PRIMARY CARE SAFEGUARDING ADULT POLICY

North West Surrey Integrated Care Service (NICS) Ltd

May 2018

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1. Introduction

1.1 Safeguarding is everyone's responsibility and aims to protect people's health, wellbeing and human rights, and enable them to live free from harm, abuse and neglect.

1.2 **The aims of adult safeguarding are to:**

- Stop abuse, neglect and exploitation wherever possible
- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- Safeguard adults in a way that supports them in making choices and having control about how they want to live
- Promote '*making safeguarding personal' (*NHSE 2016) an approach that concentrates on improving life for the adults concerned http://www.local.gov.uk/documents/10180/5854661/Making+Safeguarding+Personal+-+Guide+2014/4213d016-2732-40d4-bbc0-d0d8639ef0df
- Raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect
- Provide information and support in accessible ways '*Accessible Information: Specification'* (NHSE 2015) directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.https://www.england.nhs.uk/wp-content/uploads/2015/07/access-info-spec-fin.pdf
- Help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult; and address what has caused the abuse or neglect

1.3 The Care Act 2014 sets out the first ever statutory framework for adult safeguarding, stating that Local Authorities are required to make enquiries into allegations of abuse or neglect. Safeguarding is mainly aimed at people with care and support needs who may be in vulnerable circumstances and at risk of abuse or neglect by others. In these cases, local services must work together to identify those at risk and take steps to protect them.

1.4 Local Authority (LA) statutory adult safeguarding duties apply equally to those adults with care and support needs regardless of whether those needs are being met, regardless of whether the adult lacks mental capacity or not, and regardless of setting.

1.5 The support and protection of adults at risk cannot be achieved by a single agency, every service has a responsibility. The Host Site staff are not responsible for making a diagnosis of adult abuse and neglect, however they are responsible to share concerns appropriately and refer onto the LA who have the Statutory Lead.

1.6 This policy outlines how NICS will fulfil their legal duties and statutory responsibilities effectively and should be read in conjunction with Surrey Safeguarding Adult Board (SSAB) safeguarding adults multiagency procedures:

Surrey safeguarding adults multi agency procedures, information and guidance https://www.surreycc.gov.uk/social-care-and-health/contacting-social-care/surrey-safeguarding-adults-board/surrey-safeguarding-adults-board-information-for-professionals/surrey-safeguarding-adults-multi-agency-procedures-information-and-guidance

2. Safeguarding Adults in General Practice

2.1 General Practitioners (GP) are the first point of contact for most people with health problems, this sometimes includes individuals who are not registered but seek medical attention. Safeguarding adults is a complex area of practice. The client group is extremely wide, ranging from adults who are incapable of looking after any aspect of their lives, to individuals experiencing a short period of illness or disability. Individuals may have a wide range of services and service providers involved in their lives, making it difficult to identify those with responsibility.

2.2 GPs may be the first to recognise an individual's health problems, carer related stress issues, or someone whose behaviour may pose a risk to adults at risk. The Primary Health Care Team (PHCT) may be the only professionals to have contact with adults at risk and it is important that any response taken is appropriate, proportionate and timely, thereby preventing the potential long term effects of abuse and neglect.

2.3 It is essential that safeguarding adults is considered in line with the Mental Capacity Act (MCA) 2005 which provides a statutory framework for people who lack capacity to make decisions for themselves. It sets out who can take decisions, in which situations, and how they should go about this. A person who lacks capacity may not always recognise that they are at risk of or are being abused or neglected.

3. Engagement

3.1 This policy was developed by the Safeguarding Adults Specialist Nurse for use in General Practices within Kent. Permission has been given for its implementation in Surrey

4. Impact Analyses

4.1 In line with the NICS Equality and Diversity Policies and Sustainability impact assessment, this policy aims to safeguard all adults who may be at risk of abuse, irrespective of disability, race, religion/belief, colour, language, birth, nationality, ethnic or national origin, gender or sexual orientation.

4.2 All Staff must respect the adult at risk's (and their family's/ carers) culture, religious beliefs, gender and sexuality. However this must not prevent action to safeguard adults who are at risk of, or experiencing, abuse.

4.3. All reasonable endeavours should be used to establish the adult at risk and their families/carer's preferred method of communication, and to communicate in a way they can understand.

4.4. Due consideration has been given to the Bribery Act 2010 in the development of this policy and no specific risks were identified.

5. Scope

5.1. This policy applies to all staff employed by the NICS including; all employees (including those on fixed-term contracts), temporary staff, bank staff, locums, agency staff, contractors, volunteers (including celebrities), students and any other learners undertaking any type of work experience or work related activity.

5.2. All staff have an individual responsibility to safeguard and promote the welfare of individuals and must know what to do if concerned that an adult is at risk of being abused or neglected.

6. Policy Aim

6.1. Nics adopts a zero tolerance approach to abuse and neglect and in doing so ensures that safeguarding the rights of adults at risk of abuse is integral to all we do.

6.2 This policy outlines how NICS will fulfil its statutory responsibilities and ensure that there are in place robust structures, systems and quality standards for safeguarding adults, which are in line with SSAB safeguarding adult procedures.

7. Adult Safeguarding

7.1. All adults (those over 18 years of age) have the right to live a life free from abuse and neglect. Abuse is a violation of an individual's human and civil rights by any other person or persons.

7.2 Where someone is 18 or over but is still receiving children's services and a safeguarding issue is raised, the matter should be dealt with through adult safeguarding arrangements. For example, this could occur when a young person with substantial and complex needs continues to be supported in a residential educational setting until the age of 25. Where appropriate, adult safeguarding services should involve the LAs children's safeguarding colleagues as well as any relevant partners.

7.3. The safeguarding duties apply to an adult who:

- Has needs for care and support (whether or not the LA is meeting any of those needs) and
- Is experiencing, or at risk of, abuse or neglect and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect neglect.

7.4 Consideration needs to be given to a number of factors. Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological. It may be an act of neglect or an omission to act or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented to, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.

7.5 *The Care Bill in many respects marks a quiet revolution in our attitudes towards, and expectations of, carers. At last, carers will be given the same recognition, respect and parity of esteem with those they support. Historically, many carers have felt that their roles and their own well-being have been undervalued and under-supported. Now we have a once in a lifetime opportunity to be truly acknowledged and valued as expert partners in care.*
Dame Philippa Russell, Chair, Standing Commission on Carers

8. Principles of adult safeguarding

8.1. Nics acknowledges the six principles of adult safeguarding and ensures these principles underpin safeguarding work:

1. **Empowerment** People being supported and encouraged to make their own decisions and informed consent.
   "*I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens*."
2. **Prevention** It is better to take action before harm occurs.
   "*I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."*
3. **Proportionality** The least intrusive response appropriate to the risk presented.
   "*I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."*
4. **Protection** Support and representation for those in greatest need.
   "*I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."*
5. **Partnership** Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
   "I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."
6. **Accountability** and transparency in delivering
   "I understand the role of everyone involved in my life"

8.2 **Making Safeguarding Personal (MSP)**

MSP is a personalised approach that enables safeguarding to be done with, not to, people and practice that focuses on achieving meaningful improvement to people's circumstances rather than just on 'investigation' and 'conclusion'. It is an approach that utilises social work skills rather than just 'putting people through a process' and enables practitioners, families, teams and to know what difference has been made.

Practitioners should be supporting people who use safeguarding services to ensure they feel listened to and to make choices and not to be treated like children. Their experience of how it feels throughout any safeguarding intervention is as important as the end outcomes.

8.3 **Carers**

The Care Act introduced a general duty on local authorities to promote an individual's 'wellbeing'. This means that they should always have a person's wellbeing in mind and when making decisions about them or planning services.

The Care Act also recognises the key role of Carers in relation to safeguarding. For example a carer may witness or report abuse or neglect; experience intentional or unintentional harm from the adult they are trying to support or a carer may (unintentionally or intentionally) harm or neglect the adult they support. It is important to view the situation holistically and look at the safety and well-being of both. The Act makes it clear throughout the need for preventing abuse and neglect wherever possible. Observant professionals and other staff making early, positive interventions with individuals and families can make a huge difference to their lives, preventing the deterioration of a situation or breakdown of a support network.

