Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Reference Number: FOI202324//060
From: Private Individual

Date: 09 May 2023

Subject: Support for Hoarding and Self-neglect

Q1 Does your organisation have a panel which focuses on supporting adults who hoard (or a 'hoarding panel')?

A1 No

Q2 If yes, please can you provide me with a copy of the policy/guidance/standard operating procedure/terms of reference that informs the remit of the panel?

A2 Information not held – as per A1

Q3 Is there policy or guidance in the organisation to support staff working with people who self-neglect?

A3 This falls under the Trust's Safeguarding Adults policy

Q4 If yes, please can you provide me with a copy?

A4 See attachment – *Safeguarding Adults policy*

Safeguarding Adults

Policy

For completion by Author			
Author(s) Name and Title:	Joanne Shaw HON Clinical Services and Safeguarding Updated – Angela McKenna – Operational Nurse Lead Safeguarding Adults & Children		
Scope:	Trust wide	Classification:	Clinical
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To be read in conjunction with the following documents:	Children's Safeguarding policy Mental Capacity Act Policy Deprivation of Liberty Safeguards Policy		
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Executive Lead	Sue Pemberton		

For completion by Approving Committee				
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For completion by Document Control					
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Archive:	Document Control		Date Added to Archive:		
Officer responsible for Archive:		IG and Document Control Facilitator			

Contents

Policy Statement

The aims of safeguarding adults Policy

Safeguarding at LHCH is everybody's business; everyone within the Trust has a responsibility for and is committed to safeguarding and promoting the welfare of adults at risk, children and young people".

Health services have a duty to safeguard all patients but provide additional measures for patients who are less able to protect themselves from harm or abuse.

Safeguarding adults at risk is an integral part of patient care and is a fundamental part of patient safety and wellbeing and the outcomes expected of the NHS .

The empowerment of adults underpins all safeguarding adults work. The focus of safeguarding adults should always be to identify and endeavour to meet the desired outcomes of the adult. Every person has a right to live a life free from abuse, neglect and fear

Duties to safeguard patients are required by professional regulators, service regulators and supported in law. Safeguarding adults covers a spectrum of activity from prevention through to multi-agency responses where harm and abuse has occurred.

The Trust is committed to safeguarding and promoting the welfare of adults at risk. This Policy outlines the duties and responsibilities of all Trust staff to safeguard adults at risk and the actions to be taken where there are concerns for an adult's safety or welfare.

Adult safeguarding is the process of protecting adults at risk with care and support needs from abuse or neglect (hereafter referred to as "adults"). It is an important part of what many public services do, but the key responsibility is with Local Authorities [LAs] in partnership with the police and the NHS. The Care Act 2014 puts adult safeguarding on a legal footing. It also updates the scope of adult safeguarding.

Where a LA has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):
(a) has needs for care and support (whether or not the authority is meeting any of those needs)
(b) is experiencing, or is at risk of, abuse or neglect, and
(c) as a result of those needs is unable to protect him or her against the abuse or neglect or the risk of it

All organisations who are involved in adult safeguarding will need to reflect the statutory guidance, good practice guidance and ancillary products that have been developed when devising their training and implementation plans for staff. Policies and procedures should be based on the processes laid out in the statutory guidance.

It signals a major change in practice - a move away from the process-led, tick box culture to a person centred social work approach which achieves the outcomes that people want. Practitioners must take a flexible approach and work with the adult all the way through the enquiry and beyond where necessary. This is illustrated in the guidance with the use of a decision tree. Practice must focus on what the adult wants, which accounts for the possibility

that individuals can change their mind on what outcomes they want through the course of the intervention.

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

Contact Details

Police: 999
Police non-emergency: 101
The CCG adult safeguarding service now has a single point of access (care line): 0151 495 5469
or email ccg.adultssafguarding@nhs.net. This service operates Monday to Friday 9am till 5pm.
The contact number for the Head of safeguarding at LHCH is Joanne Shaw is 0151 600 1857 or joanne.shaw@lhch.nhs.uk.
The Operational Nurse lead for Adult & Children's safeguarding at LHCH is 0151 254 3058 or Angela.Mckenna@lhch.nhs.uk
The Named Doctor can be contacted via switch or by emailing petra.jenkins@lhch.nhs.uk

1. Roles and Responsibilities

1.1 Chief Executive

The Chief Executive has a statutory responsibility. It is their responsibility to:

- identify a person at Executive level with responsibility for Safeguarding Children and Adults at risk
- identify a named nurse and doctor for matters concerning the safeguarding of adults at risk

1.2 Trust Board

The Trust Board are responsible for ensuring that the annual report received is an accurate reflection of work undertaken and are assured that processes for safeguarding are in place to protect adults at risk.

1.3 Executive Lead – Director of Nursing and Quality

The Director of Nursing and Quality is accountable to the Trust Board for ensuring successful implementation and compliance with this Policy across the Trust.

1.4 Head of Safeguarding Adults

The Named head of Nursing and safeguarding is responsible to the Director of Nursing for ensuring the Policy is implemented, reviewed and evaluated.

1.5. The Operational Nurse Lead for Safeguarding Adults & Children

The Operational lead has a responsibility to ensure all referrals and contacts made to the service are reviewed, assessed and action/escalation is taken where appropriate.

1.6 The Named Doctor for Safeguarding Adults

The Named Doctor for Safeguarding Adults has a responsibility to provide Trust staff with advice regarding safeguarding adult issues.

1.7 Safeguarding Steering Group

This Group has a responsibility to review the Safeguarding Adults Policy prior to ratification by the Quality Committee and provide a forum for learning from safeguarding incidents. The Safeguarding Group is responsible for reviewing external reports and for monitoring those recommendations from local and national guidance are considered and where appropriate implemented.

1.8 Human Resources

Human Resources Department are responsible for ensuring that the Trust is undertaking all pre-employment checks including DBS and professional registration, where appropriate.

1.9 All Managers

Managers have a responsibility to ensure their staff are aware of and receive training through Trust Induction and Mandatory Training ensuring that the level of training is appropriate to their role. Managers have a duty to ensure that this policy is adhered to by staff within their area of responsibility.

1.10 All Staff

Trust staff at all levels, from strategic to operational, have a part to play in alerting concerns regarding an adult. All staff must:

- be familiar with and follow the Trust's policies and procedures for promoting and safeguarding the welfare of adults within the Trust and know who to contact within the organisation to express concern about their welfare
- receive safeguarding adults training as part of Trust induction and thereafter via mandatory training
- remember that an allegation of adult abuse or neglect may lead to a criminal investigation so staff must not do anything that may jeopardise a police investigation e.g. asking the adult leading questions or attempting to investigate allegations of abuse
- communicate with the adult in a manner appropriate to their age, understanding and preference. Reassure them but do not promise confidentiality. Discuss their concerns and any differences of opinion with their line manager and where appropriate escalated to the Named Nurse or Doctor for Safeguarding Adults
- record all concerns, discussions with the adult, decisions made and the reasons for those decisions in the nursing or medical records
- all Trust staff are responsible for co-operating with the development and implementation of corporate policies as part of their normal duties and responsibilities

1.11 Temporary Staff

Temporary or agency staff, contractors, students or others will be expected to comply with the requirements of all Trust policies applicable to their area of operation.

