Adult Safeguarding Policy

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Public Sector Equality Duty
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## Staff or Groups Consulted

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1. Summary

This policy sets out how NHS GCCG meets its corporate accountability for adult safeguarding, and provides guidance to NHS GCCG employees and commissioned provider services on their adult safeguarding duties and responsibilities. This Adult Safeguarding policy should be read in conjunction with the CCG’s Safeguarding Strategy which outlines the CCG’s safeguarding:

- Mission Statement and Vision
- Aims and Objectives
- Assurance Approach
- Monitoring the Strategy and,
- Future Developments

2. Introduction

NHS Greenwich Clinical Commissioning Group (NHS GCCG) is committed to ensuring the safety and welfare of adults experiencing, or at risk of abuse or neglect and their families. The CCG has a statutory duty to members of the Royal of Borough of Greenwich Safeguarding Adult Board (RBG SAB) to ensure that there are effective NHS safeguarding arrangements across the local health community working closely together with NHS England and RBG.

NHS GCCG has a statutory obligation to uphold and protect people’s fundamental rights under the Human Rights Act 1998. It has an ethical and moral duty as a commissioner of services to commission high quality safe services for the residents
of Greenwich. NHS GCCG endorses the philosophy of the Care Act 2014\(^1\), and the related statutory guidance\(^2\), which is designed with the aim of creating a framework for action within which all responsible agencies work together to ensure a coherent policy for the protection of adults experiencing, or at risk of, abuse or neglect.

Lessons from recent inquiries such as the failings identified at Mid-Staffordshire NHS Foundation Trust, Winterbourne View Nursing Home and the inquiry into Jimmy Savile have highlighted the importance and need to make safeguarding integral to care and of having robust safeguarding policies and procedures in place. Prevention and effective responses to abuse and neglect is a basic requirement of all health care services and need to be addressed in all aspects of commissioning.

Adult safeguarding is a fundamental element of patient safety and well-being and involves a range of additional measures taken to protect people in the most vulnerable circumstances. The Care Act 2014 is the most significant piece of legislation and biggest change to English adult social care law in over 70 years. It sets out a statutory framework for adult safeguarding.

The Act builds on recent reviews and reforms, and replaces numerous laws to provide a coherent approach to adult social care in England. The bulk of the specific adult safeguarding duties and powers are set out in section 42 – 45, 68 and schedule 2 of the Act. Whilst the responsibility for coordinating Adult Safeguarding lies with Royal Borough of Greenwich as lead agency, other agencies such as health, police and housing all have responsibilities with regard to adult safeguarding, based on a multi-agency partnership approach.

### 3. Scope

This policy relates to all adults experiencing, or at risk of abuse and/or neglect that are resident in the CCG area, or access NHS GCCG commissioned provider services. All CCG members of staff have an individual responsibility for raising concerns where an adult is being abused or neglected and to consider their safety and welfare.

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This policy applies to all NHS GCCG employees (directly or indirectly) including agency, self-employed or temporary staff across all areas of service delivery, as well as commissioned provider services. It applies to all staff and volunteers.

4. Roles and Responsibilities

Adult safeguarding is a collective responsibility, therefore, greater clarity and collaboration around roles and responsibilities should take place at all levels of the system.

5.1. NHS GCCG: is a key component of safeguarding and one of the three statutory core partners of the Safeguarding Adult Board. The CCG needs to ensure its NHS commissioned providers meets their responsibilities through its commissioning arrangements with them.

5.2. NHS GCCG Governing Body: is responsible for ensuring that the CCG has robust adult safeguarding systems which are monitored. They are also responsible for ensuring that all commissioned provider services have in place arrangements to meet their statutory duties in relation to adult safeguarding. They ensure that adult safeguarding and promoting the welfare of adults experiencing or at risk of abuse and neglect is implemented effectively across the local health economy, both through commissioning arrangements and through the responsibilities of commissioned provider services’ boards and committees. The Governing Body will receive an annual adult safeguarding report and be kept informed of adult safeguarding enquiries and issues.

5.3. CCG Chief Officer: has overall accountability for ensuring that the CCG has appropriate strategies, structures, policies and procedures in place to ensure that adults experiencing or at risk of abuse and neglect are safeguarded and that the commissioned provider services comply with relevant national legislation and discharge their duties effectively. They are also responsible for ensuring the contribution by health services to safeguarding and in partnership with the Royal Borough of Greenwich for promoting the development of initiatives to improve the prevention, identification, response and welfare of adults experiencing or at risk of abuse and neglect across the whole local health economy. They need to be aware of and able to respond to national developments and ask searching questions of the
CCG to obtain assurance that the systems and practices are effective in recognising and preventing abuse and neglect. The CCG Chief Officer must sign off the CCG’s strategic plan and annual report.

5.4. **CCG Director of Integrated Governance:** is the Board Executive Lead with responsibility for ensuring that adult safeguarding is represented at Board Level. They will act as a champion in the CCG’s vision and responses and provide high level support for the CCG in leadership positions related to adult safeguarding issues. They are accountable for ensuring strategic ownership of adult safeguarding, providing feedback to the Board on all adult safeguarding activity and the effective implementation of the adult safeguarding policy. They have delegated adult safeguarding responsibilities to the Lead Nurse Adult Safeguarding & Care Home Quality Assurance.

5.5. **CCG Lead Nurse Adult Safeguarding & Care Home Quality Assurance:** is the strategic, professional and operational lead with responsibility for providing senior clinical leadership and overseeing the development of adult safeguarding governance, systems and organisational focus to ensure robust assurance arrangements and monitoring systems are in place within the CCG and the wider health economy, and reports progress to the Board via the Director of Integrated Governance. The Lead Nurse is also the Designated Adult Safeguarding Manager (DASM) as required by the Care Act, the MCA lead and the PREVENT lead. They ensure that the CCG has in place assurance processes to ensure compliance with adult safeguarding legislation, guidance, policy, procedures, quality standards, and contract monitoring. They are responsible for ensuring that the CCG senior management team are made aware of any concerns relating to a commissioned provider services which may be presenting a safeguarding risk. They are a member of the RBG SAB and represent the CCG on the relevant committees, networks and multi-agency groups charged with the management of adult safeguarding.

5.6. **CCG Director of Integrated Commissioning:** is responsible for ensuring the CCG’s procurement processes, service specifications, invitations to tender guidance and service contracts have clear adult safeguarding requirements considered in all prospective and new contracts. They ensure that existing contracts have adult safeguarding explicitly stated and that all commissioned provider services and
contractors are fully aware and adhere to the agreed CCG and multi-agency procedures.

5.7. **CCG Patient Safety Manager:** is responsible for the day-to-day management and oversight of all commissioned provider services serious incident (SI) process. The Patient Safety Manager will work with and support the Lead Nurse Adult Safeguarding and the Continuing Healthcare Team in the management of all adult safeguarding serious incidents and safeguarding adult reviews (SARs).

5.8. **CCG Directors and Managers:** are responsible for ensuring the adult safeguarding policy is implemented within their area of responsibility and that all staff undertake mandatory adult safeguarding training at the appropriate level for their role and that a record of this training is maintained. They support staff in responding to and reporting concerns of abuse against adults. All managers are responsible for ensuring that staff within the CCG have read and understood this document and are competent to carry out their duties in accordance with the procedures described. It is the responsibility of line managers to oversee and record the attendance at adult safeguarding training by their staff appropriate to their level of responsibility and to provide reports on attendance to ensure optimal coverage across all staff groups. Line managers are also responsible for ensuring that staff members receive clinical and managerial supervision which allows them to reflect on their practice and the impact of their actions on others.

5.9. **CCG Continuing Healthcare Manager (CHC):** is responsible for ensuring that adult safeguarding concerns identified by CHC staff are raised with the Lead Nurse Adult Safeguarding via the CCG Adult Safeguarding Inbox greccg.safeguardingadult@nhs.net. The CHC Manager is responsible for ensuring CHC representation at adult safeguarding strategy and progress meetings. They are responsible for ensuring the provision of relevant and timely information to multi-agency adult safeguarding meetings. The CHC Manager is responsible for ensuring all CHC staff members undertake mandatory adult safeguarding training in accordance with their role and that they are familiar with and implement the adult safeguarding policy and procedures.

5.10. **CCG Continuing Healthcare Nurse Assessors:** are responsible for ensuring they attend multi-agency adult safeguarding meetings as determined by the CHC
Manager, as well as providing relevant and timely information to multi-agency adult safeguarding meetings. They are also responsible for maintaining their own professional registration and complying with their respective professional bodies’ code of conduct and for ensuring any safeguarding concerns in relation to NHS funded services are raised with the Lead Nurse Adult Safeguarding via the CCG Adult Safeguarding Inbox greccg.safeguardingadult@nhs.net.

