LONDON MULTI-AGENCY ADULT SAFEGUARDING POLICY & PROCEDURES

Final version *(as agreed by the London Safeguarding Adult Board)*

April 2019

Foreword

The introduction of the Care Act 2014 put adult safeguarding on a statutory footing for the first time, embracing the principle that the 'person knows best'. It laid the foundation for change in the way that care and support is provided to adults, encouraging greater self-determination, so people maintain independence and have real choice. There is an emphasis on working with adults at risk of abuse and neglect to have greater control in their lives to both prevent it from happening, and to give meaningful options of dealing with it should it occur. For staff the Care Act provides clearer guidance, and supports pathways to working in an integrated way, breaking down barriers between organisations. This approach has been championed by all the organisations who have worked together to produce this new policy and procedures which replaces (London multi-agency policy and procedures, 2015).

The increased involvement of adults who use services, carers, statutory and non-statutory groups in the production of this document embraces the spirit of the Act and the vision for safeguarding to be everyone's business. The policy and procedures have benefitted from carers and adults who might be at risk, to provide a reality check on what is meaningful and makes sense. This approach is a core element of a personalised adult safeguarding service.

Since the earlier policy and procedures, progress has been made to improve practice, through learnt experience, feedback and translating policy and procedures so that there is a shared approach to adult safeguarding. This policy and procedures take us further towards putting the adults at the centre of their own safeguarding experience. By developing practice that listens and learns, staff working with the person at risk can share information, facilitating a one team approach to improve the chances of safeguarding adults in the way that they want to be safeguarded. Learning from the experiences of people, publicised safeguarding annual reports, and events to raise greater awareness has enabled staff and SAB partnerships to reflect on safeguarding practice. All organisations involved have been consulted and worked collaboratively to update this policy and procedures. They are therefore, for all organisations and all those working in them, whether they hold a strategic leadership role or work directly with adults.

This policy and procedures consolidate our experience to date. It aims to encourage the continuous development of best practice in order to better safeguard adults throughout London. We welcome the advances we have made in adult safeguarding and the collegiate approach that this revised edition has taken.

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- London Fire Brigade
- National Probation Service – London
- London Provider Alliance
- London Safeguarding Adults Network
- London Social Care Partnership Networks:
  - Assistant Directors
  - Carers Leads
  - Commissioners
  - Learning Disability
  - SAB Chairs
- Metropolitan Police Service
- NHS England (London) CCG Safeguarding Forum
- NHS England NHS Provider Safeguarding Forum
- Social Care Institute for Excellence
- Skills for Care
- West Midlands Safeguarding Adults Board
- Women's Aid

Glossary and Acronyms

In using this document, a number of phrases, wording or acronyms have been used. The following provides more information and, where necessary, a definition:

Adult at risk is a person aged 18 or over who is in need of care and support (whether or not those needs are being met), who is experiencing or at risk of abuse or neglect, and because of those needs is unable to protect themselves against the abuse or neglect or the risk of it.

Adult safeguarding means protecting a person's right to live in safety, free from abuse and neglect.

Adult safeguarding lead is the title given to the member of staff in an organisation who is given the lead for Safeguarding Adults.

Advocacy is supporting a person to understand information, express their needs and wishes, secure their rights, represent their interests and obtain the care and support they need.

Appropriate Adult is a specific role prescribed under the Police & Criminal Evidence Act 1984. The role of an appropriate adult is confined to instances where a police officer has any suspicion, or is told in good faith, that a person of any age may be mentally disordered or otherwise mentally vulnerable, in the absence of clear evidence to dispel that suspicion, the person shall be treated as a vulnerable adult and supported by an 'Appropriate Adult'.

Appropriate individual within this document an 'appropriate individual' is a person who supports an adult at risk typically but not exclusively in an advocacy role and is separate to an Appropriate Adult as described above.

Borough Operational Command Unit (BOCU) the regional units of the Metropolitan Police based on the 32 London Boroughs.

Best Interest - the Mental Capacity Act 2005 (MCA) states that if a person lacks mental capacity to make a particular decision then whoever is making that decision or taking any action on that person's behalf must do so in the person's best interest. This is one of the principles of the MCA.

Care setting is where a person receives care and support from health and social care organisations. This includes hospitals, hospices, respite units, nursing homes, residential care homes, and day opportunities arrangements.

Carer throughout these policy and procedures refers to a Family/Friend Carer as distinct from a paid carer, who is referred to throughout as Support Worker. The Association of Directors of Adult Social Services (ADASS) define a carer as someone who '*spends a significant proportion of their time providing unpaid support to a family member, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems'*.

Commissioning is the cyclical activity, to assess the needs of local populations for care and support services, determining what element of this, needs to be arranged by the respective organisations, then designing, delivering, monitoring and evaluating those services.

Community Safety Units (CSUs) operate in every area in London with dedicated staff who receive special training in community relations, including local cultural issues. The CSUs will investigate the following incidents: domestic violence, homophobia, transphobia and racism, criminal offences where a person has been targeted because of their perceived 'race', faith, sexual orientation or disability.

Concern is the term used to describe when there is or might be an incident of abuse or neglect and it replaces the previously use term of ‘alert’.

Contracting is the means by which a process is made legally binding. Contract management is the process that then ensures that services continue to be delivered to the agreed quality standards.

Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA).

Enquiry establishes whether any action needs to be taken to stop or prevent abuse or neglect, and if so, what action and by whom the action is taken. Previously this may have been referred to as a ‘referral’

Enquiry Lead is the agency who leads the enquiry described above.

Enquiry Officer is the member of staff who undertakes and co-ordinates the actions under Section 42 (Care Act 2014) enquiries.

Equality Act 2010 legally protects people from discrimination in the workplace and in wider society. It replaced previous anti-discrimination laws with a single Act, making the law easier to understand and strengthening protection in some situations. It sets out the different ways in which it is unlawful to treat someone.

General Data Protection Regulation (GDPR) is a legal framework that sets guidelines for the collection and processing of personal information of individuals within the European Union (EU). The GDPR sets out the principles for data management and the rights of the individual, while also imposing fines that can be revenue-based. The GDPR came into effect across the EU on May 25, 2018 and its requirements are part of English law under the Data Protection Act 2018.

Independent Domestic Violence Advisor (IDVA) - Adults who are the subject of domestic violence may be supported by an IDVA. IDVAs provide practical and emotional support to people who are at the highest levels of risk. Practitioners should consult with the adult at risk to consider if the IDVA is the most appropriate person to support them and ensure their eligibility for the service.

Independent Mental Capacity Advocate (IMCA) - established by the Mental Capacity Act (MCA) 2005 IMCAs are mainly instructed to represent people who lack capacity where there is no one else, such as family or a friend, who is able to support and represent them independently. IMCAs are a legal safeguard for people who lack the mental capacity to make specific important decisions about where they live, serious medical treatment options, care reviews or adult safeguarding concerns.

Independent Mental Health Advocate (IMHA) - under the Mental Health Act 1983 certain people known as ‘qualifying patients’ are entitled to the help and support from an Independent Mental Health Advocate. If there is a safeguarding matter whilst the IMHA is working with the adult at risk, consideration for that person to be supported by the same advocate should be given.

Independent Sexual Violence Advocate (ISVA) - is trained to provide support to people in rape or sexual assault cases. They help victims to understand how the criminal justice process works and explain processes, for example, what will happen following a report to the police and the importance of forensic DNA retrieval.

LGBT is an acronym used to refer collectively to lesbian, gay, bisexual and transgender people.

Making Safeguarding Personal (MSP) is about person centred and outcome focussed practice. It is how professionals are assured by adults at risk that they have made a difference to people by taking action on what matters to people and is personal and meaningful to them.

MAPPA (Multi-Agency Public Protection Arrangements) are a set of arrangements to manage the risk posed by the most serious sexual and violent offenders (MAPPA-eligible offenders) under the provisions of sections 325 to 327B of the Criminal Justice Act 2003.

Natural justice refers to the principles and procedures that govern the adjudication of an issue, which should be unbiased, without prejudice, and there is equal right to being heard.

Person/organisation alleged to have caused harm is the person/organisation suspected to be the source of risk to an adult at risk.

Procurement is the specific function to buy or acquire services which commissioners have duties to arrange to meet people's needs, to agreed quality standards, providing value for money to the public purse.

Public interest Test refers to the test used under data protection legislation when deciding whether the public interest in disclosing information in order to protect a vulnerable adult justifies interfering with another individual's right to privacy.

Registered Intermediaries (RI) play an important role in improving understanding of the justice process for people who have communication difficulties. They help people to understand the questions that are put to them and to have their answers understood, enabling them to achieve best evidence for the police and the courts.

Regulated Provider is an individual, organisation or partnership that carries on activities that are specified in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding Adults Manager (SAM) is the person who manages, provides guidance and has oversight of safeguarding concerns that are raised to the Local Authority.

Sexual Assault Referral Centres (The Havens) Havens are sexual assault referral centres (SARCs) in London for people who have been raped or sexually assaulted within the past 12 months. If the assault took place more than 12 months ago, the Haven can provide information and signpost people to other organisations.

If a person has reported the rape or assault to the police, first they will organise the visit to the Haven. The Haven also takes self-referrals from people who do not wish to report to the police. Referrals are also accepted from professionals in London such as GPs, sexual health clinics and A&E departments. This service is available 24 hours a day, seven days a week. Adults are only offered appointments through consent and direct initial contact following referrals. Havens also offer follow-up medical and counselling care, including full health screening for sexually transmitted infections, a pregnancy test and emergency contraception. More information is available here[1].

[1] The Havens. Available at http://www.thehavens.org.uk/about-us/

Strategic Executive Information System (StEIS) Reporting a Serious Incident must be done by recording the incident on this system, which facilitates the reporting of Serious Incidents and the monitoring of investigations between NHS providers and commissioners. More information is available here[2].

Victim Support is a national charity, which provides support for victims and witnesses of crime in England and Wales. It provides free and confidential help to family, friends and anyone else affected by crime, which includes information, emotional and practical support. Help can be accessed either directly from local branches or through the Victim Support helpline.

Vital interest a term used in the General Data Protection Regulation (GDPR) to permit sharing of information where it is critical to prevent serious harm or distress, or in life-threatening situations.

[2] StEIS. See https://improvement.nhs.uk/resources/steis/

Contents

PURPOSE AND HOW TO USE THIS DOCUMENT

Aim: - to better safeguard adults at risk of abuse throughout London; and in using this document better encourage the continuous development of best practice.

The document is structured into the following sections and appendices:

Section 1 – Context, Principle and Values - sets out the shared vision for adult safeguarding and the key national and local drivers

Section 2: Adult Safeguarding Policy - sets out an interpretation of the Care Act 2014, so that there is a consistent approach across London to adult safeguarding.

Section 3: Adult Safeguarding Practice - sets out an interpretation of the Care Act 2014, so that there is a consistent approach across London to adult safeguarding. Includes the key areas of mental capacity and consent, advocacy and support, managing risk, record keeping and organisational learning.

Section 4: Adult Safeguarding Procedures - sets out the changes in adult safeguarding from a process driven stand-alone entity, to one where adult safeguarding is part of everyday practice about supporting adults who are unable to protect themselves without support towards achieving better outcomes for their safety and well-being. It provides the reader with a framework that can be adjusted to meet individual need.

Section 5: Working with care and support providers - sets out how commissioners work with providers so that adults receive high quality safe services. It details how good commissioning and effective contract monitoring can support providers to take early action to reduce risk and the need for adult safeguarding.

Appendices

Appendix 1 contains information about carers (family/friends) and adult safeguarding, and the different areas where it has an impact on the carer, or the carer can have an impact on adult safeguarding functions.

Appendix 2 is about information governance and the standards, legislation and compliance requirements that all organisations are accountable for meeting.

Appendix 3 is about workforce development and is a broad brush ranging from recruitment and safe organisations to support to staff through supervision and training.

Appendix 4 details the structures and organisations who work with adults at risk. It provides detail on the Safeguarding Adults Board roles and responsibilities and the links to other strategic partnerships. It sets out the changes brought about by the Care Act 2014 for the role and responsibilities of the statutory organisations and lists those organisations who work together to safeguard adults at risk.

Appendix 5 contains a supplementary note on domestic violence

Appendix 6 - Data Sharing Agreement

This document should be read in conjunction with the following documents:

- Care Act 2014[i],
- Care and Support Statutory Guidance 2018[ii] and the Adult Safeguarding Improvement Tool[iii].

It covers:

- The legislative requirements and expectations on individual services to safeguard and promote the well-being of adults in the exercise of their respective functions, relating to adults with needs for care and support and carers[3]; and
- A framework for SABs to monitor the effective implementation of policies and procedures.

This document embeds relevant national developments including the current Safeguarding Vulnerable People in the NHS Accountability and Assurance Framework' (2015) [iv] which outlines the roles and responsibilities of the health service. It takes into account relevant Metropolitan Police Service internal operational toolkits and aims to be consistent with them. This document also takes account of national initiatives about housing and safeguarding[v] and draws on the commitment for organisations to work together championed by the Association of Directors of Adult Social Services.

It is steered by the personalisation of health and adult social care through the national Making Safeguarding Personal[vi] programme. This programme arose following feedback from many people who had used safeguarding services, reporting that they felt they were being driven through a process and felt out of control. The shift in culture, by developing a personalised approach to supporting people is a shared vision for all organisations working with adults who may be or are at risk of abuse and neglect.

The Mental Capacity Act 2005[vii] is relevant throughout safeguarding practice, and staff should ensure that all decisions and actions are taken in line with the requirements of the Act. (See Best Practice)

Reference to key documents and resources are made throughout in particular:

- Care and Support Statutory Guidance [ii]
- Skills for Care [viii]
- Social Care Institute for Excellence [ix]

[3] See 14.2 of the Care Act statutory guidance

THE POLICY

1. CONTEXT, PRINCIPLES AND VALUES

1.1 Context

The Care Act[i] puts adult safeguarding on a legal footing and requires each Local Authority to set up a Safeguarding Adults Board (SAB – Section 43[x]) with core membership from the Local Authority, the Police and the NHS (specifically local Clinical Commissioning Group/s). It has the power to include other relevant bodies (See appendix 4). Each organisation involved in adult safeguarding also has obligations under data protection legislation. One of the key functions of the SAB is to ensure that the policies and procedures governing adult safeguarding are fit for purpose and can be translated into effective adult safeguarding practice.

London SABs are asked to adopt this revised policy and procedures so that there is consistency across London in the way in which adults are safeguarded from neglect or abuse, and in how information is shared for that purpose. All organisations involved in safeguarding are asked to adopt this revised policy and procedures in respect of their relevant roles and functions, but may wish to add local practice guidance, protocols and organisation operation manuals. These procedures should also be used in conjunction with partnerships and individual organisations' procedures on related issues such as fraud, disciplinary procedures and health and safety.

1.1.1 Principles

The policy and procedures are based on **The Six Principles of Safeguarding** that underpin all adult safeguarding work.

Table 1: The Six Principles of Safeguarding that underpin all adult safeguarding work

Empowerment	Adults are encouraged to make their own decisions and are provided with support and information	I am consulted about the outcomes I want from the safeguarding process and these directly inform what happens
Prevention	Strategies are developed to prevent abuse and neglect that promotes resilience and self-determination	I am provided with easily understood information about what abuse is, how to recognise the signs and what I can do to seek help
Proportionate	A proportionate and least intrusive response is made balanced with the level of risk	I am confident that the professionals will work in my interest and only get involved as much as needed
Protection	Adults are offered ways to protect themselves, and there is a co-ordinated response to adult safeguarding	I am provided with help and support to report abuse. I am supported to take part in the safeguarding process to the extent to which I want and to which I am able
Partnerships	Local solutions through services working together within their communities	I am confident that information will be appropriately shared in a way that takes into account its personal and sensitive nature. I am confident that agencies will work together to find the most effective responses for my own situation
Accountable	Accountability and transparency in delivering a safeguarding response	I am clear about the roles and responsibilities of all those involved in the solution to the problem

The Care Act and Guidance state that safeguarding:

- Is person led
- Engages the person from the start, throughout and at the end to address their needs
- Is outcome focused
- Is based upon a community approach from all partners and providers

The London multi-agency adult safeguarding policy and procedures are built on strong multi-agency partnerships working together with adults to prevent abuse and neglect where possible and provide a consistent approach when responding to safeguarding concerns. This entails joint accountability for the management of risk, timely information sharing, co-operation and a collegiate approach that respects boundaries and confidentiality within legal frameworks.

1.1.2 Risk Management

Safeguarding is fundamentally about promoting the safety and well-being of an adult in line with the above six principles. This involves risk management, which is used:

- To promote, and thereby support, inclusive decision making as a collaborative and empowering process, which takes full account of the individual's perspective and views of primary carers;
- To enable and support the positive management of risks where this is fully endorsed by the multi-agency partners as having positive outcomes;
- To promote the adoption by all staff of 'defensible decisions' rather than 'defensive actions'.

Effective risk management strategies identify risks and provide an action or means of mitigation against each identified risk and have a mechanism in place for early escalation if the mitigation is no longer viable. Contingency arrangements should always be part of risk management. Risk assessments and risk management should take a holistic approach and partners should ensure that they have the systems in place that enable early identification and assessment of risk through timely information sharing and targeted multi-agency intervention. (See Practice Section 3).

Where an individual is not able to protect themselves without support, the aim should be to support them to make their own informed decisions which preserve their safety. However, people involved in safeguarding need to acknowledge that there is a balance to be struck between risk and an individual's right to make their own informed decisions, even if others consider the decision to be unwise or puts the individual at risk. The importance of their right to make decisions about their own life, which is part of an individual's well-being, needs to be considered as well as the safeguarding concerns.

1.1.3 Co-operation and Information Sharing

Learning from recommendations of Safeguarding Adult Reviews, the importance of effective multi-agency working is a common feature. The Local Authority retains responsibility as the lead co-ordinating organisation. All other relevant organisations and partners, including NHS bodies; the Departments of Social Security, Employment and Training; the Police and Probation Services have legal duties and responsibilities in relation to safeguarding of adults. Organisations contributing to effective inter-agency working can achieve this through creative

joint working partnerships that focus on positive outcomes for the individual(s). Co-operation between organisations that take a broad community approach to establishing safeguarding arrangements, working together on prevention strategies and awareness raising also supports the aims and objectives of Health and Wellbeing Boards, and Community Safety Partnership. (See Appendix 4)

Local authorities and partner organisations should co-operate in order to deliver effective safeguarding, both at a strategic level and in individual cases, where they may need to ask one another to take specific action in that case. This co-operation and information sharing for safeguarding purposes is supported by all data protection legislation where there is a lawful basis, such as the Care Act, for sharing personal data and compliance with the Caldicott Principles will help to ensure that information sharing is justified and proportionate.

Section 6, the Care Act 2014[xi] describes a general duty to co-operate between the Local Authority and other organisations providing care and support. This includes a duty on the Local Authority itself to ensure co-operation between its adult care and support, housing, public health and children's services.

Local authorities and their relevant partners must respond to requests to cooperate under their general public law duties to act reasonably.

If an organisation is refusing to share information, the organisation conducting an enquiry can escalate to the SAB to consider using Section 45, Care Act 2014 powers[xii], which puts an obligation on organisations to comply with a request for information in order that the SAB can perform its duties.

The Care Act 2014 sets out five aims of co-operation between partners which are relevant to care and support, although it should be noted that the purposes of co-operation are not limited to these matters. The five aims include:

- Promoting the wellbeing of adults needing care and support and of carers;
- Improving the quality of care and support for adults and support for carers (including the outcomes from such provision);
- Smoothing the transition from children's to adults' services;
- Protecting adults with care and support needs who are currently experiencing or at risk of abuse or neglect and
- Identifying lessons to be learned from cases where adults with needs for care and support have experienced serious abuse or neglect.

Organisations that refuse to comply with requests for co-operation or information should provide written reasons for the refusal.

The SAB needs to be assured that any shared learning identifies where co-operation has strengthened adult safeguarding and where improvements may be needed, publicising the effectiveness in its annual report.

1.1.4 Information Sharing

Sharing the right information, at the right time with the right people, is fundamental to good safeguarding practice, but it has been highlighted as a difficult area of practice. The Care Act 2014 Section 45 'supply of information' duty[xii] covers the responsibilities of others to comply with requests for information from the SAB as detailed above. Sharing information between organisations as part of day-to-day safeguarding practice is covered by the common law duty of confidentiality, the General Data Protection Regulation (GDPR")[xiii], Data Protection Act 2018[xiv], the Human Rights Act 1998[xv] and the Crime and Disorder Act 1998[xvi].

As a general principle people must assume it is their responsibility to raise a safeguarding concern if they believe an adult at risk is suffering or likely to suffer abuse or neglect, and/or are a risk to themselves or another, rather than assume someone else will do so. They should share the information with the local authority and/or the police if they believe or suspect that a crime has been committed or that the individual is immediately at risk.

Helpful guidance to ensure that information sharing is justified and proportionate is set out in the Caldicott principles[xvii]

Partner organisations may be asked to share information through agreed information sharing protocols. SCIE has produced helpful practice guidance.[xviii] Each SAB should have a protocol in place for information sharing, with clear governance on how it will be implemented. The Metropolitan Police Service Information Sharing protocol is one such example, soon to be published.

1.1.5 Confidentiality

A duty of confidence arises when sensitive personal information is obtained and/or recorded in circumstances where it is reasonable for the subject of the information to expect that the information will be held in confidence.

Adults at risk provide sensitive information and have a right to expect that the information about themselves that they directly provide, and information obtained from others will be treated respectfully and that their privacy will be maintained.

The challenges of working within the boundaries of confidentiality should not impede taking appropriate action. Whenever possible, informed consent to the sharing of information should be obtained. However:

- Emergency or life-threatening situations may warrant the sharing of relevant information with the relevant emergency services without consent.
- The law does not prevent the sharing of sensitive, personal information **within** organisations. If the information is confidential, but there is a safeguarding concern, sharing it may be justified.
- The law does not prevent the sharing of sensitive, personal information **between** organisations where the public interest served outweighs the public interest served by protecting confidentiality – for example, where a serious crime may be prevented.

Whether information is shared with or without the adult at risk's consent, the information sharing process must abide by the principles of the General Data Protection Regulation (GDPR). The GDPR should not be a barrier to sharing information. It provides a framework to ensure that personal information about living persons is shared appropriately.

In those instances where the person lacks the mental capacity to give informed consent, staff should always bear in mind the requirements of the Mental Capacity Act 2005[vii], and whether sharing it will be in the person's best interest.

1.2 Well-being

Section 1 of the Care Act 2014[xix] states that Local Authorities must promote well-being when carrying out any of their care and support functions in respect of a person. This may sometimes be referred to as 'the wellbeing principle' because it is a guiding principle that puts wellbeing at the heart of care and support. For safeguarding, this would include safeguarding activities in the widest community sense and is not confined to safeguarding enquiries under Section 42 of the Care Act 2014[xx] (See Procedures section 4).

Paragraphs 14.14 and 14.15 of the Guidance support the need for the safeguarding to be person led and outcome focused.

"14.14. In addition to these principles, it is also important that all safeguarding partners take a broad community approach to establishing safeguarding arrangements. It is vital that all organisations recognise that adult safeguarding arrangements are there to protect individuals. We all have different preferences, histories, circumstances and life-styles, so it is unhelpful to prescribe a process that must be followed whenever a concern is raised; and the case study below helps illustrate this.

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

'Well-being' is a broad concept, and it is described as relating to the following areas:

- Personal dignity (including treatment of the individual with respect);
- Physical and mental health and emotional wellbeing;
- Protection from abuse and neglect;
- Control by the individual over day-to-day life (including over care and support provided and the way it is provided);
- Participation in work, education, training or recreation;
- Social and economic wellbeing;
- Domestic, family and personal;
- Suitability of accommodation;
- The individual's contribution to society

All organisations working with adults who are or may be at risk of abuse and neglect, must aim to ensure that they are supporting people to make their own informed and safe decisions as well as taking or prompting action to protect people who are not able to protect themselves. This should underpin every activity through consistent safeguarding adults work. This includes any safeguarding activity that is outside the scope of a Section 42 Care Act 2014 enquiry.

Wellbeing is central to the NHS strategies encompassed within the Compassion in Practice programme[xxi] and the Ministry of Justice commitment to support victims[xxii]. The wellbeing principle should apply to all agencies involved in safeguarding adults.

1.3 Values - Supporting adults at risk of abuse and neglect

Safeguarding has the highest priority across all organisations. There is a shared value of placing safeguarding within the highest of corporate priorities. Organisations are judged on the effectiveness of safe communities and their values towards safeguarding adults who may be at risk of abuse or neglect.

Values include:

- People are able to access support and protection to live independently and have control over their lives;
- Appropriate safeguarding options should be discussed with the adult at risk according to their wishes and preferences. They should take proper account of any additional factors associated with the individual's disability, age, gender, sexual orientation, 'race', religion, culture or lifestyle;
- The adult at risk should be the primary focus of decision making, determining what safeguards they want in place and provided with options so that they maintain choice and control;
- All action should begin with the assumption that the adult at risk is best-placed to judge their own situation and knows best the outcomes, goals and wellbeing they want to achieve;
- The individual's views, wishes, feelings and beliefs should be paramount and are critical to a personalised way of working with them;
- There is a presumption that adults have mental capacity to make informed decisions about their lives. If someone has been assessed as not having mental capacity, to make decisions about their safety, decision making will be made in their best interests as set out in the Mental Capacity Act 2005 and Mental Capacity Act Code of Practice;
- People will have access to supported decision making;
- The adult at risk should be the primary focus of decision making, determining what safeguards they want in place and have support to explore options so that they can take, exercise and maintain choice and control over their own lives;
- All decisions should be made with the adult at risk and promote their wellbeing and be reasonable, justified, proportionate and ethical;
- Timeliness should be determined by the personal circumstances of the adult at risk;
- Every effort should be made to ensure that adults at risk are afforded appropriate protection under the law and have full access to the criminal justice system when a crime has been committed.

2. ADULT SAFEGUARDING POLICY

2.1 What is safeguarding?

Safeguarding is defined as '*protecting an adult's right to live in safety, free from abuse and neglect.*' (Care and Support statutory guidance, chapter 14[ii]). Adult safeguarding is about preventing and responding to concerns of abuse, harm or neglect of adults. Staff should work together in partnership with adults so that they are:

- Safe and able to protect themselves from abuse and neglect;
- Treated fairly and with dignity and respect;
- Protected when they need to be;
- Able easily to get the support, protection and services that they need.

2.1.1 The aims of Adult Safeguarding are to:

- Stop abuse or neglect wherever possible;
- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs;
- Safeguard adults in a way that supports them in making informed choices and having control about how they want to live;
- Promote an approach that concentrates on improving life for the adults concerned;
- Raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect;
- Provide information and support in accessible ways to help adults understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult; and
- Address what has caused the abuse.

2.1.2 Prevention

Section 2 of the Care Act[xxiii] requires Local Authorities to ensure the provision of preventative services (i.e. services which help prevent or delay the development of care and support needs or reduce care and support needs). Organisations should take a broad community approach to establishing safeguarding arrangements, working together on prevention strategies.

A core responsibility of a SAB is to have an overview of prevention strategies and ensure that they are linked to the Health and Wellbeing Board's, Quality Surveillance Group's (QSG), and Community Safety Partnerships prevention strategies (See appendix 4). Prevention strategies might include:

- Identifying adults at risk of abuse;
- Public awareness;
- Information, advice and advocacy;
- Inter-agency cooperation;
- Training and education;
- Integrated policies and procedures;
- Integrated quality and safeguarding strategies;
- Community links and community support;
- Regulation and legislation;
- Proactive approach to Prevent.

Partners should embrace strategies that support action before harm can occur. Where abuse or neglect has occurred, steps should be taken to prevent it from reoccurring wherever possible, doing so within relevant parameters and sharing information in ways which are proportionate and lawful to support a holistic partnership approach to prevention. For example, visiting staff might identify an adult with a combination of characteristics that may render them more vulnerable to a fire risk and take action to refer to the London Fire Brigade for a fire safety visit[xxiv].

Organisations should implement robust risk management processes that identify adults at risk of abuse or neglect and take timely appropriate action. Safeguarding functions should be integrated into quality management and assurance structures.

Prevention should be discussed at every stage of safeguarding and is especially important at the closure stage (which can happen at any time) when working with adults on resilience and recovery. Discussions between staff and adults, their personal network and the wider community (if appropriate) help build resilience as part of the recovery process. Where support is needed to prevent abuse, this needs to be identified and put into safeguarding planning.

2.1.3 Raising awareness

Public awareness campaigns can make a significant contribution to the prevention of abuse. They are more effective if backed up by information and advice about where to get help, and there is effective training for staff and services to respond. Joint initiatives to raise awareness can be very effective.

2.1.4 Information

The term ‘information’ means the communication of knowledge and facts regarding care. ‘Advice’ means helping a person to identify choices and/or providing an opinion or recommendation regarding a course of action in relation to care and support. Local Authorities are required to establish and maintain an information and advice service relating to all local residents within its area, not just adults with care and support needs.

Information and advice are critical to preventing or delaying the need for services and, in relation to safeguarding, can be the first step to responding to a concern. Section 4, the Care Act[xxv] states that Local Authorities must: ‘*establish and maintain a service for providing people in its area with information and advice relating to care and support for adults and support for carers*.’ This includes information and advice about safeguarding and should include:

- How to raise concerns about the safety or wellbeing of an adult who has needs for care and support needs;
- Awareness of different types of abuse (including neglect) and harm and indicators to look out for;
- How people can keep safe, and how to support people to keep safe;
- The safeguarding adults process;
- How SABs work.

All organisations should ensure that they are able to provide this service and can signpost adults to receive the right kind of help by the right organisation.

2.1.5 Advice

Information and advice need to be tailored to the person seeking them, recognising people may need different mediums through which to communicate. Information and advice should, where possible, be provided in the manner preferred by the person and in a way to help them understand the information being conveyed. This should be carried out with an awareness of the Equality Act 2010[xxvi]. 'Reasonable adjustments' should be made to ensure that disabled people have equal access to information and advice services. Reasonable adjustments could include the provision of information in accessible formats or with communication support.

Organisations have a number of direct opportunities to provide, or signpost people to information and advice, in particular if an adult at risk (or a person who knows and cares about them) indicates or tells you that they are concerned for their safety/wellbeing:

- At first point of contact;
- During or following an adult safeguarding enquiry;
- Safeguarding planning;
- Risk management;
- Through complaints and feedback about a service which identifies a safeguarding concern.

2.2 Who do adult safeguarding duties apply to?

In the context of the legislation, specific adult safeguarding duties apply to *any* adult who:

- Has care and support needs, and
- Is experiencing, or is at risk of, abuse or neglect, and
- Is unable to protect themselves from either the risk of, or the experience of abuse or neglect, because of those needs.

Within the scope of this definition are:

- All adults who meet the above criteria regardless of their mental capacity to make decisions about their own safety or other decisions relating to safeguarding processes and activities;
- Adults who manage their own care and support through personal or health budgets;
- Adults whose needs for care and support have not been assessed as eligible or which have been assessed as below the level of eligibility for support;
- Adults who fund their own care and support;
- Children and young people in specific circumstances as detailed below.

Outside of scope of this policy and procedures

- Adults in custodial settings i.e. prisons and approved premises. Prison governors and National Offender Management Services have responsibility for these arrangements.[xxvii] The Safeguarding Adults Board does however have a duty to assist prison governors on adult safeguarding matters. Local Authorities are required to assess for care and support needs of prisoners[xxviii] which take account of their wellbeing. Equally NHS England has a responsibility to commission health services delivered through offender health teams which contributes towards safeguarding offenders.

For more information on the role of the Local Authority in relation to safeguarding in prisons, click here[xxix].

2.2.1 Children and Young People

The Children Act 1989[xxx] provides the legislative framework for agencies to take decisions on behalf of children and to take action to protect them from abuse and neglect. Young people who receive leaving or after care support from children and family services, are included in the scope of adult safeguarding, but close liaison with children and family service providers is key to establishing who is the best person to lead or support young people through adult safeguarding processes.

Section 11 of the Children Act 2004[xxxi] places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

In all adult safeguarding work, staff working with the person at risk should establish whether there are children in the family and whether checks should be made on children and young people who are part of the same household, irrespective of whether they are dependent on care either from the adult at risk, or the person alleged to have caused harm.

Children and young people may be at greater risk of harm or be in need of additional help in families where adults have mental health problems, misuse substances or alcohol, are in a violent relationship, have complex needs or have learning difficulties.' For further information see Working Together to Safeguard Children[xxxii].

Abuse within families reflects a diverse range of relationships and power dynamics, which may affect the causes and impact of abuse. These can challenge professionals to work across multi-disciplinary boundaries in order to protect all those at risk. In particular staff may be assisted by using Domestic Abuse risk management tools such as the SafeLives Dash risk checklist. Staff providing services to adults, children and families should have appropriate training whereby they are able to identify risks and abuse to children and vulnerable adults.

2.2.2 Transition

Together the Children and Families Act 2014[xxxiii] and the Care Act 2014, create a new comprehensive legislative framework for transition[xxxiv], 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 set out in Section 2.2 of this document. The care needs of the young person 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 needs to ensure that the young adult's safety is not put at risk through delays in providing the services they need to maintain their independence, wellbeing and choice.

Where there are on-going safeguarding issues for a young person and it is anticipated that on reaching 18 years of age, they are likely to require adult

safeguarding, safeguarding arrangements should be discussed as part of transition support 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 professionals meeting.

2.2.3 Children and Young People who abuse

If a child or children is/are causing harm to an adult covered by the adult safeguarding procedures, action should be taken under these procedures, and a referral and close liaison with children's services should take place.

Physical and sexual abuse towards parents and other relatives (for example, grandparents, aunts, uncles) some of whom, may be adults at risk, can be carried out by adults and by young people and children, some of which can cause serious harm or death. The UK prevalence study of elder abuse identified younger adults (rather than the person's partner) as the main perpetrators of financial abuse.[xxxv]

2.2.4 Young Carers

In respect of young carers, Section 1 of the Care Act 2014[xix], alongside Section 96[xxxvi] and Section 97[xxxvii] of the Children and Families Act 2014, offers a joined up legal framework to identify young carers and parent carers and their support needs. Both Acts have a strong emphasis on outcomes and wellbeing.

2.2.5 Carers and safeguarding

Circumstances in which a carer could be involved in a situation that may require a safeguarding response includes when:

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

Where there is intentional abuse, adult safeguarding under Section 42, the Care Act[xx], should always be considered.

Work developed by ADASS[xxxviii], carers groups, commissioners and organisations working with carers, identify six distinct areas related to carers and safeguarding which can be viewed by clicking on the links below *(if unable to access hyperlink, see Appendix 1)*:

- Partnership working
- Prevention
- Support

- Information and Advice
- Advocacy
- Role of carers in strategic planning

2.2.6 Risk factors (relevant to rough sleepers)

There are a range of risks experienced by people living on the streets that expose them to a higher level of vulnerability to harm and abuse. A risk assessment tool designed to support front line practitioners can be found at pages 12 & 13[xxxix].

The risk factors identified in this tool highlight some particular risk issues that may be more prevalent amongst people who sleep rough.

2.3 Types and indicators of abuse and neglect

There are 10 categories of abuse described within the Care and Support Statutory Guidance[xl]. These categories are expansive and cover a range of abusive situations or behaviours. It is important to recognise that exploitation is a common theme in nearly all types of abuse and neglect. The Statutory Guidance (para 14.17) states that:

"Local authorities should not limit their view of what constitutes abuse or neglect, as they can take many forms and the circumstances of the individual case should always be considered; although the 3 stage criteria will need to be met before the issue is considered as a safeguarding concern".

Types of Abuse	Description from Statutory Guidance and/or other supporting guidance
Physical abuse	Including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions. In extreme circumstances unlawful or inappropriate use of restraint may constitute a criminal offence. **Restraint** covers a wide range of actions. It includes the use of active or passive means to ensure that the person concerned complies. Restrictive interventions are defined as: *'deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and /or freedom to act independently in order to;* • *Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and* • *End or educe significantly the danger to the person and others; and* • *Contain or limit the persons freedom for longer than is necessary'* If restrictive interventions are carried out for any other purpose than those listed above, concerns should always be escalated through safeguarding procedures (DH 2014)[xli] ***Female Genital Mutilation*** *(FGM) is a very specific form of physical (and psychological) abuse. FGM* is a procedure where the female genitals are deliberately cut, injured or changed, but where there's no medical reason for this to be done. FGM is also known as "female circumcision" or "cutting", and by other terms such as sunna, gudniin, halalays, tahur, megrez and khitan, among others. FGM is usually carried out on young girls between infancy and the age of 15, most commonly before puberty starts. It is illegal to practice FGM in the UK and is child abuse. It is also illegal to take girls who are British Nationals or who are permanent residents of the UK abroad for FGM. There is a mandatory duty on healthcare professionals to report any identified cases of FGM in females under the age of 18 years. FGM is very painful and can seriously harm the health of women and girls. It can also cause long-term problems with sex, childbirth and mental health.

