North East Ambulance Service NHS
NHS Foundation Trust

Policy for the Safeguarding of Adults at Risk

Document Control Sheet

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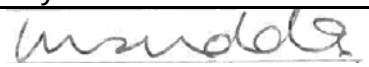
Signature of Chairman of Ratification Committee	
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Table of Revisions

Version number	Status	Document section	Description of change	Author	Date revised
02	Draft		Policy reviewed and has undergone re-write due to changes in Legislation – The Care Act 2014	C McManus	02 March 2015
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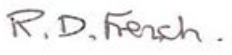
Executive Directors Signature

Directors signature	Print name	Date
	Joanne Baxter	18 February 2016
	Paul Liversidge	18 February 2016
	Roger French	18 February 2016
	Caroline Thurlbeck	18 February 2016

Executive Directors who will be responsible for ensuring staff within their directorates abide by the policy should sign here to evidence they have seen the policy and agree to its content.

Contents

1. Introduction

1.1 The North East Ambulance Service (NEAS) NHS Foundation Trust aspires to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients, public, staff, stakeholders and the use of public resources. In order to provide clear and consistent guidance, NEAS will develop documents to fulfil all statutory, organisational and best practice requirements.

1.2 NEAS delivers a service provision across the 12 Local Authority areas; each individual local authority has specific multi-agency Safeguarding Adults at Risk Procedures.

1.3 Key to successful prevention of abuse is an open culture with a genuinely person-centred approach to care underpinned by a zero tolerance policy towards abuse and neglect. The value of raising awareness about abuse within a service context lies in linking it with a zero tolerance policy on abuse and supportive policies and procedures to support whistle blowing.

1.4 This policy sets out the statutory requirements for NEAS and supersedes the 2014 version of the Safeguarding Adults at Risk Policy. It sets out NEAS's approach to provide guidance to staff regarding the safeguarding of adults at risk. It defines the course of action that should be taken to protect people at risk of harm from abuse and gives a framework to all staff that will enable them to ensure the safety of individuals and to understand each other's role in carrying out this task.

1.5 Government reforms have put patients and the quality of their care at the heart of the NHS. The commitment to patient choice, control and accountability includes support for those in the most vulnerable situations.

1.6 The overarching purpose of adult safeguarding is to protect an adult's right to live in safety and to be free from abuse and neglect. It is also crucial to safeguard adults in a way that supports them to make choices and to have control over how they live in order to improve their quality of life.

1.7 Safeguarding encompasses:

- Prevention of harm and abuse through provision of high quality care;
- Effective responses to allegations of harm and abuse, responses that are in line with local multi-agency procedures;
- Using learning to improve services to patients.

1.8 This policy is developed in accordance with The Care Act 2014 which provides a legal framework for adults with care and support needs and includes statutory requirements for the safeguarding of adults.

- **The Care Act: Chapter 14 Safeguarding**, replaces the 'No Secrets' (DH 2000) guidance. All statutory agencies – local councils, the police and National Health Services (NHS) organisations need to work together both to promote safer communities, thereby preventing harm and abuse and to deal well with suspected or actual cases.

1.9 The NHS Commissioning Board (NHS CB): Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework – health providers are required to demonstrate that they have safeguarding leadership and commitment at all levels of the organisation and that they are fully engaged and in support of local accountability and assurance structures, in particular via the Local Safeguarding Children's Boards (LSCB), Safeguarding Adults Board (SAB) and their commissioners. Most importantly, they must **ensure a culture exists where safeguarding is everybody's business and poor practice is identified and tackled.**

1.10 Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework (2015), to be superseded by any up dated version of the Accountability and Assurance Framework, sets out the safeguarding roles, duties and responsibilities of all organisations in the NHS. It has been developed by NHS England 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 the new responsibilities set out in the Care Act 2014.

1.11 All providers are required to have effective arrangements in place to safeguard vulnerable children and adults and to assure themselves, regulators and their commissioners that these are working. These arrangements include:

- Safe recruitment;
- Effective training of all staff;
- Effective supervision arrangements;
- Working in partnership with other agencies;
- Ambulance Trusts – named professional

2. Purpose

2.1 Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must be recognised that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.

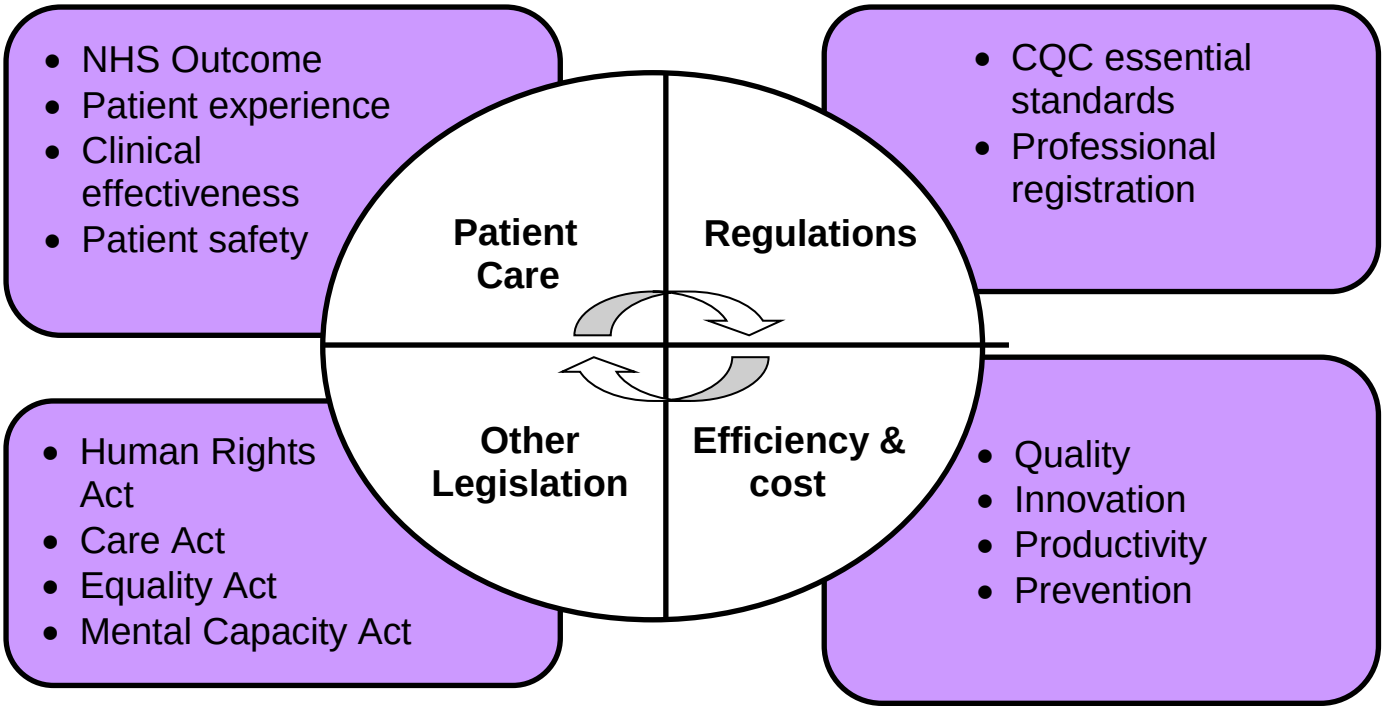
2.2 Professionals should work with the adult to establish what being safe means to them and how that can be best achieved, staff should not be advocating 'safety' measures that do not take account of individual well-being, as defined in Section 1 of the Care Act.

2.3 NEAS has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare of children and young people, to protect adults at risk of abuse and support the Home Office Counter Terrorism strategy CONTEST, which includes a specific focus on PREVENT. This policy will support NEAS in

demonstrating compliance with Local and National agenda for Safeguarding Adults at Risk by:

- Ensuring NEAS promotes a culture in which patients and staff feel they are able to raise concerns.
- Managing its services in a way that minimises the risk of abuse/neglect from occurring.
- Ensuring that concerns or allegations of abuse or neglect are always taken seriously.
- Ensuring that staff have access to and are familiar with this Safeguarding Policy and Procedures and understand their responsibilities within it.
- Ensuring that adults at risk are not subject to any form of abuse.
- Ensuring the Mental Capacity Act is understood and used appropriately to make decisions on behalf of those adults with needs for care and support and who are unable to make particular decisions for themselves. Also excepting adults with mental capacity have a right to make unwise decisions.
- Ensuring that all staff and volunteers receive training in relation to safeguarding adults to a level that is appropriate to their role.
- Ensuring that any allegations of abuse are effectively managed, reported immediately, are thoroughly investigated and appropriate action taken. Staff and volunteers must fully understand that they have a duty to act on any allegations that are disclosed to them.
- Ensuring that there is a named lead person to promote safeguarding awareness and practice within the Trust.
- Ensuring partnership working with other agencies

2.4 Quality Innovation Productivity and Prevention (QIPP) – harm, neglect and abuse cost the NHS millions each year in avoidable admissions and care.



The development of multi-agency policies is led by the Local Authority with agreed commitment to them by partner agencies.

NEAS is a partner agency. The Trust is signed up to their role in, and committed to, the multi-agency policies and procedures developed by the local authority. As a partner agency NEAS is required to have internal guidelines which set out the responsibilities for their staff regarding how they should respond to concerns in line with the multi-agency policies.

3. Scope

3.1 This policy is applicable to all NEAS staff including students, volunteers, third party provider and contracted staff that come into contact with vulnerable adults and to ensure that staff are aware of and can recognise cases of suspected abuse (refer to section 5.3). All staff have a role in safeguarding adults at risk and raising an alert where abuse is suspected, disclosed or discovered.

3.2 For ease of reference, all employees and workers who fall under the staff groups above will be uniformly referred to as ‘staff’ in this document.

3.3 This policy is intended to safeguard any adult who:

- Is aged 18 or over; and
- Had needs for care and support (whether or not those needs are being met); and
- Is experiencing; or is at risk of, abuse or neglect; and
- As a result of those needs is unable to protect him or herself against the abuse or neglect or the risk of it.

3.4 To provide guidance for Operational (Emergency Care Service and Patient Transport Service), 111 service, Urgent Care, Control Centre, Ambulance Care Service (ACS), taxi drivers, Community First Responders and those third party providers who provide support to NEAS enabling them to assess and report on cases of suspected adult abuse, domestic violence as well as possible threats to unborn babies.

3.5 To ensure that all NEAS and other agencies/staff noted above involved in a case of reported abuse are aware of the possible outcome of any subsequent actions.

3.6 To promote education and training in all aspects of safeguarding.

3.7 To ensure the Trust complies with the Health Act to safeguard and promote the welfare of adults.

4. Roles & Responsibilities/Duties

The following section details the responsibilities of specific individuals and groups involved in compliance with this document.

Safeguarding Adults – EVERYBODY'S BUSINESS. All staff have a responsibility to report safeguarding concerns.

4.1 Chief Executive

The Chief Executive is accountable for the proper and effective management of risk within the Trust and is responsible for ensuring the safety of patients, visitors and staff within the organisation. To support and comply with the Local Multi-Agency guidelines for safeguarding adults, ensure compliance with national, statutory and mandatory legislation. Lead and promote the development of initiatives to improve the prevention, identification and response to abuse and neglect.

4.2 Trust Board

4.2.1 The Board is responsible for ensuring that effective systems are in place to safeguard adults at risk. Good governance in safeguarding will follow where it is seen as an integral part of patient care and all staff take responsibility.

4.2.2 Risk of neglect, harm and abuse will be reduced where there is strong leadership and a shared value base. The Board will provide that strong leadership and will demonstrate this across the organisation, set strategic safeguarding objectives and connect aligned strategic areas. The Board will also promote an organisational culture which endeavors to prevent and learn from safeguarding incidents.

4.2.3 The Board will provide accountability for the governance of safeguarding to the service, partners and regulators.

4.2.4 Non-executive Directors and lay members of the Trust also have vital role to play in embedding the safeguarding agenda. They have an opportunity to provide independent scrutiny and hold services to account. They can also ensure the quality and safety are not pushed from the agenda by other operational or financial pressures.

4.3 Quality Committee

4.3.1 The Quality Committee reports directly to the Trust Board. The purpose of the Committee with regard to Safeguarding is to monitor trends arising from the Safeguarding Group and provide assurance to the Trust Board that the Policy and Procedures for the Safeguarding of Adults at Risk within the Organisation is working effectively.

4.4 Patient Safety Group (PSG)

4.4.1 The PSG supports the Quality Governance Group in providing assurance that the Trust delivers high quality, patient centred care particularly with regard to patient safety through the delivery of the Trusts Quality Strategy and relevant

organisational objectives. It will ensure that any risks are minimised and that there are effective systems in place to ensure compliance with legislative, mandatory and regulatory requirements.

It will also monitor the delivery of patient safety improvement initiatives which support the trusts objectives in relation to safety and quality and reducing harm events.

4.5 Safeguarding Steering Group

4.5.1 The Safeguarding Group is a sub-group reporting to the Patient Safety Group which then reports to the Quality Committee and is responsible for monitoring and reviewing the arrangements in place across the Trust to safeguard vulnerable persons.

4.6 Director of Clinical Care and Patient Safety

4.6.1 The Director of Clinical Care and Patient Safety will:

- Act as the nominated Executive Director within the Trust for Safeguarding Adults at Risk and ensuring the Trust complies with the statutory duties for the safeguarding of adults.
- Be accountable for reporting on the governance for Safeguarding Adults to the Trust Board, its regulators, people who use the service, their carers, families and partner agencies.
- Represent the Trust at Quality Review Group (QRG) locally and Quality Governance and Risk Directors (QGARD) nationally for adults at risk issues.
- They are also the nominated Caldicott Guardian and responsible for ensuring Caldicott principles are followed in relation to safeguarding and information sharing.

4.7 The Head of Clinical Care and Patient Safety

4.7.1 Is the Strategic Lead for Safeguarding development and ensure the Safeguarding Adults at Risk Policy is developed and delivered in line with National and Local Legislative and Statutory requirements. Will provide supervision on day to day basis for the Named Professional for the Safeguarding of Vulnerable Groups (Adults and Children) and manage the Safeguarding Team, its roles and functions. They will also be responsible for the authorisation and sign off of Individual Management Reviews (IMR) following Serious Adult Reviews (SAR) completed by the Named Professional for the Safeguarding of Vulnerable Groups.

4.7.2 They are also the designated Chair of the Safeguarding Group.

4.8 The Named Professional for the Safeguarding of Vulnerable Groups (Adult)

4.8.1 Named professionals have a key role in promoting good professional practice within the Trust.

- Joint responsibility with the Named Professional (Children's) for the management of the Safeguarding Team;
- Responsible for implementing the review of the Trust's Adults at Risk Policy and procedures as and when required;
- Responsible for liaising with external stakeholders and the sharing of information where appropriate in accordance with the Trust's information sharing policy and associated procedures;
- Communication learning points identified during investigations to relevant internal and external stakeholders;
- To be accessible to frontline staff for advice and guidance within the multi-agency guidance and trust policy;
- To ensure patients reported via the Trust procedures for Safeguarding Adults at Risk are recorded on the Trust record of safeguarding alerts (Ulysses);
- Responsible for producing safeguarding reports for relevant sub-groups, committees and the Trust Board;
- Responsible for the contribution to Serious Adult Reviews (SAR) reports and co-ordination of requests for information for legal cases;
- Represent the Trust at appropriate external safeguarding meetings (multi-disciplinary / strategy / Domestic Homicide Reviews (DHR) / Serious Adult Reviews / patient review) across the North East;
- Provide clinical leadership and expert practice, lead improvements, innovations and best practice;
- Coordinating the production of the Trust's annual Safeguarding report;
- Maintaining links with the wider safeguarding adults at risk network and ensure that relevant information is disseminated as required to all staff within NEAS and external third party providers;
- Promoting the need for all staff to receive the appropriate level of safeguarding training via the Essential Annual Training (EAT) programme, working in partnership with the training department;
- Offer where necessary support, guidance and supervision to staff with concerns relating to safeguarding adults at risk;
- Update data base following case review meetings;
- Undertaking enquiries internally to establish facts as and when requested by the Local Authority where the service user resides and there has been a safeguarding alert raised by NEAS or external agency;
- Authorise Safeguarding Adult Strategy reports produced by the Safeguarding Officer;
- Develop, monitor and review the Safeguarding Annual Work Plan following discussion at the Safeguarding Group;
- The Named Professional for the Safeguarding of Vulnerable Groups (Children's) is responsible for the updating and monitoring of the Safeguarding Risk Register which details the significant risks identified and associated risk action plans;
- The Trust is a member of the National Ambulance Safeguarding Network which promotes best practice in the ambulance sector for the Safeguarding agenda. The Named Professionals for the Safeguarding of Vulnerable Groups are the representatives of this group on behalf of NEAS.

4.9 Safeguarding Administrator / Officer

- To be the single point of access internally within the Trust for all Safeguarding Adult enquiries and to receive notifications from the Local Authority regarding Safeguarding Referral Alerts against the Trust ensuring all processes and policy guidance is adhered to.
- Maintain the Ulysses Safeguarding Module – creating and maintaining case files along with the Named Professionals for the Safeguarding of Vulnerable Groups.
- Research the relevant databases to capture information to be included in Safeguarding reports for external agencies.
- Will co-ordinate meetings with relevant NEAS staff and the Named Professional for the Safeguarding of Vulnerable Groups in order to collect further information or completion of statements.
- Manage on a day to day basis the diaries for the Named Professional for the Safeguarding of Vulnerable Groups for meeting requests.
- Manage day to day the secure Safeguarding email account, to ensure all Safeguarding Referrals have been attached and respond to enquiries and meeting requests.
- The Safeguarding Officer is responsible for:
    - Analysing data relating to the safeguarding of adults at risk and identify any trends or common themes. Produces and updates the Integrated Performance Report (IPR) on a monthly basis.
    - Produce Safeguarding Adult reports following requests by the relevant Local Authority.
    - Research and complete Chronology templates on behalf of NEAS following requests by the relevant Local Authority for SAR and DHR.
    - Log Multi-Agency Public Protection Arrangements (MAPPA) and Multi-Agency Risk Assessment Conference (MARAC) notifications.

4.10 Head of Workforce Development

4.10.11 Is responsible for ensuring that all clinical and non-clinical staff receive sufficient information, instruction and training at the appropriate level for their role in accordance with the training needs analysis (TNA) plan.

4.10.2 Participation and completion of training will be monitored by the Training Department and reported to the Safeguarding Group. Lack of action will be identified through the Personal Development Plans (PDP) review process.

4.11 Logistic Officers

4.11.1 Are responsible for taking telephone referrals from staff and accurately populating the electronic referral form. They must ensure that the referrer is happy with the content of the referral by reading back the free text.

4.11.2 Will pass the referral securely to the relevant Adult Social Care department and alerting the Trust Safeguarding Team of any related issues. The Trust has identified all Social Care Departments within our boundaries, established contact and gained contact numbers for referral of vulnerable adults. The list is maintained and regularly updated in the Contact Centre.

4.11.3 Will ensure all referrals are passed securely to the Trust Safeguarding Team.

4.11.4 Urgent concerns: on receiving details about a potential case of abuse or concern from any source within NEAS the Logistic Officer will contact the relevant Social Care or Emergency Duty Team (out of hours) to inform and seek advice regarding action to be taken.

4.12 Directors / Business Managers / Head of Services

4.12.1 Responsible for ensuring they have a comprehensive understanding of their own remit within this policy and any associated procedures and guidance documentation. They must set an example and ensure that the professional standards of practice for all staff are enforced thus promoting dignity in the workplace and in clinical practice.

