Safeguarding Adults Policy

Policy Reference Number:	CG 3.18
Version number:	5.0
Date authorised for minor changes:	3rd February 2021
Date approved:	5th May 2021
Approved by:	National Safeguarding Panel
Date ratified:	11th May 2021
Ratified by:	Integrated Quality Audit and Compliance Group (IQACG)
Expiry date:	11th May 2023
Withdrawn date:	N/A
Date Issued:	18th May 2021
Director Sponsor:	 Graeme Wilkes, Chief Medical Officer
Policy Review Date:	11th May 2022

Associated Policies & Documents:	- Mental Capacity Policy - Safeguarding Children Policy - Pre-Employment Screening Policy - Learning and Development Policy - Consent to examination or treatment Policy - Privacy and Dignity Policy - Management of allegations against staff Policy - Complaints & Feedback Policy - Incidents reporting & management Policy - Clinical Supervision Policy
Legislation /Guidelines that apply to this policy	- Health & Social Care Act (2012) - Care Act (DH, 2014) - Statement of Government Policy on Adult Safeguarding (DH, 2013) - Safeguarding Vulnerable People in the NHS: Accountability & Assurance Framework (2015) - Safeguarding Vulnerable Groups Act (2006) - Safeguarding Adults - National Framework of Best Practice (2005) - Mental Capacity (Amendment) Act (2019) - The Data Protection Act (2018) - Counter Terrorism & Security Act (2019) - Serious Crime Act (2015) - Care Standards Act (2000) - Intercollegiate document Adult Safeguarding: Roles and competencies for healthcare staff – (August 2018) - Statement on CQC's roles and responsibilities for safeguarding children and adults (June 2015)

Equality Impact Assessment (EIA)

Initial Equality Impact Assessment Carried Out	**Yes/No**	**Date Carried Out**
	Yes	06/05/2021
Any Significant Impact Following EIA	**No**	
Full Equality Impact Assessment Required	**Yes/No**	**Date Carried Out**
	N/A	
Outcome of Full EIA		

Contents

1. Introduction

'*Organisations have a duty to promote the adult's wellbeing in their safeguarding arrangements. People want to feel safe and those who work to support and care for them should establish what being safe means to them and how that can be best achieved. This respectful and inclusive approach is at the heart of personalisation. Staff and managers should not implement measures that do not take account of individual circumstances and well-being.' (Care Act: Section 14.8)*

Connect Health recognises the importance of identifying any concerns in relation to adults at risk of abuse and neglect as well as children at risk in their families. Further we understand our responsibilities to identify, report and escalate concerns in an appropriate fashion.

This Policy defines the principles of Safeguarding Adults in Connect Health, including assessing mental capacity, the essential standards in relation to Safeguarding Adults, training of staff and standard operating processes including suicidal ideation.

2. Policy scope

Connect Health protects and promotes the welfare of all patients who use the service including Adults at Risk.

This Policy applies to all Connect Health colleagues and locums who have any patient contact. This Policy should be read alongside the following policies: Safeguarding Children Policy, Management of Allegations Against Staff Policy, Whistleblowing policy, Learning and Development Policy (mandatory training), Staff Induction Policy, Privacy and Dignity Policy, Patient Complaints Reporting & Management Policy, Prevent Policy and HR Recruitment & Selection Policies, Mental Capacity Policy

The introduction of *The Care Act 2016* provides a clear legal framework as to how providers work in partnership with Commissioners and with other public services to protect adults at risk, placing Safeguarding Adults on the same statutory footing as Safeguarding Children and Young People. The updated *Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework (NHS England 2015)* outlines this position further.

Promoting the health and well-being of those who are at risk of being abused or neglected in our services and working with other agencies in the local areas where services are provided, are key priorities for Connect Health to provide safe and effective clinical care.

Connect Health understand and accept responsibility to promote the welfare of all service users and to keep them safe. This includes a close link between this policy and our child protection requirements covered under different legislation and regulations. Specifically, it is important to acknowledge that it is our responsibility for looking after the adult **but also to recognise, consider and act upon risk of harm to any children that are associated with our adult patients or any other relative of person relevant to that child.**

3. Aims & Objectives.

The Government sets out six principles for safeguarding adults (DH - *Statement of Government Policy on Adult Safeguarding* (2013). Whilst not legal duties, these do represent

best practice and provide a foundation for achieving good outcomes:

- Empowerment - presumption of person led decisions and consent
- Protection - support and representation for those in greatest need
- Prevention of harm or abuse
- Proportionality and least intrusive response appropriate to the risk presented
- Partnerships - local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse
- Accountability and transparency in delivering safeguarding

This policy therefore outlines the Connect Health's plans regarding Safeguarding of Adults at Risk.

4. Duties: Roles & Responsibilities

Chief Medical Officer
To be accountable for the implementation of this policy including holding named professional status and Board representation in relation to safeguarding adults and vulnerable patients. To retain ultimate accountability for safeguarding of all service users and arrangements within the business. To ensure that the organisation has appropriate infrastructure and resources to meet legislative and regulatory requirements.

Director of Clinical Delivery
Will promote a culture of supporting good practice regarding adult protection/safeguarding within their organisations and promote a culture of learning and professional curiosity, and collaborative working with other agencies. Responsible for ensuring the clinical teams have robust safeguarding arrangements in place throughout services and that the workforces have the required training to ensure we keep adults at risk within our services safe.

Registered Manager
CQC regulations say that the 'registered person' must submit notifications. Registered persons are the organisation's, partnerships or individuals registered to provide regulated activities under the Health and Social Care Act 2008, and any registered managers they employ. Notifications may be submitted by registered managers, but this task can be delegated to other appropriate members of staff. Delegation arrangements will clearly show which members of staff are responsible for submitting notifications. Within Connect Health this will be the CQC Manager or in the absence of this the Operational Governance and Quality Manager.

Chief People Officer:
To ensure that appropriate recruitment and selection processes are completed in relation to safeguarding of adults at risk as outlined in this policy such as DBS checks (appropriate to level of staff)

Deputy Director - Integrated Governance & Quality
To contribute to the development of robust internal adult safeguarding policy, guidelines, and protocols as a member of the safeguarding team. To lead on the delivery of the infrastructure of this policy and chair the National Safeguarding Panel. To provide oversight of the safeguarding process, ensuring that the monitoring and audit of this document is completed and reported, and that the results are appropriately actioned. There will be oversight of learning from significant incidents.

Regional/Service Managers

- To ensure that all staff within their services have completed appropriate training, undergo correct induction in relation to safeguarding and that Service Directories provide local authority contact details for the staff to utilise.
- They will identify any concerns/risks within their region or service in relation to Safeguarding Adults at Risk processes and escalate these to the Chief Medical Officer.
- They will ensure Safeguarding information is on notice boards in every venue.
- They will liaise with Commissioners (NHS) or Employers (OHP) in matters relating to Safeguarding

Designated Safeguarding Officers (DSO)

Trained to Level-4 Safeguarding, will be able to contribute to the development of robust internal safeguarding policy, guidelines, and protocols as a member of the safeguarding team. To be able to discuss, share and apply the best practice and knowledge in safeguarding including:

- the latest research evidence and the implications for practice
- an advanced understanding of adult safeguarding legislation, information sharing, information governance, confidentiality, and consent.
- an advanced knowledge of relevant national issues, policies and their implications for practice

The role includes:

- to effectively communicate local safeguarding knowledge, research, and findings from audits and from concerns reported
- to take part in the on-call safeguarding rota, offering advice on any safeguarding issue that arises which may include taking control and reporting the concerns to the appropriate MASH team.
- to follow-up all MASH reports on their duty with the reporting colleague including outcome of MASH investigation and reporting at monthly DSO meeting
- to work effectively with all colleagues in safeguarding/child protection clinical networks.
- To provide advice and information about safeguarding to the employing authority, both proactively and reactively – this includes the Board, directors, and senior managers.

Head of Learning & Development

To work with the DSOs to evaluate the quality of training, including those providers/suppliers for safeguarding of adults at risk, to ensure it meets the needs of the business. To monitor completion rate for mandatory training for all staff, including completion of safeguarding supervision. To escalate noncompliance to the Clinical Governance Group as appropriate.

