Cheshire and Wirral Partnership
NHS Foundation Trust

Document level: Trustwide (TW)
Code: CP10
Issue number: 12

Safeguarding adults policy (including domestic abuse)

Lead executive	Director of Nursing Therapies Patient Partnership
Authors details	Head of Safeguarding & Nurse Specialists for Safeguarding Adults

Type of document	Policy
Target audience	All CWP staff
Document purpose	Policy outlines roles and responsibilities of all employees of CWP to safeguard adults at risk of being abused. It also outlines how employees need to respond to Domestic Abuse, Prevent, Modern Slavery and Harmful Practices.

Approving meeting	Trustwide Safeguarding Subcommittee	Sept 2018
Implementation date	Sept 2018	

CWP documents to be read in conjunction with	
HR6	Essentials Mandatory Employee Learning
HR22	Supervision Policy
GR4	Policy for the recording, investigation and management of complaints /concerns
GR1	Incident reporting and managing policy
IM6	Information (overarching) sharing policy
HR2.1	Recruitment and selection policy
CP3	Trust records policy
CP6	The Management of challenging behaviour violence and aggression policy (Incorporating verbal threat to staff and offensive weapons)
HR3.7	Dignity at work policy and procedure (incorporating harassment and bullying)
CP40	Safeguarding children policy
HR3.8	How to raise and escalate concerns within work (incorporating whistleblowing) policy
CP38	Seclusion policy
MH1	Mental Health Law Policy suite
CP5	Clinical Risk assessment Policy
CP11	Multi agency public protection arrangements (MAPPA) guidance

Document change history	
What is different?	Updated CWP Safeguarding Notification form Linked to additional guidance for staff in managing self-neglect
Appendices / electronic forms	Updated CWP Safeguarding Notification form
What is the impact of change?	Will this new document change the way we do things currently – no significant changes to existing practice

Training requirements	Yes - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

Financial resource	No

implications	

External references
Care Act 2014. Mental Capacity Act 2005, Serious Crime Act 2015 North West Safeguarding Adult Policy. Department of Health (2011) Safeguarding Adults Role of Health Service Practitioners http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125233.pdf Mental Capacity Act 2005 Code of Practice http://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf Mental Capacity Act 2005 Deprivation of Liberty Safeguards https://digital.nhs.uk/data-and-information/publications/statistical/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments/mental-capacity-act-2005-deprivation-of-liberty-safeguards-england-annual-report-2015-16 Self-neglect and Adult Safeguarding - Findings from research www.scie.org.uk Home Office (2016) Statutory Guidance on conducting Domestic Homicide Review http://www.homeoffice.gov.uk/publications/crime/DHR-guidance?view=Binary Home Office (2012) Call to End Violence Against Women and Girls Taking Action http://www.homeoffice.gov.uk/publications/crime/DHR-guidance?view=Binary Home Office 2011 Prevent Strategy http://www.homeoffice.gov.uk/publications/counter-terrorism/prevent/prevent-strategy/prevent-strategy-review?view=Binary Department of Health: Identifying and Supporting Victims of Human Trafficking: Guidance for Health Staff 2013 https://www.gov.uk/government/publications/identifying-and-supporting-victims-of-human-trafficking-guidance-for-health-staff NICE Guidance: Domestic violence and abuse public health guidance 50 (2014) https://www.nice.org.uk/guidance/ph50 Early Intervention Fountain – Evidence in Domestic Violence and Abuse http://www.eif.org.uk/wp-content/uploads/2014/03/Early-Intervention-in-Domestic-Violence-and-Abuse-Full-Report.pdf Victim Care Merseyside http://www.victimcaremerseyside.org/

Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Comments
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
Is the impact of the document likely to be negative? - If so can the impact be avoided? - What alternatives are there to achieving the document without the impact? - Can we reduce the impact by taking different action?	No N/A N/A N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

Contents

Quick reference flowchart – **What To Do If You Have Concerns About An Adult at Risk**

What to Do If you Have Concerns About An Adult at Risk

CWP Executive Board Lead for Safeguarding – Director of Nursing, Therapies & Patient Partnership

Dial 999 and dependent on circumstances contact appropriate emergency service.(Patient/service user also has the right to do this)

In the event of an alleged crime preserve any evidence.

Telephone 101 Non-Emergency for Police

Suspicion/Concern/Allegation/Disclosure Relating to abuse of an adult at risk

YES

IS THE PERSON IN IMMEDIATE DANGER?

NO

CONTACT AND DISCUSS WITH LINE MANAGER/SENIOR COLLEAGUE OR SAFEGUARDING ADULTS TEAM AND TOGETHER CONSIDER IF A REFERRAL IS REQUIRED.
OUT OF HOURS (5PM TO 9AM OR WK/ENDS) CONSULT WITH ON CALL MANAGER

YES

NO

Document any actions taken to resolve issue. Review Risk and care plan.

Refer to Relevant Local Authority following Safeguarding Adult's procedures
Ensure CWP Safeguarding is informed of Referral and copied into any relevant documentation

For advice please call:

CWP Safeguarding Adult Team
(9-5 Monday – Friday)
Tel: 01244 393330
Duty Mobile: 07917264090

Carron Pygott & Steve Lee
Adult Safeguarding Nurse Specialists

Sara Scott
Named Lead for Adult Safeguarding

Christine Dyson,
Interim Head of CWP Safeguarding

01244 393330

Email cwp.safeguardingadults@nhs.net

THE SAFEGUARDING ADULT TEAM WILL PROVIDE ADVICE AND SUPPORT THROUGHOUT THE PROCESS

Emergency Out of Hours (EDT)

Cheshire West & Chester Council	01244 977277
Wirral	0151 677 6557
East Cheshire Council	0300 123 5022
Trafford	0161 912 2020
Warrington	01925 44 4400
Sefton	0151 934 3555
Bolton	01204 337777

Local Authority

Cheshire West & Chester Council
Telephone Advice & Contact Team (ACT) 0300 123 8 123

Wirral
Central Advice and Duty Team (CADT) 0151 514 2222

East Cheshire Council
Skilled Multi Agency Response Team (SMART) 0300 123 5010
(complete First Account Report)
Adult safeguarding first account report form

Trafford
Community Screening Team (CST) 0161 912 5199

Warrington
Access Social Care Team 01925 44 4239

Sefton Local Authority & Social Care 0345 140 0845

Bolton Local Authority & Social Care 01204 337777
http://www.bolton.gov.uk/website/pages/Adultsocialcare.aspx

1. Introduction

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

Health services have a duty to safeguard all patients but provide additional measures for patients who are less able to protect themselves from harm or abuse. Safeguarding adults is an integral part of patient care and is a fundamental part of patient safety and wellbeing and the outcomes expected of the NHS (DH 2011). Duties to safeguard patients are required by professional regulators, service regulators and supported in law. Safeguarding adults covers a spectrum of activity from prevention through to multi-agency responses where harm and abuse has occurred.

Cheshire and Wirral Partnership NHS Foundation Trust (CWP) is committed to safeguarding and promoting the welfare of adults at risk. This policy outlines the duties and responsibilities of all staff of CWP to safeguard adults at risk and the actions to be taken where there are concerns for an adult's safety or welfare (including domestic abuse).

This policy is to be read in conjunction with the Local Safeguarding Adult Board (LSAB). It is important to note that a number of Safeguarding boards have to come together and have developed the North West Safeguarding Adult policy and this policy needs to be read in conjunction with that. All staff are required to have electronic access to the LSAB procedures and to be familiar with them. The links to the various LSAB / SAPB Safeguarding Adult Procedures (which would incorporate the North West Adult Safeguarding Policy) can be found in appendix 1.

The All Age Disability Social workers need to follow Wirral Borough Council Adult safeguarding policies.
https://www.wirral.gov.uk/health-and-social-care/adult-social-care/safeguarding-adults/policies-procedures-guidance-and

1.1 Purpose

The purpose of this policy is twofold. Firstly, to provide staff clarity on their duties and responsibilities and to know what they need to do when they have safeguarding concerns and / or domestic abuse regarding an adult. Secondly the purpose of the policy is to outline the governance arrangements that are in place within CWP to safeguard adults, including the training requirements of staff.

