Bath and North East Somerset Clinical Commissioning Group

Safeguarding Adults in BaNES

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Healthier. Stronger. Together.

Aims and objectives

By the end of this session you should be able to:

- Recognise an adult who may be at risk of abuse or neglect
- Recognise types and indicators of abuse
- Recognise factors which may increase the risk of abuse
- Know how to report concerns about abuse & support a safeguarding investigation
- Understand how to support the prevention of adult neglect and abuse
- Have an overview of FGM/Modern Slavery/PREVENT

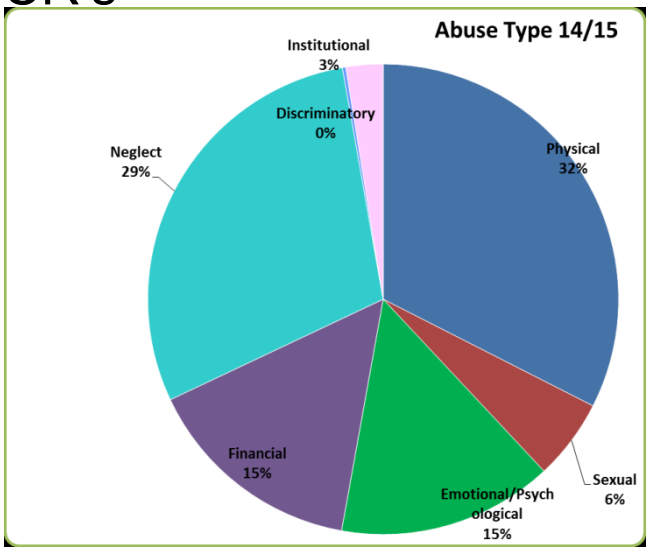
Care Act 2014

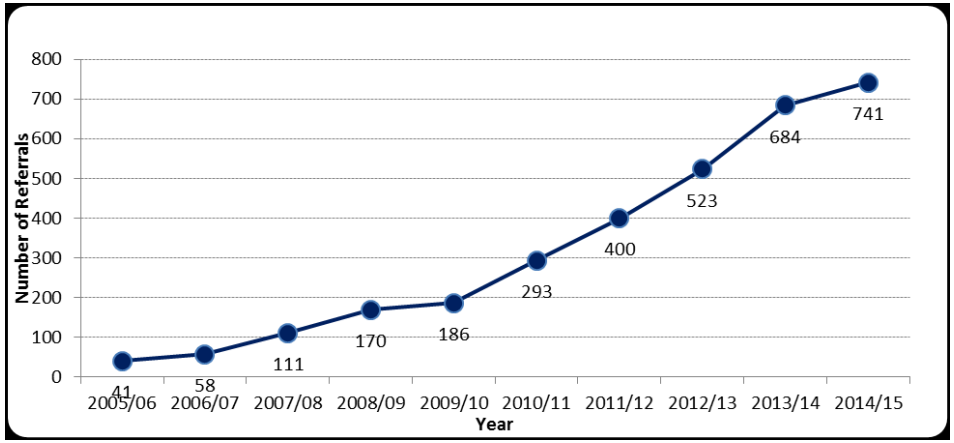
Six key principles underpin adult safeguarding:

1. *Empowerment:* Personalisation & presumption of person-led decisions & informed consent. Acknowledges that adults have the right to make unwise choices
2. *Prevention:* Taking action before harm occurs
3. *Proportionality:* Proportionate & least intrusive response appropriate to the risk
4. *Protection:* Support & representation for those in greatest need
5. *Partnership:* multi-agency working with police, CQC, probation, health & local communities.
6. *Accountability:* Accountability & transparency in delivering safeguarding

Adult Safeguarding in B&NES

- Applies to anyone 18 or over & at risk of abuse or neglect because of their needs for care & support
- Local Authority (LA) is the lead agency for safeguarding. In B&NES, Virgin & AWP act on behalf of the LA
- Local Safeguarding Adults Board (LSAB) oversees the planning, implementation & monitoring of Adult Safeguarding in B&NES. Includes representation from all appropriate statutory agencies & manages the SCR's

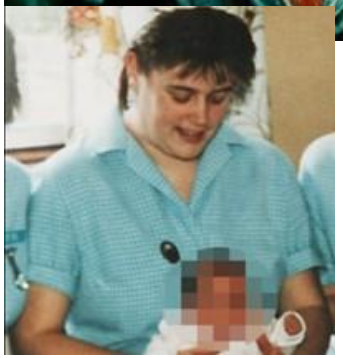




Where does abuse occur & by whom?

Abuse can occur anywhere

And it can be perpetrated by anyone



Risk Factors & Indicators of Abuse

Factors associated with increased risk of abuse

- Mental ill health
- Domestic violence
- Substance misuse
- History of abuse as a child
- Socio-economic problems
- Learning disability
- Dementia

Potential indicators of abuse include:

- Direct or indirect disclosure
- Changes in behaviour
- Withdrawal
- Fear of going home or any other location
- Unexplained injuries
- Money or possessions going missing
- Inappropriate behaviour of staff member/family/carer

