Policy Reference:		Org 1
Issue Number:		01
Date of Issue:		September 21
Review date:		August 22
Title:		Safeguarding Adults and Children at Risk Policy and Procedures
Policy Owner		Head of Operations
Other Relevant Policies:		

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1. Introduction

1.1 ategi is committed to the fundamental principle of protecting people from harm and this is developed and sustained through a positive culture of vigilance, implementing learned lessons from incidences and working in partnership with statutory agencies, partner services and organisations, trustees, managers, staff, Shared Lives Carers, service users and their families.

The organisation provides the following services:

- **Shared Lives Scheme** - supports people with a learning disability, physical disability, mental health concerns, older and younger adults. The scheme supports people to live within a shared lives arrangement.
- **Supported Living Service** - supporting individuals aged 18 and over with learning and physical disabilities, mental health needs and those with an autistic spectrum diagnosis.
- **Visiting Support** - a flexible service, supporting people who live in and around Cardiff who are vulnerable because of their

learning disability and/or their physical/ sensory difficulties, from 2 hours at a time, up to a full week, depending on their needs.

1.2 The values that ategi was built on remain strong and clear today ensuring that anyone who makes use of our services has full control over their lives and the support they have, are respected as equal partners in the planning of their support and are enabled to live the life that they want to live.

2. Scope and Purpose of the Policy

2.1 This policy and the supporting procedures seek to ensure that ategi undertakes its responsibilities to safeguard adults at risk and children consistently and effectively. It establishes a framework to support all those who come into contact with ategi, protect them from abuse and maltreatment of any kind and clarifies the organisation's expectations of trustees, managers, staff and Shared Lives Carers.

2.2 ategi's approach to safeguarding adults at risk and children will operate in line with the key principles of the European Convention of Human Rights and the Human Rights Act 1998, namely:

- Everyone has the right to live their lives free from coercion, intimidation, oppression and physical, sexual, emotional or mental harm.
- Everyone has the right to a family life and privacy.
- Everyone has a right to confidentiality in respect of personal information, where this does not infringe the rights of other people.
- Everyone has the right to receive full and comprehensive information to allow them to make informed choices about their own circumstances.
- Everyone has the right to the protection of the law and full access to the judicial process and criminal justice system.

2.3 Putting these principles into practice means ategi is committed to the principle that protecting a person at risk of abuse of neglect should be everyone's paramount concern.

2.4 Safeguarding adults at risk and children is everyone's responsibility. Therefore, all ategi trustees, managers, staff and Shared Lives Carers have an ethical and professional duty of care to act if they:

- witness abuse;
- receive information about abuse, suspected abuse or concerns about the care or treatment of a person at risk of abuse or neglect; or

- have concerns or suspicions about possible abuse or inappropriate care.

2.5 The Wales Adult Protection Policy and Procedures including criminal investigations, override other organisational procedures, such as disciplinary and complaints investigations (this is stated in Listening and Learning, Section 7: Guidance for local authorities about managing complaints).

2.6 The Adult & Child Protection and Safeguarding Policies and Procedures in each area we work in England override other organisational procedures such as disciplinary, complaints, investigations etc.

3. Breaches of Policy and Procedures

3.1 For ategi staff, failure to adhere to this Policy and Procedures could lead to disciplinary action, including dismissal. For Shared Lives Carers and partner organisations their individual relationship with ategi may be terminated.

4. Values

4.1 The following values and rights underpin the way a person at risk of abuse of neglect should be supported and cared for in whatever setting or place they live in or use:

- **Independence:** to think, act and make decisions, even when this involves a level of risk
- **Dignity:** recognition that everyone is unique, with intrinsic value as a person
- **Respect:** for a person's needs, wishes, preferences, language, race, religion and culture
- **Equality:** the right of people to be treated no less favourably than others because of their age, gender, disability, sexual orientation, religion, class, culture, language, race, ethnic origin or other relevant distinctions
- **Privacy:** the right of the individual to be left alone or undisturbed and fee from intrusion or public attention in their affairs
- **Choice:** the right to make choices, and to have the alternatives and information that enable choices to be made

4.2 Putting these principles and values into practice in ategi means:

- Safeguarding and adult protection is everyone's concern.

- All trustees, managers, staff and Shared Lives Carers, paid or unpaid, should understand the nature of abuse, how people might be at risk of harm and work to prevent it.

- ategi trustees, managers, staff and Shared Lives Carers and professionals in all agencies must work actively and proactively with each other, with other agencies, and with the person at risk of abuse or neglect and their family or carers, to ensure protection and prevention.