9. Categories of abuse

9.1 **'Honour' based violence (HBV)**

The term HBV is the internationally recognised term describing cultural justifications for violence and abuse against women, men and children. There is no specific offence of "*honour based crime*". It is an umbrella term to encompass various offences covered by existing legislation. HBV can be described as a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour. It is a violation of human rights and may be a form of domestic and/or sexual violence. There is no, and cannot be, honour or justification for abusing the human rights of others.

HBV is normally associated with cultures and communities from Asia, the Middle East and Africa as well as Gypsies and Travellers, but in reality, HBV cuts across all cultures, nationalities, faith groups and communities and transcends national and international boundaries. HBV is also a Domestic Abuse issue, a Child Abuse concern and a crime. In terms of Domestic Abuse risk assessment, HBV is a significant risk factor for victims and must be regarded as a significant predictor of the likelihood of future harm or homicide.

9.2 **Forced marriage**

A Forced Marriage (FM) is a marriage in which one or both spouses do not (or, in the case of some adults with learning or physical disabilities, cannot) consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and emotional pressure (UK FM Unit, 2009).

There is a clear distinction between an arranged and forced marriage. An arranged marriage is entered into freely by both parties, although their families take a leading role in the choice of the partner. FM is a form of abuse and should be treated as such. Cases should be tackled using existing structures, policies and procedures designed to safeguard children and victims of domestic abuse. FM is now a specific offence under s121 of the Anti-Social Behaviour, Crime and Policing Act 2014.

FM can affect both genders. It is also important to be aware that both practices are not linked to religion, but are a result of cultural influence.

9.3 **Exploitation**

Opportunistically or premeditated

Unfairly manipulating someone for profit

'Mate' crime - There is no statutory definition of mate crime in UK law. The term is generally understood to refer to the befriending of people, who are perceived by perpetrators to be vulnerable, for the purposes of taking advantage of, exploiting and/or abusing them. This can strongly be associated, but not exclusively associated, with people with a learning disability, learning difficulties or mental health conditions.

9.4 **Physical abuse**

- Hitting, slapping, scratching
- Pushing or rough handling
  Assault and battery
- Restraining without justifiable reasons
- Inappropriate and unauthorised use of medication
- Using medication as a chemical form of restraint
- Inappropriate sanctions including deprivation of food, clothing, warmth and health care needs

9.5 **Female Genital Mutilation (FGM)**

The FGM Act 2003 states that a person is guilty of an offence if they excise, infibulate or otherwise mutilate the whole or any part of a girl or woman's labia majora, labia minora or clitoris, but no offence is committed by an approved person who performs a surgical operation, necessary for physical or mental health, or surgical operation on a girl or woman in any stage of labour, or has just given birth. A person is also guilty of an offence if they, aid, abet counsel or procure a girl to excise infibulate or otherwise mutilate the whole or any part of her own labia majora, labia minora or clitoris. Penalties are up to 14 years in prison or a fine or both.

Section 5b of the FGM Act 2003 introduces a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report "*known"* cases of FGM in under 18's which they identify in the course of their professional work to the police. The duty applies from 31st October 2015 onwards. For further information please see link below:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/469448/FGM-Mandatory-Reporting-procedural-info-FINAL.pdf

Link to SSAB

NICS FGM Lead/Champion is : Dr Nicki Mantel-Cooper

Nics.admin@nhs.net

9.6 **Sexual abuse**

- Sexual activity which an adult cannot or has not consented to or has been pressured into
- Sexual activity which takes place when the adult client is unaware of the consequences or risks involved
- Rape or attempted rape
- Sexual assault or harassment
- Non-contact abuse e.g. voyeurism, pornography

9.7 **Child Sexual Exploitation**

Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.

NICS CSE Lead/Champion is :

Dr Nicki mantel-Cooper

Nics.admin@nhs.net

9.8 **Psychological abuse**

- Emotional abuse.
- Verbal abuse.
- Humiliation and ridicule.
- Threats of punishment, abandonment, intimidation or exclusion from services.

- Isolation or withdrawal from services or supportive networks.
- Deliberate denial of religious or cultural needs
- FM

9.9 **Financial or material abuse**

- Having money misused or stolen
- Having property stolen
- Being defrauded
- Being put under pressure in relation to money or property
- Having money or property misused

9.10 **Domestic Abuse (DA)**

A pattern of incidents of controlling, coercive or threatening behaviour violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. Including:

- Psychological
- Physical
- Sexual
- Financial
- Emotional abuse
- Personal gain
- Modern slavery
- Human trafficking
- Radicalisation

Nics DA Lead/Champion is :

Dr Nicki Mantel-Coooper

Nics.admin@nhs.net

9.11 **Discrimination**

- Discrimination demonstrated on any grounds including sex, race, colour, language, culture, religion, politics or sexual orientation
- Discrimination that is based on a person's disability or age
- Harassment and slurs which are degrading
- Hate crime

9.12 **Organisational abuse**

Including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This

may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

9.13 **Neglect and acts of omission**

Including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating

9.14 **Self-neglect**

This covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. NB: KMSABs have different self-neglect guidance.

10. Consent

10.1 When the extent of the patient's mental capacity is in doubt GPs must assess the information which is available from the patient's health record and from third parties. They should attempt to discuss with patients their needs and preferences as well as assess their ability to understand their condition and prognosis. If there is still doubt about a patient's competence to give or withhold consent, GPs should seek a second opinion.

11. Adults with capacity

11.1 A person's ability to make a particular decision may at a particular time be affected by:

- Duress and undue influence
- Lack of mental capacity

11.2 There may be a fine distinction between a person who lacks the mental capacity to make a particular decision and a person whose ability to make a decision is impaired, e.g. by duress or undue influence or the perceived lack of any alternative choice. Nonetheless, it is an important distinction to make.

11.3 Safeguarding interventions must ensure that when an adult with mental capacity takes a decision to remain in an abusive situation, they do so without duress or undue influence, with an understanding of the risks involved, and with access to appropriate services should they change their mind. The exception to this principle would occur in situations where the decision

may have been influenced by threat or coercion and consequently lack validity and need to be over-ridden.

12. Adults who lack mental capacity

12.1 The MCA 2005 provides a statutory framework that underpins issues relating to capacity and protects the rights of individuals where capacity may be in question. MCA implementation is integral to safeguarding adults.at risk.

12.2 The 5 principles of the MCA must be followed when the adult at risk lacks the decision making capacity and are directly applicable to safeguarding:

1. **A person must be assumed to have capacity unless it is established that they lack capacity**. Assumptions should not be made that a person lacks capacity merely because they appear to be vulnerable. Capacity must be assessed where there is doubt.
2. **A person is not to be treated as unable to make a decision unless all practicable steps to help them do so have been taken without success.** Empower individuals to make decisions about managing risks e.g. use communication aides to assist someone to make decisions; for example, choose the optimum time of day where a person with dementia may best be able to evaluate risks;
3. **A person is not to be treated as unable to make a decision because they make an unwise decision.** Individuals may wish to balance their safety with other qualities of life such as independence and family life. This may lead them to make choices about their safety that others may deem to be unwise but they have the right to make those choices;
4. **An act or decision made under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.** Best interest decisions in safeguarding take account of all relevant factors including the views of the individual, their values, lifestyle and beliefs and the views of others involved in their care;
5. **Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's right and freedom of action.** Any use of restriction and restraint must be necessary and proportionate to prevent harm to that individual. Safeguarding interventions need to balance the wish to protect the individual from harm with protecting other rights such as right to family life.

12.3 **The link between DoLS and safeguarding adults processes**

12.4 DoLS are essential to protect people who are unable to make decisions about their care and whose liberty has *been* deprived. DoLS still only apply to care homes and hospitals. GPs should establish a link with care homes that they are responsible for to make sure that they are alerted to who these patients are.

12.5 If someone is being deprived of their liberty in community settings, LAs are now encouraged to apply to the Court of Protection (CoP) for authorisation. With the recognition that deprivation of liberty is widespread in the community too, it has become more important than ever for GPs to be confident with how and when these safeguards apply. Health and social care professionals have a duty to reduce the risk of depriving people of their freedom, keeping their best interests central to planning and providing care. When this is unavoidable authorisation must be sought and any restrictions must be regularly reviewed.

