# POLICY AND PROCEDURES FOR THE PROTECTION OF VULNERABLE ADULTS (POVA)

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<tr>
<th>Date to be Reviewed:</th>
<th>October 2012</th>
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<tr>
<td>No of Pages:</td>
<td>31</td>
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<tr>
<td>Approval body:</td>
<td>Safeguarding Children and Vulnerable Adult Board (previous North Wales Trust version approved)</td>
</tr>
<tr>
<td>Date approved:</td>
<td>June 2009</td>
</tr>
<tr>
<td>Endorsing body:</td>
<td>BCUHB Board</td>
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<tr>
<td>Date endorsed:</td>
<td>October 2009</td>
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<tr>
<td>Date activated (live):</td>
<td>Date becomes live</td>
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## Documents to be read alongside this policy:
- WAG guidance “In Safe Hands” (2000)
- North Wales Interagency Policy and the Procedure for the Protection of Vulnerable Adults (2005)
- Physical Intervention Policy (2005)
- Incident Reporting Policy
- Consent Policy
- Disciplinary Policy
- Policy on Confidentiality
- Information sharing Protocol
- Whistle Blowing Policy

## Current review changes:
In collaboration the previous NHS trusts across N Wales developed an Adult Protection Policy for the North Wales NHS Trust during Feb 2009. Following wider consultation with statutory and non statutory agencies and equality impact assessment, the draft policy was Draft Approved by the North Wales NHS Trust Risk Management Committee and the Safeguarding Children and Vulnerable Adult Board and Endorsed by the Executive/Trust Management Team in June 2009.

Further work was undertaken with the previous LHBs, to ensure BCUHB compliance. This revised policy reflects all the changes arising from this collaboration.

This policy has been re-written to create a new joint policy for the merged BCUHB. It reflects the impact of current legislation and other Policy documents to Safeguard Vulnerable Adults from Abuse.
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1. Policy Statement
The Betsi Cadwaladr University Local Health Board (BCUHB) has a responsibility
to tackle abuse and has a zero tolerance of abuse, regardless of who the potential
abuser is. Therefore, the BCUHB has a key role to co-ordinate the development of
policy and guidance for the protection of Vulnerable Adults who are at risk of
abuse. Social Services remains the lead Adult Protection Agency. However,
partner agencies have respective responsibilities to ensure that staff are
competent to respond to suspicion, allegation or incident of abuse as described in
the policy.

2. Introduction
This policy underpins the core principles and values arising from the WAG
guidance “In Safe Hands” (2000) and the North Wales Policy and Procedures for
the Protection of Vulnerable Adults (2005) in hospital, community or other
residential establishments. Furthermore, the policy commits the need for all agencies holding a duty to work together, to protect Vulnerable Adults from abuse. The identification, assessment, protection and care of Vulnerable Adult at risk is a multidisciplinary, interagency responsibility, and should involve anyone with relevant knowledge to ensure the safety and the wellbeing of the individual concerned.

3. **Aim of the policy**
The aim of the document is to provide a robust framework for action and staff support from across the partner agencies and to clarify line of responsibility and accountability.

4. **Accountability**
The BCUHB has established a reporting mechanism arising from all Adult Protection issues at local, operational and strategic level. The Head of Adult Protection is responsible directly to the Associate Director for Safeguarding Children and Vulnerable Adult Team. He/she reports to the Director of Nursing, Midwifery and Patient Services who has the lead for safeguarding across the BCUHB.

5. **Structure**
The Director of Nursing, Midwifery and Patient Services has the lead for Safeguarding Vulnerable Adults across the BCUHB. However, that responsibility is devolved to the Assistant Director of Nursing with responsibility for adult protection at operational and strategic level. The Head of POVA has lead responsibility to ensure that the core principles and values of “In Safe Hands” (2000) is delivered consistently across the BCUHB. He/she remains responsible to advise the Director lead/ Assistant Director of the impact of any legislation, policy changes, reviews and inspection report that may affect adult protection ensuring that both the policy and ongoing training is fit for purpose.

The BCUHB has a robust system in place to report all Adult Protection issues. Issues are reported to the Safeguarding Sub-Committee which reports to the Quality and Safety Committee.

Health Care Standards 17.3 and 17.4 submissions and ‘Star Chambers’ provide another reporting mechanism specific to Adult Protection.

6. **Scope**
The policy applies to all BCUHB staff who have contact with Vulnerable Adults directly or indirectly in their work environment.

7. **Definitions – Vulnerable Adult**
7.1 There is no legal definition as to what constitutes a Vulnerable Adult. However, for the purpose of this guidance a Vulnerable Adult is a person over 18 years of age who:

- is or may be, in need of community care services by reason of mental or other disability, age or illness and who is, or may be, unable to take care of himself or
herself, or unable to protect himself or herself against significant harm or serious exploitation. Law Commission (Who Decides?: Making decisions on behalf of mentally incapacitated adults 1997).

Or

for reason of language or other medical reason cannot, or finds difficulty in, communicating.

7.2 Abuse
The following definition of abuse provides a basis from which to develop practice:

‘Abuse is a violation of an individual’s human and civil rights by any other person or persons’.

The abuser may be either an unpaid carer such as family or friend, a paid carer such as a health or social service care worker, or a stranger who may have befriended the Vulnerable Adult.

7.2.1 Type of Abuse
Abuse may take different forms. The Association of Directors of Social Services (ADSS) endorsed the following categorisation which is used as a basis for recording, reporting and monitoring in Wales.

- **PHYSICAL ABUSE**, including hitting, slapping, over or misuse of medication, undue restraint, inappropriate sanctions and other body impairment, such as dehydration, malnutrition, poor hygiene or sleep deprivation.

- **PSYCHOLOGICAL ABUSE**, including threats of human harm or abandonment, humiliation, verbal or racial abuse, isolation or withdrawal from services or supportive network.
  Possible Indicators: Withdrawal, depression, cowering and fearfulness, sudden changes in behavior, deliberate self harm.

- **SEXUAL ABUSE**, including rape and sexual assault or sexual acts to which the Vulnerable Adult has not or could not consent and/or was pressurised into consenting.

- **FINANCIAL OR MATERIAL ABUSE**, including theft, fraud, pressure around wills, property or inheritance, misuse or misappropriation of benefits.