1.12 Social Services/Local Authority

The Local Authority Safeguarding Department has a statutory responsibility for the

protection of adults. Their aim is to make all local services for adults coherent and to ensure that relevant organisations identify, assess and manage adults in need of protection. Social Services will decide the process to follow once an alert has been made. They will lead the strategy meeting process and ensure the Trust is informed of any outcomes, through close liaisons with the safeguarding team.

1.13 Named Leads with specific duties and responsibilities within the Trust are:

- The Executive Lead for Safeguarding Adults at risk is Mrs Sue Pemberton (Director of Nursing and Quality)
- The Head of Nursing for Safeguarding Adults at risk is Mrs Joanne Shaw
- The Named Consultant for Safeguarding Adults is Dr Petra Jenkins
- The Operational Nurse is Miss Angela Mckenna
- Administrative support is Terri Marshall.

2. Procedure

2.1 The Safeguarding Principles

The DoH Care and Support Statutory Guidance 2014 identifies the 6 Safeguarding Adult Principles to assist health practitioners achieve good outcomes for patients. The principles should inform the ways in which professionals and other staff work with people at risk of abuse or neglect. The statutory guidance enshrines the six principles of safeguarding.

They are as follows:

Principle 1 - Empowerment
Personalisation and the presumption of person-led decisions and informed consent.

Principle 2 - Protection
Support and representation for those in greatest need.

Principle 3 - Prevention
It is better to take action before harm occurs.

Principle 4 - Proportionality
Proportionate and least intrusive response appropriate to the risk presented.

Principle 5 - Partnerships
Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Principle 6 - Accountability
Accountability and transparency in delivering safeguarding.

Further information can be found in appendix 3 and via the following link: DoH Care and Support Statutory Guidance p.194-195

Duties to empower people to make decisions and be in control of their care and treatment are underpinned by the Human Rights Act 1998, the Equality Act 2010 and the Mental Capacity Act 2005.

It is important to remember that the duty of care involves taking reasonable steps to identify and to reduce risk while respecting the person's right to make choices and that person led safeguarding does not override the duty to protect others from harm (DoH 2011).

2.2 Making Safeguarding Personal

Making Safeguarding Personal is a shift in culture and practice in response to what makes safeguarding more or less effective from the perspective of the person being safeguarded. It is about having conversations with people about how we might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives, talking through with people the options they have and what they want to do about their situation to improve their quality of life as well as their safety. Since 2000 and the publication of "No Secrets", the LA has been required to take a leading coordinating role with all relevant organisations on safeguarding adults in its area, the Care Act now places this in primary legislation for the first time.

The Care Act introduces new legislation governing social care but there is still a need for specialist and on-going training to keep up the legal literacy of specialist practitioners. LAs must also ensure they support workers to make sure they use the least restrictive options and comply with the Human Rights Act [HRA] and the Mental Capacity Act [MCA].

The focus is on both how people experience safeguarding services and the difference that it makes (through outcomes and through experience of the process).

Examples of the kind of outcomes that people might want are:

- To be and to feel safer
- To maintain a key relationship
- To get new friends
- To have help to recover
- To have access to justice or an apology, or to know that disciplinary or other action has been taken
- To know that this won't happen to anyone else
- To maintain control over the situation
- To be involved in making decisions
- To have exercised choice
- To be able to protect self in the future
- To know where to get help.

This is not an exhaustive list.

Where an adult lacks capacity to make decisions about their safeguarding plans, then a range of options should be identified, which help the adult stay as much in control of their life as possible. Wherever possible, the adult should be supported to recognise risks and to manage them. Safeguarding plans should empower the adult as far as possible to make choices and to develop their own capability to respond to risks.

2.3 Mental Capacity Act 2005 [MCA]

"A person lacks capacity in relation to a decision or proposed intervention if, at the material

time, he is unable to make a decision for himself in relation to the matter or proposed intervention because of an impairment of, or a disturbance in the functioning of the mind or brain. It does not matter whether the impairment or disturbance is permanent or temporary." (S2 (1) and (2) MCA 2005).

Professionals and other staff need to understand and always work in line with the MCA. They should use their professional judgment and balance many competing views.

Mental capacity is frequently raised in relation to adult safeguarding. The requirement to apply the MCA in adult safeguarding enquiries challenges many professionals, particularly where it appears someone has capacity for making decisions that nevertheless results in them being abused or neglected.

The MCA 2005 created the criminal offences of ill-treatment and wilful neglect in respect of people who lack the ability to make decisions. The offences can be committed by anyone responsible for that adult's care and support.

Ill-treatment covers both deliberate acts of ill-treatment and also those acts which are reckless which results in ill-treatment. Wilful neglect requires a serious departure from the required standards of treatment and usually means that a person has deliberately failed to carry out an act that they knew they were under a duty to perform.

Further information can be found via the link.

A person's capacity to make a decision will be established at the time that a decision needs to be made. A lack of capacity could be because of a severe learning disability, dementia, mental health problems, a brain injury, a stroke or unconsciousness due to an anaesthetic or a sudden accident.

It should also be noted that a person, who has mental capacity to make decisions, may have their ability to give free and true consent impaired, if they are under constraint, coercion or undue influence. Some situations may involve a criminal act and involve the police. In other circumstances, the High Court could be approached to exercise inherent jurisdiction.

Further information can be found in the mental capacity policy) or via the following link.

2.4 Deprivation of Liberty Safeguards [DoLS]

The Deprivation of Liberty Safeguards covers those individuals who lack the capacity to consent to make a decision to be accommodated in a hospital, hospice, residential care home or nursing home and for certain types of supported living which offers 24/7 care (or maybe less) and who are under constant control and supervision by staff and are not free to leave.

The safeguards apply to people aged 18 and over whom:

- suffer from a disorder or disability of mind
- lack the capacity to give consent to the arrangements made for their care or treatment
- for whom such care (in circumstances that amount to a deprivation of liberty within the meaning of Article 5 of the European Court of Human Rights) is considered, after an independent assessment, to be a necessary and proportionate response in their best interests to protect them from harm

The application of DoLS cannot be used to detain people in hospital for treatment of mental disorder in situations where the Mental Health Act 1983 could be used instead if they are thought to object to being in hospital or to treatment.