Clinicians

- To deliver a patient centred approach to clinical care as outlined in this policy
- To demonstrate the ability to identify concerns regarding adults at risk, safeguarding, welfare and child protection
- To quickly assess mental capacity in each consultation
- To be able to safely manage and direct patients who express suicidal thoughts
- To understand the processes for escalating concerns regarding adults at risk, welfare and safeguarding for their service or region
- To consider the " child behind the adult" at all times
- To understand their legal accountability to report concerns when identified. To ensure that their own personal mandatory training is up to date including refresher training

Team Leaders

- To ensure that all employees are inducted to the Safeguarding Adults Policy and its procedures as outlined in this policy

- To be available to field queries and support/guide staff to the local authorities with adult safeguarding queries
- To reinforce these skills within clinical supervision including patient centred approach to clinical care

Administrators (patient care advisors/receptionists/patient facing):

- To deliver a patient centred approach to clinical care as outlined in this policy.
- To demonstrate ability to identify concerns regarding adults at risk, safeguarding and welfare.
- To understand the processes for escalating concerns regarding adults at risk and safeguarding for their service or region and available DSOs for guidance and advice.
- To be able to safely and confidently understand and direct patients who express suicidal thoughts
- To understand their legal accountability to report concerns when identified to manager/supervisor and DSO.
- To ensure that their own personal mandatory training is up to date, including refresher training.

All Colleagues

One of the most important principles of safeguarding is that it is everyone's responsibility. All colleagues must do everything they can to ensure that adults at risk are protected from abuse, harm and neglect.

National Safeguarding Panel

This group will act as a central national group to facilitate and drive an integrated approach to adults at risk safeguarding across the organisation in line with strategic objectives and the clinical governance agenda. Further aims are to steer, review and improve local and national practice in relation to safeguarding within the corporate safeguarding framework. An annual Safeguarding Audit will be presented to the NSP to assess Safeguarding in the organisation and contribute to continual improvement. This panel reports directly into the Clinical Governance group who in turn report to the Integrated Quality Audit and Compliance Group (IQACG) and Board.

Monthly DSO meeting

This meeting will allow DSOs to discuss matters relevant to their delivery of Safeguarding advice according to Connect Health and national standards. This will include review of cases since the last meeting and organise and/or provide Safeguarding Supervision and Continuing Professional Development to the DSOs using internal and external resources. The meeting will be organised and chaired by a nominated DSO and will feed into the National Safeguarding Panel.

5. Definitions

'***Adult at Risk'*** - any person aged 18 years and over who has or may need community care services by reason of mental health issues, learning or physical disability, sensory impairment, age or illness and who is or may be unable to take care of him/herself or unable to protect him/herself against significant harm or serious exploitation. The range of people considered to be vulnerable has been widened to include people encountering domestic violence, substance misusers and those vulnerable to radicalisation and modern slavery
'Staff, Employee, workers and contractors' - All employees, both contracted and substantive who work for Connect Health. This includes students and volunteers and clinical and non-clinical staff as well as managers and directors.

'Abuse'- mistreatment that violates a person's human and civil rights. The abuse can vary

from treating someone with disrespect in a way which significantly affects the person's quality of life, to causing actual physical suffering. Abuse can be:

- physical (for example hitting, pushing, shaking, misusing medication)
- sexual (for example rape, sexual assault, being forced or persuaded to take part in sexual activities and doesn't need to include physical contact)
- domestic (for example controlling, coercive or threatening behaviour, 'honour' based violence, female genital mutilation, forced marriage)
- emotional or psychological (for example threats of harm or abandonment, humiliation, controlling, intimidation)
- financial or material (for example theft, fraud, misuse, pressure in connection with wills of property or possessions)
- neglect (for example ignoring medical or physical care needs)
- self-neglectful (for example neglecting to care for one's personal hygiene or health)
- discriminatory (for example abuse based on race, sexuality or a person's disability)
- Modern Slavery is the term used within the UK and is defined in the Modern Slavery Act (2015). The Act categorises offences of slavery, servitude and forced or compulsory labour and human trafficking. These crimes include holding a person in a position of slavery, servitude, forced or compulsory labour, facilitating their travel with the intention of exploiting them soon after. Modern Slavery is part of Connect Health's Safeguarding agenda for children and adults. Colleagues should be aware of the potential for patients to be victims of Modern Slavery and should report this concern as they would any other safeguarding concern
- organisational or institutional abuse (mistreatment of people brought about by poor or inadequate care or support, or systematic poor practice that affects the whole care setting)
- Prevent guidance is about safeguarding and supporting those vulnerable to radicalisation

'Significant harm'- The impairment of, or an avoidable deterioration in; physical or mental health leading to the impairment of physical, emotional, social or behavioural development.

'Adult at Risk- "is a person aged 18 years or over, who is in receipt of or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation".

6. Safeguarding Adults Procedure/Process

We value, listen to and respect all our patients who encounter our services; this includes patients their carers and families. Connect Health believes in a patient-centred approach to clinical care and are always alert to potential indicators of abuse or neglect.

Safe Recruitment Practices
Connect Health undergoes rigorous recruitment and selection processes, and we recruit colleagues and volunteers safely, ensuring all necessary checks are made. Further information can be found in *Connect Health Disclosure and Barring Service Policy* as to the process of DBS checks as well as the level of DBS checks by role type are completed as a part of recruitment and selection.

Connect Health provides induction training and effective management support for colleagues and locums to ensure they have up to date skills and knowledge to enable them to effectively safeguard adults. Connect Health will confirm that contractors and suppliers have similar

arrangements in place. More information can be found in Connect Health *Pre-Employment Screening Policy*

Closed Cultures
CQC guidance around closed cultures was published July 2020. A closed culture is a poor culture in a health or care service that increases the risk of harm. This includes abuse and human rights breaches. The development of closed cultures can be deliberate or unintentional – either way it can cause unacceptable harm to a person and their loved ones. Reports into Closed Cultures identified people with Learning Disability or Autism as "Adults at Risk". We recognise that lessons learned from the historical abuse of these groups should translate to increased vigilance when they present to our services.

Mental Capacity
Mental capacity should be assessed during every patient consultation and not be assumed to be absent because the clinical notes, GP letter or accompanying relative outlines this. Mental capacity can change and so the starting point is that the patient has capacity until a current assessment has occurred. All colleagues should be aware that any assumption on lack of mental capacity as a default could risk conspiring in patient harm in removing their right to make decisions including those that may appear "unwise".

A full outline of mental capacity and its assessment in a clinical consultation context is contained in the *Mental Capacity Policy* which must be understood in relation to this Safeguarding Adult policy

Colleagues will receive training regarding Mental Capacity and Consent in their mandatory training and these skills are reviewed during clinical supervision and embedded within their clinical competences. For details regarding this please see *Learning & Development Policy* and *Clinical Supervision & Competence Assessment Policies (*by profession).

Deprivation of Liberty (DoLS)

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

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

Connect Health does not provide in-patient care and so we will not be involved directly in any such decisions. This is included for awareness as we will see patients who are resident in care homes and issues of DoLS may apply.

Any concerns about DoLS for a patient should be raised with a DSO.

Clear processes for identifying and escalating concerns or those at risk of abuse or neglect in families

We should respond to safeguarding concerns promptly and effectively in the best interests of the persons and families involved.

Examples of concerns:

- An active disclosure of abuse by the adult, where the adult tells a member of staff that they are experiencing abuse and/or neglect.
- A passive disclosure of abuse where someone has noticed signs of abuse or neglect, for example clinical staff who notice unexplained injuries
- An allegation of abuse by a third party, for example a family/friend who have observed abuse or neglect or have been told of it by the adult
- A complaint or concern raised by an adult or a third party who doesn't perceive that it is abuse or neglect. All patient facing colleagues should consider whether there are safeguarding matters
- A concern raised by staff or volunteers, others using the service, a carer or a member of the public
- An observation of the behaviour of the adult at risk
- An observation of the behaviour of another linked person

This policy outlines the procedures for the escalation of concerns for Adults at Risk. This includes.

- Procedure for Reporting Suspected Adult at Risk Concern – Appendix 1
- Procedure for Management of Adults at Risk and Those who Do Not Attend (DNA) - Appendix 2.

If a colleague identifies a safeguarding concern for an Adult at Risk which may affect a child within that family or a risk to a child independent of any risk to that Adult - the *Safeguarding Children Policy should be applied even though the child is not a patient.* It is vital colleagues are vigilant and "see the child behind the adult".

Safeguarding Children Policy can be found here:
https://connectphc.sharepoint.com/sites/Quality/Shared%20Documents/Safeguarding%20Children%20Policy.docx

Once a concern about an Adult at Risk is identified, it is important that it is escalated in a timely, appropriate manner. Connect Health aim to have in place 10 Designated Safeguarding Officers who are available on an on-call rota and have the responsibility internally to field queries from any colleague at any time regarding potential safeguarding concerns.

The process for this escalating and reporting concerns includes the following "four Rs'" approach:

1. **Recognise**: All colleagues should recognise possible harm from their mandatory training and reinforced through bi-annual education/supervision updates

2. **Respond**: having identified a concern, all colleagues will be aware of the process to respond to the concern and escalate this with appropriate urgency within the organisation. The process is outlined in Appendix 1 of this policy and is made available electronically and in paper format where possible for reference. Line managers and DSOs are the key personnel who will help any colleague consider and advise on their concerns.

