**dUKE sTREET SURGERY**

**SAFEGUARDING Adult Policy**

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| **Document Reference:** | AdultSGpolicy |
| **Document Title:** | Duke Street Surgery Adult Safeguarding Policy |
| **Version:** | 2.0 |
| **Supersedes:** | 1.0 |
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| **Date Ratified:** | March 2017 |
| **Review Date:** | March 2019 |

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**Version Control**

| **Version** | **Date** | **Author** | **Status** | **Comment / Details of Amendments** |
| --- | --- | --- | --- | --- |
| 1.1 | 26/11/2014 | Lorraine Elliott | Final |  |
| 1.2 | 19/02/2015 | Lorraine Elliott | Final | Amended to reflect the Care Act requirements |
| 1.3 | 18/11/2015 | Lorraine Elliott | Final | Amended to reflect new LCFT SG contact number |
| 1.4 | 21/11/16 | Lorraine Elliott | Final | Amended to reflect updated Care and Support Statutory Guidance and Section 54 of the Modern Slavery Act |
| 2.0 | 15.03.17 | Lorraine Elliott | Final | Updated to reflect guidance |
| 2.1 | 23/10/2017 | Kirsty Byrne | Final | Updated to reflect MBCCG boundary change |

**Circulation List**

Following Approval this Policy Document will be circulated to:

* GP Practices

**Review of Policy: This document will be reviewed in 2019 or before this date in the event of national updates.**

This sample Safeguarding Adult Policy is based on the Pan Lancashire and Cumbria Safeguarding Adults Board procedures and RCGP GP Toolkit. It will support GP Practices in promoting the wellbeing of adults with care and support needs who may be experiencing or at risk of abuse.

It has been adapted by the Designated Lead Nurse for Safeguarding Adults and Mental Capacity Act from NHS Chorley and South Ribble CCG, NHS Greater Preston CCG and NHS West Lancashire CCG.

Further adaptations have been made by MBCCG SG Team to reflect local boundary changes and provision of services.

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**1. INTRODUCTION**

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

“The support and protection of adults cannot be achieved by a single agency, every service has a responsibility”. **Safeguarding is a shared responsibility**. The practice team is not responsible for making a diagnosis of adult abuse and neglect; however is responsible to share concerns appropriately and refer onto the relevant agency responsible for carrying out an assessment of need based on the safeguarding allegations.

* 1. **Why is safeguarding necessary in general practice?**

GPs remain the **first point of contact** for most people with health problems, this sometimes includes families who are not registered but seek medical attention. Adults with care and support needs are part of the general practice population and should be registered with a general practitioner (GP); it is important that a coordinated approach is taken in response to management of their health needs.

Safeguarding adults is a complex area of practice. The client group is extremely wide, ranging from adults who are incapable of looking after any aspect of their lives, to individuals experiencing a short period of illness or disability. A wide range of services and service providers can also be involved, making it difficult to identify those with responsibility. Safeguarding adults is everybody’s responsibility.

A key area of consideration is the implementation of the **Mental Capacity Act (MCA)** which is supported by a Code of Practice and sets out the legal framework for people who lack capacity. The MCA identifies who can take decisions and in what situations, as well as protecting the right of the individual not to be treated as unable to make a decision merely because they make an unwise decision.

There is also the question of whether the adult can best be safeguarded through ordinary care routes, or whether the risks require the involvement of dedicated multi-agency safeguarding procedures. Health services have a duty to safeguard all patients and provide additional measures for patients who are less able to protect themselves from harm or abuse.

A GP may be the first to recognise an individual’s health problems or carer related stress issues, or someone whose behaviour may pose a risk to adults with care and support needs. The primary health care team may be the only professionals to have contact with vulnerable adults and it is important that any response taken is appropriate and timely.

The long-term effects of abuse are widely documented and include a range of physical, psychological, emotional and social effects, early detection and intervention where appropriate is paramount.

It is crucial that a holistic approach is taken with families when treating a patient or carer who may be experiencing domestic abuse, mental health or learning difficulties or where there is substance misuse (including alcohol). This includes ensuring that the needs of the individual and any adults they are caring for are assessed and that referral on to appropriate services such as social care is considered.

GP practices have a **duty of care** for all those to whom they provide care and services. This includes ensuring their safety on GP premises and minimising any risk presented by practice staff, including GPs, by having in place within the practice, guidance for safe recruitment practices, procedures for managing allegations against workers and whistle blowing procedures that reflect the policies within Lancashire Safeguarding Adult Board.