5.11. CCG Contract and Commissioning Managers: the role of contract and commissioning managers is to promote and make explicit reference to adult safeguarding principles in the contracts, service level agreements and commissioning arrangements with all commissioned provider services. They are responsible for supporting the Lead Nurse Adult Safeguarding in obtaining assurance, monitoring and ensuring appropriate systems are in place which provides assurance to that adults experiencing or at risk of experiencing abuse and neglect receive appropriate care.

5.12. CCG Communication Team: has responsibility for identifying a clear communication plan for working with relevant colleagues both internally and externally to support effective management of adult safeguarding concerns. They will work with the relevant parties to prepare media statements. They will also confirm proposed handling arrangements with NHSE, and where necessary develop communications/media handling strategies with other organisations and liaise with relevant stakeholders as appropriate. The Communication Team will design and implement a strategy for on-going and longer-term management of communications.

5.13. All CCG Staff: are responsible for actively co-operating with managers in the application of this policy to enable the CCG to discharge its legal obligations. All staff must be aware of the potential for abuse of adults at risk and the actions required of them should they have any concerns. All staff should act in a timely manner on any concern or suspicion that an adult is being or is at risk of being abused, neglected or exploited and ensure that the situation is assessed and investigated. They should be familiar with the agreed CCG and multi-agency policy and procedure and attend relevant training commensurate with their role. Staff must adhere to this policy.

5.14. NHS England (London Region): has responsibility for assuring the Department of Health that all NHS organisations in London are complying with
government legislation as it relates to adult safeguarding and for commissioning independent investigations/inquiries in adult safeguarding cases which meet national agreed criteria.

5.15. **NHS GCCG Commissioned Provider Services**: have responsibility for ensuring that all staff have a responsibility to safeguarding adults at risk and to demonstrate that they have adult safeguarding expertise and commitment at all levels of their organisation and that they are fully engaged and in support of local accountability and assurance structure, in particular via the SABs and in regular monitoring meetings with the CCG as their commissioner. The CCG expects its commissioned provider services to have the effective arrangements in place as outlined within the CCG’s indicators and contract document, including:

- Ensure staff are effectively and appropriately trained in adult safeguarding, the Mental Capacity Act and Deprivation of Liberty at a level commensurate with their role and in line with any relevant adult safeguarding competencies.
- Ensure that adult safeguarding forms part of any induction or mandatory training in order to develop and embed a culture within their organisation that ensures safeguarding is acknowledged to be everybody’s business.
- Ensure safe recruitment practices and arrangements for dealing with allegations against people who work with adults at risk as required.
- Develop a suite of adult safeguarding policies and procedures, and records including chaperoning policy, consent to care and treatment outlined in line with legislation and guidance including the Mental Capacity Act 2005 that reflects the frameworks set by the CCG and the SAB in consultation with them.
- Ensure effective supervision arrangements for staff working with adult at risk
- Ensure effective arrangements for engaging and working in partnership with other agencies
- Identify of a named lead for adult safeguarding allegations against staff. Share information in a timely way with relevant partners such as the RBG and the CCG even where they are taking action themselves. It is of critical importance that allegations are handled sensitively and in a timely way both to stop any abuse and neglect but also to ensure a fair and transparent process. It is in no-one’s interests to unnecessarily prolong enquiries.
• Develop an organisational culture such that all staff are aware of their personal responsibility to report concerns and to ensure that poor practice is identified and tackled
• Have in place a policy which identifies organisational and individual responsibilities for whistleblowing, including assurances of protection for whistle blowers;
• Be registered with the Care Quality Commission. In order to be registered, provider services must ensure that those who use their services are safeguarded and that staff are suitably skilled and supported.
• Have available an MCA Lead who is responsible for providing support and advice to clinicians in individual cases and supervision for staff in areas where these issues may be particularly prevalent and/or complex. Have a role in highlighting the extent to which their own organisation is compliant with the MCA through undertaking audit, reporting to the governance structures and providing training.

5. Adult Safeguarding – What it is and why it matters

Local authorities and their partners must focus on joining up around an individual, making the person the starting point for planning and looking at the person holistically. It is not possible to promote wellbeing without establishing a basic foundation where people are safe and their care and support in on a secure footing.

Adult safeguarding is the process of protecting adults who:

• Have care and support needs (whether or not the authority is meeting any of those need),
• Are experiencing, or are at risk of, abuse or neglect, and,
• As a result of those needs are unable to protect themselves from either the risk of, or the experiencing of abuse or neglect.

It is about protecting an adult’s right to live in safety, free from abuse and neglect. It is about people and the CCG working together to prevent abuse and neglect, while at the same time making sure that the adult's wellbeing is promoted including, where
appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action.

This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances. It is about seeking the views of adults experiencing, or at risk of abuse or neglect and their families to influence the commissioning of services. Adult safeguarding is not a substitute for:

- providers’ responsibilities to provide safe and high quality care and support,
- commissioners regularly assuring themselves of the safety and effectiveness of commissioned services,
- the Care Quality Commission (CQC) ensuring that regulated providers comply with the fundamental standards of care or by taking enforcement action; and,
- the core duties of the police to prevent and detect crime and protect life and property.

6. Six Principles for Adult Safeguarding

The Care Act 2014 outlines the following six principles:

- **Empowerment** – people being supported and encouraged to make their own decisions and informed consent;
- **Prevention** – it is better to take action before harm occurs;
- **Proportionality** – the least intrusive response appropriate to the risk presented;
- **Protection** – support and representation for those in greatest need;
- **Partnership** – local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse;
- **Accountability** – accountability and transparency in delivering safeguarding

These principles apply to all sectors and settings; inform the ways in which professionals and other staff work with adults, and sets out how to examine and measure existing adult safeguarding arrangements and to measure future improvements. The six principles are not in order of priority; they are all of equal
importance. However, prevention of harm is always better than investigating harm that individuals have experienced, after the event. Empowerment and proportionality are critical in ensuring that individuals have the best experience possible when they are involved in safeguarding enquiries.

7. Making Safeguarding Personal (MSP)

In addition to the above principles, the Care Act 2014 signals a major change in practice – a move away from the process-driven, tick-box culture when dealing with adult safeguarding to a person-centred outcome-focused approach. This involves engaging the person in a conversation to identify what the person wants, take into account the possibility that individuals can change their minds on what outcomes they want, how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

In Making Safeguarding Personal, NHS GCCG expects all its commissioned provider services to produce a set of internal guidelines for all staff which relates clearly to the CCG’s Adult Safeguarding Policy and multiagency policy and which set out the responsibilities of all staff to operate within. The expectation of the guidelines is outlined in points 14.205 and 14.206 of the Care and Support Statutory Guidance (DH: 2014)

NHS GCCG expects all its commissioned provider services to always promote the adult’s wellbeing in their safeguarding arrangement. Professionals and other staff should not be advocating “safety” measures that do not take account of individual wellbeing as defined in Section 1 of the Care Act 2014.

8. Better Care Fund plans:

The Better Care Fund (BCF) is a government-funded, single pooled budget to help transform integrated care on a local level. Better integrated care means that patients with complex needs will enjoy a more joined-up service across health and social care. The Better Care Fund has been implemented in the context of an ageing population and an increasing number of people who have one or more long-term
conditions. These two factors mean that the needs of patients and service users increasingly cut across multiple health and social care services. Increasing demand and financial pressures mean there is a need to focus on prevention, reducing the demand for services and making the most efficient and effective use of health and social care resources. It is vital that clinical commissioning groups and local authorities understand the populations they serve and how the use of services is distributed within their populations in order to target interventions where they can have the most impact. The impact of the BCF is to be measured against the following: Delayed transfers of care, emergency admissions, admissions to residential and nursing care, effectiveness of reablement, and patient/service user experience.

9. What is Abuse and Neglect?

The Care Act 2014 recognises that there are different types and patterns of abuse and neglect and different circumstances in which they may take place. The types of abuse and neglect list as defined in appendix 2 is not intended to be an exhaustive list nor do they prove that there is actual abuse occurring but an illustrative guide as to the sort of behaviour which could give rise to an adult safeguarding concern, indicating that a closer look and possible investigation may be needed.

NHS GCCG expects its commissioned provider services not to limit their view of what constitutes abuse or neglect as they can take many forms and the circumstances of the individual case should always be considered, although the criteria at section 5 above will need to be met before the issue is referred as an adult safeguarding concern.