The policy has been informed by relevant legislation, statutory and non-statutory best practice guidance as well as Local Authority Safeguarding Adult's Procedures see appendix 1.

1.2 Scope

The Safeguarding Adult Policy sets out CWP's approach to ensure that:

- No act or omission on behalf of the organisation puts an adult inadvertently at risk;
- Rigorous systems are in place to proactively safeguard and promote the welfare of adults at risk from abuse, or the risk of abuse;
- Support is available to staff in fulfilling their obligations.

This policy applies to all employers and employees of CWP including volunteers.

2.0 Terms and Definitions

For the purpose of this policy, CWP have adopted the definitions of the various terms as defined in the Care Act 2014 and the North West Safeguarding Adult Policy.

Adults with care and support needs are potentially less likely to be able to protect themselves from the risk of abuse or neglect. This can include such adults who have capacity to make their own decision. Statutory adult safeguarding duties apply equally to those adults with care and support needs regardless of whether those needs are being met, regardless of whether the adult lacks

mental capacity or not, and regardless of setting. Abuse and neglect can take many forms- the different types of abuse and neglect as defined in the Care Act 2014 are as follows:

- Physical;
- Sexual;
- Financial / material;
- Psychological;
- Neglect and acts of omission;
- Discriminatory;
- Domestic
- Organisational

There are other forms of abuse which are covered by different legislation for example Modern slavery. Table 1 gives a definition of the main terms that are used in the context of adult safeguarding.

Table 1: Glossary of Safeguarding Terms.

Term	Definition
Adult at Risk	A person aged 18 or over who is need of care and support regardless of whether they are receiving them, and because of those needs who is or may be unable to take of themselves or unable to protect themselves against abuse or neglect.
Adult Safeguarding	Protecting a person's right to live in safety, free from abuse and neglect.
Discriminatory Abuse	Includes discrimination on grounds of race, gender and gender identity, disability, sexual orientation, religion, and other forms of harassment, slurs or similar treatment.
Domestic Abuse	Any abuse perpetrated within a family or close relationship, regardless of gender or sexuality. It may include physical, emotional, sexual or financial abuse. It also includes coercion and control. Female genital mutilation or 'honour based violence' may feature for some.
Exploitation	This can be either opportunistically or premeditated, unfairly manipulating someone for profit or personal gain.
Female Genital Mutilation (FGM)	FGM involves procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life.
Forced Marriage	A marriage in which one or both spouses do not (or in the case of some adults with learning or physical disabilities, cannot) consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and emotional pressure.
Honour Based Abuse	A crime that is or has been justified / explained / mitigated by the perpetrator of that crime on the ground that it was committed as a consequence of the need to defend or protect the honour of the family.
Human Trafficking	Human trafficking is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, and abuse of vulnerability, deception or other means for the purpose of exploitation.
Making	This refers to person-centred and outcome focused practice in adult

Term	Definition
Safeguarding Personal	safeguarding.
Neglect / Acts of omission	Ignoring medical or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.
Organisational Abuse	Mistreatment abuse or neglect of an adult by a regime or people in a setting or service where the adult lives or they use.
Physical Abuse	Assault, hitting, slapping, pushing, misuse of medication or inappropriate physical sanctions.
Psychological abuse	Emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.
Sexual abuse	Rape, indecent exposure, inappropriate touching, and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.
Self-Neglect	This covers a wide range of behaviours concerning a person's personal hygiene, health or surroundings and includes behaviour such as hoarding.

2.1 The Safeguarding Principles

There are six safeguarding adult principles that practitioners should apply and underpin all adult safeguarding work (DOH 2014). These 6 principles are listed in Table 2.

Table 2: The Six Safeguarding Adult Principles

Empowerment	Personalisation and the presumption of person-led decisions and informed consent. In practice this means: ***"I am consulted about the outcome I want from the safeguarding process and these inform what happens."***
Prevention	It is better to take action before harm occurs. In practice this means: ***"I am provided with easily understood information about what abuse is, how to recognize the signs and what I can do to seek help."***
Proportionality	Proportionate and least intrusive response is made balanced with the level of risk presented. In practice this means: ***"I am confident that professionals will work in my best interests and only get involved as much as needed."***
Protection	Adults are offered ways to protect themselves and there is a coordinated response to adult safeguarding. In practice this means: ***"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. I feel part of the safeguarding process and it is not something which happens around me."***
Partnerships	Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse. In practice this means: ***"I know that information will only be shared that is helpful and necessary and in a way that takes into account its personal and sensitive nature. I am confident that agencies will work together to get the most effective responses for my own situation."***
Accountability	Accountability and transparency in delivering a safeguarding response. In practice this means: ***"I understand the roles and responsibilities of all the people involved in my life to safeguard me."***

Further information can be found via the link below:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf

Duties to empower people to make decisions and be in control of their care and treatment are underpinned by the Human Rights Act 1998, the Equality Act 2010 and the Mental Capacity Act 2005. It is important to remember that the duty of care involves taking reasonable steps to identify and reduce risk while respecting the person's right to make choices and that person led safeguarding does not override the duty to protect others from harm.

2.2 Making Safeguarding Personal Values

2.2.1 Person centred (person-led) safeguarding

Making Safeguarding Personal is involving the person and the cares/advocates about how all are working together with agencies to respond to safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.
A person led approach leads to services which are person centred and focused on the outcomes identified by the person; planned, commissioned and delivered in a joined up way. It is congruent with CWP approach to person centred care (see Overarching principles for the person centred framework (http://www.cwp.nhs.uk/about-us/our-campaigns/person-centred-framework/).

Person centred care and support is for everyone, but some people will need more support to make choices and manage risks. Making risks clear and ensuring it is understood is key to empowering and safeguarding adults. It is recognising people as "experts" in their own lives and where needed, access to advocacy support.
Where an adult lacks capacity (see section 2.3 and appendix 2) to make decisions about their safeguarding plans, then a range of options should be identified, which help the adult stay as much in control of their life as possible. Wherever possible, the adult should be supported to recognise risks and to manage them. Safeguarding plans should empower the adult as far as possible to make choices and to develop their own capability to respond to risks. Further information can be found via the following link: https://www.local.gov.uk/sites/default/files/documents/Making%20Safeguarding%20Personal%20-%20Guide%202014.pdf

2.3 Mental Capacity and Best Interests

"A person lacks capacity in relation to a decision or proposed intervention if, at the material time, he is unable to make a decision for himself in relation to the matter or proposed intervention because of an impairment of, or a disturbance in the functioning of the mind or brain. It does not matter whether the impairment or disturbance is permanent or temporary."

S2 (1) and (2) Mental Capacity Act 2005.

The Mental Capacity Act 2005 (MCA) empowers individuals to make their own decisions where possible and protects the rights of those who lack capacity. Where an individual lacks capacity to make a specific decision, the MCA provides a legal framework for others to make a decision, in their best interests, on their behalf. Staff need to understand and always work in line with the Mental Capacity Act 2005.

Mental capacity is frequently raised in relation to adult safeguarding. The requirement to apply the MCA 2005 in adult safeguarding challenges many professionals, particularly where it appears someone has capacity for making decisions that nevertheless results in them being abused or neglected.

A person's capacity to make a decision needs to be established at the time that a decision needs to be made (see appendix 2 and MH1). Where an adult has been assessed as lacking capacity, then any action taken or any decision made for, or on their behalf must be made in their best

interests (see MH1 policy). Even when a person is assessed as lacking capacity they must still be encouraged to participate in the safeguarding process.

CWP staff need to be familiar and refer to MH1 policy for further information regarding Mental Capacity and to appendix 2 for an aide memoire. Guidance can also be found via the following links:http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/@disabled/documents/digitalasset/dg_186484.pdf

2.4 Deprivation of Liberty Safeguards (DoLS)

The DoLS covers those individuals who lack the capacity to consent to make a decision to be accommodated in a hospital, hospice, residential care home or nursing home and for certain types of supported living and who are under constant control and supervision by staff and are not free to leave.