Types of Abuse	Description from Statutory Guidance and/or other supporting guidance
	Professionals working with women who have been subject to FGM may want to signpost them to appropriate health services for help and support. Further information, including on safeguarding women and girls at risk of FGM is available here[xlii].
Domestic abuse	The Home Office defines domestic abuse as: any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over, who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, emotional abuse and 'honour' based violence. For more information, click here[xliii]. Honour Based Violence (HBV) is committed when families feel that dishonour has been brought to them. It will usually be a criminal offence and referring to the Police must always be considered. Women are predominantly (but not exclusively) the victims and the violence is often committed with a degree of collusion from family members and/or the community. Some victims of HBV may contact the Police or other organisations for help themselves. But many others are so isolated and controlled that they may be unable to seek help. Adult safeguarding concerns that may indicate HBV include domestic abuse, concerns about forced marriage, enforced 'house-arrest' and missing persons reports. Forced Marriage is a term used to describe a marriage in which one or both parties are married without their freely given consent or against their will. A forced marriage differs from an arranged marriage in which both parties consent to the assistance of a third party in identifying a spouse. In a situation where there is a concern that an adult is being forced into a marriage that they cannot consent to, there will be an overlap between action taken under the forced marriage provisions and adult safeguarding processes. If an adult safeguarding concern is raised about HBV or forced marriage, Police should be contacted as urgent action may need to be taken and they (in co-ordination with other relevant specialised organisations) have the necessary expertise to help manage the risk.
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, sexual assault and sexual acts to which the adult has not consented or was pressured into consenting. Sexual exploitation involves situations, contexts and relationships where adults at risk receive something (e.g. food, accommodation, drugs, alcohol, cigarettes, gifts, money, affection) as a result of them performing sexual acts (and/or another/others performing such acts on them). Sexual exploitation affects men as well as women. People who are being exploited may not always perceive such behaviours as exploitation. In all cases those exploiting the adult at risk have power over them by virtue of their position, gender, age, physical strength, intellect, economic situation or other resources. There is a distinct inequality in the relationship.
Psychological abuse	Including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation, 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,

Types of Abuse	Description from Statutory Guidance and/or other supporting guidance
	inheritance or financial transactions and the misuse or misappropriation of property, possessions or benefit. An adult at risk may be persuaded to part with large sums of money/life savings. Such concern should always be reported to the Police and if relevant, local Trading Standards for further investigation. Local Trading Standards should be involved in the work of Safeguarding Adults Boards. Where this abuse is perpetrated by someone with authority to manage the adult at risks finances, the Office of the Public Guardian should be informed (in relation to Deputies/Attorneys) or the DWP (for Appointees). Such abuse may take the form of a 'Mate Crime'. The Safety Net Project[xliv] define this as occurring 'when vulnerable people are befriended by members of the community who go on to exploit and take advantage of them. It may not be an illegal act but still has a negative effect on the individual'. Mate Crime is often difficult for the Police to investigate due to its sometimes ambiguous nature but should be reported to the Police who will decide as to if a criminal offence has been committed. Mate Crime is committed by someone the adult knows and often happens in private. In recent years there have been several Serious Case Reviews[xlv] relating to people with a learning disability who were murdered or seriously harmed by people who purported to be their friend.
Modern slavery	This type of abuse encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters using whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment. Serious and organised crime gangs make significant amounts of money from human trafficking. They exploit the social, cultural and financial vulnerabilities of the victim. They control almost all aspects of the victim's life with little regard for their welfare and health. However, adults who are enslaved are not always subject to trafficking. Someone is in slavery if they are forced to work through physical or mental threat, owned or controlled by an 'employer' (usually through abuse or threat of abuse), dehumanised and treated as a commodity (bought & sold as 'property'), physically constrained or has restrictions placed on his/her freedom of movement. Since 2015, specific authorities have had a duty to notify the Home Office of any individual suspected as a victim of slavery or human trafficking. Click here for further information[xlvi].
Discriminatory abuse	This includes harassment, slurs or similar treatment because of race, gender and gender identity, age, disability, sexual orientation or religion. Examples of discriminatory abuse may include; denying access to communication aids, not allowing access to an interpreter, signer or lip-reader. Harassment or deliberate exclusion on the grounds of a protected characteristic. Denying basic rights to healthcare, education, employment and criminal justice relating to a protected characteristic. Substandard service provision relating to a protected characteristic (SCIE 2015) Some forms of discriminatory abuse may also constitute a Hate Crime – defined by the Crown Prosecution Service as *"Any criminal offence which is perceived by the victim or any other person, to be motivated by hostility or prejudice, based on a person's disability or perceived disability; race or perceived race; or religion or perceived religion; or sexual orientation or perceived sexual orientation or transgender identity or perceived transgender identity."* There is no legal definition of hostility so the Police and CPS use the everyday understanding of the word[xlvii] which includes ill-will, spite, contempt, prejudice, unfriendliness, antagonism, resentment and dislike.

Types of Abuse	Description from Statutory Guidance and/or other supporting guidance
Organisational abuse	This includes 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. See Section 5: 'Working with Care and Support Providers'
Neglect and Acts of Omission	This includes ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services and/or the withholding of the necessities of life, such as medication, adequate nutrition and heating. Neglect also includes a failure to intervene in situations that are dangerous to the person concerned or to others, particularly where the adult at risk lacks the mental capacity to assess risk for themselves.
Self – neglect	This covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. It should be noted that self-neglect may not always prompt a section 42 enquiry. An assessment should be made on a case by case basis. A decision on 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 they are no longer able to do this, without external support.

2.4 Radicalisation

Prevent is part of the Government's counter-terrorism strategy CONTEST and aims to safeguard and provide support to divert vulnerable individuals at risk from being radicalised or groomed into supporting terrorist activity, before any crimes are committed. Radicalisation is comparable to other forms of exploitation, such as grooming and Child Sexual Exploitation. It is the process by which a person comes to support terrorism and extremist ideologies associated with terrorist groups. Radicalisation is process rather than an event, and there is no single profile or pathway by which someone can be drawn into terrorism.

There are instead a range of contributing factors including, peer pressure, bullying, family tensions, race/hate crime, lack of self-esteem or identity and personal or political grievances which can make people more vulnerable. Vulnerable individuals are often targeted and influenced by radicalisers either directly or increasingly in online chat rooms or through social media. The Counter-Terrorism and Security Act (2015)[xlviii] places a specific legal duty on specified authorities, including local authorities and health providers in the exercise of their functions, to have due regard to the need to prevent people being drawn into terrorism.

Channel is a confidential, voluntary, multi-agency safeguarding process designed to support vulnerable children and adults who may be at risk of being radicalised and drawn into terrorist activity.

It is an early intervention service which has been mandated in every local authority in England and Wales. Channel addresses all types of radicalisation including the extreme-

2.4.1 Channel Panel

A Channel Panel is chaired by the local authority and has multi agency involvement including from police, social services and health

The panel works collaboratively to assess the nature and extent of the risk and, if necessary, provide an appropriate support package tailored to the vulnerable individual's needs. This is monitored closely and regularly reviewed. The care plan will vary according to the risk that has been identified, and may include targeted interventions (including faith guidance, counselling or diversionary activities) or access to specific services, such as health or education.

Local safeguarding structures have a role to play for those eligible for adult safeguarding. Referrals to Channel can be made through the local authority Prevent lead or the local police Prevent engagement officer.

The Channel Vulnerability Assessment is used by safeguarding professionals in the Channel Panel to identify specific factors which make some vulnerable to extremist messages and provide appropriate support as required. It should be read alongside the Channel Duty Guidance (2015)[xlix].

2.5 Who abuses and neglects adults?

Anyone can carry out abuse or neglect, including:

- Spouses/partners
- Other family members
- Neighbours
- Friends
- Acquaintances
- Local residents
- People who deliberately exploit adults they perceive as vulnerable to abuse
- Paid staff or professionals
- Volunteers and strangers

Abuse can happen anywhere: for example, in someone's own home, in a public place, in hospital, in a care home or in college. It can take place when an adult lives alone or with others.

2.6 Self-neglect

There is no single operational definition of self-neglect however, the Care Act makes clear it comes within the statutory definition of abuse or neglect, if the individual concerned has care and support needs and is unable to protect him or herself from neglect. The Department of Health (2016), defines it as, *'… a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding'.*

The Department of Health commissioned the universities of Sussex and Bedford to undertake research into interventions with those that self-neglect[l]. This demonstrates how staff can assist individuals to achieve positive outcomes.

Skills for Care provided a framework for research into self-neglect[li] identifying three distinct areas that are characteristic of self-neglect:

- Lack of self-care - this includes neglect of one's personal hygiene, nutrition and hydration, or health, to an extent that may endanger safety or well-being;

- Lack of care of one's environment - this includes situations that may lead to domestic squalor or elevated levels of risk in the domestic environment (e.g., health or fire risks caused by hoarding);
- Refusal of assistance that might alleviate these issues. This might include, for example, refusal of care services in either their home or a care environment or of health assessments or interventions, even if previously agreed, which could potentially improve self-care or care of one's environment.

Self-neglect may result from a behavioural condition in which an individual neglects to attend to their basic needs such as personal hygiene, or tending appropriately to any medical conditions, or keeping their environment safe to carry out what is seen as usual activities of daily living. It can occur as a result of mental health issues, personality disorders, substance abuse, dementia, advancing age, social isolation, and cognitive impairment or through personal choice. It can be triggered by trauma and significant life events. However, if self-neglect results from free and informed personal choice, where the adult is able to care for themselves but chooses not to, this is not a safeguarding issue. Self-neglect is an issue that affects people from all backgrounds.

2.6.1 Hoarding

Hoarding may be an aspect of self-neglect. Most people associate hoarding with the acquisition of items with an associated inability to discard things that have little or no value (in the opinions of others) to the point where it interferes with use of living space or activities of daily living.

Compulsive hoarding (more accurately described as 'hoarding disorder') is a pattern of behaviour characterised by the excessive acquisition of and inability or unwillingness to discard large quantities of objects that cover the living areas of the home and cause significant distress. Compulsive hoarders may be conscious of their irrational behaviour but the emotional attachment to the hoarded objects far exceeds the motivation to discard the items. Hoarding can include new items that are purchased e.g. food items, refuse and animals. Many hoarders may be well-presented to the outside world, appearing to cope with other aspects of their life quite well, giving no indication of what is going on behind closed doors.

Compulsive hoarding behaviour has been associated with health risks, impaired functioning, economic burden, and adverse effects on friends and family members. When clinically significant enough to impair functioning, hoarding can prevent typical uses of space, enough so that it can limit activities such as cooking, cleaning, moving through the house and sleeping. It could also potentially put the adult and others at risk of causing fires. The London Fire Brigade advocates prevention strategies[lii] that consistently identify the level of hoarding and use the International OCD Foundations clutter image rating.

Example of how an organisation deals with hoarding concerns internally

The **London Fire Brigade have a Hoarding Strategy in place. The aim of the hoarding strategy is to reduce the fir**e risks associated with hoarding behaviour for people with hoarding disorder, their neighbours, and the local community and firefighters. This will be achieved by:

- Raising awareness of the fire risks associated with hoarding to people who exhibit hoarding behaviour, members of the public and staff;

- Working with local partners to identify people who hoard in their area and support effective outcomes;
- Providing people who hoard with fire safety advice specific to the risks associated with hoarding via the Home Fire Safety Visit process;
- Familiarising staff on the purpose and use of the Clutter Index Rating[1] and raising staff awareness of how to respond to and record instances of hoarding when visiting premises, whether attending an incident or during a Home Fire Safety Visit; and
- Recording instances of excessive hoarding on the Operational Risk Database to inform operational planning at future incidents.

2.6.2 Environmental Health Service (EHS)

The EHS has a range of powers to intervene where a property is in a condition that is prejudicial to health, or where the premise is materially affecting neighbouring premises. These powers do not rely on a presumption that the individual affected by such intervention lacks mental capacity. It is anticipated that EHS will have a crucial role as a frontline service in raising concerns and early identification. In addition, where properties are verminous or pose a statutory nuisance, EHS take a leading role in case managing the necessary investigations and determining the most effective means of intervention.

Where the individual is residing in conditions that pose a threat only to their own welfare the powers available to the EHS may have limited or no effect. In cases involving persistent hoarders the powers may only temporarily address and/or contain the problem. It must therefore be recognised that utilising powers under public health legislation in isolation may not be the most effective use of resources, particularly where a coordinated approach might provide immediate safeguards for the adult and others affected by the situation and promote a long-term solution. The Chartered Institute of Environmental Health have produced guidance for Environmental Health staff, Hoarding and how to approach it [iiii]

2.6.3 Response to self-neglect and hoarding

Given the complex and diverse nature of self-neglect and hoarding, responses by a range of organisations are likely to be more effective than a single agency response with particular reference to housing providers. It is important to recognise that assessments of self-neglect and hoarding are grounded in, and influenced by, personal, social and cultural values and staff working with the person at risk should always reflect on how their own values might affect their judgement. Finding the right balance between respecting the adult's autonomy and meeting the duty to protect their wellbeing may involve building up a rapport with the adult to come to a better understanding about whether self-neglect or hoarding are matters for adult safeguarding or any other kind of intervention.

Crucial to all decision making is a robust risk assessment, preferably multi-agency that includes the views of the adult and their personal network. The risk assessment might cover:

[1] The Clutter Index Rating (CIR) is a rising pictorial scale of nine equidistant photos showing clutter in three rooms – living room, bedroom and kitchen. It is an internationally recognised assessment tool produced by the International OCD Association – Hoarding Center, and used by psychologists working with people who hoard and commonly used by the health and social care sector in the UK. This can be accessed via the following link - http://hoardingdisordersuk.org/?page_id=93

- Capacity and consent;
- Indications of mental health issues;
- The level of risk to the persons physical health;
- The level of risk to their overall wellbeing;
- Effects on other people's health and wellbeing;
- Serious risk of fire;
- Serious environmental risk e.g. destruction or partial destruction of accommodation.

A significant element of self-neglect and hoarding is the risk that these behaviours pose to others. This might include members of the public, family members or professionals. Partnerships may wish to invest in agreeing local procedures with the involvement of carers and service users.

2.7 Pressure Ulcers

In response to demand from London Clinical Commissioning Groups and Providers a multi-agency task group with representation from a SAB Chair, Local Authority, CCG, provider and NHSE developed an integrated pressure ulcer pathway which aimed to support frontline staff in their local decision making to determine if a pressure ulcer is a sign of neglect. This has been revised to take into account the guidance Safeguarding Adults Protocol: Pressure Ulcers and the Interface with a Safeguarding Enquiry, DOH&SC January 2018 . If a pressure ulcer is believed to have been caused by neglect it is reported as an adult safeguarding concern. The Serious Incident (SI) Framework below outlines how the NHS investigates pressure ulcers.

2.8 Serious Incident

The Serious Incident Framework should be read in conjunction with the Never Events Policy and Framework.[liv] The Serious Incident Framework is not a substitute for safeguarding. Where safeguarding is indicated a safeguarding referral **must** be made, however a root cause analysis under the Serious Incident Framework may be considered an appropriate response to a safeguarding enquiry.

Broadly speaking there are three scenarios:

- NHS identifies a safeguarding concern, for example through staff at Accident and Emergency seeing signs of physical abuse. This may warrant a safeguarding referral to the Local Authority but would not be routinely recorded as an SI.
- If there are allegations against healthcare staff within the provider of an adult at risk, then a safeguarding referral and SI would need to be declared. Equally if there is patient against patient abuse.
- Lastly, there are incidents that are reported on Strategic Executive Information Systems (STEIS) that are not safeguarding issues, for example a pressure ulcer that was unavoidable. Investigations will still be undertaken but without referral for a safeguarding. This is obviously dependent on the situation.

2.9 Safeguarding Adult Review(s) (SARs)

Section 44, the Care Act 2014[lv] stipulates that SABs must arrange a SAR when there is concern that the SAB or partner agencies could have worked more effectively to safeguard an adult in its area with care and support needs, in two

situations: 1. The adult dies as a result of abuse or neglect, whether known or suspected, and 2. The adult has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The duty to arrange a SAR arises regardless of whether or not there has previously been an enquiry into the case by the Local Authority or by another agency, such as a Coroner, however, such an enquiry may identify that a SAR is required.

In the context of SARs, something can be considered serious abuse or neglect where, for example the individual was likely to have died but for an intervention or suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

The criteria for a mandatory review are met when:

- An adult at risk dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death; or
- An adult has sustained a potentially life-threatening injury through abuse, neglect, serious sexual abuse or sustained serious and permanent impairment of health or development through abuse or neglect.

And, in either case, there is reasonable cause for concern about how the SAB and partner agencies worked together to safeguard the adult, such as in the following circumstances:

- Where procedures may have failed, and the case gives rise to serious concerns about the way in which local professionals and/or services worked together to safeguard adults at risk;
- Serious or apparently systematic abuse that takes place in an institution or when multiple abusers are involved. Such reviews are likely to be more complex, on a larger scale and may require more time;
- Where circumstances give rise to serious public concern or adverse media interest in relation to an adult/adults at risk.

There is an expectation that individuals, agencies, organisations, cooperate with the review but the Act also gives Boards the power to require information from relevant parties.

The SAB may also commission a SAR of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) where it feels it would be useful, including learning from ‘near misses’ and situations where the arrangements worked especially well. The SAB should decide when a SAR is necessary, arrange for its conduct and if it so decides, implement the findings.

2.9.1 Criminal investigations and police involvement

Where there is an ongoing criminal investigation or criminal proceedings, the SAB will need to consider, in consultation with the police, whether continuing with the SAR might prejudice their outcome and whether the completion of the SAR should be postponed until after the criminal investigation or proceedings have been completed.

On a local level, police input will be decided by each Borough Operational Command Unit (BOCU) and will be required to participate in different methodologies of SARs. The Specialist Crime Review Group (SCRG) of the Metropolitan Police will provide the police response to SARs where the adult has

died. In non-fatal cases, police co-operation will ordinarily be at a local level. In complex non-death cases, the BCU Commander can request SCRG assistance. The SCRG involvement in a SAR does not prevent the BCU's representation within the review process.

2.9.2 Outside of SAR criteria

Where the SAB agrees that a situation does not meet the criteria but agencies will benefit from a review of actions other methodologies can be considered. These include:

- Serious Incident Review: Organisations should use their own SI procedures if this is deemed suitable and special consideration should be given to the involvement of relevant partner organisations.
- Management Review: A review by an individual organisation in relation to their understanding and management of a particular safeguarding issue.
- Reflective Practice Session: The original participants in the case may review identified aspects of the case as part a reflective practice session chaired by the Safeguarding Lead or other such suitable person, including an independent facilitator.
- 'Learning Together'[lvi]: A collaborative scrutiny approach to a case.

2.9.3 Principles

SARs should reflect the six adult safeguarding principles and be conducted within a framework of openness and transparency.

2.9.4 Purpose

The purpose of all SARs is to keep the focus on learning. The final SAR report and those responsible for disseminating the learning from it, should ensure that the recommendations can be translated into practice, not just for those involved but to a wider audience to support 'prevention strategies' and influence strategic plans.

It is not for a SAR to investigate how a death or serious incident happened. Neither is it the responsibility of the SAR to apportion blame. Such matters will be dealt with by the Coroner's or criminal courts, or other bodies.

2.9.5 The Adult or representative

The views of the adult or their representative should be central to the decision-making process about the type of SAR to undertake. Communication should be established at the earliest opportunity and advocacy provided to support the adult or their representative. Information should be given about how the SAR will be conducted and how they can be involved or, in the event that the adult has died, how nominated people can be involved.

Where there is a police led investigation, close contact with any appointed police Family Liaison Officer should be made. Communication should be clear and consistent between all designated supporters including independent advocates. See section 2.9.1 above in relation to cases where there is an ongoing criminal investigation or criminal proceedings.

2.9.6 Person alleged to have caused harm

The emphasis on learning should include the person alleged to have caused abuse or neglect so they can adjust their behaviour, act differently and reflect upon

the impact that they might have had on others. This may involve liaison with other professionals, working with, or trained to work with people who abuse.

2.9.7 Advocacy

The Local Authority must arrange, where necessary, for an independent advocate to support and represent an adult who is the subject of a SAR. Where the adult is deceased, it is good practice to provide advocacy to family/friends. (See Best Practice in Section 3)

2.9.8 Carers

The desired outcome, especially where a family is bereaved, needs to be approached with sensitivity. Consultation and involvement needs to be balanced with the overall wellbeing of the individuals involved. Throughout the process due diligence, compassion and appropriate support should be provided and the relevant Local Authority community team should be available to provide this or an alternative arranged if more appropriate

2.9.9 Staff

There will be occasions when allegations are made that staff have been guilty of abuse against adults at risk.

If the staff member is subject to a disciplinary enquiry, it is likely that the SAR will work alongside the disciplinary enquiry. However, certain disciplinary enquiries may lead to a criminal investigation. The decision to run a SAR alongside any disciplinary enquiry will be made on a case by case basis. The final decision will be made by the Independent Chair of the Safeguarding Adults Board.

2.9.10 Who should undertake a SAR?

The individual commissioned to undertake the SAR should be independent of the organisations involved. They must have the appropriate core skills including:

- Strong leadership and ability to motivate others;
- Expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics;
- Collaborative problem-solving experience and knowledge of participative approaches;
- Ability to find and evaluate best practice;
- Good analytic skills and ability to manage quantitative and qualitative data;
- Knowledge of safeguarding adults;
- Ability to write for a wide audience and
- An understanding of the complexity of the health and social care system

2.9.11 Requests

Any individual, agency or professional can request a SAR. This should be made in writing to the SAB Chair, or as agreed by the local SAB. The request should detail:

- What happened with dates if known;
- The views of the adult/family/carer;
- Where the incident/concerns took place;
- Who was involved and their organisation and
- Why the request is being made

The request should be considered against the criteria in order for a SAR process to be consistently applied. Agreement to a SAR should be recorded on relevant systems across the statutory agencies. For the NHS this will be carried out by the CCG who will record on STEIS.

2.9.12 Commissioning a SAR

The SAB is the only body authorised to commission a SAR and decide when a SAR is necessary; arrange for its conduct and if it so decides, to oversee implementation of the findings. Where the SAB decides to reject a recommendation, it must state the reason for that decision in the Annual Report.

The SAB may convene a subgroup to act on its behalf to receive and manage requests and have delegated commissioning responsibilities. In commissioning a SAR, there may be procurement or other commissioning protocols to consider and it may be helpful to establish these as part of the governance arrangements.

SAR options - A number of options may be considered by the SAB or delegated subgroup. The SAR model should be determined locally according to the specific individual circumstance. Models of a SAR have been identified by SCIE.

Safeguarding Adults Reviews: implementation support[lvii] for SABs to weigh up the most appropriate and proportionate to the situation. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, take remedial action and, very often, provide answers for families and friends of adults who have died or been seriously abused or neglected. Every effort should be made while the SAR is in progress to capture points from the case about improvements needed and to take corrective action.

When commissioning a SAR, the following points should be agreed:

- Scope of the terms of reference;
- Knowledge, skills and experience of the reviewer;
- Timescales for completion;
- Who will secure any legal advice required;
- How the interface between the SAR and any other investigations or reviews will be managed;
- How quality assurance will be managed;
- A communication strategy, including clarification about what information can be shared, when and where (conditions);
- A media strategy;
- What the arrangements for administrative and professional support are; and
- How it will be paid for.

2.9.13 Links with other reviews and investigations

All statutory agencies leading investigations following a death need to be aware of potential parallel inquiries, investigations and processes which may have been instigated as a result of the death.

For victims of domestic homicide, there is separate statutory guidance in respect of children, which provides for a

- Serious Case Review (SCR) [lviii]

and in respect of persons aged 16 or over, which provides for a

- Domestic Homicide Review (DHR)[lix]

These two sets of statutory guidance overlap where the victims are aged between 16 and 18.

When commissioning a SAR there should be consideration of how it how will dovetail with other statutory reviews and any other investigations.

The guidance for DHR states consideration should be given to how the child SCRs and DHRs can be managed in parallel in the most effective way, so that organisations/professionals can learn from the case. Different types of reviews will have their own specific areas of investigation and these should be respected. Where intelligence can be shared across reviews, there should be no organisational barriers to information sharing. It is also helpful to consider if some aspects of the reviews can be commissioned jointly to reduce duplication.

2.9.14 Coroners

Any SAR may need to take account of a Coroner's inquest, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay. Coroners are independent judicial office holders who are responsible for investigating violent, unnatural deaths or deaths of unknown cause, and deaths in custody, or otherwise in state detention, which are reported to them. The Coroner may have specific questions arising from the death of an adult at risk. These are likely to fall within one of the following categories:

- Where there is an obvious and serious failing by one or more organisations;
- Where there are no obvious failings, but the actions taken by organisations require further exploration/explanation;
- Where a death has occurred and there are concerns for others in the same household or other setting (such as a care home);
- Deaths that fall outside the requirement to hold an inquest, but follow-up enquiries/actions are identified by the Coroner or his or her officers.

In the above situations the local SAB should give serious consideration to instigating a SAR.

2.9.15 Findings from SARs

The Home Office, Domestic Homicide Review Toolkit Guide to Overview Report Writing[lx] offers a helpful steer on the production of reports, so that they satisfy families, public, professionals and others who will read the report and look to it for explanation and for reassurance that it has captured the essence of any learning needed to improve services and reduce the likelihood of future similar incidents.

SCIE has suggested that SABs can take advantage of data from other quality assurance and feedback sources such as audits and complaints, to inform decision making about the kind of case or issue that would benefit the review. The review formally concludes when agreed by the SAB.

The findings and outcomes of any SAR should be captured within the Annual Report of the local SAB.

2.9.16 Timetable

The timescale from the decision to conduct a SAR to completion is 6 months**.** In the event that the SAR is likely to take longer for example, because of potential prejudice to related court proceedings, the adult/advocate and others should be advised in writing the reasons for the delay and kept updated on progress.

2.10 Mechanisms to support adult safeguarding

2.10.1 Multi Agency Safeguarding Hubs (MASH)

The MASH is one model where concerns may be risk assessed and decisions made about how concerns are taken forward. The MASH is a partnership of agencies that have a duty to safeguard and have agreed to share information they hold on adults at risk. Their shared vision for safeguarding is to work in an integrated way to improve the outcomes for adults at risk.

Research carried out by the Home Office provides Local Authorities and partners with information on the efficacy of a MASH[lxi].

The Hull Safeguarding Adult Partnership Board's adoption of a MASH is an example of a MASH in practice[lxii].

2.10.2 Multi-Agency Risk Assessment Conference (MARAC)

The MARAC is the multi-agency forum of organisations that manage high-risk cases of domestic abuse, stalking and 'honour'- based violence. MARAC meetings take place in each local area, usually chaired by the police, where statutory and voluntary sector partners work together. MARAC considers cases identified as 'high risk' by use of the Domestic Abuse, Stalking and Harassment and 'Honour'-based violence (DASH) - risk identification checklist (RIC) and develops a coordinated safety plan to protect each victim. This might include the actions agreed for any children, adults, and for perpetrators.

The four aims of a MARAC are as follows:

- To safeguard adult victims who are at high risk of future domestic violence;
- To make links with other public protection arrangements in relation to children, people causing harm and vulnerable adults;
- To safeguard agency staff;
- To work towards addressing and managing the behaviour of the person causing harm.

At the heart of a MARAC is a working assumption that no single agency or individual can see the complete picture of the life of a person at risk, but all may have insights that are crucial to their safety, as part of the coordinated community response to domestic violence. Safeguarding staff can refer to the MARAC if the risk of domestic abuse is found to be high. The MARAC may also make a referral to safeguarding services if someone has care and support needs.

Referrals should be made to specialist domestic violence services regardless of the level of risk and thresholds for the MARAC. One of the major challenges with the high-risk approach is that women described as in standard or medium risk can have very high needs and they do not get the support needed and this impacts on their safety and wellbeing.

2.10.3 Multi-agency Public Protection Arrangements (MAPPA)

The purpose of the multi-agency public protection arrangements (MAPPA) framework is to reduce the risks posed by sexual and violent offenders in order to protect the public, including previous victims, from serious harm.

MAPPA brings together the Police, Probation and Prison Service into what is known as the MAPPA Responsible Authority. The Responsible Authority has a statutory duty to ensure that MAPPA is established in its geographic areas and to undertake the risk assessment and management of all identified MAPPA offenders.

A number of other agencies are under a 'Duty to Co-operate' with the Responsible Authority. These include Social Services, Health Services, Youth Offending Teams, Jobcentre Plus and Local Housing and Education Authorities. The Duty to Co-operate agencies are represented on the London Strategic Management Board (SMB), which is the means by which the Responsible Authority fulfils its duties under the Act.

The London SMB has determined that Local Authority Adult Social Care Services should be a 'core member' of MAPPA. Where, in exceptional circumstances, attendance is not possible and where, by agreement with MAPPA, Adult Services are represented by Children's Services or Mental Health Services, that representative must also be able to obtain any relevant information from Adult Services where this is necessary.

2.10.4 Community Multi-Agency Risk Assessment Panels (or High-Risk Panels)

Community Multi-Agency Risk Panels are one type of multi-agency working on complex and high-risk cases, often where agencies spend significant amounts of time responding to difficult, chaotic or problematic behaviour or lifestyles that place the person, and possibly others, at significant risk. Panels can be created with all necessary partners, both statutory and third party and will vary depending on local need of the case in question. Any situation calling for multi-agency action could be discussed at panel meetings. The panel will support agencies in their work to lower and manage risk for both individuals and the wider community.

Community Multi-Agency Risk Panels are based on the belief that shared decision making is the most effective, transparent and safe way to reach a decision, where there is challenge with the adult at risk and professionals working with them to mitigate the risk; or where there is a highly complex case and the risk needs to be escalated for consideration by such a panel. The purpose of the Panel is to agree a risk reduction plan that is owned and progressed by the most relevant agency with the support of necessary partners.

3. ADULT SAFEGUARDING PRACTICE

This section sets out the essential work that must be considered throughout adult safeguarding. In every case there must be evidence of due diligence and attention to mental capacity and consent.

3.1 Mental Capacity and Consent

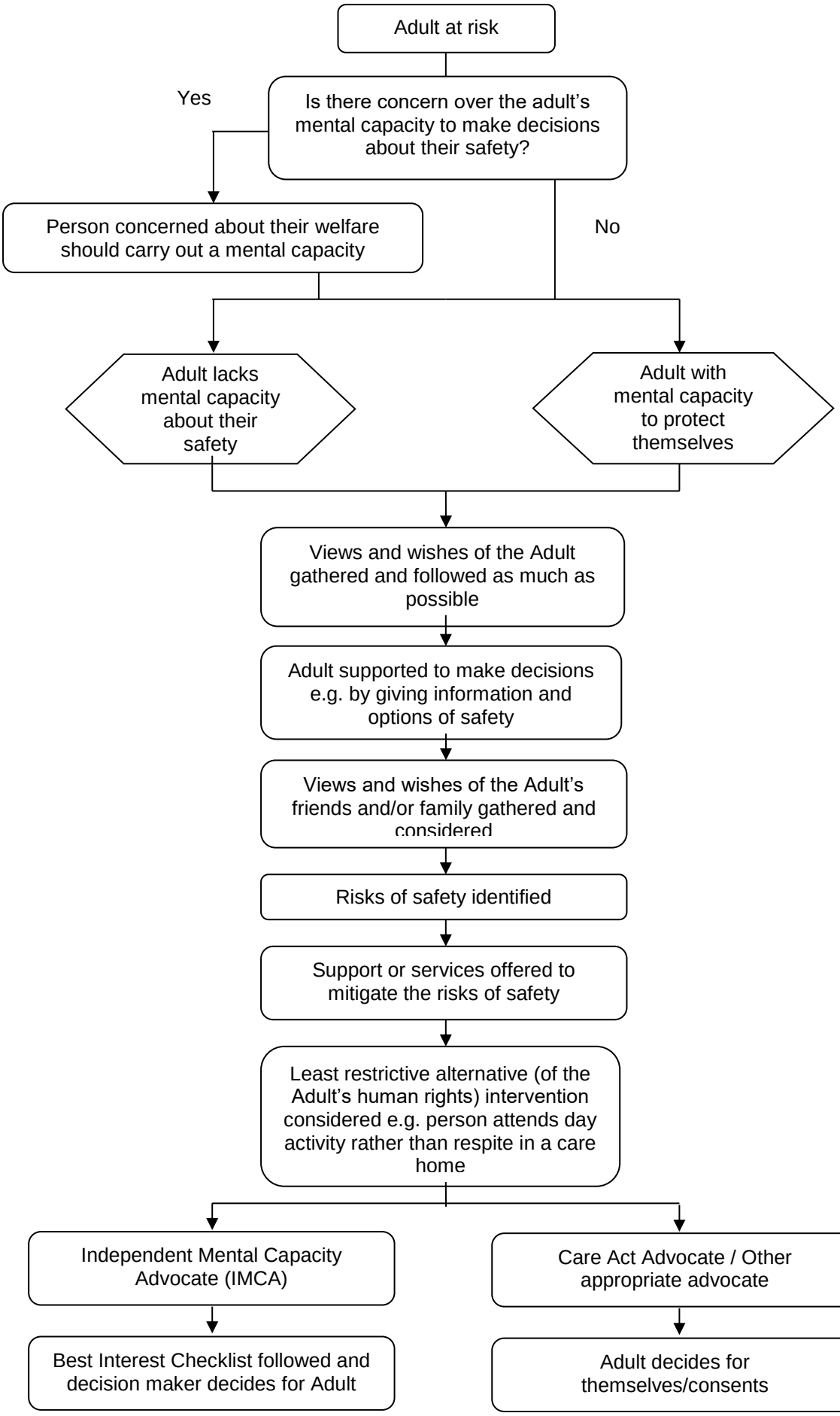
The Mental Capacity Act 2005[vii] provides a statutory framework to empower and protect people who may lack capacity to make decisions for themselves; and establishes a framework for making decisions on their behalf. This applies whether the decisions are life-changing events or everyday matters. All decisions taken in the adult safeguarding process must comply with the Act.

The Mental Capacity Act outlines five statutory principles[lxiii] that underpin the work with adults who may lack mental capacity:

- A person must be assumed to have capacity unless it is established that he lacks capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- 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 rights and freedom of action.

Learning from Safeguarding Adults Reviews continues to show that staff working with adults who lack mental capacity are not fully complying with principle 5 above.

Figure 1: Mental Capacity Assessment



The majority of adults that require additional safeguards are people who are likely to lack mental capacity to make decisions about their care and support needs.

Mental Capacity refers to the ability to make a decision about a particular matter at the time the decision is needed. It is always important to establish the mental capacity of an adult who is at risk of abuse or neglect, should there be concerns over their ability to give informed consent to:

- Planned interventions and decisions about their safety
- Their safeguarding plan and how risks are to be managed to prevent future harm

3.1.1 Mental Capacity Assessment

The Act says that:

'…*a person lacks capacity in relation to a matter if at the material time he/she is unable to make a decision for him/herself in relation to the matter because of an impairment of, or disturbance in the functioning of the mind or brain. Further, a person is not able to make a decision if they are unable to:*

- *Understand the information relevant to the decision; or*
- *Retain that information long enough for them to make the decision; or*
- *Use or weigh that information as part of the process of making the decision; or*
- *Communicate their decision (whether by talking, using sign language or by any other means such as muscle movements, blinking an eye or squeezing a hand)'.*

Mental capacity is time and decision-specific. This means that an adult may be able to make some decisions at one point but not at other points in time. Their ability to make a decision may also fluctuate over time. If an adult is subject to coercion or undue influence by another person this may impair their judgement and could impact on their ability to make decisions about their safety. Thus, an adult could be put under pressure, for example in domestic abuse situations, that they lack the mental capacity to make the decisions about their safety. Staff must satisfy themselves that the adult has the mental ability to make the decision themselves, if not, it is best to err on the side of caution, identify the risks and consider support or services that will mitigate the risk. Preventing the person from isolation can be a protective factor. Involving an advocate could assist in such circumstances. Advocacy support can be invaluable and may be provided by an IMCA or other appropriate advocate.

3.1.2 Consent in relation to safeguarding

Consent in relation to safeguarding

The Care Act 2014[i] statutory guidance advises that the first priority in safeguarding should always be to ensure the safety and well-being of the adult.

Making Safeguarding Personal[vi] is a person-centred approach which means that adults are encouraged to make their own decisions and are provided with support and information to empower them to do so. This approach recognises that adults have a general right to independence, choice and self-determination including control over information about themselves. Staff should strive to deliver effective safeguarding consistently with both of the above principles. They should ensure that the adult has accessible information so that the adult can make informed choices about safeguarding: what it means, risks and benefits and possible

consequences. Staff will need to clearly define the various options to help support them to make a decision about their safety.

Adults may not give their consent to the sharing of safeguarding information for a number of reasons. For example, they may be unduly influenced, coerced or intimidated by another person, they may be frightened of reprisals, they may fear losing control, they may not trust social services or other partners, or they may fear that their relationship with the abuser will be damaged. Reassurance and appropriate support may help to change their view on whether it is best to share information. Staff should consider the following and:

- Explore the reasons for the adult's objections – what are they worried about?
- Explain the concern and why you think it is important to share the information
- Tell the adult with whom you may be sharing the information with and why
- Explain the benefits, to them or others, of sharing information – could they access better help and support?
- Discuss the consequences of not sharing the information – could someone come to harm?
- Reassure them that the information will not be shared with anyone who does not need to know
- Reassure them that they are not alone and that support is available to them.