Incidents of abuse may be one-off or multiple, and affect one or more persons. Professionals and others should look beyond single incidents or individuals to identify patterns of harm, just as the Care Quality Commission, as the regulator of service quality, does when it looks at the quality of care in health and care services. Repeated instances of poor care may be an indication of more serious problems and of what the Care Act 2014 now describe as organisational abuse. In order to see these patterns, it is important that the CCG’s commissioned provider services record and appropriately share these patterns with the CCG.
10. Who Abuses and Neglects Adults?

Anyone can carry out abuse and neglect, including:

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

While a lot of attention is paid, for example, to targeted fraud or internet scams perpetrated by complete strangers, it is far more likely that the person responsible for abuse is known to the adult and is in a position of trust and power. Abuse can happen anywhere: for example, in someone’s own home, in a public place, in hospital, in a care home or in an education facility. It can take place when an adult lives alone or with others. Staff members need to be vigilant to the possibility of abuse or neglect at all times.

11. Adult Safeguarding Procedures

11.1. Spotting Signs of Abuse and Neglect

Workers across a wide range of organisations need to be vigilant about adult safeguarding concerns in all walks of life including, amongst others in health and social care, welfare, policing, banking, fire and rescue services and trading standards; leisure services, faith groups, and housing. Primary care staff members, in particular, are often well-placed to notice changes in an adult that may indicate they are being abused or neglected.

Anyone can witness or become aware of information suggesting that abuse and neglect is occurring. The adult may say or do things that hint that all is not well. It
may come in the form of a complaint, a call for a police response, an expression of concern, or come to light during a needs assessment.

Regardless of how the safeguarding concern is identified, NHS GCGG expects that everyone in commissioning and commissioned provider services should understand what to do, and where to go locally to get help and advice. It is vital that professionals, other staff and members of the public are vigilant on behalf of those unable to protect themselves. This will include:

- Knowing about different types of abuse and neglect and their signs;
- Supporting adults to keep safe;
- Knowing who to tell about suspected abuse or neglect; and
- Supporting adults to think and weigh up the risks and benefits of different options when exercising choice and control.

Awareness campaigns for the general public and multi-agency training for all staff will contribute to achieving these objectives. NHS GCGG expects all its commissioned provider services to ensure that:

- Staff members, including volunteers, are trained in recognising the symptoms of abuse or neglect, how to respond and where to go for advice and assistance. These are best written down in shared policy documents that can be easily understood and used by all the key commissioned provider services.
- Staff members keep accurate records, stating what the facts are and what are the known opinions of professionals and others and differentiating between facts and opinion. It is vital that the views of the adult are sought and recorded and these should include the outcomes that the adult wants.

Staff members employed by NHS GCGG do not directly provide care to patients; however, they may identify risks to the safety of adults during the course of their role, for example:

- direct observation during visits to commissioned provider services;
- conversations with patients, family, carers and/or staff from commissioned provider services;
- complaints enquiries;
- incident reporting and/or audits;
• concerns raised through whistleblowing;
• concerns raised by an organisation following the transfer of a patient from another organisation’s care

11.2. Reporting and responding to Abuse and Neglect

It is important to understand the circumstances of abuse, including the wider context such as whether others may be at risk of abuse, whether there is any emerging pattern of abuse, whether others have witnessed abuse and the role of family members and paid staff or professionals. The circumstance surrounding any actual or suspected case of abuse or neglect will inform the response. The primary focus must be how to safeguard the adult.

Where the safeguarding concerns arise from abuse or neglect deliberately intended to cause harm, then it would not only be necessary to immediately consider what steps are needed to protect the adult but also whether to refer the matter to the police to consider whether a criminal investigation would be required or appropriate. To ensure effective adult safeguarding arrangements, the CCG expects all its commissioned provider services to have:

• Formalised arrangements in place which set out clearly the agreement, processes and the principles for sharing information with the commissioners, RBG, police, other organisations and the SAB.
• Clear outline of where responsibility lies where abuse or neglect is carried out by employees. The first responsibility to act must be with the employer, involving the relevant key stakeholders such as social workers or counsellors to support the adult to recover
• Robust systems in place to protect adults from harm and are under a duty to correct any awareness of abuse or neglect in their services as soon as possible and to inform the RBG and the CCG.
• Systems and processes to investigate any concern (and provide any additional support that the adult may need), unless there is compelling reason why it is inappropriate or unsafe to do this
Everyone has a duty to care to an adult experiencing or at risk of abuse or neglect, and where abuse or neglect becomes known or suspected the member or staff needs to:

- Listen carefully to what is being said, reassure the person that you are taking them seriously, and get a clear and factual picture of the concern;
- Be honest and avoid making assurances that you may not be able to keep, for example: promising complete confidentiality;
- Act to protect the adult at risk;
- Deal with immediate needs and ensure the person is, as far as possible, central to the decision making process;
- Be clear and say that you need to report the abuse. Do not be judgmental and try to keep an open mind;
- All staff must inform the relevant manager if they are concerned that an adult has been abused/neglected or may be at risk of harm;
- Seek advice from the relevant Safeguarding Adult Lead as to the way forward in relation to referral to local authority and the police where a crime may have been committed, as well as complying with relevant statutory health reporting mechanisms; CQC, SI reporting, etc.;
- If you hear about an incident of abuse from a third party (this is when someone else tells you about what they have heard or seen happen to a vulnerable adult at risk), encourage them to report it themselves or help them to report the facts of what they know. However if the third party refuses to report the abuse then NHS GCCG staff must report it;
- Report the abuse to an appropriate person or service (e.g. your line manager);
- Make a clear record of the events; timed, dated and signed

If a carer speaks up about abuse and neglect, NHS GCCG expects commissioned provider services to listen to them and where appropriate undertake an adult safeguarding enquiry and involve other agencies as appropriate. RBG will set out the case where an external person will be appointed to investigate any concern due to conflict of interest.
11.3. Reporting Abuse or Neglect:

Where concerns are raised an alert referral needs to be made to the RBG Contact Assessment Team (CAT). The key stages of the Adult Safeguarding Process are:

- **Stage 1:** Raising an alert
- **Stage 2:** Making a referral by ringing
  - 0208 921 2304 (office hours)
  - 020 8854 8888 (out of hours), or
  - e-mail at aops.contact.officers@royalgreenwich.gov.uk
- **Stage 3:** RBG responds to the alert referral within 48 working hours of the alert/referral being raised. RBG will identify whether or not the alert referral meets the criteria for strategy meeting or service level concerns.
- **Stage 4:** RBG notifies NHS GCCG Adult Safeguarding inbox: greccg.safeguardingadult@nhs.net of alerts involved NHS funded care patients and/or commissioned provider services.
- **Stage 5:** Where required, NHS GCCG Lead Nurse Adult Safeguarding and the CCG CHC Team will carry out a risk assessment.
- **Stage 6:** Post risk assessment. The CCG’s Senior Management Team will be notified based on the risk assessment score. STEIS notification will be completed by CCG’s Patient Safety Manager were relevant.
- **Stage 7:** CCG Lead Nurse Adult Safeguarding and/or CCG CHC Team will be involved in the RBG Strategy discussion or meeting. The CCG communication team will also be involved in cases risk assessed as high risk.
- **Stage 8:** The commissioned provider services will carry out an investigation.
- **Stage 9:** Case Conference meetings and review of the investigation report (including the recommendations and action plan),
- **Stage 10:** Closure of the Adult Safeguarding Process (includes on-going monitoring where indicated)

The algorithm in appendix 5 further illustrates the reporting of abuse and/or neglect. During these stages, key considerations are:

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3 Safeguarding enquiries and reviews are not indicated where an adult was detained in prison at the time
• Supporting and enabling the adult at risk to achieve outcomes that they see as the best for them, where possible,
• The need for the person at risk to be represented by an advocate, including if required an Independent Mental Capacity Advocate (IMCA),
• Assessing and addressing risk,
• Taking action to protect and support the adult;
• Deciding whether a mental capacity assessment is needed to clarify issues of consent;
• Taking appropriate action for the person causing harm;
• Taking appropriate action with a service and/or its management if they have been culpable, ineffective or negligent;
• Identifying any lessons to be learnt for the future, including recommendations for any changes to the organisation and service delivery.

12. Safeguarding Adult Review (SAR)

Consideration should be given to referring a case to the Safeguarding Adult Board for a potential SAR if an adult dies as a result of abuse or neglect, whether known or suspected, or it is known or suspected that the adult has experienced serious abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult. CCG staff should raise this with the Lead Nurse for Safeguarding Adults who will refer on to the Safeguarding Adult Board if required.