1.2 **Scope**

The aim of this policy is to ensure that throughout the work of Duke Street Surgery we will safeguard and promote the welfare of adults with care and support needs. We aim to do this by ensuring that we comply with statutory and local guidance for safeguarding and by ensuring safeguarding the rights of adults with care and support needs is integral to all we do.

Duke Street Surgeryis committed to implementing this policy and the practices it sets out. The Practice will provide learning opportunities and make provision for appropriate safeguarding adults training to all staff and partners. This policy will be made widely accessible to staff and partners and reviewed on **[Published on 12th March 2018].**

This policy addresses the responsibilities of all partners and practice employees and those with whom we have arrangements. It is the responsibility of the practice manager and the practice lead for safeguarding, to brief the staff and partners on their responsibilities under the policy.

1.3 **Principles**

Duke Street Surgery recognise that safeguarding adults is a shared responsibility with the need for effective joint working between agencies and professionals, with acknowledgement of different roles and expertise if the adult at risk is to be protected from harm. In order to achieve effective joint working there must be constructive relationships at all levels, promoted and supported by:

* the **commitment** of all staff, at all levels within the practice to safeguarding and promoting the welfare of adults with care and support needs;
* clear lines of **accountability** within the practice for work on safeguarding;
* practice **developments** that take account of the need to safeguard and promote the welfare of adults and is informed, where appropriate, by the views of the adult and their families where appropriate;
* staff **training and continuing professional development** so that staff have an understanding of their roles and responsibilities, and those of other professionals and organisations in relation to safeguarding adults;
* Safe working practices including **recruitment and vetting** procedures;
* Effective **interagency working**, including effective information sharing.

1.4 Breaches of policy

For employees, failure to adhere to the Safeguarding Adults Policy could lead to dismissal or constitute gross misconduct. For others (volunteers, supporters, donors, and partner organisations) their individual relationship with the practice may be terminated.

**1.5 Key Definitions**

**1.5.1 Adult Safeguarding**

The Department of Health (2011) have agreed best practice principles for safeguarding adults that should be utilised to provide a benchmark 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. Clear justification must be made and documented 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 should 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**

All staff have a duty to support all patients to protect themselves. Staff have 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*.* The skills of the multiagency team should be utilised when safeguarding adults with care and support needs.

# **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.

**1.5.2 Adult at Risk**

The Care Act 2014 defines safeguarding duties which apply to an adult who

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

This could include people with learning disabilities, mental health problems, older people and people with physical disabilities or impairments. This can include people who are vulnerable themselves as a consequence of their role as a carer for such a person. They may need additional support to protect themselves, for example, in situations such as domestic abuse, physical frailty or chronic illness, sensory impairment, challenging behaviour, drug or alcohol problems.

The risks that increase a person’s vulnerability should be appropriately assessed and identified by the health care professional at the first contact and continue throughout the care pathway (DH 2010).

Support provided should be appropriate to the person's physical and mental abilities, culture, religion, gender and sexual orientation and tailored to enable people to live lives that are free from violence, harassment, humiliation and degradation.

**1.5.3 Adults with capacity**

A person’s ability to make a particular decision may be affected by:

* Duress and undue influence;
* Lack of mental capacity.

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

Safeguarding interventions must ensure that when an adult with mental capacity takes a decision to remain in an abusive situation, they do so **without duress or** **undue influence**, with an understanding of the risks involved, and with access to appropriate services should they change their mind. The exception to this principle would occur in situations where the decision may have been influenced by threat or coercion and consequently lack validity and need to be over-ridden.

The Royal College of General Practitioners, with IRIS and CAADA have produced guidance for general practices to help them respond effectively to patients experiencing domestic abuse. The [guidance](http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/Clinical%20Priorities/Domestic%20Violence/RCGP-Responding%20to%20abuse%20in%20domestic%20violence-January-2013.ashx) includes key principles to help you develop your domestic abuse policy.

The Association of Directors of Adult Social Services (ADASS) have also published [guidance](https://www.adass.org.uk/AdassMedia/stories/Adult%20safeguarding%20and%20domestic%20abuse%20April%202013.pdf) on making the connection between domestic abuse and adult safeguarding where they should be considered in tandem due to the overlap.

The guidance will support the knowledge and confidence of professionals so that the complexities of working with people who need care and support and who are also experiencing/reporting domestic abuse are better understood and better outcomes for people can be achieved as a result. It also makes links with children’s safeguarding where adult safeguarding and domestic abuse are being addressed and children are involved or present as family members. Professionals have a duty to refer to children’s services, using local policies and procedures, even if the adult victim chooses not to, or is not able to, accept help for themselves. This policy must be read in conjunction the GP Sample Domestic Violence and Abuse Policy.