Requests for authorisation to deprive someone of their liberty, if considered in the person's best interests are made with the supervisory body (which is the local authority)

Further information regarding Deprivation of Liberty can be found in the LSAB procedures (appendix 1) or via CWP Policy MH1 Mental Health Law policy suite.

3. How to Raise Safeguarding Concerns

Health staff are uniquely placed to identify safeguarding concerns for example the community nurse may suspect a neighbour is financially exploiting a service user; a nurse observes neglectful practice on a ward. It is essential that staff are aware of the various types and indicators of abuse as suspected abuse or mistreatment of an adult at risk. It may come to the notice of staff in several ways:

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

All staff has a responsibility to act (summarised in flowchart):

- Staff must take responsibility for immediate safety i.e. contacting emergency services and the Local Authority;
- Record and preserve evidence i.e. write down in the persons own words and keep this hand written record dated and signed; secure the room / clothing in cases of sexual assault;
- Raise an alert i.e. inform line manager and CWP Safeguarding Adult Team by completing the notification form appendix 3 and/or by telephone.

Making decisions about when to refer can sometimes be complex. If staff are unsure of whether the situation should be raised as a safeguarding or are not sure of what action to take, staff should seek guidance from either the senior nurse manager and/or CWP Safeguarding Adult Team (see What to Do If You Have Concerns About An Adult at Risk flowchart). It is important that even if a case does not meet the criteria for a referral to the Local Authority it still needs to be managed, with the risks reviewed for all parties concerned and a safeguarding care plan should be developed and a copy forwarded by email to cwp.safeguardingadults@nhs.net. Please refer to flowchart for raising a safeguarding concern.

Staff must also report via the incident reporting system – DATIX. Involvement of the police is indicated in incidents of suspected theft, common assault (including sexual assault) and assault causing actual bodily harm. However, police may also be involved in other patient safety incidents such as wilful neglect for a person lacking capacity. Staff should make the referral to the police especially if the incident has occurred on CWP premises and obtain a police incident number.

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

- Evidence or suspicion that the actions leading to harm were intended;
- Evidence or suspicion that the adverse consequences were intended;

- Evidence or suspicion of gross negligence and/or recklessness in a serious safety incident.

If a concern that has been raised does not meet the criteria for referral into the Local Authority this should be clearly documented in the health records. The heading for the clinical note entry should indicate 'Safeguarding Adults' and a care plan should be devised addressing the concern.

For incidents that meet the threshold for referral to Local Authority, staff must follow CWP Safeguarding Adult flowchart. CWP Safeguarding Adult Team must be informed of all referrals to the local authority and staff should make referrals according to the local LSAB procedure. (appendix 1). CWP Safeguarding Adults Team will be available to offer advice and support to staff throughout the process and offer safeguarding supervision for complex cases.

Making a referral is the start of the process and staff should be involved throughout. Once a referral is accepted there is an expectation that the member of staff will participate in the safeguarding process. This may include attending a multi-agency strategy discussion or meeting. The purpose of the multi-agency strategy discussion or meeting will enable professionals to share and gather information, devise an action plan and agree duties and responsibilities. The member of staff may be asked to gather more information as they are the person most involved with the service user and may be best placed to do this rather than a person unknown to the victim of abuse. Outcomes of referrals/strategy meetings should be shared with CWP Safeguarding adult team.

The only time that the referrer may not be invited to the multi-agency strategy meeting is if the alleged perpetrator is a member of staff / colleague (see section 3.3). This situation would involve senior managers, CWP Safeguarding Adult team and Human Resource service and would follow HR 3.8 How to raise and escalate concerns within work incorporating whistleblowing policy.

3.1 Information Sharing

3.1.1 Principles of sharing information

Personal information held by professionals and agencies is subject to a duty of confidence and should normally only be disclosed to third parties, including other agencies, with the consent of the subject of the information. However there may be times when it will be necessary to disclose information without the subject's consent. Below is a summary of the key principles that need to be applied when safeguarding adults:

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

3.1.2 Sharing personal information

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

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

See below for a summary of 7 golden rules and 7 key questions:

7 Golden rules for information sharing:

1. Remember that the Data Protection Act (DPA) is not a barrier to sharing information.
2. Be open and honest with the person or family.
3. Seek advice if you are in any doubt.
4. Share with consent where appropriate.

5. Consider safety and well-being.
6. Necessary, proportionate, relevant, accurate, timely, and secure.
7. Keep a record of your decision and reasons.

7 Key questions for information sharing:

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

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

- Risk to others;
- Public interest;
- Impaired capacity.

3.2 Safeguarding Enquiry

This refers to any enquiries made or instigated by the local authority **AFTER** receiving a safeguarding concern. There are two types of enquiries:

1. Statutory Safeguarding Enquiry

If the adult fits the criteria outlined in Section 42 of the Care Act, then the local authority is required by law to conduct enquiries or ensure that enquiries are made to enable it to decide whether any action should be taken in the adult's case and if so, what should happen and who should do it.

2. Non-statutory Safeguarding Enquiry

These are safeguarding enquiries carried out on behalf of adults who **do not** fit the criteria outlined in Section 42 of the Care Act. These may relate to an adult who:

- is believed to be experiencing, or is at risk of, abuse or neglect
- does not have care and support needs (but might just have support needs)

There will be occasions when the local authority request a provider led enquiry/investigation is undertaken. If this is requested, CWP Safeguarding Adult team should be notified.
Investigations/enquiries should be undertaken by appropriately trained staff and need to embrace the Making Safeguarding Personal principles. All reports and findings should be shared with the CWP safeguarding adult team.

Further information can be found in the LSAB procedures (appendix 1) or via the following link:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf

3.3 Responding to Concerns about a Person in a Position of Trust

There are occasions when staff may have a concern regarding a person in a position of trust for example that person may be taking advantage of their client or patient's trust, exploits their vulnerability, does not act in their best interests and/or fails to keep professional boundaries.

Any allegation made against staff that may constitute abuse must be referred immediately to CWP Safeguarding Adult Nurse specialists, ensuring any immediate safety are managed appropriately and any evidence is preserved. In addition the Head of Service must be immediately informed of the allegation in order that a decision can be made in conjunction with HR and the Head of Safeguarding deputy regarding any immediate action that needs to be taken in relation to staff involved. If this involves a professional registrant or senior manager the Director of Nursing (or the associate director) will be informed and will be part of the decision making process. For medical staff, the Medical Director would be involved. Appropriate HR policies would be followed as well as adhering to the LSAB procedures. CWP Safeguarding adult team will record details of the

allegations, the decision made, why and by whom and agreed next steps.

In the case of an allegation being made outside of office hours and during the weekend, CWP on-call procedure should be followed to seek advice and action required to ensure staff and service users are safeguarded. Please refer to the flowchart. CWP Safeguarding Adult team should be notified of all allegations and the immediate actions taken by the next working day.

Safeguarding strategy meetings relating to CWP staff will be managed in accordance to the respective LSAB procedures. Terms of reference for any investigation will be approved and describe the relationship with the safeguarding adult's process. It is important to remember that any safeguarding investigation is a process that has a different purpose to that of a HR investigation.

CWP will have due regard to the statutory powers of the police in relation to the investigation of suspected criminal acts and acknowledges that it is an offence under S129 of the Mental Health Act 1983 for any of its staff to obstruct an investigation by an authorised person.

3.3.1 If a manager is involved

If staff suspect their manager is involved in the abuse they must report to another senior manager and the CWP Safeguarding Adults Nurses as soon as possible. Refer to HR 3.8 How to raise and escalate concerns within work (incorporating whistleblowing) policy. The Safeguarding Adult lead will inform the Director of Nursing/ Associate Director of Nursing of all staff allegations and actions taken.

3.4 Recording incidents

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

3.5 Notes of allegations or disclosures

If someone is making an allegation or disclosing abuse, staff must maintain contemporaneous records of what was reported to them and record verbatim what was said, by whom and when.
(See appendix 4 on Good Practices).