13. Serious Incident Reporting and Safeguarding Adult Procedures

The CCG aims to ensure that there are effective interface between adult safeguarding procedures and serious incident procedures. The coordination of investigations requires a mutual understanding of organisations’ statutory and legal responsibilities, effective communication and cooperation and transparency and learning across the multi-agency safeguarding adult partnership

Serious incidents requiring investigation is defined in the revised NHS England Serious Incident Framework (March 2015). From a safeguarding perspective in the revised framework, serious incidents include actual or alleged abuse; sexual abuse,
physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:

- healthcare did not take appropriate action/intervention to safeguard against such abuse occurring – this may include failure to take a complete history, gather information from which to base care plan/treatment, assess mental capacity and/or seek consent to treatment; or
- healthcare failed to share information when to do so would be in the best interest of the client in an effort to prevent further abuse by a third party and/or to follow policy on safer recruitment; or
- where abuse occurred during the provision of NHS-funded care.

Serious incident investigations take a systematic approach, that seek to improve the way services are being provided and to minimise the risk that incidents of concern will reoccur through sharing lessons learned. Each NHS funded organisation will have a separate serious incident policy which is in conjunction with the overarching commissioning policy.

A number of events that are reported as a serious incident are often safeguarding issues as well (for example, neglect or poor care in a health setting). Whilst such incidents should always be reported as serious incidents they are also a safeguarding issue and an alert must also be raised in line with multi agency procedures. Integrating the processes allows:

- Ensures responses in line with requirements of multi-agency safeguarding adults procedures;
- Enables effective communication and support to those patients and service users involved;
- Enables a transparent, coordinated and comprehensive investigation;
- Brings together learning for continuous improvement;
- Avoids duplication of effort from multiple investigations.

14. Risk Management
The CCG’s Risk Management Strategy sets out the CCG’s overarching approach to the management of risk in the organisation. The Risk Management Framework is an integral part of good general management practice consisting of steps that, when undertaken in sequence, enable continual improvement in decision-making. The adult safeguarding risk management flow aligned to the CCG’s Risk Management Strategy is outlined as follows:

- On the identification of a new risk, the risk assessment form should be completed post discussion with the adult safeguarding Clinical Lead, Director of Integrated Governance and/or at the Joint Safeguarding Children & Adult Executive Group
- The identified risk will be presented for discussion by the responsible person (adult safeguarding lead) at the Joint Safeguarding Children & Adult Executive Group
- The risk register is a standing agenda item on the Joint Safeguarding Children & Adult Executive Group
- The Joint Safeguarding Children & Adult Executive Group is responsible for approving, reviewing, monitoring and closing of all identified adult safeguarding risks
- Responsible person (adult safeguarding lead) would provide regular updates to the CCG’s Patient Safety Manager until the risk is closed.

15. Being Open

Good safeguarding practice requires openness, transparency and trust. There is a legal “duty of candour” on all commissioned provider services. This duty is to tell people (both in person and in writing) about mistakes or other incidents which have not produced the desired outcome, apologies where appropriate, and advise on any action taken as a result. NHS GCCG expects it commissioned provider services to have an open culture around adult safeguarding, working in partnership with commissioners to ensure the best outcome for the adult.

16. Disclosure and Barring Services (DBS)
The Disclosure and Barring Service is a statutory scheme for vetting people working with adults at risk of abuse and neglect. The system provides for checks on people entering the workforce, and maintains lists of individuals who are barred from undertaking regulated activity. NHS GCCG recognises that a disciplinary investigation, and potentially a hearing, may result in the commissioned provider service taking informal or formal measure which may include dismissal and possibly referral to the DBS.

There are three levels of a DBS check. Each contains different information and the eligibility for each check is set out in law. They are:

- **Standard check**: This allows employers to access the criminal record history of people working, or seeking to work, in certain positions, especially those that involve working with adults in specific situations. A standard check discloses details of an individual’s convictions, cautions, reprimands and warnings recorded on police systems and includes both ‘spent’ and ‘unspent’ convictions;

- **Enhanced checks**: This discloses the same information provided on a Standard certificate, together with any local police information that the police believe is relevant and ought to be disclosed;

- **Enhanced with barred list checks**: This check includes the same level of disclosure as the enhanced check, plus a check of the appropriate barred lists. An individual may only be checked against the children’s and adults’ barred lists if their job falls within the definition of ‘regulated activity’ with children and/or adults under the Safeguarding Vulnerable Groups Act 2006, as amended by the Protection of Freedoms Act 2012. It should be noted that in ‘signing off’ or agreeing a personal budget or personal health budget the CCG may add conditions such as a DBS check as part of its risk assessment of safeguarding in specific cases. The CCG may also require personal budget holders using Direct Payments to specify whom they are employing to the CCG.

If someone is removed from their role providing CQC regulated activity by being either dismissed or redeployed following a safeguarding incident, or a person leaves their role (resignation, retirement) to avoid a disciplinary hearing following a safeguarding incident and the employer feels they would have dismissed the person
based on the information they hold, they have a legal duty to refer to the DBS. In circumstances where these actions are not undertaken then RBG can make such a referral.

17. Safeguarding Adult Assurance Approach

The CCG’s approach to obtaining assurance from its commissioned provider services is set out within section 8 of the CCG’s Safeguarding Strategy 2015 – 2016. This policy should be read in conjunction with that strategy.

18. Carrying out Enquiries

RBG will cause any NHS GCCG commissioned provider service to make enquiries if they reasonably suspect an adult is, or is at risk of, being abused or neglected.

An enquiry is the action taken or instigated by RBG in response to a concern that abuse or neglect may be taking place. An enquiry could range from a conversation with the adult (or their representative or advocate) prior to initiating a formal enquiry under section 42, right through to a much more formal multi-agency plan or course of action. Whatever the course of subsequent action, the professional concerned should record the concern, the adult’s views and wishes, any immediate action has taken and the reasons for those actions.

The purpose of the enquiry is to decide whether or not RBG or another organisation, or person, should do something to help and protect the adult. If the RBG decides that another organisation should make the enquiry, for example a commissioned provider service, then RBG will be clear about timescales, the need to know the outcomes of the enquiry and what action will follow if this is not done.

What happens as a result of an enquiry should reflect the adult’s wishes wherever possible, as stated by them or by their representative or advocate. If they lack capacity it should be in their best interests if they are not able to make the decision, and be proportionate to the level of concern.

The adult should always be involved from the beginning of the enquiry unless there are exceptional circumstances that would increase the risk of abuse. If the adult has
substantial difficulty in being involved, and where there is no one appropriate to support them, then RBG will arrange for an independent advocate to represent them for the purpose of facilitating their involvement.

The CCG expects providers to handle enquiries in a sensitive and skilled way to ensure distress to the adult is minimised. The scope of the enquiry, who leads it and its nature, and how long it takes will depend on the particular circumstances. It will usually start with asking the adult their view and wishes which will often determine what steps to take next.

Everyone involved in an enquiry must focus on improving the adult’s well-being and work together to that shared aim. At this stage, there is a duty to consider whether the adult requires an independent advocate to represent and support the adult in the enquiry.

**Objectives of an enquiry:** the objectives of an enquiry into abuse or neglect are to:

- Establish facts;
-Ascertain the adult’s views and wishes;
-Assess the needs of the adult for protection, support and redress and how they might be met;
- Protect from the abuse and neglect, in accordance with the wishes of the adult;
- Make decisions as to what follow-up action should be taken with regard to the person or organisation responsible for the abuse or neglect; and
- Enable the adult to achieve resolution and recovery.

NHS GCCG expects providers wherever possible to seek the consent of the adult before taking action. However, there may be circumstances when consent cannot be obtained because the adult lacks the capacity to give it, but it is in their best interests to undertake an enquiry. Whether or not the adult has capacity to give consent, action may need to be taken if others are or will be put at risk if nothing is done or where it is in the public interest to take action because a criminal offence has occurred. It is the responsibility of all staff and members of the public to act on any suspicion or evidence of abuse or neglect and to pass on their concerns to a responsible person or agency.
What happens after an enquiry: Once the wishes of the adult have been ascertained and an initial enquiry undertaken, discussions should be undertaken with them as to whether further enquiry is needed and what further action could be taken. Actions could take a number of courses: it could include disciplinary, complaints or criminal investigations or work by contracts managers and CQC to improve care standards. RBG must be notified of the outcome of the enquiry and they would then determine the appropriateness of the outcome and whether any further action is necessary and acceptable.

Criminal Offences: Everyone is entitled to the protection of the law and access to justice. Behaviour which amounts to abuse and neglect, for example physical or sexual assault or rape, psychological abuse or hate crime, wilful neglect, unlawful imprisonment, theft and fraud and certain forms of discrimination also often constitute specific criminal offences under various pieces of legislation. Although RBG has the lead role in making enquiries, where criminal activity is suspected, then the early involvement of the police is likely to have benefits in many cases, especially in ensuring that forensic evidence is not lost or contaminated.

