Primary Healthcare Centre Chopwell

SAFEGUARDING ADULTS POLICY

This Protocol should be READ in conjunction with the Safegaurding Adults Practice Toolkit by Gateshead CCG

Date 22/05/2019

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Ratified by:	Partners at *Primary Healthcare Centre Chopwell*
Date Ratified:	3/8/2015
Name & title of Originator/Author:	Dr Karen Hutchinson GP Lead, Safeguarding Adults NHS Newcastle Gateshead CCG Alliance
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Safeguarding Adults Policy for *Primary Healthcare Centre Chopwell*

Safeguarding Adults Policy Statement

This policy will enable *Primary Healthcare Centre Chopwell* to demonstrate its commitment to keeping safe patients who have care and support needs and who are at risk of abuse or neglect. *Primary Healthcare Centre Chopwell* acknowledges its duty to respond appropriately to any allegations, reports or suspicions of abuse and some cases of self-neglect.

It is important to have the policy and procedures in place so that all who work at *Primary Healthcare Centre Chopwell* can work to prevent abuse and know what to do in the event of abuse.

The Policy Statement and Procedures have been drawn up in order to enable *Primary Healthcare Centre Chopwell* to:

- promote good practice and work in a way that can prevent harm, abuse and coercion occurring.
- to ensure that any allegations of abuse or suspicions are dealt with appropriately and the person experiencing abuse is supported and included in the process
- and to stop that abuse occurring.

The Policy and Procedures relate to any adult who

- is aged 18 or over, and
- has needs for care and support (whether or not these needs are being met); and
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

It is acknowledged that significant numbers of adults are abused and it is important that *Primary Healthcare Centre Chopwell* has a Safeguarding Adults Policy, a set of procedures to follow and puts in place preventative measures to try and reduce these numbers.

Primary Healthcare Centre Chopwell is committed to implementing this policy. The protocols it sets out for all staff and partners will provide in-house learning opportunities. This policy will be made accessible to staff and partners via the practice Safeguarding folder in the shared drive and paper copy in the Safeguarding file locked in the cupboard in the Practice Manager's room. It will be reviewed every 3 years or earlier in the event of significant changes in National policy or guidance.

It addresses the responsibilities of all members of the practice team and those outside the team with whom we work. It is the role of the practice manager and Safeguarding Adults Lead to brief the staff and partners on their responsibilities under the policy, including new starters and sessional GPs. For employees, failure to adhere to the policy could lead to disciplinary measures.

In order to implement the policy *Primary Healthcare Centre Chopwell* will work:

- to promote the freedom and dignity of the person who has or is experiencing abuse
- to promote the rights of all people to live free from abuse and coercion
- to ensure the safety and well being of people who do not have the capacity to decide how they want to respond to abuse that they are experiencing
- to manage services in a way which promotes safety and prevents abuse
- to recruit staff safely, ensuring all necessary checks are made
- to provide effective management for staff through supervision, support and training. The practice will seek to meet the requirements of the NHS Newcastle Gateshead CCG Alliance Safeguarding Adults Training plan.

Primary Healthcare Centre Chopwell

- will work with other agencies within the framework of the Gateshead Safeguarding Adults Board Policy and Procedures, updated to take into account the requirements of The Care Act 2014
- will act within GMC guidance on confidentiality and will usually gain permission from patients before sharing information about them with another agency
- will pass information to Adult Services when more than one person is at risk. For example: if there are concerns regarding any form of abuse, including neglect, within a care home.
- will inform patients that where a person is in danger, a child is at risk or a crime has been committed then a decision may be taken to pass information to another agency without the service user's consent
- will make a referral to Adult Services or Children's Services as appropriate
- will endeavour to keep up to date with national developments relating to preventing abuse and welfare of adults

The Practice Safeguarding Adults Lead is **Dr M S Hassan.**

Primary Healthcare Centre Chopwell recognises that it is the role of the practice to be aware of maltreatment (abuse and mistreatment) and share concerns but not to investigate or to decide whether or not an adult has been abused.

This policy should be read in conjunction with the local Multi-Agency Safeguarding Adults Policy and Procedures documents which are available at:

http://www.gateshead.gov.uk/Health-and-Social-Care/Adult-Social-Care/Keeping-people-safe/Safeguarding-Adults/home.aspx

Procedures Template

1. Introduction

These procedures have been designed to ensure the welfare and protection of any adult who accesses services provided by *Primary Healthcare Centre Chopwell*. The procedures recognise that adult abuse can be a difficult subject for workers to deal with. *Primary Healthcare Centre Chopwell* is committed to the belief that the protection of adults from harm and abuse is everybody's responsibility and the aim of these procedures is to ensure that all partners and staff act appropriately in response to any concern around adult abuse.

2. Recognising the signs and symptoms of abuse

All who work at *Primary Healthcare Centre Chopwell* should take part in training and if appropriate significant event discussion regarding safeguarding adults. Reference should be made to Safeguarding Vulnerable Adults – a toolkit for General Practitioners published by the British Medical Association which identified that is essential that

- Health professionals should be able to identify adults whose physical, psychological or social conditions are likely to render them vulnerable
- Health professionals should be able to recognise signs of abuse and neglect, including institutional neglect
- Health professionals need to familiarise themselves with local procedures and protocols for supporting and protecting vulnerable adults

The practice will seek to meet the requirements of the NHS Newcastle Gateshead CCG Safeguarding Adults Training Plan.

Abuse and neglect can take many forms. Professionals should not be constrained in their view of what constitutes abuse or neglect, and the circumstances of an individual case should always be considered.

Abuse may be:

- A single act or repeated acts;
- an opportunistic act or a form of serial abusing where the perpetrator seeks out and "grooms" individuals;
- an act of neglect or a failure to act;
- multiple in form (many situations involve more than one type of abuse);

- deliberate or the result of negligence or ignorance;
- a crime.
- Unintentional abuse (e.g. due to carer stress)

For the purposes of this policy, abuse is categorised as follows:

- **Discriminatory**

Including forms of harassment, bullying, slurs, isolation, neglect, denial of access to services or similar treatment; because of race, gender and gender identity, age, disability, religion or because someone is lesbian, gay, bisexual or transgender. This includes racism, sexism, ageism, homophobia or any other form of hate incident or crime.

- **Domestic abuse or violence**

Including an incident or a pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse, by someone who is, or has been, an intimate partner or family member regardless of gender or sexual orientation. This includes psychological/emotional, physical, sexual, financial abuse; so called 'honour' based violence, forced marriage or Female Genital Mutilation (FGM).

