NHS Brent Clinical Commissioning Group

Checklist for the Review and Approval of Procedural Documents

To be completed and attached to any document which guides practices when submitted to the appropriate committee for consideration and approval.

	Yes/No/ Unsure	Comments
Title of Document		Safeguarding Adult Policy
Could this policy be incorporated within an existing policy?	No	
Does this policy follow the style and format of the agreed template?	Yes	
Has the front sheet been completed?	Yes	
Is there an appropriate review date?	Yes	
Does the contents page reflect the body of the document?	Yes	
Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	
Are all appendices appropriate and/or applicable?	Yes	
Have all appropriate stakeholders been consulted?	Yes	
Has an Equality Impact Assessment been undertaken?	Yes	
Is there a clear plan for implementation?	Yes	
Has the document control sheet been completed?	Yes	
Are key references cited and, supporting documents referenced?	Yes	

Does the document identify which Committee/Group will approve it?	Yes	

Individual Approval

This document is approved for forwarding to the committee/group.

Name		Date	

Committee Approval

This document has been approved and can be forwarded to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.

Name	Integrated Governance Committee	Date	17/10/2018

Safeguarding Adult Policy

DOCUMENT HISTORY

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Name of Author	Joy Maguire Designated Nurse for Safeguarding Adults
Responsible Director	Diane Jones, Chief Nurse / Director of Quality
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Version No.	Date	Changes Made:
0.1	December 2015	Initial model version
0.2	February 2016	Nicky Brown John (BHH)
0.3	June 2017	Updated by Norma Johnson Criteria of Abuse and Adult Safeguarding, Intercollegiate Training Document NHS England in 2016 and Role clarity for CCG
0.4	June 2018	Joy Maguire all aspects

1. Introduction

This policy sets out the safeguarding responsibilities for those directly employed by the Clinical Commissioning Group to ensure that, in their role of commissioning and improving the health of their population, they promote and respond to the welfare and safeguarding of adults who are in need of care and support. The policy has been developed to support NHS Brent CCG in its commissioning role with providers across the health economy and any provider function undertaken by the CCG. This is not a replacement for the safeguarding adult procedures as set out in the London Multi-agency Guidelines.

NHS Brent Clinical Commissioning Group (CCG) is committed to working with partner agencies to safeguard adults at risk. Protecting the adults at risk is a key part of our approach to commissioning and together with a focus on quality and patient experience, is integral to how we work. Our approach to safeguarding is underpinned by a performance management culture, contracting systems and processes that aim to reduce the risk of harm and respond quickly to any concerns. People have fundamental rights contained within the Human Rights Act 1998, NHS Brent CCG as a public body has statutory obligations to uphold these rights and protect patients who are unable to do this for themselves by commissioning high quality safe services for the population of Brent and to work closely with partner agencies to ensure a coherent policy for the protection of adults experiencing, or at risk of, abuse or neglect.

NHS Brent CCG have a responsibility to ensure that clear arrangements are in place with health providers they commission from (including those subcontracted to deliver commissioning services on behalf of the CCG) as well as any provider services delivered directly by the CCG to safeguard and promote the welfare of adults at risk of abuse or neglect. It is the expectation that health providers must have their own safeguarding adults' policies and procedures which must be reflective of current national practice/guidance.
Accountability and Responsibility of the Clinical Commissioning Groups

The NHS Accountability and Assurance Framework 2015 sets out that CCGs are required to ensure that they have appropriate systems in place for discharging their responsibilities in respect of safeguarding, including:

- Plans to train their employees in recognising and reporting safeguarding issues
- A clear line of accountability for safeguarding, properly reflected in the CCG governance arrangements.
- Appropriate arrangements to co-operate with local authorities in the operation of Safeguarding Adult Boards (SAB).
- Ensuring effective arrangements for information sharing

Link to Brent CCG vision **http://brentccg.nhs.uk/en/about-us/our-vision**

The Care Act 2014 provides a clear legal framework for how CCGs are to work in partnership with other public services to protect adults at risk, placing safeguarding adults on the same statutory footing as Safeguarding Children. Lessons from recent inquiries such as the failings identified at Mid-Staffordshire NHS Foundation Trust, Winterbourne View Nursing Home and the inquiry into Jimmy Saville have highlighted the importance and need to make safeguarding integral to care and of having robust safeguarding policies and

procedures in place. Prevention and effective responses to abuse and neglect need to be addressed in all aspects of commissioning and the business work of the CCG.

Safeguarding is linked to the NHS Outcomes Framework in terms of:

- Domain 4 – ensuring people have a positive experience of care and
- Domain 5 – Caring for people in a safe environment and protecting them from harm.

The CCG is one of three statutory members of the Safeguarding Adults Board (SAB) and, therefore, has a responsibility to work with the other statutory members (Local Authority and police) to ensure that SAB has sufficient resources to deliver its functions. The Department of Health Guidance 'Safeguarding Adults: The Role of Commissioners' (March 2011) sets the expectation that NHS commissioners must work proactively with all contractors and service providers to ensure safeguarding arrangements are in place that maintain the safety and wellbeing of those adults who are contractually under the care of the NHS.

NHS Brent CCG must operate and discharge their duties in relation to adult safeguarding under the Multi-Agency Safeguarding Adults Policy and Procedures (Dec 2016). This provides a framework for the CCGs to apply the health contribution for safeguarding adults that is discharged effectively across the health economy through the CCGs' commissioning arrangements, including joint commissioning with the LA.

2. Purpose

This policy sets out the key arrangements and systems the CCGs must have in place for safeguarding and promoting the welfare of adults. These arrangements follow Care Act 2014 guidance which sets out the requirements for statutory, voluntary and independent sector agencies to work together to produce policy, guidance and training about working with adults in need of safeguarding.

All commissioners and contractors have to assure themselves that care providers know about and adhere to relevant CQC Standards. Contract monitoring must have a clear focus on safeguarding and robustly follow up any shortfalls in standards or other concerns about patient safety. Commissioners must also want to assure that when abuse or neglect occurs, responses are in line with local multi-agency safeguarding procedures, national frameworks for clinical governance and investigating patient safety incidents. Therefore these services must produce clear guidance to managers and staff that sets out the processes for initiating action and who is responsible for any decision making.

3. Application and Scope

This policy applies to all employees and workers of NHS Brent CCG, including all staff (temporary or permanent) within the CCG involved in commissioning or delivery of services and also the independent practitioners who deliver services on behalf of the CCGs. For ease of reference, all employees and workers who fall under these groups will be uniformly referred to as "CCG staff" in this document.

4. Legislations and NHS Outcome Framework

People have fundamental rights contained within the Human Rights Act 1998.
Health services have positive obligations to uphold these rights and protect patients who are unable to do this for themselves.

Other legislations relevant to safeguarding adults includes in the table below:

Care Act 2014	Female Genital Mutilation Act (2003)	Mental Health Act 1983 (amended 2007)
Mental Capacity Act 2005	Domestic violence protection orders 2010	Deprivation of Liberty Safeguards (2009)
Modern Slavery Act 2015	Counter Terrorism and Security Act (2015)	Equality Act 2010
Criminal Justice and Courts Act (2015)	Data Protection Act 1998	Human Rights Act (1998)

5. What is safeguarding

Safeguarding is defined as 'protecting an adult's right to live in safety, free from abuse and neglect' (Care Act, 2014). Safeguarding Adults is about preventing and responding to concerns of abuse, harm or neglect of adults. Professionals should work together in partnership to ensure adults 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 to easily get the support, protection and services that they need.

5.1. The aims of safeguarding adults

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

5.2. Who is an adult at risk?

The Care Act 2014 defined an adult at risk as a person over the age is 18 years and who:

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

The above conditions also apply to a person aged 18 or over who are still receiving children's services. It is clear within the Care Act 2014 that safeguarding matters in these cases should be dealt with through adult safeguarding procedures, with involvement from children's safeguarding, NHS and police, as necessary.

The Care Act 2014 introduces a duty to promote wellbeing when carrying out any care and support functions in respect of a person. This is sometimes referred to as "the wellbeing principle" because it is a guiding principle that puts wellbeing at the heart of care and support.