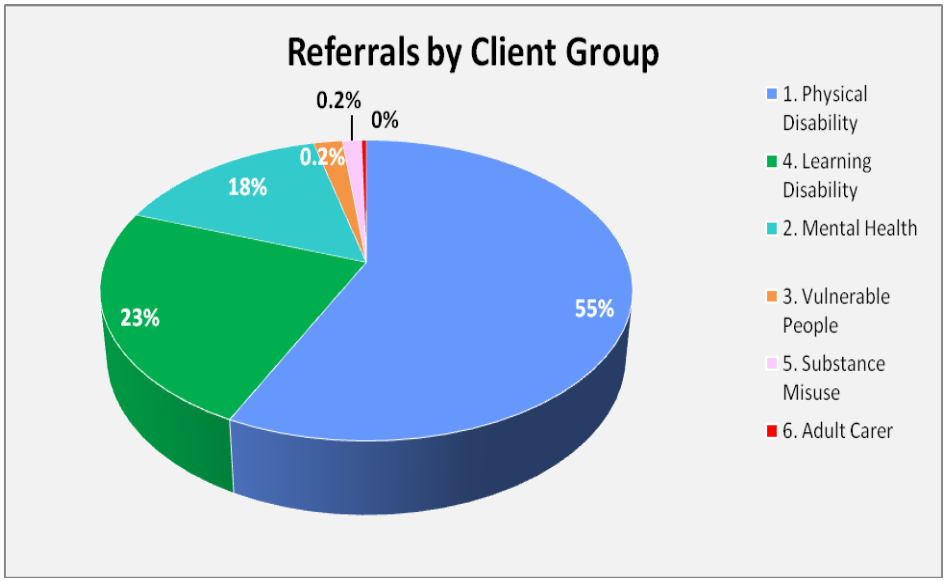
Categories of abuse

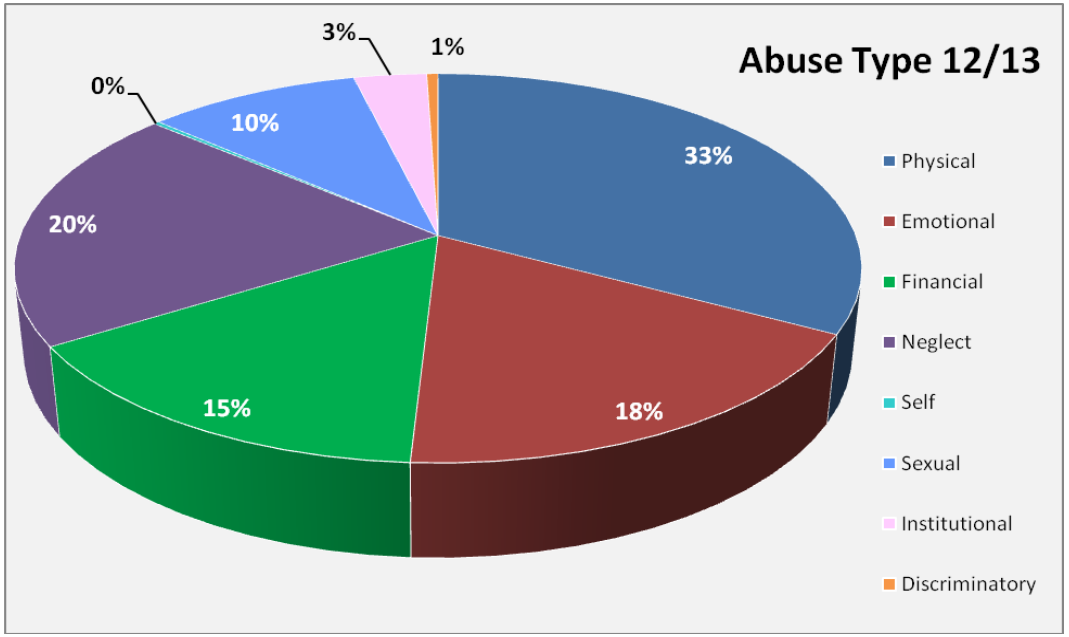
Adults at risk may be abused in more than one category within the same relationship, setting or incident

- Physical
- Sexual
- Psychological/emotional
- Financial/material
- Neglect/acts of omission
- Institutional
- Discrimination: criminal offence motivated by prejudice towards victim's religion/belief, race, disability, sexual orientation or transgender identity

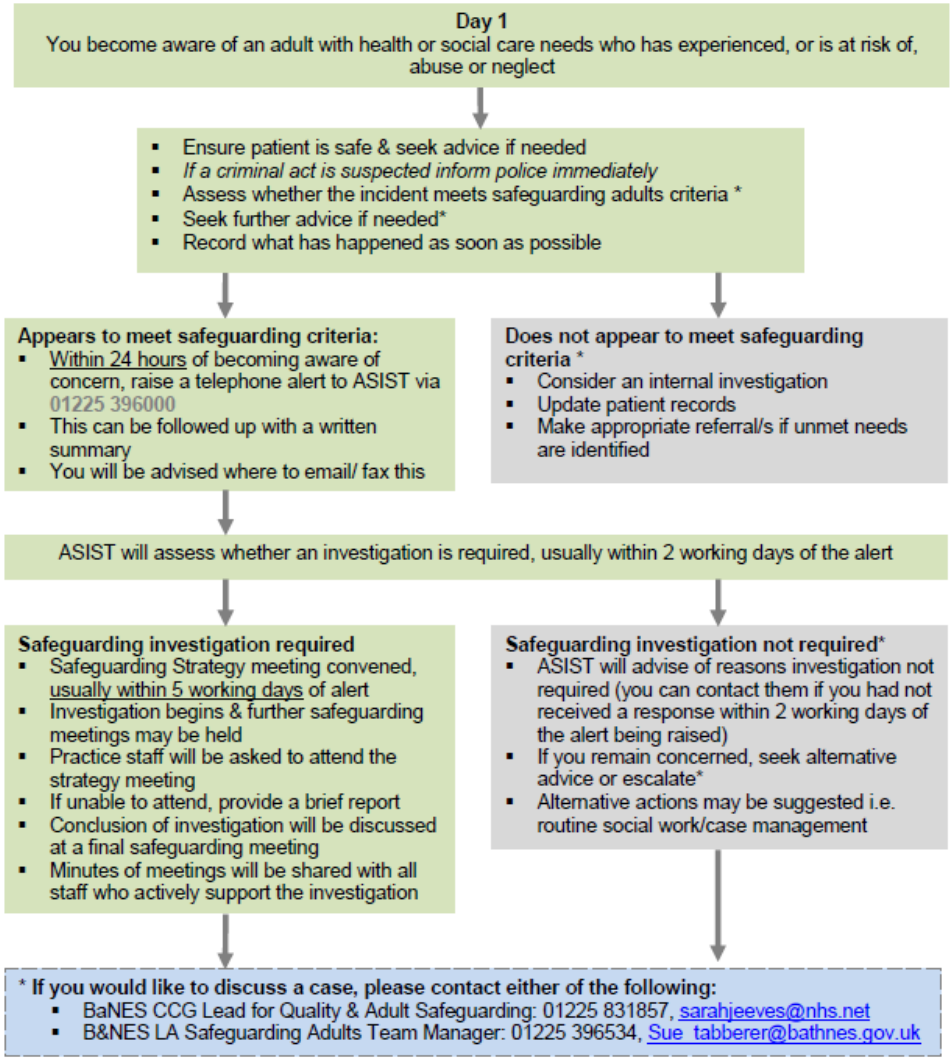
- *Domestic Abuse/violence
- Forced marriage
- Female genital mutilation
- *Modern slavery and human trafficking
- *Self-neglect

Referral type





B&NES Adult Safeguarding Reporting Flow Chart



NB: Following the introduction of the Care Act, timescales for dealing with safeguarding alerts are now based on service users needs, so may vary from the times given above

Mental Capacity Act 2007

5 Key principles:

1. Every adult must be assumed to have capacity to make their own decisions unless proved otherwise

2. Individuals must be given help to make a decision themselves, e.g. providing easy read information

3. Individuals are entitled to make decisions that others may consider "unwise" or eccentric, as long as they have capacity to make that decision.

4. Anything done for or on behalf of a person who has been assessed as lacking mental capacity, must be done in their best interest

5. Treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms, while still providing the required treatment and care.

Mental Capacity

2 stage test:

1. Does the person have an impairment of, or disturbance in the functioning of, their mind or brain?
2. Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

A person is unable to make a decision if they cannot:

1. Understand information given to them
2. Retain the information long enough to make a decision
3. Weigh up the information in order to make the decision
4. Communicate their decision by speech, sign language or any other means

Best Interest Decisions

- If a person is assessed as lacking capacity to make a decision, a decision must be made in their 'Best Interest'
- For those without an appropriate relative/carer an IMCA (Independent Mental Capacity Advocate) should be appointed
- In liaison with the MDT, family/carer etc:
  1. Encourage the participation of the person who lacks capacity
  2. Have regard for past & present wishes including written statements
  3. Will the person regain capacity? Can the decision wait?
  4. Avoid discrimination

Deprivation of Liberty Safeguards (DoLS)

- Protects vulnerable people who lack capacity & need to have their liberty restricted in order to receive treatment & care that is in their best interest
- If a persons freedom is being compromised alterative / less restrictive ways of providing that care or treatment must be considered
- Factors which may indicate the need for DoLS are that the person:
  1. Lacks capacity to determine their care, treatment or location
  2. Is subject to continuous supervision and control
  3. Is not free to leave

Death of a Patient Whilst Under a DoLS

- Death whilst under a DoLS is no longer technically a death in custody so does not need to be referred to the coroner.