4.12.2 Managers will deal with unprofessional behaviour in accordance with the Trust's Disciplinary Policy to quickly address inappropriate behaviour thus preserving the good reputation of the Trust and confidence of staff and the public.

4.12.3 If a member of staff is dismissed or removed from regulated activity (or they would have been if they had not already left) because they harmed or posed a risk of harm to vulnerable groups, then the Trust is legally required to forward information about that person to the Disclosure and Barring Service (DBS). It is a criminal offence not to do so. If it is believed that the person has committed a criminal offence, information about this must be passed to the police. Senior Managers would be expected to work with the Human Resources Department in relation to the decision of referral to the DBS.

4.13 Operations Managers (OM) are responsible for:

- Ensuring adherence to the Safeguarding Adults at Risk Policy and Procedures.
- Ensuring that staff have access to relevant education and training.
- Informing the Named Professional for the Safeguarding of Vulnerable Groups of any incident taking place within their area of responsibility.
- Setting an example and ensure that the professional standards of practice for all staff at work are enforced thus promoting dignity in the workplace and in clinical practice.

- Notify the Trusts Risk and Claims / Legal Team if there are any contentious issues regarding patient care or conduct by staff from NEAS.
- Providing supervision or support to those members of staff i.e. Emergency Care Clinical Manager (ECCM) following a traumatic or stressful situation that may impact on mental wellbeing and service delivery, by providing Post Incident Care process. This process involves recording information of what has happened, actions taken and what actions need to be taken. It will identify if further welfare checks for staff are required and captures the need to provide further support services i.e. referral to Occupational Health.
- On occasions may be required to support staff when attending court.
- Taking seriously and listening to reports or suspicions raised by service users, staff, relatives or visitors.

4.14 Emergency Care Clinical Managers (ECCM) are responsible for:

- Ensuring adherence to the Safeguarding of Adults at Risk Policy and Procedures
- Setting an example and ensure that the professionals standards of practice for all staff at work are enforced thus promoting dignity in the workplace and in clinical practice.
- Providing supervision or support to those members of staff whom they line manage following a traumatic or stressful situation that may impact on mental wellbeing and service provision.
- Assist the Safeguarding Team when investigations are required which will include discussion with staff members and statement taking. Where possible attend safeguarding strategy / multi-disciplinary meetings on behalf of the Safeguarding Leads.

4.15 All Employees (including bank/volunteers/third party providers)

- All employees of the NEAS are responsible for the safety and well-being of patients and have a duty of care for those patients who are less able to protect themselves from harm, abuse or neglect. This also includes ‘avoidable harm’ which may be caused to a patient e.g. through inappropriate positioning, moving or handling;
- It is the responsibility of all NEAS employees to be familiar with the Safeguarding Adults at Risk Policy and Procedures, and to implement them when abuse is known or suspected;
- To familiarise themselves with the definitions and application of vulnerable adults and abuse, to ensure protection measures are applied in their practice;
- To attend safeguarding adults training as part of the Trust’s Induction and Essential Annual Training (EAT) in accordance with requirements in training needs analysis (TNA);

- Comply with the Trust's Incident Reporting and Investigation, Being Open Policies and Duty of Candour;
- They are personally responsible for any action or omission which could knowingly cause offence or risk to others;
- Ensure that they are able to recognise when abuse may be happening and that they have the knowledge and skills to fulfill their responsibilities in relation to safeguarding adults;
- Acting as an alerter and reporting any concerns about abuse or neglect and informing and gaining consent from the service user where possible without endangering them further of your concerns and that a referral will be made to the relevant Social Care organisation. **It is a professional duty to refer concerns appropriately and failure to act on concerns is a breach of the Safeguarding Adults at Risk Policy and could result in further harm or death to the patient and possible disciplinary action for the staff member;**
- Responding to the immediate safety needs of an adult at risk;
- Ensure they document all actions in the patient's electronic Patient Reporting Form (PRF);
- Ensure all the relevant information is given to the Logistics Officer who will be completing the electronic referral form and that this is repeated back to them in order to ensure all concerns are noted and accurately recorded;
- Staff may be requested to attend strategy meetings, Serious Adult Reviews (SAR) as part of a multi-agency response and attend Court / Coroners Court to give evidence in a particular case.
- They co-operate with investigations to ensure that any lessons can be identified appropriately and acted upon.

4.16 Safeguarding Champions:

- Act as designated person working within their identified department, base or team within the limits of their own professional accountability and responsibility to disseminate information received from the Trust Safeguarding Leads regarding Safeguarding adults within their service area.
- Act as a link to the Trust Safeguarding Lead for the Safeguarding Adults.
- To receive information, guidance, suggested changes from the Safeguarding Team, Safeguarding Group and Training to enable improved practice (to cascade and explain information to staff within their own directorate in timely manner).
- To receive updates from the Safeguarding Team on key legislation, policies and other information that, impacts on vulnerable adults and the work of the practitioners and providers and disseminate to colleagues.
- To receive updates on the latest research in safeguarding work.

- To receive updates on the work of other agencies involved in safeguarding vulnerable adults work.
- To be pro-active in accessing information in relation to safeguarding issues and to have a coaching role within your workplace.
- Act as resource for when staff have queries regarding reporting Safeguarding concerns and completion of alerts.
- To formally highlight areas that need further clarification or are of concern that have been raised with you by individual teams or services.
- To encourage staff and ensure they receive appropriate Safeguarding training.

4.17 Human Resources Department

- Will provide advice to managers on investigation of allegations of inappropriate conduct relating to vulnerable adults whether safeguarding alerts have been initiated internally or externally.
- Advice on how to respond to safeguarding allegations against staff.
- Ensure that staff are checked by the Disclosure and Barring Service (DBS) in accordance with Trust Policy.
- To be represented on the Trust Safeguarding Steering Group.

4.18 Other Specialist Advisers may include:

- Head of Risk and Claims - responsible for ensuring compliance and ensuring that all investigations adhere to the Trust's Incident Reporting policy and procedures.
- Multi-Agency Risk Assessment Committees (MARAC)
- Local Police Constabularies
- Trust Solicitors
- Clinical Commissioning Groups (CCGs)
- Local Authorities Safeguarding Adult units & Safeguarding Adults Boards

4.19 Safeguarding Adults Board (SAB)

4.19.1 The SAB is a voluntary partnership formed to improve the inter-agency activity associated with protecting adults at risk. There are separate Boards covering all areas in which NEAs provides a service. The Boards have a role in coordinating and ensuring the effectiveness of local individuals and organisations work to safeguard adults at risk.

4.19.2 Local Safeguarding Adults Board is the multi-agency partnership responsible or leading the strategic and operational safeguarding adults work within each Authority area. Safeguarding principles and accountability means:

- Working collaboratively with the local SAB partners

- Contributing to the setting and achievement of local SAB objectives.
- Demonstrating transparency in how safeguarding is being delivered.
- Sharing learning with patients, public, multi-agency partners, commissioners and regulators.

4.20 Safeguarding Clinical Leadership and Support Forums / Networks – Local and National

The role of the Safeguarding Forums / Network groups includes:

- Provision of supervision and support to designated, specialist and named professionals;
- Provision of specialist advice and expertise to CCGs and area teams;
- Driving improvement in safeguarding practice;
- Underpinning system accountability through peer review based assurance, that will be developed in line with the overall NHS CB approach to quality improvement;
- Ensuring succession planning and the commissioning of appropriate education and development for designated, specialist and named professionals.

4.21 Patients Advice and Liaison Service (PALS)

PALS is a service within Trusts whose role is to assist service users, their carers and families resolve any issues or concerns that arise during a period of contact with the Trust – either as an in-patient or out-patient. PALS staff should be in a position to recognise that a concern raised by patient, carer or friend could indicate that a person is at risk of abuse or neglect. They should raise concern within their own safeguarding / complaints policy.

5. Policy Content

5.1 Legislative Framework

5.1.1 The legislative framework that supports and informs the actions taken by responsible authorities in relation to safeguarding people at risk of harm from abuse. The following list is neither exhaustive nor should it replace legal advice. If in any doubt, advice must always be sought from Legal Services.

5.1.2 Legislative Framework includes the following:

- The Care Act 2014: Care and Support Statutory Guidance (Chapter 14 – Safeguarding)

- Care Quality Commission: Fundamental Standards of quality and safety.
- Safeguarding Accountability and Assurance Framework (NHS England, June 2015)
- NHS Outcomes Framework – Domain 5
- Forced Marriage: The Anti-Social Behaviour, Crime and Policing Act 2014
- The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards, and MCA Codes of Practice which supplement the Act)
- The Mental Health Act 1983 (as amended 2007 and 2015)
- The Health and Social Care Act 2008
- The Human Rights Act 1998
- Data Protection Act 1998
- Public Interest Disclosure Act 1998 (Whistle Blowing)
- Crime and Disorder Act 1998
- Disclosure and Barring Service

5.1.1 The Care Act 2014: Sections 42-46 / Section 14: Safeguarding from the Care and Support Statutory Guidance

5.1.1.1 The Care Act – Protecting adults from abuse or neglect creates a legal framework so key organisations and individuals with responsibilities for adult safeguarding can agree on how they must work together and what roles they must play to keep adults at risk safe. This Act now places Safeguarding Adults on a statutory footing.

5.1.1.2 Its main aim is to ensure that Safeguarding is everyone's business, and the importance of organisations working together to protect people who need help and support.

5.1.1.3 The overarching purpose of adult safeguarding is to protect an adult's right to live safely and to be free from abuse and neglect. It is also crucial to safeguard adults in a way that supports them to make choices and to have control over how they live in order to improve their quality of life.

5.1.1.4 The guidance notes state that safeguarding duties apply to an adult who:

- Has needs for care and support;
- Is experiencing, or at risk of, abuse or neglect and
- As a result of those care and support need is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

5.1.1.5 The Act requires Local Authorities (LA) to set a Safeguarding Adults Board (SAB) in their area, giving these boards a clear basis in law for the first time.

5.1.1.6 The SAB must:

- Include the LA, the NHS and the Police, who should 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 this 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.
- Arrange a Safeguarding Adult Review to be undertaken where a case involving an adult at risk where the statutory criteria are met and identify and apply the lessons learnt from those cases.

5.1.1.7 The Local Authority must:

- Make enquires, or ask others to make enquires, when they think an adult with care and support needs may be at risk of abuse or neglect in their area and to find out what, if any, action may be needed.

5.1.1.8 Section 14. Safeguarding provides guidance on sections 42-46 of the Care Act 2014, replaces the 'No Secrets' guidance and covers:

- Adult safeguarding – what it is and why it matters
- Abuse and neglect – understanding what they are and spotting the signs; reporting and responding to abuse and neglect
- Carers and adult safeguarding
- Adult safeguarding procedures
- LA role and multi-agency working
- Criminal offences and adult safeguarding
- Safeguarding enquiries
- Safeguarding Adult Boards
- Safeguarding Adult Reviews
- Information sharing, confidentiality and record keeping
- Roles, responsibilities and training in LA, the NJHS and other agencies.

5.1.1.9 The guidance notes state that safeguarding duties apply to an adult who:

- Has a need for care and support.
- Is experiencing, or at risk of abuse or neglect.

5.1.1.10 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.

5.1.2 Care Quality Commission: Fundamental Standards of quality and safety.

5.1.2.1 There are 11 new regulations that set out the fundamental standards of quality and safety. These replace the current 16 regulations which are contained within the 'Essential Standards of Quality and Safety'. The new regulations are more

focused and enable the CQC to pinpoint more clearly the standards which care must not fall, and take appropriate enforcement action.

- The new regulations consist of the following:
- Person-centered care
- Dignity and respect
- Need for consent*
- Safe care and treatment*
- **Safeguarding service users from abuse***
- Meeting nutritional needs*
- Cleanliness, safety and suitability of premises and equipment
- Receiving and acting on complaints
- Good governance
- Staffing
- Fit and proper persons employed

And

- Fit and proper person requirement for Directors
- Duty of Candour*

*These regulations have prosecutable clauses relating specifically to harm or the risk of harm.

5.1.2.2 CQC approach to enforcement: the regulations will allow the CQC to take action to help people who are at risk of receiving poor quality care.

5.1.2.3 Safeguarding from abuse: you must not suffer any form of abuse or improper treatment while receiving care. This includes: neglect, degrading treatment, unnecessary or disproportionate restraint and inappropriate limits on your freedom.

5.1.3 Safeguarding Vulnerable People in the NHS - Accountability and Assurance Framework – NHS England

5.1.3.1 This document updates and replaces Safeguarding Vulnerable People in the Reformed NHS – Accountability and Assurance Framework issued by the NHS Commissioning Board in March 2013.

5.1.3.2 The document sets out clearly the safeguarding roles, duties and responsibilities of all organisations commissioning NHS health and social care. Clearly sets out the legal framework for safeguarding as it relates to the various NHS organisations in order to support them in discharging their statutory requirements to safeguard children and adults.

5.1.3.3 This framework aims to provide guidance and minimum standards but should not be seen as constraining the development of effective local safeguarding practice and arrangements in line with the underlying duties.

5.1.4 NHS Outcomes Framework

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.

5.1.5 Forced Marriage: The Anti-Social Behaviour, Crime and Policing Act 2014

This makes it a criminal offence to force someone to marry. This includes:

- Taking someone overseas to force them to marry (whether or not the forced marriage takes place)
- Marrying someone who lacks the mental capacity to consent to the marriage (whether they're pressured to or not)
- Breaching a Forced Marriage Protection Order is also a criminal offence.
- The civil remedy of obtaining a Forced Marriage Protection Order through the family courts will continue to exist alongside the new criminal offence, so victims can choose how they wish to be assisted.

5.1.6 The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards, and MCA Codes of Practice which supplement the Act)

5.1.6.1 The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves.

5.1.6.2 The MCA also supports those who have capacity and choose to plan for their future – this applies to everyone in the general population who is over the age of 16. Though Lasting Powers of Attorney (LPA), Deputyship and Advanced Decisions to Refuse Treatment (ADRT) are 18 plus, MCA applies from 16 thus wishes and feelings apply.

5.1.6.3 Professionals and other staff need to understand and always work in line with the MCA. They should use their professional judgment and balance competing views. All professionals have a duty to comply with the Code of Practice. It also provides support and guidance for less formal carers.

5.1.6.4 The Act's five statutory principles are the benchmark and underpin all acts carried out and decisions taken in relation to the Act. These are:

- **Principle 1: A presumption of capacity** – 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 you cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability.
- **Principle 2: Individuals being supported to make their own decisions** – a person must be given all practicable help before anyone treats them as not being able to make their own decisions. This means you should make every effort to encourage and support people to make the decision for themselves. If lack of capacity is established, it is still important that you involve the person as far as possible in making decisions.

- **Principle 3: Unwise decisions** – people have the right to make what others might regard as 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 that reason.
- **Principle 4: Best Interests** – If a person has been assessed as lacking capacity for a particular decision then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests.
- **Principle 5: Less restrictive option** – someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the person's rights and freedoms of action, or whether there is a need to decide or act at all. In essence, any intervention should be proportionate to the particular circumstances of the case.

5.1.6.5 Anyone caring for or supporting a person who may lack capacity could be involved in assessing capacity.

5.1.6.6 The MCA is designed to empower those in health and social care to assess capacity themselves, rather than rely on expert testing.

5.1.5.7 **Unwise decisions**

- A person with capacity is entitled to make unwise decisions relating to abuse;
- If a person making an unwise decision lacks capacity to make that decision, then a decision needs to be made by others in the person's best interests;
- 'Best interests' decisions must comply with the Mental Capacity Act;
- It may be necessary and justified to contest an unwise decision if it appears to be related to exploitation, coercion, grooming, undue influence or duress;
- Individuals should be given the opportunity to disclose undue influence and seek appropriate support;
- If a person with capacity is making an unwise decision that puts others at risk then it may be justified to share information without their consent. Also if they are at significant risk of serious harm.

5.1.6.8 **Best Interests**

5.1.6.9 The best interests principle underpins the MCA, it is set out in section 1(5) of the Act.

'An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.'

5.1.6.10 As long as these acts or decisions are in the best interest of the person who lacks capacity to make the decision for themselves, or to consent to acts

concerned with their care or treatment, then the decision-maker or carer will be protected from liability.

5.1.6.11 There are exceptions to this, including circumstances where a person has made an advance decision to refuse treatment and, in specific circumstances, the involvement of a person who lacks capacity in research.

5.1.6.12 A person trying to work out the best interests of a person who lacks capacity to make a particular decision 'lacks capacity' should:

- **Encourage participation** – do whatever is practicable to permit and encourage the person to take part, or to improve their ability to take part, in making the decision;
- **Identify all relevant circumstances** – try to identify all the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves;
- **The Persons Wishes:** find out the person's views – past and present wishes and feeling, these may have been expressed verbally, in writing or through behaviour or habits. Any beliefs or values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question.;
- **Avoid discrimination** – do not make assumptions about someone's best interests simply on the basis of a person's age, appearance, condition or behaviour;
- **Regaining Capacity –** assess whether the person may regain capacity – e.g. after receiving medical treatment. If so, can the decision wait until then? If urgent treatment is required, treat under best interests
- **If the decision concerns life-sustaining treatment** – not be motivated in any way by a desire to bring about the person's death. They should not make assumptions about the person's quality of life;
- **Consult with others -** if it is practical and appropriate to do so, consult with other people for their views about the person's best interests and to see if they have any information about the person's wishes and feelings, beliefs and values.;
- **Written statements –** is there any written statement made by the person when they had capacity.

5.1.6.13 **Test used to assess capacity is a two-stage functional test:**

- Stage 1: is there an impairment of, or disturbance in the functioning of a person's mind or brain? If so:

- Stage 2: is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?

5.1.6.14 The MCA states that a person is unable to make their own decision if they cannot do one or more of the following four things:

- **Understand** information relevant to the decision;

- **Retain** that information long enough to be able to make a decision;
- **Weigh up** the information available to make the decision;
- **Communicate** their decision by any means – this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.

5.1.6.15 **Other considerations:**

- Different methods (e.g. pictures, communication cards or signing) should be used to support people with communication effort should be made to find ways of communicating with someone before deciding difficulties to make sure their views are heard;
- Family, friends, career's or other professionals should be involved as appropriate;
- The mental capacity assessment must be made on the *balance of probabilities* – is it more likely than not that the person lacks capacity?

5.1.6.16 The professional undertaking the test with the patient must show in records why they have come to the conclusion that capacity is lacking for the particular decision.

5.1.6.17 **Deprivation of Liberty Safeguards**

The Deprivation of Liberty Safeguards (DOLS) came into force in April 2009. The aim of the safeguards is to make lawful the DOL of a person who does not have capacity to consent, where it is necessary and in a person's best interests to be deprived.

5.1.6.18 The Safeguards do not apply to people living in their own homes (tenancy, including ISL / owner occupier). Matters concerning a breach of Article 5 where a deprivation is considered to be occurring in such circumstances should be Authorised by an application to the Court of Protection. Legal advice should always be sought in such circumstances.

5.1.6.19 **Ill Treatment or willful neglect**

An allegation of abuse or neglect of an adult at risk who does not have capacity to consent on issues about their own safety will always give rise to action under the Safeguarding Adults process. Subsequent decisions will then be made in their best interests in line with the Mental Capacity Act and the Mental Capacity Act Code as outlined above. Section 44 of the Act makes it a specific criminal offence to willfully ill-treat or neglect a person who lacks capacity.