5.3. 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;

Appendix 1: Types and indicators of abuse and neglect

6. Six Principles of Safeguarding

The six core safeguarding principles and the associated 'I' statements

These principles can be used by the safeguarding adult board and partner organisations to review, examine and improve local arrangements, both at practice and strategic levels. The principles apply to all sectors and settings and must inform the ways in which professionals and other staff work with adults.

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.'
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.'

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.'
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.'
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 treats 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.'
Accountability: Accountability and transparency in delivering safeguarding.	'I understand the role of everyone involved in my life and so do they.'

7. Mental Capacity

The Mental Capacity Act 2005 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. It makes it clear who can take decisions in which situations and how they should go about this. It enables people to plan ahead for a time when they may lose capacity. It applies to anyone aged 16 years and over, therefore appropriate liaison needs to occur for young people.

All decisions taken in the adult safeguarding process must comply with the Act. Mental Capacity refers to the ability to make a decision about a particular matter at the time the decision is needed.

The Mental Capacity Act 2005 outlines five statutory principles 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 / she 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.

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. 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.

Brent CCG has a legal responsibility to ensure that all providers from whom it commissions services are compliant with the MCA and Deprivation of Liberty Safeguards (DoLs) and must regularly monitor providers to ensure their compliance with the Act.

NHSE produced MCA GP resource 'my next patient may lack capacity'.

http://www.asist.co.uk/assets/uploads/PDF/My_next_patient_lacks_capacity_pack_17-12-14_NAT.pdf

All healthcare professionals have a legal duty to adhere with the Mental Capacity Act and its Code of Practice (DoH 2005), which has its guidance on its implementations. It is expected under the Act to use the 'Best Interest Decision', if the patient does not have capacity. This implies that healthcare professionals should take the views of others, such as carers, relatives, friends, advocates and to reflect the least restrictive options when taking decisions. Mental Capacity Act 2005 section 3, Code of Practice 4.49 – 4.54

Section 3 states that a person is unable to make a decision if s/he is unable

- To understand the information relevant to the decision
- To retain the information
- To use or weigh that information as part of the process of making the decision
- To communicate his decision by any means.

7.1 Lasting powers of attorney: The Act allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future. This allows people to let an attorney make health and welfare and / or financial decisions. The latter is similar to previously available Enduring Power of Attorney (EPA).

7.2 Court appointed deputies: The Act provides for a system of court appointed deputies. Deputies will be able to take decisions on welfare, healthcare and financial matters as authorised by the Court but will not be able to refuse consent to life-sustaining treatment. They will only be appointed if the Court cannot make a one-off decision to resolve the issues.

7.3 Advance decisions to refuse treatment: Statutory rules with clear safeguards confirm that people may make a decision in advance to refuse treatment if they should lose capacity in the future. It is made clear in the Act that an advance decision will have no application to any treatment, which a doctor considers necessary to sustain life, unless strict formalities have been complied with. These formalities are that the decision must be in writing, signed and witnessed. In addition, there must be an express statement that the decision stands 'even if life is at risk'.

7.4 Independent Mental Capacity Advocate (IMCA)

The purpose of the Independent Mental Capacity Advocacy Service is to help particularly adults at risk who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about those decisions. The role of the Independent Mental Capacity Advocate (IMCA) is to work with and support people who lack capacity, and represent their views to those who are working out their best interests.

The Department of Health has extended the Act through Regulations to cover circumstances where a safeguarding adult's allegation has been made. The Regulations specify that Local Authorities and the NHS have powers to instruct an IMCA if the following requirements are met:

- Where safeguarding measures are being put in place in relation to the protection from abuse of adults at risk; and
- Where the person lacks capacity.

In these circumstances, the Local Authority or NHS providers must instruct an IMCA to represent the person concerned, if it is satisfied that it would be of benefit for the person to do so.

The tables below are services that offer IMCA in Brent.

To make a referral to the advocacy services in Brent, you can download the forms below: Independent Mental Capacity Advocacy (IMCA) referral form

You can get an advocate, or for more information, advice and support in your area, you can contact us on **0300 456 2370** or email pohwer@pohwer.net. https://www.pohwer.net/brent

VoiceAbility IMCA Referral Line is: **0845 017 5198**
https://www.voiceability.org/services/london-borough-of-brent

8. Deprivation of Liberty Safeguards (DoLs)

The Deprivation of Liberty Safeguards are an amendment to the Mental Capacity Act 2005. The Mental Capacity Act allows restraint and restorations to be used – but only if they are in a person's best interests and for their own safety. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards.

"Deprivation of liberty" is a term originating from the European Convention on Human Rights and it effectively means "detention". A person who is detained is said to be "deprived of liberty". **The Supreme Court holds that a person is deprived of their liberty if: they are confined in a particular restricted space for a not-negligible length of time; they are subject to continuous supervision and control; and they are not free to leave;** the state is responsible for that confinement (NHS Trusts and Local Authorities are considered

part of “the state”). The criteria above are called the “acid test” for identifying deprivations of liberty. How the “acid test” should be interpreted is different from situation to situation. A patient’s “Supervisory Body” is the Local Authority in which the person is ordinarily resident. Each Local Authority will have a “DoLS Office” to which DoLS forms should be sent. Care homes or hospitals must ask either a local authority or health body if they can deprive a person of their liberty. This is called requesting a standard authorisation (and in some cases, an urgent authorisation).

Although DoLs issues would not normally be considered through the safeguarding adults route, there may be occasions when the consequences or implications of bad practice should be considered. Issues that might prompt consideration of raising a safeguarding concern would be if applications are not being initiated by the organization, where the conditions of the authorisation are not being complied with, where the least restrictive interventions are not being applied or where someone’s human rights are not being respected. Note: a Deprivation of Liberty should not be used as a means of restricting a person’s access to family and/or friends.

8.1 Court Of Protection: The Court of Protection deals with disputes or serious decisions relating to the MCA. It can also make orders authorising deprivations of liberty outside of hospital and care home setting, and for 16 and 17 year olds**.** Court of Protection has jurisdiction relating to the whole Act and will be the final arbiter for capacity matters. It has its own procedures and nominated judges.

8.2 Liberty Protection Safeguards (LiPS)

In March 2017, the Law Commission produced its final proposal on a replacement for the Deprivation of Liberty Safeguards (DoLS), and suggested amendments to the Mental Capacity Act itself. The changes to the act are to incorporate the new scheme, called the Liberty Protection Safeguards (LiPS), and to strengthen people’s rights in areas such as best interest decisions. Read more: Liberty Protection Safeguards.
The proposed scheme:

Applies in any health and social care setting, not just care homes and hospitals. It applies to anyone from **16 years old and above, rather than 18**, as is the case with DoLS.

This will require authorizations be in place in advance of any deprivation of liberty and will apply to those aged 16 across if necessary, multiple settings. Under the proposals, the new scheme will see **Hospital Trusts, CCGs and Local Authorities** become responsible bodies able to authorise deprivations following a capacity assessment, medical assessment and necessary and proportionate assessment. Authorisations could apply even where someone’s capacity fluctuates; and a responsible body should in some circumstances be able to rely on previous capacity and medical assessments.

The proposal introduces a two-tier system of protection. In most cases, the “responsible body” (which replaces the supervisory body, and which would be the local authority in most social care cases, and the NHS for most hospitals) would conduct – making use of existing assessments where possible – a capacity assessment, a medical assessment, and an assessment of whether the planned care arrangements are “necessary and proportionate”.

An independent reviewer, working for the responsible body but not otherwise involved in the person's care, would then look at the assessments, and approve the arrangements if satisfied. An Approved Mental Capacity Professional (replacing the Best Interests Assessor role) would only be called in on those cases where the person was objecting to their care arrangements, or had made previous statements that would indicate a likely objection to their care arrangements. **This proposal is still under review.**

A patient's Supervisory Body will be the borough they are ordinarily resident.

