NHS North and West Reading Clinical Commissioning Group

NHS Newbury and District Clinical Commissioning Group

NHS South Reading Clinical Commissioning Group

NHS Wokingham Clinical Commissioning Group

Safeguarding Children and Adults at Risk Policy

Incorporating Safeguarding and Mental Capacity Act Standards for Commissioned Services

November 2016

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1. INTRODUCTION

The Clinical Commissioning Group (now referred to as the CCG), as with all other NHS bodies, has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare of children and young people that effect the needs of the children they deal with; and to protect adults at risk from abuse or the risk of abuse.

As a commissioning organisation, the CCG is required to ensure that all health providers from whom it commissions services (both public and independent sector) have comprehensive single and multi-agency policies and procedures in place to safeguard and promote the welfare of children and to protect adults at risk from abuse or the risk of abuse. The CCG should also ensure that health providers are linked into the local safeguarding children and safeguarding adult boards and that health workers contribute to multi-agency working.

This policy has two functions: it details the roles and responsibilities of the CCG as a commissioning organisation, of its employees and GP practice members. The policy also provides clear service standards against which healthcare providers (including independent providers, voluntary, community and faith sector (VCFS)) will be monitored to ensure that all service users are protected from abuse and the risk of abuse.

2. SCOPE

This policy aims to ensure that no act or omission by the CCG as a commissioning organisation, or via the services it commissions, puts a service user at risk; and that robust systems are in place to safeguard and promote the welfare of children, and to protect adults at risk of harm.

Where the CCG is identified as the lead commissioner it will notify associate commissioners of a provider's non-compliance with the standards contained in this policy or of any serious untoward incident that is considered to be a safeguarding issue.

3. PRINCIPLES

In developing this policy the CCG recognises that safeguarding children and adults at risk is a shared responsibility with the need for effective joint working between agencies and professionals that have different roles and expertise if those vulnerable groups in society are to be protected from harm. In order to achieve effective joint working there must be constructive relationships at all levels, promoted and supported by:

- a commitment of senior managers and board members to seek continuous improvement with regards to safeguarding both within the work of the CCG and within those services commissioned;
- clear lines of accountability within the CCG for safeguarding;
- service developments that take account of the need to safeguard all service users, and is informed, where appropriate, by the views of service users;
- staff training and continuing professional development so that staff have an understanding of their roles and responsibilities in regards to safeguarding children, adults at risk, children looked after and the Mental Capacity Act;
- safe working practices including recruitment and vetting procedures;
- effective interagency working, including effective information sharing.

4.0 DEFINITIONS

4.1 Children

In this policy, as in the Children Act (1989) and (2004 additions), **a child** is defined as anyone who has not yet reached their eighteenth birthday. 'Children' therefore means children and young people throughout.

Safeguarding children is defined in the Joint Chief Inspectors' report *Safeguarding Children* (2002) as:

- All agencies working with children, young people and their families take all reasonable measures to ensure that the risks of harm to children's welfare is minimised; and
- Where there are concerns about children and young people's welfare all agencies take all appropriate actions to address those concerns, working to agreed local policies and procedures in partnership with other agencies.

4.2 Abuse of Adults at risk, 'adults at risk'

Care and Support Statutory Guidance Updated 27 October 2016
(https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance)

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)
- is experiencing or at risk of abuse or neglect
- 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.

See Appendix 1 and 1a for more information on definition, capacity, consent and Deprivation of Liberty Safeguards (DoLS)

4.3 See Appendix 2 for Definitions of abuse

5.0 ROLES AND RESPONSIBILITIES FOR SAFEGUARDING

5.1 CCG Safeguarding Team Structure – see Appendix 3

- The ultimate accountability for safeguarding sits with the chief officer of the CCG. Any failure to have systems and processes in place to protect children and adults at risk in the commissioning process, or by providers of health care that the CCG commissions would result in failure to meet statutory and non-statutory constitutional and governance requirements.
- The CCG must demonstrate robust arrangements are in place to demonstrate compliance with safeguarding responsibilities. The NHS Commissioning Board will monitor compliance with safeguarding as required in the authorisation document (and any superseding guidance)
- The CCG must establish and maintain good constitutional and governance arrangements with capacity and capability to deliver safeguarding duties and responsibilities, as well as effectively commission services ensuring that all service

users are protected from abuse and neglect.

- Establish clear lines of accountability for safeguarding, reflected in governance arrangements
- To co-operate with the local authority in the operation of the local safeguarding children board (LSCB) and safeguarding adults board (SAB) and contribute to work undertaken by the Boards and it's sub-groups
- To participate in domestic homicide reviews.
- To participate in serious case reviews where a child has died or been seriously injured and abuse or neglect is suspected.
- Secure the expertise of a designated doctor and nurse for safeguarding children; a designated doctor and nurse for Looked After Children (LAC), designated paediatrician for child deaths; a safeguarding adult lead and a mental capacity act lead.
- Ensure that all providers with whom there are commissioning arrangements have in place comprehensive and effective policies and procedures to safeguard children and adults at risk in line with those of the LSCB and the SAB
- Ensure that plans are in place to train all staff in contact with children, adults who are parents/carers and adults at risk in the course of their normal duties are trained and competent to be alert to the potential indicators of abuse or neglect for children and adults at risk and know how to act on those concerns in line with local guidance, policies and procedures.
- Ensure that appropriate systems and processes are in place to fulfil specific duties of cooperation and partnership and the ability to demonstrate that the CCG meets best practice in respect of safeguarding children and adults at risk and children looked after.
- Ensure that safeguarding is at the forefront of service planning and a regular agenda item of the CCG governing body business.
- Ensure that all decisions in respect of adult care placements are based on knowledge of standards of care and safeguarding concerns.

5.2 Chief Officer

All officers, including the chief executive of the local authority, NHS and police chief officers and executives should lead and promote the development of initiatives to improve the prevention, identification and response to abuse and neglect. They need to be aware of and able to respond to national developments and ask searching questions within their own organisations to assure themselves that their systems and practices are effective in recognising and preventing abuse and neglect. The Chief Officers must sign off their organisation's contributions to the Strategic Plan and Annual reports.