Further information regarding Deprivation of Liberty can be found in Deprivation of Liberty policy.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300106/DH_Note_re_S upreme_Court_DoLS_Judgment.pdf

3. Policy Implementation Plan

3.1 How to Raise Concerns

Health staff are uniquely placed to identify a possible safeguarding concern i.e. the community nurse may suspect a neighbour is financially exploiting a patient, a bank nurse may observe neglectful practice on a ward. It is essential that staff are aware of the types and indicators of abuse as suspected abuse or mistreatment of an adult at risk may come to the notice of staff in several ways:

- abuse or mistreatment is disclosed by the client / patient or third party
- there is evidence to suggest that abuse / neglect is taking place
- abuse / neglect are directly observed by a member of staff

All staff have a responsibility to act:

- staff must take responsibility for immediate safety i.e. contacting emergency services and the LA
- record and preserve evidence i.e. write down any disclosure in the persons own words and keep this hand written record; secure the room / clothing in cases of sexual assault
- raise an alert i.e. informs line manager and Trust safeguarding team or Named Doctor for Safeguarding. Making decisions about when to refer can sometimes be complex

If staff are unsure of actions they need to take they should seek guidance from the safeguarding team.It is important that if a case does not meet the criteria for a referral to the LA it still needs to be managed as a ‘Care Concern’ and a care plan should be developed and shared with the team by referral on the Electronic Patient Record [EPR] as an order.

All appropriate forms should be completed on EPR. Staff must also report via the incident reporting system. Involvement of the police is indicated in incidents of suspected theft, common assault (including sexual assault) and assault causing actual bodily harm. However, police may also be involved in other patient safety incidents such as wilful neglect for a person lacking capacity.

Additionally staff needs to be aware that certain types of patient safety incidents may prompt a healthcare provider to involve the police where there is:

- evidence or suspicion that the actions leading to harm were intended

- evidence or suspicion that the adverse consequences were intended
- evidence or suspicion of gross negligence and/or recklessness in a serious safety incident

When a decision is made not to refer through to the LA but to manage as a Care Concern this should be clearly documented in the health records. The heading for the clinical note entry should indicate 'Safeguarding Adults' and an enhanced care flow sheet care plan should be devised addressing the concern.

For incidents that meet the threshold for referral to LA staff must follow the local procedures for where the patient lives. The head of safeguarding must also be informed.

Making a referral is the start of the process and staff should be involved throughout. Once a referral is accepted there is an expectation that the member of staff will participate in the safeguarding process. This may include a multi-agency strategy discussion or meeting for which attendance is not optional. The purpose of the multi-agency strategy discussion or meeting will enable professionals to share and gather information, devise an action plan and agree duties and responsibilities. The member of staff may be asked to gather more information as they are the person most involved with the patient and may be best placed to do this rather than a person unknown to the potential victim of abuse.

The only time that the referrer may not be invited to the multi-agency strategy meeting is if the alleged perpetrator is a member of staff / colleague. This situation would involve senior managers,

3.1.1 Information Sharing

3.1.1.1 Principles of Sharing Information

Personal information held by professionals and agencies is subject to a legal duty of confidence and should normally only be disclosed to third parties, including other agencies, with the consent of the subject of the information. However there may be times when it will be necessary to disclose information without the subject's consent. Summarising the principles set out in the Caldecott Committees, No Secrets states that:

- information will only be shared on a need to know basis when it is in the best interest of the patient
- confidentiality must never be confused with secrecy
- informed consent should be obtained but if this is not possible and others are at risk it may be necessary to override this requirement
- it is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in situations when other people may be at risk

3.1.1.2 Sharing Personal Information

Before you share information you need to ask yourself the following questions:

- do I have the permission off the person to disclose personal information? If not;
    - do I have the legal power to disclose this information?
- is there a duty to protect the wider public interest, are other people at risk?
- am I proposing to share information with due regard to both common and statute

law?
- do I have the correct level of seniority to disclose this information?

The sharing of personal information must always be discussed.

Guidance From HM Government (2008) 7 Golden Rules and 7 Key Questions

7 Golden Rules for Information Sharing

1. Remember that the Data Protection Act (DPA) is not a barrier to sharing information.
2. be open and honest with the person or family.
3. Seek advice if you are in any doubt.
4. Share with consent where appropriate.
5. Consider safety and well-being.
6. Necessary, proportionate, relevant, accurate, timely, and secure.
7. Keep a record of your decision and reasons.

7 Key Questions for Information Sharing:

1. Is there a clear and legitimate purpose for sharing information?
2. Does the information enable a living person to be identified?
3. is the information confidential?
4. Do you have consent?
5. is there sufficient public interest?
6. Are you sharing appropriately and securely?
7. Have you properly recorded your decision?

Factors that may impact upon a person's rights to control safeguarding decisions include:

- risk to others
- public interest
- impaired capacity

3.1.2 Responding to Allegations of Professional Abuse

Professional abuse occurs when a professional takes advantage of their patient's trust, exploits their vulnerability, does not act in their best interests and fails to keep professional boundaries.

Any injury to a patient during restraint should always be considered as a safeguarding issue and a discussion should take place with the team . Injuries sustained during restraint should be recorded in line with Trust procedures and highlighted as 'safeguarding' and an entry recorded in clinical notes.

Any allegation made against staff that may constitute abuse must be referred immediately to the Head of Safeguarding , ensuring any immediate safety is managed appropriately and any evidence is preserved. In addition the Head of Nursing within the service must be immediately informed of the allegation in order that a decision can be made in conjunction with HR and the LA regarding any immediate action that needs to be taken in relation to staff involved.

In the case of an allegation made outside of office hours and during the weekend then the on-call procedure should be followed to seek advice and action required to ensure staff and patients are safeguarded.

Safeguarding strategy meetings relating to professional abuse will be chaired by a senior person independent of the Trust where Trust representation should be at a senior level. Terms of Reference for any investigation will be approved by the strategy group and clearly describe the relationship with the safeguarding adult's process.

The Trust will be guided by existing policies when requested to undertake an internal investigation but will, whenever possible, seek to complement any external investigation. The Trust will have due regard to the statutory powers of the police in relation to the investigation of suspected criminal acts and acknowledges that it is an offence under S129 of the Mental Health Act 1983 for any of its staff to obstruct an investigation by an authorised person.

3.1.2.1If a Manager is Involved

If staff suspect their manager is involved in the abuse they must report to another senior manager and the Named Nurse as soon as possible.

3.1.2.2Recording Incidents
Any staff member identifying potential abuse must clearly document the details of the incident. This record should include when and what happened, environment, individuals involved, objects etc. and a description of the scene.

3.1.2.3Notes of Allegations or Disclosures
If someone is making an allegation or disclosing abuse, staff must maintain contemporaneous records of what was reported to them and record verbatim what was said.

3.1.2.4Never Keep Secrets
Staff cannot ensure absolute confidentiality to patients if allegations or disclosures are made. Secrets cannot be kept. Staff must always share concerns, allegations or disclosures with their manager.