Adults who are or may be eligible for social care or health services and whose independence and well-being is at risk due to abuse can expect arrangements to be made that will promote their safety, independence and well-being in both the short and longer term. All adults should have wherever possible:-

* The right to be **safeguarded** from abuse.
* Their **needs** regarded as paramount.
* The right to be taken **seriously.**
* To be offered **independent advocacy** and/or support and be kept **informed** of safeguarding processes and outcomes, as appropriate.
* The right to appropriate **information** on the safeguarding adult process.
* The right to **privacy and confidentiality** throughout the safeguarding process, except where there is a requirement to override.
* The right to be **involved** in decisions regarding themselves, made as a result of the safeguarding process.

Any intervention to protect an adult must be carried out with the **consent** of the adult concerned. There may be occasions where their consent may not be valid, due to consent needing to be over-ridden by an agency’s duty to protect others.

**1.5.4 Lack of mental capacity for a specific decision**

The Mental Capacity Act (MCA) 2005 provides a [statutory framework](http://www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act) that underpins issues relating to capacity and protects the rights of individuals where capacity may be in question. MCA implementation is integral to safeguarding adults.

The 5 principles of the MCA must be followed and are directly applicable to safeguarding:

1. **A person must be assumed to have capacity unless it is established that he lacks capacity**. Assumptions should not be made that a person lacks capacity merely because they appear to be vulnerable;
2. **A person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success**. Empower patients to make decisions about managing risks e.g. use communication aides to assist someone to make decisions; choose the optimum time of day where a person with cognitive impairment may best be able to evaluate risks;
3. **A person is not to be treated as unable to make a decision because he makes an unwise decision**. Patients will wish to balance their safety with other qualities of life such as independence and family life. This may lead them to make choices about their safety that others may deem to be unwise but they have the right to make those choices;
4. **An act or decision made under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests**. Best interest decisions in safeguarding take account of all relevant factors including the views of the patient, their values, lifestyle and beliefs and the views of others involved in their care;
5. **Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s right and freedom of action**.

Where a person lacks capacity to make a decision, any use or restriction and restraint must be necessary and proportionate and to prevent harm to that person. Safeguarding interventions need to balance the wish to protect the patient from harm with protecting other rights such as right to family life.

**All interventions in safeguarding vulnerable adults must be:-**

* lawful
* proportionate to the risk
* respectful of the wishes of the person at risk with regard to their human rights

**1.5.5 Deprivation of Liberty Safeguards**

The practice will also consider whether a person is deprived or their liberty as defined by the MCA in its Deprivation of Liberty Safeguards. If this deprivation is thought to be unlawful, this will be reported to the Local Authority within a reasonable time frame of usually no longer than 48 hours. The Local Authority holds the legal power to process an application and make a Deprivation of Liberty Safeguard (DOLS) order where it is decided that a person’s freedom needs to be restricted in their best interests.

**1.5.6 Independent Mental Capacity Advocate (IMCA)**

An independent Mental Capacity Advocate (IMCA) will be sought by the practice if the person lacking capacity has no one to represent them. The process for sourcing an advocate is as follows: insert local procedure here. An IMCA must be engaged if major treatment decisions are being made or if a change of residence is being considered. If a patient has no one to represent them during the course of a safeguarding investigation an IMCA should be used.

This service is available from **People First Independent Advocacy service**

**2. SAfeguarding Adults Policy**

2.1 **Statement of Responsibilities**

**Partners**

* To ensure that safeguarding adults is integral to clinical governance and audit arrangements within the practice;
* Ensure that the practice meets the contractual and clinical governance arrangements on safeguarding adults;
* To ensure that all staff in contact with adults with care and support needs are alert to the potential indicators of abuse or neglect, and know how to act on those concerns in line with local guidance;

**Practice Manager**

* To ensure that the practice operates safe recruitment processes in line with national and local guidance including disclosure and barring and managing allegations against staff;
* Ensure safeguarding responsibilities are reflected in all job descriptions;

**Practice Safeguarding Lead**

This person cannot be the practice manager as they have a separate disciplinary role and it cannot be a non-employed member of the team. The roles and responsibilities do not equate to a full time role but where a person is identified to take on this role, these duties should be included in the job description. (Consideration should be given to a GP or practice nurse taking on this role).