The local DoLS offices is: **Brent Local authority**

Phone Number Mon – Fri 9am-5pm 020 8937 4098/4099 Out of Hours- 020 8937 4300 or fax to 0208 937 4027

Contact details for the DoLs team are: dols@brent.gov.uk You can also please visit the http://www.brent.gov.uk or for more information about

safeguarding adults open the following;
https://www.brent.gov.uk/media/251071/safeguarding%20leaflet%20FINAL.PDF

9. Pressure Ulcers

Management of pressure ulcer: working together to put the patient at the Centre of care. Prevention of pressure ulcers is not only ideal but, in most cases, perfectly possible. Taking a proactive approach will reduce harm to individuals and secure efficiencies to the wider health and social care system. 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 outlines how the NHS investigates pressure ulcers.

NHS Brent CCG (member of the NW London Collaboration of CCGs) has adopted DH Safeguarding Adults Protocol. The principles of the safeguarding adult decision guide are used to assess all grade 3, 4, unstageable deep tissue injuries or multiple sites of grade 2 damage pressure ulcers.

10. PREVENT

In April 2015, the Prevent Statutory Duty under Section 26 of the Counter-Terrorism and Security Act 2015 was made a statutory responsibility for the health sector.

There are four key principles:

Principles	Description
Protect	To strengthen our protection against a terrorist attack
Prepare	To mitigate the impact of a terrorist attack
Pursue	To disrupt or stop terrorist attacks
Prevent	To stop people becoming terrorists or supporting terrorism

This statutory responsibility aims to reduce the threat to the UK from terrorism by stopping people becoming or been drawn into terrorist acts or extremism and to divert vulnerable people from radicalisation. Prevent is part of the UK's Counter Terrorism Strategy known as CONTEST. Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity. Radicalisation is a psychological process where vulnerable and/or susceptible individuals are groomed to engage into criminal, terrorist activity.

The Prevent Programme is designed to safeguard people in a similar way to safeguarding processes to protect people from gang activity, drug abuse, and physical and sexual abuse. Tailored support for any individual identified as being vulnerable to being drawn into terrorism is offered through the Voluntary Channel programme. This is a local authority led multi-agency panel, which decides on what the most appropriate support package for that person will be. Prevent is part of mainstream safeguarding and therefore all health staff must ensure vulnerable people are safeguarded.

The NHS Standards Contract requires all NHS funded providers to demonstrate they comply with the requirements of the Prevent Duty. This includes ensuring that there is a named Prevent Lead and that there is access to quality training for staff in their organization. The Safeguarding Team represents the CCG at Channel meetings and the team work in partnership with the Safeguarding Children's Team where appropriate.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445977/3799_Revised_Prevent_Duty_Guidance__England_Wales_V2-Interactive.pdf

NHS Brent CCG Designated Nurse for Safeguarding Adults is also the Prevent lead who acts as a single point of contact for the CCG. NHS providers prevent leads are responsible for raising awareness of prevent within their respective organisations.

Competency can be acquired by attending a Workshop to Raise Awareness of Prevent (WRAP) or by completing an approved e-learning package. Ongoing: Organisations should ensure that staff is provided with appropriate updating/briefing on Prevent at least yearly; relevant training may also be accessed in a number of ways at local, regional or national level and may be multi-disciplinary or inter-agency, all training and development undertaken should be recorded on completion.
e-Learning (e-Learning for Healthcare) Preventing Radicalisation Level 3: https://portal.e-lfh.org.uk/Component/Details/511790

The CCG has Prevent policy, which should be read in conjunction with this policy.

Further details can be found in Prevent Training and Competencies Framework
https://www.england.nhs.uk/wp-content/uploads/2017/10/prevent-training-competencies-framework-v3.pdf

You can read the CONTEST strategy in full at www.homeoffice.gov.uk.

11. Safeguarding - Provider Concerns

Provider Concerns refer to issues that affect a group of people, for example adults living in a care setting. 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.

Safeguarding is everyone's business. By working in partnership, we can assist early identification if providers are at risk of falling standards that might lead to wider concerns and the need for safeguarding intervention. 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 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.

Principles

- The safety and well-being of people using the service is paramount.
- Strong partnerships that acknowledge the expertise of others.
- Openness and transparency to achieve positive outcomes.
- Joint accountability
- Wise targeted use of resources
- Information shared responsibly

Six Step Process below

12. Modern Slavery

Modern Slavery – The Modern Slavery Act 2015 encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment. Trafficking is the movement of people by means such as force, fraud, coercion or deception with the aim of exploiting them. People can be trafficked for many different forms of exploitation such as forced prostitution, forced labour, forced begging, and forced criminality, forced marriage, domestic servitude, forced marriage, forced organ removal. Trafficking can occur within the UK as well as countries outside the UK. **See Appendix 2 for more information on Modern slavery**

13. Learning Disabilities Mortality Review Programme

NHS England is committed to making sure that people with learning disabilities receive the right care in the right settings, with the right support. This is one of the national priorities. There is the need to understand and reduce health inequalities amongst this group, which is why; the Learning Disabilities Mortality Review (LeDeR) Programme is commissioned.
The LeDeR programme is the first of its kind in the world and is managed by the University of Bristol, Funding is provided by NHS England. People with learning disabilities are four times as likely to die of preventable causes compared with the general population (Disability Rights Commission, 2006).

Following the Confidential inquiry into premature deaths of people with learning disabilities (CIPOLD, 2013) one of the key recommendations was the establishment of a national learning disability mortality review to understand the circumstances leading to a death and whether such deaths could potentially be avoided in the future through improvements to health and care services. The LeDeR programme was subsequently established and has very clear aims to help reduce these health inequalities.

13.1 Mortality review

People with a learning disability, autism or both often have poorer physical and mental health than other people. To help this programme make the most difference, there is need to know about as many deaths of people with a learning disability, autism or both as possible.

Reporting the death of a person with learning disabilities

Anyone can notify NHS of a death online: https://www.bris.ac.uk/sps/leder/notification-system/

Or filling in the easy online form

Or

Calling 0300 777 4774.

The University of Bristol will contact NHS Brent CCG who will allocate a reviewer to look at what happened in more detail.

The LeDeR programme aims to support services in Brent to review the deaths of people with a learning disability to identify common themes and learning points and provide support to the development of action plans to take forward the lessons learned.

There are two specific ways that healthcare professionals may be involved in the LeDeR Programme:

- One is to notifying the death of any of their patients with a learning disability.
- To input into a review into the circumstances leading to the death, of those aged 4 years and over. This may involve sharing information about a patient who has died or participating in a multi-agency review where knowledge and perspectives in primary care will be of significant importance.

The LeDeR programme strives to ensure that reviews of deaths lead to learning which will result in improved health and social care services for people with learning disabilities. It is not an investigation nor is it aimed at holding any individual or organisation to account. If individuals and organisations are to be able to learn lessons from the past it is important that the reviews are trusted and safe experiences that encourage honesty, transparency and the sharing of information in order to obtain maximum benefit from them.

For more information and latest news on the programme visit the University of Bristol's website, email leder-team@bristol.ac.uk or call 0117 331 0686.

14. Making Safeguarding Personal (MSP)

What is Making Safeguarding Personal?

Making Safeguarding Personal sits firmly within the Department of Health's Care and Support Statutory Guidance, as revised in 2017. It means safeguarding adults:

- is person-led
- is outcome-focused
- engages the person and enhances involvement, choice and control improves quality of life, wellbeing and safety.

This is a 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. It is about seeing people as experts in their own lives and working alongside them in a way that is consistent with their rights and capacity and that prevents abuse occurring wherever possible. Safeguarding should be person-led and outcome focused, engaging the adult at risk 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.
It is also important that all safeguarding partners take a broad community approach to establishing safeguarding arrangements. The key principle of MSP is to support and empower each adult to make decisions about how they want to live their own life. MSP focuses on achieving meaningful improvements to people's lives to prevent abuse and neglect occurring in the future, including ways for them to protect themselves. People are individuals with a variety of different preferences, histories, circumstances and life-styles; so safeguarding arrangements should not prescribe a process that must be followed whenever a concern is raised, but instead take a more personalised approach. For more info see link below:

https://www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/making-safeguarding-personal

15. Multi-Agency Risk Assessment Conference (MARAC)

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 authority, usually chaired by the police, where statutory and voluntary sector partners work together. MARAC considers cases identified as 'high risk' and develops a coordinated

safety plan to protect each victim. This might include the actions agreed for any children, adults, and for perpetrators.

