handicap'; and

(ii) reception into Guardianship must be necessary in the interests of the welfare of the person.

The purpose of appointing a Guardian is to enable the *'establishment of an authoritative framework for working with the person with a minimum of constraint, to help them achieve as independent a life as possible within the community'*.

A Guardian has three essential powers:

(i) to require the person to reside at a certain place;

(ii) to require the person to attend for medical treatment, occupation, education or training at specific times and places; and

(iii) to require access to be given at any place where the person is residing, to a doctor, Approved Social Worker or other person so specified by the Board.

Article 107 imposes a duty on employees of any Board, Trust, Nursing Home or home for persons in need to refer cases of adults deemed incapable of managing their affairs to the Office of Care and Protection, where no suitable arrangements are in place for the administration of their finance and business affairs. Even in cases where the estate may

not be sizeable and where there are no suitable arrangements in place to deal with the estate, there is a statutory duty on the aforementioned to refer the case to the Office of Care and Protection. The responsibility is on the social worker to make adequate representation to the Court and to provide as much information as possible.

Article 121 states that it is an offence for a member of an administrative board or a staff member of a hospital or private nursing home to ill-treat or neglect a patient who is either receiving in-patient or out-patient treatment. Any individual who ill-treats or neglects a patient who is subject to Guardianship under this Order or who is otherwise owed a duty of care will also be guilty of an offence.

Article 122 offers protection to women who have a severe learning disability. It specifies that it is unlawful to have sexual intercourse with them, to encourage their prostitution, to supply premises for the purpose of sexual intercourse with them, or to take the person away from their carers in order to have sexual intercourse with them. Clinical assessment of their degree of disability is therefore very important when considering issues concerned with sexual activity either potential or actual and should be carried out by a clinical psychologist or psychiatrist specialising in the field of learning disability.

Article 123 makes it an offence for a man to have unlawful sexual intercourse with a woman suffering from any form of mental disorder if the man is a manager or, is on the staff of a hospital or residential home in which the woman is an in-patient. This applies to any mental disorder. The same prohibition applies to Guardians.

Article 37 of the Health and Personal Social Services (Northern Ireland) Order 1972 makes provision to allow the removal to suitable premises of ‘persons in need of care and attention’. It is usually only applicable in situations of self neglect and where the risk to the person’s health is so great that intervention is deemed necessary although there is not a clearly defined mental disorder sufficient to require admission for assessment under the Mental Health (Northern Ireland) Order 1986.

Public health legislation may be used in circumstances where a person who is vulnerable is living in conditions of extreme squalor. An Environmental Health Officer from the local Council would carry out an assessment and issue an Improvement Notice. This notice is served on the person responsible for the property, for example, the landlord. The Environmental Health Department should be approached for advice.

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 empowers the Regulation and Quality Improvement Authority to register and inspect residential care homes and nursing homes based on care standards.

The Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003 (POCVA) commenced in April 2005 and provides the legislative basis for the maintenance of a list of individuals who are considered unsuitable to work with vulnerable adults.

Civil Law

This includes family law and property law.

The Enduring Power of Attorney (Northern Ireland) Order 1987 enables people, while they are still mentally capable to decide who they would like to deal with their affairs on their behalf, should they become mentally incapable. The Court of Protection has powers to revoke an enduring power in the event of its abuse.

The Family Homes and Domestic Violence (Northern Ireland) Order 1998 is designed to provide a coherent legal approach to deal with two separate, but related, issues; providing protection from violence or molestation in families and regulating occupation of the family home when a relationship breaks down.

The main features of this legislation in relation to adult protection are:

(i) it replaces the provisions under previous legislation with a single set of remedies which both improve and extend the level of protection available;

(ii) a Non-Molestation Order and Occupation Order replace Personal Protection, Ouster and Exclusion Order. 'Molestation' is to be broadly interpreted and will be viewed on a case-by-case basis;

(iii) the range of people who can apply for a Non-Molestation Order is extended to include parents, grandparents or friends sharing a house. However, an Occupation Order can only be made in favour of a spouse, former spouse, co-habitee or former co-habitee unless the applicant has a legal share in the property;

(iv) Breach of Orders made for protective purposes is a criminal offence and an arrest without warrant can be made;

(v) provision is included to allow specified third parties ("a representative") to act on behalf of victims of domestic violence to apply for a Non-Molestation or Occupation Order;

(vi) the legislation allows a Court to exclude a domestic violence perpetrator from other premises/areas apart from the family home.

The Public Interest Disclosure (Northern Ireland) Order 1998 is designed to:

"*protect individuals who make certain disclosures of information in the public interest; to allow such individuals to bring action in respect of victimisation; and for connected purpose".*

The type of information includes disclosures of criminal offences, miscarriages of justice, endangerments to health or safety of individuals or damage to the work environment.

Compensation Law

This legislation enables a private action to be taken against an individual in the Civil Courts for compensation. The criminal injuries compensation scheme enables recompense for criminal injury or damage.

PART IV REFERENCES

1. Department of Health (2000) No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse. London: HMSO;

2. Law Commission for England and Wales (1995) Mental Incapacity, Report No. 231. London: HMSO;

3. Guidance on Abuse of Vulnerable Adults (Management Executive, Department of Health and Social Services: 1996);

4. Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults, December 2003;

5. Good Practice in Consent (Department of Health Social Services and Public Safety, 2003);

6. Mental Capacity Act 2005;

7. Achieving Best Evidence in Criminal Proceedings (Northern Ireland): Guidance for Vulnerable or Intimidated Witnesses, including Children (2003).

PART V GLOSSARY OF TERMS

Designated Officer	This is the person within the Trust deemed to be responsible for the decision to proceed under the Adult Protection Procedures and for co-ordinating any subsequent investigation which takes place. The title used can vary, for example, in some Trusts this person is referred to as the Adult Protection Co-ordinator. This person will usually be a Social Work Manager.
Investigating Officer	This is the experienced and suitably qualified professional appointed by the Designated Officer to carry out an investigation of the alleged abuse as agreed at the Strategy Discussion.
Key Worker	This is the professional who is appointed by the Designated Officer/Chair of formal Case Discussion meeting to monitor the Care and Protection Plan.
Police Liaison Officer	This is the designated person within the Police who will help determine whether a criminal offence has been committed and advise on what level of enquiry/investigation is necessary.

Crime Manager	This is the person within the Police at District Command Unit level who holds the role of Police Liaison Officer for non-sexual crimes.
Formal Case Discussion	This is the formally convened forum used to share and evaluate the information gathered in the investigation and to formulate a Care and Protection Plan for the vulnerable adult. This meeting may also take the form, for example, of a Family Group Conference or Risk Management Meeting.
Family Group Conference	This is a family centred decision making forum. It aims to enable families to take collective responsibility for decisions regarding the care and protection of family members. It involves a network of family, friends and significant others and attempts to capitalise on the knowledge, skills and resources of the family community and agency systems.
Risk Management Meeting	This is a meeting where the focus of the discussion is on the identification of a specific risk; eg the misuse of medication, and the measures necessary to reduce that risk.

Achieving Best Evidence	This guidance is intended to assist those conducting video-recorded interviews with vulnerable or intimidated witnesses as well as giving guidance to those who are tasked with preparing and supporting such witnesses throughout the criminal justice process.
Proportionality	The intervention or limitation on any human right adopted should achieve the objective in question.
Equality of Arms	Neither party should suffer a procedural disadvantage compared with the other.

APPENDIX
REGIONAL ADULT PROTECTION FORUM MEMBERS

Dominic Burke	Western Health and Social Services Board
Kevin Keenan	Northern Health and Social Services Board
Jan Maconachie	Northern Health and Social Services Board
Noel Quigley	Western Health and Social Services Board
Joyce McKee	Eastern Health and Social Services Board
Dessie Lowry	Royal College of Nursing
Marian Corrigan	Southern Health and Social Services Board
Angela Cole	Ulster Community and Hospitals Trust
Brian Serplus	Homefirst Community Health and Social Services Trust
Phil Mahon	Foyle Health and Social Services Trust
Grace Henry	Help the Aged NI
Sandra Pentland	Craigavon Banbridge Community Trust
Theresa Burns	Sperrin Lakeland Health and Social Services Trust
Linda Johnston	Ulster Community and Hospitals Trust
Dr Stephen Compton	Mater Hospital Trust
Stuart Baxter	Department of Health, Social Services and Public Safety
Gary Mullan	PSNI
Kieran Downey	Sperrin Lakeland Health and Social Services Trust
Maureen Piggot	Mencap NI

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Protocol for JOINT INVESTIGATION of Alleged and Suspected Cases of Abuse of Vulnerable Adults

July 2009

Health and Social Care

The Regulation and Quality Improvement Authority

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APPENDICES

Appendix 1: The European Convention for the Protection of Human Rights and Fundamental Freedoms into the UK Domestic Law - The Human Rights Act 1998 Main Conventions Rights

Appendix 2: Human Rights List of Considerations

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FOREWORD

In recent years, significant efforts have been made within Health and Social Services and the Police Service to establish procedural and operational arrangements in order to respond effectively to the abuse or exploitation of vulnerable adults. This has involved a considerable degree of interagency liaison in order to develop effective partnership working which will help to prevent abuse and respond appropriately and sensitively when it is alleged, suspected or occurs.

Measures designed to support vulnerable and intimidated witnesses introduced in 2003 have contributed to even closer working arrangements between police officers and health and social services staff.

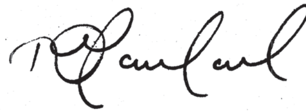
This Protocol is an important aspect of these changes. It outlines the roles and responsibilities of the respective agencies and provides guidance about joint working arrangements and investigation. It has been developed in partnership between the Police Service of Northern Ireland (PSNI), Department of Health, Social Services and Public Safety (DHSSPS), the Regulation and Quality Improvement Authority (RQIA), the Health and Social Care Trusts and the former Health and Social Services Boards in Northern Ireland. It is based on the recognition of the need for more co-ordinated interagency working to ensure that vulnerable adults, who are at risk of abuse, receive protection, support and equitable access to the criminal justice system.

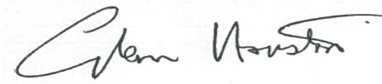
The Protocol has been developed on the basis of research, best practice and on extant guidance, both regional and from elsewhere in the UK which requires agencies to develop interagency policies, procedures and joint protocols that draw on good practice and to investigate and take action when a vulnerable adult is believed to be at risk of abuse. [1,2,3]

[1] Bailey A (2001) 'Factors influencing police investigation of sexual crimes committed against people who have a learning disability and implications for public policy'.
[2] 'No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse'. Home Office/DOH 2000.
[3] 'Safeguarding Vulnerable Adults Regional Adult Protection Policy & Procedural Guidance', September 2006.

Although other agencies will be involved in aspects of the investigative process, the PSNI, Trusts and the RQIA have traditionally taken the lead roles in investigating abuse and reporting crimes. The Protocol has been designed as a basis for improved interagency working and will need to be closely monitored, reviewed and revised in the light of experience. It is supported by an ongoing programme of interagency training.

We commend this Protocol to all who are involved in this critical and demanding area of work and would like to place on record our thanks to all who contributed to its development.





Chief Executive
Health and Social
Care Board

Assistant Chief
Constable Criminal
Justice
Police Service of
Northern Ireland

Chief Executive
Regulation and Quality
Improvement Authority

1 Introduction

1.1 The PSNI and Health and Social Care (HSC) bodies are committed to tackling abuse in all its forms and to the development of collaborative working which will enhance arrangements for the protection and support of vulnerable individuals and groups. This will include responding to the specific needs of vulnerable and intimidated victims of crime. In 1998, the Home Office published a report prepared by an Interdepartmental Working Group on the treatment of vulnerable victims and witnesses, entitled 'Speaking Up for Justice'.[4] The report recommended that the existing special measures introduced for children, e.g. live CCTV links and video recorded evidence-in-chief, be extended to include vulnerable adults.

1.2 The subsequent enactment of the Criminal Evidence (Northern Ireland) Order in 1999 (the 'Criminal Evidence Order') made provision for these arrangements, or 'special measures' to be introduced locally. Guidance on the application of special measures can be found in 'Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable Intimidated Witnesses, including Children' ('Achieving Best Evidence').[5]

1.3 Other statutory agencies, for example, the RQIA, and voluntary organisations may be involved in aspects of the investigative process. However, the PSNI and HSC Trusts are primarily responsible for the investigation of abuse and the protection of vulnerable adults. This Protocol is designed to ensure staff from these agencies work together in a way that ensures the well-being and rights of vulnerable adults are paramount. It also helps to ensure that people receive equitable access to justice.

1.4 This Protocol sets out a framework for joint working in a complex area of practice and emphasises the need to involve all other relevant agencies in information sharing, early assessment and the planning process. It is important that Trust and PSNI staff read this Protocol in conjunction with 'Safeguarding Vulnerable Adults

[4] 'Speaking up for Justice' - Home Office (1998).

[5] 'Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses, including Children' - Home Office Communication Directorate (2002). Work is currently being done to produce a version specifically for Northern Ireland.

Regional Adult Protection Policy and Procedural Guidance', September 2006 ('Safeguarding Vulnerable Adults'). Police officers should also be mindful of relevant PSNI Service Procedures. This Protocol extends to suspected crimes in domiciliary, community and hospital care if the victim is a vulnerable adult as defined in paragraph 2.1.

1.5 The Aims and Objectives (Section 3), Principles (Section 4) and Rights and Responsibilities (Section 5) set out in this Protocol extend to vulnerable adults both as victims and as witnesses.

2 Definition

Definition of a Vulnerable Adult

2.1 For the purposes of this Protocol the definition of a vulnerable adult has been taken from 'Safeguarding Vulnerable Adults'. It applies to adults:

a) **who are 18 years old and over; and**
b) **who are, or may be, in need of community care services OR are resident in a continuing care facility by reason of mental or other disability, age or illness OR who are, or may be, unable to take care of themselves, OR unable to protect themselves against significant harm or exploitation.**

2.2 This is more inclusive than the definition of vulnerability contained in the Criminal Evidence Order. It is likely that some cases of alleged or suspected abuse against vulnerable adults will require a joint approach to investigation but will not qualify for the special measures outlined in the Order in relation to accessing the criminal justice system. It should also be borne in mind that the human and civil rights of the individual may have been breached.

2.3 'No Secrets' which was produced by the Department of Health, London and the Home Office offered a brief definition of abuse as being:

'the violation of an individual's human and civil rights by any other person'.

The original DHSS guidance, produced in 1996 as a basis for developing Board and Trust adult protection policies, offered a more detailed definition of abuse as being:

'the physical, psychological, emotional, financial, sexual maltreatment or neglect of a vulnerable adult by another person. The abuse may be a single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is the expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependant, whether they be informal or formal carers, staff or family members or others. It can occur outside such a relationship'.

3 Aims and Objectives

3.1 The overall aim of the Protocol is to prevent abuse by promoting a multi-agency approach to the protection of vulnerable adults, and to ensure that they receive equitable access to justice in a way that promotes their rights and well-being.

3.2 The Protocol aims to:

- ensure effective communication and collaboration between Trusts, RQIA and PSNI to protect vulnerable adults;
- involve Trusts and PSNI in determining whether a single agency or a joint agency investigation is required;
- provide a framework for early consultation, cross referral of appropriate cases and joint working arrangements for investigation and interviewing;
- define the roles and responsibilities of PSNI and Trust staff in the joint investigation;
- minimise the number of interviews conducted with the victim; and
- ensure that protective measures are paramount and run in parallel with the criminal inquiry or any other lines of enquiry, such as civil action or disciplinary proceedings.

4 Principles

4.1 The Protocol aims to promote the following principles in protecting vulnerable adults from abuse and the investigation of alleged or suspected crimes:

- the well-being and rights of the vulnerable adult are paramount;
- the processes should minimise distress to the vulnerable adult by maximising co-operation between agencies;
- adult protection procedures must be properly followed; and
- mechanisms should be available to resolve differences of opinion amongst staff/agencies through appropriate management structures.

5 Rights and Responsibilities

5.1 The Protocol is also committed to ensuring that the rights of vulnerable adults are upheld. These include the right to:

- receive protection for themselves and their property under the law;
- be supported in reporting the circumstances of any abuse;
- have alleged, suspected or confirmed cases of abuse thoroughly investigated as a matter of urgency;
- have options for resolution and the appropriate processes explained to them;
- be supported in making decisions about how they wish to proceed in the event of abuse and to be kept informed of progress;
- have issues of consent and capacity considered;
- be given information in accessible formats on how to protect themselves;
- be given practical help in protecting themselves;
- be supported when deciding whether to pursue a formal complaint;
- be subjected to the minimum degree of disruption; and
- receive support on a longer-term basis, following the abuse.

5.2 In order to promote these rights effectively PSNI, Trust and RQIA staff must be aware of their responsibilities in this very difficult area of work. If an allegation of abuse does not appear to relate to criminal conduct, there is no statutory duty to report the matter to the PSNI and the decision about whether or not to investigate should be judged on the ‘best interest’ test. In the case of non-criminal matters it may not be in the best interests of the vulnerable adult to investigate if the person has specifically indicated a preference for no investigation. However, in reaching this conclusion, it is necessary to take into account the capacity of the person making the decision and any other regulatory or personnel arrangements, e.g. disciplinary procedures, referral to a

professional body such as the Northern Ireland Social Care Council (NISCC); etc.

5.3 Although all members of society are duty bound to report offences, this Protocol requires staff to consider the cross-referral of alleged or suspected offences. In general, the PSNI is authorised to investigate alleged or suspected criminal abuse against the vulnerable adult where this is agreed to be in the best interests of the person. In the majority of cases, in particular where the vulnerable adult is deemed to have capacity, the PSNI will only proceed with the consent of the vulnerable adult. In practice this means that the vulnerable adult should be willing to make a complaint to the PSNI. However, there are some exceptions to this e.g. where the vulnerable adult is deemed not to have capacity, is subject to undue influence or where others may be at risk. In some circumstances the PSNI may also intervene to prevent a crime being committed.

5.4 Where criminal abuse may have been committed a referral between the agencies should be made and an agreed strategy should be developed which takes account of the wishes of the alleged victim. The PSNI and Trust should work sensitively in these enquiries and must secure the co-operation and consent of the victim unless there may be issues in relation to capacity and/or the potential for abuse to third parties. After referral between agencies the agreed strategy should take account of the wishes of the alleged victim. When there are concerns, but no real grounds to suspect that an offence may have been committed, there is a duty on Trust staff to investigate and report any criminal offences or concerns that may be identified as a result of the investigation.

5.5 When judging whether the individual has capacity to give or withhold consent, guidance in 'Safeguarding Vulnerable Adults' should be followed. This should take into account professional opinion as appropriate e.g. psychiatrists, psychologists, GPs, nurses and social workers.

5.6 The Human Rights Act 1998 has been fully effective from 2nd October 2000. It incorporates the European Convention for the Protection of Human Rights and Fundamental Freedoms into United Kingdom Domestic Law. This makes it unlawful for public authorities to act in a manner which is incompatible with the rights and freedoms guaranteed by the Convention. **Appendix 1** sets out the main Convention Rights enshrined in the 1998 Act.

Public authorities can interfere with an individual's rights providing it is lawful, proportionate and necessary in a democratic society.

Lawful means 'prescribed by law' and the legal basis for any restriction on rights and freedoms must be established and identified.

Proportionate means any interference with a Convention Right must be proportionate to the intended objective and not arbitrary or unfair.

Necessary in a Democratic Society means (1) Does it fulfil a pressing social need? (2) Does it pursue a legitimate aim? and (3) Is it proportionate to the aims being pursued?

The Decision Making Process

In applying the key principles of lawfulness, proportionality and whether it is necessary in a democratic society, a public authority representative must ask the following questions:

- Is there a legal basis for my actions?
- Is it proportionate and necessary in a democratic society?
- Is the procedure involved in the decision-making process fair and does it contain safeguards against abuse?
- Was there an alternative and less restrictive course of action available? (The intervention should be strictly limited to what is required to achieve the objective).
- Is the restriction required for legitimate purposes?
- If I fail to interfere with this individual's rights could there be a more serious outcome in not affording the individual adequate protection in fulfilment of their Article 2 rights?

Decisions to interfere with an individual's rights may be subject to scrutiny by the Courts. However, if public authorities can show that they applied the relevant Human Rights principles when making their decision, they are less likely to be over-ruled. It is very important to keep notes and decisions should be recorded in full (see **Appendix 2**).

6 Reporting

6.1 This Protocol is designed to be compatible with current 'Safeguarding Vulnerable Adults' guidance in requiring all staff to report suspected, alleged or confirmed instances of abuse. It provides a framework within which staff exercise their professional judgement and discharge their legal responsibility. It ensures that all cases are given appropriate consideration and are not screened out inappropriately. Added safeguards to prevent this include the requirement to report cases to a designated adult protection officer ('Designated Officer') and to consult, where necessary, with the relevant Police Liaison Officer (see paragraph 6.6). Where a crime is suspected or alleged and the vulnerable adult does not wish to make a formal complaint, the agencies should consider the following factors:

- the individual's capacity to provide consent to a formal complaint;
- the opportunity to prevent crime being committed;
- the extent to which other vulnerable persons, including children, are likely to be at risk; and
- whether the vulnerable adult is subject to undue influence or coercion.

6.2 A referral to the PSNI does not automatically mean that a joint investigation will be initiated. Such a decision should involve discussion with the Police Liaison Officer. Where the PSNI is informed directly of suspected abuse which is clearly non-criminal, the individual should be made aware of other sources of support and options to have the matter resolved and his/her agreement sought to refer to the Trust.

6.3 Alleged or suspected instances of abuse occurring in a regulated service must be reported to the RQIA. The RQIA must ensure that alleged or suspected instances of abuse in regulated services are referred to the PSNI and the appropriate Trust.

6.4 Reports of alleged or suspected abuse, which may be a criminal offence, will be categorised as:

(a) Sexual (e.g. rape, indecent assault); or
(b) Non-sexual (e.g. physical assault, theft).

The PSNI will be responsible for determining the category of offence.

6.5 Where alleged or suspected crimes are reported to the PSNI they have a duty to conduct criminal investigations. The decision to investigate will be made at a Strategy Discussion and will be informed by the views of the victim and Trust staff.

6.6 Referral to PSNI by Health and Social Care Trusts

a) In all cases of alleged or suspected criminal abuse the Designated Officer for the Trust should discuss the case with the relevant Police Liaison Officer. It will be the responsibility of the Police Liaison Officer to help determine whether the matter may involve criminal abuse and thereby to inform the decision concerning what level of enquiry/investigation is necessary.

b) Alleged or suspected abuse, whether sexual or non-sexual, should be reported to the Inspector, Public Protection Unit (PPU) or nominated deputy who holds the role of Police Liaison Officer. The Inspector or nominated deputy will allocate any investigation regarding the alleged abuse whether it is uniform or the Criminal Investigation Department (CID).

c) Outside of PPU working hours (9.00 am – 5.00 pm Monday to Friday), the Duty Inspector in the relevant district should be contacted who will determine what preliminary action is required. In all such reported cases of alleged abuse the Duty Inspector will inform the PPU Inspector or nominated deputy as soon as is practicable.

d) A list of contact numbers for the PPUs is contained in **Appendix 3**.

6.7 Referral to Health and Social Care Trusts by PSNI

a) Police officers who encounter vulnerable adults who may have been the subject of abuse, whether criminal or not, should contact the relevant Designated Officer to establish whether the vulnerable adult is known, or should be referred, to the Trust.

b) Where concerns are raised in relation to the care or treatment, which may involve criminal abuse of a vulnerable adult outside normal working hours (9.00 am - 5.00 pm Monday to Friday),

these concerns should be referred immediately to the Out-of-Hours Social Work Co-ordinator (the Co-ordinator).

c) The Co-ordinator will take whatever action is necessary to ensure the protection of the vulnerable adult. Depending on the scale of the concern this may involve referral to other agencies. The Co-ordinator will make the appropriate Designated Officer for the Trust aware of the referral details and any action taken/required, as a matter of urgency on the first working day following the date of the referral being made.

d) Contact details for Trusts and contact points for Out-of-Hours Services can be found in **Appendix 4**.

Alleged or Suspected Criminal Abuse in a Regulated Service

6.8 When criminal abuse is alleged or suspected to have occurred in a regulated service and is reported to, or comes to the attention of the RQIA, the relevant programme head at the RQIA should ensure that the matter is referred to both the Police Liaison Officer and to the relevant Trust Designated Officer as soon as is practicable (see **Appendix 5** for contact details). If an incident of suspected or alleged criminal abuse in a regulated service comes to the attention of Trust staff, the RQIA must be informed by the Designated Officer as soon as is practicable.

Referral from PSNI to RQIA

6.9 Police officers, who encounter a vulnerable adult who is a service user within a regulated service and who may have been subjected to abuse, whether criminal or not, should contact the relevant Trust Designated Officer and RQIA. This will enable RQIA to establish if there has been any breach in the relevant legislation that requires regulatory action.

Inappropriate Referral

6.10 In any event where a referral is made inappropriately between agencies the receiving agency will have responsibility for referring the matter to the appropriate agency.

7 Initial Assessment Consultation - Planning and Investigation

Clarification of Roles

7.1 The PSNI and Trust staff have specialist and complementary skills in terms of assessing and investigating allegations of abuse of vulnerable adults. The process is outlined in **Figure 1** (see page 17). In appropriate cases it is necessary to combine these skills to provide maximum protection and support for those individuals who have been the subject of, or are at risk of harm. This Protocol recognises that the various agencies may have different priorities or emphasis in relation to adult protection work.

7.2 The Protocol is not designed to make Trust or PSNI personnel undertake roles which are at variance with their primary professional responsibilities. However it is intended to provide a basis for maximising co-operation and a shared understanding of the issues involved. Differences of opinion, or approach, amongst staff should be resolved in a manner that does not hinder the protection of the vulnerable adult. Protection of the individual is paramount and staff should not inappropriately screen out cases by failure to follow this Protocol.

7.3 The strategy to be adopted must be informed by the professional views of PSNI, Trust and, as appropriate, RQIA staff. The strategy for investigation should always be influenced by information gained from professionals or other persons who may have knowledge of the vulnerable adult, his/her family or circumstances.

7.4 The primary objective of PSNI, Trust and RQIA is the protection of the vulnerable adult. In addressing this shared objective, the primary role of PSNI personnel is determined by their statutory responsibility to protect life and property, preserve order, prevent crime and, where a criminal offence has been committed, bring offenders to justice.

7.5 The primary role of Trust and RQIA staff is determined by their statutory responsibility and Duty of Care, to promote the care and well-being of vulnerable adults in situations of alleged or confirmed abuse.

7.6 Assaults (including minor assaults), thefts, criminal damage, sexual assaults and threats of force or violence are all likely to be criminal offences. PSNI and Trust staff must recognise that the non co-operation of the victim does not always preclude a prosecution. However, the views of the victim are vital to the decision to prosecute.

Joint Agency Consultation

7.7 When either Trust or PSNI personnel identify the need for a joint agency approach, a staff member from the referring agency will take responsibility for instigating a Joint Agency Consultation. This should be the person within the Trust deemed to be responsible for the decision to proceed in cases of alleged or confirmed abuse. The Designated Officer will take responsibility for co-ordinating the practical arrangements associated with this action.

7.8 The purpose of the Consultation is to discuss the case with other relevant agencies and organisations and to reach a decision on the need for a Joint Investigation involving Trust and PSNI. This communication may be by telephone or direct contact and should occur within 24 hours of the decision that Consultation with the other agency is necessary.

7.9 The outcome of this Consultation may be:

- no further action;
- a Trust investigation;
- a criminal investigation by PSNI; or
- a Joint Investigation involving Trust and PSNI.

The results of this Consultation must be clearly recorded and shared between agencies. Form AJP1 - Record of Joint Agency Consultation (**Appendix 6**) should be used for this process. The completion and appropriate sharing of this and other records, e.g. Form AJP2 - Strategy for Investigation (**Appendix 7**) and Form AJP3 - Clarification Discussion (**Appendix 8**) is the responsibility of the lead agency in the investigation. Where it is agreed that a Trust investigation is appropriate the guidance contained in ‘Safeguarding Vulnerable Adults’ should be followed.

Criteria for Joint Investigation by Trust and PSNI

7.10 A detailed consideration of the need for a Joint Investigation will be triggered when there is an allegation or suspicion that one of the criminal offences described below has been committed against a vulnerable adult. The likelihood or otherwise of a prosecution is not a criterion for a Joint Investigation.

- A sexual offence committed against a vulnerable adult;
- Physical abuse or ill treatment amounting to a criminal offence;
- Financial abuse involving a criminal offence, e.g. fraud, theft; or abuse which involves a criminal offence e.g. blackmail.

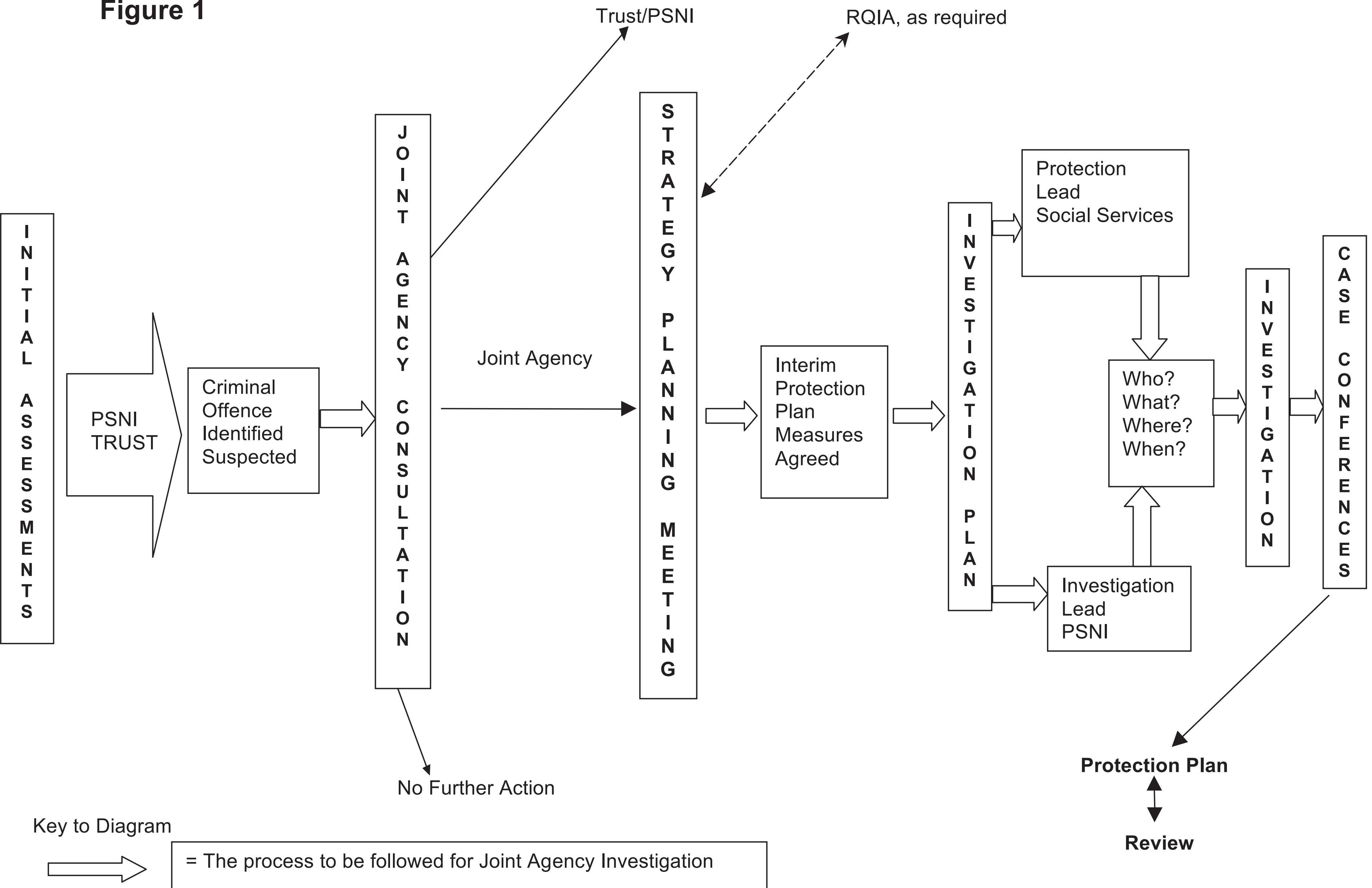
Preliminary Information Gathering

7.11 Following the decision of the Joint Agency Consultation to initiate a Joint Investigation, each agency will nominate a staff member to gather information for the Strategy Planning Meeting which will be the basis for planning any subsequent investigation. The nominated officer will carry out checks on internal systems for information that may be of use in deciding the strategy to be employed. At this stage consideration must be given to the communication needs of all those involved.

Strategy Planning Meeting

7.12 When sufficient preliminary information is available to facilitate the development of a strategy for dealing with the case, a Strategy Planning Meeting should be convened. This should occur as soon as is practicable. The responsibility for convening this meeting lies with the designated staff member who initiated the Joint Agency Consultation.

Figure 1



7.13 The purpose of the Strategy Planning Meeting is to ensure an early exchange of information and to clarify what action needs to be taken jointly or separately in the investigation. It is an action orientated discussion, which should be convened to plan the investigation and agree any necessary interim protection measures.

7.14 A Strategy Planning Meeting will always include PSNI, Trust and RQIA staff, where appropriate. Other professionals, agency representatives and persons with specialist knowledge/skills may also be included to ensure the protection of the vulnerable adult.

7.15 Where the Strategy Planning Meeting concludes that a vulnerable adult has been the victim of criminal abuse or may be at risk of serious criminal abuse and that issues arise about the protection of the individual, the Strategy Planning Meeting should address the following points:

- whether action is needed to protect the vulnerable adult and who will be responsible for such action;
- the need to consider the issue of capacity to consent and the most appropriate person to deal with it;
- the requirement for a medical examination to be undertaken and if so, by whom;
- what issues of special needs, race, culture, gender, language, communication or religion are raised in the case, how and by whom they are to be addressed and what advice needs to be sought;
- what specialist support or advice may be needed and who obtains it;
- what other information is needed to complete the investigation and who will seek it;
- the order in which the interviews will take place and who will carry out each interview;
- practical arrangements for reporting back to those involved in the investigation; and

- refining internal processes for communication and agreeing the communication strategy, and who should lead it, where there are matters likely to be of public interest.

7.16 It is the responsibility of the person who convenes the meeting to ensure that a record of the Strategy Planning Meeting is made and shared between agencies. Form AJP2 - Strategy for Investigation (**Appendix 7**) should be used for this purpose. Although strategy planning will generally take place in a formally constituted meeting, there may be occasions where this may need to be conducted by telephone.

8 Joint Investigation Interviews

8.1 Interviews with vulnerable adults will be conducted in accordance with the guidelines contained in 'Achieving Best Evidence'.

Joint Interviews by Police Officers and Social Workers

8.2 Where it is agreed in the Strategy Planning Meeting that interviews should be conducted jointly by a police officer and social worker the following procedures will apply. It must be emphasised that the decision about which interviews should be conducted jointly, and the sequence of interviews, is a matter for the group planning the investigation at the Strategy Planning Meeting.

Selection of Interviewers

8.3 Only PSNI and Trust personnel, who have received specialist training in joint interviewing, should be appointed to the task. Where a vulnerable adult has requested the interviewer to be of a specific gender all reasonable steps must be taken to facilitate this request.

Supervision of Interviewers

8.4 It will be the responsibility of each agency to ensure that the interview and investigation process is properly supervised and supported by relevant managers who have been trained in these procedures.

Clarification Discussion

8.5 In making decisions about the method of interviewing vulnerable adults it may be necessary to have a short Clarification Discussion. This should normally be undertaken by the persons who will conduct any subsequent interview. However, where this is not possible, the Clarification Discussion may be carried out by other staff who have received Joint Protocol training. Once a decision has been made that an interview of a vulnerable adult should be conducted on video, a specialist investigative interviewer will be tasked to carry out the interview.

8.6 The purpose of the Clarification Discussion is:

- to establish whether or not the vulnerable adult has made an allegation or raised suspicions which have led to the referral. The substance and detail of the allegation or disclosure should not be part of the Clarification Discussion;

- to assess the vulnerable adult's willingness and ability to pursue the matter to court;

- to inform the PSNI decision about which format should be used for the interview, (e.g. videotape, statement or question and answer. Videotaping is the preferred method of interviewing vulnerable adults. Statements are the alternative and questions and answers should only be used when neither videotaping or statements are possible) and whether the use of video in the interview is likely to maximise the quality of that particular vulnerable adult's evidence.

8.7 The Clarification Discussion must be recorded and responsibility for this will lie with the person conducting it. The Clarification Discussion is not an investigative interview and should never replace or over-shadow the Joint Investigation interview with the vulnerable adult. Strictly no further examination of the allegation should take place beyond that which has been disclosed. It is important not to coach the interviewee in respect of the interview. If the discussion includes the disclosure of a criminal offence, that part must be recorded verbatim and contemporaneously, or at the very least as soon as possible after the contact. Even if no criminal disclosure is made, accurate recording is essential. Decisions about risk may be made on the strength of the Clarification Discussion. Form AJP3 (**Appendix 8**) must be completed in respect of every Clarification Discussion.

Preparation for a Joint Interview

8.8 The following should be considered when preparing for a Joint Interview:

- the needs and circumstances of the vulnerable adult (e.g. development, impairments, degree of trauma experienced, whether he/she is now in a safe environment);

- the vulnerable adult's state of mind (e.g. likely distress, and/or shock);

- perceived fears about intimidation and recrimination;

- the circumstances of the suspected offence (e.g. relationship of the vulnerable adult to the alleged offender);

- location of interview;

- time of interview;

- preferred gender of interviewer; and

- additional requirements (e.g. preparation of staff and interpreters).

  (**Note:** Where a language barrier exists an independent interpreter should be used as opposed to a family member).

Other persons with specialist skills may be needed to assist the interviewer conduct the interview. This might include, specialist communicators using sign language, etc.

8.9 Purposes of the Joint Interview

The purposes of the Joint Interview are to:

- promote the well-being and protection of the vulnerable adult;

- validate or negate allegations or suspicions of abuse by helping the vulnerable adult to give as much information as possible;

- avoid multiple interviews where possible;

- identify the suspected abuser;

- ensure that all decisions made are based on the experience of the vulnerable adult and not the influence or beliefs of the interviewer; and

- provide a record of the vulnerable adult's evidence-in-chief which may be used at a consequent criminal hearing.

Persons Present at Joint Interview

8.10 Normally no-one else should be in the interview room apart from the vulnerable adult and the interviewers. Limiting the number of people present at the interview should lessen the possibility of the vulnerable adult feeling overwhelmed by the situation and uncomfortable about revealing information.

8.11 It is good practice for the vulnerable adult to know that a supportive person is available in an adjoining room. A suspected offender should never be present in an interview. However, if it is the vulnerable adult's wish to have a supportive person present in the interview room it should be made clear to that person that he/she must take no part in the interview.

Recording Information that is not Video Recorded

8.12 When a Joint Interview with a vulnerable adult is not video recorded a written account of the information given should be made. If it is assessed by the interviewers, or on the basis of consultation with other expert opinion, that the vulnerable adult is capable of giving an account of relevant matters, the police officer may invite the adult to make a signed, written statement on Form 38/36. The evidence of a vulnerable adult who is not capable of making a statement should be recorded as questions and answers and certified by them and any other person present.

The Video Interview

8.13 The Criminal Evidence Order provides for the video recording of interviews with vulnerable adults to be admitted as evidence-in-chief at criminal proceedings. The guidance accompanying the legislation is designed to help those police officers and any Trust staff involved in making a video recording of an interview with a vulnerable adult, where it is intended that the result should be admissible in criminal proceedings.

8.14 The Order is 'Permissive' legislation. There should be a general assumption that a video interview will be conducted where the criteria are met (e.g. an eligible witness in an indictable [Crown Court] case). Use of a video for interviews is not necessary in all cases and, on occasions, might add to the interviewee's trauma unnecessarily. The decision as to whether the interview will be videotaped will be taken by

the investigating police officer in consultation with Trust staff following the Clarification Discussion.

Planning the Joint Interview

8.15 In order to be fully and properly prepared for an interview the Joint Investigation Team of PSNI and Trust staff should normally plan the interview in line with the 'four phased' approach set out in 'Achieving Best Evidence' and adhere to the criteria which it has identified. The four phases are:

- **Rapport;**
- **Free Narrative;**
- **Questioning; and**
- **Closure.**

8.16 Planning should include deciding whether PSNI or Trust team member should take the role of lead interviewer, the proposed time scale, any special arrangements/allowances which are required to take account of the vulnerable adult's individual difficulties, agreed signals on when to take breaks or terminate the interview. As video recording of investigative interviews is aimed at providing evidence-in-chief at criminal courts, planning must include coverage of the 'points-to-prove' in criminal offences.

8.17 Where it appears, before interviewing a vulnerable adult, that the history of the case indicates a considerable amount of information is likely to be forthcoming, a series of interviews may be planned. The second, third, etc, interviews in this series will be considered part of the original interview without any automatic need to consult with the Public Prosecution Service (the PPS).

8.18 The Joint Investigation Team must be given sufficient time to carry out this planning process, prior to a Joint Investigative Interview. Failure to do so may limit the effectiveness of the process and do a disservice to the vulnerable adult. Preparation will include the following activities:

- **Technical Preparation;**
- **Consideration of Consultation with Specialists; and**
- **Consideration of Communicative Competency of Vulnerable Adult and Interviewer.**

Technical Preparation

8.19 The Joint Investigation Team will need to carefully prepare for the interview, ensure that the equipment is in working order, test for vision and sound quality and ensure that tapes are correctly prepared, checked and inserted. Consideration should also be given to whether other equipment will be needed, e.g. hearing aids, communication boards, etc.

Consideration of Consultation with Specialists

8.20 The Joint Investigation Team should consider the conclusions of the Clarification Discussion about the need to involve staff with specialist skills in the Joint Investigative Interview and any role they should take in it. Due to the nature of this type of investigative interviewing it will often be necessary to seek specialist assistance with issues such as communication difficulties, mental ill-health or learning disability. If a specialist is asked to facilitate the Joint Interview, he/she should be informed of the purpose of the interview and the limitations placed on his/her role.

8.21 If an interpreter is required to assist in criminal proceedings involving a vulnerable adult who uses sign language the person must have attained at least Stage 3 British Sign Language or Irish Sign Language qualification, as appropriate.

Consideration of Communicative Competency of Vulnerable Adult and Interviewer

8.22 The vulnerable adult and interviewers need to be able to achieve the minimum requirements for communication. The Joint Investigation Team must establish whether a vulnerable adult has a reliable method of communication which he/she can use intentionally and that the interviewers can understand either directly or via a suitable interpreter.

8.23 If the vulnerable adult has specific difficulties with comprehension or use of language (vocabulary, ideas and grammar) associated with physical or intellectual impairment careful consideration must be given to how these could be overcome. Speech and language therapists, sign language interpreters or facilitators in augmentative communication may be required.

8.24 The competency of the interviewers in communicating will be the single greatest factor in determining whether a vulnerable adult will be able to deal with, and participate effectively in, an interview situation. The

interviewer will also require information about the vulnerable adult's knowledge and understanding of him/herself, about objects, about places and events and how these things may be affected by his/her impairment or disability.

Conduct of the Interview

8.25 The interviewers need to provide the vulnerable adult with information at a level which will help him/her to understand who and what will be involved. Initially they should cover:

- introduction of the social worker (or other professional), the police officer and any other person who requires to be present, with an explanation of each of their roles;
- an explanation of the purpose of the interview in a sensitive way that the vulnerable adult can understand;
- an acknowledgement that it is a difficult situation for the vulnerable adult and that some things, particularly sexual assault, may be difficult to talk about; and
- introduction of the video equipment and seeking consent to use it in the interview.

8.26 The following are categories of facts, which, if contained in the vulnerable adult's evidence, will enable properly informed decisions to be taken regarding the subsequent conduct of the investigation and ultimately whether or not to prosecute any person for any offence committed against the vulnerable adult:

- name/identity of the alleged abuser/offender, his/her present whereabouts, and the relationship of that individual to the vulnerable adult;
- the duration and extent of the abuse/offence;
- what happened in detail, when it happened, where, and how often, being mindful of the 'points-to-prove' for each offence;
- date/time of last occurrence, likelihood of physical evidence;

- names/identity of anyone else having knowledge of the abuse/offence;
- names of anyone else involved in, or observing, the abuse/offence; and
- identity of anyone the vulnerable adult has told about the abuse/offence.

8.27 After the interview, the vulnerable adult and/or their representative should be given as much information as possible about what will happen next including arrangements for his/her protection. If he/she is to be interviewed again, he/she should be informed of where and when it may take place.

8.28 If the interview or series of interviews has/have been completed and further information comes to light which makes it necessary to conduct another interview with the vulnerable adult, or where it is believed the vulnerable adult has more to tell, this should be considered a further or supplementary interview. In this case the matter should be discussed with the PPS. This will cover cases where, for example, conflicting evidence comes to light, a vulnerable adult makes further disclosures or names other suspects. 'Achieving Best Evidence' should be referred to when considering the further interview of a vulnerable adult.

8.29 Once the interview is complete, the Joint Investigation Team should give consideration to the individual's need for any counselling or therapeutic requirements which this may have indicated. PSNI and the PPS must be informed about the nature of such therapy in each case. This is to ensure that the evidence provided to a court is not contaminated or contradicted by the vulnerable adult.

The Vulnerable Adult who Becomes a Suspect

8.30 If a vulnerable adult becomes suspected of a crime during the course of an interview, a decision will have to be made on whether to proceed or terminate the interview. The interviewers should take a short break to consult, and if necessary seek advice, on the matter, in addition to being mindful of the need for sensitive handling of the situation. If it is concluded that the evidence of the vulnerable adult as a suspect is paramount in a particular case, the interview should be terminated so that any further questioning can be carried out in accordance with the Police and Criminal Evidence (NI) Order 1989, (PACE) at an appropriate location.

Further Interviews

8.31 Occasions may arise where a police officer or a social worker may wish to further interview a vulnerable adult who is the victim of some criminal offence. It will be the responsibility of that police officer or social worker to advise the other agency of the intention to further interview the individual. The same procedures will apply to a further interview as apply to the original interview. No agency should unilaterally conduct further interviews with the vulnerable adult who may be central to criminal proceedings.

Records of Joint Investigative Interviews

8.32 PSNI staff will retain a written statement, recorded as a Joint Interview, for evidential purposes. A copy may be provided to Trust staff, provided that the vulnerable adult agrees. Where a Joint Interview has been video recorded the original will be labelled and secured for court purposes by the PSNI. The working copy will be available for viewing by Trust staff by arrangement with the officer-in-charge of the case. A log will be completed on each occasion that the tape is viewed by anyone and will detail the reasons for it having been viewed. This will be retained with the working copy of the tape.

8.33 Arrangements for viewing the tape by persons other than those identified above, e.g. defence or any subsequent court hearing will be the responsibility of the PSNI. PSNI General Order C(c) 70/96 must be complied with. Where investigation involves PSNI and HSC participation, the police officer in the case will be responsible as the prime keeper of all exhibits, letters, drawings, notes, etc.

Review of Ongoing Management of the Case

8.34 When the formal Joint Interview process has been concluded there may be a need for further interagency discussions, outside of any judicial procedures, to agree a course of action to address the practical and emotional implications for the vulnerable adult, his/her carers and staff involved in the case. In the majority of cases this can be most comprehensively dealt with by convening a Case Conference, although other, less formalised, mechanisms should be considered to optimise client/family involvement in the process. This is the responsibility of the Designated Officer from the relevant Trust in consultation with PSNI colleagues. Consultation should also take place on an interagency basis to identify the need for any staff debriefing/counselling which may be required as a result of the work which has been undertaken.

MAHI - STM - 089 - 3597

Glossary of Terms

Glossary of Terms

Achieving Best Evidence

A voluntary code of practice for interviewing vulnerable witnesses for criminal proceedings and where video is used to record the witness' testimony.

Case Conference

Is a meeting of those involved in a case which can include the client/victim. The purpose is to establish potential risk to the individual and what action, if any, would be required.

Criminal Investigation Department (CID)

Police team of Detective Officers based in each District Command Unit with responsibility for the investigation of crime other than sexual crime.

Cross Examination

The secondary stage of evidence giving in Court where the testimony that a witness has already given is examined by counsel for the defence.

Counsel for the Defence

The legal representative responsible for conducting the case for the defence.

Designated Officer

Person within the Trust responsible for managing investigations of suspected, alleged or confirmed instances of abuse against vulnerable adults.

District Command Units

There are eight District Command Units in Northern Ireland headed by a Chief Superintendent.

Evidence

The term 'evidence' in its legal sense embraces all matters exclusive of mere argument, which can be placed before a Court to prove or disprove any matter or fact, the truth of which is the subject of judicial investigation.

Evidence-In-Chief

The initial stage of giving evidence in Court where the witness is taken through their evidence by counsel for the prosecution.

Form 38/36

Form used by PSNI for making a written record of witness evidence when video is not seen as an appropriate form of recording - known as ‘a statement’.

Hearsay Evidence

Evidence of what a person has heard another person, not the accused, say. It is not admissible in criminal proceedings.

Investigating Officer

Trust professional with responsibility for investigating the alleged abuse. Their role is to establish the facts, look at alternatives available and to provide counselling and support.

Line Manager

Management grade within the Trust to whom an individual directly reports.

Live Television Link

A system allowed under the Police and Criminal Evidence (NI) Order 1989 whereby certain witnesses can give evidence from a television monitor in a room separate from the main body of the Court.

NISCC (Northern Ireland Social Care Council)

NISCC is the independent regulatory body for the Northern Ireland Social Care workforce, established to increase public protection by improving and regulating standards of training and practice for social care workers.

Nominated Officer

The agency staff member with the delegated role of gathering information for the Strategy Planning Meeting which will be the basis for planning any subsequent investigation. The nominated officer will check internal systems for information that may be of use in deciding the strategy to be employed.

Points to Prove

The ingredients of a criminal offence, each of which must be satisfactorily proven in a criminal trial.

Police Service Procedure

A written instruction, which is issued to the PSNI.

Protection Plan

A plan developed to clarify the protection measures put in place to protect the individual. Roles and responsibilities for doing so are clearly identified.

Public Prosecution Service (PPS)

A body of legal staff who work independently from the Police and who are responsible for directing on cases forwarded for prosecution or otherwise.

Public Protection Units (PPUs)

Police team with specific responsibility for the following:

- Child Abuse Enquiry Unit;
- Domestic Violence;
- Management of Violent/Sex Offenders;
- Missing and Vulnerable Persons Enquiries/Investigations.

Regulation and Quality Improvement Authority (RQIA)

The RQIA is the independent body responsible for monitoring and inspecting the availability and quality of Health and Social Care services in Northern Ireland, and encouraging improvements in the quality of those services. The role of RQIA is to ensure that the Health and Social Care services in Northern Ireland are accessible, well managed and meet the required standards.

Regulated Service

The RQIA is responsible for registering, inspecting and encouraging improvement in a range of health and social care services delivered by statutory and independent providers, in accordance with The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and its supporting regulations.

The services which it regulates include residential care homes; nursing homes; children's homes; independent health care providers; nursing agencies; adult placement agencies; domiciliary care agencies; residential family centres; day care settings; and boarding schools.

Third Party Material

Matters of potential relevance to a Police investigation, which are not in possession of PSNI.

APPENDICES

Appendix 1

THE EUROPEAN CONVENTION FOR THE PROTECTION OF HUMAN RIGHTS AND FUNDAMENTAL FREEDOMS INTO THE UK DOMESTIC LAW

THE HUMAN RIGHTS ACT 1998

MAIN CONVENTION RIGHTS:

Article 2	- Right to life
Article 3	- Prohibition of torture
Article 4	- Prohibition of slavery and forced labour
Article 5	- Right to liberty and security of person
Article 6	- Right to a fair trial
Article 7	- No punishment without law
Article 8	- Right to respect for private and family life
Article 9	- Freedom of thought, conscience and religion
Article 10	- Freedom of expression
Article 11	- Freedom of assembly and association
Article 12	- Right to marry
Article 14	- Prohibition of discrimination
Article 16	- Restrictions on political activity of aliens
Article 17	- Prohibition of abuse of rights
Article 18	- Limitation on use of restriction on rights

FIRST PROTOCOL:

Article 1	- Protection of property
Article 2	- Right to education
Article 3	- Right to free elections

SIXTH PROTOCOL:

Article 1	- Abolition of the death penalty

NOTE: The following Articles are omitted from the Act:

Article 1	**- Obligation to respect Human Rights**
Article 13	**- Right to effective remedy**
Articles 15 - 59	**- Operational provisions for the European Court**

Appendix 2

HUMAN RIGHTS - List of Considerations

If you cannot answer a question, you cannot proceed to the next question. Only take action when you have completed the list.

1. Is there any necessity to take action?
   What are you doing? Why are you doing it?

2. Is there any legal basis upon which to take action? Is there a statutory/mandatory/discretionary power you are using? If so, state it. If not, on what basis are you taking action? (You should seek legal advice).

3. What are the Human Rights implications of the proposed action? (Go through Convention List and mark the relevant article and the relevant limitation).
   (See Appendix 1)

Specify Article and Limitation

4. Is the proposed action proportionate? Is the scale of the action appropriate to the size of the problem? (i.e. consider whether it is intrusive or invasive). Is there an alternative?

Give reasons for your decision

5. Is there an independent public remedy available? If not, consider what will be the effect of failure to give a remedy i.e. Ombudsman/Judicial Review/other Court action).

Specify all available remedies

6. If action is taken, is there “equality of arms”?
Does the person have the same opportunity to gather evidence as you and present it to the Court/Tribunal?

7. Is the action the least possible one?
Is it the least intrusive or invasive?

Post-event Evaluation

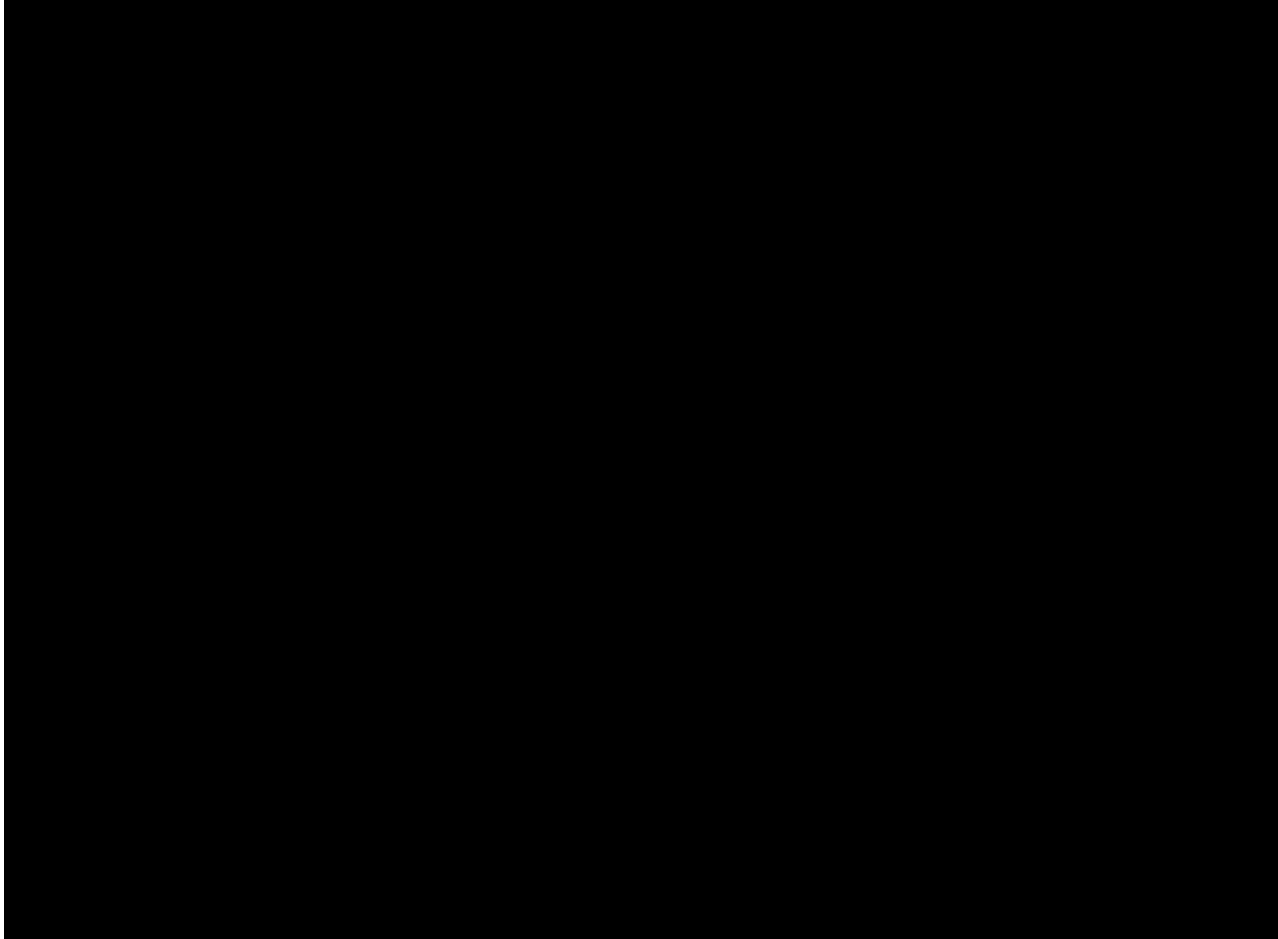
Signed: **Dated:**

Print Name:

Position/Rank:

Appendix 3

Police Service of Northern Ireland - Contact Number (028) 9065 0222
Contact details for referrals to PPUs between
9.00 am - 5.00 pm Monday to Friday



In all referrals regarding Vulnerable Adults the Sergeant attached to the relevant PPU will be the first point of contact.