- **CHEMICAL ABUSE**
  - The consequence of receiving medication improperly e.g. being refused medication, receiving too much or too little medication.
  - Administering medication which has not been prescribed for that person.
  - Using medication for the purpose of confinement or restraining or primarily for the convenience of staff or carers (refer to BCUHB/local physical restrictive practice policy).

Possible Indicators – Excessive request for repeat prescriptions or misuse of medications.
- **NEGLECT**, including failure to access medical care or other services, negligence in the face of risk – taking, failure to give prescribed medication, poor nutrition or lack of heating and failure to maintain skin integrity. Under the Mental Capacity Act 2005, Willful neglect is classified as a criminal offence for patients who do not have Mental Capacity.

- **INSTITUTIONAL / ABUSE**
  
  "No Secret" guidance refers to institutional abuse and provides the following example:

  “Neglect and poor professional practice also needs to be taken into account. This may take the form of isolated incidents of poor or unsatisfactory professional practice, at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other”

  “Patterns of institutional abuse features poor care standards, lack of positive response to complex needs, rigid routines, staffing and insufficient knowledge base within the Service”.

### 8. Legislative Framework to Protect Adults from Abuse

Currently there is no legislation specific to Adult protection in England and Wales. However, there is a range of legislations which regulate the protection of vulnerable adult from abuse. The relevant legislations fall into 5 broad groups.

1. **That which bars certain individuals from working with vulnerable people. Care Standard Act (CSA)2000**
   Part 7 provides for the establishment of a set of controls to prevent unsuitable persons from working with Vulnerable Adults in England and Wales. Hence, the introduction of the (POVA) scheme list. The scheme extends to persons working for, or providing care homes and domiciliary care agencies provided by local authorities and is not at present extended to nurses and NHS staff.

2. **Care Standards Act 2000 – Protocols and procedures**
   The National Minimum Standards (NMS) under the CSA 2000 have a number of standards that relates to the prevention of abuse.

3. **Safeguarding provisions in relation to people who lack capacity**
   The Mental Capacity Act (MCA) 2005, a direct outcome of the Law Commission study. The Act contains various provisions that may prove to be of value with regard to:

   - Best interest.
   - The power of the new office of public guardian to investigate certain cases of abuse.
   - The power to appoint deputies.
   - The creation of new criminal offence of ill treating or willfully neglecting people who lacks capacity.
   - The role of the Independent Mental Capacity Advocate (IMCA).

   MCA 2005 places a duty on local authorities and NHS bodies to provide Independent Mental Capacity Advocate Service when contemplating Adult Protection measures whether or not family, friends or others are involved.
• Deprivation of Liberty safeguards arising from the amendment of the MCA during 2007.

The five principles to determine Mental Capacity Act (2005) as outlined in the Act is referred to in Appendix 4.

The role of an IMCA
Having the power to instruct an IMCA in adult protection cases means that the Local Authority or BCUHB needs to consider each individual who meets the qualifying criteria whether an IMCA should be instructed.

Eligibility criteria
Local authorities and the NHS have powers to instruct an IMCA under the following circumstances.

➢ Where they propose to take protective measures in relation to a person who lacks capacity to agree one or more of the measures; and
➢ Where it is alleged that the person is or has been abused or neglected; or where it is alleged that the person is abusing or has abused another person.
➢ In adult protection cases (and no other cases) access to IMCA is not restricted to people who have no one else to support or represent them. People who lack capacity who have family and friends can still have an IMCA to support them through the adult protection process.

Criteria for referring an Individual to IMCA Services
Referral should be made where one or more of the following applies:

For someone who may have been abused or neglected.

• Where there is a serious exposure to risk.
• Death of a Vulnerable Adult.
• Serious physical injury or illness.
• Serious deterioration in physical or mental health.
• Serious emotional distress.
• Serious sexual assault or exploitation.
• Serious financial or material exploitation.
• Where a life-changing decision is involved and consulting family or friends is compromised by the reasonable belief that they would not have the person’s best interest.
• Where the vulnerable adult is indicating that their views and wishes have not been taken into account by the decision makers.

For someone who is alleged to be the abuser

• Where a life changing decision is involved and consulting family or friends is compromised by the reasonable belief that they would not have the person’s best interest at heart.
• Where there is a conflict of views between the decision makers regarding the best interest of the person.

Particular consideration should be given to whether a vulnerable person who is alleged to have abused another vulnerable adult would benefit from
the appointment of an IMCA. This may be necessary to ensure that the alleged abuser’s best interests are met, particularly if the case of the alleged abuse is very serious or is likely to provoke a strong reaction from others.

4. **That which may act as a deterrent by criminalizing certain actions in relation to vulnerable adults e.g.:**
   - Mental Health Act 1983/2007
   - Fraud Act 2006
   - Sexual Offences Act 2003
   - Domestic Violence, Crimes and Victims Act 2004

5. **Deprivation of Liberty**
   The Mental Health Act 2007 has amended the Mental Capacity Act 2005 to introduce the Deprivation of Liberty Safeguards. The Safeguards will apply to hospital and care homes to ensure that people who lack Capacity are not deprived of their liberty without lawful authorisation. Staff contemplating restrictive practice must be aware as to what constitutes Deprivation and Restriction of Liberty as defined in the statute.

6. **Safeguarding Vulnerable Groups Act 2006**
   The Safeguarding Vulnerable Group Act (SVGA) 2006 introduces a new Vetting and Barring Scheme for those who work with children and Vulnerable Adults in either a paid or volunteer capacity. The scheme will be phased in over 5 years starting on July 12th 2010. This will include all staff working directly in statutory, voluntary and other Independent services with Vulnerable Adults and Children.
   For further information refer to appendix 5. Important update for hiring managers.
   - Frequently Asked Questions (ISA July 2009)
   - Deprivation of Liberty Safeguards (DOLS) 2007

9. **Stages of POVA Intervention**
   Once an allegation of abuse is recorded or reported a series of stage intervention follows led by Social Services. However, in exceptional cases Health may lead in the Mental Health and Social Care Partnership.