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.

16. Safeguarding Adult Reviews

In cases where an adult dies as a result of abuse or neglect, or suffers significant harm or abuse and it is believed that the death, abuse or harm was due to a lack of collaborative working between agencies the Safeguarding Adult Board (SAB) must undertake a Safeguarding Adult Review (SAR).

All relevant agencies are expected to participate in SARs and provide a chronology of involvement and any requirements of the review model commissioned by the SAB. This participation extends to and includes all professionals who had some involvement or contact with the adult including health, police, social services, housing and other partners as determined by SAB. The learning from SAR will be shared with all relevant parties and any actions identified closely monitored by the SAB.

17. 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 high 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

18. 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. The responsible authorities in respect of MAPPA are the Police, Prison and Probation Services who have a statutory duty to ensure that MAPPA is established in each of their geographic areas and to undertake the risk assessment and management of all identified MAPPA offenders. Other organizations have a duty to co-operate with the responsible authority, including the sharing of information.

19. Serious Incident and Safeguarding Adult Concern

It is important that when a Serious Incident occurs within commissioned health services, it is considered for a possible safeguarding concern. 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 appropriate response to a safeguarding enquiry. There are incidents that are reported on 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.

20. Children and Young People

Section 11 of the Children Act 2004 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.

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. Staff providing services to adults, children and families should have appropriate training whereby they are able to identify risks and abuse to children and adults at risk.

All Children will have parents or a significant adult in their lives– if you have a concern regarding an adult -THINK how will this affects the CHILD.

Think Child – Think Parent – Think Family

http://londonadass.org.uk/wp-content/uploads/2015/02/LONDON-MULTI-AGENCY-ADULT-SAFEGUARDING-POLICY-AND-PROCEDURES.pdf

21. The Care Quality Commission

The Care Quality Commission is the independent regulator of health and social care in England. Their aim is to make sure better care is provided for everyone, whether that's in hospital, in care homes, in people's own homes, or elsewhere. The Care Quality Commission regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. They also protect the rights of people detained under the Mental Health Act. The Commission makes sure that essential quality standards are being met where care is provided and work towards the improvement of services. It promotes the rights and interests of people who use care services and has a wide range of enforcement powers to take action on their behalf if services are unacceptably poor. For further information about The Care Quality Commission visit:

http://www.cqc.org.uk/sites/default/files/media/documents/201202-cqc-about_us.pdf

22. Roles and Responsibilities

22.1 Local Authority (LA)

According to the Care Act 2014, if the Local Authority becomes aware of a situation that meets the criteria of Section 42 enquiries; it must make or arrange an enquiry under Section 42 of the Care Act 2014. '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 and, if so, what and by whom.' The aim is to provide swift and personalised safeguarding responses, involving the adult at risk in the decision making process as far as possible.

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 could undertake an additional enquiry, for example, if the original fails to address significant issues.

In some safeguarding cases, the degree of involvement of LA 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.

22.2 The Police engagement in Safeguarding

Consultation with the Police at the earliest possible point is essential when alleged abuse or neglect may be a criminal offence. It is important for the Police and the local authority to formulate a collaborative approach identifying what each are to do. Early involvement of the Police will help ensure that forensic evidence is not lost or contaminated, and may prevent the alleged abused adult being interviewed unnecessarily on subsequent occasions. Any police investigation will be planned alongside managing and dealing with the health and social care issues.
Staff contact with the police will fall mainly into four main areas:

- Reporting a crime – if an individual witnesses a crime, they have a duty to report it to the police;
- 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);
- Consultation with the police – seeking advice;
- 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.

22.3 All Provider Organisations

All providers have a duty of care for the people for whom services are provided. The duty includes having relevant policies and practices to prevent abuse occurring. If abuse does occur staff must record information and a referral must be made to safeguarding team Brent council. There is an expectation that all residential care homes / nursing homes and domiciliary care agencies participate in a cooperative and timely manner with the Local Authority.

22.4 NHS Brent CCG

Is one of the three statutory core partners of the Safeguarding Adult Board, and must ensure its NHS commissioned providers meets their responsibilities through its commissioning arrangements with them. The CCG staff working with the Continuing Healthcare (CHC) team must have adult safeguarding training that is relevant to their sphere of responsibility and role. It is the responsibility of the CHC manager and individual staff members in the CHC team to ensure they have the necessary adult safeguarding skills in order to undertake their role. Safeguarding adults is a collective responsibility and it is important that all staff members within the CCG are aware of their responsibilities.

Safeguarding adults is a fundamental part of the commissioning strategy with systems and processes in place that set safeguarding adults into all parts of the commissioning cycle. Systems and processes should be in place that enables assurance to be sought, making sure contracts are clear and detailed in respect of the service specification and provider duties in respect of safeguarding adults.

22.5 NHS Brent CCG's Governing Body

They ensures adult safeguarding and promoting the welfare of adults experiencing or at risk of abuse and neglect is implemented effectively across the local health economy, both through commissioning arrangements and through the responsibilities of commissioned provider services' boards and committees. The Governing Body will receive an annual adult safeguarding report and be kept informed of adult safeguarding enquiries and issues. Ensuring that the health contribution to safeguarding from all commissioned service providers is discharged effectively, monitored for early warning signs of issues, responded to robustly and assurance gained on high quality care across the whole health economy. Ensuring the culture of the organisation is to promote safeguarding by enabling issues to be addressed, actions taken and outcomes properly recorded.

22.6 NHS Brent CCG Managing Director: has overall accountability for ensuring that the CCG has appropriate strategies, structures, policies and procedures in place to ensure that adults experiencing or at risk of abuse and neglect are safeguarded and that the commissioned provider services comply with relevant national legislation and discharge their duties effectively. The CCG Chief Operating Officer must sign off the CCG's strategic plan and annual report.

22.7 NWL CCGs Chief Nurse / Director of Quality: is the Board Executive Lead with responsibility for ensuring that adult safeguarding is represented at Board Level. They will act as a champion in the CCG's vision and responses and provide high-level support for the CCG in leadership positions related to adult safeguarding issues. They are accountable for

ensuring strategic ownership of adult safeguarding, providing feedback to the Board on all adult safeguarding activity and the effective implementation of the adult safeguarding policy, and a member of the local Adult Safeguarding Board.

22.8 NHS Brent CCG Designated Nurse for Safeguarding Adults: is the strategic, and professional with responsibility for providing senior clinical leadership and overseeing the development of adult safeguarding governance, systems and organisation. Focus to ensure robust assurance arrangements and monitoring systems are in place within the CCG and the wider health economy, and reports progress to the Board. Ensuring learning from local adult safeguarding issues, as well as regional and national inquiries and cases, is used by the CCG to improve care for patients through commissioning and their member practices.
Other roles bellow:

- MCA Dols lead
- Prevent lead.
- The Local Area Contact for Learning Disabilities Mortality Review

22.9 NHS Brent CCG staff: are responsible for actively co-operating with managers in the application of this policy to enable the CCG to discharge its legal obligations. Have a responsibility to play a part in the prevention, detection and reporting of neglect and abuse. As such, responsibilities include:

- Following the safeguarding policies and procedures at all times, particularly if concerns arise about the safety or welfare of an adult.
- Participating in safeguarding adults training and maintaining current working knowledge.
- All staff should act in a timely manner on any concern or suspicion that an adult is being or is at risk of being abused, neglected.
- Highlighting any concerns about the welfare of an adult with their line manager and ensuring the completion of a safeguarding adult concerns.
- Working collaboratively with other agencies to safeguard and protect the welfare of people who use services.

23 Raising an adult safeguarding concern

The procedure for raising adult safeguarding concerns is detailed in the Multi-Agency Adult Safeguarding Policies and Procedures document but is summarised by flow chart in appendix 5.

If an adult has capacity to provide informed consent they must be asked to give their permission before a safeguarding concern can be raised. If they refuse, the staff member with the concern must discuss with the Safeguarding Team at Brent Council. There are situations when a referral can still be made without the competent adult's consent if such a referral is:

- within the public interest
- if other adults may be at risk
- if a child or young person may be at risk

Where an adult does not have capacity to give informed consent to the referral, the principals of the MCA and Best Interest decision making process must be followed. In most cases it will always be in the Best Interest of a person who lacks capacity to make an adult safeguarding referral if necessary.