- Ensures that the health contribution to safeguarding and promoting the welfare of children and adults at risk is discharged effectively across the whole local health economy through the organisation's commissioning arrangements.
- Promotes that the organisation not only commissions specific clinical services but exercises a public health responsibility in promoting that all service users are safeguarded from abuse or the risk of abuse.
- Ensures that safeguarding is identified as a key priority area in all strategic planning processes.
- Promotes that safeguarding is integral to clinical governance and audit arrangements.
- Promote and gain assurance that all health providers from whom services are commissioned have comprehensive single and multi-agency policies and procedures for safeguarding which are in line with the LSCB and SAB procedures, and are easily accessible for staff at all levels.

- Promote and gain assurance that all contracts for the delivery of health care include clear standards for safeguarding and that these standards are monitored thereby providing assurance that service users are effectively safeguarded.
- Promote and gain assurance that their staff and those in services contracted by the CCG are trained and competent to be alert to potential indicators of abuse or neglect in children and know how to act on their concerns and fulfil their responsibilities in line with LSCB policies and procedures
- Ensures the CCG co-operates with the local authority in the operation of the LSCB the SAB and the Health and Wellbeing Boards.
- Ensures that all health organisations with which the CCG has commissioning arrangements have links with their LSCB and the SAB; that there is appropriate representation at an appropriate level of seniority; and that health workers contribute to multi-agency working.
- To promote that any systems and processes that include decision making about an individual patient (e.g. funding panels) take account of the requirements of the Mental Capacity Act (2 005); this includes ensuring that actions and decisions are documented in a way that demonstrates compliance with the Act.

5.3 CCG Governing Body Lead with responsibility for Safeguarding – This role is fulfilled by the Nurse Director for the CCGs

- Promotes that the CCG has management and accountability structures that deliver safe and effective services in accordance with statutory, national and local guidance for safeguarding children and children looked after.
- Promotes and advises commissioning that service plans/specifications/contracts/ invitations to tender etc. include reference to the CCG's standards expected for safeguarding children and adults at risk.
- Ensures that safe recruitment practices are adhered to in line with national and local guidance and that safeguarding responsibilities are reflected in all job descriptions.
- Ensures that staff in contact with children and or adults in the course of their normal duties, are trained and competent to be alert to the potential indicators of abuse or neglect and know how to act on those concerns in line with local guidance.
- Ensure the monitoring of safeguarding with commissioned providers and contracts includes safeguarding.
- Ensures that quality assurance process within the CCG includes any necessary escalation process of serious incident reports to the SAB and or LSCBs for consideration of a multi-agency case review.

5.4 CCG Individual Staff Members

- To be alert to the potential indicators of abuse or neglect for children and adults **(Appendix 2)** and know how to act on those concerns in line with their duties to comply with LSCB and SAB procedures.
- To report concerns of suspected abuse about a child or adult, to the Local Authority (LA) in accordance with Berkshire Procedures. Advice and support can be sought from the CCG Safeguarding Team,
- To undertake training in accordance with their roles and responsibilities as outlined by the training frameworks of the LSCBs and SAB so that they maintain their skills and are familiar with procedures aimed at safeguarding children and adults at risk.
- Understand the principles of confidentiality and information sharing in line with local and national guidance.

- All staff contribute, when requested to do so, to the multi-agency meetings established to safeguard children and adults at risk.
- Report and inform their managers who have a responsibility to inform the Nurse Director of any allegations of abuse or investigations concerning individual staff or members of the CCG.

5.5 Prevent Counter Terrorism Strategy

Prevent is part of the Government's Counter Terrorism Strategy led by the Home Office, which focuses on working with individuals and communities who may be vulnerable to the threat of violent extremism, radicalisation and terrorism. Supporting vulnerable individuals and reducing the threat from violent extremism and radicalisation in local communities is a priority for the health service and its partners.

- The CCG will ensure that there are robust Prevent arrangements in place across the health economy. This will be monitored through safeguarding assurance processes and form part of quality contracting monitoring.
- The Operational Lead for Prevent will be the Named Professional for Safeguarding Adults within the CCG. This will be delegated from the Assistant Director of Safeguarding.
- All concerns within the CCG regarding both Staff and Patients in relation to counter terrorism will be discussed with the delegated Prevent Lead/appropriate manager who will escalate accordingly. Urgent concerns should be reported directly to the police.

5.6 Serious Case Reviews, Partnership Reviews/Domestic Homicide Reviews

The CCG has a statutory duty to work in partnership with the LSCBs and/or any other Safeguarding Children Boards and Adult Safeguarding Boards across the country in conducting serious case reviews, in accordance with statutory guidance. The CCG must ensure that reviews and all actions taken following reviews are carried out according to the timescale set out by the Serious Case Review Panel.

- The CCG must ensure that sufficient resources are in place to meet this requirement. This will usually mean that there must be sufficient resources and support to allow the designated professionals to fulfil the key roles of SCR panel membership and preparation of reports where required.
- Where there are a number of simultaneous reviews, or where the designated professional has had significant case involvement, the commissioning of additional capacity for these functions must be considered. This may be identified internally or externally depending on case circumstances.
- The CCG will also commission Independent Management Reviews (IMRs) on behalf of any general practices involved in a serious case review, normally undertaken by the GP named doctor. Again the CCG must ensure that sufficient capacity is available for this function, including commissioning additional capacity e.g. an external author where there are two or more ongoing reviews or any significant conflict of interest for the named GP in relation to the case.
- The CCG should seek assurance that the IMRs is also sufficient capacity in provider organisations to produce when required.
- The designated safeguarding professionals will inform the relevant authorities when a Serious Case Review has commissioned.
- The Safeguarding Executive Lead for the CCG will commission and sign off health overview reports and internal management reviews for serious case reviews.

- The CCG Governing Body will be notified that a review has commenced and will receive updates on identified learning, recommendations and action plans, and progress towards publication where relevant.