3.1.3 Patient on Patient Incidents

All patients on patient incidents are safeguarding issues. If they amount to assault (physical or sexual abuse), on-going verbal altercation / bullying (emotional abuse) or misappropriating another patients money / property (financial abuse) then they should be managed through the appropriate LA.

Making decisions about when to refer can sometimes be complex.

If staff are unsure of actions they need to take they should seek guidance from the team. It is important that if a case does not meet the criteria for a referral to the LA it still needs to be managed as a 'Care Concern' and a care plan should be developed and shared .

3.1.4 Self-Neglect

Mental capacity is a highly significant factor in both understanding and intervening in situations of self- neglect.

A duty of care is a requirement placed on an individual to exercise a reasonable standard of care while undertaking activities (or omissions) that could foreseeably harm others. However, duty of care also includes respecting the persons wishes and protecting and respecting their rights.

The Health Professionals Council standards state:

'…. A person who is capable of giving their consent has the right to refuse treatment. You must respect this right. You must also make sure they are fully aware of the risk of refusing treatment, particularly if you think there is a significant or immediate risk to life'.

Duty of care can be said to have reasonably been met where an objective group of professionals consider:

- all reasonable steps have been taken
- reliable assessment methods have been used
- information has been collated and thoroughly evaluated
- decisions are recorded, communicated and thoroughly evaluated
- policies and procedures have been followed
- practitioners and their managers adopt an investigative approach and are proactive

Extract from Scie report 46 - In the UK self-neglect currently falls outside the definitions that regulates adult safeguarding activities. Responses nationally are therefore diverse, and may be led through adult social care or through safeguarding procedures, depending on local arrangements. Whichever structure is used, strong emphasis is placed by practitioners on the importance of interagency communication, collaboration and the sharing of risk.

3.1.5 Responding To Discriminatory Abuse

Discriminatory abuse is a criminal offence committed against a person or property that is motivated, in whole or in part, by an offender's hatred of someone because of their:

- race / ethnic origin
- religion
- gender identity
- sexual orientation
- disability

Discriminatory abuse can take many forms including:

- physical attacks - such as physical assault, damage to property, offensive graffiti, neighbour disputes and arson
- threat of attack - including offensive letters, abusive or obscene telephone calls, and groups
- hanging around to intimidate and unfounded, malicious complaints
- verbal abuse or insults - offensive leaflets and posters, abusive gestures, dumping of rubbish outside homes or through letterboxes, and bullying at school or in the workplace

Where a criminal offence has not occurred this is referred to as a hate incident. Police are keen to be informed of any incidents as this enables them to try and address issues before a

crime is committed. It also assists in cases where crimes have been committed in evidencing the background / intention of the offender.

An example is a person with a learning disability who is befriended and exploited – financially, physically, and sexually. Often the person with learning disability 'accepts' the exploitation because they want the relationship with the 'friend'.

If staff becomes aware of situations they can refer directly to the LA.

3.1.6 Human Trafficking

Human trafficking is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, and abuse of vulnerability, deception or other means for the purpose of exploitation. British and foreign nationals can be trafficked into, around and out of the UK.
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Children, women and men can all be victims of human trafficking for a number of reasons:

- 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 benefits fraud
- organ harvesting

It is usually a combination of triggers, an inconsistent story and a pattern of symptoms that may cause a member of staff to suspect trafficking.

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 health worker

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

Staff have a duty of care to take appropriate action and a legal obligation in the case of any children under the age of 18 years.

If staff become aware of a person who they believe, or suspect, is a victim of trafficking they should contact the Named Nurse for further advice. This applies to both children and adults. https://www.gov.uk/government/publications/identifying-and-supporting-victims-of-human-

trafficking- guidance-for-health-staff

3.1.7 PREVENT Strategy

PREVENT is part of the Government's counter terrorism strategy (CONTEST), to identify and support those individuals at risk of being radicalised and drawn into terrorism and prevent them from doing so This is undertaken through a multi-agency approach known as 'Channel', where the individual who has been identified as at risk is discussed and actions agreed to help support them.

The strategy states:
"Healthcare professionals may meet and treat people who are vulnerable to radicalisation. People with mental health issues or learning disabilities (such as Nicky Reilly and Andrew Ibrahim, separately convicted in 2009 for terrorist-related offences) may be more easily drawn into terrorism. We also know that people connected to the healthcare sector have taken part in terrorist acts in the past."

The key challenge for the healthcare sector is to ensure that, where there are signs that someone has been or is being drawn into terrorism, the healthcare worker can interpret those signs correctly, is aware of the support which is available and is confident in referring

the person for further support. Preventing someone from becoming a terrorist or from supporting terrorism is substantially comparable to safeguarding in other areas, including child abuse or domestic violence.

If staff become aware of a person who they believe, or suspect, is being targeted staff must contact Helen Martin (PREVENT Lead). This applies to both children and adults.

Further information regarding the PREVENT Strategy can be found via the following link:

3.1.8 Responding to Domestic Abuse

Domestic abuse can include physical assault, sexual abuse, psychological abuse and financial exploitation. Anyone in society can suffer from this type of abuse, regardless of their age, gender sexual orientation, financial position, culture or beliefs. The abuse may be from someone they are currently in a relationship with or have previously had a relationship with. This includes abuse from family members (family members are defined as mother, father son, daughter, brother, sister and grandparents whether directly related, in-laws or step family) as well as opposite and same sex partners. Whatever form the abuse takes, it is rarely a one-off incident. It usually forms a pattern of coercive and controlling behaviour with which the abuser seeks power over the victim.

In all cases of domestic abuse where children are present in the household the case must be reported to Children's Social Care in accordance with Safeguarding Children Policy.

Incidents of domestic abuse should be reported the same day to the safeguarding team . The incident can be referred to the Domestic Abuse Family Safety Unit based within each locality area by the practitioner or Safeguarding Team.

Consideration should be given as to whether the incident also warrants a safeguarding referral as the two processes should run concurrently if required.

Health staff are in a unique position in that they may be the only professional involved with a victim or child who are in a domestic abuse situation, during the care / treatment episode they should ensure they see the person at least once on their own to give the opportunity to discuss and to make a disclosure. Questions relating to abuse should never be asked in the presence of a potential perpetrator.

As a minimum, staff who receives a disclosure should provide the victim / discloser with the National Domestic Abuse 24hr Helpline Freephone number: 0808 808 4494.

Clare's Law – Domestic Advice Disclosure Scheme

In addition, in March 2014 the Home Office introduced a scheme allowing police to disclose to individuals details of their partners' abusive pasts across England and Wales known as 'Clare's Law'. The aim of this is to give members of the public a formal mechanism to make enquires about an individual who they are in a relationship with or who is in a relationship with someone they know, and there is a concern that the individual may be abusive towards their partner.

For further information regarding Domestic Violence Disclosure Scheme follow the link.