If, after this, the adult refuses intervention to support them with a safeguarding concern, or requests that information about them is not shared with other safeguarding partners, in general, their wishes should be respected. However, there are a number of circumstances where staff can reasonably override such a decision, including:

- The adult lacks the mental capacity to make that decision – this must be properly explored and recorded in line with the Mental Capacity Act[vii]
- Emergency or life-threatening situations may warrant the sharing of relevant information with the emergency services without consent
- Other people are, or may be, at risk, including children
- Sharing the information could prevent a serious crime
- A serious crime has been committed
- The risk is unreasonably high and meets the criteria for a multi-agency risk assessment conference referral[lxiv]
- Staff are implicated

There is a court order or other legal authority for taking action without consent. In such circumstances, it is important to keep a careful record of the decision-making process. Staff should seek advice from managers in line with their organisations' policy before overriding the adult's decision, except in emergency situations. Managers should make decisions based on whether there is an overriding reason which makes it necessary to take action without consent and whether doing so is proportionate because there is no less intrusive way of ensuring safety. Legal advice should be sought where appropriate. If the decision is to take action without the adult's consent, then unless it is unsafe to do so, the adult should be informed that this is being done and of the reasons why.

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

- Support the adult to weigh up the risks and benefits of different options
- Ensure they are aware of the level of risk and possible outcomes
- Offer to arrange for them to have an advocate or peer supporter
- Offer support for them to build confidence and self-esteem if necessary
- Agree on and record the level of risk the adult is taking
- Record the reasons for not intervening or sharing information
- Regularly review the situation
- Try to build trust to enable the adult to better protect themselves.

It is important that the risk of sharing information is also considered. In some cases, such as domestic violence or hate crime, it is possible that sharing information could increase the risk to the adult. Safeguarding partners need to work jointly to provide advice, support and protection to the adult in order to minimise the possibility of worsening the relationship or triggering retribution from the abuser.

3.1.3 Mental Health Act 1983[lxv] (amended 2007[lxvi]) and Mental Capacity Act 2005[vii]

There are important differences between being treated under the Mental Health Act (MHA) and the Mental Capacity Act[vii] (MCA). If adults are treated under the MCA, their lack of mental capacity to make decisions must be established. Adults, who have mental capacity and refuse treatment for mental illness, should be treated under the MHA if they are subject to the Mental Health Act 1983[lxv].

- The Mental Health Act[lxvi] is used to ensure that people who need treatment for serious mental disorder receive this treatment, even against their wishes, if there are sufficient risks to their own health or safety or risks to the safety of other people.
- The MCA Code of Practice[lxvii] makes it clear that all professionals should seek to use the MCA to make decisions if that is possible rather than using the MHA. (Code of Practice chap 13 introduction)

CASE STUDY ON MENTAL CAPACITY AND ADULT SAFEGUARDING AND INTERFACE WITH DEPRIVATION OF LIBERTY SAFEGUARDS

Mrs Smith is 78 years of age and lives with her son in her owner-occupied house with three cats. Mrs Smith is not very mobile as she has oedema in her legs and has some open wounds that are weeping fluid and she is diabetic. She has twice daily support from a care agency. She relies on her son to do her shopping and prepare a daily main meal. The son does not work, and it is suspected that he misuses alcohol. Lately Mrs Smith has not been eating well, and is worried about her finances, as her son always asks her for money, which he lends to other friends. She has confided her situation to her neighbour. Mrs Smith has repeatedly said she feels very unwell and is worried that her son has borrowed tens of thousands of pounds from her and that he has no plans to pay this back. She says it is so bad she cannot afford any food or heating in the house. She appears confused about letters from the council stating that council tax has not been paid for many months. Mrs Smith's neighbour is so concerned she takes her to see her GP, who confirms that she has lost a lot of weight. The GP raises a safeguarding concern to the Local Authority about possible financial abuse and makes an initial diagnosis of memory impairment as a result of possible dementia. The GP refers to a psychiatrist who makes a home visit and carries out a mental capacity assessment with regards to whether Mrs Smith is able to manage her finances. The psychiatrist shares the information with the GP and Local Authority.

Mrs Smith is visited by a social worker who carries out a safeguarding enquiry whilst the son is out. The social worker meets with Mrs Smith to see whether she understands the concerns

and to gather her views and establish the outcome that she wants. As an immediate safeguard she is given the option to stay at home or accept respite in a care home. She decides to go to a care home as she has not eaten for days and feels pressured by her son to always give him money. The social worker reports to the police the possibility of a crime. The police proceed to investigate and also consider action under Section 44 of the Mental Capacity Act[lxviii] which stipulates that someone can be prosecuted if found to wilfully abuse, or neglect an adult who lacks mental capacity.

At the care home Mrs Smith continues to be visited by her son, who asks her for money and searches her purse for small change. He brings letters with him which his friends have written to Mrs Smith, asking her to give the son money for their needs. Care staff tell the son not to put any pressure on his mother and notify the home manager and the Local Authority care management team. As Mrs Smith has memory problems and is deemed not to have mental capacity, her neighbour is consulted, and it is agreed that she can take on the role of advocate.

In response to the safeguarding enquiry, Mr Smith says that he can take care of his mother and that she must come home. Staff prevent Mrs Smith from leaving and explain to the son that Mrs Smith would like to remain and that her care and support is best met in the care home at this point in time.

Mr Smith has also asked his mother to sign cheques, which staff members advise her not to sign as she appears confused about financial matters. He often arrives intoxicated and has put his mother into a broken wheelchair making it unsafe for her, staff have observed she is distressed by his behaviour.

A safeguarding planning meeting was held, and a risk management plan formulated based on a best interest decision that the son will only be allowed supervised visits with his mother in the lounge area where staff can help prevent financial and psychological abuse. Mrs Smith's neighbour is at the meeting to advocate for her and to ensure that Mrs Smith's wishes are considered.

The Care Home made an Urgent Deprivation of Liberty Safeguard (DoLS) application as Mrs Smith is deemed to lack the mental capacity to decide about her stay. She is under continuous supervision of staff in the care home and she is not able to leave. Her stay is considered to be in her best interests, so she can have the necessary care which includes regular dressings and medical attention to her legs and to ensure she has sufficient nutritious meals. Her son is informed of the arrangement and is informed that the Local Authority has lodged an application to the Court of Protection with regards to the DoLS and the safeguarding plan. Furthermore, as Mrs Smith lacks capacity to manage her own financial affairs the Local Authority included a request to the Court for a decision for a deputyship.

The application to the court of Protection was made to consider:

- Whether the DoLS is lawful and should continue;
- Whether supervised visits by the son are lawful;
- Who is best suited to manage Mrs Smith's finances.

This case study also identifies the balance required to work with people who are the source of abuse and neglect to be compliant with the Mental Capacity Act 2005[vii],safeguard the adult and ensure that their wishes are paramount.

3.2 Advocacy & Support

3.2.1 Advocacy

The Care Act 2014[i] requires that a Local Authority must arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or SAR where the adult has 'substantial difficulty' in being involved in the process and where there is no other appropriate individual to help them. (Section 68[lxix]).

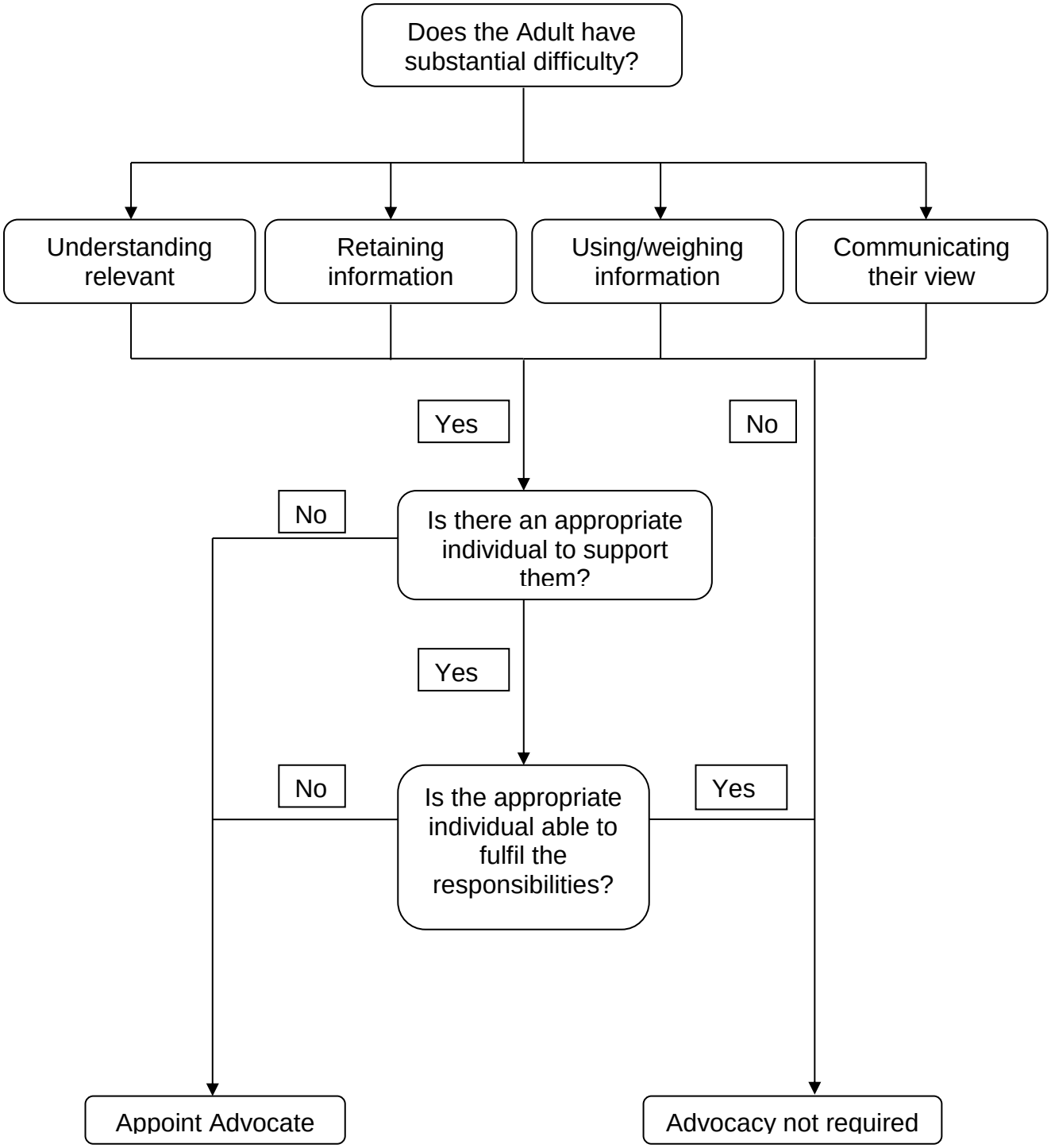
There are distinct differences between an Independent Mental Capacity Advocate (IMCA) introduced under the Mental Capacity Act 2005[vii], and an Independent Advocate introduced under the Care Act 2014. Independent advocates cannot undertake advocacy services under the Mental Capacity Act 2005, however where there is an appointed IMCA they may also take on the role of Independent Advocate under the Care Act 2014.

The figure one flowchart illustrates the interface between mental capacity and advocacy.

Briefing Note: Independent Advocacy under the Care Act 2014[lxx] - Care and Support Providers

Figure 2: When to appoint an independent advocate

Advocacy



It should be remembered that where the adult does not want support from family or friends that their wishes should be respected, and an independent advocate provided. Further advocacy resources are available below:

- An overview of advocacy requirements under the Care Act 2014[lxxi].
- Guidance for care and support providers[lxx]
- Helpful workbook to assist compliance with the Care Act 2014 and acts as practice guidance for staff[lxxii].

3.2.2 Support to adults

A requirement under the Equality Act 2010[xxvi] is for provision and adjustments to enable disabled people equal access to information and advice. Ensuring equality may reduce or remove substantial difficulty. Access to other services for example, translators should always be considered to ensure that the adults are afforded every opportunity to participate and be involved.

3.2.3 Support for vulnerable witnesses in the criminal justice process

Research has found that sometimes evidence from victims and witnesses with learning disabilities is discounted. This may also be true of others such as people with dementia. It is crucial that reasonable adjustments are made, and appropriate support given, so people can get equal access to justice;

- Guidance should include reference to support relating to criminal justice matters which is available locally from such organisations as Victim Support and court preparation schemes;
- Some witnesses will need protection; and the police may be able to get victim support in place.

Special Measures were introduced through legislation in the Youth Justice and Criminal Evidence Act 1999[lxxiii] (YJCEA) and include a range of measures to support witnesses to give their best evidence and to help reduce some of the anxiety when attending court. Measures in place include the use of screens around the witness box, the use of live-link or recorded evidence-in-chief and the use of an intermediary to help witnesses understand the questions they are being asked and to give their answers accurately.

Vulnerable Adult Witnesses (Section16 YJCEA[lxxiv]) have a:

- Mental disorder
- Learning disability, or
- Physical disability

These witnesses are only eligible for special measures if the quality of evidence that is given by them is likely to be diminished by reason of the disorder or disability.

Intimidated Witnesses (Section 17 YJCEA[lxxv]): Intimidated witnesses are defined by Section 17 of the Act as those whose quality of evidence is likely to be diminished by reason of fear or distress. In determining whether a witness falls into this category the court takes account of:

- The nature and alleged circumstances of the offence;
- The age of the witness;
- The social and cultural background and ethnic origins of the witness;
- The domestic and employment circumstances of the witness;
- Any religious beliefs or political opinions of the witness;

- Any behaviour towards the witness by the accused or third party.

Also falling into this category are:

- Complainants in cases of sexual assault;
- Witnesses to specified gun and knife offences;
- Victims of and witnesses to domestic violence, racially motivated crime, crime motivated by reasons relating to religion, homophobic crime, gang related violence and repeat victimisation;
- Those who are older and frail;
- The families of homicide victims.

Registered Intermediaries (RIs) have been facilitating communication with vulnerable witnesses in the criminal justice system in England and Wales since 2004.

Special measure includes practical and emotional support to victims and witnesses (either for the defence or for the prosecution) provided by the Witness Service. Support is available before, during and after a court case to enable adults and their family and friends to have information about court proceedings and could include arrangements to:

- Visit the court in advance of the trial;
- Consider the use of screens in court proceedings;
- The removal of wigs and gowns;
- The sharing of use of intermediaries and aids to communication.

If the person alleged to have caused harm is a young person or has a mental disorder, including a learning disability, and they are interviewed at the police station, they are entitled to the support of an 'appropriate adult' under the provisions of the Police and Criminal Evidence Act 1984 Code of Practice[lxxvi].

There is an automatic referral to Victim Support services for all victims of crime whether they are deemed vulnerable or not.

3.3 Managing Risk

There is a range of risk assessment tools available such as use by the MPS of the Domestic Abuse risk matrix to identify and manage risk. It is important that tools are available locally to support staff to evidence professional judgement during their decision making. Issues around information sharing may be relevant in this context. See Section 1.1.4 for more details.

3.3.1 Involving the adult

Making Safeguarding Personal (MSP) stresses the importance of keeping the adult at the centre of positive approaches to managing risks to their safety. Under MSP the adult is best placed to identify risks, provide details of its impact and whether or not they find the mitigation acceptable. Working with the adult to lead and manage the level of risk that they identify as acceptable creates a culture where: -

- Adults feel more in control;
- Adults are empowered and have ownership of the risk;
- There is improved effectiveness and resilience in dealing with a situation;
- There are better relationships with professionals;
- Good information sharing to manage risk, involving all the key stakeholders (see Information Sharing part one);

- Key elements of the person's quality of life and well-being can be safeguarded.

3.3.2 Identifying Risk

Not every situation or activity will entail a risk that needs to be assessed or managed. The risk may be minimal and no greater for the adult, than it would be for any other person.

- Risks can be real or potential;
- Risks can be positive or negative;
- Risks should take into account all aspects of an individual's wellbeing and personal circumstances.

Sources of risk might fall into one of the four categories below:

- Private and family life: The source of risk might be someone like an intimate partner or a family member;
- Community based risks: This includes issues like 'mate crime', anti-social behaviour, and gang-related issues;
- Risks associated with service provision: This might be concerns about poor care which could be neglect or organisational abuse, or where a person in a position of trust because of the job they do financially or sexually exploits someone;
- Self-neglect: Where the source of risk is the person themselves.

3.3.3 Risk Assessment

Risk assessment involves collecting and sharing information through observation, communication and investigation. It is an on-going process that involves persistence and skill to assemble and manage relevant information in ways that are meaningful to all concerned. Risk assessment that includes the assessment of risks of abuse, neglect and exploitation of people should be integral in all assessment and planning processes, including assessments for self-directed support and the setting up of personal budget arrangements. Assessment of risk is dynamic and on-going and a flexible approach to changing circumstances is needed. The primary aim of a safeguarding adults risk assessment is to assess current risks that people face and potential risks that they and other adults may face. Specific to safeguarding, risk assessments should encompass:

- The views and wishes of the adult;
- The person's ability to protect themselves;
- Factors that contribute to the risk, for example, personal, environmental
- The risk of future harm from the same source;
- Identification of the person causing the harm and establishing if the person causing the harm is also someone who needs care and support;
- Deciding if domestic abuse is indicated and the need for a referral to a MARAC;
- Deciding if a community multi-agency risk assessment (high risk panel) is needed;
- Identify people causing harm who should be referred to MAPPA;
- It may increase risk where information is not shared.

3.3.4 Risk Management

The focus must be on the management of risks not just a description of risks. Employers need to take responsibility for the management of risk within their own organisation and share information responsibly where others may be at risk from the same source. The Local Authority may be ultimately accountable for the quality of Section 42 enquiries, but all organisations are responsible for supporting holistic risk management, with the adult and in partnership with other agencies.

It is the collective responsibility of all organisations to share relevant information, make decisions and plan intervention with the adult. A plan to manage the identified risk and put in place safeguarding measures includes:

- What immediate action must be taken to safeguard the adult and/others;
- Who else needs to contribute and support decisions and actions;
- What the adult sees as proportionate and acceptable;
- What options there are to address risks;
- When action needs to be taken and by whom;
- What the strengths, resilience and resources of the adult are;
- What needs to be put in place to meet the on-going support needs of the adult;
- What the contingency arrangements are;
- How will the plan be monitored?

Positive risk management needs to be underpinned by widely shared and updated contingency planning for any anticipated adverse eventualities. This includes warning signs that indicate risks are increasing and the point at which they become unacceptable and therefore trigger a review.

Effective risk management requires exploration with the adult using a person-centred approach, asking the right questions to build up a full picture. Not all risks will be immediately apparent; therefore, risk assessments need to be regularly updated as part of the safeguarding process and possibly beyond.

3.3.5 Reviewing Risk

Individual need will determine how frequently risk assessments are reviewed and wherever possible there should be multi-agency input. These should always be in consultation with the adult at risk.

3.3.6 Risk disputes

Throughout these policies and procedures risk assessment and risk management is carried out in partnership with the adult, wider support network and others. The decision to involve others or not is in itself a decision which may give rise to risk, and the individual may need support to make this decision.

The professional views of risk may differ from the views of the adult. Perceived risks have implications for the safety and the independence of the individual, but they also have implications for the accountability of professionals. This highlights the importance of training and/or regular practice in making independent decisions by adults. Accessible knowledge through information and advice, assertiveness through the right kind of advocacy and support may be appropriate.

Professionals need to embrace and support positive risk taking by finding out why the person wishes to make a particular choice, what this will bring to their life, and how their life may be adversely affected if they are not supported in their choice.

The promotion of choice and control, of more creative and positive risk-taking, implies greater responsibility on the part of the adult and greater emphasis on keeping them at the centre of decision making.

It may not be possible to reach agreement, but professionals need to evidence that all attempts to reach agreement were taken. Where there are concerns about people making unwise decisions, or there is high risk that requires wider collaboration; Community Multi-Agency Risk Panel sometimes referred to as High Risk Panels is one model used to support safeguarding adults' processes.

Other models include Risk Enablement Panels, where there is an emphasis on shared responsibility, including the adult at risk, and advocate. A risk enablement panel should only be convened as a last resort.

3.4 Recording actions under adult safeguarding

A record of all actions and decisions must be made, as record keeping is a vital component of professional practice and is an essential element in documenting the legal justification for decisions. When abuse or neglect is raised, managers need to look for past incidents, concerns, risks and patterns. We know that in many situations, abuse and neglect arise from a range of incidents over a period of time. In the case of providers registered with CQC, records of these should be available to service commissioners and the CQC so they can take the necessary action. At a minimum there should be an audit trail of:

- Date and circumstances of concerns and subsequent action;
- Decision making processes and rationales;
- Risk assessments and risk management plans;
- Consultations and correspondence with key people;
- Advocacy and support arrangements;
- Safeguarding plans;
- Outcomes;
- Feedback from the adult and their personal support network;
- Differences of professional opinion;
- Referrals to professional bodies.

As records may be disclosed in courts in criminal or civil actions and to individuals under data protection legislation, all organisations should audit safeguarding concerns and outcomes as part of their quality assurance (Local Authority should use existing codes within the Safeguarding Adult Collections categories). Supervisors should ensure that recording is addressed in supervision and that staff are clear of their responsibilities. SABs should regularly review the quality of recording as part of their performance and quality data scrutiny.

Learning lessons from past mistakes and missed opportunities highlighted in Safeguarding Adult Reviews, Serious Case Reviews and other reports emphasise the need for quality recording especially when managing abuse, neglect and risk. This includes providing rationales for actions and decisions, whether or not they were taken, and if not the reasons for this.

Quality recording of adult safeguarding not only safeguards adults, but also protects workers by evidencing decision making based on the information available at the time. For more information see the University of the West of England advice on the importance of keeping records[lxxvii]

3.5 Organisational learning

It is essential that all aspects of safeguarding practice are monitored and scrutinised on a regular basis. All staff have a responsibility to audit their work and a set of local outcome focused standards might support staff.

All agencies need to take responsibility for organisational learning and implement changes to their practice as a result of audits, complaints, SARs, and most importantly feedback from adults at risk about what works well and what needs to improve provide opportunities for learning from themes and patterns of practice that can add value to learning from good practice and pinpointing necessary changes.

In addition to practice guidance highlighted throughout this document, staff may find the following information from SCIE helpful on adult safeguarding questions[lxxviii].

THE PROCEDURES

4. ADULT SAFEGUARDING PROCEDURES

4.1 Context

The main objective of adult safeguarding procedures is to provide guidance to mitigate against the risks to adults from abuse or neglect, ensuring that any outcomes from an enquiry are client focused and achievable and identify immediate action to be taken where required.

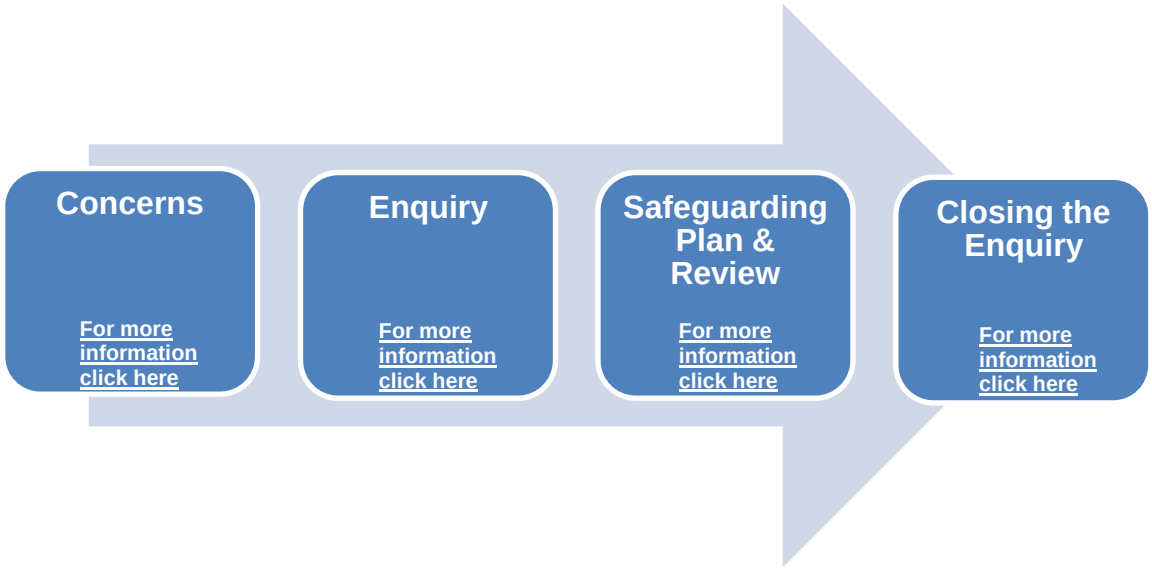
The procedures are a means for staff to combine principles of protection and prevention with individuals' self-determination, respecting their views, wishes and preferences in accordance with Making Safeguarding Personal. They are a framework for managing safeguarding interventions that are fair and just, through strong multi-agency partnerships that provide timely and effective prevention of and responses to abuse and neglect. All organisations who work with or support adults experiencing, or who are at risk of, abuse and neglect may be called upon to lead or contribute to a safeguarding concern and need to be prepared to take on this responsibility.

Guidance is often criticised for over-standardising practice and undervaluing the skills required when applying policies in diverse circumstances. The key focus is on using professional skills to ensure safeguarding is personalised and the outcomes and goals from any enquiry are client focused, realistic and attainable.

4.2 The Four Stage process

The Procedures Chapter has been structured within a Four Stage Process:

Figure 3: The procedures four stage process



Before going through each stage of the process in depth, the next section will define roles and responsibilities and provide context within which the procedures operate.

4.3 Responsibilities

4.3.1 Local Authority and NHS partnerships

'Local Authorities can continue to enter into partnership arrangements with the NHS for the NHS to carry out a Local Authority's 'health-related functions' (as defined in the 2000 Regulations [the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000[lxxix]]). This effectively authorises NHS bodies to exercise those prescribed functions, including adult safeguarding functions. These arrangements are 'partnership arrangements' rather than 'delegations'. In addition, by virtue of Regulation 4 of the 2000 Regulations[lxxx], arrangements may only be entered into 'if the partnership arrangements are likely to lead to an improvement in the way in which those functions are exercised'. The Local Authority would still remain legally responsible for how its functions (including adult safeguarding) are carried out via partnership arrangements.' (Department of Health March 2015).

Within this policy and procedure, where there are partnership agreements under Section 75 of the NHS Act 2006[lxxxi] with Mental Health Trusts, appropriately trained managers within the Trust can act on behalf of the Local Authority to undertake adult safeguarding duties. Where this is done, the legal responsibility for safeguarding remains with the Local Authority. This is in particular reference to who can act as a Safeguarding Adult Manager (SAM), which is a role particular to the Local Authority and its Section 75 partners under the above agreements and local protocols.

4.3.2 Safeguarding Managers/Leads in all organisations

Safeguarding adults manager/lead throughout refers to members of staff responsible in an organisation to provide:

- Managerial support and direction to staff in that organisation
- Decision making for concerns raised by members of staff and/or members of the public

4.3.3 Safeguarding Adult Referral Points

Each organisation must have its own operational policy on how it manages adult safeguarding concerns, including a list of referral points with up-to-date contact details, so that staff and the public know how to report abuse and neglect. Referral points may be through a contact centre, specific access team or through a MASH or other locally agreed arrangements. The Local Authority is the main referral point even if others have their own and all Local Authorities should provide referral points that are accessible outside normal working hours, in order to respond to urgent concerns.

4.3.4 Enquiry Officer

An enquiry officer is responsible for undertaking actions under adult safeguarding. In some instances, there is a lead Enquiry Officer supported by other staff also acting as enquiry officers, where there are complex issues or additional skills and expertise is required. The lead Enquiry Officer will retain responsibility for undertaking and co-ordinating actions under Section 42 enquiries.

4.3.5 Safeguarding Adults Manager (SAM)

Safeguarding Adult Manager or Lead is the Local Authority member of staff who manages, makes decisions, provides guidance and has oversight of safeguarding concerns that are referred to the Local Authority, or through the Mental Health Trust where there are the above agreements in place.

4.3.6 Feedback

All adult safeguarding concerns referred to the Local Authority should be assessed to decide if the criteria for adult safeguarding are met. Keeping the person who raised the concern informed is an essential requirement under these policies and procedures. Feedback provides assurance that action has been taken whether under adult safeguarding or not. Organisations raising concerns may want to challenge or discuss decisions and need to be updated on what action has been taken. It is more likely that the public will continue to raise concerns, where there is an acknowledgement that their concern has reached the right agency and is being taken seriously. Feedback to the wider community needs to take account of confidentiality and requirements of data protection legislation. (See Information Governance Appendix Two).

4.3.7 Feedback to people alleged to have caused harm

The principles of natural justice must be applied, consistently with the overriding aim of safety and the requirements of the GDPR.

An evaluation should be carried out as to whether it is safe to share information about the complaint with the person allegedly responsible. If the adult at risk has capacity, their informed consent should be sought before sharing information with the person allegedly responsible. However, where the sharing of information to prevent harm is necessary, lack of consent to information sharing can be overridden. It may be a necessary part of a safeguarding enquiry to put information to the person allegedly responsible, where it has not been possible to obtain consent to this.

Providing information on the nature and outcomes of concerns to people alleged to have caused harm also needs to be seen in the wider context of prevention; for example, information can be used to support people to change or modify their behaviour. The person/organisation that is alleged to be responsible for abuse and/or neglect should be provided with sufficient information to enable them to understand what it is that they are alleged to have done or threatened to do that is wrong and to allow their view to be heard and considered. Whilst the safety of the adult remains paramount the right of reply should be offered where it is safe to do so. Decision making should take into consideration:

- The possibility that the referral may be malicious
- The right to challenge and natural justice
- Whether there are underlying issues for example employment disputes
- Family conflict
- Relationship dynamics
- Whether it is safe to disclose particularly where there is domestic abuse
- Compliance with the Mental Capacity Act 2005[vii]

Feedback should be provided in a way that will not exacerbate the situation or breach the GDPR[xiii].

If the matter is subject to police involvement, the police should always be consulted so criminal investigations are not compromised.

The Local Government Ombudsman[lxxxii] and the Parliamentary and Health Ombudsman[lxxxiii] are both useful sources to explore case examples. The Information Commissioner[lxxxiv] provides advice on sharing information.

4.3.8 Dealing with repeat allegations

All concerns should be considered on their own merit and recorded individually. An adult who makes repeated allegations that have been investigated and decided to be unfounded should be treated without prejudice. Where there are patterns of similar concerns being raised by the same adult within a short time period, a risk assessment and risk management plan should be developed, and a local process agreed for responding to further concerns of the same nature from the same adult. All organisations are responsible for recording and noting where there are such situations and may be asked to contribute to a multi-agency response. Information sharing to assess and analyse data is essential to ensure that adults are safeguarded, and an appropriate response is made. Staff should also be mindful of public interest issues.

In considering how to respond to repeated concerns the following factors need to be considered:

- The safety of the adult who the concern is about;
- Mental capacity and ability of the individual's support networks to raise the concern, or to increase support to meet outcomes of safeguarding concerns;
- Wishes of the adult at risk and impact of the concern on them;
- Impact on important relationships;
- Level of risk.

4.3.9 Dispute resolution and escalation

Professional disagreements should be resolved at the earliest opportunity, ensuring that the safety and wellbeing of the adult at risk remains paramount. Challenges to decisions should be respectful and resolved through co-operation. Disagreements can arise in a number of areas and staff should always be prepared to review decisions and plans with an open mind. Assurance that the adult at risk is safe takes priority. Disagreements should be talked through and appropriate channels of communication established to avoid misinterpretation.

In the event that operational staff are unable to resolve matters, more senior managers should be consulted. Multi-agency network meetings may be a helpful way to explore issues with a view to improving practice. In exceptional circumstances or where it is likely that partnership protocols are needed the SAB should kept appraised of the issues and agree what type of evaluation will be undertaken.

In the case of care providers, unresolved disputes should be raised with the relevant managers leading on the concern and commissioners.

4.3.10 Cross-boundary and inter-authority adult safeguarding enquiries

Risks may be increased by complicated cross-boundary arrangements, and it may be dangerous and unproductive for organisations to delay action due to disagreements over responsibilities. The rule for managing safeguarding enquiries is that the Local Authority for the area where the abuse occurred has the responsibility to carry out the duties under Section 42 Care Act 2014, but there should be close liaison with the placing authority.

The ‘placing Local Authority’ continues to hold responsibility for commissioning and funding a placement. However, many people at risk live in residential settings outside the area of the placing authority. In addition, a safeguarding incident might occur during a short-term health or social care stay, or on a trip, requiring police action in that area or immediate steps to protect the person while they are in that area.

The initial lead in response to a safeguarding concern should always be taken by the Local Authority for the area where the incident occurred. This might include taking immediate action to ensure the safety of the person or arranging an early discussion with the police when a criminal offence is suspected. Additional guidance on responding to safeguarding concerns which involve cross-boundary considerations can be found here

Further action should then be taken in line with Making Safeguarding Personal[vi] on the views of the adult, and the Care and Support statutory guidance[ii] on who is best placed to lead on an enquiry.

4.3.11 Timescales

The adult safeguarding procedures do not set definitive timescales for each element of the process; however, target timescales are indicated. In addition, individual local authorities or SABs may make decisions on timescales for their own performance monitoring. Local guidance on timescales should reflect the ethos of the Making Safeguarding Personal agenda. It is important that timely action is taken, whilst respecting the principle that the views of the adult at risk are paramount. It is the responsibility of all agencies proactively to monitor concerns to ensure that drift does not prevent timely action and place people at further risk. Divergence from any target timescales may be justified where:

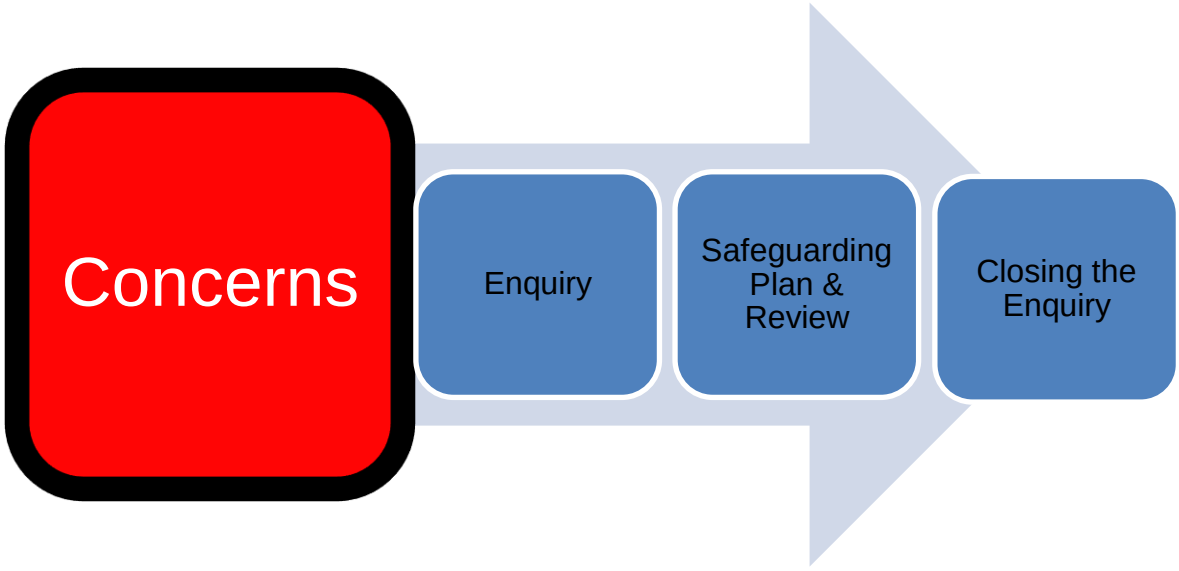
- Adherence to the agreed timescales would jeopardise achieving the outcome that the adult at risk wants;
- It would not be in the best interests of the adult at risk;
- Significant changes in risk are identified that need to be addressed;
- Supported decision making may require an appropriate resource not immediately available;
- Persons’ physical, mental and/or emotional wellbeing may be temporarily compromised.

The timescales need to reflect:

- All other investigations such as NHS Serious Incidents (SI)
- The investigation that takes priority – this needs to be agreed on a case by case basis

INDICATIVE TIMESCALES	
Stage one: Concerns	Immediate action in cases of emergency Within one working day in other cases
Stage two: Enquiries • Initial conversation • Planning meetings • Enquiry actions • Agreeing outcomes	 Same day concern received if not already taken place Within 5 working days Target time within 20 working days Within 5 working days of enquiry report

• Respond to the referrer	
Stage three: Safeguarding Plan & Review • Safeguarding Plan • Review	Within 5 working days of enquiry report Not more than 3 months, but dependent upon risk
Stage four: Closing the Enquiry Closing the enquiry	Actions immediately following decision to close where possible. Other actions within 5 working days



STAGE 1: CONCERNS

What is an adult safeguarding concern?

An adult safeguarding concern is any worry about an adult who has or appears to have care and support needs, that they may be subject to, or may be at risk of, abuse and neglect and may be unable to protect themselves against this. The adult does not need to be already in receipt of care and support.