- **Financial or material**

Including theft, fraud, internet scamming, 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.

- **Modern slavery**

Encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

- **Neglect and acts of omission**

Including ignoring medical, emotional or physical care needs, failure to access appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

- **Organisational (sometimes referred to as institutional)**

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

- **Physical**

Including assault, hitting, slapping, pushing, burning, misuse of medication, restraint or inappropriate physical sanctions.

- **Psychological (sometimes referred to as emotional)**

Including 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 support networks.

- **Sexual**

Including rape, indecent exposure, sexual assault, sexual acts, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts to which the adult has not consented or was pressured into consenting. It also includes sexual exploitation which is exploitative situations, contexts and relationships where the person receives “something” (e.g. food, accommodation, drugs, alcohol, mobile phones, cigarettes, gifts, money) or perceived friendship/relationship as a result of them performing, and/or another or others performing sexual acts.

- **Self-neglect**

Includes a person neglecting to care for their personal hygiene, health or surroundings; or an inability to provide essential food, clothing, shelter or medical care necessary to maintain their physical and mental health, emotional wellbeing and general safety. It includes behaviour such as hoarding.

The response to the concern of abuse or neglect will be proportionate to the level of harm that has occurred or may occur. There is a Risk Threshold Tool which explains the types of response that can be expected. This will be used by Adult Social Care to guide the action required.

The seriousness of harm, or extent of the abuse, is not always clear at the point of concern or referral. All reports of suspicions or concerns should be approached with an open mind.

Abuse can be perpetrated by anyone and can occur in any relationship. More often, people are abused by someone who is well known to them.

Abusers may be:

- Spouses/partners
- Other family members
- Neighbours
- Friends
- Acquaintances
- Local Residents
- People who deliberately exploit adults they perceive as vulnerable to

abuse
- Paid staff or professionals
- Volunteers
- Strangers.

Abuse often occurs where the person who is abusing is in a more powerful position than the person who is being abused. In some instances, the abuser themselves may be at risk of, or vulnerable to, abuse.

Abuse can take place anywhere, including in people's own homes, in the homes of their family or friends, in a public place, in care settings such as hospitals or care homes, at places of work or education

3. Guiding Principles and Values

The practice is committed to ensuring that all adults have the right to:

- live their lives free from fear, violence, harassment, humiliation, degradation, abuse and neglect
- be safeguarded from harm and exploitation
- be protected from mistreatment and abuse; and
- live an independent lifestyle and to make choices, even if some of those choices involve a degree of risk.

In recognition of this, the practice identifies the following principles (from the Care Act 2014) and commitments that underpin safeguarding adults work. We are committed to ensuring:

- **Empowerment.** We ask people what outcomes they want as a result of the safeguarding adults process and these directly inform what happens.
- **Protection.** We help and support people to report abuse. We support people to be involved in the safeguarding adults process to the extent to which the adult wants.
- **Prevention.** We can effectively identify and appropriately respond to signs of abuse and suspected criminal offences and take action before harm occurs. We make everyone aware, through provision of appropriate training and guidance, of how to recognise signs and take any appropriate action to prevent abuse occurring.
- **Proportionality.** We work in the best interests of the adult and undertake the least intrusive response appropriate to the risk that is presented.
- **Partnership.** We will work together to place the welfare of individuals above organisational boundaries. We contribute to local information-sharing and multi-agency partnership arrangements and staff understand these.

- **Accountability.** The practice and our staff understand our role and what is expected of us.

In addition to these principles, the practice recognises the importance of ensuring that safeguarding adults interventions are person-led and outcome-focused. This means that we will have regard to the views, wishes, feelings and beliefs of the adult whom the concern is about in determining what action to take.

4. *Practice Lead for* Safeguarding Adults

The Practice Safeguarding Adults Lead is **Dr M S Hassan**

The practice lead

- implements *Primary Healthcare Centre Chopwell* safeguarding adults policy
- ensures that the practice meets contractual guidance
- ensures safe recruitment procedures
- supports reporting and complaints procedures
- advises practice members about any concerns that they have
- ensures that practice members receive adequate support when dealing with safeguarding adults concerns
- leads on analysis of relevant significant events
- determines training needs and ensures they are met
- makes recommendations for change or improvements in practice procedural policy
- acts as a focus for external contacts
- has regular meetings with others in the Primary Healthcare Team to discuss particular concerns

5. Responding to people who have experienced or are experiencing abuse (With the Mental Capacity Act taken into account)

Primary Healthcare Centre Chopwell recognises that it has a duty to act on reports, or suspicions of abuse or neglect. It also acknowledges that taking action in cases of adult abuse is never easy.

How to respond if you receive an allegation:

- Reassure the person concerned
- Listen to what they are saying
- Record what you have been told/witnessed as soon as possible
- Remain calm and do not show shock or disbelief
- Tell them that the information will be treated seriously
- Don’t start to investigate or ask detailed or probing questions

- Don’t promise to keep it a secret

If you witness abuse or abuse has just taken place the priorities will be:

- To call an ambulance if required
- To call the police if a crime has been committed
- To preserve evidence
- To keep yourself, staff, volunteers and service users safe
- To inform the patient’s GP or the Practice Adult Safeguarding Lead
- To record what happened in the medical records

The practice will follow the Safeguarding Adults Board procedure (see appendix) for responding to abuse or neglect. Key points include

The primary focus/point of decision-making must be as close as possible to the adult, and individuals must be supported to make their own choices. The circumstances surrounding any actual or suspected case of abuse will also inform the response.

Adults should be offered support services as appropriate to their needs. This includes support to participate in all aspects of the safeguarding adults process. Under the Care Act 2014, there is a duty to provide independent advocacy for adults who have a substantial difficulty in participating in the safeguarding adults process and where there is no other appropriate adult to represent them

There is a presumption that adults have the mental capacity to make informed decisions about their lives. If someone has been assessed as not having mental capacity to make decisions about their safety, those decisions will be made in their best interests as set out in the Mental Capacity Act (MCA) 2005 and the MCA Code of Practice.

Where an adult who has mental capacity takes a decision to remain in an abusive situation, consideration must be given to whether the adult is making the decision free from intimidation or coercion, with an understanding of the risks involved, and with access to appropriate services should they change their mind. If it is felt that a person’s decision may have been influenced by threat or coercion, and consequently lack validity, consideration will need to be given to their best interests and overriding their consent to take further action.

It is important that decisions made about safeguarding interventions at any one time are not taken to be irreversible or non-negotiable.