All domestic abuse incidents are documented on the victim, children's and / or perpetrator's EPR to ensure practitioners continue to monitor and assess on-going risks Staff should also be alert to possible cases of Honour Based Violence, Forced Marriage and Female Genital Mutilation [FGM]; often these are mistaken as 'cultural norms'. A definition of each is listed below to assist staff in recognising possible cases all of which should be referred through Domestic Abuse / Safeguarding Procedures:

3.1.9 Honour Based Violence [HBV]

"'Honour based violence' is a crime or incident which has or may have been committed to protect or defend the honour of the family and/or community."

HBV is a form of domestic abuse which is perpetrated in the name of so called 'honour'. The honour code which it refers to is set at the discretion of male relatives and women who do not abide by the rules are then punished for bringing shame on the family. Infringements may include a woman having a boyfriend, rejecting a forced marriage, pregnancy outside of marriage, interfaith relationships, seeking divorce, inappropriate dress or make-up and even kissing in a public place.

HBV can exist in any culture or community where males are in position to establish and enforce women's conduct, examples include: Turkish, Kurdish, Afghani, South Asian, African, Middle Eastern, South and Eastern European, Gypsy and the travelling community (this is not an exhaustive list).

Males can also be victims, sometimes as a consequence of a relationship which is deemed to be inappropriate, if they are gay, have a disability or if they have assisted a victim. This is not a crime which is perpetrated by men only, sometimes female relatives will support, incite or assist. It is also not unusual for younger relatives to be selected to undertake the abuse as a way to protect senior members of the family. Sometimes contract killers and bounty hunters will also be employed. If staff have concerns they must contact the Named Nurse and police. Further information can be found via the following link.

3.1.3.1Forced Marriage

…'is a marriage in which one or both spouses do not (or in the case of some adults with learning or physical disabilities, cannot) consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and emotional pressure."

A Forced Marriage [FM] is a marriage conducted without the valid consent of one or both parties and where duress is a factor. FM is now a specific offence under 121 of the Anti-Social Behaviour, Crime and Policing Act 2014 and came into force on 16th June 2014. Prior to the introduction of the new offence, prosecutors have dealt with FM cases using existing legislation such as false imprisonment, kidnapping and offences of violence where this is a feature of the offending.

While it is important to have an understanding of the motives that drive parents to force their children to marry, these motives should not be accepted as justification for denying them the right to choose a marriage partner and enter freely into marriage. Forced marriage is a breach of children's rights under the UN Convention on the Rights of the Child [UNCRC] as well as an abuse of human rights.

Some of the key motives that have been identified are:

- controlling unwanted sexuality (including perceived promiscuity, or being lesbian, gay, bisexual or transgender) – particularly the behaviour and sexuality of women
- controlling unwanted behaviour, for example, alcohol and drug use, wearing make-up or behaving in a "westernised manner"
- preventing "unsuitable" relationships, e.g. outside the ethnic, cultural, religious or caste group
- protecting "family honour" or "izzat"
- responding to peer group or family pressure
- attempting to strengthen family links
- achieving financial gain
- ensuring land, property and wealth remain within the family
- protecting perceived cultural ideals
- protecting perceived religious ideals which are misguided
- ensuring care for a child or adult with support needs when parents or existing carers are unable to fulfil that role
- assisting claims for UK residence and citizenship
- long-standing family commitments

If staff have concerns they must contact the safeguarding team and or the police. Further information

3.1.3.2Female Genital Mutilation [FGM]

FGM involves procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life. From 31st October 2015 FGM became mandatory to report. This is a personal duty; the professional who identifies FGM/receives the disclosure must report.

NSPCC FGM helpline: 08000283550 fgmhelp@nspcc.org.uk

We must phone 101 if a girl we treat a) tells you she has had FGM b) Has signs which appear to show she has had FGM. Quick guide for professional.

Specific factors that may heighten a girl's or woman's risk of being affected by FGM
There are a number of factors in addition to a girl's or woman's community that could increase the risk that she will be subjected to FGM:

- the position of the family and the level of integration within UK society – it is believed that communities less integrated into British society are more likely to carry out FGM
- any girl born to a woman who has been subjected to FGM must be considered to be at risk, as must other female children in the extended family
- any girl who has a sister who has already undergone FGM must be considered to be at risk, as must other female children in the extended family
- any girl withdrawn from personal, social and health education or personal
- social education may be at risk as a result of her parents wishing to keep her uninformed about her body and rights

The age at which girls undergo FGM varies enormously according to the community. The procedure may be carried out when the girl is new-born, during childhood or adolescence, at marriage or during the first pregnancy. However, the majority of cases of FGM are thought to take place between the ages of 5 and 8 and therefore girls within that age bracket are at a higher risk.

Indications that FGM may have already taken place
It is important that professionals look out for signs that FGM has already taken place so that:

- the girl or woman affected can be offered help to deal with the consequences of FGM
- enquiries can be made about other female family members who may need to be safeguarded from harm
- criminal investigations into the perpetrators, including those who carry out the procedure, can be considered to prosecute those breaking the law and to protect others from harm

There are a number of indications that a girl or woman has already been subjected to FGM:

- may have difficulty walking, sitting or standing
- may spend longer than normal in the bathroom or toilet due to difficulties urinating
- a girl may spend long periods of time away from a classroom during the day with bladder or menstrual problems
- may have frequent urinary or menstrual problems
- may have prolonged or repeated absences from school or college;
- prolonged absence from school or college with noticeable behaviour changes (e.g. withdrawal or depression) on the girl's return could be an indication that a girl has recently undergone FGM
- may be particularly reluctant to undergo normal medical examinations
- may confide in a professional
- may ask for help, but may not be explicit about the problem due to embarrassment or fear

If staff have concerns they must contact the Named Nurse. Further information.

3.1.10 Responding to Historical Sexual Abuse

It is important to establish if there are any current risks by whom and to whom, if this information is given staff have a duty to report this to the relevant LA. Patients can be encouraged and supported to report the details of any historic abuse to the police.

Patients may need time to consider whether to report for various reasons, staff can revisit this at appropriate periods during therapy / interventions, it may also be appropriate to provide details of external agencies that specialise in supporting people who are victims of historical sexual abuse such as the Rape and Sexual Assault services [RASA].

Ensure that decisions are documented (i.e. if the patients refuses to give any details of the alleged perpetrator), staff would be unable to proceed with any referral.

3.1.11 Referral to Social Care and Escalation Process

Staff should follow the Local Authority Safeguarding Adult procedures. Staff should record in electronic health record the date and who they have spoken to in the Local Authority Access Team. This can be done using the document called professional discussion on EPR or as a note in EMIS for the Knowsley community team.

Acknowledgement of the referral from social care should be received within 48 working hours; the referrer should follow-up their referral if, after 3 working days, they have not had a response.

If staff have any concerns with regard to the outcome of the referral e.g. no further action and they have been unable to resolve this through further discussion with the social worker, they should escalate their concerns through the safeguarding team.

