

Safeguarding Adults



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The Care Act 2014

The Care Act 2014¹ sets out statutory responsibility for the integration of care and support between health and local authorities. NHS England, Clinical Commissioning Groups are working in partnership with local and neighbouring social care services. The Local Authority has statutory responsibility for safeguarding. In partnership with health demonstrate all reasonable requirements for healthcare, including the principles to promote wellbeing within local communities.

What is adult safeguarding and why it matters²

Adult safeguarding means protecting a person's right to live in safety, free from abuse and neglect. The Care Act requires that each local authority must:

- Make enquiries, or ensure others do so, if it believes an adult is, or is at risk of, abuse or neglect
- An enquiry should establish whether any action needs to be taken to stop prevent abuse or neglect, and if so, by whom

- Set up a Safeguarding Adults Board
- Arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry
- Or Safeguarding Adult Review where the adult has 'substantial difficulty' in being involved in the process and where there is no other appropriate adult to help them
- Cooperate with each of its relevant partners in order to protect adults experiencing or at risk of abuse or neglect.

An adult at risk is any person who is aged 18 years or over and at risk of abuse or neglect because of their needs for care and support. Where someone is over 18 but still receiving children's services and a safeguarding issue is raised, the matter should be dealt with as a matter of course by the adult safeguarding team.

The Care Act 2014

The aims of adult safeguarding are:

- To prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- To safeguard individuals in a way that supports them in making choices and having control in how they choose to live their lives
“Making Safeguarding Personal”
- To promote an outcomes approach in safeguarding that works for people resulting in the best experience possible
- To raise public awareness so that professionals, other staff and communities as a whole play their part in preventing, identifying and responding to abuse and neglect.

In order to achieve these aims, it is necessary:

- To ensure that the roles and responsibilities of individuals and organisations are clearly laid out.
- To create a strong multi-agency framework for safeguarding.
- To enable access to mainstream community safety measures.
- To clarify the interface between safeguarding and quality of service provision.

A word cloud featuring the word 'safeguarding' in large, bold, orange letters at the center. Surrounding it are various related terms in different colors and sizes, including: 'adult', 'abuse', 'risk', 'neglect', 'care', 'support', 'partnership', 'communities', 'order', 'enquiry', 'needs', 'act', 'ensure', 'prevent', 'aims', 'adults', 'where', 'local', 'between', 'health', 'promote', 'live', 'appropriate', 'matter', 'authority', and 'individuals'.

Your Responsibilities

Safeguarding adults

All staff within health services have a responsibility for the safety and wellbeing of patients and colleagues.

Living a life that is free from harm and abuse is a fundamental human right of every person and an essential requirement for health and well-being.

Safeguarding adults is about the safety and well-being of all patients but providing additional measures for those least able to protect themselves from harm or abuse.

Safeguarding adults is a fundamental part of patient safety and wellbeing and the outcomes expected of the NHS. Safeguarding adults is also integral to complying with legislation, regulations and delivering cost effective care.

These cards should be used by you as a guide should you have a safeguarding concern and should always be used alongside your organisations safeguarding policy and procedures.

Definition of an adult at risk:

Aged 18 years or over;
Who may be in need of community care services by reason of mental or other disability, age or illness; and
who is or may be unable to take care of him or herself, or unable

to protect him or herself against significant harm or exploitation

NB: Throughout this publication we have used the term 'patient' to refer to patients and clients.

Your responsibilities when you have safeguarding concerns:

- Assess the situation i.e. are emergency services required?
- Ensure the safety and wellbeing of the individual
- Establish what the individual's views and wishes are about the safeguarding issue and procedure
- Maintain any evidence
- Follow internal procedures for reporting incidents/risks
- Remain calm and try not to show any shock or disbelief
- Listen carefully and demonstrate understanding by acknowledging regret and concern that this has happened
- Inform the person that you are required to share the information, explaining what information will be shared and why
- Make a written record of what the person has told you, using their words or what you have seen as well as your actions.

Your Responsibilities

Duty of care:

You have a duty of care to your patients/service users, your colleagues, your employer, yourself and the public interest. Everyone has a duty of care – it is not something that you can opt out of.

The Health Professions 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 professional considers.

- 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 managers should seek to ascertain the facts and are proactive.

You should always treat every individual with dignity and respect to ensure that they feel safe in services and empowered to make choices and decisions.

Ensure that significant others, i.e family member, friend or advocate, are involved to support the individual where appropriate.

However it is important to recognise that though an individual with capacity has the right to refuse care for themselves, the duty of care extends to considering where others may be at risk and action is needed to protect them.

You have the responsibility to follow the 6 safeguarding principles enshrined within the Care Act 2014:

Six key principles underpin all adult safeguarding work:

Principle 1

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

"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."

Continued over..

Your Responsibilities

Principle 2

Prevention – It is better to take action before harm occurs.