5.7 Contract Monitoring

The CCG is required to have appropriate contract monitoring arrangements in place to ensure all providers are meeting their statutory and contractual responsibilities. All provider health organisations commissioned by the CCG must have their own polices for safeguarding children and adults in line with their own statutory responsibilities and with Berkshire LSCBs child and Adult Safeguarding procedures.

5.8 Confidentiality and Information Sharing

Appropriate and proportionate information sharing is the key to safeguarding children and adults at risk. This relies upon open and honest dialogue with families and wherever possible, seeking consent to share information.

Confidentiality runs closely alongside this and it is essential that when there are concerns about a child or adult at risk, that the rules around confidentiality and information sharing are closely adhered to.

Rules for information sharing are similar but there are nuances in both children and adults:

- The child's welfare is paramount – information can be disclosed without consent in some circumstances but consideration must be given to obtaining consent and where it has not been obtained, a clear rationale for this must be recorded.
- In some cases it might not be safe to obtain consent, for example, where alerting a parent to concerns might put the child in immediate danger
- The police and local authority can request information for child protection investigations under section 47 of the Children Act (1989) and there is a statutory duty to disclose relevant and proportionate information.
- With regard to adults there are many types of information which should not be disclosed without consent in any event. Disclosure will only be made without the consent of the person causing concern where it is assessed that the person lacks the capacity to give informed consent or the person has failed to respond despite reasonable attempts to obtain their consent
- In this case disclosure might be necessary because of a legal duty on the part of the holder or recipient of the information, the risk to an adult is such that the infringement of the person's rights to privacy and confidentiality is outweighed by the harm which would be caused by withholding the information.'

6. IMPLEMENTATION

6.1 Method of Monitoring Compliance

The standards expected of all healthcare providers are detailed in **Appendix 4.** Compliance will be measured by annual audit – an audit tool will be made available to all providers to facilitate the recording of information.

The audit tool should be completed using the RAG definitions outlined in the procedure for monitoring safeguarding children and adults at risk via provider contracts. This procedure was developed in order to standardise the monitoring and escalation approach across Berkshire West and for quality assurance of the processes being used to safeguard children and adults.

The CCG quality assurance framework for Serious Incident reporting and quality schedules monitors compliance on safeguarding in line with national and local guidance.

6.2 Reviewing the Policy

The policy will be reviewed 2 yearly to ensure that it meets the requirements of up-to-date legislation and guidance in respect of safeguarding adults and children.

6.3 Recruitment and Personnel Process

The organisation has a duty to introduce safer working practices, in line with statutory guidance in Working Together to Safeguard Children (2015) and with the disclosure and barring service.

This includes recruitment processes that filter out people who are not suitable or safe to work with vulnerable groups, including children, and ensure appropriate regard to the need to safeguard children by a sound process of:

- Training staff involved in recruitment,
- Ensuring all references are taken up prior to starting work
- Stringent and appropriate Criminal Records Bureau disclosure, based on assessment of risk to children
- Appropriate management of allegations against staff.

Clinical Commissioning Groups have a statutory duty to ensure that appropriate action is taken, if an allegation is made, or suspicion or concern arises, about harm to a child or adult by an employee. The CCG will apply an allegations management procedure consistent with statutory guidance and Berkshire LSCB and SAB procedures and consult with the Local Designated Officer as appropriate.

6.4 Breaches of policy

This policy is mandatory. Where it is not possible to comply with the policy or a decision is taken to depart from it, this must be notified to the CCG so that the level of risk can be assessed and an action plan can be formulated.

The CCG, as host commissioner, will notify associate commissioners of a providers non-compliance with the standards legislation/guidance including action taken where there has been a significant breach.

7. REFERENCE DOCUMENTS

In developing this policy, account has been taken of the following statutory and non-statutory guidance, best practice guidance and the policies and procedures of the LSCB and SAB.

7.1 Statutory Guidance

- Care and Support Statutory Guidance Updated (2016). Department of Health
- Care and Support Statutory Guidance (2014) Department of Health
  Care Act (2014)
- Working Together to Safeguard Children (2015) HM
- Children Acts (1989) and (2004)
- Department for Constitutional Affairs (2007) Mental Capacity Act (2005): Code of Practice, TSO: London
- Department of Health (2000) *Framework for the Assessment of Children in Need and their Families*, London, HMSO
- Department of Health, Home Office (2000) *No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect adults at risk from abuse* (issued under Section7 of the Local Authority Social Services Act 1970)
- Department of Health et al (2015) *Promoting the Health and well-being of Looked After Children*,
- HM Government (2011) *Safeguarding children who may have been trafficked*, DfE publications
- HM Government (2007) *Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act (2004)*, DCSF
- publications
- HM Government (2008) *Safeguarding Children in whom illness is fabricated or induced*, DCSF publications
- HM Government (2009) *The Right to Choose: multi-agency statutory guidance for dealing with Forced marriage,* Forced Marriage Unit: London
- HM Government (2015) *Working Together to Safeguard Children*, Nottingham, DfE publications
- Ministry of Justice (2008) *Deprivation of Liberty Safeguards Code of Practice to supplement Mental Capacity Act (2005),* London TSO

7.2 Non-statutory Guidance

- Children's Workforce Development Council (March 2010) Early identification, assessment of needs and intervention. The Common Assessment Framework for Children and Young People: A practitioner's guide, CWCD
- DH (June 2012) The Functions of Clinical Commissioning Groups (updated to reflect the final Health and Social Care Act 2012)
- DH (March, 2011) Adult Safeguarding: The Role of Health Services
- DH (May, 2011) Statement of Government Policy on Adult Safeguarding
- HM Government (2015) What to do if you're worried a child is being abused, DSCF publications
- HM Government (2008) Information Sharing: Guidance for practitioners and managers, DCSF publications
- Law Commission (May, 2011) Adult Social Care Report
- Royal College Paediatrics and Child Health et al (2014) Safeguarding Children and Young people: Roles and Competencies for Health Care Staff. Intercollegiate Document supported by the Department of Health