3. **Referral**: A decision to refer an adult to an outside agency will be made with support from the on-call Designated Safeguarding Officer (DSO). The on-call rota and process is available at Safeguarding (sharepoint.com)

   Following a decision to refer to either the Police, the Local authority Multi-Agency Safeguarding Hub (MASH) team or as a backup, the DSO will take the reporting responsibility though if a Police referral is deemed necessary by the colleague prior to

DSO response, this should be made via 999 so as not to delay response.

MASH referral will be completed using the correct forms within the specific CCG. In many cases this is via an online form. In each service location the appropriate MASH/ Adult Services team can be found using the NHS GUIDE Safeguarding APP which all DSOs have installed on their mobile phone:
https://www.england.nhs.uk/safeguarding/nhs-england-safeguarding-app/

An Incident must be recorded on Datix for any referral made to MASH or the Police and the CQC Registered Manager should be informed by email for reporting.

4. **Record:** It is essential that contemporaneous notes are recorded on SystmOne or OHP system surrounding the detail. This should include events that have occurred and include exactly what was said by the person who witnessed events, whether viewed in clinics or heard on the telephone with any "quotes" ascribed as accurately as possible within that record

Consent
Wherever practicable, the consent of the adult should be obtained before taking action. However, there may be circumstances when consent is not given but it is in their best interests for to protect them or another person, especially where a child is involved. This is a common issue where domestic violence is involved.

Adults may not give their consent to the sharing of safeguarding information for a number of reasons. For example:

- They may be unduly influenced, coerced or intimidated by another person
- They may be frightened of reprisals
- They may fear losing control
- They may not trust social services or other partners
- They may fear that their relationship with the abuser will be damaged

Reassurance and appropriate support may help to change their view on whether it is best to share information.

Involvement of the Caldicott Guardian
Where a breach of confidentiality may be indicated a Connect Health Caldicott Guardian should be contacted for support and guidance ideally ahead of making a decision to breach confidentiality. Caldicott Guardians are trained to help make decisions on confidentiality issues, where often the issues can be complex.

Reasons to breach confidentiality include:

- Emergency or life-threatening situations may warrant the sharing of relevant information with the emergency services without consent
- Other people are or may be at risk - especially children
- Sharing the information could prevent a serious crime
- A serious crime has been committed
- The risk is unreasonably high –such as in domestic abuse cases - and meets the criteria for a multi-agency risk assessment conference referral
- There is a court order or other legal authority for taking action without consent

Connect Health has two Caldicott Guardians, one of whom is the Chief Medical Officer. Access details for our Caldicott Guardians are identified in each Service Manual.

Prevent/Terrorism
There is a close relationship between this policy and Connect Health's *Prevent Policy,* which

outlined the processes and requirements for staff to report concerns for adults and families at risk in relation to the Counter Terrorism Act (2015). Please see further details for this in Connect Health's *Prevent* https://connectphc.sharepoint.com/:w:/r/sites/Quality/Shared%20Documents/Prevent%20Policy.doc?d=w5bbb61ba23bc48108f7cb04c61ba4f55&csf=1&web=1&e=KdbO8T

Suicidal Ideation/Intent
Many patients referred to Connect Health services with complex problems may be concurrently suffering a depressive illness which may be already diagnosed but often may not be. Suicidal thoughts can be common and fortunately are usually not converted to a suicide attempt.

Suicidal patients are "at risk" whatever their mental capacity and we recognise the responsibility to detect signs of depression and suicidal risk. Suicidal emotions and sometime voiced threats are presented to our Patient Co-ordination Centre staff as much as to clinicians. Not infrequently, perceived delay in obtaining an appointment can lead to suicide ideation. Sometimes this may represent true suicidal thoughts and sometimes this is expressed as part of the frustration of perceived system delays. All such comments must be treated seriously by following the Suicide Prevention Standard Operating Procedure (SOP) in Appendix 5.

It is Connect Health policy to react appropriately to any suggestion of suicide voiced or implied. Our policy also supports our Colleagues where such discussions can be distressing and contribute to anxiety and worry.

Our approach to this is to ensure that all appropriate colleagues receive appropriate training to prepare them for this scenario and to support them after such a call. The Suicide Prevention SOP applies to all Connect staff and volunteers who have any patient contact and is part of Connect Health's Safeguarding Policy.

The SOP provides a process for staff to follow in order to enable early identification of individuals at risk, use best practice in assessing risk in relation to suicide, take the appropriate action in terms of mitigating risk and access post-incident debrief/support.

Clear policies for dealing with allegations against colleagues or volunteers
If the allegation relates to action or inaction of a Connect Health colleague or volunteer, we respond in a way that is fair to the individual allegations made but we prioritise the safety of the service users.

We meet our legal responsibilities as an employer, to refer any colleague or volunteer who poses a risk of harm to adults to the relevant authority. Connect Health have outlined in a separate policy regarding these standards in *Policy for the Management of Allegations Against Colleagues;* this policy further outlines the importance of immediacy and timely risk assessments in this process and can be found HERE:
https://connectphc.sharepoint.com/:w:/r/sites/Quality/Shared%20Documents/Management%20of%20allegations%20against%20staff%20policy.doc?d=w9e850404d0ea46838bd3c71d0330a883&csf=1&web=1&e=akYw4I

CQC Notifications
We have a duty to notify the CQC about abuse or allegations of abuse concerning a person using our service if any of the following applies:

- the person is affected by abuse
- they are affected by alleged abuse
- the person is potentially at risk of harm
- the person is an abuser
- they are an alleged abuser

Any case reported to the local MASH team should be notified to the CQC via Connect Health's Registered Manager as outlined within the CQC regulations. DSOs will hold responsibility for ensuring that this is actioned for any reported case they are involved in. All notifications must be submitted in required timescales (ASAP or within 48 hours) and recorded within the DATIX system.
https://www.cqc.org.uk/guidance-providers/notifications/allegations-abuse-safeguarding-notification-form

Safeguarding for FCPs in Primary Care
In circumstances where Connect Health colleagues are working in GP practices as first contact practitioners (FCP), these patients are working under Primary Care contracts and supervision. In these situations where a safeguarding concern may be raised, the clinician should utilise knowledge from this policy but follow the standard operating procedure and guidance for that GP surgery. All connect staff should familiarise themselves with the GP practice Safeguarding policies.

Recording and sharing information
Sharing information where there are concerns about significant harm to an adult or further to a child who stands behind the adult is essential (*Information sharing: Guidance of Practitioners and Manager DOH 2008*).

In cases of suspected abuse, the duty of care that a health professional owes to a patient or person in care may take precedence over any data protection obligation. This will always be the case for Children.

Personal information about adults held by health professionals is normally subject to a duty of confidence and would not normally be disclosed without the consent of the subject (common law duty of confidence, Human Rights Act 1998 and the Data Protection Act 2018 (GDPR)). However, the law allows disclosure of confidential information necessary to safeguard the welfare of adults at risk of abuse or neglect.

Consent should always be sought from the patient before making a referral or disclosing information however this should be balanced with the risk to the patient or others where the risk may be increased by doing so. Consideration must be made as to whether obtaining consent is appropriate. If a breach of confidentiality is required, then the Caldicott Guardian should be contacted for advice where possible ahead of breaching confidentiality.

Further information can be found in *Connect Health's Information Governance Framework*.

Safeguarding conference
Following a report to MASH after a full enquiry, a Section 42 safeguarding case conference meeting may be held with request for attendance from Connect Health. It is chaired by a professional who has not been involved in the safeguarding enquiry. A report to and attendance at the enquiry may be required and will usually be led by the relevant DSO.

Examples of types of scenarios that are low risk, significant risk and critical risk are outlined in Appendix 4.

7. Training requirements

Connect Health's Learning & Development Framework outlines the Mandatory Training requirements for all colleagues including those in relation to Safeguarding of Adults at Risk and separately for Safeguarding Children. In addition to safeguarding training, it is also a

requirement that colleagues have training on GDPR, Mental Capacity assessment to effectively respond to the safeguarding needs of adults.

The requirements for mandatory training in relation to safeguarding of adults include:

Level 1 – All colleagues in the organisation who do not have contact with patients - administrative and clinical - but should have awareness of safeguarding concerns. This includes initial and refresher training to ensure that they are competent to identify and be aware of processes for reporting suspected harm.

Level 2 - All colleagues in the organisation who have direct contact with patients – administrative, clinical and Students. This includes initial and refresher training to ensure that they are competent to identify and be aware of processes for reporting suspected harm.

Level 3 - This higher level of clinician training will be determined on a contract by contract basis in discussion with the CCG

Level 4 - Named Professional and Designated Safeguarding Officers

Board Level
All board members both executive and Non-Executive should have level 1 core competencies in safeguarding and must know the common presenting features of abuse and neglect and the context in which it presents to healthcare staff. In addition, board members/commissioning leads should understand the statutory role of the board in safeguarding, including partnership arrangements, policies, risks and performance indicators; staff's roles and responsibilities in safeguarding; and the expectations of regulatory bodies in safeguarding.