The practice safeguarding lead is **Dr Alistair Harrison**

His/her deputy is **Dr Ian Wear**

* Act as a focus for external contacts on safeguarding adult and Mental Capacity Act matters; this may include requests to contribute to sharing information required for adult reviews, domestic homicide reviews, multi-agency/ individual agency reviews and contribution to safeguarding investigations where appropriate;
* Disseminate information in relation to safeguarding adults/Mental Capacity Act to all practice members;
* Act as a point of contact for practice members to bring any concerns that they have, to document those concerns and to take any necessary action to address concerns raised;
* Assess information received on safeguarding concerns promptly and carefully, clarifying or obtaining more information about the matter as appropriate;
* Facilitate access to support and supervision for staff working with adults with care and support needs and their families;
* Ensure that the practice team completes the practice’s agreed **incident forms** and **analysis of significant events forms**

The responsibilities are to:

* Be fully conversant with the practice safeguarding adult policy, the policies and procedures of Cumbria Safeguarding Adult Board; and the integrated processes that support safeguarding;
* Be responsible for facilitating training opportunities for individual staff groups;

**Individual staff members, including all partners, employed staff and volunteers**

* To be alert to the potential indicators of abuse or neglect for adults with care and support needs and know how to act on those concerns in line with national guidance and Lancashire safeguarding adult procedures;
* To be aware of and know how to access Pan Lancashire and Cumbria Safeguarding Adults Board’s (LSAB) [policies and procedures](http://www.lancashiresafeguarding.org.uk/lancashire-safeguarding-adults/policies-and-procedures.aspx) for safeguarding adults;
* To take part in training, including attending regular updates so that they maintain their skills and are familiar with procedures aimed at safeguarding adults and implementation of the Mental Capacity Act;
* Understand the principles of confidentiality and information sharing in line with local and [government guidance](https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice);
* To contribute, when requested to do so, to the multi-agency meetings established to safeguard and protect adults with care and support needs;
* To minimise any potential risk to adults with care and support needs;

**3. RECOGNITION OF THE ABUSE AND NEGLECT OF ADULTS WITH CARE AND SUPPORT NEEDS**

Safeguarding duties have a legal effect in relation to all organisations. The aim of safeguarding is to prevent harm and reduce the risk of abuse or neglect and to stop or prevent abuse or neglect wherever possible. Safeguarding means protecting an adult’s right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult’s wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances. Professionals should work with the adult at risk to establish what being safe means to them.

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

**3.1 Categories of Abuse**

# **Physical abuse:** including assault, hitting, slapping, pushing and misuse of medication, restraint or inappropriate physical sanctions.

# **Domestic abuse:** including psychological, physical, sexual, financial, emotional abuse; so called ‘honour’ based violence, forced marriage or female genital mutilation. The cross government definition of domestic violence and abuse is any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those age 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.

# **Sexual abuse:** including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

# **Psychological abuse:** including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.

# **Financial or material abuse:** including theft, fraud, internet scamming, coercion in relation to an adult’s financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

# **Modern slavery:** encompasses slavery, human trafficking and forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment. The Modern Slavery Act 2015 was introduced in the UK with the intention of combatting slavery and human trafficking.

# **Discriminatory abuse:** including forms of harassment, slurs or similar treatment;

# because of race, gender and gender identity, age, disability, sexual orientation or

# religion.

# **Organisational abuse:** including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one’s own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

# **Neglect and acts of omission**: including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

# **Self-neglect**: covers a wide range of behaviour, neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding. Self-neglect may not prompt a section 42 enquiry however an assessment will be made on a case by case basis. A decision as to whether a response is required under safeguarding will depend on the adult’s ability to protect themselves by controlling their own behaviour. There may come a point when the individual is no longer able to do this without external support.

# It is important to note that any or all of these types of abuse may be perpetrated as the result of deliberate intent, negligence or ignorance.

**3.2 Prevent**

**Radicalisation** is defined as the process by which people (children or adults) begin to support terrorism and violent extremism and in some cases, to then participate in terrorist groups. Radicalisation is the process where someone has their **vulnerabilities** or susceptibilities exploited towards crime or terrorism – more often by a third party, who has their own agenda; this may take place face to face or via social media or the internet

Prevent is a vital part of the UK’s counter-terrorism strategy, to stop people becoming terrorists or supporting terrorism. It seeks to:

* Respond to the ideological challenge of terrorism and aspects of extremism, and the threat we face from those who promote these views;
* Provide practical help to prevent people from being drawn into terrorism and ensure they are given appropriate advice and support;
* Work with a wide range of sectors where there are risks of radicalisation and a multi-agency approach is needed including education, criminal justice, faith, charities, the internet and health.

Prevent addresses all forms of terrorism, including Far Right extremism and some aspects of non-violent extremism. Work is conducted with the Police, Local Authorities, Government Departments and health services.

**Channel** is a multi-agency process within Prevent, which aims to support those who may be vulnerable to being drawn into violent extremism. It works by Identifying individuals who may be at risk, assessing the nature and extent of the risk; and where necessary, referring cases to a multi-agency panel which decides on the most appropriate support package to divert and support the individual at risk.