19. Person Alleged to be Responsible for Abuse or Neglect

NHS GCCG expects the following of provider services:

- When a complaint or allegation has been made against a member of staff, including people employed by the adult, they should be made aware of their rights under employment legislation and any internal disciplinary procedures.
- Where the person who is alleged to have carried out the abuse themselves has care and support needs and is unable to understand the significance of questions put to them or their replies, they should be assured of their right to the support of an ‘appropriate’ adult if they are questioned in relation to a suspected crime by the police under the Police and Criminal Evidence Act 1984 (PACE). Victims of crime and witnesses may also require the support of an ‘appropriate’ adult. Under the MCA, people who lack capacity and are alleged to be responsible for abuse, are entitled to the help of an Independent Mental Capacity Advocate, to support and represent them in the enquiries that
are taking place. This is separate from the decision whether or not to provide the victim of abuse with an independent advocate under the Care Act.

- Have a duty to the adult and also a responsibility to take action in relation to the employee when allegations of abuse are made against them.
- Disciplinary procedures are compatible with the responsibility to protect adults at risk of abuse or neglect.
- With regard to abuse, neglect and misconduct within a professional relationship, codes of professional conduct and/or employment contracts should be followed and should determine the action that can be taken.
- Robust employment practices, with checkable references and recent DBS checks are important and should be in place.
- Reports of abuse, neglect and misconduct should be investigated and evidence collected.

**CCG Members of staff:**

- If a CCG member of staff is accused of abuse or neglect within their personal life outside of work, they should inform their line manager. Consideration will then be given to their suitability to continue with their work role.
- In the first instance, any allegations of this type must be communicated immediately to the relevant director, who will then inform the Lead Nurse Adult Safeguarding.
- All allegations must be taken seriously but treated with fairness and openness and in accordance with the relevant CCG staff disciplinary policies.
  - If, on the other hand, the incident occurs when the member of staff is at work, immediate steps must be taken to remove the member of staff from continuing direct contact with the patient and their relatives. This may be achieved through temporary exclusion or redeployment as appropriate.
  - If the allegation/witnessed incident is of a criminal nature, then the Police must be contacted. If the Police decide to initiate an investigation, NHS GCCG is still obliged to follow its own disciplinary procedures. These investigations may run concurrently.
  - Any actions taken following the allegations/complaints being made must be taken by the relevant associate director/director.
o Complex cases may involve other organisations or agencies. The RBG Lead Officer for Adult Protection should be contacted and any investigation should be carried out in accordance with the procedures set out in ‘Protecting Adults at Risk: London multi-agency policy and procedures to safeguard adults from abuse’ (SCIE 2011).

o The member of staff must be informed immediately about the allegations made against him/her and clearly understand the decisions and actions taken in that initial phase and possible outcomes of investigations i.e. disciplinary hearing. Union representation should be sought if applicable, and counselling should be offered.

o Confidentiality is paramount to protect the alleged victim(s) and the accused member of staff. Support for the adult at risk must be in place to ensure needs are addressed and catered for.

o The lead director will identify a senior person to undertake an investigation into the allegations. This investigation will also conform to the standards set out by NHS GCCG HR lead.

o All staff involved will be asked for a written statement and may be interviewed by the investigating officer. An investigation will be undertaken with the same timeframes as an SI investigation.

o All investigations into allegations of abuse by NHS GCCG staff must be reported to the Lead Nurse Adult Safeguarding.

o Following the investigation, the member of staff will be informed in writing of the outcome and recommendations of the investigating officer.

The Police and Crown Prosecution Service (CPS) should agree procedures with the local authority, care providers, housing providers, and the NHS/CCG to cover the following situations:

- action pending the outcome of the police and the employer’s investigations;
- action following a decision to prosecute an individual;
- action following a decision not to prosecute;
- action pending trial; and
- responses to both acquittal and conviction.
Where appropriate, workers should be reported to the statutory and other bodies responsible for professional regulation such as the General Medical Council and the Nursing and Midwifery Council. The standard of proof for prosecution is ‘beyond reasonable doubt’. The standard of proof for internal disciplinary procedures and for discretionary barring consideration by the DBS and the Vetting and Barring Board is usually the civil standard of ‘on the balance of probabilities’. This means that when criminal procedures are concluded without action being taken this does not automatically mean that regulatory or disciplinary procedures should cease or not be considered.

20. Mental Capacity Act 2005

The Mental Capacity Act (MCA) came into force in 2007 and covers England and Wales and provides a statutory framework for people who lack the capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack it in the future. MCA is vital to high quality and effective healthcare. It is central to quality improvement and patient involvement.

The MCA is supported by a statutory Code of Practice which provides guidance and information about how the Act works in practice and that certain categories of people have a legal duty to have regard to it when working with or caring for adults who may lack mental capacity. These categories include health and social care staff. The MCA sets out who can take decisions, in which situations, and how they should go about this.

The MCA consolidates human rights law, and promotes the empowerment of individuals and the protection of their rights. The MCA places on staff a duty to help patients make decisions for themselves. If they cannot it sets out a clear and challenging process for determining whether patients have mental capacity and, if not, how decisions should made on their behalf.

NHS GCCG expects its commissioned provider services to be compliant with the five statutory principles which provide a framework and guide and inform decision-making in respect of people who may lack mental capacity for decision-making in some aspects of their life including their healthcare:
• **A presumption of capacity:** every adult (aged over 16) has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise in respect of each specific decision.

• **Individuals must be supported to make their own decisions:** a person must be given all practicable help before any anyone treats them as not being able to make their own decisions.

• **Unwise decisions:** just because an individual makes a decision others may consider to be unwise, they should not be treated as lacking capacity to make that decision.

• **Best interests:** an act done or decision made under the Act for or on behalf of a person who lacks capacity must be done in that person’s best interests.

• **Less restrictive option:** a person doing anything for or on behalf of a person who lacks capacity should consider options that are less restrictive of their basic rights and freedoms while meeting the identified need.

The CCG expects all its commissioned provider services to understand and always work in line with the MCA 2005.

### 21. Deprivation of Liberty Safeguards

The deprivation of liberty safeguards (DoLS) are part of the Mental Capacity Act but were introduced at a later date coming into operation in April 2009. The safeguard provides a legal framework to prevent deprivations of liberty without proper safeguards including independent consideration and authorisation.

The framework applies to people in hospital, homes (whether privately or publicly funded) and/or supported living, and allows them to be detained for their own safety if they lack capacity, and are objecting to their care, and/or making active attempts to leave. The Supreme Court broadened the threshold for what constitutes a deprivation of liberty in care to introduce a new acid test to identify whether a person:

- Lacks capacity to make decisions in regards to their care needs; and
- Is under continuous close supervision, control and not free to leave without permission even if the opportunity became available (hospitals including ITU and residential care, supported living, sheltered housing, domestic settings).
DoLS cases which are challenged, or cases which do not meet the criteria for a deprivation of liberty require referral to the Court of Protection. To deprive a person of their liberty six assessments are undertaken by a qualified Best Interests Assessor and a qualified Section 12 doctor in order to satisfy the requirements of the MCA DoLS:

- Age assessment,
- No refusals assessment,
- Mental capacity assessment,
- Mental health assessment,
- Eligibility assessment,
- Best interest assessment (most significant)

The MCA gives certain responsibilities to staff caring for vulnerable people who lack the capacity to consent to their care and treatment to use restriction and restraint where it is in the best interests of the person and is necessary to prevent harm. If, however, that restriction and restraint moves towards depriving that person of their liberty it could be unlawful unless authorised by the local authority following an assessment process determined in law. Application for considering a deprivation of liberty should be made to DOLS@royalgreenwich.gov.uk or on 020 8921 5273

22. Legal Advice

In complex situations it may be necessary to seek legal advice and guidance on specific adult safeguarding issues. Access to legal advice/solicitors for NHS GCCG is managed by the Director of Integrated Governance who can access legal advice via a Legal Services Framework Agreement.

23. Information Sharing

Early sharing of information is the key to providing an effective response where there are emerging concerns. No professional should assume that someone else will pass on information which they think may be critical to the safety and wellbeing of the adult. If a professional has concerns about the adult's welfare and believes they are suffering or likely to suffer abuse or neglect, then they should share the information
with the local authority and, or, the police if they believe or suspect that a crime has been committed.

The CCG expects all its commissioned provider services to have arrangements and mechanisms in place which set out clearly the processes and the principles for sharing information between each other, with other professionals, CCG and the SAB: this could be via an Information Sharing Agreement to formalise the arrangements.