“I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.”

Principle 3

Proportionality – Proportionate and least intrusive response appropriate to the risk presented.

“I am sure that the professionals will work for my best interests, as I see them and they will only get involved as.”

Principle 4

Protection – Support and representation for those in greatest need.

“I get help and support to report abuse. I get help to take part in the safeguarding process to the extent to which I want and to which I am able.”

Principle 5

Partnership – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

“I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together to get the best result for me.”

Principle 6

Accountability – Accountability and transparency in delivering safeguarding.

“I understand the role of everyone involved in my life.”

1. Categories of Abuse

Abuse and neglect can take many forms. Local Authorities should not be constrained in their view of what constitutes abuse or neglect, and should always consider the circumstances of the individual case. Abuse includes:

Physical abuse – including assault hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.

Sexual abuse – including rape and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

Your Responsibilities

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

Modern Slavery – See human trafficking section

Financial or material abuse – including theft, fraud, exploitation, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

Neglect and acts of omission – including 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.

Self – Neglect – this covers a wide range of behavior neglecting to care for one's personal hygiene, health or surrounding and includes behaviours such as hoarding

Domestic Violence – See DV Section

Discriminatory abuse – including discrimination on grounds of race, gender and gender identity, disability, sexual orientation, religion, and other forms of harassment, slurs or similar treatment.

Organisational abuse – including neglect and poor care practice within an institution or specific care setting like a hospital or care home, e.g. this may range from isolated incidents to continuing ill-treatment.

2. Significant Harm

Commissioners and the NHS have robust processes in place to learn lessons from cases where children or adults die or are seriously harmed and abuse or neglect is suspected.

For adults this includes contributing fully to Safeguarding Adult Reviews (SARs) which are commissioned by the Local Safeguarding Adult Board (LSAB).

(Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework)³

3. Whistle blowing

Always act whenever abuse is suspected including when your legitimate concern is not acted upon. Whistle blowers are given protection under the Public Interest Disclosure Act 1998.

If in doubt contact your nominated lead for adult safeguarding.

Your Role as Alerter

Your role as 'Alerter' in the Safeguarding Process

- The 'alerter' raises a safeguarding concern within their own agency following own policy and procedures
- This concern may result from something that you have seen, been told or heard
- Make a Safeguarding Adult referral where this is necessary.

Assessment

Your assessment should be holistic and thorough considering the patient's emotional, social, psychological and physical presentation as well as the identified clinical need. You need to be alert to:

- Inconsistencies in the history or explanation
- Skin integrity
- Hydration
- Personal presentation e.g. is the person unkempt
- Delays or evidence of obstacles in seeking or receiving treatment
- Evidence of frequent attendances to health services or repeated failure to attend (DNA)
- Environmental factors eg. signs of neglect, the reactions and responses of other people with the patient

- Does the patient have capacity for the decision required?
- Are they able to give informed consent or is action needed in their best interests?
- Are there others at risk e.g. children or other vulnerable adults?
- Is immediate protection required?
- Has a crime been committed and should the Police be informed?
- Preserving any evidence
- Is any action that is being considered proportionate to the risk identified?
- What are the patient's views/wishes?
- Cultural differences or religious beliefs
- Are there valid reasons to act even without the patient's consent? E.g. where others are at risk; need to address a service failure that may affect others.

Your Role as Alerter

Golden rules: Holistic assessment

On admission or initial contact:

- Does this fall under adult safeguarding duties as defined by the Care Act 2014?
- Are there any existing alerts relating to the patient?
- Is there any current agency involvement. Consider both statutory and private providers
- What are the home circumstances?
- Is the patient likely to require more input on discharge?
- Who else lives in the household?
- Skin integrity
- Nutritional state including hydration
- Personal presentation
- Person's communication and behaviour
- Are any reasonable adjustments required
- Treat the person with dignity and respect

Before discharge:

- Where is the patient being discharged to?
- Don't transfer problems

- Is there any previous involvement/support (consider statutory and private providers and informal carers) that needs re-engaging?
- Think about information sharing when transferring patient
- Will they be safe on discharge?
- Is this the patient's choice?
- Does there need to be a referral to Adult Social Care?
- Have community nurse referrals been made?
- Has the care package been restarted?
- Check for outcomes of any Safeguarding referrals
- Does an alert need adding to patient notes?

Communication

- Consider use of communication aids/language line if required to involve the patient
- Take account of individual differences
- Listen carefully, remain calm and try not to show shock or disbelief
- Acknowledge what is being said

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Your Role as Alerter

- Do not ask probing or leading questions which may affect credibility of evidence
- Be open and honest and do not promise to keep a secret
- Seek consent to share information if patient has capacity and if this does not place you or them at increased risk
- You may share information without consent if it is in the public interest in order to prevent a crime or protect others from harm (follow own organisation's policy and procedures)

Reporting

- Report concern following your safeguarding adult policy and procedures
- Make clear and concise referral so that person reading the form understands the key issues
- Do not delay unnecessarily
- Concern about a colleague should be raised through your organisations Managing Allegations against staff or Whistle blowing policy.