5.1.7 The Mental Health Act 1983 (as amended 2007 and 2015)

5.1.7.1 Since the last Mental Health Act 1983: Code of Practice was introduced in 2008 there have been substantial changes and updates in legislation, policy, case law and professional practice. The revised Code (2015) reflects and embeds developments since then in areas including the use of restrictive interventions, seclusion, use of police powers to detain people in places of safety, and the use of community treatment orders.

5.1.7.2 The Code of Practice provides statutory guidance to registered medical practitioners, approved clinicians, managers and staff of providers, and approved mental health professionals on how they should carry out functions under the Mental Health Act ('the Act') in practice.

5.1.7.3 The Code applies to the care and treatment of all patients in England who are subject to the exercise of powers and the discharge of duties under the Act, including patients who are detained, subject to community treatment orders (CTOs) or guardianship, or on leave under the Act.

5.1.8 The Human Rights Act 1998

5.1.8.1 Many of the key provisions of the Act came into force in October 2000. The Act makes it unlawful for a public body to act in a way that it incompatible with a right created by the European Convention on Human Rights 1950. This includes a duty to intervene proportionately to protect the rights of citizens, such as those specified in the Convention Articles as follows:

- Article 2 Right to life.
- Article 3 Prohibition of torture (no one shall be subjected to torture or to inhuman or degrading treatment or punishment)
- Article 5 Right to liberty and security
- Article 6 Right to a fair trial
- Article 8 Right to respect for private and family life.
- Article 14 Prohibition of discrimination.

5.1.8.2 Article 8 of the Human Rights Act 1998 states that everyone has a right to respect for private and family life, and the right to make autonomous decisions home and correspondence, except when it is necessary in a democratic society in the following circumstances:

- In the interests of national security, public safety or the economic well-being of the country.
- For the prevention of disorder or crime.
- For the protection of health or morals, or for the protection of the rights and freedoms of others.

5.1.9 Data Protection Act 1998

5.1.9.1 The disclosure of personal information must be in accordance with the Data Protection Act 1998 and information about individuals must be:

- Fairly and lawfully processed
- Obtained for one or more specific and lawful purposes and not processed in any manner incompatible with those purposes

- Adequate, relevant and not excessive
- Accurate and kept up to date where necessary
- Not kept longer than necessary
- Processed in line with the data subject rights
- Secure
- Not transferred outside the European Economic Community (EEC)

5.1.9.2 The Data Protection Act covers all recording, storage and sharing of personal information held either on paper files or electronically. All personal data must be recorded a shared lawfully. It should only be shared if disclosure is either:

- Agreed by the data subject (the person the information is about)
- Required by court order or some legal duty
- Necessary to protect the 'vital interests' of the date subject or
- Necessary to carry out a statutory function such as a duty to assess

5.1.9.3 Where personal data is sensitive (includes racial or ethnic origin; physical or mental health or condition; any criminal conviction), stricter safeguards apply e.g.

- Any consent must be explicit and not implicit
- If made without consent, such consent must be unreasonable to obtain or must be being unreasonably withheld.

5.1.9.4 Vital interest: is a term used in the Data Protection Act to permit sharing of information where it is critical to prevent serious harm or distress, or in life-threatening situations. If the only person that would suffer if the information is not shared is the subject of that information, and they have mental capacity to make a decision about it, then sharing it may not be justified.

5.1.10 Public Interest Disclosure Act 1998

5.1.10.1 The Act came into force on 2 July 1999 and protects workers that disclose information about malpractice at their workplace, or former workplace, provided certain conditions are met. The conditions concern the nature of the information disclosed and the person to whom it is disclosed. If these conditions are met, the Act protects the worker from suffering detriment as a result of having made the disclosure. If the conditions are not met a disclosure may constitute a breach of the worker's duty of confidence to his employer.

5.1.10.2 'Gagging clauses' are clauses in employment contracts or compromise agreements which purport to prohibit a worker from disclosing information about his current or former workplace. A compromise agreement is a contract concluded at the end of an employment relationship that seeks to prevent future disputes. A gagging clause is unenforceable in so far as it purports to preclude a worker from making a protected disclosure.

5.1.11 Crime and Disorder Act 1998

5.1.11.1 Section 115 of the Act provides a legal power to share information to prevent crime. Some instances of abuse will constitute a criminal offence e.g. assault,

whether physical or psychological, sexual assault and / or rape, theft, fraud or other forms of financial exploitation and certain forms of discrimination, whether on racial or gender grounds. **It is imperative that when alleged abuse is a potential criminal offence that the police are contacted as a matter of urgency.** A criminal investigation by the police will take priority over all other lines of enquiry.

5.1.12 Disclosure and Barring Service (DBS)

5.1.12.1 The Safeguarding Vulnerable Groups Act (2006) places specific duties on those providing 'regulated activities'. They must refer to the DBS anyone who has been dismissed or removed from their role because they are thought to have harmed, or pose a risk to, a child or adult with care and support needs. This applies even if they have left their job and regardless of whether they have been convicted of a related crime.

5.1.12.2 The DBS aims to prevent unsuitable people from undertaking certain paid or volunteer work with vulnerable adults or children ('regulated activity'). It vets all those who wish to do such work with vulnerable groups and barring those where the information shows they pose a risk of harm and vetting those who wish to do certain other types of work ('controlled activity').

5.1.12.3 DBS's aim is for a system of safeguarding that is proportionate, balanced and effective and meets public concerns without being a burden. DBS offers much greater assurance that unsuitable people are prevented from working or volunteering with children or vulnerable adults than previously.

5.1.12.4 The potential for enhancing the dignity of people using services is that the Act allows for effective checking of staff. It is a criminal offence for individuals barred by the DBS to work or apply for work with children or adults at risk in a wide range of posts. Employers face criminal sanctions for knowingly employing a barred individual.

5.2 Information Sharing

5.2.1 Adults have a general right to independence, choice and self-determination including control over information about themselves. In the context of adult safeguarding this can be overridden in certain circumstances. Emergency or life-threatening situations may warrant the sharing of relevant information with the relevant emergency services without consent.

5.2.2 The Care Act emphasizes the need to empower people, to balance choice and control for individuals against preventing harm and reducing risk, and to respond appropriately to safeguarding concerns.

5.2.3 It is good practice to always try to gain the person's consent to share information when submitting a Safeguarding referral, as long as it does not increase risk, staff should inform the person if they need to share information without consent.

5.2.4 All staff, in all partner agencies, should understand the importance of sharing safeguarding information and the potential risks of not sharing it. The management interests of the Trust should not override the need to share information to safeguard adults at risk of abuse.

5.2.5 Sharing information between organizations as part of day-to-day safeguarding practice is already covered in the common law duty of confidentiality, the Data Protection Act, the Human Rights Act and the Crime and Disorder Act. The Mental Capacity Act is also relevant as all those coming into contact with adults with care and support needs should be able to assess whether someone has the mental capacity to make a decision concerning risk, safety or sharing of information.

5.2.6 It is recognised that responsible information sharing plays a key role in safeguarding and there is evidence from Serious Case Reviews (SCR) that children and adults have come to harm when services do not openly share the information they have.

5.2.7 The need to distinguish between the principles of confidentiality and the need to share must be in accordance with legislation and the guidance provided by the Trust. All NEAS staff are required to adhere to the legislation in relation to patient confidentiality and the disclosure of information.

5.2.8 Reasons for the sharing of adult safeguarding information

The Trust needs to share safeguarding information with the right people at the right time to:

- Prevent death or serious harm
- Co-ordinate effective and efficient responses
- Enable early interventions to prevent the escalation of risk
- Prevent abuse and harm that may increase the need for care and support
- Maintain and improve good practice in safeguarding adults
- Reveal patterns of abuse were previously undetected and that could identify others at risk or abuse
- Identify low-level concerns that may reveal people at risk and promote wellbeing
- Help identify people who may pose a risk to others and, where possible, work to reduce offending behaviour
- Reduce organisational risk and protect reputation.

5.2.9 Seven golden rules to information sharing

1. Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.

2. Be open and honest with the person (and / or their family where appropriate) from the outset about why, what, how and with whom information will, or

could be shared, and seek agreement, unless it is unsafe or inappropriate to do so.

3. Seek advice if you are in doubt, without disclosing the identity of the person where possible.

4. Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You should go ahead and share information without consent if, in your judgment, the lack of consent can be overridden in the public interest, or where a child is at risk of significant harm. You will need to base your judgment on the facts of the case.

5. Consider safety and well-being: base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.

6. Necessary, proportionate, relevant, accurate, timely and secure: ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those who need to have it, is accurate and up to date, is shared in a timely fashion, and is shared securely.

7. Keep a record of your decision and the reasons for it – whether it is shared information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

5.2.10 Consent for sharing information

5.2.10.1 NEAS staff will adhere to the principles of the Caldicott Committee's report on the review of patient-identifiable information sharing by recognising that confidential patient information may need to be disclosed in the best interests of the patient on the basis that:

- Information can only be shared on a 'need to know' basis when it is in the best interest of the patient.
- Confidentiality must not be confused with secrecy.
- Informed consent **must** be obtained **if referring an adult at risk** but, if this is not possible and others are at risk, it may be necessary to override the requirement, always document the reason as to why the decision to override consent was taken.

5.2.11 When an adult at risk refuses to consent to share information

5.2.11.1 Individuals may not give their consent to the sharing of information for a number of reasons e.g. they may be frightened of reprisals, they may fear losing control, they may not trust social services or other partners or they may fear that a relationship with the abuser will be damaged. Reassurance and appropriate support may assist with their view on whether it is best to share information.
5.2.11.2 If a person refuses intervention to support them with a safeguarding concern, or requests the information about them is not shared with other safeguarding partners, their wishes should be respected. However, there are a

number of circumstances where the practitioner can reasonably override such a decision, including:

- The person lacks the mental capacity to make the decision – this must be properly explored and recorded in line with Mental Capacity Act.
- Other people are, or may be, at risk, including children.
- Sharing the information could prevent a crime.
- The alleged abuser has care and support needs and may also be at risk.
- A serious crime has been committed.
- Staff are implicated.
- The person has the mental capacity to make that decision but they may be under duress or being coerced.
- The risk is unreasonably high and meets the criteria for a multi-agency risk assessment conference referral (MARAC).
- A court order or other legal authority has requested the information.

5.2.11.3 If none of the above apply and the decision is not to share safeguarding information with other safeguarding partners, or not to intervene to safeguard the person:

- Support the person to weigh up the risks and benefits of different options.
- Ensure they are aware of the level of risk and possible outcomes.
- Record the reasons for not intervening or sharing information.
- Ensure they know they can change their minds and tell them how they can access support

5.2.11.4 If is it necessary to share information outside the Trust:

- Explore the reasons for the person's objections – what are they worried about?
- Explain the concern and why you think it is important to share the information.
- Tell the person who you will be sharing the information with and why.
- Explain the benefits, to them or others, of sharing information – could they access better help and support.

5.2.11.5 If a patient is identified as lacking capacity there is no need to seek consent to share the information in the patients best interest. Where actions are taken without the patients consent this must be clearly recorded on the electronic Patient Report Form (ePRF) and on the Safeguarding Referral Form.

Please note: The capacity test should also be documented (ePRF) and safeguarding referral form, to demonstrate how this was carried out.

5.2.11.6 If the person cannot be persuaded to give their consent then, unless it is considered dangerous to do so, it should be explained to them that the information will be shared without consent. The reasons should be given and recorded.

5.2.11.7 It is important that the risk of sharing information is also considered. In some cases, such as domestic violence or hate crime, it is possible that sharing information could increase the risk of the individual.

5.2.11.8 Adults have the right to take risks and may choose to live at risk if they have capacity to make such a decision and this must be respected and all decisions documented.

5.2.11.9 If there are any doubts as to whether information should be shared advice should be sought from the Clinician on Call (out of hours) or the Safeguarding Team (in hours).

5.2.12 Sharing information and address flags

5.2.12.1 Occasionally external agencies may request that any contact with a child or adult at risk is notified to them due to safeguarding issues or concerns for their welfare.

5.2.12.2 These notifications are made to the NEAS Safeguarding Team or via the Handover mailbox, who collect relevant details including detail of risk, who should be notified (agency and name of professional) and agree a time frame and process for the address flag to be removed. The flag is then placed against the address by the Flagging Coordinator in the Contact Centre.

5.2.12.3 The Safeguarding Team will work with external agencies and within NEAS governance arrangements to appropriately place flags for vulnerable persons and have these reviewed and decision to either leave the flag in place or remove within agreed timescales based on risk.

5.2.12.4 Risks that involve violence and aggression will be notified by the Incident Report Form completed by the crews.

5.2.13 Frequent callers / multiple safeguarding referrals for one service user

5.2.13.1 The Trust receives many calls from the public some of whom meet the criteria of a ‘frequent caller’.

5.2.13.2 Any adult at risk who is identified as a frequent caller will be notified either by the Safeguarding Team or the Customer Care Team. Where the Safeguarding team is alerted via the Ulysses Safeguarding Module of multiple referrals placed regarding a service user, the Safeguarding Team will perform further checks with the Customer Care Team and the local Health and Adult Social Care within the locality the service user resides.

5.2.13.3 The Named Professional for the Safeguarding of Vulnerable Groups will work together with the Customer Care Team who may also place a flag against the address if necessary to assist crews and the patient regarding on-going care requirements.

5.2.14 Record keeping

5.2.14.1 Good record keeping is a vital component of professional practice. Whenever a complaint or allegation of abuse is made, all agencies should keep clear and accurate records and have procedures for incorporating, on receipt of a complaint or allegation, all relevant records into a file to record all action taken.

5.2.14.2 All staff are accountable for the initiation and maintenance of accurate, current, comprehensive and concise records were safeguarding concerns are identified. Reliable recording of information in care record is the cornerstone of clinical are, underpinning safety and quality of care. Records must be accurate and written in such a way that the meaning is clear (NMC 2009 / HCPC 2008).

5.2.14.3 Records must demonstrate a full account of the assessment made, the care planned, provided and actions taken including information shared with other health professionals.

5.2.14.4 All entries in a records must be recorded as soon as possible after an event has occurred, providing current information on the care and condition of the patient.

5.2.14.5 When making a referral to the Logistics Desk – the Logistics Officer will record details of the referral and complete an electronic safeguarding referral form. Staff **must** ensure that details of the referral are read back to ensure the context of the referral is correct.

5.2.15 Duty of Candour – Regulation 20

5.2.15.1 The aim of this regulation is to ensure that health service bodies are open and transparent with the 'relevant person' when certain incidents occur in relation to the care and treatment provided by people who use services in the carrying on of a regulated activity.

5.2.15.2 The regulation defines the relevant person as the person using the service and, in certain situations, extends to people acting lawfully on their behalf, i.e. a person under 16 who is not competent to make decision about their care and treatment.

5.2.15.3 The following definitions on interpreting the regulation have been taken from the report produced by Robert Francis:

- **Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered;
- **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators;
- **Candour**- any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a compliant has been made or a question asked about it.

5.2.15.4 Requires providers to tell the person concerned when something has gone wrong as soon as possible to provide support to them and includes giving an apology and keeping the person informed about any further enquiries.

5.3 Safeguarding Adults at Risk

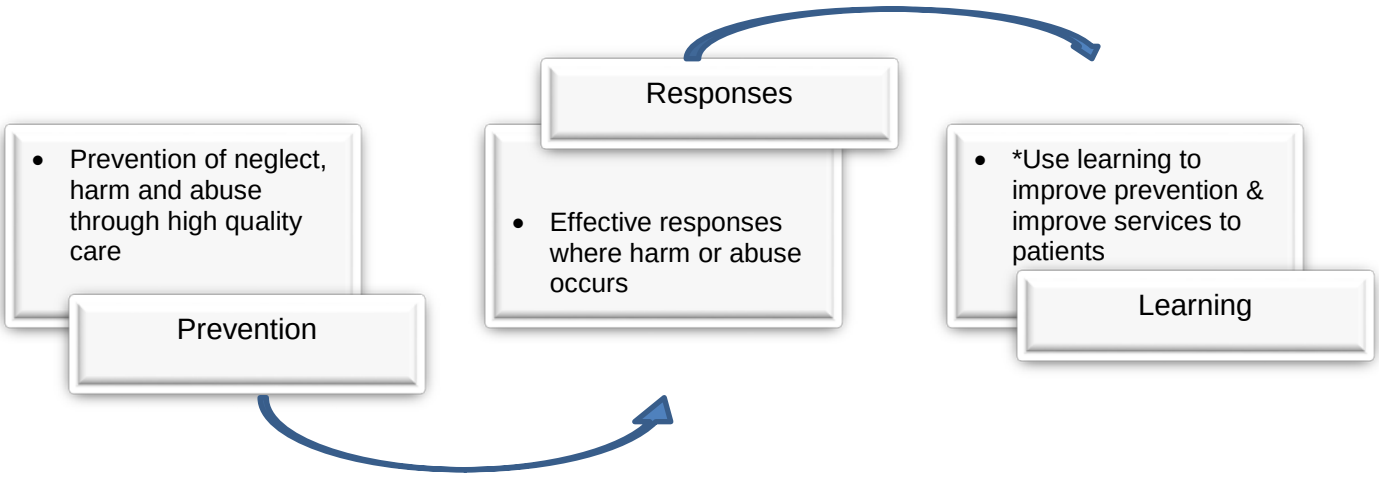
5.3.1 Safeguarding Adults at risk is about people and organisations working together to:

- Prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adults wellbeing is promoted;
- Where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and maybe ambivalent, unclear or unrealistic about their personal circumstances;
- Empower and support people to make their choices;
- Investigate actual or suspected abuse and neglect.

5.3.2 The aims of safeguarding are to:

- Stop abuse or neglect 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 an approach that concentrates on improving life for the adults concerned
- 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 was to 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
- Address what has caused the abuse or neglect.

Safeguarding includes:



Safeguarding adults concerns vary according to the nature of harm, the circumstances it arose in and the people concerned.

5.3.2 People can be abused by anyone, older people or people with disabilities are more likely to be abused or neglected. People can develop care and support needs at any stage in their lives.

They may be seen as easy targets and may be less likely to identify themselves or report it, for fear of the consequences. They may also be subjected to hate-motivated harassment or domestic abuse. People with care and support needs may have difficulty in escaping abuse due to their reliance on the abuser, adapted accommodation and care provision. Many people with care and support needs live in sheltered housing, supported or extra-care housing but a high, and increasing proportion of people live in general needs housing.

5.3.3 Degrees of harm: refer to the Safeguarding Adults at Risk Threshold Tool in appendix L.

5.3.3 The Six Key Principles

5.3.3.1 The key principles agreed by the Department of Health are set out below, to ensure consistent standards in delivering safeguarding. The principles are seen as the foundation for achieving good outcomes for patients and should be used by all agencies to build robust safeguarding processes.

Principle 1: **Empowerment** – people being supported and encouraged to make their own decisions.

'*I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens.'*

Principle 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.'

Principle 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.'

Principle 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.'

Principle 5: Partnership – local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect.

'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 with me to get the best result for me'

Principle 6: Accountability – accountability and transparency in delivering safeguarding.