**Record Keeping:** Good record keeping is a vital component of professional practice. Whenever a complaint or allegation of abuse is made, NHS GCCG expects its commissioned provider services to:

- keep clear and accurate records and to have procedures for incorporating, on receipt of a complaint or allegation, all relevant records into a file to record all action taken;
- keep records in such a way that the information can easily be collated for local use and national data collections;
- identify arrangements, consistent with principles and rules of fairness, confidentiality and data protection for making records available to those adults affected by, and subject to, an enquiry. If the alleged abuser is using care and support themselves, then information about their involvement in an adult safeguarding enquiry, including the outcome, should be included in their case record. If it is assessed that the individual continues to pose a threat to other people then this should be included in any information that is passed on to service providers or other people who need to know;
- Make information available to the RBG SAB or CCG on request.

When abuse or neglect is raised, NHS GCCG expects managers of commissioned provider services to look for past incidents, concerns, risks and patterns. This information needs to be made available to RBG, the CCG and the CQC so necessary action can be taken. NHS GCCG expects its commissioned provider services to give staff clear direction as to what information should be recorded and in what format. The following questions would need to be addressed:

- What information do members of staff need to know in order to provide a high quality response to the adult concerned?
- What information do members of staff need to know in order to keep adults safe under the service’s duty to protect people from harm?
- What information is not necessary?
- What is the basis for any decision to share (or not) information with a third party?

Confidentiality: NHS GCCG expects its commissioned provider services to have agreement relating to confidentiality and setting out principles governing the sharing of information. The CCG expects any agreement to be consistent with the principles set out in the Caldicott Review: information governance in the health and care system ensuring that:

- information will only be shared on a ‘need to know’ basis when it is in the interests of the adult;
- confidentiality must not be confused with secrecy;
- informed consent should be obtained but, if this is not possible and other adults are at risk of abuse or neglect, it may be necessary to override the requirement; and
- it is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other adults may be at risk.
- Where an adult has refused to consent to information being disclosed for these purposes, then it must be considered whether there is an overriding public interest that would justify information sharing (e.g. because there is a risk that others are at risk of serious harm) and wherever possible, the appropriate Caldicott Guardian should be involved.
- Decisions about who needs to know and what needs to be known should be taken on a case by case basis, within agency policies and the constraints of the legal framework.
- Principles of confidentiality designed to safeguard and promote the interests of an adult should not be confused with those designed to protect the management interests of a commissioned provider service. These have a
legitimate role but must never be allowed to conflict with the welfare of an adult. If it appears to an employee or person in a similar role that such confidentiality rules may be operating against the interests of the adult then a duty arises to make full disclosure in the public interest.

- Information in a range of media should be produced in different, user-friendly formats for people with care and support needs and their carers. These should explain clearly what abuse is and also how to express concern and make a complaint.

- Adults with care and support needs and carers should be informed that their concern or complaint will be taken seriously, be dealt with independently and that they will be kept involved in the process to the degree that they wish to be. They should be reassured that they will receive help and support in taking action on their own behalf. They should also be advised that they can nominate an advocate or representative to speak and act on their behalf if they wish.

- Commissioned provider services to disseminate information about multi-agency policy and procedures. Staff should be made aware through internal guidelines of what to do when they suspect or encounter abuse of adults in vulnerable situations. This should be incorporated in staff manuals or handbooks detailing terms and conditions of appointment and other employment procedures so that individual staff members will be aware of their responsibilities in relation to adult safeguarding.

In certain circumstances, it will be necessary to exchange or disclose personal information which will need to be in accordance with the law on confidentiality and the Data Protection Act 1998 where this applies. The Home Office and the Office of the Information Commissioner have issued general guidance on the preparation and use of information sharing protocols.

### 24. Awareness/ advice and support

The key element of adult safeguarding is that all staff in all agencies and services have a clear understanding of their individual and their agencies’ roles and
responsibilities and are able to undertake these in an effective manner. Practitioners and managers must also be able to work effectively with others both within their own agency and across organisational boundaries.

The CCG will ensure that its staff members receive training at an appropriate level in adult safeguarding. Adult safeguarding is part of the CCG mandatory training programme, and the staff induction programme must include safeguarding training, including training in the Mental Capacity Act and Deprivation of Liberty where relevant.

The CCG expects commissioned provider services provide:

- Training for staff and volunteers on their adult safeguarding policy, procedures and professional practices that are in place locally which reflects their roles and responsibilities in adult safeguarding arrangements
- Basic mandatory induction training with respect to awareness that abuse can take place and duty to report
- More detailed awareness training, including training on recognition of abuse and responsibilities with respect to the procedures in their particular agency;
- Specialist training for those who will be undertaking enquiries, and managers;
- Post qualifying or advanced training for those who work with more complex enquiries and responses or who act as the commissioned provider service’s expert in a particular field, for example in relation to legal or those who provide medical or nursing advice to the commissioned provider services or the Board;

Training should take place at all levels in an organisation and be updated regularly to reflect best practice. To ensure that practice is consistent - no staff group should be excluded;

Training should include issues relating to staff safety within a Health and Safety framework and also include volunteers;

Providing regular face-to-face supervision from skilled managers and reflective practice is essential to enable staff to work confidently and competently with difficult and sensitive situations

In a context of personalisation, the CCG expects the commissioned provider services’ boards to seek assurances that directly employed staff (e.g. Personal
Assistants) have access to training and advice on safeguarding. Training is a continuing responsibility and should be provided as a rolling programme. Whilst training may be undertaken on a joint basis and the SAB has an overview of standards and content, it is the responsibility of each commissioned provider services to train its own staff.

25. Prevent

The Prevent Strategy was published in June 2011, and further reinforced by the Prevent and Channel statutory duties set out in the Counter-Terrorism and Security Act (2015). This strategy sets out how the UK Government aims to stop people becoming terrorists or supporting terrorism. Channel is a supportive multi-agency process, designed to safeguard those individuals who may be vulnerable to being drawn into any form of terrorism.

Channel works by identifying individuals who may be at risk, assessing the nature and extent of the risk, and where necessary, providing an appropriate support package tailored to their needs. A multi-agency panel, chaired by the local authority, decides on the most appropriate action to support an individual after considering their circumstances. Prevent aims to deliver early intervention to protect and divert people away from the risk they may face at an early opportunity. Partners already work with individuals vulnerable to being drawn into criminal activity such as drugs, knife or gang crime. In a similar way the process of radicalisation allows us to intervene to prevent individuals being drawn into terrorist related activity.

NHS GCCG expects its commissioned provider services to report on PREVENT activities in accordance with the NHS England Prevent quarterly returns and discussed at their respective safeguarding committee.

26. Domestic Violence and Homicides

A domestic homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lays for establishing a view of the case.
Domestic homicide review (DHR) is convened by the local CSP when the defined criteria has been met following the death of a person aged 16 or over which has, or appears to have, resulted from violence, abuse or neglect by—

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death. The local CSP will utilise local contact and request the establishment of a DHR panel.

The CCG expects its provider services that are asked to participate in these as requested must do so. Provider services who had contact with the individual(s) are required to produce an individual management review (IMR) which allows them to look openly and critically at individual and organisational practice and the context within which people were working to see whether these are changes in practice that could, and should, be made.

The CCG as commissioners will provide a panel member, provide oversight of health IMRs at panel meetings, and work with the CSP to ensure that recommendations and actions are achievable, implemented and disseminate learning across the NHS locally.

It is the responsibility of the CSP to inform NHS England of a domestic homicide; however NHS GCCG must inform the London lead if they are informed of a domestic homicide.

The Violence Against Women and Girls (VAWG) multi-agency group is concerned with monitoring domestic abuse including the performance of the Multi-Agency Risk Assessment Conferences (MARACs) where high risk domestic abuse cases are discussed and action plans developed. In turn, the VAWG reports to the Community Safety Partnership (Safer Greenwich Partnership). It is expected that provider agencies will contribute to MARACs where requested.

27. Out of Area Safeguarding Adult Arrangements: NHS Placements
This section clarifies responsibilities and actions to be taken by host authorities and placing authorities with respect to people who live in one area, but for whom commissioning responsibility remains with the area from which they originated.

**Host Authority:** the Local Authority or NHS Body in the area where the abuse occurred.

**Placing Authority:** the Local Authority or NHS Body that has commissioned the service for an individual involved in a safeguarding adults allegation.

It can be particularly complex and demanding for a host authority to manage a large scale safeguarding adults’ investigation when there are many different placing authorities involved.

Who Pays? Establishing the Responsible Commissioner requires a placing CCG, when placing a patient requiring continuing care in a care home of independent hospital in another CCG area, to notify the CCG where the care home or independent hospital is located.