23.1 Safeguarding Adults Procedures

Adult safeguarding referrals are managed and overseen by the Adult Safeguarding Team within the London Borough of Brent.

The Four Stage Process to Responding to Safeguarding Concerns

Stage One: Raising a Concern: A concern may be: a direct disclosure by the adult at risk, raised by staff or another service users, staff, family / carer or a member of the public.

Stage Two: Enquiries: Establish facts; ascertain the adult's views and wishes and preferred outcomes, assess the needs of the adult for protection, support and redress, protect from the abuse and neglect, in accordance with the wishes of the adult where possible.

Stage 3 Safeguarding Plan and Review – The safeguarding plan sets out what steps are to be taken to assure the future safety of the adult at risk which may include requesting support, treatment or therapy.

Stage 4 Closing the Enquiry - The case is closed to safeguarding when all inquiries are completed and the agencies are satisfied that the adult is no-longer at risk and appropriate outcomes for the person have been established where possible. There will be multi-agency agreement to case closure and for any subsequent action plan follow up if required. It would however be good practice for a reassessment of care and support for a standard check to be made about how safe the person is feeling.

24 Information sharing

The DPA 2018, and amendment 85, goes further in empowering organisations to process personal data for safeguarding purposes lawfully, without consent where appropriate. The new amendment provides a lawful ground for the processing of special category personal data – without consent if the circumstances justify it – where it is in the substantial public interest, and necessary for the purpose of: (i) protecting an individual from neglect or physical, mental or emotional harm; or (ii) protecting the physical, mental or emotional well-being of an individual.

Where that individual is:

- a child or an adult at risk
- under 18 or,
- having needs for care and support,
- experiencing or at risk of neglect or any type of harm
- Unable to protect themselves.

The amendment still expects the **possibility** of obtaining consent, unless it would prejudice the safeguarding purpose (i.e. the protection of the individual). The question must be whether the use of the personal data is **proportionate** to the lawful aim.

The law intends any justifiable step to protect individuals at risk to be considered as being in the substantial public interest.

Main grounds in UK legislation which require the sharing of information

Requirement	Legal authority
Prevention and detection of crime	s.115 Crime and Disorder Act 1998
To protect vital interests of the data subject; serious harm or matter of life or death	Schedule 8, DPA 2018
For the administration of justice (usually bringing perpetrators to justice)	Part 3 & Schedule 8 DPA 2018
For 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.	Part 3 s.31 & 35 DPA 2018
Child protection. Disclosure to Children's Social Care or the Police for the exercise of functions under:	Children Act 1989 & 2004
In accordance with a court order	(requests to share information must show why it is relevant for the purpose for which they are requested, including a Court Order)
Overriding public interest	Common law
Right to life Right to be free from torture or inhuman or degrading treatment	Human Rights Act, Articles 2 & 3
Prevention of Abuse and Neglect	The Care Act 2014
Person lacks the mental capacity to make the decision regarding consent	Mental Capacity Act 2005

Further details on information sharing and references see appendix 3

25 Putting Patients First

The safeguarding principles of empowerment, partnership and accountability reflect the central role of involving patients both in safeguarding and the wider CCG business. The CCGs support this through:

- Empowerment at a patient level through the choice agenda and in all aspects of their care, including responses to harm and abuse. This includes making sure
- providers make reasonable adjustments to meet individual needs and ensuring high quality care.
- Partnerships at a service level engaging with Healthwatch and by involving patients and carers in service and pathway design to deliver more personalised, culturally responsive care that helps prevent neglect, harm and abuse.

26 Duty of Candour

There is contractual requirement for candour for NHS bodies in the standard contract, and professional requirements for candour in the practice of a regulated activity. The duty set out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology. Providers must promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning. There should also be a commitment to being open and transparent at board level, or its equivalent such as a governing body.

In interpreting the regulation on the duty of candour we use the definitions of openness, transparency and candour used by Robert Francis in his report:

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

Good safeguarding practice requires openness, transparency and trust. There is a legal "duty of candour" on health service bodies. This duty is to inform people (both in person and in writing) about mistakes or other incidents which have not produced the desired outcome, apologise where appropriate, and advise on any action taken as a result.

27 Professionals

Safeguarding concerns relating to professionals will take into account the Codes of Professional Conduct and/or employment contracts. Where appropriate, report workers to the statutory and other bodies responsible for professional regulation such as the General Medical Council and the Nursing and Midwifery Council etc. The standard of proof for prosecution is 'beyond reasonable doubt'. The standard of proof for internal disciplinary procedures and for discretionary barring consideration by the Disclosure and Barring Service (DBS) and the Vetting and Barring Board is usually the civil standard of 'on the balance of probabilities'. There is a legal duty to make a safeguarding referral to DBS if a person is dismissed or removed from their role due to harm to a child or an adult at risk.

28 Whistle-Blowing (Raising Concern)

The aim of the raising concerns at work policy is to support a working environment and culture for individuals in which areas of concern raised will be reported and treated seriously when it is about a possible danger, professional misconduct or financial malpractice that might affect patients, colleagues or the CCG in order to provide our staff with a safe, secure and honest environment to work. The Public Interest Disclosure Act 1998 protects workers that disclose information about malpractice at their workplace, or former workplace, provided certain conditions are met. 'Whistleblowing' is when a worker reports suspected

wrongdoing at work. Officially this is called ‘making a disclosure in the public interest.’ A worker can report things that aren’t right, are illegal or if anyone at work is neglecting their duties, including:

- someone’s health and safety is in danger
- damage to the environment
- a criminal offence
- the company isn’t obeying the law
- covering up wrongdoing

Some people who raise a concern through safeguarding in some cases may request that their personal details remain confidential and that the adult at risk or the person alleged to have caused harm are not informed. If that person is a professional they should be reminded of their duty of care and advised to report to their line manager.

29 Allegation of abuse against a staff member

Staff must be aware that abuse is a serious matter that can lead to a criminal conviction. Where applicable, the NHS CCG’s disciplinary policy should be implemented.
If a member of staff becomes aware of any information regarding another member of staff, which identifies that an adult may be at risk of abuse or has been harmed, they should follow in the Whistleblowing or Raising Concerns at Work guidance.

30 Safer Recruitment

The CCG Human Resources and Recruitment policies and procedures must be compliant with all legislative and best practice standards relating to safer recruitment. These include appropriate checks at recruitments and the defined periods post-employment, compliance with mandated training requirements including safeguarding. These policies apply to all substantive, temporary and agency staff including volunteers. Recruiting managers are required to ensure that all checks have been carried out as per the CCG policy for themselves and raise any concerns immediately and prior to the person starting employment with the CCGs. Where the CCGs are employing a staff member through an agency, the agency will be required to provide proof that all checks have been completed by themselves as the employer to the same level as if the CCGs were employing the person directly.

31 Training and Development

Safeguarding adults training is a mandatory requirement for all staff employed by the CCGs; substantively, temporarily, on a contract basis or in member practices of the CCGs. The level of training is commensurate with their profession, level of interaction with adults in their day to day role and their position within the organization. As a minimum, all staff will have safeguarding awareness training at induction to the CCGs. This will ensure they are trained appropriately to be aware to potential indicators of abuse or neglect and know how to act on their concerns commensurate to their role.

32 Policy Monitoring

The CCGs adherence to this policy will be evaluated annually through the safeguarding adult annual reports to the Governing Bodies. This policy will be implemented and monitored through the CCG Governing Bodies’ approved Governance frameworks with

scrutiny and assurance being undertaken by the Quality and Governance Committees (meeting jointly) and reported to the CCG Governing Bodies.

All CCG managers are responsible for the implementation of this policy within their area. If they have concerns regarding adult safeguarding either within the services commissioned or other areas of practice, they are advised to report their concerns to the NHS Brent CCG Designated Nurse for Safeguarding Adults.