Safeguarding Supervision
All Clinical and Patient Co-ordination Centre colleagues will undergo a bi-annual review of reported cases for concern, refresher on procedures for reporting concerns and how to assess mental capacity. This will allow for sharing of serious cases for reflection of clinicians in their practice. The content from this is shared from the NSP and delivered via the Duty Safeguarding officers in clinician and administrators twice per year.

Designated Safeguarding Officers will undergo Safeguarding Supervision via monthly Safeguarding Meetings (1-hour) and an annual update and discussion forum using an external Training Agency experienced in delivering Level-4training. This is in addition to the requirement for DSOs to recertify in Level-4 Safeguarding every three years.

Clinical Supervision
Connect Health has a long-standing and well-defined programme of direct Clinical Supervision for all colleagues including close supervision of new or less experienced staff and locums. At clinical supervision, safeguarding standards are reviewed including supervisors' observation of mental capacity assessment with consenting for examination and treatment and reflect this in clinical supervision records.

8. Diversity and Inclusion

Connect Health is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat colleagues reflects their individual needs and does not unlawfully discriminate against individuals or groups on the grounds of any protected characteristic (Equality Act 2010). This policy aims to uphold the right of all colleagues to be treated fairly and consistently and adopts a human rights approach. This

policy has been appropriately assessed. An equality analysis has been undertaken for this policy, in accordance with the Equality Act (2010).

9. Assurance and Monitoring Compliance

Standard/process/issue	Method	By	Group/meeting	Frequency
Safeguarding Audits	SAAF audit	Lead DSO	Review in National Safeguarding Panel (NSP)	Annual
Colleague Training	Training will be provided at induction annual mandatory training and bi-annual CPD sessions	1.DSOs 2.Learning and Development	NSP	Annual mandatory Bi annual CPD
This policy will be reviewed every 3 years	Review of policy in line with law, recommendations and standards	Clinical Governance Group	CGG Meeting	Every 3 years

10. Consultation and Review

This policy will be reviewed by Connect Health's Safeguarding Named Professional, Director of Quality and Governance and all Designated Safeguarding Officers. After review, the policy will be approved by the Integrated Quality Audit & Compliance Group (IQACG) and ratified by the Board via the Integrated Quality Audit & Compliance Committee (IQACC).

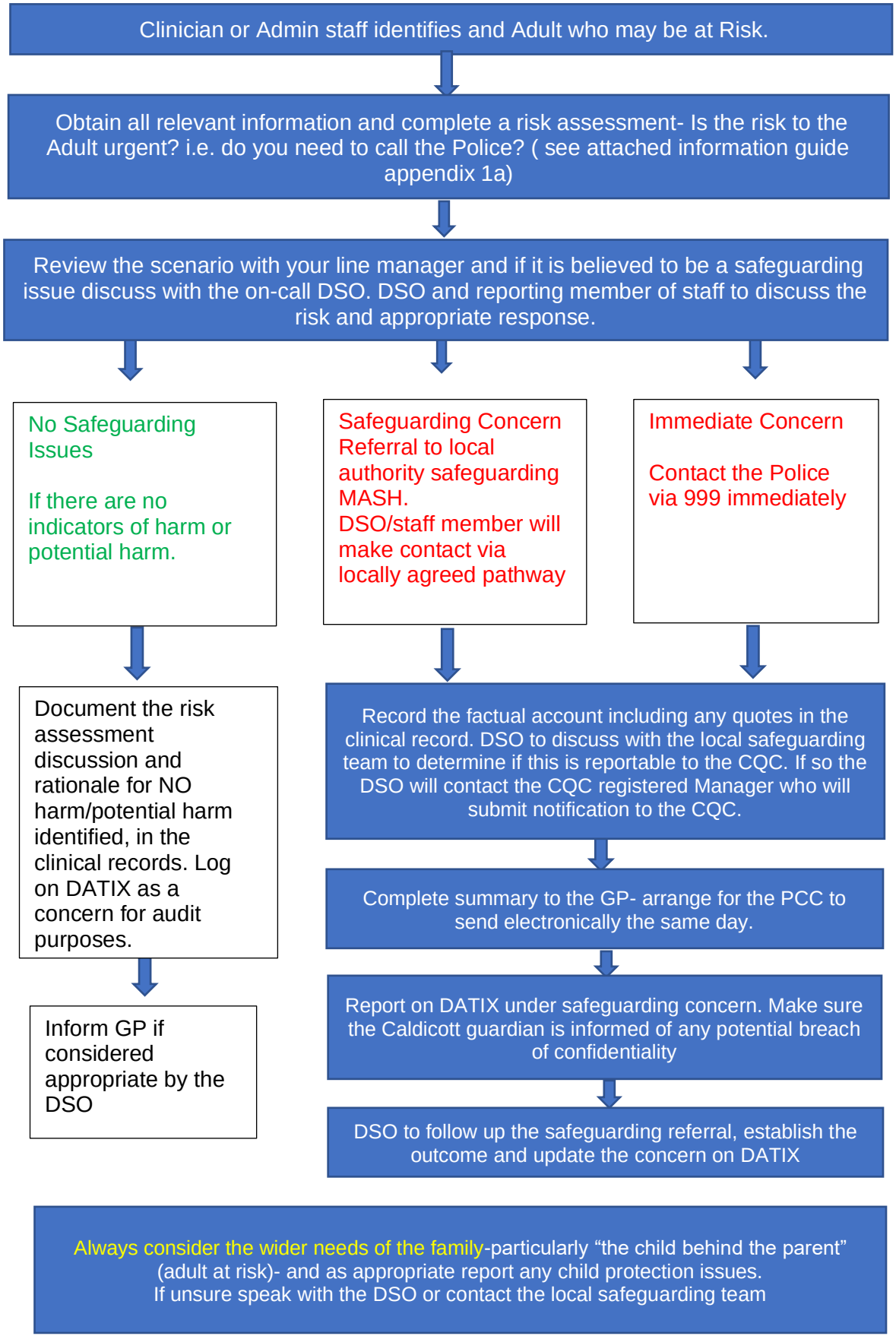
11. References

- Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework (NHS England 2015)
- Counter Terrorism Act (2015)
- Care Act (2016)
- Department of health- *Statement of Government Policy on Adult Safeguarding* (2013): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/197402/Statement_of_Gov_Policy.pdf
- Health & Social Care Act (2012)
- Department of Health (2011) - The role of health service managers and their board.
- *Regulation 5:* Fit and proper persons: directors and Regulation 20:
- Duty of candour Guidance for NHS bodies (Care Quality Commission,
- November 2014)
- Francis Report (2013)
- Regulation 13: Safeguarding service users from abuse and improper treatment https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-13-safeguarding-service-users-abuse-improper

- Safeguarding Vulnerable Groups Act 2006
- Mental Capacity (Amendment) Act (2019)
- Safeguarding adults- national framework of best practice (2005)
- Safeguarding Adults in Cheshire East - (*Break the Silenc*e) Inter-Agency Policy Procedures and Guidance part 1, 2 & 3
- Care Standards Act 2000
- Data Protection Act 1998
- The Police Act 1997
- Serious Crime Act 2007

12. Appendices

Appendix 1 – Process for Reporting Safeguarding of Adults at Risk Concerns



Appendix 1a - Guide to what type of information should be obtained in support of an Adult Safeguarding Referral:

Name and date of birth of the person at risk.

Current home address

Contact telephone number (Remember to check if the number is a safe number to contact the person at risk)

Does the person at risk consent/know about the referral? If not consult with Caldicott Guardian.

What type of concern has been identified: E.G. Physical abuse, Sexual abuse, Neglect, Domestic abuse etc.