3.6 Never keep secrets

Staff cannot ensure absolute confidentiality to service users if allegations or disclosures are made. Secrets cannot be kept. Staff must always share concerns, allegations or disclosures with their manager/safeguarding adult team. Refer to HR 3.8.

3.7 Injury to Patient during Restraint

Any injury to a patient during restraint should always be considered as a safeguarding issue and a discussion should take place with the CWP Safeguarding Adults Team. Injuries sustained during restraint should be recorded in line with Trust procedures including a DATIX report, highlighted as 'safeguarding' and an entry recorded in clinical notes. Body maps should be used to document where injuries are.

3.8 Patient on patient incidents

All patients on patient incidents are safeguarding issues. If they amount to assault (physical or sexual abuse), ongoing verbal altercation / bullying (emotional abuse) or misappropriating another patients money / property (financial abuse) then they should be managed through the appropriate Local Authority Safeguarding Adult Procedures (appendix 1). All appropriate forms should be completed as per LSAB procedures (appendix 1). Staff must also report via the incident reporting system – DATIX.

Making decisions about when to refer can sometimes be complex. If staff are unsure of actions they need to take they should seek guidance from CWP Safeguarding Adult Team or a senior manager. It is important that if a case does not meet the criteria for a referral to the Local Authority it still needs to be managed as a 'safeguarding concern' and a care plan should be developed and

shared with CWP Safeguarding Adult Team and **a copy forwarded by email** to cwp.safeguardingadults@nhs.net. All concerns should be reported on DATIX.

3.9 Self neglect

Mental capacity is a highly significant factor in both understanding and intervening in situations of self-neglect. A duty of care is a requirement placed on an individual to exercise a reasonable standard of care while undertaking activities (or omissions) that could foreseeably harm others. However, duty of care also includes respecting the persons wishes and protecting and respecting their rights.

The Health Professionals Council standards state:

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

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

- All reasonable steps have been taken;
- Reliable assessment methods have been used;
- Information has been collated and thoroughly evaluated;
- Decisions are recorded, communicated and thoroughly evaluated;
- Policies and procedures have been followed;
- Practitioners and their managers adopt an investigative approach and are proactive.

Managing self neglect can be complex and safeguarding supervision should be sought when dealing with such cases. Staff should also adhere to the local LSAB procedures in the management of these cases.

More information around self neglect can be found in the short guide to working with complex self-neglect cases which is available to staff via the safeguarding intranet pages.

3.10 Responding to discriminatory abuse

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

- Race / ethnic origin;
- Religion;
- Gender identity;
- Sexual orientation;
- Disability.

Discriminatory abuse can take many forms including:

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

Where a criminal offence has not occurred this is referred to as a hate incident. Police are to be informed of any incidents as this enables them to address issues before a crime is committed. It also assists in cases where crimes have been committed in evidencing the background / intention of the offender.

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

If staff becomes aware of situations they can refer directly to the **Hate Crime Unit** using the electronic reporting form which is available on the intranet Safeguarding pages and send a copy to cwp.safeguarding@nhs.net. Cases should also be discussed with the CWP Safeguarding Adult Team as to whether this should be progressed through Local Authority Safeguarding or managed as a safeguarding concern.

3.11 Human Trafficking

Human trafficking can involve children and adults being brought into a situation of exploitation through the use of violence, deception, through the use of force and/or coercion. People can be trafficked for many different forms of exploitation for example:

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

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

Signs of trafficking include:

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

The person:

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

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

If staff become aware of a person who they believe, or suspect, is a victim of trafficking they should contact CWP Safeguarding Adult Team for further advice as support can be provided in reporting these concerns to the police. This applies to both children and adults.

Further information can also be found following the links below:
https://www.gov.uk/government/publications/identifying-and-supporting-victims-of-human-trafficking-guidance-for-health-staff

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/626770/6_3505_HO_Child_exploitation_FINAL_web__2_.pdf

3.12 Modern Slavery

This is the illegal exploitation of people for personal commercial gains. Victims trapped in servitude they were deceived or coerced into. It can include people being sexually exploited, criminally exploited, victims of labour exploitation and /or a victim of domestic servitude. If staff are concerned or suspect that a service user/ patient is a victim of this crime, staff must seek further advice and support from CWP safeguarding Nurses.

3.13 Prevent

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

The strategy states:

> *Healthcare professionals may meet and treat people who are vulnerable to radicalisation. People with mental health issues or learning disabilities (such as Nicky Reilly and Andrew Ibrahim, separately convicted in 2009 for terrorist-related offences) may be more easily drawn into terrorism. We also know that people connected to the healthcare sector have taken part in terrorist acts in the past.*
>
> *The key challenge for the healthcare sector is to ensure that, where there are signs that someone has been or is being drawn into terrorism, the healthcare worker can interpret those signs correctly, is aware of the support which is available and is confident in referring the person for further support. Preventing someone from becoming a terrorist or from supporting terrorism is substantially comparable to safeguarding in other areas, including child abuse or domestic violence.*

If staff become aware of a person (including children and staff/volunteers) who they believe, or suspect, is being targeted staff must contact CWP Safeguarding Adult Team for advice and support to ensure appropriate referrals are made (see appendix 5 for Prevent flowchart).

CWP will attend and present appropriate information to Channel Panel. This will be attended by appropriately trained personnel within CWP. It is therefore vitally important ant that all case are therefore discussed with CWP safeguarding team.

Further information regarding the PREVENT Strategy and guidance can be found via the following links:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97976/prevent-strategy-review.pdf

https://www.gov.uk/government/publications/prevent-duty-guidance

3.14 Responding to Domestic Abuse

Domestic abuse can include physical assault, sexual abuse, psychological abuse and financial exploitation. Anyone in society can suffer from this type of abuse, regardless of their age, gender sexual orientation, financial position, culture or beliefs. The abuse may be from someone they are currently in a relationship with or have previously had a relationship with. This includes abuse from family members (family members are defined as mother, father son, daughter, brother, sister and grandparents whether directly related, in-laws or step family) as well as opposite and same sex partners. Whatever form the abuse takes, it is rarely a one-off incident. It usually forms a pattern of coercive and controlling behaviour with which the abuser seeks power over the victim.
Controlling or coercive behaviour in an intimate or family relationship is an offence (Section 76. Serious Crime Act 2015).

CWP staff are in a unique position in that they may be the only professional involved with a victim or child who is in a domestic abuse situation. During the care / treatment episode they should ensure they see the person at least once on their own for the individual to be asked about abuse and given the opportunity to discuss and/or to make a disclosure. Questions relating to abuse should never be asked in the presence of a potential perpetrator or in front of children aged 2 years plus. Further guidance on "How to ask the question" can be found in appendix 6.

A Domestic Abuse Stalking and harassment Risk Indicator Checklist (RIC) will need to be completed to assess if the incident meets the requirements to be referred to Multi Agency Risk Assessment Conference (MARAC). The RIC can be accessed through CWP intranet Child and

Adult Safeguarding pages and via the links found in appendix 1. All clinical staff should be familiar with the RIC and have it readily available for its use especially when working in community settings.

In all cases of domestic abuse where children are present in the household the case **must** be responded to in accordance with the CP40 Safeguarding Children Policy.

Incidents of domestic abuse should be reported the same day to the Safeguarding Nurse Specialist and/or line manager. The incident may need to be referred to the Domestic Abuse Family Safety Unit/ Domestic Abuse Hub based within each local authority by the practitioner.

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

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

All domestic abuse incidents should be documented on the victim, children's and / or perpetrator's Clinical record and an alert added to ensure practitioners continue to monitor and assess ongoing risks. For staff working in mental health services the domestic abuse incident /concerns needs to be considered within the CARSO risk assessment (CP5 Clinical Risk Assessment Policy).

3.14.1 Multi Agency Risk Assessment Conference (MARAC)

If the score of the RIC is 14+ this indicates high risk and the case will meet the criteria for MARAC, in some circumstances cases can be taken on professional concern if the score is under 14. However in this circumstance this must be a discussion with a CWP Safeguarding nurse specialist before referring the case on professional concerns. Best practice is to have consent from the victim for the case to be heard. However, there are certain circumstances whereby cases are taken to MARAC without consent, for example this may occur if children are involved or there is a high risk to life.