Resources

Professionals should use the RCP leaflet
http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/deprivationlibertysafeguards.aspx

NHSE safeguarding Tools
http://brentccg.nhs.uk/safeguarding/safeguarding-adults?lang=en

The London Multi-Agency Safeguarding Adult Policy and Procedures
http://londonadass.org.uk/wp-content/uploads/2015/02/LONDON-MULTI-AGENCY-ADULT-SAFEGUARDING-POLICY-AND-PROCEDURES.pdf

You can also please visit the http://www.brent.gov.uk or for more information about safeguarding adults open the following;
https://www.brent.gov.uk/media/251071/safeguarding%20leaflet%20FINAL.PDF

Service users and their representatives should refer to the Age Concern leaflet:
http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/FS62_Deprivation_of_Liberty_Safeguards_fcs.pdf?dtrk=true

Professionals should use the RCP leaflet
http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/deprivationlibertysafeguards.aspx

There are many useful online resources for the MCA 2005: www.scie.org.uk/publications/mca/ www.dh.gov.uk/

Mental Capacity Act 2005: http://www.legislation.gov.uk/ukpga/2005/9/contents

Best interests decision-making www.bestinterests.org.uk

CQC – MCA DoLS guidance for providers

http://www.cqc.org.uk/search/apachesolr_search/Mental%20Capacity%20Act

Lasting Power of Attorney https://www.gov.uk/power-of-attorney/if-you-have-an-enduring-power-of-attorney

MCA 2005 www.legislation.gov.uk/ukpga/2005http://www.legislation.gov.uk/ukpga/2005/9/contents

MCA 'Code of practice' http://www.tsoshop.co.uk/www.publicguardian.gov.uk/mca/code-practice.htm

Appendix 1

Types of abuse and indicators

Physical abuse

Examples include: Slapping, pushing, kicking, rough handling, twisting of limbs/ extremities, misuse of medication, or inappropriate sanctions or restraint.

Sexual abuse

Examples include: Rape and sexual assault or sexual acts to which the vulnerable adult has not consented, could not consent or was pressured into consenting. Non-contact abuse such as voyeurism, involvement in pornography.

Psychological / Emotional abuse

Examples include: verbal assault or intimidation, emotional abuse, deprivation of contact verbal abuse, threats of harm or abandonment, humiliation or blaming, overriding of consent, choices or wishes, felling worthless, frightened or unloved. NB: Psychological/emotional abuse will usually occur in conjunction with other forms of abuse.

Financial abuse

Examples include: theft, fraud, exploitation, and pressure in connections with wills, property, possessions or benefits.

Neglect and acts of omission

Examples include: 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

This abuse is usually motivated by discriminatory and oppressive attitudes towards race gender, culture background, religion physical and/ or sensory impairment, sexual orientation and age. Discriminatory abuse can be a form of harassment, or similar treatment; because of someone's race, gender and disability, sexual orientation or religion, Hate/Mate Crime also falls under this group.

Domestic Abuse

Any incident or pattern of incidents of controlling, coercive, 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. The abuse can encompass, but is not limited to psychological, physical, sexual, financial, emotional.

Organizational abuse

Neglect and poor practice. This may take the form of isolated incidents of poor or unsatisfactory professional practice at one end of the spectrum, through to persuasive ill treatment or gross misconduct.

Self-Neglect

Cover a wide range of manner neglecting to care for one's personal hygiene, which can be health or someone's surroundings for example, hoarding behaviour.

Modern Day Slavery

There are many different characteristics that distinguish slavery from other human rights violations, however only one needs to be present for slavery to exist. Someone is in slavery if they are:

- forced to work - through mental or physical threat;
- owned or controlled by an 'employer', usually through mental or physical abuse or the threat of abuse;
- dehumanised, treated as a commodity or bought and sold as 'property';
- physically constrained or has restrictions placed on his/her freedom of movement.

Other types of abuse

Female Genital Mutilation

Female genital mutilation (sometimes referred to as female circumcision) refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. It is a criminal offence.

Honour Based Violence

Honour based violence is a violent crime or incident which may have been committed to protect or defend the honour of the family or community. Crimes committed in the name of 'honour' might include:

- domestic abuse
- threats of violence
- sexual or psychological abuse
- forced marriage
- being held against your will or taken somewhere you don't want to go
- assault

The DoH, (2014 Chapter 15.)

Appendix 2 The Modern Slavery

The Modern Slavery Act 2015 has introduced changes in UK law focused on increasing transparency in supply chains, to ensure they are free from modern slavery (that is, slavery, servitude, forced and compulsory labour and human trafficking).

NHS Brent CCG acts as the commissioner for the local NHS providers (including hospital, community and mental health services) NHS Brent Clinical Commissioning Group (CCG) provides annual statements in respect of its commitment to, and efforts in, preventing slavery and human trafficking practices in the supply chain and employment practices.

What is modern slavery?

Modern Slavery is a violation of a person's human rights. It can take the form of human trafficking, forced labour, bonded labour, forced or servile marriage, descent-based slavery and domestic slavery. A person is considered to be in modern slavery if they are;

- Forced to work through mental or physical threat
- Owned or controlled by an "employer", usually through mental or physical abuse
- Dehumanised, treated as a commodity or sold or bought as "property"
- Physically constrained or has restrictions placed on their freedom of movement

The Modern Slavery Bill proposes to place a duty on specified public authorities to notify the National Crime Agency of those whom they believe to be victims of modern slavery. This includes basic details of those who wish to remain anonymous and those who do not want assistance; this, alongside the current communications plan, will be part of the solution to this problem.

The National Referral Mechanism (known as the NRM) is the process by which people who may have been trafficked are identified, referred, assessed and supported by the Government of the United Kingdom. The process, set up in 2009 following the signing of the Council of Europe Convention on Action against Trafficking in Human Beings (2005) (the trafficking convention), has matured during the subsequent years; as at 30 September 2014 approximately 6,800 people had been referred into the National Referral Mechanism since its establishment.

Why do we report?

There are opportunities for improving successful identification by:

- greater awareness raising more generally and within front line organisations;
- co-ordinated gathering of information to provide intelligence;
- ensuring the quality of referrals through training and a feedback process.

Access to support for victims is a key function of the NRM; but access to support must be well managed and appropriate for individual victim's needs.

Duty to notify

From 1 November 2015, specified public authorities are required to notify the Home Office about any potential victims of modern slavery they encounter in England and Wales. They

are required to notify the Home Office by completing NRM form. However, if the potential victim does not want to be referred to the NRM, then an MS1 form is completed and sent to dutytonotify@homeoffice.gsi.gov.uk.

Human Trafficking can affect anyone, of any age, gender or nationality.
KNOW THE SIGNS:

Is someone:	Do they appear to:
Working against their will?	Have little or no time off?
Having their movements controlled?	Live in overcrowded accommodation?
Subject to violence or threats?	Have bruises or unexplained injuries?
Distrustful of authorities?	Be subject to security at their accommodation or work premises?
Unable to communicate freely with others?	Have no access to their earnings?
Unsure of where they are?	Work excessive hours
Not integrated with the local community?	Be in a situation of dependence?

Support for victims- visit

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/510593/6_1672_HO_VictimsModernSlavery_DL_FINAL_WEB_230316.pdf

Appendix 3 Lawful basis & legal grounds for sharing information

The lawful bases for processing are set out in Article 6 of the GDPR. At least one of these must apply whenever you share information (see also special category data below):

(a) Consent: the individual has given clear consent for you to process their personal data for a specific purpose.

(b) Contract: the processing is necessary for a contract you have with the individual, or because they have asked you to take specific steps before entering into a contract.

(c) Legal obligation: the processing is necessary for you to comply with the law (not including contractual obligations).

(d) Vital interests: the processing is necessary to protect someone's life.

(e) Public task: the processing is necessary for you to perform a task in the public interest or for your official functions, and the task or function has a clear basis in law.