   - **Stage 1** - Referral and collection of further information. Emergency action / protection plan where necessary.
   - **Stage 2** - Strategy discussion as soon as possible after referral preferably within 48 hours to galvanize agencies.
   - **Stage 3** - Strategy meeting. Possible immediate action by S.S, police, CSSIW, H&S Executive and BCUHBs. However, it could take up to 3 days to convene a meeting.
   - **Stage 4** - Investigation / assessment to monitor case.
   - **Stage 5** - Adult Protection Case Conference.
   - **Stage 6** - Adult Protection Review Case Conference.
10. Confidentiality
It is crucial that in working towards solutions an atmosphere of open
information is fostered subject to the consent of the Vulnerable Adult, where they
are able to give consent. Staff must recognize that complete confidentiality cannot
be offered to a person making a disclosure, relative or member of the public.
Information given to a member of staff belongs to that agency and must be shared
on a “need to know” basis. The BCUHB confidentiality policy outlines that the law
permits the disclosure of any confidential information (Public Interest Disclosure
Act 1998) necessary to safeguard a person in the public interest and that it may
not be possible to assure a service user of absolute confidentiality because of this
requirement. However, anonymity could be offered but the BCUHB may not be
able to guarantee this. This section should be read in conjunction with the BCUHB
policy on confidentiality.

The following key principles underpin confidentiality:

- Information will be shared only on a “need to know” basis.
- Information will be shared only when it is in the best interest of the service user.
- Confidentiality must not be confused with secrecy.
- Informed consent should be obtained where possible.
- Decision about who needs to know and what needs to be known should be
  considered on a case-by-case basis.

11. Informed Consent Prior to Reporting Abuse – Points to
Consider

- **Risks** – Does the Vulnerable Adult understand the nature of the allegation and
  any potential risk to themselves and others. Any protection plan to be
  considered here.
- **Mental Capacity** – If in doubt of their ability to make decisions, has Mental
  Capacity Assessment been undertaken specific to the decision? (Refer to
  Mental Capacity assessment Appendix II (MCA 2005)). Has the person’s best
  interest been considered?
- Is the vulnerable adult able to make their own decision and choices if they wish
  to do so?
- Does the person subjected to abuse have the capacity to consent to the
  reporting process or have they been pressurised in anyway to do so.
- Fundamental duty to balance the person’s right to autonomy, empowerment
  and choice with their need for protection.

12. Points to Consider When Reporting Incidents of
Alleged Abuse

- Approach each incident with an open mind.
- Assess the vulnerability of the individual.
- Establish the length of time abuse has been going on.
- Assess the risk of repeated or escalating acts of abuse. (Refer to risk
  assessment Appendix II).
- It is best practice to inform the vulnerable adult of the reporting process. If
  they do not have the capacity to understand then the next-of-kin or
immediate carer should be informed, as long as they are not the alleged perpetrator and acts in the best interest of the individual.

13. Action to be Taken Following an Allegation/Disclosure/Suspicion of Abuse Reported to BCUHB Staff

- The priority is to ensure the safety of the vulnerable adult at the earliest possible stage.
- Undertake a risk assessment.
- Staff have a duty to report to their Line of Manager any concern arising from Adult abuse, as soon as possible.
- However, if the Line Manager is suspected of being the perpetrator, then this information should be escalated to a higher level immediately.
- The Alerter must ensure that there is a protection plan immediately based upon the initial risk assessment.
- A POVA referral form marked Appendix I, on BCUHB information intranet server, must be completed and copy sent to the BCUHB POVA lead and Social Services for Adult Protection.
- The allegation will be reported by the alerter to the respective social services in all cases and or police where appropriate. The Social Services department is responsible for notifying the care for Social Services Inspectorate Wales (CSSIW).
- Should BCUHB Staff be implicated in the abuse, then the BCUHB Disciplinary Policy should be invoked and HR involved.
- In case of allegation against a care home, both Social Services and CSSIW are informed.
- Social Services, as the lead agency may hold a strategy discussion or may convene a strategy meeting to decide whether an abuse has occurred and an investigation warranted.
- Staff from the Health Board will be represented at any strategy meeting, co-coordinated by Social Services.
- All information shared at this point will be on a need to know basis.
- The Social Services POVA Co-ordinator is responsible to update BCUHB POVA lead of progress arising from any allegation.

14. Commissioning services with Independent providers

- The BCUHB has a commissioning role for a group of Vulnerable Adults requiring ongoing care funded by the NHS and contracted out to the Independent sector providers.
- The Commissioner must ensure that there is sufficient safeguards in its contract arising from service level agreement to protect Vulnerable Adults from abuse in line with WAG Guidance “In Safe Hands” and “No Secrets” in England. i.e if a patient has to be placed out of county in England.

The BCUHB to comply with WAG guidance on:
To work jointly with other partners to ensure that local protocols are in place to comply with escalation procedures leading to care home closure.

- All staff will be required to follow the BCUHB ‘Policy and Procedures for the Protection Vulnerable Adults across North Wales’ which underpins the North Wales Vulnerable Adults policy and WAG ‘In Safe Hands’ and ‘No Secrets’ DOH 2000.

In discharging that responsibility, staff must ensure that:

- The Local Authority where the abuse has occurred will have overall responsibility for coordinating and implementing the adult protection arrangements.
- The placing authority (i.e the Local authority / BCUHB with funding/commissioning responsibility) will have an ongoing duty of care to the Vulnerable Adult and will be responsible for ensuring regular reviews of the Patient's ongoing care needs.
- The placing authority will ensure that the provider has arrangements in place for protecting Vulnerable Adults and for managing concerns and link in with local policy and procedures as set out by the host authority. This should be recorded in any service level agreement or a care specification.
- The placing authority will provide all necessary support and information to the host authority to facilitate a prompt and thorough investigation arising from Adult Protection issues.
- The host authority will make provision for in service contracts, which refer to the policy outlining the responsibilities of the provider to notify the host authority of any adult protection concern.
- The authority must nominate a link person acting as a liaison during an investigation. They will be invited to attend any Adult Protection strategy meeting and/or may be required to submit a written report.

14a Responsibilities of Host Authorities

- The authority where the abuse occurred should always take the initial lead following any reported abuse to a Vulnerable Adult. This may include taking immediate action to protect the victim, if appropriate, and arranging an early discussion with the police or CSSIW, if a criminal offence or regulatory breach may have been committed.
- The host authority will also co-ordinate initial information gathering, background checks and ensure a prompt notification to the placing authority and other relevant agencies.