Remember that you are accountable for what you do or choose not to do.

Recording

- You are accountable for your actions or omissions
- Make a legible, factual, timely and accurate record of what you did and why, to demonstrate transparent, defensible decision making e.g. capacity assessment made, best interest decision, any restraint which was required which must be proportionate to the situation.

To report any concerns of suspected or actual abuse, follow your multi-agency adult safeguarding procedures.

Information Sharing

Information sharing

Where there are safeguarding concerns staff have a duty to share information. It is important to remember that in most serious case reviews, lack of information sharing can be a significant contributor when things go wrong.

Information should be shared with consent wherever possible.

A person's right to confidentiality is not absolute and may be overridden where there is evidence that sharing information is necessary to support an investigation or in best interests e.g. in the interests of public safety, police investigation, implications for regulated service.

1. **Remember that the Data Protection Act is not a barrier to sharing information** but provides a framework to ensure that personal information about living persons is shared appropriately
2. **Be open and honest** with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so

3. **Seek advice** if you are in any doubt, without disclosing the identity of the person where possible
4. **Share with consent where appropriate** and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgment, that lack of consent can be overridden in the public interest. You will need to base your judgment on the facts of the case
5. **Consider safety and well-being:** Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions
6. **Necessary, proportionate, relevant, accurate, timely and secure:** Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely

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Information Sharing

7. **Keep a record** of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose

Any information disclosed should be:

- clear regarding the nature of the problem and purpose of sharing information
- based on fact, not assumption
- restricted to those with a legitimate need to know
- relevant to specific incident
- strictly limited to the needs of the situation at that time
- recorded in writing with reasons stated

Sharing data when someone lacks mental capacity

- Can the patient give consent to disclosure of information?
- You have a responsibility to explore approaches to help them understand
- In some instances the individual will not have the capacity to consent to disclosure of personal information relating to them. Where this is the case any disclosure of information needs to be considered against the conditions set out in the Data Protection Act and Best interests

The Mental Capacity Act

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 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:

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 they 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 (i.e. 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

Continued over...

The Mental Capacity Act

- Take into account the views of others – i.e. carers, relatives, friends, advocates
- Consider the least restrictive options
- Best Interests checklist will be available as part of local policy and procedure

What else Do You Need To Consider?

MCA Code of Practice: Professionals and carers 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 sets up a new service, the Independent Mental Capacity Advocate (IMCA), to help vulnerable people who lack capacity and are facing important decisions including serious healthcare treatment decisions and who have no one else to speak for them.

Are the decisions being taken in the person's best interest the least restrictive option? Consider is an authorisation required to deprive the person of their liberty?
(MCA Code of Practice 2005)⁴

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.

NB there may not always be time in emergency situations for all investigation and consultation, and there should be no liability for acting in the reasonable belief that someone lacks capacity, and what you do is reasonably believed to be in their best interests (MCA s5). This can include restraint if need be, if it is proportionate and necessary to prevent harm (MCA s6), and even "a deprivation of liberty", if this is necessary for "life sustaining treatment or a vital act", while a Court Order is sought if need be (MCA s4B).

Assessing Capacity Chart

Assessing Capacity



If the answer to 1. is YES and the answer to any of 2. is NO then the person lacks capacity under the Mental Capacity Act 2005.

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Assessing Capacity Chart

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
- have regard for past and present wishes and feelings, especially written statements
- consult with others who are involved in the person's care
- there can be no discrimination
- the decision is the least restrictive option
- take into consideration the benefits and burdens to the person



Deprivation of Liberty Safeguards

Deprivation of Liberty Safeguards

What are they?

The deprivation of Liberty Safeguards 2009 (DoLS) are an amendment to the Mental Capacity Act 2005. They provide a legal framework to protect those who lack the capacity to consent to the arrangements for their treatment or care, for example by reason of their Dementia, Learning disability or Brain Injury and where levels of restriction or restraint used in delivering that care for the purpose of protection from risk/harm are so extensive as to potentially be depriving the person of their liberty. Deprivation of Liberty Safeguards goes beyond the actions permitted under section 5 of the Mental Capacity Act (MCA) 2005.

Who does it apply to?

An application is required to the Court of Protection where the following conditions are met:-

- The person has an impairment or disturbance in the functioning of their mind or brain which could affect their ability to make a decision
- The person does not have the capacity to consent to their circumstances/care arrangements and/or treatment.
- Their situation meets the acid test;

Are they under continuous supervision? and Are not free to leave and live somewhere else

- Their care is imputable to the state – the local authority or CCG is responsible for the person's care.