Outside of usual office hours (9.00 am - 5.00 pm, Monday to Friday) **the Duty Inspector in the relevant District should be contacted.**

Appendix 4

Contact details for Designated Officers and Contact points for Out-of-Hours Emergency Social Work Co-ordinators

HSC Trust	Designated Officer Contact
Belfast	Phone: (028) 9032 7156
South Eastern	Phone: (028) 9266 5181 Ext 4544
Western	Phone: (028) 7131 4090
Northern	**Learning Disability** Phone: (028) 2766 1393
	Mental Health Phone: (028) 9441 3114
	Older People Phone: (028) 2563 5558
	Physical Disability and Sensory Impairment Phone: (028) 2766 1217
Southern	**Learning Disability** Phone: (028) 3752 2381
	Mental Health Phone: (028) 3883 1983
	Older People Phone: (028) 3082 5120
	Physical Disability and Sensory Impairment Phone: (028) 3833 3332

Out-of-Hours Emergency Social Work Co-ordinators - Contact Points

Belfast Health and Social Care Trust and South Eastern Health and Social Care Trust (Knockbracken Healthcare Park)	(028) 9056 5444
Northern Health and Social Care Trust (Holywell Hospital)	(028) 9446 8833
Southern Health and Social Care Trust (Daisy Hill Hospital)	(028) 3083 5000
Western Health and Social Care Trust (Altnagelvin Hospital)	(028) 7134 5171

Appendix 5

Contact details for the Regulation and Quality Improvement Authority between 9.00 am - 5.00 pm Monday to Friday

The RQIA's headquarters is located in Belfast at :

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT
Phone: (028) 9051 7500

Contact details for the RQIA's Omagh office are:

The Regulation and Quality Improvement Authority
Hilltop
Tyrone and Fermanagh Hospital
OMAGH
BT79 0NS
Phone: (028) 8224 5828

Appendix 6

ADULT PROTECTION: FORM AJP1 - RECORD OF JOINT AGENCY CONSULTATION

Referral by telephone on ________/______/________________________________
To: ______________________________ Designation: ____________________
Person referring: ____________________ Designation: ____________________
Address: ____
Contact Tel No:

Name of Vulnerable Adult: ___________________________________ DOB: __/__/___
Home Address: ____
Present Location: ____

____

Gender*: M ☐ F ☐

Nature of Vulnerability*: ☐ Frail Older Person ☐ Dementia ☐ Learning Disability
☐ Physical/Sensory Disability ☐ Mental Illness ☐ Other (please specify)

Is the Vulnerable Adult subject to any legal/statutory status?*
(e.g. Guardianship, Non-Molestation Order) Yes ☐ No ☐

If yes please provide details: ____

Details of any current or past involvement with Social Services, Police and/or the Regulation and Quality Improvement Authority: ____

____

Name of Carer/Next of Kin: ____

Address: ____

Contact Tel No: _________________________

WHAT IS THE MAIN FORM OF SUSPECTED, ADMITTED OR KNOWN ABUSE?*

☐ Physical ☐ Sexual ☐ Psychological/Emotional
☐ Financial ☐ Neglect ☐ Institutional Abuse
☐ Other (please specify)

HAS THERE BEEN PREVIOUS CONCERN OR EVIDENCE OF ABUSE?*

☐ Yes ☐ No ☐ Don't know
If yes, what was the nature of the concern and the outcome?

____

*Please tick appropriate box/es

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Outcome of Joint Agency Consultation*

Single Agency Investigation by:

Social Services ☐ Police ☐ RQIA ☐

Joint Investigation by:

Social Services ☐ Police ☐ RQIA ☐

OR

Protocol for Joint Investigation of alleged and suspected cases of abuse of vulnerable adults ☐

Please specify if any other follow up will take place.

____

____

Signature of person completing form: ______________________

Print Name: ______________________________________

Designation: _____________________________________

Date: ____________________

- Please tick appropriate box/es

ORIGINAL FOR POLICE FILE AND COPY TO SOCIAL SERVICES

Appendix 7

ADULT PROTECTION: FORM AJP2 - STRATEGY FOR INVESTIGATION

Name of Vulnerable Adult: ______________________________ DOB: __/___/__

(A) PEOPLE IN ATTENDANCE/INVOLVED (NAME & AGENCY):

____

____

OTHERS CONSULTED:

____

____

(B) INITIAL STRATEGY: Date: ___/___/___

____

____

____

Next of Kin/Carer to be informed: YES/NO By Whom: ____________

(i) Amendments to strategy Date:

____

____

____

Telephone/Meeting*
Persons Involved/Designation:

____

____

(ii) Amendments to strategy Date:

(C) PERSONS TO BE INTERVIEWED

____

____

____

Telephone/Meeting*
Persons Involved/Designation:

____

____

* Please delete as appropriate

ORIGINAL FOR POLICE FILE AND COPY TO SOCIAL SERVICES

1 Person making the allegation to clarify all facts about referral

Name: ______________________________

Address: ______________________________

2 Next of kin or other carers:

Name: ____________ Relationship to Vulnerable Adult: ________

Address: ______________________________

3 Significant others
(attach separate sheet if necessary)
Name: ____________________

Relationship: ____________________

Address: ____________________

____

Date & Time: ____________

Venue: ____________

Who will conduct?

SW: ____________

PSNI: ____________

Other: ____________

4 The Vulnerable Adult
Name: ____________________

Address: ____________________

____

Date & Time: ____________

Venue: ____________

Who will conduct?

SW: ____________

PSNI: ____________

Other: ____________

5 The Alleged Perpetrator

Name: ____________________

D.O.B: ____________________

Address: ____________________

Date & Time: ____________

Venue: ____________

Who will conduct?

SW: ____________

PSNI: ____________

Other: ____________

Relationship to Vulnerable Adult: ______________________________

* Please delete as appropriate

ORIGINAL FOR POLICE FILE AND COPY TO SOCIAL SERVICES

(D) Has a statement of complaint been made? YES/NO*

By Whom: ______________________________

Does the vulnerable adult have the capacity to:

(a) Consent to interview? YES/NO*

b) Consent to medical examination? YES/NO*

On what basis were these decisions made? ______________________________

____

Signature: ____________________ Designation: ______________________________

(of Person completing form)

Print Name: ____________________ Date: ______________________________

* Please delete as appropriate

ORIGINAL FOR POLICE FILE AND COPY TO SOCIAL SERVICES

Appendix 8

ADULT PROTECTION: FORM AJP3 - CLARIFICATION DISCUSSION

Name: ____ DOB: ____/ ___ / _____

Address:

____

Date: ____ Time: ________________

Venue: ____

CONSIDERATIONS:

1 Has the adult previously made a clear disclosure of abuse or are there substantive grounds for suspecting abuse has occurred?

Comment:

____

____

2 Is the adult willing to engage in an interview?

Comment:

____

____

3 Is the adult able to engage in an interview?

Comment:

____

____

4 Has the purpose of the interview been explained to the adult?

Comment:

____

____

5 Which format is the most suitable for the interview? If a video interview appears to be the most appropriate option assess the adult's willingness to be interviewed on video.

Comment:

____

____

Decision: VIDEO STATEMENT QUESTION AND ANSWER

(Circle format to be used)

NATURE OF DISCUSSION:

CONTEMPORANEOUS, VERBATIM RECORD OF DISCLOSURE:

___

___

___

___

___

___

___

___

___

___

___

(Please close with diagonal line)

SIGNATURE OF PERSON MAKING NOTES: ___

PRINT NAME: ___

DESIGNATION: ___ DATE: ___

(NOTE: Responsibility for completion rests with either **Police or Social Services)**

The Protocol has been produced by the Health & Social Care Board in partnership with the Health & Social Care Trusts, Police Service of Northern Ireland and The Regulation and Quality Improvement Authority.

Northern
Ireland
Office

Department of
Health, Social Services
and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin
an Fowk Siccar

ADULT SAFEGUARDING

IN

NORTHERN IRELAND

REGIONAL AND LOCAL

PARTNERSHIP ARRANGEMENTS

March 2010

ADULT SAFEGUARDING IN NORTHERN IRELAND
REGIONAL AND LOCAL PARTNERSHIP ARRANGEMENTS

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ADULT SAFEGUARDING IN NORTHERN IRELAND REGIONAL AND LOCAL PARTNERSHIP ARRANGEMENTS

Introduction

1. This guidance is being issued in the context of a developing government policy framework which aims to improve safeguarding and protection outcomes for adults in Northern Ireland who are vulnerable. The development of the policy framework is being undertaken jointly by the Department of Health, Social Services and Public Safety (DHSSPS) and the Northern Ireland Office (NIO) with the support of other government departments.

2. Health and social care and criminal justice agencies have a lead role to play in preventing, detecting and providing protection to vulnerable adults. Specifically they seek to ensure that vulnerable adults receive protection, support and equitable access to the criminal justice system. However, a successful safeguarding agenda requires the support of a much wider network of agencies, organisations, bodies and communities of interest across the statutory, voluntary, community, private and faith sectors. Safeguarding involves not only high quality health and social care provision and responsive policing but also safer communities, coherent public transport policies, public health, housing, promotion of social inclusion, education and adult learning opportunities and effective preventative services. It also requires the support of families and carers and the general public, who, through general good neighbourliness and acts of citizenship, are also key to securing improved safeguarding outcomes for adults who are vulnerable. The overall aim is to move focus from objectives to outcomes as illustrated in **Appendix 1.**

3. The abuse of adults must be recognised for what it actually is. It is an assault on the human and civil rights of the abused individual and can have a significant impact on independence, health and social well-being. Our collective aim is to prevent the abuse of adults whose vulnerability heightens the risk of abuse. A rights-based, multi-disciplinary, interagency approach to adult safeguarding is essential with partner organisations and groups working together in a spirit of co-operation, openness and transparency. Each partner member must be clear about what is expected from it, what its obligations are and where its involvement ends.

4. Adult safeguarding and protection work must be conducted in a way which is person-centred, underpinned by human rights considerations and guided by the principles and approaches set out in *Safeguarding Vulnerable Adults,*[1] the Regional Adult Protection Policy & Procedural Guidance, published in

[1] Safeguarding Vulnerable Adults can be accessed at: http://www.nhssb.n-i.nhs.uk/publications/social_services/Safeguarding_Vulnerable_Adults.pdf

September 2006 and its associated Joint Protocol,[2] revised and published in July 2009.

5. For the purposes of this guidance and the outworking of the partnership arrangements it describes, the definition of vulnerable adult as set out in *Safeguarding Vulnerable Adults* will continue to apply. The definition is:

   "a person aged 18 years or over who is, or may be, in need of community care services ***or*** *is resident in a continuing care facility by reason of mental or other disability, age or illness* ***or*** *who is, or may be, unable to take care of him or herself* ***or*** *unable to protect him or herself against significant harm or exploitation."*

6. However, this definition will be subject to further consideration and potential revision as part of ongoing policy development work. It is important that adult protection investigations should at all times be conducted in accordance with *Safeguarding Vulnerable Adults* and the associated Joint Protocol.

7. While much learning can be derived from the experience of child protection and working with families, there are important differences in work related to safeguarding vulnerable adults. For example, there are considerations to be taken account of such as balancing safeguarding with the right to autonomy and self-determination, securing meaningful consent, assessing mental capacity and assessing and managing risk; adults may be subject to financial exploitation in addition to other forms of abuse; and a different approach is needed for carers, who are often partners, from that which is needed for parents. An important emphasis in adult safeguarding work is on empowerment which enables people, whose situation makes them vulnerable, to keep themselves safe. These are just some of the issues for consideration by the new Safeguarding Partnerships:

   - the regional body - the ***Northern Ireland Adult Safeguarding Partnership*** **(NIASP)**; and

   - the local bodies - ***the five Local Adult Safeguarding Partnerships (LASPs)***.

8. In summary, the NIASP will determine the strategy for safeguarding vulnerable adults, develop and disseminate guidance and operational policies and procedures, monitor trends and outcomes and monitor and evaluate the effectiveness of partnership arrangements. In broad terms the LASPs will facilitate practice, including engagement with service users, families and carers and the wider public, at a local level. The roles and responsibilities of the NIASP and LASPs, the relationship between them and the mechanisms for

---

[2] The Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults can be accessed through: http://www.hscboard.hscni.net/publications/index.html

securing meaningful participation from service users and carers or their representative organisations, are set out in detail below.

THE NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)

Role and Responsibilities

9. The role of the NIASP is to develop a strategic approach to safeguarding vulnerable adults. Its specific responsibilities are:

a) to determine, in conjunction with LASPs, the strategy for safeguarding vulnerable adults, identify agreed objectives and priorities for its work, set out in a 3-5 year Strategic Safeguarding Plan for Northern Ireland. The Strategic Safeguarding Plan will be supported by annual Safeguarding Work Plans;

b) to promote activity that raises awareness of adult abuse and the need to safeguard adults at risk of abuse and which highlights the contribution that individuals, carers, families, communities and the wider public can make to safeguarding;

c) to seek continuous improvement in preventive and early intervention services and in services designed to support victims and their carers and families when abuse occurs;

d) to develop, agree, disseminate and keep under review guidance, operational policies and procedures for multi-disciplinary, interagency work to safeguard vulnerable adults, including time frames for action;

e) to improve outcomes for vulnerable adults by setting objectives, performance indicators and, where appropriate, establishing appropriate thresholds for intervention taking account of multi-professional, organisation and other contributions to safeguarding and the views of service users, families, carers and the wider public;

f) to ensure that equality of opportunity is central to the development of safeguarding policies and procedures and to guarantee that an equality perspective is incorporated in safeguarding policy at all levels and all stages;

g) to communicate clearly to partner organisations, individual services and professional groups and the wider public a shared responsibility for safeguarding vulnerable adults, and to explain how that responsibility can be fulfilled;

h) to bring to the attention of each member organisation's board/executive body their responsibilities for safeguarding vulnerable adults and developments needed in the arena, including resource requirements or changes needed in practice or service provision, and how the NIASP Strategic Safeguarding Plan and annual Safeguarding Work Plans will address these;

i) to monitor and evaluate on a regular and continuing basis how well services work individually and collectively to safeguard vulnerable adults and how well the partnerships are working;

j) to ensure that each partner organisation has a clear, well-publicised policy of "Zero-Tolerance" of neglect, exploitation or abuse wherever they occur;

k) to develop and secure delivery of an interagency/inter-disciplinary training and development strategy with the aim of improving the quality of safeguarding work and of interagency/inter-disciplinary working having identified the training needs of those involved in safeguarding work across Northern Ireland. The strategy should take account of how training partnerships with LASPs can be developed;

l) to ensure that each partner organisation has effective training arrangements for its personnel ranging from awareness training for front line staff to the more in depth training required to discharge specialist functions;

m) to develop and maintain strong links between NIASP and LASPs and equivalent child protection structures in Northern Ireland; and to:

- facilitate better information sharing between them for the purposes of shared learning;

- secure effective co-working where this is required; and

- make sure that young people, particularly around the ages of 16 to 19, do not fall through gaps in processes and practice because of any uncertainty about which professionals and bodies have safeguarding responsibility, particularly if there is a safeguarding concern which lasts some time and covers the transition from children's to adult services;

n) to ensure that there are strong and effective links between the NIASP and Multi-Agency Risk Assessment Conferences (MARAC); Public Protection Arrangements Northern Ireland (PPANI); the United Kingdom Human Trafficking Centre (UKHTC); and the United Kingdom Border Agency (UKBA);

o) to forge effective links with bodies outside Northern Ireland that impact on the lives and well-being of vulnerable adults here, e.g. the approach to track and manage sex offenders in the Republic of Ireland;

p) to properly integrate adult safeguarding strategies with other relevant strategies and procedures, e.g. child protection; domestic violence; sexual violence and abuse; human trafficking; and the assessment and management of individuals who may be a risk to themselves or others due to mental disorder;

q) to develop a public communication strategy, and ensure its implementation in conjunction with LASPs, to raise awareness within the wider community of adult abuse, the need to safeguard adults at risk of harm from neglect, exploitation and abuse and to highlight the contribution to safeguarding that individuals, carers, families, communities and the wider public can make;

r) to develop and deliver an information strategy aimed at vulnerable adults, carers and families to enable them to understand safeguarding vulnerable adult processes, particularly those involved in them;

s) to provide information and advice to practitioners, organisations, service providers and the wider public;

t) to continually review local ways of working, identifying and promoting what works well, taking account of best practice and evidence-based knowledge gained through research and international, national and local experience to bring about service and practice improvements with regard to safeguarding vulnerable adults;

u) to establish an internet presence to act as a repository of information relevant to the work of the NIASP, LASPs and safeguarding more generally;

v) to provide information on a regular basis to the board/executive bodies of partner organisations and relevant government departments, particularly in relation to statutory functions; and advise on the development of information systems to facilitate data capture, management and analysis. As a minimum, information provided should cover safeguarding and protection activity, trends, support provided and outcomes for vulnerable adults involved in safeguarding processes, and how well the partnership is working so as to inform performance management, quality assessments, and policy development; and

w) to produce an annual report to provide an update on progress against objectives set out in the Strategic Safeguarding Plan and annual Safeguarding Work Plans; to ensure that the annual report addresses, in particular, safeguarding activity, trends, outcomes for vulnerable adults

involved in safeguarding processes, and how well the partnership is working; and to ensure that reporting on safeguarding vulnerable adult activity is reflected in the annual report of each partner organisation.

Serious Case Reviews (SCRs)

10. In time, NIASP will undertake SCRs, where necessary. The purpose of a SCR is:

    - to establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and organisations work together to safeguard vulnerable adults;
    - to review the effectiveness of procedures;
    - to inform and improve local interagency and/or inter-disciplinary practice and working together to better safeguard adults;
    - to improve practice by acting on learning and emerging best practice and making sure that the lessons learned are clearly communicated in a timely fashion, understood, and appropriate action is taken within agreed timeframes; and
    - to prepare or commission an overview report which brings together and analyses the findings of the various reports from organisations in order to make recommendations for future action.

11. Partner organisations will have their own internal or statutory review procedures to investigate serious incidents and untoward incidents. The SCR process is not intended to duplicate or replace these. There may be grounds for a SCR, a Children's Case Management Review, a Mental Health Independent Inquiry, or other formal review process. Various regulatory bodies also undertake investigations into serious incidents and Ministers can direct statutory organisations to conduct investigations or approve public inquiries. Where this is the case, a decision should be made at the outset by the decision makers involved as to whether a joint approach is required, who will lead, what needs to be addressed, who needs to be involved, who will chair and to whom the final report, joint if need be, will be made. Legal advice should be sought as necessary.

12. The circumstances which might trigger a SCR include:

    - the death of a vulnerable adult (including death by suicide) and abuse or neglect is known or suspected to be a factor in the death;

- the vulnerable adult has sustained a potentially life-threatening injury through abuse, including sexual abuse, or neglect; serious or permanent impairment of health, development or well-being through abuse or neglect or serious inhuman or degrading treatment; and the case gives rise to concerns about the way in which local professionals and services work together to protect adults at risk of harm; or

- serious abuse takes place in an institution or when multiple abusers are involved, the same principles of review apply. Such reviews are, however, likely to be more complex, on a larger scale, and may require more time.

13. The NIASP can also consider conducting a SCR into any incident(s) or case(s) involving adults at risk of harm where it is clearly in the public interest. Terms of reference will need to be carefully constructed to explore the issues relevant to each specific case.

14. SCRs are not inquiries into how a person died or suffered injury; nor is their purpose to re-investigate, or to apportion blame. Further work will be undertaken to produce SCR Review Guidance which will cover, *inter alia*, the purpose of, and criteria which trigger, a SCR, the review process and the constitution of a SCR Panel.

Leadership and Accountability

15. Each partner organisation will identify a lead at board/executive level responsible for safeguarding vulnerable adults work within the organisation; to champion the rights of vulnerable adults; and to ensure that safeguarding issues become more central to the work of the organisation. In addition, each organisation will nominate a lead manager with responsibility for safeguarding vulnerable adults to act as that organisation's representative on the NIASP and LASP, as specified. A specimen role profile for the Lead Manager Safeguarding Vulnerable Adults – NIASP & LASPs is set out in **Appendix 2**. Constructive relationships between individual workers and organisations need to be supported by senior management in each partner organisation. Each partner organisation will provide a statement setting out its role and responsibilities in relation to safeguarding vulnerable adults work, including any statutory responsibilities and services provided.

16. The NIASP and its Chair are accountable, in the first instance, to the Health and Social Care (HSC) Board. NIASP members are also, however, accountable to the organisations that they represent which, in turn, are responsible for taking any action properly falling within their respective remits. The NIASP must work to agreed written terms of reference which set out its remit, including the level of decision-making which can be agreed by partner organisations' representatives without referral back to the individual member organisation. Each partner organisation must accept that it is responsible for the contribution made by its

own representative. Each representative is responsible for ensuring that the issues applicable to their organisation for safeguarding vulnerable adults are given proper consideration by NIASP. Each partner organisation must have a mechanism in place for considering and responding to the policy, planning and resource implications of issues brought to the attention of the organisation by its NIASP representative.

17. The HSC Board should, through the Director of Social Care and Children's Services, take lead responsibility for the establishment and effective working of the NIASP. The Director of Social Care and Children's Services, with relevant members of the NIASP, will put in place a mechanism, which ensures that ownership of safeguarding issues is promoted within all partner organisations and across all professional groups and service delivery settings in health and social care. They will also ensure that safeguarding issues of general or particular relevance to professional groups and service areas are brought to the attention of the relevant Directors in the HSC Board and the Public Health Agency (PHA) in line with the established governance arrangements within each of those bodies. In non-HSC bodies, the lead at board/executive level will ensure that safeguarding issues of a general or particular nature are dealt with in line with their organisation's established governance arrangements. All partner organisations are responsible for contributing fully and effectively to the work of the NIASP.

18. The NIASP should contribute to, and work within the framework of the planning, commissioning and performance framework established by the HSC Board in partnership with the PHA and have regard to the requirements of partner organisations. Within this framework, different organisations will also work together in different forums to plan co-ordinated action.

NIASP Membership

19. The NIASP should be made up of members from the main statutory and voluntary and community organisations involved in adult safeguarding work across the region and include representation from service providers and service users. Some NIASP members may carry a dual role e.g. they may chair a LASP and represent a professional group or lead in an area of service delivery. Contributing to the work of the NIASP is an important responsibility for partner organisations.

20. Each partner organisation should ensure active participation and representation at a sufficiently senior level. Where possible, representation should be set at not less than 3rd level in the organisation, so that the NIASP can effectively influence the development of guidance, policy and practice with regard to safeguarding vulnerable adults. Where 3rd level representation is problematic, partner organisations should appoint an individual, who is sufficiently senior to represent the organisation's views and to make decisions on behalf of the

organisation. Consideration should also be given at the outset, to identifying an officer to deputise for the lead manager, should this prove necessary. A deputising officer should only be appointed on the basis of authority to represent and make decisions on behalf of the organisation. The name of the deputising officer should be communicated in writing to the chair of the NIASP. Representatives should attend regularly to ensure continuity from all partner interests. This includes membership of subcommittees or working groups.

21. Membership of NIASP will comprise a Chair and 24 members. Membership will include service users and carers or their representative groups, and be drawn from senior staff with responsibility for policy development and implementation representing:

a) relevant professional groups from the HSC Board and PHA, including social work, primary care, medicine, nursing and allied health professionals and training managers;

b) Chairs of LASPs to represent the view and contribution of all its members;

c) the Police Service of Northern Ireland (PSNI);

d) the Probation Board for Northern Ireland (PBNI);

e) the Social Security Agency (SSA);

f) the Northern Ireland Housing Executive (NIHE) and providers of sheltered housing;

g) independent sector providers of health and social care services;

h) Society of Local Authority Chief Executives (Northern Ireland);

i) the Patient and Client Council; and

j) voluntary, community and private sector groups and faith communities working in the safeguarding vulnerable adults arena or relevant service provision, including advocacy, victim support, ‘appropriate adult’ support and services meeting the needs of specific groups experiencing neglect, exploitation or abuse. Representation from the voluntary, community and faith sectors, and service users, carers or their representative groups should also reflect the rich range of vulnerable adult interests in Northern Ireland. Where this cannot be fully accommodated on the NIASP, it should be accommodated, as far as possible, across the five LASPs.

22. The NIASP should introduce a system of decision-making by quorum. At the outset, members should agree at what number the quorum will be set and how it will be weighted to determine the validity of NIASP decision-making. The NIASP should also determine and publish nomination and selection criteria for representation by the voluntary, community, private and faith sectors who, with service users and carers or their representatives, are expected to make up one-third of the NIASP membership. It is possible that the NIASP could draw its voluntary, community and faith sector representation and representation from service users, carers or their representative groups from the suggested Adult Safeguarding Forum arrangements (see paragraphs 23 - 25). This is a matter for the NIASP. The NIASP Chair should keep membership under review and, with the agreement of other partners, revise membership as necessary to reflect the changing nature of safeguarding work.

THE ADULT SAFEGUARDING FORUM (ASF)

23. Adults may be at risk for many reasons, for example, poverty, living circumstances, isolation, age, disability or deteriorating physical or mental health, alcohol or substance misuse, reduced ability to make decisions or choices, exploitation or poor family dynamics. It is essential that the voice of adults who are vulnerable, including those who have had experience of protection services, is at the centre of safeguarding and protection systems. Such systems work more effectively when they have clear ways of engaging people in local communities.

24. In recognition of the diversity of interests and the requirement to have regard to the particular needs of different groups, the NIASP, in partnership with LASPs, should consider the establishment of and provision of support to an ASF. The ASF is a mechanism by which the NIASP and LASPs facilitate much wider user participation in the work of the partnerships. Members of the ASF should be representative of the rich range of interests in Northern Ireland. As a key partner for NIASP and the LASPs, the ASF would, among other things:

- inform the development and review of strategies, policies and procedures;
- help with the development, and promote awareness of, risk indicators;
- help inform/equip people with information and plans to safeguard themselves;
- help identify barriers to uptake of access to safeguarding services;
- facilitate development of ‘user-friendly’ information about what to do and how to get help when needed; and

- promote access to and dialogue with local community and particular interest groups.

25. The agreed operational model should promote maximum opportunity for personal and public participation in safeguarding work at a local level, having regard to existing networks, whilst, at the same time, be able to come together on matters that are of interest across the region. The final model adopted will be a matter for the NIASP in consultation with the LASPs and should be fully operational by the end of year 2 of the establishment of the NIASP/LASPs.

Links with other Bodies

26. The NIASP should also establish definitive links with:

    a) the Regulation and Quality Improvement Authority (RQIA);

    b) the Coroners Service for Northern Ireland;

    c) the Northern Ireland Court Service, including the Office of Care and Protection;

    d) relevant bodies with an enforcement and/or inspection/improvement function, e.g. the Health and Safety Executive for Northern Ireland; Criminal Justice Inspection Northern Ireland; and the Education and Training Inspectorate;

    e) the Youth Justice Agency of Northern Ireland;

    f) the Northern Ireland Fire and Rescue Service;

    g) the Northern Ireland Ambulance Service;

    h) the Northern Ireland Prison Service;

    i) child protection structures in Northern Ireland; the PPANI Strategic Management Board; the UKHTC; and the UKBA;

    j) the Co-ordinator or Senior Social Work Practitioner, Soldiers, Sailors, Airmen and Families Association (SSAFA) Forces Help;

    k) universities and colleges and other education and training providers;

    l) relevant employer and business groups;

m) organisations representative of Section 75 groups and other communities of interest;

n) professional regulatory bodies, e.g. Northern Ireland Social Care Council; Nursing and Midwifery Council; General Medical Council; Health Professions Council; and Pharmaceutical Society Northern Ireland;

o) professional bodies and staff groups; and

p) other strategic partnerships, e.g. those dealing with regeneration, community safety, policing, domestic violence, drug and alcohol matters.

27. The NIASP should also make appropriate arrangements to involve other organisations and professionals in its work as necessary and the NIASP's Annual Report should provide information on their contribution to the business of the NIASP.

Working Groups

28. The NIASP should consider setting up working groups to:

a) carry out specific tasks (e.g. maintaining and updating guidance and operational procedures; developing and reviewing information sharing protocols; identifying interagency training needs and arranging appropriate training);

b) provide specialist advice (e.g. working with specific ethnic or cultural groups);

c) monitor activity and trends in adult protection work, including establishing core data sets to measure activity and outcomes; and

d) carry out audits and research, in conjunction with LASPs, to examine interagency safeguarding arrangements, identify good practice and highlight areas for improvement.

29. All groups working under the auspices of the NIASP should have been established by the NIASP, chaired by a NIASP member, and should work to agreed terms of reference within the framework of the Strategic Safeguarding Plan and annual Safeguarding Work Plans, and with explicit lines of communication and accountability to the NIASP. Groups may be established on a standing or time-limited basis. The continuing need for all groups should be kept under regular review by the NIASP. NIASP should, as a minimum, move quickly to establish four separate working groups to further progress work in relation to training; communication and user engagement; information management; and operational policies and procedures.

Chair and Secretariat

30. It is essential that the NIASP has a Chair with established authority who has a firm grasp of safeguarding issues across the region and is of sufficient standing and expertise to command the support and respect of all member organisations. Consequently, in the first instance, the Chair of NIASP will be the Director of Social Care and Children's Services in the HSC Board or a nominated representative. Consideration should also be given to the appointment of a Vice Chair from within the membership of the NIASP to share responsibility for chairing meetings and to deputise in the chair's absence.

31. The HSC Board is responsible for providing the NIASP with a secretariat and other support services.

Finance and Administration

32. NIASP expenditure, and administrative and policy support, is a matter for local agreement. As a partnership, the NIASP should be supported in its work by all its constituent members, reflecting the investment of each partner organisation in activities that are of benefit to all. This can be achieved in a variety of ways ranging from the commitment of resources to financial contributions for particular activities. The DHSSPS has provided recurrent funding for a Regional Adult Protection Officer and associated administrative provision to support the work of the NIASP and ensure the smooth running of its operation, working groups and management of its resources.

33. Each partner organisation must, however, accept that it has a responsibility to contribute to the effective working of the partnership and is responsible for the contribution made by its own representative. Each representative is responsible for ensuring that the issues applicable to their organisation for safeguarding vulnerable adults are given proper consideration by NIASP. Partner organisations must have a mechanism for considering and responding to the policy, planning and resource implications of issues brought to the attention of the organisation by its NIASP representative. Organisations which require resources to discharge, or change the way they discharge, their safeguarding responsibilities or to respond to any increase in safeguarding activity should bid for these in line with their usual process. Information, collected, collated and analysed by the NIASP will be of benefit in this regard.

NIASP Procedures

34. The NIASP should have in place procedures covering:

    a) reporting and responding to concerns about neglect, exploitation or abuse;

b) determining when a case should be managed under adult protection arrangements;

c) the management of a case from referral and through each stage of the process with associated time frames;

d) information sharing, incorporating the principles of the Data Protection Act 1998, and which balance the requirements of confidentiality with the need to safeguard the vulnerable adult;

e) safeguarding adults in groups known to be vulnerable and in specific circumstances;

f) how adult protection inquiries should be conducted, including links with associated police investigations, and in particular, the circumstances in which joint enquiries are necessary and/or appropriate;

g) the arrangements for supporting reluctant or vulnerable or intimidated witnesses, for example, the Northern Ireland Appropriate Adult Scheme which provides protections and safeguards for mentally disordered or otherwise mentally vulnerable people who are detained in police custody;

h) the arrangements for managing complex investigations; investigations into organised abuse; and investigations involving 'out-of-area' placements;

i) the arrangements to enable the police to make referrals to social services when adult protection concerns emerge during the course of a police investigation;

j) the arrangements to receive referrals from the RQIA in relation to allegations of abuse in regulated establishments and agencies[3] and to make referrals to RQIA where a failure to comply with regulations or standards is suspected;

k) arrangements for the investigation and management of allegations of abuse against staff members;

l) the roles and responsibilities of particular disciplines and staff within organisations working to safeguard vulnerable adults;

[3] RQIA is responsible for registering, inspecting and encouraging improvement in a range of health and social care services delivered by statutory and independent providers, in accordance with The Health and Personal Social Services (Quality, Improvement and Regulation)(Northern Ireland) Order 2003 and its supporting regulations. Services currently regulated by RQIA include residential care homes; nursing homes; children's homes; independent health care providers; nursing agencies; adult placement agencies; domiciliary care agencies; residential family centres; day care settings; and boarding schools. Further information can be accessed through the RQIA website: http://www.rqia.org.uk/home/index.cfm

m) a quick, effective and straightforward means of resolving professional and/or organisation differences of view in individual cases, for example, on whether an adult protection case discussion, including the form of case discussion, should be convened or about respective roles and responsibilities;

n) participation in strategy discussions and adult protection case discussions;

o) the involvement of carers and family members in strategy discussions and adult protection case discussions, the role of advocates as well as criteria for excluding carers/family members in exceptional circumstances;

p) decision-making processes for monitoring vulnerable adults; and

q) the handling of complaints from service users, families and carers about the functioning of adult protection strategy discussions and case discussions having regard to the HSC Complaints Procedure.

Frequency of NIASP meetings

35. As a minimum, meeting of NIASP should occur on a quarterly basis. Regular attendance by partner members is critical for the continuity of business. In the event of an absence of any organisation for more than 2 successive meetings, the Chair will seek a fresh nomination from the organisation concerned.

Monitoring, Review and Audit

36. NIASP, with LASPs, should develop and agree a 3-5 year audit/review plan with performance indicators against which audits/reviews will be conducted. In conjunction with LASPs, the NIASP should conduct audits/reviews against the plan to, *inter alia*, monitor and evaluate the way in which their policies, procedures and practices for the protection of vulnerable adults are working; how well organisations respond individually and collectively to allegations of abuse; and how well the partnerships are working. For this purpose, organisations should work together. Feedback on performance to all organisations should be a key feature of the audit/review process.

37. In determining the content of the audit/review plan, NIASP, with LASPs, should consider the following elements:

- an evaluation of community and public understanding – the extent to which there is an awareness of indicators of possible abuse; the policy and procedures and services for safeguarding vulnerable adults; and how to access them;

- links with other systems for protecting those at risk – for example, child protection, public protection, domestic violence, victim support and community safety;

- an evaluation of how staff and organisations are working together (e.g. timely and appropriate information sharing; sharing of skills, knowledge and expertise; the fostering of shared decision-making, shared ownership and shared responsibility; and effective co-ordination of responses and incorporation of different professional/organisation perspectives) and how far policies and procedures continue to be appropriate;

- the extent to which operational guidance continues to be appropriate in general and, in the light of reported cases of abuse, in particular;

- increase in staff awareness of abuse and safeguarding processes across all organisations and service settings – the extent to which there is an awareness of indicators of possible abuse; the policy and procedures and services for safeguarding vulnerable adults; and how to access them;

- the range, uptake and quality of training available to staff in all organisations relevant to their roles and responsibilities;

- the performance and quality of services for the protection of vulnerable adults;

- the conduct of investigations in individual cases;

- identification of barriers to the uptake of safeguarding services; and

- the development of services and models of practice to respond to the needs of adults who have been abused.

38. The above elements, proportionate to the role of partner organisations, should form the basis for informing outcome measures which can be used by partner organisations, and commissioners and providers of services to monitor and evaluate effectiveness of service provision. It should also inform the planning and reporting processes and, for partner organisations, identify the need, if any, for resources to deliver service or practice change or development. It will also help identify any matters that require clarification of, or further development in, government policy with regard to safeguarding. Bids for resources should be progressed in line with each partner organisation’s usual process.

Strategic Safeguarding Plan and Annual Safeguarding Work Plans

39. The NIASP will, in conjunction with LASPs set out its strategy for safeguarding vulnerable adults with agreed objectives and priorities for its work in a rolling 3-5 year Strategic Safeguarding Plan for Northern Ireland. The Strategic Safeguarding Plan will be supported by annual Safeguarding Work Plans. The annual Safeguarding Work Plan should set out a work programme for the forthcoming year and include measurable objectives. The NIASP's plan should both contribute to, and derive from the framework for planning and commissioning health and social care services and their performance management. It should reflect the objectives of partner organisations and be endorsed by senior managers in each of the organisations.

40. The NIASP may wish to make the Strategic Safeguarding Plan and Safeguarding Work Plans, or an edited version of them, available to a wider audience, for example, to explain to the wider community the work of local organisations in helping to safeguard vulnerable adults.

41. Production of comprehensive communication and information strategies and associated action plans, in partnership with LASPs will be a priority in Year 1 of the NIASP's work.

Annual Report – NIASP and LASP

42. The annual report presents an opportunity for the NIASP and LASPs to reflect on their roles, responsibilities and functioning. The reports also provide an opportunity to promote dialogue within and between organisations and to communicate with the wider public.

43. The reports should contain analysis, review and comment on NIASP and LASP processes and functioning, and on how well they are discharging their responsibilities. The reports should also include statements of progress against objectives for the previous year; indicate how well services work individually and collectively to safeguard vulnerable adults and how well the partnerships are working; set out developments in service and practice; actions for improvement still required and timeframe for delivery. Management information on adult protection activity and outcomes in the course of the previous year and objectives for the coming year should also be included.

44. As a minimum NIASP's Annual Report should contain sections on:

    a) membership, vision, roles and responsibilities and the principles underpinning safeguarding work with vulnerable adults;

    b) the work of the NIASP in-year, including information about activity undertaken by sub-groups and partner organisations;

c) information on activity, trends, support provided and outcomes in relation to safeguarding and the protection of adults at risk; and audits undertaken (**Appendix 3** provides an outline of matters for consideration);

d) information on training provided and community and public awareness work undertaken;

e) reports from the LASPs;

f) feedback on service user, family and carer experience of safeguarding activity;

g) audit, review and research activity undertaken;

h) its conclusions about the effectiveness of safeguarding arrangements, how well organisations have worked together and the effectiveness of partnership arrangements and what, if anything needs to be addressed, by whom and by when; and

i) its objectives for the coming year.

45. Constituent organisations should, commensurate with their role in safeguarding, provide the NIASP with management information on safeguarding work in general and, in particular, on the level of activity, trends, support provided and outcomes in adult protection work within their organisation on an annual basis. The information provided should not include identifying details of individuals. Each organisation should submit annual progress reports to its board/executive body to ensure that adult safeguarding and protection requirements are part of the organisation's overall approach to service provision and service development. Reports to each board/executive body should be commensurate with the organisation’s safeguarding role and be sufficient for it to be assured that it is discharging its responsibilities and partnership commitments appropriately and effectively. NIASP may need to provide further guidance on reporting requirements as they apply to all partner organisations. NIASP should keep reporting requirements under review. The structure of the LASPs’ Annual Reports should reflect that of the NIASP as set out above. An item about work undertaken in relation to safeguarding vulnerable adults should be included in each organisation’s annual report.

46. The NIASP and LASPs will also want to consider how to make the findings set out in their reports more widely available:

- within member organisations;
- to other organisations with a role in, and responsibilities for, safeguarding and the support and protection of vulnerable adults;

- to service users and carers; and
- to the general public.

The NIASP and LASPs will therefore want to consider the issue of publication and the formats in which the reports' findings are made available; the NIASP web site will be an important mechanism for dissemination of Annual Reports and information relevant to safeguarding vulnerable adults more generally.

THE LOCAL ADULT SAFEGUARDING PARTNERSHIP (LASP)

Role and Responsibilities

47. The role of the LASP located within each of the HSC Trust areas is to implement locally the NIASP's guidance and operational policy and procedures ensuring a high standard of professional practice. Its main tasks are:

    a) to work within, and contribute to the NIASP Strategic Safeguarding Plan, and ultimately the framework for planning, commissioning and performance management of health and social care services having due regard to the objectives of partner organisations;

    b) to contribute to delivery of the annual Safeguarding Work Plan;

    c) to implement the NIASP's guidance and operational policies and procedures;

    d) in partnership with the NIASP to measure how and to what degree the objectives, performance indicators and outcome measures set by the NIASP have improved outcomes for vulnerable adults in the locality;

    e) to monitor and evaluate how well local services work together to safeguard vulnerable adults. This should be done in partnership with the NIASP and form part of the NIASP annual Safeguarding Work Plan;

    f) to encourage and develop good working relationships between different services, professionals, and community, voluntary and private sector groups with the aim of developing trust and mutual understanding;

    g) to ensure that each partner organisation has a clear, well-publicised policy of "Zero-Tolerance" of neglect, exploitation or abuse wherever they occur;

    h) to ensure that there are strong and effective links between the LASP and MARAC, PPANI and SSAFA Forces Help (where there is a large service base in the area) at local level;

i) to develop and maintain strong links with local child protection structures;

j) to properly integrate adult safeguarding strategies with other relevant strategies and procedures, e.g. child protection; domestic violence; sexual violence and abuse; human trafficking; and the assessment and management of individuals who may be a risk to themselves or others due to mental disorder;

k) to advise the NIASP and LASP's constituent organisations on resource needs;

l) to develop an outline training plan, contribute to the NIASP training and development strategy and to the delivery of training and development programmes on a multi-agency/disciplinary basis and, in partnership with NIASP, to assess how identified training/development needs are being met;

m) to promote public awareness about adult safeguarding and protection services in keeping with the NIASP public communication and information strategies; and

n) to provide an annual report to the NIASP.

Accountability

48. The LASP as a body is accountable to the HSC Trust in which it is located, although its members are accountable to the organisations they represent. The LASP should work within the agreed NIASP Strategic Safeguarding Plan and associated Safeguarding Work Plans, guidance and adult protection operational policies and procedures, which they do not have the discretion to amend. Each partner organisation should accept that it is responsible for monitoring the performance of its own representative.

49. Each partner organisation must accept that it has a responsibility to contribute to the effective working of the partnership and is responsible for the contribution made by its own representative. Each representative is responsible for ensuring that the issues applicable to their organisation for safeguarding vulnerable adults are given proper consideration by the LASP. Each partner organisation must have procedures in place for considering reports from its LASP representative and for responding to the policy, planning and resource implications of issues brought to its attention by its LASP representative.

Terms of Reference

50. The LASP should work within agreed terms of reference that set out its remit. The terms of reference should be agreed with members of the LASP, endorsed by the NIASP, and include the level of decision-making that may be agreed by

partner organisation representatives, without referral back to individual member organisations.

LASP Membership

51. The LASP should be made up of members from the main statutory and voluntary and community organisations involved in adult safeguarding work and service providers in the HSC Trust's area, and include representation from service users. Each partner organisation should ensure active participation and representation at a sufficiently senior level so that the LASP is effective in the implementation of guidance, policy and procedures at a local level, including engagement with service users, families, carers and the wider public. Membership will comprise a Chair and 24 members which should include service users and carers or their representative groups and practitioners and managers from a range of disciplines and organisations **in the HSC Trust area**, including:

a) relevant professional groups from the HSC Trust, including social work, medicine, nursing, allied health professionals and training managers;

b) the PSNI;

c) general practitioners;

d) the relevant Local Commissioning Group;

e) the PBNI;

f) the SSA;

g) the NIHE and providers of sheltered housing;

h) independent sector providers of health and social care services;

i) relevant District Council(s);

j) the Patient and Client Council; and

k) voluntary, community and private sector groups and faith communities working in the safeguarding vulnerable adults arena or relevant service provision, including advocacy, victim support, 'appropriate adult' support and services meeting the needs of specific groups experiencing neglect, exploitation or abuse. Representation from the voluntary, community and faith sectors, and service users, carers or their representative groups should also reflect the rich range of vulnerable adult interests in Northern Ireland.

52. Consideration should also be given, at the outset, to identifying an officer to deputise for the lead manager, should this prove necessary. A deputising officer should only be appointed on the basis of authority to represent and make decisions on behalf of the organisation. The name of the deputising officer should be communicated in writing to the chair of the LASP. Representatives should attend regularly to ensure continuity from all partner interests. This includes membership of subcommittees or working groups.

53. The LASP, in consultation with NIASP, should introduce a system of decision-making by quorum. At the outset, members should agree at what number the quorum will be set and how it will be weighted to determine the validity of LASP decision-making. The LASP, in consultation with NIASP, should also determine and publish nomination and selection criteria for representation by the voluntary, community, private and faith sectors who with service users and carers or their representative groups are expected to make up one-third of the LASP membership. It is possible that the LASP could draw its voluntary, community and faith sector representation and representation from service users, carers or their representative groups from the suggested Adult Safeguarding Forum arrangements (see paragraphs 23 - 25). This is a matter for the LASPs. The LASP Chair should keep membership under review and, with the agreement of other partners, revise membership as necessary to reflect the changing nature of safeguarding work.

Links with other Bodies

54. The LASP should seek to establish links locally with RQIA and with other relevant local professionals, bodies, organisations and groups which have a contribution to make with regard to safeguarding vulnerable adults, for example, relevant employer and business groups; organisations representative of Section 75 groups; and other communities of interest. Examples of local partnership arrangements with which links should also be forged include: Domestic Violence Partnerships, Child Protection Panels, Local Area Public Protection Panels and Community Safety Partnerships. Where such links are established, the LASP's Annual Report should provide information on their contribution to the work of the LASP.

Working Groups

55. The LASP will also have the capacity to utilise sub-groups to reflect 'special interest' and service user needs and to draw on the expertise of groups and practitioners, for example, with regard to accident & emergency departments, mental health, learning disability, physical disability and sensory impairment, dementia and geriatrics. Groups may be established on a standing or time-limited basis. The continuing need for all groups should be kept under regular review by the LASP. As a minimum, LASPs will need to move quickly to establish groups in relation to training; communication and user engagement;

information management; and operational policies and procedures to mirror arrangements within the NIASP.

Chairing

56. At the outset, the LASP should be chaired by the Trust's Executive Director of Social Work or a senior designated nominee, on the grounds that existing partnership arrangements are led by senior social care staff. Over time, it may be possible to rotate chairing arrangements among partnership members. However, it is essential that the Chair has a firm grasp of local safeguarding issues and is of sufficient standing and expertise to command the support and respect of all member organisations. Consideration should also be given to the appointment of a Vice Chair from within the membership of the LASP to share responsibility for chairing meetings and to deputise in the chair's absence. The Trust's Executive Director of Social Work or nominee, with relevant members of the LASP, will put in place a mechanism, which ensures that ownership of safeguarding issues is promoted across all professional groups and service delivery settings in health and social care. They will also ensure that safeguarding issues of general or particular relevance to professional groups and service areas within the HSC Trust are brought to the attention of the relevant Trust Director, in line with established governance arrangements within the Trust. In non-HSC bodies, the lead at board/executive level will ensure that safeguarding issues of a general or particular nature are dealt with in line with their organisation's established governance arrangements.

Finance and Administration

57. The HSC Trust is responsible for core funding the LASP and providing it with a secretariat and other support services. As a partnership, the LASP should be supported in its work by all its constituent organisations, reflecting the investment of each partner organisation in activities that are of benefit to all. This can be achieved in a variety of ways ranging from the commitment of resources to financial contributions for particular activities. The DHSSPS has provided recurrent funding for a Specialist Adult Protection Manager and associated administrative provision to support the work of each LASP to ensure the smooth running of its operation and management of its resources.

58. Each partner organisation must, however, accept that it has a responsibility to contribute to the effective working of the partnership and is responsible for the contribution made by its own representative. Each representative is responsible for ensuring that the issues applicable to their organisation for safeguarding vulnerable adults are given proper consideration by LASP. Partner organisations must have a mechanism for considering and responding to the policy, planning and resource implications of issues brought to the attention of the organisation by its LASP representative. Organisations which require resources to discharge, or change the way they discharge, their safeguarding

responsibilities or to respond to any increase in safeguarding activity should bid for these in line with their usual process. Information, collected, collated and analysed by the LASP will be of benefit in this regard.

Frequency of LASP meetings

59. At a minimum, meeting of LASPs should occur on a quarterly basis, synchronised with the quarterly meeting of the NIASP. Regular attendance by partner members is critical for the continuity of business. In the event of an absence of an organisation for more than 2 successive meetings, the Chair will seek a fresh nomination from the organisation concerned.

Monitoring, Review and Audit

60. In accordance with the agreed 3-5 year audit/review plan and in conjunction with the NIASP, LASPs, should audit, monitor and review the way in which their policies, procedures and practices for the protection of vulnerable adults are working; how well organisations respond individually and collectively to allegations of abuse; and how well the partnership is working. Further guidance in determining the content of the audit/review process is set out in paragraph 37.

Information for the LASP

61. Constituent organisations should, commensurate with their role in safeguarding, provide the LASP with management information on safeguarding work in general and, in particular, on the level of activity, trends, support provided and outcomes in adult protection work within their organisation on an annual basis. The information provided should not include information capable of identifying any individual (see also paragraphs 42 - 46).

Information from the LASP

62. The LASP should review annually the adult safeguarding work in its area and plan for the year ahead. This information should be submitted to the HSC Trust board, copied to the NIASP and circulated to all constituent organisations as soon as possible after the end of the financial year. As safeguarding work evolves, there should be a periodic review by NIASP, in conjunction with LASPs, of the information collected to make sure of its continued relevance and to identify and address any information gaps (see also paragraphs 42 - 46).

ADULT SAFEGUARDING IN NORTHERN IRELAND: OBJECTIVES TO OUTCOMES – AN ILLUSTRATION

Objectives…	…pursued through functions…	… help produce outputs…	…that contribute to overall outcomes…
1. To secure effective co-ordination of what is done by each person and partner organisation on the NIASP for the purpose of safeguarding and promoting the welfare of vulnerable adults in Northern Ireland	Overseeing the development of person-centred, rights-based policies and procedures for safeguarding and promoting the welfare of vulnerable adults, including: - action where there are concerns, including thresholds; - training of persons who work with vulnerable adults; - co-operation with relevant authorities in other parts of the United Kingdom and in the Republic of Ireland; and - participating in the planning of services for vulnerable adults in Northern Ireland.	Effective local work to safeguard and promote the welfare of vulnerable adults	The general well-being of vulnerable adults is promoted and, in particular, they are kept safe.
2. To ensure the effectiveness of what is done by each person or partner organisation for that purpose.	Monitoring effectiveness of what is done to safeguard and promote the welfare of vulnerable adults. Procedures to ensure a co-ordinated response to suspected or allegations of abuse. Collecting, collating and analysing information abuse and operation of safeguarding procedures. In time, ensuring that Serious Case Reviews are undertaken.	Evaluating effectiveness and advising on way to improve.	
3. To raise awareness of adult abuse and communicate the need to safeguard and promote the welfare of vulnerable adults to the wider community.	Raise awareness of: - adult abuse and risk to vulnerable adults and the danger signs in relation to neglect, exploitation and abuse; and - sources of help and how to access them for vulnerable adults, carers, families and the wider community.	All citizens accept mutual responsibility to safeguard the vulnerable, to be aware of the danger signs and to act on concerns.	

APPENDIX 1

APPENDIX 2

ROLE PROFILE FOR LEAD MANAGER SAFEGUARDING VULNERABLE ADULTS – NIASP & LASPS

1. To represent their organisation at the NIASP or LASP, as appropriate.

2. To promote the role of their organisation within safeguarding adults work. To provide a summary of that role to the LASP and NIASP, as appropriate.

3. To promote effective multi-professional, inter-disciplinary, interagency working on safeguarding adult issues and in particular in relation to adult protection procedures. To negotiate changes to internal and interagency processes to facilitate this.

4. To lead the implementation of safeguarding adults work within their organisation in line with current good practice, including:

   - the safeguarding of people using the organisation's services;
   - the appropriate use of the regional adult protection procedures; and
   - ensuring staff, volunteers and service users and carers are informed about safeguarding adults work and have appropriate skills relevant to their role.

5. To give regular reports to the LASP and NIASP, as appropriate, of progress on implementation of safeguarding adults work within their organisation including:

   - numbers and roles of staff trained, including range, uptake and quality of training;
   - monitoring and quality assurance data in relation to adult protection referrals;
   - services delivered to victims or perpetrators of adult abuse; and
   - any issues arising in relation to the implementation of safeguarding adults work.

6. To ensure that the organisation is appropriately and consistently represented on NIASP, LASP or any sub-groups, work groups or task groups.

7. To report to the organisation's board/executive body member with responsibility for Safeguarding Adults and make regular reports to that board/executive body and, in particular, to identify any resources required to discharge, or change the way safeguarding responsibilities are discharged or as a consequence of any increase in safeguarding to ensure that bids for resources are progressed in line with the organisation's usual process.

8. To promote the work of the LASP and NIASP, as appropriate and represent the NIASP or LASP in other multi-organisation forums as agreed.

APPENDIX 3

MANAGEMENT INFORMATION – A SUGGESTED OUTLINE

Information should be routinely gathered in two categories, namely:

1. Activity and trends; and

2. Outcomes and performance indicators.

1. INFORMATION ON ACTIVITY AND TRENDS

a) Safeguarding activity to include, for example, evidence of:

- awareness campaigns, e.g. about abuse and how to prevent it; support services and how to access them; promotion of health and well-being and social inclusion;

- stay safe, keep safe and dignity in care initiatives;

- Safeguarding Adults Conferences which incorporate the range of safeguarding networks;

- publicity materials available in formats and languages required;

- participation by partnerships/member organisations in events to mark international awareness days, e.g. World Elder Abuse Day which happens each year on 15 June;

- information and awareness raising events held in and by partner organisations;

- systems in place for the management of malpractice and to ensure, as far as possible, that service users are safeguarded against potential risks from employees;

- embedding of safeguarding and protection policies in service agreements/contracts with providers of services to adults who are vulnerable;

- proactivity in early intervention and promotion of a culture of service users' rights to high standards of care, treatment and service;

- availability of advocacy services which reflect the needs of the population served; and/or

- dissemination of learning by staff/organisations from safeguarding/protection work.

b) Protection work to include:

- number and source of referrals, e.g. self-referral, carer/family member, friend, member of public, care worker, service provider, police, acute hospital, incl. A&E, RQIA, GP, anonymous, other;

- information about the abused person, such as age, marital and dependent status, gender, ethnicity and primary service user group, e.g. physical disability, sensory impairment, learning disability, older person, dementia, mental health, acquired brain injury, alcohol/substance misuse, other, e.g. data collection should be sensitive to abuse perpetrated because of an individual's religion, political opinion or sexual orientation;

- information about the alleged abuser, e.g. institutional setting, partner, main family carer, other relationship paid carer, friend, service user, professional, other family member, stranger;

- type(s) of abuse referred using commonly agreed categories as suggested in *Safeguarding Vulnerable Adults* (September 2006), Paragraph 3.3, i.e. physical abuse (including inappropriate restraint or use of medication); sexual abuse; psychological abuse; financial or material abuse; neglect and acts of omission; institutional abuse; and discriminatory abuse;

- location in which abuse took place, e.g. own home, alleged abuser's home, other person's home, residential care home (statutory, voluntary or private), nursing home, day care setting; adult placement setting, hospital, public place;

- outcomes of investigation, e.g. abuse discontinued, allegation unsubstantiated, current/open case, changes in care arrangements, increased monitoring of situation, family/carer support, use of protective legislation (specify), admission to residential care/hospital, specialist external service, vulnerable adult reluctant to continue, allegation withdrawn, lack of evidence, awaiting outcome of police investigation, case proven, prosecution brought, not adult protection;

- whether the person is already known to any organisation or whether it is a new referral;

- how the profile of activity has changed from previous year; and

- service user/carer views on how policy has worked for them.

c) Processes, by Programme of Care, to include:

- number of current cases;

- number of cases closed;

- number of new referrals, identifying whether received in or out of hours;

- number of consultations with designated officers
- number of initial assessments/screenings;
- number of strategy discussions;
- number of case discussions, identifying participation by service user, family and carer;
- number of single agency investigations;
- number of joint protocol investigations;
- number of 'complex' investigations, including profile of activity undertaken, e.g. interviews of service users, staff, etc;
- number of investigations involving regulated establishments and agencies, by type, e.g. residential care homes, nursing homes, day care settings, domiciliary agencies, etc;
- number of care and protection plans;
- number of review meetings;
- number of other related professional meetings;
- number of repeat victims of abuse;
- proactive use of available legislative provision to safeguard, e.g. guardianship, powers of attorney, non-molestation orders, etc;
- percentage of successful prosecutions; and
- number and nature of interventions that prevented further abuse.

d) The partnership, to include:

- representation of member organisations and level of representation;
- attendances at meetings;
- representing organisation needs to LASP/NIASP;
- representing LASP/NIASP to organisation;
- contributing to annual report;
- single agency and interagency training activity; and

- initiatives to engage with service users, family, carers and wider public.