7.3 Best Practice Guidance

- Department of Health (2004) Core Standard 5 of the *National Service Framework for Children Young People and Maternity Services* plus those elements beyond standard 5 that deal with safeguarding and promoting the welfare of children
- Department of Health (2009) *Responding to domestic abuse: a handbook for health professionals*
- Department of Health (2010) *Clinical Governance and adult safeguarding: an integrated approach*, Department of Health
- HM Government (2011) *Multi-agency Practice Guidelines: Female Genital Mutilation*
- HM Government (2009) *Multi-agency practice guidelines: Handling cases of Forced Marriage,* Forced Marriage Unit: London
- National Institute for Health and Clinical Excellence (2009) *When to suspect child maltreatmen*t, Nice clinical guideline 89
- Department of Health (2006) *Mental Capacity Act Best Practice Tool*, Gateway reference: 6703

7.4 Local Safeguarding Children Board

Pan Berkshire Safeguarding Children policies, procedures and practice guidance accessible at http://berks.proceduresonline.com/

7.5 Local Safeguarding Adult Board

Berkshire safeguarding adult policies, procedures and practice guidance accessible at: http://berksadultsg.proceduresonline.com/index.htm

7.6 Care Quality Commission

Care Quality Commission (2009) guidance about compliance: *Essential Standards of Quality and Safety and the introduction of the (2015) the new framework to assess quality standard is in place. http://www.cqc.org.uk/*

7.7 Disclosure and Barring

The government review of the vetting and barring scheme has now ended. The vetting and barring scheme is being scaled back to 'common-sense levels'. Further guidance is available at: https://www.gov.uk/disclosure-barring-service-check/overview

GLOSSARY

CAF	Common assessment framework
CCGs	Clinical commissioning Groups
LAC	Looked After Children
MCA	Mental Capacity Act (2005)
LSCB	Local safeguarding children board
LSAB	Local safeguarding adult board
SI	Serious incidents reporting
DOLS	Deprivation of Liberty Safeguards

APPENDIX 1

Adult Safeguarding Definition Care Act (2014)

People over 18 years.
Safeguarding means protecting an adults right to live in safety, free from abuse and neglect.

Making Safeguarding Personal

This means it should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety

The principles for adult safeguarding are as follows (DH,2011) Supported in Care Act (2014) : https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

- **Empowerment** - Presumption of person led decisions and informed consent.
- **Protection** - Support and representation for those in greatest need.
- **Prevention** - It is better to take action before harm occurs.
- **Proportionality** – Proportionate and least intrusive response appropriate to the risk presented.
- **Partnership** - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability** - Accountability and transparency in delivering safeguarding

Capacity, Consent and Safeguarding – The Mental Capacity Act (2005)

One of the overriding principles in Safeguarding Adults at risk is capacity and consent. Whenever possible every effort must be made to obtain the consent of an adult to report abuse taking into consideration the definitions of the Mental Capacity Act (2005). However when there is a duty of care when the adult does *not* have the capacity to protect him / herself, the matter must be discussed with the Safeguarding Adults at risk Lead to determine how best to proceed. If a person who lacks mental capacity in relation to agreeing to be in a harmful situation is subject to abuse or neglect a safeguarding concern would be necessary as this is potentially a criminal offence (S. 44 Mental Capacity Act).

Guidance on the Mental Capacity Act can be found at:
http://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf and http://berksadultsg.proceduresonline.com/index.htm

Choices and Risk

On occasions, vulnerable adults are left in situations, which leave them seriously at risk of abuse. Sometimes attempts to justify this are made on the grounds of a person's right to make choices about their lifestyle, which may involve risk.

Decisions about risk at this level should *never* be taken by individual staff but through a properly constituted professionals meeting and by involving risk assessments.

Any patient affected by abuse, who has capacity, should be consulted as to whether or not they wish action to be taken in relation to their own situation. However, their response will be viewed in the context of the need for any intervention in order to protect other service users and / or staff from harm or risk of harm. If the individual does not wish to report the abuse a discussion must take place the Safeguarding Named Professional or Local Authority Team as to the appropriate course of action to safeguard other service users and staff or in the public interest.

Deprivation of Liberty

This amendment to the Mental Capacity Act (2005) (introduced by the Mental Health Act 2007) is to provide for procedures to authorise the deprivation of liberty of a person in a hospital or care home who lacks Capacity to consent to being there. These are known as the MCA Deprivation of Liberty Safeguards (MCA DOLS).

The acid test sets out two questions that professionals should consider when determining whether an adult who has been assessed as lacking capacity to consent to their care arrangements is being deprived of their liberty or not: is the person subject to continuous supervision and control? And is the person free to leave?

If both conditions of the 'acid test' are met, the person is deprived of their liberty. This means the care arrangements must be authorised by a supervisory authority via the deprivation of liberty safeguards (DoLS) if the care setting is in a care home, hospice or hospital;(Local Authorities are the supervisory body) or via a Court of Protection order if the placement is outside of those settings (e.g. supported living community setting).

Unauthorised Restraint

Unauthorised restriction/restraint may constitute a deprivation of liberty therefor abuse, as it breach of Article 5 Human Rights. Further guidance on DoLS can be found at: http://berksadultsg.proceduresonline.com/index.htm

APPENDIX 1a

MCA & DoLS Information Sheet

Why is the MCA important?
The MCA is rights legislation. It protects the rights of all patients to take as many decisions about themselves for as long as possible. It places on staff a duty to help patients make decisions for themselves. If they cannot it sets out a clear and challenging process for determining whether patients have capacity and if they do not how decisions should made on their behalf. The Act lays down the firm principle that because a patient cannot make a particular decision it does not automatically follow they cannot make the next one required of them.