The following groups of individuals are covered by these safeguards:

- a) People in hospitals, care homes, residential and nursing homes (i.e. all CQC registered settings)
Currently the provider organisation is required to apply to the Local Authority where the patient is from to have the application for Deprivation of Liberty authorised.
- b) 16-17 age cohort and Looked after Children
Currently the commissioning body (NHS or Local Authority) is required to apply to the Court of Protection to have the application for Deprivation of Liberty authorised. In hospital settings it will be the responsibility of the hospital to make an application to the court of Protection where a Deprivation of Liberty is identified.
- c) NHS or local authority funded care in people's homes, supported living accommodation and in shared lives placement arrangements.

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Deprivation of Liberty Safeguards

CCGs and Local Authorities are required to apply to the Court of Protection, to have the application for Deprivation of Liberty authorised. If the care is jointly commissioned a joint arrangement should be made.

Supreme Court Ruling 2014

The supreme Court ruling in March 2014 significantly lowered the threshold regarding what could be considered a Deprivation of Liberty.

It is no longer relevant whether the person is compliant or whether there is a lack of objection. The focus is not on the person's ability to express a desire to leave, but on what those with control over their care arrangement would do if they sought to leave.

Defining a Deprivation of Liberty
The test of Deprivation of Liberty has now been revised into a so-called "acid test" by the Supreme Court as follows The person is under continuous supervision and control AND is not free to leave Every element of this must be satisfied i.e.

- Continuous
- Supervision
- Control
- Not freed to leave

What you need to know

- Sometimes deprivation of liberty (DoL) is required to provide care/treatment and protect people from harm, BUT every effort should be made to prevent DoL by making provision to avoid placing restrictions, if DoL cannot be avoided it should be for no longer than is necessary
- There is a legal duty on the hospital or care home, if the Safeguards apply, to request authorisation from local authority to deprive someone of their liberty for a limited period of time
- A major part of preventing DoL is minimising any restraint. Restraint must be appropriate, proportionate and in the patient's best interests

A "deprivation of liberty" where care is funded by the local authority or a CCG can occur in other "community settings". This Includes supported living arrangements and domestic settings. In these settings, the DoLS scheme is not available and Instead, an application must be made to the Court of Protection

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Deprivation of Liberty Safeguards

- The Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) provide protection for vulnerable people who are accommodated in hospitals or care homes in circumstances that amount to a deprivation of their liberty and who lack the capacity to consent to the care or treatment they need.

What to do

- If you are worried about a patient in your care who you think might be being deprived of their liberty, consider ways in which you can minimise restrictions. Please refer to your local DoLS procedures.
- Discuss the case with your Adult Safeguarding Lead or Local authority DoLS team who will be able to assist
- It is important to act promptly to comply with legislation.

Pressure Ulcer Staging

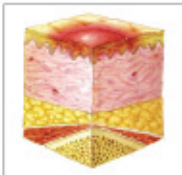
A pressure ulcer is a localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.

INTERNATIONAL NPUAP/EPUAP PRESSURE ULCER CLASSIFICATION SYSTEM

Category/Stage I: Nonblanchable Erythema

Intact skin with non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" individuals (a heralding sign of risk).

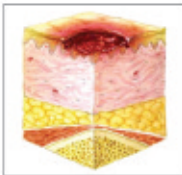


Category/Stage II: Partial Thickness Skin Loss

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

Presents as a shiny or dry shallow ulcer without slough or bruising.* This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

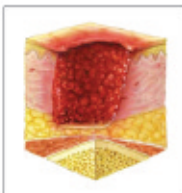
*Bruising indicates suspected deep tissue injury.



Category/Stage III: Full Thickness Skin Loss

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.



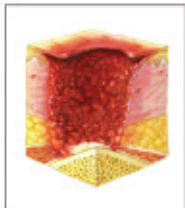
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Pressure Ulcer Staging

Category/Stage IV: Full Thickness Tissue Loss

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

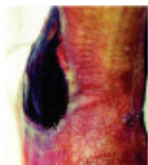
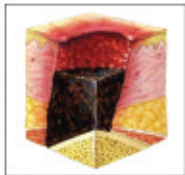
The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.



Unstageable: Depth Unknown

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

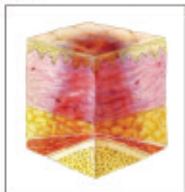
Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.



Suspected Deep Tissue Injury: Depth Unknown

Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.



If patient has pressure ulcer ask yourself was the development of the ulcer

Avoidable/Unavoidable – See local policies for safeguarding referral

Prevent/Channel

What is Prevent?

The Government's counter-terrorism strategy is known as CONTEST.