Channel aims to draw vulnerable individuals away from violent extremism before they become involved in criminal activity. Partnership working and effective information sharing is crucial in ensuring that multi-agency partners are able to build a comprehensive picture of an individual’s vulnerability and therefore provide the appropriate type and level of support to safeguard the individual at risk.

Healthcare professionals may meet and treat people who are vulnerable to radicalisation. People with mental health issues or learning difficulties may be more easily drawn into terrorism. We also know that people connected to the health sector have taken part in terrorist acts.

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

The GP Practice Safeguarding/Prevent Lead will advise and signpost in raising concerns following the referral pathway in line with the policy and procedure.

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

* **NOTICE** – if you have a cause for concern about someone, perhaps their altered attitude or change in behaviour
* **CHECK -** discuss concern with appropriate other (safeguarding lead)
* **SHARE** – appropriate, proportionate information (safeguarding lead/police)

**4. WHAT TO DO IF YOU HAVE CONCERNS ABOUT AN ADULTS WELFARE**

**4.1 Responding to an adult who tells you about abuse**

Concerns about the wellbeing and safety of an [Adult at Risk](http://trixresources.proceduresonline.com/nat_key/keywords/adult_at_risk.html) must always be taken seriously; this includes situations where the alerter remains anonymous.

A worker, who is either directly or indirectly involved, who first becomes aware of concerns of abuse must report those concerns as soon as possible and in any case within the same working day to the relevant senior manager/safeguarding lead within the practice.

When an adult makes a disclosure it is important to reassure the adult at risk that the information will be taken seriously.

Give them information about what steps will be taken also including any emergency action to address their immediate safety or well-being.

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

If it is thought a crime could have been committed. It is important that you do not contact the alleged perpetrator or anyone that might be in touch with them. The disclosed information must be recorded in the health care records in the way that the adult at risk describes the events, as this information could be required at a later stage to support the investigation.

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

Making Safeguarding Personal means that safeguarding should be person led, engaging the individual in a conversation about how best to respond to their safeguarding situation, in a way that enhances their involvement choice and control as well as improving quality of life. Ability to consent to the safeguarding process should be determined by the person’s mental capacity at that specific time in their understanding of risk and consequences of their situation. In determining validity of consent to making a safeguarding adult alert, the possibility of threat or coercion from others should also be explored and considered.

There may be instances where a safeguarding alert can be made without an adult at risk’s consent. This could include circumstances where others could be at risk if the alert is not made or instances where a crime may have been committed; this is known as a public interest disclosure, to share information. In circumstances where information is shared using public interest disclosure the alerter must be able to justify their decision to raise an alert in that information is accurate, shared in a timely manner and necessary and proportionate to the identified risk. If in doubt about making an alert, the case can be discussed with a senior colleague/line manager, safeguarding practice lead or a member of the safeguarding team. (See Appendix 1 for contact details)

Anyone who is unsure as to whether abuse has occurred should make an alert in order for the relevant information to be gathered and a decision made about the appropriate course of action. Advice can be sought from the CCG safeguarding team / LCFT safeguarding team and by contacting the Local Authority Safeguarding Adults Enquiry Team.

**4.2 Risk Assessment**

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

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

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

**4.3 Making an alert to Local Authority Safeguarding Adults Enquiry Team**

An ‘alert’ is a response to a concern, where an individual believes that a vulnerable adult may be at risk of harm or abuse. Alerts should be raised as soon as abuse or neglect is witnessed or suspected. This should always be the case if the adult remains in or is about to return to the place where the suspected/alleged abuse occurred and the alleged abuser is likely to have access to the adult or others who might be at risk.

On receiving an alert, the person responsible must decide whether to make a referral to the Local Authority safeguarding enquiry team. Anyone who suspects or knows that abuse has taken place (or is still occurring) has a duty of care to report immediately to their own line manager and raise an alert directly to the local authority safeguarding adults enquiry team immediately when the concern is identified.

The alerter is not expected to prove abuse has happened but to provide information based on the disclosure from the adult with care and support needs. All professionals have a duty of care in terms of challenging poor practice and escalating their concerns appropriately.

|  |  |
| --- | --- |
| **Information required to raise the alert** | |
| Who the alleged victim is | |
| Who the alleged perpetrator is | |
| What has happened | |
| When abuse has happened | |
| Where abuse has happened | |
| How often is it happening | |
| Who witnessed it | |
|  | |
| **Contact Numbers** | | | |
| **Safeguarding Adults Enquiry Team**  between 9am - 5pm | | **0300 303 2704 South Lakes and Furness** | |
| **Out of hours** | | **01228 526690** | |
| **In an emergency** if a person is at risk of serious harm or needs immediate medical attention | | **999** | |
| **Police Public Protection Unit** | | **101 or 0845 125 35 45** | |

4.4 What to do if members of the public raise concerns

Members of the public may talk to GPs and their practice staff about the abuse of adults known to them. They may specifically allege incidents or knowledge of abuse to an adult or may refer to it when discussing other issues. The type and nature of the abuse may be quite specific or it may be described only in very general terms.