Information Sharing – GMC & BMA Guidance

- Where a competent adult states that information should not be shared, this should ordinarily be respected
- However, multi-agency approach to adult safeguarding means that, where it is lawful & ethical, appropriate information should be shared
- Confidentiality can be overridden if required by a legal authority; the patient consents or if justified in public interest
- Disclosure in the public interest is likely to be justified where it is essential to prevent a serious risk to public health, to protect other people from serious harm or death, or to prevent or detect serious crime.
- Also, if an adult lacks capacity, information can be disclosed in accordance with the Mental Capacity Act, where it is in the incapacitated person's best interests
- If you decide not to disclose information, clearly document your actions & rationale & be prepared to justify your decision

Domestic Violence & Abuse (DV & A)

- DV & A is behaviour that controls/intimidates a partner or family member
- DV can occur in any relationship - heterosexual, same sex & also within extended families
- 30% of women & 17% of men in England & Wales have experienced DV in their lives
- DV is the cause of approx.1/3 of female homicides & leads to the death of at least 2 women a week
- Women experience around 35 incidents of DV before reporting it to the police
- IRIS training and advocacy package is being delivered to all practices in BANES

MARAC

- **What is a Multi-Agency Risk Assessment Conference (MARAC)?** A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors.

- After sharing all relevant information they have about a victim, the representatives discuss options for increasing the safety of the victim and turn these into a co-ordinated action plan. The primary focus of the MARAC is to safeguard the adult victim. The MARAC will also make links to safeguard children and manage the behaviour of the perpetrator

- At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety. The victim does not attend the meeting but is represented by an IDVA who speaks on their behalf.

- **MARACs and Safeguarding Adults Meetings** In common with safeguarding procedures, information about the risks faced by those victims is shared and the actions needed to address safety are agreed to create a risk management plan involving all relevant agencies. However at MARAC, the level of focus is at a less detailed level, with the ongoing case work being typically carried by the IDVA.

MASH

It has a joint focus on adults with care and support needs and young people that may be vulnerable because of child protection issues. The MASH team is based at Keynsham Police Station and the agencies participating in the MASH are;

- Police
- AWP (Avon and Wiltshire Mental Health Partnership Trust)
- Virgin care and health (Children's health colleagues and the ASIST Team)
- B&NES Council Safeguarding Adults and Quality Assurance Team
- B&NES Council Children's Social Care

What will the MASH do?

The aims of the MASH are:

- To improve communication and information sharing on the cases that are passed to the MASH
- To reduce agency disagreements over about thresholds
- To promote co-location and "joined-up" decision making
- Improve the timeliness of decision making
- To improve the quality of information used to make decisions about adults and children.
- Ensure that decisions on cases are communicated to referring agencies promptly.

The MASH will operate within normal office hours. The focus of cases passed to the MASH will be those where safeguarding concerns are felt to be present but additional clarification is required before a more informed decision is taken. The introduction of the MASH will not change the existing referral routes into both Adult Services and Children's Services where safeguarding concerns may be present.

What the MASH will not do;

- The MASH will not work with cases where there are clear and agreed safeguarding concerns. It is felt that current Safeguarding arrangements for these types of concerns work well. The focus for the MASH will be those cases where there are concerns, but the extent and seriousness of them require additional and timely clarification in order to make a more informed decision about the level of safeguarding concern.

- The MASH will not take referrals directly from agencies. All concerns must continue to go through existing routes.

If you suspect that your patient may be a victim of modern slavery take the following action:

Children and young people under 18 years

For concerns about a child or young adult follow all child protection guidelines and speak to your designated Child Protection Lead. Please note that health professionals have a legal obligation to safeguard children that present to them.

Out of hours, contact your Local Children's Social Services or police service, ***specifically highlighting your concern for child trafficking***

Consider referral to your hospital paediatric team for admission

Adults

Contact the Salvation Army 24 hour confidential helpline for professional advice and support and referrals on 0300 303 8151 operating 7 days a week

Only make referrals if the person is able to give consent and has agreed to the referral

Consider using maternity services to admit pregnant women for observation

Local designated Child Protection Lead:

Name:

Telephone:

Email:

For further resources and eLearning module on identifying and supporting victims of modern slavery see www.e-lfh.org.uk/projects

This leaflet has been produced by the Department of Health with guidance from a steering group comprising representatives from: British Association of Sexual Health and HIV, Child Trafficking Advice Centre NSPCC, College of Emergency Medicine, Department of Health, Home Office; UK Human Trafficking Centre Serious Organised Crime Agency, Ministry of Justice, Royal College of General Practitioners, Royal College of Midwives, Royal College of Nursing, Royal College of Paediatric and Child Health, Royal College of Psychiatrists, Salvation Army; Poppy Project, Section for Women's Health Institute of Psychiatry Kings College London.

Identifying and supporting victims of modern slavery

Guidance for health staff

All staff in every health care setting could spot a victim of modern slavery

All staff have a duty of care to take appropriate action and legal obligation in the case of children under 18

All immediately necessary treatment should be provided

What is modern slavery?

Modern Slavery is the illegal trade of human beings for the purposes of commercial sexual exploitation or reproductive slavery, forced labour, or a modern-day form of slavery.

Who is trafficked?

British and foreign nationals can be trafficked into, around and out of the UK. Children, women and men can all be victims of modern slavery.

Why are people trafficked?

Children, women and men are trafficked for a wide range of reasons including:

- Sexual exploitation
- Domestic servitude
- Forced labour including in the agricultural, construction, food processing, hospitality industries and in factories
- Criminal activity including cannabis cultivation, street crime, forced begging and benefit fraud
- Organ harvesting

How might you encounter a victim of modern slavery?

- A person may tell you about their experience
- You detect signs that suggest a person may have been trafficked
- A trafficked person may be referred to you

Supported by

Department of Health

Signs of trafficking for adults, children and young people include:

- A person being accompanied by someone who appears controlling, who insists on giving information and coming to see the healthworker

The person:

- Is withdrawn and submissive, seems afraid to speak to a person in authority and the accompanying person speaks for them
- Gives a vague and inconsistent explanation of where they live, their employment or schooling
- Has old or serious injuries left untreated. Has delayed presentation and is vague and reluctant to explain how the injury occurred or to give a medical history
- Is not registered with a GP, nursery or school
- Has experienced being moved locally, regionally, nationally or internationally
- Appears to be moving location frequently
- Their appearance suggests general physical neglect
- They may struggle to speak English

In addition

Children and young people

Have an unclear relationship with the accompanying adult

Go missing quickly (sometimes within 48 hours of going into care) and repeatedly from school, home and care

Give inconsistent information about their age

Adults

Have no official means of identification or suspicious looking documents

What are the possible health care issues of trafficked people?