'I understand the role of everyone involved in my life and so do they'

5.3.4 Making safeguarding personal (MSP)

5.3.4.1 Making safeguarding personal means it should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

MSP seeks to achieve:

- A personalised approach that enables safeguarding to be done with, not to, people involving adults at risk and their families/carers in safeguarding in the outset of safeguarding activity;
- Making sure adults at risk and their families/carers receive information which allows them to understand the process, so that they can make informed choices about the outcomes they would like to achieve;
- Making sure adults at risk and their families /carers are supported to enable them to participate fully in discussions and meetings;
- Practice that focuses on achieving meaningful improvement to people's circumstances rather than just on 'investigation' and 'conclusion'.
- An approach that utilises social skills rather than just 'putting people through a process'.
- An approach that enables practitioners, families, teams and SABs to know what difference had been made.

5.3.5 What are abuse and neglect?

5.3.5.1 This section considers the different types and patterns of abuse and neglect and the different circumstances in which they may take place. This is not intended to be an exhaustive list but an illustrative guide as to the sort of behaviour which could give rise to a safeguarding concern.

5.3.5.2 Incidents of abuse may be one-off or multiple, and affect one person or more. Professionals and others should look beyond single incidents or individuals to identify patterns of harm. Repeated instances of poor care may be an indication of more serious problems and of what we now describe as organisational abuse. In order to see these patterns it is important that information is recorded and appropriately shared.

5.3.5.4 Patterns of abuse vary and include:

- Serial abusing in which the perpetrator seeks out and 'grooms' individuals. Sexual abuse sometimes falls into this pattern as do some forms of financial abuse.
- Long-term abuse in the context of an ongoing family relationship such as domestic violence between spouses or generations or persistent psychological abuse.

- Opportunistic abuse such as theft occurring because money or jewelry has been left lying around.
- It can occur in any relationship and may be a result of deliberate intent, ignorance or neglect. It may be a criminal offence, such as rape, assault or theft.

5.3.5.5 Types of Abuse:

1. Physical
2. Domestic violence
3. Sexual abuse
4. Psychological abuse
5. Financial or material abuse
6. Modern slavery
7. Discriminatory abuse
8. Organisational abuse
9. Neglect and acts of omission
10. Self-neglect

(1) Physical abuse – is physical ill-treatment, which may or may not cause physical injury. This includes assault, rough handling, hitting, pushing, pinching, shaking, misusing medication, scalding, inappropriate sanctions and exposure to excessive heat or cold. Unlawful or inappropriate use of restraint or physical interventions and/or deprivation of liberty are also physical abuse.

Indicators of abuse (this list is not exhaustive):

- Injuries that are not fully explained;
- Person exhibiting untypical self-harm;
- Unexplained bruising in well protected areas, on the soft parts of the body or clustered as from repeated striking;
- Unexplained burns in an unusual location or of an unusual type;
- Unexplained fractures to any part of the body that may be at various stages in the healing process;
- Unexplained lacerations, abrasions, cuts or scratches;
- Slap, kick, pinch or finger marks;
- Injury shape similar to an object;
- Medical conditions which are not treated;
- Sudden or unexplained incontinence;
- Evidence of over or under medication;
- Person appears frightened or subdued in the presence of particular people;
- Weight loss – due to malnutrition or dehydration: complaints of hunger;
- Appearing to be over medicated;
- Person may ask not to be hurt;
- Person may repeat what the perpetrator has said;
- Reluctance to undress or uncover parts of the body.

(2) **Domestic violence / abuse** – can happen to anyone and includes; psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence; Female Genital Mutilation (FGM); forced marriage.

Domestic abuse: In 2013, the Home Office announces changes to the definition of domestic abuse:

Incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse… by someone who is or has been an intimate partner or family member regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- Psychological
- Physical
- Sexual
- Financial
- emotional

It also includes:

- 'Honour' based violence
- Forced marriage

Age range extended down to 16.

"Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

"Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

* This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

Many people think that domestic abuse is about intimate partners, but it is clear that other family members are included and that much safeguarding work that occurs at home is, in fact concerned with domestic abuse.

While the majority of domestic violence victims are women, abuse of men happens far more often than expected. It is important to recognise that men experience domestic abuse as victims too. All statutory agencies have a responsibility to support male victims of domestic violence.

Women Living with Domestic Abuse:

Domestic violence is the systematic use of violence and abuse to gain power over and to control a partner or ex-partner. Domestic violence occurs across all cultures, genders, ages, ethnic groups and social classes. As well as covering physical violence - including all forms of aggressive or unwanted physical contact and sexual violence - domestic violence includes non-physical abuse such as verbal, social, racist, psychological or emotional abuse, threats, neglect, harassment and the use of economic, structural, institutional or even spiritual abuse.

While Black & Minority Ethnic (BME) women and children are just as likely as others to be victims, it is becoming clear that there are important differences in their experiences which can influence their responses and the way they are treated by service providers.

50% of all disabled women have experienced domestic abuse and are raped twice as often as non-disabled women.

Men living with domestic abuse

Men can be victims of domestic abuse, whether their partner is a man or a woman. Men's experiences of domestic violence often differ from that of women and it is insufficient to apply knowledge gained from working with women to that of men in a one size fits all approach. Men may find it difficult to acknowledge their situation, discuss experiences and get appropriate support because of their gender. Men were victims of just over a quarter of incidents of domestic violence in 2010, according to the British Crime Survey.

The Men's Advice Line can refer men to local places that can help, such as health services and voluntary organisations. For help and support, call the Men's Advice Line free on 0808 801 0327 10am-1pm and 2-5pm, Mon-Fri, or email: info@mensadviceline.org.uk

Lesbian, Gay & Bisexual People Living with Domestic Abuse

Like heterosexual people, lesbian, gay and bisexual people can experience domestic abuse from family members and also within same-sex relationships. However, lesbian, gay and bisexual people also report having their sexual orientation used against them by partners and family members. Assumptions of who experiences domestic violence makes it particularly difficult for lesbian, gay and bisexual people to talk to someone and seek help.

Stonewall research has shown that lesbians and bisexual women experience the same levels of domestic abuse as heterosexual women, and gay and bisexual men are much more likely than heterosexual men to experience domestic abuse.

Elder abuse – domestic abuse can include elder abuse. This is where harm is done, or distress caused, to an older person within a relationship where there is an expectation of trust. Most victims of elder abuse are older women with a chronic illness or disability. Like family violence, elder abuse is about one person having power and control over another person.

See appendix K for reporting domestic abuse.

Female Genital Mutilation (FGM): refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. The practice is illegal in the UK. It has been estimated that over 20,000 girls under the age of 15 are at risk of FGM in the UK each year and that 66,000 women in the UK are living with the consequences of FGM.

FGM is usually carried out on young girls between infancy and the age of 15, most commonly before puberty starts. The procedure is carried out by a woman with no medical training. Anesthetics and antiseptic treatments are not generally used, and the practice is usually carried out using knives, scissors, scalpels, pieces of glass or razor blades.

Immediate effects:

- Severe pain
- Shock
- Bleeding
- Wound infections, inc. tetanus and gangrene, as well as blood-borne viruses such as HIV, Hepatitis B and C
- Inability to pass urine
- Injury to vulval tissues surrounding the entrance to the vagina
- Damage to other organs nearby i.e. urethra and the bowel
- In some cases can be fatal

Long-term consequences:

- Chronic vaginal and pelvic infections
- Abnormal periods
- Difficulty in passing urine, persistent urine infections
- Kidney impairment and possible kidney failure
- Damage to the reproductive system, including infertility
- Cysts and the formation of scar tissue
- Complications in pregnancy and newborn infants
- Pain during sex and lack of pleasurable sensation
- Psychological damage, including low libido, depression and anxiety
- Flashbacks during pregnancy and childbirth
- The need for later surgery to open the lower vagina for sexual intercourse and childbirth

FGM is carried out for cultural, religious and social reasons and is prevalent in Africa, Middle East and Asia.

In the UK, FGM tends to occur in areas with larger populations of communities who practices FGM, such as first-generation immigrants, refugees and asylum seekers.

Staff who have concerns for anyone at risk of FGM or has had FGM, must share this information with social care or the police.

(3) Sexual abuse and Sexual Exploitation – is any form of sexual activity that the adult does not want and to which they have not consented, or to which they cannot give informed consent. Sexual abuse includes: rape; buggery; incest; indecent exposure, sexual harassment, inappropriate poking or touching, sexual teasing or innuendo, coercing a person into participating in or watching pornographic photographs or videos; sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

Indicators of sexual abuse (the list is not exhaustive):

- Person discloses, either fully or partially, that sexual abuse is occurring or has occurred in the past;
- Person has urinary tract infections, vaginal infections or sexually transmitted diseases that are not otherwise explained;
- Pain or itching, bruising or bleeding in the genital area;
- Person appears unusually subdued, withdrawn or has poor concentration;
- A change in usual behaviour for no apparent or obvious reason
- Person exhibits significant change in sexual behaviour or outlook;
- Person experiences pain, itching or bleeding in genital/anal area;
- Person's underclothing is torn, stained or bloody;
- Bruising to the thighs and upper arms;
- Sever upset or agitation when being bathed / dressed / undressed / medically examined
- A woman who lacks the mental capacity to consent to sexual intercourse becomes pregnant;
- A person found having any sexual activity with a person with mental incapacity
- Images of sexual abuse on the internet.

(4) Psychological or emotional abuse – this may be intentional or unintentional. It may involve the use of intimidation, indifference, hostility, rejection, threats, humiliation, shouting, swearing or the use of discriminatory and / or oppressive language which results in:

- The adult's choices, opinions and wishes are neglected;
- The adult becoming isolated or over-dependent
- Racial or religious harassment.

Psychological abuse includes the denial of a person's human and civil rights including choice and opinion, privacy and dignity and being able to follow one's own spiritual and cultural beliefs or sexual orientation.

It includes preventing the adult from using services that would otherwise support them and enhance their lives. It includes the intentional and unintentional withholding of information.

Indicators of psychological / emotional abuse (this list is not exhaustive):

- Untypical ambivalence, deference, resignation, becoming passive;
- Appears withdrawn or anxious, especially in the presence of the alleged perpetrator;
- Exhibits low self-esteem;
- Unusual weight loss/gain;
- Rejects their own cultural background and / or racial origin;
- Untypical changes in behaviour, e.g. continence problems, sleep disturbance/insomnia/sleep deprivation, depression or fear;
- Person is not allowed visitors or phone calls (deprivation of contact, unjustified withdrawal of services or supportive networks);
- Person locked in a room / in their home;
- Is denied access to aids or equipment, e.g. glasses, hearing aid, crutches;
- Person's access to personal hygiene and toilet is restricted;
- Person's freedom of movement is restricted by use of furniture or other equipment;
- Exposed to inappropriate stimuli;
- Person feels isolated;
- Low self-esteem, excessive fears;
- Confusion and agitation;
- Threats of harm or abandonment, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying.

Every other category of abuse will almost inevitably involve elements of psychological abuse. Signs of psychological abuse may indicate that other forms of abuse are taking place.

(5) Financial or material abuse – including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

Financial abuse is the main form of abuse according to the Office of the Public Guardian both amongst adults and children at risk. Financial recorded abuse can occur in isolation, but as research has shown, where there are other forms of abuse, there is likely to be financial abuse occurring. Although this is not always the case, everyone should

also be aware of this possibility. Potential indicators of financial abuse include:

- Change in living conditions;
- Lack of heating, clothing or food;
- Inability to pay bills/unexplained shortage of money;
- Unexplained withdrawals from an account;
- Unexplained loss/misplacement of financial documents;
- The recent addition of authorised signers on a client's or donor's signature card;
- Person lacks belongings or services, which they can clearly afford;
- Extraordinary interest by family members and other people in the vulnerable person's assets;
- Lasting Power of Attorney obtained when the vulnerable adult is not able to understand the purpose of the document they are signing;
- Carer only asks questions of the worker about the user's financial affairs and does not appear to be concerned about the physical or emotional care of the person;
- Sudden or unexpected changes in a will or other financial documents;
- A reluctance or refusal to take up care assessed as being needed;
- Personal items going missing from the home;
- Unreasonable and/or inappropriate gifts.

(6) **Modern slavery** – encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into life of abuse, servitude and inhumane treatment.

(7) **Discriminatory abuse** – means treating someone unfairly or differently because of race, gender and gender identity, age, disability, sexual orientation or religion. This type of abuse can be identified by forms of harassment, slurs or similar treatment.

- Hate mail;
- Verbal or physical abuse in public places or residential setting;
- Criminal damage to property;
- Target of distraction burglary, bogus officials or unrequested building / household services.

(8) **Organisational / institutional abuse** – including neglect and poor care practice within an institution or specific care setting such as a hospital or care home or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment.

- Institutions may include residential and nursing homes, hospitals, day centers, sheltered housing schemes, group or supported

housing projects. It should be noted that all organisations and services, whatever their setting, can have institutional practices which can cause harm to vulnerable adults.

- It may be reflected in an enforced schedule of activities, the limiting of personal freedom, the control of personal finances, a lack of adequate clothing, poor personal hygiene, a lack of stimulating activities or a low quality diet – in fact anything which treats service users as not being entitled to a 'normal' life.

The distinction between abuse in institutions and poor care standards is not easily made and judgments about whether an event or situation is abusive should be made with advice from appropriate professionals and regulatory bodies.

The main areas to think about:

- Managers – management of the home/organisation, staff recruitment etc.
- Members of staff – what are they like? Staff knowledge, skills and actions. Values and attitudes, inconsistency and lack of reliability.
- People with learning disabilities – how are they? Are they behaving in ways which suggest they may be at risk of abuse.
- Isolation – are the people in the home cut off from other people? Includes – isolation of individuals, defensiveness and lack of openness
- The service – service design and placement planning
- The care and the environment – are basic needs being met.

(9) **Neglect and acts of omission** – is the deliberate withholding or unintentional failure to provide help or support which is necessary for the adult to carry out activities of daily living. Neglect also includes a failure to intervene in situations that are dangerous to the person, particularly when the person lacks the mental capacity to assess risk.

Neglect can be intentional (active) or unintentional (passive).

Intentional or active neglect occurs when a caregiver knowingly and intentionally fails to provide a vulnerable person with basic necessities.

Unintentional or passive neglect occurs when a caregiver unknowingly fails to provide basic necessities or care. There are a number of reasons for this, such as the caregiver's lack of experience, information or ability.

Indicators of neglect (this list is not exhaustive):

- Person has inadequate heating and / or lighting:

- Person's physical condition / appearance is poor, e.g. ulcers, pressure sores, soiled or wet clothing;
- Person is malnourished, has a sudden or continuous weight loss, and is dehydrated;
- Person cannot access appropriate medication or medical care;
- Person is not afforded appropriate privacy and dignity;
- Person and / or their carer has an inconsistent or reluctant contact with health and social services;
- Callers / visitors are not allowed access to the person;
- Person is exposed to unacceptable risk;
- Neglect of environment;
- Ignoring emotional and physical care needs;
- Withholding the necessities of daily living e.g. missing dentures, glasses, hearing aids, walkers, canes or grab bars;
- Failing to provide adequate supervision or safety precautions;
- Abandonment.

(10) **Self-neglect** – predominantly occurs in older people, by choice or due to lack of awareness or ability, lives in ways that disregards his or her own health or safety. It can also include when the person refuses needed care or help with daily activities. Self-neglect may occur in conjunction with other issues such as alcohol or drug problems, mental health challenges, brain injury or dementia. Older persons who neglect themselves can be more at risk to falls, medication errors, isolation and depression. It can be result of any mental or physical illness which has an effect on the person's physical abilities, energy levels, attention, organisational skills or motivation.

Risk factors: age-related changes that result in functional decline, cognitive impairment, fragility, or psychiatric illness increase vulnerability for self-neglect. While self-neglect can occur across the lifespan it is more common in older people. Risk factors include: advancing age; mental health problems; cognitive impairment; dementia; frontal lobe dysfunction; depression; chronic illness; nutritional deficiency; alcohol and substance misuse; functional and social dependency; social isolation and delirium.

Examples of self-neglect include:

- Inadequate personal hygiene;
- Not taking needed medication;
- Poor and unsafe living conditions - hoarding;
- Lack of heat and proper nutrition.

Consequences of self-neglect: without sufficient personal hygiene, sores can develop and minor wounds may become infected. Existing health problems may be exacerbated, due to insufficient attention being paid to them by an individual. Neglect of personal hygiene may mean that the person suffers social difficulties and isolation.

Self-neglect and also lead to the individual having a general reduction in attempts to maintain a healthy lifestyle, with increase smoking, drug misuse or lack of exercise.

5.3.6 Prevent

5.3.6.1 Exploitation by radicalisers who promote violence. Individuals may be susceptible to exploitation into violent extremism by radicalisers.

5.3.6.2 Violent extremists often use a persuasive rationale and charismatic individuals to attract people to their cause. The aim is to attract people to their reasoning, inspire new recruits and embed their extreme views and persuade vulnerable individuals of the legitimacy of their cause.

5.3.6.3 There are a number of factors that may make the individual susceptible to exploitation by violent extremists. None of these factors should be considered in isolation but in conjunction with the particular circumstances of the individual: identity or personal crisis, particular personal circumstances, unemployment or underemployment and criminality.

5.3.6.4 All of these may contribute to alienation from UK values and a decision to cause harm to symbols of the community or the state. The Home Office leads on the United Kingdom's Strategy for Countering Terrorism - CONTEST.

5.3.6.5 The aim of CONTEST is to reduce the risk to the UK and its interests overseas from terrorism, so that people can go about their lives freely and with confidence.

5.3.6.6 Counter-terrorism continues to be organised around 4 work streams, each comprising a number of key objectives:

- Protect: to strengthen our protection against a terrorist attack;
- Prepare: to mitigate the impact of a terrorist attack;
- Pursue: to disrupt or stop terrorist attacks;
- Prevent: to stop people becoming terrorists or supporting terrorism.

5.3.6.7 **Prevent** is part one of the 4 elements of the CONTEST strategy, aiming to stop people becoming terrorists or supporting violent extremism. The Prevent strategy:

- Responds to the ideological challenge we face from terrorism and aspects of extremism, and the threat we face from those who promote these views;
- Provides practical help to prevent people from being drawn into terrorism and ensure they are given appropriate advice and support;
- Works with a wide range of sectors (including education, criminal justice, faith, charities, online and health) where there are risks of radicalisation that we need to deal with.

5.3.6.8 The strategy covers all forms of terrorism, including far right extremism and some aspects of non-violent extremism.

5.3.6.9 The Home Office works with local authorities, a wide range of government departments, and community organisations to deliver the Prevent strategy. The police also play a significant role in Prevent, in much the same way as they do when taking a preventative approach to other crimes.

5.3.6.10 Local safeguarding structures have a role to play for those eligible for adult protection.

5.3.6.11 If staff identify any potential PREVENT issues in a vulnerable patient / carer they should completed a Safeguarding referral.

Refer to Appendix E

5.3.6.11 **Channel** uses existing collaboration between local authorities, statutory partners (such as the education and health sectors, social services, children's and youth services and offender management services), the police and the local community to:

- Identify individuals at risk of being drawn into terrorism;
- Assess the nature and extent of that risk;
- Develop the most appropriate support plan for the individuals concerned

Channel is about safeguarding children and adults from being drawn into committing terrorist-related activity. It is about early intervention to protect and divert people away from the risk they face before illegality occurs.

5.3.6.12 **Hate Crime** – is defined as any incident that is perceived by the victim, or any other person, to be racist, homophobic, transphobic or due to a person's religion, belief, gender identity or disability. It should be noted that this definition is based on the perception of the victim or anyone else and is not reliant on evidence.