14b Responsibilities of Provider Agencies
• Provider agencies should have in place suitable adult protection procedures to prevent abuse from occurring.
• Providers should ensure that any allegation or complaint about abuse is brought promptly to the attention of Social Services, the Police, Health and Safety Executive, the care for Social Services Inspectorate in accordance with local multi agency policy and procedures.
• Provider agencies will have responsibilities under the Care Standards Act 2000 to notify their local CSSIW/ Care Quality Commission area office of any allegations of abuse or any other significant incidents.

15. Allegation of Abuse against BCUHB Staff
The BCUHB Adult Protection policy provides safeguards for:
➢ Primarily the Vulnerable Adult at risk but also for staff working with Vulnerable Adults.

The following guidelines to be followed where BCUHB staff are implicated.
 a. On the basis of an allegation against staff, they remain innocent until proven otherwise.
 b. The line manager and HR will be involved to support the staff member during suspension from duty.
 c. It must be made clear to staff that suspension is applied for their protection while an investigation takes place.
 d. At the strategy meeting it will be decided whether an investigation is required and the terms of reference agreed.
 e. If a crime has been committed, the lead agency will be the police whose advice must be sought.
 f. The police will only undertake an investigation to determine whether a crime has been committed.
 g. All POVA investigations must be concluded within an agreed timescale as discussed at the strategy meeting.
 h. The staff affected to be briefed of progress by the Line Manager/HR within the constraints of confidentiality.
 i. Any further case reviews following POVA investigation is at the discretion of the BCUHB.
 j. If an allegation is proven, the employer has a duty in law to report the incident to the Barring and Vetting Board (ISA) and the relevant professional regulators. However, if a crime has been committed it will go down the prosecution route.

16. Training
Careful recruitment and selection of staff must take place underpinning the legal requirements as outlined under the Independent Safeguarding Authority which will be responsible to set up the Barring and Vetting scheme. POVA training is mandatory across the BCUHB. All staff are required to undertake a level of training based upon their level of contact they have with their patients. Training will last up to 3 years following which a refresher course will be provided.
To date the following level of Training is co-coordinated and provided to BCUHB Staff.

**Level I**
Induction level within first period of employment. (15min)
Aim
- Briefing on POVA in line with Induction requirement.
- Become familiar of BCUHB Policy.
- Become familiar with how and where to access BCUHB Policy.

**Level II**
Vulnerable Adult basic awareness (2 hours)
Aim
- Raise staff awareness regarding BCUHB Policy
- Ensure staff are aware of system and process.
- Reporting and recording mechanism.
- Reference to other Policies and legislation.
- Defining role and responsibility.

**Level III**
POVA Policy and Procedure Awareness Training (Full day)
Aim
- Defining role and responsibility underpinning BCUHB Policy.
- Provide a higher level of exposure re strategy meetings.
- Multi agency presentation.
- Impact of Legislation and links with other policies.
- Relevant to staff working in Mental Health Services, Care of the Elderly and Primary Care.

**Level IV**
Investigation and Case Chairing Conference (2 days)
Aim
- Enable staff to develop their skills and knowledge in carrying out Investigations into allegation / suspicion of adult abuse and who also chairs strategy meetings.
- Links with other policies.

It remains at the discretion of CPGs to determine level of training for their staff. However, it is desirable and is recommended for all trained staff working in Mental Health, Learning Disabilities, Community Services, care of the elderly and Primary Care to undertake level 3 training.

### 17. Users Perspective

The BCUHB will continue to engage and consult with the Users groups to develop and review POVA policy arising from case reviews and to improve practice in order to Safeguard Vulnerable Adult from abuse. The North Wales Interagency Adult Protection forum has produced an information leaflet “What to do about abuse” specific for the public across North Wales. These are circulated across the BCUHB to be readily accessible by service users.

Although, the BCUHB Policy is designed and written for staff in the first instance, nevertheless, copies are available to the user. In cases where a patient is vulnerable and for reason of language or other medical reason cannot communicate in such cases staff are advised to refer to the BCUHB Translation Policy for further guidance.

The Health Board has also identified key staff at local levels to be designated Adult Protection Champions to provide further guidance locally.
17.1 Role of the Head of Adult Protection

- To be notified of all POVA activities across the BCUHB.
- The BCUHB POVA lead is responsible to ensure that Adult Protection Policy is fit for purpose with a Single Policy across BCUHB.
- To co-ordinate varied levels of training across the BCUHB ensuring compliance level as agreed with CPGs. BCUHB to ensure that all improvement plans are being met arising from Health Care Standards and that progress is reported on a quarterly basis to the regional office.
- To provide an expert opinion on all Adult Protection matters which is likely to impact on the service to the Executive lead/Associate, Safeguarding.
- To represent the BCUHB in all Adult Protection network locally, regionally and nationally in the spirit of joint working and improving practice.
- To feedback on Adult Protection reviews as required by WAG.
- To monitor all POVA activities across the BCUHB and feedback to the Executive lead/Associates.
- To chair BCUHB POVA Operational Committee.
- To undertake relevant audit in line with Heath care Standards and Health Inspectorate Wales inspection report.
- To report significant event to the Safeguarding Board.
- To submit an annual report specific to adult protection to the Board.

18. Links with Multi Agency Risk Assessment Conference (MARAC) and Multi Agency Public Protection Arrangements (MAPPA)

18.1 MARAC

MARAC provides a multi agency approach to managing the risks associated with domestic violence and requires service providers across health, social services and criminal justice services to work together to protect victims. The N Wales Domestic Abuse Forum produced a Good Practice Guidance Resource Directory for N Wales in 2004 which has been widely distributed across all agencies.

The Adult Protection Strategy Discussion/ Meeting and Case Conference will decide which cases are likely to be referred to the appropriate MARAC/MAPPA Groups. The key criterias are the risk factors and the safety of the individual and that of the public. There is a list of named individuals from the different services nominated to notify MARAC, arising from case review. The Safeguarding team has devolved responsibility to nominate representation from the appropriate services to attend the conference. (Safeguarding Strategy DRAFT 2009)

18.2 MAPPA

MAPPA are the statutory arrangement for managing the risk posed by certain sexual and violent offenders. MAPPA is not a statutory body itself but a mechanism through which agencies can better discharge their statutory responsibilities to protect the public in a co-ordinated manner. The Act required the policy, prison and probation services, the Responsible Authority (RA) to establish arrangements for the assessment, management and monitoring of these individuals. The Criminal Justice Act (2003) which came into effect on April 1st.
2004, re-enacted the original MAPPA legislation and includes health along with other public bodies as having a ‘duty to co-operate’ (DTC) with the Responsible Authority. (Safeguarding Strategy DRAFT 2009)
19. Flow Chart Reporting Alleged Abuse

Responsibility of all hospital, community and Primary Care Staff

Allegation of abuse made to or identified by a member of Staff

Is the adult in immediate danger?
Risk assessment to be undertaken.