What are the principles of the MCA?
A presumption of capacity: every adult (aged over 16) has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise in respect of each specific decision. **Individuals must be supported to make their own decisions:** a person must be given all practicable help before any anyone treats them as not being able to make their own decisions. **Unwise decisions:** just because an individual makes a decision others may consider to be unwise, they should not be treated as lacking capacity to make that decision. **Best interests:** an act done or decision made under the Act for or on behalf of a person who lacks capacity must be done in that person's best interests. **Less restrictive option:** a person doing anything for or on behalf of a person who lacks capacity should consider options that are less restrictive of their basic rights and freedoms while meeting the identified need.

Assessing capacity
Anyone assessing someone's capacity to make a decision for themselves should use the two-stage test of capacity; 1. Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn't matter whether the impairment or disturbance is temporary or permanent) 2. If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made? A person is unable to make a decision if they cannot; 1. Understand information about the decision to be made (the MCA calls this 'relevant information') 2. Retain that information in their mind 3. Use or weigh that information as part of the decision-making process, or 4. Communicate their decision (by talking, using sign language or any other means).

Making a decision in a person's Best Interests

Anyone making a decision on behalf of a person they believe to lack mental capacity must do so in that person's best interests. To work out what is in the person's best interests, the decision maker must:

- not assume the decision should be based on the person's age, appearance, condition or behaviour
- consider if the decision can be postponed until the person has sufficient mental capacity to make the decision themselves
- involve the person who lacks mental capacity in the decision as much as possible
- find out the person's views (current or past), if possible, and take these into account
- consider the views of others, such as carers and people interested in the person's welfare, where appropriate, and take these into account
- not be motivated by a wish to bring about the person's death if the decision relates to life-sustaining treatment.

Once the decision maker has considered the relevant information, they should weigh up all the points and make a decision they believe to be in the person's best interests.

When is an IMCA needed?

DUTY to Appoint an IMCA

There is under a **statutory duty to instruct** an IMCA to support and represent the person concerned in the situations set out below:

- Decisions relating to providing, withholding, or withdrawing **serious medical treatment OR**
- Where it is proposed to move a person into **long-term care in a hospital or care-home OR**
- Where a long-term move to a **different hospital or care home** is proposed **AND**
- The person **lacks capacity in relation to one of the specific decisions AND**
- They have **no one close to them whom it would be appropriate to consult**, other than people engaged in their care or treatment in a professional capacity.

POWER to appoint an IMCA

Regulations issued under the Mental Capacity Act (2005) extend the role of the IMCA, providing powers to the NHS to also instruct IMCAs in **accommodation reviews** and **adult protection** cases.

These powers are subject to qualifying criteria, which may be summarised as follows:

Accommodation reviews:

- The LA or the NHS must have arranged the original accommodation; and
- The person whose accommodation is being reviewed must lack the capacity to make a decision about accommodation; and
- There is no other person appropriate to consult.

Adult protection cases:

- Where safeguarding measures are being put in place in relation to the protection of vulnerable adults from abuse; and
- Where the person lacks capacity to consent to one or more of the proposed safeguards

Where the qualifying criteria are met, it would be **unlawful** for the Local Authority or the NHS **not to *consider*** the exercise of their power to instruct an IMCA.
Therefore, in **Accommodation Reviews** (care reviews) and **Adult Protection** plans we **must consider** the instruction of an **IMCA**

DOLS IMCA
There are a number of different IMCA roles involved in supporting and representing people who may be subject to the Deprivation of Liberty Safeguards. These are set out in Section 39 of the amended Mental Capacity Act 2005 (MCA). It is important to be clear which role an IMCA is taking, as they are instructed for different reasons and have different rights and responsibilities.
Briefly the roles are:
Section 39A IMCAs are instructed when there is an assessment in response to a request for a standard authorisation, or a concern about a potentially unauthorised deprivation of liberty.
Section 39C IMCAs cover the role of the relevant person's representative when there is a gap between appointments.
Section 39D IMCAs support the person, or their relevant person's representative, when a standard authorisation is in place.

What is Deprivation of Liberty?

Briefly there will be a need to consider a DoLS application if the following 'acid test' is met;

- Are they under 'continuous control and supervision'? and
- Are they 'free to leave'?

If you are unsure, please contact your Safeguarding Team/Lead within your organisation.

APPENDIX 2

Definitions of Abuse

Abuse of Children

Abuse and neglect: Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or an institutional or community setting, by those known to them or, more rarely, by a stranger for example, via the internet. They may be abused by an adult or adults, or another child or children.

Physical abuse: May involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

Emotional abuse: The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Sexual abuse: Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children. Children may also suffer abuse from being sexually exploited (referred to as Child Sexual Exploitation or CSE) where often children are groomed into intimate relationships with adults where the child receives something (e.g. drugs, alcohol, food, shelter) in exchange for the sexual act.

Neglect: Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care-givers); or
- ensure access to appropriate medical care or treatment.
- It may also include neglect of, or unresponsiveness to, a child's basic emotional needs

Abuse of Adults

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

Domestic violence – including psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence.

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

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

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

Modern slavery -encompasses slavery, human trafficking, and 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 institutional 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. *Neglect can occur because of lack of knowledge by the carer.*

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. It should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support.

Incidents of abuse may be one-off or multiple, and affect one person or more. Professionals and others should look beyond single incidents or individuals to identify patterns of harm, just as the CCG, as the regulator of service quality, does when it looks at the quality of care in health and care services. Repeated instances of poor care may be an indication of more serious problems and of what we now describe as organisational abuse. In order to see these patterns it is important that information is recorded and appropriately shared.

Patterns of abuse vary and include:

- serial abuse, in which the perpetrator seeks out and 'grooms' individuals. Sexual abuse sometimes falls into this pattern as do some forms of financial abuse
- long-term abuse, in the context of an ongoing family relationship such as domestic violence between spouses or generations or persistent psychological abuse
- opportunistic abuse, such as theft occurring because money or jewellery has been left lying around

Domestic abuse - The cross-government definition of domestic violence and abuse is: any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- psychological
- sexual
- financial
- emotional

A new offence of coercive and controlling behaviour in intimate and familial relationships was introduced into the Serious Crime Act 2015. The offence will impose a maximum 5 years imprisonment, a fine or both.