The National Protocol for Notification of NHS Out of Area Placements for Individual Packages of Care (including Continuing Healthcare) requires all placing CCGs to notify the host CCG, whenever a patient is placed in the host CCG area. It also requires the host CCG to be notified when the placement comes to an end.

This supports host authorities, working in partnership across health and social care to be aware of NHS placements in their area. The host authority will have overall responsibility for co-ordinating the safeguarding adults investigation and for ensuring clear communication with all placing authorities and other stakeholders, especially with regards to the scheduling of meetings and the planning of the investigation.

The placing authority will have a continuing duty of care to the adult at risk that they have placed. The placing authority will contribute to the investigation as required, and maintain overall responsibility for the individual they have placed. The placing authority will ensure, through contracting arrangements and in service specifications, that the provider has arrangements in place for protecting adults at risk of harm and form managing concerns, which in turn link with local (host authority) multi-agency safeguarding adults policy and procedures. This includes the requirement to inform
the host authority of both individuals and placing authorities affected by the safeguarding concerns.

Authorities will negotiate flexible arrangements, for example relating to another authority undertaking assessments, reviews, investigative activities or other supportive activities on behalf of a placing authority.

28. Adult Safeguarding Contract Monitoring Arrangements

The NHS Standard Contract requires that all provider services comply with commissioner’s policy for safeguarding. NHS GCCG expects all its commissioned provider services to demonstrate strong commitment to adult safeguarding within all the services they provide and to comply with the commissioner’s policy, adult safeguarding metrics, standards and training documents. The CCG expects all commissioned provider services to demonstrate evidence that it is

- addressing safeguarding concerns,
- meeting expected standards,
- training its staff in accordance with its training strategy and policy
- This includes the metrics, standards and concerns being discussed at the provider services’ safeguarding committee prior to submission to the CCG.
- Participating in the development of any local multi-agency safeguarding quality indicators

Compliance monitoring is based on the identified adult safeguarding indicators identified within the contract and demonstrated via the CCG’s adult safeguarding dashboard. All provider services are expected to present the CCG’s adult safeguarding dashboard to their respective safeguarding committee. The completed dashboard plus the minutes from there respective safeguarding committee will then be submitted to the CCG. The completed adult safeguarding provider dashboard will be discussed at the CCG’s Joint Children and Adult Safeguarding Executive Group meeting.

29. Review
This policy will be reviewed in 3 years’ time unless earlier review is indicated and will be kept under review annually in the light of changing circumstances and requirements. Policy monitoring standards to confirm this policy document has been implemented:

- Six monthly reports on NHS GCCG staff training levels,
- Attendance report on NHS GCCG representation at the RBG SAB,
- Bi-monthly update reports of all adult safeguarding alerts reported to RBG involving an NHS GCCG commissioned provider services or patient,
- Six monthly update report on adult safeguarding service standards include within all contracts, service level agreements and service specifications
- Annual completion of the NHS England assurance framework audit.
- Completion of a CCG annual safeguarding adult report

30. Monitoring/Audit

A range of Committee, Groups and Sub-Groups have been established by the CCG to support the delivery of the adult safeguarding objectives and work plan and to facilitate a co-ordinated approach to safeguarding across the NHS system:

**Quality Committee:** is directly accountable to the CCG Governing Body and provides assurance that the governance systems, processes and behaviours by which the CCG leads, directs and controls functions in order to achieve its organisational objectives, and the way in which they relate to patients and carers, the wider community and partner organisations are integrated and effective. The Quality Committee oversees processes and compliance issues concerning adult safeguarding and informs the CCG Governing Body of any escalation or sensitive issue in good time.

**Joint Safeguarding Children and Adult Executive Group:** has delegated responsibility and is directly accountable to the Quality Committee for ensuring that the CCG discharges its statutory responsibilities in relation to safeguarding and promoting the welfare of children and adults experiencing or at risk of abuse and neglect, and the Mental Capacity Act 2005: Deprivation of Liberty Safeguards (DOLS). The Committee will ensure that national and local adult safeguarding policy
directives are incorporated into NHS GCCG’s processes including commissioning processes. The Committee provides clinical leadership and expert advice, informs service delivery and development, and provides assurance to NHS GCCG and partner agencies that effective processes are in place for safeguarding adults experiencing or at risk of abuse and neglect.

**RBG SAB:** provides strategic multi-agency leadership to obtain assurance that local safeguarding arrangements and partners act to help and protect adults in Greenwich who require safeguarding. The SAB is responsible for developing, promoting and monitoring multi-agency adult safeguarding arrangements. NHS GCCG is represented on the RBG SAB by the Director of Integrated Governance and the Lead Nurse Adult Safeguarding. NHS GCCG is responsible for providing and/or ensuring the availability of appropriate expertise and advice and support to the SAB, in respect of a range of specialist health functions, e.g. primary care, mental health and sexual health and for co-ordinating the health component of Safeguarding Adult Reviews.

**Greenwich Health and Wellbeing Board:** the Greenwich Health and Wellbeing Board has overall strategic responsibility for assessing local health and wellbeing needs in the Joint Strategic Needs Assessment (JSNA) and agreeing Joint Health and Wellbeing Strategies for RBG and GCCG. They play a vital role in identifying and ensuring that the needs of adults at risk of abuse or neglect are identified and addressed. The JSNA will support the commissioning of services so that effective coordinated help can be provided to those at risk and their families. The exact relationship between the CCG, RBG, SAB and Greenwich Health and Wellbeing Board is for local determination.

**31. Sources of Evidence**

- Care Act 2014
- Care and Support Statutory Guidance Department of Health (DH:2014)

Care Quality Commission. Essential standards of quality and safety. CQC. (2010); Available at: www.cqc.org.uk


Royal Borough of Greenwich safeguarding adult website

Mental Capacity Act (2005) (including 2011 amendments)

Deprivation of Liberty Safeguards: A guide for primary care trusts and local authorities. DH (2009)

Clinical governance and adult safeguarding: an integrated process. DH (2010).


Winterbourne View Serious Case Review

NHS Litigation Authority; NHSLA Risk Management Standards for Acute Trusts, Primary Care Trusts and Independent Sector Providers of NHS Care (2009/10)

Safeguarding Adults: The role of NHS Commissioners. DH (2011)


The Functions of Clinical Commissioning Groups (DH Gateway ref: 17005) June 2012; NHSE (March 2013)

Safeguarding Adults the Role of Health Services

NHS Outcomes Framework 2015 - 16

Statutory Guidance for the conduct of Domestic Homicide Reviews

Protection of Freedoms Act 2012

Independent Safeguarding Authority

4 http://www.royalgreenwich.gov.uk/info/200050/adults_and_older_people/1546/protecting_adults_at_risk
## Appendix 1: Equality & Equity Impact Assessment & EDS2 Checklist

This is a checklist to ensure relevant equality and equity aspects of proposals have been addressed either in the main body of the document or in a separate equality & equity impact assessment (EEIA)/equality analysis. It is not a substitute for an EEIA which is required unless it can be shown that a proposal has no capacity to influence equality. The checklist is to enable the policy lead and the relevant committee to see whether an EEIA is required and to give assurance that the proposals will be legal, fair and equitable.

The word proposal is a generic term for any policy, procedure or strategy that requires assessment.

<table>
<thead>
<tr>
<th>Challenge questions</th>
<th>Yes/No</th>
<th>What positive or negative impact do you assess there may be?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the proposal affect one group more or less favourably than another on the basis of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Race</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Pregnancy and Maternity</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Sex</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Gender and Gender Re-Assignment</td>
<td>No</td>
<td>The policy overall is designed to ensure that adults who are identified to be vulnerable or at risk are not treated any less favourably than any others and are protected against the risk of abuse or neglect.</td>
</tr>
<tr>
<td>• Marriage or Civil Partnership</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Religion or belief</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Sexual orientation (including lesbian, gay bisexual and transgender people)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Disability (including learning disabilities, physical disability, sensory impairment and mental health problems)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>2. Will the proposal have an impact on lifestyle? (e.g. diet and nutrition, exercise, physical activity, substance use, risk taking behaviour, education and learning)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>3. Will the proposal have an impact on social environment? (e.g. social status, employment (whether paid or not), social/family support, stress, income)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>4. Will the proposal have an impact on physical environment? (e.g. living conditions, working conditions, pollution or climate change, accidental injury, public safety, transmission of infectious disease)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>5. Will the proposal affect access to or experience of services? (e.g. Health Care, Transport, Social Services, Housing Services, Education)</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