Yes

1. Instigate immediate Protection Plan.
2. In life threatening situations contact the police.
3. Inform CPG Lead, Manager.
4. Inform patients/clients Medical Officer (GP or Consultant).
5. Where BCUHB staff is involved, inform HR.
6. Complete POVA proforma
7. Inform BCUHB POVA lead.
8. Inform Social Services in all cases and other key agencies where appropriate.
9. Lead Agency to determine whether multi agency strategy discussion / meeting to take place. Health Board Lead /Alerter to be informed by Lead agency of progress.

No

1. Inform CPG Lead Manager.
2. Inform patients/clients Medical Officer (GP or Consultant).
3. Complete vulnerable Adult Abuse Reporting Form (appendix 1).
4. Refer to Lead Agency (refer all cases to Social Services).
5. BCUHB Adult Protection Lead to be informed of all referrals as soon as possible.
6. Lead Agency to determine whether multi agency/strategy meeting required.
7. Decision will be made on the basis of the information gathered/evidence by the lead agency.

In the absence of the CPG Leads the Clinical Site Facilitators to be informed during out of hours (Hospital only)
SUMMARY OF PROCESS FOR ADULT PROTECTION
Responsibility of SS as the lead agencies

Stage 1

Disclosure/Concern raised through:
Initial Contact / Referral – Complete Incident Form

Is urgent action needed?

Yes

Take necessary action
Appropriate liaises with:
Police/CSIW/Social Services/ whichever appropriate

No

Inform appropriate Manager within BCUHB

Stage 2

Stage 1

Stage 2

Stage 3

Stage 3

END

Appropriate POVA lead SS agrees to support care needs and signs off case as adult protection gives feedback to referrer/vulnerable adult

Is strategy meeting needed?

Yes

Appropriate POVA lead SS arrange meeting

By Day 2

No

Appropriate POVA lead SS agrees to support care needs and signs off case as adult protection gives feedback to referrer/vulnerable adult

Stage 4

Stage 4

Is Adult Protection Case Conference needed?

Yes

Appropriate POVA lead SS arranges Adult Protection Case Conference which identifies future actions/adult protection plans agreed and key worker appointed and review date set. Complete PVA 2

By Day 15

No

Appropriate POVA lead SS records decisions and considers actions needed relating to risk management, support, monitoring. Appropriate Manager sets review date if necessary and appoints key worker and feedback to referrer/vulnerable adult

Review Adult Protection Plan.
Review takes place within 3 months or as within time scale determined by Case Conference and subsequent review dates set
Outcome
• Where a crime is committed – will go down the CPS route
• Regulatory breaches – CSSIW could impose an improvement order / notice.
• Health and Safety breaches – appropriate action
• Professional misconduct – Report to regulatory bodies
• Where appropriate refer to ISA

By Day 3

Day 1-2

Day 1-2

If crime alleged, Police take lead in investigation where there has been a Health & Safety breach H&S exec takes the lead

Strategy Meeting held and actions agreed. Investigation Officer(s) appointed if required. Form PVA1 completed.

Investigation / Assessment
Report carried out by appointed person(s)

If non-criminal:
Social Services/Health/CSIW Contracts lead and Commissioning Agencies may be involved.

By Day 3

Between 1-2

SUMMARY OF PROCESS FOR ADULT PROTECTION
Responsibility of SS as the lead agencies

Stage 1

Disclosure/Concern raised through:
Initial Contact / Referral – Complete Incident Form

Is urgent action needed?

Yes

Take necessary action
Appropriate liaises with:
Police/CSIW/Social Services/ whichever appropriate

No

Inform appropriate Manager within BCUHB

Stage 2

Stage 1

Stage 2

Stage 3

END

Appropriate POVA lead SS agrees to support care needs and signs off case as adult protection gives feedback to referrer/vulnerable adult

Is strategy meeting needed?

Yes

Appropriate POVA lead SS arrange meeting

By Day 2

No

Appropriate POVA lead SS agrees to support care needs and signs off case as adult protection gives feedback to referrer/vulnerable adult

Stage 4

Stage 4

Is Adult Protection Case Conference needed?

Yes

Appropriate POVA lead SS arranges Adult Protection Case Conference which identifies future actions/adult protection plans agreed and key worker appointed and review date set. Complete PVA 2

By Day 15

No

Appropriate POVA lead SS records decisions and considers actions needed relating to risk management, support, monitoring. Appropriate Manager sets review date if necessary and appoints key worker and feedback to referrer/vulnerable adult

Review Adult Protection Plan.
Review takes place within 3 months or as within time scale determined by Case Conference and subsequent review dates set
Outcome
• Where a crime is committed – will go down the CPS route
• Regulatory breaches – CSSIW could impose an improvement order / notice.
• Health and Safety breaches – appropriate action
• Professional misconduct – Report to regulatory bodies
• Where appropriate refer to ISA

By Day 3

Day 1-2

Day 1-2

If crime alleged, Police take lead in investigation where there has been a Health & Safety breach H&S exec takes the lead

Strategy Meeting held and actions agreed. Investigation Officer(s) appointed if required. Form PVA1 completed.