All copies of referrals to MARAC should be sent to CWP Safeguarding team as they coordinate and attend MARAC on behalf of CWP.

Representatives from health, social care, police, probation, housing, fire and rescue services, DAFSU and victim support services review the current risk management plan. Actions to be completed by the appropriate agency are agreed and the outcome is fed back to the MARAC co-coordinator. The Independent Domestic Violence Advocate (IDVA) works with the victim and their family to ensure all identified risks are resolved / reduced and appropriate support services are in place.

Staff should be aware that evidence shows at the point where a victim decides to leave an abusive partner they are at the highest risk of harm. It is therefore essential that staff refer victims of abuse to have support from specialist services and that where possible this is planned appropriately.

Staff should never approach / discuss disclosures with the perpetrator as this heightens risk to the victim. If a vulnerable adult is in immediate harm or risk, staff should contact the police, follow their Local Authority Safeguarding procedures and notify CWP Safeguarding Adults team.

If staff receive a disclosure from a perpetrator they should establish the level of risk and to whom this may be directed, this information will need to be shared with appropriate agencies e.g. police. Staff should also explore willingness to change and referral made to appropriate services.

In addition to the Safeguarding family training offered within CWP, multi-agency domestic abuse training is available across CWP footprint and it is highly recommended that all practitioners attend. Useful documents and toolkits are also available on the CWP Safeguarding Intranet page. http://nww.cwp.nhs.uk/TeamCentre/Safeguarding/Pages/home.aspx

3.14.2 Clare's Law – Domestic Advice Disclosure Scheme

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

For further information regarding Domestic Violence Disclosure Scheme, can be found via the link; https://www.gov.uk/government/news/clares-law-to-become-a-national-scheme

3.15 Harmful Practices

Harmful practices are broadly considered to incorporate Honour Based Abuse (HBA), Forced Marriage (FM) and Female Genital Mutilation (FGM). These are by the nature largely hidden crimes. Some victims and perpetrators do not recognise harmful practices as illegal but as a 'normal' feature/response to the circumstances present at the time.

It is important to remember the difficult position of victims regarding their relationship with the perpetrators. Many victims do not want to criminalise their parents, siblings and/or communities. Therefore professionals may only have one chance to deal with effectively with a disclosure of HBA, FM or FGM. Where there is a Harmful Practice strategy within a particular local authority CWP staff need to be aware of this and follow the appropriate pathways (appendix 1).

3.15.1 Honour Based Abuse (HBA)

This incorporates a variety of practices used to control the victim's behaviour within families or other social groups to protect perceived cultural and religious beliefs or honour. Such abuse can occur when perpetrators believe that a relative has shamed the family and/community by breaking the code of behaviour, way of life or honour code. HBA can be distinguished from other forms of abuse which demonstrate similar characteristics as often committed with some degree of approval/ collusion from family/community members.

If staff have concerns they must contact and seek advice from the CWP safeguarding adult team who can support the practitioner in contacting the police. All cases need to be notified to the Named Nurse/ Head of Safeguarding in CWP.

3.15.2 Forced Marriage

A Forced Marriage (FM) is defined as a "marriage conducted without the valid consent of one or both parties and where duress is a factor. Duress includes emotional pressure as well as criminal actions such as assault imprisonment and abduction"

Forced Marriage is a specific criminal offence under sections 121 and 122 of the Anti-Social Behavior, Crime and Policing Act 2014.

If staff have concerns they must contact and seek advice from the CWP safeguarding team who can support the practitioner in contacting the police. If the concerns involve anyone under the age of 18 years the CWP CP40 Safeguarding Children policy needs to be followed. All cases need to be notified to the Named Nurse/ Head of Safeguarding in CWP.

3.15.3 Female Genital Mutilation (FGM)

FGM relates to 'all procedures that include the partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons.'

The age at which this occurs varies enormously according to the community. In practice CWP staff need consider the following:

- Is it going to occur?
- Has it occurred?

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

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

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

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

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

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

FGM is a criminal offence. It is an offence to make arrangements for FGM to be undertaken within the UK or to take, or plan to take a child out of the UK for the purpose of FGM

If staff have concerns or been made aware FGM has occurred, it is a mandatory duty for Regulated professionals to report any concerns that they have about a female under 18 years and record when FGM is disclosed or identified as part of care (appendix 7) the duty is a personal duty which requires the individual professional who becomes aware of the case to make a report.

CWP safeguarding nurses can support staff with this process and all cases should be notified to them. If the concerns involve anyone under the age of 18 years old Children Social Care and Police would need to be contacted.

There is also a mandatory requirement for CWP to submit FGM data for both children and adults and therefore this information needs to be recorded as detailed in appendix 7.

Further information:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/512906/Multi_Agency_Statutory_Guidance_on_FGM__-_FINAL.pdf

3.16 MAPPA (Multi Agency Public Protection Arrangement)

All CWP staff need to be familiar with CP11 MAPPA Policy. Where there are safeguarding concerns regarding a service user who is subject to a MAPPA this must be discussed with a CWP Safeguarding nurse.

3.17 Responding to Historical Abuse (including Sexual Abuse)

It needs to be acknowledged that it is very difficult for anyone to inform another person that they have been abused. However, it is important to establish if there are any current risks by who and to whom. Service users should be encouraged and supported to report the details of any historic abuse to the police. In all circumstance CWP safeguarding nurses should be informed as they would need to consider whether further action in the best interest of others safety needs to happen without the consent of the service user. These cases can be complex and it is important that advice and support is sought especially if it concerns a person in a position of trust.

Service users may need time to consider whether to report for various reasons, staff can revisit this at appropriate periods during therapy / interventions. Details of external agencies that specialise in supporting people who are victims of historical sexual abuse such as the Rape and Sexual Assault services (RASA) should be given.

All decisions should be documented especially if the service user does not give any details of the alleged perpetrator as this may result in no referrals being made at that point in time.

3.18 Referral to Social Care and Escalation Process

Staff should follow the Local Authority Safeguarding Adult procedures and CWP Safeguarding flowchart for making referrals**.** Staff should record in the clinical record the date, time and who they have spoken to in the Local Authority.

Acknowledgement of the referral from social care should be received within 1 working day; the referrer should follow-up their referral if, after 3 working days, they have not had a response.

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

The team manager should contact the social worker team manager to discuss the case / concerns. If concerns continue this should be discussed with the Safeguarding Nurse Specialist.

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

3.19 Safeguarding Strategy Meetings

As lead agency the Local Authority set out guidance within their Safeguarding Procedures for chairing strategy meetings. Staff who undertake this role should be appropriately trained / experienced and **must** always ensure Local Authority overview.

3.20 Safeguarding Adult supervision

All staff who are involved in safeguarding adult issues should access supervision for this aspect of their clinical work. Safeguarding adult supervision can be arranged for cases with the Adult Safeguarding Nurse Specialist.

3.21 Safeguarding Adult Reviews

The Care Act 2014 requires that each local safeguarding adult boards conduct a safeguarding adult review when someone with care and support needs dies as a result of neglect or abuse and there is a concern that an agency or agencies could have done more to protect them (section 44).

Any agency can refer a case for case consideration. If any practitioner has a case that they are concerned about and feels that the case warrants consideration, this must be discussed with the head of safeguarding. Cases would need to be referred as per LSAB procedure.

CWP will be notified of any cases that are being considered for review, case notes will be secured and a brief chronology will be requested by the Head of Safeguarding. If a decision is made for a SAR an independent author will be commissioned by the LSAB and a more detailed report/chronology may be required which will be completed by a senior manager and named professionals. CWP will share any learning points and action plans through the Trustwide Safeguarding Committee.

3.22 Domestic Homicide Reviews

Domestic homicide reviews should be carried out to make sure lessons are learned when a person has been killed as a result of domestic violence (domestic homicide) or where there has been coercion and control in cases of suicide. Any case consideration should be referred to the appropriate Community Safety Partnership (CSP) Board having been discussed with the head of safeguarding.