The offence closes a gap in the law around patterns of coercive and controlling behaviour during a relationship between intimate partners, former partners who still live together, or family members, sending a clear message that it is wrong to violate the trust of those closest to you, providing better protection to victims experiencing continuous abuse and allowing for earlier identification, intervention and prevention.

The offence criminalising coercive or controlling behaviour was commenced on 29 December 2015.

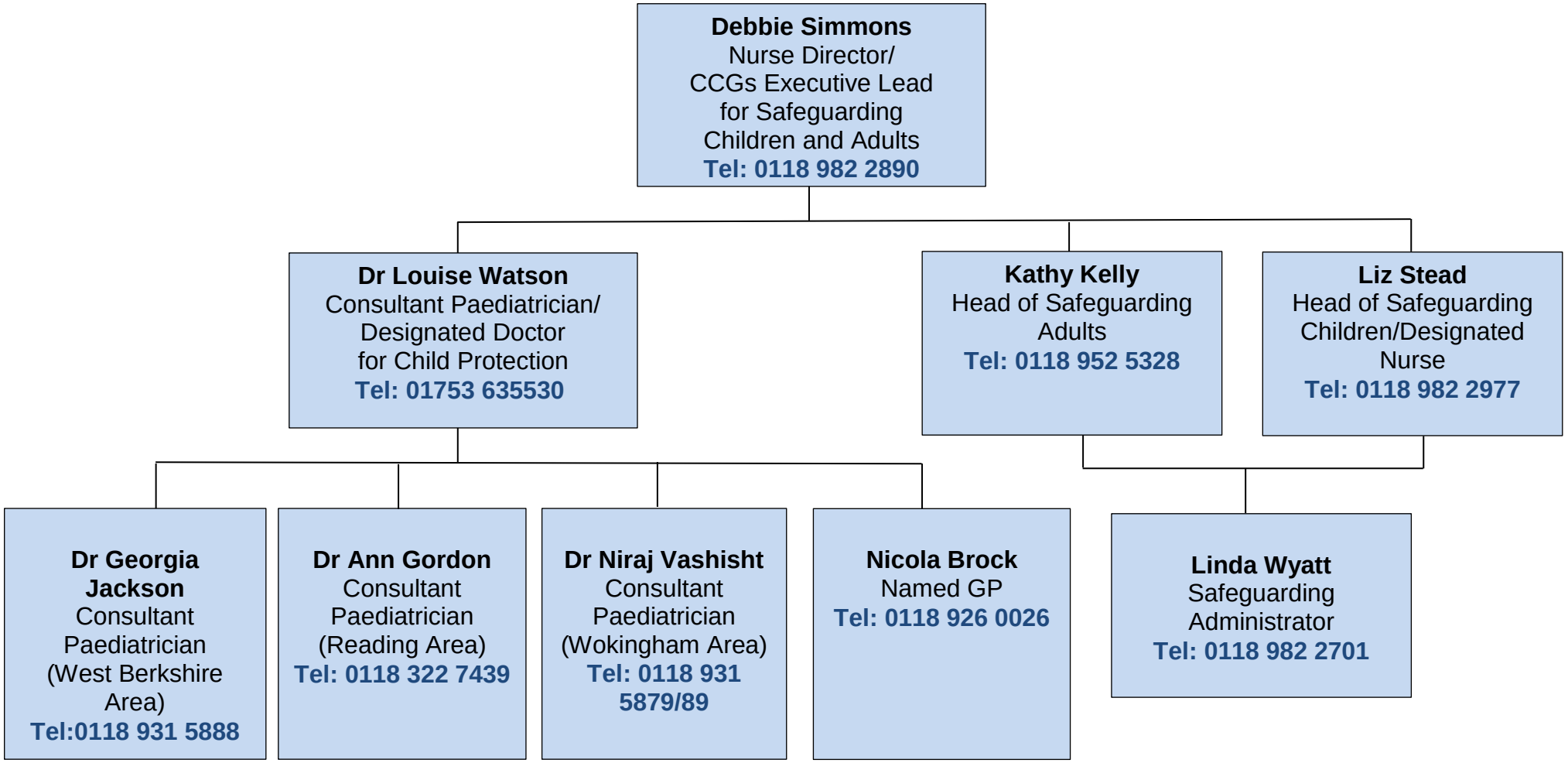
Financial abuse - Financial abuse is the main form of abuse investigated by the Office of the Public Guardian both amongst adults and children at risk. Financial recorded abuse can occur in isolation, but as research has shown, where there are other forms of abuse, there is likely to be financial abuse occurring. Although this is not always the case, everyone should also be aware of this possibility.

Potential indicators of financial abuse include:

- change in living conditions
- lack of heating, clothing or food
- inability to pay bills/unexplained shortage of money
- unexplained withdrawals from an account
- unexplained loss/misplacement of financial documents
- the recent addition of authorised signers on a client or donor's signature card
- sudden or unexpected changes in a will or other financial documents

This is not an exhaustive list, nor do these examples prove that there is actual abuse occurring. However, they do indicate that a closer look and possible investigation may be needed.

APPENDIX 3 Safeguarding Leads Berkshire West Clinical Commissioning Groups (CCGs) Structure



APPENDIX 4 Safeguarding Standards for the CCGs
Key Hospital providers - SELF audit questions

1.1 There is a board lead for safeguarding children and vulnerable adults (these roles can be combined).

1.2 The organisation is a partner member of; (for independent provider access to board information) and participates with; the Local Safeguarding Children Boards (LSCBs) and Local Safeguarding Adult Boards (LSABs).

1.3 There is a named lead for safeguarding children and a named lead for vulnerable adults. The focus for the named professionals is safeguarding within their own organisation. There is a named MCA/Deprivation of Liberty Safeguards (DoLS) lead. There is a named executive and operational Prevent lead covering both Adults and Children's services.

2.1 The board regularly reviews safeguarding across the organisation and disseminates learning from the SAB and LSCB. Provide examples how this is communicated.