It is important that all such allegations or references to abuse are taken seriously and relevant details should be referred to adult safeguarding for further enquires to be made. In such circumstances, you should be clear with that person that you have a duty to report any alleged abuse, and encourage the person to make a direct referral to the adult safeguarding enquiry team where there are concerns for the safety and wellbeing of the adult, remembering that safeguarding is everyone’s responsibility.

It is essential that clear notes of any such allegation are kept within the records as these may be required at a later date. If possible take the name and contact details of the person alleging the abuse – it may be necessary for the adult safeguarding enquiry team or the Police to talk to them further.

**4.5 What to do if there is a professional disagreement**

Generally there are good working relationships between agencies, but occasionally there will be a difference of professional views. At no time must professional disagreement detract from ensuring that the adult is safeguarded. The person’s welfare and safety must remain paramount throughout.

Where there is a difference of opinion between professionals, refer to Lancashire safeguarding adult board procedures.

**Stage 1:** If professionals are unable to reach agreement about the way forward regarding an individual issue then their disagreement must be addressed by more senior staff. In most cases this will mean the safeguarding practice lead, discussing the issue of dispute and seeking to reach a resolution.

**Stage 2:** If the issue cannot be resolved at this level then the matter must be referred up through to GP senior partner.

**Stage 3:** If the issue cannot be resolved at senior partner level then consideration should be given to progressing the dispute through the CCG Designated Lead Nurse Safeguarding Adults/ Mental Capacity Act. The CCG Designated Nurse will ensure that issues relating to professional disagreements are escalated and a resolution focused approach is sought. (Contact details available in appendix 1.)

Where there is a need for intervention to prevent a life threatening episode (for example risk of suicide) immediate action to reduce the risk of harm will be required by all relevant parties whilst the dispute is on-going. In such circumstances, where certain agencies maintain a position of non-involvement and other agencies disagree with this position, the CCG safeguarding team should be informed at the earliest opportunity.

Written records of all these discussions must be kept.

**5. INFORMATION SHARING**

Sharing of information is vital for early intervention to ensure that adults with care and support needs get the services they require. It is also essential to protect adults from suffering harm from abuse or neglect and essential that all practitioners understand when, why and how they should share information.

Always consider the safety and welfare of the adult when making decisions on whether to share information about them.

Where there is concern that the adult may be suffering or is at risk of suffering significant harm then their safety and welfare **must** be the overriding consideration. Information may also be shared where an adult is at risk of serious harm, or if it would undermine the prevention, detection, or prosecution of a serious crime including where consent might lead to interference with any potential investigation.

Below are 7 key points on information sharing but for further detailed guidance refer to [*Information sharing: Guidance for practitioners and managers*](https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice)(HM Government 2008) accessed at:

**Seven key points on information sharing:**

1. **Remember that the Data Protection Act is not a barrier to sharing information** but provides a framework to ensure that personal information about living persons is shared appropriately.
2. **Be open and honest** with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
3. **Seek advice** if you are in any doubt, without disclosing the identity of the person where possible.
4. **Share with consent where appropriate** and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest. You will need to base your judgement on the facts of the case.
5. **Consider safety and well-being**:Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.
6. **Necessary, proportionate, relevant, accurate, timely and secure**: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.
7. **Keep a record** of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

**6. gp attendance AT SAFEGUARDING MeEtings**

The GP contribution to multiagency safeguarding adults meetings is invaluable and supports best practice within the Royal College of General Practitioners. Priority should be given to attendance wherever possible. A **written report** should be made available for the meeting where the GP will not be in attendance.

Within the Care Act, Safeguarding Adult Boards must arrange safeguarding adult reviews where an adult in its areas has died as a result of abuse or neglect whether known or suspected and there is a concern that partner agencies could have worked more effectively to protect the adult. The practice will be required to cooperate in the sharing of information and timeline of events to support continuous learning and the opportunity to improve and promote good practice in the protection of adults with care and support needs.

**7. Recording information**

Good record keeping is a vital component of professional practice. Where there are concerns about a vulnerable adult’s welfare, all concerns, discussions and decisions made and the reasons for those decisions must be recorded in writing in the medical records. Any bruises, marks and/or unexplained injuries observed should be clearly documented on a [body map](http://plcsab.proceduresonline.com/chapters/pr_body_maps.html) within the records.