CWP will be notified of any cases that are being considered for review, case notes will be secured and a brief chronology will be requested by the Head of Safeguarding. If a decision is made for a DHR an independent author will be commissioned by CSP and a more detailed chronology will be required in the form of an Individual Management Review (IMR) which will be completed by a senior manager and named professionals. CWP will share any learning points and action plans through the Trustwide Safeguarding Committee.

For further information; https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

3.23 Training

Training is mandatory for **all** CWP employees whether on temporary or permanent contracts. It encompasses a “think family” approach and therefore encompasses safeguarding children, safeguarding adult, Prevent Domestic Abuse, Harmful Practices and MAPPA within the CWP safeguarding training. The level and frequency of safeguarding training undertaken will be identified within the Training Needs Analysis (MEL)

All training activity should support the knowledge and skills framework (KSF) and should follow a logical sequence of progression. Training should be linked to increasing levels of specialism, complexity of task and role within the context of adults at risk.

Information on external courses can be found on CWP education and / or Safeguarding intranet page. Safeguarding training compliance will be overseen by the Safeguarding Committee (appendix 8)

3.24 Process for Quality Improvement, Monitoring and Compliance

In order to ensure that as an organisation we are collectively engaging with the safeguarding process to ensure that adults at risk are safeguarded, quality improvement processes are vital. These processes can be either local to the trust or multi-agency. Head of clinical services are expected to assist in these as they are developed and reviewed.

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

Quality Improvement

There is a quality improvement strategy for safeguarding within CWP, staff will be expected to support this programme. The implementation of this will be overseen by the Safeguarding Committee. (appendix 8 for the Terms of Reference).

Appendix 1 - Links to Local Authority Safeguarding Adults Procedures, Forms and Domestic Abuse Risk Indicator Checklist (RIC)

Local Authority	Procedures	Referral Forms/ Contact Nos	RIC	Harmful Strategy Links
West	https://cheshirewestandchester.gov.uk/residents/health-and-social-care/adult-social-care/service-search-and-contact-us/contact-adult-social-care.aspx	Phone: Advice and Contact Team (ACT) 0300 123 8 123	http://nww.cwp.nhs.uk/TeamCentre/Safeguarding/Pages/DomesticAbuse.aspx	http://haltonsafeguarding.co.uk/docs/PanCheshire%20HarmfulPracticesStrategy.pdf
East	https://www.cheshireeast.gov.uk/livewell/staying-safe/keeping-adults-safe/keeping-adults-safe.aspx	Adult safeguarding first account report form 0300 1235010	http://nww.cwp.nhs.uk/TeamCentre/Safeguarding/Pages/home.aspx	
Warrington	https://www.warrington.gov.uk/info/201189/warrington-safeguarding-adults-board-wsab/215/warrington-safeguarding-adults-board-wsab	Phone: Access Social Care Team 01925 444239	https://www.warrington.gov.uk/info/201136/crime_support_and_prevention/101/domestic_abuse_support	
Wirral	https://www.wirral.gov.uk/health-and-social-care/adult-social-care/safeguarding-adults/reporting-abuse-or-neglect-adult	Paperless Phone Central Advice and Duty Team (CADT) 0151 6062006	http://nww.cwp.nhs.uk/TeamCentre/Safeguarding/Pages/DomesticAbuse.aspx	http://www.victimcaremerseyside.org/home/harmfulpractices.aspx
Sefton	https://www.sefton.gov.uk/social-care.aspx	0345 1400845	http://nww.cwp.nhs.uk/TeamCentre/Safeguarding/Pages/home.aspx	
Trafford	http://myway.trafford.gov.uk/i-need-help-with/keeping-people-safe/safeguarding-adults.aspx	0161 912 5199	http://nww.cwp.nhs.uk/TeamCentre/Safeguarding/Pages/DomesticAbuse.aspx	
Bolton	ww.bolton.gov.uk/website/pages/Safeguardingadultsatrisk.aspx	01204 337777	Not applicable refer to policy	
Northwest	http://www.stopadultabuse.org.uk/pdf/north-west-safeguarding-adults-policy-2018.pdf			

Appendix 2 - The Mental Capacity Act (MCA) 2005

5 Principles Which Underpin the Mental Capacity Act:

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 much 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 much 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:
Follow the 2 stage test for capacity:

- **Stage 1:** Does the person have an impairment of the mind or brain (temporary or permanent)?

If Yes:

- **Stage 2:** Is the person able to:
- Understand the decision they need to make and why then need to make it?
- Understand, 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 (ie. speech, sign language)?
- Failure on one point will determine lack of capacity.

How To Act In Someone's Best Interests:

- Do not make assumptions about capacity based on age, appearance or medical condition.
- Encourage the person to participate as fully as possible.
- Consider whether the person will in the future have capacity in relation to the matter in question.
- Consider the person's past and present beliefs, values, wishes and feelings.
- Take into account the views of others – ie. Careers, relatives, friends, advocates.
- Consider the least restrictive options.
- Best Interests checklist will be available as part of local policy and procedure and the MCA Code of Practice.

What Else Do You Need to Consider?

MCA Code of Practice: Professionals and careers must have regard to the Code and record reasons for assessing capacity or best interests. If anyone decides to depart from the Code
they must record their reasons for doing so.

LPAs & ADs: Is there a valid/current Lasting Power of Attorney or an Advance Decision in place?

IMCAs: The Mental Capacity Act set up a service, the independent Mental Capacity Advocate (IMCA), to help vulnerable people who lack capacity and are facing important decisions including serious healthcare treatment decisions including serous healthcare treatment decisions and who have no one else to speak for them.

Are the decisions being taken in the person's best interests the least restrictive option? Consider whether an authorisation is required to deprive the person of their liberty?

Where to Find Guidance
The full text of the Act and the Code of Practice is available on website address: www.dca.gov.uk/legal-policy/mental-capacity.

Best Interests
If the patient is not able to consent or refuse treatment, there is a duty to make a best interest decision about whether to treat the patient.

You must:

- involve the person who lacks capacity to the fullest extent possible
- have regard for past and present wishes and feelings, especially written statements
- consult with others who are involved in the person's care
- not be discriminatory
- choose or decide on the least restrictive option
- take into consideration the benefits and burdens to the person.

Appendix 3 – CWP Notification form and Aide Memoire to support safeguarding advice

To support efficient and appropriate response when requesting advice from Adult Safeguarding Team please give the information below:

1. Basic Details – name, role and where you work (ward/department/service/locality)

2. Victim details – name and DOB of person at risk/potential risk and your relationship with them i.e. care co-ordinator. Are they victim or perpetrator?

3. Perpetrator details – name and relationship to the victim of alleged perpetrator(s)

4. Children – have details (name, address, DOB) available where children are involved

5. Concern – type of abuse (physical, psychological, financial, sexual, neglect, domestic), details of incident including any substantive evidence/involvement of other agencies ie Police.

6. Capacity – does the victim have capacity? Has an issue specific capacity assessment been completed and documented?

7. Risk – is there risk to others? What are they and to whom?

8. Actions – what action has been taken to reduce risk?

9. Expectations – what type of advice do you need:
    - Confirmation of action taken
    - How to proceed
    - Support / supervision
    - Attendance at meetings
    - Contact numbers / advice of other agencies

10. Record – document in service user record under heading Safeguarding, make a note who you have spoken to and advice that has been given.

CWP Safeguarding Notification Form

This form should be used by the practitioner to inform CWP Safeguarding Adults Team about an adult at risk of abuse and neglect as defined in The Care Act 2014. Please refer to CWP CP10 Safeguarding Adults Policy for further guidance.

Please note, completion of this form is to support and advise CWP practitioners in relation to safeguarding concerns only and does **NOT** constitute a referral to the relevant local authority.

For more complex cases, please can we request that practitioners contact the team directly by telephone, **01244 393330** to discuss the safeguarding concerns.