2.2 An adverse incident reporting system is in place which identifies circumstances/incidents which have compromised the safety and welfare of children and/or adults at risk.

2.3 A programme of internal audit and review is in place that enables the organisation to continuously improve the protection of all service users from abuse or the risk of abuse.

2.4 The service has clear and accessible systems in place for the views of patients, service users and carers to be heard and influence change. This promotes the safeguarding adults making safeguarding personal ethos and recording people's views in safeguarding both adult and children views.

3.1 Staff at all levels have easy access to safeguarding children and vulnerable adult policies and procedures. These policies and procedures must be consistent with statutory national and local guidance.

3.2 There are clear systems and procedures for recording and reporting concerns, suspicions and allegations of abuse to children and to vulnerable adults in line with national and local guidance.

3.3 There is clear guidance on how to respond to a disclosure of abuse from all children and vulnerable adults which includes a confidentiality policy and procedure.

3.4 There is clear guidance on managing allegations against staff and volunteers working with children and/or vulnerable adults in line with those of the LSCBs and LSABs.

3.5 There are robust complaints and whistle blowing policies/procedures in place that are linked to the safeguarding policy

3.6 There is a process for ensuring that all patients are routinely asked about dependents such as children or about any caring responsibilities.

3.7 There is clear guidance as to the action to take where there is concern a child is being deliberately harmed through fabricating or inducing illness (F11). Guidance to be in line with national and LSCB guidance. (Sections 3.7-3.13 apply only to providers of services to children and young people)

3.8 There is clear guidance for practitioners working with sexually active children under 18 years which is in line with that of the LSCBs. This includes Child sexual exploitation. (Sections 3.7-3.13 apply only to providers of services to children and young people)

3.9 There is clear guidance for working with children and young people who are at risk of domestic violence and for recognising/acting on concern. (Sections 3.7-3.13 apply only to providers of services to children and young people)

3.10 There is a process for following up children who are not brought for health appointments. (Sections 3.7-3.13 apply only to providers of services to children and young people)

3.11 There is a system for flagging children for whom there are safeguarding concerns and for children who are looked after by a local authority. (Sections 3.7-3.13 apply only to providers of services to children and young people)

3.12 General guidance is provided to staff on appropriate behaviours when working with children and young people in line with national and local guidance. (Sections 3.7-3.13 apply only to providers of services to children and young people)
3.13 There is an operational strategy for safeguarding children and adults in place which includes quality indicators to evidence best practice in safeguarding in accordance with the Quality Schedule agreed by CCG and provider organisation. (Applies to all Provider services)
3.14 There are clear procedures on the implementation and management of Deprivation of Liberty Safeguards in line with the Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice. (Applies to NHS commissioners and hospitals providing care for adults)
4.1 All staff working with clients who are parents or carers who are experiencing personal problems (including substance misuse, mental health issues, domestic abuse or who may have learning disabilities) must give consideration to the needs of the children and the impact of the parent's vulnerabilities on their parenting capacity and, where necessary, ensure that they are assessed and appropriate referrals are made.
5.1 The organisation takes account of national and local guidance to safeguard children and adults experiencing domestic abuse.
5.2 There is a designated person within the organisation who is accountable for promoting awareness of forced marriage. This may be incorporated into the position of the safeguarding children, safeguarding adult or domestic abuse lead.
5.3 The organisation takes account of statutory and best practice guidance for forced marriage.
5.4 The organisation takes account of statutory and best practice guidance for girls at risk of female genital mutilation (FGM). The organisation is aware of, and complies with the mandatory reporting duties in respect of FGM.
6.1 There are agreed systems, standards and protocols for sharing information within the service and between agencies in accordance with national and local guidance.
7.1 The organisation is aware of local referral routes to children services including early help, voluntary sector services and support for adults, children and families.
7.2 The organisation works with partners to protect children and vulnerable adults and participates in reviews as set out in statutory, national and local guidance.
8.1 Robust recruitment and vetting procedures are in place to help prevent unsuitable people from working with vulnerable adults and children.
8.2 Safeguarding responsibilities are reflected in all job descriptions relevant to role and responsibilities.
8.3 Staff involved in employing staff are trained in the processes of 'safe recruitment' or alternative process to ensure safer recruitment including volunteers and agency.
9.1 Staff working with children and vulnerable adults record their work in accordance with statutory and best practice guidance.
9.2 Applies to services working with children.
10.1 Staff working directly with children and vulnerable adults have access to advice support and supervision to enable them to manage the stresses inherent with this work. All Named and Designated Professionals access formal reflective supervision relating directly to safe-guarding activities.
10.2 Named professionals seek advice from designated professionals for complex issues or where concerns may have to be escalated.
11.1 There is a funded training strategy for safeguarding.
11.2 All staff (including administrative staff and volunteers) have an understanding of their roles and responsibilities, and those of other professionals and organisations in relation to safeguarding children and vulnerable adults.