12.6 A Supreme Court judgement in March 2014 made reference to the *'acid test'* to identify whether a person is being deprived of their liberty, and consisted of two questions:

1. Is the person subject to continuous supervision and control?

and

2. Is the person free to leave? – with the focus being not on whether a person seems to be wanting to leave, but on how those who support them would react if they did want to leave.

12.7 If someone is subject to that level of supervision, and is not free to leave, then it is likely that they are being deprived of their liberty.

12.8 The principles of the MCA and DoLS, and the key areas affecting GPs are:

- Individuals are presumed to have capacity
- All practical steps must be taken to support someone in decision-making
- A person is not to be treated as lacking capacity merely through making an unwise decision
- An action taken on behalf of a person must be in their best interests
- Regard must be had as to whether an act or decision is the least restrictive of a person's rights and freedoms
- Prescription of frequent use of sedation/medication to control behaviour. When using chemical restraint the appropriate safeguards and scrutiny is to be applied

12.9 The MCA prohibits blanket decision-making on behalf of people with capacity issues and introduces a functional test of capacity that is time and decision specific.

12.10 It requires everyone who cares for or treats people with capacity issues to respect their individual rights and to act in their best interests when making decisions on their behalf.

12.11 For example, if a patient suffers from early stage dementia, and needs to make a decision on whether to be referred for investigations for a possible cancer and whether or not they would want treatment if they were found to have cancer.

12.12 A GP becomes the decision-maker only if the patient lacks the capacity to make that decision for them and has not made an Lasting Power of Attorney (LPA) granting the done the power to make decisions about medical treatment. GPs must make the decision for the patient in their best interests and need to know when they can and cannot disclose confidential information.

12.13 Other key areas of the MCA affecting GPs are:

- Independent Mental Capacity Advocates (IMCAs).
- The ability for adult patients to make a LPA
- The establishment of a new CoP
- Court-appointed deputies. GPs need to be aware of people appointed to these roles and when to involve them in decision-making about patients who lack capacity

12.14 Where a Best Interests Assessor (BIA) concludes that deprivation of liberty is not occurring, a DoLS authorisation would not be granted. In cases where authorisation is not granted because the best interest's assessment fails for other reasons, e.g. the deprivation is not considered to be in the relevant person's best interests, or mental capacity assessment fails because the person is assessed to have capacity, then it becomes a situation of unlawful deprivation of liberty and potential safeguarding concern.

12.15 Restrictions and restraint can be used in a person's support, but only if this is in the best interests of the person who lacks capacity to make the decision themselves. Restrictions and restraint must be proportionate to the harm the caregiver is seeking to prevent.

12.16 Covert medication involves administering medicines in disguised form, for example in food and drink, where a person is refusing treatment necessary for their physical or mental health. Covert medication must never be given to someone who is capable of consenting to medical treatment. If a service user's decision is thought to be unwise or eccentric it does not necessarily mean they lack capacity to consent. Administration of medication against a person's wish may be unlawful. Adults who have been assessed as lacking capacity are only administered medicine covertly if a management plan is agreed after a best interests' assessment.

12.17 Close, effective working relationships between care homes and GPs are associated with several positive outcomes including:

- Better access to services such as regular visits, prescriptions and out of hours contact, greater continuity of care and higher service efficiency
- Better partnership working between care homes and GPs
- Better end of life care (reported to be more important than the use of end of life tools)
- Reducing care homes' isolation and supporting them in their caring responsibilities
- Care home staff feeling more confident about their judgement to refer residents to the GP and other health services
- Professional advice from GPs to care homes.

13. CONTEST and PREVENT (Radicalisation of vulnerable people)

13.1 Contest is the Government's Counter Terrorism Strategy, which aims to reduce the risk from terrorism, so that people can go about their lives freely and with confidence.

13.2 Contest has four strands which encompass:

1) **PREVENT** to stop people becoming terrorists or supporting violent extremism.
2) **PURSUE** to stop terrorist attacks through disruption, investigation and detection.
3) **PREPARE** where an attack cannot be stopped, to mitigate its impact.
4) **PROTECT** to strengthen against terrorist attack, including borders, utilities, transport infrastructure and crowded places.

13.3 PREVENT focuses on preventing people becoming involved in terrorism, supporting extreme violence or becoming susceptible to radicalisation. Alongside other agencies, such as education services, LAs and the police, healthcare services have been identified as a key strategic partner in supporting this strategy.

13.4. Healthcare professionals may meet and treat people who are vulnerable to radicalisation, such as people with mental health issues or learning disabilities who may have a heightened susceptibility to being influenced by others.

13.5. The key challenge for the health sector is to be vigilant for signs that someone has been or is being drawn into terrorism. GPs and their staff are the first point of contact for most people and are in a prime position to safeguard those people they feel may be at risk of radicalisation.

13.6 Practice staff who have concerns that someone may be becoming radicalised must seek advice and support from the Safeguarding and PREVENT Lead.

13.7 The Designated Nurse Adult Safeguarding is the point for contact and advice. **See Appendix 3 Surrey wide CCG Safeguarding Adults Contact Details**

13.8 **Nics PREVENT Lead / Champion is :**

Dr Nicki Mantel-Cooper

Nics.admin@nhs.et

13.9 It is important to note that PREVENT operates within the pre-criminal space and is aligned to the multi-agency safeguarding agenda.

- **Notice:** if you have a cause for concern about someone, perhaps their altered attitude or change in behaviour
- **Check:** discuss concern with Safeguarding/PREVENT Lead
- **Share:** appropriate, proportionate information with Safeguarding/PREVENT Lead

14. Roles and Responsibilities

14.1 **The Surrey Safeguarding Adults Board (SSAB)** is responsible for ensuring that:

- Partner agencies including the LA, the NHS and the police, meet regularly to discuss and act upon local safeguarding issues.
- Develop shared plans for safeguarding, working with local people to decide how best to protect adults in vulnerable situations.
- Publish a safeguarding plan and report to the public annually on its progress, so that different organisations can make sure they are working together in the best way.
- Undertake Safeguarding Adult Reviews (SAR) in order to learn lessons where an adult has died or suffered significant harm as a result of abuse or neglect and multi-agency failure is indicated as playing a part.

14.2 **The LA** is responsible for making enquires, or asking others to make enquiries, when they think an adult with care and support needs may be at risk of abuse or neglect and to find out what, if any, action may be needed. This applies whether or not the authority is actually providing any care and support services to that adult.

14.3 **Clinical Commissioning Groups** (CCGs) are statutory NHS bodies with a range of statutory duties, including safeguarding adults. CCGs as commissioners of local health services need to assure themselves that the organisations which they commission have effective

safeguarding arrangements in place. CCGs are responsible for securing the expertise of Designated Professionals on behalf of the local health system. Designated Professionals and Adult Safeguarding Leads undertake a whole health economy role and play an integral role in all parts of the commissioning cycle, from procurement to quality assurance if appropriate services are to be commissioned that support adults at risk of abuse or neglect, as well as effectively safeguard their well-being. CCGs are required to demonstrate that they have appropriate systems in place for discharging their statutory duties in terms of safeguarding.

14.4 **Designated Nurse Safeguarding Adults role** incorporates the **Safeguarding Adult Lead** and **Designated MCA Lead**. As a clinical expert and a strategic leader for safeguarding their role is to work across the local health economy to support other professionals in their agencies on all aspects of safeguarding. Is a member of the SAB and will ensure the regular provision of training to the staff and Board of the CCG. He or she will advise the LA, police and other organisations on health matters in relation to adult safeguarding.

14.5 **The Practice team** The Care Quality Commission (CQC) will want GPs and all other practice staff to demonstrate their competence in safeguarding adults at risk:

- Demonstrate their understanding of the definition of an adult at risk and the types of abuse they may be subject to
- Be aware of the internal arrangements for recording a safeguarding adult concern and this will be set out in this Safeguarding Adults policy
- Be aware of the external process for reporting the concern and that this is in line with local multi-agency policy and procedures
- Disclosure and Barring System (DBS) checks are only one aspect of ensuring effective and safe recruitment practices and should not be used in isolation. GPs should also use other mechanisms, such as checking employment history and any gaps, reviewing references, etc. to assure themselves as far as possible that all employees are of good character and are fit to work in their health practice.
- Significant events and complaints analysis can be used to show quality improvements and should be part of GP revalidation.