SERVICE USER/ CLIENT INFORMATION	
Name:	**Date of Birth:**
Gender:	**Trust ID number:**
Current Address:	

Category of abuse (place an 'x' in the box that applies)

- ☐ **Physical**
- ☐ **Sexual**
- ☐ **Financial/material**
- ☐ **Psychological**
- ☐ **Neglect or acts of omission**
- ☐ **Discriminatory**
- ☐ **Domestic**
- ☐ **Organisational**

Other types of abuse:

- ☐ **Modern Slavery**
- ☐ **Human Trafficking**
- ☐ **Exploitation**
- ☐ **Female Genital Mutilation (FGM)**
- ☐ **Forced Marriage**
- ☐ **'Honour' violence**

☐ **Self-neglect**	
Is the adult at risk aware that this form has been completed? **Yes** ☐ **No** ☐	**Does the adult at risk lack capacity?** **Yes** ☐ **No** ☐
DETAILS OF THE INCIDENT/SAFEGUARDING CONCERN	
Date of incident:	**Location of incident:**
Description of the incident/safeguarding concern, including name of individuals involved.	
MAKING SAFEGUARDING PERSONAL What does the adult at risk and/or their representative (with consent AND/OR in their best interests AND/OR their legal status) want to happen (desired outcomes)?	
Please provide detail below:	
Actions taken to manage the safeguarding concern and by whom?	
DO YOU REQUIRE ADVICE/SUPPORT?	
Please provide detail below:	
FOR INFORMATION ONLY? *Delete as appropriate* YES/NO	
PRACTITIONER DETAILS	
Name:	**Designation:**
Clinical team:	**Contact number:**
Date: Email cwp.safeguardingadults@nhs.net	
CWP SAFEGUARDIING ADULT TEAM INFORMATION	
Advice/support given:	
Name:	**Date:**

Appendix 4 – Good Practice Guidelines - Recognising Signs of Adult Abuse

Thinking about what you see and asking yourself if it is acceptable practice;

- Working strictly in accordance with anti-oppressive practice;
- Taking seriously what you are told;
- Being alert to hints, signals, non-verbal communication that could indicate abuse.

Responding to Disclosure

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

Coping with disclosure

If someone makes an allegation or discloses abuse to you:

DO

- Stay calm and try not to show shock;
- Listen carefully;
- Be sympathetic.

Tell the person that:

- They did the right thing to tell you;
- You are treating the information seriously;
- It was not their fault;
- You will have to report the information to your manager;
- Report to your manager;
- Write down what the person said to you as soon as possible.

DO NOT

- Question the person about the incident;
- Ask the person who, what, why where, when questions, this is the role of the police;
- Promise to keep secrets;
- Make promises that you cannot keep, for example. 'This will not happen to you again;
- Contact the alleged abuser;
- Be judgmental, for example, 'Why didn't you run away?'
- Gossip about the incident;
- Bathe the person;
- Wash the person's clothes or bedding;
- Touch or move anything in the room where the person has been abused.

When in doubt seek advice from your Manager

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

Consent Not Given

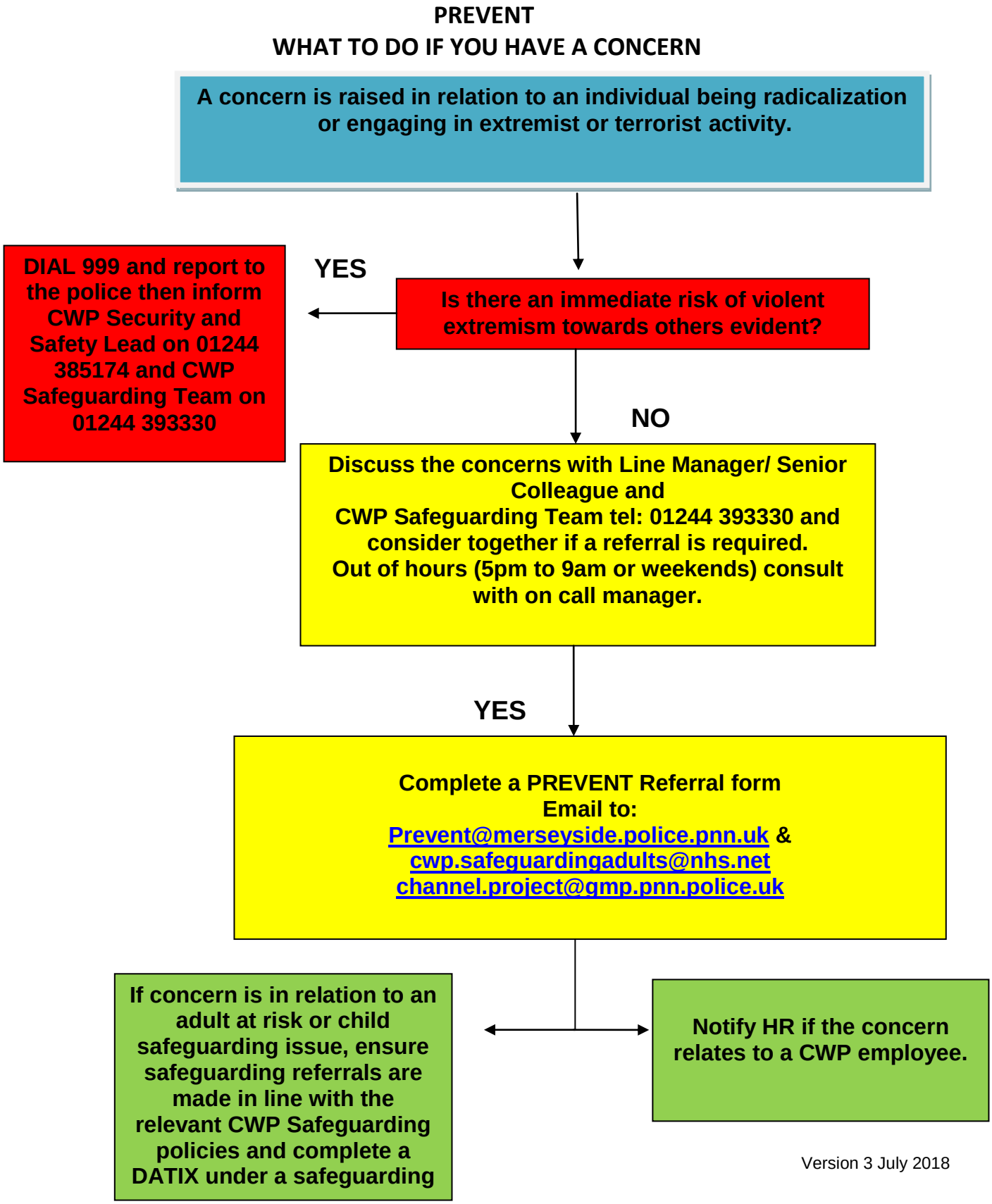
1. The wishes of the adult at risk should be respected unless it is established that they lack the capacity to recognise their vulnerability / situation;

2. If in doubt of the vulnerable adult's ability to give consent or make an informed choice, discuss with your line manager;

3. If the circumstance is such that, other people are at risk, then discuss with the line manager for appropriate action;

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

Appendix 5 – Prevent. What to do if you have a suspicion/concern or allegation



Version 3 July 2018

Appendix 6 - "How to Ask the Question" Domestic Violence and Abuse

The following is guidance on "Asking the Question" taken from www.gov.uk

Asking the question - A Guide

Ensure it is safe to ask

1. Consider the environment
    - Is it conducive to ask?
    - Is it safe to ask?
    - Never ask if in the presence of another family member, friend, or child over the age of 2 years (or any other persons including a partner)

2. Create the opportunity to ask the question

3. Use an appropriate professional interpreter (never a family member).

Ask

Frame the topic first then ask a direct question.

Framing:

"As violence and abuse in the home are so common we now ask contacts about it routinely."

Direct Question:

"Are you in a relationship with someone who hurts, threatens or abuses you?" Did someone cause these injuries to you?"