The team should contact the social worker team manager to discuss the case / concerns.

If concerns persist and remain unresolved the issue will continue to be escalated through health and social care management structures until a resolution is reached.

3.1.12 Safeguarding Strategy Meetings and Case Conferences

As lead agency the LA set out guidance within their Safeguarding Procedures for chairing strategy meetings and case conferences, staff who undertake this role should be appropriately trained/ experienced and must always ensure LA overview.

3.1.13 Safeguarding Adult Supervision

All staff who are involved in safeguarding adult issues should access supervision for this aspect of their clinical work. For further information please refer to the safeguarding supervision policy.

3.1.14 Serious Case Review and Domestic Homicide Reviews

If an adult at risk dies or experiences serious harm, the Local Safeguarding Adults Board will

consider if a Serious Case Review [SCR] is required. Nationally there is no requirement to undertake reviews, but they evidence best practice and commitment to improve Safeguarding Adult's services.

In 2013 the multi-agency statutory guidance for the conduct of Domestic Homicide reviews was revised by the Home Office to review its effectiveness.

Domestic homicide reviews should be carried out to make sure lessons are learned when a person has been killed as a result of domestic violence (domestic homicide).

In order for these lessons to be learned as widely and thoroughly as possible, professionals need to understand fully what happened in each homicide, and most importantly, to identify what needs to change in order to reduce the risk of such tragedies happening in the future.

The Trust will be notified of any cases that are being considered for review, case notes will be secured and a brief chronology will be requested. If a decision is made for review an independent author will be commissioned and a more detailed chronology will be required in the form of an Individual. The head of safeguarding will share any learning points and action plans through the Trust's Safeguarding Steering Group. For further information

3.1.15 Process for Audit, Monitoring and Compliance

In order to ensure that as an organisation we are collectively engaging with the safeguarding process to ensure that adults at risk are safeguarded, audit and monitoring processes are vital. These processes can be either local to the trust or multi agency.

Monitoring of this policy will be on-going to ensure it is current it will be reviewed and up-dated in line with any changes to policy or legislation.

Audit

There is an annual audit of safeguarding within the Trust and staff will be expected to support this programme and findings will be shared at the Trust's Safeguarding Steering Group and cascaded to all staff through the Divisions.

Through the Trust's membership with the Local Safeguarding Adults Health Sub Group, there may also be a requirement to participate in multi-agency audits. Again, the staff will be expected to support this programme.

3.1.16 Transition

Together the Children and Families Act 2014 and the Care Act, create a new comprehensive legislative framework for transition, when a child turns 18 (MCA applies once a person turns 16). The duties in both Acts are on the local authority, but this does not exclude the need for all organisations to work together to ensure that the safeguarding adult's policy and procedures work in conjunction with those for children and young people.

There should be robust joint working arrangements between children's and adults' services for young people who meet the criteria. The young person's care needs should be at the forefront of any support planning and requires a co-ordinated multi-agency approach. Assessments of care needs should include issues of

safeguarding and risk. Care planning must ensure that the young adult's safety is not put at risk through delays in providing services that they need to maintain their independence, well-being and choice.

Where there are on-going safeguarding issues for a young person and it is a n ticipated that on reaching 18 they are likely to require adult safeguarding, safeguarding arrangements should be discussed as part of transition. planning and protection. Conference chairs and Independent Reviewing Officers, if involved, should seek assurance that there has been appropriate consultation with the young person by adult social care and invite them to any relevant conference or review. Clarification should be sought on:

• What information and advice the young person has received about adult safeguarding
• The need for advocacy and support
• Whether a mental capacity assessment is needed and who will undertake it.
• If best interest decisions need to be made
• Whether any application needs to be made to the Court of Protection
If the young person is not subject to a plan, it may be prudent to hold a safeguarding meeting

3.2 Implentation

3.2.1 Training Requirements

Safeguarding awareness training will be delivered to staff groups as identified in the Trust's Training Needs Analysis [TNA] for safeguarding as part of their corporate induction and thereafter at mandatory training. This training includes as a minimum:

- changes in legislation, policy or requirements
- review of duties and responsibilities.

The Safeguarding ambassadors will be required to attend Level 3 training.

3.2.2 Implementation Responsibilities

The Director of Nursing is responsible for monitoring the implementation of this Policy.

The Head of Nursing for Clinical services and safeguarding and Safeguarding is responsible for ensuring that this document is reviewed and if required, revised in the light of legislative, guidance or organisational change. Once the document is revised it will be re-issued to departments and wards and posted on the intranet.

Ward Managers and Departmental Heads should ensure full implementation within their area.

3.2.3 Implementation Plan

- Policy update to be included in weekly communication email bulletin
- Policy to be appropriately archived and up to date policy on intranet
- Policy to be made available to public via the intranet

4. Monitoring of Compliance

The Education Department will produce quarterly training reports indicating the level of Safeguarding Adults training undertaken by staff this will be monitored by the head of safeguarding and the trust KPIs with the local commissioners .

- The policy will be audited annually by the Operational nurse on behalf of the Safeguarding Steering Group to ensure compliance. This will be reported in the annual Trust Board report.
- Reported cases will be reviewed by the Safeguarding Steering Group to ensure compliance with the policy; these will be reported in the annual Trust Board report.
- Any updates to this policy will be reviewed and agreed by the Safeguarding Steering Group and ratified by the Quality Committee.

5. References

https://www.gov.uk/government/publications/no-secrets-guidance-on-protecting-vulnerable-adults-in- care

Department of Health (2011) Safeguarding Adults Role of Health Service Practitioners

Mental Capacity Act (2005) Code of Practice

Mental Capacity Act (2005) Deprivation of Liberty Safeguards

The Law Commission Adult Social Care (2012)

The Forced Marriage (Civil Protection) Act (2007)

Self-neglect and Adult Safeguarding - Findings from Research 2011
www.scie.org.uk

Home Office (2011) Statutory Guidance on conducting Domestic Homicide Review

Home Office (2012) Call to End Violence against Women and Girls Taking Action

Home Office (2011) PREVENT Strategy

Department of Health: Identifying and Supporting Victims of Human Trafficking: Guidance for Health Staff (2013)

NICE Guidance: Domestic violence and abuse public health guidance 50 (2014)

Care Act (2014), HMSO (June 2014)

Care Act Learning and Development Programme - safeguarding Adults, Skills for Care

(October 2014)

Cheshire and Wirral partnerships safeguarding adults CP10 issue 8

Care Act Operational Guidance, Department of Health (due for publication 2014). Care and Support Statutory Guidance issued under the Care Act (2014), Department of Health (June 2014 with revised guidance due Autumn 2014)

Carers and Safeguarding Adults - Working Together to Improve Outcomes", ADASS publication (July 2011)

Making Safeguarding Personal 2013/14 Report of findings, LGA &ADASS (March 2014)

Making Safeguarding Personal 2013/14: selection of tools used by participating councils, LGA and ADASS (April 2014)

National Competence Framework for Safeguarding Adults", Bournemouth University, Learn to Care, Skills for Care and the Social Care Institute for Excellence (September 2010)

Reading Notes

Care Act 2014 Statutory Guidance (Department of Health, 2016)

The legal framework for the Care Act 2014 is supported by this statutory guidance which provides information and guidance about how the Care Act works in practice. The guidance has statutory status which means that there is a legal duty to have regard to it when working with adults who have care and support needs and carers.