Sometimes an adult with mental capacity may not want action to be taken but their consent has to be overridden because: there are risks to others; there is a risk of serious harm; or a serious crime has occurred or is at risk of occurring.

Adults who have been or are at risk of abuse should be given information, advice and support in a form that they can understand and have their views included in all forums that are making decisions about their lives.

All decisions taken by professionals about a person's life should be timely, reasonable, justified, proportionate, ethical and fully recorded.

Adults have the right to privacy and confidentiality throughout the safeguarding adults process, except where there is a requirement to override this e.g. where it is needed to share the person's information to safeguard others who may be at risk. The need for an adult to be identified should be considered at each stage to ensure it is not shared unless it is absolutely necessary to do so.

Staff have a duty to report promptly any concerns or suspicions that an adult is being, or is at risk of being, abused. Staff should fully understand their role and responsibilities in regard to this policy and procedures and that they know how to recognise abuse and how to report and respond to it.

When a concern is reported on a multi-agency basis to the local authority, Gateshead Council must make enquiries, or cause others to do so, if they reasonably suspect that an adult who meets the criteria in section 2 is, or is at risk of, being abused or neglected

Where it is believed that the abuse or neglect is a crime, the Police should be notified as soon as possible in discussion with the Adult Safeguarding Unit.

Actions to protect the adult from abuse should always be given high priority by all organisations involved. Concerns or allegations should be reported without delay and all agencies must cooperate with each-other to protect the adult(s) concerned. Early sharing of information is key to providing an effective response where there are emerging concerns.

Any action taken to stop or prevent abuse must be lawful and proportionate to the risk. The practice will make the dignity, safety and wellbeing of the individual a priority in their actions.

As far as possible the practice will respect the rights of the person causing, or alleged to be causing, harm. If the person alleged to have caused harm is also an adult with care and support needs, then these should be taken into consideration.

Action taken under these procedures does not affect the obligations on the practice to comply with statutory responsibilities, such as notification to regulatory authorities, employment legislation or other regulatory requirements.

The practice will contribute to effective inter-agency working, multidisciplinary assessments and joint working partnerships in order to provide the most effective means of safeguarding adults.

The practice will have information about individuals who may be at risk from abuse and may be asked to share this where appropriate. We will do this, with due regard to confidentiality and information sharing protocols.

6. Mental Capacity Act

The presumption is that adults have mental capacity to make informed choices about their own safety and how they live their lives. Issues of mental capacity and the ability to give informed consent are central to decisions and actions in Safeguarding Adults. Mental capacity is time and decision specific. The practice will work within the principles of the Mental Capacity Act 2005.

- An Adult at Risk has the right to make their own decisions and must be assumed to have capacity to make decisions about their own safety unless it is proved (on a balance of probabilities) otherwise.
- Adults at Risk must receive all appropriate help and support to make decisions before anyone concludes that they cannot make their own decisions.
- Adults at Risk have the right to make decisions that others might regard as being unwise or eccentric and a person cannot be treated as lacking capacity for these reasons.
- Decisions made on behalf of a person who lacks mental capacity must be done in their best interests and should be the least restrictive of their basic rights and freedoms.

Deprivation of Liberty Safeguards (DoLS) provide protection to people in hospitals and care homes who lack mental capacity for decisions about their care and treatment. Advice will be sought if there is concern that a person may be being deprived of their liberty.

Independent Mental Capacity Advocates (IMCAs) have a statutory role in proving safeguards for people who lack capacity to make important decisions and who do not have family or friends who can represent them to do so. Referrals will be made in these circumstances during safeguarding procedures or if it is necessary to make a decision about serious medical treatment in a non-emergency situation.

7. Prevention

It is far better to put in place strategies to minimise the likelihood of abuse occurring – preventative strategies – than to deal with abuse after it has happened. The practice is committed to playing its part in prevention of abuse and neglect.

People can be at risk of abuse whilst they are receiving health and/or care services, whether that is in a care setting or in their own home. Successful prevention of abuse and neglect demands that service providers tackle the factors which contribute to its occurrence at all levels.

The practice has

- a clear, well-publicised policy of ‘zero-tolerance’ of abuse within its organisation;

- a safeguarding adults policy and clear procedural framework that is consistent with the multi-agency policy, and which is publicised and made available to all staff, volunteers, patients and carers in a range of appropriate and accessible formats;
- a clear policy and procedure for reporting to the Police all suspected serious crimes taking place within its service;
- clear policies against discrimination and harassment towards any person on any grounds;
- a code of conduct or policy - compatible with the law - for all staff and volunteers, setting clear standards for relationships between people in a position of trust and patients;
- a 'whistle blowing' or 'speaking out' protocol, cross-referenced with these safeguarding adults procedures;
- a commitment to implementing the safeguarding adults information sharing protocol, and to encouraging good communication between staff, managers and stakeholders;
- a clear, accessible and well-publicised complaints procedure, which includes information about how to contact and escalate concerns to external bodies such as regulators and service commissioners;
- effective quality assurance and governance processes that are cross-referenced with safeguarding adults issues; and
- a clear policy and procedure for dealing with staff disciplinary and grievance issues.

Additionally the practice has clear operational guidelines in accordance with regulations and best practice in respect of:

- robust recruitment standards;
- the provision of adequate induction and relevant ongoing learning and development.
- its response to concerns or allegations that a member of staff has perpetrated or contributed to abuse; and
- referral to the Disclosure and Barring Service (formerly the Independent Safeguarding Authority) of managers, staff or volunteers who are engaged in regulated activity and are believed to have harmed an adult or a child, whether or not that is in the course of their employment.

The practice has

- guidance in place for staff undertaking personal and intimate care tasks with service users/patients, moving and handling tasks, physical interventions (restraint), control and administration of medicines, handling of finances and risk assessment and risk management;
- clear procedures for dealing with, recording, and monitoring: serious incidents; accidents; health and safety issues; violent and challenging behaviour; tissue viability; sexuality and relationships between service users.
- where a safeguarding issue has been identified for a particular individual, that this is reflected in their care/treatment/support plan where relevant. This may include a risk assessment in relation to the person's safety or any risk they may pose to others;
- methods for addressing identified risks will be clearly documented and where appropriate joint risk assessment processes will be used.

Organisations will carry out regular reviews of incidents not referred to the safeguarding adults procedures. If as a result of these reviews safeguarding adults concerns come to light, these should be shared on a multi-agency basis as per this policy and procedure.