Investigation / Assessment
Report carried out by appointed person(s)

If non-criminal:
Social Services/Health/CSIW Contracts lead and Commissioning Agencies may be involved.
### BCUHB Adult Protection

**Contact Numbers**

<table>
<thead>
<tr>
<th>Safeguarding Lead</th>
<th>Base</th>
<th>Telephone</th>
<th>Bleep/Pager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Director of Nursing Safeguarding Vulnerable Adults, Children, Domestic Violence</td>
<td>To be agreed</td>
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**Adult Protection**

<table>
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<tbody>
<tr>
<td>Head of Adult Protection</td>
<td>Glan Clwyd Bodelwyddan</td>
<td>01745/583910 Ext 4269</td>
<td>4890</td>
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**POVA Admin**

<table>
<thead>
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<tr>
<td>Support</td>
<td>Glan Clwyd Bodelwyddan</td>
<td>01745/583910 Ext 5749</td>
<td>Safe Haven Fax 01745/445929</td>
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<tr>
<td>Ysbyty Gwynedd</td>
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<td>079000 52096</td>
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**Local Authority POVA Co-ordinator**

<table>
<thead>
<tr>
<th>Locality</th>
<th>Base</th>
<th>Telephone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flintshire</td>
<td>Shire Hall Mold</td>
<td>01352 701369</td>
<td>01352 702635</td>
</tr>
<tr>
<td>Denbighshire</td>
<td>Tynant Prestatyn</td>
<td>01824 706675</td>
<td>01824 706660</td>
</tr>
<tr>
<td>Conwy</td>
<td>Town Hall Llandudno</td>
<td>01492 575686</td>
<td>01492 575693 01978 352284</td>
</tr>
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<td>Wrexham</td>
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<td></td>
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</tr>
<tr>
<td>Gwynedd</td>
<td>Council Offices Caernarfon</td>
<td>01286 679956</td>
<td>01286 677486</td>
</tr>
<tr>
<td>Ynys Mon</td>
<td>Council Office Llangernyw</td>
<td>01248 752736</td>
<td>01248 750107</td>
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**Police = Public Protection Unit**

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<td>Wrexham</td>
<td>St Asaph</td>
<td></td>
<td>Awaiting contact no</td>
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### References

- WAG guidance “In Safe Hands”. Implementing Adult protection procedures in Wales office, July 2005
- Policy and Procedures for responding to the alleged or continued abuse of Vulnerable Adults, agreed by North Wales Multi-Agency Forum for responding to The Abuse of Vulnerable Adults, North Wales Forum 2005.
- Law Commission 1997 – who decides?
- Caldicott Committee 1997 – Patient Identifiable information.
- Data protection Act 1998.
- Information Sharing protocol.
- Community Care & The Law 2007
  Clements, L & Thompson  P.
- “No Secret” DOH Guidance 2000 England
- Action on Elder Abuse.
- Health Care Standards 17.3 17.4
- MCA 2005 Code of Practice
- DOLS Code of Practice
- ISA Vetting and Barring Scheme 2007
- NMC Caring for Older Person Guidance.
- Dignity in Care 2008.
- Escalating Concern with, and closures of Care Homes in providing Services for Adult (May 2009)
- Care Quality Commission (2009)

**BCUHB Adult Protection Operational Committee**

Health Board Representative based on CPG’s / Localities

<table>
<thead>
<tr>
<th>Representations</th>
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<tbody>
<tr>
<td>Associate Director of Nursing Safeguard</td>
</tr>
<tr>
<td>Medicine</td>
</tr>
<tr>
<td>Surgery</td>
</tr>
<tr>
<td>Mental Health</td>
</tr>
<tr>
<td>Community Services</td>
</tr>
<tr>
<td>Clinical Support Services</td>
</tr>
<tr>
<td>Radiology</td>
</tr>
<tr>
<td>Facility Services</td>
</tr>
<tr>
<td>Hematology</td>
</tr>
<tr>
<td>Human Resources</td>
</tr>
<tr>
<td>Clinical Site Facilitator</td>
</tr>
<tr>
<td>Children Services</td>
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<td>Family Services</td>
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<td>Cancer Services</td>
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<tr>
<td>Primary Care</td>
</tr>
<tr>
<td>Clinical Governance</td>
</tr>
<tr>
<td>i.e Risk Manager</td>
</tr>
<tr>
<td>i.e Litigation Manager</td>
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<tr>
<td>Representative from the POVA Sub-training Group</td>
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**Local Authority POVA Co-ordinator**

<table>
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<th>Wrexham</th>
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<th>Flintshire</th>
<th>Conwy</th>
<th>Gwynedd</th>
<th>Ynys Mon</th>
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**Family Protection Services Police**

**CSSIW**

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<tr>
<th>Voluntary services</th>
<th>CHC Advocate</th>
<th>Regulatory Manager</th>
<th>Patient representative CHC</th>
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**IMCA**

**Ambulance**

Number: to be decided  Version: final to BCUHB Board  Reviewed by: Oct 2012
Title: Policy and Procedures for the Protection of Vulnerable Adults
Consultation has taken place with the membership of the BCUHB Adult Protection Committee and Sub-training group as above.

The Policy has been widely circulated for consultation across the BCUHB, other statutory and non statutory organisations. These are:-

**BCUHB**

Members of the POVA Monitoring Group, Members of the BCUHB Sub-training Group, BCUHB Executive Directors, Divisional Clinical Director, Members of the EMT

Members of the TMT, General Managers, Heads of Departments, Service Managers, Heads of Nursing, Community Hospital / Unit Managers, Head of Services, Welsh Risk Pool, Assistant General Managers, Clinical Nurse Manager

EBME Manager, Head of CAMHS Early Intervention Service, Chief Executive BSP

Head of BSP, Director of Pharmacy, Head of Clinical Governance, Equalities Manager, Welsh Language Development Officer, Clinical Support Services

Security Advisor, Director of Therapy Services, Adult Mental Health Partnership, Patient Services Manager, HR Recruitment Manager, Sterile Service Manager, CAMHS Tier 4 Project Manager, Library Service Manager, Information Governance Manager, Community Intermediate Care Services, Health and Safety Manager, Training & Development Manager, Clinical Specialist Nurses.

Child Protection leads, Associates Director of Nursing, Head of Midwifery and Family Services, Head of Radiology, Medical Record Manager, Practice Development Nurse Leadership, Local Authorities Gwynedd, Ynys Mon, Conwy, Denbighshire, Flintshire, Wrexham. Primary Care GP, Litigation Managers

Clinical Site Facilitators, Patient Connect Group

Primary Care Lead

POVA Lead - West

- Advocacy experience
- Independent Mental Capacity Advocate (IMCA)
- North Wales Police Authority
- CSSIW
- Age Concern.
### Vulnerable Adult Abuse Reporting Form

**NHS n.o**  
**Hospital n.o**  
**GMC n.o**

#### Vulnerable Adult Abuse Reporting Form

<table>
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<tr>
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<th>Known as:</th>
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<table>
<thead>
<tr>
<th>Post Code:</th>
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<table>
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<tr>
<th>Single ☐</th>
<th>Divorced ☐</th>
<th>Partner ☐</th>
<th>Preferred Language: Welsh ☐ English ☐ Other</th>
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<tbody>
<tr>
<td>Married ☐</td>
<td>Widowed ☐</td>
<td>Other ☐</td>
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#### Other Agencies/Support Services Involved/Main Carer

1.  
2.  
3.  
4.  