A concern may be raised by anyone, and can be:

- An active disclosure of abuse by the adult, where the adult tells a member of staff that they are experiencing abuse and/or neglect;
- A passive disclosure of abuse where someone has noticed signs of abuse or neglect, for example clinical staff who notice unexplained injuries;
- An allegation of abuse by a third party, for example a family/friend or neighbour who have observed abuse or neglect or have been told of it by the adult;
- A complaint or concern raised by an adult or a third party who doesn't perceive that it is abuse or neglect. Complaint officers should consider whether there are safeguarding matters;
- A concern raised by staff or volunteers, others using the service, a carer or a member of the public;
- An observation of the behaviour of the adult at risk;
- An observation of the behaviour of another;
- Patterns of concerns or risks that emerge through reviews, audits and complaints or regulatory inspections or monitoring visits (CQC, Monitor etc.).

Concerns can be raised in person, by telephone, email or letter. They may also be raised through specific organisation processes for example London Ambulance Notifications and police Merlin Adult Come to Notice (ACN) reports.

Merlin ACNs are reports completed by operational police officers and sent to local authorities where they have concerns about people who may be adults at risk, whether they are a victim, witness, suspect or member of the public. The police will make a decision about whether to refer to the Local Authority, using their operational toolkit.

Some concerns may not sit under adult safeguarding processes but remain concerns that may require other action. All concerns should be responded to, and SABs should be satisfied that concerns are being addressed appropriately through their oversight of safeguarding practice.

EXAMPLE OF HOW AN ORGANISATION DEALS WITH CONCERNS INTERNALLY

London Ambulance Service (LAS) staff come into contact with many adults who require care and support. If the adult has experienced abuse or neglect or there is a suspicion that they are likely to be at risk of abuse and neglect, a concern will be raised by LAS. LAS use a single form for both reporting safeguarding concerns and a referral for individuals who may have care and support needs. Where they indicate they have a concern about actual or possible abuse or neglect, it should be dealt with as an adult safeguarding concern. Where they have not indicated either way, judgement will be made by the Local Authority.

All should be treated equally by Safeguarding Referral Points. It should always be borne in mind that some concerns will be about issues that might also be crimes and early referral to the police should always be considered.

Police Engagement

Staff contact with the police will fall mainly into four main areas:

A. Reporting a crime – if an individual witnesses a crime, they have a duty to report it to the police via 999 if an emergency or for non-emergency via 101 or online reporting service
B. Third party reporting of a crime – if an individual is made aware of a crime, they should support the adult at risk to report to the police or make a best interest decision to do so. In domestic abuse situations practitioners should be aware of the principles of 'Safe Enquires' (see domestic abuse and safeguarding adults);
C. Consultation with the police – seeking advice;
D. Sharing intelligence and managing risk – where there is an integrated MASH, this will be the channel for information sharing, in addition to agreed information sharing protocols.

Where the safeguarding concerns arise from abuse or neglect deliberately intended to cause harm, then it will not only be necessary to immediately consider what steps are needed to protect the adult but also how best to report as a possible crime. **Early consultation with the police is vital to support the criminal investigation.**

IMMEDIATE ACTION BY THE PERSON RAISING THE CONCERN

The person who raises the concern has a responsibility to first and foremost safeguard the adult at risk.

a. Make an evaluation of the risk and take steps to ensure that the adult is in no immediate danger;
b. Arrange any medical treatment. (Note that offences of a sexual nature will require expert advice from the police);
c. If a crime is in progress or life is at risk, dial emergency services – 999;
d. Encourage and support the adult to report the matter to the police if a crime is suspected and not an emergency situation;
e. Take steps to preserve any physical evidence if a crime may have been committed, and preserve evidence through recording;
f. Ensure that other people are not in danger;
g. If you are a paid employee, inform your manager. Report the matter internally through your internal agency reporting procedures (e.g. NHS colleagues may still need to report under clinical governance or serious incident processes, report to HR department if an employee is the source of risk);
h. Record the information received, risk evaluation and all actions.

THE SAFEGUARDING MANAGER/LEAD SHOULD REVIEW ACTION TAKEN, AND:

a. Clarify that the adult at risk is safe, that their views have been clearly sought and recorded and that they are aware what action will be taken;
b. Address any gaps;
c. Check that issues of consent and mental capacity have been addressed;
d. In the event that a person's wishes are being overridden, check that this is appropriate and that the adult understands why;
e. Contact the children and families department if a child or young person is also at risk;
f. If the person allegedly causing the harm is also an adult at risk, arrange appropriate care and support;
g. Make sure action is taken to safeguard other people;
h. Take any action in line with disciplinary procedures; including whether it is appropriate to suspend staff or move them to alternative duties;
i. If your service is registered with the Care Quality Commission, and the incident constitutes a notifiable event, complete and send a notification to CQC;
j. In addition, if a criminal offence has occurred or may occur, contact the Police force where the crime has / may occur;
k. Preserve forensic evidence and consider a referral to specialist services for example the Haven;
l. Make a referral under Prevent if appropriate;
m. Consider if the case should be put forward for a SAR;
n. Record the information received and all actions and decisions.

Decision Making: Pre-Referral to the Local Authority

The manager/safeguarding lead will usually lead on decision making. Where such support is unavailable, consultation with other more senior staff should take place. In the event that these are unavailable, seeking the advice of the Local Authority should be considered.

Staff should also take action without the immediate authority of a line manager:

- If discussion with the manager would involve delay in an apparently high-risk situation;
- If the person has raised concerns with their manager and they have not taken appropriate action (whistleblowing).

Decisions need to take into account all relevant information that is available, including the views of the adult in all circumstances where it is possible and safe to seek their views. If the adult does not want to pursue matters through safeguarding action, staff should be sure that the adult is fully aware of the consequences of their decisions, and that all options have been explored and that not proceeding further is consistent with legal duties.

There may be some occasions when the adult at risk does not want to pursue a referral to the Local Authority. Where it is a personal matter and may cause family disharmony, if possible, the adult at risk's wishes should be respected and other ways of ensuring the adult's safety explored. Where there is a potentially high-risk situation, staff should be vigilant of possible coercion and the emotional or psychological impact that the abuse may have had on the adult.

Decision makers also need to take account of whether or not there is a public or vital interest to refer the concern to the Local Authority. Where there is a risk to other adults, children or young people or there is a public interest to take action because a criminal offence had occurred, and the view is that it is a safeguarding matter, the wishes of the individual may be overridden. **Where the sharing of information to prevent harm is necessary, lack of consent to information sharing can also be overridden.** This should include where the adult at risk is deceased or the alleged perpetrator is a professional.

In the event that people lack the capacity to provide consent, action should be taken in line with the Mental Capacity Act 2005. Please refer to Practice in Section 3.

GOOD PRACTICE GUIDANCE - DISCLOSURE

- Speak in a private and safe place
- Accept what the person is saying
- Don't 'interview' the person; but establish the basic facts avoiding asking the same questions more than once
- Ask them what they would like to happen and what they would like you to do
- Don't promise the person that you'll keep what they tell you confidential; explain who you will tell and why
- Explain that you will respect their wishes where possible, but that referrals and actions can be taken without their consent. Tell them what action you will be taking.
- Make a best interest decision about the risks and protection needed if the person is unable to provide informed consent
- Document rationale for sharing
- Explain how the adult will be involved and kept informed
- Provide information and advice on keeping safe and the safeguarding process

Establish

- The risks and what immediate steps to take. consider the hazard within the risks and use a risk screening tool

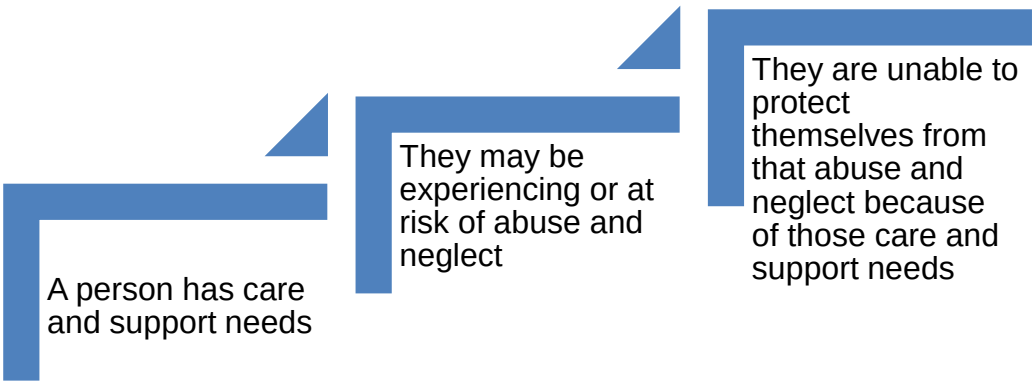
- Communication needs, whether an interpreter or other support is needed
- Whether it is likely that advocacy may be required
- Personal care and support arrangements
- Mental capacity to make decisions about whether the adult is able to protect themselves and understand the safeguarding process

CONCERNS CHECKLIST

- Safety of adult and others made
- Initial conversation held with the adult
- Emergency services contacted and recorded
- Medical treatment sought
- Consent sought
- Mental Capacity considered
- Best Interest Decisions made and recorded
- Public and vital interest considered and recorded
- Police report made
- Evidence preserved
- Referrals to specialist agencies e.g. Haven and Channel
- Referral to children services if there are children and young people safeguarding matters
- Action taken to remove/reduce risk where possible and recorded
- Recorded clear rationales for decision making
- Referral to Local Authority included relevant information

Referral to the Local Authority

If, on the basis of the information available, it appears that the following three steps are met a referral **must** be made to the Local Authority.

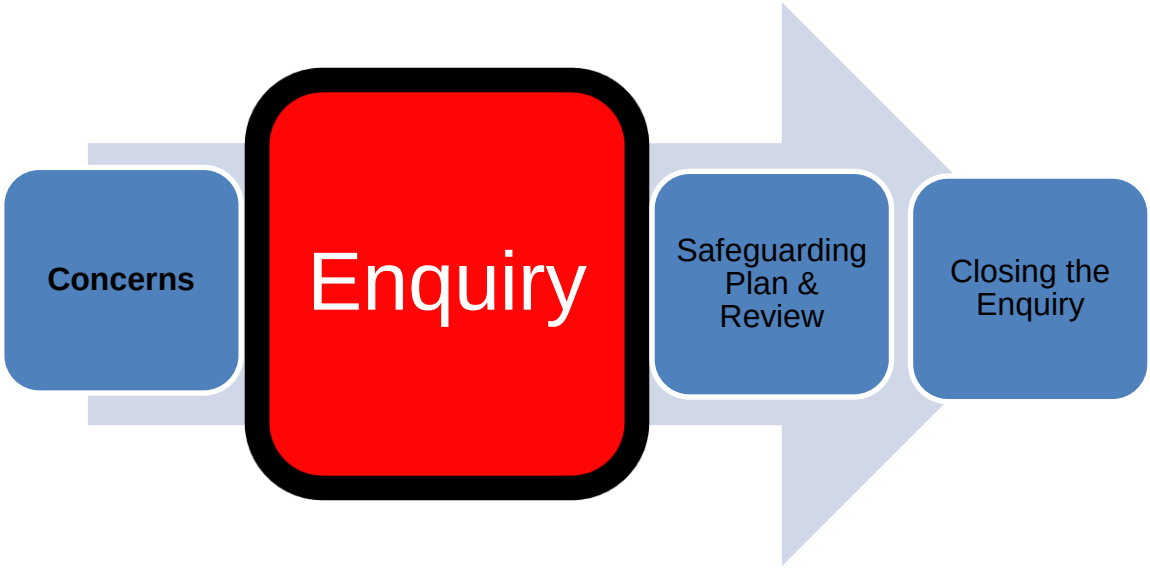


Information the referral might contain

Organisations that refer to the Local Authority should include the following information:

- Demographic and contact details for the adult at risk, the person who raised the concern and for any other relevant individual, specifically carers and relevant family members and friends, and those holding powers of attorney;
- Basic facts, focussing on whether or not the person has care and support needs including communication and on-going health needs;
- Factual details of what the concern is about; what, when, who, where;

- Immediate risks and action taken to address risk;
- Preferred method of communication;
- If reported as a crime - details of which police station/officer, crime reference number etc.;
- Whether the adult at risk has any cognitive impairment which may impede their ability to protect themselves;
- Any information on the person alleged to have caused harm;
- Wishes and views of the adult at risk, in particular consent;
- Advocacy involvement (includes family/friends);
- Information from other relevant organisations for example, the Care Quality Commission;
- Any recent history (if known) about previous concerns of a similar nature or concerns raised about the same person, or someone within the same household.



STAGE 2: ENQUIRY

When the Local Authority becomes aware of a situation that meets the criteria described in the above three steps, it **must** make or arrange an enquiry under Section 42 of the Care Act 2014[xx]. 'The Local Authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.'

Where the circumstances are not such as to trigger the Section 42 safeguarding duty, the Local Authority may choose to carry out proportionate safeguarding enquiries, in order to promote the adult's well-being and to support preventative action.

An enquiry should establish whether and what action needs to be taken to prevent or stop abuse or neglect.

Local Authorities should aim to provide swift and personalised safeguarding responses, involving the adult at risk in the decision-making process as far as possible. Further guidance is given about cases in which the adult at risk may lack capacity or has a substantial difficulty in being involved is given in Section 3. Local Authorities should record the information received, the views and wishes ascertained, the decisions taken and the reasons for them and any advice and

information given. There also needs to be a focus on multi-agency communication and consideration should be given on setting up a multi-agency planning group.

Role of the Local Authority

The Local Authority should decide very early on in the process who is the best person/organisation to lead on the enquiry. The Local Authority retains the responsibility for ensuring that the enquiry is referred to the right place and is acted upon. If the Local Authority has asked someone else to make enquiries, it is able to challenge the organisation/individual making the enquiry if it considers that the process and/or outcome is unsatisfactory. In exceptional cases, the Local Authority may undertake an additional enquiry, for example, if the original fails to address significant issues.

The information in some referrals may be sufficiently comprehensive that it is clear that immediate risks are being managed, and that the criteria are met for a formal Section 42 enquiry. In other cases, some additional information gathering may be needed to fully establish that the three steps are met. Decisions need to take into account all relevant information through a multi-agency planning group wherever possible, including the views of the adult taking into consideration mental capacity and consent. (See Best Practice)

The degree of involvement of the Local Authority will vary from case-to-case, but at a minimum must involve decision making about how the enquiry will be carried out, oversight of the enquiry, decision making at the conclusion of the enquiry about what actions are required, ensuring data collection is carried out, and quality assurance of the enquiry has been undertaken.

This decision on how the enquiry is progressed is made by the manager acting in the role of the SAM at the time.

Criminal Investigations

Although the Local Authority has the lead role in making enquiries or requesting others to do so, where criminal activity is suspected, early involvement of the police is essential. Police investigations should be coordinated with the Local Authority who may support other actions but should always be police led.

Ill treatment and wilful neglect

The police will determine whether there should be criminal investigations of people in positions of trust where there is ill treatment and wilful neglect. There are a number of possible offences which may apply, including the specific offences mentioned below.

Section 44 Mental Capacity Act 2005[lxxxv] makes it a specific criminal offence to wilfully ill-treat or neglect a person who lacks capacity.

Section 127 Mental Health Act 1983[lxxxvi] creates an offence in relation to staff employed in hospitals or mental health nursing homes where there is ill-treatment or wilful neglect.

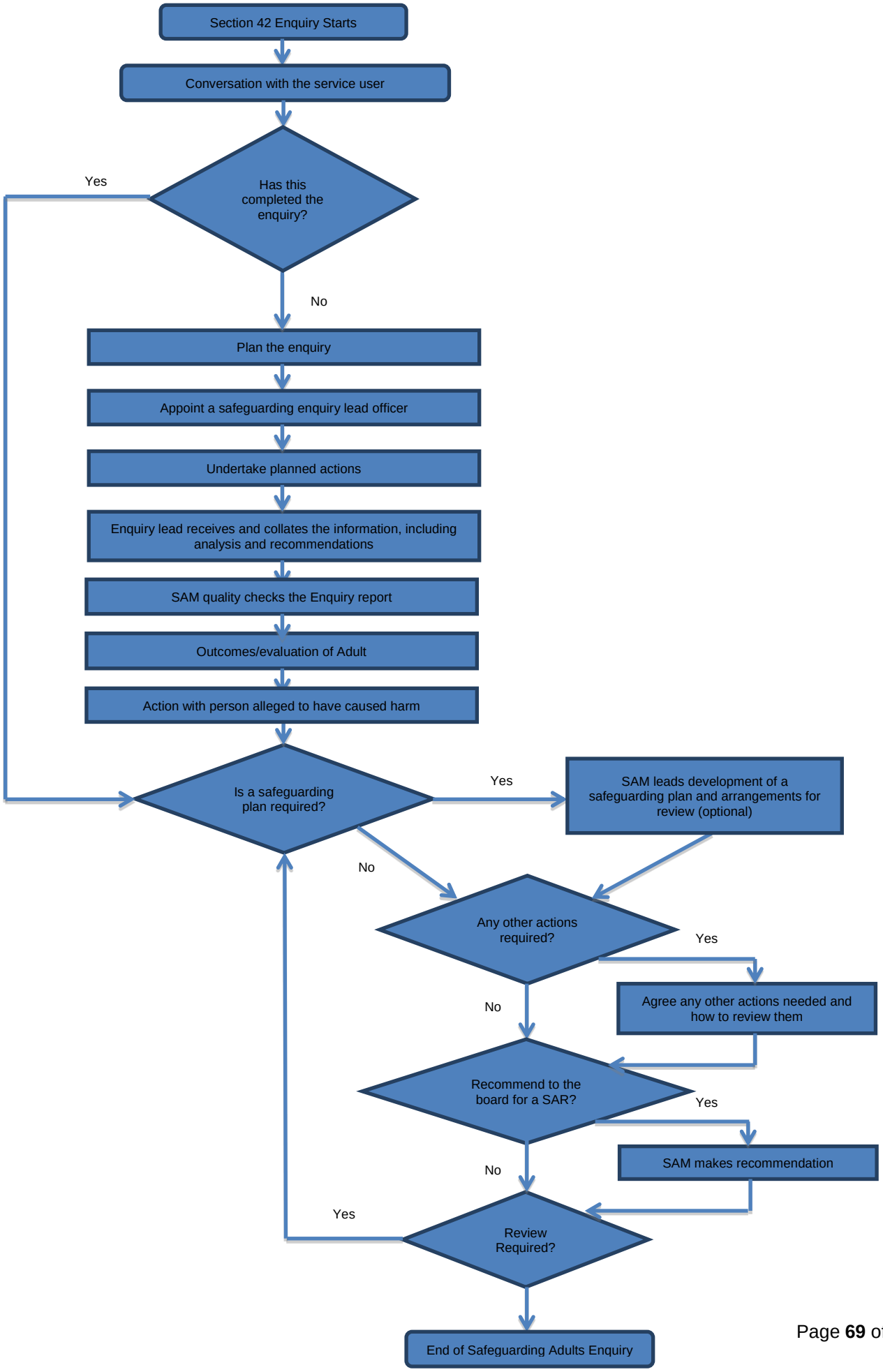
Sections 20 to 25 of the Criminal Justice and Courts Act 2015[lxxxvii] relate to offences by care workers and care providers.

Suspending placements

Where the safeguarding concern raised is about a person in a position of trust and there may be a risk of that person in a position of trust causing harm to other adults at risk adults or children early consideration should be given to:

- Sharing information with the employer and other partner agencies
- The Local Authority and/or CCG suspending placements with the provider and seeking a voluntary undertaking not to admit self-funders until the conclusion of the enquiry

Section 42 Enquiry Flowchart



Conversations with the adult (including appropriate support)

In the majority of cases, unless it is unsafe to do so each enquiry will start with a conversation with the adult at risk. The SAM should ensure if conversations have already taken place and are sufficient. The adult and/or their advocate should not have to repeat their story. In many cases staff/organisation who already knows the adult well maybe best placed to lead on the enquiry. They may be a housing support worker, a GP or other health worker such as a community nurse or a social worker. While many enquiries will require significant input from a social care practitioner, there will be aspects that should and can be undertaken by other professionals.

Points to consider:

- The pace of conversations
- Whether the presenting issue identifies the risk to the adult's safety, or whether there are additional risks to be considered
- Wider understanding and assessment of the adult overall wellbeing

The adult should be aware at the end of the conversation what action will be taken and provided with contact details for key people.

Objectives

- Establish the facts;
- Ascertain the adult's views and wishes and preferred outcomes;
- Assess the needs of the adult for protection, support and redress and how these might be met;
- Protect the person from the abuse and neglect, in accordance with the wishes of the adult where possible;
- Enable the adult to achieve resolution where possible.
- Wider potential risk to other adults to be considered

Staff need to handle enquiries in a sensitive and skilled way to ensure minimal distress to the adult and where information is already known people should not have to tell their story again, this doesn't prevent clarification being sought where necessary. There is a skill involved in eliciting information and asking the right questions, to ascertain what the concern is, how it impacts on the adult at risk, what action they would find acceptable and the level of associated risk. Whilst it is essential to put the adult at risk at ease, and to build up a rapport, the objectives of an enquiry should focus the conversation. (See Good Practice Guidance)

Desired Outcomes identified by the adult

The desired outcome by the adult at risk should be clarified and confirmed at the end of the conversation(s), to:

- Ensure that the outcome is achievable;
- Manage any expectations that the adult at risk may have and;
- Give focus to the enquiry.

Staff should support adults at risk to think in terms of realistic outcomes but should not restrict or unduly influence the outcome that the adult would like. Outcomes should make a difference to risk, and at the same time satisfy the persons' desire for justice and enhance their wellbeing.

The adult's views, wishes, and desired outcomes may change throughout the course of the enquiry process. There should be an on-going dialogue and

conversation with the adult to ensure their views and wishes are gained as the process continues, and enquiries re-planned should the adult change their views.

INITIAL ACTION AND DECISION MAKING UNDER SECTION 42		
Action	• Establish the adult is safe • Establish need for advocacy • Establish consent and capacity to make relevant decisions by understanding the management of risk, what a safeguarding enquiry is, how they might protect themselves • Is the adult aware of the safeguarding concern and do they perceive it as a concern and want action/support • Is there suspicion that a crime may have been committed and a report to the police needed • The adult at risk desired outcome is established • Provide feedback to the person making the referral • Record all actions and conversations	Enquiry lead
Decisions	• Who is best placed to speak with the adult at risk • Are there any reasons to delay speaking with the adult at risk • What the safeguarding enquiry might consist of • Whether to proceed without consent • What follow-up action may be needed • Whether actions so far have completed the enquiry	Decisions made by the SAM

Talking through an enquiry may result in resolving it, if not, the duties under Section 42 continue. If the adult has capacity and expresses a clear and informed wish not to pursue the matter further, the Local Authority should consider whether it is appropriate to end the enquiry. It should consider whether it still has reasonable cause to suspect that the adult is at risk and whether further enquiries are necessary before deciding whether further action should be taken. The adult's consent is not required to take further steps, but the Local Authority must bear in mind the importance of respecting the adult's own views.

This decision must be made by the Local Authority SAM by checking with the adult and consulting with relevant partners and advocate.

Planning an Enquiry under further Section 42 duties

All enquiries need to be planned and co-ordinated and key people identified. No agency should undertake an enquiry prior to a planning discussion, unless it is necessary for the protection of the adult at risk or others.

The **Enquiry Officer** should be confident and understand what is required. Dependent upon the complexity of an enquiry the SAM may wish to convene a multi-agency planning group.

Enquiries are proportionate to the particular situation. The circumstances of each individual case determine the scope and who leads it. Enquiries should be outcome focussed, and best suit the particular circumstances to achieve the outcomes for the adult.

There is a statutory duty of co-operation and in most cases, there will be an expectation that enquiry will be made as requested. The statutory duty does not apply if co-operation would be incompatible with its own duties or would have an adverse effect on its own functions.

Local authorities and their relevant partners must respond to requests to cooperate under their general public law duties to act reasonably.

If an organisation declines to undertake an enquiry or if the enquiry is not done, local escalation procedures should be followed. The key consideration of the safety and wellbeing of the adult must not be compromised in the course of any discussions or escalation and it is important to emphasise that the duty to co-operate is mutual.

When planning an enquiry, a review should be made of:

- The adult's mental capacity to understand the type of enquiry, the outcomes and the effect on their safety now and in the future;
- Whether consent has been sought;
- Whether an advocate or other support is needed;
- The level and impact of risk of abuse and neglect;
- The adults' desired outcome;
- The adult's own strengths and support networks.

Communication and actions

It may be helpful to agree the best way to keep the adult and relevant parties informed. Where the enquiry is complicated and requires a number of actions that may be taken by others to support the outcome. It may be appropriate for a round table meeting. Where enquiries are simple, single agency enquiries it may not be necessary to hold a meeting. Action should never be put on hold, due to the logistics of arranging meetings. Proportionality should be the guiding principle.

If the adult wishes to participate in meetings with relevant partners, one should be convened. Action, however, should not be 'on hold' until a meeting can be convened. If the adult does not have the capacity to attend, then an advocate should represent their views.

GOOD PRACTICE GUIDE INVOLVING ADULTS IN SAFEGUARDING MEETINGS
Effective involvement of adults and/or their representatives in safeguarding meetings requires professionals to be creative and to think in a person-centred way. • How should the adult be involved? • Where is the best place to hold the meeting? • How long should the meeting last? • Timing of the meeting? • Agenda • Preparation with the adult • Who should chair? • Agreement by all parties to equality

Information sharing should be timely, co-operation between organisations to achieve outcomes essential and action co-ordinated keeping the safety of the adult as paramount. Information sharing should comply with all legislative requirements.

Where one agency is unable to progress matters further, for example a criminal investigation may be completed but not necessarily achieve desired outcomes (e.g. criminal conviction), the Local Authority in consultation with the adult and others decide if and what further action is needed.

Support networks

The strengths of the adult at risk should always be considered. Mapping out with the adult and identifying their strengths and that of their personal network may reduce risks sufficiently so that people feel safe without the need to take matters further.

Any risk should be assessed and managed at the beginning of the enquiry and reviewed throughout.

Types of safeguarding enquiries

GOOD PRACTICE GUIDE	
Types of enquiries	**Who might lead**
Criminal (including assault, theft, fraud, hate crime, domestic violence and abuse or wilful neglect.	Police
Domestic abuse (serious risk of harm)	Police chair the MARAC process and are supported by the MARAC coordinator and IDVAS
Anti-social behaviour (e.g. harassment, nuisance by neighbours)	Community safety services/local Policing (e.g. Safer Neighbourhood Teams).
Breach of tenancy agreement (e.g. harassment, nuisance by neighbours)	Landlord/registered social landlord/housing trust/community safety services
Bogus callers or rogue traders	Trading Standards/Police
Complaint regarding failure of service provision (including neglect of provision of care and failure to protect one service user from the actions of another)	Manager/proprietor of service/complaints department Ombudsman (if unresolved through complaints procedure)
Breach of contract to provide care and support	Service commissioner (e.g. Local Authority, NHS CCG)

GOOD PRACTICE GUIDE Types of enquiries	Who might lead
Fitness of registered service provider	CQC
Serious Incident (SI) in NHS settings	Root cause analysis investigation by relevant NHS Provider
Unresolved serious complaint in health care setting	CQC, Health Service Ombudsman
Breach of rights of person detained under the MCA 2007 Deprivation of Liberty Safeguards (DoLS)	CQC, Local Authority, OPG/Court of Protection
Breach of terms of employment/disciplinary procedures	Employer
Breach of professional code of conduct	Professional regulatory body
Breach of health and safety legislation and regulations	HSE/CQC/Local Authority Link to – 2015 MoU[lxxxviii]
Misuse of enduring or lasting power of attorney or misconduct of a court-appointed deputy	OPG/Court of Protection/Police
Inappropriate person making decisions about the care and wellbeing of an adult who does not have mental capacity to make decisions about their safety and which are not in their best interests	OPG/Court of Protection
Misuse of Appointeeship or agency	DWP
Safeguarding Adults Review (Care Act Section 44[lv])	Local Safeguarding Adults Boards

A range of options can also be found at the LGA website for Making Safeguarding Personal.

Enquiries can range from non-complex single agency interventions to multi-agency complex enquiries. The key questions in choosing the right type of enquiry, is dependent on:

- What outcome does the adult want?
- How can enquiries be assessed as successful in achieving outcomes?
- What prevention measures need to be in place?
- How can risk be reduced?

Identifying the primary source of risk may assist in deciding what the most appropriate and proportionate response to the individual enquiry might be. There are no hard and fast rules and judgement will need to be made about what type of enquiry and actions are right for each particular situation.

Linking different types of enquiries

There are a number of different types of enquiries. It is important to ensure that where there is more than one enquiry that information is dovetailed to avoid delays, interviewing staff more than once, making people repeat their story.

Other processes, including police investigations, can continue alongside the safeguarding adult's enquiry. Where there are HR processes to consider, it is important to ensure an open and transparent approach with staff, and that they are provided with the appropriate support, including trade union representation. The remit and authority of organisations need to be clear when considering how different types of investigations might support Section 42 enquiries.

Enquiry Reports

Once all actions have been completed a report should be collated and drawn up by the Enquiry Officer overseen by the Enquiry Lead. In some more complex enquiries, there may be a number of actions taken by other staff that support the enquiry. Where there are contributions from other agencies/staff, these should be sent to the Enquiry Officer within agreed formats and timeframes, so that there is one comprehensive report that includes all sources of information.

Reports need to be concise, factual and accurate. Reports should be drafted and discussed with the adult at risk/advocate. Reports need to address general and specific personalised issues. They should cover:

- Views of the adult at risk
- Whether outcomes were achieved
- Is there evidence that Section 42 criteria were met
- Whether any further action is required and if so by whom
- Who supported the adult and if this is an on-going requirement

In some enquiries, there will be an investigation for example, a disciplinary investigation; which may form part of the Enquiry Report. In drawing up the report, the risk assessment should be reviewed, and any safeguarding plan adjusted accordingly.

Recommendations should be monitored and taken forward. Agencies are responsible for carrying out the recommendations which might be included in future safeguarding plans.

Standards and Analysis

The report should be tested to ensure that it meets the standards above, and analysed to assess whether there are gaps, contradictions and that information has been triangulated, i.e. is the report evidence based, and is there sufficient corroboration to draw conclusions.

The report and recommendations of the enquiry should be discussed with the adult at risk and or their advocate, who may have a view about whether it has been completed to a satisfactory standard.

Overall the Local Authority should decide if the enquiry is completed to a satisfactory standard. In reaching this decision, the Local Authority may wish to consult partner organisations involved in the enquiry. If another organisation has led on the enquiry, the Local Authority may decide that a further enquiry should be undertaken by the Local Authority. The exception to this is where there is a criminal investigation, and, in this case, the Local Authority should consider if any other enquiry is needed that will not compromise action taken by the police.

Outcome to the enquiry

All enquiries should have established outcomes that determine the effectiveness of interventions. Decisions should be made whether:

1. The adult has needs for care and support
2. They were experiencing or at risk of abuse or neglect
3. They were unable to protect themselves
4. Further action should be taken to protect the adult from abuse or neglect

These decisions are made by the SAM in consultation with the adult and other parties involved in the enquiry.

Evaluation by the adult at risk

1. Were the desired outcomes met? (In exploring this, there is a need to clarify whether they were):
    a. Fully met;
    b. Partially met;
    c. Not met.
2. Do they feel safer?
    a. Yes;
    b. Partially - in some areas but not others;
    c. No.

The evaluation is that of the adult, and not of other parties. Whilst staff may consider that enquiry and actions already taken have made the adult safe, and that their outcomes were met, the important factor is how actions have impacted on the adult. This should be clarified when assessing the performance of safeguarding.

Outcome for the person(s) alleged to have caused harm

To ensure the safety and wellbeing of other people, it may be necessary to take action against the person/organisation alleged to have caused harm. Where this may involve a prosecution, the police and the Crown Prosecution Service lead sharing information within statutory guidance.

The police may also consider action under the Common Law Police Disclosure (CLPD) which are the name for the system that has replaced the 'Notifiable Occupations Scheme'. The CLPD addresses risk of harm regardless of the employer or regulatory body and there are no lists of specific occupations. The CLPD focusses on:

- Disclosure where there is a public protection risk
- Disclosures are subject to thresholds of 'pressing social need'.
- The 'pressing social need' threshold for making a disclosure under common law powers is considered to be the same as that required for the disclosure of non-conviction information by the Disclosure and Barring Service under Part V of the Police Act 1997 (as amended).

People in a position of trust

If someone is removed from their role providing regulated activity following a safeguarding incident the regulated activity provider (or if the person has been provided by an agency or personnel supplier, the legal duty sits with them) has a legal duty to refer to the Disclosure and Barring Service (DBS). The legal duty to refer to the DBS also applies where a person leaves their role before a disciplinary hearing has taken place following a safeguarding incident and the employer/volunteer organisation feels they would or might have dismissed the person based on the information they hold.

Where it is considered that a referral should be made to the DBS careful consideration should be given to the type of information needed. This is particularly pertinent for people in a position of trust. Where appropriate, employers should report workers to the statutory and other bodies responsible for professional regulation such as the General Medical Council the Nursing and Midwifery Council and the Health & Care Professions Council. The legal duty to

refer to the Disclosure and Barring Service may apply regardless of a referral to other bodies. Please refer to Appendix 3.

Even if the safeguarding concerns arising from a person in a position of trust have been satisfactorily resolved in an individual case, where there is an ongoing risk of that person in a position of trust causing harm to other vulnerable adults or children consideration should be given to:

- Sharing information with the employer and other partner agencies
- The Local Authority and/or CCG issuing an improvement notice under their contract with the provider requiring the concerns to be resolved and risks to be managed
- Increasing the number of visits by quality control officers
- The Local Authority and/or CCG suspending placements with the provider and seeking a voluntary undertaking not to admit self-funders until the concerns are resolved and risks managed
- Where there is evidence of organisational abuse, initiating a Provider Concerns process (see section 5)

Care providers will be expected to work together with the Local Authority, CCG and other partner organisations in order to resolve concerns, manage risks and to make any necessary improvements.

Support for people who are alleged to have caused harm

Where the person is also an adult who has care and support needs, organisations should consider what support and actions may help them not to abuse others. For example, enquiries may indicate that abuse was caused because the adult's needs were not met and therefore a review of their needs should be made.

Where the person alleged to have caused harm is a carer, consideration should be given to whether they are themselves in need of care and support.

Checks might be made whether staff were provided with the right training, supervision and support. Whilst this does not condone deliberate intentions of abuse, prevention strategies to reduce the risk of it occurring again to the adult or other people should be considered.

People who are known perpetrators of domestic violence may benefit from **Domestic Violence Prevention Programmes**[lxxxix].

When considering action for people who abuse, prevention and action to safeguard adults should work in tandem.

Recovery & Resilience

Adults who have experienced abuse and neglect may need support to build up their resilience to move on from the incident. This support should enable people to use their own strengths and abilities to overcome what has happened, learn from the experience and develop an awareness that may prevent a reoccurrence. As a minimum it should enable people to recognise the signs and risks of abuse and neglect and know how to contact support if required.

Resilience is supported by recovery actions, which includes adults identifying actions that they would like to see to prevent the same situation arising. The process of resilience is evidenced by:

- The ability to make realistic plans and being capable of taking the steps necessary to follow through with them;

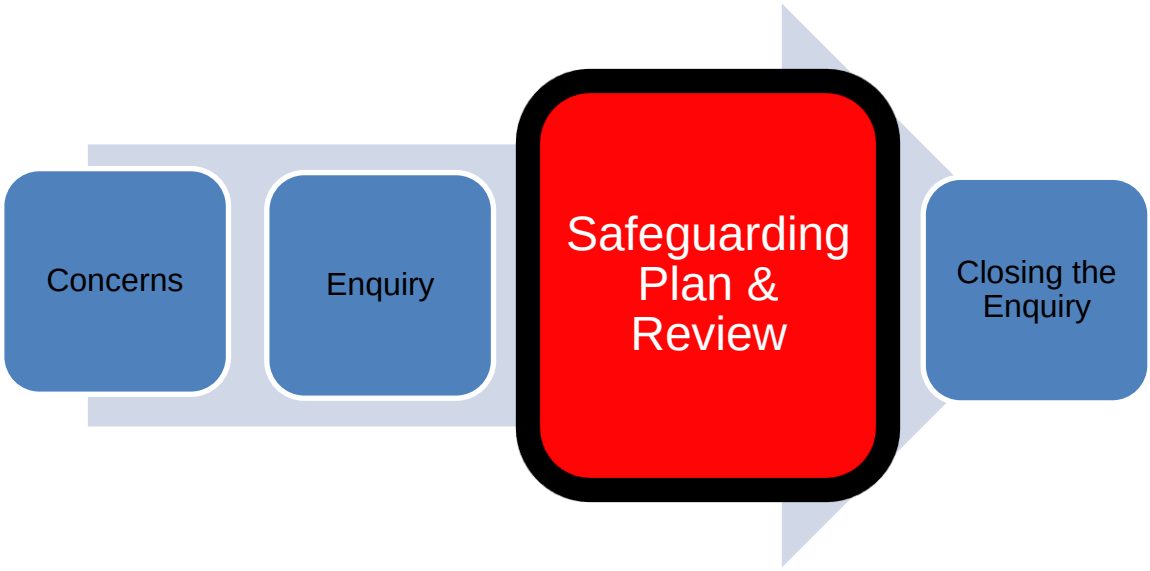
- A positive perception of the situation and confidence in the adult at risks own strengths and abilities;
- Increasing their communication and problem-solving skills.