To minimise the reporting burden, NIASP and LASPs should have regard to other reporting arrangements within the organisation, for example in HSC Trusts, reports provided:

- in compliance with Circular: CC3/02 - Role and Responsibilities of Directors for the Care and Protection of Children;
- in relation to serious adverse incident reporting;
- in relation to the discharge of delegated statutory functions; and
- in relation to the monitoring of complaints and their resolution.

2. OUTCOMES AND PERFORMANCE INDICATORS

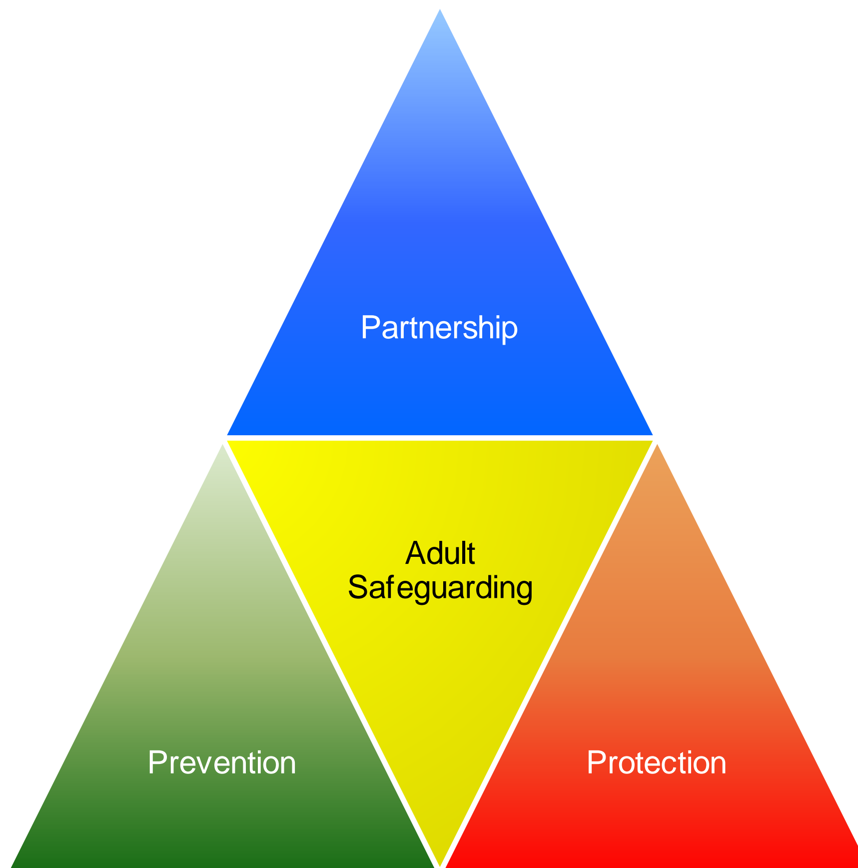
Outcomes are important not only in terms of the experience of the vulnerable adult but also in focusing organisations on their objectives and giving greater priority to safeguarding as core area of work for partner organisations and others. Outcomes and performance indicators may include:

- A demonstrated improvement in the quality of life for a person who had been 'safeguarded'.
- A reduction in incidents of abuse reported.
- Increased numbers of care and protection plans created and closed.
- Identification of under-reporting by programmes of care, teams and/or sectors and management/organisational action to address this.
- Support for "whistleblowers".
- Timeliness of organisation responses.
- A quantifiably better understanding of abuse issues in local communities.
- A quantifiably better understanding of abuse issues in constituent parts of partner organisations.
- People empowered and better able to protect themselves.
- People able to raise alerts and better awareness of safeguarding.
- More referrals, on the basis of robust and thorough investigative and decision-making processes, to the Independent Safeguarding Authority (ISA) in accordance with Safeguarding Vulnerable Groups requirements.

- Progress with regard to ISA-registration in accordance with the phasing rules determined by AccessNI.
- More referrals, on the basis of robust and thorough investigative and decision-making processes, to professional regulatory bodies.
- Improved service planning.
- Better partnership arrangements.
- Effective working with other strategic partnerships.
- More and better training.
- Continuous improvement in the quality of record keeping, personalisation of care and protection plans, communication of information and management of records.
- Initiatives which demonstrate a move from a reactive to a proactive safeguarding system.

Adult Safeguarding

Prevention and Protection in Partnership



Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Department of Justice
www.dojni.gov.uk

July 2015

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This policy document replaces Part 1 of ‘Safeguarding Vulnerable Adults: Regional Adult Protection Policy & Procedural Guidance’ September 2006.

Foreword by the Minister for Health, Social Services and Public Safety

As each of us goes through life we encounter many challenges. For the most part we are able to overcome them, equipped with our experiences, knowledge and with support from friends or family.

The challenges of dealing with abuse, exploitation or neglect should never arise, but they can and they do. The harm caused can have a devastating and long-lasting impact on victims, their families and carers.

Unfortunately, some adults are more at risk of harm than others. Safeguarding adults at risk is a priority for the Northern Ireland Executive and a Programme for Government commitment.

As far as possible, the aim of the policy is to prevent harm from occurring in the first place, to offer effective protection to those who are harmed and to provide them access to justice.

This policy makes it clear that we must not tolerate harm to adults caused by abuse, exploitation or neglect. It promotes partnership working for the purpose of safeguarding and seeks to keep adults safe wherever they live and whenever they access services.

It is acknowledged that safeguarding adults is complex and challenging and requires the careful exercise of professional judgement.

I want to acknowledge the very positive contribution to safeguarding delivered by a wide range of organisations across the statutory, voluntary, community, independent and faith sectors. I believe this adult safeguarding policy sets the way forward for all of us to work together to improve adult safeguarding practice.

I am confident that the implementation of this policy will prevent and reduce the risk of harm and improve safeguarding outcomes and I commend it to you.

Simon Hamilton MLA
Minister for Health, Social Services and Public Safety

Foreword by the Minister of Justice

As Ministers we are committed to ensuring that steps are taken to identify those who may be at risk of harm and, working together with others, improve the safeguards that are in place to protect them. Along with other institutions and bodies, we can provide increased protections and ensure that where a crime has been committed support services and access to justice are available. There are many areas in which adult safeguarding issues are of interest to the criminal justice sector, including a range of crime types such as domestic and sexual violence, hate crime and human trafficking among others. The publication of this adult safeguarding policy improves the safeguards that are in place and, in conjunction with a range of changes to the criminal justice system in recent years, means that more support is available for those who are unfortunate enough to become a victim of crime.

Recent improvements to the criminal justice system mean that those that are at risk of harm and the victim of crime are provided with additional support and entitlements. A victim and witness care unit has been established, providing victims of crime with a single point of contact for as much of the criminal justice system as possible. Registered intermediaries schemes are enabling those with significant communication difficulties to give evidence to the police and at court. In addition, a range of special measures continue to be available to enable vulnerable and intimidated victims and witnesses give their best evidence to both the police and at court. A Victim Charter has also been published, setting out the services to be provided to, and entitlements of, victims of crime as they move through the criminal justice process. This will be placed on a statutory footing later this year.

While it will never be possible to remove the potential for harm to occur, what we can do is ensure that there is effective support and protection for those individuals who have been subject to harm as they move through the criminal justice process. We can also provide increased access to justice for victims and their families when harm does occur and a crime has been committed. We want to place a greater focus on early intervention, protection and enabling those who suffer harm to have a greater voice within the justice process. The publication of the new adult safeguarding policy is a key development in this area.

David Ford MLA
Minister of Justice

1. INTRODUCTION

Everyone has a fundamental right to be safe. Whatever the cause, and wherever it occurs, harm caused to adults by abuse, exploitation or neglect is not acceptable. This policy emphasises that safeguarding is everyone's business and that as good citizens we should all strive to prevent harm to adults from abuse, exploitation or neglect.

The aim of this policy is to improve safeguarding arrangements for adults who are at risk of harm from abuse, exploitation or neglect. It has been jointly developed and published by the Department of Health, Social Services and Public Safety (DHSSPS) and the Department of Justice (DOJ) on behalf of the Northern Ireland Executive. It sets out how the Northern Ireland Executive intends adult safeguarding to be taken forward across all Government Departments, their agencies and in partnership with voluntary, community, independent and faith organisations. A key objective is to reduce the incidence of harm from abuse, exploitation or neglect of adults who are at risk in Northern Ireland; to provide them with effective support and, where necessary, protective responses and access to justice for victims and their families. The policy contributes to fulfilment of a Northern Ireland Executive Programme for Government commitment to deliver a package of measures to safeguard children and adults who may be at risk of harm and to promote a culture where safeguarding is everyone's business.

The policy requires a cross-departmental approach within government because the delivery of improved safeguarding outcomes is the business of us all, as individuals, as members of communities, as providers of services, and as Government Departments responsible for the delivery of strategies and policies which directly or indirectly impact on the lives of all adults including those at risk. The policy requires us to put all individuals who may be at risk at the centre, to listen to and respect their views, and to work in partnership with them and on an inter-agency basis to create a society which has a zero-tolerance of harm to the most vulnerable adults living in Northern Ireland.

Within this policy the term 'safeguarding' is used in its widest sense, that is, to encompass both activity which **prevents** harm from occurring in the first place and activity which **protects** adults at risk where harm has occurred or is likely to occur without intervention.

By introducing this policy we aim to raise awareness of harm to adults at risk, define what harm is, how it manifests itself and importantly how we respond to it. The act of protecting against harm is principally the responsibility of Health and Social Care Trusts (HSC Trusts), and the Police Service of Northern Ireland (PSNI) where a crime is alleged or suspected. However the responsibility of preventing harm is shared more widely. It extends beyond statutory providers of services to the voluntary and community sector, financial institutions, the legal profession, faith-based organisations, independent health and social care providers, carers and all citizens.

2. WHAT DO WE MEAN BY SAFEGUARDING

The majority of adults live full, independent lives free from harm caused by abuse, exploitation or neglect. However, there is a growing recognition that some adults, for a wide variety of reasons, may have been harmed or may be at risk of harm. The full extent of the incidents of harm caused to adults in Northern Ireland is not known but it is suspected to be significantly under-reported.

The language of adult safeguarding previously focused on protection and used the term 'vulnerable adult.' This was widely misinterpreted, often used out of context and, for some, the term implied weakness on the part of the adult, which many found unacceptable. This policy moves away from the concept of 'vulnerability' and towards establishing the concept of 'risk of harm' in adulthood. It places the responsibility for harm caused with those who perpetrate it. Harm resulting from abuse, exploitation or neglect violates the basic human rights of a person to be treated with respect and dignity, to have control over their life and property, and to live a life free from fear. Harm can have a devastating and long lasting impact on victims, their families and carers. It is the impact of an act, or omission of actions, on the individual that determines whether harm has occurred. Any action which causes harm may constitute a criminal offence and/or professional misconduct on the part of an employee.

Adult safeguarding is based on fundamental human rights and on respecting the rights of adults as individuals, treating all adults with dignity and respecting their right to choose. It involves empowering and enabling all adults, including those at risk of harm, to manage their own health and well-being and to keep themselves safe. It extends to intervening to protect where harm has occurred or is likely to occur and promoting access to justice. All adults at risk should be central to any actions and decisions affecting their lives.

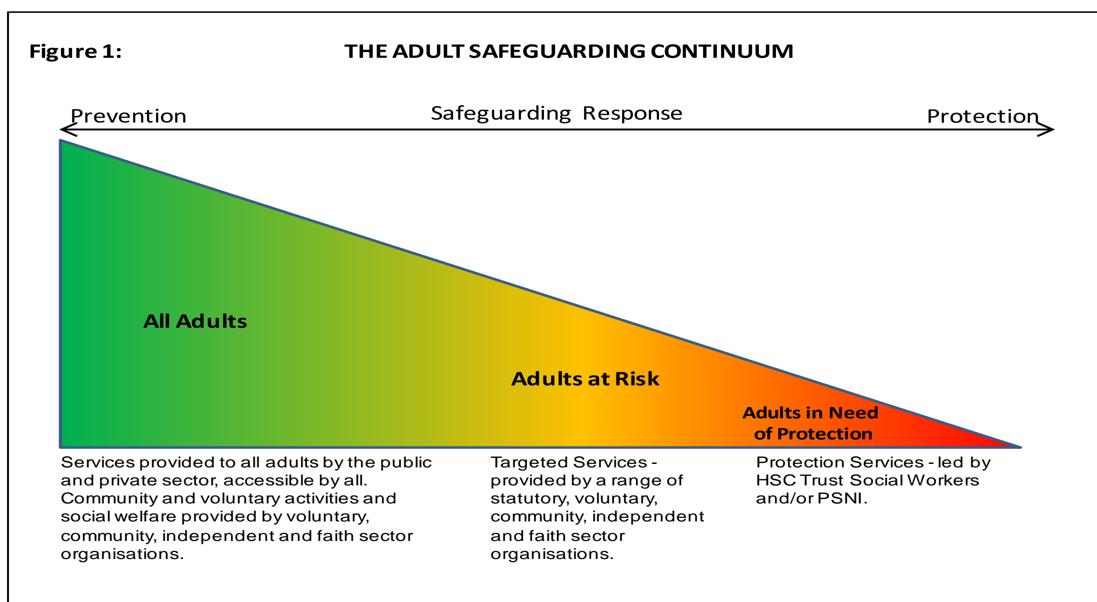
Safeguarding adults is complex and challenging. The focus of any intervention must be on promoting a proportionate, measured approach to balancing the risk of harm with respecting the adult's choices and preferred outcome for their own life circumstances. The right of a person with capacity to make decisions and remain in control of their life must be respected. Consideration of 'capacity' and 'consent' are central to adult safeguarding, for example, in determining the ability of an adult to make lifestyle choices, such as choosing to remain in a situation where they risk being harmed or where they choose to take risks. There should always be a presumption of capacity to make decisions unless there is evidence to suggest otherwise and current guidance for professionals in respect of determining capacity should be followed (see section 12). However there are also some circumstances when it may be necessary to consider the protection and rights of others, and overriding the withholding of consent may be necessary to ensure the protection of others.

Preventative Safeguarding includes a range of actions and measures such as practical help, care, support and interventions designed to promote the safety, well-being and rights of adults which reduce the likelihood of, or opportunities for, harm to occur. Effective preventative safeguarding requires partnership working, that is, individuals, professionals and agencies working together to recognise the potential for, and to prevent, harm. Prevention is therefore the responsibility of a wide range of

agencies, organisations and groups; indeed it is the responsibility and concern of us all as good citizens and neighbours. All professionals and service providers across the public, private, statutory, voluntary, community, independent, and faith sectors that come into contact with adults, including those who may be at risk of harm, must be alert to the individual's needs and any risks of harm to which they may be exposed. Prevention will strive towards early intervention to provide additional supports at all levels for adults whose personal characteristics or life circumstances may increase their exposure to harm.

Protective Safeguarding will be targeted at adults who are in need of protection, that is, when harm from abuse, exploitation or neglect is suspected, has occurred, or is likely to occur. The protection service is led by HSC Trusts and the PSNI. The input of other individuals, disciplines or agencies may be required, either in the course of an investigation of an allegation of harm or in the formulation and delivery of a care and protection plan.

Figure 1 shows the continuum of adult safeguarding activity from prevention to protection.



3. THE AIMS OF THIS POLICY

This policy aims to:

- promote zero-tolerance of harm to all adults from abuse, exploitation or neglect;

- influence the way society thinks about harm to adults resulting from abuse, exploitation or neglect by embedding a culture which recognises every adult's right to respect and dignity, honesty, humanity and compassion in every aspect of their life;

- prevent and reduce the risk of harm to adults, while supporting people's right to maintain control over their lives and make informed choices free from coercion;

- encourage organisations to work collaboratively across sectors and on an inter-agency and multi-disciplinary basis, to introduce a range of preventative measures to promote an individual's capacity to keep themselves safe and to prevent harm occurring;

- establish clear guidance for **reporting** concerns that an adult is, or may be, at risk of being harmed or in need of protection and how these will be **responded** to;

- promote access to justice for adults at risk who have been harmed as a result of abuse, exploitation or neglect;

- promote a continuous learning approach to adult safeguarding.

3.1. WHO IS THIS POLICY FOR?

The policy is intended to assist organisations, their staff and volunteers who are in contact with or providing services to adults across the statutory, voluntary, community, independent and faith sectors. While it is intended to be applied by managers, employees and volunteers in the course of the delivery of services and organisational activity, it can also be applied by individuals acting as responsible citizens at home and in local communities.

There is an expectation that all organisations and their staff will work in partnership as they apply this policy to their work with adults who may be at risk of harm or in need of protection. Appendix 1 lists some examples of organisations for whom this policy may have specific relevance, however this is not intended to be an exhaustive list.

4. UNDERPINNING PRINCIPLES

All Adult Safeguarding activity must be guided by five underpinning principles:

A Rights-Based Approach: To promote and respect an adult's right to be safe and secure; to freedom from harm and coercion; to equality of treatment; to the protection of the law; to privacy; to confidentiality; and freedom from discrimination.

Agencies and professionals who intervene in the lives of adults at risk should be guided by current best practice, the law and respect for rights set out in the European Convention on Human Rights[1] and enshrined in domestic law by the Human Rights Act 1998[2], acting in accordance with relevant UN and EU Conventions[3] on the Rights of Persons with Disabilities and the UN Principles for Older Person's 1991[4]. Any intervention to safeguard an adult at risk should be human rights compliant. It should be reasonable, justified, proportionate to the perceived level of risk and perceived impact of harm, carried out appropriately, and be the least restrictive of the individual's rights and freedoms. It cannot be arbitrary or unfair, and all adults should be offered the same services on an equal basis.

An Empowering Approach: To empower adults to make informed choices about their lives, to maximise their opportunities to participate in wider society, to keep themselves safe and free from harm and enabled to manage their own decisions in respect of exposure to risk.

For adults at risk of harm, empowerment is a process through which individuals are: enabled to recognise, avoid and stop harm; facilitated to make decisions based on informed choices including provision of support for those who lack capacity to make decisions; assisted to balance taking risks with quality of life decisions; supported and enabled to seek redress; and for adults who have been harmed, a process whereby they are enabled to recover their self-confidence and self-determination and make informed choices about how they wish to live their lives.

A Person-Centred Approach: To promote and facilitate full participation of adults in all decisions affecting their lives taking full account of their views, wishes and feelings and, where appropriate, the views of others who have an interest in his or her safety and well-being.

A person-centred approach is a way of working with an individual to identify how he or she wishes to live their life and what support they require. A person-centred approach to adult safeguarding demonstrates respect for the rights of the individual

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[1] *The European Convention on Human Rights* can be accessed at: http://www.echr.coe.int/Documents/Convention_ENG.pdf

[2] The *Human Rights Act 1998* can be accessed at: http://www.legislation.gov.uk/ukpga/1998/42/contents

[3] Relevant Conventions include The *UN Convention on the Rights of Persons with Disabilities*, the *UN Convention on the Elimination of Discrimination Against Women* (CEDAW), and the *EU Istanbul Convention* on domestic and sexual violence against women

[4] The *UN Principles for Older Person's (1991)* can be accessed at: http://www.un.org/documents/ga/res/46/a46r091.htm

at its core, in particular, respect for the right of the individual to make their own informed choices and decisions. A person-centred approach should result in the individual making informed choices about how he or she wants to live and about what services and supports will best assist them, with cognitive and communication support being provided where necessary. Where the person lacks capacity to make a decision, best interest decisions should be made by professionals which take all available information into account, including information about previously expressed preferences or choices made by the person being safeguarded.

A Consent-Driven Approach: To make a presumption that the adult has the ability to give or withhold consent; to make informed choices; to help inform choice through the provision of information, and the identification of options and alternatives; to have particular regard to the needs of individuals who require support with communication, advocacy or who lack the capacity to consent; and intervening in the life of an adult against his or her wishes only in particular circumstances, for very specific purposes and always in accordance with the law.

Consideration of consent is central to adult safeguarding in determining the ability of an adult at risk to make lifestyle choices, including choosing to remain in a situation where they risk being harmed; determining whether a particular act or transaction is harmful or consensual; and determining to what extent the adult can and should be asked to take decisions about how best to deal with a given safeguarding situation. For consent to be valid, the decision needs to be informed, made by an individual with capacity to make decisions and made free from coercion, constraint or undue influence. Each decision must be considered on its own merits as an adult may possess capacity to make some decisions but not others and/or the adult’s lack of capacity to make decisions may be temporary rather than permanent. A consent-driven approach to adult safeguarding will always involve making a presumption that the adult at the centre of a safeguarding decision or action has the capacity to give or withhold consent unless it is established otherwise (see section 12).

A Collaborative Approach: To acknowledge that adult safeguarding will be most effective when it has the full support of the wider public and of safeguarding partners across the statutory, voluntary, community, independent and faith sectors working together and is delivered in a way where roles, responsibilities and lines of accountability are clearly defined and understood. Working in partnership and a person-centred approach will work hand-in-hand.

Harm resulting from abuse, exploitation or neglect can be experienced by adults in a range of circumstances, regardless of gender, age, class or ethnicity. Adults who are at risk, suitably supported, must be central to the partnership, either as participants in preventative activities or protection intervention, or as contributors to decision-making in connection with the development of safeguarding policy, strategy and procedures. Where it is not possible for the adult at risk to contribute directly as participants or contributors, consideration must be given as to how they can be suitably supported to ensure that they are involved at an appropriate level. Successful adult safeguarding requires effective arrangements for all involved to work together. The strength of a collaborative approach will depend on the commitment and support from the highest level to safeguarding adults at the highest level.

5. KEY DEFINITIONS

The risk of harm occurs in all socio-economic, racial and ethnic groups, regardless of gender, age or sexual orientation. All adults at risk should be supported and empowered to minimise their own exposure to risk and to find their own balance between taking risks and making the most of the strengths in their own life circumstances.

The definition of an 'adult at risk of harm' takes account of a complex range of interconnected personal characteristics and/or life circumstances, which may increase exposure to harm either because a person may be unable to protect him/herself or their situation may provide opportunities for others to neglect, exploit or abuse them. It is not possible to definitively state when an adult is at risk of harm, as this will vary on a case by case basis. The following definition is intended to provide guidance as to when an adult may be at risk of harm, in order that further professional assessment can be sought.

An '**Adult at risk of harm'** is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) **personal characteristics**

AND/OR

b) **life circumstances**

Personal characteristics may include, but are not limited to, age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain. **Life circumstances** may include, but are not limited to, isolation, socio-economic factors and environmental living conditions.

An '**Adult in need of protection'** is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) **personal characteristics**

AND/OR

b) **life circumstances**

AND

c) who is **unable to protect** their own well-being, property, assets, rights or other interests;

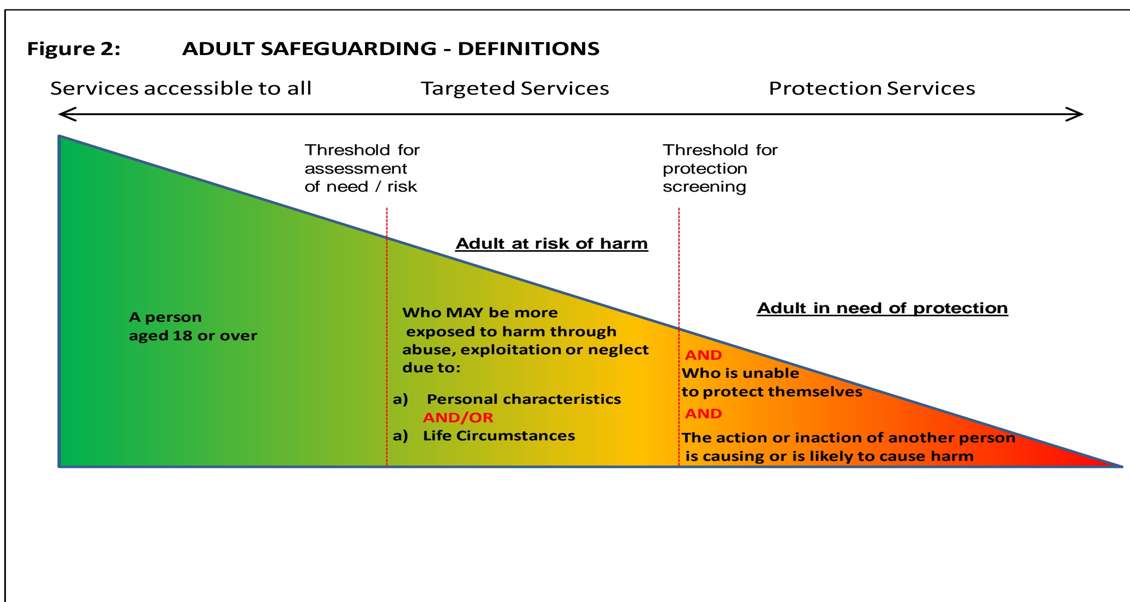
AND

d) where the **action or inaction of another person or persons** is causing, or is likely to cause, him/her to be harmed.

In order to meet the definition of an 'adult in need of protection' either (a) or (b) must be present, in addition to both elements (c), and (d).

The decision as to whether the definition of an 'adult in need of protection' is met will demand the careful exercise of professional judgement applied on a case by case basis. This will take into account all the available evidence, concerns, the impact of harm, degree of risk and other matters relating to the individual and his or her circumstances. The seriousness and the degree of risk of harm are key to determining the most appropriate response and establishing whether the threshold for protective intervention has been met.

Figure 2 below shows where the definitions sit on the continuum of adult safeguarding activity.



Harm is the impact on the victim of abuse, exploitation or neglect. It is the result of any action whether by commission or omission, deliberate, or as the result of a lack of knowledge or awareness which may result in the impairment of physical, intellectual, emotional, or mental health or well-being.

The full impact of harm is not always clear from the outset, or even at the time it is first reported. Consideration must be given not only to the immediate impact of harm and risk to the victim, but also the potential longer term impact and the risk of future harm.

Harmful conduct may constitute a criminal offence or professional misconduct.

A number of factors will influence the determination of the seriousness of harm. A single traumatic incident may cause harm or a number of 'small' incidents may accumulate into 'serious harm' against one individual, or reveal persistent or recurring harm perpetrated against many individuals.

The judgement of what constitutes '**serious harm'** is a complex one and demands careful application of professional judgement against a number of criteria. Assessments conducted by or on behalf of statutory HSC professionals (see section 10) should include consideration of the following:

a) the impact on the adult at risk;
b) the reactions, perceptions, wishes and feelings of the adult at risk;
c) the frailty or vulnerability of the adult at risk;
d) the ability of the adult at risk to consent and participate in the decision making process;
e) the illegality of the act(s);
f) the nature, degree and extent of harm;
g) the pattern of the harm-causing behaviour;
h) previous incidents, including any previous HSC Trust involvement
i) the level of threat to the adult at risk's right to independence;
j) the apparent intent of the alleged perpetrator and extent of premeditation;
k) the relationship between the alleged perpetrator and the adult at risk;
l) the context in which the alleged harm takes place;
m) the risk of repetition or escalation of harm involving increasingly serious acts relating to this individual or other adults at risk; and
n) the factors which mitigate the risk through service provision or wider arrangements.

There are no absolute criteria for judging when harm has become 'serious harm'; however this decision should include consideration of the degree, severity, duration and frequency of harm. The seriousness of harm depends on the impact experienced by the individual. Particularly careful consideration must be given to cases where the adult is unable to understand the impact harm is having on them. This will demand the application of professional judgement to consider all of the available evidence, the concerns and the wishes of the individual and to determine the seriousness of harm and the most appropriate intervention.

Abuse is 'a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to another individual or violates their human or civil rights'[5].

Abuse is the misuse of power and control that one person has over another. Abuse may be perpetrated by a wide range of people, including those who are usually physically and/or emotionally close to the individual and on whom the individual may depend and trust. This may include, but is not limited to, a partner, relative or other family member, a person entrusted to act on behalf of the adult in some aspect of their affairs, a service or care provider, a neighbour, a health or social care worker or professional, an employer, a volunteer or another service user. It may also be perpetrated by those who have no previous connection to the victim.

[5] Action on Elder Abuse: definition of abuse 1993 which can be accessed at: http://www.elderabuse.org.uk/Mainpages/Abuse/abuse.html. This was later adopted by the World Health Organisation - http://www.who.int/ageing/projects/elder_abuse/en/

The main forms of abuse are:

Physical abuse

Physical abuse is the use of physical force or mistreatment of one person by another which may or may not result in actual physical injury. This may include hitting, pushing, rough handling, exposure to heat or cold, force feeding, improper administration of medication, denial of treatment, misuse or illegal use of restraint and deprivation of liberty.

Sexual violence and abuse

Sexual abuse is any behaviour perceived to be of a sexual nature which is unwanted or takes place without consent or understanding[6]. Sexual violence and abuse can take many forms and may include non-contact sexual activities, such as indecent exposure, stalking, grooming, being made to look at or be involved in the production of sexually abusive material, or being made to watch sexual activities. It may involve physical contact, including but not limited to non-consensual penetrative sexual activities or non-penetrative sexual activities, such as intentional touching (known as groping). Sexual violence can be found across all sections of society, irrelevant of gender, age, ability, religion, race, ethnicity, personal circumstances, financial background or sexual orientation.

Psychological / emotional abuse

Psychological / emotional abuse is behaviour that is psychologically harmful or inflicts mental distress by threat, humiliation or other verbal/non-verbal conduct. This may include threats, humiliation or ridicule, provoking fear of violence, shouting, yelling and swearing, blaming, controlling, intimidation and coercion.

Financial abuse

Financial abuse is actual or attempted theft, fraud or burglary. It is the misappropriation or misuse of money, property, benefits, material goods or other asset transactions which the person did not or could not consent to, or which were invalidated by intimidation, coercion or deception. This may include exploitation, embezzlement, withholding pension or benefits or pressure exerted around wills, property or inheritance.

Institutional abuse

Institutional abuse is the mistreatment or neglect of an adult by a regime or individuals in settings which adults who may be at risk reside in or use. This can occur in any organisation, within and outside the HSC sector. Institutional abuse may occur when the routines, systems and regimes result in poor standards of care, poor practice and behaviours, inflexible regimes and rigid routines which violate the dignity and human rights of the adults and place them at risk of harm. Institutional abuse may occur within a culture that denies, restricts or curtails privacy, dignity, choice and independence. It involves the collective failure of a service provider or an organisation to provide safe and appropriate services, and includes a failure to ensure that the necessary preventative and/or protective measures are in place.

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[6] The definitions of 'sexual violence and abuse' and 'domestic violence and abuse' will be amended to reflect those included within their revised strategies once published.

Neglect occurs when a person deliberately withholds, or fails to provide, appropriate and adequate care and support which is required by another adult. It may be through a lack of knowledge or awareness, or through a failure to take reasonable action given the information and facts available to them at the time. It may include physical neglect to the extent that health or well-being is impaired, administering too much or too little medication, failure to provide access to appropriate health or social care, withholding the necessities of life, such as adequate nutrition, heating or clothing, or failure to intervene in situations that are dangerous to the person concerned or to others particularly when the person lacks the capacity to assess risk.

This policy does not include self harm or self neglect within the definition of an 'adult in need of protection'. Each case will require a professional Health and Social Care (HSC) assessment to determine the appropriate response and consider if any underlying factors require a protection response. For example self harm may be the manifestation of harm which has been perpetrated by a third party and which the adult feels unable to disclose.

Exploitation is the deliberate maltreatment, manipulation or abuse of power and control over another person; to take advantage of another person or situation usually, but not always, for personal gain from using them as a commodity. It may manifest itself in many forms including slavery, servitude, forced or compulsory labour, domestic violence and abuse, sexual violence and abuse, or human trafficking.

This list of types of harmful conduct is not exhaustive, nor listed here in any order of priority. There are other indicators which should not be ignored. It is also possible that if a person is being harmed in one way, he/ she may very well be experiencing harm in other ways.

5.1. Related Definitions

There are related definitions which interface with Adult Safeguarding, each of which have their own associated adult protection processes in place.

Domestic violence and abuse

Domestic violence and abuse is threatening behaviour, violence or abuse (psychological, physical, verbal, sexual, financial or emotional) inflicted on one person by another where they are or have been intimate partners or family members, irrespective of gender or sexual orientation. Domestic violence and abuse is essentially a pattern of behaviour which is characterised by the exercise of control and the misuse of power by one person over another. It is usually frequent and persistent. It can include violence by a son, daughter, mother, father, husband, wife, life partner or any other person who has a close relationship with the victim. It occurs right across society, regardless of age, gender, race, ethnic or religious group, sexual orientation, wealth, disability or geography.

Human trafficking

Human trafficking involves the acquisition and movement of people by improper means, such as force, threat or deception, for the purposes of exploiting them. It can take many forms, such as domestic servitude, forced criminality, forced labour, sexual exploitation and organ harvesting. Victims of human trafficking can come from all walks of life; they can be male or female, children or adults, and they may come

from migrant or indigenous communities.

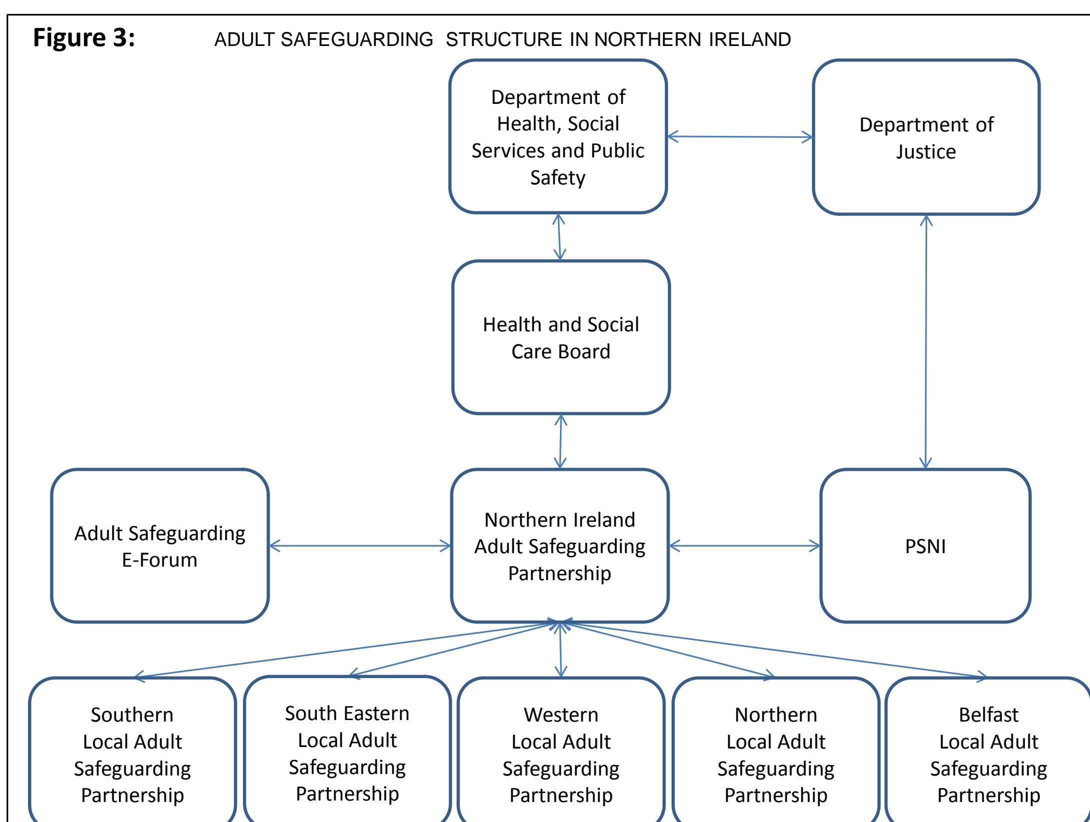
Hate crime

Hate crime is any incident which constitutes a criminal offence perceived by the victim or any other person as being motivated by prejudice, discrimination or hate towards a person's actual or perceived race, religious belief, sexual orientation, disability, political opinion or gender identity.

Victims of domestic violence and abuse, sexual violence and abuse, human trafficking and hate crime are regarded as adults in need of protection. There are specific strategies and mechanisms in place designed to meet the particular care and protection needs of these adults and to promote access to justice through the criminal justice system. It is essential that there is an interface between these existing justice led mechanisms and the HSC Trust adult protection arrangements described in this policy.

6. THE ADULT SAFEGUARDING INFRASTRUCTURE

The **Northern Ireland Adult Safeguarding Partnership (NIASP)** and five **Local Adult Safeguarding Partnerships (LASPs)** were established under the Adult Safeguarding in Northern Ireland, Regional and Local Partnership Arrangements (2010) [7]. They are collaborative partnerships with a responsibility for adult safeguarding in Northern Ireland. The partnerships are tasked by DHSSPS, with the support of the DOJ, with the delivery of improved adult safeguarding outcomes by way of a strategic plan[8], operational policies and procedures and effective practice, which will be developed and implemented in accordance with this policy. An outline of the structure is provided in Figure 3 below.



6.1. The Northern Ireland Adult Safeguarding Partnership (NIASP)

The NIASP is a regional collaborative body led by the Health and Social Care Board (HSCB). It is supported in its work by all its constituent members, who have made a commitment to adult safeguarding. The membership is drawn from the main statutory, voluntary, community, independent and faith organisations involved in adult safeguarding across the region and includes representation from service providers and users. The NIASP is responsible for promoting and supporting a co-ordinated

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[7] *Adult Safeguarding in Northern Ireland – New Regional and Local Partnership Arrangements – March 2010* can be accessed at: http://www.dhsspsni.gov.uk/asva- march 2010.pdf

[8] The *NIASP Strategic Plan* can be accessed at: http://www.hscboard.hscni.net/NIASP/Publications/NIASP%20-%20Strategic%20Plan%202013-2018.pdf

and multi-agency approach and for creating a culture of continuous improvement in adult safeguarding practice and service responses. The NIASP strategy promotes ownership of adult safeguarding issues within all partner organisations and across all professional groups and service areas.

The HSCB has lead responsibility for the effective working of the NIASP, which is chaired by the Director of Social Care and Children's Services, or a nominated deputy. The Chair ensures that safeguarding matters are brought to the attention of the appropriate Directors in the HSCB and the Public Health Agency (PHA). The Chair is accountable to the HSCB and is responsible for ensuring that there are robust governance arrangements in place and compliance with the HSCB's responsibility for Delegated Statutory Functions.

Each member representative is accountable to their employing organisation and should be of sufficient seniority to bring adult safeguarding issues to the attention of NIASP and to make decisions on behalf of their organisation. Each representative should ensure that any actions and decisions taken by the NIASP are shared and implemented as appropriate within their organisation.

6.2. Local Adult Safeguarding Partnerships (LASPs)

The five LASPs are located within, and accountable to, their respective HSC Trusts. Their role is to implement the NIASP Strategic Plan, policy and operational procedures locally. Each LASP has responsibility to promote all aspects of safeguarding activity in its area and to promote multi-disciplinary, multi-agency and interagency cooperation, including the sharing of learning and best practice. They will be visible within, and engage locally with, communities to raise the profile of adult safeguarding.

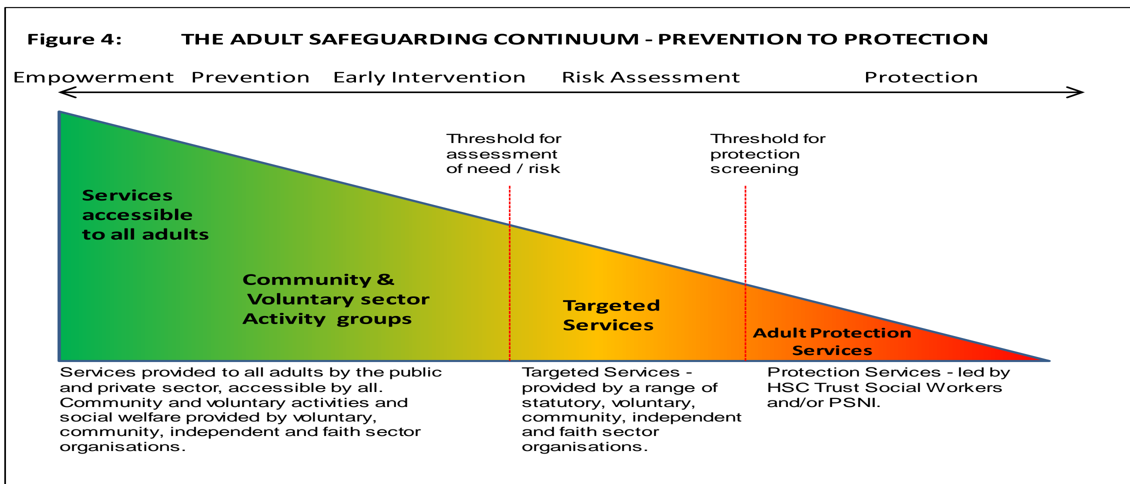
The LASP is chaired by the HSC Trust's Executive Director of Social Work or a senior designated nominee. It is responsible for ensuring that there are robust governance arrangements in place and ensuring compliance with the agreed statutory functions delegated by the HSCB.

Each partner organisation should be represented at a sufficiently senior level so that the LASP is effective in the implementation of guidance, policy and procedures at a local level, including engagement with service users, families, carers and the wider public. Each representative should be sufficiently senior to represent his/her organisation's views, to make decisions on its behalf and to ensure that safeguarding issues are dealt with in line with the organisation's established governance arrangements. Each representative should ensure that any actions and decisions taken by the LASP are shared and implemented as appropriate within their organisation.

7. THE CONTINUUM OF SAFEGUARDING – PREVENTION TO PROTECTION

Safeguarding is a broad continuum of activity. It ranges from the empowerment and strengthening of communities, through prevention and early intervention, to risk assessment and management, including investigation and protective intervention. At all stages along this continuum, safeguarding interventions will aim to provide appropriate information, supportive responses and services which become increasingly more targeted and specialist as the risk of harm increases. Presenting safeguarding activity in this way is intended to reflect the importance of prevention and early intervention, both as a means of improving the safety and quality of life and outcomes for all adults and reducing the risks of incidents of harm and need for more intrusive protection interventions. This is not intended to suggest that any stage or intervention along the continuum is mutually exclusive of the others. Throughout the continuum it is essential to recognise the importance of promoting empowerment and self-determination and the rights of all adults to make informed lifestyle choices.

Figure 4 below shows adult safeguarding interventions as a continuum of activity.



Local communities and services provided to the adult population are the starting point of the adult safeguarding continuum. Individuals will in the first instance be supported by their families and friends and by local community involvement and support. Using community development approaches, and working in partnership with local communities and organisations, we must build stronger, self-reliant communities and effective working relationships that promote people's rights, challenge inequalities and improve local support. Building safer communities involves helping adults to minimise their own exposure to the risk of harm from abuse, exploitation or neglect by empowering, equipping and enabling them to keep themselves safe, while at the same time enabling them to live their lives and pursue their interests to the fullest extent possible. Within communities there are a range of public and private services which will be available to and accessed by all adults.

This policy advocates that where there are potential interfaces with adults who may be at risk of harm, the organisations delivering such services should consider how adult safeguarding may be relevant to them and the actions they can take to prevent harm arising from abuse, exploitation or neglect to those using their services.

Within communities there are **recreational social, sporting or educational activities** available to all adults provided by a range of organisations across the statutory, voluntary, community, independent and faith sectors. Organisations providing these activities contribute to safeguarding adults by ensuring that these activities are delivered in a way which keeps adults safe. These organisations will need to assure themselves and everyone who comes in contact with them, that the organisation is committed to best safeguarding practice and to uphold the rights of all adults to live a life free from harm from abuse, exploitation and neglect. These organisations should have in place a culture of zero-tolerance of harm to adults which necessitates: the recognition of adults who may be at risk and the circumstances which may increase risk; knowing how adult abuse, exploitation or neglect manifests itself; and being willing to report safeguarding concerns. This extends to recognising and reporting harm experienced anywhere, including in the person's own home, in any care setting, in the community, and within organised community or voluntary activities (see section 8).

Voluntary, community, faith and independent service and/or activity providers are at the forefront of **preventative** safeguarding responses within the community. To be effective, preventative safeguarding requires everyone in society to work as partners, that is, individuals, families, carers, professionals and agencies working together to keep individuals safe and to prevent harm from abuse, exploitation or neglect.

One of the key ways of preventing escalation of the risk of harm is to intervene early. **Early intervention** is part of the safeguarding continuum and provides help and support to prevent problems reaching a point where a protection response becomes necessary.

In circumstances where community based activities can no longer meet the needs of an adult, or where there are emerging safeguarding concerns, contact should be made with the local HSC Trust for a professional **assessment of needs and/or risks**. All actions or interventions must be person centred and put the adult in need or at risk of harm at the centre of decision making.

If the concern relates to serious harm a referral may be made directly to the Adult Protection Gateway Service.

Very often it is the General Medical Practitioner (GP) who will be the first point of contact for adults and their families where an individual's needs are changing and they require further support. GPs and other allied health professionals, such as opticians, pharmacists, dentists or therapists, have a key role in the identification of risks of harm and ensuring appropriate referral to the HSC Trust for a further assessment of needs and/or risks.

Targeted services are services delivered specifically to 'adults who may be at risk' in order to meet assessed needs and/or address risks. The scale and intensity of service provision and intervention is likely to increase in proportion to the level of assessed need or risk. As the level of need or risk increases HSC Trusts may need to take action to prevent or manage any identified need or risk of harm, through provision of a service such as domiciliary based care, supported living, residential or nursing care. Targeted services will normally be delivered by, commissioned or contracted by, HSC Trusts. However voluntary, community, independent and faith

sector organisations may provide services targeted specifically at groups of adults at risk for recreational, social, sporting or educational purposes.

Targeted services include all services which fall under the definition of Regulated Activity contained within Schedule 2 of the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007[9]. This includes all health and social care services, whether delivered by statutory or independent providers, such as hospitals and GPs.

Many adults at risk will spend most of their time where they live, particularly those adults with restricted mobility and/or limited capacity to make decisions. These people may be more heavily dependent upon targeted services and the support of others, and their level of risk may increase as they spend much of their time in their home, often alone, or with the same people surrounding them, and with greater dependency on individuals or carers.

All targeted service providers, must be zero-tolerant of harm. There is an expectation that providers of targeted services will have robust governance and safeguarding procedures in place within their organisations to ensure that care is delivered in a way which instils confidence amongst those who use the service, staff, management, regulators and the public.

There is an expectation that commissioners of services will require, by way of service level agreements or contracts, the providers of targeted services to have robust governance and safeguarding regimes in place. There is an expectation that as employers, both service providers and commissioners must also ensure their organisations promote zero-tolerance of harm to adults within the workplace.

As the risk of harm increases, the safeguarding response required to mitigate it also increases. At the higher end of the safeguarding continuum is the **Adult Protection Gateway Service**. This service is provided for 'adults in need of protection', that is, those adults for who harm from abuse, exploitation or neglect, is a reality either because it has already occurred or, without intervention, is at serious risk of occurring. Protection interventions are led by social workers within the HSC Trusts and/or PSNI officers; the latter primarily where a crime or criminal act is alleged or suspected. These lead agencies will engage with the adult in need of protection in the first instance. They will also require information, action and support from other disciplines, agencies and organisations to assist with an adult protection or criminal investigation, or to contribute to the development and delivery of a care and protection plan for an adult in need of protection.

[9] The SVG Order can be accessed at: http://www.legislation.gov.uk/nisi/2007/1351/contents

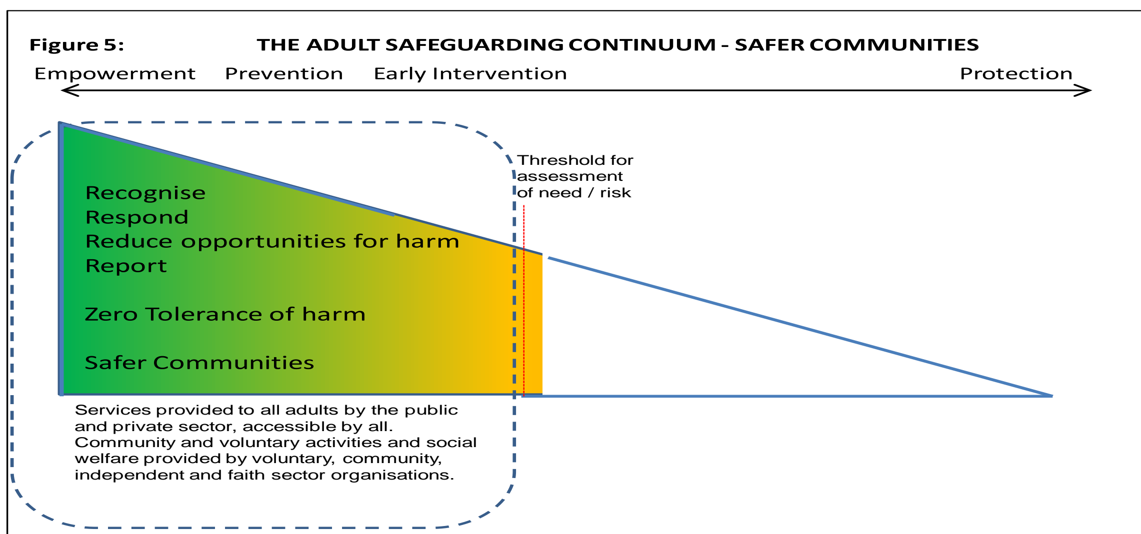
8. PREVENTION – PROMOTING SAFER COMMUNITIES AND SAFER ORGANISATIONS

The prevention of harm requires the promotion and creation of:

- **safer communities**, that is, safe places for all adults to live in, including those who may be at risk; and
- **safer organisations**, that is, safe places where all adults, including those who may be at risk, access and receive services or participate in organised activities.

Whether living in communities or working or volunteering in organisations, each of us needs to be zero-tolerant of potentially harmful behaviours against others, and when we suspect something is wrong, to report it (see section 10).

Figure 5 shows where safer communities sit on the Adult Safeguarding continuum.



8.1. Safer Communities

A key objective of this policy is to promote safer communities for adults to live in and safer organisations for them to be actively part of. The more socially isolated people are the greater the risk of harm arising from abuse, exploitation or neglect. The creation of safer communities for all adults is the responsibility of central and local government; of statutory sector service providers; and of voluntary, community, independent and faith sector providers. Local communities, neighbours and citizens also have a key role to play.

Empowerment is key to the promotion of safer communities and the prevention of harm. We should seek to connect people with the resources, activities and services that promote involvement and minimise opportunities for people to cause harm to others. Communities should aim to create opportunities to encourage and empower people to participate as fully as possible in their communities and broader society. Safer communities can play a vital signposting role in connecting people with local resources and supports that enable them to resolve their own problems and challenges.

There are a number of strands to the creation of safer communities that will greatly contribute to the prevention of harm.

Effective Health and Social Care Policies and Strategies

Being fit and well means people are better placed to ensure their personal safety. Initiatives which:

- aim to prevent slips, trips and falls;
- promote healthy eating, exercise and the sensible use of alcohol;
- ensure good dental and eye care;
- promote personal resilience, self awareness and independence;
- encourage and assist people where necessary to feel safe in their own home

all contribute to assisting people to be better able to address their personal well-being and safety. This requires effective health and social care planning and implementation, robust public health strategies and responses, and commissioning and delivery underpinned by standards frameworks[10] which set out the care that patients, clients, their carers and wider family can expect to receive.

Effective Community Safety Policies and Strategies

People who feel safe in their homes and community are more likely to feel in control of their lives and to take positive steps to ensure their personal safety. A number of types of crime – such as doorstep crime; distraction burglaries; bogus callers; rogue traders; cold callers and cyber crime are of particular concern with regard to adults at risk in our communities. The work of voluntary and community groups is critical to help adults who may be at risk to live safer lives and minimise their exposure to risk of harm through the promotion of local initiatives to provide information and support.

The 'Building Safer, Shared and Confident Communities – A Community Safety Strategy for Northern Ireland 2012-2017'[11] contains commitments to reduce fear of crime and help people to feel safer through regional and local programmes to increase trust and confidence. Through engagement with the voluntary and community sector, the strategy aims to:

- improve understanding of fear of crime and deliver tailored projects to reduce fear;
- promote intergenerational projects to bring old and young together to increase confidence;
- promote positive perceptions of young people; and
- engage with the media on reporting of crime and anti-social behaviour and its impact on fear and confidence.

The Policing and Community Safety Partnerships (PCSPs)[12] which operate in each council area are central to the delivery of safer communities. Each PCSP works with its local community to identify and address issues of concern in the local area and

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[10] Frameworks for Mental Health and Wellbeing, Learning Disability and Older People's Health and Wellbeing can be accessed at: http://www.dhsspsni.gov.uk/mhsf_final_pdf.pdf
http://www.dhsspsni.gov.uk/learning_disability_service_framework_june_2013.pdf
http://www.dhsspsni.gov.uk/service_framework_for_older_people-2.pdf

[11] http://www.dojni.gov.uk/community-safety-strategy-2012-2017.htm

[12] Further information on PCSPs can be obtained from www.pcsps.org

PCSP Policing Committees work with local PSNI to develop local policing plans and monitor their performance in enhancing community safety in their area. They also work to secure the co-operation of the public to prevent crime and enhance community safety.

Effective Awareness of Adult Harm and Abuse and Responsibility to Report

Adult abuse is underreported. People may not report their concerns for a number of reasons, including not recognising it for what it is or fear of 'getting it wrong'. It is a reality that the adult who is at risk is often dependent on the person whose behaviour is, either intentionally or unintentionally, causing the harm.

Public awareness campaigns and education programmes can help the public to recognise that adult harm and abuse is unacceptable in a civilised society and encourages the reporting of concerns to the HSC Trust and the Adult Protection Gateway Service. Education programmes in schools and colleges encompassing 'good citizenship' principles and social responsibilities can help begin the shift towards a society which is zero-tolerant of adult harm.

Many public and private service providers within the community are well placed to identify early indications that an adult may be at risk, for example banks or legal services such as solicitors. Providers of services who are in a position of trust, in particular GPs and providers of primary care services, will have access to information regarding adults which may suggest they are at risk of harm. Service providers should be aware of the signs of harm to adults within their respective sectors, and should ensure organisational procedures are in place to guide staff when concerns are identified. All those working to provide services to the community generally have a responsibility to refer concerns to their local HSC Trust, and to cooperate and share information where necessary with any adult safeguarding investigations.

8.2. Safer Organisations

The continuum of adult safeguarding outlines the wide range of organisations involved in people's lives, from the small community activity groups through to larger organisations and statutory services. All organisations should ensure that any service they deliver is underpinned by the principles of respect and treating others with dignity (see section 4). This is the first and crucial step to ensuring that services are high quality, that the focus is on the individual receiving the service which may help to provide support and that harm is prevented. Increasing levels of need and risk are likely to lead to greater targeting of service provision, which, in turn, requires a heightened awareness of risk of harm and more robust measures will be required to prevent harm.

Robust governance arrangements are key to an organisation's ability to keep adults safe from harm. A range of governance arrangements exist, which should not and cannot operate in isolation. No single governance measure will ensure the safety of adults at risk. Both internal governance and external measures are vital to ensure that safeguarding concerns are identified early and escalated to enable appropriate action to be taken. Governance arrangements must be brought together to provide a level of assurance to managers and leaders that the organisation is doing all it can to keep adults in receipt of its services safe from harm.