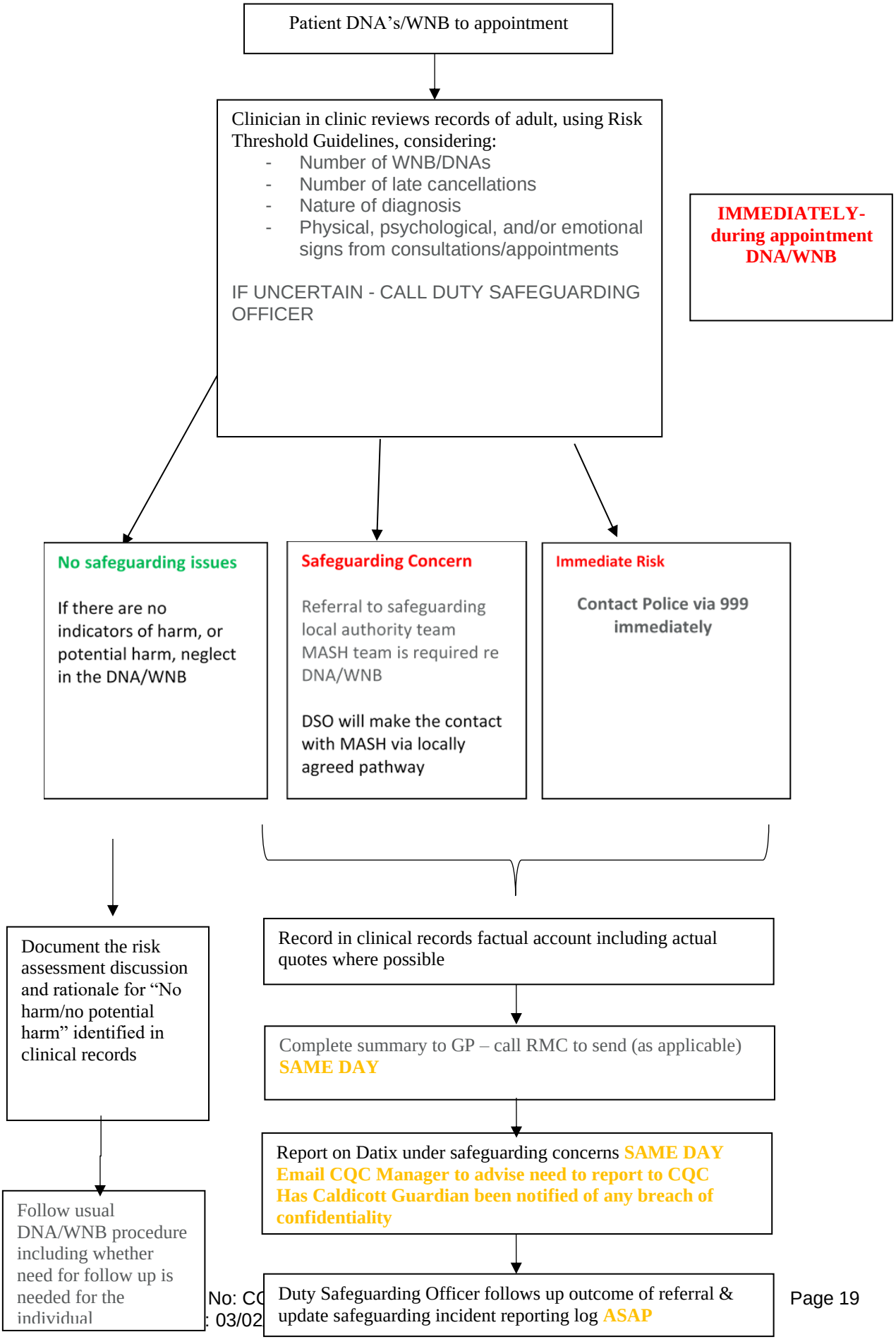
Details of the circumstances which have raised the concern.

Details of the perpetrator if relevant/ known.

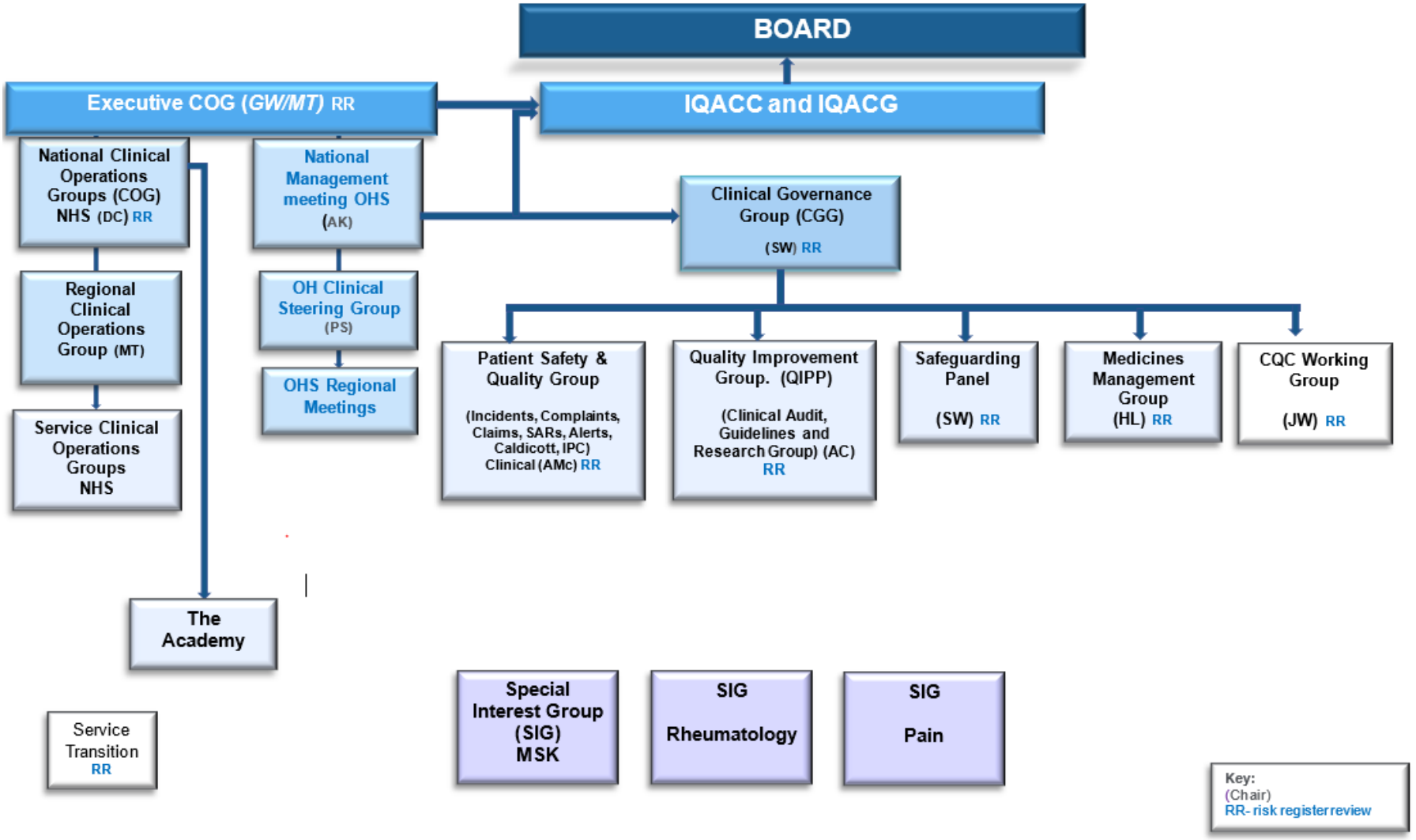
In addition to the above where possible you should consider the **WIDER FAMILY** of any patient or the person at risk taking into account their Job Role (e.g. sport coach or teacher) and try and establish if there are any linked children or other vulnerable adults who may also be at risk and obtain as much information as possible about them.

You will need to collect details of the child including name, age and address.

Appendix 2 - Procedure for the Management of Adults at Risk who DNA/WNB



Appendix 3 – Connect Health Clinical Governance Structure



Appendix 4 - Risk Thresholds Guideline for Safeguarding

Types of Abuse	**Lower-Level Harm** Could be addressed via agency internal process/procedures e.g., disciplinary, care management or consider referral to safeguarding to be made. **If unsure contact local authority team**		Referral to safeguarding local authority team is required **If potential criminal matter – contact Police/Emergency Services**		**Critical** **Addressed as potential criminal matter – contact Police/Emergency Services**
Physical	Staff error causing no/ little harm, e.g., skin friction mark due to ill-fitting hoist sling	Inexplicable very light marking found on one occasion	Inexplicable marking or lesions, cuts or grip marks on number of occasions	Inappropriate restraint Inexplicable fractures/injures Assault	Grievous bodily harm/ assault with weapon leading to irreversible damage or death
Neglect	Single, one off DNA/WNB of child or adult at risk	Multiple DNA/WNB or multiple late or advanced cancellations of child or adult at risk	Recurrent DNA/WNB or cancellations in child or adult at risk under active MARAC or CPP	Ongoing lack of care to extent that health and well-being deteriorate significantly e.g., pressure wounds, dehydration, malnutrition, loss of independence/confidence	Failure to arrange access to life saving services or medical care Failure to intervene in dangerous situations where the adult lacks the capacity to assess risk
Psychological	Isolated incident where adult is spoken to in a rude or inappropriate way – respect is undermined but no or little distress caused	Occasional taunts or verbal outbursts which caused distress The withholding of information to dis-empower	Treatment that undermines dignity and damages esteem Denying or failing to recognise an adult's choice or opinion	Humiliation or emotional blackmail e.g., threats of abandonment/ harm Radicalisation /counterterrorism concern	Denial of basic human rights/ civil liberties, overriding advance directive, forced marriage Vicious/personalised verbal attacks
Sexual	Isolated incident of teasing or low-level unwanted sexualised attention (verbal or by gestures) directed at an adult by another whether or not capacity exists	Verbal sexualised teasing or harassment	Sexualised touch or masturbation without valid consent Indecent exposure Contact or non-contact sexualised behaviour which causes distress to the person at risk	Attempted penetration by any means (whether or not it occurs within a relationship) without valid consent Being made to look at pornographic material against will/where valid consent cannot be given	Sex in a relationship characterised by authority, inequality or exploitation, e.g., staff and service user Sex without valid consent (rape) Voyeurism