Resilience processes that either promote well-being or protect against risk factors, benefits individuals and increases their capacity for recovery. This can be done through individual coping strategies assisted by:

- Strong personal networks and communities
- Social policies that make resilience more likely to occur
- Handovers/referrals to other services for example care management, or psychological services to assist building up resilience
- Restorative practice

If no further safeguarding action is required and there are alternative ways of supporting adults where they may be needed, then the adult safeguarding process can be closed down.

ACTIONS AND DECISIONS UNDER SECTION 42 ENQUIRIES		
Actions	• Plan the Enquiry • Identify enquiry lead/officer • Clarify desired outcomes • Identify links to other procedures in progress • Undertake agreed action • Update safeguarding plan • Agree communication • Agree outcomes for person(s) alleged to have caused harm • Make referrals as agreed in relation to the person alleged to have caused harm • Make referrals in relation to the adult • Evaluation by the adult/advocate • Explore recovery and resilience	Adult /advocate SAM Enquiry Lead
Decisions	• What type of enquiry is appropriate and proportionate • Who should lead and who should contribute • Does the report meet standards • Necessary for the enquiry to be taken over by the Local Authority • Whether to close the enquiry down or take forward for review • Actions for the adult • Actions for the person alleged to have caused harm	SAM in consultation with the adult and others



STAGE 3: SAFEGUARDING PLAN AND REVIEW

In most cases there will be a natural transition between deciding what actions are needed and the end of the enquiry, into formalising what these actions are and who needs to be responsible for each action- this is the adult safeguarding plan.

An adult safeguarding plan is not a care and support plan, and it will focus on care provision only in relation to the aspects that safeguard against abuse or neglect, or which offer a therapeutic or recovery-based resolution. In many cases the provision of care and support may be important in addressing the risk of abuse or neglect, but where this is the intention the adult safeguarding plan must be specific as to how this intervention will achieve this outcome.

The **Safeguarding Plan** should set out:

- What steps are to be taken to assure the future safety of the adult at risk;
- The provision of any support, treatment or therapy, including on-going advocacy;
- Any modifications needed in the way services are provided (e.g. same gender care or placement; appointment of an OPG deputy);
- How best to support the adult through any action they may want to take to seek justice or redress;
- Any on-going risk management strategy as appropriate.

The plan should outline the roles and responsibilities of all individuals and agencies involved and should identify the lead professional who will monitor and review the plan, and when this will happen. Adult safeguarding plans should be person-centred and outcome-focused. Safeguarding plans should be made with the full participation of the adult at risk. In some circumstances it may be appropriate for safeguarding plans to be monitored through ongoing care management responsibilities. In other situations, a specific safeguarding review may be required.

Review of the enquiry (optional)

The identified lead should monitor the plan on an on-going basis, within agreed timescales. The purpose of the review is to:

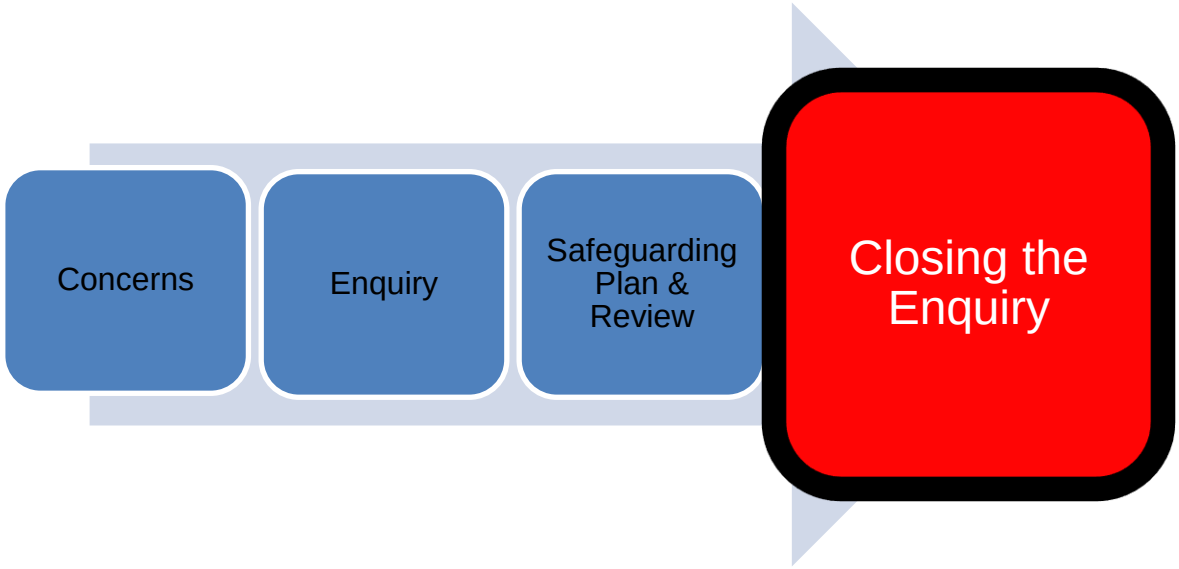
- Evaluate the effectiveness of the adult safeguarding plan;
- Evaluate whether the plan is meeting/achieving outcomes;

- Evaluate risk.

Reviews of adult safeguarding plans, and decisions about plans should be communicated and agreed with the adult at risk. Following the review process, it may be determined that:

- The adult safeguarding plan is no longer required; or
- The adult safeguarding plan needs to continue.

Any changes or revisions to the plan should be made, new review timescales set (if needed) and agreement reached regarding the lead professional who will continue monitoring and reviewing; or, it may also be agreed, if needed, to instigate a new adult safeguarding Section 42 Enquiry. New safeguarding enquiries will only be needed when the Local Authority determines it is necessary. If the decision is that further enquiries would be a disproportionate response to new or changed risks, further review and monitoring may continue.



STAGE 4: CLOSING THE ENQUIRY

Safeguarding can be closed at any stage. Individuals should be advised on how and who to contact with agreement on how matters will be followed up with the adult at risk if there are further concerns. It is good practice where a care management assessment, Care Programme Approach (CPA), reassessment of care and support, health review, placement review or any other pre-booked review is due to take place following the safeguarding enquiry, for a standard check to be made that there has been no reoccurrence of concerns.

Closure records should note the reason for this decision and the views of the adult at risk to the proposed closure. The SAM responsible should ensure that all actions have been taken, building in any personalised actions:

- Agreements with the adult at risk to closure;
- Referral for assessment and support;
- Advice and Information provided;
- All organisations involved in the enquiry updated and informed;
- Feedback has been provided to the referrer;
- Action taken with the person alleged to have caused harm;
- Action taken to support other service users;
- Referral to children and young people made (if necessary);
- Outcomes noted and evaluated by adult at risk;

- Consideration for a SAR;
- Any lessons to be learnt.

Closing enquiries down when other processes continue

The adult safeguarding process may be closed but other processes may continue, for example, a disciplinary or professional body investigation. These processes may take some time. Consideration may need to be given to the impact of these on the adult and how this will be monitored. Where there are outstanding criminal investigations and pending court actions, the adult safeguarding process can also be closed providing that the adult is safeguarded.

All closures no matter at what stage are subject to an evaluation of outcomes by the adult at risk. If the adult at risk disagrees with the decision to close safeguarding down their reasons should be fully explored and alternatives offered.

At the close of each enquiry there should be evidence of:

- Enhanced safeguarding practice ensuring that people have an opportunity to discuss the outcomes they want at the start of safeguarding activity
- Follow-up discussions with people at the end of safeguarding activity to see to what extent their desired outcomes have been met
- Recording the results in an anonymised way that can be used to inform practice and provide aggregated outcomes information for safeguarding adults boards

5. WORKING WITH CARE AND SUPPORT PROVIDERS

5.1 Introduction

Safeguarding is everyone's business. This section considers a range of issues about quality and safety, positive practice, safeguarding concerns and managing large scale enquiries. Partnerships between safeguarding and commissioning functions, and their interdependent roles and responsibilities towards providers are explored. It is essential to know what works well to support a positive culture of co-operation and information sharing with joint accountability for risk and benefits. It identifies the role and responsibilities of the five groups that influence quality:

- **Professionals and staff**
- **Commissioners and funders** (Local authorities, CCG and NHS England)
- **Regulators** (CQC, Trust Development Agency, Monitor)
- **The public**, including adults who use services, their families and care
- **Providers** - A provider for the purposes of this policy and procedure is any care or health provider who delivers support and care to a group of individuals. This would include but is not exclusive to the following:
    - Domiciliary Care Providers
    - Residential Care Homes
    - Nursing Homes
    - Supported Living
    - Private hospitals
    - NHS provision
    - Day Care/Opportunities Providers
    - Rehabilitation Units for people who misuse drugs or alcohol
    - Voluntary agencies

By working in partnership these groups can assist early identification if providers are at risk of falling standards that might lead to wider concerns and the need for safeguarding intervention. There is a clear responsibility on commissioners and providers to ensure safe, quality services that will reduce the need for safeguarding interventions.

This section is relevant to all providers not just those in the CQC inspection regime. The CQC are responsible for inspecting and monitoring providers registered under the Health and Social Care Act 2008[xc]. It has statutory powers to inspect how well services are performing against 'Fundamental Standards' of quality and safety and can take proportionate enforcement action to ensure providers improve where there is poor care.

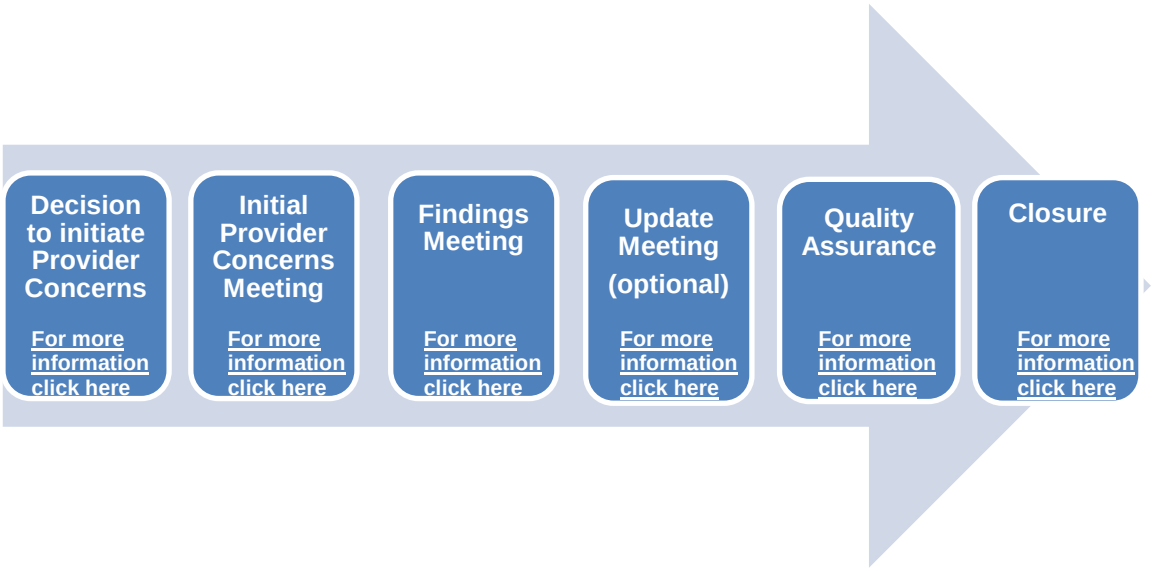
This section explores work with providers as a means for responding to potential business failure (contracts and commissioning responsibilities) and details how allegations of organisational abuse are managed where safeguarding concerns are identified as serious matters within an organisation as opposed to single concerns that may be addressed under Section 42 (safeguarding responsibilities). Safeguarding concerns in this sense relate to patterns of reported abuse or neglect, about one provider, or where a single concern indicates a serious matter that warrants closer inspection under adult safeguarding processes. In some instances, safeguarding action may be initiated following a Safeguarding Adult Review or run in parallel to one.

The focus of this section is on prevention, in particular actions that might be taken in response to concerns about quality issues, to reduce the risk of escalation to safety and safeguarding issues.

Finally, this section aims to ensure that people have a voice in influencing how services are delivered and where there are concerns, and how their views and experiences lay at the heart of improvements.

5.2 Six Step Process

The procedures section follows a Six Step Process



5.3 Who does this procedure apply to?

The procedure applies to all care and support provision, whether directly commissioned or not by a Local Authority or Clinical Commissioning Group (CCG) or NHS England; and irrespective of whether or not it is included in the CQC market oversight regime. Services managed by the Local Authority or NHS are subject to the same level of scrutiny as independent care providers.

Risk Summits

This guidance should be considered in parallel to Risk Summits. Within the NHS, The National Quality Board has implemented guidance on the Risk Summit process. The risk summit process can be implemented if any part of the local, regional or national system has concerns that there may be serious quality failures within a provider organisation and which cannot be addressed through established and routine operational systems. This includes where there are significant safeguarding breaches and breakdown in systems which compromise the safety of an individual with care and support needs. The Risk Summit can be an effective and non-prejudicial method for facilitating the rapid sharing of information and intelligence across different organisations, and for initiating remedial actions where it is required to safeguard or improve quality. Risk Summits can both inform and be informed of quality concerns that arise at 'Quality and Safeguarding Information Panels.' Where a Risk Summit notes safeguarding concerns, these should be managed through local adult safeguarding arrangements. For further guidance on the risk summit process, click here[xci].

There are three local and one regional Quality Surveillance Groups established in London to bring together different parts of health and care economies locally to

routinely share information and intelligence to safeguard the quality of care individuals receive. (Structures and Organisations Appendix 4)

5.4 Working in partnership with providers

A shared goal between all parties is that adults can expect to receive a safe, quality service. Integral to the effectiveness of partnerships is the need to work in a transparent and open way. It is not the intention of this policy and procedures to be punitive in its dealings with providers but to implement quality and safeguarding principles by supporting and giving a helpful steer when concerns arise, to assist providers in getting back on track. Open dialogue can only be achieved where there is trust and a willingness on all parties to work together.

The rules of natural justice should be observed, and where there are organisational concerns enquiries or investigations should be based on evidence and a thorough assessment.

Providers should underpin their own policies and procedures under the six safeguarding principles. They should empower adults to fully participate in how services are run by creating a culture of dignity and respect.

Providers are accountable to adults using their services and commissioners for meeting the expected standard of care agreed in individual care plans, contracts and commissions. They are expected to have a robust quality assurance framework in place that evidences commitment to prevention and early intervention. Such commitments are about recognising potential abuse and learning from past situations to inform better practice. Undertaking regular staff training, supervision and appraisals, self-audits and making changes as a result, reduces the risk of matters escalating to safeguarding action. Providers should publish an open and transparent complaints procedure with the assurance of no retribution; and offer ways of gaining customer feedback that supports empowerment and quality assurance. Independent advocacy and regular service user/carer/patient led meetings are equally important to ensuring that services are influenced by adults who use them. The Local Government Association resources[xcii] gives guidance for providers to audit the quality and safety of their services.

Providers have a duty of care to protect adults at risk and meet safeguarding standards; this can be evidenced where there is a clear commitment to protection in their policy and procedures that is observed in practice.

Action taken in response to safeguarding should always be proportionate with the least intrusive response that will effectively manage risk.

5.4.1 Commissioning support to Providers

In turn commissioning organisations should offer support and guidance where it is asked for or identified through constructive dialogue. Provider Forums are a constructive mechanism for sharing best practice and identifying areas of risk. Transparency and information sharing, as per the following example Care Provider Forums | Central Bedfordshire Council[xciii] demonstrates effective partnership working and mutual benefits.

5.4.2 Multiple Care Provision

Where providers support adults in or from a number of different establishments within the same locality, care should be taken that one establishment is not seen in isolation. This is to ensure that any failings are not endemic and embedded in corporate cultures and systems. This may impact on the capacity and capability of the provider to implement agreed improvements, but ensures that improvements are made on firm, sustainable foundations.

5.4.3 Duty of Candour[xciv]

The Francis Report recommended the development of a culture of openness, transparency and candour in all organisations providing care and support. Since October 2014, NHS providers are required to comply with the duty of candour. Meaning providers must be open and transparent with service users about their care and treatment, including when it goes wrong.

The duty is part of the fundamental standard requirements for all providers. It applies to all NHS trusts, foundation trusts and special health authorities from October 2014 and for all other service providers or registered managers, from April 2015 under regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

5.4.4 Natural Justice

The principles of natural justice concern procedural fairness and ensure a fair decision is reached by objective decision making. Where there are concerns about quality or safety these should be evidenced, and parties provided with information and opportunity to take action to address concerns.

5.4.5 Workers who raise concerns within their organisations

Each organisation will have its own whistleblowing policy and provide staff with protection from victimisation or detriment when genuine concerns have been raised about malpractice.

5.4.6 Allegations against people in a position of trust - See Procedures section

5.4.7 Criminal investigations - See Procedures section

5.4.8 Suspension of staff pending enquiry outcomes

In the event that staff are suspended, adult safeguarding processes should consider how it can dovetail any agreed disciplinary processes. It should be borne in mind that a Provider Concerns process may feed into HR processes, but the Provider Concerns process in itself cannot determine outcomes for staff under employment laws.

The importance of employers complying with their duties to notify the Disclosure Barring Service (DBS) be noted. In particular, the legal duty to refer to the DBS applies where a person leaves their role before a disciplinary hearing has taken place following a safeguarding incident and the employer/volunteer organisation feels they would or might have dismissed the person based on the information they hold.

5.4.9 People who fund their own care

People, who arrange their own care and support, may not be known to either the Local Authority or its partners. In order to safeguard them and meet the duty of care to offer protection to all people who are in need of care and support, and unable to protect themselves (the majority of people living in a care setting), providers are required to work with the Local Authority and its partners, to ensure that information and advice is readily available, and that information is shared when requested.

5.4.10 Adults at risk who cause harm

Where the person alleged to cause harm is also an adult at risk, the safety and wellbeing of both the individual subject to possible abuse, and the person alleged to have caused harm needs to be addressed separately. In most cases, this can be considered through the application of Section 42 enquiries as appropriate. The least intrusive action should be taken to support adults using the service. The provider is responsible for ensuring that actions are taken that support the person alleged to have caused harm in consultation and collaboration with commissioners, and the safety and wellbeing of other adults using the service. Commissioners are responsible for ensuring that the service meets the assessed needs of adults and that regular reviews are carried out to ensure this (refer to section 4.3.10)

5.5 Commissioning for Quality

The Care Act 2014 puts emphasis on greater integration of services provided by the Local Authority and its relevant partners to:

- Create a service market of diverse and quality services
- Foster continuous improvements in the quality and effectiveness of provider services; and
- Foster a workforce whose members are able to ensure the delivery of high-quality services.

Quality services are those that place the health and welfare of people who use services as paramount and deliver positive outcomes. These are evidenced in the characteristics of the service through policy, procedures, standards, and structures for overseeing and maintaining service delivery to the requirements set by the Regulator (CQC) and/or by robust contract monitoring. In some instances, a Local Authority may not contract with a provider; neither may the provider be subject to the CQC inspection regime. Providers, who fall under this category, will still need to maintain health and safety standards and where it delivers care and support through regulated activity, it should still have quality and safeguarding measures in place. Click here for more information on regulated activity[xciv].

Commissioners should set out clear expectations of providers within contracts and monitor compliance. Commissioners have a responsibility to ensure that commissioned services:

- Know about and adhere to relevant provider registration requirements and guidance
- Meet the CQC, legal or contract standards
- Ensure that all documents such as service specifications, invitations to tender, service contracts and service-level agreements adhere to safeguarding principles and standards

Effective and strong commissioning under the Commissioning for Better Outcomes Framework[xcv] supports prevention strategies and sets out the key criteria commissioners are seeking from providers to evidence their commitment to delivering high quality, safe services. The domains stress that services should be:

- Person-centred and outcomes-focused
- Inclusive
- Well Led
- Promote a sustainable and diverse market place

Standards developed by national organisations for example National Institute for Health and Care Excellence https://www.nice.org.uk/guidance[xcvi] offers providers guidance on standards.

Additionally the Safeguarding Adults: The Role of NHS Commissioners[xcvii] provides helpful advice for NHS commissioners to identify quality services.

5.6 Business Failure and Service Interruptions - Impact for Safeguarding

Local Authorities should have knowledge of market vulnerabilities in order to respond effectively to service interruptions[xcviii]. Where there is a danger of a provider going into liquidation, commissioners should be informed so adequate safeguards can be put in place for adults currently using the service. Periodic market analysis (market shaping) to assess capacity and viability of services is helpful to ensure that in the event that additional resources might be needed local needs can be met.

The CQC is charged with the responsibility for market oversight of adult social care in England. This is a statutory scheme through which the CQC assesses the financial sustainability of those care organisations that Local Authorities would find difficult to replace (due to their size, specialism or concentration in the market) should they fail and become unable to carry on delivering a service. The CQC must give Local Authorities an early warning of likely failure affecting adults receiving care in their areas, so that Local Authorities can make contingency plans to enable them to meet their statutory duty to ensure continuity of care.

Most service interruptions are relatively small scale and low risk and are therefore easily managed, but those on a larger scale have much greater potential impact. A key learning point from major commercial failures in recent years was that few Local Authorities could respond effectively without working with their partners, including other providers.

Where the continued provision of care and support to those receiving services is at major risk and there is no likelihood of returning to a ‘business as usual’ situation in the immediate future, adults may have urgent needs which must be met, including safeguarding.

5.6.1 Contingency planning

The aim should be that contingency planning sits alongside other emergency planning activities. Not all situations where a service has been interrupted or closed will warrant Local Authority/CCG involvement because not all cases will have the same risks associated with safeguarding. For example, if a care home closes and residents have agreed to the provider’s plans to move to a nearby care home that the provider also owns, the level of risk or the need to invoke

safeguarding will be lessened. The aim is to return to 'Business As Usual', wherever possible, and with the least disruption to adults who use the service.

5.7 Safeguarding - Provider Concerns

Provider Concerns refer to issues that affect a group of people, for example adults living in a care setting. Where safeguarding concerns are raised about an individual these should be progressed under Section 42 enquiry (See procedures). The outcome of any individual Section 42 enquiry related to a provider where there is a Provider Concerns process in place, should be fed back to the Provider Concerns process.

The Provider Concerns process should only be invoked where there are patterns of safeguarding concerns that indicate that the provider has not made any changes to reduce the number of incidents surrounding the same or similar situations and there is concern that the provider is unable to provide care and support in a safe environment that respects the human rights of people in receipt of that care.

5.7.1 Organisational Abuse

Organisational abuse (or Organisational safeguarding) is a broad concept and is not just applicable to high profile cases, for example Winterbourne. It is an umbrella term defined as, 'the mistreatment or abuse or neglect of an adult at risk by a regime or individual's within settings and services that adults at risk live in or use, that violate the person's dignity, resulting in lack of respect for their human rights.' (Care and Support statutory guidance, 2014[ii])

Organisational abuse occurs when the routines, systems and regimes of an institution result in poor or inadequate standards of care and poor practice which affects the whole setting and denies, restricts or curtails the dignity, privacy, choice, independence or fulfilment of adults at risk. Organisational abuse can occur in any setting providing health and social care. A number of inquiries into care in residential settings have highlighted that Organisational abuse is most likely to occur when staff:

- Receive little support from management;
- Are inadequately trained;
- Are poorly supervised and poorly supported in their work; and
- Receive inadequate guidance.

Early identification

Hull University (Abuse in Care Project, 2012[xcix]), identified over ninety individual indicators or warning signs for concern. A summary of factors which can increase the likelihood of abuse occurring within provider settings are drawn from these indicators:

- Management and leadership
- Staff skills, knowledge and practice
- Residents' behaviours and wellbeing
- The service resisting the involvement of external people and isolating individuals
- The way services are planned and delivered
- The quality of basic care and the environment

Where there is proof or suspicion of organisational abuse by commission, for example the abuse and neglect highlighted in the Winterbourne View[c] and the Old Deanery reports; or omission to provide care and support that puts adults at risk, action will be channelled through the Provider Concerns process.

Principles

- The safety and wellbeing of adults using the service is paramount;
- Strong partnerships that acknowledge the expertise of others;
- Openness and transparency to achieve positive outcomes;
- Joint accountability for risk between commissioners, safeguarding leads, providers, the police, the Local Authority, the CCG and other stakeholders who may be involved;
- Prudent targeted use of resources;
- Information shared responsibly between all agencies, including the provider;
- Co-operation between agencies;
- Natural justice.

How concerns are addressed depends on level of risk and the impact on people using the service. There are no hard and fast rules, and each case should be considered on its own merit. The process can challenge capacity of one service/organisation therefore it is important that there is a shared approach, breaking down barriers between services and organisations to provide a joined up, one team approach.

5.7.2 Roles and Responsibilities

Host Authority – The Local Authority and CCG's in the area where abuse or neglect has occurred.

The host authority is responsible for:

- Liaising with the regulator if any concerns are identified about a registered Provider.
- Determining if any other authorities are making placements, alerting them and liaising with them over the issues in question/under investigation.
- Co-ordinating action under safeguarding and has the overall responsibility to ensure that appropriate action is taken and monitoring the quality of the service provided.
- Ensuring that advocacy arrangements are in place where needed, and care management responsibilities are clearly defined and agreed with placing authorities.
- Ensuring that there is a Chair and the administration of meetings, and provides a clear audit trail of agreements, responsible leads for particular actions and timescales.
- Taking on the lead commissioner role in relation to monitoring the quality of the service provision.

Placing Authority – The Local Authority (or CCG) that has commissioned the service for an individual(s) delivered by a Provider where there is a Provider Concerns.

The placing authority is responsible for:

- Duty of care to people it has placed that their needs continue to be met.
- Contribute to safeguarding activities as requested by the host authority, and maintain overall responsibility for the individual they have placed

- Ensure that the Provider, in service specifications, has arrangements in place for safeguarding.
- The placement continues to meet the individual's needs
- Undertaking specific mental capacity assessments, or best interest decisions for, individuals they have placed
- Reviewing the contract specification, monitoring the service provided and negotiating changes to the care plan in a robust and timely way
- All usual care management responsibilities
- Assessments under the Deprivation of Liberty Safeguards
- Keeping the host authority informed of any changes in individual needs and/or service provision

The Care Quality Commission (CQC)

The CQC[ci] acts independently and is a valued partner in the process of information sharing and working to tackle areas of concern. Their expertise in working with providers and standard setting may support safeguarding processes.

The CQC have the authority to take appropriate enforcement action where providers are found to be slipping but have not yet breached the requirement. This supports CQC's approach to inspection and enforcement which is based less around compliance of set outcomes, and instead focuses on five key questions about care:

- Is it safe?
- Is it effective?
- Is it responsive?
- Is it caring?
- Is it well-led?

Where there has been a recent inspection it may be helpful for providers to share pre-publicised reports, to support the principle of openness and transparency. In some instances, providers may be addressing issues identified by inspections and adult safeguarding and it makes sense to address both through agreed joint processes.

Lead Agency

The lead agency will be responsible for chairing and co-ordinating the enquiry. The Chair in this instance takes on the responsibilities of a SAM. The co-ordinator is the appointed member of staff who co-ordinates and undertakes actions and is responsible for documenting and recording. The chair should be a person of seniority with adult safeguarding experience including commissioners.

Local Authority

In most cases, the Local Authority will lead on safeguarding action in consultation with partners and in particular Regulators. The principle on who is best to lead on an enquiry should always be determined by the issue, who the lead commissioner is, and the knowledge and expertise required.

CCG

The CCG may also lead on the enquiry, especially where the concern is about health provision, as their clinical knowledge and expertise is likely to be needed.

Police

As with all criminal matters the police are the leads and must be consulted about any additional proposed action.

Front line workers

Throughout the safeguarding processes a number of tasks and actions will be identified. The table below are suggested roles, although action should always be determined on a case by case basis and the best qualified person to assess or assure the issue assigned. A system whereby professional knowledge and skills complement each other is the most effective way to safeguard people.

AGENCY/INDIVIDUAL	TASKS
Social workers/managers Care managers Reviewing officers Contract monitoring officers Commissioners	Review care plans and risk assessments Analyse staff rotas Check incident/accident reports Review policy and procedures Mental capacity and DoLS audits
Nurses Occupational therapists Physiotherapists Behavioural therapists Pharmacists	Infection control Review nursing and treatment plans Manual handling assessments Safety and use of equipment e.g. hoists Falls policies and strategies to reduce falls Medicine management
General Practitioners	Raising safeguarding concerns Maintaining a programme for monitoring individual patient care plans
Metropolitan Police Service Community Safety Unit	Criminal investigations Wilful neglect Provide expertise on investigative practice Crime prevention visits
Legal Services	Advice where there are legal challenges to safeguarding or contractual matters Advice on decommissioning decisions
Adults who use services	Raising concerns and complaints Monitoring improvements
Advocates Family/friends Visitors	Supported decision making Best interest decisions Raising concerns, monitoring improvements

Adults who use services/advocates/ carers

As with Section 42 enquiries it is essential that adults using the service are spoken to; encouraged and supported to raise complaints and concerns, questioning when care is not provided according to care plans; or care is not delivered when expected; or care is not provided with dignity and respect. Where there are patterns of complaints and concerns these may indicate poor quality service or a safeguarding concern.

Differentiating between poor care and potential safeguarding issues

Poor care

- A one-off medication error (although this could of course have had very serious consequences)
- An incident of under-staffing, resulting in a person's incontinence pad being unchanged all day
- Poor quality, unappetising food
- One missed visit by a Care Worker from a Home Care Agency

Potential causes for concern

- A series of medication errors
- An increase in the number of visits to A&E, especially if the same injuries happen more than once
- Changes in the behaviour and demeanour of adults with care and support needs
- Nutritionally inadequate food
- Signs of neglect such as clothes being dirty
- Repeated missed visits by a Home Care Agency
- An increase in the number of complaints received about the service
- An increase in the use of agency or bank staff
- A pattern of missed GP or dental appointments
- An unusually high or unusually low number of safeguarding alerts

There should be careful analysis to understand what is intentional and unintentional harm. However, where there is unintentional harm due to lack of guidance for staff this may also constitute organisational abuse.

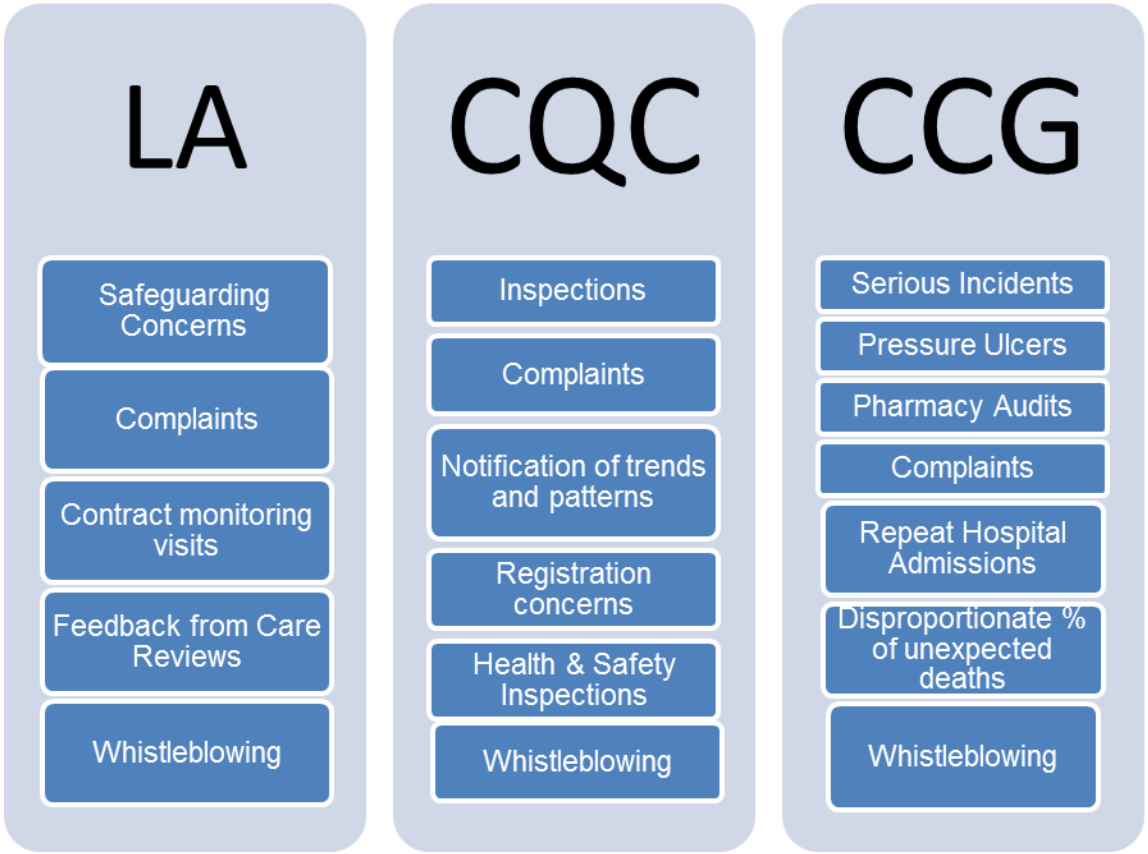
THRESHOLDS				
Example Thresholds for Provider Concerns process	**Level of Risk**	**Impact on People Using the Service**	**Potential Action**	**Lead**
• A death related to a safeguarding concern • Concern related to serious abuse or neglect • CQC enforcements related to quality of care • Criminal proceedings relating to poor care	**Major**	People who use the service are not protected from unsafe or inappropriate care. The provision of care does not meet quality & safety standards	Immediate suspension of new placements. Contact with the Police Possible SAR.	Commissioning in consultation with the police and safeguarding
			Increased monitoring activity	Contracts
			Formal meeting with provider following police advice	Safeguarding Commissioning
• Information linking concerns about the manager or responsible person High use of agency staff, poor induction and training	**Moderate**	People who use the service are generally safe, but there is a risk to their health and wellbeing. Provision of care is inconsistent and may not always meet quality & safety standards.	Suspension or 'place with caution' Consultation with the Police	Commissioning Consultation with Police and Safeguarding
			Increased monitoring activity	Contracts Care Reviews
			Formal meeting with provider following Police advice	Commissioning Safeguarding
• A disproportionate number of low-level concerns identified, from contract monitoring, CCG, or Community Care Reviews	**Minor**	People who use the service are safe, but care provision may not always meet safety and quality standards.	Monitoring visit.	Contracts
			Formal meeting with provider if necessary	Commissioning Contracts Manager

Quality and Safeguarding Information Panels

Sharing information on quality and safeguarding, strengthening the relationship and knowledge sources from commissioning, safeguarding, CQC, CCG and front-line practitioners assists in driving up standards. Formal mechanisms for sharing information between agencies are helpful to determine risk levels and the most proportionate response. The purpose of such mechanisms is to ensure both soft and hard intelligence, available agencies is brought together in an effective and cohesive manner to facilitate timely action.

Most Local Authorities have implemented a formal information sharing meeting, with key partners from the CQC and the CCG. These 'Quality & Safeguarding Information Panels' have the ability to:

- Reduce the need for safeguarding under Provider Concerns procedures through early warning systems
- Enhance the standards of care and support by sharing early warning signs with providers
- Target resources effectively to reduce duplication
- Support prevention strategies
- Support continuous service improvements

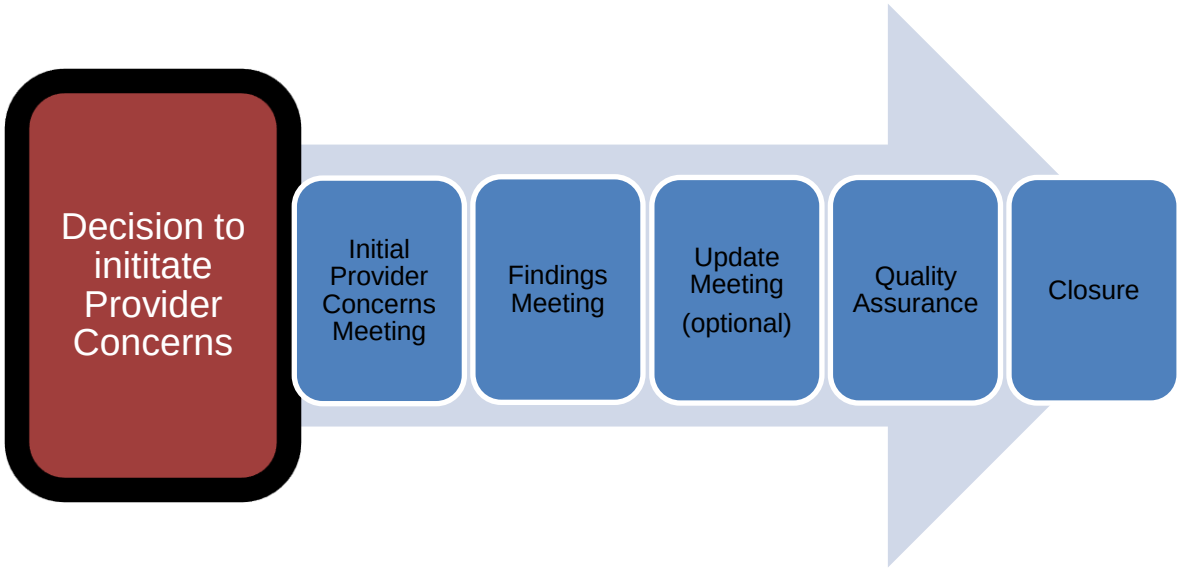


The illustration above represents the core organisations and the information that they may hold. Other organisations that might be involved, may include, London Ambulance Service, local Healthwatch, and Community Nursing Services. Establishing Quality and Safeguarding Information Panels will be locally determined.