Anyone can be a victim of abuse regardless of sexuality or gender. However lesbian, gay, bisexual and transgender (LGBT) individuals could face additional concerns around homophobia and gender discrimination. There may be concerns that individuals would not be recognised as victims or be believed and taken seriously. Abusers may also control their victims, threatening to 'out' them to friends, family or support agencies.

5.3.7 Who abuses and neglects adults at risk?

5.3.7.1 The abuser could be anyone, a man or a woman. Anyone can carry out abuse or neglect including:

- Spouses or partners;
- Other family members;
- Neighbours;
- Friends;
- Acquaintances;
- Local residents;

- People who deliberately exploit adults they perceive as vulnerable to abuse;
- Paid staff or professionals;
- Volunteers and strangers.

Abuse can take place anywhere:

- In public places
- In the victim's own home
- At work
- In hospital
- In places of worship
- In care homes
- At day care

5.3.8 Identifying people at risk of abuse

5.3.8.1 Identifying risk factors can help prevent abuse by raising awareness among staff of the people in their care who may be most at risk of abuse. By making staff aware of risk factors, they can use these insights to develop effective risk assessments and prevention strategies.

Who might be at risk? A person who:

- Is elderly, with poor health, a physical disability or cognitive impairment;
- Has a learning disability;
- Has a physical disability and/or sensory impairment;
- Has mental health needs including dementia or a personality disorder;
- Has a long-term illness / condition;
- Misuses substances or alcohol;
- Is a carer, providing unpaid care to a family member or friend;
- Is unable to demonstrate the capacity to make a decision as defined by the MCA and is need of care and support.

5.3.8.2 Certain situations may place people more at risk of being abused. However, this does not mean that a person will be abused; only that is more likely. These situations include:

- A person needs support with personal care. Certain personal care needs may present more opportunity for abuse;
- Role reversal, e.g. the adult child taking over the parental role;
- When someone is living with a known abuser;
- Where there is a family history of abuse;
- Where an adult is dependent on others, or others are dependent on them;
- Inappropriate or dangerous physical or emotional environment;
- When there is a change in the lifestyle of a member of the household e.g. unemployment, employment, illness;
- A member of the household experiencing emotional or social isolation;
- Where there is an absence of local support networks;

- Alcohol / substance misuse;
- The existence of financial problems;
- Breakdown in communication.

5.3.9 Carers and Safeguarding

5.2.9.1 Circumstances in which a carer (family member or friend) could be involved in a situation that may require a safeguarding response:

- A carer may witness or speak up about abuse or neglect;
- A carer may experience intentional or unintentional harm from the adult they are trying to support or from professionals and organisations they are in contact with;
- A carer may unintentionally or intentionally harm or neglect the adult they support on their own or with others.

5.3.10 Allegations against staff

Please refer to the Management of Allegations Against Staff Policy

5.4 Recruitment and training for staff and volunteers

5.4.1 Recruitment

5.4.1.1 The Trust must have rigorous recruitment practices which are relevant to safeguarding. There are three levels of a DBS check, each contains different information and the eligibility for each check is set out in law. They are:

- Standard check: discloses details of an individual's convictions, cautions, reprimands and warnings recorded on police systems;
- Enhanced checks: discloses the same information on a Standard certificate, together with any local police information that the police believe is relevant and ought to be disclosed.
- Enhanced with barred list checks: includes the same level of disclosure as the enhanced check, plus a check of the appropriate barred lists. An individual may only be checked against the children's and adult's barred lists if their job falls within the definition of 'regulated activity' with children and/or adults under the Safeguarding Vulnerable Groups Act 2006, as amended by the Protection of Freedoms Act 2012.

5.4.1.2 Volunteers and Visitors: in relation to recent media coverage highlighting alleged abuse of vulnerable patients by a celebrity, all staff to be aware that all volunteers must undergo a thorough recruitment process.

5.4.2 Induction, Training and Supervision

5.4.2.1 **Induction and Training**.

The Trust is committed to ensuring that all staff receive awareness training and that different levels of staff will have appropriate knowledge for their role. All

staff including volunteers must be provided with training on the Trust's Safeguarding policy and procedures.

This should include:

- Mandatory induction training with respect to awareness that abuse can take place and the duty to report;
- More detailed awareness training through the Essential Annual Training (EAT) training programme. Training to include: recognition of abuse and responsibilities with respect to the procedures within the Trust;
- Universal awareness across the Trust of the Safeguarding Policy;
- Specialist training for the Named Professionals for the Safeguarding of Vulnerable Groups as they will be responsible for undertaking enquiries which can be complex in nature.
- Training should take place at all levels in the Trust and be updated regularly to update practice as per the Trust's Training Needs Analysis (TNA).
- Line Managers are responsible for monitoring employees' compliance with mandatory training and Trust policy through supervision and appraisal.
- Records of attendance on EAT and Induction will be collected and held by the Education and Training Unit.

5.4.2.2 **Supervision:**

- For staff working with adults, where there are safeguarding concerns, is integral to making sound judgments and providing an effective service. It is recognised that staff who work directly with adults who are in need of support services or in need of protection, may be subjected to particular stresses and anxieties.
- Supervision is defined as: *An activity that brings skilled supervisors and practitioners together in order to reflect upon their practice.*
- NEAS will make support available to employees involved in safeguarding. The Trust will provide support through Managers, Human Resources, Occupational Health and Trust counselling services.
- Supervisors should be sensitive to the supervisee's own experiences that may render them particularly vulnerable in certain situations and signpost them as appropriate.

5.5 Safeguarding Adult Procedures

5.5.1 In order to respond appropriately where abuse or neglect may be taking place, anyone in contact with the adult, whether in a volunteer or paid role, must understand their own role and responsibility. Observant professionals and other staff making early, positive interventions with individuals and families can make a difference to their lives.

5.5.2 The Local Authorities (LA) **must** make enquiries, or cause others to do so. An enquiry is the action taken or instigated by the LA in response to a concern that abuse or neglect may be taking place. An enquiry could range from a

conversation with the adult, or if they lack capacity, or have substantial difficultly in understanding the enquiry their representative or advocate, prior to initiating a formal enquiry under Section 42, right through to a much more formal multi-agency plan or course of action.

5.5.3 The purpose of the enquiry is to decide whether or not the LA or another organisation, or person should do something to help and protect the adult. Objectives of an enquiry are to:

- Establish facts;
- Ascertain the adult's views and wishes;
- Assess the needs of the adult for protection, support and redress and how they might be met;
- Protect from abuse and neglect, in accordance with the wishes of the adult;
- Make decisions as to what follow-up action should be taken with regard to the person or organisation responsible for the abuse or neglect; and
- Enable the adult to achieve resolution and recovery.

5.5.1 Responding when abuse or risk of harm is suspected

5.5.1.1 The principles of adult protection differ from those of child protection, in that adults have the right to take risks and may choose to live at risk if they have the capacity to make such a decision. There wishes should not be overruled lightly. Guidance about assessing patients' capacity is available from either the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) or Clinical Practice Circular (CPC) / Patient Care Update (PCU) 5027.

5.5.1.2 Observations about the condition of children or other adults in the household might suggest risk (e.g. child living in an environment where domestic violence has taken place). Staff may observe hazards in the home, or find that children have been locked in a room. Signs of distress shown by other children in the home should be recorded.

5.5.1.3 Operational staff are uniquely placed to identify a possible safeguarding concern, they will often be the first professional on scene and their actions and recording of information may be crucial to subsequent safeguarding adult enquiries.

5.5.1.4 Contact Centre – 999 / 111 call handlers and Clinicians may overhear or suspect a possibility of abuse or risk of harm.

5.5.1.5 When staff identify a safeguarding concern regarding an adult at risk i.e. they suspect abuse or there are indicators of abuse they **MUST** make a safeguarding referral.

5.5.1.6 Use the safeguarding principles as a guide to decision making see the six key principles mentioned in section 5.5.1.6

5.5.1.7 **Handling disclosure**

If an adult makes a disclosure of abuse (including domestic abuse) it is important to remain calm, ensure the vulnerable person is safe and show that you are not judging them and that you take the concern seriously.

Do not:

- Show shock or disbelief;
- Stop people talking or state your personal views about what has happened;
- Press for details – allow the person to say what they need to say to you;
- Make promises that you cannot keep. You may have to share the information;
- Discuss concerns with the alleged abuser, you may increase risks to the vulnerable person;
- Record assumptions or personal opinions;
- Ignore the disclosure and hope someone else will deal with it. The person may never disclose again;
- Do not investigate or ask probing questions.

If it is safe to do so you must:

- Keep calm;
- Reassure the person concern;
- Allow the person to speak;
- Listen to what is being said;
- Ensure the vulnerable persons' immediate safety. This may involve getting the police or Adult Social Care on scene. Do not allow the abuser to be left alone with the vulnerable person after a disclosure has been made;
- If the adult discloses abuse do not leave children at home with the alleged abuser while transporting to hospital;
- Do make a vulnerable adult / child referral and ensure your concerns and the nature of the disclosure is accurately recorded as per procedure;
- Record relevant information on the Patient Report Form and who was informed of the concerns when verbally handing over to staff at receiving hospital.

Your responsibilities are:

- To call the police if a crime has been committed;
- To keep yourself, staff and service users safe;
- To factually record what you have witnessed, has been disclosed, what has happened and any actions taken.

5.5.1.7 **Decision making for adult safeguarding**

See Appendix F and K: Referral pathway and Adults at Risk Threshold Tool and Guidance

5.5.2 Safeguarding referral process

5.5.2.1 The procedures apply to NEAS staff including front-line staff, call takers, managers, third party providers and volunteers. The aim of the procedures is to highlight the joined up approach required for effective safeguarding throughout the Trust. Engagement in these procedures will help safeguard the vulnerable people we work with and protect the Trust's reputation by demonstrating we deal with things that go wrong and are transparent in trying to learn lessons from those incidents.

5.5.2.2 As part of this policy and procedure the Trust has identified all Social Care Departments within our boundaries, established contact and gained contact numbers for referral of adults at risk, this list is maintained and regularly updated.

5.5.2.3 **999/111 Call handlers and Patient Transport Service (PTS) Contact Centre Staff**

In all cases where abuse is suspected a Safeguarding Adult Referral Form must be completed by contacting the Logistics Desk as detailed in **Appendix G**.

5.5.2.4 **Patient Assessment face to face ambulance crews (Emergency Care / Patient Transport Service / Third Party Providers)**

There are a number of ways in which ambulance crews may receive information or make observations which suggest a vulnerable adult has been abused or is at risk of harm. It is particularly important that other people who may be present should not be informed of an ambulance crew's concerns in circumstances when this may result in a refusal to attend hospital or in any situation where a vulnerable adult may be placed at further risk.

5.5.2.5 NEAS crews should:

- Follow normal history-taking routine, taking particular note of any inconsistency in history or any delay in calling for assistance. If necessary, they should ask appropriate questions of those present to clarify what they are saying;
- Be aware that someone who is frightened may be reluctant to say what may be the cause of their injury, especially if the person responsible for the abuse is present. It may be helpful to make a note of the person's body language. It is important to stop questioning when suspicions are clarified. Avoid unnecessary questioning or probing, as this may affect the credibility of subsequent evidence.
- If the patient is conveyed to hospital, **must** inform a senior member of the Accident and Emergency (A&E) staff or nursing staff if conveying to another department, of their concerns about possible abuse.
- **Must** complete the electronic Patient Report Form (ePRF) and contact the Logistics Desk in order for the safeguarding referral to be completed. Details of the concern must be factual, non-opinion based statement.

Refer to Appendix H

5.5.2.6 When making a referral, staff contact the NEAS Logistics Desk by phone on 0300 011 0132 and pass on the relevant details. **The referral should be made before attending the next patient while the details are readily recalled.**

Information required when making a referral – minimum data

- Patients full name, address, telephone number, DOB, ethnic origin, first language, case number for the patient.
- Referrer's name, job title, base station
- Whether referral is urgent or non-urgent
- Contact details (NoK)
- GP details
- Residential setting – care home / residential home. Give care provider details.
- Details of concern – please identify what the concerns are, the information **must be concise, non-judgmental and not include any personal opinions or view. Only factual information should be given. Detail / description of any injuries. State the source of any third party information**
- Record the category of the suspected abuse – maybe more than one category
- Details of any other person(s) on scene with patient
- Details of alleged perpetrator if known or suspected including their relationship to the patient
- **Patient consent** – this **must** always be sought where ever possible, the referrer must inform the patient and explain why they are making the referral, and where the referral is sent to. If **consent cannot be given or has not been given by the patient**, **the reason for this must be recorded under the appropriated section of the referral form.**
- Any additional information can be recorded

5.5.2.7 If there are Operational pressures and the referral cannot be made immediately then the crew **MUST** be given time to make the referral during that shift within eight hours of the incident occurring, this relates to patient safety and failure to achieve this must be reported by the crew using the Incident Reporting system and the reasons for non-compliance investigated.

5.5.2.8 In urgent circumstances where frontline staff think an adult is at immediate risk of significant harm, they should inform Ambulance control who will request police attendance.

5.5.2.9 It should be **standard practice** for staff to ensure that a **check is made to ensure that no child or vulnerable adult is left alone** without being advised of the fact that the patient is being transferred to hospital and if required arrangements being made to care for the vulnerable adult or child.

5.5.2.10 Operational crews may be 'flagged down' by a member of the public or any other member of the emergency services. This may occur at any time including

when the crew are already dealing with a case. Individuals who 'flag down' a vehicle may require assistance themselves or to pass information regarding another member of the public. The crew must:

- Contact Control immediately to notify them that they have been 'flagged down';
- Information must be provided to Control as to the nature of the incident;
- Depending on the incident it may be possible to continue with the current case without detrimental impact on patient care. This will be decided by the Control staff based on the information provided by the crew following a dynamic risk assessment of outstanding demand and availability of resources.
- The crew will explain to the person who has 'flagged down' the vehicle of the outcome and decision of the Control staff.
- A&E Dispatchers – if a crew advises of the above and they do not need to be allocated to the detail, an INFO call should be logged within CAD with the details that are provided by the crew. If it is necessary to inform the Police / Social Care etc., this should be logged in the case notes and passed as appropriate to other providers.
- If there are any safeguarding concerns perceived then a referral through Logistics Desk should still be made by the responding crew as procedure.

5.5.2.11 Non-urgent concerns

- If the threshold for harm has been assessed as being one of lower level concerns i.e. an adult who is vulnerable and in need, rather than an adult who is vulnerable and at risk of abuse, then you should proceed to provide appropriate medical assessment and intervention;
- Those identified as non-urgent can be forwarded in hours 8-5pm only.

5.5.2.11 Urgent Concerns

- If you have any doubt as to the level of concern, you must seek advice from the On-Call Paramedic / Clinician; they will discuss any problem with you. Please do not hesitate to seek advice if you are in any doubt or wish to review your decision with a senior colleague;
- If you believe that a vulnerable adult is suffering or is at risk of suffering abuse, discuss your concerns with the Adult Protection Team for the relevant area prior to a formal referral. Together with the Adult Protection Team agree on the strategy for the case including involvement with other agencies including the Police;
- Agree how this strategy will be managed and monitored and the role and responsibility for yourself and the organisation;
- Where immediate action is required, clarify the wishes and capacity of the patient if known, or who will establish these if unknown;
- Document fully and accurately any decisions or actions made with regard to the patient.
- Contact Logistics Desk for completion of Safeguarding Adult Referral Form.

- Those referrals identified as URGENT – time of notification will need to be forwarded to the appropriate Social Care unit.
- **Out of hours urgent referrals** will be sent to the Emergency Duty Team (EDT) usually via fax or telephone call for immediate action.

5.5.2.12 **Conveyance to hospital:**

It is important to ascertain the wishes of the patient and to take into account whether or not they want to be conveyed to hospital. However, the decision not to convey a patient to hospital is one that must not be taken lightly. In some cases the crew may assess that the patient clearly does not have the capacity to make a judgment with respect to their needs for medical care, and may decide to act under Section 4 MCA Best Interest Checklist (if there is a risk to life or limb) or make alternative arrangements for the patient if their condition requires less immediate treatment e.g. a GP visit the following day.

5.5.2.13 If the patient needs to be conveyed to hospital and another person tries to prevent this, crews may need to consider whether to involve the police.

5.5.2.14 If the patient is not conveyed to hospital, or the crew have concerns about someone else in their household or on the premises, they should contact A&E Control and inform them of their concerns. If the vulnerable person is not the patient but is accompanying someone else to hospital, the crew must inform A&E, or other hospital nursing staff of their concerns. At the earliest opportunity the crew must contact Logistics and complete the Adult Referral form.

5.5.2.15 **NEAS Contact Centre Clinicians, Northern Doctor Urgent Care (NDUC) and 111 Contact Centre Clinicians.**

- Any concern must be carefully documented in the case notes on Cleric or for NDUC Clinicians in the patient case notes by making a factual, non-opinion based statement.
- In all cases where abuse is suspected an Adult Safeguarding Referral Form must be completed by contacting the Logistics Desk – refer to Appendix G

5.5.2.16 **111 NDUC Clinicians must:**

- Clarify in what sense this patient is an Adult at risk of abuse;
- Establish the nature of the actual or potential harm to the vulnerable adult;
- Non-urgent Concerns – if the threshold for harm has been assessed as being one of a lower level concern e.g. an adult who is vulnerable and in need, rather than an adult who is vulnerable and at risk of abuse, then you should proceed to provide appropriate medical assessment and intervention;
- Urgent Concerns – if you have any doubt as to the level of concern, you must seek the advice from the NDUC On-Call Executive, who will discuss the problem with you. Please do not hesitate to seek advice if you are in any doubt or wish to review your decision with a senior colleague;

- If you believe that a vulnerable adult is suffering or is at risk of suffering abuse, discuss your concerns immediately with the Adult Protection Team (APT) for the relevant area prior to a formal referral;
- Together with the APT agree on the strategy for the case including the involvement of other agencies including the Police;
- Agree how this strategy will be managed and monitored and the role and responsibility for yourself and the organisation;
- Where immediate action is required, clarify the wishes and the capacity of the patient if known, or who will establish these if unknown;
- Clarify the point at which your responsibility will end;
- Contact the Logistics Desk in order to complete the Safeguarding Adult Referral Form, the Logistics Officer will then forward the concern to the relevant safeguarding team via secure email / fax;
- A copy of the referral will be forwarded to NDUC to be filed with the patient's records.

5.5.2.17 **Logistics Officer**

Refer to 4.11

5.5.2.18 **Safeguarding Team**

- The Administration team will check the secure safeguarding mailbox on a regular basis.
- There is a single point of access contact telephone number / safeguarding mailbox to which all enquires and meeting requests will be made. The safeguarding administrator will ensure the meetings are placed in the relevant Lead's calendar, gather information and notes will be added to Ulysses and case number identified.
- If necessary the Safeguarding Officer will generate a report and / or chronology and this will be sent securely to the appropriate Adult Social Care email address.
- The Named Professional for the Safeguarding of Vulnerable Groups will were appropriate attend any relevant Strategy Meetings, Serious Adult Reviews and Domestic Homicide Reviews as and when requested.

5.5.2.19 **Management Responsibilities**

NEAS Managers will:

- Ensure that any request from a statutory agency for a statement or other information will be communicated through the crew's line manager.
- Ensure that any member of staff instructed to attend court to give evidence will receive appropriate support and advice from the Trust. This will include ensuring the documentation is available in good time, allowing time for brief / debrief before and after a court appearance or case conference.