14.6 Each practice should have a designated lead for safeguarding adults at risk who should be aware of the respective Safeguarding Designated Adults Lead within the local CCG and the LA Safeguarding Adults contact.

14.7 In a ‘good’ practice:

- There will be evidence that safeguarding adults at risk is given sufficient priority.
- Staff will take a proactive approach to safeguarding and focus on early identification.

- Steps are taken to protect people where there are known risks, with appropriate responses to any signs or allegations of abuse and effective work with other organisations to implement protection plans.
- There are active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations.
- All complaints are considered and screened for any safeguarding concerns

14.8 *Safeguarding Vulnerable People in the NHS – Accountability and Assurance NHS England* (updated June 2015) sets out clearly the safeguarding roles, duties and responsibilities of all organisations commissioning NHS health and social care. It has been refreshed in partnership with colleagues from across the health and social care system, the Department of Health (DH) and the Department for Education (DfE), particularly recognising that the new responsibilities set out in the Care Act 2014 that came into force on 1st April 2015: https://www.england.nhs.uk/wp-content/uploads/2015/07/safeguarding-accountability-assurance-framework.pdf

15. Practice Arrangements

15.1 NICS has clearly identified lines of accountability within the practice to promote the work of safeguarding vulnerable adults within the practice. Safeguarding responsibilities will be clearly defined in all job descriptions and there are nominated leads for safeguarding adults**.**

15.2 **The Practice Lead for Safeguarding Adults (MCA/DoLS) is:**
Dr Nicki Mantel-Cooper
The Administration Lead for managing Safeguarding data is:
Mrs Claire Laing

15.3 **NICS Lead for Safeguarding Adults** is responsible for ensuring that they are fully conversant with the practice safeguarding adult policy, the policies and procedures of SAB and the integrated processes that support safeguarding:

- Facilitating training opportunities for staff groups
- Acting as a focus for external contacts on safeguarding adult and MCA matters; this may include requests to contribute to sharing information required for SARs, Domestic Homicide Reviews (DHRs), multi-agency/Individual Management Reviews (IMRs) and contribution to safeguarding investigations where appropriate
- Disseminating information in relation to safeguarding adults/MCA to all practice members

- Act as a point of contact for practice members to bring any concerns that they have, to document those concerns and to take any necessary action to address concerns raised
- Assess information received on safeguarding concerns promptly and carefully, clarifying or obtaining more information about the matter as appropriate
- Facilitate access to support and supervision for staff working with adults at risk and families
- Ensure that Nics team completes the agreed incident forms and analysis of significant events forms which are available shared documents
- Is required to contribute to DHR/SAR and IMRs specifically
- Will respond to and write reports for LA Section 42 enquiries
- Will disseminate and develop action plans to ensure lessons learnt are embedded in best practice following publication of SAR and DHRs

15.4 **The Chief Operating Officer (George Roe)** is responsible for ensuring that safeguarding responsibilities are clearly defined in all job descriptions. For employees of Nics, failure to adhere to this policy and procedures could lead to action under the disciplinary policy. The COO has a responsibility to ensure that Nics has a clear safer recruitment policy and that this is adhered to.

15.5 **The Directors** are responsible for ensuring that:

- Safeguarding adults at risk is integral to clinical governance and audit arrangements
- Nics meets the contractual and clinical governance arrangements on safeguarding adults
- All staff are alert to the potential indicators of abuse or neglect, and know how to act on those concerns in line with local guidance

15.6 **GPs** have an important role to play in safeguarding and promoting the welfare of adults**.** Identification of abuse has been likened to putting together a complex multi-dimensional jigsaw. GPs hold knowledge of family circumstances and can interpret multiple observations accurately recorded over time, and may be the only professionals holding vital pieces necessary to complete the picture. The General Medical Councils (GMC) '*Good medical practice code'* (2013) stresses the need for doctors to protect patients and take prompt action if "*patient safety, dignity or comfort is or may be seriously compromised".*

15.7 **Practice nurses** must ensure that Safeguarding is part of everyday nursing practice. The Nursing and Midwifery Council's (NMC) Code of Conduct states that Nurses should raise

concerns immediately if they believe a person is vulnerable or at risk and needs extra support and protection. The Code states that Nurses must:

- Take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse
- Share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information
- Have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

15.8 **Staff members, including directors, employed staff and volunteers** have an individual responsibility to:

- Be alert to the potential indicators of adult abuse or neglect and know how to act on those concerns in line with national guidance and the safeguarding adult procedures;
- Be aware of and know how to access SSAB's policies and procedures
- Take part in training, including attending regular updates to maintain their skills and are familiar with procedures aimed at safeguarding adults and implementation of the MCA
- Understand the principles of confidentiality and information sharing in line with local and government guidance
- Contribute, when requested to do so, to the multi-agency meetings established to safeguard and protect vulnerable adults

16. What to do if you have concerns about an Adult's welfare or an adult tells you about abuse

16.1. Concerns about the wellbeing and safety of an Adult at Risk must always be taken seriously. Any Practice member of staff who first becomes aware of concerns of abuse must report those concerns as soon as possible and if possible within the same working day to the relevant senior manager/ safeguarding lead within the practice and make a referral to Surrey **Multi Agency Safeguarding Hub (MASH) either by phone or by submitting the Safeguarding Adults form to raise a concern See Appendix One Contact details & Appendix Two Adult Safeguarding Referral Flowchart. Appendix Six**

16.2 When an adult makes a disclosure it is important to reassure the adult at risk and that the information will be taken seriously. It is good practice to ensure that the adult is given information about what steps will be taken, including any emergency action to address their immediate safety or well-being.

16.3 The human rights and views of the adult at risk should be considered as a priority, with opportunities for their involvement in the safeguarding process to be sought in ensuring that the safeguarding process is person centred.

16.4 If an adult in need of protection or any other person makes an allegation to you asking that you keep it confidential, you should inform the person that you will respect their right to confidentiality as far as you are able to, but that you are not able to keep the matter secret and that you must inform your manager/safeguarding lead within the practice, the Designated Nurse Safeguarding Adults and the LA safeguarding team.

16.5 If it is suspected that a crime could have been committed, it is important that you do not contact the person alleged to have caused harm or anyone that might be in touch with them. Contact the police 999 in an emergency or 101 for non-emergencies. Ensure that steps are taken to preserve any forensic evidence as advised by the police.

16.6 The disclosed information must be recorded in the health records in the way that the adult at risk describes the events.

16.7 Ability to consent to the safeguarding process should be determined by the person's mental capacity at that specific time and their understanding of risk and consequences of their situation. In determining validity of consent to making a safeguarding adult alert, the possibility of threat or coercion from others should also be explored and considered.

16.8 Where patients are mentally competent they should be included in any decision about disclosure of their information to a third party, such as the LA. If abuse is suspected, considerate discussions must take place with the patient. Patients often disclose matters to their doctor/nurse in the expectation that their information will be kept confidential and maintaining confidentiality can form the basis of valuable trust and support.

16.9 Ideally, the patient will give their consent before any of their personal information is disclosed to a third party. There are however some circumstances when disclosure is in the public interest and this may outweigh the potential harm of breaching confidentiality. This can occur when there is a risk of a serious crime or serious harm.

16.10 The GMC advises that:

"Personal information may… be disclosed in the public interest, without patients' consent, and in exceptional cases where patients have withheld consent, if the benefits to an individual or to society of the disclosure outweigh both the public and the

patient's interest in keeping the information confidential. You must weigh the harms that are likely to arise from non-disclosure of information against the possible harm both to the patient, and to the overall trust between doctors and patients, arising from the release of that information."