Prevent is part of the strategy and its aim is to stop people becoming terrorists or supporting terrorism. The strategy promotes collaboration and co-operation among public service organisations. The Office for Security and Counter Terrorism in the Home Office is responsible for providing strategic direction and governance on CONTEST. You can read the CONTEST strategy in full at www.homeoffice.gov.uk.

CONTEST has four key principles:

Pursue: to stop terrorist attacks

Prevent: to stop people becoming terrorists or supporting terrorism

Protect: to strengthen our protection against a terrorist attack

Prepare: to mitigate the impact of a terrorist attack.

The health service is a key partner in Prevent and encompasses all parts of the NHS, charitable organisations and private sector bodies which deliver health services to NHS patients.

How does Prevent affect you in your work?

Healthcare professionals have a key role in Prevent. Prevent focuses on working with vulnerable individuals who may be at risk of being exploited by radicalisers and subsequently drawn into terrorist-related activity. Prevent does not require you to do anything in addition to your normal duties.

What is important is that if you are concerned that a vulnerable individual is being exploited in this way, you can raise these concerns in accordance with your organisation's policies and procedures, as you would do with any Safeguarding issue.

Prevent works in what is described as the 'pre-criminal' space. It's about identifying people and behaviour BEFORE it becomes criminal. Nobody is asking you to deal with behaviour in the 'criminal' space. That is for the police. Nobody is asking you to spy or inform. This is about Safeguarding and protecting vulnerable people. It's no more than that.

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Prevent/Channel

Working with others

Collaborative working adds real value to patient care. Healthcare services cannot meet all of the needs of a vulnerable person and in many cases the wider range of support and services available from other public sector bodies, charitable organisations and private sector bodies will be required.

Developing an appreciation of the roles of others and understanding how they contribute to the safety of vulnerable people will help you to work more effectively. It is important that we all share a responsibility for safeguarding and promoting the welfare of vulnerable individuals.

Practical steps for healthcare workers

In your work you may notice unusual changes in the behaviour of patients and/or colleagues which are sufficient to cause concern. It is important that if you have a cause for concern, you know how to raise it, as well as what will happen once you have raised it.

It is important that you attend any Prevent training and awareness programmes sponsored or provided by your organisation, and also be sure that you are:

- aware of your professional responsibilities, particularly in relation to the safeguarding of adults at risk and children;
- familiar with your organisation's protocols, policies and procedures;
- aware of whom within your organisation you should contact to discuss your concerns;
- aware of the processes and support available when you raise a concern;
- aware of current patient confidentiality policy

PURPOSE

Effective information sharing is vital for early intervention and lies at the heart of good safeguarding practice. Information should be shared if to do so protects children or adults or to prevent a crime.

As part of the Prevent duty the Channel guidance states:

“Partners may consider sharing personal information with each other for Prevent purposes, subject to a case-by-case assessment which considers whether the informed consent of the individual can be obtained and the proposed sharing being necessary, proportionate and lawful.” (Channel guidance 2015)

Continued over...

Prevent/Channel

The sharing of information must have due regard for the law relating to confidentiality, data protection and human rights. Having a legitimate purpose for sharing information is an important part of meeting those legal requirements.

Five key documents provide the main national framework for information sharing:

Data Protection Act 1998 – this act provides the main legislative framework and information sharing issues and stipulates the conditions under which information may be shared i.e. the legal justifications.

Human Rights Act 1998 – this ACT INCORPORATES ARTICLE 8 OF THE European Convention of Human Rights which states that everyone has the right to respect for their private and family life.

Caldicott & Caldicott 2 – This is a set of principles to support the appropriate sharing of personal information about those who use the health and social care services they were reviewed in 2013, there are 7 principles outlined:

- 1 Justify the purpose
- 2 Use only when absolutely necessary
- 3 Use the minimum required
- 4 Access on a strict need to know basis

- 5 Everyone with access to personal confidential data should be aware of their responsibilities
- 6 Understand and comply with the law
- 7 The duty to share information can be as important as the duty to protect patient confidentiality.

What factors might make people vulnerable to exploitation?

Some of the following factors are already known to contribute to the vulnerability of individuals and could put them at risk of exploitation by radicalisers.

Identity crisis –

Adolescents/vulnerable adults who are exploring issues of identity can feel both distant from their parents/family and cultural and religious heritage, and uncomfortable with their place in society around them. Radicalisers can exploit this by providing a sense of purpose or feelings of belonging. Where this occurs, it can often manifest itself in a change in a person's behaviour, their circle of friends, and the way in which they interact with others and spend their time.

Continued on next card...

Prevent/Channel

Personal crisis – This may, for example, include significant tensions within the family that produce a sense of isolation of the vulnerable individual from the traditional certainties of family life.

Personal circumstances – Individuals may perceive their aspirations for career and lifestyle to be undermined by limited achievements or employment prospects. This can translate to a generalised rejection of civic life and adoption of violence as a symbolic act.