Victims of modern slavery may only come to your attention when seriously ill or injured or with an injury or illness that has been left untreated for a while. Health care issues may include:

- Evidence of long term multiple injuries
- Indications of mental, physical and sexual trauma
- Sexually Transmitted Infections
- Pregnant, or a late booking over 24 weeks for maternity care
- Disordered eating or poor nutrition
- Evidence of self-harm
- Dental pain
- Fatigue
- Non-specific symptoms of Post-Traumatic Stress Disorder
- Symptoms of psychiatric and psychological distress
- Back pain, stomach pain, skin problems; headaches and dizzy spells

How might you suspect that a person is a victim of modern slavery?

In all cases, trust and act on your professional instinct that something is not quite right. It is usually a combination of triggers, an inconsistent story and a pattern of symptoms that may cause you to suspect trafficking.

If you have *any* concerns about a child, young person or adult take immediate action to ask further questions and seek out additional information and support.

Remember:

- Trafficked people may not self-identify as victims of modern slavery
- Trafficking victims can be prevented from revealing their experience to health care staff from fear, shame, language barriers and a lack of opportunity to do so. It can take time for a person to feel safe enough to open up
- Err on the side of caution regarding age - if a person tells you they are under 18 or if a person says they are an adult, but you suspect they are not, then take action as though they were under 18 years old
- Support for victims of human trafficking is available

What do you do next?

In all cases for children, young people and adults:

Do not raise your trafficking concerns with anyone accompanying the person

Ensure you address the health needs of the person by continuing to provide care

Ensure the person knows that the health facility is a safe place

React in a sensitive way that ensures the safety of the person

Think about support and referral

Use an interpreter if translation is necessary

Only use an independent, qualified and police checked interpreter or Language Line.

Do not use anyone accompanying the person as an interpreter. This applies to children, young people and adults.

- Try to find out more about the situation and speak to the person in private without anyone who accompanied them
- When speaking to the person reassure them that it is safe for them to speak
- Do not make promises you cannot keep
- Only ask non-judgemental relevant questions
- Allow the person time to tell you their experiences
- Do not let concerns you may have about challenging cultural beliefs stand in the way of making informed assessments about the safety of a child, young person or adult
- Speak to your manager, colleagues or Local Safeguarding Leads for support and advice

Signs of Modern Slavery in Health Care Settings

- Stated age older than appearance
- Frequent or forced abortions
- Lack of English
- **Accompanying individual insists on providing translation, refuses to leave exam room or answers for the patient**
- No identification documents
- Confused story or inability to provide basic information
- Scripted or mechanically recited history
- **Multiple Unrelated people using the same address**
- Tattoos or marks that may indicate ownership (names, brands, logos)
- Evidence of physical violence – burn marks etc
- Delayed presentation of medical care
- Frequent change of location
- Overcrowded accommodation

How to support potential victims

- Speak to local safeguarding teams (MASH) – local authorities and the police have a duty to notify
- Support for adult victims is offered through the National Referral Mechanism – the Government's identification and support mechanism
- Support for child victims is offered through local authority child safeguarding teams
- Seek access to wider support services such as counselling, legal advice, employment support
- Call the modern slavery for support and signposts to help, information and guidance

REPORT MODERN SLAVERY | MODERN SLAVERY

If you suspect that someone is a victim
or is being exploited for commercial gain:

Call the modern slavery
helpline on 0800 0121 700

Report it online at
www.modernslavery.co.uk

Female Genital Mutilation (FGM)

What is Female Genital Mutilation (FGM)? FGM comprises of all procedures involving partial or total removal of the external female genital organs or any other injury to the female genital organs for non-medical reasons. FGM is most often carried out on young girls aged between infancy and 15 years old. It is often referred to as 'cutting', 'female circumcision', 'initiation', 'Sunna' and 'infibulation'.

It is estimated that 65,000 girls aged 13 and under are at risk of FGM in the UK. UK communities most at risk include Kenyan, Somalian, Sudanese, Sierra Leonean, Egyptian, Nigerian and Eritrean. Non-African countries that practise FGM include Yemen, Afghanistan, Kurdistan, Indonesia, Malaysia, Turkey, Thailand (South) and Pakistani.

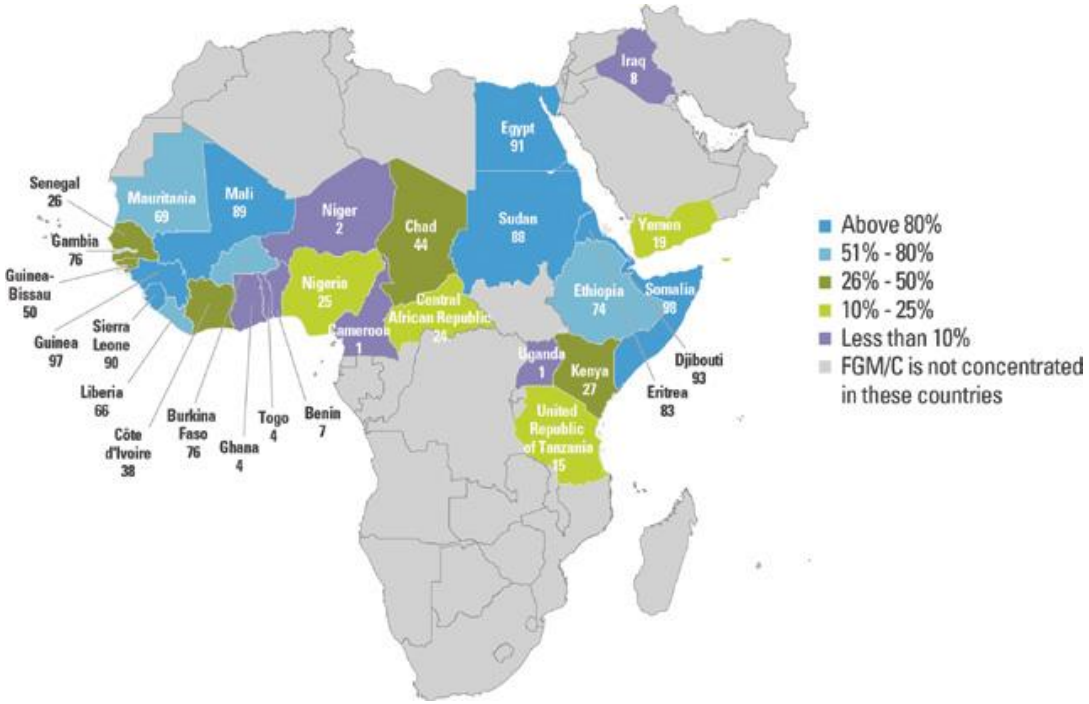
It is a mandatory duty for a regulated healthcare professional to report any concerns they have about a female under 18 years and record when FGM is disclosed or identified as part of NHS healthcare. As FGM is illegal this should be reported to the Police via the 101 non-emergency number. The duty is a personal duty which requires the individual professional who becomes aware of the case to make a report; the responsibility cannot be transferred. There is a mandatory requirement for health care professionals to submit their FGM data for both children and adults via the Health & Social Care Information Centre. Further details can be accessed on their website: http://www.hscic.gov.uk/FGM. Submission became mandatory for acute trusts, GP practices and mental health trusts in 2015.