8. Case conferences, strategy meetings etc.

The contribution of GP practices to safeguarding adults is invaluable and priority will be given to attendance and sending a report to meetings wherever possible. The practice will respond to requests for information for safeguarding adults enquiries with due consideration of consent, confidentiality and information sharing principles.

9. Recording Information

- Concerns and information about vulnerable adults should be recorded in the medical records. These should be recorded using recognised computer codes provided at the end of this document.
- Concerns and information from other agencies such as social care, the police or from other members of the Primary Health Care Team, including district nurses should be recorded in the notes under a computer code
- Email should only be used when secure, [e.g. nhs.net to nhs.net] and the email and any response(s) should be copied into the record
- Conversations with and referrals to outside agencies should be recorded under an appropriate computer code
- Case Conference notes may be scanned in to electronic patient records as described below. This will usually involve the summary/actions, appropriately annotated by the patient's usual doctor or Practice Adults Safeguarding Lead

- Records, storage and disposal must follow national guidance for example, *Records Management, NHS Code of Practice* 2009
- If information is about a member of staff this will be recorded securely in the staff personnel file and in line with your own jurisdiction guidance

10. Guidance on dealing with third party concerns

This guidance gives some general principles of how GPs should respond if they are given third party information about one of their patients e.g. information about a patient's alcohol consumption or mental health.

Each situation is different and GPs who are in doubt as to how to proceed should seek advice e.g. from Safeguarding leads or their Defence Union.

1. Clarify with the person providing the information what they wish you to do with the information.

2. Do not guarantee confidentiality. It may not be possible to keep the information confidential for example if it relates to safeguarding children or vulnerable adults or if a serious crime has been committed or may be committed

3. If you are provided with information that raises concern about safeguarding children or vulnerable adults you do not need to be certain that the information is accurate before sharing it.

4. Advise the information giver what you plan to do with the information particularly if you intend to share the information unless this will increase risk to the patient or information giver.

5. Document what the information is and who gave it

6. Consider how to prevent inadvertent disclosure of the information to the patient such as computer screens being visible by patients during consultations or when patient summaries or full patient records are released.

7. Take care when someone provides you with information about a patient that you do not disclose to them any information about your patient.

11. Case Conference Summaries & Minutes

Case conference minutes frequently raise concerns - much of it about information concerning third parties. See also the Good Practice Guidance to GP electronic records:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125310

Case conference minutes should be stored in the patient's records.

Conference minutes should not be stored separately from the medical records because:

- they are unlikely to be accessed unless part of the record
- they are unlikely to be sent on to the new GP should the patient register elsewhere
- they may possibly become mislaid and lead to a potentially serious breach in patient confidentiality.

Whilst GPs may have concerns about third party information contained in case conference minutes, part of the solution is to remove this information if copies of medical records are released for any reason, rather than not permitting its entry into the medical record in the first place.

10. Sharing Information and Confidentiality

The practice will follow GMC guidance on patient confidentiality.

In most situations patient consent must be obtained prior to release of information including making a safeguarding adults alert.

If the patient may lack capacity an assessment of mental capacity should be undertaken. If this assessment indicates that the patient lacks capacity then a referral may be made and information shared under best interest's guidance.

In some circumstances disclosure of confidential information should be made without patient's consent in the public interest. This is most commonly if there is a risk to a third party. An example would be it children or other vulnerable adults were potentially at risk. The patient should normally be informed that the information will be shared but this should not be done if it will place the patient, yourself or others at increased risk.

General Principles of Information Sharing

The 'Seven Golden Rules' of information sharing are set out in the government guidance, *Information Sharing: Pocket Guide.* This guidance is applicable to all professionals charged with the responsibility of sharing information, including in safeguarding adults scenarios.

1. **The Data Protection Act is not a barrier to sharing information** but provides a framework to ensure personal information about living persons is shared appropriately.
2. **Be open and honest** with the person/family from the outset about why, what, how and with whom information will be shared and seek their agreement, unless it is unsafe or inappropriate to do so.
3. **Seek advice** if you have any doubt, without disclosing the identity of the person if 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 by 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.
7. **Keep a record of your concerns, the reasons for them and decisions** 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

Declaration

In law, the responsibility for ensuring that this policy is reviewed belongs to the partners of the practice.

We have reviewed and accepted this policy

Signed by: Dr M S Hassan Date: 22/05/2019

Signed: *mshassan*

on behalf of the partnership

The practice team has been consulted on how we implement this policy

Signed by: Miss Samantha Cromar Date: 22/05/2019

Signed: *SHCromar*

This policy will be reviewed on DATE**:** 22/05/2020

THRESHOLD INFORMATION: APPENDIX 1 – USE AS A GUIDE ONLY AND IF IN DOUBT SEEK ADVICE

These examples provide a limited illustration of the abuse that can occur, along with an indication of the possible range of severity

Type of Abuse	**Lower Level Harm** Could be addressed via agency internal process/procedures e.g. disciplinary, care management or consider referral to safeguarding to be made. It is not a 'given' that any concerns falling into this section would be dealt with internally		**Significant Very significant Harm** Addressed under Safeguarding Procedures - referral to safeguarding to be made		**Critical** Addressed as potential criminal matter - contact Police/Emergency Services - could be addressed as MAPPA, MARAC, Hate Crime.
Physical	• Staff error causing no/little harm, e.g. skin friction mark due to ill-fitting hoist sling • Minor events that still meet criteria for 'incident reporting'	• Isolated incident involving service user on service user • Inexplicable very light marking found on one occasion	• Inexplicable marking or lesions, cuts or grip marks on a number of occasions	• Inappropriate restraint • Withholding of food, drinks or aids to independence • Inexplicable fractures/injuries • Assault	• Grievous bodily harm/assault with weapon leading to irreversible damage or death
Medication	• Adult does not receive prescribed medication (missed/wrong dose) on one occasion - no harm occurs	• Recurring missed medication or administration errors that cause no harm	• Recurring missed medication or errors that affect more than one adult and/or result in harm	• Deliberate maladministration of medications • Covert administration without proper medical authorisation	• Pattern of recurring errors or an incident of deliberate maladministration that results in ill-health or death