Criminality – In some cases a vulnerable individual may have been involved in a group that engages in criminal activity or, on occasion, a group that has links to organised crime and be further drawn to engagement in terrorist-related activity.

Grievances – The following are examples of grievances which may play an important part in the early indoctrination of vulnerable individuals into the acceptance of a radical view and extremist ideology:

- a misconception and/or rejection of UK foreign policy
- distrust of western media reporting
- perceptions that UK government policy is discriminatory (e.g. counter-terrorist legislation)

Other Factors – Similarly to the above, the following have also been found to contribute to vulnerable people joining certain groups supporting terrorist-related activity:

- ideology and politics
- provocation and anger (grievance)
- need for protection
- seeking excitement and action
- fascination with violence, weapons and uniforms
- youth rebellion
- seeking family and father substitutes
- seeking friends and community
- seeking status and identity

Any change in an individual's behaviour should not be viewed in isolation and you will need to consider how reliable or significant these changes are.

But some signs might include:

- parental/family reports of unusual changes in behaviour, friendships or actions and requests for assistance;
- patients/staff accessing extremist material online;
- use of extremist or hate terms to exclude others or incite violence;

Continued over...

Prevent/Channel

- Writing or artwork promoting violent extremist messages or images.

You will need to use your judgement in determining the significance of any unusual changes in behaviour, and where you have concerns you should raise these in accordance with our policy.

Raising Prevent concerns about patients

Every healthcare organisation will have in place existing arrangements for reporting concerns which comply with good governance and safeguarding practices. **If you find that you need to raise concerns, you should use your own organisation's policies and procedures that reflect the process.**

If you are uncertain about what to do, speak with your manager as the first step, or another person with authority.

Notice - Check - Share

Allows concerns to be checked in order to understand them better.

NOTICE

There is a change in the behaviour of a patient or colleague or you see something that concerns you.

CHECK

Discuss your concerns with a colleague, supervisor or manager.

SHARE

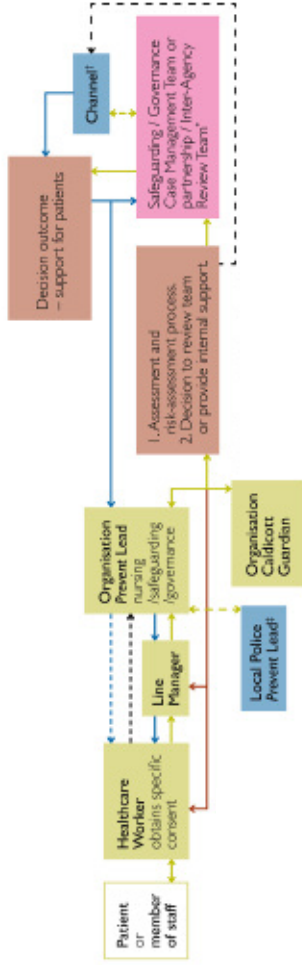
Share your concerns with the Prevent Lead in your organisation.

Continued on next card...

Prevent/Channel

In the absence of any existing arrangements for raising concerns, the Following flow chart is provided as an example of an escalation procedure.

If you have any concerns talk to your line manager, Prevent Lead or Safeguarding Professional.



KEY

- - Public
- - Internal Health process
- - Decision
- - External Organisation
- - Inter-agency partnership

* To include representatives from other public sector services, such as local authorities, education, social care, etc.
 † This is an advisory role and it will be at the discretion of healthcare practitioners and safeguarding leads to contact police Prevent leads for advice and support as necessary. Police Prevent leads can also assist safeguarding leads and Caldicott Guardians with advice on risk-assessment procedures. ‡ Channel Groups provide a mechanism for supporting individuals who may be vulnerable to terrorism-related activity by assessing the nature and the extent of the potential risk, agreeing and providing an appropriate support package tailored to an individual's needs. Channel is a multi-agency panel (including Health) and the local Channel lead is normally located within police or local authority.

Domestic Violence and Abuse

Domestic Violence/Abuse

One woman in three (and one man in five) in the UK will be a victim of domestic violence during their lifetime, according to research estimates.

Two women a week are killed by a current or former male partner.

Domestic violence and abuse is officially classified as “any incident of threatening behaviors, violence or abuse between adults who are or have been in a relationship together, or between family members, regardless of gender or sexuality”

We think of domestic violence as hitting, slapping and beating, but it can also include emotional abuse as well as forced marriage and so-called “honour crimes”. Its abuse if a partner, ex-partner or a family member:

- Threatens/frightens an individual
- Shoves or pushes an individual
- Makes an individual fear for their physical safety
- Puts an individual fear for their physical safety
- Puts an individual down, or attempts to undermine their self-esteem

- Controls an individual, for example by stopping them seeing friends and family
- Is jealous and possessive, such as being suspicious of friendships and conversations

Key Principles

The following are some key principles to remember when encountering service users that may have been victims of Domestic Violence or Sexual Abuse.