If you believe that a victim or potential victim of FGM is in immediate danger, always dial 999. If you are concerned that a child is at risk you must make a referral to Children's Social Care immediately using your local Safeguarding Board procedures. The NSPCC has a 24 hour helpline to provide advice and support to victims of FGM, or to anyone who may be concerned a child is at risk - call the helpline on 0800 028 3550 or email fgmhelp@nspcc.org.uk

Female Genital Mutilation (FGM)

Countries that practice FGM

FGM/C is concentrated in a swathe of countries from the Atlantic coast to the Horn of Africa



FGM has also been documented in communities including:

- Iraq
- Israel
- Oman
- the United Arab Emirates
- the Occupied Palestinian Territories
- India
- Indonesia
- Malaysia
- Pakistan

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C

Note: In Liberia, girls and women who have heard of the Sando society were asked whether they were members; this provides indirect information on FGM/C since it is performed during invitation into the society

Source: UNICEF global databases, 2014, based on DHS, MCS and other nationally representative surveys, 2004-2013
http://www.data.unicef.org/child-protection/fgmc

Non-Pregnant Adult Woman (over 18)

This is to help decide whether any female children are at risk of FGC, whether there are other children in the family for whom a risk assessment may be required or whether the woman herself is at risk of further harm in relation to her FGM.

Date: _____ Completed by: _____

Initial/On-going Assessment

Indicator	Yes	No	Details
CONSIDER RISK			
Woman already has daughters who have undergone FGM – who are over 18 years of age			
Husband/partner comes from a community known to practice FGM			
Grandmother (maternal or paternal) is influential in family or female family elder is involved in care of children			
Woman and family have limited integration in UK community			
Woman's husband/partner/other family member may be very dominant in the family and have not been present during consultations with the woman			
Woman/family have limited/ no understanding of harm of FGM or UK law			
Woman's nieces (by sibling or in-laws) have undergone FGM Please note:– If they are under 18 years you have a professional duty of care to refer to social care			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment			
Family are already known to social services – If known, and you have identified FGM within a family, you must share this information with social services			
SIGNIFICANT OR IMMEDIATE RISK			
Woman/family believe FGM is integral to cultural or religious identity			
Woman already has daughters who have undergone FGM – who are under 18 years of age			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be triggered if she is found to have FGM			

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

Significant or Immediate risk – if you identify one or more serious or immediate risk, or the other risks are, by your judgement, sufficient to be considered serious, you should look to refer to Social Services/CAIT team/ Police/MASH, in accordance with your local safeguarding procedures.

If the risk of harm is imminent, emergency measures may be required and any action taken must reflect the required urgency.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

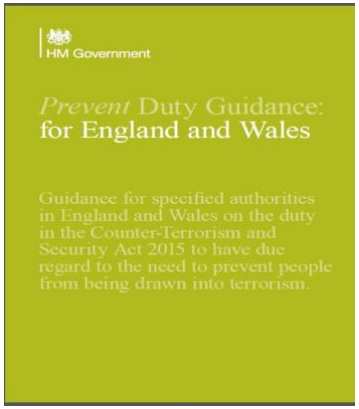
Please remember any child under 18 who has undergone FGM should be referred to Social Services.

PREVENT

- **Prevent** is one element of **Contest**, the government's anti-terrorist strategy which aims to prevent the radicalisation of adults at risk
- Health organisations work with partner organisations to contribute to the prevention of terrorism by safeguarding & protecting vulnerable individuals
- NHS experience of managing adults at risk via safeguarding places clinicians in a key position to support individuals, while providing advice & support to public sector partners
- Patient/clinician relationship needs to be balanced with duty of care & responsibility for public safety

Background

- In 2006, the Government launched CONTEST, the UK counter-terrorism strategy. The Strategy has 4 elements:
- Pursue - to stop terrorist attacks
- Prepare - to mitigate the impact of a terrorist attack
- Protect - to strengthen our protection against a terrorist attack
- Prevent - *to stop people becoming terrorists or supporting terrorism*



So What Exactly is Prevent?

Prevent is a statutory duty that:

- Applies to health, education and local government with the Council & Police acting as lead agencies
- responds to the ideological challenge of terrorism and the threat we face from those who promote it
- Is a non-enforcement, pre-criminal strategy
- Intervenes early to protect and divert people away from the risk they face before they commit criminal activity
- Helps to ensure individuals are given appropriate advice and support.
- The most serious cases (around 20%) can be referred into the Channel programme but only if they consent to this.

What Do You Need to Do?

- Remember that Prevent is not just about extreme religious groups, it also includes extreme domestic groups such as right and left wing extremists and animal rights activists.

- If you are concerned that an individual is at risk of, or is actually being radicalised, inform your line manager or safeguarding lead.

- They will then need to inform either the CCG Adult Safeguarding Lead (Sarah Jeeves) or the police via: channelsw@avonandsomerset.pnn.police.uk

- Please note that this will not lead to a criminal investigation/prosecution and the individual can choose whether or not they want to be supported

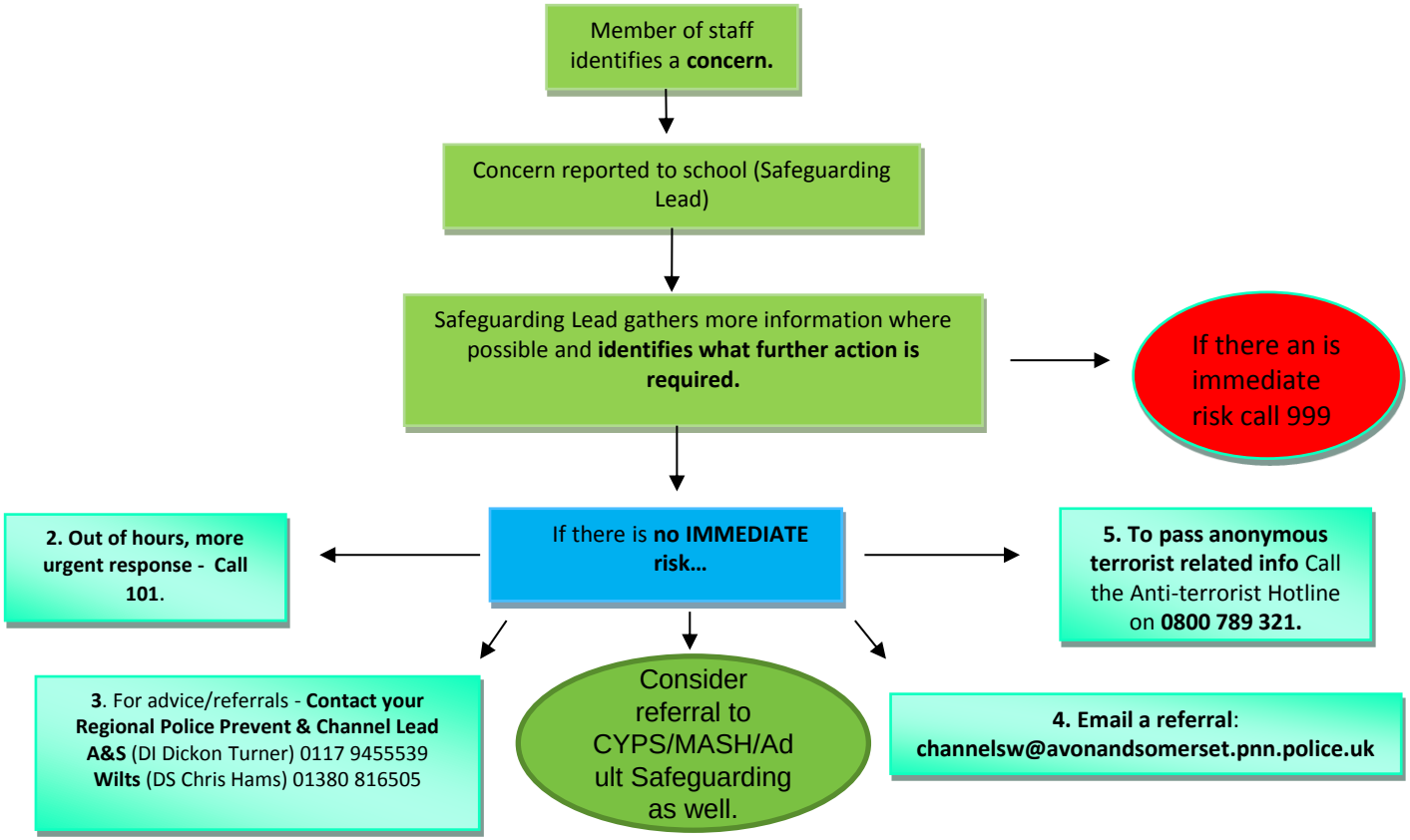
The health sector contribution is:

- **Skilling up staff to recognise signs that people are being radicalised towards violence; notice- check - share**
- **Ensure individuals are supported when they are identified and given the correct care plans from a health perspective;**
- **Work with organisations where there are risks that radicalisation can take place un-hindered;**
- **Work with other key stakeholders e.g. local authorities to ensure that communities remain safe**
- **Commissioning projects and research in collaboration with partners**

The health sector is NOT required to:

- **Maintain surveillance or take on an enforcement role**
- **No expectation for practitioners to challenge ideology – Health does not have the skills**

Prevent/Channel Process Map for Referring a Concern of a Vulnerable Individual

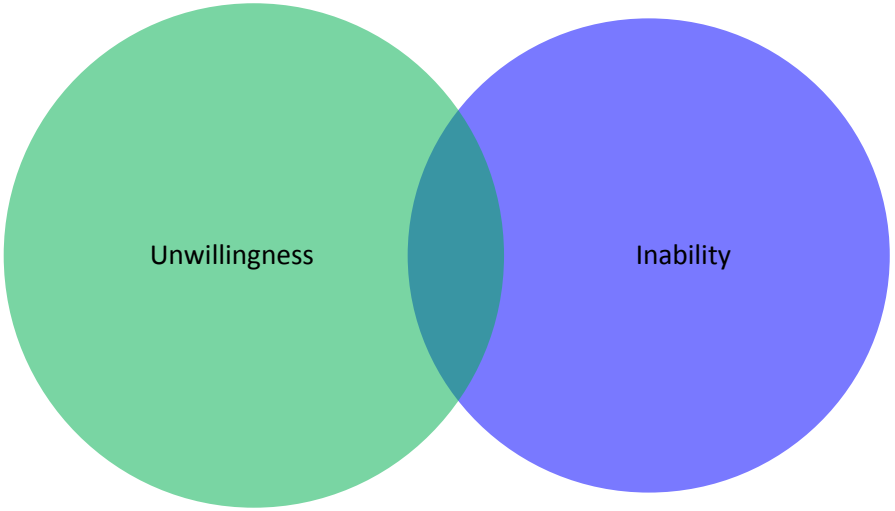


What is Self – Neglect?

- **Cases usually encompass a complex interplay between mental, physical, social and environmental factors. Covers inter-related issues such as drug and alcohol misuse, homelessness, street working, mental health issues, criminality, anti-social behaviour, inability to access benefits and/or other health related issues. Such cases are a challenge for agencies/practitioners involved.**
- **Self-neglect, particularly where people with mental capacity refuse care and support, has emerged as a matter of widespread concern, and featured in a number of serious case reviews.**

Definitional complexity

- **A wide range of manifestations**
- **Arising from an unwillingness or inability, <u>or both</u>**
- **Interlinked and indistinguishable where unwillingness arises from the care and support needs of the individual**



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LSAB Policy and Procedure

- Agreed structure and process against which to consider a concern
- Either supported through case management **OR** safeguarding procedures
- Decision is based on an assessment of level of risk and significance to the individuals circumstances and possible consequences.
- Decision is made by the Council's Safeguarding and Quality Assurance Team.
- If supported through case management the lead agency will be identified by the Safeguarding and Quality Assurance Team.

Bath & North East Somerset Council

LSAB Policy and Procedure

Decision to come under safeguarding process will be guided by:

Has or is assumed to have mental capacity to make relevant decisions but has refused essential services without which their health and safety needs cannot be met;

And

The review of health and social care processes/care management approach/their support plan including risk management plans have not been able to mitigate the risk of serious self-neglect that could result in serious harm.

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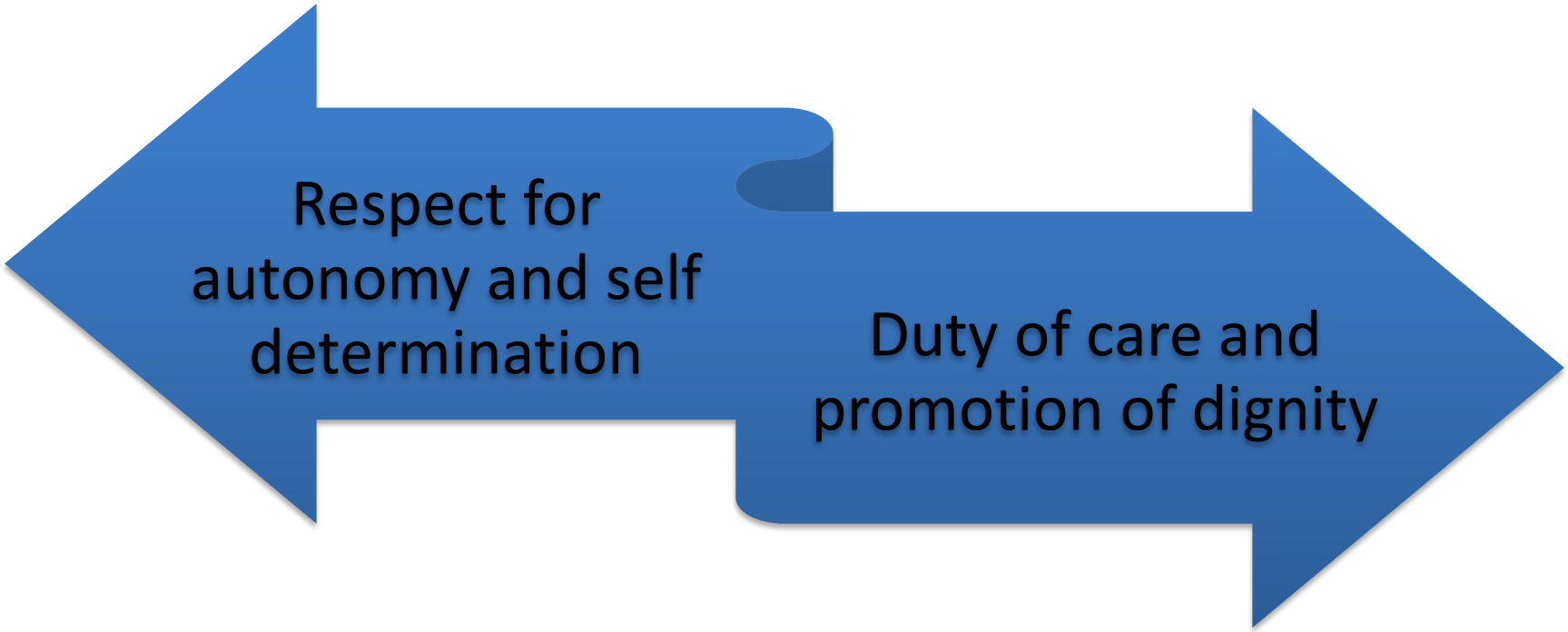
Competing moral imperatives