16.11 If any member of the team is unsure how to proceed or is in doubt about making an alert, the case can be discussed with a senior colleague/line manager, Safeguarding lead, Designated Nurse Safeguarding Adults or a member of the Adult Safeguarding team. **See Appendix Three Surrey wide CCG Safeguarding Adults Contact Details**

17. Risk Assessment

17.1 It is best practice to raise an alert at the earliest opportunity of the allegation from when the abuse or neglect was witnessed or suspected. A preliminary risk assessment should be undertaken with the main objective to act in the best interest of the adult at risk and to prevent the further risk of potential harm. It is important to consider the following:

- Is the adult at risk, still in the place where the abuse was alleged or suspected or is the adult about to return to the place where the abuse was alleged or suspected.
- Will the person alleged to have caused harm have access to the adult at risk or others who might be at risk?
- What degree of harm is likely to be suffered if the person alleged to have caused harm is able to come into contact with the adult at risk or others again?

17.2 Once the alert has been raised and if appropriate to be managed by the safeguarding process, the safeguarding plan sets out an individual risk assessment plan to ascertain what steps can be taken to safeguard the adult at risk, review their health or social care needs to ensure appropriate accessibility to relevant services and how best to support them through any action to seek justice or reduce the risk of further harm.

17.3 An adult who has capacity may choose to stay in an abusive situation or choose to not take part in the safeguarding process. In such a case the plan may therefore be centred around managing the risk of the situation with the person ensuring that they are aware of options to support their safety. Such cases will require careful monitoring and recording so it is recommended to seek advice if this occurs.

18. Multi-Agency Risk Assessment Conference (MARAC)

18.1 A MARAC is the multi-agency meeting that manage high-risk cases of Domestic Abuse. At the heart of a MARAC is a working assumption that no single agency or individual can see the

complete picture of the life of a person at risk, but all may have insights that are crucial to their safety as part of the coordinated community response to DV and abuse. If a safeguarding adult's referral indicates that there are issues of DV and abuse, stalking or honour-based violence, a decision must be taken about referral to the MARAC and who should make that referral. In most cases this would be the Practice Lead for Safeguarding.

18.2 **Aims of a MARAC:**

- Increase the safety, health and well-being of victims, including adults and their children
- Determine the level of risk that the perpetrator poses to the victim and associated children, and whether there is any risk to the general public
- Implement a risk management plan that provides professional support to all those at risk and reduce the likelihood of further harm
- Reduce repeat victimisation
- Improve agency accountability
- Improve support for staff involved in high risk domestic abuse cases
- Contribute to the development of best practice
- Identify policy issues arising from cases discussed at MARACs and address these through the appropriate channels

18.3 Consideration needs to be given when sharing information for these meeting with regard to appropriate information sharing i.e. with consent of adult at risk; or overriding consent if life-threatening situation or in wider public interest.

18.4 Surrey Police MARAC Coordinators, based in the Surrey Police Safeguarding Investigation Units (SIU) can provide appropriate guidance for making a referral. Contact via 101 or telephone number: 01483 630015 or email: MARACCRU@surrey.pnn.police.uk).

18.5 Surrey MARAC Protocol
https://www.surreycc.gov.uk/social-care-and-health/care-and-support-for-adults/raising-concerns-and-staying-safe/domestic-abuse/domestic-abuse-information-for-professionals/multi-agency-risk-assessment-conference

Domestic Abuse Resources for GPs: http://www.caada.org.uk/gp

Royal College of General Practitioners Guidance for GP's: http://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/domestic-violence.aspx

19. Multi-Agency Public Protection Arrangements (MAPPA)

19.1 Since June 2014 the National Probation Service (NPS) and Community Rehabilitation Company (CRC) are the responsible body to manage high risk offenders. NPS works in partnership with police, prison and local authorities through the MAPPA.

19.2 The purpose of MAPPA is to help reduce the re-offending behaviour of sexual and violent offenders in order to protect the public, including previous victims, from serious harm. It aims to do this by ensuring that all relevant agencies work together effectively to:

- Identify all relevant offenders complete comprehensive risk assessments that take advantage of coordinated information sharing across the agencies.
- Devise, implement and review robust risk management plans; and focus the available resources to best protect the public from serious harm.

19.3 The NPS, police and prison service are the responsible authorities required to ensure the effective management of offenders, however NHS, social services, education and housing all have a duty to cooperate under the Criminal Justice Act (2003).

20.0 Safeguarding Adults Review (SAR)

20.1 The term Serious Case Review has been replaced under the Care Act 2014 with SAR.

20.2 A SAR will be commissioned when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. The SAB must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

21.0 Domestic Homicide Reviews (DHR)

21.1 In 2013 the Home Office published the revised '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews',* which was created as part of the framework of the over-arching '*Domestic Violence, Crime and Victims Act 2004'*

The purpose for undertaking DHRs is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

21.2 DHR means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) A person to whom she/he was related or with whom she/he was or had been in an intimate personal relationship, or

(b) A member of the same household as her/himself.

21.3 It should be noted that an '*intimate personal relationship'* includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

21.4 This legal requirement has been established to ensure agencies are responding appropriately to victims of DV by offering and putting in place appropriate support mechanisms, procedure, resources and interventions. The aim is to avoid future incidents of domestic homicide and violence.

22. Information Sharing

22.1 Sharing of information is vital for early intervention and is essential to protect adults at risk from suffering harm from abuse or neglect. It is important that all practitioners understand when, why and how they should share information.

22.2 Always consider the safety and welfare of the adult at risk when making decisions on whether to share information about them. Where there is concern that the adult may be suffering or is at risk of suffering significant harm then their safety and welfare **must** be the overriding consideration.

22.3 Information may also be shared where an adult is at risk of serious harm, or if it would undermine the prevention, detection, or prosecution of a serious crime including where consent might lead to interference with any potential investigation.

22.4 Sharing the right information, at the right time, with the right people, is fundamental to good practice in safeguarding adults but has been highlighted as a difficult area of practice. It is

important to keep a balance between the need to maintain confidentiality and the need to share information to protect others. Decisions to share information must always be based on professional judgement about the safety and wellbeing of the individual and in accordance with legal, ethical and professional obligations.

22.5 Ideally consent should be provided along with the request for adult health information however there are times when the concerns/risks to the adult are such that it is not appropriate to seek consent, principally as this may increase the risk of further abuse. A lack of consent should not prevent a GP or other practitioner within Nics from sharing information if there is sufficient need in the public interest to override the lack of consent. Where the practitioner is uncertain advice about consent is available from Nics Lead, Designated Nurse Safeguarding Adults, Named GP Safeguarding, Surrey LAs, the GMC, NMC, LMC or medical and nursing defence organisations.

22.6 The '***Seven Golden Rules'*** of information sharing are set out in the "*Information Sharing Advice for practitioners*" providing safeguarding services to children, young people, parents and carers (2015)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf.
This guidance is applicable to all professionals charged with the responsibility of sharing information, including in safeguarding adults scenarios.

1. **The Data Protection Act is not a barrier**
2. **Be open and honest**
3. **Seek advice**
4. **Share with informed consent**
5. **Consider safety and well-being**
6. **Necessary, proportionate, relevant, accurate, timely and secure**
7. **Keep a record of your concerns**

23. Recording Information

23.1 Where there are concerns about an adult's welfare, discussions and decisions made and the reasons for those decisions must be recorded in writing in the person's medical records.

23.2 Nics ensures that computer systems are used to identify those patients and families with risk factors or concerns using locally agreed Read Codes.

23.3 It is recognised that it is as important to be alert to the children and other members of the household as the adult there are direct concerns about.

23.4. Nics has a dedicated Administration Team who are responsible for managing alerts and Safeguarding Adult information/correspondence held together within one health record.

24. Implementation

24.1 Nics staff will be advised of this policy through staff meetings. The Safeguarding Adult Policy will be available via the Nics website www.nicsfed.co.uk

24.2. Breaches of this policy may be investigated and may result in the matter being treated as a disciplinary offence under the Practice disciplinary procedure.

25. Training and Awareness

25.1 Nics induction for employees will include a briefing on the Safeguarding Adult Policy by the COO or Practice Lead for Safeguarding. At induction new employees will be given information about who to inform if they have concerns about an Adult's safety or welfare and how to access the Surrey Safeguarding Adult procedures.