Liaising and Reporting to the Police

Information arising from these meetings should always be provided to the Police where there is an indication of possible crime. It may also be prudent to have Police presence at such meetings, so that they can make an early assessment. Local protocols will determine how information is shared with the police.

5.8 Organisational Procedures



Step 1: Decision for Provider Concerns

The decision to initiate a Provider Concerns process may be the outcome of a Quality and Safeguarding meeting, or considered through other means for example, consequence of a SAR or a serious concern that meets agreed threshold criteria.

Action:

a. Immediate checks on safety and welfare of people using the service
b. Consult Police about whether there are criminal matters
c. Contact placing authorities
d. Agree Chair and lead organisation
e. Appoint Provider Concerns Co-ordinator
f. Convene Provider Concerns meeting
g. Set up meeting with the Provider
h. Map out risk and risk management plan
i. Consider commissioning intentions

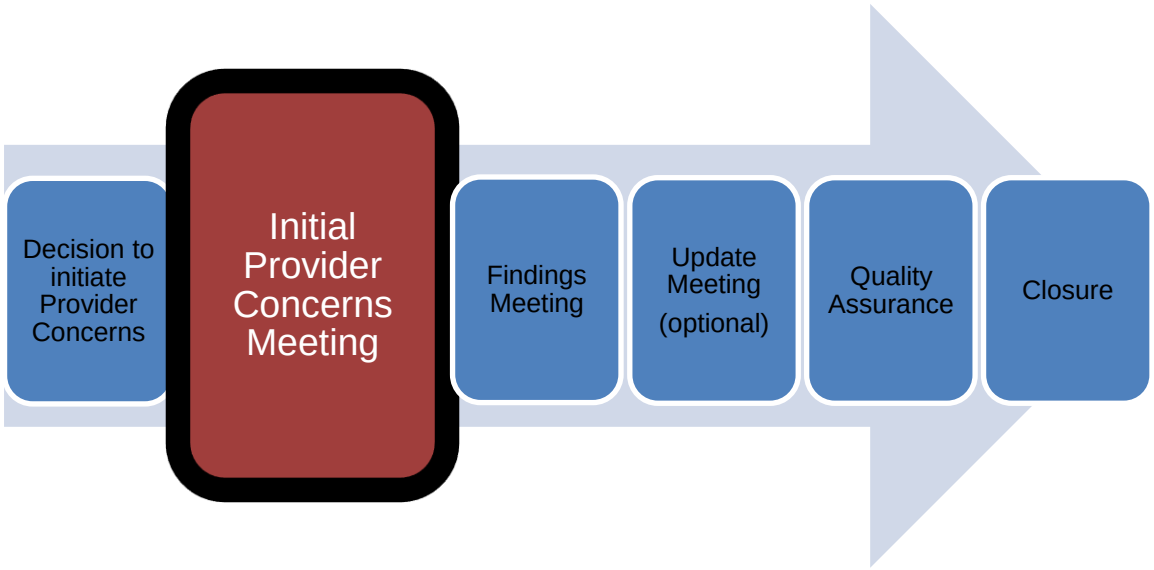
Risk

A risk management plan should be drawn up and updated throughout the process. Where there are high risk concerns, there will be a need to put in place safeguards and agreed triggers to escalate matters. Risk management to be assured that action will be timely and safeguard people on a sustainable basis is essential. Risk will determine commissioning intentions and be the evidence base upon how decisions are made.

Risk management for commissioning authorities may be additional visits both announced and unannounced. Training support for example, an occupational therapist ensuring the right slings are used to reduce immediate risks of falls, or a community fire safety advisor to identify fire risks and provide adequate smoke detection in the property.

The level of risk should be shared with the provider and frank discussions about any proposed action that might be taken by commissioners, providing adults are not put at further risk by doing so. Providers should be encouraged to find solutions to mitigate against risk. Actions might include providing additional resources to support improvement planning, resourcing training, and purchasing new equipment.

Timescale: Actions to be completed within 5 working days



Step 2: Initial Provider Concerns Meeting

The purpose of the meeting is to:

- Identify and clarify concerns
- Devise a communication strategy about how adults using the service will be informed and updated
- Ensure appropriate advocacy and support
- Listen to the views of the provider
- Safeguarding planning to consider the type of enquiries, leads and timescales
- Risk management
- Consider commissioning intentions
- Set date for Findings Meeting

Safeguarding planning

Actions need to be able to support a factual based assessment of the validity and likelihood of concerns, their severity and impact, and identify any new concerns. Intelligence as far as possible should be triangulated and the source of information identified and based on (a) views of adults using the service (b) factual information for example staff rotas and (c) professional assessment of documentation for example care plans and risk assessments. Safeguarding planning will address

alleged issues with suggested methodology for enabling decision making about whether improvements are needed or not, and who has the appropriate skills to carry out enquiries.

Communication strategy

The strategy should address both internal and external communications. A check list for information might include:

- Senior Management - Need to Know
- Information to the provider and how on-going communication will be managed
- If a suspension on admissions is considered how this is communicated to front line staff and other commissioners and the public
- Press release
- Briefing for Chief Executives and /or Elected Members
- Consultation with adults who use services, their families and friends
- How information and advice is provided to include adults who fund their own care

Meetings with the Provider

The Chair will inform the provider that it is subject to the Provider Concerns process and share as much information as possible, without compromising any subsequent lines of enquiry. They will be informed of the process and provisional timescales if available. If there is a criminal investigation, the provider will be informed in accordance with Police advice.

The Chair and Senior Commissioning Officer should establish regular meetings with the provider. The ethos of meetings should be non-adversarial and promote a culture of partnership ensuring a fair and just process.

Communication with adults who use services

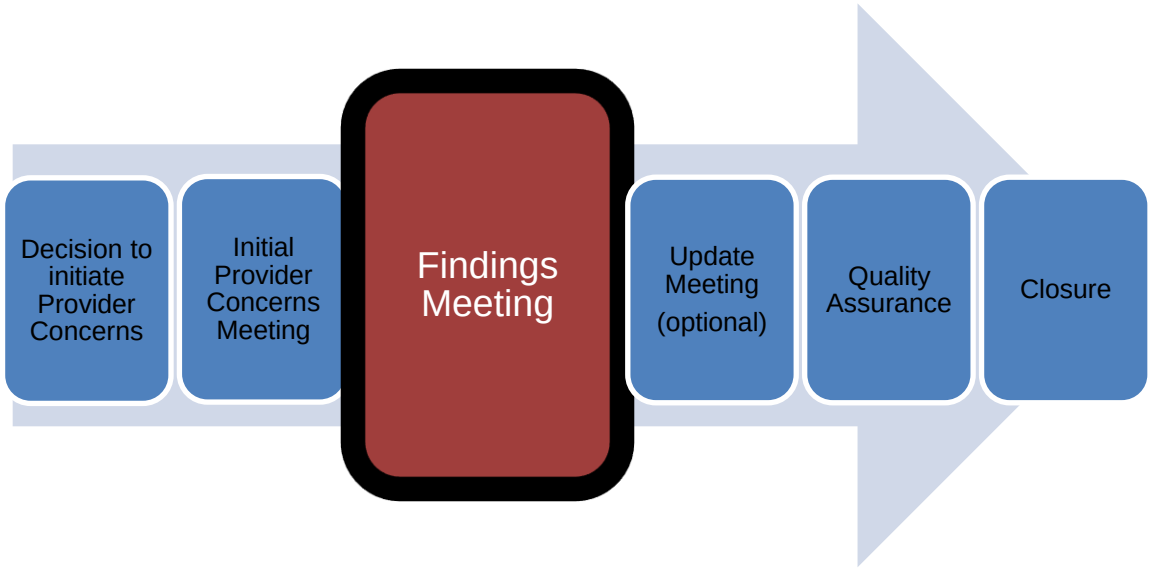
Adults who use services should be provided with the opportunity of shaping and influencing the quality of services and be kept central to the process. In a residential setting, service users and their families may become anxious about increased activity, seeing more visiting professionals etc., and have the right to be informed, but care should be taken not to raise anxiety. Information sharing should always include adults who use services and their carers so that they are able to make informed choices and retain their independence.

Where there is opportunity for presenting to adults who use the service and carers through a meeting, negotiation with the provider should take place about how this is managed. In those instances where adults receive support at home, as part of the safeguarding plan, care management staff (including Continuing Health Care staff) should make targeted visits to (a) ensure that people are safe and (b) record their views so that they are considered in the organisational risk management plan.

Adults should be provided with the means of sharing their experiences independently of the provider, and if it is deemed necessary a link worker for adults and their families should be identified and a dedicated phone line available to raise issues in confidence.

At the very minimum, checks that the provider has taken action in relation to complaints and acted upon service user surveys should be made.

Timescales: If possible, actions should aim to be completed within 10 working days. Where the concern is about a large organisation or particularly complicated, action may take longer. The provider however should be kept informed.



Step 3: Findings meeting

The purpose of the meeting is to:

- Assess and agree the findings from 'Fact Finding' enquiries.
- Draw up issues for a Service Improvement Plan
- Update the risk management plan and agree safeguarding measures
- Consider actions to monitor the safety of people and agree triggers to escalate risk, whilst improvements are being made
- Consider commissioning intentions
- Preserve information that may be helpful to police investigations

Where immediate action is needed this should be taken and not be put on hold until the Findings meeting. The chair should be informed and immediate authorisation for action is made.

Service Improvement Plan

This is the high-level plan for measuring the effectiveness of interventions to ensure safety, governance, compliance, clinical effectiveness referencing throughout the experience of adults using the service and their informal network. The Co-ordinator should set out the concerns and risks, which should also include any concerns in relation to mental capacity and the Deprivation of Liberty Safeguards. It is important to distinguish between what is safeguarding and what are quality issues that may impact on safeguarding and prioritise high risk areas.

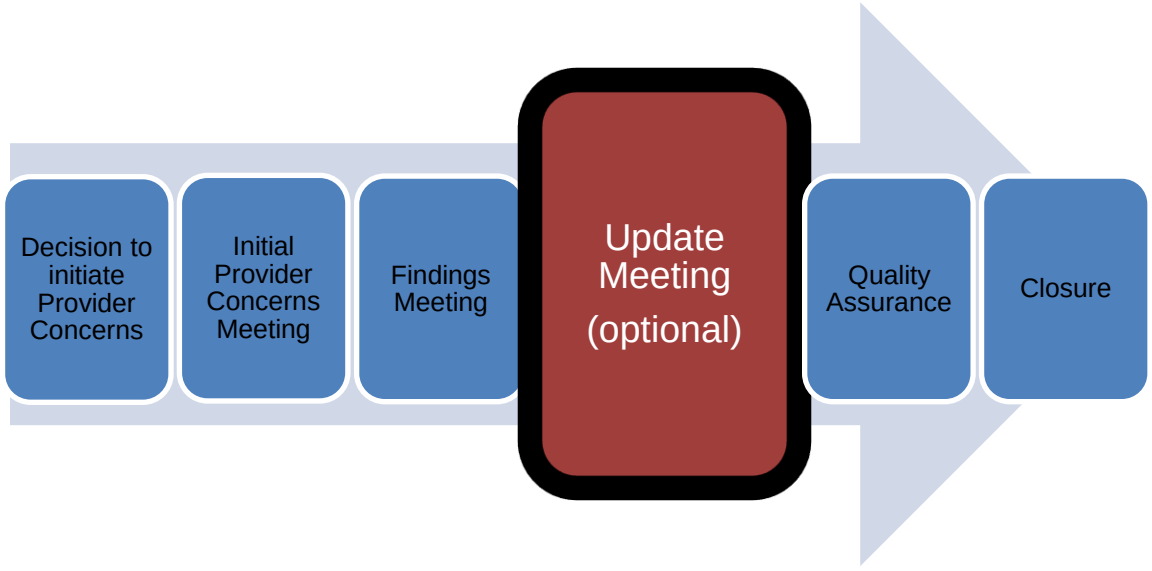
Meetings with the Provider

The chair and lead commissioner (if not the chair) should hold a meeting with the provider as soon after the findings meeting as possible.

The Provider will propose actions, leads, timescales and progress to address the concerns within **48 hours of the meeting.** The Service Improvement Plan will be the

agreed reference point for assessing and monitoring progress and both the co-ordinator and the provider will retain a copy and update it through a series of monitoring meetings. If there is a Contract Monitoring Officer, commissioner or other relevant member of staff they should be part of these meetings.

In the event that the provider advises that they are unable to make the improvements or of possible service failure or interruptions, a further meeting with all stakeholders should be convened to assess risks and impact on service users to determine commissioning based on the risk and safety of adults using the service.

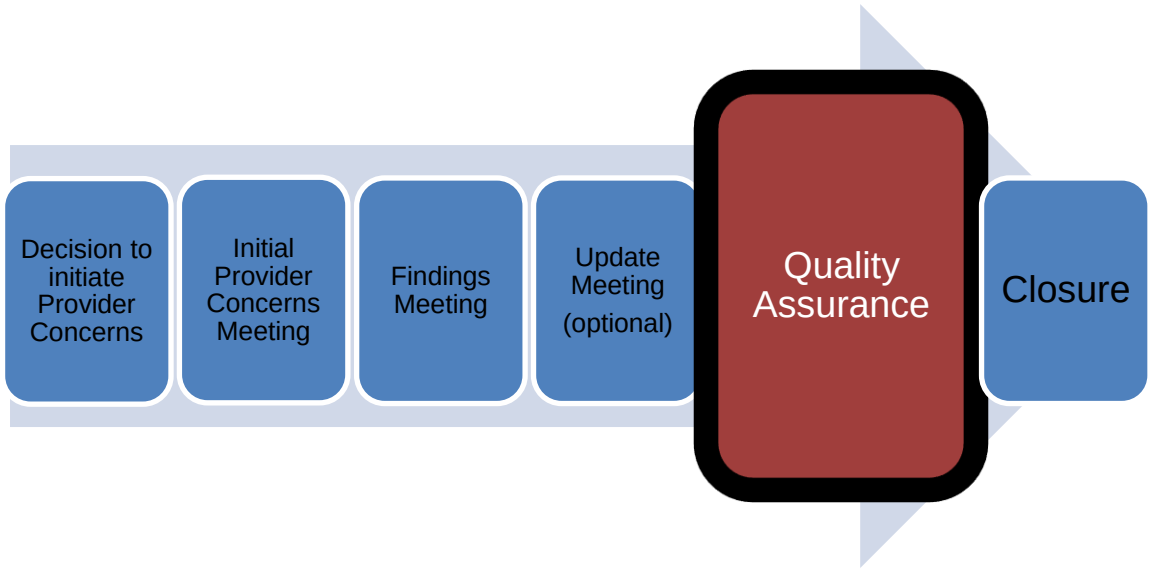


Step 4: Update Meeting (optional)

Further meetings to update stakeholders will be made if and when necessary. Where there are wide reaching, complex concerns, and there is high risk, it is likely that updated meetings are needed more frequently. Where there are serious delays by the provider to implement improvements, a further meeting should always be held to consider the level of risk and appropriate action. Focus should be on risk and the impact on adults using the service. It is important to distinguish between what is safeguarding and what are commissioning responsibilities and if further incidents have occurred.

Where there is a high risk and likely need to source alternative provision, commissioners should hold a specific contingency meeting. The chair and the Co-ordinator should be invited.

Timescales for further safeguarding meetings are dependent upon progress of the Service Improvement Plan and the level of risk.



Step 5: Quality Assurance

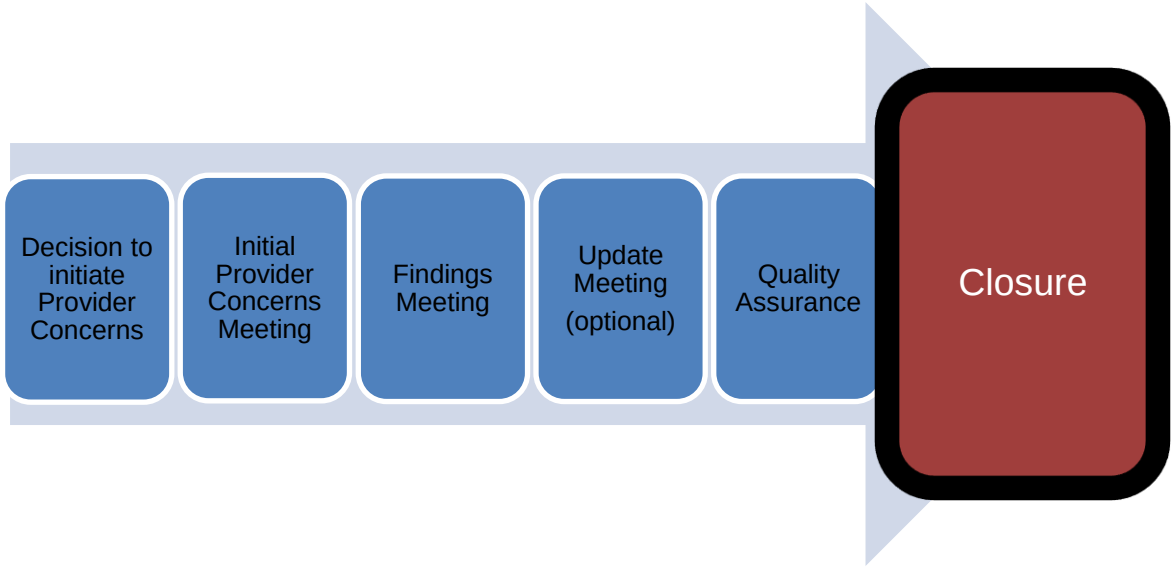
A quality assurance strategy should be agreed that will rigorously test whether improvements have been attained and can be sustained. This may involve a range of staff with the right knowledge, skills and experience to assess the viability of the improvements and might be the same staff involved in fact finding so that they can provide a comparative narrative.

Quality assurance activities may include testing an on-call emergency out of hour's system by calling at the evening and weekend; assessing the impact of training by competency testing staff; making both announced and unannounced visits.

Feedback from adults and carers will act as a control measure to assess whether there has been any noted difference in the service delivery. This may be obtained from holding a follow up meeting with adults in care settings or from a sample of telephone calls to those adults who said that they had experienced a poor service, to see if their view has changed.

Support from local Healthwatch may be appropriate, or other locally managed groups for example, Quality Checkers to add an independent view.

A target time of 10 working days to complete the quality assurance process should be factored into the strategy



Step 6: Closing the Provider Concerns process

Following evidence-based improvement, the process will formally come to an end and the relevant parties including the provider and the CQC will be notified in writing by the chair.

A Lessons Learnt Exercise with stakeholders and representatives from all stakeholders should be held. Feedback from the provider, adults and carers will be collated by the co-ordinator. This feedback will be reported to the SAB together with a summary report detailing the concerns, actions, risk management, outcomes and the effectiveness of safeguarding.

Assurances should be made that adults and carers know how to raise any further concerns. It may also be helpful to agree a reviewing and escalation process.

Appendix One: Additional Carers Information

Partnership working

Carers have a wealth of information and knowledge about the person that they support. As well as raising concerns, carers are able to support safeguarding enquiries by sharing information and are valued partners in such enquiries. Their views may hold the key to protecting people. If a carer speaks up about abuse or neglect, it is essential that they are listened to and appropriate enquiries made Carers may identify and mitigate risk and act as advocates. The lessons from Transforming Care[cii] and other public inquiries need to be taken forward in viewing carers as equal partners unless there are valid reasons not to.

Where the adult at risk lacks capacity, carers may reasonably provide professionals with the outcome they consider the adult at risk would want, as they know the persons likes and dislikes, what relationships are important to them and what relationships they may find difficult. Consideration for the carer and adult in safeguarding plans, for example, family conferences that have their own dynamics need to take into account conflicting views as carers may not want the same outcome as the adult they are supporting. *Go back to 'carers and safeguarding' (main document)*

Prevention

Carers play a significant role in preventing the need for services and it is important that professionals consider preventing carers from developing needs for care and support themselves. There is a plethora of research findings that people who act as long-time carers, have poorer physical and mental health. Strategies that support carers to continue to care should take carer resilience into account. Listening to local carer communities about the pressures they are face should be reflected in Joint Strategic Needs Assessments. Partnership working between, health, social care and carers groups is one way of working effectively to ensure that prevention strategies reduce the incidents of safeguarding and support carers to carry out their duties safely. *Go back to 'carers and safeguarding' (main document)*

Support

'*If a carer experiences intentional or unintentional harm from the adult they are supporting, or if a carer unintentionally or intentionally harms or neglects the adult they support, consideration should be given to whether, as part of the assessment and support planning process for the carer and, or, the adult they care for, support can be provided that removes or mitigates the risk of abuse*.' (Statutory Guidance 14.35). One vehicle for assessing individual need is a carer's assessment which is distinct from a needs assessment. Safeguarding should always be at the forefront of assessments. Professionals need to be candid with carers about the risks that a carer's assessment may identify for either preventing the need for safeguarding to them or preventing the risk of the carer abusing the person that they are caring for.

Whole family assessments might also be considered using the framework of Think Family as an appropriate way forward. Working collaboratively with other agencies, carers may also receive support from a number of agencies. *Go back to 'carers and safeguarding' (main document)*

Information and Advice

Carers need to know how they can find support and services available in their area, and be able to access advice, information. Carers need to know, that they can raise a concern in a safe environment and be confident that their concerns will be acted upon. It might be that people are unaware that the actions that they take could be perceived by others as abusive. For example, someone with a learning disability entitled to state benefits to meet their living expenses, and to have money as part of their access to leisure and other personal requirements may have this controlled by a family member. Families, who view individual benefits as part of the family income, may not view their actions as abusive, but where the adult they are supporting has little or no choice about how their money is spent, this could be seen as financial abuse by others.

Where carers may have acted in a way that constitutes abuse staff should respond according to adult safeguarding procedures so that the adult is safeguarded appropriately. Whilst there may be mitigating circumstances to take into consideration the wellbeing and safety of the adult should be paramount.

Carers should have access to information and advice in a way that is meaningful to them and may themselves be in need of care and support and need to know how they can access services. *Go back to 'carers and safeguarding' (main document)*

Advocacy

In some instances, the most appropriate person to support the adult at risk and act as an advocate is the primary carer. Where the carer is acting in the role of advocate, they may need support to do so, therefore professionals need to provide information and ensure that it is understood. The carer themselves may be in need of an advocate. For example, where there are safeguarding concerns about an older person with their own care and support needs caring for a partner with dementia. Assumptions should not be made about carers acting as advocates or being in need of advocacy and each case should take account of the personal circumstances. *Go back to 'carers and safeguarding' (main document)*

The Role of Carers in Strategic Planning

There are two key areas that should take account of carers in safeguarding strategic plans. First, SABs should ensure their policies, procedures and practice recognise the need to support carers and also to work with carers who are experiencing or causing harm or abuse. Second, SABs should engage with carers and local stakeholders and work together for better safeguarding practice. *Go back to 'carers and safeguarding' (main document)*

Appendix Two: Information Governance

People have a right to know how information will be used and the right to restrict the use of information when exercising choice and control over how they are safeguarded. This may impact on the service that they are offered but it is their right to make an informed choice.

Information Governance is subject to a range of legislation, in particular the:

- Local Authorities (Goods and Services) Act 1970 [ciii]
- General Data Protection Regulation (GDPR)[xiii]
- Human Rights Act 1998[xv]
- Public Interest Disclosure Act 1998[civ]
- Freedom of Information Act 2000[cv]
- Mental Capacity Act 2005[vii]
- Health and Social Care Act 2008[xc]
- The Local Authority Social Services and National Health Services Complaints (England) (Amendment) Regulations 2009[cvi]

Practitioners must be mindful that the information that they collect is lawful and that people are routinely informed about why the information is collected, what will be done with the information and who it is likely to be shared with.

A London wide information sharing protocol is in development by the Metropolitan Police Service.

Information management requires organisations to have policies and procedures in line with the above.

Local authorities and the NHS are required to appoint a Caldicott Guardian[xvii] to advise and manage its information governance arrangements.

Data Protection

The General Data Protection Regulation (GDPR) applies to all organisations in the UK that processes personal information. The GDPR goes hand-in-hand with the common law duty of confidence and professional and local confidentiality codes of practice to provide individuals with a statutory route to monitor the use of their personal information.

In the UK the Information Commissioner is responsible for the enforcement of the GDPR[xiii] and Freedom of Information Act 2000[cv]. Advice and guidance on responding to access to files and freedom of information requests can also be found on the Information Commissioner website[lxxxiv].

The rights of adults at risk, and people alleged to have caused harm including providers are upheld under the GDPR[xiii]. This means that people have the

- Right of access to personal information held about them
- Right to prevent processing likely to cause damage or distress
- Right to have inaccurate data about them corrected, blocked or erased
- Right to prevent processing of information about themselves for purposes of direct marketing

Applying the data protection principles to the safeguarding principles means that people should be advised at the earliest opportunity of any safeguarding concerns.

SCIE resource Sharing Information[xviii] provides guidance for staff on matters of consent and sharing information with family and friends. Additionally intercollegiate guidance is available through Skills for Health recommended link here[cvii].

Professional accountability

Every time a record is made of a conversation, observation, telephone call, assessment, professionals should quality assure their own work, so it measures up to good information governance:

- Contemporaneous
- Discerns fact from opinion
- Compliant with legislation
- Thorough and relevant
- Contains up to date details

Professionals should be confident that if the service user/provider were to view the record, it would be (a) evidence based (b) written in a professional and respectful manner (c) compliant with relevant legislation. The following questions are a guide:

- What information do staff need to know in order to provide a high-quality response?
- What information is needed to keep adults safe?
- What information is not necessary?
- What is the basis for any decision to share (or not) information with a Third Party?

Care should be taken to avoid personal opinion and comments. There is a risk that that this type of recording is seen at a later date as fact which cannot be evidenced. Accuracy is essential, not only for effective safeguarding but ensures resources are not wasted. Using abbreviations is unacceptable unless there is an explanation. Copying of medical notes for example ‘R. sided CVA’ can waste time and impact on the ability to protect someone. Noting that the person has had a stroke and finds it difficult to talk on the telephone is relevant and provides information that is easily understood by everyone.

A judgement framework needs to consider facts, how different types of evidence can be corroborated and how information can support a reasonable and rational assessment. Checking with the adult at risk for accuracy is good practice.

Assessments are an on-going process and therefore there is a need to ensure that information is up to date. Ensuring only one record for one person may be part of auditing. Managers might note any concerns where there are duplicate records and implement an immediate action for data cleansing.

When working with Providers, it should be borne in mind that they are reliant upon reputation for their business. Accurate recording that can be backed up by examples and corroborated supports defensible practice.

All records are subject to the retention guidelines set out by the organisation. Through the auditing process records may be disposed of according to each organisations policy. Electronic records should be updated and maintained according to the policy.

Appendix Three: Workforce Development

This section covers the responsibility of organisations, with leadership from SABs, to support staff and to ensure that there is a well-trained workforce equipped to safeguard people at risk of abuse and neglect. These responsibilities are highlighted in the Adult Safeguarding Improvement Tool[iii], which was developed in partnership by:

- Association of Chief Police Officers (ACPO)
- Association of Directors of Adult Social Services (ADASS)
- Local Government Association (LGA)
- NHS Confederation
- NHS Clinical Commissioners

Workforce development is a key enabler of change to meet the standards set out. The tool enables effective scrutiny of safeguarding work at all levels and across all agencies with safeguarding responsibilities in the context of making safeguarding personal and ensuring greater independence and choice for users of services. The shift in culture and practice, in response to what we now know about what makes safeguarding more or less effective from the perspective of the person being safeguarded, is the greatest challenge for organisations.

For agencies involved in making Section 42 enquires, there may be particular cultural and learning and development needs including improving skills in:

- Communication with a wider range of people
- Risk assessment – making complex interpretations of information about the safety and well-being of people in order to balance professional assessment of risk with the rights of adults at risk to determine their own safeguarding outcomes.

Learning from the work of Munro[4], there is a danger that, 'When the organisation does not pay sufficient attention to these skills, then procedures may be followed in a way that is technically correct but is so inexpert that the desired result is not achieved.'

A positive workplace Culture[cviii] (key in preventing abuse in the provision of care) should be developed through strong leadership and management.

Changes in the way that the workforce responds to concerns about abuse or neglect may mean that some organisations may have to assess their capacity to meet their safeguarding responsibilities. Skills for Care have produced a capacity planning model: Workforce capacity planning[cix] that organisations working in adult social care might find helpful.

Prevention

Knowing how to stop abuse and neglect and prevent it happening in the first place should be at the forefront of safeguarding developments. Staff need to be mindful of potential risks and discuss these with people who might be at risk of abuse or neglect at every opportunity, giving them information and support that enables them to make informed choices. Awareness campaigns for the general public and multi-agency training for all staff might contribute to achieving these objectives

[4] The Munro Review of Child Protection: Final Report A child-centred system (2011)

Dealing with the variety of need is better achieved by professionals understanding the underlying principles of good practice in assessment, risk management and safeguarding work, and developing the expertise to apply them throughout.

Safe organisations

A safe organisation ensures that its governing body, all of its employees, commissioned or contracted agents and volunteers or adult participants are aware of their responsibilities to safeguard children and adults. This includes:

- Safe recruitment/selection practice
- Good induction systems
- Ongoing training/updates for staff (and others) in minimum standards in adult safeguarding
- Clear access to guidance / procedures for both children and adult safeguarding
- Awareness of local protocols and systems for information sharing and referral
- Developing a listening culture to adults with an open mind and promoting person-centred
- Clear and accessible complaints and whistle-blowing procedures
- Adherence to agreed local procedures for responding to concerns and allegations of abuse and neglect of harm by persons in positions of trust
- Independent advocacy and support
- Good record keeping
- A formal and independent review process for learning from serious incidents, SARs and other reviews that may impact on adult safeguarding
- Regular audits of the above to ensure compliance
- Leadership/accountability in a named senior manager and clear access to specialist advice about adult safeguarding (externally if not available within the organisation)

Recruitment

All organisations that employ adults or volunteers to work with children or vulnerable adults should adopt a consistent thorough process of safer recruitment to ensure those recruited are the best candidates for the role and are suitable to work with vulnerable groups. The Disclosure and Barring Service (DBS)[cx] provides criminal records checking and barring functions[cxi] to help employers make safe recruitment decisions. In addition, recruitment processes should evidence:

1. Right to work in the UK
2. Application process (forms, supporting statements, Curriculum Vitae, interview and selection)
3. Qualifications
4. Verifiable references

Standards and guidance on safe recruitment can be found in the following documents, helping employers make safer recruiting decisions[cxii] and Values based recruitment[cxiii].

Related issues

- Rehabilitation of Offenders Act 1974[cxiv] - People working with children or vulnerable adults are required to reveal all convictions, both spent and unspent.
- Registration with professional bodies – if registration with a professional body is a condition of employment, staff are responsible for maintaining their registration. Employers should carry out compliance audits as part of their safeguarding quality assurance measures.

Induction

It is important for all workers to know exactly what is expected of them in their role. Employers should ensure that there is an agreed induction period that covers cultures, standards, HR policy and procedures, terms and conditions. Additionally, staff should be supported through this period to understand their safeguarding role and responsibility.

Professional Development

For frontline workers in health and social care the Care Certificate[cxv] sets out the minimum standards required and aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

It is designed for new staff, and also offers opportunities for existing staff to refresh or improve their knowledge. It was developed jointly by Skills for Care[viii], Health Education England[cxvi] and Skills for Health[cxvii]. The Care Certificate[cxv].

- Links to National Occupational Standards and units in qualifications
- Gives workers a good basis from which they can further develop their knowledge and skills

For managers in adult social care there are also Manager Induction Standards[cxviii].

Assessed and supported year in employment[cxix] (ASYE) is designed to help newly qualified social workers (NQSWs) to develop their skills, knowledge and capability. It aims to strengthen their professional confidence. It aims to provide them with access to regular and focused support during their first year of employment. Their safeguarding skills should be developed part of this process.

Learning and Development

Safeguarding Boards will lead, and each organisation will determine their own Learning and Development activities which may include seminars on specific topics, practice development forums whereby staff learn from audits and performance data, and peer challenges as well as formal training. Learning and Development activity should be informed by learning from SARs and a shared approach to learning.

Training

All organisations need to ensure that staff and volunteers have access to training and continuous professional development that is appropriate to their level of responsibility. Safeguarding adults and mental capacity training are mandatory in most organisations. It is suggested that at a minimum it should cover:

1. Recognising different types of abuse and how to raise a concern
2. Mental Capacity, consent and best interest
3. Making Safeguarding Personal

4. Risk and how to manage it
5. Duties under Section 42 on enquiries
6. Recording
7. Lawful handling and sharing of personal information

Skills for Care[viii] and the Social Care Institute for Excellence[ix] have produced a library of training resources for adult safeguarding work

In addition to the suggested mandatory training, other areas to consider are:

- Advocacy
- Dignity and respect
- Domestic Abuse
- Mediation
- Living with risk
- People whose behaviour challenges
- SARs
- Self-neglect
- Complaints
- Working with carers

Some organisations may have specific mandatory training for example NHS staff are required to undertake Prevent training. The National Skills Academy[cxx] provides information about training specifically for NHS organisations. Adult Social Care providers might find helpful training suggestions from the Care Quality Commission and Skills for Care[viii] website. Regulated professionals such as nurses and social workers will have specific requirements for CPD that include Safeguarding. Organisations might append their own training manuals to this policy.

Capability framework

Learn to Care and Bournemouth University National Capability Framework[cxxi] sets out levels of skills, knowledge and experience expected of individual staff. The framework supports organisations:

- To raise standards and ensure consistent and proportionate response to safeguarding
- Improve partnership working and consistency to secure better outcomes for people
- To support work-based evidence of learning and competence in practice
- To provide managers with a framework to evaluate performance and identify training needs
- Clarify expectations of the role of all relevant members of the workforce in safeguarding
- Provide quality assurance tools for commissioners and contract monitoring officers

All staff should be assessed as competent against the competences that are relevant to their occupational role. Whatever their role, all staff should know when and how to report any concern about abuse or neglect of an adult. Therefore, all staff need to be competent at the first level and beyond this it will depend on their occupational role and level responsibilities. Training can be linked to a particular staff group to ensure the workforce is able to meet the specified competence. All commissioned training can be evaluated against the specific competences for specific roles.

An updated framework is available here[cxxii].

The required staff training levels will be determined locally, and organisations may wish to reflect similar levels of training for specific staff in line with training available in safeguarding children. There may be scope for joint training for example domestic abuse.

Supervision and Appraisal

Supervision[cxxiii] is essential to supporting practitioners and provides assurance for both the organisation and the practitioner. Workers should feel confident that they are supported to deliver safeguarding and have the right training and professional development through regular supervision and appraisal. Staff should be encouraged to further their knowledge base through gaining additional skills and knowledge. Organisations should ensure that staff receive clinical and/or management supervision that affords them the opportunity to reflect on their practice and the impact of their actions on the adult at risk and others. Supervisors should be qualified to take on these responsibilities.

Appraisals are central to effective practice. Appraisals ensure that all staff are focused on outcomes and have clarity about their role. Staff should expect to receive an annual appraisal, linked to the overall safeguarding strategic plan.

Appendix Four: Safeguarding Adults Structures and Organisations

SAB

All Local Authorities must establish a SAB as set out in the Care Act. The Act (Schedule 2) gives the local SAB three specific duties it must do:

1. Publish a strategic plan for each financial year that sets out how it will meet its main objective and what each member is to do to implement that strategy. In developing the plan, it must consult the Local Healthwatch organisation and involve the community.
2. Publish an annual report detailing what the SAB has done during the year to achieve its objective and what it and each member has done to implement its strategy as well as reporting the findings of any SARs including any ongoing reviews
3. Decide when a SAR is necessary, arrange for its conduct and if it so decides, to implement the findings.

The Social Care Institute for Excellence Safeguarding Adults Board[cxxiv] Checklist and Resources provides a comprehensive narrative and account of the roles and responsibilities of the SAB.

Partnerships with SABs may include:

- Community Safety Partnerships;
- Local Children Safeguarding Boards;
- Health and Wellbeing Boards;
- Quality Surveillance Groups;
- Clinical Commissioning Group Boards; and
- Health Overview and Scrutiny Committees (OSCs).

Community Safety Partnerships

Community safety partnerships (CSPs) are made up of representatives from the 'responsible authorities', which are the:

- Police
- Local Authorities
- Fire and Rescue Authorities
- Probation Service
- Health

The responsible authorities work together to protect their local communities from crime and to help people feel safer. They work out how to deal with local issues like antisocial behaviour, drug or alcohol misuse and reoffending. They annually assess local crime priorities and consult partners and the local community about how to deal with them.