By using evidence and insight to assess and grade our equality performance, NHS Greenwich can generate much of the information we will require to demonstrate compliance with the PSED. The checklist is to enable the policy lead and the relevant committee to see if a particular policy or project will provide the relevant evidence to assist NHS Greenwich CCG meet the set out EDS goals to achieve better outcomes for patients and staff. Please assess your policy, project or service against the following:
<table>
<thead>
<tr>
<th><strong>The goals and outcomes of EDS2</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Better health outcomes</strong></td>
</tr>
<tr>
<td>1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities</td>
</tr>
<tr>
<td>1.2 Individual people’s health needs are assessed and met in appropriate and effective ways</td>
</tr>
<tr>
<td>1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed</td>
</tr>
<tr>
<td>1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse</td>
</tr>
<tr>
<td>1.5 Screening, vaccination and other health promotion services reach and benefit all local communities</td>
</tr>
<tr>
<td><strong>Improved patient access and experience</strong></td>
</tr>
<tr>
<td>2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds</td>
</tr>
<tr>
<td>2.2 People are informed and supported to be as involved as they wish to be in decisions about their care</td>
</tr>
<tr>
<td>2.3 People report positive experiences of the NHS</td>
</tr>
<tr>
<td>2.4 People’s complaints about services are handled respectfully and efficiently</td>
</tr>
<tr>
<td><strong>A representative and supported workforce</strong></td>
</tr>
<tr>
<td>3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels</td>
</tr>
<tr>
<td>3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations</td>
</tr>
<tr>
<td>3.3 Training and development opportunities are taken up and positively evaluated by all staff</td>
</tr>
<tr>
<td>3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source</td>
</tr>
<tr>
<td>3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives</td>
</tr>
<tr>
<td>3.6 Staff report positive experiences of their membership of the workforce</td>
</tr>
<tr>
<td><strong>Inclusive leadership</strong></td>
</tr>
<tr>
<td>4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations</td>
</tr>
<tr>
<td>4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed</td>
</tr>
<tr>
<td>4.3</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td><strong>Policy Author</strong></td>
</tr>
<tr>
<td><strong>Equalities Lead</strong></td>
</tr>
</tbody>
</table>
Appendix 2: Types of Abuse and Neglect

The types of abuse and neglect list is not intended to be an exhaustive list nor do they prove that there is actual abuse occurring but an illustrative guide as to the sort of behaviour which could give rise to an adult safeguarding concern, indicating that a closer look and possible investigation may be needed. Exploitation, in particular, is a common theme in the following list of the types of abuse and neglect.

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

- **Domestic violence**: including psychological, physical, sexual, financial, emotional abuse; so called ‘honour’ based violence.

- **Sexual abuse**: including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

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

- **Financial or material abuse**: including theft, fraud, internet scamming, coercion in relation to an adult’s financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits. Most financial abuse is also capable of amounting to theft or fraud and so would be a matter for the police to investigate

- **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.

- **Discriminatory abuse**: including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.
- **Organisational abuse**: 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 one’s own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

- **Neglect and acts of omission**: including ignoring medical, emotional 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 behaviour neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding.
Appendix 3: CCG’s Safeguarding Structure Chart
Appendix 4: CCG’s Safeguarding Governance Structure
Appendix 5: Reporting Abuse Algorithm

1. Allegation of Abuse

Urgent?
Is medical treatment required or is there indication of assault?

Call 999 for ambulance (if possible sexual or physical assault call 999 for police).
Preserve evidence if possible sexual or physical assault. SAM/Senior staff to check that action has been taken to preserve evidence.

Safety
Staff to take any urgent action needed to keep the vulnerable adult safe.

Report and Records
A) Report to manager or senior staff on duty or call
Make a written record of the abuse allegation complete an incident Report if required by your organisation
B) Manager or senior staff to send Adult Abuse Report Form

Further Action to be taken under the Safeguarding Policy
To be decided either by Team Manager (SAM)/Safeguarding Advisors as appropriate

Report to the Police
To be decided by Team Manager (SAM) in consultation with the police. The adult at risk and service provider will be consulted as appropriate.

Yes
Team Manager or SAM as agreed to inform the Community Safety Unit

No
Multi-Agency Strategy Meeting to be held within 5 working days of allegations

CQC Registered Services
Send Regulation 16 & 18 form to CQC
Glossary

Acts covered by the MCA: Tasks carried out by carers, healthcare or social care members of staff which involve the personal care, healthcare or medical treatment of people who lack capacity to consent to them.

Acts in connection with care and treatment – offers a statutory protection from liability where a person is performing an act in connection with the care and treatment of someone who lacks capacity assuming the decision is made within the framework provided by the Act.

Advance Decision to Refuse Treatment: A decision to refuse specified treatment made in advance by a person who has capacity to do so. The decision will then apply at a future time when the person lacks the capacity to consent to, or refuse, the specified treatment (Specific rules apply to advance decisions to refuse life sustaining treatment). The Act provides for patients a right to refuse treatment should they lose capacity in the future. It also provides for refusal of end of life treatment but such instructions must be in writing.

Adult Protection Procedures: Procedures devised by local authorities, with partner organisations, to investigate and deal with allegations of abuse or ill treatment of vulnerable people and to put in place appropriate safeguards.

Assessing capacity: sets down a test for assessing whether a person lacks capacity to take a particular decision at a particular time – the test is decision and time specific.

Attorney: someone appointed under either a Lasting Power of Attorney (LPA) or an Enduring Power of Attorney (EPA), who has the legal right to make decisions within the scope of their authority on behalf of the person (known as the donor) who made the power of attorney. The holder of a LPA can make decisions about the donor’s personal welfare (including healthcare) and/or the donor’s property and affairs.

Best interests: Any decision made, or anything done for a person who lacks capacity to make specific decisions, must be in the person’s best interests. There are standard minimum steps to follow when working out someone’s best interests. Best interest underlines the importance of best interests decision making and provides a non-exhaustive checklist of factors that decision-makers must work through when deciding what is in the best interests of a person assessed as lacking capacity.
**Capacity:** The ability to make a decision about a particular matter at the time the decision needs to be made.

**Court of Protection:** The specialist Court for all issues relating to people who lack capacity to make a specific decision. The Act created this Court which had jurisdiction relating to the whole of the Act.

**Criminal Offence:** The Act introduced a new criminal offence of ill treatment or wilful neglect of a person who lack capacity.

**Decision-maker:** The person responsible for taking a specific decision on behalf of someone who lacks the capacity to make that decision for themselves. This person is identified by the nature of the task. It is the decision-makers responsibility to work out what would be in the best interests of the person lacking capacity.

**Deputy (also known as Court appointed deputies):** Someone appointed by the Court of Protection with on-going legal authority as prescribed by the Court to make decisions on behalf of a person who lacks capacity to make particular decisions. The Act allows the Court of Protection to appoint deputies on behalf of people lacking capacity to take decisions on welfare, healthcare and financial matters.

**Future Decision-Making:** the Act allows a person, while they have capacity, to plan ahead for a time when they lack it through the appointment or a person(s) to take decisions in relation to property and affairs and/or health and welfare on their behalf.

**Ill-treatment or neglect:** New offences introduced by the Act in relation to people lacking capacity.

**Independent Mental Capacity Advocate (IMCA):** A specially trained advocate who provides support and representation to person who lacks capacity to make a specific decision and has no-one else to speak on their behalf and is facing a serious medical treatment or long term accommodation decision. Patients, who lack the capacity to take decisions in relation to serious medical treatment, and have nobody to speak on their behalf, have a legal entitlement to an advocate (IMCA) who will bring to the attention of the decision maker information regarding the patient’s wishes, feelings, beliefs and values as well as other factors which may be relevant to the decision.
**Office of the Public Guardian:** Provides a range of services in relation to deputys and attorneys including supervision, registration and investigation of complaints.

**Official Solicitor:** Provides legal services for vulnerable adults including representing those who lack capacity to conduct litigation in Court.

**Research:** The Act sets out parameters in relation to research involving those who may lack capacity.

**Restraint:** The use or threat of force to help do an act which a person who lacks capacity resists. The act must be in the best interests of the person and to protect them from harm. It must be proportionate to that risk of harm. The Act defines this and provides for the circumstances in which restrain can be used in relation to the care and treatment of somebody lacking capacity (in those circumstances where restriction and restraint may move towards deprivation of liberty the DoLS safeguards must be considered)

**Statutory principles:** The five key principles set out at the beginning of the Act which set down the fundamental concepts and core values of the Act and provide a benchmark to guide decision-makers and all those involved in the care and treatment of people who may lack capacity.

**Two-stage Test of Capacity:** The procedures set down in the Act to determine whether a person has the capacity to take a specific decision at the time they need to take it.

**Wishes and feelings:** Statements a person might have made before losing capacity about their wishes and feelings regarding their future treatment and care. Although not binding they should be used to shape best interest decisions.