Types of Abuse	**Lower-Level Harm** Could be addressed via agency internal process/procedures e.g., disciplinary, care management or consider referral to safeguarding to be made. **If unsure contact local authority team**		**Significant Very significant Harm** Referral to safeguarding local authority team is required **If potential criminal matter – contact Police/Emergency Services**		**Critical** **Addressed as potential criminal matter – contact Police/Emergency Services**
Discriminatory / Hate Crime	Isolated incident of teasing motivated by prejudicial attitudes towards an adult's individual differences	Isolated incident of care planning that fails to address an adult's specific diversity associated needs for a short period Recurring taunts	Inequitable access to service provision as a result of diversity issue Recurring failure to meet specific care/support needs associated with diversity	Being refused access to essential services Denial of civil liberties e.g., voting, making a complaint Humiliation or threats on a regular basis	Hate crime resulting in injury/emergency medical treatment/fear for life Hate crime resulting in serious injury/attempted murder/honour-based violence
Institutional (anyone or combination of the other forms of abuse)	Lack of stimulation/ opportunities to engage in social and leisure activities	Denial of individuality and opportunities to make informed choices and take responsible risk Care-planning documentation not person-centred	Rigid/inflexible routines Service users' dignity is undermined e.g., lack of privacy during support with intimate care needs, pooled under-clothing	Bad practice not being reported and going unchecked Unsafe and unhygienic living environments	Staff misusing position of power over service users Over medication and/ or inappropriate restraint managing behaviour Widespread, consistent ill treatment
Professional	Service design where groups of service users living together are incompatible	Poor, ill-informed or outmoded care practice no significant harm Denying VA access to professional support and services such as advocacy	Failure to whistle blow on serious issues when internal procedures to highlight issues are exhausted Failure to refer disclosure of abuse	Failure to support adults at risk to access health, care, treatments Punitive responses to challenging behaviours	Entering into a sexual relationship with a patient/client
Financial	Money is not recorded safely or recorded properly	Adult not routinely involved in decisions about how their money is spent or kept safe - capacity in this respect is not properly considered	Adult's monies kept in a joint bank account – unclear arrangements for equitable sharing of interest Adult denied access to his/her own funds or possessions	Misuse/misappropriation of property, possessions or benefits by a person in a position of trust or control. To include misusing loyalty cards Personal finances removed from adult's control	Fraud/exploitation relating to benefits, income, property or will Theft

Appendix 5 – Suicide Prevention SOP

SUICIDE PREVENTION: STANDARD OPERATING PROCEDURE

This Suicide Prevention Standard Operating Procedure (SOP) applies to all Connect staff and volunteers who have any patient contact and is part of Connect Health's Safeguarding Policy.

This SOP provides a process for staff to follow in order to enable early identification of individuals at risk, use best practice in assessing risk in relation to suicide, take the appropriate action in terms of mitigating risk and access post-incident debrief/support.

Consent

Wherever practicable, the consent of the adult should be obtained before taking action. However, there may be circumstances when consent is not given but contacting other Health or relevant Professionals (e.g., GP, Emergency Department, Police) is in an individual's best interests, in order to protect them or another person.

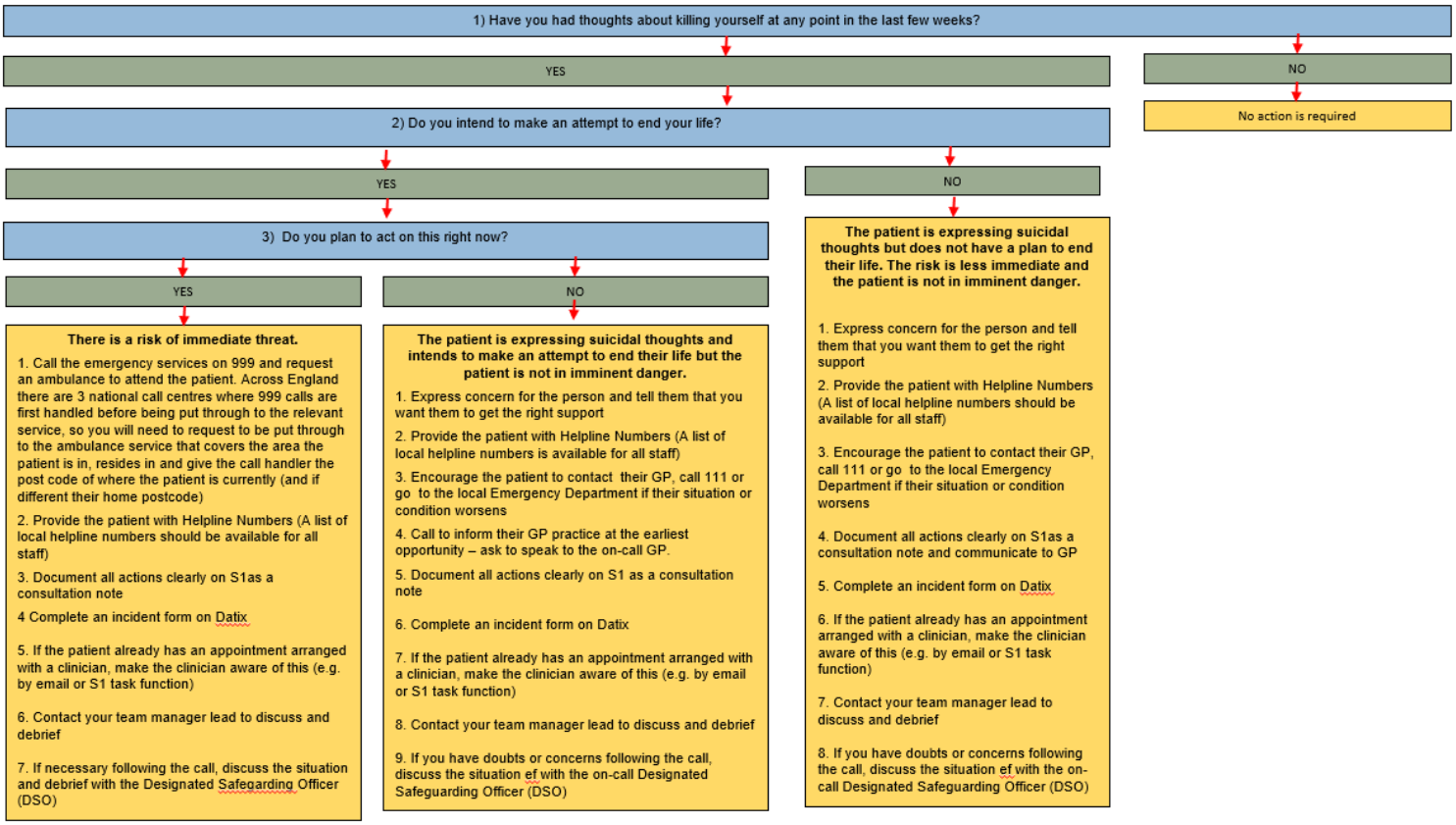
Involvement of the Caldicott Guardian

Where a breach of confidentiality may be indicated a Connect Health Caldicott Guardian should be contacted for support and guidance, ideally ahead of making a decision to breach confidentiality. Caldicott Guardians are trained to help make decisions on confidentiality issues, where often the issues can be complex. If a clinician has contacted any third person e.g. the Police, without the patient's consent to do so, then they must inform the Caldicott Guardian.

1. for Administrative Staff

If a telephone encounter by an administrator (Patient Care Co-ordinator) with a patient leads to concerns related to reports of suicidal thoughts (thinking about suicide or taking their own life) or planned behaviour in relation to suicide, administrative staff should ask about suicide, clearly and directly, bearing the following principles in mind:

- Be yourself. The right words are unimportant. If you are concerned, your voice and manner will show it.
- Listen. Let the person unload despair, ventilate anger. If given an opportunity to do this, he or she will feel better by the end of the call. No matter how negative the individual seems, the fact that there is a conversation shows it is a positive sign, a cry for help.
- Be sympathetic, non-judgmental, patient, calm, accepting. The patient has done the right thing by getting in touch with another person.
- If the patient is clearly distressed, then ask questions and follow the algorithm below:



2. Clinical Staff

All clinical health staff who come into contact with people expressing suicidal thoughts or suicidal behaviour must perform a preliminary suicide risk assessment and exploration of protective factors using a 'structured clinical judgment'. This should include consideration of the following three areas:

1.Situational – access to means, settling of affairs, impending life crisis, previous suicide attempt, physical illness/loss, family history of suicide

2.Clinical – e.g. diagnosis of depression, Functional disability and physical conditions, Mental and neurocognitive disorders, use of illicit drugs/alcohol, signs of hopelessness, anger, compulsions

3.Social – e.g. Social exclusion, loneliness, single, widowed, separated, homeless, living alone, male

It is important, as part of risk assessment to check for protective factors. Protective factors may include:

- strong perceived social support
- family cohesion
- peer group affiliation
- good coping and problem-solving skills
- positive values and beliefs
- ability to seek and access help

The quality of the risk assessment depends on the information available. The amount and accuracy of the information available may vary considerably according to the circumstances and setting where it is carried out. For example, the information available to make an informed risk assessment of a new patient may vary greatly compared with the information known about a patient having regular contact with a health professional.

Where possible you should consider discussing the patient with the patients GP or on-call GP at the practice either whilst the patient is with you or after they have departed.

In some cases, clinical staff will not have full information and should make the best possible assessment based upon what information is available. Where in doubt you should seek help, which can include:

1. Your Line Manager
2. The on call Designated Safeguarding Officer (DSO)
3. The patients GP or on-call GP
4. Clinical staff at the local Emergency Department

Process for Connect Health Ltd (CH) and Connect Health Pain Service (CHPS) Clinical Staff

(this does not apply to Increasing Access to Psychological Therapist (IAPT) clinicians)

Following a recent acquisition, there are two groups of clinical staff within the Connect Health Group, Connect Health Ltd (CH) clinical staff and Connect Health Pain Service (CHPS) clinical staff. Different processes apply to each group at the time of writing of this process.

Until full integration:

- **CHPS clinical staff will complete a suicide risk assessment questionnaire on System1**
- **Connect Health clinical staff's risk assessment will be based upon a series of questions**. These questions are listed within the suicide prevention protocol below.

Where risk is identified the level of risk should be determined and recorded in the patient's medical record, along with the risk mitigation plan.

1. CHPS clinical staff

All CHPS clinical staff will use the Suicide Risk Questionnaire on SystmOne to assess:

■ the severity and nature of the individual's problems

■ the risk of danger to self or others

■ whether a more detailed risk assessment is indicated.

■ Any Protective factors

The suicide risk questionnaire can also be used to generate a letter to the GP. The questions on the risk questionnaire are:

2. Do you consider yourself at immediate risk of making an attempt to end your life now? Yes/ No (if yes consider calling an ambulance)
3. Do you intend to make an attempt to end your life? Yes/ No
4. Have you made a plan on how you will end your life Yes/ No (how does the patient plan to end their life?)
5. Are you thinking about taking your own life (suicidal ideation)? Yes/ No

<u>Identifying risk factors:</u>

6. Have you been diagnosed with any psychiatric problems in the past? Yes/ No
7. Have you made any preparations for ending life? E.g., giving things away Yes/ No

<u>Identifying protective factors:</u>

8. Is there anyone you feel you could talk to about this? Yes/ No
9. Have you overcome difficult times in the past? Yes/ No
10. Is there anything that would stop you from attempting suicide? Yes/ No

2. Connect Health Clinical Staff

Whilst every situation is different, consider covering the following questions to ascertain level of risk, decide on action to be taken, and then document in patient's medical records.

1. Enquire about suicidal ideation.

"Have things got so bad that you have thought about suicide?"

2. Determine suicidal intent and plans.

"Is it likely that you would make an attempt to end your life?"

"Have you thought about how you would do this?" "Do you have a plan for how to do this?"

3. Enquire about risk factors that might increase the likelihood of attempted suicide.

"Have you ever attempted suicide in the past?"

4. Enquire about the protective factors that might reduce the risk of suicide

"Is there anyone you feel you could talk to about this?"

"Is there anything that would stop you from attempting suicide?"

Outcome : Non-immediate positive screen.

This is identified by clinical staff when a patient is expressing suicidal ideation <u>but has</u> <u>no active plans</u>. They are not at immediate risk.

1. Provide the patient with the relevant contact details for local and/or national services for crisis management.
2. Consider contacting the GP by phone to alert them immediately of the issue.
3. Document the GP via letter making this issue prominent in the format
4. Document this evidence as an alert for possible future risks in clinical notes

(N.B. There is no need to complete an incident form)

Outcome: Acute positive screen – requires action now

This is identified by clinical staff when a patient has plans in place with poor protective factors. The individual's risk of acting on suicidal ideation is likely to be high.

There are two potential scenarios:

Scenario one: The clinician is not convinced that the patient is immediately safe.

There are different options, depending on the clinician's judgement of the level of risk:

1. Inform the patient that you are going to call the ambulance and call an ambulance to get the patient the help they need. Across England there are 3 national call centres where 999 calls are first handled before being put through to the relevant service, so you will need to request to be put through to the ambulance service that covers the area the patient resides in and give the call handler the post code for the patient's current location (and the post code they reside at, if different).

   After the call is directed, confirm that the appropriate ambulance service covering the patient's demographic area has been contacted. Whilst waiting for the ambulance stay with the patient either on the telephone, on the video link or in the clinic room. Alert your line manager to the situation and so that they can offer support with for example cancelling your next patient if needed.

2. OR Telephone the local mental health crisis team to discuss best course of action
3. OR Telephone the GP or the GP out of hours team (England) for an emergency appointment - out of hours details will be given on the GP phone message
4. OR Contact the police and request a welfare check

In addition:

5. Provide the patient with key contacts for mental health support in their area
6. Inform the GP by telephone (if you have not already spoken to them) and in writing by email/fax as soon as possible.
7. Consider safeguarding issues, for example if the patient has any dependents in their care then consider alert the safeguarding team – discuss this with the on-call DSO
8. Document your assessment and all actions taken clearly
9. Complete an incident form on Datix
10. If the patient has an appointment arranged with another CH or CHPS clinician, make the clinician aware of the assessment and action taken (e.g. by email or S1 task function)
11. Discuss the situation and if necessary debrief with your team manager, an appropriate clinician (e.g. psychologist if available) and/or Designated Safety Officer (DSO)

Scenario two: The patient may act but not immediately:

- Who to discuss with:

1. Discuss with the GP or GP out of hours service by telephone and in writing by email/fax as soon as possible.
2. If the patient is under Mental Health Services and has a key worker e.g., Community Psychiatric Nurse (CPN) consider contacting them for advice.
3. Consider discussing with the on-call DSO

- Agree a plan with the patient to keep themselves safe:

1. Help the patient identify what has helped to keep them safe until now and what would help to keep them safe from acting on their thoughts in the next hour, or day, or week.
2. Make sure the patient is clear on how to get support if they are continuing to feel suicidal, they can:
   - Telephone the GP or GP out of hours team (number on GP phone message)
   - Contact the local crisis team (the number should be provided to the patient)
   - Contact Mental Health Services if they have a contact/ key worker.
   - Contact Mental Health Helpline numbers (provide them with a list of these)

- Follow up actions

1. Document your assessment and all actions taken clearly.
2. Complete an incident form on Datix.
3. If the patient has an appointment arranged with another CH or CHPS clinician, make the clinician aware of the assessment and action taken (e.g. by email or S1 task function
4. Discuss the situation and if necessary, debrief with your team manager, an appropriate clinician (e.g. psychologist if available) and/or Designated Safety Officer (DSO)

3. IAPT Services Clinical Staff

From a patient information system perspective, the management of risk is key to IAPT services and the IAPTUS system. It forms part of the main clinical contact information, together with the client's problem statement, treatment goals and the main clinical record. The client record in Iaptus provides entries for risks to self, risks to others, neglect and exploitation. However, this record is a basic risk classification of low, medium, high.

Assessing whether clients are a risk to themselves or others is an area which should be prioritised within the IAPT service. Although level of risk will have been assessed at Triage, level of risk may change on a daily basis, and therefore clinicians should maintain a constant awareness of this issue. For this reason, risk assessment is a mandatory field for every contact. In assessing risk, the following areas are good indicators of level of risk to self:

*Level of ideation and hopelessness

*Extent of planning

*Likelihood of action and previous attempts

At each contact the IAPT minimum data set questionnaires should be completed.

Attend particularly to PHQ 9 item 9: "Thoughts that you would be better off dead or thoughts of hurting yourself in some way". If the response is 1 or above (several days or more), then the following questions available on IAPTUS are used to determine risk levels. The outcome of this assessment is a rating of the degree of risk thereby enabling the development of a risk management plan.

Q1. Do you ever feel that bad that you think about harming or killing yourself?