11.3 Staff required to use restrictive physical interventions have training in line with MCA . This may include Specialist training and policy if the organisation requires it and should include the legal duties enshrined in the Mental Capacity Act 2005 (including the law relating to assault against a person) and national guidance on consent for examination or treatment.
12.1 There is clear guidance on the management of children admitted to adult wards which ensures that care is delivered in a safe environment.
12.2 There is clear guidance as to the discharge of children for whom there are child protection concerns.
12.3 Specialist paediatric advice is available at all times.
12.4 The child's GP and health visitor/school nurse is notified of admissions and discharges.
12.5 Berkshire East and West CCGs and the relevant Local Authority shall be notified of any child (normally resident in Berkshire likely to be accommodated for a consecutive period of at least 3 months; or with the intention of accommodating him/her for such a period (ref x.85 & s.86 CA 1989).
13.1 As part of the assessment and care planning, child and mental health professionals should identify whether abuse, neglect or domestic abuse are factors in a child's mental health problems and should ensure that this is addressed appropriately in the child's treatment and care, and where a child is currently affected, referral is made in line with LSCB procedures.
13.2 There are clear procedures for staff to follow in situations when inpatient beds are required, but not immediately available within the relevant service.
14.1 Deprivation of Liberty Safeguards is only used when it is in the best interests of the person.
14.2 The use of restraint is always appropriate, reasonable, proportionate and justifiable to that individual.
14.3 Rapid tranquilisation will only be used in accordance with NICE clinical guidelines on Violence.
15.1 Practitioners working within adult mental health services should routinely record details of patient's responsibilities in relation to children and consider the support needs of patients who are parents, and of their children in all aspects of their work, using the Care Programme Approach (CPA).
15.2 All inpatient mental health services must have policies and procedures relating to children visiting inpatients, as set out in the Guidance on the Visiting of Psychiatric Patients by Children (HS 1999/222: LAC(99)32), to NHS Trusts.
15.3 Staff routinely assess the risk and history of abuse and the person's vulnerability to abuse, including predatory behaviour or sexual vulnerability, and manage any identified risks.
15.4 A consultant psychiatrist should be directly involved in all clinical decision-making for service users who may pose a risk to children.
15.5 All assessment, CPA monitoring, review, and discharge planning documentation and procedures should prompt staff to consider whether the service user is likely to have, or resume contact with their own child, or other children in their network of family and friends, even when the children are not living with the service user, and a level of risk recorded in the records.
15.6 Safeguarding training specifically includes the risks posed to children from parents with delusional beliefs involving their children, or who might harm their children as part of a suicide plan.
16.1 Specialist paediatric advice is available at all times to A&E departments and all units where children receive care.
16.2 All staff working in the above-named services/departments should:
· be able to recognise abuse in children/vulnerable adults
· be familiar with local procedures for making enquiries to find out whether a child is subject

to a child protection plan.
16.3 All attendances for children to A&E, ambulatory care units, walk-in health centres, urgent care centres and minor injury units should be notified to the child's GP. Attendances at A&E will also be copied to the health visitor and/or school nurse, depending on the age of the child.
17.1 As part of the Healthy Child Programme, regular health reviews are undertaken which provide the opportunity to identify risk factors that make children more likely to experience poorer outcomes.
17.2 All professionals delivering primary care should know when it is appropriate to refer a child to children's social care for help as a 'child in need' and know how to act on concerns that a child may be at risk of significant harm.
17.3 Community health practitioners should have a clear means of identifying in records those children (together with their parents and siblings) who are subject to a child protection plan or who are LAC.
17.4 There is good communication between GPs, community nursing services (i.e. health visiting, school nursing and community midwifery services) in respect of children for whom there are concern
17.5 Promotion and arrangements are in place to meet the health needs of LAC children in line with statutory guidance 2009. Looked After Children (LAC) receive priority health assessments as outlined in legislation and health services based on their individual need and vulnerabilities.
18.1 ALL SERVICES The organisation supports individuals to access their right to an independent advocate where an adult has substantial difficulty in being involved in the safeguarding process and they have no suitable representation or support (Care and Support Statutory Guidance (DH, Oct 2014) paragraph 14.43).
18.2 ALL SERVICES : Carers are identified in both adult and children services and there is evidence of signposted to LA for a carers assessment (evidence inserted please could be literature or ammonised referral or carers data / services.
18.3 ALL SERVICES: The organisation demonstrates a clear, working understanding and evidenced competence in applying the MCA and of the core principles within it. Please insert an example of how you have achieved this a case study service user feedback, audit summary. Adult or child or both.
18.4 ALL SERVICES: Person-led and outcome-focused practice in safeguarding is demonstrated. Please insert ammonised 1 case example sharing practice or learning that demonstrates person lead practice in safeguarding within the last year.
19.1 ALL SERVICES: Please provide an assurance report (as per template) regarding the findings as a result of the workforce staff questionnaire. The report should detail actions with associated timescales and owners to aid commissioner understanding of any identified issues.

Appendix 4a

NHS Berkshire West Clinical Commissioning Group

Safeguarding Self-assessment Practitioner Questionnaire
Questionnaire for frontline staff and volunteers

Please find the below questionnaire for completion in order for the CCG to assess the effectiveness of safeguarding arrangements. This will assist the CCG to identify any areas or teams which require additional support.

Please note that this questionnaire is confidential and anonymous.

Thanks in advance for your contribution.

Topic	Item	Comment / evidence
1. Training	When did you last have training about safeguarding and the Mental Capacity Act? How have you developed your practice to incorporate your revised or new safeguarding knowledge?	
	Please provide an example of how it has improved outcomes for the person you were working with?	
2. Knowledge	What would you do if you had a safeguarding concern about a child or adult with care and support needs?	
	What procedures would you use and where would you find them?	
	What is your understanding of a whole-family approach to safeguarding? How does a whole family approach influence your practice?	
	How confident do you feel asking if the child/family/adult needs any help?	1= Confident 2= Not confident
3. Action	How would you as a member of staff respond to a safeguarding allegation made to you from either a service user or colleague against another member of staff?	

4. Action	In your conversations with services users do you routinely ask and record the views of families, children *(where appropriate)* and adults in safeguarding cases?	Y or N
5. Action	Do you know how to access the Berkshire wide multi agency safeguarding procedures for both adults and children?	Y or N
6. Action	'Making Safeguarding Personal' is about listening, enabling and involving families, children and adults in any safeguarding conversations and decisions. Please give an example of how you would do this.	
7. Support	What's the name and contact details of your organisation's lead officer for safeguarding?	
	Do you have supervision to support you in your work?	Y/N
	How confident are you that your supervision meets your needs in fulfilling your safeguarding responsibilities?	Score 1= Confident 2 = Not confident 0 = No regular supervision in place
8. Documentation	Do you know how to make a safeguarding referral? Client information is confidential and needs to be stored securely. Where do you usually keep your clients' paperwork?	Y/N
9. Follow up	Do you feel you can discuss with your manager any safeguarding issues or additional support you may need arising from this questionnaire? If not where will you go for support?	Y/N
Date submitted		