Bath & North East Somerset Council

Effective working

- Knowledge of self-neglect and the legal framework surrounding it
- Duty of care
- Assessment skills
- Relationship – building skills and a person centred approach
- Effective multi-disciplinary working

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Challenges

- Often no answers or quick fixes
- Self determination v duty of care
- Need to review the individual holistically and address manifestations rather than just the root causes
- Non – engagement of individual – small wins
- Cumbersome legal system
- Poor multi-agency engagement
- Stigma and discrimination – around choices
- Support and supervision for staff involved

Example

Tinker's Lane Surgery, Wootton Bassett

- Davinderjit Bains was arrested in June 2012 on suspicion of sexual assault & voyeurism
- He was charged with 39 offences affecting 32 patients & subsequently sentenced to 12 years imprisonment
- Wiltshire PCT reviewed governance arrangements at the practice & recommended that polices were required for:
  1. Safeguarding arrangements for Children & Adults
  2. Serious untoward event reporting & management
  3. Handling of complaints & concerns
  4. Professional performance issues (inc. management of intimate examination & chaperoning)
  5. Medicines Governance

Recommendations from SCR

Recommendations from the review:

1. Professionals should feel able to collate information from other agencies
2. Referring agencies need to be clear about how & when they escalate concerns if they get an unsatisfactory response.
3. It is better to instigate the safeguarding process &then stand it down if it doesn't meet safeguarding thresholds
4. Greater awareness & application of the Mental Capacity Act
5. All staff should receive mandatory domestic abuse awareness training
6. Raise awareness of MARAC process

CQC 5 key questions about services

Are they safe?

Are they effective?

Are they caring?

Are they responsive to people's needs

Are they well-led?

CQC Safeguarding service users from abuse and improper treatment

Safeguarding adults includes:

- Protecting their rights to live in safety, free from abuse and neglect.
- People and organisations working together to prevent the risk of abuse or neglect, and to stop them from happening.
- Making sure people's wellbeing is promoted, taking their views, wishes, feelings and beliefs into account

People must not suffer any form of abuse or improper treatment while receiving care.
This includes:

- Neglect
- Degrading treatment
- Unnecessary or disproportionate restraint
- Inappropriate limits on your freedom.

CQC: Suggested minimum evidence

Staffing

- Current DBS checks for all staff
- Evidence of safeguarding training
- Whistleblowing policy
- Policy for managing staff allegations, inc. awareness of where to take concerns about clinicians

Processes

- Complaints policy
- Significant Event policy with evidence of clinical engagement
- Chaperone & intimate examination policy with notices in the practice
- Awareness of safeguarding referral pathway
- Knowledge & implementation of MCA & DOLS
- Consent policies

What CQC is looking for in relation to Safeguarding (SG) – common themes identified in inspection reports mapped against each Key Line of Enquiry (KLOE) – July 2015

Themes	Safe	Effective	Caring	Responsive	Well-led
SG Lead	**CQC expects to see that:** Practice has a named SG lead and a deputy SG lead with delegated responsibility to act in the lead's absence. All staff know who the SG lead is.				Clear leadership structure and designated SG responsibility. Named SG lead and named clinical governance lead.
Children and adult SG training	SG lead & all GPs (inc locums) - Level 3 training. Practice Nurses/Nurse Practitioners - Level 2 training. Practice staff - Level 1 Training. Practice maintains up to date SG training records for all clinicians & staff, showing that identified staff have received the appropriate level of training for their respective roles.	Evidence of staff training on: • Child protection and adult SG • Mental Capacity Act (MCA) 2005 • Deprivation of Liberty Safeguards (DoLS) • Children's Act 2004 and • Gillick Competency (i.e. a child's ability to consent to his/her own treatment without parental or carer's consent).			SG lead ensures all staff are appropriately trained for their role and are aware of all relevant legislation.
Recruitment checks	DBS checks for all clinicians (if no DBS check, evidence of a risk assessment should be available). Appropriate recruitment checks on all staff, including references and DBS checks where appropriate (according to risk assessment of each role).				
What all staff need to know	Staff are aware of practice's SG and chaperone policies. Staff know how to recognise signs of abuse in children, young people and vulnerable adults and are able to describe various types of abuse. Staff are aware of their responsibilities regarding information sharing, documentation of SG concerns and how to contact relevant agencies in and out of hours. Staff know how to report and escalate SG concerns in and outside of the practice. Staff are aware of significant events and subsequent changes to practice policies and procedures.	Staff are aware of all the practice's vulnerable population groups and whether or not they have been offered an annual health check. Staff across the practice have key roles in monitoring and improving outcomes for patients - these roles include data input, scheduling clinical reviews, health promotion, referral management and safeguarding. Evidence of staff understanding of patients' consent to care (MCA 2005, DoLS and Gillick Competence).			Staff are aware of the named SG lead. Staff are aware of the practice's children and adult SG policy and chaperone policy. Staff know how to recognise signs of abuse and are aware of their responsibilities in terms of raising concerns, documenting them and contacting the relevant agencies.