- **Act** – Never assume someone else is addressing the domestic violence and abuse issues
- **Respect** – Remember it is not the professional's role to comment on or encourage a person experiencing abuse to leave their partner
- **Revisit** – If a patient does not disclose but you suspect otherwise, accept what is being said but offer other opportunities to talk and consider giving information (e.g. ‘for a friend’)
- **Act** – Share information appropriately subject to policy and local guidance

Continued on next card...

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 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 if 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. (not in service user held record) **Medical records can be used by survivors in future criminal justice proceedings.**

Female Genital Mutilation

What is Female Genital Mutilation (FGM)?

FGM comprises of all procedures involving partial or total removal of the external female genital organs or any other injury to the female genital organs for non-medical reasons. FGM is most often carried out on young girls aged between infancy and 15 years old. It is often referred to as 'cutting', 'female circumcision', 'initiation', 'Sunna' and 'infibulation'.

FGM in the UK

It is estimated that 65,000 girls aged 13 and under are at risk of FGM in the UK. UK communities most at risk include Kenyan, Somalian, Sudanese, Sierra Leonean, Egyptian, Nigerian and Eritrean. Non-African countries that practise FGM include Yemen, Afghanistan, Kurdistan, Indonesia, Malaysia, Turkey, Thailand (South) and Pakistani. Please note this List is not exhaustive.

In practice what you should consider:-

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

Spotting the signs

Suspicious may arise in a number of ways that a child may be at risk of FGM. These include:-

- Knowing that a mother or older sibling has undergone FGM
- A girl talks about plans to have a 'special procedure' or to attend a special occasion/celebration to 'become a woman'
- A girl's parents state that they or a relative will take the child out of the country for a prolonged period, or school holidays or when attending for travel vaccinations
- A girl may talk about a long holiday to her country of origin or another country where the practice is present
- The girl is a member of the community that is less integrated into UK society and whose country of origin practices FGM.

Signs that a child may have already undergone FGM:-

- Difficulty walking, sitting or standing
- Spending longer than normal in the bathroom or toilet due to difficulties urinating

Continued on next card...

Female Genital Mutilation

- Soreness, infection or unusual presentation noticed by practitioner when changing a nappy or helping with toileting
- Spending long periods of time away from the classroom during the day with bladder or menstrual problems
- Having frequent unusual menstrual problems
- Prolonged or repeated absence from school or college
- A prolonged absence from school or college with personal or behaviour changes e.g. withdrawn, depressed
- Being particularly reluctant to undergo normal medical examinations
- Asking for help or advice but not being explicit about the procedure due to embarrassment or fear.

FGM is child abuse

FGM causes significant harm and constitutes physical and emotional abuse. FGM is a violation of a child's right to life, their bodily integrity as well as their right to health.

The FGM Prevention Programme is a programme of work led by the Department of Health to improve the NHS response to FGM;

this includes projects to improve awareness, provision of services and management of FGM, and safeguarding of girls at risk.

The UK Law

FGM is against the law in the UK and has been a criminal offence since 1985. It is a serious crime that carries a penalty of 14 years in prison. 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.

What to do if you are concerned or have been made aware FGM has occurred

It is a mandatory duty for a regulated healthcare professional to report any concerns they have about a female under 18 years and record when FGM is disclosed or identified as part of NHS healthcare.

As FGM is **illegal** this should be **reported to the Police via the 101 non-emergency number.** (See overleaf for links to Home Office guidance).

Continued over...

Female Genital Mutilation

The duty is a personal duty which requires the individual professional who becomes aware of the case to make a report; the responsibility cannot be transferred.

There is a mandatory requirement for health care professionals to submit their FGM data for both children and adults via The Health & Social Care Information Centre.

Further details can be accessed on their website:

<http://www.hscic.gov.uk/FGM>

Submission became mandatory for acute trusts, GP practices and mental health trusts in 2015.

If you believe that a victim or potential victim of FGM is in immediate danger, always dial 999.

If you are concerned that a child is at risk you must make a referral to Children's Social Care immediately using your local Safeguarding Board procedures. The NSPCC has a 24 hour helpline to provide advice and support to victims of FGM, or to anyone who may be concerned a child is at risk - call the helpline on **0800 028 3550** or email fgmhelp@nspcc.org.uk

Further information

Guidance and resources have been published by the Home Office that give relevant professionals and the police an understanding of the

new (FGM) mandatory reporting duty, which can be accessed in the link below:-

<https://www.gov.uk/government/publications/mandatory-reporting-of-female-genitalmutilation-procedural-information>

<https://www.gov.uk/government/publications/female-genital-mutilation-resource-pack/female-genital-mutilation-resource-pack>

Reporting Flowchart:-

<https://www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare>

Further help and information including multi agency procedures for FGM can be found on your local authority Safeguarding Children Board website.