Local Safeguarding Children Board (LSCB)

Section 13 of the Children Act 2004[cxxv] requires each Local Authority to establish a LSCB for their area and specifies the organisations and individuals (other than the Local Authority) that should be represented on the LSCBs. The Police and health are core members of both the LSCB and the SAB. These will be replaced with Safeguarding Children Partnerships[cxxvi].

Health and Wellbeing Boards

The Health and Social Care Act 2012[xc] establishes health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. They are an important feature of the NHS reforms and are key to promoting greater integration of health and local government services. Boards strike a balance between status as a council committee and role as a partnership body.

Quality Surveillance Groups (QSGs)

Quality Surveillance Groups are primarily concerned with NHS commissioned services: those services that are funded by the NHS, including relevant public health services. There are strategic links between SABs and QSGs. The National Quality Board (NQB) published a second edition of the QSG operating model How to make your Quality Surveillance Group effective[cxxvii]

The QSGs are supported by NHS England (London). They provide an open forum for local supervisory, commissioning and regulatory bodies to share intelligence and give the opportunity to co-ordinate actions to ensure improvements in services. Its purpose is to ensure quality by early identification of risk, and; reduce the burden of performance management and regulation on providers.

The strategic links with the SAB provides further opportunity to escalate concerns and share risks, and take a sub-region view of quality concerns.

Senior Strategic Roles

The Care Act 2014 prescribes that each SAB should include the Local Authority, the Clinical Commissioning Group and the Police. The Chief Officers[1] must sign off their organisation's contributions to the Strategic Plan and Annual Reports. Chief Officers should receive regular briefings of case law from the Court of Protection and the High Courts. Roles and responsibilities are outlined in this link[c].

Briefings produced by Skills for Care[i] provide further detail on the role of the three statutory members of the SAB. In relation to senior strategic roles in health and CCGs – these are set out as recommended by the Accountability and Assurance Framework: Safeguarding Vulnerable People in the NHS Accountability and Assurance Framework. Available at http://londonadass.org.uk/wp-content/uploads/2014/12/safeguarding-accountability-assurance-framework.pdf

Strategic leadership and practice leadership

Each SAB member agency should appoint a senior manager to take the lead strategic and inter-agency role in safeguarding arrangements, including the SAB.

Within each partner agency, clearly understood roles should be created for practice leadership in safeguarding.

Principal Social Workers are well placed to provide professional leadership, act as Safeguarding Adult Managers or Leads (SAMs) and to provide additional advice and guidance to social workers in complex and contentious cases.

Healthcare providers should have in place named professionals to provide additional advice and support in complex and contentious cases within their organisations.

[1] Borough lead for the MPS

There should be a designated professional lead within the CCG, to act as the lead in the management of complex cases and to provide advice and support to the governing body.

Arrangements should be made to enable officers investigating safeguarding concerns to access advice from specially trained investigators and/or units within the Police.

The role and function of the police

Although the police are a mandatory member of the SAB by virtue of Section 43 of the Care Act 2014[x], they are not an agency responsible for the provision of care. The police role in adult safeguarding is related to their policing function. The core duties of the police are to:

- Prevent and detect crime
- Keep the peace
- Protect life and property

The Police are now represented on every local SAB and contact details for the individuals concerned will be available to the board and all board members. Each SAB is supported by a senior officer, Superintendent or Detective Chief Inspector. Each Community Safety Unit is headed up by a Detective Inspector.

If you are unsure which Police Force area you need to contact, then contact the Force area where the incident or concern is/was located. This is the way primacy for investigation is determined within the Police.

Other Organisations with adult safeguarding responsibilities

Care Quality Commission (CQC)

Safeguarding is a key priority for CQC and people who use services are at the heart of their policy. Their work to help safeguard children and adults reflects both their focus on human rights and the requirement within the Health and Social Care Act 2008 to have regard to the need to protect and promote the rights of people who use health and social care services.

Health and adult social care regulated services all have a key role in safeguarding vulnerable children and adults at risk. The CQC will monitor how these roles are fulfilled through its regulatory processes by assessing the quality and safety of care provided based on the things that matter to people. It does this by using five key lines of enquiry to ensure that health and social care services provide people with safe, effective, caring, responsive and well led services. Specifically, it considers safeguarding within the ‘Safe’ key line of enquiry.

CQC will share with local partners, where they are not already aware, the safeguarding information that it receives so that they can take the appropriate action to protect the individual. Safeguarding information is also used within its intelligent monitoring systems in order to assess its impact upon the service and the associated level of risk. This information is then used to inform CQC inspection process.

Although there are differences in the statutory basis and policy context between safeguarding children and adult safeguarding, the CQC have the same approach with an overarching objective of enabling people to live a life free from abuse.

The CQC also has a role in health and safety in collaboration with the Health and Safety Executive and local authorities[lxxxviii].

Commissioners

Commissioners from the CCG, Local Authority, and NHS England are all vital to promoting adult safeguarding. Commissioners have a responsibility to assure themselves of the quality and safety of the organisations they procure and ensure that contracts have explicit clauses that holds Providers to account for preventing and dealing promptly and appropriately with any concerns of abuse and neglect. Commissioners have a shared and common vision to prevent, reduce and delay the need for care and support. For safeguarding this means, ensuring that people have easy access to information and advice, and early intervention services. Increasingly there is joint commissioning to meet the growing needs within a financial climate of austerity, with greater emphasis on prevention and early intervention. This is in line with the safeguarding principles.

Community Nursing

Community nurses largely provide treatment in individual's own homes which includes care homes. A high proportion of people they visit are adults at risk of abuse or neglect by the fact that they have care and support needs, and many cannot protect themselves. Community nurses are trained to recognise the signs of abuse and neglect, and to raise their concerns through their line manager, or directly with Local Authorities. The most common concerns raised relate to neglect.

Through holistic assessments, nursing staff may identity that the person is not getting their health or social care needs met. This could be because of gaps in what is provided by the statutory agencies, or because of decisions made on their behalf by family or friends. Nurses are in a good position to identify possible abuse or neglect particularly financial abuse or domestic violence, including where this could be a response to the pressures of caring.

Pressure ulcer management and quality of care in care settings, are further areas that nursing staff are able to use their clinical judgements about whether or not abuse and neglect has or is likely to arise. Because community nurses make repeated visits to their patients, they are also in a good position to review risks and the effectiveness of safeguarding plans in response to concerns.

The Coroner

Coroners are independent judicial officer holders who are responsible for investigating violent, unnatural deaths or deaths of unknown cause, and deaths in custody or otherwise in state detention, which must be reported to them. The Coroner may have specific questions arising from the death of an adult at risk. These are likely to fall within one of the following categories:

- Where there is an obvious and serious failing by one or more organisations
- Where there are no obvious failings, but the actions taken by organisations require further exploration/explanation
- Where a death has occurred and there are concerns for others in the same household or setting (such as a care home) or
- Deaths that fall outside the requirement to hold an inquest but follow-up
- Enquiries / actions are identified by the Coroner or his or her officers

Crown Prosecution Service

The CPS is the principal public prosecuting authority for England and Wales and is headed by the Director of Public Prosecutions. Support is available within the judicial system to support adults at risk to enable them to bring cases to court and to give best evidence. If a person has been the victim of abuse that is also a crime, their support needs can be identified by the police, the CPS and others who have contact with the adult at risk. Witness Care Units exist in all judicial areas and are run jointly by the CPS and the police.

Court of Protection

The Court of Protection deals with decisions and orders affecting people who lack capacity. The court can make major decisions about health and welfare, as well as property and financial affairs. The court has powers to:

- Decide whether a person has capacity to make a particular decision for themselves
- Make declarations, decisions or orders on financial and welfare matters affecting
- Individuals who lack capacity to make such decisions
- Appoint deputies to make decisions for persons lacking capacity to make those decisions
- Decide whether a lasting power of attorney or an enduring power of attorney is valid
- Remove deputies or attorneys who fail to carry out their duties.

In most cases decisions about personal welfare will be able to be made legally without making an application to the court, as long as the decisions are made in accordance with the core principles set out in the Mental Capacity Act 2005[vii] and the Best Interests Checklist and any disagreements can be resolved informally. However, it may be necessary and desirable to make an application to the Court in a safeguarding situation where there are:

- Particularly difficult decisions to be made
- Disagreements that cannot be resolved by any other means
- Ongoing decisions needed about the personal welfare of a person who lacks capacity to make such decisions for themselves
- Matters relating to property and/or financial issues to be resolved
- Serious healthcare and treatment decisions, for example, withdrawal of artificial nutrition or hydration
- Concerns that a person should be moved from a place where they are believed to be at risk
- Concerns or a desire to place restrictions on contact with named individuals because of risk or where proposed Adult safeguarding actions may amount to a deprivation of liberty outside of a care home or hospital.

Environmental Health – responsible for health and safety enforcement in businesses, investigating food poisoning outbreaks, pest control, noise pollution and issues related to health and safety. Local authorities are responsible for the enforcement of health and safety legislation in shops, offices, and other parts of the service sector.

General Practitioners

GPs have a significant role in Safeguarding Adults. This includes:

- Making a referral to a Safeguarding Adults referral point should they suspect or know of abuse and neglect in line with these procedures
- Playing an active role in planning meetings and safeguarding plans
- Supporting safeguarding actions where there is organisational abuse and/or neglect

Health Providers - All health providers are responsible for the safety and quality of services. Health Providers are required to demonstrate that they have safeguarding leadership, expertise and commitment at all levels. Health Providers are required to have effective arrangements in place to safeguard adults at risk of abuse or neglect and to assure themselves, regulators and their commissioners that these are effective and meet the required standards. Safeguarding arrangements mirror those of the CCG. All health Service Providers are required to be registered with the Care Quality Commission (CQC).

Named professionals (health providers) - Named professionals have a key role in promoting good professional practice within their organisation, supporting the local safeguarding system and processes, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place. They should work closely with their organisation's safeguarding lead, designated professionals and the SAB.

Safeguarding adult leads support and advise commissioners on adult safeguarding within contracts and commissioned services. They also have responsibility to improve systems and embed referral routes for adults at risk across the health system. They provide a health advisory role to the SAB, supporting the CCG SAB member.

Healthwatch

Healthwatch England is the national consumer champion in Health and Care and must be consulted on the strategic plan. It has significant statutory powers to ensure the voice of the consumer is strengthened. It challenges and holds to account commissioners, the Regulator and Providers of health and social care services. Healthwatch

- Identifies common problems with health and social care based on people's experiences
- Recommends changes to health and social care services that they know will benefit people
- Hold those services and decision makers to account and demands action.

As a statutory watchdog, their role is to ensure that health and social care services, and the government, put people at the heart of their care.

Housing Providers

The Care Act states that a Local Authority must consider cooperating with Social Housing Providers in order to exercise its care and support duties. An authority must do this in particular when protecting adults at risk of harm and neglect and when identifying and sharing lessons to be learned from cases of serious abuse or neglect.

Social Housing Providers are registered with, and regulated, by the Homes & Communities Agency. They are also known as Registered Providers of Social

Housing (RPs) or registered social landlords (RSLs). They include Local Authority landlords, arm's-length management organisations (ALMOs) that manage council housing stock, private for-profit or not-for-profit housing providers, and Voluntary Sector Providers such as alms houses. Most not-for-profit RPs are also known as Housing Associations.

RPs provide a wide range of housing and housing-related services. They provide much of the supported accommodation in England, such as sheltered housing, care homes, supported living scheme housing, extra care schemes, hostels, foyers for young people, domestic abuse refuges, etc.

Implementing the principles

Beyond the core service of providing housing, RPs may also engage in initiatives that enhance their customers' wellbeing and create sustainable communities, such as: housing support, community safety, better neighbourhoods, responding to anti-social behaviour, employment & training, domestic abuse, self-neglect & hoarding, fraud awareness, debt & financial inclusion, reducing isolation, tenancy sustainment support, etc.

Local Authorities must take into account that the suitability of accommodation is a core component of wellbeing and good housing provision can variously promote that wellbeing. This includes minimising the circumstances, such as isolation, which can make some adults more vulnerable to abuse or neglect in the first place. The nature and diversity of RPs' work, therefore, can mean that their staff are often well placed to:

- Have a good knowledge of the individual and the communities with whom they work
- Be working with persons who are unable to protect themselves from abuse or neglect due to their care and support needs, but who are not already known to Adult Social Care Services
- Identify individuals experiencing or at risk of abuse or neglect and raise concerns
- Be the first professionals to whom individuals might first disclose abuse or neglect concerns
- Be the only professionals working with the adult at risk
- Provide essential information and advice regarding the adult at risk
- Contribute actively to person-led safeguarding risk assessments and arrangements to support and protect an individual, where appropriate
- Carry out a safeguarding enquiry, or elements of one
- Work with agencies to support someone who is hoarding
- Work together with agencies to resolve issues with someone who refuses support or self-neglects, or when someone may not be eligible for a safeguarding service or social care support
- Work with Local Authorities to promote safeguarding awareness, information and prevention campaigns
- Be instrumental in helping a Local Authority to successfully exercise its safeguarding and well-being duties

Housing Providers should ensure that they develop a safeguarding culture through:

- Board and Leadership commitment & ownership of safeguarding responsibilities
- Policies or guidance that promote the 6 principles of adult safeguarding
- Policies that reflect the adult safeguarding framework set out by a SAB
- Staff being vigilant about adult safeguarding concerns
- Learning and development for staff on adult safeguarding and the Mental Capacity Act 2005 enabling them to fulfil their roles and responsibilities
- Sharing information appropriately to safeguard adults at risk and engaging with Information Sharing Agreements where required
- Developing inter-housing networks as well as multi-agency mechanisms

London Ambulance Service

There are a number of ways in which LAS staff may receive information or make observations which suggest that an adult at risk has been abused, neglected or is at risk of abuse and neglect. At a strategic level LAS have embedded the six safeguarding principles into its business plans and aims to translate them into practice by using them to shape strategic and operational safeguarding arrangements.

- Use integrated governance systems and processes to prevent abuse occurring and respond effectively where harm does occur
- Work to support SABs by providing policy updates, and its annual report to support, patients and community partners to create safeguards.
- Provide leadership for safeguard adults policies
- Ensure accountability and use learning within the service and the partnership to bring about improvement

London Fire Brigade

London Fire Brigade (LFB) staff become aware of safeguarding concerns in a number of ways, not only when responding to emergency calls, but during community safety preventative work such as home fire safety visits. LFB staff do receive safeguarding training so that they are able to identify whether an adult has been or is at risk of being abused and/or neglected and are aware of how to report concerns following the procedures for recording, managing and referring concerns to Local Authorities set out in our safeguarding policies.

The Head of Community Safety is the appointed Lead Officer for Safeguarding within LFB and is supported by members of the LFB Central Community Safety team and local borough commanders in discharging this function.

Borough commanders represent LFB locally at SAB as non-statutory members. Each LFB borough commander reports any adult safeguarding concerns through their SAB and engages in multi-agency partnerships and information sharing as appropriate

National Probation Service and London Community Rehabilitation Company
Since 1st June 2014 the delivery of Probation Services has been carried out by the National Probation Service (NPS) and Community Rehabilitation Company (CRC). NPS are responsible for supervising high and very high risk of serious harm offenders on licence and community orders, and/ or those subject to Multi-Agency Public Protection Arrangement (MAPPA), preparing pre-sentence reports for courts, preparing parole reports, supervising offenders in approved premises, and delivering

sex offender treatment programmes, support to victims of serious violent and sexual offences through the Victim Liaison Unit.

The CRC are responsible for supervising low and medium risk of serious harm offenders on licence and community orders, Community Payback, Accredited Programmes and other interventions.

Both services have a remit to demonstrate a continuous focus on assessment and risk of harm, to protect adults at risk, children and young people, and victims of crime. One of their key objectives is to evidence that routine checks are completed (with appropriate agencies) and information accessed is used to inform the assessment and management of risk in all cases. There is an emphasis on partnership working across London at a strategic and local level. Whilst each division has its own role and responsibilities, a close working relationship with each other is maintained.

The NPS works in partnership with other agencies through the Multi Agency Public Protection Arrangements (MAPPA). The purpose of the MAPPA framework is to reduce the risks posed by sexual and violent offenders in order to protect the public. The responsible authorities in respect of MAPPA are the police, prison and the National Probation Service that have a duty to ensure that a local MAPPA is established, and the risk assessment and management of all identified MAPPA offenders is addressed through multi-agency working.

Although not a statutory requirement, representation from the National Probation Service and the Community Rehabilitation Company on the Safeguarding Adults Board should be considered.

NHS England

The general function of NHS England is to promote a comprehensive health service to improve the health outcomes for people in England. NHS England has a statutory requirement to oversee assurance of CCGs in their commissioning role.

The mandate from Government sets out a number of objectives which NHS England is legally obliged to pursue. The objectives relevant to safeguarding are:

- Continuing to improve safeguarding practice in the NHS;
- Contributing to multi-agency family support services for vulnerable and troubled families; and
- Contributing to reducing violence, in particular by improving the way the NHS shares information about violent assaults with partners and supports victims of crime.

They have two distinct safeguarding roles:

1. Direct commissioning: Commissioning primary care, specialised services, health care services in justice, health services for armed forces and families and some public health services. As a commissioner of health services, NHS England also needs to assure itself that the organisations from which it commissions have effective safeguarding arrangements in place.
2. Assurance and system leadership[cxxviii]: discharged through the Chief Nursing Officer (CNO) who has a national safeguarding leadership role. The CNO is the Lead Board Director for safeguarding and has a number of forums through which to gain assurance and oversight, particularly through the NHS England National Safeguarding Steering Group

In addition, NHS England is responsible for ensuring, in conjunction with local CCG Clinical Leads, that there are effective arrangements for the employment and development of a named GP/named professional capacity for supporting Primary Care within the local area.

Safeguarding networks

CCGs and NHS England provide support and advice to the designated and specialist professionals to be able to access the widest possible expertise to support improving safeguarding practice across the NHS system. In order to support this, NHS England has established local 'safeguarding networks'.

Safeguarding networks have taken forward the lessons learnt from the Robert Francis Inquiry (2013)[cxxix] and other key safeguarding reports. The safety and quality of NHS services runs through NHS England (London) and the 32 CCG's NHS Five Year Forward plan[cxxx] address the concerns raised, in the above reports. The complexity of the healthcare system is outlined in Understanding the New NHS[cxxxi].

Office of the Public Guardian (OPG)

The OPG was established under the Mental Capacity Act 2005[vii] to support the Public Guardian and to protect people lacking capacity by:

- Setting up and managing separate registers of lasting powers of attorney, and of court- appointed deputies
- Supervising deputies
- Sending Court of Protection visitors to visit individuals who lack capacity and also those for whom it has formal powers to act on their behalf
- Receiving reports from attorneys acting under lasting powers of attorney and deputies
- Providing reports to the Court of Protection
- Dealing with complaints about the way in which attorneys or deputies carry out their duties.

The OPG can carry out an investigation into the actions of a deputy, of a registered attorney (lasting powers of attorney or enduring powers of attorney) or someone authorised by the Court of Protection to carry out a transaction for someone who lacks capacity, and report to the Public Guardian or the court.

Providers

All commissioned service provider organisations should produce their own guidelines that are consistent with the multi-agency Safeguarding Adults policy and procedures. These should set out the responsibilities of staff, clear internal reporting procedures and clear procedures for reporting to the local Safeguarding Adults process. In addition, provider organisations' internal guidelines should cover:

- A 'whistleblowing' policy which sets out assurances and protection for staff to raise concerns
- How to work within best practice as specified in contracts
- How to meet the standards in the Health and Social Care Act 2008[xc] (regulated activities) and the Care Quality Commission (Registration) Regulations 2009[cxxxii]
- How to fulfil their legal obligations under statutory processes
- Robust recruitment arrangements

- Training and supervision for staff.

Public Health

The Health & Social Care Act 2012 set out the legislative framework for the changes to the health and care system that led to the creation of Public Health England and the transfer of responsibility for most public health duties at a local level to local government. Public Health England (PHE) was established on 1 April 2013 to bring together public health specialists from more than 70 organisations into a single public health service, for the first-time combining health protection and health improvement in one organisation. From April 2013 responsibility for public health transferred from the NHS to local government and Public Health England.

Trading Standards

Trading standards provide advice for businesses and is responsible for enforcing laws covering the safety, descriptions and pricing of products and services. Trading Standards Officers have particular skills in dealing with fraud, tricks and scams

The Voluntary Sector or **Community Sector** (also non-profit sector or 'not-for-profit' sector) is the duty of social activity undertaken by non-statutory organisations.

The Voluntary and Community Sector should include safeguarding adults within their induction programmes.

Safeguarding should be integral to policies and procedures and policies, for example:

- Staff and volunteers are aware of what abuse is and how to spot it
- Having a clear system of reporting concerns as soon as abuse is identified or suspected
- Respond to abuse appropriately respecting confidentially
- Prevent harm and abuse through rigorous recruitment and interview process

The Voluntary and Community organisations can promote safeguarding and support statutory organisations through consultations on policy and developments, work on prevention strategies and promoting wider public awareness. The SAB has the discretion to invite membership to Voluntary and Community Sector.

Appendix Five: Supplementary Note on Domestic Violence

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

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This definition includes so called Honour Based Violence (HBV) and Forced Marriage (FM), and is clear that victims are not confined to one gender or ethnic group. Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family.

By these means the perpetrators deplete the victim's self-worth, isolating them from others with the perpetrators exercising psychological and emotional control. Intimate partner violence which disproportionately affects women includes physical and/or sexual violence, intimidation, isolation and the micro management of everyday life.

Financial abuse is a significant problem for people who are in abusive domestic arrangements. Control of money can sabotage efforts to gain independence through employment. This is usually linked to coercive and controlling behaviour.

All domestic abuse falls under the remit of the Metropolitan Police Service including cases involving 16 – 17-year olds. Where an offence has been committed officers should arrest the suspect where there are reasonable grounds to suspect their involvement in the alleged crime and the conditions under Section 24 of PACE are met. The exercise of arrest powers will be subject to a test of necessity based around the nature and circumstances of the offence and the interests of the criminal justice system. An arrest will only be justified if the constable believes it is necessary for any of the reasons set out in Section 24(5). Failure to arrest in appropriate circumstances may result in a neglect of duty or other failure in standards. Officers must fully justify any decisions not to arrest and clearly document their decision. This challenges and holds perpetrators to account for their actions. However, positive action also requires enhanced levels of victim care. The police strategy is that the safety of victims is paramount, particularly where children are involved and referral to independent advocates is part of police procedures.

Positive outcomes for those affected by domestic abuse are achieved in many ways including:

- Successful prosecution;
- Reducing cases of repeat victimization, and;
- Prevention through other means such as the Sanctuary scheme, civil remedies, re-housing and
- Pro-active operations and referrals to support agencies

Appendix Six: Data Sharing Agreement

This Data Sharing Agreement should be used if you are processing personal data for the law enforcement purposes[5], as described under Part 3 of the Data Protection Act (DPA) 2018.

Data Sharing Agreement

Between

[Enter name] Safeguarding Adults Board

London Borough of [Enter name],

Metropolitan Police Service [Enter BCU name],

[Enter name] NHS Trust,

[Enter name] Council Adult Social Care Service

[Enter name] Clinical Commissioning Group
and
Other relevant partners

for the purpose of Safeguarding Adults at Risk within the London Borough of [Enter name]

(BOROUGH LOGO)

[5] *"the law enforcement purposes" are the purposes of the prevention, investigation, detection or prosecution of criminal offences or the execution of criminal penalties, including the safeguarding against and the prevention of threats to public security.*

Freedom of Information Act Publication Scheme	
Government Security Classification	Official
Publication Scheme Y/N	Yes / No
Title	A purpose specific data sharing agreement between [Enter dept/directorate/BCU or MPS if a corporate agreement] and [Enter name of partner(s)]
Version	[Enter Number]
Summary	An agreement to formalise information sharing arrangements between [Enter dept/directorate/BCU or MPS if a corporate agreement] and [Enter name of partner(s)] for the purpose of [Enter Details] for the Adults at Risk partnership
BCU or Unit, Directorate	[Enter Details]
Author	[Enter Details]
Review Date	[Enter Details]
Date Issued	[Enter Details]
ISA Ref:	[General Registry File number obtained via Form 911]

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FOREWORD

The Care Act 2014 statutory guidance advises that the first priority should always be to ensure the safety and well-being of the adult at risk.

The guidance also states that all organisations must have arrangements in place which set out clearly the processes and the principles for sharing information between each other, with other professionals and the Safeguarding Adults Board (SAB).

The Act puts adult safeguarding on a statutory footing and requires each Local Authority to set up a Safeguarding Adults Board (SAB) with core membership from the Local Authority, the Police, and the NHS (specifically the local Clinical Commissioning Group/s). The SAB has the power to include other relevant bodies. One of the key functions of the SAB is to ensure that the policies and procedures governing adult safeguarding are fit for purpose and can be translated into effective adult safeguarding practice.

The statutory guidance under the Act states that six key principles underpin all adult safeguarding work. These apply across all agencies involved in the process. These principles can be found in Appendix A.

Safeguarding adults at risk is a complex area of work that involves a number of professional organisations working together with the common purpose of preventing or reducing the risk of significant harm to adults at risk from abuse or other types of exploitation, whilst supporting individuals to maintain control over their lives. This includes being able to make choices without coercion. To achieve this, the sharing of information amongst professional organisations who work with vulnerable adults is essential. Early sharing of information is the key to providing an effective response where there are emerging concerns. Sometimes it is only once information from a range of sources is co-ordinated that an adult is identified as being at risk. It is better that information is shared rather than withheld if this may prevent a vulnerable adult from suffering harm.

By signing up to this agreement the relevant Signatory Organisations are recognising that working together and sharing information effectively is imperative to safeguard those that are at risk or pose a risk to themselves or another, and to prevent, detect and prosecute offences against adults at risk. This agreement formalises the processes and principles for sharing information between each other, with other professionals and the SAB and any other relevant parties.

Section 1 - The Purpose of the Agreement

1.1 This Agreement –

- describes the basis for the lawful exchange of information between signatory organisations involved in adult safeguarding;

- puts in place arrangements which set out clearly the processes and the principles for sharing information;

- sets out the basis upon which requests for information will be made by the signatory organisations involved in adult safeguarding, and how they will deal with those requests;

- provides a framework for the secure and confidential sharing of information between signatories;

- describes the roles and structures that will support the exchange of information between the signatory organisations, and security procedures necessary to ensure compliance with responsibilities under the Data Protection Act, Caldicott Principles and organisation specific security requirements;

- will ensure that the Metropolitan Police Service will in addition adhere to requirements of the Guidance on the Management of Police Information (MoPI) and the Authorised Professional Practice (APP);

- describes how this arrangement will be monitored and reviewed, with the recommendation being 6 months initially and annually thereafter;

- summarises the signatories' legal obligations in relation to information sharing;

- does **not** create an absolute obligation to share information: in particular it will not be a breach of the agreement for a signatory organisation to refuse to share information where disclosure of such would constitute a breach of legal or professional obligations owed by that Signatory Organisation in respect of that information.

1.2 Scope of this Data Sharing Agreement

The signatories to this agreement are the following agencies/bodies:
1. [Enter Borough name] Safeguarding Adult Board
2. [Enter Borough name] Council Adult Social Care Services
3. Metropolitan Police Service [Enter BCU]
4. [Enter name] NHS Trust
5. [Enter Borough name] Approved Mental Health Professionals (AMHPs)
6. [Enter name] NHS Foundation Trust
7. [Enter name] Clinical Commissioning Group
8. [Insert any additional local organisations]

Together the “Signatory Organisations”

This agreement **does** cover the sharing and assessing of information held by the Signatory Organisations by:

- **[Enter BCU name]** High Risk Panel if set up after the date of this Agreement
- A multi-agency group that is not a High-Risk Panel and which relates to an adult with social care needs

This agreement **does not** cover the sharing and processing of information held by the Signatory Organisations for the purposes of:

- **[Enter BCU name]** Public Protection Unit (Jigsaw) through MAPPA process
- **[Enter BCU name]** Prolific Priority Offender Unit
- **[Enter BCU name] DV** Multi Agency Risk Assessment Conference (MARAC) information sharing
- **[Enter BCU name]** Community MARAC
- Disability Targeted Hate Crime - managed under the current MPS Hate Crime Policy
- Domestic Abuse - managed under the current Domestic Abuse Policy
- Information required by the police for criminal investigations

These activities are covered by separate information sharing agreements / policies.

1.3 Information Sharing in the Context of a Safeguarding Adults Enquiry

1.3.1 Safeguarding Adults Enquiry

The Care Act 2014 says that the duty to undertake a safeguarding adults enquiry arises where a Local Authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)

- has needs for care and support (whether or not the authority is meeting any of those needs);
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

An adult that any Signatory Organisation suspects may fall into the above categories will be referred to in this agreement as an “Adult at Risk”.

The Care Act 2014 guidance states that early sharing of information is the key to providing an effective response where there are emerging concerns for an Adult at Risk, and no professional should assume that someone else will pass on information which they think may be critical to the safety and wellbeing of the adult. If concerns are raised about the adult's welfare, whether this be the belief that they are suffering or likely to suffer abuse or neglect, and/or are a risk to themselves or another, information should be shared with the local authority and/or the police if the professional/Signatory Organisation believes or suspects that a crime has been committed or that the individual is immediately at risk.

Explanations of the type of abuse and criminal offences of which Adults at Risk may become victims, are listed in Appendix B. This is not an exhaustive list.

In the majority of cases, the response to a safeguarding enquiry will involve other agencies, for example, a safeguarding enquiry may result in referrals to the police, a change of accommodation, or action by Care Quality Commission (CQC). Where a number of professional organisations are involved

in a combined plan, it is recommended that the Local Authority should seek to establish a 'lead' agency for the monitoring and assurance of the plan. Information sharing should be rapid and seek to minimise bureaucracy.

1.3.2 The National Standards

The Association of Directors of Adult Social Services (ADSS) has published a National Standards document in conjunction with key partners including the National Police Chiefs Council (NPCC). This framework is intended to consolidate the experience to date and to further the development of 'Safeguarding Adults at Risk' work throughout England. The implementation of the eleven good practices (Standards) in every local area will lead to the development of consistent, high quality adult protection work across the country. (See Appendix C for a headline copy of the National Standard Framework).

This agreement has been produced in compliance with the National Standard Framework, and the signing of this agreement will help the signatories comply with the Framework in particular Standards 1, 4 and 8. It has been recognised that a number of agencies may be involved in different aspects of the care and support of an adult at risk and this agreement will contribute to achieving the aims of building strong multi-agency partnerships at a local level with agreed working practices in response to instances of abuse and neglect.

By effective information sharing among the Signatory Organisations and drawing upon partner organisations' specialist skill sets, all Signatory Organisations can offer the best possible service to safeguard adults at risk and make a positive impact on public protection.

1.3.3 Assessments and Investigation Strategies

It is key that the adult at risk is involved from the outset in any investigation strategies (unless doing so would put them at greater risk of harm). Family, friends and other relevant people who are not implicated in any suspected abuse or neglect have an important part to play, especially if the adult at risk lacks capacity. In such cases, the friends or family should be consulted, where practicable, in line with the Mental Capacity Act 2005. The role of Signatory Organisation representatives, their duties and powers will be governed by the relationship of the person that has caused the harm to the adult at risk.

Staff and volunteers should be aware of the London Multi Agency Safeguarding Policy and Procedures and be aware of issues regarding abuse, neglect or exploitation. The document recognises variation in terminology between Signatory Organisations regarding adults at risk who may be considered as vulnerable, and that the terms vulnerable adult and adult at risk are used interchangeably.

Managers of Signatory Organisations have a key role in the management and coordination of information in response to a Safeguarding Adult Concern.

1.4 Types of Information to be Shared through this Agreement

The disclosure of any particular information should be proportionate and necessary for the purposes of safeguarding.

The types of information likely to be required to be shared include the following.
Due to the complexity and uniqueness of each situation, it is difficult to provide an exhaustive list of what information will be shared but as a minimum the following information should be considered.

1.4.1 Personal Information about Individuals Considered to be a Risk to an Adult at Risk

Personal information ("Personal Data" and "Special Category data and Conviction Data" in the language of the Data Protection Act 2018) needs to be shared to allow relevant Signatory Organisations to identify these individuals and explain why they are a risk to vulnerable adults (the "Adult at Risk"). Examples of the kind of personal & special category and conviction data that may be shared include:

- Personal identifiers (names, addresses, dates of birth)
- Current photograph of the suspected offender (if appropriate)
- Descriptive information (photographs, marks, scars)
- Relevant warning markers (e.g. Violence, Drugs, Mental Health, Weapons)
- Reason why they are considered to be a risk
- Details of relevant criminal convictions and non-conviction information
- Relationship with the adult at risk

1.4.2 Personal Information about Adults at Risk

- Name of subject (Adult at Risk) and other family members, their carers and other persons whose presence and/or relationship with the subject, is relevant to identifying and assessing the risks to that vulnerable adult
- Age/date of birth of subject and other family members, carers, other details including addresses and telephone numbers
- Ethnic origin
- Description of incident and organisational action;
- The nature and circumstances of the ongoing risk to the Adult at Risk.

1.4.3 Personal information Disclosed about Third Parties may include:

- Adult at Risk relevant family members or other personal contacts
- GP who is the primary record holder for all individuals registered with them - where relevant and known
- Employer - where necessary and known

Relevant results from police checks on **relevant** family members mentioned within police databases, or persons such as a general practitioner or an employer again where relevant. This information will only be considered on a case by case basis and is not a blanket for sharing on everybody associated with an Adult at Risk. Information shared on these individuals must be necessary to assist in the assessment of safeguarding needs and delivery of safeguarding services and only the minimum required for these purposes.

Information considered for sharing in regard to associated individuals can include but is not limited to personal identifiers, relationship to the Adult at Risk and information and or intelligence held by Signatory Organisations that is **relevant** to assisting partners in services or duties towards the adult at risk concerned.

This information may need to be shared to enable Signatory Organisations to fully understand the risks posed to/by the individual and stop them from being a victim, repeat victim, suspect or risk to themselves, and to ensure that all relevant avenues for assistance are considered.

Section 2 - Description of Arrangements including Security Matters

2.1 Security Classification

The information shared through this agreement will be marked in accordance with the Government Security Classification (GSC) and information to be shared will not exceed the level of Official Sensitive.

2.2 Accuracy of Information

If information held is found to be inaccurate, the Signatory Organisation producing the information will be notified. The producing Signatory Organisation will be responsible for correcting this information and notifying other recipients of this information of the inaccuracy and the correction. The other recipients will then be responsible for relevant information in their possession being corrected.

2.3 How the Information will be processed

2.3.1 The sharing of information between Signatory Organisations may be proactive or as a result of a request for information. Signatory Organisations will inform the police about Adults at Risk where a crime may have been committed and equally, police will notify Safeguarding Adults Services and the relevant NHS bodies about adults at risk of abuse or neglect, and/or experiencing abuse or neglect, and individuals who pose a risk to Adults at Risk.

Requests will include an explanation as to why the information is necessary and they will be considered on a case by case basis by the recipient Signatory Organisations.

Information handling and requests by the Metropolitan Police Service (MPS)

2.3.2 Where it has come to the MPS's attention that an Adult at Risk is in circumstances that are adversely impacting upon their welfare or safety and/or they are a risk to themselves or others, as well as a crime or intelligence report being created, the reporting officer will create an 'Adult Coming to Notice' (ACN) MERLIN report.

This report will be viewed by **[Enter BCU name]** police Public Protection Desk (PPD) / Multi Agency Safeguarding Hub (MASH) contact. If deemed appropriate and necessary to do so to protect and safeguard the adult at risk, they will share the ACN on to **[Enter Borough name]** relevant partnership team via the secure email link within MERLIN.

Information handling and requests by the Local Authority

2.3.3 Any requests under a Section 42 Care Act enquiry must be dealt with expeditiously. Any requests from the Local Authority to partner Signatory Organisations must be in a written format and for police information. Requests to any partner Signatory Organisation asking for information will include reasons why they require any relevant information held. In the case of requests to police, the completed form will be sent to the Borough PPD/MASH or BCU Mental Health Team. For criminal investigations, partner Signatory Organisations should initially liaise with the police officer in charge of the enquiry.

2.3.4 The PPD or designated BCU unit will search the appropriate MPS databases and also national police systems for relevant information. The designated unit will consider the information gathered and decide whether it is adequate, relevant and not excessive for disclosure, for the specified, explicit and lawful purpose requested.

2.3.5 Any Signatory Organisation refusal to share information under Section 42 Care Act 2014 must be in writing and will be returned to the authorising manager. The reply will include an explanation as to why the request did not fall within the defined categories.

2.3.6 In the case of a request to the police, if it is decided that it is proportionate and necessary to disclose information, then the results of the search of MPS and police systems will be collated within an Adult Come to Notice report (on MERLIN) and/or a CRIMINT relating to that request. After removing, where necessary, any information that is not appropriate to be shared from each report, the police unit will send the finalised answer back to the requesting agency via the secure email link in MERLIN or other agreed secure email address listed in section 2.6 of this agreement.