**8. MANAGING ALLEGATIONS**

**8.1 Managing allegations against workers who have contact with vulnerable adults**

Adults with care and support needs can be subjected to abuse by those who work with them in any and every setting. All allegations of abuse or maltreatment of vulnerable adults by an employee, agency worker, independent contractor or volunteer will be taken seriously and treated in accordance with Cumbria Safeguarding Adult Board policy and procedures (LSAB). This includes implementation of the practice’s disciplinary procedures and possible suspension without prejudice.

Suspension of the employee concerned from his or her employment should not be automatic, but should be considered if:

* There is cause to suspect an adult at risk has suffered abuse or neglect; and/or
* The allegation warrants investigation by the police; and/or
* The allegation is so serious that it might be grounds for dismissal.

The GP practice safeguarding lead should, following consultation with the local authority Safeguarding Adults Enquiry Team and the Police where appropriate, inform the subject of the allegations. If it is deemed appropriate to conduct an investigation prior to informing those who are implicated, clear records need to be made of who took the decision and why.

Further information can be found on the **Cumbria County Council Safeguarding Adult Board website.**

The manager will need to balance supporting the alleged victim, the wider staff team, the investigation and being fair to the alleged perpetrator. The alleged perpetrator will be considered innocent until proven otherwise. Suspension offers protection for them as well as the alleged victim and other service users, and enables a full and fair investigation/safeguarding risk assessment to take place.

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

When it is concluded there is insufficient evidence to determine whether the allegation is substantiated, the chair of the safeguarding strategy meeting will ensure that relevant information is passed to the practice safeguarding lead. The senior manager of the practice will consider what further action, if any, should be taken in consultation with the Local Authority Safeguarding Lead for Managing Allegations.

When an allegation of abuse or neglect has been substantiated, the practice safeguarding lead should consult with the Local Authority Safeguarding Enquiry team for advice on referral to the Local Authority Designated Officer (LADO); and whether it’s appropriate to make a referral to the professional or regulatory body; and to the Disclosure and Barring Service **(DBS),** because the person concerned is considered unsuitable to work with Adults with care and support needs.

The safeguarding practice lead should review the practice procedures to help prevent similar events from occurring in the future and to ensure lessons learnt are implemented.

**8.2 Whistle-blowing**

Duke Street Surgery recognises the importance of building a culture that allows all GPs and their practice staff to feel comfortable about sharing information, in confidence and with a lead person, regarding concerns they have about a colleague’s behaviour. This will also include behaviour that is not linked to safeguarding but that has pushed the boundaries beyond acceptable limits. Further guidance can be found on the [RCGP website](http://www.rcgp.org.uk/policy/rcgp-policy-areas/whistle-blowing-in-the-nhs.aspx). See Practice Whistle Blowing procedure.

**8.3 Complaints procedure**

Duke Street Surgery has a clear well publicised procedure that is capable of dealing with complaints from all patients and employees.



Please refer to:-

Consideration should always be given to whether a complaint meets the criteria for managing allegations procedures.

1. **LEARNING AND DEVELOPMENT OF STAFF**

To protect adults from harm, all health staff must have the competences to recognise adults with care and support needs of or actual abuse and to take effective action as appropriate to their role.

The Pan Lancashire and Cumbria Safeguarding Adult Board (LSAB) has adopted the safeguarding adults’ competency passport ([link](https://www.cumbria.gov.uk/elibrary/Content/Internet/327/949/42451133546.pdf)); it is considered best practice to utilise this.

All staff undergoing learning and development are expected to keep a learning log for their appraisals and/ or personal development.

The practice will hold at least one meeting a year to discuss safeguarding adults within the practice. The purpose of this meeting is to make sure all members of staff are fully aware of the practice policy and know what to do if they are worried an adult is being abused or neglected.

1. **Supervision of staff**

Staff working with adults with care and support needs need to have access to support and supervision; this will provide an opportunity for practitioners to share their concerns and to enable them to manage the stresses inherent in this work. It also promotes good standards of practice, which are soundly based and consistent with local and national guidance for safeguarding adults.

Supervision also provides an opportunity to ensure there is an understanding of roles and responsibilities, as well as the scope of professional discretion and authority. Key decisions taken during supervision must be recorded in the medical records. Safeguarding incidents should be discussed at practice learning reflection events to support in wider learning of recommendations for practice. Opportunities for reflection and to identify any development needs may also be available through the GP appraisal process as safeguarding issues should form a standard part of this process.