Alternatively you can contact:-

NSPCC FGM helpline: 0808 028 3550

or email: fgmhelp@nspcc.org.uk

Childline helpline: 0800 1111

Website: www.childline.org.uk

or your local designated nurse for safeguarding children.

NHS Choices also has information on support:- <http://www.nhs.uk/NHSENGLAND/ABOUTNHSSERVICES/SEXUAL-HEALTHSERVICES/Pages/fgm-resources.aspx>

Police dial 101 (if a non-emergency)

Human Trafficking

Trafficking and Modern slavery

Human Trafficking involves men, women and children being brought into a situation of exploitation through the use of violence, deception or coercion and forced to work against their will. People can be trafficked for many different forms of exploitation such as forced prostitution, forced labour, forced begging, and forced criminality, domestic servitude, forced marriage, forced organ removal.

When children are trafficked, no violence, deception or coercion needs to be involved: simply bringing them into exploitative conditions constitutes trafficking.

The difference between Smuggling or Trafficking

People trafficking and people smuggling are often confused. People smuggling is the illegal movement of people across international border for a fee and upon arrival in the country of destination the smuggled person is free.

The trafficking of people is fundamentally different as the trafficker is facilitating the movement of that person for the purpose of exploitation. There is no need for an international border to be crossed in cases of trafficking, it occurs also nationally, even within one community.

If you suspect human trafficking/modern slavery⁵ contact 101 to report your information.

Modern Slavery

What is Modern Slavery?

Illegal Exploitation of people for personal/commercial gain. Victims trapped in servitude they were deceived or coerced into

The Movement

Transport, transfer, harbour and receipt

The Control

Force, threat, coercion, abduction, deception

The Purpose

Exploitation, forced labour, slavery



Criminal Exploitation

pick pocketing, shop-lifting, drug trafficking. **16% financial fraud** (benefits or loans)



Domestic Servitude

forced to work in private houses with restricted freedoms, long hours, no pay. **24% are children**



Forced labour

long hours, no pay, poor conditions, verbal and physical threats. **36% of cases, 1/5 children, 3/4 are male**



Sexual Exploitation

prostitution and child abuse. **42% of all trafficking, 20% of which are children**



Other forms

Organ removal, forced begging, forced marriage and illegal adoption

Continued on next card...

Modern Slavery

What should I look for?

- Look malnourished or unkempt
- Withdrawn, anxious and unwilling to interact
- Under the control and influence of others
- Live in cramped, dirty, overcrowded accommodation
- No access or control of their passport or identity documents or use false or forged documents
- Appear scared, avoid eye contact, and be untrusting
- Show signs of abuse and/or have health issues
- Show old/untreated injuries, or delay seeking medical care with vague/inconsistent explanation for injuries
- Appear to wear the same or unsuitable clothes, with few personal possessions
- Fear authorities and in fear of removal or consequences for family
- In debt to others or a situation of dependence

Continued over...

HELP FREE THE UK FROM
**MODERN
SLAVERY**

MODERN SLAVERY INCLUDES:



Modern Slavery is the illegal exploitation of people for personal or commercial gain. Victims are trapped in servitude, which they were deceived or coerced into, and cannot leave.



**ONE THIRD
OF VICTIMS
ARE MALE**



SEXUAL EXPLOITATION



MOST COMMON
ABUSE AMONG
ALL VICTIMS

20%

CHILD
VICTIMS



1
10

CHILDREN



COMMON AREAS OF LABOUR EXPLOITATION



FACTORIES



FOOD PROCESSING



LABOURING



RESTAURANTS



MARITIME



AGRICULTURE

VICTIMS OF LABOUR EXPLOITATION



Resources

- 1 http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf
- 2 Care Act 2014 Part 1: factsheets - Publications - GOV.UK
- 3 NHS England » Search Results » safeguarding adults
- 4 Mental Capacity Act Code of Practice - Publications - GOV.UK
- 5 Modern Slavery Act 2015

For the resources listed below, visit:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124882

- Clinical Governance and Adult Safeguarding: An integrated process. February 2010
- Safeguarding Adults: The Role of Health Service Managers and their Boards DH March 2011
- Safeguarding Adults: The Role of Health Service Practitioners DH March 2011
- Safeguarding Adults: The Role of NHS Commissioners DH March 2011

- Safeguarding Adults: Self Assessment and Assurance Framework DH March 2011
- Safeguarding Adults and the Role of Health Services: Analysis of the Impact on Equality
- Statement of Government Policy on Adult Safeguarding DH May 2011



NHS Safeguarding Guide App



A resource for healthcare professionals to increase their awareness and understanding of safeguarding requirements



Access on web at:

www.nhs.uk/apps/nhs_safeguarding

My Notes & Contacts:

