

Safeguarding Adults at Risk of Harm

**A sample policy for general
practice**

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1.0 Introduction

1.1 Safeguarding is everyone's responsibility and aims to protect people's health, wellbeing and human rights, and enable them to live free from harm, abuse and neglect.

1.2 The aims of adult safeguarding are to:

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

1.3 The Care Act 2014 sets out the first ever statutory framework for adult safeguarding, stating that Local Authorities are required to make enquiries into allegations of abuse or neglect. Safeguarding is mainly aimed at people with care and support needs who may be in vulnerable circumstances and at risk of abuse or neglect by others. In these cases, local services must work together to identify those at risk and take steps to protect them.

(In Wales: The Social Services and Well-being Act and Mental Capacity Act; In Scotland: The Adult Support and Protection (Scotland) Act 2007 and Adults With Incapacity (Scotland) Act 2000; In Northern Ireland: The Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003.)

1.4 Local authority statutory adult safeguarding duties apply equally to those adults with care and support needs regardless of whether those needs are being met, regardless of whether the adult lacks mental capacity or not, and regardless of setting.

1.5 The support and protection of vulnerable adults cannot be achieved by a single agency, every service has a responsibility. The Practice staff are not responsible for making a diagnosis of adult abuse and neglect, however they are responsible to share concerns appropriately and refer onto the relevant agency responsible for carrying out an assessment of need based on the safeguarding allegations.

- 1.6 This policy outlines how **insert name of Practice** will fulfil their legal duties and statutory responsibilities effectively in accordance with safeguarding adult procedures of **insert Local Safeguarding Adult Boards here**.

2. Safeguarding Adults in General Practice

- 2.1 GPs are the first point of contact for most people with health problems, this sometimes includes individuals who are not registered but seek medical attention. Safeguarding adults is a complex area of practice. The client group is extremely wide, ranging from adults who are incapable of looking after any aspect of their lives, to individuals experiencing a short period of illness or disability. Individuals may have a wide range of services and service providers involved in their lives, making it difficult to identify those with responsibility.
- 2.2 GPs may be the first to recognise an individual's health problems, carer related stress issues, or someone whose behaviour may pose a risk to vulnerable adults. The primary health care team may be the only professionals to have contact with vulnerable adults and it is important that any response taken is appropriate and timely, thereby preventing the potential long term effects of abuse and neglect.
- 2.3 It is essential that safeguarding adults is considered in line with the Mental Capacity Act 2005 which provides a statutory framework for people who lack capacity to make decisions for themselves. It sets out who can take decisions, in which situations, and how they should go about this. A person who lacks capacity may not always recognise that they are at risk of or are being abused or neglected.

3. Impact Analyses

3.1. Equality

- 3.1.1. In line with the **insert name of Practice** Equality and Diversity Policies and Sustainability impact assessment, this policy aims to safeguard all adults who may be at risk of abuse, irrespective of disability, race, religion/belief, colour, language, birth, nationality, ethnic or national origin, gender or sexual orientation. **Embed or attach as appendices Practice Equality and Diversity and Sustainability impact assessments.**
- 3.1.2. All Practice Staff must respect the adult at risk's (and their family's/ carers) culture, religious beliefs, gender and sexuality. However this must not prevent action to safeguard adults who are at risk of, or experiencing, abuse.
- 3.1.3. All reasonable endeavours should be used to establish the adult at risk and their family/carer's preferred method of communication, and to communicate in a way they can understand.

3.2. Bribery Act 2010

Due consideration has been given to the Bribery Act 2010 in the development of this policy and no specific risks were identified.

4. Scope

4.1. This policy applies to GP Partners and all staff employed by the **insert name of Practice** including; all employees (including those on fixed-term contracts), temporary staff, bank staff, locums, agency staff, contractors, volunteers (including celebrities), students and any other learners undertaking any type of work experience or work related activity.

4.2. All Practice staff have an individual responsibility to safeguard and promote the welfare of individuals and must know what to do if concerned that an adult is at risk of being abused or neglected.

5. Policy Aim

5.1. The Practice adopts a zero tolerance approach to abuse and neglect and in doing so ensures that safeguarding the rights of adults at risk of abuse is integral to all we do.

5.2. This policy outlines how the Practice will fulfil its statutory responsibilities and ensure that there are in place robust structures, systems and quality standards for safeguarding adults, which are in line with City of York, East Riding and North Yorkshire Safeguarding Adult Boards procedures.

6. Adult Safeguarding

6.1. All adults (those over 18 years of age) have the right to live a life free from abuse and neglect. Abuse is a violation of an individual's human and civil rights by any other person or persons.

6.2. Where someone is 18 or over but is still receiving children's services and a safeguarding issue is raised, the matter should be dealt with through adult safeguarding arrangements. For example, this could occur when a young person with substantial and complex needs continues to be supported in a residential educational setting until the age of 25. Where appropriate, adult safeguarding services should involve the local authority's children's safeguarding colleagues as well as any relevant partners.

6.3. The safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing, or at risk of, abuse or neglect;
- and as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect neglect.

- 6.4. Consideration needs to be given to a number of factors; abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented to, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.

7. Principles of adult safeguarding

- 7.1. The Practice acknowledges the six principles of adult safeguarding and ensures these principles underpin Practice Staff safeguarding work
- Empowerment; People being supported and encouraged to make their own decisions and informed consent.
“I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens.”
 - Prevention; It is better to take action before harm occurs.
“I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.”
 - Proportionality; The least intrusive response appropriate to the risk presented.
“I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed.”
 - Protection; Support and representation for those in greatest need.
“I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want.”
 - Partnership; Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
“I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me.”
 - Accountability; Accountability and transparency in delivering
“I understand the role of everyone involved in my life”

7.2 Making Safeguarding Personal

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 there is no one appropriate to support them for the purpose of facilitating their involvement, then the practice must arrange for an independent advocate to represent them for the purpose of facilitating their involvement.

‘Making Safeguarding Personal’ involves

- giving people the opportunity to discuss the outcomes they want at the start of the safeguarding process,
- engaging them in discussions and planning throughout the process
- following up discussions with people at the end of the process to see to what extent their desired outcomes have been met. This may be done in conjunction with Adult Social Care.

8. Categories of abuse

- Physical abuse; including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions including female genital mutilation.
- Domestic violence; including psychological, physical, sexual, financial, emotional abuse. So called ‘honour’ based violence and forced marriage.
- 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.
- 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.

9. Adults with capacity

- 9.1 A person's ability to make a particular decision may at a particular time be affected by:
- Duress and undue influence;
 - Lack of mental capacity.
- 9.2. There may be a fine distinction between a person who lacks the mental capacity to make a particular decision and a person whose ability to make a decision is impaired, e.g. by duress or undue influence or the perceived lack of any alternative choice. Nonetheless, it is an important distinction to make.
- 9.3. Safeguarding interventions must ensure that when an adult with mental capacity takes a decision to remain in an abusive situation, they do so without duress or undue influence, with an understanding of the risks involved, and with access to appropriate services should they change their mind. The exception to this principle would occur in situations where the decision may have been influenced by threat or coercion and consequently lack validity and need to be over-ridden.

10. Adults who lack mental capacity to make a specific decision.

- 10.1 The Mental Capacity Act (MCA) 2005 provides a statutory framework that underpins issues relating to capacity and protects the rights of individuals where capacity may be in question. MCA implementation is integral to safeguarding vulnerable adults.

10.2 The 5 principles of the MCA must be followed and are directly applicable to safeguarding:

1. A person must be assumed to have capacity unless it is established that they lack capacity. Assumptions should not be made that a person lacks capacity merely because they appear to be vulnerable;

2. A person is not to be treated as unable to make a decision unless all practicable steps to help them do so have been taken without success. Empower individuals to make decisions about managing risks e.g. use communication aides to assist someone to make decisions; for example, choose the optimum time of day where a person with dementia may best be able to evaluate risks;

3. A person is not to be treated as unable to make a decision because they make an unwise decision. Individuals may wish to balance their safety with other qualities of life such as independence and family life. This may lead them to make choices about their safety that others may deem to be unwise but they have the right to make those choices;

4. An act or decision made under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests. Best interest decisions in safeguarding take account of all relevant factors including the views of the individual, their values, lifestyle and beliefs and the views of others involved in their care;

5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's right and freedom of action. Any use of restriction and restraint must be necessary and proportionate to prevent harm to that individual. Safeguarding interventions need to balance the wish to protect the individual from harm with protecting other rights such as right to family life.

10.3 Deprivation of Liberty Safeguards

The practice will also consider whether a person is deprived of their liberty as defined by the MCA in its *Deprivation of Liberty Safeguards*. If this deprivation is thought to be unlawful, this will be reported to the Local Authority within a reasonable time frame of usually no longer than 48 hours. The Local Authority holds the legal power to process an application and make a *Deprivation of Liberty Safeguard* (DOLS) order where it is decided that a person's freedom needs to be restricted in their best interests.

10.4 Independent Mental Capacity Advocate (IMCA)

An independent Mental Capacity Advocate (IMCA) will be sought by the practice if the person lacking capacity has no one to represent them. The process for sourcing an advocate is as follows: **insert local procedure here**. An IMCA must be engaged if major treatment decisions are being made or if a change of residence is being

considered. If a patient has no one to represent them during the course of a safeguarding investigation an IMCA should be used.

11 CONTEST and PREVENT (Radicalisation of vulnerable people)

- 11.1. Contest is the Government's Counter Terrorism Strategy, which aims to reduce the risk from terrorism, so that people can go about their lives freely and with confidence.
- 11.2 Contest has four strands which encompass;
- PREVENT; to stop people becoming terrorists or supporting violent extremism.
 - PURSUE; to stop terrorist attacks through disruption, investigation and detection.
 - PREPARE; where an attack cannot be stopped, to mitigate its impact.
 - PROTECT; to strengthen against terrorist attack, including borders, utilities, transport infrastructure and crowded places.
- 11.3 Prevent focuses on preventing people becoming involved in terrorism, supporting extreme violence or becoming susceptible to radicalisation. Alongside other agencies, such as education services, local authorities and the police, healthcare services have been identified as a key strategic partner in supporting this strategy.
- 11.4 Channel is a programme which focuses on providing support at an early stage to people who are identified as being vulnerable to being drawn into terrorism. The programme uses a multi-agency approach to protect vulnerable people by:
- Identifying individuals at risk
 - Assessing the nature and extent of that risk
 - Developing the most appropriate support plan for the individuals concerned
- 11.5. Healthcare professionals may meet and treat people who are vulnerable to radicalisation, such as people with mental health issues or learning disabilities, who may have a heightened susceptibility to being influenced by others.
- 11.6. The key challenge for the health sector is to be vigilant for signs that someone has been or is being drawn into terrorism. GPs and their staff are the first point of contact for most people and are in a prime position to safeguard those people they feel may be at risk of radicalisation.
- 11.7 Practice staff who have concerns about that someone may be becoming radicalised must seek advice and support from the Safeguarding Lead and dedicated PREVENT Lead.

11.8. The Designated Professional for Adult Safeguarding acts as the PREVENT lead for General Practice and will advise on concerns following the referral pathway in line with the policy and procedure.

The Practice PREVENT Lead is:

Insert Name and contact

The PREVENT Lead for General Practice is:

Insert Name and contact

11.9. **It is important to note that PREVENT operates within the pre-criminal space and is aligned to the multi-agency safeguarding agenda.**

- **Notice:** if you have a cause for concern about someone, perhaps their altered attitude or change in behaviour
- **Check:** discuss concern with appropriate other (safeguarding lead)
- **Share:** appropriate, proportionate information (safeguarding lead/PREVENT lead)

12. Roles and Responsibilities

12.1. The Safeguarding Adults Boards (SAB) are responsible for ensuring that ;

- partner agencies including the local authority, the NHS and the police, meet regularly to discuss and act upon local safeguarding issues;
- develop shared plans for safeguarding, working with local people to decide how best to protect adults in vulnerable situations;
- publish a safeguarding plan and report to the public annually on its progress, so that different organisations can make sure they are working together in the best way.
- Undertake Safeguarding Adult Reviews in order to learn lessons where an adult has died or suffered significant harm as a result of abuse or neglect and multi-agency failure is indicated as playing a part

12.2. The Local Authority is responsible for making enquires, or asking others to make enquiries, when they think an adult with care and support needs may be at risk of abuse or neglect and to find out what, if any, action may be needed. This applies whether or not the authority is actually providing any care and support services to that adult.

12.3 The Practice team have a responsibility for recognising the potential signs and indicators of abuse, sharing information appropriately, and acting on concerns in a timely manner. The Practice recognises that safeguarding adults is a shared responsibility with the need for effective joint working between professionals and agencies. In order to achieve effective joint working there must be constructive relationships at all levels, promoted and supported by:

- the commitment of all staff within the practice to safeguarding and promoting the welfare of adults;
- clear lines of accountability within the practice for work on safeguarding;
- practice developments that take account of the need to safeguard and promote the welfare of adults and is informed, where appropriate, by the views of the adult at risk and their families;
- staff training and continuing professional development enabling staff to fulfil their roles and responsibilities, and have an understanding of other professionals and organisations in relation to safeguarding adults;
- Safe working practices including recruitment and vetting procedures;
- Effective interagency working, including effective information sharing

12.4 When an Adult Safeguarding Referral is not accepted by the Local Authority

There may be times when the Local Authority may not accept a safeguarding referral for a variety of reasons, so other measures may need to be taken to protect adults at risk of harm.

These may include:

- Reviewing your Adult Safeguarding Referral to see if you can make your concerns clearer or add additional information and resend it
- Assessment of either the adult's service need or review of how the service is being delivered
- Complaints investigation
- Referral to CQC
- Significant incident investigation within the practice
- Disciplinary procedures
- Referral to the local authority business management unit where there are concerns about the quality of a care provider
- Police/criminal investigation
- Whistleblowing

13. Practice Arrangements

13.1 **Insert Name of Practice** has clearly identified lines of accountability within the practice to promote the work of safeguarding vulnerable adults within the practice. Safeguarding responsibilities will be clearly defined in all job descriptions and there are nominated leads for safeguarding adults.

13.2. The Practice Lead for Safeguarding Adults is:

Insert name and contact

The Deputy Practice Lead for Safeguarding Adults is:

Insert name and contact

The Administration Lead for managing Safeguarding data is:

Insert name and contact

13.3. The **Practice Lead** for Safeguarding Adults is responsible for;

- Ensuring that they are fully conversant with the practice safeguarding adult policy, the policies and procedures of Safeguarding Adults Board; and the integrated processes that support safeguarding;
- Facilitating training opportunities for staff groups (see Primary Care Training strategy) ;
- Acting as a focus for external contacts on safeguarding adult and Mental Capacity Act matters; this may include requests to contribute to sharing information required for safeguarding adult reviews, domestic homicide reviews, multi-agency/ individual agency reviews and contribution to safeguarding investigations where appropriate;
- Disseminating information in relation to safeguarding adults/Mental Capacity Act to all practice members;
- Act as a point of contact for practice members to bring any concerns that they have, to document those concerns and to take any necessary action to address concerns raised;
- Assess information received on safeguarding concerns promptly and carefully, clarifying or obtaining more information about the matter as appropriate;
- Facilitate access to support and supervision for staff working with vulnerable adults and families;
- Ensure that the practice team completes the practice's agreed incident forms and analysis of significant events forms which are available **state where in practice** ;
- Makes recommendations for change or improvements in practice

13.4. The **Practice Manager** is responsible for ensuring that safeguarding responsibilities are clearly defined in all job descriptions. For employees of the practice, failure to adhere to this policy and procedures could lead to dismissal and/or constitute gross misconduct. The Practice Manager has a responsibility to ensure that Practice has a clear safer recruitment policy and that this is adhered to.

13.5 **Partners** are responsible for ensuring that;

- safeguarding vulnerable adults is integral to clinical governance and audit arrangements within the practice;
- the practice meets the contractual and clinical governance arrangements on safeguarding adults;
- all practice staff are alert to the potential indicators of abuse or neglect, and know how to act on those concerns in line with local guidance;

13.6. **GPs** have an important role to play in safeguarding and promoting the welfare of adults. Identification of abuse has been likened to putting together a complex multi-dimensional jigsaw. GPs hold knowledge of family circumstances and can interpret multiple observations accurately recorded over time, and may be the only professionals holding vital pieces necessary to complete the picture.

The GMCs 'Good medical practice code' (2013) stresses the need for doctors to

- protect patients and take prompt action if “patient safety, dignity or comfort is or may be seriously compromised”.

GPs contribution to multi-agency safeguarding adults meetings and other such meetings including Multi Agency Risk Assessment Conferences (MARAC) for cases of high risk domestic violence is important and supports guidance from the Royal College of General Practitioners.

- Priority should be given to the attendance and a written report should be made available for meetings where the GP will not be in attendance
- Consideration needs to be given when sharing information for these meeting with regard to appropriate information sharing i.e. with consent of adult at risk; or overriding consent if life-threatening situation or in wider public interest (See section 15 Information Sharing)

13.7 **Practice nurses** must ensure that Safeguarding is part of everyday nursing practice. The Nursing and Midwifery Council’s Code of Conduct states that Nurses should raise concerns immediately if they believe a person is vulnerable or at risk and needs extra support and protection’

The Code states that Nurses must:

- take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse
- share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information, and
- have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

13.8 **All individual staff members, including partners, employed staff and volunteers** have an individual responsibility to;

- Be alert to the potential indicators of adult abuse or neglect and know how to act on those concerns in line with national guidance and the safeguarding adult procedures;
- Be aware of and know how to access their local Safeguarding Adult Board’s policies and procedures for safeguarding adults;
- Take part in training, including attending regular updates so that they maintain their skills and are familiar with procedures aimed at safeguarding adults and implementation of the Mental Capacity Act;
- Understand the principles of confidentiality and information sharing in line with local and government guidance;
- Contribute, when requested to do so, to the multi-agency meetings established to safeguard and protect vulnerable adults;

14. What to do if you have concerns about an Adult's welfare or an adult tells you about abuse

- 14.1. Concerns about the wellbeing and safety of an Adult at Risk must always be taken seriously. Any Practice member of staff who first becomes aware of concerns of abuse must report those concerns as soon as possible and if possible within the same working day to the relevant senior manager/ safeguarding lead within the practice.
 - 14.1.1. When an adult makes a disclosure it is important to reassure the adult at risk and that the information will be taken seriously. It is good practice to ensure that the adult is given information about what steps will be taken, including any emergency action to address their immediate safety or well-being.
 - 14.1.2. When suspecting or having abuse reported to them by a patient or member of the public, practice staff will initially:
 - Remain calm and non-judgemental
 - Take immediate action to ensure the safety or medical welfare of the adult
 - Not discourage the adult from further disclosure
 - Use active listening skill, clarify the main facts and summarise what has been said to you
 - Remain supportive, sensitive and attentive
 - Give reassurance but do not press for more detail or make promises
 - Retain, record and report information
 - Ensure all potential evidence has been preserved
 - Inform the Practice Safeguarding Lead
 - 14.1.2. The human rights and views of the adult at risk should be considered as a priority, with opportunities for their involvement in the safeguarding process to be sought in ensuring that the safeguarding process is person centred.
 - 14.1.3. If an adult in need of protection or any other person makes an allegation to you asking that you keep it confidential, you should inform the person that you will respect their right to confidentiality as far as you are able to, but that you are not able to keep the matter secret and that you must inform your manager/safeguarding lead within the practice and the Local Authority safeguarding team.
 - 14.1.4. If it is suspected that a crime could have been committed, it is important that you do not contact the person alleged to have caused harm or anyone that might be in touch with them. Contact the police 999 in an emergency or 101 for non-emergencies.
 - 14.1.5. The disclosed information must be recorded in the health records in the way that the adult at risk describes the events.
 - 14.1.6. Ability to consent to the safeguarding process should be determined by the person's mental capacity at that specific time and their understanding of risk and consequences of their situation. In determining validity of consent to

making a safeguarding adult alert, the possibility of threat or coercion from others should also be explored and considered.

14.1.7. There may be instances where a safeguarding alert can be made without an adult at risk's consent, this could include circumstances where others could be at risk if the alert is not made or instances where a crime may have been committed. This is known as a public interest disclosure to share information. In circumstances where information is shared using public interest disclosure the 'alerter' must be able to justify their decision to raise an alert in that information is accurate, shared in a timely manner and necessary and proportionate to the identified risk.

14.1.8 If any member of the Practice team is unsure how to proceed or is in doubt about making an alert, the case can be discussed with a senior colleague/ line manager, Safeguarding Practice lead or a member of the Adult Safeguarding team.

14.2. Risk Assessment

14.2.1. It is best practice to raise an alert at the earliest opportunity of the allegation from when the abuse or neglect was witnessed or suspected. A preliminary risk assessment should be undertaken with the main objective to act in the adult at risks best interest and to prevent the further risk of potential harm. It is important to consider the following:

- Is the adult at risk, still in the place where the abuse was alleged or suspected or is the adult about to return to the place where the abuse was alleged or suspected.
- Will the person alleged to have caused harm have access to the adult at risk or others who might be at risk?
- What degree of harm is likely to be suffered if the person alleged to have caused harm is able to come into contact with the adult at risk or others again?

14.2.2. Once the alert has been raised and if appropriate to be managed by the safeguarding process, the safeguarding plan sets out an individual risk assessment plan to ascertain what steps can be taken to safeguard the adult at risk, review their health or social care needs to ensure appropriate accessibility to relevant services and how best to support them through any action to seek justice or reduce the risk of further harm.

14.2.3 An adult who has capacity may choose to stay in an abusive situation or choose to not take part in the safeguarding process. In such a case the plan may therefore be centred around managing the risk of the situation with the person ensuring that they are aware of options to support their safety. Such cases will require careful monitoring and recording so it is recommended to seek advice if this occurs.

14.2.4 To seek further advice contact :

Different areas will have different Safeguarding professionals which may include Designated Professionals, Named GPs, Nurse Consultants or others. Insert contact details of your local professionals here:

14.2.5. Local Safeguarding Adult Board:

Insert links here

15. Information Sharing

- 15.1. Sharing of information is vital for early intervention and is essential to protect adults at risk from suffering harm from abuse or neglect. It is important that all practitioners understand when, why and how they should share information.
- 15.2. Always consider the safety and welfare of the adult at risk when making decisions on whether to share information about them. Where there is concern that the adult may be suffering or is at risk of suffering significant harm then their safety and welfare **must** be the overriding consideration.
- 15.3. Information may also be shared where an adult is at risk of serious harm, or if it would undermine the prevention, detection, or prosecution of a serious crime including where consent might lead to interference with any potential investigation.
- 15.4. Sharing the right information, at the right time, with the right people, is fundamental to good practice in safeguarding adults but has been highlighted as a difficult area of practice. It is important to keep a balance between the need to maintain confidentiality and the need to share information to protect others. Decisions to share information must always be based on professional judgement about the safety and wellbeing of the individual and in accordance with legal, ethical and professional obligations.
- 15.5. Ideally consent should be provided along with the request for adult health information however there are times when the concerns/risks to the adult are such that it is not appropriate to seek consent, principally as this may increase the risk of further abuse. A lack of consent should not prevent a GP or other practitioner within the Practice from sharing information if there is sufficient need in the public interest to override the lack of consent. Where the practitioner is uncertain advice about consent is available from the Safeguarding Practice Lead, Named GP, Nurse Consultant for Safeguarding in Primary Care, Designated Professional for Adult Safeguarding, the GMC, LMC or medical defence organisation
- 15.5. The 'Seven Golden Rules' of information sharing are set out in the Information Sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers (2015) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.

[pdf](#). This guidance is applicable to all professionals charged with the responsibility of sharing information, including in safeguarding adults scenarios.

Key points about information sharing:

- **The Data Protection Act is not a barrier** to sharing information but provides a framework to ensure personal information about living persons is shared appropriately.
- **Be open and honest** with the person/family from the outset about why, what, how and with whom information will be shared and seek their agreement, unless it is unsafe or inappropriate to do so.
- **Seek advice** if you have any doubt, without disclosing the identity of the person if possible.
- **Share with consent** where appropriate and where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent, if, in your judgment, that lack of consent can be overridden by the public interest. You will need to base your judgment on the facts of the case, on considerations of the safety and well-being of the person and others who may be affected by their actions.
- **Necessary, proportionate, relevant, accurate, timely and secure**, ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up to date, is shared in a timely fashion and is shared securely.
- **Keep a record of your concerns**, the reasons for them and decisions. Whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose

16. Recording Information

- 16.1 Where there are concerns about an adult's welfare, all concerns, discussions and decisions made and the reasons for those decisions must be recorded in writing in the person's medical records.
- 16.2 This Practice ensures that computer systems are used to identify those patients and families with risk factors or concerns using locally agreed Read Codes.
- 16.3 It is recognised that it is as important to be alert to the children and other members of the household as the adult there are direct concerns about.
- 16.4. The Practice has a dedicated Administration Team who are responsible for managing alerts and Safeguarding Adult information/ correspondence which is all held together within one health record.

17. Implementation

- 17.1. Practice staff will be advised of this policy through Practice meetings. The Safeguarding Adult Policy will be available via the **please insert per practice**
- 17.2. Breaches of this policy may be investigated and may result in the matter being treated as a disciplinary offence under the Practice disciplinary procedure.

18. Training and Awareness

- 18.1. The Practice's induction for partners and employees will include a briefing on the Safeguarding Adult Policy by the Practice Manager or Practice Lead for Safeguarding. At induction new employees will be given information about who to inform if they have concerns about an Adult's safety or welfare and how to access the Local Safeguarding Adult procedures.
- 18.2 All Practice staff must be trained and competent to be alert to potential indicators of abuse and neglect in Adults, know how to act on their concerns and fulfil their responsibilities in line with LSAB policy and procedures.
- 18.3. The Practice will enable staff to participate in training on adult safeguarding and promoting their welfare provided on both a single and interagency basis. The training will be proportionate and relevant to the roles and responsibilities of each staff member.
- 18.4. The Practice will keep a training database detailing the uptake of all staff training so that the Practice Manager and Safeguarding Leads can be alerted to unmet training needs.
- 18.5 All GPs and Practice staff should keep a learning log for their appraisals and or personal development plans

19. Safer Employment

- 19.1. The Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) functions have now merged to create the Disclosure and Barring Service (DBS).
- 19.2. The Practice recruitment process recognises that it has a responsibility to ensure that it undertakes appropriate criminal record checks on applicants for any position within the practice that qualifies for either an enhanced or standard level check. Any requirement for a check and eligibility for the level of check is dependent on the roles and responsibilities of the job.
- 19.3. The Practice recognises that it has a legal duty to refer information to the DBS if an employee has harmed, or poses a risk of harm, to vulnerable groups and where they have dismissed them or are considering dismissal. This includes situations where an employee has resigned before a decision to dismiss them has been made.

19.4. For further information see

<http://www.homeoffice.gov.uk/agencies-public-bodies/dbs>

or

<http://www.nhsemployers.org/case-studies-and-resources/2014/08/an-employers-guide-to-using-the-dbs-update-service>

19.5. Safer employment extends beyond criminal record checks to other aspects of the recruitment process including:

- making clear statement in adverts and job descriptions regarding commitment to safeguarding
- seeking proof of identity and qualifications
- providing two references, one of which should be the most recent employer
- evidence of the person's right to work in the UK is obtained

20. Managing Allegations against Staff who have contact with Vulnerable Adults

20.1. Vulnerable adults can be subjected to abuse by those who work with them in any and every setting. All allegations of abuse or maltreatment of vulnerable adults by an employee, agency worker, independent contractor or volunteer will be taken seriously and treated in accordance with Safeguarding Adult Board policy and procedures (SAB).