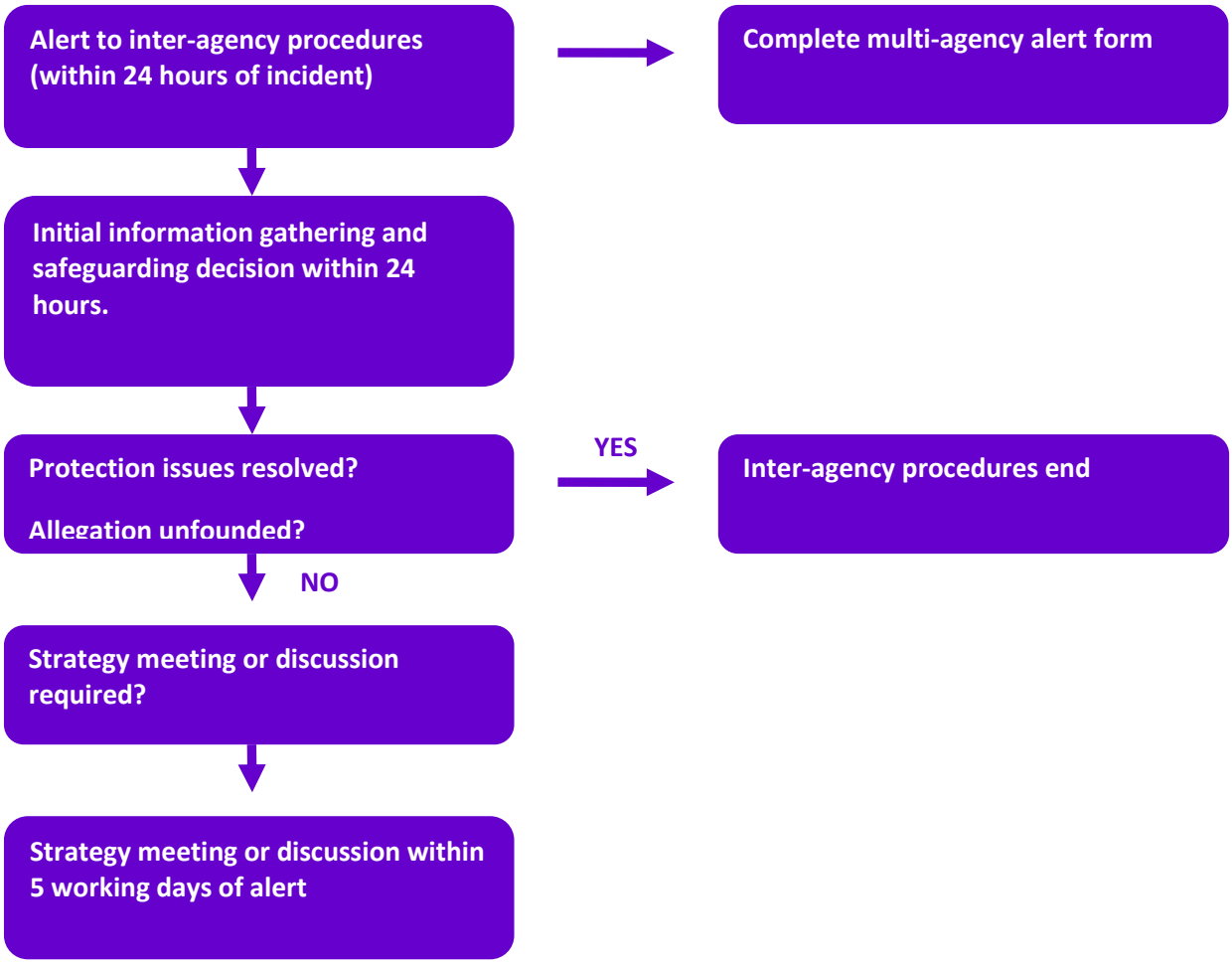
Sexual	• Isolated incident of teasing or low-level unwanted sexualised attention (verbal or by gestures) directed at one adult by another whether or not capacity exists	• Verbal sexualised teasing or harassment	• Sexualised touch or masturbation without valid consent • Being subject to indecent exposure • Contact or non-contact sexualised behaviour which causes distress to the person at risk	• Attempted penetration by any means (whether or not it occurs within a relationship) without valid consent • Being made to look at pornographic material against will/where valid consent cannot be given	• Sex in a relationship characterised by authority, inequality or exploitation, e.g. staff and service user • Sex without valid consent (rape) • Voyeurism
Psychological	• Isolated incident where adult is spoken to in a rude or inappropriate way – respect is undermined but no or little distress caused •	• Occasional taunts or verbal outbursts which cause distress • The withholding of information to dis-empower	• Treatment that undermines dignity and damages esteem • Denying or failing to recognise an adult's choice or opinion • Frequent verbal outbursts	• Humiliation • Emotional blackmail e.g. threats of abandonment/ harm • Frequent and frightening verbal outbursts	• Denial of basic human rights/civil liberties, over-riding advance directive, forced marriage • Prolonged intimidation • Vicious/personalised verbal attacks
Financial	• Money is not recorded safely or recorded properly	• Adult not routinely involved in decisions about how their money is spent or kept safe - capacity in this respect is not properly considered	• Adult's monies kept in a joint bank account – unclear arrangements for equitable sharing of interest • Adult denied access to his/her own funds or possessions	• Misuse/misappropriation of property, possessions or benefits by a person in a position of trust or control. To include misusing loyalty cards • Personal finances removed from adult's control	• Fraud/exploitation relating to benefits, income, property or will • Theft
Neglect	• Isolated missed home care visit - no harm occurs • Adult is not assisted	• Inadequacies in care provision leading to discomfort - no significant harm e.g.	• Recurrent missed home care visits where risk of harm escalates, or one miss where	• Ongoing lack of care to extent that health and well-being deteriorate significantly e.g. pressure	• Failure to arrange access to life saving services or medical care • Failure to intervene in

	with a meal/drink on one occasion and no harm occurs	occasionally left wet. • No access to aids for independence	harm occurs • Hospital discharge, no adequate planning and harm occurs	wounds, dehydration, malnutrition, loss of independence/confidence	dangerous situations where the adult lacks the capacity to assess risk
Discriminatory/Hate Crime	• Isolated incident of teasing motivated by prejudicial attitudes towards an adult's individual differences	• Isolated incident of care planning that fails to address an adult's specific diversity associated needs for a short period • Recurring taunts	• Inequitable access to service provision as a result of diversity issue • Recurring failure to meet specific care/support needs associated with diversity	• Being refused access to essential services • Denial of civil liberties e.g. voting, making a complaint • Humiliation or threats on a regular basis	• Hate crime resulting in injury/emergency medical treatment/fear for life • Hate crime resulting in serious injury/attempted murder/honour-based violence
Institutional (any one or combination of the other forms of abuse)	• Lack of stimulation/ opportunities to engage in social and leisure activities • SU not enabled to be involved in the running of service	• Denial of individuality and opportunities to make informed choices and take responsible risk • Care-planning documentation not person-centred	• Rigid/inflexible routines • Service users' dignity is undermined e.g. lack of privacy during support with intimate care needs, pooled under-clothing	• Bad practice not being reported and going unchecked • Unsafe and unhygienic living environments	• Staff misusing position of power over service users • Over-medication and/or inappropriate restraint managing behaviour • Widespread, consistent ill treatment
Professional	• Service design where groups of service users living together are incompatible	• Poor, ill informed or outmoded care practice no significant harm • Denying VA access to professional support and services such as advocacy	• Failure to whistle blow on serious issues when internal procedures to highlight issues are exhausted • Failure to refer disclosure of abuse	• Failure to support vulnerable adult to access health, care, treatments • Punitive responses to challenging behaviours	• Entering into a sexual relationship with a patient/client,