Validate

Validate what's happening to the individual and send important messages to the contact:

- "you are not alone"
- "You are not to blame for what is happening to you"
- "You do not deserve to be treated in this way"

Assess

Assess contact safety:

- "Is your partner here with you?"
- "Where are the children?"
- "Do you have any immediate concerns?"
- Do you have a place of safety?"

Action

Be aware of your local domestic violence agency, how to contact local independent domestic violence advisor (IDVA), offer leaflet and suggest referral. **Action any local safeguarding procedures.**

Document

Consider safety and confidentiality when recording information in patient notes. **Medical records can be used by survivors in future criminal justice proceedings.**

Appendix 7 - Female Genital Mutilation (FGM) – Understanding the reporting of FGM

FGM multi-agency practice guidance published by Department of Health:
https://www.gov.uk/government/publications/female-genital-mutilation-guidelines

There is a programme of work, led by the Department of Health, to improve the NHS response to FGM, including the management of women's services and safeguarding of girls at risk. The Department of Health and HSCIC published **Understanding the FGM Enhanced dataset** which highlighted the need of NHS organisations to capture information to understand the prevalence of FGM.

FGM Enhanced Dataset
The data set focuses on 2 specific elements:

- the recording and sharing of FGM information locally, specifically for the provision of care
- the central submission of relevant information when FGM has been identified

The FGM Enhanced Dataset requires all health organisations to record and collect information about the prevalence of FGM within the female population as treated by the NHS in England. This will include if a woman is receiving treatment for any condition; it is not limited to reporting upon women receiving treatment for FGM-related conditions.

The FGM Enhanced Dataset will use patient identifiable information.

Recording FGM information - The FGM information that needs to be captured and includes the following;

1. All clinical staff to record in clinical notes when FGM is identified, and what type it is following clinical examination (clinical examinations will only need to be undertaken as part of a usual, routine or requested provision of care)

2. All babies born to a mother with FGM must have the relevant FGM information recorded in the baby's patient healthcare record (GP records and PCHR Red Book) to help identify the potential risk of FGM facing the girl.

3. Where FGM is identified, all referrals made by General Practitioners MUST include FGM information when referring to relevant services where FGM may be applicable.

Recording of Information Locally

- **Health Visitors -** Asking if women have undergone FGM pre-natal.
- **GP** - on receipt of maternity discharge summary must update baby and mothers records.
- **GP** - discharge summaries or referrals from other healthcare organisations, information must be recorded within the woman or girl's healthcare record, as applicable.
- **GP** - where FGM is identified within a General Practice, all referrals MUST include all known FGM information when referring the woman or girl to relevant services where FGM may be applicable
- **Health Visitors** - It is the responsibility of the Health Visitor, to update the following section within the Red Book, "Are there any other particular illnesses or conditions in the mother's or father's family that you feel are important?"
- **Health Visitor** – where identified by HV - responsible for updating GP if sisters of a girl with FGM.

- **School Nurses** – where identified by SN - responsible for updating GP if sisters of a girl with FGM.

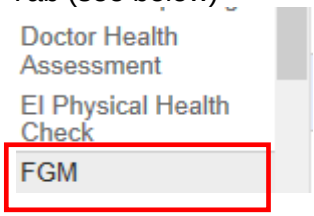
- **Mental Health Clinicians** – when identified in an Acute or **Mental Health Trust** that a girl or woman has had FGM undertaken – information to be shared with GP and other NHS organisations.

- When it has been identified in **CWP** that a girl has had FGM undertaken, in addition to the GP being informed of the FGM, information in any clinical notes or discharge summary should also be sent to the girl's **Health Visitor** if the girl is under five or the girl's **School Nurse** if the girl is five or over.

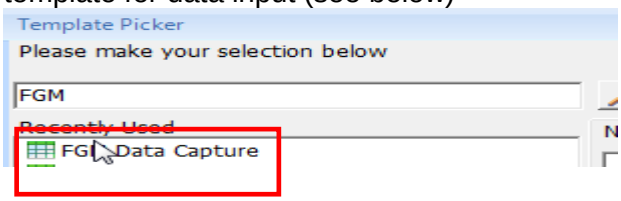
If a girl under the age of 18 years has been identified as having undergone FGM, then local safeguarding procedures MUST be followed in order to protect the child. ALL concerns must be reported to CWP safeguarding children team

Recording FGM on Carenotes

There is a form in Carenotes to record the relevant FGM Data. You can find this via the Assessment Tab (see below)



Recording FGM on EMIS There is a Template on EMIS to allow the recording of FGM Data. In Consultations use "Add Data via Template". Enter FGM in the search field and you will find the template for data input (see below)



Appendix 8 – Safeguarding Sub Committee

TERMS OF REFERENCE

Constitution:

The Quality Committee hereby resolves to establish a sub-committee known as Safeguarding Committee.

Purpose

The Safeguarding Committee is responsible for receiving assurance on safeguarding matters across the organisation and to provide strategic direction to meet the trusts safeguarding priorities. The safeguarding committee is responsible for assuring that the Trust meets all the regulations and legislation to safeguarding individuals and communities that the Trust serves. The committee will receive assurance from safeguarding locality groups and/representatives from care groups and provide assurance to Trust Board through direct reporting to the Quality Committee on all relevant aspects of the safeguarding agenda.

Duties will include:

The committee will assure that the organisation has:

1. A Safeguarding Strategy evidenced by a Safeguarding Quality Charter and Associated Improvement Programme.
2. A developed and implements a Safeguarding Audit Programme to identify areas of good practice and those for improvement.
3. Processes and systems in place to quality assure safeguarding practice.
4. Ensure that appropriate safeguarding policies, procedures and guidelines are in place and monitored in line with the safeguarding legislation and Care Quality Commission compliance.
5. To receive assurance that the organisation is represented at the Safeguarding Board and associated sub groups and appropriately acts upon outputs.
6. Developed and approves the safeguarding reports to Trust Board including the Annual Safeguarding Report.

The Committee will receive assurance from the Safeguarding Locality Groups and representatives from the Care Group that the Trust:

1. Has processes and systems in place to manage the Safeguarding Agenda.
2. Engages with patients to provide feedback from people who have been involved in safeguarding matters.
3. Safeguarding matters are effectively managed and escalated as necessary.
4. Lessons are learnt from safeguarding investigations and through review of safeguarding processes and practice.
5. To receive assurance that the Trust's safeguarding training needs are identified, delivered upon and attainment of the required training standards are met.
6. Implements the safeguarding audit schedule and associated areas for improvement and sustainability.

Risk Responsibility

The risk areas that the Safeguarding Committee has responsibility for will be those that fall within the remit of safeguarding.

Membership:

Will include:

- Co-Chairs: Director of Nursing, Therapies and Patient Partnership and/or Associate Director of Nursing and Therapies
- Deputy Chair: Head of Safeguarding (or identified deputy)
- Named Nurse for Safeguarding Children (or identified deputy)
- Named Doctors for Safeguarding Children
- Chairs from each safeguarding locality group (or identified deputy)
- Head of Governance (or identified deputy)

The committee will need to ensure that each care group is represented and if required co-op additional members.

A quorum shall be 5 members to include representation from each locality
(a deputy will attend if the Locality Chair is unavailable).

Attendance will be 80% aided by nominated deputies.

Attendance
The Co-Chairs will be the Director of Nursing, Therapies and Patient Partnership and the Associate Director of Nursing and Therapies.

Frequency
Meetings shall be quarterly. Additional ad-hoc meetings may be constituted if a specific, more urgent, consideration is required for an identified issue.

Authority
The Safeguarding Committee is compliant with the Quality Committee to ensure the Trust meets its statutory responsibilities for safeguarding issues.

Reporting
The Safeguarding Committee is accountable to the Quality Committee and will report directly by ensuring that the minutes are submitted to the Quality Committee and that minutes are distributed to group members.

An annual report will be produced and presented to the Quality Committee. This will be linked to an annual business cycle.

Date reviewed by Safeguarding sub-committee meeting	5th September 2018
Date approved by the Quality Committee	12th September 2018
Review date	September 2019

Updated: August 2018