<table>
<thead>
<tr>
<th>Date of Incident/Visit:</th>
<th>Patient/Advocate aware of report: YES ☐ NO ☐</th>
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<tbody>
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#### Type of Abuse:

- Physical ☐  
- Psychological ☐  
- Neglect ☐  
- Chemical ☐  
- Institutional ☐  
- Sexual ☐  
- Financial ☐

#### Identify Source of Abuse:

- BCUHB Employee ☐  
- Voluntary ☐  
- Unknown ☐  
- Home Employee ☐  
- Relative ☐  
- Paid Carer ☐  
- Carer ☐

#### Client Group:

- Physical Disability ☐  
- Substance Misuse ☐  
- Learning Disability ☐  
- Mental Health Problems ☐

#### Location of Alleged Abuse:

- Own Home ☐  
- Registered Home ☐  
- Relatives Home Hospital ☐  
- Day Centre ☐

Other (Specify):
### Details of Alleged or Suspected Abuse:

**Action Taken:**

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<th>Date</th>
<th>Y</th>
<th>N</th>
<th>Comment</th>
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<td>Doctor Informed</td>
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<tr>
<td>Department/Practice Address:</td>
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<tr>
<td>Tel No:</td>
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**Date:**

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<th>Position Held:</th>
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**Further Action By Line Manager:**

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<th>Date</th>
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<th>N</th>
<th>Comments:</th>
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**Date:**

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<th>Signed:</th>
<th>Position Held:</th>
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### Action by BCUHB Lead

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<td>Check referral</td>
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<td>Other Agencies</td>
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<tr>
<td>Strategy Discussion / Meeting</td>
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<tr>
<td>Outcome</td>
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<td>Review Date</td>
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Date ............................................................

Taken from a Denbighshire Social Services Document.

Number: to be decided  Version: final to BCUHB Board  Reviewed by: Oct 2012
Title: Policy and Procedures for the Protection of Vulnerable Adults  Page 22 of 31
### Appendix 2

**Risk Assessment Worksheet**

**Protection Of Vulnerable Adults**

**RISK CATEGORY**

**Risk Category RED**— immediate review based on level of risk.

Risk Category ORANGE— action in 3 months, review in 6 months, where appropriate.

Risk Category YELLOW – action in 6 months, review in 9 months, where appropriate

Risk Category GREEN – action and review in 12 months if necessary where appropriate.

<table>
<thead>
<tr>
<th>DIRECTORATE or DIVISION</th>
<th>DEPT/SECTION OR AREA</th>
<th>Details of Assessment Identifying any Hazards or risks</th>
<th>ASSESSOR(S)</th>
<th>DATE</th>
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**What control measures are in place?** (Specific to adult protection)

**What control measures are needed and by when?** (Protection plan)

Has the Lead Agency been informed

<table>
<thead>
<tr>
<th>CSSIW</th>
<th>BCUHB Lead</th>
<th>S.S</th>
<th>Police</th>
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## Adult Protection Plan

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<tr>
<th>BY WHOM: Name here</th>
<th>JOB TITLE:</th>
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<tbody>
<tr>
<td>DATE</td>
<td>REVIEW DATE:</td>
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Re-assessment of Risk Category

Risk: GREEN – Very low  YELLOW – Low ORANGE-Moderate RED- HIGH

Review Date/s  Following Strategy Meeting /Discussion

Review by:

Outcome

Signed off by:

Job Title

Job Title

*Attach completed and signed off assessment to your Risk Profile and Submit to BCUHB POVA Lead*
Appendix 3a
This form must be placed in the healthcare record

Assessment of Mental Capacity and Best Interests Decision Form

Surname
First name
NHS / Hospital no
Date of birth _____/_____/_______

ASSESSMENT OF PATIENT’S CAPACITY (in accordance with the Mental Capacity Act 2005)

NB: The Mental Capacity Act’s first principle is that a person must be assumed to have capacity to make a decision or act for themselves unless it is established that they lack capacity in relation to those matters. Before deciding that someone lacks capacity, it is important to take all practical and appropriate steps to enable a patient to make a decision for themselves.

I confirm that this patient _____Insert name________lacks the capacity to give or withhold consent to their admission, treatment / procedure or change of accommodation proposed, because of an impairment of the mind or brain or disturbance (temporary or permanent) affecting the way their mind or brain works (for example, a disability, condition or trauma, or the effect of drugs or alcohol) and they cannot do one or more of the following elements:

- understand information about the procedure or course of treatment;
- retain that information in their mind for long enough to make a decision;
- use or weigh that information as part of the decision-making process;
- communicate their decision (by talking, using sign language or any other means)

(You must be able to tick a box – otherwise capacity must be presumed)

Provide details of admission, treatment / procedure or change of accommodation proposed and evidence in respect of the person’s ability in relation to each of the four elements stated above:
(Continue in healthcare record if necessary)
On the balance of probabilities, there is a reasonable belief that:

☐ The patient has capacity to make this particular decision at this time

Or

☐ The person does not have capacity to make this particular decision at this time

NB: If the decision in question relates to consent to a procedure / investigation which would, under normal circumstances, require written consent, then Form 4 must be used in conjunction with this assessment form.

Signature……Decision-Maker……(PRINT)…………………………
Date_____/_____/_____
Job Title……………………………………Contact
Details……………………………………
GMC No. / NMC Pin No. / HPC No. / HPC Pre-Registered Group
No…………………………
Appendix 3b
This form must be placed in the healthcare record

Assessment of Mental Capacity and Best Interests Decision Form

Surname
First name
NHS / Hospital no
Date of birth _____/_____/_______

BEST INTERESTS DECISION – Factors to be considered.