(f) Legitimate interests: the processing is necessary for your legitimate interests or the legitimate interests of a third party unless there is a good reason to protect the individual's personal data which overrides those legitimate interests. (This cannot apply if you are a public authority processing data to

The Care Act 2014 puts a legal responsibility on Local authorities to make enquiries, or ensure others do so, if it reasonably suspects an adult who has care and support needs and is, or is at risk of, being abused or neglected and unable to protect themselves against the abuse or neglect or risk of it because of those needs. An enquiry is the action taken or instigated by the local authority in response to a concern that abuse or neglect may be taking place.
If in doubt, **always** seek specialist advice and **always** consult with your supervisor or line manager.
Remember: Information shared must be adequate, relevant and limited to what is necessary in relation to the purposes for which they are processed

Further advice on information sharing

Confidentiality and Information Sharing for Direct Care (Department of Health)

Making effective use of data and information to improve safety and quality in adult safeguarding (Association of Directors of Adult Social Services and the Local Government Association, 2013)

What if a person does not want you to share their information? - Adult safeguarding: sharing information (Social Care Institute for Excellence)

Information: To share or not to share? - The Information Governance Review (Department of Health, 2013).

Appendix 4 The Mental Capacity ACT – Summary

The five principles that underpin the Mental Capacity Act 2005:

In order to protect those who lack capacity, and to enable them to take part as much as possible in decisions that affect them, the following statutory principles apply:

- You must always assume a person has capacity unless it is proved otherwise
- You must take all practicable steps to enable people to make their own decisions
- You must not assume incapacity simply because someone makes an unwise decision
- Always act, or decide, for a person without capacity in their best interests
- Carefully consider actions to ensure the least restrictive option is taken

Assessment of capacity: There is a two-stage test for capacity:

Stage one: Does the person have an impairment of the mind or brain (e.g mental illness, learning disability, brain injury etc – can be temporary or permanent)? If Yes:

Stage two: Is the person able to:

- understand the decision they need to make and why they need to make it?
- retain, use and weigh information relevant to the decision?
- understand the consequences of making, or not making, this decision?
- communicate their decision by any means (i.e. does not need to be verbally)? Failure on any point may indicate lack of capacity, but….

1. Do not make assumptions about capacity based on age, appearance or medical condition
2. Encourage the person to participate as fully as possible
3. Consider whether the person will in the future have capacity, which cans fluctuation anyway, in relation to the matter in question – so can it wait?

Acting “in someone’s best interests”:

1. Consider the person’s past and present beliefs, values, wishes and feelings
2. Take into account the views of others – i.e. carers, relatives, friends, advocates
3. Consider the least restrictive options
4. Is there an LPA or an AD?
5. Should an IMCA be appointed?

Appendix 5 Deprivation of liberty safeguards – Summary

What are they?

The Deprivation of Liberty Safeguards 2009 (DoLS) provide a legal protective framework for those aged 18 years and over who lack the capacity to consent to the arrangements for their treatment or care. DoLS may be applied for if, by reason of dementia, mental illness, learning disability or brain injury, the levels of restriction or restraint required to deliver treatment and/or care in order to protect the person from risk or harm are so extensive that they potentially deprive the person of their liberty.

Who do they apply to?

The safeguards only apply to people who:

• lack capacity to consent to care/treatment they receive

• are over 18 years of age

• are receiving care in a hospital, hospice or a care home setting (i.e. not in their own home)

• are not otherwise detained under the Mental Health Act 1983

"Cheshire West" Ruling 2014

This case law resulted in a new "acid test" being used to define if an individual should be considered as having had their liberty restricted and therefore requiring a DoLS.

- Is the person subject to continuous supervision and control?

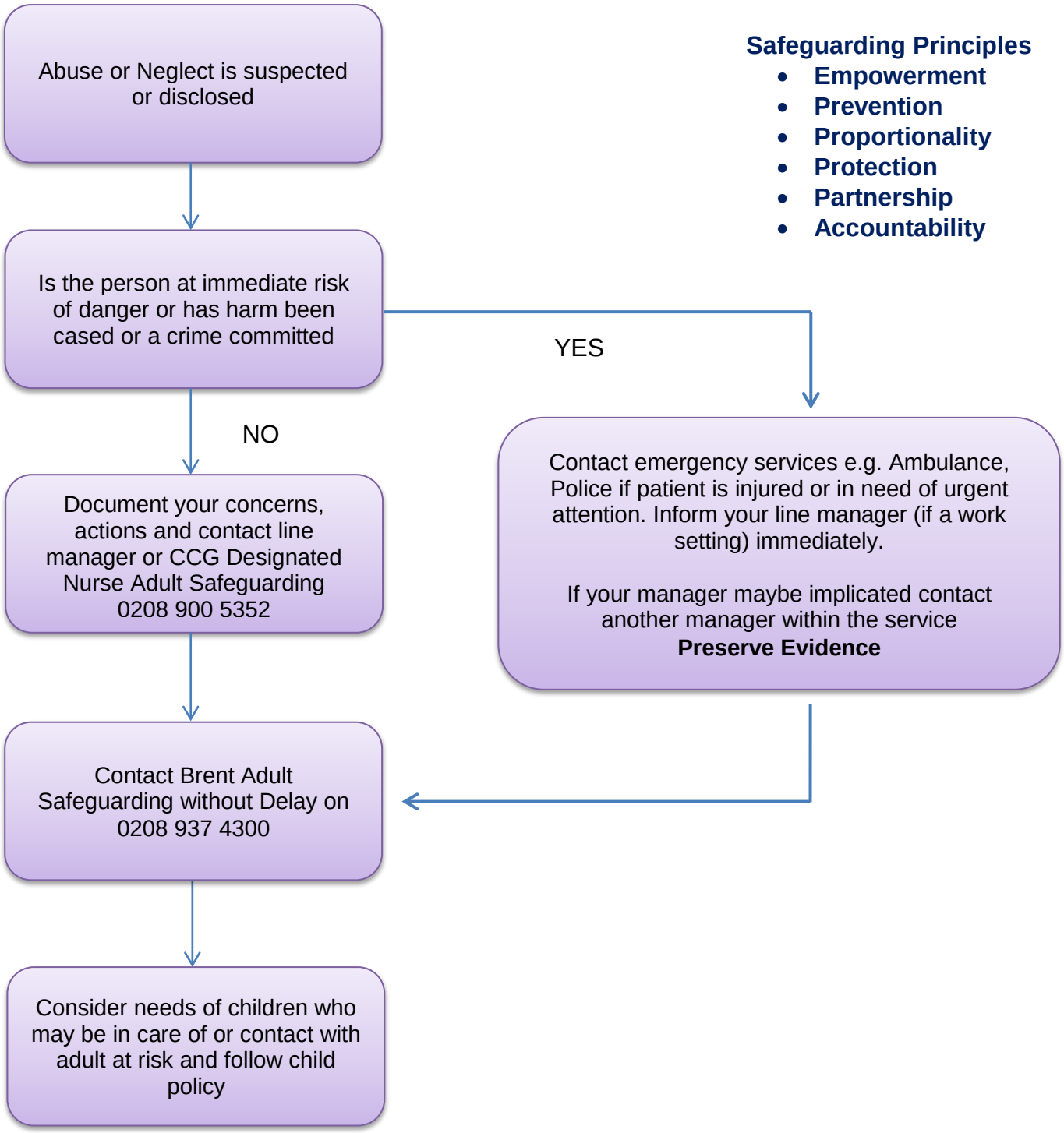
"Continuous" has not been defined and as such, practitioners should consider seeking advice from the Local Authority if intensive levels of support are being provided to any person as part of a package of care or treatment.

- Is the person free to leave?

The focus is not on the person's ability to express a desire to leave, or attempt to do so, but on what those with control over their care arrangements would do if they sought to leave. In the event of someone being wholly incapacitated (for example at end of life) the question clinicians could ask in relation to this would be: "If a member of their family said they wanted to take them home (to die) would I allow them to"?