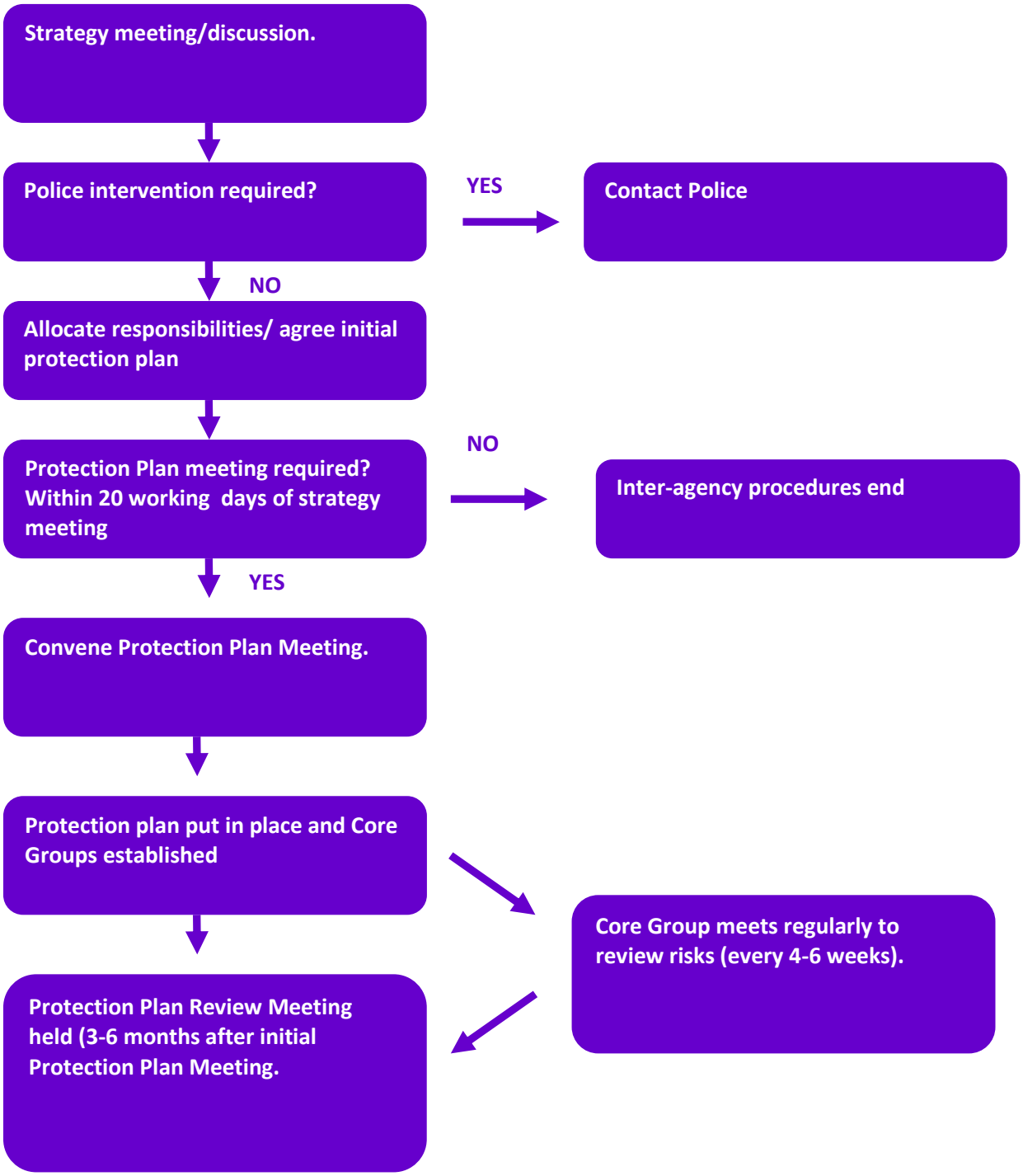
If you are in any doubt about whether a concern constitutes a safeguarding matter, then you should submit an alert your local Team see **http//:www.safeguardingadultsne.co.uk.**

Appendix 2

Decision and strategy stage



Strategy and Protection Plan Stage



SAFEGUARDING ADULTS CONTACT DETAILS

Gateshead Adult Social Care Direct – To make a referral
Tel: 0191 4337033 24 hours a day, 7 days a week or via the website
www.gatesheadsafeguarding.org.uk

Newcastle Adult Social Care Direct – To make a referral
Monday to Friday 08:00 to 17:00hrs.
Tel: 0191 278 8377 Mob: 07968 474891 Fax: 0191 278 8312
This should be followed up by completing an adult safeguarding initial enquiry form. The more information provided, the easier it is for them to assess the referral.

Newcastle Adult Social Care Direct – Emergency out of office hours contact the Emergency Duty Team

Opening times: 5pm to 8.45am on weekdays and 24 hours at weekends

Helpline outside normal hours: 0191 278 7878

Report abuse or neglect: 0191 278 8156

Newcastle Safeguarding Adults referral form
Secure email: scdadmin@newcastle.gov.uk

Northumbria Police
Tel: 101 – Ask for local police station or Protecting Vulnerable Persons Unit

Safeguarding Adults Co-ordination Team
(Mon – Thurs 9am-5pm, Friday 9am-4.30pm)
Tel: 0191 433 2378/ 3929/ 3928 / 3361
Fax: 0191 4332487

Available daily, Monday to Friday 09:00 – 16:00hrs. **Please note that this is an advice service ONLY**. All concerns should be raised with Adult Social Care Direct.