Each organisation will have its own internal governance arrangements depending on the size of the organisation and the nature of its activities. The governance arrangements should be proportionately robust to enable managers at all levels, including the Chief Executive and Board members where applicable, to assure themselves that the organisation is delivering a safe, high quality service to all, and that it is effectively adhering to the adult safeguarding expectations appropriate to the organisation.

Senior managers should create a culture where staff and volunteers feel that their role and contribution is valued and that they are empowered, and supported in decision making by line managers. Senior management must ensure good governance is cascaded throughout the organisation. Line managers should ensure decisions taken by their staff which relate to adult safeguarding are consistent with organisational safeguarding policies.

Where an organisation permits, by way of contracts or otherwise, the use of its facilities or services by third parties to provide services or activities to adults, assurances should be sought from the third party that it is adhering to the appropriate level of governance as described below.

8.3. Minimum Safeguarding Expectations

At a minimum, any public service, voluntary, community, independent or faith organisation providing recreational social, sporting or educational activities or services will be expected to safeguard adults who may be at risk by:

- **recognising** that adult harm is wrong and that it should not be tolerated;
- **being aware** of the signs of harm from abuse, exploitation and neglect;
- **reducing opportunities for harm** from abuse, exploitation and neglect to occur; and
- **knowing how and when to report** safeguarding concerns to HSC Trusts or the PSNI.

8.4. Internal Governance – Policy and Procedures

The following policies and procedures are the building blocks of good governance that contribute to safe high quality care and they should be robustly implemented by any organisation.

These are essential for any organisation delivering, commissioned or contracted to deliver targeted services.

- Robust selection and recruitment procedures;
- Effective management, support, supervision and training of staff;
- Procedures for responding to, recording and reporting safeguarding concerns in a timely manner to the HSC Trusts;
- Procedures for cooperating within the organisation and with others as required to address safeguarding concerns;
- Procedures for assessing and managing risks;
- Management of reporting and escalating untoward/adverse incidents;

- Procedures for managing comments, complaints and suggestions;
- Procedures on the management of records, confidentiality, and the sharing of information, (see section 14);
- A written code of behaviour/conduct;
- A disciplinary policy, including referral to regulatory bodies where relevant; and
- A whistle-blowing policy.

Care and Service Standards

All providers of targeted services are required to have in place the above governance arrangements and, depending on the nature and level of the service delivered, providers may also be required to ensure compliance with care and/or service standards and regulations against which they will be inspected or audited. Where there are breaches in compliance with standards or regulations and the quality of care or the safety of service users is compromised, the role of inspection and that of the relevant regulator is critical in addressing the safeguarding concern and the prevention of harm.

All organisations providing targeted services to adults who may be at risk must have the above governance arrangements in place, supported by the implementation of an adult safeguarding policy.

Adult Safeguarding Policy

The **Adult Safeguarding Policy** will clearly demonstrate the organisation's commitment to a zero tolerance of adult harm. The policy must be owned and supported by senior management and be accessible to all within the organisation.

A key element of the adult safeguarding policy will be the nomination of **Adult Safeguarding Champions** (ASC)[13]. An ASC must be accessible to all service areas in the organisation as a source of advice and guidance. The nominated ASCs should be senior people within the organisation, suitably trained, experienced and skilled to carry out the role (see section 15).

The role of the **Adult Safeguarding Champion** is:

- to provide information and support for staff on adult safeguarding within the organisation;
- to ensure that the organisation's adult safeguarding policy is disseminated and support implementation throughout the organisation;
- to advise within the organisation regarding adult safeguarding training needs;
- to provide advice to staff or volunteers who have concerns about the signs of harm, and ensure reporting to HSC Trusts where there is a safeguarding concern (see section 10);
- to support staff to ensure that any actions take account of what the adult wishes to achieve – this should not prevent information about any risk of

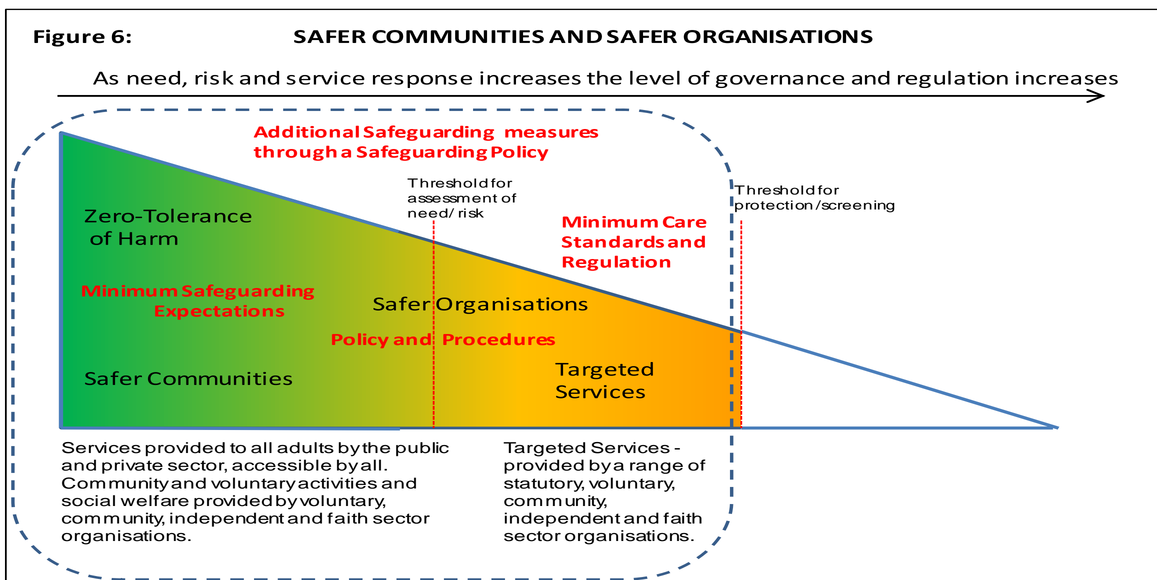
[13] The term Adult Safeguarding Champion is intended to encompass the roles of the 'Nominated Manager' referred to in the Volunteer Now Standards and Guidance document 'Safeguarding Vulnerable Adults – a Shared Responsibility' and the role of the 'Alerting Manager' in the NIASP Adult Safeguarding Strategic Plan 2013-2018.

serious harm being passed to the relevant HSC Trust Adult Protection Gateway Service for assessment and decision-making;

- to establish contact with the HSC Trust Designated Adult Protection Officer (DAPO) (see section 11), PSNI and other agencies as appropriate;
- to ensure accurate and up to date records are maintained detailing all decisions made, the reasons for those decisions and any actions taken;
- to compile and analyse records of reported concerns to determine whether a number of low-level concerns are accumulating to become significant; and make records available for inspection.

Where the ASC is not immediately available, this should not prevent action being taken or a referral being made to the HSC Trust in respect of any safeguarding concern.

Figure 6 below shows the relationship between safer communities, safer organisations and the increasing governance arrangements.



As the level of need or risk and service intervention increases, more robust governance measures and requirements will apply.

9. EXTERNAL GOVERNANCE

9.1. Commissioning/ Subcontracting Arrangements

Services for adults at risk may be commissioned or sub-contracted by a range of organisations across the statutory, voluntary, community, independent or faith sectors. This may include, for example, commissioning by the NIHE, local councils, PSNI and other justice organisations, or the HSC sector. Any organisation which commissions or sub-contracts provision of a service for adults at risk to another third party organisation retains responsibility and accountability for the quality of the provision of that service.

The HSCB, HSC Trusts and the PHA may commission or purchase health and social care services from third party providers, whether from the voluntary, community, independent or faith sectors. This will include GP and other primary or health care services, such as private hospitals, nursing or residential care, supported housing, day care or domiciliary care services.

It is critical that all commissioning or subcontracting organisations ensure that it is a condition of all contracts or service level agreements with service providers that there are robust governance arrangements in place within those provider organisations to ensure that adults at risk are safe from harm and receive a high quality service.

HSC Trusts must provide advice and guidance to adults who may be at risk who are commissioning their own care, for example those in receipt of direct payments or self directed support, outlining what they should expect from their service provider in terms of governance arrangements and good safeguarding practice.

Those who have a role in the management and monitoring of **contracts** have a responsibility:

- to specify and issue contracts for the purchase of services commissioned to address identified needs;
- to acquire and maintain a sufficient level of knowledge about adult safeguarding relevant to their role;
- to require that all services meet their safeguarding requirements described in this policy and other standards of quality set by the DHSSPS;
- to work closely with service providers to assist them to address ongoing concerns that may relate to contractual/service level agreement requirements;
- to monitor the quality of the performance of service providers and identify any deterioration in standards of care and risks this may present;
- to regularly audit the third party service provider to ensure the service is being delivered in accordance with the contract and this policy;
- to escalate any concerns about the provision of care to the care manager / key worker or senior management; and
- where requirements are not being met, to use appropriate reporting mechanisms to ensure adults at risk are kept safe, and where necessary impose appropriate sanctions.

All professionals with responsibility for carrying out the **care management** process and function must:

- ensure that needs and risks to the adult at risk are identified and assessed, taking account of their views and preferences;
- ensure that there is a personalised care plan detailing the needs of the adult and specifying how the service provided will safely meet the needs and mitigate any risks identified;
- ensure the care plan is being implemented as agreed by the service provider;
- ensure that the care plan is reviewed regularly, as specified in the Care Management Guidance, or more frequently as required in order to respond to changing needs and/or risks;
- ensure a safe and high quality service is provided, noting any patterns emerging which suggest that there may be a cause for concern and acting upon any such concerns;
- ensure that they are informed of any incidents, accidents or "near misses" in respect of the individuals for whom they have commissioned care;
- ensure that they are informed of any changes in financial circumstances that come to the attention of the HSC Trust;
- ensure that they are informed of any complaints made and action taken to address them;
- analyse trends to identify patterns which may indicate low-level concerns or poor quality care issues which may accumulate to indicate that there is a risk of harm; and
- escalate concerns which may indicate serious harm or risk of serious harm to an adult at risk (see section 10).

9.2. Professional Regulation

Regulatory bodies are responsible for establishing and operating statutory schemes of regulation underpinned by professional standards and Codes of Conduct relating to the conduct and practice of their respective professions. They maintain registers of workers who meet those standards and this information is publicly available. Within the health and social care sector for example, doctors, nurses, social workers and allied health professionals must register with their respective regulatory body before being able to practice. Where risks of harm to a service user are identified, all professionals must act in accordance with any professional Code of Conduct agreed with their regulatory body.

A person who is the subject of an investigation by their regulatory body may also be under investigation in respect of an adult protection investigation. Where both investigations run in parallel, the adult protection investigation must take precedence to ensure that the rights and safeguarding needs of adults at risk are being protected and the integrity of any criminal investigation is maintained.

9.3. Legal Requirements

Where there are statutory requirements linked to safeguarding or quality of service provision, all organisations will need to be assured that they are fully compliant with the requirements of the law.

Of particular relevance to adult safeguarding is the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007, which seeks to protect children and vulnerable adults from harm caused by those who work closely with them. Schedule 2 of this Order contains a definition of Regulated Activity, and anyone engaging in Regulated Activity should have their suitability checked through AccessNI prior to employment.

The **Disclosure and Barring Service**[14] (DBS) is responsible for maintaining the list of individuals barred from engaging in Regulated Activity with children and vulnerable adults across England, Wales and Northern Ireland. A regulated activity provider must refer anyone to the DBS who has harmed or poses a risk of harm to a child or a 'vulnerable adult' and who has been removed from working (paid or unpaid) in regulated activity, or would have been removed had they not left. The DBS will decide whether the person should be barred from working in regulated activity with children, or adults, or both.

It is an offence to knowingly engage a barred person in regulated activity and it is an offence to engage or offer to engage in regulated activity if you are barred.

Within the health and social care sector, HSC Trusts, voluntary, community, independent and faith sector providers must be assured that they are fully compliant with the duty of quality imposed on them by the Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003[15] and the Regulations made under that Order.

9.4. Regulation

There is a broad range of regulators, auditors and inspectorates which are relevant to adult safeguarding. Each has a specific role in measuring and ensuring that organisations comply with their own particular service or quality standards and the regulatory framework within which they operate.

Regulation, inspection and audit should make clear the expectation that service providers must meet the relevant quality standards, detect failings in provision of care or services early, and take appropriate action when sub-standard care is found.

Regulation needs to be responsive and proportionate, with the aim of ensuring public confidence in the services provided. This can only be achieved by a highly coordinated, integrated and expert regulatory system employing intelligent and thoughtful inspection. It will require the ability to apply both qualitative and quantitative judgement and to take effective enforcement action when necessary.

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[14] Information on the Disclosure and Barring Service can be accessed at: http://www.nidirect.gov.uk/disclosure-and-barring-protecting-children-and-vulnerable-adults

[15] The 2003 Order can be accessed at: http://www.legislation.gov.uk/nisi/2003/431/contents

The Role of Regulation and Quality Improvement Authority (RQIA)

The RQIA is the independent regulator of the health and social care sector and has an important role in promoting continuous improvement in the quality and safety of care delivered across the range of health and personal social services. RQIA registers and inspects a range of services described in the Health and Person Social Services (Quality, Improvement and Regulation) Order (Northern Ireland) 2003. These services are subject to regulation and are provided by both the statutory and independent sectors. RQIA's regulatory function operates within a framework of regulations and standards produced by DHSSPS.

RQIA inspections and reviews are conducted across a range of HSC settings in the statutory, independent and voluntary sectors. RQIA has a specific role in inspecting mental health and learning disability hospital wards. RQIA, through its inspections and reviews, makes an independent assessment of the safety, quality and availability of health and social care services. Within the regulated care sector, inspections may be announced or unannounced, and examine compliance with regulations and minimum standards in the areas of care, medicines management, estates and finance. Other inspections or reviews can be commissioned and conducted across a range of health and personal social services. Where the service inspected is not meeting the required quality standards, or where compliance issues or concerns are identified, there are a range of robust sanctions and powers available to RQIA.

The RQIA has a key preventative role in adult safeguarding practice. As the independent regulator, RQIA has both a responsibility and the authority to ensure that safety and quality of care concerns which put service users at risk are addressed in the services which they inspect. The RQIA also has a key role in service improvement with the aim of encouraging improvement in the quality of the services they inspect and securing public confidence in the provision of those services by keeping the Department of Health, Social Services and Public Safety informed of their availability and their quality.

Governance information is essential to RQIA in the conduct of its inspections and reviews. It assists with the assessment of the service with specific regard to safeguarding performance. There are core governance elements which should be included in all inspections conducted within regulated services. These are the number, nature and outcome of:

- complaints made;
- safeguarding concerns raised with the Adult Safeguarding Champions;
- notifiable incidents or accidents which occurred as appropriate to that service setting; and
- any disciplinary procedures conducted.

Information collected during inspections and other information which may come to the attention of the RQIA, from a range of sources, including statutory notifications, must be collated and analysed to ensure trends are identified. In particular, information on complaints, notifiable incidents and accidents should be triangulated as these are key indicators of risk to service users. Inspectors should be aware that a number of low-level concerns could suggest patterns or trends which accumulate to a risk of serious harm to one or more adults.

Enforcement action is an essential element of the responsibilities of RQIA. There is a range of enforcement options which RQIA can use to ensure compliance with regulations and minimum standards, to effect improvements and to afford protection to service users. In most circumstances, and where appropriate, RQIA will make recommendations and requirements for quality improvement through regulation and inspection activity. Where a service is identified as being at risk of failing to meet minimum standards and/or comply with regulations, RQIA will consider the various options to enable the registered establishment or agency to make the necessary improvements. RQIA will normally adopt a stepped approach to enforcement. However, this would not rule out the option of moving directly to legal action, including prosecution, if the circumstances require. RQIA may increase inspection activity to monitor compliance and ensure that the necessary improvements are being made. RQIA may escalate enforcement actions at any time, proportionately and in relation to the level of risk to service users and the seriousness of any breach of regulation. RQIA will follow up enforcement action to ensure that quality improvements are achieved. In certain circumstances, where there is deemed to be a risk of serious harm to service users, RQIA may take urgent action. Such circumstances include, but are not exclusive to, those falling under the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009). This may involve, where necessary, using its powers to cancel registration and/or to seek the urgent closure of a registered service. RQIA publishes its enforcement policy and procedures online, along with copies of its inspection reports[16].

The RQIA will notify any serious concerns in relation to the quality of service provision or risk of harm to an individual/s to the relevant HSC Trust or the PSNI, and will be a key partner contributing to investigations with the other agencies to protect adults at risk who are in receipt of a regulated service.

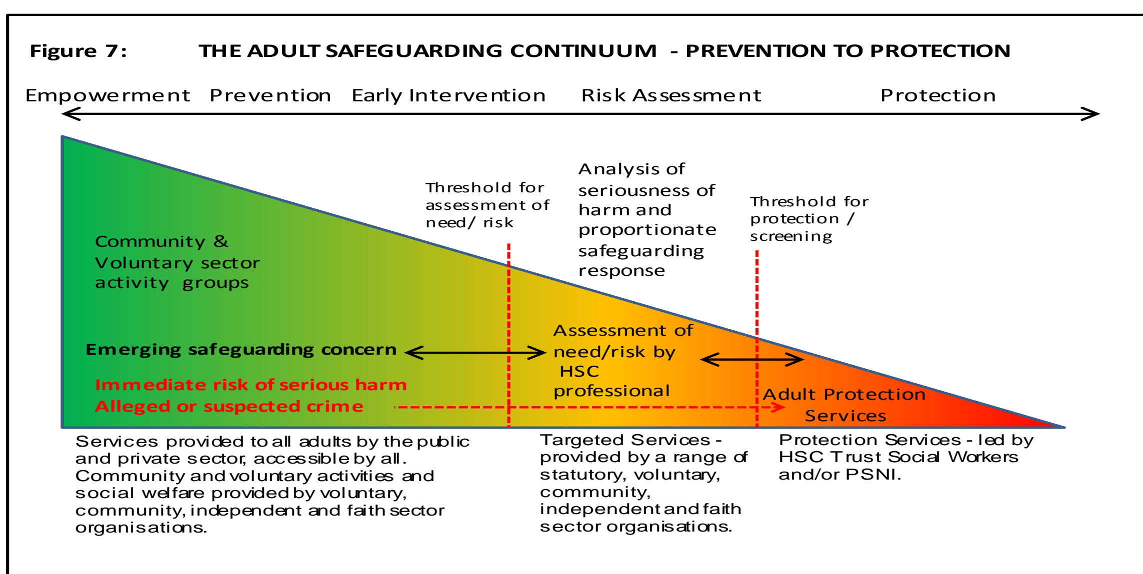
[16] RQIA publications are available on www.rqia.org.uk

10. REFERRAL PATHWAY FOR SAFEGUARDING CONCERNS

If there is a clear and immediate risk of harm or a crime is alleged or suspected, the matter should be referred directly to the PSNI or HSC Trust Adult Protection Gateway Service.

However in most circumstances there will be an emerging safeguarding concern which should normally be referred to the HSC Trust, for a professional assessment. It will be a matter for HSC professionals to judge whether the threshold for an adult protection intervention has been met, or whether alternative responses are more appropriate. Referrals can be made from any source.

Figure 7 shows the pathway for reporting emerging safeguarding concerns through targeted HSC services and if necessary to the HSC Trust adult protection service.



All HSC Trusts must have a single point of access for receipt of referrals regarding concerns about adults who may be at risk, and will promote and publicise contact arrangements within its area. HSC Trust arrangements must accommodate referrals which do not obviously fit existing Programme of Care structures, ensuring there are no safeguarding gaps.

10.1. Risk Assessment

When any risk of harm is identified, a risk assessment must be undertaken to establish the degree of risk of harm to that individual and to others. It is the responsibility of suitably qualified statutory HSC professionals to undertake such risk assessments once a concern has been raised. In certain circumstances HSC Trusts may ask another organisation to conduct risk assessments on its behalf.

HSC professionals are required to put the individual's needs and wishes at the heart of the risk assessment process, and to use their expert skills and professional judgement so that the most appropriate and preferred course of action or outcome is found for each individual.

Assessment is a process which focuses on the individual and their circumstances at the time, recognising that needs and risks can change over time. Assessment will analyse and be sensitive to the changing levels of need and risk faced by an individual. It may require specialist assessments or expert opinion to inform the evidence gathering. All information should be analysed to determine the nature and level of risk. The assessment will inform a proportionate response based on the views and wishes and the preferred outcomes of the individual.

In gathering information to inform the assessment, professionals should be aware that this may also be required as part of a criminal investigation. Therefore it is critical to ensure that any potential evidence that may be later required by the PSNI is not compromised.

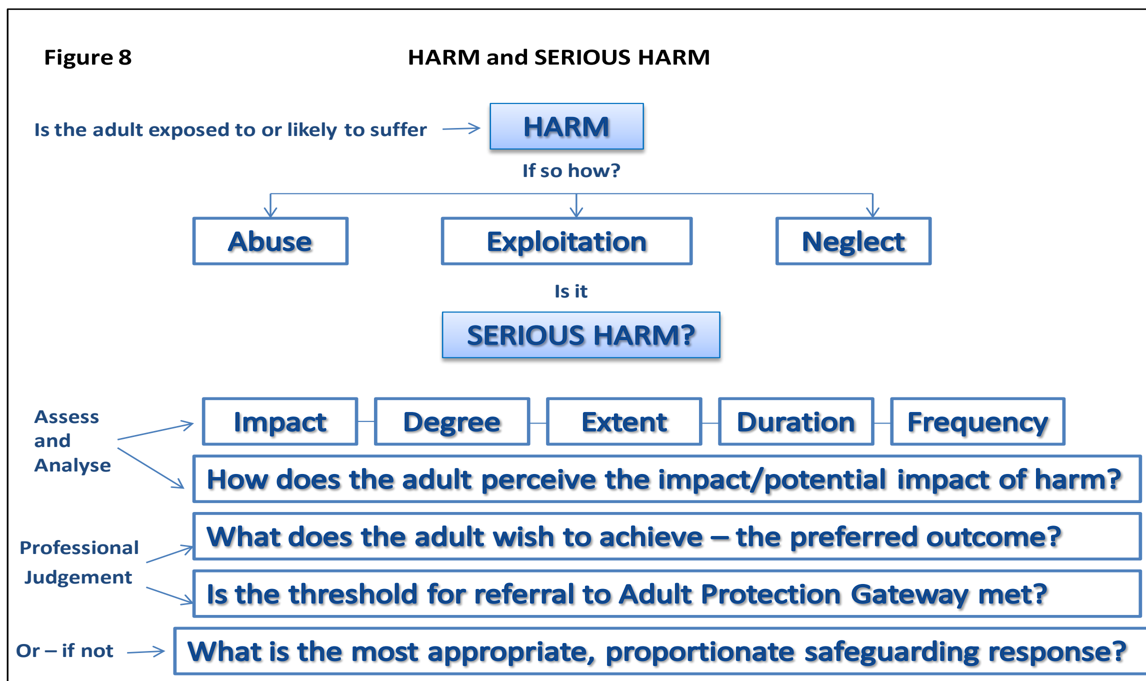
In making professional judgements, due regard should be given to the capacity of the adult to make informed choices, free from duress, pressure or undue influence and their capacity to make decisions to protect themselves from harm. All adults, including those at risk will always be assumed to have capacity to make decisions unless it has been determined otherwise (see section 12) and, ideally, a referral to the HSC Trust should be made with the adult's agreement and full participation. However, there may be circumstances in which the person concerned about an adult at risk may not be best placed to seek their consent to a referral being made, or the adult at risk is clearly stating that they do not want a referral to be made. Whilst the wishes of the adult should always be the paramount consideration, it is important to remember that there will be circumstances when other factors may be overriding, for example, where undue influence or coercion is suspected to have influenced the adult's decision or other people may be at risk. The inability to obtain an adult's consent in these circumstances should not prevent or delay concerns about that adult being reported to adult protection services. A balance must also be struck between an individual's human rights and the need to intervene to protect them from harming themselves or others.

Consideration should be given to the vulnerability of the alleged perpetrator. It is possible that a risk assessment may also be required for the perpetrator.

The analysis of risk will be central to decisions about future intervention. Any safeguarding intervention is not about being risk averse, nor simply about eliminating risk; adult safeguarding is about empowering and supporting people to make decisions that balance acceptable levels of risk in their lives. This may mean that individuals choose to live with risks or to take risks. The exercise of professional judgement in determining the level of risk of harm and whether a referral for an adult protection intervention is required is critical.

Where professionals have contact with an adult at risk they may have opportunities to identify risk of harm. Within the HSC sector this may be for example a GP, District Nurse, Social Worker or another Allied Health Professional, or may be within acute or hospital settings. Professionals must be alert to signs of harm and escalate their concerns to the Adult Protection Gateway Service with the local HSC Trust (see section 11).

Figure 8 illustrates the factors for consideration in determining whether harm has become 'serious harm'.



Where a risk assessment concludes that the adult is at risk of serious harm, or has experienced serious harm (see section 5), then consideration must be given to whether the threshold for referral to Adult Protection Gateway Service has been met.

10.2. Determining Whether the Thresholds for Referral to Adult Protection Gateway Service Are Met

In the majority of cases where serious harm has been identified, the thresholds for Adult Protection Gateway Service will be met. However it must be remembered that in some circumstances referral into the Adult Protection Gateway Service may not be the most appropriate response. This may include, for example, a peer on peer incident where capacity is an issue and alternative responses are more appropriate (see below). At all times the least intrusive and most effective response should guide the intervention. The following thresholds are intended as a guide.

Thresholds are not intended to be used as exclusion criteria, but should be used positively to assist professional judgements about making referrals into the HSC Trust Adult Protection Gateway Service, and, critically, to enable informed decisions in respect of the most appropriate or proportionate safeguarding response.

The threshold for referral to the HSC Trust Adult Protection Gateway Service is likely to be met if one or a number of the following characteristics are met:

- the perceptions of the adult(s) concerned and whether they perceive the impact of harm as serious;
- it has a clear and significant impact on the physical, sexual, psychological and/or financial health and well-being of the person affected;
- it has a clear and significant impact, or potential impact, on the health and

well-being of others;
- it involves serious or repeated acts of omission or neglect that compromise an adult's safety or well-being;
- it constitutes a potential criminal offence against the adult at risk;
- the action appears to have been committed with the deliberate and harmful intent of the perpetrator(s);
- it involves an abuse of trust by individuals in a position of power or authority; and
- it has previously been referred to a regulated service provider for action, and has not been sufficiently addressed.

If there is doubt about whether the threshold for Adult Protection has been reached, the concern should be discussed with the HSC Trust Adult Protection Gateway Service and a DAPO will advise whether the matter meets the threshold for referral into the Adult Protection Gateway Service.

Where a criminal act is either alleged or suspected, a report must be made to the PSNI.

10.3. A Determination that the Threshold for Referral to Adult Protection Gateway Service is Not Met – Alternative Safeguarding Responses

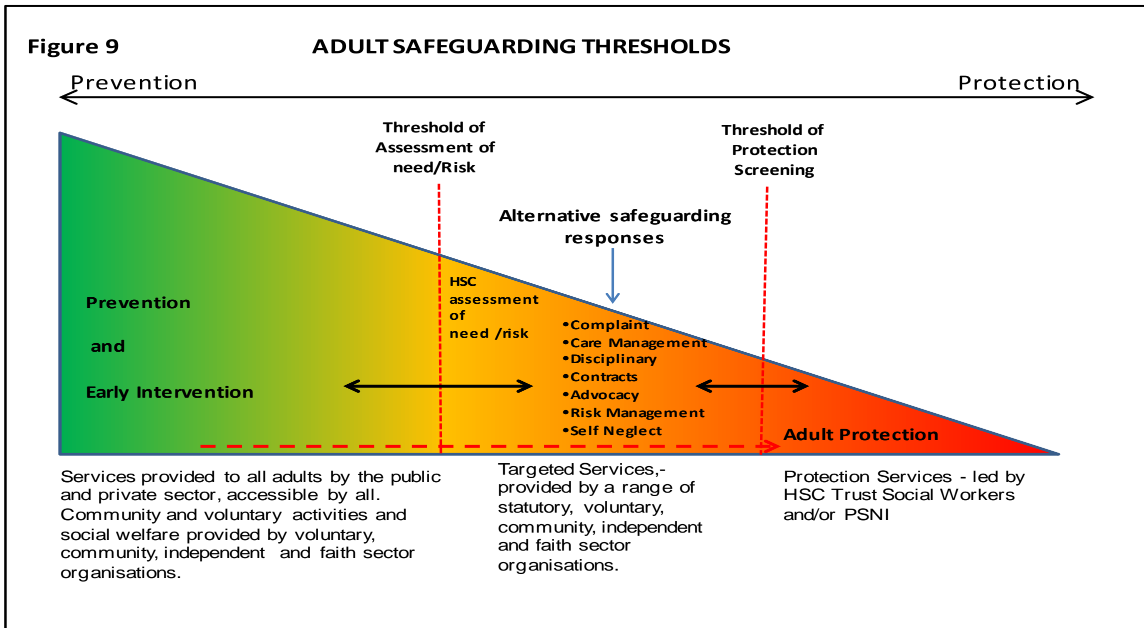
Where it is determined that the threshold for Adult Protection has not been met, other alternative courses of action should be explored with the adult. At all times the least intrusive and most effective response should be made. This is a matter for professional judgement, taking account of the individual circumstances and the wishes and views of the adult and may include:

a) escalation to the service manager to address any issues about the quality of service provision;
b) referral to the RQIA for action as the regulator in respect of quality of care concerns or where concerns have been raised and there has been a lack of action by the service provider;
c) referral to a care manager/key worker for re-assessment and review of service user/carer's needs, views and care plan, or where appropriate a mental capacity assessment;
d) action taken under complaints procedures;
e) action taken under human resources/disciplinary procedures and referral to professional bodies, statutory regulatory bodies and/or the Disclosure and Barring Service where appropriate;
f) referral to an advocacy service;
g) referral to another service;
h) a risk management intervention in relation to self neglect;
i) a strategy to manage risks within a complex group living environment and the management of challenging behaviour;
j) no further action required;

or a combination of two or more of the above.

Where an HSC Trust Adult Protection Gateway Service has agreed an alternative course of action, there must be mechanisms in place to ensure that those given lead responsibility to take certain actions report back to the DAPO on the outcome of the actions taken. All organisations involved in contributing to alternative courses of action will be expected to cooperate fully with HSC Trusts.

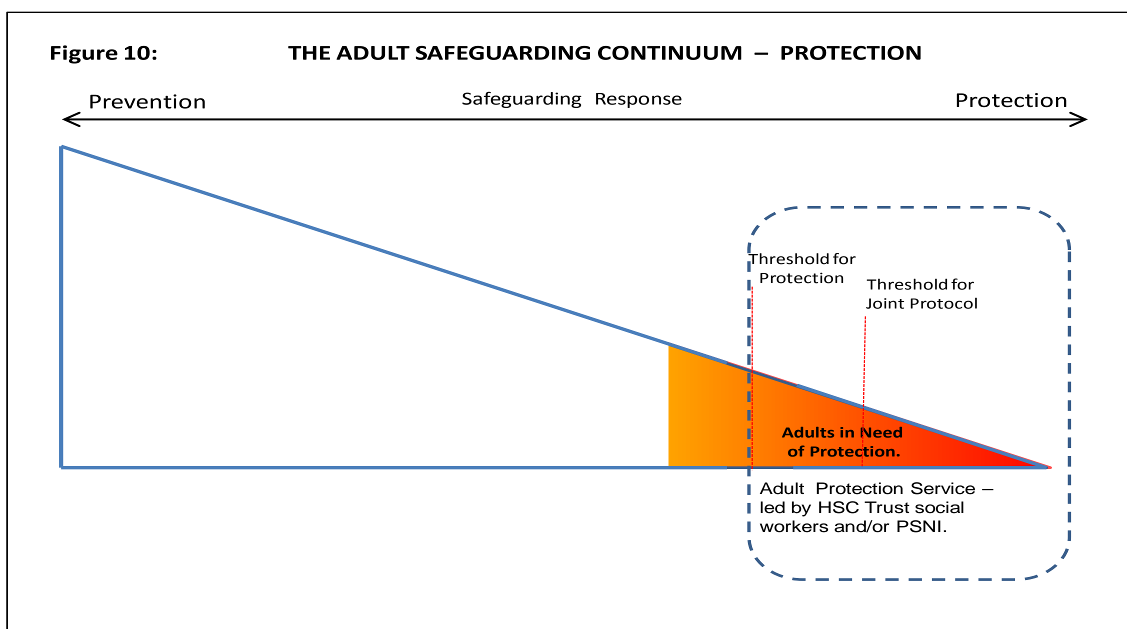
Figure 9 below shows where the thresholds sit in relation to the continuum of safeguarding activity.



Any safeguarding concerns relating to breaches of regulations or non-compliance with care or service standards are matters for the regulator, regardless of whether the threshold of serious harm has been reached. The HSC Trust should raise such concerns with the RQIA and will then co-ordinate an interagency response. The role of RQIA in inspection and regulation is outlined in section 9 and will be critical in the identification and prevention of safeguarding concerns or incidents in a proportionate manner to prevent unnecessary engagement of the Adult Protection Gateway Service.

11. ADULT PROTECTION SERVICES

Figure 10 shows the Adult Protection Service on the safeguarding continuum.



HSC Trusts and the PSNI are the lead agencies with responsibility for adult protection.

Each **HSC Trust** will have an Adult Protection Gateway Service which will receive adult protection referrals. Referrals outside normal working hours should be made to the Regional Emergency Social Work Service (RESWS). Referrals will be accepted from any source, irrespective of Programme of Care boundaries.

HSC Trusts will be the lead agency in terms of the co-ordination of joint Adult Protection responses. Within each HSC Trust, responsibility for the Adult Protection rests with the Executive Director of Social Work, and the lead profession within HSC Trusts is social work.

In circumstances where a crime is alleged or suspected, a referral to the **PSNI** should be made by telephoning 101, or in an emergency, 999. Both numbers are accessible on a 24 hour, 7 days per week basis. The PSNI will be the lead criminal investigative agency and will progress a criminal investigation where required.

The **PSNI** will be the lead criminal investigation agency and a report should be made to the PSNI where a crime is alleged or suspected. Within PSNI, responsibility for Adult Protection rests with the Chief Superintendent who has responsibility for the Public Protection Branch[17].

A Joint Protocol will guide interagency referral, consultation and information exchange and working arrangements and will provide clarity in respect of the roles of

[17] Responsibility for Adult Safeguarding within PSNI is subject to organisational change. Changes will be reflected within the policy once completed.

the PSNI and HSC Trusts in the delivery of the adult protection response. The Joint Protocol will outline when and how other agencies will be engaged for the purpose of an adult protection investigation and protection planning.

Regional adult protection procedures for HSC Trusts will be developed by the HSCB, endorsed by the NIASP and LASPs and implemented across the region to ensure that adult protection responses and practice are consistent across all HSC Trust areas. HSC Trusts will be responsible for implementing these procedures on behalf of the HSCB.

PSNI is guided by current the Association of Chief Police Officers (ACPO) guidance 'Safeguarding and Investigating the Abuse of Vulnerable Adults 2012' as well as established protocols such as Safeguarding Vulnerable Adults (Regional Adult Protection Policy and Procedural Guidance) 2006 and 'Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults' NIASP 2009. The Public Protection Branch (PPB) will be responsible for triaging reports under Joint Protocol arrangements. When a PPB passes the adult protection response to another branch of PSNI, the PPB will retain oversight and ensure ongoing engagement and communication with other partners under Joint Protocol.

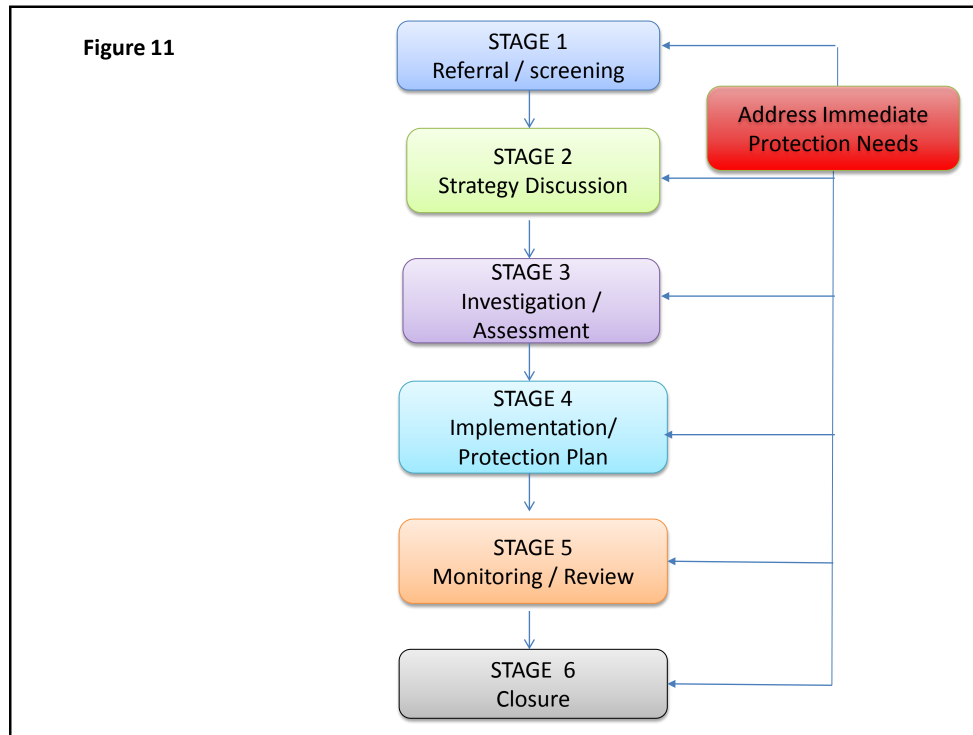
All operational adult safeguarding policies, procedures and protocols in support of this policy must be consistent with the underpinning principles contained in section 5 of this policy.

11.1. Adult Protection Process

Each adult protection intervention is likely to be unique and the response made must allow for flexibility and individualised decision-making. It is important that each adult protection intervention is conducted without undue delay, remains outcome focused, rather than process driven, and is subject to ongoing monitoring and review at an appropriately senior level. At all stages throughout the adult protection intervention, consideration should be given to whether the threshold for the Adult Protection Gateway Service continues to be met. Any action necessary to address immediate protection needs of the adult must be taken regardless of which stage of the process has been reached.

Each intervention will be made in accordance with an agreed process. A typical protection process is contained in figure 11 below encompassing 6 distinct stages. While presented in stages, the process is not intended to be linear in nature. It is possible that some stages will run in parallel and it may also require moving between stages in both directions. This policy does not advocate specific timescales for progressing through the stages of the protection process, because it is important that flexibility is maintained to allow for professional decision making. There can be complex issues to be managed such as fluctuating capacity to make decisions and complex investigations that may require interagency collaboration and consultation including cooperation with any PSNI investigations. Nonetheless, it is important that all adult protection interventions are progressed in a timely manner, and must not be allowed to drift unnecessarily.

Figure 11 shows the six stages of the Adult Protection Process.



At every stage the adult's human rights must be considered, and evidence of this recorded. The adult's rights, needs, views and wishes, should be central to the protection intervention to ensure that they receive the support needed to achieve an agreed outcome.

Processes and procedures in themselves will not protect, people and good practice will.

A **Designated Adult Protection Officer** (DAPO) will be responsible for the management of each referral received by a HSC Trust. DAPOs will be in place both within the Adult Protection Gateway Service, and within core services teams. Following initial screening by the Adult Protection Gateway Service, a DAPO in core services may be asked to manage the referral going forward.

Every DAPO must:

- be social work qualified;
- be working in a minimum of a band seven;
- have first line management responsibilities, or in a senior practitioner role;
- be suitably experienced; and
- have undertaken the necessary training (see section 15).

The role of the DAPO is to:

- make sure the needs, safety and wishes of the adult at risk are kept central to any actions and decisions taken;
- screen the referral;
- make contact with PSNI if a crime is alleged or suspected, or there is an

immediate risk of harm to an adult at risk;

- make key decisions including whether the threshold for protection intervention has been met;
- manage and coordinate the adult protection intervention;
- ensure that any risks to the adult(s) and others potentially at risk are assessed and agreed actions taken;
- analyse needs and risk assessments to determine the most appropriate course of action;
- inform and involve other agencies as necessary, and work with them to plan and carry out actions taken;
- be responsible for coordinating the sharing of information between agencies;
- ensure the support needs of the adult at risk and others affected are considered throughout;
- ensure appropriate documentation and records are fully completed, including records of all decisions taken;
- make sure the adult at risk and the referrer are given regular feedback, insofar as this is possible;
- analyse the adult safeguarding data within their service area and contribute to the governance arrangements as appropriate; and
- ensure that the connections are made with related interagency mechanisms such as:
    - Multi Agency Risk Assessment Conference (MARAC)
    - Domestic and sexual violence services
    - Public Protection Arrangements in Northern Ireland framework (PPANI)
    - Human trafficking procedures
    - Hate Crime Practical Action Scheme
    - The Office of Care and Protection (or equivalent)
    - Child Protection Gateway Service
    - Business Services Organisation Counter-Fraud Unit.

The DAPO may decide to close the adult protection process at any stage if:

- it is agreed that further investigation, assessment or intervention is not required to protect the adult at risk;
- the DAPO decides that an alternative safeguarding response is more appropriate, proportionate and effective to address the concern identified;
- a Protection Plan has been agreed and is in place and is effectively addressing the needs of and the risks to the adult; or
- the adult chooses to withdraw from the protection process.

Where the safeguarding concern relates to the quality of care provided to an adult in receipt of a regulated HSC service, the DAPO will engage the RQIA to ascertain whether the provider is in breach of regulation or minimum standards. The RQIA will act on all safeguarding concerns where there are breaches of standards or regulation and, where necessary, use their powers of improvement or sanction to ensure that the provider addresses any breach of the minimum standards to the satisfaction of RQIA.

The PSNI will be the lead agency when a criminal investigation is required, and any other related investigations or assessments must be coordinated with the PSNI.

Responsibility for coordinating, and communicating the outcome of, the criminal investigation lies with the Detective Inspector PPB. A criminal investigation will take precedence over any other adult safeguarding process. For example, a disciplinary process should not commence until after the conclusion of an adult protection criminal investigation by the PSNI, or following approval by PSNI.

11.2. Large Scale and/or Complex Investigations

A large-scale adult protection investigation may be initiated when a number of adults at risk have allegedly been abused or patterns or trends are emerging which suggest serious concerns about the quality of care, which put the safety of service users at risk.

This could include any of the following:

- multiple concerns within one service provider;
- one person is suspected of causing harm to multiple adults and/or in a number of settings;
- a group of individuals are alleged to be causing harm to one or more adults;
- where care arrangements are complicated by cross-boundary considerations.

A large-scale adult protection investigation is likely to involve a range of organisations, and potentially a number of individual adult protection interventions.

Complex (i.e. organised or multiple) abuse is defined as abuse involving one or more abusers and a number of related or non-related adults at risk. The abuser concerned may be acting with others to abuse adults at risk, may be acting in isolation, or may be using an institutional framework or position of authority to access adults at risk for abuse.

Such abuse can occur both as part of a network of abuse across a family or community and within institutions such as residential or nursing homes, supported living facilities, day support settings and in other provisions such as voluntary groups. There may also be cases of adults at risk being abused through the use of the internet. Such abuse is profoundly traumatic for the adults at risk who are involved. The investigation of large scale and/or complex abuse requires specialist skills from PSNI and HSC Trust staff.

Every investigation will require careful and thorough planning, effective inter-agency working and attention to the needs of the adult(s) involved. Some investigations become extremely complex because of the number of people or places involved and the timescale over which the abuse is alleged to have occurred.

On receipt of information which may indicate organised or multiple abuses, the HSC Trust Designated Officer should immediately consider whether a report to the PSNI is appropriate, initiate a joint strategy meeting and, where necessary, establish a Strategy Management Group (SMG) to oversee the process of investigation. Core representatives of SMG are:

- PSNI;
- HSC Trust nominated DAPO;
- a senior manager from the relevant adult programme of care; and

- RQIA (where the allegation relates to a regulated service).

Appropriate legal advice will be necessary and should be sought through PSNI and HSC Trust legal advisers.

The SMG will:

- establish the principles and practice of the investigation, draw up an investigation plan and ensure regular review of progress against that plan;
- establish and manage an Investigative Team within their respective agencies;
- ensure co-ordination between the key agencies and Investigative Team
- address the issue of resourcing individual investigations;
- act in a consultative capacity to those professionals who are involved in the investigation;
- draw up a media strategy that will address who will take responsibility for responding to the media;
- agree communication strategy/liaison with victims/families and carers involved in the investigation;
- agree level of information sharing, where appropriate to do so, with the proprietor and the staff of the facility/service under investigation;
- at the conclusion of the investigation, discuss salient features of the investigation with a view to making recommendations for improvements either in policy or in practice.

11.3. Operational Protection Policies and Procedures

The HSCB's regional operational adult protection procedures will underpin this policy and provide guidance to support good practice and sound professional decision making. Procedures will be subject to regular review.

Operational policies and procedures should:

a) clarify roles, responsibilities and expectations at all levels;
b) outline the importance of, and interface with, the Joint Protocol;
c) provide procedures for inter-agency working across the full range of organisations;
d) provide a consistent framework to guide adult protection interventions;
e) promote flexibility and a focus on outcome;
f) describe how the threshold of serious harm is applied at each stage of the process to enable the most proportionate response to be identified;
g) provide guidance on the management of adult protection referrals where more than one HSC Trust is involved;
h) encourage reflective professional practice;
i) support robust decision making;
j) strengthen professional line management and governance arrangements;
k) outline procedures for integration with the other investigations (see the role of the DAPO earlier in this section);
l) define information exchange procedures;
m) outline record keeping requirements; and
n) describe how large scale and/or complex investigations should be conducted.

12. CONSENT AND CAPACITY

12.1. Consent

Consideration of consent is central to adult safeguarding. Consent is a clear indication of a willingness to participate in an activity or to accept a service, including a protection service. It may be signalled verbally, by gesture, by willing participation or in writing. No one can give, or withhold, consent on behalf of another adult unless special legal provision for particular purposes has been made for this.

For consent to be valid, it must be given voluntarily by an appropriately informed person who is able to consent to the intervention being proposed. In cases where the individual lacks capacity, decisions will usually be made on behalf of the individual in accordance with current legal provisions.

A consent-driven approach to adult safeguarding will always involve:

- a presumption that the adult at the centre of a safeguarding decision or action is able to give or withhold consent unless it is established otherwise;
- acknowledging that an adult who lacks capacity to make a decision cannot give consent but that he or she should still be involved in decision-making as far as possible and given appropriate support;
- acknowledging that everyone who has capacity to make a certain decision has the right to pursue a course of action that others may judge to be unwise, but that sometimes a balance must be struck between an individual's human rights and the need to intervene to protect others;
- providing support to an adult where they have withheld consent and this has been overridden;
- ensuring consent/non-consent is informed through the provision of full and accurate information, making sure that the information is conveyed in a way which the adult fully understands and taking all practicable steps to help the person make and communicate the decision; and
- understanding that the choices and decisions made by the individual at any one time are not seen as irrevocable or non-negotiable.

Where there is a concern that an adult may be at risk of, or experiencing, harm and there are concerns about coercion or undue influence, this should be referred to the HSC Trust in accordance with section 11.

12.2. Capacity

An adult will always be assumed to have capacity to make a decision unless it is suspected otherwise. Capacity can fluctuate, and is both issue and time specific, therefore should be kept under regular review in connection with any safeguarding intervention, in particular a protection intervention.

Where there is a reasonable doubt regarding the capacity of an adult to make a specific decision or series of decisions, a referral must be made to the HSC Trust. The organisation or individual making the referral may need to consider any reasonable and proportionate interim steps necessary to protect the adult pending

further enquiries by the HSC Trust. An HSC professional within the HSC Trust will conduct a capacity assessment in accordance with existing legislation and guidance.

Lack of capacity

Tensions between an adult's autonomy and the need to intervene to keep an adult safe makes deciding whether or not to intervene when an adult lacks capacity to make a decision particularly difficult, and one that must always requires professional judgement in respect of the individual circumstances of the adult.

Where an adult lacks capacity to make a certain decision, they should be supported so they can be involved to the fullest extent in the decision that affects their life. Any interventions and actions taken by the HSC Trust must be in the best interests of the person being safeguarded, and in accordance with existing legislation and policy. HSC Trusts should, where appropriate, consult relevant family members or carers when considering action to be taken regarding an adult who lacks capacity to make a decision.

12.3. Lack of Consent

In some circumstances it may be necessary for the withholding of consent to be overridden. Where consent to intervene is not provided by the adult at risk, action to progress a case may still be taken in circumstances where there is a strong overriding public interest, or where a crime is alleged or suspected. This may happen when:

- the person causing the harm is a member of staff, a volunteer or someone who only has contact with the adult at risk because they both use the service; or
- consent has been provided under undue influence, coercion or duress;
- other people are at risk from the person causing harm; or
- a crime is alleged or suspected.

In these circumstances, the adult should be informed of that decision, the reason for the decision, and reassured that as far as possible no actions will be taken which affect them personally without their involvement. Consideration should be given to any support the adult may need at this time, as they may be distressed by the prospect of their information being shared without their consent.

12.4. Advocacy

Advocacy involves enabling people to say what they want, to have their views heard, and empowering them to speak up for themselves. It informs the person about their options and helps them to take action when necessary to have their voice heard and secure their rights.

Whilst advocacy is a social work role, the use of independent advocacy services to support the adult at risk in making their choices may be appropriate, particularly for those who have difficulty being heard or expressing their views, or where there are conflicting interests. This is particularly the case where HSC staff, professionals or family are of the opinion that what the person wants is not in their best interests.

Advocacy can assist adults to be involved in, and influence, decisions taken about their care. It helps to ensure that the adult at risk remains central to the decision making process. Advocacy should not make decisions on behalf of the adult at risk, but always work in partnership with the adult they are supporting. People who are lack capacity to make a decision rely more heavily on others for many aspects of their care, treatment and support, and have the potential to benefit more from advocacy services to assist them exercise their rights.

13. ACCESS TO JUSTICE: SUPPORT FOR VICTIMS

Where a crime is alleged to have occurred there is a duty on PSNI to investigate. There are also a range of mechanisms in place to support a victim when giving a statement to the PSNI, evidence at court and in terms of emotional and practical support services more generally. The provision of these services requires effective cooperation across a range of organisations including the PSNI, HSC Trusts, the Public Prosecution Service and voluntary sector service and support providers.

Where a crime is reported to the PSNI a victim of crime information leaflet is available which provides contact details of general support services such as Victim Support NI and NSPCC Young Witness Service, as well as specialist support services, including for families bereaved through murder or manslaughter, victims of domestic and sexual violence, victims of trafficking and young victims of crime among others. The PSNI can refer victims of crime to Victim Support NI, where referral to specialist support services is also available dependent on the needs of the individual. Where an individual has concerns about their safety they should refer this to the police.

Victims of crime can have access to additional support to help them give evidence, as part of criminal proceedings where a person is under the age of 18, or where the quality of the evidence is likely to be affected because the person has mental health issues, learning or communication difficulties, a neurological disorder or a physical disability. Additional support is also available to those victims who are intimidated and the quality of whose evidence is likely to be affected because of fear or distress about testifying, for example, where the person is a victim of domestic violence, hate crime, trafficking, exploitation, bullying or abuse by professionals or carers or family members.

For these types of victims the PSNI will carry out interviews in accordance with 'Achieving Best Evidence in Criminal Proceedings' guidance. This sets out good practice in interviewing victims and witnesses and in preparing them to give their best possible evidence in court, so that they have an opportunity to access justice and provide their best evidence. Such interviews are normally video recorded.

Victims will have their needs assessed by the PSNI or Victim and Witness Care Unit (which provides a single point of contact from the point when the case file is transferred from the PSNI to the Public Prosecution Service).

Additional support at court, such as special measures[18], may be applied for by the Public Prosecution Service, with final decisions taken by the judge on their availability. More than one special measure may be granted in a particular case, with this again a decision for the judge. The special measures, as set out below, include:

- screens/curtains in the courtroom so the victim does not have to see the defendant;

[18] A leaflet on special measures is available at http://www.psni.police.uk/special_measures_leaflet.pdf. The legislation governing special measures can be found at: http://www.legislation.gov.uk/nisi/1999/2789/contents]

- a live video link allowing evidence to be given away from the courtroom, which also allows for a support to be present with the witness in the live link room;
- giving evidence in private, where the case involves a sexual offence, a slavery or human trafficking offence, or the person is deemed to be intimidated;
- video recorded statements – these allow the main evidence to be given using a pre-recorded video statement;
- using communication aids, such as alphabet boards (where the person's evidence is likely to be affected due to a learning or communication difficulty, mental health issue, physical disability etc.); and
- removal of wigs or gowns.

Another special measure is assistance from a communication specialist (a Registered Intermediary) when a person is telling the police what happened to them or is giving evidence in court. Registered Intermediaries are professionals with specialist skills in communication. The role of Registered Intermediaries is to facilitate the giving of evidence rather than provide a general support role. They assist a vulnerable person, who has a significant communication difficulty, during the criminal justice process if their communication difficulties would diminish the quality of their evidence. The Registered Intermediaries Schemes pilot is helping vulnerable people have access to justice where it may not have been possible before.

As well as help when giving evidence victims also have access to a range of general support services. Victim Support NI[19] helps people who have been a victim of, or a witness to, a crime. They provide emotional support, information and practical help to victims, witnesses and others affected by crime through compensation, community and witness services. Victim Support NI can also refer victims to specialist support services, where appropriate and available.

A Victim Charter provides victims of crime with relevant information, sets out what their entitlements are and the standards of service that they can expect to receive as they move through the criminal justice process. It will also make clear to service providers exactly what their duties are in ensuring victims receive the right level of service. The Charter provides information on the support services that are available to victims of crime, including specialist services.

[19] Further information on Victim Support NI can be found at: www.victimsupportni.co.uk/

14. INFORMATION MANAGEMENT AND INFORMATION SHARING

14.1. Information and Record Management

Information associated with adult safeguarding is likely to be of a personal and sensitive nature and its use is governed by the common law duty of confidentiality. At all times 'personal data' and 'sensitive personal data' [20] must be managed in accordance with the law, primarily the Data Protection Act 1998 (DPA) and the Human Rights Act 1998 which, among other things, gives individuals the right to respect for private and family life, home and correspondence.

The eight principles of the DPA state that personal data must be:

- processed fairly and lawfully and only for purposes compatible with the reason(s) for which the information was originally obtained;
- adequate, relevant and not excessive for the purposes for which it is processed;
- accurate and kept up to date;
- not kept for longer than is necessary;
- processed in line with the rights of the data subject;
- held securely; and
- not transferred to other countries outside the EEA without adequate protection.

All organisations providing targeted services to adults at risk must have an information management policy and associated governance arrangements in place which complies with the DPA and the Human Rights Act 1998. These policies must include the procedures to be followed by staff and volunteers in relation to:

- information management, including recording of information, its secure storage, and how this can be accessed and by whom;
- sharing information outside of the organisation for safeguarding purposes, and how requests for information will be considered and assessed (see Information Sharing for Safeguarding Purposes below);
- training to be provided to staff in relation to their duties under the DPA;
- subject access requests;
- complaints about information management; and
- identified breaches of data protection within the organisation.

Good records management standards and practices are required for the organisation to ensure confidentiality and that the security of service user information is respected. Many professionals are governed by a Code of Practice or Code of Conduct issued by the professional body with which they are registered, which will contain guidance on information management to support organisational policies. Guidance for voluntary, community, independent and faith sector organisations on the management of records, confidentiality and sharing of information is available in the Volunteer Now guidance document 'A Shared Responsibility'[21]. 'Good Management

[20] 'Sensitive Personal Data' is defined by Section 2 of the Data Protection Act 1998: http://www.legislation.gov.uk/ukpga/1998/29/section/2

[21] 'Safeguarding Vulnerable Adults: A Shared Responsibility' can be accessed at: http://www.volunteernow.co.uk/fs/doc/publications/vn-sva-web-full-colour.pdf

Good Records'[22] provides guidance for those who work within or under contract to Health and Social Care statutory organisations on the required standards of practice in the management of records.

14.2. Information Sharing for Safeguarding Purposes

In relation to adult safeguarding, the duty to share information about an individual can be as important as the duty to protect it. Effective safeguarding will depend on information being made available to those who need it at the right time. Proportionate information sharing may be required to prevent harm to the adult at risk or to others, and can facilitate preventative or early intervention approaches.