1. **REFERENCE DOCUMENTS**

In developing this Policy account has been taken of the following statutory and non-statutory guidance, best practice guidance and the policies and procedures of Lancashire Safeguarding Adults Board.

Adult Safeguarding and Domestic Abuse(2013)  [*A guide to support practitioners and managers*](http://www.local.gov.uk/c/document_library/get_file?uuid=5928377b-8eb3-4518-84ac-61ea6e19a026&groupId=10180)

Care Quality Commission *CQC (2009)* [*Guidance about compliance: Essential Standards of Quality and Safety Guidance*](http://www.cqc.org.uk/content/essential-standards)

*Care Quality Commission CQC (2016)* [*NHS GP practices and GP out of Hours Services*](http://www.cqc.org.uk/content/gp-practices-and-out-hours-service-providers)

[DH (2016) Care and Support Statutory Guidance](https://www.gov.uk/government/publications/care-act-statutory-guidance)

DH (2011) [*Adult Safeguarding: The Role of Health Services*](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124882)

DH (November, 2011)**,** [*Building Partnerships, Staying Safe. - The Health Sector Contribution to HM Governments Prevent Strategy. Guidance for Healthcare organisations.*](https://www.gov.uk/government/publications/building-partnerships-staying-safe-guidance-for-healthcare-organisations)

DH (June 2012)[*The Functions of Clinical Commissioning Groups*](https://www.gov.uk/government/news/functions-of-clinical-commissioning-groups) (updated to reflect the final Health and Social Care Act 2012)

HM Government (2008)[*Information Sharing: Advice for safeguarding practitioners*](https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice)

HM Government (2014)[*The Care Act*](http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted)

Law Commission ( 2011) [*Adult Social Care Report*](http://www.justice.gov.uk/lawcommission/publications/1460.htm)

Local Safeguarding Adults Board [Policies, Procedures and Practice Guidance](http://www.lancashiresafeguarding.org.uk/lancashire-safeguarding-adults/policies-and-procedures.aspx)

NHS Commissioning Board March 2015[*Safeguarding Vulnerable people in the Reformed NHS - accountability and assurance framework*](https://www.england.nhs.uk/wp-content/uploads/2015/07/safeguarding-accountability-assurance-framework.pdf)

[NHS Employment Check standards (2013):](http://www.nhsemployers.org/recruitmentandretention/employment-checks/employment-check-standards/pages/employment-check-standards.aspx)

RCGP IRIS CAADA (2012) [*Responding to domestic abuse, Guidance for General Practices*](http://www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx)

NHS Chorley & South Ribble CCG and NHS Greater Preston CCG Sample Domestic Violence and Abuse Policy

The responsibility for ensuring policies are reviewed belongs to the partners, who may delegate this responsibility to either the practice manager (Laura Hodgkinson) or a member of the administration team.

**We have reviewed and accepted this policy.**

**Signed: Dated:**

(Signed by on behalf of the partnership)

The practice team have been consulted on how we implement this policy.

**Signed: Dated:**

**Appendix l**

What to do if an adult is at risk of harm

Contact emergency service e.g. police ambulance or GP

* Document all discussions held, actions taken, decision made including who was informed and who was spoken to
* All information to be passed to designated professional for safeguarding on next working day
* Record incident on DATIX or incident reporting form

**Yes**

Referral to Safeguarding

Adults Enquiry Team

0300 303 2704 9am-5pm

01228 526690 out of hours

**No**

Safeguarding adults

issue confirmed?

Contact the Duty Social Worker In adults social care or contact the CCG Safeguarding Adult Lead for advice

**No**

**Yes**

Is the adult at risk of immediate danger or in need of emergency medical treatment?

And/or has a crime been committed?

And/or is there a need to protect forensic evidence?

Is anyone at risk of harm e.g. another adult or child?

Abuse discovered or suspected

Staff should update their knowledge by accessing regular training and be familiar with local safeguarding policies, including those of Local Safeguarding Adults Board.

PREVENT Lead CCG: **Tel: 01524 518957**

Who to contact in the Police Public Protection Unit:

Tel: **0845 123 35 45** or **101** and request to speak to the PPU for the area in which the person resides

In an emergency contact the police on **999**

Who to contact for local NHS advice:

Lead Nurse for Safeguarding Adults and Mental Capacity Act Implementation for the Clinical Commissioning Group **Tel: 01524 518957**

Safeguarding Administrator: **Tel: 01524 518957**

Who to contact in Adult Social Care:

Lancashire Safeguarding Adults Enquiry Team: **0300 123 6721**

Emergency Duty Team (every day out of hours): **0300 123 6722**

Cumbria Adult Social Care: **03003032704**

Out of Hours: **01228 526690**