Q2. Do you ever feel that life is not worth living?

Q3. Have you made plans to end your life?

Q4. Do you know how you would kill yourself?

Q5. Have you made any actual preparations to kill yourself?

Q6. Have you ever attempted suicide in the past?

Q7. How likely is it that you will act on such thoughts and plans? (0 – 10, 10 being certain)

Q8. What is stopping you killing or harming yourself at the moment?

In particular, if the client answers yes to questions 1, 3, 4, or 5 then this together with the intent rating on question 7 may indicate a high level of risk. If the patient presents a level of risk to themselves or others speak to a line manager as soon as possible.

In terms of risk to others, supplementary questions will need to be asked if there are indications that the patient may pose a risk to others, e.g. anger problems. Also consider child protection issues. Again, areas to assess include level of ideation, extent of planning and previous history. The police may need to be informed if a serious crime is planned or disclosed. If that is the case, the lead clinician/ DSO/ Caldicott Guardian should be consulted.

If there is a high level of risk identified, then phone the crisis team. The patient can also access the crisis team by attending the local hospital A & E department. The GP should also be informed by telephone and in writing as soon as possible.

Suicidal Ideation: Free confidential helplines and sources of support

- Samaritans 116 123 or 08457 90 90 90 (24 hours) www.samaritans.org or email: jo@samaritans.org for a reply within 24 hours

- PAPYRUS for people under 35 years 0800 068 41 41 (Mon–Fri, 10am–5pm and 7pm–10pm; weekends 2pm–5pm, bank holidays 2pm to 5pm) Text 07786 209697 Email pat@papyrus-uk.org (website www.papyrus-uk.org)

- The Silver Line- for older people 0800 4 70 80 90

- Campaign Against Living Miserably CALM for men 0800 58 58 58 (7 days a week, 5pm–midnight) www.thecalmzone.net

- SANE 0845 767 8000 (7 days a week, 6pm–11pm) www.sane.org.uk

- MIND 0300 123 3393 (Mon–Fri, 9am–6pm) www.mind.org.uk . MIND has information on ways to help during a crisis. This includes calming exercises and a tool to get someone through the next few hours. https://www.mind.org.uk/need-urgent-help/what-can-i-do-to-help-myself-cope/

- Maytree A sanctuary for the suicidal 020 7263 7070 www.maytree.org.uk/index.phpText "SHOUT" to 85258 to contact the Shout Crisis Text Line, or text "YM" if under 19

- If under 19, call 0800 1111 to talk to Childline. The number will not appear on the phone bill

Appendix 6 – Equality Impact Assessment

Equality Impact Assessment

Question	Response
1) Name of policy/strategy/service redesign or activity	**3.18 Adult Safeguarding**
2) Summary of aims and objectives of the policy/strategy/service redesign or activity	-This policy is to protect Adult patients from harm – updated to include work in 2021 on Mental Capacity assessment and new Safeguarding Designated Safeguarding Officers and rota plus SOP for suicide prevention -Application of this policy ensures all colleagues working at Connect Health know and understand their responsibilities in working together with other agencies to safeguard adults from neglect or abuse. -To ensure that adults with care and support needs who access Connect Health services are safeguarded in line with relevant legal duties as applicable.
3) What involvement and consultation has been done in relation to this policy? (e.g. with relevant groups and stakeholders)	1. All Designated Safeguarding Officers (DSO) based on recent training. 2. Senior medical and colleagues for consultation and feedback to ensure that it effectively meets the needs of all colleagues and patients. 3. Members of Integrated Quality Audit and Compliance Group
4) Who is affected by the policy/strategy/service redesign or activity?	All colleagues and all adult patients
5) What are the arrangements for monitoring and reviewing the actual impact of the policy/strategy/service redesign or activity?	1. Incidents monitoring for Safeguarding 2. Monthly DSO meetings 3. Quarterly National Safeguarding Panel 4. We have an annual Safeguarding Audit 5. Data reviewed bi-monthly at Board subcommittee IQACC

Protected Characteristic Group	Is there a potential for positive or negative impact?	Please explain and give examples of any evidence/data used	Action to address negative impact (e.g adjustment to the policy)
Disability	**Positive**	**Clearer Mental capacity assessment**	
Gender reassignment	**Positive** safeguarding duty may apply to trans-gender adults who are at risk or are experiencing abuse and neglect – if the adult also has care and	**Enhanced function e.g. DSO rota**	

	support needs and is unable to protect themselves from the abuse or neglect. Such adults may be at greater risk of discriminatory abuse.		
Marriage or civil partnership	**Positive** Safeguarding adults will apply irrespective of marital status	**Enhanced function e.g. DSO rota**	
Pregnancy and maternity	**Positive** Safeguarding adults legal duty also covers the issue of Domestic Abuse, women who are pregnant or who have recently given birth might be at greater risk of experiencing such abuse.	**Enhanced function e.g. DSO rota**	
Race	**Positive** safeguarding duty will apply to ALL adults who are at risk of or are experiencing abuse and neglect – if the adult also has care and support needs and is unable to protect themselves from the abuse or neglect. Some such adults may be at greater risk of discriminatory abuse or hate crime due to their race.	**Enhanced function e.g. DSO rota**	
Religion or belief	**Positive** This policy provides equitable care for all irrespective of religion or belief	**Enhanced function e.g. DSO rota**	
Sexual orientation	**Positive** safeguarding duty will apply to adults who are at risk of or are experiencing abuse and neglect – if the adult also has care and support needs and is unable to protect themselves from the abuse or neglect. Some such adults may be at greater risk of discriminatory abuse, sexual abuse/exploitation domestic abuse or homelessness due to their sexual orientation.	**Enhanced function e.g. DSO rota**	
Sex (gender)	**Positive** safeguarding duty will apply to adults who are at risk of or are experiencing abuse and neglect – if the adult also has care and support needs and	**Enhanced function e.g. DSO rota**	

	is unable to protect themselves from the abuse or neglect. Some such adults may be at greater risk of discriminatory abuse, sexual abuse/exploitation, or domestic abuse due to their sex.		
Age	**positive** This policy is related to people aged 18 and over with care and support needs who may be experiencing abuse or neglect.	**Better systems linked to mental capacity assessment**	

Question	**Explanation/justification**	
Is it possible the proposed policy or activity or change in policy or activity could discriminate or unfairly disadvantage people?	No – this policy is generic for all patients and changes enhance equality especially where disability or age	
Final Decision:	**Tick the relevant box**	**Include any explanation/justification required**
1. No barriers identified, therefore activity will **proceed**	**x**	This policy updates the previous Adults Safeguarding Policy
2. You can decide to **stop** the policy or practice at some point because the data shows bias towards one or more groups		
3. You can **adapt or change** the policy in a way which you think will eliminate the bias	**x**	At any time linked to monitoring of impact and learning from safeguarding incidents
4. Barriers and impact identified, however having considered all available options carefully, there appear to be no other proportionate ways to achieve the aim of the policy or practice (eg in extreme cases or where positive action is taken) Therefore you are going to **proceed with caution** with this policy or practice knowing that it may favour some people less than others, providing justification for this decision.		

Date completed:	**6th May 2021**
Review date (if applicable):	**11th May 2023**

13. Document Control

Revision Number	Revision Date	Description of Change	Reason for Change	Author of change
1.0	18/12/13	N/A	Policy Created	N/A
1.1	14/01/15	Geographical safeguarding leads	Safeguarding Leads	AR
2.0	04/01/16	Additional regulations required	New standards/regulations	AR
2.1	01/02/16	Addition of safeguarding agencies	New contracts	EW
2.2	23/03/16	Amending procedure for reporting concerns	Annual SAAF self-assessment	AR
2.3	28/03/16	Addition of Procedure	Procedure for management of adults at risk who DNA	AR
2.4	20/09/16	Addition of Safeguarding contacts	New contracts	EW
2.5	07/04/17	Amend definition of organisational abuse Amend appendix 1 regarding consent Addition of new contracts & removal of discontinued contacts Details of local risk assessment tools and examples provided	Feedback from safeguarding teams Discontinuation of 2 contracts - removal of their details	AR
3.0	25/07/17	Revision of Procedure for reporting concerns to include change in terminology to duty safeguarding officer Updated position on mandatory training for level 4	Internal review of mandatory training requirements against legislation	AR
4.0	02/04/18	Change of process and Designating Safety Officers now in place	Simplified procedures and introduced Designated Safeguarding Officers	GW
4.1	05/12/18	Addition of new services safeguarding contacts	New contracts	WM
4.2	09/01/19	Addition of new services safeguarding contacts and addition of paragraph regarding modern slavery	New contracts and policy update	WM
4.3	28/05/20	Transferred to new Connect template	New company template and logo	EW
5.0	05/05/21	Re-write to reflect new practices and link to Mental Capacity and Suicide Policy work	Policy updated/ re-written	GW