It is important that confidentiality is not confused with secrecy. Proportionality is the key in respect of the risks associated with deciding whether or not to share information.

Organisations and professionals should not give assurances of absolute confidentiality in adult safeguarding where there are concerns about risk of harm to one or more adults, nor should it be assumed that someone else will pass on information which may be critical to the prevention of harm to an adult.

Information sharing is one form of data processing, and as such is covered by principles and requirements of the DPA. The Information Commission's Office (ICO) has published a statutory Data Sharing Code of Practice[23] to assist organisations to comply with the DPA. The code is applicable to all organisations involved in sharing personal data, whether this is within different branches of the same organisation, or with a third party organisation. It contains guidance in factors to consider when deciding whether or not to share personal data, including checklists to assist organisations in their decision making.

Organisations that collect or hold personal data or sensitive personal data should explain in advance to the data subject how their information will be used, including under what circumstances the information might be shared. Guidance on how this can be undertaken is contained in the Privacy Notices Code of Practice[24] published by the ICO.

Targeted services providers must have procedures for staff and volunteers on how to share information in compliance with the DPA and the ICO Code of Practice. Decisions about what information should be shared and with whom should be taken on a case by case basis, and in accordance with organisational information management policies and the legal framework, and in line with this policy. The management interests of an organisation should not override the need to share information for safeguarding purposes.

[22] 'Good Management Good Records' can be accessed at: http://www.dhsspsni.gov.uk/index/gmgr.htm

[23] The Data Sharing Code of Practice can be accessed at: https://ico.org.uk/media/for-organisations/documents/1068/data_sharing_code_of_practice.pdf

[24] The 'Privacy Notices Code of Practice' can be accessed at: https://ico.org.uk/media/for-organisations/documents/1610/privacy_notices_cop.pdf

If anyone has concerns about risk of harm to an adult, they should seek advice from the relevant HSC Trust or the PSNI.

Personal data may be shared when:

- the adult has given his or her valid consent (which in the case of sensitive personal data must be explicit); or
- where information sharing is necessary for matters of life or death or for the prevention of serious harm to the individual; or
- where sharing is necessary for the purposes of the administration of justice;
- where sharing information is for public or statutory duties.

Where the decision is made to share information without consent, the organisation must ensure that the adult is clearly informed of what information will be shared, why it will be shared, and who it will be shared with, providing this does not increase the risk to the adult. Organisations should avoid asking for consent to share information when it is likely that a decision will be taken to share the information regardless of whether consent is given. Any sharing of information must meet conditions under Schedules 2 and 3 of the Data Protection Act.

If there is reason to believe that sharing information due to a statutory duty to disclose may increase the risk of harm, or where there is doubt about whether the organisation can or should share information, the organisation may wish to obtain legal advice.

Good record keeping of decision making is essential in cases where information sharing is being considered. Staff should maintain records of the information gathered which explains and justifies their decisions.

14.3. Sharing Information Between Agencies

Effective safeguarding cannot be achieved without organisations working collaboratively to ensure the safety of the adult at risk is prioritised. Working together is dependent on there being a clear framework for doing so, and adult safeguarding should be based on good communication across sector and agency boundaries.

The effective and timely sharing of information between organisations is essential to deliver high quality adult safeguarding services focused on the needs of the adult.

Agencies and organisations which are required to share information on a regular basis to safeguard adults at risk must have Information Sharing Agreements (ISAs) in place which identify key members of staff and contact points within the organisation through which information can be channelled, including out of normal working hours. The agreements should be agreed at Board/Director level and subject to regular review.

Member organisations of NIASP have all signed an information sharing agreement. This agreement will stipulate when information may be shared without the subject's consent.

An ISA should outline how organisations have agreed to share information and ensure compliance with legal requirements. The purpose of an ISA is:

- to facilitate the secure exchange of information in an appropriate format, where necessary, to ensure the health, well-being and safeguarding of adults at risk;
- to provide a framework for the secure and confidential sharing of personal data between the partner organisations;
- to promote consistency of information sharing across partner organisations; and
- to support professional decision making in individual cases.

When an HSC Trust has a contract or commissioning arrangement with a third party organisation, the contract or commissioning agreement must state how the third party organisation must handle any personal data obtained through provision of the service. This must include how the information will be securely stored, managed, disposed of, and where appropriate shared, in compliance with the DPA and the Human Rights Act 1998.

15. SAFEGUARDING TRAINING

Effective adult safeguarding requires a specific level of knowledge, expertise and skill and understanding. Adult safeguarding is complex and must be delivered by a confident, competent and trained workforce, which includes those working in a voluntary or unpaid capacity.

NIASP has a responsibility to develop an inter-agency and inter-disciplinary approach to adult safeguarding training and practice development. NIASP will develop and agree a Regional Adult Safeguarding Training Framework which will specify learning outcomes and core content to meet a range of identified training needs within partner organisations.

The framework will provide a number of levels of training which reflect the varying levels of expertise required and the differing needs of organisations across the safeguarding continuum. The appropriate level of training will be determined by the roles and responsibilities of the individual.

Service providers should use the NIASP framework to identify and set out training and development pathways for their staff and volunteers, to ensure they have the appropriate skills and knowledge to engage in preventative activity and respond to safeguarding concerns commensurate with their role. This may involve a combination of formal training events, and time for staff to reflect on their own practice and the practice of others. Records should be maintained of all training and development undertaken by staff and volunteers.

16. A CONTINUOUS LEARNING APPROACH

All practitioners, agencies and organisations involved in work with adults at risk must ensure that the highest possible standards of care, support and protection are provided and maintained at all times, and improvements identified and put in place on a continuous basis. The NIASP will foster a culture of collaborative learning and continuous practice and service improvement in connection with adult safeguarding. This will require knowledge and understanding of the 'system' at the front-line, the identification of and exploration of learning from cases with different outcomes for adults at risk of harm, or adults who have been harmed and the implementation of learning from both. The emphasis should be on learning for the purpose of positive proactive change and improvement. It will require the support of staff who will be responsible for the implementation of change.

The NIASP will promote a culture of continuous improvement and collaborative learning to improve outcomes for adults who may be at risk and their experience of the adult protection responses.

This does not mean that those responsible for harming an adult at risk by an act of commission or omission should not be held to account. A range of accountability mechanisms already exist, including disciplinary mechanisms. These should be used where it is appropriate to do so.

The ultimate aim is to establish a system which promotes continuous learning and improvement to:

- establish whether there are lessons to be learned about the way in which local professionals, agencies and organisations work together to safeguard adults at risk;
- identify clearly what those lessons are, how they will be acted upon, by whom and by when, and what is expected to change as a results;
- improve multi-disciplinary and interagency working, and promote better approaches to prevention, protection and support of adults at risk.

The NIASP will seek the full support, cooperation and participation of its member organisations to identify opportunities for learning and to bring these to the attention of the NIASP.

APPENDIX 1

This policy is of specific relevance to:

- all NI Government Departments, their agencies and arm's length bodies;
- local councils;
- the Health and Social Care Board and Health and Social Care Trusts;
- Business Services Organisation;
- The Northern Ireland Ambulance Service HSC Trust;
- The Public Health Agency;
- The Northern Ireland Adult Safeguarding Partnership and the five Local Adult Safeguarding Partnerships;
- The Police Service of Northern Ireland;
- The Public Prosecution Service;
- The Probation Board for Northern Ireland;
- Policing and Community Safety Partnerships;
- The Northern Ireland Prison Service;
- The Northern Ireland Housing Executive;
- The Social Security Agency;
- regulatory and Inspection bodies across all sectors, including: Criminal Justice Inspection Northern Ireland, the Regulation and Quality Improvement Authority, The Education and Training Inspectorate, the General Teaching Council for Northern Ireland, the Northern Ireland Social Care Council, the General Medical Council, the Nursing and Midwifery Council and the Charities Commission;
- schools;
- Domestic and Sexual Violence Partnerships;
- voluntary and community organisations who work with, provide services to, or engage in, activities with adults;
- voluntary and community organisation umbrella bodies;
- Faith organisations and communities;
- care staff agencies;
- organisations and individuals who provide personal care funded through direct payments or through an individual's own funds;
- carers;
- Carers NI and other advocacy groups representing carers;
- housing associations;
- supported housing providers, the Northern Ireland Federation of Housing Associations Private landlords;
- accommodation providers;
- financial institutions, including: banks, Post Offices and building societies;
- credit unions;
- professions, including solicitors and barristers;
- The Office of Care and Protection;
- Northern Ireland Courts and Tribunal Service;
- independent Providers of health and social care service, including: General Medical Practitioners, pharmacists, dentists, private hospitals, private sector providers of domiciliary care, residential and nursing care homes, independent counsellors and independent therapist services;
- Allied Health Professionals and their regulatory bodies;

- opticians;
- further and higher education institutions;
- advice groups and helplines; for example, disability groups such as Disability Action and Action for Hearing Loss;
- Self help, user and advocacy groups;
- leisure facilities; and
- members of the public.

APPENDIX 2

Glossary

Access NI	AccessNI is a criminal history disclosure service in Northern Ireland. By law some employers must check your criminal history before they recruit. When asked by these employers, AccessNI supplies criminal history information about job applicants, volunteers and employees.
Adult Protection Gateway Service	The **Adult Protection Gateway Service** is the central referral point within the HSC Trust for all concerns about an adult who is, or may be, at risk.
Care Plan	A care plan sets out the assessed care and support needs of an individual and how those needs will be met to best achieve the individual's desired outcome. The individual should be fully involved in the development of the care plan.
Care Management	Care Management embraces the key functions of: case finding; case screening; undertaking proportionate, person-centred assessment of individual's needs; determining eligibility for service(s); developing a care plan and implementing a care package; monitoring and reassessing need and adjusting the care package as required.
Child Protection Gateway Service	The **Child Protection Gateway Service** is the central referral point within the HSC Trust for all concerns regarding the safety and welfare of children.
CJINI	Criminal Justice Inspection Northern Ireland is the independent statutory inspectorate with responsibility for inspecting all aspects of the criminal justice system in Northern Ireland apart from the judiciary. It also inspects a number of other agencies and organisations that link into the criminal justice system. CJI is funded by the Department of Justice and the Chief Inspector reports to the Minister for Justice.
Delegated Statutory Functions	Delegated Statutory Functions refer to all requirements of legislation with which statutory HSC organisations must comply. In successive legislation, the Health and Social Care Board (HSCB) is designated as 'The Authority' that is required to fulfill all relevant statutes. The HSCB delegates this responsibility to HSC Trusts under legally binding schemes referred to as 'Schemes for the Delegation of Statutory Functions'.
Designated Adult Protection Officer	A social worker within the HSC Trust with responsibility for managing and co-ordinating the adult protection process. The DAPO must: • be social work qualified; • be working in a minimum of a band seven; • have first line management responsibilities, or in a senior practitioner role;

	• be suitably experienced; and • have undertaken the necessary training.
DHSSPS	The Department of Health, Social Services and Public Safety.
DOJ	The Department of Justice.
Direct Payments	Direct payments are paid by an HSC Trust to people who have been assessed by an HSC Trust to meet the eligibility criteria for assistance from social services. A payment is made in lieu of the service so that the person can arrange and pay for their own care and support services instead of receiving them directly from the HSC Trust.
ETI	The Education and Training Inspectorate. The organisation which provides inspection services and information about the quality of education being offered including that within schools, further education and work-based learning, where adults at risk may be enrolled.
HSCB	The Health and Social Care Board. This is the body responsible for arranging or 'commissioning' a comprehensive range of modern, effective and safe health and social services for the people of Northern Ireland.
HSC Trust	Health and Social Care Trust. There are five Health and Social Care Trusts in Northern Ireland, providing local and regional health and social care services to the Northern Ireland public. The use of "HSC Trust" in the Policy document refers to the following five HSC Trusts: • The Belfast Trust • The South Eastern Trust • The Southern Trust • The Northern Trust • The Western Trust.
Joint Protocol	The Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults 2009. The Protocol sets out a framework for joint working in a complex area of practice and emphasises the need to involve all other relevant agencies in information sharing, early assessment and the planning process. The overall aim of the Protocol is to prevent abuse by promoting a multi-agency approach to the protection of vulnerable adults, and to ensure that they receive equitable access to justice in a way that promotes their rights and well-being.
LASP	Local Adult Safeguarding Partnerships. The five local multi-agency, multi-disciplinary partnerships located within their respective HSC Trusts.
MARAC	A MARAC is a Multi-Agency Risk Assessment Conference. It is a forum for local agencies to meet with the aim of sharing information about the highest risk

	cases of domestic violence and abuse and to agree a safety plan around victims.
National Referral Mechanism	A framework which exists to assist in the formal identification of victims of human trafficking and help to coordinate support to potential victims to appropriate service. The Department of Justice (DOJ) funds organisations to provide this support to adult potential victims of human trafficking. The PSNI are the lead agency in managing this response. However, consideration should be given to use of the Joint Protocol arrangements.
NIASP	The Northern Ireland Adult Safeguarding Partnership. The regional multi-agency, multi-disciplinary partnership that brings together representatives from organisations and communities of interest who have a significant contribution to make to adult safeguarding.
Office of Care and Protection	Office of Care and Protection is the department of the Court with responsibility for the administrative work associated with Part VIII of the Mental Health Order. This includes matters relating to enduring or lasting powers of attorney, and court-appointed deputies.
PBNI	Probation Board for Northern Ireland. PBNI works alongside statutory and other partners to minimise the risk of harm posed by offenders. PBNI is a Non Departmental Public Body of the Department of Justice (DOJ).
PCSP	Police and Community Safety Partnerships. Local bodies made up of Councillors and independent people in each Council area. PCSPs work with their community to identify issues of concern in the local area and potential solutions, and prepare plans to address these concerns.
Personal data	Personal data means data which relate to a living individual who can be identified – (a) from those data, or (b) from those data and other information which is in the possession of, or is likely to come into the possession of, the data controller, and includes any expression of opinion about the individual and any indication of the intentions of the data controller or any other person in respect of the individual. It is important to note that, where the ability to identify an individual depends partly on the data held and partly on other information (not necessarily data), the data held will still be “personal data”. The definition also specifically includes opinions about the individual, or what is intended for them.
PPANI	Public Protection Arrangements Northern Ireland. The

	purpose of the PPANI framework is to reduce the risks posed by sexual and violent offenders when they are released into the community in order to protect the public, including previous victims, from serious harm.
PPT	Public Protection Team. These are located in police stations throughout Northern Ireland.
Programme of Care	The structure in HSC Trusts within which social care is commissioned and delivered in Northern Ireland.
Protection Plan	A plan agreed with the adult at risk (or the person representing them or their best interests) detailing the actions to be taken, with timescales and responsibilities, to support and protect the person from harm.
PSNI	The Police Service of Northern Ireland.
RQIA	The Regulatory and Quality Improvement Authority. Northern Ireland's independent health and social care regulator, responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.
Sensitive Personal Data	Sensitive Personal Data means personal data consisting of information as to— (a) the racial or ethnic origin of the data subject, (b) his political opinions, (c) his religious beliefs or other beliefs of a similar nature, (d) whether he is a member of a trade union (within the meaning of the M1Trade Union and Labour Relations (Consolidation) Act 1992), (e) his physical or mental health or condition, (f) his sexual life, (g) the commission or alleged commission by him of any offence, or (h) any proceedings for any offence committed or alleged to have been committed by him, the disposal of such proceedings or the sentence of any court in such proceedings. Sensitive Personal Data has a higher threshold when considering whether or not it can be shared, and carries higher requirements for secure management.

APPENDIX 3

Bibliography

The list below contains a list of sources used during the development of this policy. There may have been other documents which were reviewed during the course of the policy development which have been omitted, and where these are identified these will be included in future updates of this document.

Document Title	Author
Adult Support and Protection: Ensuring Rights and Preventing Harm	Edinburgh, Lothian and Borders Executive Group
Evidence Review – Adult Safeguarding	Institute of Public Care
Haringey Safeguarding Adults Multi Agency Information Sharing Protocol	Haringey Council
Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse.	Social Care Institute for Excellence with the Pan London Adult Safeguarding Editorial Board
Protecting our Older People in Northern Ireland: A Call for Adult Safeguarding Legislation	Commissioner for Older People for Northern Ireland
Safeguarding Adults: a National Framework of Standards for good practice and outcomes in adults protection work	The Association of Directors of Social Services
Safeguarding Vulnerable Adults Regional Adult Protection Policy and Procedural Guidance	Health and Social Care Board
Safeguarding Vulnerable Adults A Shared Responsibility	Volunteer Now

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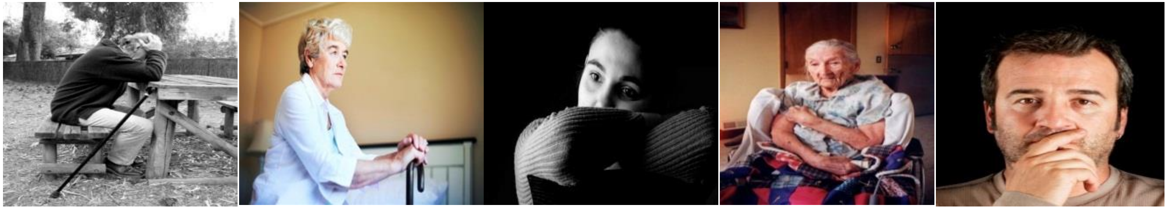
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP



Protocol for Joint Investigation of Adult Safeguarding Cases

August 2016

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SECTION 1

1.1 Introduction

Living a life that is free from harm and abuse is a fundamental right for every person.

There has been growing recognition that a wide range of adults may, for a variety of reasons, be at risk of harm from abuse, exploitation or neglect. This has been reflected in the continuing evolution of government thinking and policy in relation to adult safeguarding at national, regional and local levels.

In a Northern Ireland context, there has been a series of documents published in recent years that have had considerable influence in the delivery of safeguarding services.

They include The Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2003 and revised in 2009) and Achieving Best Evidence in Criminal Proceedings (Northern Ireland) (2003, revised in 2010 and again in 2012) which set out in detail how health and social care and criminal justice professionals should work together to more effectively support adult victims when harm/abuse constitutes a possible crime.

'Adult Safeguarding in Northern Ireland: Regional and Local Partnership Arrangements' (DHSSPS and DoJ) was published in 2010 and led to the establishment of the Northern Ireland Adult Safeguarding Partnership (NIASP) and the five Local Adult Safeguarding Partnerships (LASPs).

It is important to note that there have also been many developments over the last few years in terms of entitlements and support to victims of crime.

The Victim Charter (Justice Act (Northern Ireland) 2015) Order 2015 sets out requirements in relation to entitlements and supports to victims of crime and the standards of service that victims can expect to receive when they come in contact with the Criminal Justice System.

The Victim Charter - a Charter for Victims of Crime, published by the Department of Justice in September 2015, provides information on the range of entitlements aimed at supporting victims of crime and details the roles and responsibilities of relevant agencies in relation to delivering of these supports. Some of the entitlements are available to all victims of crime such as crime information leaflets and access to Victim Support Northern Ireland.

Other entitlements are targeted at the most vulnerable in our society and include, but are not limited to, Achieving Best Evidence in Criminal Proceedings, the use of Special Measures and, where appropriate, use of Registered Intermediaries.

These supports aim to assist the victim through the criminal justice process from the point of referral to PSNI, making a statement of complaint, giving evidence in Court and follow up in terms of outcome. There are other arrangements in place to support a vulnerable individual who is suspected of committing a crime.

In July 2015 the Adult Safeguarding Prevention and Protection in Partnership Policy (the Policy) was produced jointly by the Department of Health Social Services and Public Safety (DHSSPS) and Department of Justice.

The Policy sets out the future agenda for adult safeguarding in a Northern Ireland context. It extends safeguarding to encompass both prevention and protection and places a very strong emphasis on partnership working. The responsibilities of different organisations are clearly set out within the Policy which includes thresholds for referrals to adult protection services.

This Protocol for Joint Investigation of Adult Safeguarding Cases (the Joint Protocol) will provide clarity in respect of the roles and responsibilities of adult protection services where the nature of the harm to the adult in need of protection constitutes a potential criminal offence.

1.2 Background

This is the third edition of the Joint Protocol and replaces the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults 2009. It should be read in conjunction with the regional adult safeguarding policy Adult Safeguarding: Prevention and Protection in Partnership (DHSSPS & DOJ) 2015 and Adult Safeguarding Operational Procedures (NIASP) 2016.

Health and Social Care Trusts (HSC Trusts) and the Police Service of Northern Ireland (PSNI) are identified as the lead agencies with responsibility for adult protection. The Regulation and Quality Improvement Authority (RQIA) is recognised as a key partner when the concern relates to a regulated service.

The Joint Protocol aims to provide a framework within which HSC Trusts, PSNI and RQIA can work in partnership to ensure adults at risk and in need of protection have equal access to the justice system when harm/abuse constitutes a potential crime.

It reflects the experience and learning of practitioners from a range of agencies, including HSC Trusts, PSNI, RQIA and the Public Prosecution Service (PPS). It also incorporates recommendations contained in the Joint Review by RQIA and CJINI of the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults, 2009.

1.3 Scope of the Protocol

The Joint Protocol relates to adults who are at risk and in need of protection where the harm caused by abuse, exploitation or neglect constitutes a potential criminal offence.

It adopts the definitions of an adult at risk and in need of protection as detailed in Adult Safeguarding Prevention and Protection in Partnership 2015:

An **adult at risk of harm** is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

i) **personal characteristics** (may include but are not limited to age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain);

and/or

ii) **life circumstances** (may include, but are not limited to, isolation, socio-economic factors and environmental living conditions);

An **adult in need of protection** is an adult at risk of harm (above):

i) who is **unable to protect** their own well-being, property, assets, rights or other interests;

and

ii) where the **action or inaction of another person or persons** is causing, or is likely to cause, him/her to be harmed.

"Harm" is defined as the impact on the victim of abuse, exploitation or neglect (Appendix 1 Definitions of Abuse, Neglect, Exploitation and related definitions).

The decision as to whether the definition of an adult in need of protection is met will require the careful application of professional judgement on a case by case basis. This should take into account all the available evidence, concerns, the impact of harm, degree of risk and other matters relating to the individual and his or her circumstances. The seriousness and the degree of risk of harm are key to determining the most appropriate response and establishing whether the threshold for protective intervention has been met.

It is important to note that when harm caused by abuse, exploitation or neglect constitutes a potential crime, the PSNI have the lead role and responsibility to investigate. The adult in need of protection should be made aware of their fundamental right to make a report to the police.

The Joint Protocol recognises the dilemmas and complexities posed when an adult in need of protection withholds consent to a police referral and/or there is a lack of clarity regarding whether a concern constitutes a potential crime.

The Joint Protocol provides a framework to support the HSC Trust Designated Adult Protection Officers (DAPO) in making decisions. It is intended as a guide only and there is an expectation that the HSC Trust DAPO must ensure that a professional assessment/risk assessment is carried out for each individual. While each case is unique, this professional assessment process will begin from the perspective that any potential criminal offence should be reported to the PSNI.

The Joint Protocol sets out requirements to ensure that the welfare and protection needs of the adult in need of protection are met as fully as possible. Throughout the Joint Protocol processes, HSC Trusts and PSNI will work in partnership to take these needs into account.

Where the adult in need of protection is known to regulated services, RQIA and the Registered Provider/Manager will be expected to co-operate fully with all processes being put in place to support them.

1.4 Aim and Objectives

Aim

The aim of the Joint Protocol is to ensure that the adult in need of protection is supported in a manner which upholds his/her rights, in particular their right to equal access to the criminal justice system and to prevent further abuse through a collaborative multi-agency partnership.

Objectives

- To provide a framework for effective communication and collaboration between HSC Trusts, PSNI, RQIA and PPS in relation to Joint Protocol referrals and investigations
- To support staff in the decision making process involved in the Joint Protocol
- To provide details of the Joint Protocol processes to be followed.

1.5 Underpinning Principles

Adult safeguarding is complex and challenging and therefore should at all times be guided by a number of underpinning principles. In this context the Joint Protocol adopts the same guiding principles as the Adult Safeguarding: Prevention and Protection in Partnership regional policy:

- **a rights-based approach** which promotes and respects an adult's rights to the protection of the law; to freedom from harm and coercion; to privacy; to confidentiality; to equality of treatment, free from discrimination; and to be safe and secure

- **an empowering approach** which empowers adults to keep themselves safe and free from harm in ways that manage exposure to risk and maximise opportunities to participate in wider society

- **a person-centred approach** which promotes and facilitates full participation by the adult in all decisions affecting his or her life and take full cognisance of the views, wishes and feelings of the individual and, where safe and appropriate, the views of others who have an interest in his or her well-being

- **a consent-driven approach** which makes a presumption of the adult's decision-making capacity and ability to make informed choices; to help inform choice through the provision of information, and advocacy where needed, and the identification of options and alternatives; to have particular regard to the needs of individuals who lack the capacity to consent; and intervening in the life of an adult against his or her wishes only in very particular circumstances, for very specific purposes and always in accordance with the law

- **a partnership approach** which acknowledges that safeguarding will be most effective when it has the full support of the wider public and of safeguarding partners across the statutory, voluntary, community and private sectors working together with and for adults at risk; and is delivered in a way where roles, responsibilities and lines of accountability are clearly defined and understood.

1.6 Roles and Responsibilities of Key Agencies

Health and Social Care Trusts

There are 5 Health and Social Care (HSC) Trusts - Belfast HSC Trust, South Eastern HSC Trust, Western HSC Trust, Southern HSC Trust and Northern HSC Trust. The HSC Trusts provide integrated health and social care services across Northern Ireland. HSC Trusts manage and administer hospitals, health centres, residential homes, day centres and other health and social care facilities and they provide a wide range of health and social care services to the community. HSC Trusts have a significant role in adult safeguarding, including both prevention and protection of adults at risk.

Within each HSC Trust there are key personnel with responsibility for delivering on the requirements set out in the Joint Protocol. These are Designated Adult Protection Officers (DAPOs); Investigating Officers (IOs) and Specialist ABE Interviewers.

HSC Regional Emergency Social Work Service

The Regional Emergency Social Work Service (RESWS) provides an emergency social work service outside normal office hours including weekends and public holidays. These are 5pm to 9am Monday to Thursday and 5pm on Friday to 9am on Monday. There is 24 hour cover over public holidays. Contact details are contained in Appendix 2.

The RESWS responds to a wide range of people in crisis and deals with situations which cannot be left until the next working day. People in crisis can include older people, people with mental health issues, learning disabilities, physical disabilities and children and young people.

There are a number of situations in which the RESWS will become involved or work with other agencies to ensure the safety of an individual and others who may be at risk. Examples of emergency situations are where:

- There are immediate significant protection and welfare concerns in relation to an adult at risk and/or an adult in need of protection;
- There are immediate significant protection and welfare concerns in relation to children and young people;
- Urgent advice and/or support is required by families or carers;
- Older people are at risk;
- There is consideration that compulsory admission to hospital under the Mental Health Order (NI) 1986 is required.

Staff within RESWS will provide an adult safeguarding and adult protection service where required and staff will therefore fulfil the role of DAPOs. As DAPOs, RESWS will respond to all elements of the role in emergency situations which require an urgent response.

Police Service of Northern Ireland

The Police Service of Northern Ireland (PSNI)'s purpose is 'keeping people safe'. This goal is achieved through policing in partnership with the community. This proactive, community-driven approach sees the police and local community working together to identify and solve problems.

The Central Referral Unit (CRU) is the regional PSNI centre for all referrals made by either HSC Trusts or PSNI where harm caused by abuse, exploitation or neglect to adult in need of protection constitutes a potential crime. The CRU will, in consultation with HSC Trust DAPO determine whether a criminal investigation is appropriate and, if required, CRU will make a decision regarding which branch of the police service is best placed to conduct the criminal investigation.

In many cases the PSNI Public Protection Branch (PPB) will be appointed to conduct the criminal investigation. CRU and PPB have officers experienced in adult protection work and officers trained as specialist interviewers under Achieving Best Evidence (ABE).

Depending on the nature of the crime CRU may refer the case to other PSNI branches, for example Response Teams, the Rape Crime Unit or CID. These branches will also include specially trained officers in adult protection work and ABE.

It is the responsibility of the PSNI to investigate alleged offences and to gather evidence about what has occurred. When the police have obtained evidence that an identifiable individual may have committed an offence, a file will be prepared and forwarded to the Public Prosecution Service (PPS).

PSNI contact details can be found in Appendix 3.

Public Prosecution Service

The Public Prosecution Service takes prosecution decisions and conducts prosecutions on behalf of a number of Government bodies, including the PSNI.
The PPS will determine whether criminal proceedings should be instituted or, where criminal proceedings have been instituted, whether they should be continued or discontinued, and also what charges should be preferred. The PPS provides the people of Northern Ireland with an independent, fair and effective prosecution service.

The PPS is wholly independent from both the police and government and its decisions are based on an impartial and professional assessment of the available evidence and the public interest. All actions are undertaken with complete impartiality, to the highest ethical and professional standards. All persons, including those accused of offences, will be treated fairly. All victims and witnesses will be treated with respect and sensitivity. All prosecution decisions are taken and every prosecution conducted in an

effective and efficient manner (Appendix 4 - Guidance in Relation to Test for Prosecution).

Regulation and Quality Improvement Authority (RQIA)

RQIA is an independent regulator with responsibility for registering, inspecting and encouraging improvement in a range of health and social care services delivered by statutory and independent providers, in accordance with The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and its supporting regulations. The services which it regulates include residential care homes; nursing homes; supported living facilities; supporting people services; children's homes; independent health care providers; nursing agencies; adult placement agencies; domiciliary care agencies; residential family centres; day care settings; and boarding schools. RQIA also have a specific role in relation to inspections in mental health and learning disability hospitals. Other inspections or reviews can be commissioned and conducted across a range of health and personal social services. Where the service inspected is not meeting the required quality standards or where compliance issues or concerns are identified, there are a range of robust sanctions and powers available to RQIA.

RQIA's remit therefore involves prevention, safeguarding and protection of adults at risk of harm and adults in need of protection. With regard to the Joint Protocol RQIA are a key partner in relation to investigations and protection planning in all regulated services.

Contact details can be found in Appendix 5.

1.7 Reporting and Referral Arrangements

Harm to adults in need of protection can take place in any setting; in the person's own home, in the wider community, in a residential or nursing home, hospital or indeed anywhere. It can also be perpetrated by anyone - family, friends, paid staff including professional staff such as doctors, nurses, social workers, police, volunteers, clergy, etc.

Where the harm constitutes a potential criminal offence the adult in need of protection has a right to make a report to the police and should if necessary be supported to make this report.

The arrangements below set out the requirements for reporting a concern which may constitute a criminal offence to either the HSC Trust and/or the PSNI.

a) Referrals to HSC Trusts and/or PSNI by organisations that have direct contact with adults at risk:

The regional policy places a responsibility on organisations that have direct contact with adults at risk to nominate an Adult Safeguarding Champion (ASC). One of the key responsibilities of the ASC is to advise and support staff when there are concerns that an adult at risk may have been subjected to serious harm through abuse, neglect or exploitation (Appendix 6 Definitions of Harm and Serious Harm).

The ASC should ensure that a referral to HSC Trust Adult Protection Gateway Service is made. The ASC should also consider whether there is a need to make an immediate report to the PSNI where there is an imminent risk to the adult.

The adult in need of protection's views and wishes are paramount and any decisions taken should involve consultation with them. Where it is feasible to do so, the consent of the individual should be sought before a referral/report is made to the HSC Trust or PSNI.

However, if there is an adult protection concern which constitutes a possible crime the ASC must consult with the HSC Trust Adult Protection Gateway Service and/or PSNI as appropriate.

b) Referrals/Reports to HSC Trusts by PSNI

Where PSNI have a concern that the individual may be an adult in need of protection, and a crime is suspected, the individual should be advised of the support and protection role of the HSC Trust. In these situations the consent of the individual to contact the relevant HSC Trust should be sought (Appendix **7** Consent and Capacity).

Where an adult in need of protection withholds consent to a referral to the HSC Trust for support and/or protection, the police officer will need to make a professional assessment based on available information as to whether a report/referral to the HSC Trust is nonetheless appropriate.

The following factors should be considered:

- whether the individual has the capacity to make an informed decision in relation to a referral; and
- the level of risk of harm to the individual and /or others including children

Where a police officer decides that a referral to the HSC Trust against the expressed preference of the individual involved is appropriate the rationale for the decision must be clearly recorded.

Each HSC Trust has an Adult Protection Gateway Service which is the central point of contact for all new adult in need of protection referrals. (Appendix 2: HSC Trust Adult Safeguarding contact details).

If a police officer has any concerns that a child or children are in any danger or at risk of harm they should contact the local HSC Trust's Child Protection Gateway Team (Appendix 2 HSC Trust Child Protection contact details).

Where there is a concern regarding the safety of an adult in need of protection or a child outside of normal working hours (Monday-Friday 9am to 5pm) the HSC Regional Emergency Social Work Service (RESWS) will work with the PSNI to ensure the immediate protection of the Adult at Risk and/or a child/children.

It will be the responsibility of the RESWS to either update the relevant HSC DAPO if the person is already known to HSC, or to make a referral to the Adult Protection Gateway Service (Appendix 2 RESWS contact details).

Where PSNI identify an adult at risk and have a welfare or care concern that falls outside the Joint Protocol, consideration should be given to whether a referral to HSC Trusts might be appropriate. General referrals in relation to an adult at risk can be made to local Trust offices.

c) Referrals to PSNI by HSC Trusts

In all cases of alleged or suspected harm caused by abuse, exploitation or neglect of an adult in need of protection which constitutes a potential crime, a report to PSNI should be made **except where there is clear and compelling evidence which supports a decision not to report (**see below).

In situations where there is a potential relevant offence under Section 5 of the Criminal Law Northern Ireland Act 1967, HSC Trusts **must** report the matter to the PSNI. (See Appendix 8 Section 5 Criminal Law (Northern Ireland) Act 1967)

The adult in need of protection should always be advised of their right to have the incident reported to the PSNI for investigation. However, if they withhold consent to the referral to the PSNI, then immediate consideration should be given to the balance between the individual's human rights and the obligation to address the risks to the individual and/or others, including children.

Issues in relation to the individual's capacity to consent should be considered (Appendix 7 Human Rights Consent and Capacity) alongside the HSC Trust's legal obligation to report the matter to the PSNI.

No action should be taken until the Joint Agency Consultation (see below) takes place.

Section 2 of this document provides detailed guidance for HSC Trust DAPOs in relation to referrals to PSNI.

In all emergency cases there should be no delay in contacting PSNI via telephone using the 999 telephone number.

The central point of contact for all other reports/referrals to the PSNI is the Central Referral Unit (CRU). Referrals to PSNI CRU will be made by forwarding an AJP1 form to the CRU. This must only be done via secure email using the Criminal Justice Secure Messaging (CJSM) system. All related correspondence must be sent via the same secure system (Appendix 3 PSNI Contact Details; Appendix 14 Adult Joint Protocol Forms).

d) Referrals/Reports to HSC Trusts and/or PSNI by RQIA

RQIA have a responsibility to identify issues that may have an impact on the wellbeing and welfare of adults at risk and to address safeguarding concerns in relation to regulated services. RQIA have a range of mechanisms in place to respond to and address such issues (Appendix 5 RQIA Contact Details and list of RQIA Regulations).

Where there is a concern regarding an individual or group of individuals, RQIA should consider whether this has been caused by abuse, exploitation or neglect. In these circumstances a report to the relevant HSC Trust should be made.

In situations where there is an alleged or suspected concern which constitutes a potential crime, consideration should be given as to whether a referral to the HSC Trust should be made alongside a report to the PSNI. RQIA will make an immediate report to the PSNI if there is an imminent risk to any service user.

1.8 Escalation Arrangements

At any point of the Joint Protocol process where an adult in need of protection and/or their family have a concern regarding how the situation is being handled by any agency, that agency's arrangements for addressing such concerns should be implemented. This can include, for example, local resolution, escalation through the line management structure, or application of the relevant complaints procedure. If the concern remains unresolved, it can be referred to either the Ombudsman for HSC Trust issues or the Police Ombudsman for Northern Ireland.

In the majority of situations it is hoped that positive outcomes will be achieved for the adult in need of protection through effective joint working.

Where there is a difference of opinion between agencies regarding how a case is being managed, every effort should be made to resolve this locally.

In the event that a situation cannot be resolved at this level the following process should be followed:

Within HSC Trusts:
The process of escalating a concern regarding how a case is being managed will involve raising the matter with the following Trust officers in sequence as required:

- DAPO
- DAPO's professional supervisor
- Adult Safeguarding Lead in the relevant Programme of Care
- Trust Adult Safeguarding Specialist Manager (TASS)
- Co-director/ Assistant Director / LASP Chair
- Executive Director of Social Work.

Within the PSNI:
The process for escalating a concern regarding any aspect of the management of a case is as follows and should again be followed in sequence as required.

At point of referral to CRU:

- CRU Sergeant
- CRU Inspector
- CRU Chief Inspector.

Following allocation of a case:

- Sergeant in relevant PSNI branch, i.e. Public Protection branch, CID
- Inspector in relevant PSNI branch or nominated Adult Safeguarding PSNI Lead within Branch
- relevant Chief Inspector

- Chief Inspector with regional responsibility for Adult Safeguarding.

Within the RQIA:

- Inspector aligned to the Regulated Service Provider
- Senior Inspector
- Head of Inspection

There is an expectation that escalation within each organisation will result in senior managers linking with their equivalents, i.e. Trust Adult Safeguarding Leads in each programme would link with the relevant PSNI Inspector.

If a Joint Protocol process has been initiated or a joint agency investigation is taking place, any relevant information arising from a Review should be shared with the other agency/agencies involved.

The framework for requesting a review as detailed above does not exclude normal line management reporting responsibilities.

SECTION 2 Joint Agency Working

2.1 Thresholds for referral to PSNI

The Joint Protocol outlines the thresholds within which a report **must** be made to PSNI and also provides a framework for consideration of a decision not to report to PSNI. The thresholds are intended as a guide for the HSC Trust DAPO and are not intended to be used as exclusion criteria. In some situations a Joint Agency Consultation will be the most appropriate way forward in determining whether a criminal offence may have been committed and/or whether a criminal investigation is required.

All harm is unacceptable and will require and receive a safeguarding response. The nature of that response will be determined by a range of factors. A critical first consideration is whether or not the harm constitutes a criminal offence.

A crime is a breach of the criminal law which is contained in statute or of common law. Not all harm constitutes a crime and only when a criminal offence is suspected is the Joint Protocol applicable.

Where harm constitutes a potential criminal offence the Joint Protocol seeks to ensure that the adult in need of protection has equal access to the criminal justice system. When a report of a potential criminal offence is made PSNI and HSC Trust Adult Protection Gateway Services will work together to:

a) support the individual through the criminal justice process; and
b) collaborate to ensure their welfare and protection needs are identified are addressed.

The Joint Protocol recognises that conflict that can arise when an adult in need of protection, who has capacity to give informed consent, withholds that consent to a police referral.

The HSC Trust DAPO has a significant role and responsibility in balancing the individual’s human rights, which include the right to choice, with the obligation to address the risks to the adult in need of protection and/or others including children.

The Protocol is predicated on the principle of reporting alleged or suspected criminal acts to PSNI. Any decision by a DAPO not to report an incident which may constitute a possible crime is a serious and significant decision which must always be supported by clear rationale.

2.2 Roles and Responsibilities of the HSC Trust DAPO

The role of the HSC Trust DAPO is to screen the referral and any other available information to ensure that all relevant HSC adult protection processes are implemented as applicable (Section 3 HSC Adult Protection Processes).

The safety of the person who is being abused is paramount. Appropriate action **must** be taken to safeguard the adult in need of protection. This should involve consultation with, and consent of, the individual concerned.

Where there is a concern regarding imminent danger to an adult in need of protection the HSC Trust DAPO must consider whether an immediate report to PSNI should be made.

When a potential crime has been committed, the HSC Trust DAPO will decide if there is a duty to report a relevant offence as outlined in the Criminal Law Act 1967 Section 5 (Appendix 7

Where any crime is suspected the issue of possible PSNI involvement should be discussed with the adult in need of protection. Their consent for contact with the PSNI should be sought and details of the nature and content of that contact should be provided.

The adult in need of protection should be provided with as much information as possible to assist them in making an informed decision about how they wish the situation to be handled, including information on their right to make a report to the PSNI. Details of all support available through the course of any investigation should also be provided.

Where there is a query regarding the capacity of the adult to make an informed decision regarding whether to report to the PSBI, the HSC Trust DAPO should ensure that every effort is made to maximise their capacity to make this decision.

In all situations where the individual and/or their family take the view that a report to the PSNI should be made, the HSC Trust should facilitate and assist them with this report.

The HSC Trust DAPO is responsible for ensuring that the adult in need of protection's views and all other relevant information inform professional judgements as to any further action to be taken. They must give full consideration to issues of consent and capacity in every case and in every circumstance (Appendix 8 Human Rights, Consent and Capacity).

In situations where the individual lacks capacity to make an informed decision regarding a report, the HSC Trust DAPO should ensure that, where appropriate, the individual's family are consulted.

Where the individual lacks capacity to make an informed judgement and he/she has no family, the HSC Trust DAPO should ensure that 'best interest' principles are applied. This can also apply in circumstances where the family of the adult in need of protection do not agree with a referral to the PSNI. In some situations use of an independent advocate may also need to be considered and/or legal advice sought.

Actions to protect the individual or other adults in need of protection or children should not be delayed pending any assessment of capacity.

Decisions taken to report to PSNI without the consent of the adult in need of protection are serious and significant decisions. The HSC Trust DAPO will need to consider whether undue influence or coercion have been factors influencing the individual's decision.

In making these decisions the HSC Trust DAPO must balance the individual's human rights under Article 8 (Right to Private and Family Life) within the context of possible risk to the individual or others at risk or children. A decision not to make a complaint to the PSNI may be outweighed by the need to ensure that other adults are given the full protection available to them under Article 3 (Prohibition of Torture, Inhuman or DegradingTtreatment) **OR** where the HSC legal obligation is to report a relevant offence.

In these circumstances any decision to report a concern to the PSNI against the expressed wishes of the adult in need of protection should be based on careful consideration of the exercise of both these Articles which indicates that there are reasonable grounds for such a report to be made. The referral to the PSNI should record the basis for this determination. (Appendix 7 Human Rights, Consent and Capacity; Appendix 8Definition of Relevant Offence)

2.3 Joint Protocol Pathways

The HSC Trust DAPO, in applying the Joint Protocol, has three possible pathways to consider. They should use the following options to achieve the best possible outcome for the adult in need of protection.

A. There is a potential crime which must be reported to PSNI

B. There is a need for a Joint Agency Consultation with PSNI CRU to determine the most appropriate course of action

C. The criteria for reporting to PSNI under the Joint Protocol are met

A. There is a potential crime which must be reported to PSNI

In the following situations there **must** be a report of the incident to the PSNI:

- An adult in need of protection is in **imminent danger** and there is a need for an immediate report to PSNI

  OR
- There has been an incident which may constitute a **relevant offence** under Section 5 of the Criminal Law Act (NI) 1967 (Appendix 8)

  OR
- Referral information clearly states the adult in need of protection wishes or has consented to PSNI involvement

  OR
- The referral information clearly states that the adult in need of protection lacks capacity to give informed consent to PSNI involvement and family members and/or professionals involved take the view that PSNI involvement is required.

When considering the urgency of the response required the following should be used as appropriate:

- 999 call – if an imminent danger has been identified
- CRU (Central Referral Unit) via email on CJSM system (Mon-Fri 8am-9pm; Sat & Sun 9am-5pm)
- Outside the CRU hours call 101 if required (non-emergency)

Incidents which may constitute a relevant reportable offence and which must be referred to the PSNI

In some situations it will be evident from the outset that a relevant offence has occurred. In other situations, assessment, professional judgement and joint agency consultation will be required to properly determine this. For example a situation where both adults at risk lack capacity and are found in bed together does not necessarily mean that a sexual offence has been committed. A professional assessment should take place to decide the most appropriate response.

- **Physical assault**
  Any form of assault is unacceptable. There are a range of potential offences which include common assault, assault occasioning actual bodily harm, grievous bodily harm, and grievous bodily harm with intent, attempted murder, manslaughter and murder. However in terms of relevant offences, common assault is not a relevant

offence under section 5 of the Criminal Law (Northern Ireland) Act 1967 (as it attracts a sentence of less than 5 years).

- **Sexual offences**
  Most sexual offences will be relevant offences under section 5 of Criminal Law Act (Northern Ireland) 1967. The DAPO as part of the professional assessment should ascertain whether any non-consensual sexual activity has occurred and taking into consideration the views of the alleged victim and/or their next of kin determine whether harm has taken place.

- **Domestic abuse incidents**
  The definition of domestic violence and abuse incorporates issues such as forced marriage, female genital mutilation and honour based violence, as well as abuse of adult in need of protection within the family or by an intimate partner.

  However not all acts which may amount to domestic abuse constitute criminal offences. For example psychological abuse, name calling or controlling behaviour are not criminal offences per se but may still require an alternative safeguarding response.

  Whether a criminal offence has been committed will depend on the circumstances of each individual case. In all domestic violence cases the CAADA/DASH/RIC form **must** be completed to determine whether a referral to MARAC is required and/or serious harm has been caused which requires a report to the PSNI.

- **Financial abuse incidents**
  Where there are reasonable grounds to suspect that a crime has been committed or there is an allegation of fraud, theft and/or misuse of finances.

- **All cases of Human Trafficking and Modern Slavery**
  Most cases of human trafficking and modern slavery will be complex in nature and may involve serious organised crime where the risk to victims and /or others can be significant. Therefore consultation with the victim and PSNI should take place and the wider public interests must be taken into consideration. The HSC Trust DAPO should seek further advice from the HSC Trust Lead officer for cases of human trafficking and modern slavery.

- **All cases where the person alleged to have caused the harm is a paid employee or a volunteer in a position of trust and there is a reasonable suspicion that a crime has been committed.** Where poor practice may constitute ill-treatment or wilful neglect, consideration may need to be given to Article 121 of the Mental Health (Northern Ireland) Order 1986. (Appendix 9)

  Not all incidents of poor practice constitute serious harm and/or an offence but may still require an alternative safeguarding response.

- **Institutional abuse** can take many forms, ranging from issues associated with poor practice to situations where serious harm may have been caused and/or a criminal offence may have been committed.

- **Historical abuse** can relate both to childhood abuse or past abuse in adulthood. The main forms of historical abuse to date have been sexual, physical, financial and institutional abuse. In cases of alleged historical childhood abuse, the lead agency will be the PSNI.

  However if the adult is considered to be an adult at risk, HSC Trusts should consider whether the individual would benefit from the support offered through the Joint Protocol process. In these cases it is essential that there is robust joint agency consultation between PSNI CRU and the Adult Protection Gateway Service. Child Protection Gateway Services should be involved as appropriate.

  In cases of historical child abuse, a PJI1 form (Appendix 14) should be completed and forwarded to the PSNI using the secure email CJSM system. Where the professional assessment indicates that the adult in need of protection will require the support mechanisms offered via the Protocol process, this should be recorded on the PJI1 form clearly stating that the Pre-Interview Assessment and Achieving Best Evidence processes should be followed.

Where there are reasonable grounds to suspect that a relevant offence has been committed, the HSC Trust has a legal obligation to report the matter to the PSNI. However this does not negate the HSC Trust responsibility to ensure that all human rights obligations are fully considered.

In order to meet these obligations there is a clear and explicit requirement for the DAPO to ensure that the HSC Investigating Officer (IO), where it is safe to do so, engages with the adult in need of protection to discuss the incident and their view on any action to be taken.

Where the individual does not want to make a report to the PSNI and the professional view is that a relevant crime may have been committed, there must be evidence of the rationale for any decisions to report the matter to the PSNI. This rationale should be recorded on the Regional ASP and Joint Protocol AJP forms (Appendix 14 AJP Forms).

B. There is a need for a Joint Agency Consultation with PSNI CRU to determine the most appropriate course of action

Where there are reasonable grounds to suspect that an adult in need of protection may be a victim of a potential criminal offence and there is uncertainty regarding the

most appropriate course of action, a Joint Agency Consultation should be considered. The views and wishes of the individual should be sought and a full explanation of the process provided.

Where the individual withholds consent to a Joint Agency Consultation, the HSC Trust DAPO may need to consider seeking legal advice on the appropriate way to proceed.

The purpose of a Joint Agency Consultation is for the HSC Trusts and PSNI to work together to reach an informed decision regarding the best possible outcome for the adult in need of protection. It ensures and facilitates an early exchange of relevant information.

This consultation should involve the relevant HSC Trust DAPO and the PSNI CRU officer and should determine whether a PSNI investigation is required and if so whether this should be a joint agency investigation.

Referrals for a Joint Agency Consultation should be made using the AJP1 form (Appendix 14). This form must be forwarded via the CJSM secure email system. On completion and forwarding of the AJP1, the referrer should make contact with the PSNI CRU and the process of Joint Agency Consultation will begin.

Not all consultations will automatically result in a police investigation. However they will be treated as a potential crime and as such will be issued a crime reference number.

Careful consideration will need to be given to all available information including active consideration of the views and wishes of the adult in need of protection and/or their family and relevant others as appropriate.

PSNI, as the lead agency in relation to criminal matters, will have a pivotal role in determining whether a criminal investigation needs to take place. Nevertheless, it is anticipated that there will be joint agency discussion and decision making.

PSNI CRU, like the HSC Trust DAPO, will need to consider issues of consent, capacity and human rights when deciding what action needs to be taken. Where a criminal investigation is to proceed against the expressed wishes of an adult in need of protection, there should be clear evidence and record of the balancing of rights and a rationale to support any decision taken.

The detail of any decision and rationale should be recorded by PSNI CRU on the AJP1 form (Section 3 and Appendix 14), along with details of agreed actions to be taken. The Joint Agency Consultation must agree a decision as to the way forward. This should not preclude an interim protection plan being implemented if required. The AJP1 outcome will be forwarded to the DAPO by PSNI.

Outcome of an Initial Joint Agency Consultation

There are a number of possible outcomes from a Joint Agency Consultation:

1. There is insufficient information available to make a decision.

In such cases the PSNI/CRU must provide detailed instructions regarding any additional preliminary information to be gathered by the HSCTrust. It will be for the PSNI to ensure that an effective balance is drawn between seeking sufficient information from the HSC Trust to make an informed judgement and not jeopardising a possible PSNI investigation.

2. Single agency HSC Trust adult protection investigation

Where a single agency HSC Trust investigation is considered to be the appropriate response, HSC Trust staff should refer to the Adult Safeguarding Operational Procedures (2016) for detailed guidance on conducting a single agency HSC Trust adult protection investigation. The decision to conduct a single agency investigation should be kept under review as new information may indicate a need to reconsider the decision in relation to the Joint Protocol.

3. Single agency PSNI investigation
Where a single agency PSNI investigation is considered to be the appropriate response, PSNI officers should refer to Police Service Procedures.

During a single agency PSNI investigation, where appropriate the HSC Trust will respond to any adult safeguarding or protection issues identified. Strategy discussions/meetings provide a forum in which any potential conflict between safeguarding adults in need of protection and criminal investigations can be discussed and resolutions agreed.

The PSNI should continue to liaise with the relevant HSC Trust DAPO in relation to any adult safeguarding or protection issues. The HSC Trust will co-operate with any PSNI request to provide a Specialist Interviewer.

4. Joint Agency collaborative working

In some cases both the PSNI and the HSC Trust will have a role. In these circumstances close liaison and communication between the two agencies and an agreed action/strategic plan will be required. This plan should, at a minimum, include:

- Clarification of the roles and responsibilities of the two agencies including details of nominated officers
- Details of the communication strategy between the two agencies

- The communication strategies with victims, carers and families and when applicable with RQIA and service providers. This should include agreed time scales and details of the named staff responsible for this
- Details of the agreed actions and sequencing of actions with associated timescales
- Arrangements for ongoing adjustments and review of the action plan

Outcomes should be formally agreed and joint agency decisions taken regarding closure.

PSNI must inform the HSCTrust DAPO of the outcome of any single agency investigation. This will allow the HSCTrust to consider if there are any additional actions and/or protective measures required.

5. Joint Agency investigation involving the PSNI and HSC Trust.
In some cases where the PSNI are taking the lead investigative role but the HSC Trust continue to be involved with the adult(s) in need of protection; joint agency collaborative working will be required.

In joint agency investigative interviews involving the HSCTrust and PSNI, the requirements in relation to collaborative working will apply (See Section 2.3).

6. No further action under the Joint Protocol.
PSNI, HSC Trusts and/or RQIA will need to consider possible alternative responses or support mechanisms, e.g. enforcement action by RQIA.

C. Criteria for NOT reporting to the PSNI using the Protocol for Joint Investigation of Adult Safeguarding Cases

There is always a need for a balanced and proportionate response to concerns. In some instances it will be clear from the outset that the harm or likelihood of harm caused by abuse, exploitation or neglect does not meet the threshold of criminality and that a single agency response under adult protection procedures is more appropriate.

In other situations referral information can be limited and where there is insufficient information to determine what is the appropriate course of action careful consideration must be given to how to proceed. (See section 3.2)

Where the threshold for a potential criminal offence is met the HSC Trust position is that reports to PSNI should be made.

In circumstances where the adult in need of protection has the capacity to make an informed decision and withholds consent to a report being made to the police, attention must be paid to the individual's right to respect, dignity and choice.

A first consideration for the DAPO will be whether there is a legal obligation to report to the police under Section 5 of the Criminal Law Act (NI) 1967 (Appendix 8).

Where there is no legal obligation to report the matter, the DAPO will need to balance the HSC Trust's broad position of reporting to the PSNI with the individual's human rights and, if applicable, the rights of others. The nature of the incident, its impact on the individual and/or others and likelihood of reoccurrence are among a number of factors which must be taken into consideration. Full consideration of all legal obligations will be required when determining the actions to be taken. The DAPO should ensure that a comprehensive risk assessment is conducted to support decision making.

A decision not to report an incident to the PSNI is a serious and significant decision and therefore only HSC Trust DAPOs who have conducted or co-ordinated an initial professional assessment will have the authority to make these decisions.

In making the decision **NOT** to report to the PSNI, the HSC Trust DAPO must as a minimum demonstrate consideration of the following:

- The adult in Need of protection has capacity to make an informed decision and does not want to make a complaint to PSNI. Full consideration will need to be given to all elements of consent, capacity and human rights, including issues of undue influence and possible coercion (Appendix 7 Consent/Capacity/Human Rights).

  AND

- The Trust is not required by law to make a referral to PSNI (if the potential offence committed is not a relevant offence under Section 5 of the Criminal Law Act (NI) 1967 (Appendix 8 Section 5 Criminal Law (Northern Ireland) Act 1967)

  AND

- It is a minor incident. A comprehensive assessment of all the factors **MUST** be completed to evidence a through risk assessment of these cases. This will include consideration of whether repeat incidents have occurred and/or whether other adults at risk or children have been or are likely to be at risk of harm (Appendix 6 Factors to be considered in the assessment of the seriousness of Harm and Risk of Harm)

AND

- The situation is being managed through an adult safeguarding process and/or there are other protective measures in place

The HSC Trust DAPO must ensure that **all** the above criteria are met and take into consideration any other relevant information. The rationale for a decision not to report an incident to PSNI must be clearly evidenced and recorded on the Regional Adult Joint Protocol forms (Appendix 14)**.**

Where the individual lacks capacity to give informed consent and their next of kin take the view that a report should not be made to the PSNI, this should be adhered to, provided all other above criteria are met and this decision is consistent with best interest principles.

Under NO circumstances should any adult in need of protection's request for a report to be made to PSNI be refused. The entitlement of all individuals to equal access to the justice system is absolute and begins with a report to PSNI.

2.4 Factors to be considered when the person alleged to have caused harm is themselves an Adult at Risk

The HSC Trust will have responsibility in situations where the person alleged to have caused the harm is also an adult at risk. The HSC Trust should take into consideration the human rights and need for protection for this individual. The HSC Trust responsibility in relation to protection remains a constant, irrespective of which pathway the investigation takes i.e. adult safeguarding, adult Protection, PSNI only or joint investigation.

The HSC Trust DAPO should consider the likelihood that the person causing the harm may present an ongoing risk to the victim and/or others including children

In situations where the victim or the victim's family decide not to make a complaint to the PSNI the HSC Trust DAPO should consider:

- The criteria for not reporting to PSNI
- The need for a Joint Agency Consultation

Obligations to report serious harm which may constitute a relevant offence to the PSNI continue to apply.