25.2 All staff must be trained and competent to be alert to potential indicators of abuse and neglect in Adults, know how to act on their concerns and fulfil their responsibilities in line with SSAB policy and procedures and NHS England (2016) Safeguarding Adults: Roles and competences for health care staff - Intercollegiate Document Safeguarding Adults. https://www.england.nhs.uk/wp-content/uploads/2016/03/safeguarding-adults-intercollegiate.pdf See also Appendix Four - Training Matrix

25.3 Nics will enable staff to participate in training on adult safeguarding and promoting their welfare provided on both a single and interagency basis. The training will be proportionate and relevant to the roles and responsibilities of each staff member.

25.4 Nics will keep a training database detailing the uptake of all staff training so that the Practice Manager and Safeguarding Leads can be alerted to unmet training needs.

25.5 All GPs and staff should keep a learning log for their appraisals and or personal development plans

26. Safer Employment

26.1 The Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) functions have now merged to create the DBS.

26.2 Nics recruitment process ensures that it undertakes appropriate criminal record checks on applicants for any position within Nics that qualifies for either an enhanced or standard level check. Any requirement for a check and eligibility for the level of check is dependent on the roles and responsibilities of the job.

26.3 Nics recognises that it has a legal duty to refer information to the DBS if an employee has harmed, or poses a risk of harm, to vulnerable groups and where they have dismissed them or are considering dismissal. This includes situations where an employee has resigned before a decision to dismiss them has been made.

26.4 For further information see
http://www.homeoffice.gov.uk/agencies-public-bodies/dbs
Or
http://www.nhsemployers.org/case-studies-and-resources/2014/08/an-employers-guide-to-using-the-dbs-update-service

26.5 Safer employment extends beyond criminal record checks to other aspects of the recruitment process including:

- Making clear statement in adverts and job descriptions regarding commitment to safeguarding
- Seeking proof of identity and qualifications
- Providing two references, one of which should be the most recent employer
- Evidence of the person's right to work in the UK is obtained

27. Managing Concerns About a Person in a Position of Trust (PiPoT)

27.1 This chapter should be read in conjunction with the SSAB, Protocol for responding to concerns about a Person in a Position of Trust (PiPoT) Responsibilities, guidance and procedure for all SSAB partner agencies and their contracted service providers
https://www.surreycc.gov.uk/__data/assets/pdf_file/0006/91914/SSAB-Position-of-Trust-Protocol-ver2.pdf

27.2 Vulnerable adults can be subjected to abuse by those who work with them in any and every setting. All allegations of abuse or maltreatment of vulnerable adults by an employee, agency

worker, independent contractor or volunteer will be taken seriously and treated in accordance with SAB policy and procedures. A referral to the Adult Local Authority Designated Officer (LADO) must take place so consideration of the safety of adults at risk to can be considered as a matter of urgency.

27.3 Nics Safeguarding Lead should, following consultation with the Designated Adult Safeguarding Nurse, LA Safeguarding Adults Enquiry Team and where appropriate the Police (and retain any evidence), inform the subject that allegations have been made against them without disclosing the nature of those allegations until further enquiry has taken place. If it is deemed appropriate to conduct an investigation prior to informing those who are implicated, clear record needs to be made of who took the decision and why.

27.4 Suspension of the employee concerned from their employment should not be automatic. Depending on the person's role within the practice and the nature of the allegation it may be possible to step the person aside from their regular duties to allow them to remain at work whilst ensuring that they are supervised or have no patient/public contact. This is known as suspension without prejudice. Suspension offers protection for them as well as the alleged victim and other service users, and enables a full and fair investigation/safeguarding risk assessment to take place. The manager will need to balance supporting the alleged victim, the wider staff team, the investigation and being fair to the person alleged to have caused harm.

27.5 All allegations should be followed up regardless of whether the person involved resigns from their post, responsibilities or a position of trust, even if the person refuses to co-operate with the process. Compromise agreements, where a person agrees to resign without any disciplinary action and agreed future reference must not be used in these cases.

27.6 If it is concluded that there is insufficient evidence to determine whether the allegation is substantiated, the chair of the safeguarding strategy meeting will ensure that relevant information is passed to the Practice Safeguarding lead. They will consider what further action, if any, should be taken in consultation with the LA Safeguarding Lead for Managing Allegations and in line with the Practice Human Resources procedures.

27.7 When an allegation of abuse or neglect has been substantiated, the Practice Safeguarding Lead will consult with the LA safeguarding team for advice and consider what further action, if any, should be taken in consultation with the LA Safeguarding Lead for Managing Allegations and in line with the Practice Human Resources procedures. It may be necessary to make a

referral to the professional or regulatory body and to the DBS, because the person concerned is considered unsuitable to work with Adults at Risk.

27.8 **The Practice PiPoT Lead is :**
Dr Nicki Mantel-Cooper

27.8 Every GP practice should have a chaperone policy in place for the benefit of both patients and staff. See the GMC guidance: Intimate examinations and chaperones - http://www.gmc-uk.org/guidance/ethical_guidance/21168.asp

28. Whistle blowing

28.1 NICS recognises that it is important to build a culture that allows staff to feel comfortable about sharing information, in confidence and with a lead person, regarding concerns about quality of care or a colleague's behaviour. Direct to or insert link to the Practice Whistle Blowing Procedure.

29. Professional Challenge

29.1 NICS enables and encourages any staff member that disagrees with an action taken and still has concerns regarding an adult at risk of abuse to either contact the Safeguarding Practice Lead or the Designated Nurse Safeguarding Adults for independent reflection and support**.**

30. Clinical and Safeguarding Supervision

30.1 Safeguarding Supervision an essential and integral component of good Clinical and safeguarding supervision for all clinical staff. In particular the practice recognises the need for heightened awareness of safeguarding issues regarding children, young people and vulnerable adults in all services. This includes services in which staff do not regularly come into contact with these patient groups as they may still be the first to identify safeguarding issues relating to a non-service user. In order to provide safe and high quality services for children, young people and vulnerable adults, practitioners require timely supervision which provides protected time to reflect on practice, make decisions, assess risks and improve the quality of practice.

30.2 Medical practitioners are responsible for maintaining their portfolio to support enhanced appraisal and revalidation. This includes a record of supervision sufficient to support their speciality's requirements which is evidenced at the revalidation appraisal.

30.3 In many practices, informal support and monitoring arrangements for staff may exist. Although this is very valuable, this should not be confused with clinical and safeguarding supervision. Clinical and safeguarding supervision is a formal arrangement, involving protected time for the supervisee to discuss issues relating to clinical practice. All clinical staff must receive regular protected clinical and safeguarding supervision time, including preparation time. Clinical and safeguarding supervision sessions should be free from interruptions and be prioritised by both supervisor and supervisee. Actions agreed as part of the clinical and safeguarding supervision process must be completed within an agreed timescale by the supervisor/supervisee.

31. Monitoring and Audit

31.1 Audit of awareness of this safeguarding adult policy and processes will be undertaken by the Practice Safeguarding Lead and lessons learned as with SARs, DHRs and IMRs.

32. Policy Review

32.1 This policy will be reviewed two years from the date of issue. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation/guidance, as instructed by the senior manager responsible for this policy.

33. References

In developing this Policy account has been taken of the following statutory and non-statutory guidance, local and national policies and procedures.