NDUC Governance team will:

- Liaise with NEAS to ensure all necessary information is available. They will coordinate any required activities and responses from NDUC clinicians.

5.5.3 Internal Process for attendance at and communication with Strategy Meetings.

5.5.3.1 Following a safeguarding referral, decisions will be taken within Adult Social Care regarding how to progress. Decisions based on level of risk and whether or not the adult is at immediate risk of harm. Not all referrals will be progressed to a strategy meeting.

5.5.3.2 A Safeguarding Strategy meeting is held to formulate a multi-agency plan to assess risk, address any immediate protection needs and to agree a plan for further assessment or investigation.

5.5.3.3 NEAS may be asked to attend the strategy meeting to share relevant information, Adult Social Care will involve NEAS Safeguarding Team to notify that a meeting is taking place and to ensure attendance if necessary.

5.5.3.4 The Safeguarding Administration team will research and gather all the necessary information required from a clinical and operational perspective and preparation is needed to ensure this is available for the meeting. Relevant information includes call logs, safeguarding referrals, electronic patient report forms etc. If the strategy meeting is in relation to allegations against NEAS staff the Disciplinary Policy must be followed.

5.5.3.5 The NEAS Safeguarding Team will ascertain if there are any contentious issues for NEAS and will liaise and share information with the Trust legal team.

5.5.4 Serious Adult Reviews (SAR) and Learning Lessons

5.5.4.1 When an adult dies or suffers significant harm and abuse or neglect is known or suspected to be a factor, the Local Safeguarding Adults Board (SAB) may recommend that a SAR is undertaken.

5.5.4.2 SARs should reflect the six safeguarding principles. SABs should agree Terms of Reference (TOR) for any SAR they arrange and these should be published and openly available.

5.5.4.3 Organisations consider whether there are lessons to be learnt about the ways in which they work together to safeguard and promote welfare of adults at risk.

5.5.4.4 The Trusts Named Professional for the Safeguarding of Vulnerable Groups contributes to the SAR process by writing the Individual Management Review (IMR) and ensures that any organisational learning outcomes are implemented via the Safeguarding Work Plan.

5.5.5 Safeguarding Adults Risk Threshold Tool

5.5.5.1 The safeguarding threshold tool has been developed to assist practitioners in assessing the seriousness and level of risk associated with a safeguarding

concern. Staff may find it helpful to refer to this tool when responding to a concern of abuse or neglect. The aim is to ensure that everyone understands the threshold consideration.

Refer to Appendix K.

6. Glossary of terms

This policy uses the following terms:

Multi-Agency Public Protection Arrangements (MAPPA)	Public protection arrangements to manage the risks from potentially dangerous individuals. Regular meetings held between the local Police Force, National Probation Service, Prison services and other partners to manage violent and sexual offenders and protect the public.
Multi-Agency Risk Assessment Conference (MARAC)	Meeting where information is shared on the highest risk domestic abuse cases between representatives of the local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from statutory and voluntary sectors.
Domestic Homicide Review (DHR)	Multi-Agency meetings of which the aim is to understand where there are lesson to be learned and make recommendations to prevent future homicides.
Coroner	Coroners are independent judicial officers who are responsible for investigating violent, unnatural deaths, sudden deaths of unknown cause, deaths whilst a person is subject to a Deprivation of Liberty and deaths in custody.
Hate crime	Involves any criminal offence which is perceived, by the victim or any other person, to be motivated by hostility or prejudice based on a personal characteristic.
Whistle blowing	Whistle blowing policies and procedures are in place to enable staff to raise serious concerns that cannot or have not been addressed through normal line management routes.
PALs	Often diffuse potential complaints and are able to work with teams to identify concerns from the public/patient perspective
Safeguarding Team	Team of dedicated posts with safeguarding interest and expertise.
Joint Royal Colleges Ambulance Liaison Committee	Clinical Practice Guidelines – provides robust clinical specialty advice to ambulance services within the UK, these guidelines are reviewed and updated when necessary.
Radicalisation	A process by which susceptible and vulnerable individuals are influenced by others to become involved in terrorist activity.

7. Monitoring

7.1 Compliance and Effectiveness Monitoring Table

Monitoring Criterion	Response
Who will perform the monitoring?	Named Professional for the Safeguarding of Vulnerable Groups, Safeguarding Administration Team and Line Managers
What are you monitoring?	Adherence with the referral pathway and referral process within the Contact Centre and Operational staff (all sectors)

When will the monitoring be performed?	Monthly basis
How are you going to monitor?	Select an agreed number of referral reports from Ulysses Safeguarding Module
What will happen if any shortfalls are identified?	Remedial action will be taken immediately by reporting to service leads
Where will the results of the monitoring be reported?	Safeguarding Steering Group
How will the resulting action plan be progressed and monitored?	Reviewed at the Safeguarding Steering Group
How will learning take place?	On 1-1 basis when individual is identified, through the training unit at Essential Annual Training and via Personal Development Plan reviews with Line Managers

7.2 Key Performance Indicators (KPI)

1. Audit of Referral process – data quality and if referral was appropriate

2. Number of Adult Referrals – themes and trends

3. Number of staff who have received safeguarding adults training – induction and Essential Annual Training

8. References

This document refers to the following guidance, including national and international standards:

- Care Quality Commission (CQC) 2014 Consultation on our guidance on the Fundermental Standards and on CQC's enforcement powers. CQC, London.
- Quality Care Commission (CQC) 2014 New regulations for NHS bodies: the fit and proper persons requirement for Directors and the Duty of Candour. CQC, London.
- Department of Health (DH) 2014 Care Act. http://www.legislation.gov.uk/2014/23/pdfs/ukpfa2_20140023_en.pdf
- Department of Health (DH) 2014 Care and Support Statutory Guidance issued under the Care Act 2014: Section 14: Safeguarding. DH, London.
- Department of Health (2005) Mental Capacity Act 2005. http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_2005009_en.pdf
- Department of Health (DH) 2007 Mental Health Act 2007 http://www.legislation.gov.uk/ukpga/2007/12/pdfs/ukpga_20070012_en.pdf
- Department of Health (DH): Code of Practice Mental Health Act 1983.

- http://webarchive.nationalarchives.gov.uk.2013107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087073.pdf
- Department of Health (DH) 2010 Clinical Governance and Adult Safeguarding and Integrated Process. DH, London.
- Department of Health (DH) 2011 Safeguarding Adults: The role of Health service practitioners. DH, London.
- Department of Health (DH) 2015 Adult safeguarding: sharing information. Social Care Institute for Excellence (SCIE), London.
- Counter-Terrorism Strategy (CONTEST) 2011 (accessed 08/03/2015)

  www.gov.uk/government/publication/counter-terrorism-strategy-contest.

- Prevent 2012 (accessed 08/03/2015)

  www.gov.uk/government/policies/protecting-the-uk-against-terrorism/supporting-pages/prevent.

- Channel 2012 (accessed 08/03/2015)

  www.gov.uk/government/publications/channel-guidance

- Female Genital Mutilation (FGM) accessed 20/02/2015

http://www.nhs.uk/conditions/female-genital-mutilation/pages/introduction/aspx

- Local Government Association 2013 Making Safeguarding Personal Local Government House, London
- Ministry of Justice: Mental Capacity Act 2005 Deprivation of liberty safeguards: Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice. http://webarchive.nationalarchives.gov.uk.2013107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf
- National Institute for Health and Care Excellence (2014): Public Health Guideline 50 Domestic violence and abuse: multi-agency working. NICE, London.

  https://www.nice.org/guidance/ph50/resources/domestic-violence-and-abuse-multiagency-working-1996411687621

- North East Safeguarding Adults Network – Safeguarding Adults at Risk Threshold. Accessed 12/03/2015

  www.safeguardingadultsne.co.uk

- NHS Commissioning Board 2013 Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework. NHS Commissioning Board.
- Social Care Institute for Excellence (SCIE) 2011 SCIE report 46: Self-neglect and adult safeguarding: findings from research. Social Care Institute for Excellence (SCIE), London.
- Social Care Institute for Excellence (SCIE) 2011 SCIE report 50: safeguarding adults at risk of harm: a legal guide for practitioners. Social Care Institute for Excellence (SCIE), London.
- Social Care Institute for Excellence (SCIE) 2011 SCIE report 69: Self-neglect policy and practice:building an evidence base for adult social care. Social Care Institute for Excellence (SCIE), London.
- Social Care Institute for Excellence (SCIE) accessed 13th July 2015

http://www.scie.org.uk/publications/guides/guide53/frontline-housing/people-at-risk/

9. Associated Documentation

This document refers to the following Trust policies and procedures:

9.1 Policies

- POL-CCPS-SG-1 Management of Allegations against Staff Policy
- POL-CCPS-SG-3 Safeguarding Children Policy
- POL-WOD-HR-7 Disciplinary Policy
- POL-WOD-RE-2 Recruitment Policy
- POL-WOD-RE-4 Employment Risk Policy (Incorporating DBS Statements)
- POL-CCPS-CP-9 Capacity to Consent to Examination or Treatment
- POL-CCPS-CP-13 Clinical Supervision
- POL-CCPS-CP-6 Resusitation and Recognition of Life Extinct Policy
- POL-CCPS-SM-4 Security Management Policy
- POL-F-IMT-7 Information Security Policy
- POL-CCPS- Comp-2 Complaints Policy
- POL-CCPS-RM-4 Reporting and Investigation of Adverse Events Policy
- POL-CCPS-Comp-3 Being Open and Duty of Candour Policy
- POL-CCPS-RM-3 Reporting and Management of Serious Incidents (SIs) Policy
- POL-F-IMT-10 Records Management Policy
- POL-F-IMT-8 Information Sharing Policy
- EXT-CE-DOC-1 Freedom to speak up: raising concerns (whistle blowing) Policy

9.2 Procedures

- Safeguarding Referral / Alert Procedure – all staff (refer to Adults at Risk Policy)
- FM-CCPS-CP-3 Recognition of Life Extinct Form (ROLE)
- SOP-O-AE-7 Flagging down of Operational Vechicles
- FM-CCPS-CP-1: Assessment of Capacity Form
- SOP-CCPS-IPC-4 Care of the Deceased Patient

APPENDICES

Appendix A Equality Screening

v1.2-01.12.14

Equality Analysis must be conducted to determine if there is a potential differential impact for any groups protected under the Equality Act 2006 and related legislation.

Date of screening	5th January 2016
Name of assessor	Christine McManus
Job title	Named Professional for the Safeguarding of Vulnerable Groups
What are you assessing? ***(name of policy, service, decision)***	Safeguarding Adults Policy

1. What is the main aim or purpose of the document or service?	
There is a statutory responsibility for NHS Organisations to have a policy that acts to prevent and reduce the risk of significant harm to service users from abuse and other types of exploitation. The NHS is accountable to patients for their safety and wellbeing through delivering high quality care. The policy details the Trust's commitment to ensure that the welfare of vulnerable people is promoted, maintaining their safety and protection by effective intervention if they are thought to be suffering, or likely to suffer, significant harm. It provides the Trust with guidance on recognising cases of suspected abuse and neglect, a procedure for referring these cases onto appropriate external agencies and the facilitation for information sharing and collaborative working.	
Who is or would be affected by the way the policy or service is or will be carried out? *Employees/service users/wider community*	Patients and members of the public

stakeholders- what is the demographic profile?	
What are the intended outcomes of the document/service? *What is it trying to achieve?*	It provides the Trust with guidance on recognising cases of suspected abuse and neglect, a procedure for referring these cases onto appropriate external agencies and the facilitation for information sharing and collaborative working.
How will you measure the outcomes? *So it does no adversely impact on any group of people?*	Data quality audit of referrals to ensure staff are following the guidance and procedures for the safeguarding of vulnerable adults.

2. Gathering information	
Please provide details of the information you have used to assess the impact *For example details/evidence of internal performance/monitoring reports, external evidence, research and guidance.*	• Polices shared by the National Ambulance Safeguarding Network / Group for bench marking purposes. • Internal policies and procedures • Research via Department of Health website, Social Care Institute for Excellence (SCIE) • The Care Act – Section 14 Guidance document • Regional Local Authority Safeguarding Networks • Regional NHS / CCG Safeguarding Networks
Are there any gaps in your information and if so how are you going to address these? *Do you have enough information to make an informed decision about each group protected by law?*	No gaps identified

3. Assessing Impact				
Equality Group	Is there potential for an adverse or positive impact?	If yes/possibly, please describe the potential impact	Is this impact legal and justifiable? If yes, please explain how	What action (if any) can be taken to address the impact

	Yes, No, Possibly			
Age	Yes	Disability through age related conditions – frailty and health conditions that disproportionately affect older people e.g. dementia Social conditions and discrimatory attitudes. Social circumstances such as isolation.	These conditions could increase a person's dependency and susceptibility to harm or abuse. These individuals could be at risk of harm and abuse and exploitation. Assumptions may be made about a person's mental capacity based upon their age.	Safeguarding Adults Policy and Procedures Management of Allegations against Staff Policy Capacity to Consent to Examination and Treatment Policy.
Disability	Yes	Disabled people may be in vulnerable situations and less able to protect themselves from harm. Their needs may relate to Physical disability, Learning disability, disability arising from illness, mental health needs, Impaired mental capacity.	As above	As above
Gender	Yes	Potential for malicious grievance against an individual because of their difference – race, gender, sexual orientation etc.	Promoting such a policy increases awareness and potential complaints. Information must be given to staff and the policy implemented	
Gender reassignment	As above	Trans people with disabilities such as a learning disability or mental health needs are likely to further discriminated	Discrimation due to assumptions related to the labels attached to them.	As above
Marriage and civil partnership	Yes	Forced marriage is where one or both parties do not consent to the marriage, or that consent is	This could be confused with an arranged marriage, where the couple's families take a leading role	Professionals could find this a particularly grey area when it comes to vulnerable adults who have impaired capacity, and

		extracted under duress which can be physical, emotional or financial.	in choosing the marriage partner, but the marriage is entered freely by both parties.	might not fully understand what marriage is or what it entails.
Maternity and pregnancy	No			
Race	Yes	Refer to Gender section		
Religion or belief	Yes	Refer to Gender section		
Sexual orientation	Yes	Refer to Gender section		

4. Considering alternatives	
Can changes be made to the document/service to reduce the impact? *(such as amending the wording of a policy or changing a procedure)* *If Yes, please detail the changes*	No

5. Legislative compliance	
Does the document/service prevent the promotion of equality of opportunity or foster good relations between different equality groups? *Please state how.*	No
Does the document/service provision infringe an individual's human rights?	No

6. Involvement consultation, feedback and partnership working	
Have you engaged/consulted on the policy/service with any patient,	Yes

community, service user, third sector, staff or any other groups representing staff or patients? *Yes / No. If yes, please provide details*	Safeguarding Steering Group Patient Safety Group Claire Nixon – Newcastle Safeguarding Adults Board – comments Mary Burns – Designated Nurse for Safeguarding Adults – Newcastle and Gateshead CCG
Have you involved, consulted or worked in partnership any specialist services, groups or practitioners? *Yes / No. If yes, please state which services, groups or practitioners.*	No

7. Monitoring - Do you break down service/policy data by each protected characteristic?									
Response = Yes / No / Partly	Age	Disability	Gender	Gender reassignment	Marriage and civil partnership	Maternity and pregnancy	Race	Religion or belief	Sexual orientation
Service Take Up – ULYSSES SG Module	Yes	Yes	Yes	No	No	No	Yes	Yes	No
Performance Targets	No	No	No	No	No	No	No	No	No
Patient Satisfaction	No	No	No	No	No	No	No	No	No
Staff Satisfaction	No	No	No	No	No	No	No	No	No

8. Action plan														
Action		Benefits / Rationale	Measures of Success	Lead Officer	Time scale	Age	Disability	Gender	Gender reassignment	Marriage and civil partnership	Maternity and pregnancy	Race	Religion or belief	Sexual orientation
1.	Compliance with this Policy and Procedure	Ensure all aspects of the process are undertaken		SG Lead involved in individual case	Throughout the investigation process	✓	✓	✓				✓	✓	
2.														
3.														
4.														

9. Sign Off			
Assessors Signature		**Date:**	05/01/2016
Director / Head of Service Signature		**Date:**	05/01/2016

Appendix B Review Process Checklist – Author to complete

Compliance Checks	Author to Complete			
	Yes/ No	Details	Comments	Action Needed
Has the document been consulted upon? (please detail stakeholders that have been consulted)	YES	Safeguarding Steering Group Patient Safety Group	Discussion and comments received and actioned	
Has the document been agreed by a sub group of the relevant Approval Committee? (if so, please specify the subgroup(s) here and confirm the date the document was endorsed by the group.	YES	Safeguarding Steering Group Patient Safety Group		
Approval: JCC (if appropriate)?	NO			
Why has this document been amended? i.e. full review, particular section/new etc.		Associated Document section updated with Policy reference codes		
Has table of revisions been completed?	YES			
Has the document author clearly identified?	YES			
Has the document sponsor been identified and consulted with	YES			
Has the date of the Ratifying Committee meeting to which the document will been submitted been specified?	YES			
Has the Ratifying Committee been correctly identified?	YES			
Has the Originating Directorate been notified?	YES			
Has the scope of the document been identified?	YES			
Content: intended outcomes clearly described?	YES			
Has the date the Document will next be reviewed been noted? (If less than the standard 3 years, please provide an explanation why)	YES			
Has the monitoring table been correctly completed?	YES			
Has the Equality Impact Screening been completed?	YES			
If warranted from the above has the Equality Impact Assessment been completed?	YES			
Has the financial implications been considered?	YES			
Has the Document been assessed as to whether its circulation should be restricted/unrestricted? If so, the outcome of this assessment should be noted on the front sheet	YES			
Does the policy need to be available to the public? If so once ratified Communication team need a copy	YES			
Name a member from the subgroup to be present to respond to any questions if author unavailable		Maureen Gordon		

Date of Policy Review Group Submitted to	
Authors Name	Christine McManus
Authors Signature	