Themes	Safe	Effective	Caring	Responsive	Well-led
Practice systems, processes and policies	Practice has systems in place to manage and review risks to children, young people & vulnerable adults. Practice has a thorough children and adult SG policy describing transparently the process staff should follow to raise and escalate concerns within and outside of the practice. System in place to identify children living in disadvantaged circumstances or those at risk. Maintain a risk register of vulnerable patients, including children on child protection plans, patients with a learning disability, mental health or dementia, housebound patients, homeless patients, travellers etc. Multi-agency SG information with contact details for external agencies is on display in reception and in all clinical rooms and staff know where all this information is kept. System in place for reporting, recording and monitoring significant events, incidents and accidents. Practice has systems in place to highlight vulnerable patients in electronic medical records, e.g. children on child protection plans, patients with mental health problems/dementia, housebound patients etc so staff are aware of relevant issues when these patients attend the surgery for an appointment. Appropriately signed PGDs in place. Patient consent policy. Robust information governance in place ensuring non-clinical staff do not have clinical level access on the clinical system. Care plans for patients with learning disabilities and dementia. Practice audits and clinical audits. Systems to monitor the issuing and handing out of repeat prescriptions, particularly for patients with co-morbidities, on multiple medications, or those experiencing poor mental health. System to establish and monitor cascading of patient safety alerts. Up to date business continuity plan.	Systems in place for identifying and following up children living in disadvantaged circumstances and those who are at risk. Complaints policy in place. Non-clinical audit looking at staff understanding and current knowledge level regarding safeguarding processes. Locum GP induction pack contains information on referral processes, safeguarding guidance and safeguarding agencies' contact numbers. Evidence of a culture in the practice of a good understanding of safeguarding and mental capacity issues and a clear process for raising concerns. Systems in place for assessing and managing patients' mental capacity. Practice policy for documenting patient consent. Arrangements in place to manage lithium therapy.	Evidence that vulnerable patients are prioritised for an appointment. System to follow up on hospital referrals for vulnerable patients who failed to attend their appointment to see a specialist. Procedure in place for staff to follow if there has been a death of one of their patients. Evidence of support for staff who feel vulnerable behind the desk when patients are being aggressive or threatening. Conflict resolution training for staff.	Electronic flagging (and appropriate read coding) to highlight vulnerable children or adults on electronic patient records. Older patients at risk of isolation are identified and discussed at clinical meetings as well as multi-disciplinary meetings to address the support they require. Evidence the practice offers care and support to patients in vulnerable circumstances, e.g. homeless people should be able to register with the practice and be seen by a GP if required. Evidence the practice offers personalised care to meet the needs of older patients and patients whose circumstances may make them vulnerable. Extended appointment slots for older patients.	Evidence of recording complaints and significant events – clear reporting processes. Practice risk log. Systems in place to identify, manage and mitigate risks to vulnerable children, young people and adults. Evidence of completed clinical audit cycles being used to drive improvements in patient care. All clinical staff are given the opportunity to be involved in practice meetings, receive relevant practice information including clinical updates and contribute to the improvement of patient care. All relevant practice policies have review dates and there is evidence that all staff have read and understood them.

Themes	Safe	Effective	Caring	Responsive	Well-led
Services / patient experience / outcomes		Evidence discrimination is avoided when making care and treatment decisions. Annual health checks for long term conditions patients, over 75s and patients with learning disabilities. Flu vaccinations for the over 65s. Evidence that patients with a learning disability and those with dementia are supported to make decisions about their care through the use of care plans.	Appointments outside school hours for children and young people. Evidence patients' privacy and dignity is protected. Practical information available in different languages or Braille. Staff treat vulnerable patients sensitively and compassionately e.g. take more time with patients with learning disabilities, not turn them away and ask them to come back etc. Evidence vulnerable patients feel involved in their care planning. Signposting palliative care patients to end of life care support groups and organisations. Referral of patients with dementia or poor mental health to local counselling or support organisations. Referral of carers to carers' support organisations.	Ensure there is no under - reporting or under - diagnosis of dementia. Evidence of high children imms rates. Chaperone service available. Emotional support from practice reviewed from patient surveys. Evidence vulnerable patients are free from discrimination. Evidence the practice engages with the local community mental health team for support. Homeless people and travellers seen as temporary patients. Drug and alcohol abuse patients seen, then signposted to the appropriate service.	Feedback from patients with learning difficulties about sensitivity / care and patience of staff.
Chaperones	Practice has a chaperone policy. There are notices/posters on the notice board in the waiting area and displayed in the clinic rooms informing patients that chaperones are available. Staff who act as chaperones receive chaperone training. Chaperones are DBS checked, even retrospectively when staff roles have changed and staff have undertaken chaperone duties long after they were recruited (If no DBS check, there should be evidence of risk assessment). Staff acting as chaperones are clear about their responsibilities, e.g. knowing where to stand in the room in order to be able to observe a patient's examination.				

Themes	Safe	Effective	Caring	Responsive	Well-led
SG referrals to Social Services, CAMHS etc	SG lead knows how many referrals have been made to Social Services, where they are kept in the practice and how data about SG referrals is collected.	Evidence of young people at risk being referred to CAMHS (Children & Adolescent Mental Health Services).		Process enabling urgent referrals to CAMHS or social services for patients deemed to be at immediate risk.	
Internal sharing of learning		Evidence of learning from complaints or incidents, discussion at practice meetings.			Child protection and SG cases are discussed at clinical meetings. Complaints and significant events are discussed at practice meetings with evidence that the learning is shared within the practice. Regular governance meetings to discuss performance, quality and risk. SG is a standing item in practice meetings.
Multidisciplinary working	Evidence that the practice has regular external meetings with health visitors, palliative care nurses etc where children and adult safeguarding cases are discussed.	Evidence of working with multidisciplinary teams for the case management of vulnerable patients. Multi-disciplinary (MDT) meetings with district nurses, health visitors, locality integrated care-coordinator and palliative care nurses to discuss the care plans of complex needs patients.			Regular meetings with Health Visitors and/or Social Workers to discuss child protection cases. Meetings with palliative care nurses to discuss end of life care patients and their needs. Evidence of good liaison with partner agencies such as the police and social services.
Practice premises, drugs and medical equipment	There should be no health and safety risks for children in the practice premises, e.g. exposed wires, trip hazards, sharps boxes on the floor etc. Drugs fridge and specimen fridge not accessible to patients. Fire risk assessment and fire log / evidence of legionella testing. Infection control policy, staff training, evidence of cleaning schedules and infection control audits. Clinical waste bins in clinical and minor ops rooms. Ensure patient confidentiality especially in the part of the reception area where patients leave prescription requests. Check expiry dates of vaccines, drugs and medical equipment e.g. syringes, needles. Oxygen and defibrillators available and checked regularly. Emergency drugs for treating anaphylaxis	Evidence of staff training in recording and monitoring drugs fridge, temperatures and taking action when temperatures are out of range Cold chain policy.		Access to premises, e.g. ramps, sufficient space for prams, wheel chairs (toilets, waiting area). Information in a variety of accessible formats, e.g. different languages and Braille.	Evidence of effective infection control management. Fire risk assessment & fire drills Up to date business continuity plan Health and safety risk assessments, legionella assessment.

Summary

- For an adult safeguarding investigation to be initiated, the abuse, or risk of abuse must occur to an adult with health or social care needs needs, as per the Care Act 2014
- Abuse can occur even when you don't expect it
- Listen to & believe those who tell you they have been abused - people who disclose abuse want it to stop
- Know your organisation's Safeguarding Adults procedures & follow them
- Never under estimate importance of information sharing
- Protecting adults at risk should be your first priority
- Never allow abusive behaviour to go unchallenged
- Don't deal with abuse alone - support is always available

Case discussion