City of York and North Yorkshire Safeguarding Adults Boards
http://www.kirklees.gov.uk/community/yourneighbourhood/crimeSafety/pdf/safeguardingAdultPolicyProcedures.pdf
Kent and Medway Safeguarding Adults Board
https://www.kent.gov.uk/__data/assets/pdf_file/0018/11574/multi-agency-safeguarding-adults-policies-protocols-and-guidance-kent-and-medway.pdf
Health and Social Care Act (2008) (Regulated Activities) regulations (2014)
http://www.legislation.gov.uk/uksi/2014/2936/pdfs/uksi_20142936_en.pdf
HM Government (2015) Information Sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf

HM Government (2015) Revised PREVENT Duty Guidance for England and Wales
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445977/3799_Revised_Prevent_Duty_Guidance__England_Wales_V2-Interactive.pdf
HM Government (2014) *The Care Act*
http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
Local Government Association (2014) Making Safeguarding Personal: Guide
http://www.local.gov.uk/documents/10180/5854661/Making+Safeguarding+Personal+-+Guide+2014/4213d016-2732-40d4-bbc0-d0d8639ef0df
NHS England (2016) Safeguarding Adults: Roles and competences for health care staff Intercollegiate Document
https://www.england.nhs.uk/wp-content/uploads/2016/03/safeguarding-adults-intercollegiate.pdf
Mental Capacity Act 2005
http://www.legislation.gov.uk/ukpga/2005/9/contents

Appendix One - Multi-Agency Safeguarding Hub (MASH)

The Surrey Multi-Agency Safeguarding Hub (MASH) is the single point of contact **for reporting concerns about the safety of a child, young person or adult.** It aims to improve the safeguarding response for children and adults at risk of abuse or neglect through better information sharing and high-quality and timely responses.

The Surrey MASH achieves this by co-locating agencies. It brings together Surrey County Council social care **workers for both children and adults**, early help services, health workers and police as well as a vast array of virtual partners across Surrey. Its aim is to identify need, risk and harm accurately to allow timely and the most appropriate intervention.

Call: 0300 470 9100 – 9am to 5pm, Monday to Friday

Out of hours: 01483 517898 – Emergency Duty Team

Email: ascmash@surreycc.gov.uk

Secure email: ascmash@surreycc.gcsx.gov.uk

Address: MASH Team, Surrey Police, PO Box 101, Guildford, Surrey GU1 9PE

In an emergency, always call **999**

Appendix Two – Adult Safeguarding Referral Flowchart

Surrey Adult Social Services Safeguarding Guidance

You are alerted by a member of staff or become aware that abuse or neglect has occurred or is suspected. Where possible, ensure the immediate safety & welfare of the adult at risk

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Call 999 if urgent medical or police attention is required. Call 101 if you believe a crime may have been committed & report your concerns. Preserve forensic evidence

↓

Decide whether to raise a concern, gathering only essential information necessary to report to The MASH. If you are unsure whether to raise an alert, consult with The MASH

↓

If the person does not consent to referral, see if there are justifiable reasons to act contrary to their best wishes, e.g. a crime, risks to others; conduct of an employee or volunteer who is part of an organisation providing services to the adult; mental capacity of the person to decide; inability to consent due to undue influence or intimidation; serious harm occurring.

↓

Report concerns to The MASH. Document the incident & any actions or decisions in your records. Inform the relevant Regulatory Body & Commissioners if relevant. Inform the manager of actions. Where possible, ensure person who raised concern is offered support

↓

The MASH will acknowledge receipt of the initial form; will assess information & decide upon the most appropriate response to the concern. This may be a statutory or non-statutory enquiry.

↓

The MASH will advise you how your concerns will be addressed. You should advise The MASH of any changes to the adult's situation.

↓

Whenever possible Surrey Adult Social Services will work in partnership with all agencies & services to address concerns, including informing regulatory bodies & relevant commissioners. They will also appoint an advocate for the adult should this be required.

Appendix Three - Contact Details

Surrey wide Clinical Commissioning Groups **Safeguarding Adults**
Designated Nurse for Safeguarding Adults Helen Blunden Mobile: 07894 599133 Email: Helen.blunden@nhs.net
Designated GP Safeguarding Adults (Post Vacant) Email: Mobile:
Lead Nurse Adult Safeguarding Dawn Henderson Mobile: 07540 675256 Email: dawnhenderson1@nhs.net
Noreen Gurner Safeguarding Nurse Advisor for Adults and Children Mobile: 07824-350491 Email: noreen.gurner@nhs.net
Rebecca Eells Safeguarding Nurse Advisor for Adults and Children Mobile: 07392 273318 Email: Rebecca.eells@nhs.net
Lisa Parry Safeguarding Adults and Children Business Manager Mobile: 0750 0990623 Email: lisa.parry1@nhs.net
Rebecca Kuzmin Safeguarding Adults Primary Care Project Manager Mobile: Email:

Appendix Three - Safeguarding Adult Training Matrix (Including Domestic Abuse and Mental Capacity Act)

Training Level Staff Group	Core Competency Required **Please refer to DRAFT NHSE Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document to identify expected knowledge, skills, attitude and values linked to their role – (to be published 2017)**	Frequency	Training
Induction - All practice staff	A mandatory in house session of at least 30 minutes duration should be included in the general staff induction programme or within twelve weeks of taking up post within a new organisation. This should provide key adult safeguarding information, including vulnerable groups, the different forms of abuse and appropriate action to take if there are concerns.	One-off Complete within 12 weeks of commencing role.	Give copy of NHS Safeguarding Adults pocket guide (updated May 2017): https://www.england.nhs.uk/publication/safeguarding-adults-a-guide-for-health-care-staff/

Level 1	Competence at this level is about individuals knowing what things to look out for which may indicate possible harm or abuse, and knowing who to contact and seek advice from within their organisation if they have concerns, and identifying when patients are at risk of abuse or are being abused within their usual environments. It comprises:- • Awareness of potential types of adult abuse and how they might be recognised, including; physical abuse, emotional, sexual, psychological, financial, material abuse and neglect. • An appreciation of the form and context abuse can take place in. This will most often be domestic abuse but it includes honour based violence, modern day slavery, organisational abuse, discrimination, female genital mutilation, radicalisation into violent extremism, internet grooming and bullying. • Awareness of the potential impact of stress on the physical and mental health of individuals and their carers. • An awareness of the rights of the individual in the adult safeguarding context, including the importance of autonomy and empowerment, the right of adults to take risks, the principles of making safeguarding personal, and a basic knowledge of consent and mental capacity. • An awareness of the Prevent agenda and how it may affect them. • Confidence and knowledge to take any necessary immediate action, seek advice and report any safeguarding concerns appropriately within their organisation or, if necessary, through local safeguarding procedures.	Competences should be reviewed annually as part of staff appraisal in conjunction with individual learning and development plan. Over a three-year period, staff at level 1 should receive refresher training equivalent to a minimum of 30 minutes. This should provide key adult safeguarding information, including about vulnerable groups, the different forms of abuse, and appropriate action to take if there are concerns. This should include Prevent awareness in relation to extreme radicalisation of individuals.	**Level 1 & 2 e-learning via E-LFH:** http://www.e-lfh.org.uk/programmes/statutory-and-mandatory-training/ **DOLs:** http://www.e-lfh.org.uk/programmes/statutory-and-mandatory-training/ **Domestic Abuse:** 1 hour online e-training programme designed by Surrey Against Domestic Abuse and recommended by SSCB/SSAB https://surreyskillsacademy.learningpool.com/enrol/index.php?id=186 **PREVENT:** http://www.e-lfh.org.uk/programmes/statutory-and-mandatory-training/ https://www.elearning.prevent.homeoffice.gov.uk/