In determining a patient’s best interests, the person making the determination (decision-maker) must not make it merely on the basis of the patient’s age, appearance, his/her condition or an aspect of his/her behaviour, which may lead others to make unjustified assumptions about what may be in the patient’s best interests. When considering whether life-sustaining treatment is in the best interests of the patient, one must not be motivated by a desire to bring about death.

(See Mental Capacity Act 2005 – Code of Practice Chapter Five) If the answer to any of questions 1-3 below is YES - you should access the appropriate information regarding the patient’s wishes. If answers are NO to all 3 questions, please continue to answer questions A – H below.

1. Is there a valid and applicable advance refusal? YES / NO
2. Is there a registered lasting power of attorney (LPA) for personal welfare that can make the specific decision? YES / NO
3. Is there a deputy appointed by the Court of Protection who can make this decision? YES / NO

Please document clearly in the patient’s healthcare record your reason for answering “yes” or “no” for any of the following questions. All questions below must be completed.

A. Is the person likely to regain capacity in the future? YES / NO
B. Is it possible to delay the decision? YES / NO
C. Have you considered the views of the person, including past and present wishes and feelings, beliefs and values (in particular, any relevant verbal or written statement made when the person had capacity)? YES / NO
D. Have other relevant people been consulted for their views about the person’s best interests? Include details of persons consulted, their role (e.g. relative, carer, spouse, partner, civil partner, attorney – specify type) and views expressed. YES / NO
E. Does the decision in question meet the criteria for an Independent Mental Capacity Advocate (IMCA)? If an IMCA is instructed, include details of the process and the consultation? YES / NO
F. Have all options that may be less restrictive of the person’s rights and freedoms been considered? YES / NO
G. Have you supported the person as much as possible to be involved with
this decision (even if they don’t have the capacity to make the decision)? YES / NO

H. Provide evidence in the patient’s healthcare record of how the decision about the person’s best interests was reached, the reasons for reaching the decision and what particular factors were taken into account.

☐

Please initial

Name(s) of any individuals that have been involved regarding the decision.
Name Relationship Contact Phone Number
Signature......Decision-Maker......(PRINT)........................
Date______/_____/_____
Job Title..............................................Contact
Details..................................................
GMC No. / NMC Pin No. / HPC No. / HPC Pre-Registered Group
No..............................................
Appendix 4

The Mental Capacity Act 2005

The Five principles:

1. Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so, unless it is proved otherwise. This means that you cannot assume that someone cannot make a decision for themselves, just because they have a particular medical condition or disability.

2. People must be supported as much as possible to make a decision before anyone concludes that they cannot make their own decision. This means that you should make every effort to encourage and support the person to make the decision for themselves. If the lack of capacity is established, it is still important that you involve a person as far as possible in making decisions.

3. People have the right to make what others might regard an unwise or eccentric decision. Everyone has their own values, beliefs and preferences, which may not be the same as those of other people. You cannot treat them as lacking capacity for the reason.

4. Anything done, or decision made, for or on behalf of a person, who lacks mental capacity must be done in their best interests.

5. Anything done or any decision made for, or on behalf of, people without capacity should be less restrictive of their basic rights and freedoms. This means that when you do anything to or for a person who lacks capacity, you must choose the option that is in their best interests, and you must consider whether you could do this in a way that interferes less with their rights and freedom of action.
Appendix 5 Important update for all hiring managers

The Independent safeguarding authority

The vetting and barring scheme (VBS), which is at the heart of the Government's strategy to increase the protection of vulnerable members of our society, commences on 12 October 2009.

Increased safeguards will begin to be brought into effect from 12 October 2009 on a phased basis. Around five million additional jobs and voluntary positions – including most NHS jobs -will become subject to checks, meaning many more people posing a risk to vulnerable people will be excluded from the workplace.

Additional safeguards starting in October are:

- **reduction of red tape** - two barring lists will be administered by a single organisation, the Independent Safeguarding Authority (ISA), rather than the three lists currently maintained by two different Government departments: Protection Of Children Act (POCA), Protection of Vulnerable Adults (PoVA) and List 99;

- **the introduction of barring from ‘regulated activities’** – people included on the new barred lists by the ISA will be barred from a much wider range of jobs and activities than before, particularly in areas of work with vulnerable adults such as the NHS;

- **a new duty to share information** - employers, social services and professional regulators will have to notify the ISA of relevant information so individuals who pose a threat to vulnerable groups can be identified and barred from working with these groups;

What will it mean for our organisation?

From 26 July 2010 all new employees joining us who will be working with vulnerable groups (majority of our staff) and those changing job roles, will need to register with the Vetting and Barring Scheme (VBS) and be checked by the Independent Safeguarding Authority (ISA). The CRB will administer this for the ISA. Our organisation will have to pay a fee of £64 per member of staff. Those who wish to work as unpaid volunteers will not have to pay a fee.

The VBS is designed to offer a more stream-lined, faster system of workplace vetting for those working with children and vulnerable adults.

The CRB will check whether there is any relevant information from the police or referred information from other sources, such as previous employers or professional bodies. If there is relevant information, the CRB will pass this to the ISA, who will decide whether the applicant should be barred. The scheme will be largely self-financing.
From July 2010, organisations will have a duty to share with ISA any relevant information about their employees, so that individuals who pose a threat to vulnerable groups can be identified and barred from working with these groups.

Employers will be able to check the registration status of the individuals they intend to employ online.

**Five year phasing programme**

Year 1: (from July 2010) new recruits and existing staff who are moving to a new position within the organisation.
Year 2: existing staff who are not moving to a new position but who have never had a CRB check (i.e. employed prior to this becoming a mandated requirement in the NHS).
Year 3: existing staff who have had a CRB check over three years ago.
Year 4: existing staff who have had a more recent CRB check (less than three years ago).
Year 5: the remainder of existing staff who have had more recent CRB checks; and new recruits and existing staff in controlled activities.

**Guidance and events**

The Home Office has published full guidance; this includes generic and sector specific guidance, information leaflets, presentations, FAQs and toolkits which will be available to download from the ISA website. [www.isa.gov.org.uk](http://www.isa.gov.org.uk)

We have ordered a supporting DVD to help, please contact your HR Manager. If you would like to view this, additional ones can be ordered via the ISA's call centre helpline 0300 123 1111.