Mental Capacity Act Lead / Deprivation of Liberty Safeguards Lead
Catherine Meredith
Tel: 0191 4333959

Designated Nurse Safeguarding Children and Adults

Howard Stanley
Tel: 0191 2172581/07825696200
howard.stanley@nhs.net

GP Lead for Adult Safeguarding
Dr Karen Hutchinson (2 sessions per week – reply will usually be within a week).
Tel: 0191 2172738
karen.hutchinson9@nhs.net

Safeguarding Adults Officer:
Marie Brown (Full time)
Tel: 0191 2172671/07825696205
mbrown14@nhs.net

Safeguarding Adults Officer:
Catherine Turner (Full time)
Tel: 0191 217 273/07467004441
catherine.turner2@nhs.net

Adult safeguarding CCG Advice: ngccg.asg@nhs.net 0191 2172829
(Checked several times daily by adult safeguarding team) Monday-Friday

Gateshead Safeguarding Adults from Abuse. Multi-agency policy and procedures

http://www.gateshead.gov.uk/DocumentLibrary/CBS/PoliciesandDocs/Safeguarding-Adults/SG-Adults-multi-agency-pols-and-procedures.pdf

Your Voice Counts (IMCA) https://www.yvc.org.uk/
Tel: 0191 478 6472

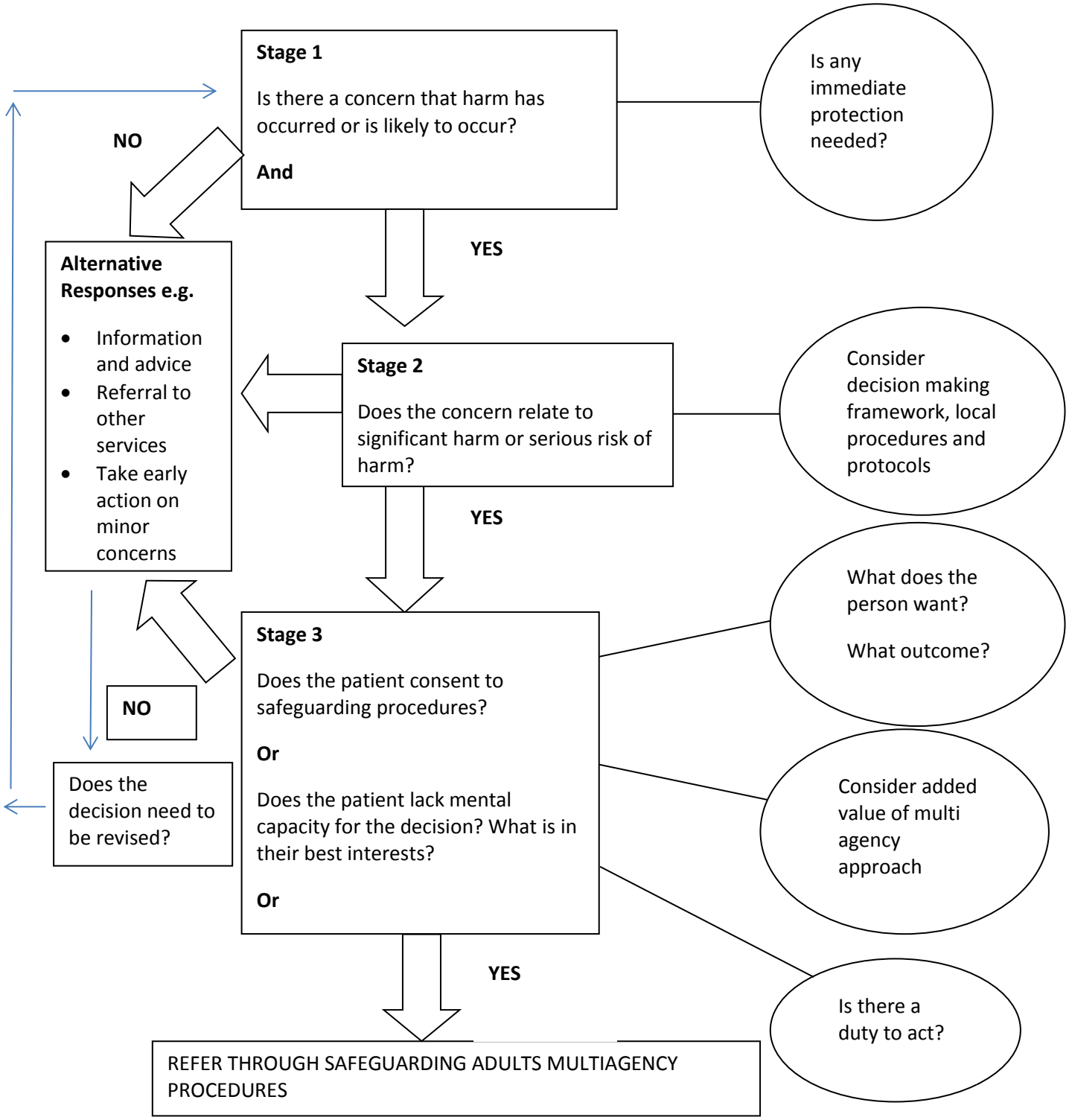
Domestic violence advice/ support
Gateshead Domestic Abuse Team
domesticabuseteam@gateshead.gcsx.gov.uk 0191 433 3538
https://www.gateshead.gov.uk/article/8723/Domestic-abuse

Newcastle Integrated Domestic Abuse Service (NIDAS)
Tel: 0191 214 6501
https://www.newcastleidas.co.uk/
email: Nidas.Team@thirteengroup.co.uk

National Stalking Helpline 0808 802 0300
https://www.suzylamplugh.org/
RAPE Crisis: Gateshead and Newcastle https://rctn.org.uk/ 0800 035 2794
(Women and girls aged 13+. Only women are employed)

SARC Sexual Assault Referral Centre (REACH)
www.reachsarc.org.uk 0333 3448283 (24/7 Crisis support: includes access to ISVA. Can have forensic medical or Non police medical within 7 days of attack if don't want to report yet.)