Appendix C Compliance Checklist – Policy Review Group

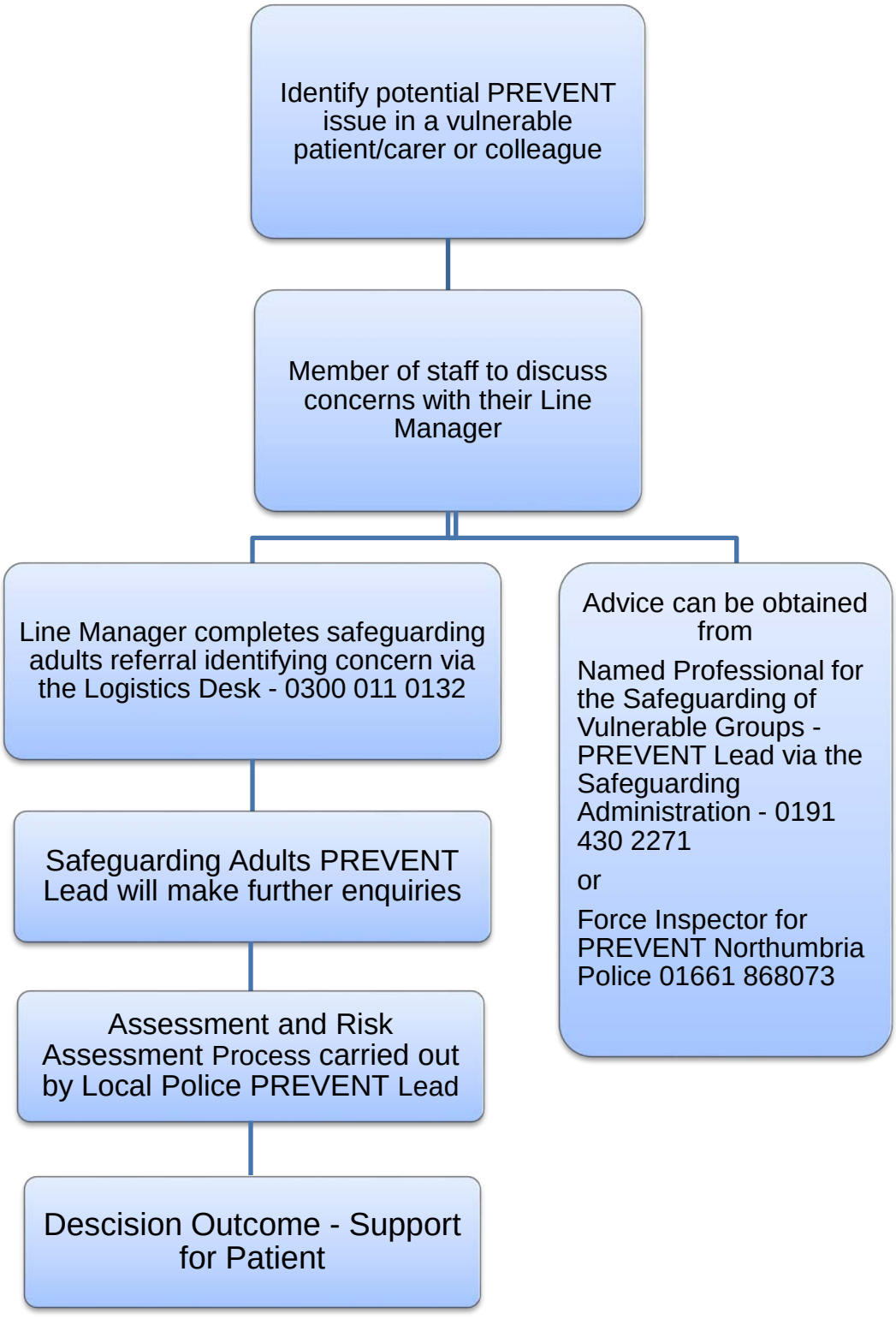
Approving Sub Committee:	Policy Review Group to Complete		
Compliance Checks	Yes/No	Comments	Actions Needed
Has the front page document been completed fully?	Yes		
Has the author completed checklist? And has this been checked by the group?	Yes		
Style and Format			
Has the correct template been used?	Yes		
Procedural Documents must use the Arial font style bold text size 12	Yes		
Section and paragraph heading should be numbered and in bold.	Yes		
Is it the EIS and EIA if applicable the latest version?	Yes		
Is the title of the Document clear and unambiguous?	Yes		
Has the new version number been amended on the Control Sheet, and Footer of each section?	Yes		
Has the version control/revision table been updated?	Yes		
Has the Document type been identified? (Policy/Procedure?)	Yes		
Explanation of Terms Used			
Acronyms are first used with explanation.	Yes		
Glossary of Terms used if helpful to the procedural documents understanding.	Yes		
Consultation & Review Arrangements			
Is it clearly apparent that the document has been consulted upon?	Yes		
Has the monitoring table been completed?	Yes		
If the monitoring of this document involves members of other teams or Health Groups, have they been informed?	Yes		
Has the name/job title of the Non-Executive Chairman of the Approval Committee been correctly identified?	Yes		
Associated documents and supporting references			
Are there full references to other Trust Policies that the Policy refers to or is associated with.	Yes		
Following satisfactory review by Policy Review Group			
Has the ratification Committee been identified and is this the right committee?	Yes		
Is there timescales identified for monitoring and reporting to appropriate committee?	Yes		

Policy Review Group Outcome	Reviewed successful

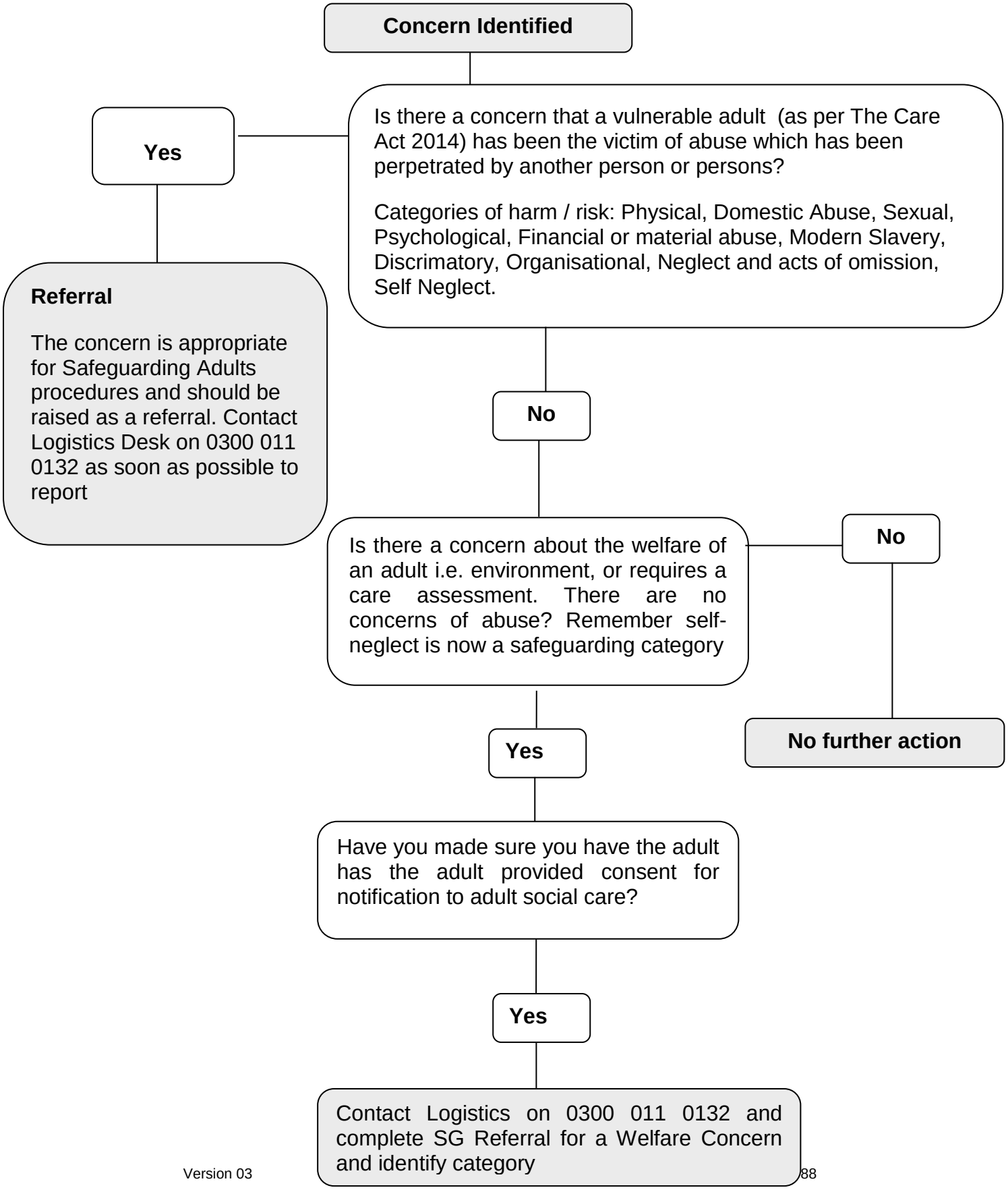
Appendix D Quality Team Checklist

Quality Team Checklist	Yes/No	Comments
Document Control Sheet complete with signatures?		
Table of revisions complete?		
All footers and watermark updated?		
Page numbers updated?		
Review process checklist and compliance checklist complete?		
Previous version of policy archived?		
QPulse upload date complete?		
Policy available to relevant staff groups?		
Process completed: Quality Team	Date	Signature

Appendix E PREVENT Escalation Concerns Flowchart



Appendix F Safeguarding Adults Referral Pathway



Appendix G Safeguarding Adults Referral Process (Operational Staff ECS/PTS)

POSSSG Notification is received via Terrafix to alert you of a possible Safeguarding situation.

Following assessment, if the Patient is to **REMAIN AT HOME**

Complete an ePRF

If concerns ARE CONFIRMED, contact Logistics Desk to document your concerns, using the vehicle mobile phone **BEFORE** leaving scene.

If concerns ARE NOT CONFIRMED, contact Control and advise why you have no concerns.

Following assessment, if the Patient is to be **TRANSPORTED TO HOSPITAL**

Complete an ePRF

If concerns ARE CONFIRMED, advise the receiving hospital that you are making a referral.

BEFORE pressing clear, contact Logistics Desk to document your concerns, using the vehicle mobile phone.

If concerns ARE NOT CONFIRMED, contact Control and advise why you have no concerns.

Logistics Desk 0300 011 0132

The Logistics Officer will complete an electronic referral. You will be asked for the minimum amount of information to process the concern and details of your concern will be typed word for word, and read back to you to confirm.

The Logistics Officer will send your concern via an agreed secure email address to Social Care and a copy will also be sent to the Safeguarding Team.

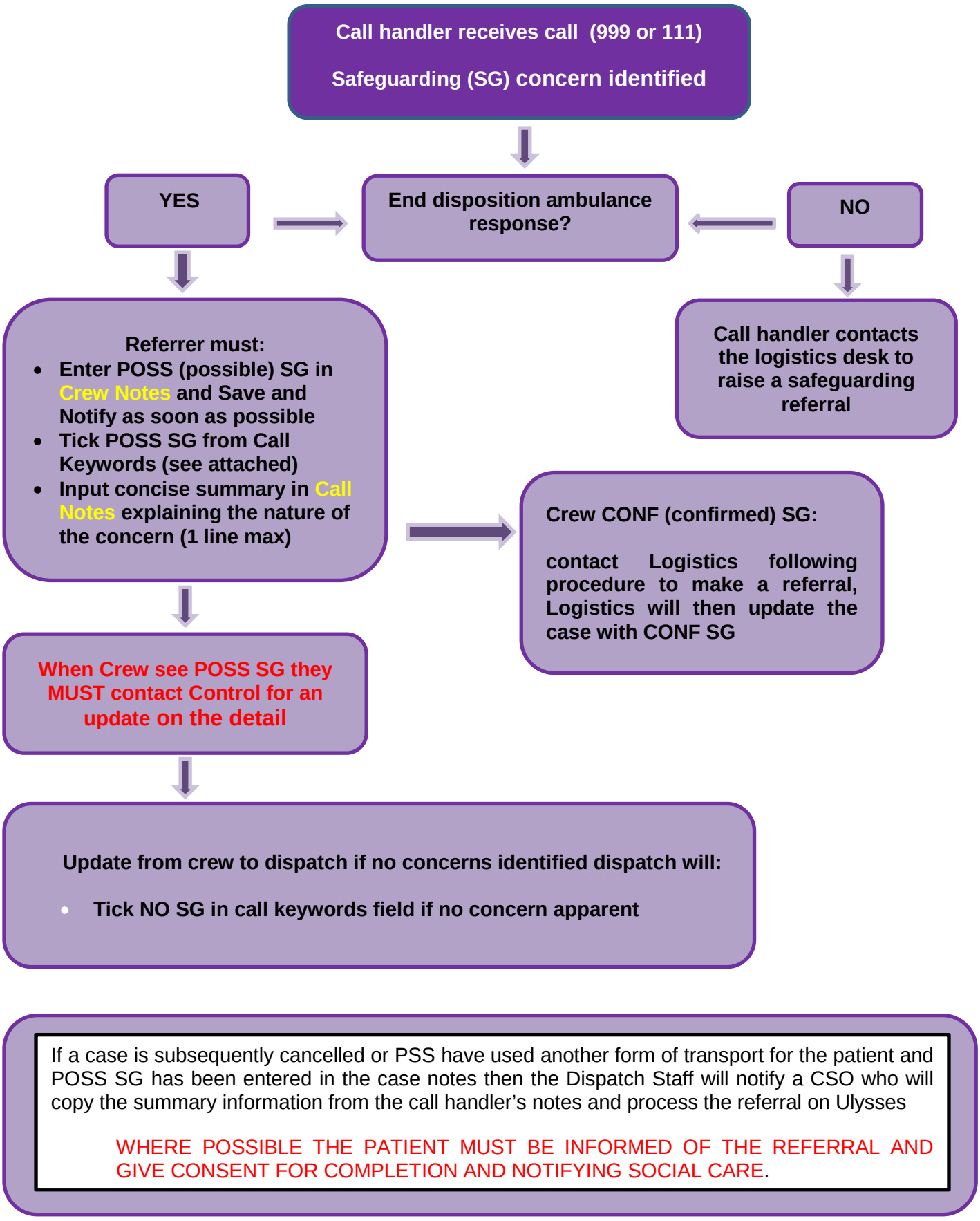
Due to the amount of referrals the Safeguarding Team receive, unfortunately we are not able to acknowledge each referral. We will however, notify you of any responses we receive from Social Care.

The Safeguarding Team can be contacted on the following numbers:

Safeguarding Admin – 0191 430 2271

Safeguarding Officer - 0191 4302245

Appendix H Safeguarding Referral Process for Call Takers (999/111)



If a case is subsequently cancelled or PSS have used another form of transport for the patient and POSS SG has been entered in the case notes then the Dispatch Staff will notify a CSO who will copy the summary information from the call handler's notes and process the referral on Ulysses

WHERE POSSIBLE THE PATIENT MUST BE INFORMED OF THE REFERRAL AND GIVE CONSENT FOR COMPLETION AND NOTIFYING SOCIAL CARE.

Appendix I Guidance for Logistics Desk regarding Child & Adult Protection & Safeguarding Concerns

All concerns should be referred to Social Care at the time of receipt.

1. On receiving details about a potential case of abuse or concern from any source within NEAS and NDUC, the Logistics Officer should contact the relevant Social Care or Emergency Duty Team (Out of Hours) by telephone to start the referral process. **Details of the referrers concern need be taken word for word and read back to them to confirm. The referral may be required as evidence and the referrer is putting their name to the document. It is therefore essential that the Logistics Officer does not add/amend or translate to how they think the concern should read.**

2. During weekends, Bank Holidays and evenings the Logistics Officer should briefly advise the Social Worker of the concerns which have been raised by the staff so that a decision can be made whether the referral can wait until the next working day or requires immediate action by the Emergency Duty Team. Logistics Officers need to be aware that **it is only a Social worker who can advise that the form can go to the EDT secure account, not a Social Services call handler** and the reason being that the inbox is not manned. **A note of the contact name and number needs to be recorded on the referral. The Logistics Officer should also complete this information on the Logistics Desk data spread sheet (found in the Information Highway).**

3. The Logistic Officer will send an email to the Safeguarding mailbox alerting them to the referral and the actions taken. As part of the policy and procedure the Trust has identified all Social Care Departments within our boundaries, established contact, gained contact numbers and secure email addresses for the referral of a vulnerable person. This list will be maintained and updated by The Safeguarding Team, when advised of any amendments. **There is now no requirement for the Logistic Officer to confirm fax numbers prior to the referral.**

4. The Social Care staff may ask for details of the incident and what the **Ambulance Crew** consider to be the level of risk, and not the Logistics Officer. This will include whether the child is at risk of 'significant harm'.

5. Police assistance, the Police have a number of legal powers to protect Children. These include the power to gain entry into a building in some circumstances, and the power to remove a Child into Police protection for up to 72 hours. Any Police Constable may affect this if he/she considers that a Child is at risk of 'significant harm'. The Child should have a clinical assessment before being taken into police protection.

6. In urgent circumstances where an Ambulance Crew thinks that a Child/Adult is at immediate risk of significant harm, they should inform Ambulance Control, who will request police attendance.

7. There may be circumstances where there are concerns for an unborn Child, e.g. when a pregnant woman has been physically assaulted. In a situation of this type, **advice should be sought initially from Social Services, which may include reporting the incident to the Police. Details of any advice given and who gave the advice always needs to be included in the referral.**

In **ALL** events the referral form should be kept up to date with any other conversations or request from police or social care.

8. Examples of immediate referrals

- Deceased patients as they may have suffered abuse or neglect which has contributed to their death, including all suicides.
- Domestic Violence – also consider police if not on scene.

9. Examples of referrals which can wait till next working day (low risk)

- Patients taken to hospital (after section 2 does this mean MHA Section 2? is completed)
- All other patients after discussion with Social Services.

Appendix J Safeguarding Referral Process for NDUC / Third Party Providers

NDUC / Third Party Providers / Volunteers

Staff are alerted to a concern or safeguarding incident and the patient is to remain at home:

- Complete the ePRF and document your concerns in the free text;
- Contact the Logistic Desk on **0300 011 0132** using the vehicle mobile phone before leaving scene
- **Remember:** if there are immediate concerns for safety then the Police **must** be called.

NDUC / Third Party Providers / Volunteers

Staff are alerted to a concern or safeguarding incident and the patient is to be transported to hospital:

- Complete the ePRF and document your concerns in the free text;
- Inform the receiving hospital of your concerns and advise them that you are going to make a Safeguarding referral;
- Before pressing clear Contact the Logistic Desk on **0300 011 0132** using the vehicle mobile phone before leaving scene.
- **Remember:** if there are immediate concerns for safety then the Police **must** be called

Logistics Officer

- Will take and record details onto the electronic Ulysses Safeguarding referral form. They will ask you for the minimum required data to proceed with the alert.
- All information must be recorded accurately and ensure all the relevant information given by the alerter is entered.
- The details of the referral must be read back to ensure the context of the referral is correct.

Then

- The Logistics Officer will send the referral via secure email address to the relevant Adult's Social Care department and copy to the safeguarding secure email (neas.safeguarding@nhs.net).
- If no agreed secure email the form will be faxed to an agreed fax number after the Logistic Officer has contacted appropriate Social Care department to confirm fax number and referral.