20.2. The Practice safeguarding lead should, following consultation with the Designated Adult Safeguarding Manager, Local Authority Safeguarding Adults Enquiry Team and where appropriate the Police, inform the subject that allegations have been made against them without disclosing the nature of those allegations until further enquiry has taken place. If it is deemed appropriate to conduct an investigation prior to informing those who are implicated, clear record needs to be made of who took the decision and why.

20.3. Suspension of the employee concerned from their employment should not be automatic. Depending on the person's role within the practice and the nature of the allegation it may be possible to step the person aside from their regular duties to allow them to remain at work whilst ensuring that they are supervised or have no patient/public contact. This is known as suspension without prejudice. Suspension offers protection for them as well as the alleged victim and other service users, and enables a full and fair investigation/safeguarding risk assessment to take place. The manager will need to balance supporting the alleged victim, the wider

staff team, the investigation and being fair to the person alleged to have caused harm.

- 20.4. All allegations should be followed up regardless of whether the person involved resigns from their post, responsibilities or a position of trust, even if the person refuses to co-operate with the process. Compromise agreements, where a person agrees to resign without any disciplinary action and agreed future reference must not be used in these cases.
- 20.5. If it is concluded that there is insufficient evidence to determine whether the allegation is substantiated, the chair of the safeguarding strategy meeting will ensure that relevant information is passed to the Practice Safeguarding lead. The senior manager of the practice will consider what further action, if any, should be taken in consultation with the Local Authority safeguarding lead for Managing Allegations and in line with the Practice HR procedures.
- 20.6. When an allegation of abuse or neglect has been substantiated, the Practice Safeguarding lead should consult with the Local Authority safeguarding team for advice and whether it is appropriate to make a referral to the professional or regulatory body and to the Disclosure and Barring Service (DBS), because the person concerned is considered unsuitable to work with Adults at Risk.

21. Whistle blowing

- 21.1. The Practice recognises that it is important to build a culture that allows practice staff to feel comfortable about sharing information, in confidence and with a lead person, regarding concerns about quality of care or a colleague's behaviour. [Direct to or insert link to the Practice Whistle Blowing Procedure.](#)

22. Professional Challenge

- 22.1. This Practice enables and encourages any practice member that disagrees with an action taken and still has concerns regarding an adult at risk of abuse to either contact the Safeguarding Practice Lead, Nurse Consultant Safeguarding Primary Care, or the Designated Professional for Safeguarding Adults for independent reflection and support.

23 Monitoring and Audit

- 23.1. Audit of awareness of this safeguarding adult policy and processes will be undertaken the Practice Manager and Practice Safeguarding lead.

24. References

In developing this Policy account has been taken of the following statutory and non-statutory guidance:

Health and Social Care Act 2008 (Regulated Activities) regulations 2014
http://www.legislation.gov.uk/uksi/2014/2936/pdfs/uksi_20142936_en.pdf

HM Government (2015) Information Sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf

HM Government (2015) Revised PREVENT Duty Guidance for England and Wales

[https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445977/3799 Revised Prevent Duty Guidance England Wales V2-Interactive.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445977/3799_Revised_Prevent_Duty_Guidance_England_Wales_V2-Interactive.pdf)

HM Government (2014) *The Care Act*
<http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

Local Government Association 2014 Making Safeguarding Personal: Guide.
<http://www.local.gov.uk/documents/10180/5854661/Making+Safeguarding+Personal+-+Guide+2014/4213d016-2732-40d4-bbc0-d0d8639ef0df>

NHS England (2016) Safeguarding Adults: Roles and competences for health care staff Intercollegiate Document
<https://www.england.nhs.uk/wp-content/uploads/2016/03/safeguarding-adults-intercollegiate.pdf>

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

Authors

- [Dr Joy Shacklock](#), RCGP Clinical Champion Good Practice Safeguarding, April 2017 – April 2018
- [Dr Elisabeth Alton](#), RCGP Lead for Safeguarding Children and Adults, April 2016 – April 2017
- Policy adapted, with permission, from the four North Yorkshire and York CCGs 'Safeguarding Adult Policy' written by [Jacqui Hourigan](#), Nurse Consultant Safeguarding Adults and Children in Primary Care, North Yorkshire and York CCGs.

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