Information sharing by NHS bodies

2.3.7 Where information is held or sought by a NHS body, the following process will be used for sharing information:

[For local completion]

Information sharing by London Ambulance Service

2.3.8 London Ambulance Service (LAS) will share information about safeguarding concerns and staff identify with the local authority and police as appropriate and in line with multi agency policy and procedures. London Ambulance Service will share its involvement and attendance at patients identified by Safeguarding Adults Board (SAB) & Safeguarding children's Board (SCB) to support investigations including Serious Adult Reviews (SARs) and Serious Children's Reviews (SCRs). Information shared pursuant to this agreement will be disclosed in accordance with the LAS flowcharts for raising a safeguarding concern and/or welfare concerns.

Information sharing at safeguarding meetings and case conferences

2.3.9 Should a meeting be called to discuss a case, a Confidentiality Statement shall be signed by all attending parties. A sample Confidentiality Statement and Register can be found in Appendix F.

Onward disclosure of shared information

2.3.10 Permission must be sought by the Signatory Organisations from the relevant partner organisation for the sharing of information outside of their respective domain. Such permission will only be granted where proposed sharing of relevant and proportionate information is within the agreed principles: i.e. for the purposes of safeguarding an Adult at Risk. This may include policing purposes, and/or the provision of care and support. All requests made should be done so by either secure e-mail or in writing so that an audit trail exists.

2.4 Critical Request for Information

A case will be considered 'Critical' if there is immediate risk of harm to the subject or others and information needs to be provided immediately to protect Adults at Risk, e.g. hostage situations, acts of terrorism, serious attempt by the individual to take their own life etc. The process in these circumstances will vary as stated below.

2.4.1 Initial contact for Critical enquiries will be made to the relevant person listed in the Contacts List found in Appendix G. In the event that the relevant person cannot be contacted a locally agreed escalation policy should be followed.

2.4.2 Upon initiating a Critical enquiry the following detail will be requested:

- Requestor's full name, job title, phone number.
- Verification that the case is genuinely 'critical' (i.e. there is immediate risk of harm to the subject or others and information needs to be provided immediately to protect individuals)
- A check that the telephone number provided is the number provided on the Contacts List. If not, the enquiry may be escalated to the 'on-call' Director to make the decision on disclosure.

For Critical enquiries, ONLY the following information will be disclosed:

- Whether they are known to [*insert relevant partner agency*].
- Whether they are currently engaged with services.
- Known risk factors - to self or others.
- Diagnosis or nature of any potentially relevant health problem or condition, including mental health diagnosis.
- Recent significant life changes that can be established from patient records that may impact on behaviour.

2.4.3 A record of the personal information disclosed to other Signatory Organisations must be created. This should include what was shared and the reason for sharing. Any decision not to share information should similarly be recorded along with the reasons for the decision.

If sharing needs to occur in fast time and a Critical enquiry is made via telephone, a record must be similarly created on an appropriate MPS corporate system as soon as possible thereafter by the requestor.

2.5 Storage, Retention and Destruction of Information

Signatories to this agreement confirm that the appropriate storage and protection measures are in place for the information that is shared through this agreement.

2.5.1 If information is backed up and stored electronically via disc, hard drive, USB stick, or any mobile device, then adequate security measures must be in place on electronic systems. This specifically means that areas where shared information is stored can only be accessed via username and password, and appropriate encryption measures are in place. Permission to access the information shared by Signatory Organisations will be granted on a strict 'need to know' basis once it is contained within the electronic system, and an audit trail will capture events which evidence successful and unsuccessful access to the system and individual records. The media being used should then be stored in a physical location that has a level of security appropriate to the level that the information held is graded to.

Where removable media is used, MPS personnel must only use an encrypted MPS approved Datashur USB. CDs are no longer acceptable.

2.5.2 If information shared under this agreement is printed it must be kept in a locked container within a secure premise with a managed access control. If printed information must be moved from its usual secure location, which is in accordance with the level of security required by this agreement, then any move temporary or permanent, must provide the same level of security in storage as per the original location. When documents are not being used, they will be stored securely.

2.5.3 Access to the information in both electronic and paper formats will be limited to relevant staff on a need to know basis. The security and maintenance of security measures and passwords will be

the responsibility of the Data Protection Officer/Caldicott Guardian or [Enter relevant role] within each Signatory Organisation. There will be a clear auditable access control system, detailing successful and unsuccessful attempts. The general public will have no access to either type of record.

2.5.4 All Signatory Organisations will have appropriate policies and procedures governing the retention and destruction of records containing personal information retained within their systems. These policies and procedures must be followed. Once the minimum retention period has expired, a risk assessment should be undertaken of whether the records should be kept for longer, if necessary. If not, the records should be promptly and securely destroyed.

2.5.5 Electronic information will be disposed of by being weeded according to each agency's standard operating procedure in relation to their IT systems, being overwritten using an approved software utility or through the physical destruction of computer media.

2.5.6 Any paper records will be disposed of through an OFFICIAL SENSITVE waste disposal system, using a cross shredder, or returned to the relevant Signatory Organisation for secure disposal.

2.6 Confidentiality and Vetting

At a minimum, all the information to be shared under this agreement will be classified and managed in accordance with GSC handling requirements.

Vetting is not mandatory to view this level of information; however, the staff within **[Enter Borough name]** Safeguarding Adults Service/relevant partner who will have access to police information are cleared to access this information within their own organisations. The information must only be processed (viewed) on a strict 'need-to-know' basis.
Use the link below to access the Government Security Classifications[6]

2.7 Transfer of Information - all agencies

Information will be transferred using secure email and preferably to and from a joint team mailbox to which appropriate staff have access, so should the responsible individual be away, work can continue as normal. The mailbox will be checked regularly throughout the day.
The email addresses to be used are;

- **[Insert Adult Services team email address, ensuring it is a CJSM or equivalent]**
- **[Insert Health email address, ensuring it is a nhs.net / Egress address]**
- **[Police Team Email]** @met.pnn.police.uk
- **[Insert any other approved secure email addresses]**

2.7.1 It is recognised that email address ending **".gov.uk"** and **"nhs.uk"** by themselves **are not secure email addresses** and so will not be used to share OFFICIAL SENSITIVE information without use of a further appropriate encryption method[7].

2.7.2 In the event of a failure of the e-mail system, Partners reports, and information forms will be shared via fax. If this is necessary, as a last resort, senders will need to verify the number of the recipient, and ensure the recipient is present at the fax, to receive the information. A test sheet will

[6]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/715778/May-2018_Government-Security-Classifications-2.pdf

[7] Secure email options are CJSM, pnn, nhs.net, gsi and Egress.

be sent first to confirm the correct number has been inputted, and a response received, before the actual reports and information forms are faxed across.

2.7.3 In cases of immediate risk, proactive and reactive sharing may occur using existing safeguarding referral processes following a telephone call to the department to make them aware of the report and to highlight any immediate action that has been completed / further actions required either by the relevant partner agency. Any sharing via telephone will be backed up in writing for audit purposes.

2.8 Security Incidents and Breaches of the Agreement

2.8.1 Security breaches, including misuse of MPS information, must be reported to the relevant Single Point of Contact (SPOC), Caldicott Guardian or Data Protection Officer (DPO) without undue delay of occurring/or no later than 24 hours after becoming aware of it. This is to allow the MPS to risk assess the security incident or breach of the Agreement, in circumstances where the security breach concerns MPS INFORMATION. A list of contacts can be found in Appendix G.

It is still the responsibility of All Signatory Organisations to comply with the obligations laid out under Section 67 and 68 of the DPA 2018.

2.8.2 Where a security incident involves health or social care information, the NHS Digital *Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation* will be followed.

2.8.3 The MPS SPOC must immediately inform the Information Assurance Unit (IAU) of any security incident or breach of MPS information, including unauthorised disclosure or loss of information, by calling the department or emailing 'IAU Mailbox - Security Incidents'.

Partner agencies, if you wish to feature a reporting procedure for a breach please complete as prompted below and embolden the text once complete, please duplicate for multiple agencies. Alternatively, if you do not wish to insert such text please delete the light grey text. Please delete this paragraph once complete.

The [*Insert relevant partner agency here*] Contact must as soon as possible inform the [*Insert relevant person or unit here*] of another Signatory Organisation of any security incident or breach of [*Insert relevant partner agency here*] information, including unauthorised disclosure or loss of information originating from the other Signatory Organisation by calling the department or emailing [*Insert relevant mailbox here].*

2.8.4 Signatory Organisations confirm that security breaches are covered within their internal disciplinary procedures. If misuse is found, consideration will be given to facilitating an investigation into initiating criminal proceedings. All Signatory Organisations are aware that in extreme circumstances, non-compliance with the terms of this agreement may result in the agreement being suspended or terminated.

2.9 Compliance

All Signatory Organisations are responsible for ensuring the security controls are implemented and staff are aware of (and where appropriate, trained in) their responsibilities under the Data Protection Act 2018.

Signatory Organisations agree where necessary to allow peer-to-peer reviews to ensure compliance with the security section of this agreement. Compliance with these security controls will be catered for in the periodic reviews of the agreement.

2.10 Review

This agreement will be reviewed six months after implementation and annually thereafter. In the event of a security incident or other issue which requires urgent attention, the Signatory Organisations may review the agreement more frequently.

2.11 Freedom of Information Act and Subject Access Requests / Right of Access Requests

2.11.1 It is recognised that Signatory Organisations to this agreement may receive a request for information made under the Freedom of Information Act 2000 that relates to the operation of this Agreement. Where applicable, they will observe the Code of Practice made under S.45 of the Freedom of Information Act 2000 in responding to the request.

2.11.2 Normal practice will be to make all information/data sharing agreements available on relevant publication schemes.

2.11.3 The Freedom of Information Act Code of Practice contains provisions relating to consultation with others who are likely to be affected by the disclosure (or non-disclosure) of the information requested. The Code also relates to the process by which one authority may transfer all or part of a request to another authority if it relates to information held only by the other authority.

2.11.4 Individuals can request a copy of all the information an organisation holds on them, by making a Subject Access Request (SAR). The MPS refer to these requests as Right of Access Requests (ROAR) under the DPA 2018. This may include information that was disclosed to a Signatory Organisation under this agreement. Where this is the case, as a matter of good practice the Signatory Organisation in receipt of the SAR/ROAR will liaise with the originating Signatory Organisation to the information to ensure that the release of the information to the individual will not prejudice any ongoing investigation/prosecution or engage other exemptions within the Data Protection Act 2018.

Section 3 - Legal Basis for information sharing and what can lawfully be shared

3.1 General Principles

All information exchanges between the Signatory Organisations must be:

- In accordance with the law (see section 3.2 below);
- Relevant to actions undertaken to safeguard adults;
- Sufficiently detailed for the specified purpose and reasonably accurate;
- Shared in a secure manner; and
- Information exchanged must be used only for the purposes for which it was shared.

Signatories to this Agreement must have regard to the Caldicott Principles (described in section 3.11 below).

3.2 Data Protection Act 2018 (the "DPA")

It is the responsibility of all signatories to this Agreement to ensure that information exchanges are justified by, and in accordance with the DPA.

The DPA acts as a framework for how to handle and process (including sharing, obtaining, recording and storing) personal and special category personal information. It contains two Schedules that list various Conditions which, when fulfilled, allow for the processing of personal data (Schedule 1) and special category data (Schedule 8). Personal data is that which can identify a living individual. Some personal data is classified as special category personal data when it relates to a person's racial or ethnic origins, physical or mental health or conditions, sexual life, criminal offences, religious beliefs and trade union membership. The 6 Data Protection Principles also need to be complied with to allow sharing to be lawful.

(The 6 Data Protection Principles are listed in Appendix H)

3.2.1 Lawful and Fair Processing (Principle 1)

Signatory Organisations are exempt from complying with their 'obligations' and the 'rights of the individual' as described in the DPA, if it would be likely to prejudice the prevention or the detection of crime, the apprehension or prosecution of offenders.[8]

Fair Processing Notices inform individuals of what we do with their personal data, however even though the processing is lawful and fair, it is the level of transparency to which we are exempt, if it would prejudice any of the law enforcement purposes. Therefore Principle 1 cannot always be fully complied with.

Any disclosure must still comply with the Data Protection Principles and legal obligations owed outside of the DPA 2018, such as confidentiality, as well as any professional responsibilities and obligations. If there is not valid consent, consideration should be given as to whether it is in the public interest to share the information.

[8] Schedule 2, Part 1, Section 1(b) Section 2(1)(a)(b) and Section 2(2) and 2(3) DPA 2018

3.2.2 Schedule 1 (Part 2 and Part 3) Data Protection Act 2018

To comply with Schedule 1, each case must be assessed on its own merit. Appropriate sharing of personal information through this agreement is likely to satisfy one of the following conditions in Schedule 1:

- **This condition is met if the data subject has given consent to the processing [29]**
  This is applicable when an individual consent to their information being shared.
  [Schedule 1, Part 3 condition 29 DPA]

Or alternatively,

- **The processing is necessary to protect the vital interests of an individual, and: the data subject is physically or legally incapable of giving consent [30]**
  This is applicable when sharing a victim's information without consent, for their own benefit and where if information was not shared, their life would be in immediate danger.
  [Schedule 1, Part 3 condition 30 DPA]

- **The data processing is necessary for the purpose of the exercise of a function conferred on a person by an enactment or rule of law [6(1)]**
  This is applicable when sharing information for the purposes of a safeguarding enquiry under section 42 Care Act 2014, complying with a section 45 request for information from a SAB or when sharing through section 115 Crime and Disorder Act 1998 regarding offenders or suspected offenders.
  [Schedule 1, Part 2 condition 6(1) DPA]

- **The processing is necessary for the exercise of any functions of a public nature exercised in the public interest by any person [36]**.
  Even where the sharing of information is not designed to meet a precise statutory function, if the processing is being done to discharge public function and the public interest favours disclosure, the Data Protection Act permits it.
  [Schedule 1, Part 3 sec 36 DPA]

- **The processing is necessary for the purpose of legitimate interests pursued by the data controller or by the third party or parties to whom the data are disclosed, except where the processing is unwarranted in any particular case by reason of prejudice to the rights and freedoms of legitimate interests of the data subject[10(1)(2)(3)]**
  This is applicable where the sharing is necessary to fulfil common law duties and responsibilities of partner agencies, and where the sharing is done in such a way as to not disadvantage the rights of individual whose data is being shared.
  [Schedule 1, Part 2 section 10(1)(2)(3) DPA]

3.2.3 Schedule 8 of the Data Protection Act 2018

In the vast majority of cases, the information potentially to be shared will be special category personal data and so will need to additionally satisfy one of the conditions in Schedule 8. Appropriate sharing of information will likely satisfy one of the following conditions:

- **The processing is necessary to protect the vital interests of the data subject or of another individual [3]**
  [Schedule 8 condition 3 DPA]

- **The processing is necessary for: the exercise of a function conferred on a person by an enactment or rule of laws, and: is necessary for reasons of substantial public interest [1]**
  [Schedule 8 condition 1 DPA]

- **The processing is necessary for the purposes of: protecting an individual from neglect or physical, mental or emotional harm, or: protecting the physical, mental or emotional well-being of an individual [4]**
  [Schedule 8 condition 4 DPA]

3.2.4 The 6 Data Protection Act Principles

All data that is to be shared is obtained for lawful purposes, connected with protecting and safeguarding vulnerable members of society and preventing criminal activities. Information will only be used and shared for the reason that the information was collected and will be considered on a case by case basis. Only relevant information will be shared, which will be enough to fulfil the reason for disclosure but will not necessarily be all the information held by a partner agency about the Adult at Risk. The data will come from corporate information systems and will be subject to validation procedures so as to ensure data quality. Inaccuracies will be notified to originating agencies. Information will be historic in nature and therefore will not require updating. The length of time that information is required to be retained will vary depending on the case. However, once the information has been reviewed and it has been decided that it is no longer needed, it will be securely destroyed in accordance with the holding agency destruction policy. No information is to be transferred outside the UK. Therefore, compliance with this agreement should ensure compliance with the Data Protection Act Principles.

Signatory agencies will respond to any notices from the Information Commissioner that imposes requirements to cease or change the way in which data is processed.

Signatories will comply with subject access/right of access requests in compliance with the relevant legislation.

3.3 Statutory Functions

3.3.1 Crime and Disorder Act 1998

A public authority must have some legal power entitling it to share the information. The Crime and Disorder Act 1998 recognises that key authorities, such as councils and the police, have a responsibility for the delivery of a wide range of services within the community. Section 17 places a duty on them to have due regard to the need to prevent crime and disorder in their area. Section 115 provides any person with the power, but not an obligation, to disclose information to relevant authorities (e.g. the police, health or local authorities) and their cooperating bodies where this is necessary or expedient for the purposes of any provision of the Act. Information sharing through this agreement is lawful under the Act as the objectives of this agreement contribute to these purposes.

3.3.2 Section 82 of the National Health Service Act 2006

This places a duty on the NHS and local authorities to cooperate with one another in order to secure and advance the health and welfare of people. NHS bodies will properly cooperate with and consider requests to share information, where appropriate and lawful to do so, will share that information.

3.3.3 Sections 13Z3 and 14Z23 NHS Act 2006 Restrictions

These sections place a general restriction on NHS England and Clinical Commissioning Groups in sharing information with others. However, disclosures for the purposes of safeguarding are permitted by these requirements.

3.3.4 s. 251B Health and Social Care Act 2012

This section imposes a duty on the commissioners and providers of healthcare and adult social care to share information with where it is likely to facilitate the provision to the individual of health services or adult social care, and in the individual's best interests.

3.3.5 The Care Act 2014

Sections 6 and 7 of the Care Act 2014 impose a general duty of co-operation between the local authority and other organisations (including NHS bodies) providing care and support. This includes a duty on the local authority itself to ensure co-operation between its adult care and support, housing, public health and children's services.

Section 42 confers a legal power on the local authority to make enquiries in relation to Adults at Risk. As explained at section 1.3 above, this is an important area in which information sharing is provided for by this agreement.

Section 44 relates to the safeguarding adults review process and imposes an obligation on all members of the SAB to co-operate in and contribute to the carrying out of the review.

Section 45 of the Care Act 2014 imposes an obligation on organisations to comply with a request for information from a SAB for the purpose of enabling or assisting the SAB to perform its functions.

3.4 Human Rights Act 1998

3.4.1 Article 3: No torture, inhuman or degrading treatment

All statutory agencies have a pro-active responsibility to ensure that no person should be subjected to inhuman or degrading treatment. This includes Adults at Risk.

3.4.2 Article 8: The Right to Respect for Private and Family Life, Home and Correspondence

There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

Disclosing private information engages the right to respect for private life under article 8. However, effective sharing of information for the purposes set out in this agreement is to the direct benefit of the citizen and so in the public interest.

This agreement is in pursuit of a legitimate aim as it helps to protect Adults at Risk, contributes to the purposes of the Crime and Disorder Act 1998 and is in accordance with the Care Act 2014 and other similar legislation.

It is also proportionate as the amount and type of information shared will be compliant with the Data Protection Act 2018, and the minimum necessary to achieve the aims of this agreement, namely, to provide a better service and protection to Adults at Risk.

3.5 Consent

Information can be shared with the consent of the individuals concerned, or without consent in pursuance of public functions, where this is justified in the public interest (or further to statutory obligations). Obtaining consent provides one of the legal bases for sharing information in compliance with both the Data Protection Act 2018 (above) and the duty of confidence (below). As a matter of good practice, where possible, the Adult at Risk (and any third parties) should be invited to consent to the sharing of information about them, but informed that it may still be necessary to share information without consent.

3.5.1 If consent is given by the data subject then it is clear to all concerned that there is no legal obstacle to sharing information. Where reasonably practicable and appropriate, informed consent should be sought. Whilst consent will provide a clear basis on which agencies can share personal data, this is not always achievable or desirable. For example, you should not ask for consent from the individual or their family in circumstances where you think this will be contrary to the Adult at Risk's welfare (for example, if the information is needed urgently then the delay in obtaining consent may not be justified), or where seeking consent may prejudice a police investigation or may increase the risk of harm to the Adult at Risk.

3.5.2 Consent can be expressed orally or in writing, or can be inferred from the circumstances in which the information is given (implied consent). For example, a person who refers an allegation of abuse to a social worker would reasonably expect that information to be shared on a "need to know" basis with those responsible for investigating and following up the allegation. Implied consent is appropriate for the sharing of personal information however, explicit consent is required for the sharing of sensitive personal data. If there is valid consent, then it will last as long as the purposes for which that consent was given continue to exist, unless consent is withdrawn. Signatories should be aware that individuals have the right to withdraw consent at any time (therefore, with regard to Schedules 1 and 8, it is preferable to not rely on consent alone wherever possible).

3.5.3 Practitioners should encourage clients to see information sharing (and giving their consent to share their personal information) in a positive light, as something which makes it easier for them to receive the services that they need. When seeking consent, signatories should be very clear about what they are asking for consent to do, and to explain the potential ways and parties with whom information will be shared.

3.5.4 In order to ensure consent to the sharing of personal information is informed, any professional must give victims appropriate information about 'Sharing Information' at the first point of contact. It is clearly an issue of great importance as to whether an individual has provided valid consent.

3.5.5. Professionals should avoid giving absolute guarantees as to confidentiality. In such cases it should be made clear from the outset that what is said will be treated in confidence but such information may need to be passed on to other professionals who may need to know.

3.5.6 Where the data subject does not have capacity to give consent to share information, consent may be sought from someone who may appropriately act on their behalf, for example, if the adult (data subject) has previously granted an applicable power of attorney, then it is this appointed person who is able to give consent on the adult's (data subject's) behalf.

3.6 How Adults at Risk will be Assessed for their Mental Capacity to Give Consent

3.6.1 All adults are presumed to have the capacity to give or withhold their consent to the sharing of confidential information, unless there is evidence to the contrary. It is likely that a proportion of Adults at Risk whose information may be shared further to this information sharing agreement will lack the mental capacity to make particular decisions about sharing information (or more generally) for

themselves because of existing health issues or infirmity. The Mental Capacity Act 2005 provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity. The A*ct* defines a person who lacks capacity as a person who is unable to make a particular decision or take a particular action for themselves, at the time the decision or action needs to be taken, because of an impairment of or disturbance in the mind or brain.

3.6.2 Section 1 of the Mental Capacity Act sets out the five statutory principles that apply to mental capacity:

1. A person must be assumed to have capacity unless it is established that they lack capacity
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so are taken without success
3. A person is not to be treated as unable to make decisions merely because he/she makes an unwise decision
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests[9]
5. Before the act is done, or the decision made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is least restrictive of the person's rights and freedom of action

3.6.3 Signatories will deal with capacity issues in accordance with these principles. Where there is doubt or difficulties arise in relation to capacity, advice should be sought from appropriately qualified mental health professionals.

3.7 Public Interest

3.7.1 If consent to share information has not been given, a professional must consider whether there is a pressing need to disclose the information. The rule of proportionality should be applied to ensure a fair balance is achieved between the public interests in safeguarding the Adult at Risk, the provision of confidential services, and the private rights and interests of the individual affected. The same overall test is applied whether the data subject is the Adult at Risk, the suspected perpetrator of abuse or a third party.

3.7.2 Signatories understand that when considering whether disclosing the information would be in the public interest, the following criteria will be of particular relevance:

- Is there credible evidence giving reasonable cause to believe that an adult is suffering, or is at risk of suffering, serious harm?
- Is the disclosure needed to protect the vulnerable adult's vital interests?
- Is the disclosure needed to detect or prevent crime?
- Does the body seeking the information have a legitimate interest in receiving it?
- Is the extent of the information disclosed and the number of people to whom it is disclosed no greater than is required to achieve the relevant aims?
- How great is the risk if disclosure is not made?

3.7.3 When considering whether disclosure is in the public interest, the rights and interests of the individual affected by disclosure must be taken into account. Signatories should consider:

- Is the intended disclosure relevant and proportionate to the intended aim?
- What is the impact of disclosure likely to be on the individual?
- Is there another equally effective means of achieving the same aim?

[9] A 'Best Interests' checklist can be found in Section 4 Mental Capacity Act 2005

3.7.4 The more sensitive the information, the greater the need to justify disclosure and the greater the need to ensure that only those professionals who have to be informed receive the information.

3.7.5 NHS bodies will also have to consider the Department of Health Code of Practice on Confidentiality, as well as the General Medical Council Guidance, in respect of patient data they hold.

3.7.6 If information is disclosed without consent, it is essential that there is a clear record of the reasons and justification for disclosure so as to demonstrate that the decision is reasonable, proportionate and justifiable.

3.7.7 The Care Act 2014 statutory guidance advises that the first priority should always be to ensure the safety and well-being of the adult.

3.8 Duty of Confidence

3.8.1 Personal information held by public authorities is subject to a common law duty of confidence and is owed to the person who has provided information on the understanding it is to be kept confidential and, in cases of medical or other private records, the person to whom the information relates. Accordingly, much information about Adults at Risk held by Signatory Organisations will be subject to a duty of confidence.

3.8.2 The Courts have found a duty of confidentiality to exist in a number of circumstances –

- where the information is confidential in nature, is more than trivial, and is not publically known. It has been imparted in circumstances importing an obligation of confidence and it's disclosure (or use outside the expected parameters of use) would cause detriment to any person
- a contract provides for information to be kept confidential
- there is a special relationship between parties, such as patient and doctor, solicitor and client, teacher and pupil, which implies confidentiality obligations
- an agency or a Government department, such as Inland Revenue, collects and holds personal information for the specific purposes of its functions.

3.8.3 However, an obligation of confidence, including where there is a confidential relationship, is not absolute and can be overridden without breaching common law duty if:

- the information is not confidential in nature;
- the person to whom the duty is owed has given consent;
- there is an overriding public interest in disclosure (see above, **Public Interest**); or
- disclosure is required or permitted by a court order, legislation or other legal obligation.

3.8.4 Some information may not be confidential, particularly if it is trivial or readily available from other sources or if the person to whom it relates would not have an interest in keeping it secret. For example, a Social Worker who was concerned about the whereabouts of their client, might telephone a family member or employer to establish where the adult was that day.

3.9 Maintaining Confidentiality

As a general rule Signatory Organisations should treat all personal information they acquire or hold in the course of working with Adults at Risk as confidential and take particular care that sensitive information is held securely (in accordance with the protective marking afforded to it by the originating organisation). Anyone who receives information, knowing it is confidential, is also subject to the duty of confidence. Whenever Signatory Organisations give or receive information in

confidence, they should ensure that there is a clear understanding as to how it may be used if shared. Where information is shared under this agreement, the terms of this agreement provide for this.

3.10 Fair Processing

Practitioners will normally be open and honest with vulnerable adults, carers, and others about why, what, how and with whom information will or could be shared with other agencies, unless to provide this information would be inappropriate – for instance because it would increase risk unmanageably to the individuals.

3.10.1 When data is obtained from data subjects, they must, so far as practicable, be provided with, or have made readily available to them, the following information so as to ensure processing is fair to the data subject:

a) The identity of the data controller
b) If the data controller has nominated a representative for the purposes of the Act, the identity of that representative
c) The purpose or purposes for which the data are intended to be processed
d) Any further information which is necessary, taking into account the specific circumstances in which the data is or will be processed

3.10.2 Where information about a data subject has been obtained from a third party, organisations must ensure that the data subject has ready access to the fair processing information, so far as practicable, either before the data is first processed or as soon as practicable after that time. Where possible, steps should be taken to provide data subjects with the information listed above.

3.10.3 In order to comply with the above obligations, and as required by the Information Commissioners Office Registration, Signatory Organisations will have a Fair Processing Notice in place which addresses information sharing for safeguarding purposes and readily accessible for inspection by the public, and this Agreement should routinely be published.

3.11 The Caldicott Principles

The Caldicott Committee's 1997 ***Report on the review of patient-identifiable information***[10] established 6 principles for sharing information, recognising that confidential patient information may need to be disclosed in the best interests of the patient. It also discusses in what circumstances this may be appropriate and what safeguards need to be observed. This report was reviewed in 2013 adding a 7th principle. Providers and commissioners of healthcare and adult social care are expected to comply with the Caldicott Principles when sharing information.

The principles are that the **use of information** should be:

1) Justified
2) Necessary
3) Minimal
4) On a need to know basis

and that **users of information** should:

5) Understand their responsibilities
6) Comply with the law

And additionally that

7) The duty to share information can be as important as protecting patient confidentiality

[10] Report on the review of patient-identifiable information, Caldicott Committee, 1997, http://www.wales.nhs.uk/sites3/Documents/950/DH_4068404.pdf

The Caldicott principles are set out more fully in appendix D below.

3.12 Summary

Providing appropriate care is taken, there are no legal barriers that prevent the appropriate and necessary sharing of information between agencies in fulfilment of their statutory duties to safeguard vulnerable adults, provided that proper agreed procedures are followed.

Section 4 - Agreement to abide by this arrangement

The signatories to this agreement accept that the procedures laid down in this document provide a secure framework for the sharing of information between their organisations in a manner compliant with their statutory and professional responsibilities.

As such they undertake to:

- Implement and adhere to the terms of this agreement.
- Ensure that the procedures set out in this agreement are complied with.
- Ensure that all information will be shared where this is lawful and permitted by this agreement.
- Engage in a review of this agreement with the other signatories six months after its implementation and annually thereafter.

We the undersigned agree on behalf of each agency/organisation to the terms of this information sharing agreement:

Agency	Post Held	Name	Signature	Date
MPS	**[Add unit head or Partnership Inspector or other Senior Officer]**	**[Add]**	**[Only for locally kept original in General Registry File]**	**[Add date of agreement - this will set 1st review date 6 months later. Also set review date in footer↓]**
[Add a Partner e.g.- Local Authority, NHS body, etc]	**[Add person with direct responsibility for this activity - a CEO need NOT sign]**			

Appendix A – Six Key Principles of Adult Safeguarding

1. Empowerment
People being supported and encouraged to make their own decisions and informed consent.

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

2. Prevention
It is better to take action before harm occurs.

"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."

3. Proportionality
The least intrusive response appropriate to the risk presented.

"I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."

4. Protection
Support and representation for those in greatest need.

"I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."

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

"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."

6. Accountability
Accountability and transparency in delivering safeguarding.

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

Appendix B - Abuse and Criminal offences that Adults at Risk may become victims of.

Below are the main forms of abused defined.

- **physical abuse**, including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions
- **sexual abuse**, including rape and sexual assault or sexual acts to which the adult at risk has not consented, or could not consent or was pressured into consenting
- **psychological abuse**, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassmen**t**, verbal abuse, isolation or withdrawal from services or supportive networks.
- **financial or material abuse**, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits
- **neglect and acts of omission**, including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating
- **Discriminatory abuse**, including racist, sexist, that based on a person's disability, and other forms of harassment, slurs or similar treatment.

A number of the other most significant laws relating to abuse faced by Adults at Risk are:

- **The Domestic Violence, Crime and Victims Act 2004** explicitly states that it is a criminal offence to physically or sexually abuse, harm or cause deliberate cruelty by neglect of a child or an adult. This legislation was introduced, in part, to emphasise the crime of abuse between partners within the home.
- **Mental Capacity Act 2005.** Creates an offence of ill-treatment or wilful neglect of a person lacking capacity by anyone responsible for that person's care.
- **Offences Against The Persons Act 1861** including grievous bodily harm with intent, grievous bodily harm, chokes /suffocates/strangles, unlawfully applies drugs with intent to commit indictable offence, poisoning with intent to endanger life/cause GBH or with intent to injure, aggrieve or annoy and assault occasioning actual bodily harm.
- **Criminal Justice Act 1988** including Common assault,
- **Medicines Act 1968** including: Unlawfully administering medication, injuriously affecting the composition of medicinal products
- **The Sexual Offences Act 2003**
- **Public Order Act 1986** including affray, fear or provocation of violence, intentional harassment, alarm or distress, and harassment/alarm or distress
- **Protection from Harassment Act 1977** including course of conduct amounting to harassment, injunctions against harassment, and course of conduct that causes another to fear.
- **Theft Act 1968** including dishonest appropriation of property, robbery, burglary dwelling house, blackmail
- **Mental Health Act 1983** including ill treatment or neglect of mentally disordered patients within hospital or nursing homes or otherwise in persons custody or care and unlawful sexual intercourse with patients/residents suffering mental disorder.

- **Criminal Justice and Courts Act 2015 sec 20-25 -** offences involving ill treatment or wilful neglect
- **Modern Slavery Act 2015 Section 52 –** duty to notify Secretary of State about suspected victims of slavery or Human Trafficking

Appendix C - The National Standards - Headline Standards [11]

Standard 1	Each local authority has established a multi-agency partnership to lead 'Safeguarding Adults' work
Standard 2	Accountability for and ownership of 'Safeguarding Adults' work is recognised by each partner organisation's executive body.
Standard 3	The 'Safeguarding Adults' policy includes a clear statement of every person's right to live a life free from abuse and neglect, and this message is actively promoted to the public by the Local Strategic Partnership, the 'Safeguarding Adults' partnership, and its member organisations.
Standard 4	Each partner agency has a clear, well-publicised policy of Zero-Tolerance of abuse within the organisation.
Standard 5	The 'Safeguarding Adults' partnership oversees a multi-agency workforce development/training sub-group. The partnership has a workforce development/training strategy and ensures that it is appropriately resourced.
Standard 6	All citizens can access information about how to gain safety from abuse and violence, including information about the local 'Safeguarding Adults' procedures.
Standard 7	There is a local multi-agency 'Safeguarding Adults' policy and procedure describing the framework for responding to all adults "who are or may be eligible for community care services" and who may be at risk of abuse or neglect.
Standard 8	Each partner agency has a set of internal guidelines, consistent with the local multi-agency 'Safeguarding Adults' policy and procedures, which set out the responsibilities of all workers to operate within it.
Standard 9	The multi-agency 'Safeguarding Adults' procedures detail the following stages: Alert, Referral, Decision, Safeguarding assessment strategy, Safeguarding assessment, Safeguarding plan, Review, Recording and Monitoring.
Standard 10	The safeguarding procedures are accessible to all adults covered by the policy.
Standard 11	The partnership explicitly includes service users as key partners in all aspects of the work. This includes building service-user participation into it's: membership; monitoring, development and implementation of its work; training strategy; and planning and implementation of their individual safeguarding assessment and plans.

[11] Safeguarding Adults ADSS, 2005

Appendix D –
Caldicott Principles (September 2013) – Health and Social Care

Principle 1
Justify the purpose(s)
Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed by an appropriate guardian.

Principle 2
Don't use personal confidential data unless it is absolutely necessary
Personal confidential data should not be included unless it is essential for the specified purposes of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s)

Principle 3
Use the minimum necessary personal confidential data
Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data transferred or accessible as is necessary for a given function to be carried out

Principle 4
Access to personal confidential data should be on a strict 'need to know' basis
Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes

Principle 5
Everyone with access to personal confidential data should be aware of their responsibilities
Action should be taken to ensure that those handling personal confidential data – both clinical and non-clinical staff – are made fully aware of their responsibilities and obligations to respect patient confidentiality

Principle 6
Comply with the law
Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements

Principle 7
The duty to share information can be as important as the duty to protect patient confidentiality
Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies

Appendix F - Confidentiality Statement

Meeting confidentiality statement / ISP Summary Brief

Chair		Date of Meeting	

Information discussed by the agency representatives, within the ambit of this meeting, is strictly confidential and must not be discussed with or disclosed to third parties.

All agencies should ensure that all minutes and related documentation are retained in a confidential manner in accordance with the classification afforded to them.

These minutes will aim to reflect that all individuals who are discussed at these meetings should be treated fairly, with respect and without improper discrimination. All work undertaken at the meetings will be informed by a commitment to equal opportunities and effective practice issues in relation to age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

THE PURPOSE OF THE MEETING IS AS FOLLOWS:

- To share information to increase the safety, health and well- being of victims – adults and their children;
- To construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm;
- To reduce repeat victimisation;
- To improve agency accountability; and
- Improve support for staff involved in high risk cases.

BY SIGNING THIS DOCUMENT, WE AGREE TO ABIDE TO THESE PRINCIPLES.

Meeting Confidentiality agreed / ISP Agreed (attendees)

Agency	Name of Representative	Signature	Email

Appendix G

Partners Contacts List for Critical Enquiries, Escalations and Incidents of Security Breaches

(to be completed locally – examples below)

Data Protection Officer

[Enter Partner name] – [Enter Role/Title/Rank]
Tel: Email:

[Enter Partner name] – [Enter Role/Title/Rank]
Tel: Email:

[Enter Partner name] – [Enter Role/Title/Rank]
Tel: Email:

Caldicott Guardian

[Enter Partner name] – [Enter Role/Title/Rank]
Tel: Email:

[Enter Partner name] – [Enter Role/Title/Rank]
Tel: Email:

[Enter Partner name] – [Enter Role/Title/Rank]
Tel: Email:

Critical Enquiries

Escalations

Appendix H- Data Protection Act 2018 Six Principles

Principle 1	The first data protection principle states that data must be processed lawfully and fairly.
Principle 2	Personal data shall be collected for specified, explicit and legitimate purposes and not further processed in a manner that is incompatible with those purposes.
Principle 3	Personal data shall be adequate, relevant and limited to the necessities of the purposes for which they are processed.
Principle 4	Personal data shall be accurate and, where necessary, kept up to date.
Principle 5	Personal data must not be kept for longer than is necessary for the purpose for which it is processed.
Principle 6	Personal data shall be processed in a manner that ensures the appropriate security of the personal data.

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