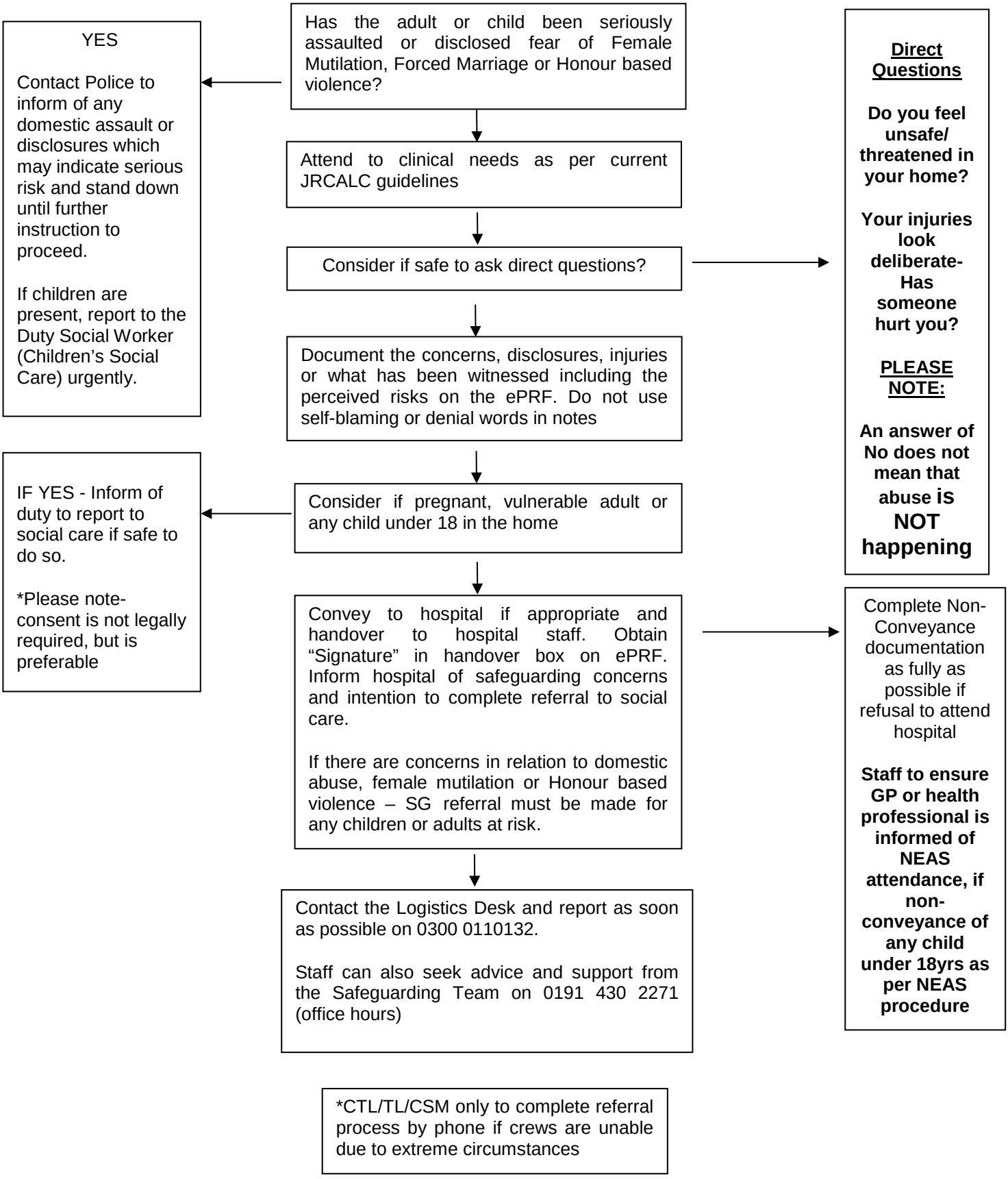
Safeguarding Team

Following the referral process the Safeguarding Team will where requested provide Social Care with any historic data regarding the patient / family you have raised concerns for.

Whenever possible the Safeguarding Team will update the alerter via email of any progress / feedback regarding the referral submitted.

It may be necessary for the Safeguarding Team to contact the alerter for further information or statement if this is required for the safeguarding report.

Appendix K: Domestic Abuse – reporting flow chart



Appendix L: Safeguarding Adults at Risk Threshold Tool (acknowledgement to Newcastle Safeguarding Adults Board)

Factors				Guidance and considerations	
1. Vulnerability of the adult at risk	**Less vulnerable**  **More vulnerable**			• Does the adult have needs for care and support? • Can the adult protect themselves? • Does the adult have the communication skills to raise an alert?	• Does the person lack mental capacity? • Is the person dependent on the alleged perpetrator? • Has the alleged victim been threatened or coerced into making decisions?
The abusive act	**Less serious**  **More Serious**			Questions 2-9 relate to the abusive act and/or the alleged perpetrator. Less serious concerns are likely to be dealt with at initial enquiry stage only, whilst the more serious concerns will progress to further stages in the safeguarding adults process.	
2. Seriousness of Abuse	Low	Significant	Critical	**Refer to the table overleaf.** Look at the relevant categories of abuse and use your knowledge of the case and your professional judgement to gauge the seriousness of concern.	
3. Patterns of abuse	Isolated incident	Recent abuse in an ongoing relationship	Repeated abuse	• Most local areas have an escalation policy in place e.g. where safeguarding adults procedures will continue if there have been a repeated number of concerns in a specific time period. Please refer to local guidance.	
4. Impact of abuse on victims	No impact	Some impact but not long-lasting	Serious long-lasting impact	• Impact of abuse does not necessarily correspond to the extent of the abuse – different people will be affected in different ways. Views of the adult at risk will be important in determining the impact of the abuse.	
5. Impact on others	No one else affected	Others indirectly affected	Others directly affected	Other people may be affected by the abuse of another adult. • Are relatives or other residents/service users are distressed or affected by the abuse? • Are other people intimidated and/or their environment affected?	
6. Intent of alleged perpetrator	Unintended/ ill-informed	Opportunistic	Deliberate / Targeted	• Is the act/omission a violent/serious unprofessional response to difficulties in caring? • Is the act/omission planned and deliberately malicious? Is the act a breach of a professional code of conduct? ***The act/omission doesn't have to be intentional to meet safeguarding criteria**	
7. Illegality of	Bad practice - not	Criminal act	Serious	Seek advice from the Police if you are unsure if a crime has been committed.	

actions	illegal		criminal act	• Is the act/omission poor or bad practice (but not illegal) or is it clearly a crime?
8. Risk of repeated abuse on victim	Unlikely to recur	Possible to recur	Likely to recur	• Is the abuse less likely to recur with significant changes e.g. training, supervision, respite, support or very likely even if changes are made and/or more support provided?
9. Risk of repeated abuse on others	Others not at risk	Possibly at risk	Others at serious risk	Are others (adults and/or children) at risk of being abused: • Very unlikely? • Less likely if significant changes are made? • This perpetrator/setting represents a threat to other vulnerable adults or children.

Types of abuse and seriousness	**Concerns may be notified to the Local Authority but these are likely to be managed at Initial Enquiry stage only. Professional judgement or concerns of repeated low level harm will progress to further stages in the safeguarding adults process.**		**Concerns of a significant or critical nature should be referred to the local authority (with consent of the alleged victim where this is relevant and appropriate to do so). They will receive additional scrutiny, and progress further, under safeguarding adults procedures. Where a criminal offence is alleged to have been committed, the Police will be contacted. Other emergency services should be contacted as required.**		
	Low		**Significant or critical**		
Physical	• Staff error causing no/little harm e.g. friction mark on skin due to ill-fitting hoist sling. • Minor events that still meet criteria for 'incident reporting' accidents. **Medication** • Adult does not receive prescribed medication (missed/wrong dose) on one occasion – no harm occurs.	• Isolated incident involving service on service user. • Inexplicable marking found on one occasion. • Minor event where users lack capacity. **Medication** • Recurring missed medication or administration errors that cause no harm.	• Inexplicable marking or lesions, cuts or grip marks on a number of occasions. • Accumulations of minor incidents. • Recurring missed medication or errors that affect more than one adult and/or result in harm. • Deliberate maladministration of medications.	• Covert administration without proper medical authorisation. • Inappropriate restraint. • Withholding of food, drinks or aids to independence. • Inexplicable fractures/injuries. • Assault.	• Grievous bodily harm/assault with a weapon leading to irreversible damage or death. • Pattern of recurring errors or an incident of deliberate maladministration that results in ill-health or death.
Sexual	• Isolated incident of	• Minimal verbal	• Recurring sexualised	• Attempted penetration by any	• Sex in a

(including sexual exploitation)	teasing or low-level unwanted sexualised attention (verbal or touching) directed at one adult by another whether or not capacity exists.	sexualised teasing or banter.	touching or isolated or recurring masturbation without consent. • Voyeurism without consent • Being subject to indecent exposure. • Grooming including via the internet and social media.	means (whether or not it occurs within a relationship) without consent. • Being made to look at pornographic material against will/where consent cannot be given.	relationship characterised by authority inequality or exploitation e.g. receiving something in return for carrying out a sexual act. • Sex without consent (rape).
Psychological/ Emotional	• Isolated incident where adult is spoken to in a rude or inappropriate way – respect is undermined but no/little distress caused.	• Occasional taunts or verbal outburst. • Withholding of information to disempower.	• Treatment that undermines dignity and esteem. • Denying or failing to recognise adult's choice or opinion.	• Humiliation. • Emotional blackmail e.g. threats or abandonment/harm. • Frequent and frightening verbal outbursts or harassment.	• Denial of basic human rights/civil liberties, over-riding advance directive. • Prolonged intimidation. • Vicious/personalised verbal attacks.
	Low		**Significant or critical**		
Financial	• Staff personally benefit from users funds e.g. accrue 'reward' points on their own store loyalty cards when shopping. • Money not recorded safely and properly.	• Adult not routinely involved in decisions about how their money is spent or kept safe – capacity in this respect is not properly considered. • Non-payment of care fees not impacting on care.	• Adult's monies kept in a joint bank account – unclear arrangements for equitable sharing of interest. • Adult denied access to his/her own funds or possessions.	• Misuse/misappropriation of property or possessions of benefits by a person in a position of trust or control. • Personal finance removed from adult's control. • Ongoing non-payment of care fees putting a person's care at risk.	• Fraud/exploitation relating to benefits, income, property or will. • Theft.
Neglect	• Isolated missed home care visit where no harm occurs.	• Inadequacies in care provision that lead to discomfort or	• Recurrent missed home care visits where risk of harm escalates, or one	• Ongoing lack of care to the extent that health and wellbeing deteriorate	• Failure to arrange access to lifesaving services or medical

	• Adult is not assisted with a meal/drink on one occasion and no harm occurs. • Adult not bathed as often as would like – possible complaint.	inconvenience- no harm occurs e.g. being left wet occasionally. • Not having access to aids to independence.	miss where harm occurs. • Hospital discharge without adequate planning and harm occurs.	significantly e.g. pressure wounds, dehydration, malnutrition, loss of independence/confidence.	care. • Failure to intervene in dangerous situations where the adult lacks the capacity to assess risk.
Self-Neglect	• Incontinence leading to health concerns	• Isolated/ occasional reports about unkempt personal appearance or property which is out of character or unusual for the person.	• Multiple reports of concerns from multiple agencies • Behaviour which poses a fire risk to self and others • Poor management of finances leading to risks to health, wellbeing or property	• Ongoing lack of care or behaviour to the extent that health and wellbeing deteriorate significantly e.g. pressure sores, wounds, dehydration, malnutrition	• Failure to seek lifesaving services or medical care where required. • Life in danger if intervention is not made in order to protect the individual.
Organisational (any one or combination of the other forms of abuse)	• Lack of stimulation/ opportunities for people to engage in social and leisure activities • Service users not given sufficient voice or involve in the running of the service	• Denial of individuality and opportunities for service user to make informed choice and take responsible risks • Care-planning documentation not person-centred	• Rigid/inflexible routines • Service user's dignity is undermined e.g. lack of privacy during support with intimate care needs, sharing under-clothing	• Bad/poor practice not being reported and going unchecked • Unsafe and unhygienic living environments	• Staff misusing their position of power over service users • Over-medication and/or inappropriate restraint used to manage behaviour • Widespread consistent ill-treatment
	Low		**Significant or critical**		
Discriminatory	• Isolated incident of teasing motivated by prejudicial attitudes towards an adult's individual differences	• Isolated incident of care planning that fails to address an adult's specific diversity associated needs for a short period	• Inequitable access to service provision as a result of a diversity issue. • Recurring failure to meet specific care/support needs associated with diversity.	• Being refused access to essential services. • Denial of civil liberties e.g. voting, making a complaint. • Humiliation or threats on a regular basis, recurring taunts.	• Hate crime resulting in injury/emergency medical treatment/fear for life. • Hate crime

	• Occasional taunts			resulting in serious injury or attempted murder/honour-based violence.
Modern Slavery	All concerns about modern slavery are deemed to be of a significant/critical level.	• Limited freedom of movement. • Being forced to work for little or no payment. • Limited or no access to medical and dental care. • No access to appropriate benefits.	• Limited access to food or shelter. • Be regularly moved (trafficked) to avoid detection. • Removal of passport or ID documents.	• Sexual exploitation. • Starvation. • Organ harvesting. • No control over movement / imprisonment. • Forced marriage.
Domestic Abuse (consult Domestic Violence and Abuse Flowchart)	• Isolated incident of abusive nature • Occasional taunts or verbal outbursts	• Inexplicable marking or lesions, cuts or grip marks on a number of occasions • Alleged perpetrator exhibits controlling behaviour • Limited access to medical and dental care	• Accumulations of minor incidents • Frequent verbal/physical outbursts • No access/control over finances • Stalking • Relationship characterised by imbalance of power	• Threats to kill, attempts to strangle choke or suffocate • Sex without consent (rape). • Forced marriage. • Female Genital Mutilation (FGM). • Honour based violence.
	The CAADA DASH Risk Assessment Checklist should be used to determine the level of risk in domestic abuse cases and a referral made into MARAC where appropriate			

Fur

Guidance on using the safeguarding adults risk threshold tool

Purpose

The safeguarding adults risk threshold tool has been developed to assist practitioners in assessing the seriousness and level of risk associated with a safeguarding adults concern. It is primarily for use by Safeguarding Adults Managers, in the Local Authority, to assist with their decision-making at the point of receiving a safeguarding adults concern; however others may find it helpful to refer to this tool when responding to a concern of abuse or neglect. The aim is to ensure that everyone understands the threshold consideration. The tool is not intended to replace professional judgement.

A clear threshold and process, together with a common understanding across local partnerships and agencies will improve consistency. A number of reasons are provided to support the need for a threshold tool. These include:

- A benchmark to assess the level of vulnerability of an individual;
- A measure of consistency;
- Managing the demand of low, significant, and critical level concerns.

Consistency

There is a need for a consistent approach to safeguarding adults. Appropriate thresholds are seen as a good way to achieve this. The safeguarding adults risk threshold is clearly explained in the multi-agency procedures and in learning and development opportunities. Practitioners are encouraged to use their professional judgement and to consider each case on an individual basis. Additional processes may need to be considered for some sections of the community who are harder to reach.

The Care Act Third time this is referenced?

The Care Act statutory guidance states that:

“Local Authorities must make enquiries, or cause others to do so, if they reasonably suspect an adult”:

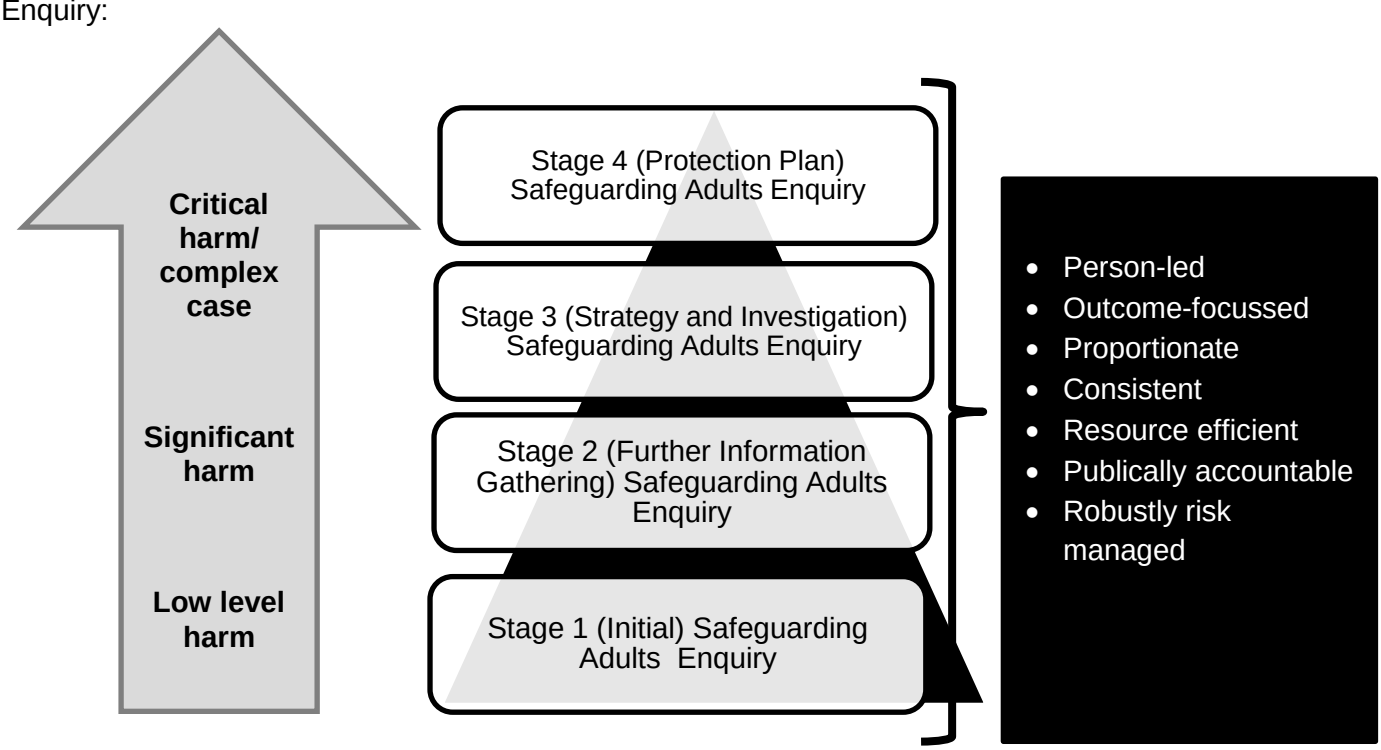
- Has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- Is experiencing, or at risk of, abuse and neglect; and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.”

There is no longer a “significant harm” threshold for action under safeguarding adults procedures. However, any actions taken must be proportionate to the level of presenting risk or harm and be driven by the desired outcomes of the adult or their representative. Referring agencies need to use their professional judgement, consider the views of the adult at risk and where appropriate, seek consent for sharing information on a multi-agency basis.

If a decision is made **not** to refer to the Local Authority, the individual agency must make a record of the concern and any action taken. Concerns should be recorded in such a way that repeated, low level harm incidents are easily identified and subsequently referred. Not referring under safeguarding adults procedures, does not negate the need to report internally or to regulators/commissioners as appropriate.

Where a concern is referred on a multi-agency basis, a Local Authority Safeguarding Adults Manager will then use the risk threshold tool to determine whether safeguarding adults procedures will continue beyond the Initial Enquiry stage.

The following diagram highlights the different stages of a Safeguarding Adults (Section 42) Enquiry:



Managing the different levels of harm

In order to manage the large volume of concerns which come under safeguarding adults policy and procedures, there is a need to differentiate between those concerns relating to low level harm/risk and those that are more serious. Whilst it is likely that concerns relating to low level harm/risk will not progress beyond an Initial Enquiry Stage, the concern will be recorded by the Local Authority and proportionate action taken to manage the risks that have been identified. This may include: provision of information or advice; referral to another agency or professional; assessment of care and support needs. The sharing of low level concerns helps the Local Authority to understand any emerging patterns or trends that may need to be taken into consideration when deciding whether safeguarding adults procedures need to continue.

Using the safeguarding adults risk threshold tool

The safeguarding adults risk threshold tool has been designed to consider both the vulnerability of the adult at risk, the seriousness of the abuse that is occurring, the impact of the abuse and the risk of it recurring.

Regular, low level concerns can amount to a far higher level of concern which then requires more in-depth investigation or assessment under safeguarding adults procedures. Each local area has an escalation policy in place to aid professional judgement in these circumstances. This means that a specified number of safeguarding adults concerns reported to the Local Authority in a specified timeframe will result in further action under safeguarding adults procedures. Please refer to each area's policy and procedure.

The tool is not designed in way in which further actions are determined by achieving a score or a specified number of ticks. It is there to provide guidance and key considerations for practitioners who are assessing and managing risk.