Mental Capacity Act 2005 Code of Practice (Department of Constitutional Affairs, 2007)

The legal framework provided by the Mental Capacity Act 2005 is supported by this Code of Practice, which provides guidance and information about how the Act works in practice. The code has statutory force, which means that certain categories of people have a legal duty to have regard to it when working with adults who may lack capacity to make decisions for themselves.

SCIE: Adult Safeguarding Sharing Information
This guide is part of a range of products to support implementation of the adult safeguarding aspects of the Care Act 2014. Sharing the right information, at the right time, with the right people, is fundamental to good practice in safeguarding adults but has been highlighted as a difficult area of practice.

- SCIE guide Adult Safeguarding: sharing information
- SCIE's seven golden rules for information sharing

NHS Accountability and Assurance Framework (Department of Health, 2015)

This document sets out the safeguarding roles, duties and responsibilities of all organisations in the NHS. It has been refreshed in partnership with colleagues from across

the health and social care system, the Department of Health and the Department for Education.

Making Safeguarding Personal Guide 2014 (Local Government Association)

This guide is intended to support councils and their partners to develop outcomes focused, person-centred safeguarding practice. It was originally drafted to support the 53 councils who signed up to Making Safeguarding Personal (MSP) in 2013/14. It has been updated based on their experience. It gives some guidance about how to embark upon and take forward Making Safeguarding Personal in your council.

Commissioning for Better Outcomes (Department of Health, Local Government Association, ADASS, Think Local, Act Personal)

This guidance outlines standards to support a dynamic process of continuous improvement and, through self-assessment and peer review, to challenge commissioners and their partners, to strengthen and innovate to achieve improved outcomes for adults using social care, their carers, families and communities. The standards are relevant to all aspects of commissioning and service redesign, including decommissioning. The standards have been designed to reflect the improvements that experience has shown are needed, to support the transformation of social care to meet people's reasonable aspirations, and to support the implementation of the Care Act 2014.

Disclosure and Barring Service

The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA). DBS is an executive non-departmental public body, sponsored by the Home Office.

Nursing and Midwifery Council [NMC]

The NMC regulates nurses and midwives in England, Wales, Scotland and Northern Ireland and exists to protect the public. They set standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare throughout their careers. They are responsible for investigating nurses and midwives who fall short of their standards. They maintain a register of nurses and midwives allowed to practise in the UK.

General Medical Council [GMC]

The GMC helps to protect patients and improve medical education and practice in the UK by setting standards for students and doctors. The GMC supports them to achieve and exceed those standards, and take action when they are not met.

Health and Care Professions Council

The Health and Care Professions Council's standards of proficiency for social workers in England. The standards of proficiency set out what a social worker should know, understand and be able to do when they complete their training so that they can register with them.

Social workers in England - Health and Care Professions Council

National Institute for Health and Care (NICE) -Transitions from Children's to Adults Services

This guidance outlines the quality standards that cover all young people (aged up to 25) using children's health and social care services who are due to make the transition to adults' services.

6. Appendices

APPENDIX 1

Indicators of Abuse

The following lists are purely indicators. The presence of one or more does not necessarily confirm abuse.

Physical Abuse Indicators

- injuries that are not explained satisfactorily
- person exhibiting untypical self-harm
- unexplained bruising to the face, torso, arms, back, buttocks, thighs in various stages of healing; collections of bruises that form regular patterns which correspond to the shape of an object or which may appear on several areas of the body
- unexplained burns to unlikely areas of the body, for example, soles of the feet, palms of the hands and back; immersion burns; rope burns; burns from an electrical appliance
- unexplained, or inappropriately explained, fractures at various stages of healing to any part of the body
- unexplained cuts or scratches to mouth, lips, gums, eyes or external genitalia;
- medical problems that go unattended
- sudden or unexplained urinary and or faecal incontinence
- evidence of over or under medication

This list is not exhaustive

Sexual Abuse Indicators

- 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
- person appears unusually subdued, withdrawn or has poor concentration
- 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
- a woman who lacks the mental capacity to consent to sexual intercourse becomes pregnant

This list is not exhaustive.

Financial Abuse Indicators

- lack of money especially after benefit day
- inadequately explained withdrawals from accounts
- inadequately explained inability to pay bills
- disparity between assets/income and the living conditions
- Power of Attorney obtained when the person lacks the necessary capacity to make this decision
- recent acquaintances expressing a sudden or disproportionate interest in the person and their money
- reluctance to pay for necessary food, clothes or items

This list is not exhaustive.

In addition there are certain factors, which may increase the risk of a person being financially abused:

- person has guaranteed high benefit, income
- person is unable to administer their own money due to lack of capacity/numeracy skills
- person has several workers/carers managing their money and accessing their pin numbers
- carers becoming financially dependent on a person/service user
- person who is isolated or lonely being exposed to financial pressure, for example from loan firms

Neglect Indicators

- person has inadequate heating and / or lighting
- person's physical condition / appearance is poor, for example, 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 or 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

This list is not exhaustive

Psychological or Emotional Abuse Indicators

- untypical changes in behaviour, for example, continence problems, sleep disturbance, depression or fear
- person is not allowed visitors or phone calls
- person locked in their home
- person is denied access to aids or equipment, for example, 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

This list is not exhaustive.

Be aware that every other category of abuse will almost inevitably involve elements of psychological abuse. Signs of psychological abuse may be indicative of other forms of abuse taking place.

APPENDIX 2

DoH Safeguarding Adults: Role of Health Service Practitioners 2011 Safeguarding Principles

The Government has agreed principles for Safeguarding Adults that can provide a foundation for achieving good outcomes for patients.

Principle 1 – Empowerment
Presumption of person led decisions and consent
Adults should be in control of their care and their consent is needed for decisions and actions designed to protect them. There must be clear justification where action is taken without consent such as lack of capacity or other legal or public interest justification. Where a person is not able to control the decision, they will still be included in decisions to the extent that they are able. Decisions made must respect the person's age, culture, beliefs and lifestyle.

Principle 2 – Protection
Support and representation for those in greatest need
There is a duty to support all patients to protect themselves. There is a positive obligation to take additional measures for patients who may be less able to protect themselves.