Safeguarding Adults Decision Making Flowchart – From Safeguarding Adults: The Role of Health Service Practitioners



Appendix 4

Safeguarding Adults – Practice Checklist

Practice Name - Primary Healthcare Centre Chopwell
Date – 22/05/2019

	Yes	No	Action Needed
The practice has agreed a safeguarding adults policy	Y		Yes available in the Safeguarding shared folder and a hard copy is in the Safeguarding folder.
The practice has a safeguarding adults lead	Y		Dr. M S Hassan
The practice highlights the records of adults at risk	Y		
Exception reporting for QOF is based on a clinician decision on a case by case basis	Y		
The practice has patient information on safeguarding adults available in the waiting room and/or other public areas	Y		G'head Safeguarding Adults poster displayed in waiting room
The practice has a record of training undertaken by all clinical and non clinical staff	Y		Yes – see training matrix – available from the Practice Manager.
Safeguarding adults issues have been discussed at a significant event meeting within the past 2 years	Y		Yes at clinical meetings which include significant events
The primary health care team regularly share concerns about adults at risk	Y		Yes at clinical and non clinical meetings.
The practice has adopted minimum safety criteria for the employment of staff	Y		All staff are DBS checked.
The practice has a complaints policy and a whistle-blowing policy	Y		Yes – complaints policy available and whistle-blowing policy available in staff handbook.
The practice has a carers' policy and the implementation of this has been reviewed	Y		Dr. M S Hassan is the carers' lead and Samantha Cromar is the carers' champion. The practice has a carers' policy.

Record keeping and coding

1. The following areas should be recorded carefully in patients' records. Records should include the reason for a decision, in addition to the decision itself.

- Concerns about abuse or neglect
- Discussions and decisions about consent and information sharing
- Mental capacity assessments and best interests decisions
- Practice discussions about individuals
- Communications with external agencies about an individual

2. **Records of safeguarding meetings, coding of MARAC meetings** etc. should be recorded in patient records. These should be removed from the notes in third party data requests. The RCGP and GMC have guides about managing records.
http://www.rcgp.org.uk/clinical-and-research/resources/toolkits/safeguarding-adults-at-risk-of-harm-toolkit.aspx (Coding and management of safeguarding information in general practice) and (MARAC guide for GPs)

https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/protecting-children-and-young-people/keeping-records

3. **Coding adults at risk**. There are many patients who are potentially 'adults at risk' including those on dementia, mental health and learning disability registers. There are two groups of patients who it makes sense to use this code for.

- Those about whom a safeguarding concern has been raised. This allows a group of patients who can be discussed in safeguarding team meetings to be readily identified.
- Those whose vulnerability might not be obvious to a doctor who did not know them or those who are particularly vulnerable. Examples might include those living alone with a heightened risk of self-neglect or those where there are concerns about the ability of the people around them to provide supportive care. It is good practice to explain to a patient why this code is being used but this is not always practical or may cause distress to the patient. In this situation make a decision as to whether the benefits of coding outweigh the issue of not seeking consent and make a note of the reason for your decision.

The codes below are a selection of possible EMIS/SYSTMONE codes to use in safeguarding. It is hoped that by practices using similar codes it will facilitate easier

identification of safeguarding concerns for staff who may work in multiple practices, and for when patients transfer surgeries locally. When SNOWMED codes are rolled out this guidance will be updated if required.

	Read	**CTv3 (Systmone)**
Adult safeguarding concern	9Ngj	XaXP4
Adult no longer safeguarding concern	9Ngk	XaXP7
Safeguarding adults protection plan agreed	8CSC	XabzB
Vulnerable adult (see note 1)	133P	XaKXv
Adult no longer vulnerable	13IU	XaX97
Referral to Safeguarding Adults Team	8Hkc	XaQok
DOMESTIC ABUSE		
Victim of domestic violence (At risk of violence in the home)	13VF	XaLVA
History of domestic abuse (see note 2)	14XD	XaN21
Domestic Abuse Victim in household (see note 3)	13Wd	XaaUL
Alleged perpetrator of domestic violence	14XC	XaLVG
Subject of MARAC	13Hm	XaX96
Referral to MARAC	8T0b	Xacv1
SEXUAL EXPLOITATION		
At risk of sexual exploitation	13VX	XabRV
Victim of sexual exploitation	14XH	XaXrY
CAPACITY		
Lacks capacity to give consent (MCA 2005)	9NdL	XaPpE
Lacks Mental capacity to make decision (MCA 2005)	2JR	XaXvr
Referral to IMCA	9Ng6	XaY1
Assessment of mental capacity (see note 4)	28N	XaXbR
Best interests decision	9NgE	XaYYQ
MAPPA		
Subject of MAPPA	13HI	XaQGW
DoLs		
Standard authorisation of deprivation of liberty	9NgzG	Xafhr
No longer subject to DoLS	9NgzW	XaeYf
MODERN SLAVERY		
Victim of Modern Slavery	14XL	Xaerb

Notes

1- This is currently the only available code to use for patients who may be at increased risk; adults may not see themselves as inherently vulnerable but that there is higher “situational risk” due to society not accommodating disability.
2- This code is ambiguous as it may relate to victim or perpetrator
3- This is useful for children to raise awareness
4- As capacity is decision and time specific it is recommended that this code is used with the outcome of the assessment in free-text

MARAC CODING QUESTIONS

The following advice has been developed by the CCG. Professionals have their own responsibility to decide what to do in each situation given the specifics of the case and the practice in which they are working. Advice can be sought from the GP safeguarding lead at the practice or Named GPs for adult and child safeguarding for Newcastle Gateshead CCG.

1. Should MARAC forms be scanned onto computer records?

MARAC forms can be scanned onto patients' records if they do not include third party data other than names. Scanning the MARAC form onto the record retains the context for MARAC codes. Alternatively, key information from the MARAC form should be added to the record under a MARAC code and the form destroyed.. If the MARAC forms are scanned onto the records third party information should be removed at the time of scanning or later if the records are disclosed. MARAC forms should normally be removed for third party data requests.

2. Should MARAC codes be removed?

The fact that MARAC has occurred is a fact so the code should not be removed. It can be made an inactive problem if the risk is reduced. This can be reviewed after a year depending on reduction of 'repeat victimisation'.

3. Records can be viewed by patients. How do we get around this in DV offenders/ those coded as MARAC whom we are not meant to inform?

All systems have the functionality to add codes and consultations which are not visible to the patient via online access. This should normally be used for DV/ MARAC codes.

4. If there are children in the household of a MARAC victim, should they be coded as MARAC too?

Code as Subject of MARAC and Domestic Abuse Victim in Household

5. When do we code a MARAC? Is it when a request comes for information or when a report comes back?

Code it as soon as you know about it as it indicates a high risk situation so important to alert clinicians to this

6. When we code children at risk of domestic violence in the home, at what age should this code be removed?

Codes should be added as sensitive issues and should be left on indefinitely because it may be relevant information in the future e.g. if there are mental health issues. They can be changed from current to past history.