Appendix 6

Safeguarding concern flow chat



Safeguarding is Everybody's Business

Appendix 7

Summary Table for Stage One – Raising a Concern

Stage 1 Raising a Concern	Action	Responsibility	Timescale
Identifying a concern	• Make sure that the person is safe • Talk with adult at risk and establish • concern • Assess situation and take any emergency actions – 999 • Make sure that the person is safe • Ensure any crime scene is not disturbed • Report to line manager • Ensure the safety of other adults/children & young people	Everyone All professionals	Immediate
Clarifying the situation	• Confirm concern, capacity, consent • If a crime, report to police • Arrange support for the adult at risk, and if the person alleged to have caused harm is also adult at risk, arrange support for them too • Report to children & families concerns regarding children & young people • Take any immediate action deemed necessary under agency policies	Manager/senior	Immediate
Questions	• Has abuse or neglect happened or is it likely to have happened? • Is the adult able to protect themselves? • Do they have capacity? • Is there a vital or public interest? • Has a crime been committed?	Manager/senior	
Decisions	• Refer to the police • Refer to the local authority • Overriding the wishes of the person	Manager/senior in all organisations	As soon as possible, avoid any delay

Stage 1 Raising a Concern	Action	Responsibility	Timescale
Referral to local authority	• Undertake checks • Inform other professionals • Identify SAM • Feedback to referrer	SA Referral Point	Same day
Questions	• Is it safeguarding? • What other actions need to be taken? • Is an advocate needed? • Does the person have capacity to make informed decisions? • What are the risks? • What is a proportionate response in this case?	SA Referral Point Manager/SAM	
Decisions	• Who is best person /organisation to assign the enquiry • What support is needed • How to manage immediate risks	SAM	Same day

Appendix 8 Timescales

In line with personalised safeguarding, timescales are a suggested guidance and not a performance target. Timescales are reliant on two variables (1) the adult at risk and the need for supported decision making and (2) the level of risk and the urgency of the situation. At all times the safety of the person is paramount and action should be taken regardless of timescales.

Summary Table for Enquiries, with indicative timescales

Enquiries	Action	Responsibility	Timescale
Initial Response	• Initial conversation with the adult at risk	Enquiry Officer	Within 24 hours of the concern being progressed to an enquiry
Information gathering	• Background checks and making contact with other professionals • Capacity assessment • Clarifying desired outcome • • Identify risk and implement any actions to mitigate against risk	Enquiry Officer	Within 5 days following initial conversation

Enquiries	Action	Responsibility	Timescale
Questions	• What needs to be done to mitigate risk? • What support is available from the personal network /community? • Is the desired outcome achievable? • Is there a need to progress further?	SAM & Enquiry Officer	
Decisions	• Progress under Section 42 • Close • Refer for other support	SAM	Total of 6 days for initial response

Further Section 42	Action	Responsibility	Timescale
Safeguarding Planning	• Obtain adults views about strategies and any further risk management • Map out support to adult • Ensure proper support for decision making by adult • Convene Core Group • Reassess Risk • Agree strategy and draw up plan	Enquiry Officer SAM Core Group	Within 5 working days from decision to pursue Section 42 enquiry
Implementation	• Implement the plan • Review risk	Enquiry Officer and any other bodies identified by the Core Group	Within 20 working days of the planning agreement
Reports	• Draft report and discuss with adult • Quality Assure report • Disseminate report	Enquiry Officer All managers and SAM SAM	Within 3 days of implementing the plan
Questions	• Have the outcomes been met? • Is there any other action needed?		
Decisions	• Is there a need for a formal meeting? • Can action be closed to safeguarding? • Is there a need for a Review?	SAM in consultation with the adult at risk and Core Group members	Within 3 days of disseminating the report

Appendix 9 Referrals forms and other contacts

Safeguarding Adult concern:

If you feel someone is at immediate risk and the situation is urgent, call **999 or call Brent Local authority.**

Brent local authority safeguarding team

Phone Number Mon – Fri 9am-5pm 020 8937 4098/4099 Out of Hours- 020 8937 4300 or fax to 0208 937 4027

You can also please visit the http://www.brent.gov.uk or for more information about safeguarding adults open the following;

https://www.brent.gov.uk/media/251071/safeguarding%20leaflet%20FINAL.PDF

Deprivation of Liberty Safeguard (DoLs):

A patient's Supervisory Body will be the borough they are ordinarily resident.

The local DoLS offices is: **Brent Local authority**

Phone Number Mon – Fri 9am-5pm 020 8937 4098/4099 Out of Hours- 020 8937 4300 or fax to 0208 937 4027

Contact details for the DoLs team are: dols@brent.gov.uk You can also please visit the http://www.brent.gov.uk or for more information about

To make a referral to the advocacy services in Brent:

You can download the forms below: Independent Mental Capacity Advocacy (IMCA) referral form

You can get an advocate, or for more information, advice and support in your area, you can contact us on **0300 456 2370** or email pohwer@pohwer.net. https://www.pohwer.net/brent

VoiceAbility IMCA Referral Line is: **0845 017 5198**
https://www.voiceability.org/services/london-borough-of-brent

Violence against women and girls:

Advance: Advance is an independent, client-led charity. We support all adult survivors (male and female), their children and teenage girls. Contact Advance:

Monday to Friday 10am to 6pm on 07398 454898. Email on brent.admin@advancecharity.org.uk

In an emergency, always call 999.

View Advance leaflet: https://www.brent.gov.uk/media/16409420/advance-poster.pdf

Advance Brent DVA referral form: https://www.brent.gov.uk/media/16409422/advance-brent-dva-referral-form.docx

MARAC referral form- Brent: https://www.brent.gov.uk/media/16409423/marac-referral-form-brent.docx

Guidance Referral Process for 'Channel' or Higher Risk Counter – Terrorism Related Cases.

Police 101 or 999 if relevant

Prevent Team Prevent.Team@brent.gcsx.gov.uk

Brent Family Front Door Family.Frontdoor@brent.gcsx.gov.uk

Safeguarding Adults safeguardingadults@brent.gov.uk

Reporting the death of a person with learning disabilities (LeDeR)

Anyone can notify NHS of a death online: https://www.bris.ac.uk/sps/leder/notification-system/

Or filling in the easy online form

Or

Calling 0300 777 4774.

The University of Bristol will contact NHS Brent CCG who will allocate a reviewer to look at what happened in more detail.

Appendix 10 Brent CCG's Safeguarding Adult Team

Brent CCG safeguarding team is available to give advice on all matters relating to adult safeguarding. If you have any concerns you would like to discuss, the team are available for advice and support to our partner agencies and health professionals, and work to ensure that safeguarding adults at risk concerns are managed appropriately.

Email: BRECCG.AdultSG@nhs.net

Address: Wembley Centre for Health and Care
116 Chaplin Road
Wembley HA0 4UZ

Designated Nurse Safeguarding adults
Joy Maguire
Tel: 020 8900 5352
Mobile: 07747756043
Email: joy.maguire@nhs.net

Safeguarding Team Administrator
Angela Rodrigues
Senior Safeguarding Administrator
Direct line 0208 900 5381
Email: Angela.Rodrigues@nhs.net

APPENDIX 11 Equality Impact Assessment Tool (Equality Analysis)

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes/ No	Comments
1	**Does the policy/guidance disadvantage one group or more than another on the basis of:**	No	
	• Race (including colour, culture, ethnicity, nationality or national origin and the travelling community)	No	
	• Religion or Belief	No	
	• Sex (e.g. male or female)	No	
	• Marriage or Civil Partnership	No	
	• Sexual Orientation (Lesbian, Gay, Bisexual, Heterosexual)	No	
	• Gender reassignment (e.g. someone who 'is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex.')	No	
	• Disability (e.g. learning disabilities, physical disability, sensory impairment, mental health problems etc.)	No	
	• Pregnancy and Maternity	No	
	• Age (children, young adolescent, older people etc.)	No	
2	**Is the policy/guidance/strategy more favourably towards one group on the basis of:**		
	• Race	No	
	• Religion or Belief	No	
	• Sex	No	
	• Marriage or Civil Partnership	No	
	• Sexual Orientation	No	

	• Gender reassignment	No	
	• Disability (e.g. learning disabilities, physical disability, sensory impairment, mental health problems etc.)	No	
	• Pregnancy and Maternity	No	
	• Age (e.g. children, young adolescent, older people etc.)	No	
3	**If you have identified potential discrimination in the policy/guidance are there any valid, legal and/or justifiable exceptions? Please list any exceptions.**	N/A	
4	**Is the policy/guidance likely to have a negative/adverse impact on any of the above group(s)?**	N/A	
5	**If so, how would you address the impact? Please explain.**	N/A	
6	**What are the associated objectives to the policy/guidance?**		

If you have identified a potential discriminatory impact in this document, please refer to the author(s) of the policy/guidance, together with any suggestions required to address the impact.