In all situations where a report is being made to the PSNI, the fact that the person causing harm is also an adult at risk should be clearly highlighted. The PSNI should also be advised if there is a concern that the adult at risk and/or the individual who is

alleged to have caused harm, may not have the capacity to engage in a PSNI interview and to give legal instruction.

There should be no assumptions made about an individual's capacity, even in situations where there is an existing diagnosis affecting cognitive functioning such as dementia or learning disability. Each case should be assessed on an individual basis to determine the person's level of cognitive functioning, whether the harm caused was intentional or unintentional and whether the person can be reasonably held accountable for their actions (Appendix 7 Human Rights, Consent and Capacity).

Capacity assessments should be carried out by an appropriately trained professional. In cases where the person alleged to have caused harm is themselves an adult in need of protection and is already known to specialist services the professional involved may be able to provide an informed opinion in relation to the individual's capacity.

Capacity assessments/reassessment should consider as a minimum:-

- The extent to which the person causing harm is able to understand his/her actions and whether there is an awareness of or intent to cause harm; and

- Whether the behaviours of the person causing harm may be associated with learning disability, mental ill-health or dementia.

In situations where the adult at risk has allegedly caused harm and is deemed to lack capacity to understand his/her actions, the harm was unintentional and does not constitute serious harm or a relevant offence, then consideration should be given to whether a single agency HSC Trust investigation may be a more appropriate response than a PSNI investigation.

In all cases where serious harm has occurred or where the potential offence reaches the threshold of a serious relevant crime, a Joint Agency Consultation with PSNI CRU must take place.

The Public Prosecution Service (PPS) will provide early direction to PSNI in relation to whether a fast track disposal can be considered (Appendix 4 PPS Test for Prosecution). In all cases where PSNI are involved a case file should be prepared by the PSNI.

In certain types of offences the PSNI can consider Discretionary Disposal. In these instances the decision regarding Discretionary Disposal is for the adult in need of protection and/or their family the detail regarding resolution is reliant on the person alleged to have caused the harm acknowledging wrong-doing and complying with the protection plan and any sanctions agreed.

In cases which require the PSNI to submit a case file to the PPS, the PSNI should liaise at an early stage with the PPS to ascertain whether a full investigation file is required to be submitted for consideration or whether a streamline file would suffice.

In any event the file submitted should provide a comprehensive record of all the relevant information and actions taken. The case file should also clearly identify if the person alleged to have caused the harm is an adult at risk and has been assessed as lacking capacity to understand the consequences of his/her actions.

In some situations the adult at risk who is allegedly causing harm will already be known to the HSC Trust and may be resident in a care setting (Residential/Nursing Home, specialist hospital or specialist facility) or in receipt of community services. In light of any identified concerns a full reassessment of this adult at risk's needs should always be conducted.

Where the victim and person alleged to have caused the harm are both considered to be adults at risk and are in the same environment, effective risk management is critical. The likelihood that the person causing the harm will present an ongoing risk to the victim and/or others including children must be considered by the HSC Trust DAPO under both the Adult Protection Operational Procedures and the Joint Protocol.

In situations where the PSNI are the first responders and have concerns that the person allegedly causing harm is an adult at risk, it is their responsibility to make a professional judgement as to whether a referral should be made to the appropriate HSC Trust.

At a minimum this judgement should consider the needs, capacity and consent of the individual and whether there are wider protection issues in relation to other Adults at Risk or children.

SECTION 3

3.1 HSC Trust Adult Protection Processes

The following grid outlines the HSC Trust Adult Protection Processes to be followed in cases where there is a concern that harm caused to an adult in need of protection which may constitute a potential criminal offence.

Stages in Joint Protocol Process	Decision	Action	Decision Process	Forms
Stage 1 DAPO screens referral to determine if Adult Protection criteria is met	a) Criteria not met	Refer to appropriate service/agency	Complete appropriate referral	Record decision on Regional Adult Protection forms
	b) Criteria met	Proceed to **Stage 2**		Record decision on Regional Adult Protection forms
Stage 2 DAPO assesses referral information to determine if a potential crime has been committed	a) Where the referral information clearly states that the adult in need of protection and/or their next of kin wants to make a complaint to the PSNI (section 2.2)	DAPO will ensure that the individual is supported in making a report to the PSNI	DAPO ensures that an immediate report is made to PSNI: - 999 if there is imminent danger to a person. - In all other cases report to CRU (Mon-Fri 8am-9pm; Sat & Sun 9am-5pm) - 101 at all other times PSNI and the DAPO will consult with the person and decide what level of response is required	Record decision on Regional Adult Protection forms DAPO completes AJP1 section 1 & 2 and forwards to CRU without undue delay
	b) Insufficient information to make decision	DAPO considers follow up actions required (section 3.2)	The DAPO will consider the additional information and decide whether a potential crime has or has not been committed and follow either (b), (c) or (d)	Record on Regional Adult Protection forms
	c) Potential crime **NOT** identified	Proceed to Regional Adult Protection Procedures	DAPO initiates single agency Adult Protection investigation	Record on Regional Adult Protection forms
	d) Potential crime identified	Trust DAPO applies threshold criteria (see section 2)	The DAPO should also consider potential additional factors e.g. - the person alleged to have caused harm is themselves an adult at risk. DAPO also needs to consider the needs of this person (see section 2.4) - the case may constitute organised or multiple abuse (see section 6) Proceed to **Stage 3**	Record decision on Regional Adult Protection forms

Stages in Joint Protocol Process	Decision	Action	Decision Process	Forms
Stage 3 Trust DAPO applies threshold criteria to the specifics of referral and considers which of the three options should be implemented (section 2)	<u>Option 1</u> Potential Crime which must be reported to the PSNI (see section 2)	DAPO ensures that the adult in need of protection is informed of requirement to make report to the PSNI	DAPO ensures that in completion of the AJP1 all the individuals and/or others human rights are considered. The rationale for decisions should be recorded (section 2 & Appendix 8)	DAPO completes AJP1 form sections 1 & 2 and forwards to CRU without undue delay via CJSM system DAPO contacts CRU to discuss referral and agree action plan. CRU officer completes AJP1 section 3 and forwards to DAPO on same day
		Where criteria for relevant offence / reportable crime are met, DAPO proceeds to report to PSNI. (see section 2)	DAPO should consider whether there is a need for an immediate report to PSNI via 999 (if there is imminent danger to a person). In all other cases report to CRU (Mon-Fri 8am-9pm; Sat & Sun 9am-5pm) and 101 at all other times (see Stage 4)	Recorded on Regional Adult Protection and AJP forms
	<u>Option 2</u> Joint Agency Consultation	Where the HSC Trust DAPO requires clarification on whether there is a need for a Police investigation, the joint agency consultation process should be initiated. HSC Trust DAPO must provide information on views and wishes of the individual and/or family if applicable. This should be central to the decision making for both agencies. The PSNI expertise in criminal offences will inform this decision (see section 2)	The joint agency consultation should agree a decision as to which option is most appropriate and any actions which are required. There are a range of options which can be considered (see section 2). The decisions regarding which option is agreed should be clearly recorded. If the decision is for joint agency collaborative working, proceed to **Stage 4.** Single Agency Trust investigations follow the Regional Adult Safeguarding Operational Procedures – Adults in Need of Protection.	CRU completes AJP1 section 3 and forwards to HSC Trust DAPO on same day
	<u>Option 3</u> **NOT** reporting case to PSNI	HSC Trust DAPO applies criteria for **NOT** reporting potential crime to PSNI (see section 2)	Where the criteria for **NOT** reporting is met HSC Trust DAPO follows Regional Single Agency adult protection procedures. Decision not to report must be kept under ongoing review	The rationale for a decision **NOT** to report an incident to PSNI must be clearly evidenced and recorded on the Regional Adult Protection Procedures forms by the HSC Trust DAPO.

Stages in Joint Protocol Process	Decision	Action	Decision Process	Forms
Stage 4 Joint Agency Collaborative Working	Joint Agency strategy discussion / meeting following CRU allocation of case to appropriate PSNI Sergeant	HSC Trust DAPO co-ordinates Joint Agency Strategy discussion / meeting Contact made between PSNI Sergeant and agrees Interim Protection Plan All immediate protection measures required should be taken in liaison with the PSNI HSC Trust DAPO ensures that adult in need of protection is informed of the report to the PSNI and their views are considered and recorded on Regional Adult Protection forms and the AJP forms	HSC Trust DAPO agrees interim protection measures as part of strategy discussion / meeting with PSNI Investigating Officer Joint agency agreement in relation to: - lead agency in investigation - Clarify roles and responsibilities - Identify key PSNI and Trust Investigating Officers - Agreed investigation plan - Agreed communication strategy	HSC Trust DAPO records decision in both the Regional Adult Protection forms and the AJP2 form
PIA and ABE				
Joint Agency Investigation Process PIA and ABE Planning	Joint Agency investigation planning	HSC Trust DAPO and PSNI agree to proceed to PIA Specialist Interviewers identified Where appropriate, ABE arranged PSNI consider referral for Registered Intermediary	Joint Agency consideration of need for PIA and ABE interview (Section 5)	AJP3 completed if PIA agreed AJP4 and AJP4(a) if ABE interview required

Closure				
Stage 5 Exit Joint Protocol Investigation	No further action under Protocol	Agreed by all agencies involved in investigation		Decisions recorded on AJP5
	PSNI single Agency Investigation	PSNI responsibility		Decisions recorded on AJP5
	PSNI progresses file to PPS	PSNI responsibility		Decisions recorded on AJP5
	Trust Single Agency Investigation	Trust continues single agency protection planning / agreed actions as appropriate		Decisions recorded on AJP5
	RQIA single agency	RQIA continues to consider regulatory issues and enforcement options as appropriate		Decisions recorded on AJP5

3.2 Initial Decision Making by HSC DAPO where there is insufficient information

Where the HSC Trust DAPO is unable to make an informed decision as to whether a report to the PSNI is appropriate, the following range of options can be considered as part of the preliminary information gathering under the adult protection process:

- Further clarification to be sought from referrer and/or relevant others as part of a preliminary screening process;
- Allocation of the case to an HSC Trust IO for an initial assessment and/or implementation of an Interim Protection Plan

Rationale for Initial Decision Making

The HSC Trust DAPO may decide that an initial Trust single agency assessment or intervention is required. There should be a clear rationale to support this decision which may include:

- There is insufficient information regarding whether serious harm has been caused

or

- There is no indication from the information currently available that a relevant crime and/or a reportable offence has been committed

or

- There are safety concerns regarding the adult in need of protection and the HSC Trust considers that it is best placed to take immediate action to assess and/or manage this risk. The safety of any adult at risk/in need of protection or children will always be paramount in any investigation process. (The DAPO must also consider whether there are any safety issues for staff)

or

- There is insufficient information to determine if the adult in need of protection has the ability to give informed consent and there are no immediate protective actions required or actions under relevant offences.

or

- There are queries regarding the reliability of the information and further checks need to be carried out.

The list above is not exhaustive. Decisions need to be taken on a case by case basis and the application of professional judgement will be critical.

However there should be no delay in establishing whether there is a protection issue to be addressed.

The HSC Trust DAPO is required to consider whether an early referral to the PSNI is appropriate. The HSC Trust DAPO needs to be mindful not to jeopardise a potential PSNI investigation and all actions taken must be considered in this context. If there is the potential to secure forensic evidence and/or possible investigative opportunities, there should be no delay in making a report to the PSNI.

If the HSC Trust DAPO takes the decision that there a need for an initial HSC Trust single agency risk assessment, the HSC Trust DAPO will appoint an IO and give explicit instructions in relation to what actions are to be taken. The HSC Trust DAPO will determine what level of information and assessment is required in order to make an informed decision regarding the nature and level of intervention.

The agreed actions should be recorded on the Regional Adult Safeguarding forms (Appendix 14).

Initial Assessment by HSC Investigating Officer

IOs conducting interviews with the adult in need of protection should be mindful not to jeopardise any potential police investigations and be aware that information obtained may be used as part of any subsequent police investigation.

An initial assessment should, as a minimum, include:

- meeting with the adult in need of protection to establish the facts of the allegation to determine whether there are reasonable grounds to suspect that a crime may have occurred;

- advising the adult in need of protection of the options available to them in terms of making an informed decision regarding their wishes;

- where the concerns constitute a possible crime, advising the adult in need of protection of their right to a referral to the PSNI and providing them with an outline of the Protocol process;

- ascertaining what course of action the adult wishes to take;

- where a **relevant offence** or other reportable offences has taken place the adult in need of protection should be advised of the HSC Trust's legal obligation to report the matter to the PSNI. At this stage particular focus should

be given to the individual's human rights and if contravention of these rights is deemed necessary the rational for this decision should be explained to the individual and recorded using the Regional Adult Safeguarding forms.

Every effort should be made to maximise the adult's capacity to make informed decisions. However if there are issues in relation to the adult's capacity then best interests principles should be applied and, where appropriate, their carer/family should be consulted.

The rights of the adult in need of protection are of paramount importance. However when the investigation and/or protection plan have the potential to infringe on the human rights of others, focused consideration needs to be given to this issue.

Critical Factors to be considered by the HSC Trust DAPO in the assessment process

When there is sufficient information to make a professional judgement regarding whether the harm constitutes a potential crime, it is the role and responsibility of the HSC Trust DAPO to fully apply the guidance provided in Section 2.

In addition the following factors should be considered:

- where the person alleged to have caused harm is themselves an Adult at risk, consideration should be given to how best to proceed. This will include a requirement to review at the needs of the person who is alleged to have caused harm (see Section 2.4)

- where the information provided indicates that there are reasonable grounds to suspect that more than one person has been harmed or there are potentially more than one person alleged to have caused the harm, consideration should be given to whether the criteria for Organised or Multiple Abuse has been met.

  While a number of cases may meet the criteria of organised or multiple abuse, it will be for the professionals involved to determine on a case by case basis whether the additional structures and supports available in these types of cases are required. Any decision not to avail of this should be agreed with senior managers and should be kept under review (Section 6 Large Scale or Complex Investigations).

- where the person under investigation is a member of staff or a paid carer there are potentially a number of investigative processes which will be required. These include a PSNI investigation, an investigation by the employing organisation, an adult safeguarding investigation and a referral to professional or regulatory body.

The interface between these investigative processes and the timescales for investigation should take into consideration the rights of the adult in need of protection and **also** the rights of the person under investigation. Any decision to delay an adult safeguarding or an agency investigation pending the outcome of a PSNI investigation should be kept under active review.

3.3 Application of Joint Protocol Threshold by HSC Trust DAPO

The HSC Trust DAPO, having made a decision based on the available information and/or the initial assessment outcome of the specific case, will determine which of the following thresholds for intervention is deemed to be the most appropriate (see Section 2)

a) Relevant crime and/or reportable crime referred to PSNI for joint agency investigation
b) Joint Agency Consultation with PSNI to determine most appropriate option
c) Criteria for not reporting to PSNI are met, in which case regional Adult Safeguarding Procedures should be followed

(Appendix 10 Joint Protocol flow charts)

3.4 Joint Agency Working

In most situations it is expected that a level of joint agency collaborative working required. The nature of this will depend on the individual case and can include the HSC Trust, PSNI, RQIA and any other relevant organisations. The HSC Trust DAPO will have the lead role in co-ordinating any joint agency meetings required.

Joint Agency Collaborative Working

In cases where the PSNI are taking the lead investigative role but the HSC Trust continue to be involved with the adult(s) in need of protection, joint agency collaborative working will apply. This requires close liaison and communication between the key agencies. It is essential that all key agencies engage in strategy discussions or meetings to facilitate close communication and coordination and effective action plan.
Where the concern relates to an individual or group of individuals known to regulated services, RQIA will be a key partner in terms of joint agency working. Clarification of roles and responsibilities specific to the case and the development of an agreed action plan will be required.

Joint Agency Investigations

It is critical that in joint agency investigations the two key agencies (PSNI and HSC Trust DAPO) work together to ensure that the adult in need of protection is supported in a manner which enables them to have equal access to the justice system. This begins with a process of joint agency strategy planning.

Joint Agency Strategy Planning

The purpose of strategy planning is to:

- share and assess available information
- agree roles and responsibilities in conducting the investigation
- agree /review the interim protection plan
- gather additional information
- formulate a multi-agency plan for the assessment of risk
- address any protection issues
- address any investigation requirements
- consider referral to other agencies or services as required
- decide whether the ABE process may be applicable
- agree a communication strategy

A number of factors will determine which method is used for strategy planning, such as the urgency of the situation, the nature of the allegation, the type of investigation required and so on.

While initial strategy discussions can take place by telephone, a comprehensive planning session can only be achieved when all key personnel are present and can contribute to the risk management process. It is recommended that in most situations where joint agency working is required, a strategy planning meeting should take place.

It is essential that the PSNI and HSC Trust are present at any strategy planning meeting. Decisions regarding the need for PSNI investigation will be reviewed in light of the information provided during the course of the meeting.

Where an allegation relates to a regulated service RQIA should be invited to attend the strategy planning meeting.

Joint Agency closure of case

It is acknowledged that the closure process can be lengthy, particularly in circumstances where a file has been sent to the PPS for a decision on whether a case will be taken forward to prosecution. Therefore it is essential that the agencies involved agree a strategy of closure including communication arrangements with adults in need of protection and relevant others when appropriate. Agreed actions should be recorded by all agencies involved and communicated by the identified lead agency, with clear arrangements in place for any ongoing work.

SECTION 4

PSNI CRU Procedures when HSC Trust DAPOs make a referral and/or seek a joint agency consultation

The HSC Trust DAPO should initially provide information on the AJP1 form via CJSM. Contact can then be made to discuss the details of the case.

The PSNI CRU Constable should establish from the information and discussion whether this relates to a report of a crime to be actioned or if this is a joint agency consultation to determine whether a criminal investigation is appropriate. Record checks should be carried out to inform the decision making process. Particular attention needs to be paid to the views and wishes of the adult in need of protection where they have the capacity to make informed decisions.

Officers need to consider issues of consent, capacity and human rights. A decision to proceed with an investigation against the expressed wishes of an adult in Need of protection is a breach of human rights and therefore any decision to do so must be supported by a clear rationale.

PSNI CRU will have the lead role in determining the most appropriate course of action, however joint agency discussion and decision making should take place where possible. In complex referrals where a joint agency strategy meeting is required, PSNI CRU will not be in a position to attend. Therefore referral information will be passed to the relevant Public Protection Branch and an officer from there will attend.

Section 3 of the AJP1 form should be completed by PSNI CRU, detailing the rationale for any decisions taken and agreed actions. The completed form should be shared between the HSC Trust and PSNI. Where a decision cannot be reached regarding this matter it should be raised immediately with the PSNI CRU Sergeant before any action is taken. If the case is to be allocated for investigation by PSNI, CRU will do this in line with the PSNI Crime Allocation Policy.

Collaborative working should be a feature throughout the Joint Protocol process, both at the point of referral and on allocation. This should ensure an agreed structure in terms of the investigation and protection planning (see Section 3.3 & 3.4).

See Appendix 11 PSNI and CRU Process Flow Chart.

Internal Reporting to PSNI CRU of Adult in Need of Protection referrals

Where PSNI become aware of an Adult in Need of Protection case which meets the threshold for the Protocol they should report this to PSNI CRU without undue delay.

PSNI CRU will then complete the AJP1 form and share with the relevant HSC Trust, emailing via CJSM.

PSNI CRU will then contact the HSC Trust by telephone to discuss the referral and the normal process of liaison will take place with the appropriate HSC Trust DAPO to discuss and agree actions. Section 3 of the AJP1 will be completed and shared between PSNI and Trust to evidence this process.

Adult in Need of Protection Referred by the Public

Where a member of the public rings the PSNI, existing call handling procedures will apply. Full details should be obtained and the occurrence tasked to the PSNI CRU whiteboard. If a call of this nature is received outside PSNI CRU operating hours, consideration should be given to the urgency and seriousness of the incident. In some situations there may be a need to maximise early investigative opportunities. If an immediate police response is required an appropriate call-sign/resource should be tasked as per existing practice. In all other circumstances the matter should be tasked to the PSNI CRU whiteboard as outlined above.

On Allocation

Where matters have been agreed as a joint investigation or police only Investigation, the PSNI will allocate the case to the relevant Public Protection Unit, local policing team or Reactive & Organised Crime Unit for further investigation (Appendix 11 flow chart re PSNI and CRU Processes).

Where a strategy meeting is required the relevant PSNI Investigating Officer will be expected to attend this meeting and any other related meetings required to ensure that a co-ordinated joint agency approach which supports the adult in need of protection is taken. In joint agency investigations close communication and co-ordination in relation to the investigation will be required. It is however important to note that in a single agency police investigation there will also be a need for ongoing communication to ensure that protection needs and/or any other actions can be progressed.

In complex cases PSNI may be asked to attend to provide advice and may be required to be members of the Strategic Management Group (see Section 6, Investigation of Organised or Multiple Abuse Cases).

For full details of procedures to be followed by PSNI, Officers should refer to Service Procedure ‘Adults at Risk of Harm and Safeguarding Procedures’ produced by Crime Operations, Public Protection Branch.

SECTION 5

Special Measures Investigative Interviews

The Criminal Evidence (NI) Order 1999 makes special provision for the gathering of evidence from adults in need of protection or intimidated witnesses.

Detailed guidance on interviewing adults as either adults in need of protection and/or intimidated witnesses, including victims, and the use of special measures in order to enable them to give their best evidence in criminal proceedings, is contained in "Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, the use of special measures and the provision of pre-trial therapy (2012)".

Pre-Interview Assessment

In all situations where a decision has been taken to conduct a joint agency investigation PSNI and HSC Trust Specialist Interviewers should meet with the adult in need of protection and complete the AJP 3 form.

Only those staff that have completed specialist training will be eligible to conduct a pre-interview assessment (PIA).

The purpose of the PIA is to:

- establish with the individual whether they are willing to make a statement of complaint;
- discuss with the individual the options regarding how this statement may be made: video or ABE statement;
- discuss in full the investigative process and the possible use of Special Measures, including the use of a Registered Intermediary (RI) (Appendix 13). This discussion should highlight to the individual that the decision regarding whether the case goes forward to Court is a decision for the PPS. The decision regarding whether the video and/or statement or other form of Special Measures are used in Court is a decision for the trial Judge;
- discuss and agree the practical arrangements regarding conducting the ABE interview and complete the AJP4 and AJP4(a) forms (Appendix 14).

Achieving Best Evidence Interviews

Only those staff that have completed further specialist training will be eligible to undertake the role of Interviewer and Second Interviewer in special measures investigative interviews.

The purpose of an investigative interview is to ascertain the witness's account of the alleged event(s) and any other information that would assist the investigation. A well conducted interview will only occur if appropriate planning has taken place. Interviews should be planned and carried out in accordance with Achieving Best Evidence Part 3A – Planning and Preparing for Interviews. The planning of the interview should be recorded using the AJP 4 form.

NB: Interviewers must be given sufficient time prior to a special measures investigative interview to carry out this planning process.

Information obtained in the planning process should be used to:

- set the aim and objectives for the interview
- determine the techniques used within the phased interview
- agree the means by which the interview is to be recorded
- who should conduct the interview and if anyone else should be present (including support for the witness such as an Interpreter or RI)
- if anybody should monitor the interview
- who will operate the equipment
- the location of the interview
- the timing of the interview
- the duration of the interview (including pace, breaks and the possibility of more than one session
- what is likely to happen after the interview

Consideration should also be given to who is best qualified to lead the interview. The lead Interviewer should be a person who has or is likely to establish rapport with the adult in need of protection, who understands how to communicate effectively with witnesses who might become distressed and who has a proper grasp of the rules of evidence and criminal offences. The lead Interviewer must have a good knowledge of information important to the investigation, including the points needed to prove particular offences.

The presence of a Second Interviewer is desirable because they can help to ensure that the interview is conducted in a professional manner, can assist in identifying any gaps that emerge in the witness's account and can ensure that the witness's needs are kept paramount.

Statements of Evidence (PSNI Form 38/36) recorded in special measures investigative interviews will be retained by the PSNI for evidential purposes. A copy may be provided to the HSC Trust, provided that the adult in need of protection or their representative agrees.

Where an interview has been video-recorded, the original will be labelled and secured for court purposes by the PSNI. The working copy will be available for viewing by HSC Trusts by prior arrangement only. A log will be completed on each occasion that the tape is viewed by anyone which details the reason for viewing. This will be retained with the working copy of the tape.

Arrangements for viewing the tape by persons other than the HSC Trusts, or at any subsequent court hearing, will be the responsibility of the PSNI. PSNI General Order C(c) 70/96 must be complied with.

The police officer in charge of the case will be responsible as the prime keeper of all exhibits, including any drawings, letters, notes etc. made in the course of the special measures investigative interview. The disclosure of third party material which may be relevant to an investigation must only be made in compliance with the Criminal Procedures Investigation Act 1996.

SECTION 6

Investigation of Large Scale and Complex Abuse Cases

Complex (organised or multiple) abuse may be defined as abuse involving one or more abusers and a number of related or non-related adults at risk. The alleged abusers concerned may be acting in concert to abuse adults at risk, may be acting in isolation, or may be using an institutional framework or position of authority to access adults at risk.

Such abuse occurs both as part of a network across a family or community and within institutions such as residential or nursing homes, supported living facilities, day support settings and in other provisions such as voluntary groups. There may also be cases of adults at risk being abused through the use of the internet. Such abuse is profoundly traumatic for the adults at risk who become involved. Its investigation is time-consuming and demanding work which requires specialist skills from PSNI and HSC Trust staff.

Each investigation of organised or multiple abuse will be different, according to the characteristics of each situation and the scale and complexity of the investigation. However, every investigation will require careful and thorough planning, effective inter-agency working and attention to the needs of the adult(s) in need of protection and the adult(s) at risk involved.

Some investigations become extremely complex because of the number of people or places involved and the timescale over which the abuse is alleged to have occurred.

Process for Investigation of Large Scale and Complex Abuse Cases

On receipt of information which may indicate organised or multiple abuse, the HSC Trust DAPO should immediately consider whether a report to the PSNI is appropriate. A Joint Agency Strategy Meeting with representatives from the key agencies should then take place as a matter of urgency to discuss and agree roles, responsibilities and an interim action plan.

Where the strategy meeting confirms that the investigation relates to organised or multiple abuse, a multi-agency Strategic Management Group will be appointed to oversee the process.

Strategic Management Group

The Strategic Management Group (SMG) will manage and support the investigation and provide the necessary response to the needs of both the adult(s) in need of

protection and the adults at risk. The SMG is comprised of the following core representatives:

- PSNI;
- HSC Trust DAPO;
- a senior manager from the relevant HSC Trust adult Programme of Care; and
- RQIA (where the allegation relates to a regulated service).

The SMG will be convened and chaired by the appropriate agency. SMG representatives may co-opt representation from relevant other disciplines or agencies, dependant on the type of alleged abuse under investigation.

Appropriate legal advice will be necessary and should be sought through PSNI and HSC Trust legal advisers.

Functions of the SMG

The SMG will:

- establish the principles and practice of the investigation and ensure regular review of progress against that plan;
- prioritise and allocate expedient resources to establish an Investigative Team within their respective agencies;
- ensure co-ordination between the key agencies and the Investigative Team within the HSC Trusts and PSNI. This includes resolving any interagency operational interface challenges between various established processes;
- ensure decisions of the strategy planning group are actioned in a timely manner.
- act in a consultative capacity to those professionals who are involved in the investigation;
- draw up a media strategy to respond to public interest issues and agree who will take responsibility for responding to media enquiries;
- have oversight of the agreed communication strategy/liaison with adults in need of protection/families and carers involved in the investigation;
- at the conclusion of the investigation, discuss salient features of the investigation with a view to making recommendations for improvements either in policy or in practice.
- The closing process must be signed off by the SMG in the case of a serious/complex Adult Protection situation.

Following agreement between the PSNI and HSC Trust that referral meets the criterion for organised or multiple abuse, the SMG will meet within 2 working days. Thereafter the SMG will meet as required to discuss and review the progress of the

investigation. The frequency will be determined by the complexity of the case. Managerial representation of the Investigative team will be present at each meeting of the SMG.

The aim of these meetings is to:

- Review all aspects of the strategy for investigation
- Provide advice on the appropriate strategic direction
- Ensure the continuing active co-operation of all relevant agencies
- Agree a response to victims, families and carers if appropriate
- Agree a joint media response
- Produce an accurate record of all meetings held.

At the conclusion of the investigation, the Joint Investigative Team should meet with the SMG to discuss salient features of the investigation with a view to making recommendations for improvements either in policy or in practice.

SECTION 7

Information Management / Information Sharing / Records Management

Adult Safeguarding: Prevention and Protection in Partnership Policy provides detailed information regarding requirements in relation to information management and information sharing. All organisations must comply with these requirements including PSNI, HSC Trusts and RQIA. It will be for each organisation to ensure they are meeting the requirements as detailed in this Policy. The Protocol must be considered within this context with agencies understanding their obligations within this.

In terms of record management it is important for all professionals involved in this process to keep factual, contemporaneous records and understand that these records are critical to the investigation. As records of investigations are likely to be subject to some level of review, judicial or otherwise and are also discoverable, accurate and timely record keeping is essential.

Manual/electronic record keeping should include a detailed rationale for decision making at all stages of the adult safeguarding process. This is particularly important when there are potential contraventions of an individual's Human Rights. Use of CJSM is considered an absolute requirement in this context.

SECTION 8

REFERENCES

- Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guidance
  Regional Adult Protection Forum (2006)

- The Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2003 and revised in 2009)
  Regional Adult Protection Forum (2006)

- Achieving Best Evidence in Criminal Proceedings (Northern Ireland)
  Department of Justice (2003, revised in 2010 and again in 2012)

- Safeguarding Vulnerable Adults: A Shared Responsibility
  Volunteer Now (2010),

- Adult Safeguarding in Northern Ireland: Regional and Local Partnership Arrangements
  Department of Health Social Services and Public Safety (DHSSPS) and the Northern Ireland Office (now Department of Justice) 2010

- The Victim Charter (Justice Act (Northern Ireland) 2015) Order 2015;

- The Victim Charter – a Charter for Victims of Crime, published by DOJ in September 2015

- MARAC – Operating Protocol for Northern Ireland Multi-agency Risk Assessment Conferences (August 2014);

- Guidance to Agencies on Public Protection Arrangements (PPANI) Article 50, Criminal Justice (Northern Ireland) Order 2008;

- Working Arrangements for the Welfare and Protection of Adult Victims of Human Trafficking (October 2012);

- The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

SECTION 9

GLOSSARY OF TERMS

Abuse is 'a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to another individual or violates their human or civil rights' Abuse is the misuse of power and control that one person has over another. It can involve direct and indirect contact and can include online abuse.

ABE (Achieving Best Evidence) Interviewer – The Specialist Achieving Best Evidence Interviewer must be a professionally qualified Social Worker. The Specialist Interviewer will be responsible for planning and conducting interviews with service users who may have been the victim of a crime. These interviews will be undertaken jointly with the PSNI and in accordance with the guidance laid out in "Protocol for Joint Investigation of Adult Safeguarding cases" and "Achieving Best Evidence in Criminal Proceedings."

Adult Protection Gateway Service – is the central referral point within the HSC Trust for all concerns about an adult who is, or may be, at risk.

Adult Safeguarding - encompasses both activity which **prevents** harm from occurring in the first place and activity which **protects** adults at risk where harm has occurred or is likely to occur without intervention.

Adult at risk of harm – A person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

iii) **personal characteristics** (*may include but are not limited to age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain*);

and/or

iv) **life circumstances** *(may include, but are not limited to, isolation, socio-economic factors and environmental living conditions);*

Adult in need of protection - An adult at risk of harm (above):
iii) who is **unable to protect** their own well-being, property, assets, rights or other interests;
and
iv) where the **action or inaction of another person or persons** is causing, or is likely to cause, him/her to be harmed.

ASC (Adult Safeguarding Champion) - The ASC should be within a senior position within the organisation and should be suitably skilled and experienced to

carry out the role. The ASC provides strategic and operational leadership and oversight in relation to adult safeguarding for an organisation or group and is responsible for implementing its adult safeguarding policy statement. The ASC is also the main point of contact with HSC Trusts and the PSNI for all adult safeguarding matters.

Case Conference - The purpose of the case conference is to evaluate the available evidence and to determine an outcome based on balance of probability

CRU (Central referral Unit) – The central point of referral to PSNI in relation to adult protection is based in Belfast.

CJINI (Criminal Justice Inspection Northern Ireland) - an independent legal inspectorate with responsibility for inspecting all aspects of the criminal justice system in Northern Ireland apart from the judiciary. It also inspects a number of other agencies and organisations that link into the criminal justice system

Domestic Abuse - Domestic violence and abuse is threatening behaviour, violence or abuse (psychological, physical, verbal, sexual, financial or emotional) inflicted on one person by another where they are or have been intimate partners or family members, irrespective of gender or sexual orientation. Domestic violence and abuse is essentially a pattern of behaviour which is characterised by the exercise of control and the misuse of power by one person over another. It is usually frequent and persistent. It can include violence by a son, daughter, mother, father, husband, wife, life partner or any other person who has a close relationship with the victim. It occurs right across society, regardless of age, gender, race, ethnic or religious group, sexual orientation, wealth, disability or geography.

Designated Adult Protection Officer (DAPO) – the person responsible for the management of each referral received by a HSC Trust. DAPOs will be in place both within the Adult Protection Gateway Service, and within core service teams. The DPAO will provide formal / informal support and debriefing to the Investigating Officer / ABE interviewer; analyse the adult safeguarding data within their service area and contribute to the governance arrangements as appropriate; and ensure that the connections are made with related interagency mechanisms.

DBS (Disclosure and Barring Service - helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA).

Exploitation - the deliberate maltreatment, manipulation or abuse of power and control over another person; to take advantage of another person or situation usually, but not always, for personal gain from using them as a commodity. It may manifest itself in many forms including slavery, servitude, forced or compulsory labour, domestic violence and abuse, sexual violence and abuse, or human

trafficking.

FGC (Family Group Conferencing) - A family group conference is a process led by family members to plan and make decisions for a person who is at risk. People are normally involved in their own family group conference, although often with support from an advocate. It is a voluntary process and families cannot be forced to have a family group conference.

Hate Crime - Hate crime is any incident which constitutes a criminal offence perceived by the victim or any other person as being motivated by prejudice, discrimination or hate towards a person's actual or perceived race, religious belief, sexual orientation, disability, political opinion or gender identity.

Harm - the impact on the victim of abuse, exploitation or neglect. It is the result of any action whether by commission or omission, deliberate, or as the result of a lack of knowledge or awareness which may result in the impairment of physical, intellectual, emotional, or mental health or well-being.

Investigating Officer (IO) - is a HSC Trust professionally qualified practitioner. Their role is to establish matters of fact, how best to protect the adult in need of protection and/or others, to explore alternatives available and to provide advice and support. The Investigating Officer alongside relevant professionals will be responsible for direct contact with the adult in need of protection, their carers and relevant others.

The Protocol – (Protocol for Joint Investigation of Adult Safeguarding Cases) - - The Protocol sets out a framework for joint working in a complex area of practice and emphasises the need to involve all other relevant agencies in information sharing, early assessment and the planning process. The overall aim of the Protocol is to prevent abuse by promoting a multi-agency approach to the protection of vulnerable adults, and to ensure that they receive equitable access to justice in a way that promotes their rights and well-being.

LASP (Local Adult Safeguarding Partnerships) - The five local multi-agency, multi-disciplinary partnerships located within their respective HSC Trusts.

MARAC (Multi Agency risk Assessment Conference) - It is a forum for local agencies to meet with the aim of sharing information about the highest risk cases of domestic violence and abuse and to agree a safety plan around victims.

Modern Slavery - Human trafficking involves the acquisition and movement of people by improper means, such as force, threat or deception, for the purposes of exploiting them. It can take many forms, such as domestic servitude, forced criminality, forced labour, sexual exploitation and organ harvesting. Victims of human trafficking can come from all walks of life; they can be male or female, children or adults, and they may come from migrant or indigenous communities.

NIASP (Northern Ireland Adult Safeguarding Partnership) – The regional multi-agency, multi-disciplinary partnership that brings together representatives from organisations and communities of interest who have a significant contribution to make to adult safeguarding.

NISCC (Northern Ireland Social Care Council) – is the independent regulatory body for the NISC workforce, established to increase public protection aby improving and regulating standards of training and practice for social care workers.

NMC (Nursing and Midwifery Council) – is the independent regulator for nurses and midwives in England, Wales, Scotland and Northern Ireland. NMC sets standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare throughout their careers.

Protection Plan - A plan agreed with the adult at risk (or the person representing them or their best interests) detailing the actions to be taken, with timescales and responsibilities, to support and protect the person from harm.

Registered Intermediary - RIs have a range of responsibilities intended to help adult witnesses who are in need of protection, defendants and criminal justice practitioners at every stage of the criminal process, from investigation to trial.

RQIA (Regulation and Quality Improvement Authority) - Northern Ireland's independent health and social care regulator, responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.

SAI (Serious Adverse Incident) - An adverse incident is an event which causes, or has the potential to cause, unexpected or unwanted effects that will involve the safety of patients, staff, users and other people.

Serious Harm – is a professional decision considering the impact, extent, degree, duration and frequency of harm; the perception of the person and their preferred outcome.

Single Agency Investigation – A single agency adult protection investigation is a **professional assessment** which analyses the risk of harm and serious harm, the impact of that harm on the adult in need and determines if this may have led to abuse. Such assessment requires experienced professional judgement to ensure outcomes are proportionate, necessary and lawful.

Special Measures - The measures specified in the Criminal Evidence (NI) Order 1999, as amended, which may be ordered in respect of some or all categories of eligible witnesses by means of a special measures direction. The special measures are the use of screens; the giving of evidence by live link; the giving of evidence in private; the removal of wigs and gowns; the showing of video recorded evidence in chief, and aids to communication.

SMG (Strategic Management Group) – has responsibility to oversee the process of investigation. Core representatives of SMG are PSNI; HSC Trust nominated Adult protection Gateway DAPO; a senior manager from the relevant adult programme of care; and RQIA (where the allegation relates to a regulated service).

Strategy Meeting - In complex situations the strategy discussion is normally a meeting of key people to decide the process to be followed after considering the initial available facts.

APPENDICES

Appendix 1

Definitions of Abuse, Neglect, Exploitation and Related Definitions

Abuse is 'a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to another individual or violates their human or civil rights'.

Abuse is the misuse of power and control that one person has over another. Abuse may be perpetrated by a wide range of people who are usually physically and/ or emotionally close to the individual and on whom the individual may depend and trust. This may include but is not limited to, a partner, relative or other family member, a person entrusted to act on behalf of the adult in some aspect of their affairs, a service or care provider, a neighbour, a health or social care worker or professional, an employer, a volunteer, another service user. It may also be perpetrated by those who have no previous connection to the victim. All forms of abuse may constitute a crime.

The main forms of abuse are:

Physical abuse

Physical abuse is the use of physical force or mistreatment of one person by another
which may or may not result in actual physical injury. This may include hitting, pushing, rough handling, exposure to heat or cold, force feeding, improper administration of medication, denial of treatment, misuse or illegal use of restraint and deprivation of liberty.

Sexual violence and abuse

Sexual abuse is any behaviour perceived to be of a sexual nature which is unwanted or takes place without consent or understanding[6]. Sexual violence and abuse can take many forms and may include non-contact sexual activities, such as indecent exposure, stalking, grooming, being made to look at or be involved in the production of sexually abusive material, or being made to watch sexual activities. It may involve physical contact, including but not limited to non-consensual penetrative sexual activities or non-penetrative sexual activities, such as intentional touching (known as groping). Sexual violence can be found across all sections of society, irrelevant of gender, age, ability, religion, race, ethnicity, personal circumstances, financial background or sexual orientation.

Psychological / emotional abuse
Psychological / emotional abuse is behaviour that is psychologically harmful or inflicts mental distress by threat, humiliation or other verbal/non-verbal conduct. This may include threats, humiliation or ridicule, provoking fear of violence, shouting, yelling and swearing, blaming, controlling, intimidation and coercion.

Financial abuse
Financial abuse is actual or attempted theft, fraud or burglary. It is the misappropriation or misuse of money, property, benefits, material goods or other asset transactions which the person did not or could not consent to, or which were invalidated by intimidation, coercion or deception. This may include exploitation, embezzlement, withholding pension or benefits or pressure exerted around wills, property or inheritance.

Institutional abuse
Institutional abuse is the mistreatment or neglect of an adult by a regime or individuals in settings which adults who may be at risk reside in or use. This can occur in any organisation, within and outside the HSC sector. Institutional abuse may occur when the routines, systems and regimes result in poor standards of care, poor practice and behaviours, inflexible regimes and rigid routines which violate the dignity and human rights of the adults and place them at risk of harm. Institutional abuse may occur within a culture that denies, restricts or curtails privacy, dignity, choice and independence. It involves the collective failure of a service provider or an organisation to provide safe and appropriate services, and includes a failure to ensure that the necessary preventative and/or protective measures are in place.

Neglect occurs when a person deliberately withholds, or fails to provide, appropriate and adequate care and support which is required by another adult. It may be through a lack of knowledge or awareness, or through a failure to take reasonable action given the information and facts available to them at the time. It may include physical neglect to the extent that health or well-being is impaired, administering too much or too little medication, failure to provide access to appropriate health or social care, withholding the necessities of life, such as adequate nutrition, heating or clothing, or failure to intervene in situations that are dangerous to the person concerned or to others particularly when the person lacks the capacity to assess risk. This policy does not include self-harm or self-neglect within the definition of an ‘adult in need of protection’. Each case will require a professional Health and Social Care (HSC) assessment to determine the appropriate response and consider if any underlying factors require a protection

response. For example self-harm may be the manifestation of harm which has been perpetrated by a third party and which the adult feels unable to disclose.

Exploitation is the deliberate maltreatment, manipulation or abuse of power and control over another person; to take advantage of another person or situation usually, but not always, for personal gain from using them as a commodity. It may manifest itself in many forms including slavery, servitude, forced or compulsory labour, domestic violence and abuse, sexual violence and abuse, or human trafficking. This list of types of harmful conduct is neither exhaustive, nor listed here in any order of priority. There are other indicators which should not be ignored. It is also possible that if a person is being harmed in one way, he/ she may very well be experiencing harm in other ways.

Domestic violence and abuse

Domestic violence and abuse is threatening behaviour, violence or abuse (psychological, physical, verbal, sexual, financial or emotional) inflicted on one person by another where they are or have been intimate partners or family members, irrespective of gender or sexual orientation. Domestic violence and abuse is essentially a pattern of behaviour which is characterised by the exercise of control and the misuse of power by one person over another. It is usually frequent and persistent. It can include violence by a son, daughter, mother, father, husband, wife, life partner or any other person who has a close relationship with the victim. It occurs right across society, regardless of age, gender, race, ethnic or religious group, sexual orientation, wealth, disability or geography.

Human trafficking

Human trafficking involves the acquisition and movement of people by improper means, such as force, threat or deception, for the purposes of exploiting them. It can take many forms, such as domestic servitude, forced criminality, forced labour, sexual exploitation and organ harvesting. Victims of human trafficking can come from all walks of life; they can be male or female, children or adults, and they may come from migrant or indigenous communities.

Hate crime

Hate crime is any incident which constitutes a criminal offence perceived by the victim or any other person as being motivated by prejudice, discrimination or hate towards a person's actual or perceived race, religious belief, sexual orientation, disability, political opinion or gender identity. Victims of domestic violence and abuse, sexual violence and abuse, human trafficking and hate crime are regarded as adults in need of protection. There are specific strategies and mechanisms in

place designed to meet the particular care and protection needs of these adults and to promote access to justice through the criminal justice system. It is essential that there is an interface between these existing justice-led mechanisms and the HSC Trust adult protection arrangements described in this policy.

Appendix 2

HSC Trust contact details

HSC Trust	Adult Safeguarding Number
Belfast	028 9504 1744
Northern	028 2563 5512
Western	028 7161 1366
South Eastern	028 9250 1227
Southern	028 3741 2015/2354

Regional Emergency Social Work Service (RESWS)

Tel: 028 9504 9999 (Mon-Fri 5pm-9am; Saturday & Sunday)

HSC Trust Child Protection Contact Details

HSC Trust	Child Protection Gateway Number
Belfast	028 9050 7000
Northern	0300 1234 333
Western	028 7131 4090
South Eastern	0300 1000 300
Southern	0800 7837 745

Appendix 3

PSNI Contact Details

Immediate report to if there is imminent danger to a person.	PSNI via 999
PSNI Central Referral Unit (CRU) CRU Hours	Contact Number 02890259299 Mon-Fri 8am-9pm; Sat & Sun 9am-5pm
At all other times	101

Completed AJP1 form should be emailed via CJSM secure email system to:

CRU@psni.pnn.police.uk.cjsm.net

In historical child abuse cases, completed PJI1 form should be emailed via CJSM secure email to:

CRU@psni.pnn.police.uk.cjsm.net

Appendix 4

Public Prosecution Service (PPS) – The Test for Prosecution

The Code for Prosecutors provides guidance on how the Public Prosecution Service makes decisions about whether or not to prosecute. It is a public document and is available upon request or can be found on the PPS website at www.ppsni.gov.uk.

Prosecutions are initiated or continued by the Public Prosecution Service only where it is satisfied that the Test for Prosecution is met. This is a two stage test as follows;

i. The Evidential Test - the evidence which can be adduced in court is sufficient to provide a reasonable prospect of conviction; and

ii The Public Interest Test - prosecution is required in the public interest.

The Public Prosecutor will analyse and evaluate all of the material submitted in a thorough and critical manner. The Evidential Test must be passed before the Public Interest Test can be considered. Each of these Tests must be separately considered and passed before a decision to prosecute can be taken.

The Evidential Test

Public Prosecutors determine whether there is sufficient evidence to provide a reasonable prospect of conviction against each defendant on each charge.

A reasonable prospect of conviction exists if, in relation to an identifiable individual, there is credible evidence which can be adduced before a court upon which evidence an impartial jury or judge properly directed in accordance with the law, may reasonably be expected to find proved beyond reasonable doubt the commission of a criminal offence by the person who is prosecuted. It is necessary that each element of this definition is fully examined when considering the Evidential Test for each particular case.

The police will gather all available evidence and report the case to the PPS. The Public Prosecutor will consider the evidence carefully and make a decision as quickly as possible. If necessary the Public Prosecutor may have to seek further information from police to enable a decision to be made. The PPS will also try to ensure that cases progress through the court without unnecessary delay.

The Public Interest Test

If a case passes the Evidential Test, the Public Prosecutor must decide if a prosecution is required in the public interest.

Prosecutors must exercise their discretion as to whether a prosecution is required in the public interest. The granting of such discretion to the prosecutor is consistent with the prosecution process in similar legal jurisdictions. In taking decisions as to prosecution the prosecutor is taking decisions for the benefit to society as a whole.

Broadly, the presumption is that the public interest requires prosecution where there has been a contravention of the criminal law. This presumption provides the starting point for consideration in each individual case. A prosecution will usually take place unless there are public interest factors tending against prosecution which clearly outweigh those tending in favour. However, there are circumstances in which, although the evidence is sufficient to provide a reasonable prospect of conviction, a court based outcome is not required in the public interest. For example, Public Prosecutors should positively consider the appropriateness of prosecuting by way of a diversionary disposal, particularly where the defendant is a young person or a vulnerable adult.

In deciding whether a prosecution is required in the public interest, prosecutors should take into account the views expressed by the victim and the impact of the offence on a victim and, in appropriate cases, their family, where such views are available. However PPS does not represent victims or their families in the same way as solicitors act for their clients. It is the duty of Public Prosecutors to form an overall view of the public interest.

Appendix 5

RQIA Contact details

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower
5 Lanyon Place
BELFAST BT1 3BT
info@rqia.org.uk
028 9051 7500 - telephone
028 9051 7501 – fax

The Regulation and Quality Improvement Authority
Hilltop
Tyrone and Fermanagh Hospital
Omagh
Co Tyrone BT79 0NS
028 8224 5828 - telephone
028 8225 2544 - fax

List of Regulations Relating To Regulated Services

Potential Articles relating to RQIA Enforcement Procedures for Regulated Services:

- Improvement Notice *- Article 39 of the 2003 Order*
- Failure to Comply Notice – *Article 15 of the 2003 Order*
- Notice of Proposal to Cancel, Refuse, Vary, and Remove or Impose Conditions in Relation to Registration – *Article 18 of the 2003 Order*
- Issuing of a Notice of Decision – under *Articles 18 & 20 of the 2003 Order*
- Urgent Procedure for Cancellation of Registration or to Vary, Remove or Impost a Condition of Registration – *Article 21 of the 2003 Order*
- Appeals to the Care Tribunal – *outlined under Article 22 of the 2003 Order*

The Residential Care Homes Regulations (Northern Ireland) 2005
The Children's Homes Regulations (Northern Ireland) 2005
The Nursing Homes Regulations (Northern Ireland) 2005
The Nursing Agencies Regulations (Northern Ireland) 2005
The Independent Health Care Regulations (Northern Ireland) 2005
The Day Care Setting Regulations (Northern Ireland) 2007
The Residential Family Centres Regulations (Northern Ireland) 2007
The Domiciliary Care Agencies Regulations (Northern Ireland) 2007
The Adult Placement Agencies Regulations (Northern Ireland) 2007
The Voluntary Adoption Agencies Regulations (Northern Ireland) 2010

Appendix 6

Definitions of Harm and Serious Harm and factors to be considered in the assessment of the seriousness of harm and risk of harm

What is meant by harm?
Adult Safeguarding – Prevention and Protection in Partnership 2015 notes that harm resulting from abuse, exploitation or neglect can be experienced by adults in a range of circumstances, regardless of age, class or ethnicity. Harm is the impact on the victim of abuse, exploitation or neglect. It is the result of any action whether by commission or omission, deliberate or as the result of a lack of knowledge or awareness, which may result in the impairment of physical, intellectual, emotional, or mental health and well-being. This includes:

(i) **Conduct which causes physical harm**, i.e. physical mistreatment of one person by another which may or may not result in physical injury. This may include, among other things, hitting; slapping; pushing or pulling; kicking; rough handling; shaking; exposure to heat and cold; not giving adequate food or drink; force-feeding; unreasonable confinement (e.g. locked in, tied to a bed or chair); the improper administration of drugs or treatments or the denial of prescribed medication; misuse of medication; misuse or illegal use of restraint, or physical interventions and/or deprivation of liberty; misuse of manual handling techniques; or inappropriate sanctions (e.g. controlling access to personal resources or withholding basic necessities of life such as food and drink).

(ii) **Conduct which causes sexual harm**, i.e. the involvement of a person in sexual activities or relationships that either he or she does not want and has not consented to or cannot consent to. This may include, among other things, use of offensive, suggestive or sexual language; indecent exposure; inappropriate touching; not allowing expression of sexuality; withholding appropriate educational information; sexual harassment; sexual assault; rape; ‘grooming’; ‘stalking’; or human trafficking.

(iii) **Conduct which causes psychological harm**, i.e. behaviour that is psychologically harmful or inflicting mental distress by threat, humiliation or other verbal/non-verbal conduct. This may include, among other things, threats of harm or abandonment; withholding of security, affection, care or support; deprivation of contact; provoking fear of violence; threat of institutional care; humiliation or ridicule; denial of the opportunity for privacy; shouting, yelling and swearing; blaming; controlling; intimidation; coercion; harassment; isolation or withdrawal from services supportive networks or cyber bullying/threats

(iv) **Conduct which causes financial, property or material harm**, i.e. misappropriation or misuse of money, material goods or other assets; transactions to which the person did not consent to, could not consent to, or which were invalidated by intimidation or deception. This may include, among other things, theft; fraud; exploitation; embezzlement; withholding pension; not spending allowances on the individual; denying the person access to his or her money; misuse of benefits; mismanagement of bank accounts; pressure in connection with wills, property, inheritance or financial transactions; unreasonable restriction of a person's right to control his or her life in financial/material terms.

(v) **Neglect** is the deliberate withholding, or failure through a lack of knowledge or awareness, to provide appropriate and adequate care and support, which is necessary for the adult to carry out daily living activities. It may include, among other things, the physical neglect of someone to such an extent that health, development and/or well-being is impaired; administering too much or too little medication; failure to provide access to appropriate health, social care or educational services; withholding the provision of the necessities of life such as adequate nutrition, heating or clothing; failure to intervene in situations that are assessed as being dangerous to the person concerned or to others, particularly when the person lacks the capacity to assess risk.

(vi) **Institutional harm**, which can occur in care settings and services as a result of poor standards, practices and behaviours, inflexible regimes and rigid routines, that place adults at risk and which violate their human rights. It involves the collective failure of an organisation to provide safe and appropriate services, and includes a failure to ensure that the necessary preventive and/or protective measures are in place; failure to maintain good standards of care in accordance with individual needs; failure to properly train, manage and supervise staff; poor record keeping; an inability or unwillingness to implement best practice guidelines; poor liaison with other providers of care; a culture that denies, restricts or curtails the dignity, privacy, choice, independence or fulfilment of adults at risk.

Generally, harm falls into one or more of the six categories listed above. However, it is important to recognise its manifestation in other ways, including

(i) **Domestic violence and abuse** is essentially a pattern of behaviour which is characterised by the exercise of control and the misuse of power by one person over another within an intimate relationship or a family. It is usually frequent and persistent. It can include violence by a son, daughter or any other person who has a close or blood relationship with the victim. It can occur right across society and is not bound by age, gender, race, ethnic or religious group, sexual orientation, wealth, disability or geography. **Forced marriage** of an adult, who may be unwilling or lack the capacity to agree to getting married is an abuse of human rights and is a form of domestic abuse, and should be treated as such. A clear distinction must be made between a forced marriage and an arranged marriage.

In arranged marriages, the families of both spouses take a leading role in arranging the marriage but the choice whether or not to accept the arrangements remains with the adult or young person. In forced marriage one or both spouses do not consent to the marriage and some element of duress is involved. Duress may include conduct which causes physical and or emotional harm. **Honour-based violence or honour crime** are also forms of domestic abuse and encompass a variety of crimes of violence (mainly but not exclusively against women), including assault, imprisonment and murder, where the person is being punished by their family or their community for actually, or allegedly, undermining what the family or community believes to be the correct code of behaviour.

(ii) **Hate crime** is any incident which constitutes a criminal offence, perceived by the victim or any other person as being motivated by prejudice or hate towards a person's actual or perceived race; faith or religion; sexual orientation; disability; political opinion or gender identity. The legislative provisions underpinning hate crime offences and penalties in Northern Ireland are set out in the Public Order (Northern Ireland) Order 1987 and the Criminal Justice (No2) (Northern Ireland) Order 2004.

(iii) **Human trafficking** involves the recruitment, transportation, transfer, harbouring or receipt of persons, by means of threat or use of force or other forms of coercion, abduction, fraud, of deception, of the abuse of power or of a position of vulnerability, or of the giving or receiving of payments or benefits to achieve the consent of a person, or have control over another person for the purpose of exploitation. There are many forms of exploitation, including prostitution or other types of sexual exploitation, forced labour, slavery, domestic servitude or the removal of organs. Human trafficking should be differentiated from 'people smuggling' which is normally defined as the facilitation of entry to the UK either secretly or by deception (whether for profit or otherwise). The immigrants concerned are normally complicit in the offence so that they can remain in the UK illegally. There is normally little coercion/violence involved or required from those assisting in the smuggling.

(iv) **Harm through discrimination** may manifest itself as any of the other categories of harm previously set out. What is distinctive, however, is that it is motivated by oppressive and discriminatory attitudes towards a person's disability; mental disorder; physical and/or mental infirmity; race; gender; age; religious belief; political opinion; cultural background; appearance; marital status; sexual orientation; whether or not he/she is a carer; or any other aspect of a person's individuality.

(v) **Harm by a professional/staff member** is the misuse of power and abuse of trust by professionals/staff members; the failure to adhere to best practice guidelines and professional codes of conduct/practice; the failure of professionals/staff members to act on suspected abuse/crimes, poor care practice

or neglect in services, resource shortfalls or service pressures that lead to service failure and culpability as a result of poor management systems.

The examples listed in each of the categories above are not exhaustive nor should they be taken as definitive proof that harm has taken place. There may be other indicators which should not be ignored. Also, some indicators may point to more than one form of harm; often if a person is being harmed in one way, he or she is being harmed in other ways. Any suggestion that all is not well should be seen as an indicator of possible harm of one form or another. It is important that any safeguarding concern is acted upon to ensure that the appropriate preventive or protective response is made.

All harm caused to adults in need of protection adult should be responded to in the context of safeguarding. It is recognised that the level of response needs to be sensitive and proportionate to the specific harm caused.

Factors to be considered in the assessment of the seriousness of harm and risk of potential harm

Consideration of the seriousness of harm and risk are central to determining which response is the most appropriate and key to establishing whether the threshold for a protective investigation/intervention has been met.

The criteria of what constitutes serious harm is imprecise and demands a careful application of professional judgment along with consideration of the available evidence, concerns raised, degree of risk and other matters relating to the individual and his or her context. Sometimes, a single traumatic event may constitute serious harm, e.g. a violent assault, sexual assault, suffocation or poisoning. More often, it is a series of events, both acute and long-standing, which interrupt, change or damage the individual's physical and/or psychological well-being. Also, it is important to note that harm does not need to be deliberate, that is, intent does not always have to be present to elevate harm to a level of seriousness, which might trigger a protective investigation/intervention. Any assessment of seriousness and risk should include

(a) the impact on the adult at risk, e.g. what is the degree of distress experienced; how resilient is the individual and his/her support networks;

(b) the reactions, perceptions, wishes and feelings of the adult at risk, e.g. how has the person responded; is he/she: shocked/resigned/cowed; aware of the harm caused;

(c) the frailty or vulnerability of the adult at risk, e.g. any special needs, such as a medical condition, communication impairment or disability that may affect care and support within the family;

(d) the ability of the adult at risk to consent, e.g. does he or she understand the nature of the concerns raised and the choices he or she faces;

(e) the illegality of the act or acts, e.g. has a criminal offence taken place;

(f) the nature, degree and extent of the harm, e.g. has it caused injury to the person's physical, sexual, psychological or financial wellbeing or property;
(g) the pattern of the harm causing behaviour, e.g. its intensity and frequency; one-off event or part of a long-standing pattern; have there been previous concerns (consider this in the widest sense, i.e. not just previous safeguarding referrals, but also whether the adult at risk has been a victim of anti-social behaviour, etc.);
(h) the level of threat to the individual's right to independence, e.g. the extent of support the person usually needs, and whether, and how much of, that support is normally provided by the alleged perpetrator;
(i) the intent of the person alleged to have caused the harm and extent of premeditation, and the presence or degree of threat, coercion, sadism, and bizarre or unusual elements, e.g. was this a deliberate act or a lack of awareness; was it a serious unprofessional response to difficulties in care giving; what is the attitude of the person alleged to have caused the harm now regarding the incident;
(j) the relationship between the person alleged to have caused the harm and the adult at risk, e.g. a balanced consideration of any positive benefits which the person may get from the relationship with the person alleged to have caused the harm/abusive situation;
(k) the context in which the alleged harm takes place, e.g. in a relationship; at home or in a care setting; in the context of a duty of care or trust that has been breached;
(l) the risk of repetition or escalation of harm involving increasingly serious acts relating to this individual or other adults at risk, to children under the age of 18 who may be at risk, or to the wider public, e.g. is there a risk that serious harm could result if no action is taken; is immediate protective action required; and
(m) the factors which mitigate the risk (protective factors), e.g. support services in place; awareness of what constitutes harm; awareness of how to raise concerns/seek help.

Consideration should also have to be given to the vulnerability of the person alleged to have caused the harm, e.g. are they an adult in need of protection or a child under the age of 18? If so, what actions are needed to support and safeguard them? Making a judgement here may mean having regard to some or all of the factors listed to inform the appropriate course of action.

The list of factors set out above is not exhaustive, and does not imply a hierarchy of importance; their analysis may point to a particular kind of response. In this context, it will also be necessary to:

- evaluate the reliability of the evidence upon which an assessment is made;
- consider any disparity between the strength of conviction of the person reporting the safeguarding concern (e.g. what was the basis of his/her concern or purpose in raising it), and the outcome of the assessment; and
- determine the need for further information gathering.

The safeguarding response made, however, should not undermine the risks identified and the outcomes sought.

Where an adult in need of protection has the ability to consent, appears to be able to make informed choices and is not being unduly intimidated, the available options should be explored with him/her and his/her wishes respected, unless these conflict with a statutory duty to intervene, or unless another person(s) is considered to be at risk.

Appendix 7

Human Rights, Consent and Capacity, The European Convention for the Protection of Human Rights and Fundamental Freedoms (Human Rights Act 1998)

Human Rights - Consent & Capacity

The Human Rights Act 1998 has been fully effective from 2nd October 2000. It incorporates the European Convention for the Protection of Human Rights and Fundamental Freedoms into United Kingdom Domestic Law. This makes it unlawful for public authorities to act in a manner which is incompatible with the rights and freedoms guaranteed by the Convention sets out the main Convention Rights enshrined in the 1998 Act.

Decisions taken not to comply with the wishes of the adults in need of protection adult/adult at risk may constitute a breach of Human Rights legislation. Where consideration is being given not to comply with the wishes of the adults in need of protection adult/adult at risk, the decision taken must be lawful, proportionate and in keeping with what is in the public interest.

Public authorities can interfere with an individual’s rights providing it is lawful, proportionate and necessary in a democratic society.

Lawful means ‘prescribed by law’ and the legal basis for any restriction on rights and freedoms must be established and identified Reporting a relevant offence as defined in the Criminal Law Northern Ireland Order 1967, is not only lawful but a legal requirement on public authorities.

Proportionate means that the proposed action is viewed by any reasonable person as fair, necessary and the least restrictive in order to benefit the individual.

Necessary in a Democratic Society means
(1) Does it fulfil a pressing social need?
(2) Does it pursue a legitimate aim? And
(3) is the proposed action in the public interest taking into consideration whether other Adults at risk or children may be at risk of harm?

The Decision Making Process

In applying the key principles of lawfulness, proportionality and whether it is necessary in a democratic society, a public authority representative must ask the following questions:

- Is there a legal basis for my actions?

- Is it proportionate and necessary in a democratic society?
- Is the procedure involved in the decision-making process fair and does it contain safeguards against abuse?
- Was there an alternative and less restrictive course of action available? (The intervention should be strictly limited to what is required to achieve the objective).
- Is the restriction required for legitimate purposes?
- If I fail to interfere with this individual's rights could there be a more serious outcome in not affording the individual adequate protection in fulfilment of their human rights

Decisions to interfere with an individual's rights may be subject to scrutiny by the Courts. However, if public authorities can show that they applied the relevant Human Rights principles when making their decision, they are less likely to be over-ruled. It is very important to keep notes and decisions should be recorded in full.

Consent

The wishes of the adult in need of protection are of paramount importance in all cases of alleged or suspected abuse. Where a crime is suspected the issue of possible PSNI involvement should be discussed with the adult in need of protection.

The consent of the adult in need of protection for contact with the PSNI should be sought as a first step and details of whether this relates to a referral to PSNI or a Joint Agency consultation should be provided.

The adult in need of protection should be provided with as much information as possible to assist them in making an informed decision regarding how they wish the situation to be handled They should be fully advised by the Trust Investigating Officer of the Joint Protocol process and of their right to have a referral made to the PSNI. Details of all supports available to assist in the JP process should also be provided, i.e. ABE 2012 document.

The adult in need of protection should be advised that agreeing to a joint agency consultation does not in its self-constitute their agreement to a full PSNI investigation. The benefits of a joint agency consultation in terms of information gathering (cross referral to ensure a comprehensive assessment of all available information) should be explained to the adult in need of protection. Their entitlement to full consultation and involvement at each stage in the joint protocol process should also be explained. All staff involved must ensure that this person centred approach is strictly adhered to. The Joint Protocol should make a

significant contribution to ensuring that the individual's human rights are upheld, protected and delivered on.

In the majority of cases where the adult in need of protection is deemed to have capacity, the PSNI will only proceed to a full investigation with the consent of the adult in need of protection. In practice this will mean that the adult in need of protection should be willing to make a complaint to the PSNI. However there are some exceptions to this.

Dispensing with Consent

In exceptional circumstances the DAPO may need to consider over riding the wishes of an adult in need of protection if they do not consent to a joint agency consultation with the PSNI. These include situations where:

1. there is reasonable evidence or information to indicate that a possible relevant offence has been committed and the Trust have a legal obligation to report to the PSNI
2. there is a significant query regarding the individual capacity to make an informed decision and therefore their ability to give or withhold consent is in question. Actions taken must be proportionate to the level of concern and the views of substitute decision makers.
3. information available clearly demonstrates that the individual is subject to undue influence or coercion (must be substantial)
4. there is a significant risk to other adults at risk and/or children
5. the likelihood of further harm is high and there is a substantial opportunity to prevent further crime.

The PSNI also have the authority to investigate alleged or suspected criminal abuse where this is agreed to be in the best interests of the adult in need of protection and or others.

The above list indicates possible situations where the DAPO may need to consider overriding the wishes of an adult in need of protection adult. The list is not exhaustive. Cases will need to be assessed on a case by case basis and requirements in relation to making decisions which are lawful, proportionate and necessary in the public interests are applicable.

Acting without Consent in Emergency Situation

In situations where the adult in need of protection is in imminent danger it may not be possible to discuss with them their wishes and obtaining a valid consent may not be achievable. Trust staff, under these circumstances, should take whatever action they feel is appropriate to protect the adult in need of protection, including seeking medical and/or PSNI intervention.

Where there is no information and/or clarity regarding the wishes of the adult in need of protection and it is safe to do so, consideration should be given to deferring a decision re a joint agency consultation until such time as the adult in need of protection's views and permission can be sought. The DAPO will need to consider this on a case by case basis, mindful that a number of factors will need to be taken into account. Where a decision is taken to consult with the PSNI and the adult in need of protection has not consented to this, a detailed rationale for this decision should be recorded.

Capacity

There should be no assumptions made regarding an individual's capacity or incapacity and in the first instance unless there is contrary information, every individual should be viewed as having the capacity to make decisions about their own situation. However, if an issue is raised in relation to any individual's cognitive ability to make an informed decision about their safety, a capacity assessment should be sought.

Capacity assessments should be carried out by an appropriately trained professional. In cases where the adults in need of protection is already known to specialist services the professional involved may be able to provide an informed opinion in relation to the individual's capacity.

Capacity assessments/reassessment should determine:

a. the extent to which the adults in need of protection adult/adult at risk is able to make informed decisions about their safety and protection

b. whether the adults in need of protection adult/adult at risk is able to make a complaint to the PSNI and/or give legal instruction

c. whether the adults in need of protection adult/adult at risk has the capacity to be interviewed by the PSNI

d. the needs of the adults in need of protection adult/adult at risk.

It is important to note that any and all information provided by an adult in need of protection adult is relevant and should be considered in a safeguarding context

THE EUROPEAN CONVENTION FOR THE PROTECTION OF HUMAN RIGHTS AND FUNDAMENTAL FREEDOMS

The Human Rights Act 1998

Main Convention Rights

Article 2 - Right to life

Article 3 - Prohibition of torture

Article 4 - Prohibition of slavery and forced labour

Article 5 - Right to liberty and security of person

Article 6 - Right to a fair trial

Article 7 - No punishment without law

Article 8 - Right to respect for private and family life

Article 9 - Freedom of thought, conscience and religion

Article 10- Freedom of expression

Article 11- Freedom of assembly and association

Article 12- Right to marry

Article 14- Prohibition of abuse of rights

Article 16- Restrictions on political activity of aliens

Article 17- Prohibition of abuse of rights

Article 18- Limitation of use of restriction of rights

Article 1, 1st protocol Protection of property

Article 2, 1st protocol Right to education

Article 3, 1st protocol Right to free elections

Article 1, 6th protocol Abolition of the death penalty

Appendix 8

Section 5 Criminal Law (Northern Ireland) Act 1967

A crime is a breach of the criminal law which is contained in statute or common law. Not all harm, abuse or exploitation of an adult in need of protection constitutes a possible crime.

However where an adult in need of protection and/or a relative or other professional (if the individual lacks capacity) makes a decision to access the Criminal Justice system, HSC Trusts in keeping with the principles of the Joint Protocol will support and assist in this process.

In cases of ill-treatment or wilful neglect by a staff member Article 121 of the Mental Health Order may need to be considered to determine if a possible offence has been committed.

The Criminal Law Act (NI) 1967

Section 5 of the Criminal Law Act (NI) 1967 states that where a person has committed a relevant offence, it shall be the duty of every other person, who knows or believes:-

(a) that the offence or some other **relevant offence** has been committed; and

(b) that he has information which is likely to secure, or to be of material assistance in securing, the apprehension, prosecution or conviction of any person for that offence,

to give that information, within a reasonable time, to a constable and if, without reasonable excuse, he fails to do so he shall be guilty of an offence and shall be liable on conviction on indictment to imprisonment according to the gravity of the offence about which he does not give that information, as follows:-

(i) if that offence is one for which the court is required by law to sentence an offender to death or to imprisonment for life or to detention during the pleasure of the Governor of Northern Ireland, he shall be liable to imprisonment for not more than ten years [or a fine or both];

(ii) if it is one for which a person (of full age and capacity and not previously convicted) may be sentenced to imprisonment for a term of fourteen years, he shall be liable to imprisonment for not more than seven years [or a fine or both];

(iii) if it is not one included above but is one for which a person (of full age and capacity and not previously convicted) may be sentenced to imprisonment for a term of ten years, he shall be liable to imprisonment for not more than five years [or a fine or both];

(iv) in any other case, he shall be liable to imprisonment for not more than three years [or a fine or both].

(2) It shall not be an offence under this section for the person suffering loss or injury by reason of the commission of the offence (in this section referred to as “the injured person”) or some other person acting on his behalf not to disclose information upon that loss or injury being made good to the injured person or upon the injured person being reasonably recompensed therefore so long as no further or other consideration is received for or on account of such non-disclosure.

Relevant offence is defined in Section 4(1A) of the Act:

4(1A) In this section and section 5, "*relevant offence*" means—

(a) an offence for which the sentence is fixed by law,

(b) an offence for which a person of 21 years or over (not previously convicted) may be sentenced to imprisonment for a term of five years (or might be so sentenced but for the restrictions imposed by Article 46(4) of the Magistrates' Courts (Northern Ireland) Order 1981),

but in section 5(1) “relevant offence” does not include an offence under Article 20 of the Sexual Offences (Northern Ireland) Order 2008 (Article 20 of the Sexual Offences (NI) Order 2008 relates to certain sexual offences committed by persons under 18 years of age)

Basically this includes any offence for which a person may be sentenced to 5 years or more in prison.

Examples of some offences which attract a sentence of 5 years or more imprisonment would include;

Offences against the person

- Murder
- Attempted murder
- Grievous bodily harm with intent
- Grievous bodily harm
- Assault occasioning actual bodily harm
- Threats to kill

Sexual offences

- Rape
- Attempted rape
- Assault by penetration
- Sexual assault
- Causing or inciting a person to engage in sexual activity without consent

- Sexual activity with a person with a mental disorder impeding choice
- Engaging in sexual activity in the presence of a person with a mental disorder impeding choice
- Causing a person with a mental disorder to engage or agree to engage in sexual activity by inducement, threats or deception

Dishonesty offences

- Theft
- Attempted theft
- Burglary with intent to steal
- Burglary with intent to cause criminal damage
- Fraud
- Conspiracy to defraud

In relation to dishonesty offences section 5(2) would be relevant i.e.-

"It shall not be an offence under this section for the person suffering loss or injury by reason of the commission of the offence (in this section referred to as "the injured person") or some other person acting on his behalf not to disclose information upon that loss or injury being made good to the injured person or upon the injured person being reasonably recompensed therefore so long as no further or other consideration is received for or on account of such non-disclosure".

Appendix 9

<u>Article 121 of the Mental Health NI Order (1986)</u>

Ill-treatment of patients

121. (1) Any person who, being an officer on the staff of or otherwise employed in a hospital, private hospital or nursing home or being a member of the**[F1** Board or a director of the **[F2**HSC trust**]** managing**]** a hospital, or a person carrying on a private hospital or nursing home—

(a)ill-treats or wilfully neglects a patient for the time being receiving treatment for mental disorder as an in-patient in that hospital or nursing home; or

(b) ill-treats or wilfully neglects, on the premises of which the hospital or nursing home forms part, a patient for the time being receiving such treatment there as an out-patient, shall be guilty of an offence.

(2) Any individual who ill-treats or wilfully neglects a patient who is for the time being subject to his guardianship under this Order or otherwise in his custody or care (whether by virtue of any legal or moral obligation or otherwise) shall be guilty of an offence.

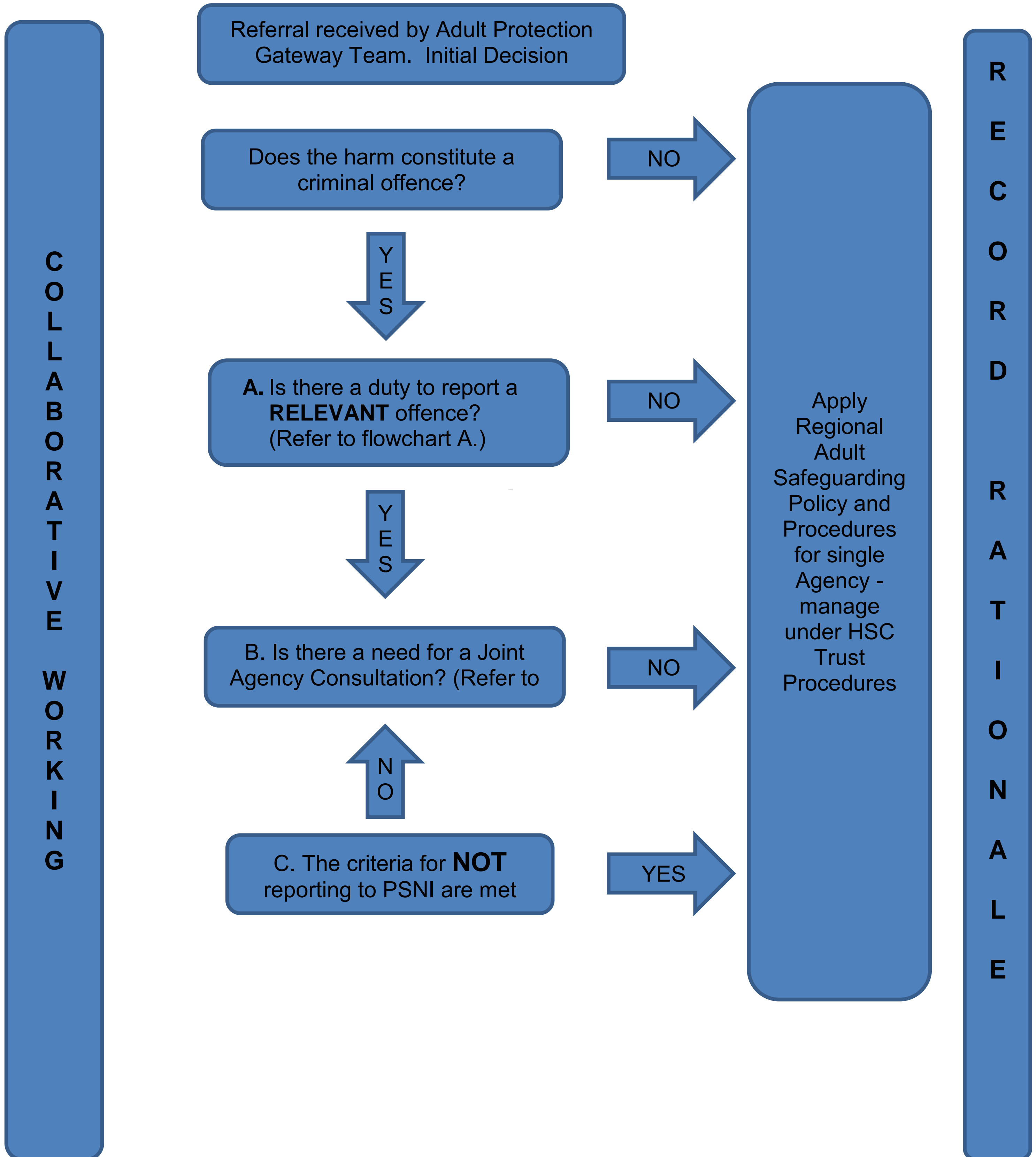
(3) Any person guilty of an offence under this Article shall be liable—

(a)on summary conviction, to imprisonment for a term not exceeding six months or to a fine not exceeding the statutory maximum, or to both;

(b)on conviction on indictment, to imprisonment for a term not exceeding two years, or to a fine of any amount, or to both.

Appendix 10

HSC Trust Flowchart for decision making and referral to PSNI CRU



A. Relevant crime and/or reportable crime referred to PSNI CRU for consideration of Joint Agency investigation

An adult in need of protection is in **imminent danger** and there is a need for an immediate report to PSNI CRU

OR

Where there has been an incident which may constitute a **relevant offence** under Section 5 of the Criminal Law Act (NI) 1967 (***Appendix 7***)

OR

Referral information clearly states the adult in need of protection **wishes** or has consented to PSNI involvement ***(Appendix 8 Human Rights)***

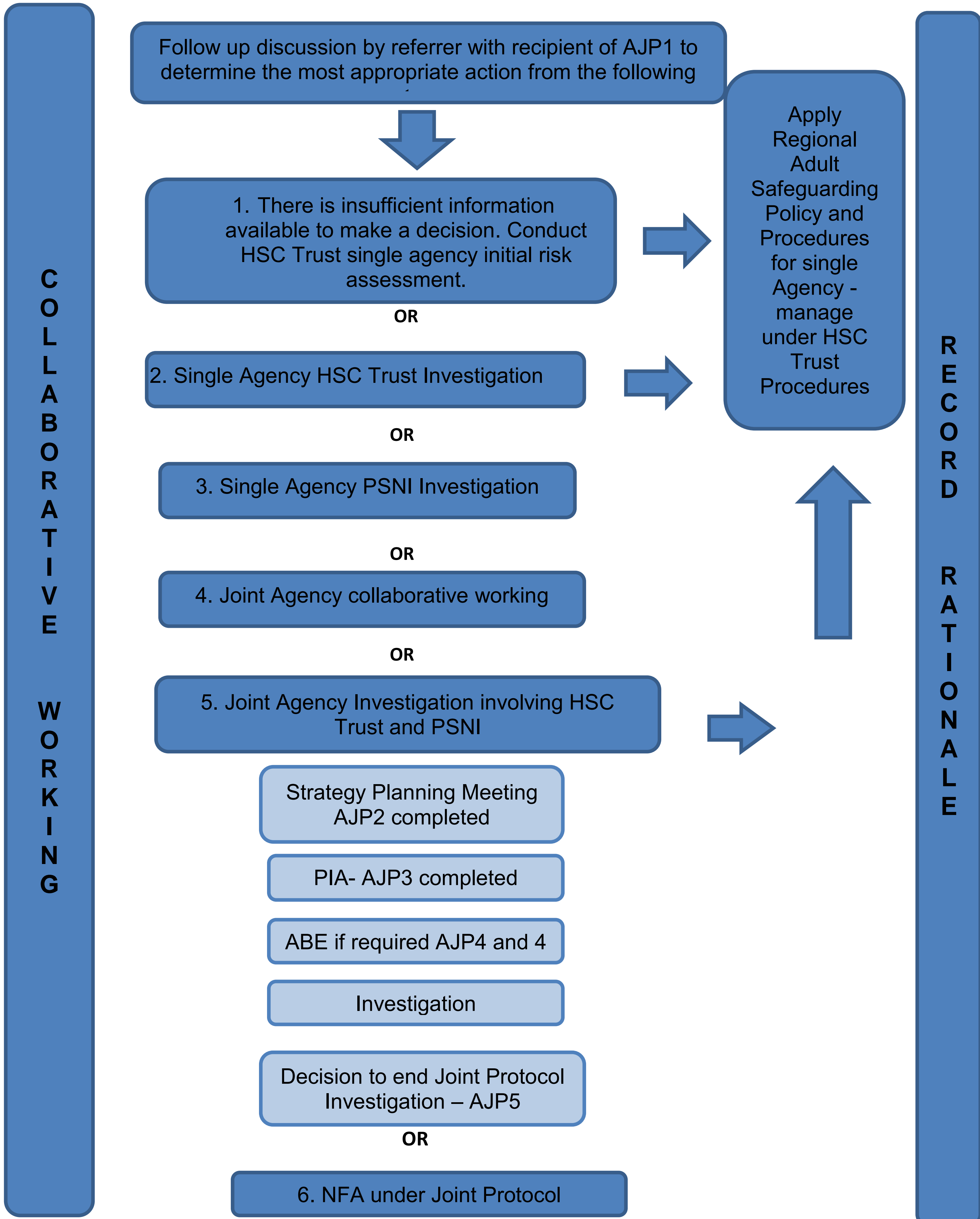
OR

If the referral information clearly states that the adult in need of protection lacks capacity to give informed consent to PSNI involvement and **the next of kin and/or professionals involved take the view that PSNI involvement is required.**

Relevant offences include

- Sexual offences
- Domestic abuse incidents which constitute a criminal offence
- Financial abuse incidents
- Human Trafficking
- All cases where alleged offender is a paid employee / volunteer or in a position of trust
- Institutional abuse
- Historical abuse

RECORD RATIONALE


B. Joint Agency Consultation with PSNI CRU and HSC Trust
- AJP1 completed and forwarded to CRU via CJSM
Follow up discussion by referrer with recipient of AJP1 to determine the most appropriate action from the following
1. There is insufficient information available to make a decision. Conduct HSC Trust single agency initial risk assessment.
OR
2. Single Agency HSC Trust Investigation
OR
3. Single Agency PSNI Investigation
OR
4. Joint Agency collaborative working
OR
5. Joint Agency Investigation involving HSC Trust and PSNI
Strategy Planning Meeting AJP2 completed
PIA- AJP3 completed
ABE if required AJP4 and 4
Investigation
Decision to end Joint Protocol Investigation – AJP5
OR
6. NFA under Joint Protocol
Apply Regional Adult Safeguarding Policy and Procedures for single Agency - manage under HSC Trust Procedures
COLLABORATIVE WORKING
RECORD RATIONALE

C. Criteria for NOT reporting to PSNI

DAPO must as a minimum demonstrate consideration of the following:

The adult in need of protection has capacity to make an informed decision and does not want to make a complaint to PSNI. Full consideration will need to be given to all elements of consent, capacity and human rights, including issues of undue influence and possible

AND

The Trust is not required by law to make a referral to PSNI (if the incident does not meet the threshold of **relevant offence** under section 5 of the Criminal Law Act (NI) 1967 (***Appendix 7*** Definition of Relevant Offence)

AND

It is a minor incident. A comprehensive assessment of all the factors **MUST** be completed to evidence a through risk assessment of these cases. This will include consideration of whether repeat incidents have occurred and/or whether other adults at risk or children have been or are likely to be at risk of harm (*Appendix 10 Factors to be considered in the assessment of the seriousness of Harm and Risk of Harm*)

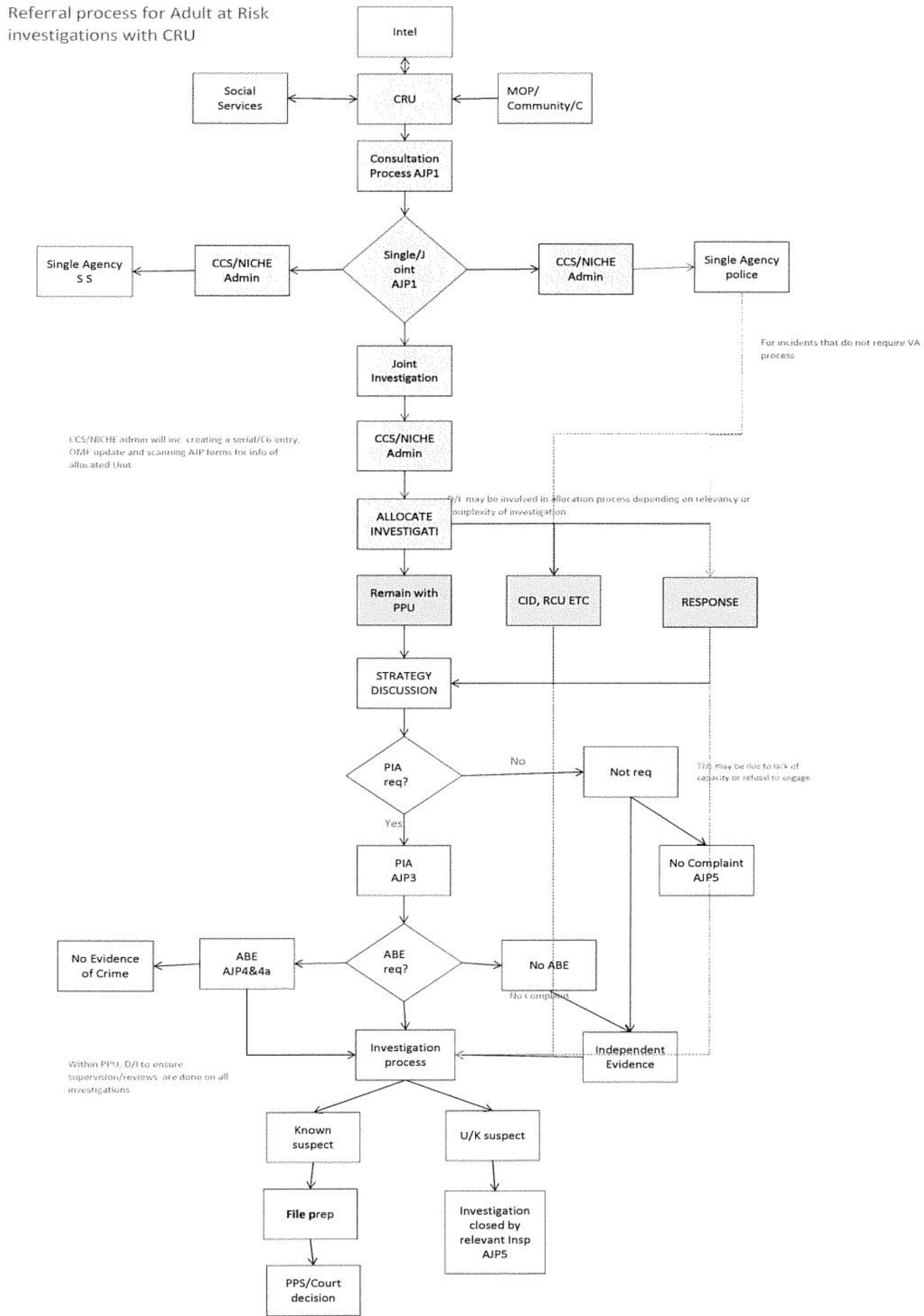
AND

The situation is being managed through an Adult Safeguarding process and/or there are other protective measures in place

RECORD RATIONALE FOR DECISIONS

Appendix 11

Referral Process for Adult at Risk Investigations with CRU



Appendix 12

Regulation and Quality Improvement Authority

Adult Safeguarding Processes

Where there is a breach of regulations RQIA have the statutory authority to issue requirements in relation to a Quality Improvement Plan, Enforcement Orders or to de-register facilities depending on nature and seriousness of the concern.

In all regulated facilities where an alleged or suspected criminal offence has occurred, RQIA should ensure that this is reported to the relevant HSC Trust Gateway Team/ DAPO and PSNI/nominated officer within Public Protection Unit. Where an incident relates to a regulated service RQIA will attend adult protection strategy meetings and case discussions to contribute to joint agency information sharing and joint agency action planning.

HSC Trusts should also ensure that RQIA are notified of these incidents *(**Appendix 6** RQIA contact details).* Where an incident occurs outside normal working hours, it is the responsibility of the Registered Manager or Senior Manager on duty to contact the Regional Out of Hours Service and if applicable the PSNI. If reports are made directly to PSNI from regulated facilities, the PSNI should contact the Regional HSC Regional Emergency Social Work Service.

Registered Intermediaries

The Criminal Evidence (NI) Order 1999 provides for a number of special measures, such as video recorded evidence-in-chief and giving evidence by live link, to assist vulnerable and intimidated witnesses (both for the prosecution and the defence) give their best possible evidence in criminal proceedings.

Article 17 of the 1999 Order provides for the examination of a witness through an intermediary.

Article 21BA of the 1999 Order, as inserted by section 12 of the Justice Act (NI) 2011, provides for the examination of a vulnerable defendant when they are giving oral evidence.

The creation of the Registered Intermediary (RI) role represents a statutory recognition that adults in need of protection witnesses and defendants with communication needs may require help and facilitation with giving evidence. RIs have a range of responsibilities intended to help adults in need of protection witnesses, defendants and criminal justice practitioners at every stage of the criminal process, from investigation to trial.

It is the responsibility of the DOJ- PPU, PSNI, and PPS, to request an assessment from a Registered Intermediary.

RI's come from a number of professional backgrounds. It is a highly specialised role and requires expertise in dealing with the communication needs of individuals with the following types of conditions

- Aphasia/Dysphasia
- Autistic Spectrum Disorder
- Brain and/or Head Injury
- Deafness/hearing Impairment
- Dementia
- Dysarthria/Dyspraxia
- Fluency Difficulties
- Language Delay/Disorder
- Learning disability
- Mental health Issues
- Neurological and other Progressive Disorders
- Phonological Delay/Disorder
- Physical Disability
- Selective/Elective Mutism
- Voice Disorders (including laryngectomy)

The above list is intended to be illustrative rather than exhaustive and whether someone should be provided with RI assistance will need to be determined on a case-by-case basis, based on the particular needs of the individual witness or defendant. It is also important to note that not all witnesses or defendants with the conditions listed above will necessarily require assistance, if their disability does not affect their ability to communicate effectively.

For police interviews, the RIs duty is to assess and facilitate effective communication and understanding between the police and the witness or defendant. In terms of the court stage, the RIs duty is to the court. RIs are there to ensure the court has access to the best possible evidence and that this can be properly examined so that justice can be done.

How the RI role is exercised

An RI will carry out an assessment of a witness or defendant's communication abilities and needs. In this assessment the RI will

- Evaluate the abilities and needs of the witness/defendant, including whether they have the ability to communicate their evidence during a police interview and at court;
- Ascertain if the witness/defendant needs an RI;
- Consider if the witness/defendant would be able to give evidence at all, even with the assistance of an RI;
- Indicate whether, in the absence of an intermediary, the quality of a witness's evidence would be diminished or a defendant would not receive a fair trial; and
- Make recommendations as to special measures to enable the best communication with and evidence from, the witness.

An RI also directly assists in the communication process – helping a witness or defendant understand the questions during an investigative interview or testimony at the trial and helping them communicate their answers. Effective means of communication may include speech, symbols, communication aids, drawing and writing.

Appendix 14

AJP Forms

AJP1 Referral Information

AJP2 Record of Joint Agency Strategy Decision Making and Investigation Planning

AJP2 (a) Amendments to Strategy For Investigation

AJP3 Pre- Interview Assessment (PIA)

AJP4 Planning the Joint Investigation Interview (ABE)

AJP4 (a) Joint Protocol ABE Interview

AJP5 Decision to End Joint Protocol Investigation

In addition PJI1 form to be used in relation to adults at risk when disclosures of historical abuse have been made. There is a requirement to clearly state whether this needs to be addressed under Adult Safeguarding Joint Protocol procedures

PJI1 Referrals to PSNI of Historical Child Abuse

AJP1

JOINT PROTOCOL – ADULT PROTECTION

Referral Information

PSNI Reference Number: ____________________

Date of Referral: ____________________

Referred To: ____________________ Designation: ____________________

Referred By: ____________________ Designation: ____________________

Referrer's Address: ____

Referrer's Telephone Number: ________________ Referrer's Email: ____________________

SECTION ONE ***(Please ensure Sections 1 & 2 are fully completed by referrer)***

DETAILS OF ALLEGED VICTIM		
Name:	Date of birth or approximate age:	Gender: Male ☐ Female ☐
Address and Postcode:	Contact No:	Programme of care if known: Information system no:
Present Location: (*if different from above)* Incident Location:		
Nature of vulnerability: *(please tick all relevant boxes)* ☐ Frail Older Person ☐ People experiencing dementia or memory impairment ☐ Learning Disability ☐ Physical/Sensory Disability ☐ Mental Health Difficulties ☐ Other *(give details)*________________		

Relevant Contacts		
	Name	**Address & Tel. No.**
Key Worker		
Care Manager		
G.P		
Other Professionals		
Next of Kin		
Significant other		

***Who Was The First Person To Note Concern*:**	
Name & Tel No:	Date:

Does This Referral Originate From:			
☐ Acute Hospital Name:	☐Adult Mental Health Unit Name:	☐Learning Disability Unit Name:	☐ Regulated Facilities Name:
☐ Community	☐ MARAC	☐ Other *(give details)*	

SECTION 2

DETAILS OF REFERRAL
Incident Report – *(Please give exact details of what has been reported and if appropriate, note injuries on the attached body chart ONLY if witnessed or observed)*
Date / Time Of Incident: Location:
Details:
Have There Been Previous Concerns Or Evidence Of Abuse To Your Knowledge? ☐ Yes ☐ No ☐ Not Known If yes, what was the nature of the concern and the outcome:

The Service User's Usual Living Arrangements:	
Does service user live alone? *(if No give details)*	☐ Yes ☐ No
Does the service user live with the person whom has allegedly caused the abuse?	☐ Yes ☐ No
Are there any support services in place? *(if yes give details)*	☐ Yes ☐ No
Are there any current court orders in place? *(if yes give details)*	☐ Yes ☐ No
Are there any concerns regarding risk to a child/children? (*if yes give details*)	☐ Yes ☐ No
Are there any concerns regarding risk to other adults in need of protection? (*if yes give details)*	☐ Yes ☐ No
Service User's Knowledge Of Referral	

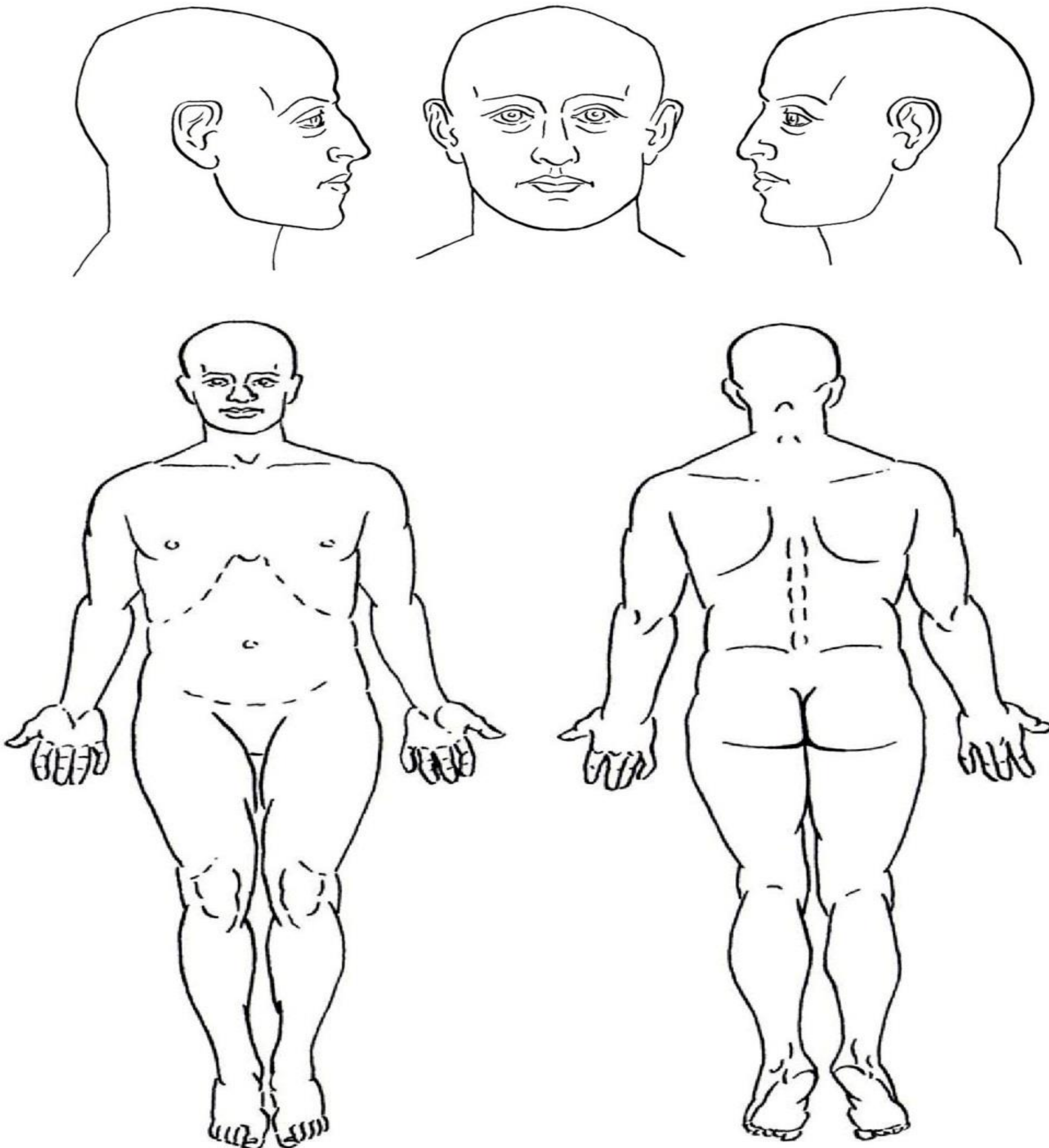
Does person know that a referral may be made?	☐ Yes ☐ No ☐ Not Known
Has the relevant explanation/information been provided in an appropriate manner? (*for example Easy Read Leaflets*)	☐ Yes ☐ No
In your view has the person capacity to make an informed decision about the referral/report?	☐ Yes ☐ No
Has the person consented to a referral? *If no give details*____ ____	☐ Yes ☐ No
If the person lacks capacity what are the views of the next of kin about the referral? *If yes:* Name: ____ Address:____ Contact No: _______________________________________ Date: ____	☐ Yes ☐ No
Is there a need to consider any immediate Human Rights issues? (**If yes identify which human rights have been considered and rationale for the decision**)	☐ Yes ☐ No

DETAILS OF PERSON/S ALLEGED TO HAVE CAUSED HARM *(If known)*		
Name provided by:	Date:	
Name:	Date of birth:	☐ M ☐ F
Address:		
Does the person alleged to have caused harm know that an allegation has been made against them?		☐ Yes ☐ No ☐ Not Known
Has the person alleged to have caused harm any known vulnerabilities? *If yes please specify:*		☐ Yes ☐ No ☐ Not Known
Is the person alleged to have caused harm known to service user? *If yes please specify below:*		☐ Yes ☐ No ☐ Not Known
☐ Family member	☐ Another service user	☐ Paid carer
☐ Trust employee	☐ Other	

BODY CHART

PLEASE USE THE BELOW IMAGE TO MARK ANY:

- **SCRATCH**
- **SKIN ABRASION**
- **CUT**
- **BRUISE**
- **BURN**
- **BITE**
- **FRACTURE**



SECTION 3 *(To be completed and shared following Joint Agency Consultation)*

PSNI Reference Number ____________________

OUTCOME OF CONSULTATION	
☐ Single agency investigation by PSNI	Allocated to: ____________________
☐ Single agency investigation by Trust	Allocated to: ____________________
☐ Joint Protocol investigation	Allocated to: ____________________
☐ Referral to RQIA	
☐ No further action	
☐ Other *(give detail below)*	

RATIONALE

Agreed By

Designated Adult Protection Officer: ______________________________

PSNI CRU Officer: ______________________________

Approved By PSNI Sergeant: ______________________________

Date: _________________________

Completed form to be emailed via CJSM secure email system to cru@psni.pnn.police.uk.cjsm.net
Joint consultation will take place on receipt of this form and outcome to be recorded and shared by PSNI CRU contact number 028 9025 9299

AJP2 **Record of Joint Agency Strategy Decision Making and Investigation Planning**

DETAILS OF ALLEGED VICTIM		
Name:	Date of Birth: *(if not known, please give approximate age)*	Gender: Male ☐ Female ☐
Address and Postcode:	Contact No:	Service Group:
Present Location: (*if different from above)*		PSNI Reference Number: *(If known)*

STRATEGY DISCUSSION	
Date & time of consultation:	☐ Telephone ☐ Meeting
Names of persons involved: 1.______ 2.______ 3.______ 4.______ 5.______	Designation: ______ ______ ______ ______ ______
DETAILS OF DISCUSSION	

AGREED ACTIONS

Forensic Considerations
Need for medical, secure possible forensic evidence

Communication Strategy
Record agreed level of information sharing and with whom

Name of:	Contact number
PSNI Investigating Unit ______________________	______________
Name of PSNI Investigating Officer ______________________	______________
Name of PSNI Line Manager______________________	______________
Name of Trust Investigating Officer______________________	______________
Name of Trust Designated Adult Protection Officer ______________	______________
Name of RQIA Inspector(if appropriate)______________________	

Please provide details below:

Media Considerations
Record agreed level of information sharing and with whom

Interviews
(Provide name, address, contact number and nature of vulnerability (if applicable) of person(s) to be interviewed)

Victim(s):		Type of interview and by whom _(If known)_
1. ______________________ ______________________ ____________	☐ None ☐ Frail Older Person ☐Physical/Sensory ☐Learning Disability ☐ Mental Health ☐ Dementia or memory impairment ☐Other _(give details)_	☐ PSNI ☐ PIA/ABE ☐ Trust PSNI ______________ Trust ______________
2. ______________________ ______________________ ____________	☐ None ☐ Frail Older Person ☐ Physical/Sensory ☐ Learning Disability ☐ Mental Health ☐ Dementia or memory impairment ☐Other _(give details)_	☐ PSNI ☐ PIA/ABE ☐ Trust PSNI ______________ Trust ______________

Witnesses: 1. ______________________ ______________________ ____________ 2. ______________________ ______________________ ____________	☐ None ☐ Frail Older Person ☐ Physical/Sensory ☐ Learning Disability ☐ Mental Health ☐ Dementia or memory impairment ☐Other*(give details)* ☐ None ☐ Frail Older Person ☐ Physical/Sensory ☐ Learning Disability ☐ Mental Health ☐ Dementia or memory impairment ☐Other*(give details)*	Who will conduct interview: ☐ PSNI ☐ Trust PSNI ____________ Trust ____________ ☐ PSNI ☐ Trust PSNI ____________ Trust ____________
Person/s alleged to have caused harm : *(as provided by Trust or other agencies)* 1. ______________________ ______________________ ____________ 2. ______________________ ______________________ ____________	☐ None ☐ Frail Older Person ☐ Physical/Sensory ☐ Learning Disability ☐ Mental Health ☐ Dementia or memory impairment ☐Other*(give details)* ☐ None ☐ Frail Older Person ☐ Physical/Sensory ☐ Learning Disability ☐ Mental Health ☐ Dementia or memory impairment ☐Other*(give details)*	Who will conduct interview:
Joint Agency Interim Protection Plan		
Adult Safeguarding Investigation Strategy and Protection Plan		

Signature of DAPO ______________________

Signature PSNI Officer: ______________________

Date: ______________________

AJP2a AMENDMENTS TO STRATEGY FOR INVESTIGATION

Completed form to be emailed via CJSM secure email system

DETAILS OF VICTIM		
Name:	Date Of Birth or Approximate Age:	Gender: Male ☐ Female ☐
Address and Postcode:	Contact No:	Service Group:
Present Location: (*if different from above)*		PSNI Reference Number: *(If known)*

INFORMATION UPDATE
AGREED AMENDMENTS TO INVESTIGATION PLAN
AGREED AMENDMENTS TO PROTECTION PLAN

Agreed by:

Police Officer: ______________________

DAPO: ______________________

Date: ______________________

AJP3

PRE- INTERVIEW ASSESSMENT (PIA)

To be completed and shared by PSNI

DETAILS OF VICTIM		
Name:	Date Of Birth or Approximate Age:	Gender: Male ☐ Female ☐
Address and Postcode:	Contact No:	Service Group:
Present Location: (*if different from above*)		PSNI Reference Number: (*If known*)

PIA PLANNING	
Date &Time Of Interview:	Venue
Names Of Interviewers:	Designation
Names of any other persons who will be present:	Role:
NOTE ANY SPECIAL REQUIREMENTS (*please give relevant details*)	

DETAILS OF PIA	
Has the purpose of the interview been explained to the adult? Comment:	☐ Yes ☐ No
Have any capacity issues been identified? Comment:	☐ Yes ☐ No
Have the types of formats for the interview been explained to the adult? Comment:	☐ Yes ☐ No
Has the adult stated a preference for which format is most suitable for him/her? Comment:	☐ Yes ☐ No
Has the adult any specific needs in relation to the interview? Comment:	☐ Yes ☐ No

Is the adult willing to engage in an interview? ☐ Yes ☐ No
Comment:

Has a need for a Registered Intermediary been identified? ☐ Yes ☐ No
Comment:

OUTCOME OF PIA

☐ **Registered Intermediary required**
☐ **Video interview** Venue:____________________

☐ **Written interview** Venue: ____________________
☐ **Victim declines criminal investigation**

AJP4 PLANNING THE JOINT INVESTIGATION INTERVIEW (ABE)

DETAILS OF VICTIM		
Name:	Date Of Birth or Approximate Age:	Gender: Male ☐ Female ☐
Address and Postcode:	Contact No:	Service Group:
Present Location: (*if different from above*)		PSNI Reference Number: *(If known)*

ABE INTERVIEW PLANNING	
Date &Time Of Interview:	Venue
Names Of Interviewers: ____________________ ____________________	Designation ____________________ ____________________
Names of any other persons who will be present: ____________________ ____________________	Role/Relationship: ____________________ ____________________

DETAILS OF PIA PLANNING *(please give relevant details)*	
Do any special considerations apply? (*If yes give details)*	☐ Yes ☐ No
Will a Registered Intermediary/ Interpreter attend? (*If yes give details)* Name:____________________ Grade/Qualification: ____________________	☐ Yes ☐ No

DETAIL SPECIFIC ARRANGEMENTS PLANNED FOR INTERVIEW *(Who? What? When? Where? How?)*

SIGNATURES OF JOINT INVESTIGATIVE INTERVIEWERS:

Police Officer: ____________________

Social Worker: ____________________

Date: __________

AJP4a

JOINT PROTOCOL ABE INTERVIEW

To be completed by PSNI

Name of Adult: ______________________ **Date of Interview:** ______________

Page No: ______________

AJP5 DECISION TO END JOINT PROTOCOL INVESTIGATION

To be completed and shared by the responsible DAPO/PSNI Officer

DETAILS OF VICTIM		
Name:	Date Of Birth or Approximate Age:	Gender: Male ☐ Female ☐
Address and Postcode:	Contact No:	Service Group:
Present Location: (*if different from above)*		PSNI Reference Number:

OUTLINE THE REASONS FOR ENDING JOINT PROTOCOL INVESTIGATION	
AGREED BY WHOM (*Record the names of any persons/agencies involved in decision)*	
Names of persons consulted:	Designation:
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Signature of DAPO: ______________________

Signature of PSNI Officer: ______________________

Date: ______________________

RESTRICTED WHEN COMPLETE **PJI1**

CC ____________

(please use this number on all future correspondence)

CONFIRMATION OF REFERRAL

Referral on Date: ____________ Time: ____________

To: ____________ Designation: ____________

From: ____________ Designation: ____________

Referrer's Telephone Number: ____________

Referrer's Address: ____________

Referrer's Email Address: ____________

Child's Name: ____________ DOB: ____________

Home Address: ____________

Present Location: ____________

Person with parental responsibility: ____________ DOB: ____________

Address: ____________

Telephone Number: ____________

Alleged Perpetrator: ____________ DOB: ____________

Telephone Number: ____________

Address: ____________

Address where alleged incident(s) has taken place, if known/suspected:

____

RESTRICTED WHEN COMPLETE

Nature of Referral – Comment
(include background of involvement with Social Services or Police)

RESTRICTED WHEN COMPLETE

RESTRICTED WHEN COMPLETE

Joint Assessment
(Considerations, concerning child/sibling, might include assessment of current placement; the CP Register; child protection concern/referral/investigation; missing episodes; attempted suicide/self-harm; misuse of drugs/alcohol; CSE indicators; or if significant person(s) in the child/young person's life is a suspected domestic /sexual abuser, misuses drugs/alcohol etc.)

HAVING REVIEWED THE AVAILABLE MATERIAL/EVIDENCE/HISTORY THE AGREED OUTCOME OF INITIAL JOINT ASSESSMENT IS:

JOINT INVESTIGATION (2.18): ☐ **YES** ☐ **NO**

If 'NO' note outcome decided, as below:

		Rationale:
☐	No Further Action	
☐	Family Support	
☐	Police Only Investigation	
☐	Duty to Investigate (Article 66)	

Agreed by: ______________________ (Social Worker) and ______________________ (Police Officer)

Completed by: ______________________________ Date: ______________

Referrer to complete Pages 1 and 2, PO to complete Pages 2 and 3.
Completed form to be emailed asap via CJSM to HSCT/CRU.

Form PJI1
06/15

Page **3** of **3**
RESTRICTED WHEN COMPLETE

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MAHI - STM -

Use and Control of Medicines

Guidelines for the safe prescribing, administration, handling, storage and custody of medicinal products in the Health and Personal Social Services

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

April 2004

Foreword

Medicines are the single most widely used technology in the HPSS accounting for some £300M of expenditure.

While these therapeutic agents undoubtedly contribute to improving health they also have associated risks, hence their propensity to be highly regulated.

Notwithstanding legislative controls, health care systems across the world are increasingly committed to develop safer systems of work to minimise the risk of adverse incidents due to medicines.

'Use and Control of Medicines' is one such measure designed to ensure that there are proper systems and procedures in place to limit risk to both practitioner and patients as well as setting out statutory obligations.

This new guidance, therefore seeks to take account of important legislative changes and developments in professional practice and accountability as well as integrating and giving consistency to associated guidelines emanating for professional bodies, agencies, reviews etc. In addition, the guidelines extend beyond the secondary care sector in recognition of the medicines control interface across primary, secondary and community care.

In commending these new guidelines to the Service I wish to acknowledge the multidisciplinary input to their development and the extent and quality of the responses to the consultative draft. Such responses give evidence to the critical and important nature of the matter and its impact across the whole of the HPSS family.

The application of these guidelines will, I believe, make a significant contribution to the clinical and social care governance agenda improving the quality of care and minimising medication related risk. Safety needs no justification and where there is good practice patients are advantaged.

Dr N C Morrow *Chief Pharmaceutical Officer*

This guidance is directed primarily towards those professionals working in a secondary care setting. However, where appropriate, the principles stated are equally applicable to primary care professionals and local health and social care groups.

Except where stated, the document is not to be regarded as a definitive statement of the law on medicines and has no statutory force. Nevertheless, it does seek to present those principles of known and accepted good practice applicable to its subject. In so doing it is not intended to supersede or conflict with professional standards or codes of practice already in place and it is recognised that more detailed guidance on some of the issues included may form part of existing local policies.

In particular, attention is drawn to the Medicines Management Controls Assurance Standard (which requires HPSS bodies to have in place systems ensuring compliance with legislative requirements and best practice.

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Guidelines for the safe handling, administration, storage and custody of medicinal products in the Health and Personal Social Services

1 Objectives

This document aims to provide practical guidelines for the safe and effective supply, storage, prescribing, administration and documented use of medicines in the health service. This may be achieved by ensuring that:-

- prescriptions are authentic and legible;
- dispensing is accurate;
- storage is adequate and secure;
- administration follows recognised procedures eg NMC Guidelines[1];
- documentation is appropriate, accurate and complete;
- misuse is prevented;
- staff and patients are safeguarded;
- all appropriate staff are kept informed of all relevant policies, procedures, guidance and instructions.

Care should be taken to ensure that all medicines are prescribed and administered with the consent of the patient and in accordance with Good Practice in Consent[2].

2 Prescribing

It is essential that prescriptions are unambiguous so that the correct medicine can be administered to the named patient in the correct dose and dosage form, by the route specified, and at the time(s) prescribed.

In order to facilitate this and eliminate errors it is essential that staff become familiar with the documents or process used. Prescription sheets (eg Kardex) are a vital part of a patient's medical records. They must therefore be, and remain, legible and complete. In the secondary sector not more than one main prescription sheet should be in use at any one time for any patient. Where necessary, a continuation sheet should be used and numbered appropriately. In addition to the main prescription sheet, supplementary sheets may be necessary for special prescribing, for example:-

- anticoagulants
- intravenous fluids

- intravenous fluid additives
- insulin
- anaesthetic agents.
- oxygen
- patient controlled analgesia (pca)

Knowledge of the fact that the patient is being treated with these medicines may affect other prescribing and a note of these treatments must always be made on the main prescription sheet. This note should also refer to the existence of any supplementary sheet(s) which would contain details of such medication.

In writing prescriptions the advice given in the British National Formulary (incorporating the Nurse Prescribers' Formulary) (under "General Information" and "Prescription Writing")[3] should be observed.

When completing prescription sheets:-

- each individual prescription must be DATED and PRINTED clearly and entirely in CAPITAL LETTERS
- each prescription sheet must show the PATIENT'S FULL NAME, DATE OF BIRTH, PATIENT REFERENCE NUMBER and/or ADDRESS
- the APPROVED NAME should be used for a medicine wherever possible. Where applicable the proprietary name should also be used, eg for insulins and long acting theophylline preparations where different brands may have varying bioavailability
- the DOSE and dosage FORM must be clearly stated. The dose should be specified in metric units or the number of individual dosage units where appropriate
- the TIME and ROUTE of administration must be indicated and where appropriate the specific site of application eg "left ear", "right ear"
- Where ABBREVIATIONS are used, only those approved by the BNF are appropriate.
- the frequency of administration of "as required" medicines must be indicated by CLEAR AND DEFINITELY STATED MINIMAL INTERVALS AND A MAXIMUM DAILY DOSE.
- when SUPPLEMENTARY SHEETS are used the person initiating the sheet should indicate such action in the appropriate space on the main prescription sheet

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- any known DRUG SENSITIVITIES and/or known DRUG ALLERGIES must be clearly indicated on the prescription sheet
- all prescriptions must be SIGNED BY THE PRESCRIBER with a LEGIBLE signature
- prescriptions for medicines must be printed DIRECTLY on to the PRESCRIPTION SHEET. Non-peelable adhesive labels are NOT acceptable.

Under no circumstances should the prescription sheet be defaced. If a prescription requires to be amended in any way, the original entry must be struck out and a new prescription written. In all cases the original entry must remain legible. To DISCONTINUE a prescription (ie to indicate the termination of a specific course of treatment) a single straight line must be drawn through the complete entry, the date inserted in the "discontinued" column and signed. To CANCEL a prescription (ie to delete an erroneous entry) a single straight line must be drawn through the complete entry, which should then be signed and dated, and the word "CANCEL" printed boldly across the "times of administration" column. All prescription sheets are part of the patient's records and must ultimately be retained as such.

Discharge prescriptions for Controlled Drugs must be written in full by the prescriber who, in addition to completion as above, must specify in words and figures the total amount of the drug or preparation to be supplied.

3 Emergency Prescriptions

Only in an emergency may a medicine be administered without a written prescription. IN ALL CASES the administration, alteration or withdrawal of medication must be immediately recorded on the Prescription Sheet and certified by the prescriber within 24 hours. In the event that the prescriber fails to provide appropriate authorisation within 24 hours, further authorisation should be sought before medication is continued.

NMC Guidelines state that instruction by telephone to a practitioner to administer a previously unprescribed substance is not acceptable. In exceptional circumstances, where the medication has been previously prescribed and the prescriber is unable to issue a new prescription, but where changes to the dose are considered necessary, the use of methods such as fax or e-mail is the preferred. This should be followed up by a new prescription confirming the changes within 24 hours. In any event, the changes must have been authorised before the new dosage is administered

In the case of the order being received from a prescriber by telephone, the message shall be taken by the practitioner who will:

- acquaint the prescriber with the name and dosages of other medicines currently prescribed for that patient,
- write down the message and read it back to the prescriber checking the patient's name, the medicine, the dose, the route and time of administration.

In an emergency situation, where a verbal order for administration of a medicine is given by a prescriber who is present, the nurse must check the medicine and measured dose with the prescriber before administration.

The normal procedures for recording the prescription and administration of the medicine must then be followed.

It should be noted that controlled drugs cannot be administered on the basis of a telephoned order.

If in doubt about a prescription or medicine for any reason the nurse must not administer until the Sister/Acting Sister/ Nurse in Charge or the prescriber has been consulted.

4 Patient Group Directions

A Patient Group Direction (PGD) is a written instruction for the sale, supply and administration of named medicines in an identified clinical situation. It applies to groups of patients who may not be individually identified before presenting for treatment. The majority of clinical care should continue to be provided on an individual, patient-specific basis and the use of PGDs should be reserved for those limited situations where this offers a distinct advantage for patient care and where it is consistent with appropriate professional relationships and accountability. PGDs are drawn up locally by doctors, pharmacists and other health professionals, signed by a doctor or dentist, as appropriate and a pharmacist and approved by an appropriate body.[4]

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IMPORTANT NOTES:

Unlicensed medicines

The use of unlicensed medicines is currently excluded from the scope of PGDs

Controlled Drugs

The Misuse of Drugs (Amendment) (No.3) Regulations (Northern Ireland) 2003 allow the PGD scheme to be extended to the following controlled drugs:

- diamorphine, but only for the treatment of cardiac pain by specialized nurses in accident and emergency departments and coronary care units in hospitals; and
- all controlled drugs listed in Schedule 4 (except the anabolic steroids and any injectable drug which is to be used for the purposes of treating addiction) and Schedule 5 of the 2002 Regulations[5].

Details Required for a Valid PGD[6]

The PGD **must**:

- be signed on behalf of the Department, Trust or Board[7];
- designate in writing the individual or individuals who may supply medicines under the PGD, who must belong to one of the classes of person specified below;
- relate to medicines that have a marketing authorisation or a homoeopathic certificate of registration;
- be in effect at the time of supply.
- and must contain the following information:
  - The name of the business to which the direction applies;
  - The period during which the PGD shall have effect; (guidance has indicated that the PGD should be reviewed at least every two years)
  - The description or class of POM to which the PGD relates;
  - The class of health professional to which the PGD relates;
  - Whether there are any restrictions on the quantity of medicine which may be supplied on any one occasion, and, if so, what those restrictions are; (This information is not required if the PGD relates to administration only.)
  - The clinical situations which the POM of that description or class may be used to treat;
  - The clinical criteria under which a person shall be eligible for treatment;

  - Whether any class of person is excluded from treatment under the PGD and, if so, what class of person;
  - Whether there are circumstances when further advice should be sought from a doctor or dentist, and, if so, what circumstances;
  - The pharmaceutical form or forms in which the POM of that description or class is to be administered;
  - The strength, or maximum strength, at which the POM of that description or class is to be administered;
  - The applicable dosage and/or maximum dosage;
  - The route of administration;
  - The frequency of administration;
  - Any minimum or maximum period of administration applicable to the POM of that description or class;
  - Whether there are any relevant warnings to note, and, if so, what warnings;
  - Whether there is any follow up action to be taken in any circumstances, and, if so, what action and in what circumstances;
  - Arrangements for referral for medical advice;
  - Details of the records to be kept of the supply and/or the administration of medicines under the PGD

In addition to the above criteria, it is a requirement of the legislation that the PGD is signed by a doctor or dentist as appropriate, and by a senior pharmacist.

Classes of Persons Permitted to Supply or Administer Medicines under PGDs.

The following is a list of persons who are permitted under the Regulations to supply or administer specified medicines under a PGD:

- State registered paramedics or individuals who hold a certificate of proficiency in ambulance paramedic skills issued by the Secretary of State, or issued with his approval;
- Registered Pharmacists;
- Registered health visitors (live on NMC Register);
- Registered midwives (live on NMC Register);
- Registered nurses (live on NMC Register);
- Registered ophthalmic opticians;
- State registered chiropodists;

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- State registered orthoptists;
- State registered physiotherapists;
- State registered radiographers.

It is important to note that the above professionals may only supply or administer medicines under a PGD as named individuals.

ADDITIONAL GUIDANCE ON THE DEVELOPMENT, USE AND REVIEW OF PGDs

1. PGDs should be drawn up by a multi-disciplinary group involving a doctor, a pharmacist and a representative of any professional group expected to supply medicines under the PGD. It is good practice to involve local Drug and Therapeutics Committees, Area Prescribing Committees and similar advisory bodies.
2. A senior person in each profession should be designated with the responsibility to ensure that only fully competent, qualified and trained professionals operate within directions.
3. All professions must act within the scope of their professional practice and according to their appropriate Code of Professional Conduct.
4. Appropriate document(s) should be signed by each member of the multidisciplinary group, the authorising body and the individual health professionals working under the direction. Generally, a direction should be reviewed every two years.
5. There must be comprehensive arrangements for the security, storage and labelling of all medicines. Wherever possible, medicines should be supplied in pre-packs supplied by the Pharmacy Department. In particular there must be a secure system for recording and monitoring medicines use from which it should be possible to reconcile incoming stock and out-goings on a patient by patient basis. Names of the health professionals providing treatment, patient identifiers and the medicine(s) provided should all be recorded.
6. The EC Leaflet and Labelling Directive 92/27 applies to all supplies of medicines, including those supplied under PGDs.

Antimicrobials

Particular caution should be exercised in any decision to draw up PGDs relating to antibiotics. Microbial resistance is a public health matter of major importance and great care should be taken to ensure that their inclusion in a direction is absolutely necessary and will not jeopardise strategies to combat increasing resistance. A local bacteriologist should be involved in drawing up the PGD. The local Drug and Therapeutics Committee or Area Prescribing Committee should ensure that any such directions are consistent with local policies and subject to regular external audit.

Black Triangle Drugs and medicines used outside the terms of the Summary of Product Characteristics

The use of any medicine should be consistent with the Summary of Product Characteristics (SPC) for the relevant product (save in special circumstances). Black triangle drugs (ie, those recently licensed and subject to special reporting arrangements for adverse reactions) and medicines used outside the terms of the SPCs may be included in PGDs provided such use is supported by best clinical practice. Each PGD should clearly state when the product is being used outside the terms of the SPC and the documentation should include the reasons why, exceptionally, such use is necessary.

5 Control of Medicines in Clinical Trials

Prior to licensing, new medicines are subject to human testing, as are established products for their use in new indications. Unlicensed products may be prescribed by registered medical practitioners for individual patients on a "named-patient" basis. Clinical Trials are within the scope of Research Governance Framework for Health and Social Care[8] which sets out the responsibilities and standards that must be applied to research conducted by or on behalf of the HPSS. In addition, the conduct of clinical trials must be in accordance with published guidelines on Good Clinical Practice (GCP). Under current arrangements, local (Northern Ireland) Ethical Committee approval must be sought prior to trials commencing. The patient/volunteer must be given adequate information about the trial on which to base his/her option to participate or not. All staff directly concerned with the treatment of a patient must be made aware of that patient's involvement in a clinical trial and its nature; this is particularly relevant to the recognition of side effects. The prescription sheet must be annotated to indicate that the patient is involved in a clinical trial. Administration

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and dispensing of trial medicines must be in accordance with locally agreed procedures and records must be kept of dispensing, issue, and administration of all medicines, and their disposal if warranted. Where trials are being conducted in a hospital the pharmacy department should hold a copy of all trial protocols, including codes, and should be involved in the control and audit of the medicines concerned in relation to procurement, storage, documentation and supply. However, local policy must fit in with national guidelines. For example, codes may be held centrally and it may not be possible for the local pharmacy to hold a copy of them. The identity of those staff involved in the trial must be recorded. Separate stocks of trial medicines must not be maintained in wards, clinics or private offices. Clinical Trials involving controlled drugs must be referred to the DHSSPS Misuse of Drugs Inspector to ensure licensing compliance.

It should be noted that from May 2004 the Clinical Trials Directive (2001/20/EC) is effective for all clinical trials conducted in the UK. This requires that clinical trials are conducted in accordance with the principles of GCP which are, for the purposes of the Directive, the current ICH principles[9].

Where patients involved in a clinical trial attend hospital as out-patients, their continuing supply of clinical trials medicines must be obtained direct from the pharmacy department where the appropriate records will be maintained.

6 Medicines Samples

The distribution of samples of medicinal products is not permitted within the hospital. Any samples received from pharmaceutical representatives must be handled through the normal pharmacy stock control system. Local arrangements should ensure that when representatives of pharmaceutical companies are visiting prescribers they should also be referred to the Pharmacy Department.

7 Medicines Brought to Hospital by Patients

Hospital in-patients must be made aware of the need to inform hospital staff of their current medicine therapy. Specific enquiries must be made by a doctor, nurse and/or

pharmacist to determine whether the patient is taking any prescribed medicines or any other medicinal preparations and if the patient has brought them to hospital. These medicines are the property of the patient to whom they were supplied and must not be taken without consent. The patient should however be asked to surrender, for examination by a doctor or pharmacist, any such medicines or other preparations brought to the hospital.

Steps should be taken to have such medicines identified and a decision made as to whether it is advisable for them to be continued. Where the patient is to continue on that medication, suitable provision for this should be made in the interests of economy, safety and good practice. On no account must one patient's medicine be given to another patient. Where these medicines are NOT to be continued, the patient, or nearest relative or representative, should be asked to give consent to their destruction. It should be explained to the patient that while in hospital all medicines will be prescribed by authorised prescribers and administered in accordance with their directions.

Where patients do not surrender their own medicines it is possible that they will continue with unapproved self medication. It should be made clear to patients, and their representatives if any, that the taking of these medicines contrary to medical advice may seriously jeopardise current treatment to the extent that it may not be safe to commence or continue it.

Where the patient has surrendered medicines but does not agree to their destruction, he/she should be asked to send them home with a responsible adult. Responsibility for security then passes to that adult. The patient or representative must be advised if the medicines are not safe for use with or without other medication.

Where the patient does not agree to the destruction of his/her surrendered medicines, and they are not taken home, the pharmacist should make arrangements for their secure storage in hospital until the patient's discharge when a decision will be made to return them to the patient or to dispose of them as appropriate. Records of the receipt of such medicines and their eventual disposal should be kept.
All medicines brought in with a patient suffering from overdose must be sealed, labelled with the patient's full

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name, reference number and date of admission before being stored in the pharmacy. These medicines must not be returned to the patient or disposed of on discharge or otherwise until it is established whether they may be required as evidence in legal proceedings.

Each hospital should include with the notice of admission, or in its admission booklet, advice for patients on the following lines:

"MEDICINES. Whilst you are in hospital the clinical staff may want to prescribe new medicines, or other treatment. Before doing so they will want to know what other medicines, including homoeopathic or herbal remedies, you are already taking, or have with you. It is therefore VERY IMPORTANT that you tell the doctor, nurse or pharmacist about such medicines and bring them with you to hospital if possible. It could be dangerous for you to continue to take your own medicines or to take any medicines brought to you by visitors during your stay in hospital. You should always tell the nurse-in-charge of any medicines brought to you in this way. If you hold a SPECIAL CARD which gives details of any current treatment, for example a steroid or warfarin card, or an allergies alert card or any devices please bring these with you into hospital and show them to the doctor, nurse or pharmacist".

Where patients are found in possession of unauthorised drugs or other suspicious substances staff should refer to the guidance issued by the Department[10]

8 Supply of Patients' "Take Home" Medicine

Provision must be made for patients on discharge or weekend leave to receive a sufficient quantity of their prescribing medicines from the hospital pharmacy to continue their therapy. This will normally be for up to 72 hours until further supplies can be prescribed (this policy is, currently, under review). This procedure will also apply to cases where 'one day' surgery schemes operate. The prescription form used for this purpose should contain a complete and accurate list of the patient's prescribed medicines on discharge, having been completed (at least in triplicate) and signed by the responsible prescriber. One copy of the form will be retained for use by the pharmacy department for dispensing, one copy for filing in the patient's records, and one copy for the patient's GP where appropriate.

However, suitable provision may be made, where applicable, for patients to continue on the medicines which they brought to hospital with them.

Local arrangements should ensure that, prior to discharge, patients are adequately advised and instructed on the use of their medicines (see section 9). Such advice should also be given to parents, guardians, or relatives where appropriate. Written details of the diagnosis and current medication together with details of any known drug allergies should also be provided for the patient's General Practitioner (see section 19).

When a patient is discharged outside normal hospital pharmacy hours, special arrangements should be made with the pharmacy to have available at the ward suitable containers, labels and patient information leaflets for the supply of medicines from the ward stock. All such containers, labels and leaflets must be in a locked cupboard and the medicines in question should be checked by a second person. **A record of all medicines so supplied must be made on the relevant prescription sheet and the copy of the prescription sent to the pharmacy**.

Medicines dispensed from ward stock to patients on discharge must bear a printed label showing the date, the name of the patient, the ward number, the name of the medicine, its strength and precise instructions for its administration.

Any medicines brought into hospital by a patient and lodged in the ward/pharmacy may be returned on discharge if the patient so requests (except for illicit drugs or medicines belonging to patients admitted with an overdose) (see section 7). The patient should be advised regarding any risk of using those medicines concurrently with existing treatment.

9 Patient Information on Medicines

Studies on the use of medicines have clearly shown that patient compliance with instructions for the self-administration of prescribed medicines is relatively poor.

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The reasons for this are diverse and include forgetfulness, misunderstanding of directions, lack of motivation, insufficient information and poor communication by health practitioners and others. In order to optimise the safe, effective, rational and economical use of medicines it is important that patients are given sufficient information and skilled counselling to allow them to use their therapy appropriately and with maximum benefit.

In addition to the printed directions on the medicine container, verbal instructions must be clear and precise, and reinforced in writing as appropriate.

Some situations already exist in Northern Ireland where pharmacists in hospital are, by arrangement with the consultants concerned, directly involved in providing advisory services to selected groups of patients in relation to their prescribed therapy during their hospital stay and prior to their discharge from hospital (eg cardiac and oncology patients).

It is essential that clinicians, in association with other health care professionals as appropriate, take the necessary steps to ensure the provision of adequate information to patients to enable them to use their medication effectively, thus promoting the continuity of care from hospital to the community. It is a legal requirement that patients discharged from hospital should receive a patient information leaflet with each medicine supplied to them.

10 Administration

Nurses

Medicines will normally be administered to a patient by a suitably qualified professional, usually a nurse. If there is any doubt, for example, regarding the legibility of the prescription, the dose of the medicine or the purpose for which the medicine is prescribed, the nurse must seek guidance from the ward manager, prescriber or pharmacist concerned, before administering any medicines. Under no circumstances should guesses be made.

Nurses and midwives whose names are on the first level parts of the Register or second level nurses who have successfully completed approved Pharmacology training should be seen by the employing authority as competent to

administer medicines on their own and responsible for their actions in so doing. The involvement of a second person in the administration of medicines with a first level practitioner need only occur where that practitioner is

- adhering to local policies
- administering a neonatal drug
- administering a Schedule 2 controlled drug
- administering an intravenous solution extemporaneously prepared using potassium chloride concentrate or other strong potassium solutions, or
- administering to a patient whose condition makes it necessary.

Where a student of nursing is administering medicines he/she must be supervised by a first level practitioner.

In hospitals or nursing homes, personnel who are not professionally registered, such as nursing auxiliaries or assistants, should not participate in the administration of medicines unless they have undertaken a course of training endorsed by their employing authority.

In a residential care setting staff involved in the administration of medicines should receive any necessary additional training to enable them to administer medicines to residents who are unable to self-administer.

Second level practitioners should not administer medicines on their own unless the employer:

- has provided additional instruction relevant to the medicines likely to be encountered in a particular setting; and
- has undertaken an assessment and is satisfied as to the individual's knowledge and competence to perform the task; and
- is prepared to accept the responsibility for any errors that are consequential upon using a second level practitioner beyond the role for which they have been trained.

Before selecting the medicine to be administered the nurse must:-

- check that there is a valid prescription (see section 2)
- check the NAME of the patient against the details on the prescription and recording sheet and check the drug allergy box which should never be left blank.

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- READ the prescription carefully; and make sure that the medicine is to be administered
- ascertain that the DOSE has not already been administered and that the total dose (where stated) will not be exceeded.
- check the DOSE prescribed and the ROUTE of administration
- Check that the dose prescribed is appropriate especially where the dosage of medication is related to body weight (this is particularly important in relation to neonates and children)

Before administering the medicine the nurse must:-
- verify the identity of the patient, by checking, for example, verbally the name, and the name and unique patient registration number on his/her identity bracelet. The date of birth must always be checked
- select the medicine required, check its STRENGTH, and CHECK THAT THE MEDICINE NAME ON THE CONTAINER LABEL MATCHES THAT ON THE PRESCRIPTION SHEET
- check that the medicine is in date and is not obviously defective in any way.

On the medicine round it is the nurse's responsibility to see that the medicines are actually taken.

Because of the more obvious risk of overdosage, particular care should be taken in the administration of all medicines to neonates and children. It is vital to ensure that the prescribed dose is an appropriate paediatric dose, and that any necessary calculations are correct and have been checked by a second person. For oral liquids a 5ml medicines spoon or measuring cup can be used to measure oral doses which are in multiples of 5ml. An appropriate oral syringe should be used for all other doses. IV syringes should not be used to measure and administer oral liquid medicines. Paediatric formulations should be supplied to wards and departments where children receive treatment. Similar care should be taken in the administration of medicines to elderly patients.

Registered Doctors

The safety of patients comes first at all times. The duties and responsibilities of a registered doctor are outlined in Good Medical Practice[11]. These include responsibilities in respect

of diagnoses, investigation and treatment of patients including those relating to the prescribing and administration of medicines and treatments and the reporting of adverse drug reactions.

Doctors who have special responsibilities for teaching and training must have the skills, attitudes and practices of a competent teacher. They must also ensure that students and junior colleagues are properly supervised. A doctor who delegates treatment or care eg to another doctor, nurse or medical student must ensure that the individual is competent to provide the therapy or carry out the procedure.

Medical Students and Pre-registration House officers

'Tomorrow's Doctor'[12] sets out the clinical and practical skills which graduates must be able to do safely and effectively. These include skills necessary to the prescribing and administration of medicines including:
- working out the drug dosage and recording the outcome accurately;
- writing safe prescriptions for different types of drugs;
- carrying out the following procedures involving veins:
  venepuncture
  inserting a cannula into peripheral veins
  giving intravenous injections
- giving intramuscular and subcutaneous injections
- using a nebuliser correctly
- administering oxygen therapy

In addition, the Student Logbook for Pre-registration House Officer Workshadowing sets out key tasks and skills which a medical student of Queen's University must achieve under the supervision of a PRHO or other junior staff. This emphasises that no drug or intravenous fluid should be prescribed by a medical student. All such medication must be prescribed by a qualified doctor. The log book sets out key tasks/skills to promote safe prescribing and practical procedures which should be achieved and written up including:

writing up a fluid balance chart;
writing a drug prescription chart;
prescribing anticoagulation based on INR chart;
prescribing insulin based on diabetic chart;

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giving summary of local antibiotic policy
compiling a list of 10 drugs most commonly used at the Unit, documenting specific details;
practical procedures, under a named supervising staff member, including IV cannula insertion, erection of IV infusions and SC/IM/IV injections

Intravenous Infusions

Medicines given via any form of intravenous infusion should be administered in accordance with the clearly written directions of the prescriber and as laid down in local procedures established by Boards under Circular HSS(OS3)6/79 "Addition of Drugs to Intravenous Infusion Fluids". Aseptic dispensing must be carried out in compliance with published standards[13] as advised in circular HSSE (OCE) 1/97

Intrathecal Administration

Due to the serious consequences resulting from maladministered spinal injections, it is essential that the National Guidance on the Safe Administration of Intrathecal Chemotherapy[14] is observed.

Potassium Chloride Solutions

Systems should be in place to avoid incidents where patients accidentally receive an overdose of intravenous potassium. Particular attention should be given to the guidance issued by the National Patient Safety Agency (NPSA) and endorsed by the Department[15].

Cytotoxic Drugs and Radioactive Substances

By their nature, cytotoxic drugs and radioactive substances constitute a hazard to healthy cells, both in the patient and those who prepare and administer them. Cytotoxic products should, preferably, be prepared in the pharmacy department by trained and experienced pharmacy staff and not at ward level.

Good practice guidelines on the safe handling and administration of cytotoxic[16] and radiopharmaceutical preparations[17] should be observed

Prescribing, supply and administration of specialist medicines[18]

As care for patients becomes more complicated, specialised medicines are increasingly being used. 'Specialist

medicines' have been defined by Departmental guidance and have been designated as 'Red' or 'Amber' List medicines.

It is recommended that the prescribing responsibility for a Red List medicine should remain with the initiating consultant and it should be supplied via a hospital pharmacy. The administration of such medicines may be undertaken by a nurse under the written direction from a doctor/consultant currently registered with the General Medical Council. A formal document should be supplied from the consultant which must state the patient's name, address, condition being treated, the dose and route of administration of the medicine. It must be signed by the consultant responsible for the treatment of the patient and the nurse once the medicine has been administered. A copy of this document should be sent to the patient's GP. The authorisation to administer must then be filed in the patient's notes. Amber List medicines may be prescribed and supplied in primary care. Prescription and supply should be done under a shared care protocol which should be agreed by the hospital and primary care prescriber.

Other Health Professionals

Administration of medicines to patients by other authorised health professionals must be in accordance with the written directions of an appropriate prescriber or in accordance with a PGD. These directions (see sections 2 and 4) must be recorded on the patient's prescription sheet(s) together with a further record of the administration of the medicine (see section 12) signed by the health professional involved.

11 Self-administration of medicines

Self-administration may be defined as a system which allows persons in health service or private care facilities to have possession of some or all of their prescribed medication and to take responsibility for administering it correctly. It is recognised that various medicines often are self-administered eg glyceryl trinitrate, aerosol bronchodilators, and that these medicines are held by the individual concerned during his stay in such establishments.

There is a case for extending this method of administration to a variety of health care situations. This relates particularly to encouraging people to take greater responsibility for their own treatment and also to improving

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the continuity of care from hospital to the community where, in the latter situation, patients almost exclusively administer their own medicines. The difficulties inherent in such a system of medicine administration in hospitals are recognised. It is essential, therefore, that where self-administration is introduced, arrangements are in place for the safe and secure storage of the medication, access to which is limited to the specific patient. In addition, records of such self-administration should be maintained appropriate to the environment in which the patient is being cared for.

Given existing practices and the possibility of the development of self-administration programmes, provision should be made for those who are judged to be competent and confident to administer their own medicines, to have a lockable drawer or cupboard in which to store them. In cases involving self administration of controlled drugs subject to Safe Custody requirements, advice should be sought from the Department's Misuse of Drugs Inspector. In addition, each preparation must be clearly labelled with the name of the patient, the name and strength of the medicine, the directions for use, and date of dispensing and the amount dispensed.

Any developments in the area of self-administration of medicines should be along multidisciplinary lines with agreed written protocols of the procedures to be followed.

12 Recording

A record of administration should be made on the medicines recording sheet, at the time the medicine is given to the patient, and initialled by the person (normally the nurse) who administered the medicine. If the medicine has not been taken, this fact should be recorded on the prescription sheet and the prescriber informed. A local system should also be developed whereby any suspected adverse drug reaction is recorded and the appropriate practitioner(s) alerted. Pharmacists could play a useful role in co-ordinating such a scheme. In addition, all suspected adverse drug reactions should be reported to the Medicines and Healthcare Products Regulatory Agency (MHRA) using the Yellow Card Scheme. Pre-paid Yellow Cards for reporting such reactions are bound within the inside back cover of the BNF.

Schedule 2 Controlled Drugs

In addition to the above, the details relating to the administration of Schedule 2 Controlled Drugs shall be entered in the ward controlled drugs register or other separate record kept specifically for that purpose. Such register/record must be signed by a First Level Registered Nurse and a witness who should also be **present at the administration of the drug**. Where two nurses are involved, one of them must always be a First Level Registered Nurse.

There is no legal requirement to keep a register for Schedule 3 Controlled Drugs, for example, temazepam. However, many hospitals, as a matter of good practice, maintain a register for selected Schedule 3 preparations.

Details concerning Controlled Drugs accidentally or deliberately wasted shall be similarly witnessed and recorded in the ward controlled drugs register/record. A documented CD audit should be carried out by the pharmacist at least three-monthly.

13 Supply of Medicines to Wards and Departments

It is recognised that a number of different methods are used to effect the supply of medicines to wards. However, pharmacists are responsible for the supervision of the dispensing of medicines and for ensuring that systems are established for the safe, secure, effective and economic supply of medicines.

Ordering

Medicines other than Controlled Drugs: All orders must be made in an approved manner and each requisition must indicate the date, ward, department or other healthcare facility and the name, quantity, strength and form of medicines required. Where a 'topping-up' system of supply is in use the requisition may be in the form of a list prepared by pharmacy staff. The Nurse in Charge is the person with responsibility for approving requisitions. In other departments, eg physiotherapy and podiatry, it is the responsibility of the senior professional to requisition designated medicines.

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Controlled Drugs: The Misuse of Drugs Regulations (Northern Ireland) 2002 specifies five schedules of medicinal substances which are subject to various forms of control. For most practical purposes hospitals and other healthcare facilities need only be concerned with the specific control requirements of Schedules 2 and 3. However, significant possibilities exist for the illegal diversion of drugs in Schedules 4 and 5 and local procedures should be commensurate with the perceived or actual risk.

- **Schedule 2 Controlled Drugs:** Orders for these medicines, which are mainly opiates, **must** be made on a separate duplicate requisition specifically designated for these preparations and signed by the Sister/Acting Sister in charge of the ward or department or other healthcare facility.
- **Schedule 3 Controlled Drugs:** Schedule 3 drugs include among others dihydrocodeine, temazepam and buprenorphine. They must be ordered on a duplicate requisition signed by the Sister/Acting Sister in charge of the ward or department.

Delivery

It is the responsibility of the pharmacy department to establish safe systems of delivery, incorporating appropriate documentation so as to allow both the issuing department and the receiving unit to effect proper audit.

Staff involved directly in the transport of medicines should be limited to a minimum practical number of identified people, ensuring, of course, a back up of available staff to maintain continuity of service. Ideally transport and portering staff should be part of the pharmacy establishment. Those transporting medicines shall be responsible for their security until delivered to an authorised person and the delivery acknowledged.

Where, in emergencies, non-Trust transport is employed to transport medicines it is the responsibility of the pharmacy department to ensure that adequate security arrangements are in place.

Medicines other than Controlled Drugs: The delivery of medicines to wards, departments etc must be carried out in a manner that ensures that the medicines reach their destination without undue risk of being stolen, damaged or tampered with in any way. Where medicine delivery is

undertaken between hospitals all containers must be locked and/or fitted with tamper-evident seals.

Controlled Drugs (Schedule 2): Where Controlled Drugs delivery is undertaken from a pharmacy department within a hospital, delivery (in a sealed package) must be effected in person by a responsible individual. That person must sign for the delivery of the Controlled Drugs before leaving the pharmacy department. At ward level the medicines must be handed to the Sister/Acting Sister who will check the medicines received against the requisition and sign for their receipt.

Where Controlled Drugs have to be delivered between hospitals they must be in a locked container or be fitted with a tamper-evident seal. Where this receptacle contains other medicines the Controlled Drugs must be sealed in a separate package. A signed record of receipt for the Controlled Drugs must be made by the Sister/Acting Sister and returned to the issuing pharmacy department.

Delivery of Medicines to Patients' Homes

Delivery of medicines to patient's homes should be undertaken in accordance with the guidance articulated in the Code of Ethics issued by the Pharmaceutical Society of Northern Ireland

14 Medicines for Staff Personal Use

Medicines for the personal use of staff will not normally be provided from hospital stocks. However, where Boards agree to such provision, where appropriate, charges for the medicines supplied should be made.

15 Storage and Custody

Storage of medicines involves both environmental and security factors. Medicines must be stored under optimum environmental conditions (temperature, lighting etc) in accordance with the manufacturers' instructions. Robust systems must be in place to ensure that unauthorised access to medicines is prevented.

Guidance on security matters may be sought from the Department's Pharmaceutical Inspectorate and PSNI Crime Prevention Officers.

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Medicines for use in wards should be stored in approved standard modular cupboards conforming to British Standards where applicable. These include the following categories:-

- Controlled Drugs Cabinet
- Internal Medicines Cupboard
- External Medicines Cupboard
- Cupboard for Disinfectants/Antiseptics used in ward cleaning
- All medicines should be stored according to manufacturers' recommendations in respect of temperature. Where products requiring refrigeration are stored the refrigerator used should be equipped with a means of ensuring that the specific temperature range specified for the product has been maintained. A daily record of such monitoring should be made.
- Cupboard for Diagnostic Reagents, including Urine Testing Cabinet
- Dedicated clinical area for Intravenous Fluids and Sterile Topical Fluids.
- Appropriately secured emergency trolley.

Where there is a perceived extra risk of theft, for example due to the nature of certain preparations, their location, or lack of 24 hour staff presence, additional safeguards should be applied as appropriate.

The area in which cupboards are located must be well lighted by day and at night. Medicines in current use, with the exception of Controlled Drugs, may be kept in a locked approved medicine trolley and not returned to the cupboard after each administration. Medicine trolleys must be parked when not in use either in a lockable cupboard or attached by lock and chain to the wall or floor. They must never be left unattended when opened.

Schedule 2 controlled drugs must always be stored in a Controlled Drugs Cabinet providing, in its construction, a level of security at least comparable to that laid down in the Misuse of Drugs (Safe Custody) Regulations 1973. In theatre suites these should be located in each anaesthetic room and/or recovery room which serves one or more theatres.

Areas where controlled drugs are stored which are regularly and routinely unmanned should, where possible, be monitored by alarm systems or CCTV. Locks securing

doors leading to areas where controlled drugs are stored must be adequate to act as a deterrent to theft.

Keys of controlled drugs cabinet must be carried on the person of the Sister/Acting Sister/Nurse in Charge and be handed over personally to the nurse responsible for taking over the custody of the cupboards. Keys to all other medicine cupboards must be held by either the Sister or a First Level Registered Nurse. Loss of keys must be reported immediately for appropriate action by the Nurse in Charge, who will also inform the pharmacy.

In clinical areas where medicines are frequently required for emergency use, local guidelines should ensure maximum security compatible with functional requirements.

In situations where controlled drugs are in daily use the stock balance should be reconciled on each occasion when responsibility for safe custody is transferred. However where controlled drugs are used less often the frequency of this check may be varied for local operational reasons at the discretion of the Sister/Acting Sister/Nurse in Charge, in consultation with the Pharmacist. This check must be carried out by two qualified nurses one of whom should be on the First Level Register, recorded and signed.

The security of ward stocks must be checked by pharmacy staff periodically, normally every three months, in accordance with locally agreed procedures. They must carry out inspections of ward stocks, with reconciliation where necessary.

Where there has been unauthorised access to, or theft of, ward medicine stock this must be reported immediately to the Nurse in Charge who will conduct an initial investigation and subsequently inform the pharmacy department. It then becomes the responsibility of the pharmacy department to investigate the matter, enlisting the support of other disciplines and liaising with the police as appropriate.

16 Labels

Medicines dispensed from pharmacy must be clearly labelled in accordance with legal requirements. If any of the details on the label on any container are defaced or obliterated, eg name, expiry date or strength, the container must be returned to the pharmacy for replacement.

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Alterations to labels must not be made under any circumstances except to indicate the addition of prescribed drug to a container of intravenous or irrigation fluid, or to indicate when any particular pack (eg eye drops) was first used.

17 Transfer of Medicines between Containers

The transfer of any medicine from one container to another, other than by pharmacy staff, is forbidden. Any loose medicines present on a ward must not be used or returned to the container but sent to the pharmacy for disposal.

18 Transfer of Medicines between Wards

Only in exceptional circumstances should medicines supplied from ward stock be used on another ward. In such cases, the smallest original pack should be supplied. Local arrangements should ensure that such transfers are fully documented. The Misuse of Drugs Regulations do not permit the transfer of controlled drugs between wards.

19 Transfer of Patients

Occasionally when a patient is transferred between hospitals insufficient information regarding treatment is given to the hospital to which the patient is transferred. It is appreciated that in some instances hospitals prefer to retain their own records and that an abbreviated summary is often more convenient for the receiving hospital, but the lack of sufficient information could have an adverse effect on the patient's treatment.

A written record of the patient's diagnosis and current treatment, including medication regimen together with any information on known drug allergies and, where appropriate, a 24 hour supply of medication, should accompany the patient on transfer to another hospital. The time when the patient received the last medication must also be given.

These principles should also be applied for the information of the appropriate General Practitioner when a patient is discharged to the Community (see also section 8) and for the information of the nursing home when a patient is discharged to a home.

20 "Out of Hours" Pharmacy Arrangements

Local arrangements for HPSS establishments should ensure the provision of a pharmacy "out of hours" service. Consideration should be given to the provision of an emergency medicines cupboard, the contents of which should be decided by the Pharmacy Department in consultation with senior medical and nursing staff. Access should be restricted to named individuals and records kept of any stock used.

21 Hospital Pharmacy Security

Responsibility

Each pharmacy department must have a pharmacist with delegated responsibility for all aspects of the safe and secure handling of medicines. The pharmacist will define suitable systems of work and storage within the department, taking account of statutory requirements and professional guidance.

Access

Access to the pharmacy stocks must be restricted to personnel authorised by the pharmacist in charge. Medicines can only be supplied in accordance with written procedures approved by the pharmacist in charge.

Emergency pharmaceutical cover should be available for occasions when access to the pharmacy is necessary when the department is closed. Hospital emergency cupboards may provide a source of emergency "out of hours" medicines (see section 20).

Physical Security

Security precautions in general should comply with recommendations made by local Health and Safety Officers, PSNI Crime Prevention Officers and Departmental Officers. There should be a suitable intruder alarm installed in each Department linked to the hospital switchboard or local police station. Such alarms should be regularly tested. Staff must be well informed of the procedures to be followed in the event of a breach of security. Additional security measures including appropriate use of CCTV, panic buttons, toughened glass and restricted access areas are now recommended for all hospital pharmacies.

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Storage of Controlled Drugs

Controlled Drugs must be stored in cabinets, safes or rooms which must at least conform to the standards laid down in the Misuse of Drugs (Safe Custody) Regulations 1973. Stock levels should be kept to a minimum compatible with hospital demand and the logistics of replenishment.

Stock Control/Recording and Reconciliation

The purchase and receipt of medicines by the pharmacy should be conducted, and recorded, according to written and approved standard operating procedures (SOPs). These must include a means of identifying the member of pharmacy staff involved at each stage of the transaction.

There must be a clear method whereby medicines being received into the pharmacy store from a supplier are co-related with an official order. The person initiating the order should not, as far as possible, be the person verifying its receipt.

Permanent records of medicines purchased must be maintained and records kept of all medicines coming into and out of the pharmacy. The date of each transaction and the identities of those involved must be recorded.

SOPs should include provision for checks enabling the tracing of medicines, for example, where defects/hazards are reported. Regular stock reconciliation spot checks should be carried out and any discrepancies investigated.

All medicines dispensed from the pharmacy must have been ordered in writing by an appropriate person and a record of the transaction must be maintained together with the signature of the authorised member of the pharmacy staff or other means of his/her identification.

Controlled Stationery

Controlled stationery is any stationery which, in the wrong hands, could be used to obtain medicines fraudulently. Stocks of controlled stationery must be received, held secure and distributed by the pharmacy department.

In normal circumstances only one book/pad of forms should be held by each ward/unit/department at any given time and replacement stationery should only be issued on the evidence that existing forms have been used. Loss or theft of any controlled stationery must be reported immediately to the person in charge of the ward/unit/department and to the pharmacy for investigation.

Inspection

The rights of access and inspection by the Department's Pharmaceutical Inspectorate apply to all health service facilities.

22 Pharmaceutical Waste

The disposal of medicines and controlled drugs should be carried out in accordance with local policies based on *Guidance on the Handling and Disposal of Pharmaceutical Clinical Waste* (Health Estates 2002)[19].

23 Residential and Nursing Homes

The principles relating to prescribing, administration and storage of medicines given in previous paragraphs should also apply to the handling of medicines in residential homes and private nursing homes. In a residential home setting, it is the responsibility of the owner/employing authority to ensure that medicines management is, as far as possible, in line with the standards and guidance given in this document. Boards should establish detailed procedures to be followed in all such homes subject to their control and inspection. The procedures should take into account the specific guidance given in the following paragraphs.

With the exception of approved "household" remedies, all medicines must be prescribed on an individual "named person" basis. Medicines must also be dispensed on an individual "named person" basis and therefore must be administered only to that person.

All prescriptions must clearly indicate the dosage, frequency and route of administration of the medicine. General instructions such as "as directed" are not acceptable.

Each facility should employ a prescription sheet that fulfils all the requirements listed in section 2 whereon a complete record of each resident's prescription(s), administration of medicine(s) etc is maintained. General Practitioners should be encouraged to verify and sign the prescription record sheet as a matter of good professional practice so as to ensure that the residents' prescribing records are at all times up to date and accurate.

Procedures should include instructions, drawn up in consultation with pharmacy, medical, nursing and social services staff as appropriate, for the Manager in relation to approved home remedies for minor ailments and the

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recording of their use. Such procedures should conform to published Regional Guidelines.

Where a resident needs a supply of medicine during a temporary absence from the Home, or on discharge, provision must be made for an adequate, suitably labelled supply to be given to the resident, or responsible adult/relative, for administration as prescribed.

All medicines which are unused and/or unfit for use should be returned to a community pharmacy for disposal.

In specialist units eg Hospice care, where specific arrangements for the procurement of medicines have been agreed with the Department of Health, Social Services and Public Safety, their control and use in those units should follow the guidelines laid down in this document for hospital wards.

24 Community Nurses and Health Visitors

Community Nurses and Health Visitors should not normally carry medicines. It is, however, acknowledged that Community Nurses may carry some medicines for emergency use eg adrenaline injection.

Except when carried on the person of the authorised nurse, medicines must be kept out of sight in the nurse's locked vehicle during domiciliary visits. When they are kept overnight in the nurse's own home, they must be securely locked away. Nurses who carry medicines must also carry an identification document, signed by a Senior Nurse, stating their authority to do so.

Each medicine carried must be related to the written prescription of a registered prescriber.

It should be remembered that medicines supplied on prescription to persons in the community are the property of the person for whom they are prescribed.

Nurses have a responsibility for assisting in the education of the public regarding the safe custody and administration of their medicines. Patients should also be warned that medicines require careful storage and that prescribed medicines must not be made available to, or given to, persons other than the patient for whom they were prescribed.

In the administration and recording of medicines by community nurses, the principles of good practice as set out in section 10 must be applied. In addition to the nurse's own records, a record of each administration must be completed for retention by the patient.

Nurses should advise patients and/or their relative(s) and representative(s) that any medicine no longer required should be returned to a pharmacy for disposal.

If at any time the availability of medicine(s) in a patient's home gives cause for concern in relation to the safety of the patient or the custody of the medicine(s), the nurse must exercise his/her professional judgement regarding the removal of medicines. A record of the action taken must be made (including reasons as appropriate) and the patient's doctor fully informed.

25 Midwives

Midwives must observe the rules set out in the Midwives Rules (NMC) and Code of Practice and follow relevant legislation and any local policy and/or procedures specified by the Supervisor of Midwives.

In the Community

Supply and Administration of Controlled Drugs

The Misuse of Drugs Act 1971 provides for the supply of pethidine and pentazocine to midwives using a 'supply order' in accordance with Regulation 11 of the Misuse of Drugs Regulations (Northern Ireland) 2002. In these circumstances full records must be maintained for pethidine in a Controlled Drugs Register which must be made available for inspection, if required, by the Department's Misuse of Drugs inspector. Any controlled drugs prescribed by a general practitioner remain the property of the woman and midwives should ensure that they are stored securely in the woman's home.

Possession and administration of Controlled Drugs by midwives must be in accordance with locally agreed procedures and Regulation 11 of the Misuse of Drugs Regulations 2002. Midwives must record full details of the administration of pethidine or other drugs in the patient's records. All records must be made available for inspection as required by the Supervisor of Midwives.

Supply and Administration of Other Medicines

A list of prescription only medicines which may be supplied to, and used, by midwives is included in the Prescription

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Only Medicines (Human Use) Order 1997. The medicines which are to be used by midwives must be decided by the Supervisor of Midwives in accordance with local policy. Supplies should be arranged as above.

Midwives must keep a record of supply, administration and disposal of all prescription-only medicines issued to them.

When in the custody of the midwife, the security of medicines is the midwife's responsibility.

Return/Disposal of Medicines

As indicated above, Controlled Drugs obtained by a woman on prescription from her doctor, for use in her home confinement, are her own property. Even when no longer required they should not be removed by the midwife, but the woman should be encouraged to return the drugs to the pharmacy from which they were supplied so that they may be safely destroyed.

Where a midwife is in possession of medicines, other than Controlled Drugs, which are no longer required, but are still usable, they may be returned to the pharmacy from which they were supplied. In the case of prescription only medicines, a receipt should be obtained and a record of their return made in the midwife's records. A record must also be made of all prescription only medicines disposed of by the midwife.

Audit of Records

Supervisors of Midwives must, as part of their duties, periodically audit the records of medicines kept by each midwife. Any discrepancies must be investigated.

In Hospitals

Midwives Working in Hospitals

Administration of Controlled Drugs and other medicines by midwives working in hospitals must be in accordance with relevant legislation, locally agreed policies and the guidance given in section 10.

26 Primary Care including GP Practices, Health Centres and Community Clinics

Security and storage of prescriptions: There should be an appropriate prescription security system in place to ensure the safe ordering, receipt and storage of prescriptions. It is recommended that practices should have a written policy and documented procedure. Unused prescriptions should be stored in a locked cabinet. It is advised that a register should be kept which should include the following information as a minimum:

- The date and procedure for ordering;
- The date of receipt of prescriptions from courier;
- The prescription serial numbers, the date and to whom prescriptions were issued from the central supply;
- The register should also record the quantity and date of supply to locums, and record the date of return of unused scripts

Prescriptions pads should not be left unattended at any time. It is recommended that a minimum number of prescriptions should be carried when working outside the practice environment. The responsibility for security of prescription pads rests solely with the prescriber to whom the pads were issued.

It is recommended that stock order forms should be used in accordance with Departmental guidance. The principles of security and storage, as outlined above, should also apply to stock order forms.

Blank computerised prescription sheets should be kept secure and the written policy on prescription security should also incorporate best practice on the issuing and use of computerised prescriptions. Detailed advice has been produced by Health and Social Services Boards and further advice may be obtained from the HSS Family Practitioner Units.

Medicines stored and used under the personal control of a doctor: In most cases supplies of medicines are carried personally by doctors. Responsibility for the safe custody of such medicines, including professional samples, rests solely with the doctor concerned and must not be delegated. There should be a practice policy and procedure in place for regularly checking the expiry date and replacement of essential medicines and consequent diposal in accordance with Special Waste Regulations..

Essential medicines (excluding Controlled Drugs) stored in treatment rooms or other clinical areas for daily use by nursing or other professional staff eg for immunisation, podiatry, dentistry, physiotherapy and family planning: The amount stored should be kept to a minimum and need not be under the direct

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control of the General Practitioner. Emergency packs of medicines should be clearly marked "For Emergency Use" and be easily accessible to staff during the hours when patients attend. All medicines should be stored according to manufacturers' recommendations in respect of temperature. Where products requiring refrigeration are stored the refrigerator used should be equipped with a means of ensuring that the specific temperature range specified for the product has been maintained . A daily record of such monitoring should be made.

Controlled Drugs: General Practitioners are obliged to store their controlled drugs in accordance with the Misuse of Drugs (Safe Custody) (Northern Ireland) Regulations 1973 which requires the use of a locked receptacle. General Practitioners are advised to use a custom made Controlled Drugs cabinet which is affixed properly in an appropriate area in the practice.

Doctors may carry their personal stock in a locked bag but are advised to ensure personal control of this at all times and should avoid storage in an unattended vehicle where it would be susceptible to theft.

It should be noted that the use of the Controlled Drugs Register is mandatory. An appropriate Register may be obtained from the Central Services Agency and guidance on good practice in respect of prescription, supply, administration and destruction of controlled drugs, which has been approved by the Department, is contained in the Register.

Prescription Pads: The importance of safe storage and custody of prescription pads (HS21 Rev) is emphasised. Responsibility for the security of these pads rests solely with the prescriber.

Out of Hours (OOH) GP Services

Providers of OOH services should note and follow the principles outlined above for the safe prescription and use of medicines. It is recommended that OOH services **should not** maintain a central supply of controlled drugs but rather ensure that doctors carry a small supply for clinical use.

In certain circumstances small amounts of immediately necessary treatment is issued by practitioners via OOH services. It is essential that these are appropriately labelled with the names of the patient and of the

medicine, the quantity supplied and clear instructions for use. The law also requires that a patient information leaflet be supplied to patients.

GP Dispensing Practices

Dispensing GP practices should operate to the same standards as community pharmacy practice.

Medicine Administration

Medicines must not be administered by nursing staff in health centres/GP practices without the written prescription of a registered prescriber or under the authority of an approved PGD.

Supply of Medicines to Community Clinics

Medicines for use in community clinics are normally supplied via Trust hospital pharmacies. The range of medicines for use in these facilities must be agreed by the practitioners involved and the hospital Trust pharmacist.

Orders for medicines must be in writing and on a supply form provided by the pharmacy. Each order must bear the signature of the person authorised to have possession of the medicines.

Primary Care Dental Practitioners

Primary care dental practitioners should familiarise themselves and put into practice those sections of the guidance which are relevant to their own clinical situation.

27 Ambulance Service

The Medicines Act 1968 restricts the administration of parenteral medicines. All medicines for parenteral administration are prescription only and unless self administered, they may be administered only by or under the directions of a doctor or dentist. Under the Prescription Only Medicines (Human Use) Order 1997 (the POM Order), exemptions from these restrictions are provided for specified persons in respect of specified medicines.

Arrangements for ambulance paramedics

Paramedics holding a certificate of proficiency in ambulance paramedic skills issued by, or with the approval of, the Secretary of State or persons who are state registered paramedics are authorised to administer a range of parenteral medicines[20] for the immediate, necessary treatment of sick or injured persons.

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Glossary

Medicinal Product Article 1 of Directive 2001/83 EC defines a medicinal product as 'any substance or combination of substances presented for treating or preventing disease in human beings or animals. Any substance or combination of substances which may be administered to human beings or animals with a view to making a diagnosis or to restoring, correcting or modifying physiological functions in human beings or animals is likewise considered a medicinal product'.

Administer means administer to a human being or an animal whether orally, by injection or by introduction into the body in any other way, or by external application, a substance or article either in its existing state or after it has been dissolved or dispensed in, or diluted or mixed with, some other substance used as a vehicle (Medicines Act 1968).

Medicine is used in this guidance to refer to all medicinal products.

Controlled Drugs (CD) are substances which are subject to the Misuse of Drugs Act 1971 and Regulations made under that Act. As medicinal products they are also subject to the Medicines Act and its Regulations.

Attention is drawn to the Misuse of Drugs Regulations (Northern Ireland) 2002 (No 1) specifying 5 schedules of Controlled Drugs, to which separate controls apply.

Register means the Single Professional register kept by the Nursing and Midwifery Council (NMC).

Parts of the Register

Part 1 First Level nurses trained in general nursing.
Part 2 Second level nurses trained in general nursing (England and Wales).
Part 3 First level nurses trained in the nursing of persons suffering from mental illness.
Part 4 Second level nurses trained in the nursing of persons suffering from mental illness (England and Wales).
Part 5 First level nurses trained in the nursing of persons with learning disabilities.
Part 6 Second level nurses trained in the nursing of persons with learning disabilities (England and Wales).
Part 7 Second level nurses (Scotland and Northern Ireland)
Part 8 Nurses trained in the nursing of sick children.
Part 9 Nurses trained in the nursing of persons suffering from fever.
Part 10 Midwives.
Part 11 Health visitors.
Part 12 First level nurses trained in adult nursing (Project 2000)
Part 13 First level nurses trained in mental health nursing (Project 2000)
Part 14 First level nurses trained in learning disabilities nursing (Project 2000)
Part 15 First level nurses trained in children's nursing (Project 2000)

Nursing and Midwifery students are persons who are undergoing pre-registration training for admission to the appropriate parts of the Register.

Sister/Acting Sister/Ward Manager is a nurse for the time being in charge of a ward, theatre or other department in a hospital or nursing home or, a caseload holder in a community setting. It includes any male nurse occupying a similar position.

Authorised Medical Officer is a doctor who is for the time being authorised in writing by the local Board's Chief Administrative Medical Officer for the purposes of Regulation 11 - Exemption for Midwives - of the Misuse of Drugs (Northern Ireland) Regulations 2002 or (for signing Midwives' Supply Orders **only**) a Supervisor of Midwives who is so authorised for the purposes of Regulation 11(2) of those Regulations.

Prescriber is a person authorised under the Medicines Act 1968 to order in writing the supply of a prescription only medicine for a named patient

Authorised person is a person authorised by the Department for the purposes of Regulation 27 of the Misuse of Drugs Regulations (Northern Ireland) 2002(destruction of controlled drugs).

Approved name of a medicine is its designated generic name devised and selected by the British Pharmacopoeia Commission and published in accordance with the Medicines Act 1968.

In this guidance all references to staff and patients should be taken as including either sex.

References

[1] *Guidelines for the administration of medicines*, Nursing and Midwifery Council, 2002
[2] *Good Practice in Consent*, issued under cover of HSS(MD)7/2003 on 13th March 2003
[3] *British National Formulary*, incorporating the Nurse Prescribers' Formulary, BMA and RPSGB
[4] A helpful flowchart for determining the appropriateness or otherwise of a PGD is provided at http://www.groupprotocols.org.uk
[5] *Misuse of Drugs Regulations (Northern Ireland) 2002*
[6] The relevant provisions are contained in *The Prescription Only Medicines (Human Use) Amendment Order 2000* (SI 2000 No 1917)
[7] By virtue of *The Prescription Only Medicines (Human Use) Amendment Order 2003* (SI 2003 No 696) the use of PGDs has been extended to the private sector.
[8] *Research Governance Framework for Health and Social Care*, DHSS&PS, November 2002
[9] http://www.emea.eu.int/pdfs/human/ich/013595en.pdf
[10] *Guidance Procedures when a Patient in a Hospital or Clinic Setting is found in possession of Unauthorised Drugs or other Suspicious Substances*, issued under cover of HSS(MD)11/95 on 14th August 1995.
[11] *Good Medical Practice*, General Medical Council, 2001
[12] *Tomorrow's doctors; Recommendations on undergraduate medical education*, General Medical Council, July 2002
[13] *Rules and Guidance for Pharmaceutical Manufacturers and Distributors 2002*, The Stationery Office, 2002
[14] *National Guidance on the Safe Administration of Intrathecal Chemotherapy*, Department of Health, London, 2001 (http://www.doh.gov.uk/intrathecalchemotherapy/guidance.pdf); issued in Northern Ireland under cover of HSS(MD)31/01 on 16th November 2001. See also letter on Frequently Asked Questions isued 3rd May 2002 and HSS(MD)2/2003 issued on 9th January 2003.
[15] *Patient Safety Alert - Potassium Chloride*, National Patient Safety Agency (NPSA), 2002 (http://www.npsa.org.uk/admin/publications/docs/riskalertpsa01.pdf); issued under cover of letter CPh2/02 on 23rd July 2002
[16] *Recommendations on Facilities, Staffing and Procedures related to Chemotherapy Administration within the Northern Ireland Cancer Treatment Service*, Regional Advisory Committee on Cancer (RACC), 1999
[17] *Notes for Guidance on the Clinical Administration of Radiopharmaceuticals and Use of Sealed Radioactive Sources*, Administration of Radioactive Substances Advisory Committee (ARSAC) 1998
[18] *The Regional Group on Specialist Drugs - Implementation of Red/Amber Lists* issued under cover of HSS(MD)16/2003 on 2nd April 2003
[19] *Pharmaceutical Clinical Waste - A Guide*, Health Estates, 2002; issued under cover of Health Estates Circular PEL (02) 10

[20] Diazepam 5 mg per ml emulsion for injection;
Succinylated Modified Fluid Gelatin 4 per cent intravenous infusion;
Medicines containing the substances ergometrine maleate 500mcg/ml with oxytocin 5iu/ml but no other active ingredient;
Prescription Only Medicines containing one or more of the following substances but no other active ingredient-

Adrenaline Acid Tartrate	Lignocaine Hydrochloride
Anhydrous Glucose	Metoclopramide
Benzylpenicillin	Morphine Sulphate
Bretylium Tosylate	Nalbuphine Hydrochloride
Compound Sodium Lactate Intravenous Infusion (Hartmann's Solution)	Naloxone Hydrochloride
	Polygeline
Ergometrine Maleate	Sodium Bicarbonate
Frusemide	Sodium Chloride
Glucose	Streptokinase
Heparin Sodium	Syntometrine

In addition, ambulance paramedics are included within the classes of persons permitted to supply or administer medicines under Patient Group Directions (see under section 4 above).

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