Level 2	Competence at this level is about individuals starting to report on the information which may indicate possible harm or abuse and knowing who to contact and seek advice from within the care team if they have concerns. It comprises:- • Uses knowledge and understanding of what constitutes adult abuse to identify any signs of harm or abuse including Domestic Abuse. • An understanding of the MCA/DoLS and to apply the principles of MCA and DoLS. • Recognise where the individual should be considered for an independent advocate under the Care Act 2014. • Able to identify and refer an adult suspected of being a victim of trafficking or sexual exploitation; or a victim of FGM, or at risk of exploitation by radicalisers. • Acts as an effective advocate for the adult at risk of harm or abuse. • Recognises the potential impact of the individual's physical, mental capacity and mental health on the well-being of an individual, including possible speech, language and communication needs. • Clear about own and colleagues' roles, responsibilities, and professional boundaries, including professional abuse and raising concerns about the conduct of colleagues. • As appropriate to role, able to refer to social care if an adult safeguarding concern is identified • Know that sharing concerns is always part of their job even though it may not be part of their job description. • Documents safeguarding concerns in order to be able to inform the relevant staff and agencies as necessary, maintains appropriate record keeping, and differentiates between fact and opinion. • Shares appropriate and relevant information within their team and when appropriate, other teams. • Understands the individual's right to privacy and autonomy and to make decision that are or seen unwise, but also understand the limited circumstances in which those rights can be overridden. • An understanding of the Prevent agenda as it affects their work. • Acts in accordance with key statutory and non-statutory guidance and legislation including the Human Rights Act and the Care Act 2014.	Competences should be reviewed annually as part of staff appraisal in conjunction with individual learning and development plan. Over a three-year period, individuals at level 2 should receive refresher training equivalent to a minimum of 3-4 hours. Training at level 2 will include the training required at level 1 and will negate the need to undertake refresher training at level 1 in addition to level 2. Training, education and learning opportunities should include multi-disciplinary and scenario-based discussion drawing on case studies and lessons from research and audit. This should be appropriate to the specialty and roles of participants, encompassing for example the importance of early help, domestic violence, adults at risk of abuse and harm, learning disability, and communicating with individuals.	**Level 1 & 2 e-learning via E-LFH:** http://www.e-lfh.org.uk/programmes/statutory-and-mandatory-training/ **RCGP safeguarding Adults at Risk of harm online training -** http://www.rcgp.org.uk/learning/online-learning/ole/safeguarding-adults-at-risk-of-harm.aspx **DOLs**: http://www.e-lfh.org.uk/programmes/statutory-and-mandatory-training/ **Domestic Abuse:** http://www.e-lfh.org.uk/programmes/domestic-violence-and-abuse/how-to-access/ 40 minute online e-training programme, designed specifically for health workers. **SSAB:** Safeguarding Adults https://www.surreycc.gov.uk/social-care-and-health/contacting-social-care/surrey-safeguarding-adults-board/surrey-safeguarding-adults-board-information-for-professionals/safeguarding-adults-training-strategy-and-courses **PREVENT:** http://www.e-lfh.org.uk/programmes/statutory-and-mandatory-training/ https://www.elearning.prevent.homeoffice.gov.uk/

Level 3	Competence at this level is about individuals starting to act on the information which may indicate possible harm or abuse and advice other members of the care team if they have concerns. It comprises:- • Draws on professional knowledge and expertise to identify signs of harm or abuse. • Ability to document and report concerns of abuse in a manner that is appropriate for safeguarding and legal processes. • Is able to undertake or contribute to enquiries, assessments and the gathering and sharing of information in line with local multiagency safeguarding adult's policies and procedures. • Uses an in-depth knowledge of local multiagency safeguarding adults' policies and procedures to advise staff in relation to identifying and responding to concerns about adult abuse. • Works with other professionals and agencies, along with individuals when there are safeguarding concerns. • Undertakes regular documented reviews of own and/or team's safeguarding practice as appropriate to role (in various ways, such as through audit, case discussion, peer review and supervision and as a component of refresher training). • Contributes to Safeguarding Adults Reviews/case management reviews, internal partnership and local forms of review. • Maintains knowledge and awareness of the Mental Capacity Act and its Code of Practice, the Deprivation of Liberty Safeguards (DoLS) and Care Act 2014, along with their impact on safeguarding adults and managing all related functions as appropriate. • To be able to highlight issues relating to vulnerable people in relation to the Prevent agenda. • Where role includes conducting detailed assessments of adults at risk of harm or abuse, demonstrates ability to apply in depth knowledge of safeguarding issues in the assessment and examination of the adult at risk and how to provide reports with an opinion. • Applies the lessons learnt from audit and Safeguarding Adults Reviews/case management reviews to improve practice. • Advises others on appropriate information sharing.	For those individuals moving into a permanent senior level post, GP or Team Leader, who have as yet not attained the relevant knowledge, skills and competence required at level 3, it is expected that within a year of appointment additional education will be completed. This is to be equivalent to a minimum of 8 hours of education and learning related to adult safeguarding, and those requiring specialist-level competences should complete a minimum of 16 hours. Over a three-year period, professionals should receive refresher training equivalent to a minimum of 6 hours (for those at Level 3 core, this equates to a minimum of 2 hours per annum), a minimum of 12-16 hours (for those at Level 3 requiring specialist knowledge and skill). Training at level 3 will include the training required at level 1 and 2 and will negate the need to undertake refresher training at levels 1 and 2. In addition to level 3 Training, education and learning opportunities should be multi-disciplinary and inter-agency, and delivered internally and externally. It should include personal reflection and scenario-based discussion, drawing on case studies, safeguarding adult's reviews, lessons from research and audit, as well as communicating with individuals about what is happening. This should be appropriate to the specialty and roles of the participants. At level 3 this could, include attendance at a WRAP 3 workshop (for Prevent), where appropriate.	**Domestic Abuse:** https://www.surreycc.gov.uk/__data/assets/pdf_file/0003/161157/Domestic-Abuse-Training-Programme-April-2018.pdf **SSAB Safeguarding Adults:** https://www.surreycc.gov.uk/social-care-and-health/contacting-social-care/surrey-safeguarding-adults-board/surrey-safeguarding-adults-board-information-for-professionals/safeguarding-adults-training-strategy-and-courses **PREVENT** The WRAP training is currently being revised by the Home Office and therefore contact Designated Nurse for Adults for an update.

Training Level	ADULT SAFEGUARDING (including domestic abuse)	PREVENT
Level 1	The minimum level of competence required of all staff working in any health care organization including Governing body members.	All staff working in the health sector. All non-clinical and clinical staff that have any contact with adults, children and young people and/or parents/carers including: administrators for LAC children and safeguarding teams, adult physicians, GP receptionists.
Level 2	All staff that have regular contact with patients, their families or carers, or the public. This is the minimum level of competence for all professionally Qualified healthcare staff. This may include - Receptionists, Domestic Assistants, Phlebotomists, Counter staff, as examples of staff who have regular contact with patients. Level 2 should be the minimum level of competence for all qualified healthcare staff.	
Level 3	Nominated primary care leads for safeguarding adults.	WRAP - All clinical staff working with adults, children and young people and/or their parents/carers including: GPs, looked after children's nurses, community services (including Practice nurses), People providing services to migrants or asylum seekers, Practitioners working in adult community services with adults of a working age and Practitioners working in children's community services with young people.
Level 4	Named Professionals including Doctors, Nurses, Allied Health Professionals, Lead Pediatricians and Consultant/Lead Nurses.	
Level 5	Designated Professionals including Doctors, Nurses, Allied Health Professionals, Lead Pediatricians and Consultant/Lead Nurses.	

Appendix Four – Additional Resources:

GMC page for adult safeguarding - http://www.gmc-uk.org/guidance/26855.asp

RCGP – Safeguarding Adults At Risk of Harm Toolkit - http://www.rcgp.org.uk/clinical-and-research/toolkits/safeguarding-adults-at-risk-of-harm-toolkit.aspx

SCIE Safeguarding resources: http://www.scie.org.uk/adults/safeguarding/

SCIE Mental Capacity Act resources: http://www.scie.org.uk/mca/

FGM mandatory reporting flowchart – https://www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare

Primary Care Resources when coming into contact with domestic abuse - http://www.safelives.org.uk/gp

Appendix Five - Glossary

Best Interests Assessor (BIA)
Care Quality Commission (CQC)
Clinical Commissioning Group (CCG)
Community Rehabilitation Company (CRC)
Court of Protection (CoP)
Criminal Records Bureau (CRB)
Disclosure and Barring System (DBS)
Domestic Homicide Reviews (DHRs)
Domestic violence (DV)
Female Genital Mutilation (FGM)
Forced Marriage (FM)
General Medical Council (GMC)
General Practitioners (GP)
Honour Based Violence' (HBV)
Independent Safeguarding Authority (ISA)
Individual Management Review (IMR)
Surrey Safeguarding Adult Board (SSAB).
Lasting Power of Attorney (LPA)
Local Authority (LA)
Mental Capacity Act (MCA)
Multi-Agency Public Protection Arrangements (MAPPA)
Multi-Agency Risk Assessment Conferences (MARAC)
National Probation Service (NPS)
Nursing and Midwifery Council's (NMC)
Primary Health Care Team (PHCT)
Safeguarding Adults Board (SAB)
Safeguarding Adult Reviews (SAR)