Principle 3 – Prevention
Prevention of harm or abuse is a primary goal. Prevention involves helping the person to reduce risks of harm and abuse that are unacceptable to them. Prevention also involves reducing risks of neglect and abuse occurring within health services.

Principle 4 – Proportionality
Proportionality and least intrusive response appropriate to the risk presented
Responses to harm and abuse should reflect the nature and seriousness of the concern. Responses must be the least restrictive of the person's rights and take account of the person's age, culture, wishes, lifestyle and beliefs. Proportionality also relates to managing concerns in the most effective and efficient way.

Principle 5 – Partnerships
Local solutions through services working with their communities
Safeguarding adults will be most effective where citizens, services and communities work collaboratively to prevent, identify and respond to harm and abuse.

Principle 6 – Accountability
Accountability and transparency in delivering safeguarding
Services are accountable to patients, public and to their governing bodies. Working in partnerships also entails being open and transparent with partner agencies about how safeguarding responsibilities are being met.

APPENDIX 3

Good Practice Guidelines

Recognising Signs of Adult Abuse

- thinking about what you see and asking yourself if it is acceptable practice
- working strictly in accordance with anti-oppressive practice
- taking seriously what you are told
- being alert to hints, signals, non-verbal communication that could indicate abuse

Responding to Disclosure

- incidents of abuse or crimes may only come to light because the abused person themselves tells someone
- the person may not consider that they are being abused when they tell you what is happening to them
- disclosure may take place many years after the actual event
- disclosure may take place when the person has left the setting in which they were abused
- even if there is a delay the information must be taken seriously

Coping with Disclosure

If someone makes an allegation or discloses abuse to you:

DO

- stay calm and try not to show shock
- listen carefully
- be sympathetic

Tell the person that:

- they did the right thing to tell you
- you are treating the information seriously
- it was not their fault
- you will have to report the information to your manager
- report to your manager
- write down what the person said to you as soon as possible

DO NOT

- question the person about the incident
- ask the person who, what, why where, when questions. This is the role of the police
- promise to keep secrets
- make promises that you cannot keep, for example. 'this will not happen to you again'
- contact the alleged abuser
- be judgmental, for example, 'why didn't you run away?'
- gossip about the incident
- bathe the person
- wash the person's clothes or bedding
- touch or move anything in the room where the person has been abused

When in doubt seek advice from your Manager.

Capacity and Consent - Person's Capacity

In every situation it will be assumed that a person can make their own decisions unless it is proved that they are unable to do so. That is, there will be a presumption of capacity.

Person Lacking Capacity

A person lacks capacity in relation to a matter if at the material time s/he is unable to make a decision for him/herself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain (Mental Capacity Act 2005)

A person is unable to make a decision for him/herself if s/he is unable:

- to understand the information relevant to make the decision and/or
- to retain the information and/or
- use or weigh that information as part of the process of making the decision and/or
- to communicate the decision (whether by talking, using sign language or any other means) (Mental Capacity Act 2005)

Importance of Capacity and Consent

Issues of capacity and consent are central both in deciding whether an act or transaction was abusive and in deciding to what extent the person can, and should be asked to take decisions about how they want the incident dealt with.

During the investigation process, it is essential that you are certain that the abused person fully understands the nature of the concerns and the choices facing them.

Lack of Capacity

Circumstances where the abused person is considered to lack capacity might include those:

- where the person does not know that they have a decision to make
- where the person does not understand the choices available or the consequences of those choices
- where the person cannot communicate their decision. Every effort must be made to assist the persons understanding of the situation and the communication of their wishes

If it is established that a person does not have capacity then staff should act in their best interest. The person's best interest must be decided in a multidisciplinary setting and not just by one individual or agency.

Intimidation and Coercion

There may be situations where the abused person seems able to make their own decisions in terms of their knowledge and understanding. However, they may be subject to undue pressure or too afraid to disagree with a particular course of action. If you feel this is the case the person should be offered distance from the situation in order to facilitate decision-making.

Consent Not Given

- the wishes of the adult at risk should be respected unless it is established that they lack the capacity to recognise their vulnerability / situation
- if in doubt of the vulnerable adult's ability to give consent or make an informed choice, discuss with your line manager
- if the circumstance is such that, other people are at risk, then discuss with the line manager for appropriate action

- if the adult at risk is a tenant, resident, patient etc., in a statutory, voluntary or private institutional setting, and it is deemed that any suspected or actual abuse incident may impinge on others' rights and / or may involve situations where the alleged abuser is a member of staff, then the incident must be reported, regardless of the vulnerable adult's wishes

To support efficient and appropriate response when requesting telephone advice from Adult Safeguarding Team have ready the information below:

1. **Basic Details –** name, role and where you work (ward/department/service/locality)
2. **Victim details –** name and DOB of person at risk/potential risk and your relationship with them i.e. care co-ordinator. Are they victim or perpetrator?
3. **Perpetrator details –** name and relationship to the victim of alleged perpetrator(s)
4. **Children –** have details (name, address, DOB) available where children are involved
5. **Concern –** type of abuse (physical, psychological, financial, sexual, neglect, domestic), details of incident including any substantive evidence/involvement of other agencies i.e. Police.
6. **Capacity –** does the victim have capacity? Has an issue specific capacity assessment been completed and documented?
7. **Risk –** is there risk to others? What are they and to whom?
8. **Actions –** what action has been taken to reduce risk?
9. **Expectations –** what type of advice do you need:
    - Confirmation of action taken
    - How to proceed
    - Support / supervision
    - Attendance at meetings
    - Contact numbers / advice of other agencies
10. **Record –** document in service user record under heading Safeguarding, make a note who you have spoken to and advice that has been given

7. Endorsed By

Name of Lead Clinician/ Manager or Committee Chair	Position of Endorser or Name of Endorsing Committee	Date

8. Record of Changes

Section Number	Version Number	Date of Change	Description of Amendment	Description of Deletion	Description of Addition	Reason
Page 4	**7**	27/5/21			The Operational Nurse lead for Adult & Children's safeguarding at LHCH is 0151 254 3058 or Angela.Mckenna@lhch.nhs.uk	Operational nurse lead contact details added.
Page 4	**7**	27/5/21			The Operational lead has a responsibility to ensure all referrals and contacts made to the service are reviewed, assessed and action/escalation is taken where appropriate.	The Operational Nurse Lead for Safeguarding Adults & Children – Added to roles and responsibilities.
Page 4	7	27/5/21		Quality and Safety Experience Committee (QSEC) This Committee has a duty to receive the Safeguarding Adults Policy and consider its content for ratification		This policy no longer gets ratified at QSEC it goes via the Safeguarding Steering Group.

Page 5	7	27/5/21	CRB check changed to DBS check			Name change updated.
Page 19, 20, 21	7	27/5/21	Safeguarding action group changed to Steering group			Name change update
Page 21	7	27/5/21	Learning and Development department changed to The Education department			Name change update