- When responding to referrals, the concerns raised must be believed/accepted without judgement.

- Trustees, managers, staff and Shared Lives Carers have a duty to report any concerns they have about the potential abuse of a person at risk of abuse or neglect.

- Careful consideration and respect of a person at risk of abuse or neglects wishes and preferences are essential to the adult safeguarding and protection process.

- A person at risk of abuse or neglect has the right to be supported and empowered when adult protection procedures are used, and to have an independent advocate if they wish. For people assessed as lacking capacity to make decisions about how they could be protected, an Independent Mental Capacity Advocate (IMCA) must be considered and may be appointed.

- A Person at risk of abuse or neglect with capacity to understand abuse and risk of abuse has the right to refuse intervention even if this leaves them at risk of significant harm, but those working in adult safeguarding and protection may need to act to protect other people at risk of abuse or neglect from the same abuser.

- A person at risk of abuse or neglect is entitled to the protection of the law and full access to all parts of the criminal justice system, in the same way as any other citizen.

- A person at risk of abuse or neglect who is allegedly a victim of abuse should have the highest priority for protection, assessment and support.

- A person at risk of abuse or neglect has the right to full and timely information about their rights, services, what is being done on their behalf and why. This can be summarised as, *'nothing about us without us.'*

- Relative Carers have the right to have their needs taken into account.

- Alleged perpetrators, including those who are relative carers, must have their rights taken into consideration.

- Alleged perpetrators who are also a person at risk of abuse or neglect have the right to be supported and to have an independent advocate if they wish.
- ategi is committed to working actively to ensure our ***Safeguarding of Adults and Children at Risk of Abuse or Neglect Policy and Procedures*** are integral to working our practices, training and governance.

5. Definitions

5.1 An **adult** is a person who is aged 18 and over and a **child** is a person who is under the age of 18.

5.2 An **adult at risk of abuse or neglect** is an adult who:
a) is experiencing or at risk of abuse or neglect;
b) has needs for care and support (whether or not the authority is meeting any of those needs); and
c) as a result of those cared and support needs is unable to protect themselves against abuse or neglect or the risk of it
(Social Services and Well-being (Wales) Act 2014); (Care Act 2014)

The above definition means that all ategi service users fall under the legal definition of an adult at risk of abuse or neglect.

5.3 **Abuse:** Abuse is the violation of a person's human, civil or legal rights by another person or persons. Abuse may be a single act, repeated acts and/or multiple acts. It may be physical, verbal, emotional or psychological. It may be perpetrated as a result of deliberate intent, negligence or ignorance.

5.4 **Abuse may be an Act of Omission:** (failing to act) or neglect. Abuse may involve the person at risk of abuse or neglect being persuaded or forced to enter into a financial or sexual arrangement to which they have not, or cannot, understand or consent.

5.5 **Abuser**: An abuser may be anyone who has contact with the person at risk of abuse or neglect. This may be a family member, carer, friend, professional staff, support staff, Adult Placement Carer, neighbour, volunteers, people in a position of trust, another service user.

5.5 **Abuse by a stranger**: Abuse or random violence by someone not known to the person at risk of abuse or neglect will still be required to be reported and police involvement required.

Categories of Abuse

ategi will recognise that the following may indicate abuse and will act appropriately upon receipt of such information.

5.6 **Physical Abuse**: The non-accidental infliction of a physical act that results, or could result, in physical injury, pain or suffering including:

- assault
- hitting
- slapping
- pushing
- misuse of medication
- restraint
- inappropriate physical sanctions

5.7 **Sexual Abuse**: The direct or indirect involvement of a person at risk of abuse or neglect in sexual activity to which they are unwilling or unable to give informed consent or which they do not fully comprehend. Any sexual activity that is not freely consenting is criminal. Where there is an abuse of trust, sexual activity may appear to be with consent, but it is unacceptable because of the differences in power and influence between the people involved. This includes:

- rape
- indecent exposure
- sexual harassment
- inappropriate looking or touching
- sexual assault
- sexual teasing or innuendo
- sexual photography
- subjection to pornography or witnessing sexual acts
- sexual acts to which the adult has not consented or was pressured into consenting

5.8 **Neglect:** This can be intentional and unintentional acts. It includes ignoring care needs, or withholding or deliberately not providing care to a person at risk of abuse or neglect. It includes the unintentional failure to provide support because of lack of knowledge or understanding of the need for services. It includes failure to follow support plans, policies and procedures. Failure to provide prescribed medication and provide poor nutrition.

5.9 **Emotional/Psychological Abuse:** The violation of the emotional and psychological health and development of the person at risk of abuse or neglect. This includes threats of harm, bullying, humiliation,

verbal abuse, isolation or withdrawal from services or support networks, coercion, control and intimidation.

5.10 **Domestic Abuse**: 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, physical, sexual, financial, emotional, or so called 'honour' based violence.

5.11 **Financial Abuse:** Includes theft, fraud, pressure around wills, property or inheritance, the misuse or misappropriation of benefits or monies.

5.12 **Discriminatory Abuse**: Includes harassment, slurs or similar treatment because of race, gender and gender identity, age, disability, sexual orientation or religion.

5.13 **Self-neglect**: This covers a wide range of behaviour neglecting to care for one's personal hygiene, health, medication (when indicated), safety precautions or surroundings and incudes behaviour such as hoarding.

This excludes a situation in which a mentally competent person who understands the consequences of their decisions, makes a conscious and voluntary decision to engage in an act that threatens their own health or safety.

5.14 **Organisational Abuse:** Includes neglect and poor care practice within an institution or specific care setting such as a hospital or a care home for example, or in relation to care provided in one's own home. This may range from a one-off incident to ongoing- ill-treatment. It can be through neglect or professional practice as a result of the structure, policies, processes and practices within an organisation.

5.15 **Modern Slavery:** Modern slavery is the severe exploitation of other people for personal or commercial gain. It includes slavery, human trafficking, forced labour and domestic servitude, traffickers and slave masters using whatever means they have at disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

5.16 **Radicalisation and Extremism:** Radicalisation is a process which somebody goes through in order to become involved in extremist activities or terrorism, from a starting point of having no particular strong opinions or being a moderate person through to holding some

extremist views, and it can be a process that happens online or in meeting people, and their conversations and their opinions are gradually changed over time.
Extremism is the demonstration of unacceptable behaviour by using any means or medium to express views which:

- Foment(incite), justify or glorify terrorist violence in furtherance of particular beliefs
- Seek to provoke others to terrorist acts
- Foment other serious criminal activity or seek to provoke others to serious criminal acts
- Foster hatred which might lead to inter-community violence in the UK.

5.17 **Criminal Exploitation:** is a geographically widespread form of harm that is a typical feature of **'County Lines'** activity. According to the UK government county lines is defined as: *"County lines is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of "deal line". They are likely to exploit children and vulnerable adults to move and store the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons."* County lines activity and the associated violence, drug dealing and exploitation has a devastating impact on young people, vulnerable adults and local communities.
People who choose to exploit will often target the most vulnerable in society. They establish a relationship with the person to access their home this is referred to as **'cuckooing'**. Once they gain control over the person- whether through drug dependency, debt or as part of their relationship – larger groups will sometimes move in. Threats are often used to control the person. It is common for the perpetrators to have access to several cuckooed addresses at once, and to move quickly between them to evade detection. The victims of cuckooing are often people who misuse substances such as drugs or alcohol, but also can be people with learning difficulties, learning disabilities, mental health issues, physical disabilities or socially isolated.

5.18 **Child Sexual Exploitation:** is as a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 years into sexual activity:
(a) in exchange for something the victim needs or wants, and /or
(b) for the financial advantage or increased status of the perpetrator or facilitator.
The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always

involve physical contact: it may also occur through the use of technology.
Sexual relationships where one or both partners are under the age of 16 remain illegal. Those aged between 13 – 16 years old are deemed competent to give consent; however, any form of sexual activity involving a child under the age of 18 may be abusive, if it involves the exercise of power over the child.

5.19 **Mate Crime:** Mate Crime is a form of hate crime and can become a very serious form of abuse. Mate Crime is defined as the exploitation, abuse or theft from any person at risk from those they consider to be their friends. Those that commit such abuse or theft are often referred to as 'fake friends.' People with disabilities, particularly those with learning disabilities, are often the targets of this type of crime. In some cases, victims of mate crime have been badly harmed or even killed. Mate crimes are likely to happen in private, often in the victim's own accommodation. They can also happen via social media, where victims are financially or sexually exploited after being befriended online.
Mate crimes often occur within long-term relationships, which may have started out as genuine friendships. They can appear to be real friendships to many observers. Social workers can be so delighted that a person with learning disabilities has a 'friend' that they don't question the relationship any further.
Indicators of mate crime can be similar to other forms of abuse.
Potential signs include:

- bills not being paid, a sudden lack of money, losing possessions, suddenly changing their will
- changes in routine, behaviour, appearance, finances or household (new people visiting or staying over, lots of new 'friends', lots more noise or rubbish than normal)
- cutting themselves off from established networks of friends/family and support, missing weekly activities
- secretive internet or mobile phone use.

5.20 Any of the above forms of abuse could be motivated by the personal characteristics of the victim. This may make it a 'hate crime'. These involve a criminal offence perceived by the victim or any other person, to be motivated by hostility or prejudice based on a person's actual or perceived disability, race, religion and belief, sexual orientation and transgender.

5.21 Further information on issues and factors that can increase the vulnerability of adults who may be at risk of abuse or neglect are outlined in Appendix C.

6. The Rights of Individuals

6.1 People who use our services will be respected with regards to their privacy, dignity, independence and choice. ategi recognises that individuals' right to an independent life may sometimes include exposure to risk. In all situations of identified risk ategi staff should assess, manage, review and minimise harmful situations.

6.2 The 'Six Key Principles' that underpin all adult safeguarding work are:

- **Empowerment:** people being supported and encouraged to make their own decisions and informed consent.
- **Prevention:** It is better to take action before harm occurs.
- **Proportionality:** The least intrusive response appropriate to the risk presented.
- **Protection:** The 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.

6.3 **Making Safeguarding Personal:** (MSP) is an initiative which aims to develop an 'outcome focus' to safeguarding work and a range of responses to support people to improve or resolve their circumstances. MSP in its simplest form means putting the person at the centre of everything we do during a safeguarding concern/enquiry, from the very beginning to the very end. MSP seeks to achieve:

- A personalised approach that enables safeguarding to be done with, not to, people.
- Practice that focuses on achieving meaningful improvement to people's circumstances rather than just on 'investigation' and 'conclusion'.
- An approach that utilises social work skills rather than just 'putting people through a process'.
- An approach that enables practitioners, families, services and organisations to know what difference has been made.

6.3 ategi aims to empower people to understand and address risks. When necessary, (and in consultation with Care Managers) decisions may need to be made to protect individuals or others from risk by denying access to certain situations considered inappropriate or harmful. Such decisions will not be made in isolation and will be recorded appropriately. Any such decision will consider both ategi's responsibilities to Service Users and the 'Duty of Care'.

7. Mental Capacity

7.1 Having mental capacity means that a person is able to make their own decisions.

7.2 The Mental Capacity Act 2005 (MCA) applies to England and Wales. The primary purpose of the MCA is to promote and safeguard decision-making within a legal framework. It does this in two ways:

- by empowering people to make decisions for themselves wherever possible, and by protecting people who lack capacity by providing a flexible framework that places individuals at the heart of the decision-making process
- by allowing people to plan ahead for a time in the future when they might lack the capacity

7.3 The MCA is underpinned by five statutory principles:

i. **presumption of capacity:** every adult has the right to make their own decisions and must be assumed to have capacity to do so unless it is proved otherwise.

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

iii. **Unwise decisions:** people have the right to make decisions that others might regard as unwise or eccentric.

iv. **Best Interests:** anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.

v. **Least restrictive:** someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the person's rights and freedoms of action.

7.4 ategi works on the assumption that people have the capacity to make decisions for themselves and that where it is established that a person does not have capacity in respect of a particular decision that they remain at the heart of the decision-making process.

7.5 It is useful to consider the principles chronologically: principles i to iii will support the process before or at the point of determining whether someone lacks capacity. Once it has been decided that capacity is lacking, principles iv and v are used to support the decision-making process. In circumstances where the person at risk of abuse or neglect is assessed against these five statutory principals as lacking capacity professionals and others are required to act in the best interest of the individual concerned. Further information on undertaking a 'Best Interest Decision Making Assessment' – see Appendix D

8. Prevention and Minimising Risk

8.1 ategi will support service users to protect themselves by:

- Having understandable and accessible information about what constitutes abuse and what to do if they are abused.
- Having support from staff or Shared Lives Carers and access to people who they can talk to about things that concern them.
- Promoting the access to advocates who can help service users speak up and take action if needed.
- Empowering them to take an active part in decisions that affect their lives
- Listening and following up all complaints.
- Having well developed communication systems for individuals.

8.2 Managers, staff and Shared Lives Carers will minimise risk by:

- Working with Service Users in an empowering way that respects their autonomy and civil rights to self-determination.
- Understanding what constitutes vulnerability and abuse and what to do if they suspect abuse.
- Taking immediate action when recognising or suspecting signs of abuse.
- Take their responsibilities under the duty of care seriously and conducting themselves within the Social Care Code of Practice or Shared Lives Agreement.
- Discussing any support issues and concerns promptly with line managers and/or with an appropriate person.
- Questioning practices that may be harmful or abusive and take further action e.g., report concerns, whistle-blowing etc.
- Taking part in training and skills development.
- Giving and receiving feedback from colleagues in developing a learning and preventative culture at work.

8.3 ategi can minimise risks by:

- Making sure that the service meets the needs of and is planned around individuals.
- Using fair and rigorous recruitment selection and induction processes.
- Working with Care Managers and commissioners to ensure the staff levels can meet the needs of service users.
- Having effective means of communication that are open and understood by service users, relatives, friends, other agencies, staff and managers.
- Operating an open-door policy and culture.
- Making sure that managers, staff, Shared Lives Carers understand what constitutes abuse and what to do if they suspect it.

- Encouraging managers, staff and Shared Lives Carers to raise concerns and question practice.
- Listening and responding to managers, staff, Shared Lives Carers and service users who raise questions about practice.
- Discussing incidents or support issues routinely and openly with managers, staff and Shared Lives Carers.
- Having efficient recording and reporting systems in place, that are used and useful.
- Recording complaints and concerns and responding to them constructively.
- Routinely reviewing apparently isolated incidents to see if they reflect wider problems in the service.
- Having clear policies and procedures that managers, staff, Shared Lives Carers, relative carers and Service Users understand and use.
- Ensuring that all managers, staff and Shared Lives Carers receive training and, through direct supervision and monitoring of their work, develop their practice.
- Addressing poor practice and setting realistic practice standards.
- Implementing robust monitoring and review systems.
- Working constructively and collaboratively with: service commissioners, statutory bodies, other agencies and the law. Supporting the prosecution of criminal acts as a deterrent to potential abusers.
- Referring people to the Disclosure and Barring Service (DBS).

9. Safeguarding Governance: Roles and Responsibilities

9.1 ategi is committed to providing support to all those involved with the organisation. A clear structure of safeguarding accountability supports everyone to understand their individual and collective responsibilities for safeguarding adults at risk and children.

9.2 ategi will ensure it has arrangements in place to fulfil its commitment and duty to safeguard adults at risk and children in accordance with legislation and statutory guidance.

9.3 **Board of Trustees**: Trustees play a vital role in ensuring that ategi is legally compliant in order to manage the organisation’s resources effectively and provide a long-term vision and protect ategi’s reputation and values. In order to fulfil these responsibilities, the Trustees may delegate some or all of these responsibilities to individual Trustees or members of the Executive Team. Trustees are responsible for:

- approving all safeguarding policies and supporting procedures.

- ensuring adequate resources are available for effective safeguarding practices and training.
- ensuring effective reporting and auditing processes are in place and that the same are regularly reviewed.
- receiving regular safeguarding reports from the Executive Team.
- developing a culture within the organisation that promotes effective safeguarding practices.

9.4 **Quality & Safeguarding Committee:** The role of the committee includes but is not limited to overseeing:

- systems for safeguarding
- care practice to ensure compliance with the Care Quality Commission and Care Inspectorate Wales fundamental standards of quality & safety
- systems for delivering a high-quality experience for all service users
- monitoring outcomes and service effectiveness
- compliance with the Care Quality Commission and Care Inspectorate Wales registration
- consider relevant risks within the corporate level risk register as they relate to the remit of the committee

9.5 **Executive Team:** The Executive Team will ensure a commitment to safeguarding is integral in the delivery of all ategi services. They will ensure that:

- a safeguarding culture of vigilance is promoted and embedded in all areas of the organisation including with the organisation's partners.
- clear and effective communication pathways for safeguarding are shared with all managers, staff, Shared Lives Carers, service users and their families.
- proposed changes to safeguarding policies and supporting procedures are presented to the Board in accordance with the agreed cycle of policy review.
- the Named Designated Safeguarding Lead (DSL) and Deputy Designated Safeguarding Leads (DDSLs) have sufficient resources in order that they may discharge their functions as outlined below.
- safe recruitment and selection practices of managers, staff and Shared Lives Carers, are implemented in accordance with the safer recruitment policy and procedures.
- concerns and allegations against managers, staff or Shared Lives Carers are investigated.

9.6 **Head of Operations (Named Designated Safeguarding Lead, (DSL)) and Deputy Designated Safeguarding Leads (DDSLs):**

The Head of Operations is the named DSL with the role of Deputy DSL being undertaken by the Head of Quality and Compliance and the Service Managers. They are responsible for:

- Providing ready and accessible support and guidance to all staff on safeguarding matters.
- Managing all safeguarding reports / logs
- Reporting safeguarding concerns to the relevant statutory services
- Ensuring accurate records for all safeguard concerns
- Undertaking case management and reviews of serious incidents
- Supporting the quality and review function for all safeguarding concerns
- Supporting the implementation and auditing of policy and strategy in relation to safeguarding
- Ensuring that serious incidents relating to safeguarding are reported immediately and managed effectively
- Ensuring all safeguarding reports are kept securely and in line with all data protection requirements
- Communicating safeguarding updates across the organisation
- Supporting the delivery of safeguarding refresher training

The named DSL will also have lead responsibility for managing safeguarding allegations against staff and act as a liaison for statutory services during any criminal or safeguarding investigations.

They will work with all appropriate governance bodies to inform of serious or untoward safeguarding incidents as appropriate.

Head of Operations - Named Designated Safeguarding Lead for ategi

Name: Lesley-Anne Ryder (CEO – Acting Head of Operations)
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Service Area: Shared Lives Wales - Deputy Designated Safeguarding Lead
Name: To be appointed
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Service Area: Supported Living - Deputy Designated Safeguarding Lead
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Service Area: Visiting Support Services - Deputy Designated Safeguarding Lead
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9.7 **Managers, Staff and Shared Lives Carers:** All have a shared responsibility to safeguard and promote the welfare of adults at risk and children. Through the provision of regular training, they will know how to recognise, respond to, report and record any safeguarding concerns.

10. Information Sharing

10.1 The General Data Protection Regulation (GDPR) and the Data Protection Act 2018 introduced new elements to the previous data protection regime established under the Data Protection Act 1998.

10.2 The GDPR and Data Protection Act 2018 place greater significance of organisations being transparent and accountable in relation to their use of data. All organisations handling personal data need to have comprehensive and proportionate arrangements for collecting, storing and sharing information.

10.3 Managers, staff and Shared Lives Carers must have due regard of the relevant data protection principles which allow them to share personal information.
GDPR and Data Protection Act 2018 DO NOT PREVENT OR LIMIT THE SHARING OF INFORMATION FOR THE PURPOSES OF SAFEGUARDING CHILDREN OR INDIVIDUALS AT RISK OF ABUSE OR NEGLECT.

10.4 Information which is relevant to safeguarding will often be data which is considered *'special category personal data'*, meaning it is sensitive and personal.

10.5 Where managers, staff or Shared Lives Carers need to share ***'special category personal data'***, they should be aware that the Data Protection Act 2018 includes, 'safeguarding of children and individuals at risk' as a condition that allows you to share information ***without consent***.

10.6 Information can be ***shared legally without consent***, if you are unable to, cannot be reasonably expected to gain consent from the individual, or if gaining consent could place a child or individual at risk.

10.7 Relevant personal information can be shared lawfully it is it to keep a child or individual at risk safe from neglect, physical, emotional or mental harm, or if it is protecting their physical, mental, or emotional well-being.

10.8 There are **'seven golden rules'** that underpin information sharing, these are:
Framework for sharing information safely

i. A framework for sharing information appropriately
ii. Be open and honest with the individual - unless unsafe or inappropriate to do so
iii. Seek Advice if in doubt about sharing information
iv. Share with consent where possible, respect wishes of those who do not consent to having their information shared
v. Consider Safety and Well-being
vi. Shared information is necessary, proportionate, relevant, adequate, accurate, timely and secure
vii. Keep a record of decisions (including if not to share) and what information is shared, with whom and for what purpose

11. Responding to a Safeguarding Concern or Disclosure

11.1 All managers, staff and Shared Lives Carers have a duty to raise concerns about a person at risk of abuse or neglect, without prejudicing their positions. Managers, staff and Shared Lives Carers have a duty under the Public Interest Disclosure Act to report any suspicion or allegation of abuse, or if they have reason to believe someone is at risk of abuse.

11.2 The following procedures relate to the action to be taken in respect of any concerns or disclosures that are made in respect of alleged abuse or inappropriate care of a person at risk of abuse or neglect.

11.3 Referrals of suspected abuse or allegations of abuse should be made following the procedure in the relevant local authority area.

11.4 **If a disclosure is made by a service user or another, alleging inappropriate care or abuse, all managers, staff and Shared Lives Carers must:**

i. **Listen carefully and sympathetically:** where a person has difficulty in explaining do not make assumptions or put words in their mouth; use your knowledge of the individual to try and understand what they are saying.

ii. **If you discover a service user is physically injured or has been subject to a recent physical or sexual assault you must seek medical assistance immediately:** call 999 if there is immediate risk or if a crime has been committed.

iii. **Do not promise to keep the information secret:** try and make it clear that you are obliged to pass the information on to people who will decide what action to take.

iv. **Consent to share information:** where possible you should seek consent from the individual to share information (if safe to do so) with the Police or Social Services Safeguarding teams.

v. **Public Interest:** there are certain situations where interventions are needed to protect service users and other vulnerable groups and consent is not needed, i.e., public interest of safeguarding a child or adult at risk or to prevent. If after discussion with the Deputy Designated Safeguarding Lead it is judged to be in the 'public interest' or under a Duty of Care to share the concern/disclosure with external statutory agencies then the DDSL will contact the Police or Social Services Safeguarding teams as soon as possible by telephone,

and in any case before the end of the day, together with alerting the Named DSL.

vi. **Avoid asking direct questions:** any questions that could be considered as formally investigating should be avoided. You are encouraged to ask questions to clarify what is being said.

vii. **Make a note:** record what the person is telling you, either at the time or immediately afterwards. You should complete the **Safeguarding Concern Form (Appendix A)** ensuring it is signed, timed and dated.

Once completed staff / Shared Lives Carers must send the Safeguarding Concern Form to their Deputy Designated Safeguarding Lead within 24hrs or if a weekend as soon as agreed.

Failure to complete the Safeguarding Concern form should not delay the matter being reported verbally to your Deputy Designated Safeguarding Lead or your line manager.

viii. **Criminal assault:** if you suspect the abuse amounts to a criminal assault, you should contact your manager or the manager on call/duty immediately. Where a criminal offence has been committed or is suspected, the police must be notified immediately. Early consultation will help them establish whether a criminal act has been committed or not. The police will follow their own procedures informing ategi of progress through updates.

11.5 Managers, staff and Shared Lives Carers must not confront the alleged abuser or investigate the matter themselves.

11.6 Managers, staff and Shared Lives Carers are reminded that all safeguarding records are official documents and important to the process of safeguarding and protecting people. This means they must be completed in full, clearly and stored securely. They will be made available to the defence if legal proceedings are taken.

11.7 Any physical evidence must be preserved e.g., clothing worn, bedding etc. The victim should not take a bath or shower until forensic medical examinations have been concluded.

- **Do not contaminate evidence.**
- **Do not inform alleged abuser of reporting.**
- **Do not inform alleged abusers of retained evidence.**

11.8 Where the alleged perpetrator is another Service User, equal consideration will need to be given to each person's needs. In instances of criminal abuse, the police will need to take into account the individual's abilities and understanding during any interview. An 'appropriate adult' should be present.

11.9 It is important to take these steps without undue delay and consideration must always be given to the victims' feelings with every effort being made to explain any action you propose taking.

11.10 No member of staff or Shared Lives Carer should assume that someone else will pass on information which they think may be critical to the safety and wellbeing of the adult. If you have a concern about an adult's welfare and believe they are suffering or likely to suffer abuse or neglect, then you should share the information with your DDSL or Named Designated Safeguarding Lead. They will notify the local authority and or, the police if they believe or suspect that a crime has been committed.

11.11 **Upon receipt of the Safeguarding Concern Form (within 24hrs of the concern or disclosure), the Deputy Designated Safeguarding Lead will:**

i. Consider the concern or disclosure and clarify any details.

ii. Consider the capacity and consent of the person at risk of abuse or neglect, if they are capable of making informed choices, they will respect any decision not to precede with a complaint unless it is in the best interest of the alleged victim or other members of the public.

iii. Consider the disclosure in the context of abuse and existing procedures.

iv. Under no circumstances should the Deputy Designated Safeguarding Lead investigate the disclosure. However, they may make some discrete enquiries to establish the credibility of the disclosure e.g., if it is alleged that a purse is stolen it would be appropriate to make tentative enquiries to make sure the purse has not been mislaid. They should consider such action carefully and if necessary, seek advice from the police.

v. Ensure that all relevant facts and decisions made in respect of the safeguarding concern or disclosure are accurately recorded including a body map form to record any physical injuries that may be present. The forms and any other records must be sufficient, accurate, prompt, concise, legible, dated, timed,

signed and factual. Where opinion or hypothesis is important, they must be clearly distinguished between facts. These forms once completed facilitate the strategy discussion or meeting process.

vi. In all instances of abuse refer the concern/incident to the relevant Social Services Department Safeguarding Manager within 24hrs or one clear working day of the concern being raised. This should be done directly in person by telephone and/or in accordance with the local multi-agency safeguarding referral form. If the concern involves more than one person at risk of abuse or neglect, a separate referral form will need to be completed for each person.

vii. A copy of the safeguarding concern form and the local authority referral form must be sent to the Named DSL.

11.12 Where a trustee or member of staff is suspected of abuse or inappropriate care, the Deputy Designated Safeguarding Lead in conjunction with the Named DSL and the Head of HR and OD must consider whether there is a need to take immediate action against the alleged perpetrator. This may involve suspending the staff member from duty pending a formal investigation. When taking such action, it is important to realise that taking this action is necessary to protect the interest of both parties involved.

11.13 Where a Shared Lives Carer is suspected of abuse or inappropriate care, the Deputy Designated Safeguarding Lead in conjunction with the Shared Lives Scheme Manager must consider whether there is a need to take immediate management action against the alleged perpetrator. This may involve suspending a shared lives arrangement or advising alternative support pending a formal investigation. When taking such action, it is important to realise that taking this action is necessary to protect the interest of both parties involved.

11.14 A summary flowchart of the procedure to follow where you have a safeguarding concern refer to Appendix B, together with guidance on Preserving Evidence following a Safeguarding Concern refer to Appendix C.

12. Statutory Social Services Safeguarding Procedures

12.1 The Care Act 2014 (Section 42) and the Social Services and Well-being (Wales) Act 2014 (Section 126 (2)) requires a local authority to make statutory enquiries, or cause others to do so, where it has reasonable cause to suspect that an adult:

i. has needs for care and support
ii. is experiencing, or at risk of, abuse or neglect
iii. as a result of their care and support needs is unable to protect themselves

12.2 The purpose of these statutory enquiries is to
i. make (or cause to be made) whatever enquiries are necessary
ii. decide whether action is necessary and if so, what and by whom

12.3 The relevant local authority is responsible for this legal decision as to whether or not to carry out a statutory (s42 or s126 (2)) enquiry. It works alongside individuals, partner organisations and agencies in gathering information connected with the enquiry to support that decision and in carrying out the enquiry process.

12.4 In broad terms, statutory safeguarding enquiries have three phases:
i. **Screening:** to check general factual accuracy of any referral.
ii. **Initial Evaluation:** collecting, reviewing and collating information.
iii. **Determination:** given the outcome of the screening & initial evaluation what, if anything, should be done? This may include initiating a single or multi-agency investigation.

12.5 When carrying out screening and initial evaluations, social services staff should also be mindful that abusers may use *"coercive controlling behaviour [and] can manipulate professionals by scene-setting or getting into character before the professional arrives which portrays them to be a caring person, reinforcing the victim's fear that they will not be believed."*

12.6 If it is determined at an early stage that an adult is not an 'adult at risk', the enquiries should end. However, the person may need to be signposted to other agencies or services if appropriate or may require an assessment, (section 19 or 24 of the Social Services and Well-being (Wales) Act 2014 or Sections 24 and 25 of the Care Act 2014). This requires the local authority to provide information, advice and assistance services to help all people access relevant, accurate and timely advice and assistance about ways to meet their care and support needs to achieve their personal well-being outcomes.

12.7 All relevant partners and agencies MUST share information in accordance with the Data Protection Act 2018 and the Wales Accord on the Sharing of Personal Information (WASPI), unless to do so would be unlawful.

12.8 The designated Safeguarding Lead Manager in Social Services will decide whether to hold a strategy discussion/meeting.

12.9 Service providers are not automatically invited to a strategy discussion/meeting. Where ategi is invited, this will usually be the Head of Quality Assurance and Safeguarding and the DDSL from the relevant service area.

12.10 It will be at the strategy meeting that the decision on how the incident will be investigated will be made. This may be one or more of the following:

- Police investigation
- CIW (Care Inspectorate Wales)
- CQC (Care Quality Commission)
- Local Authority, or
- ategi internal investigation

Whichever investigation route is determined, ategi will cooperate, and, where appropriate, will work jointly to investigate.

12.11 Any employment investigation and actions by ategi will be concluded after the investigations outlined above in 11.10.

12.12 Where there is insufficient evidence for the Police to investigate the allegation will still be considered at the strategy discussion/meeting.

12.13 The strategy discussion/meeting may decide for ategi to conduct an internal investigation. In this case the Head of Quality Assurance and Safeguarding together with the CEO will appoint an 'investigating officer.'

12.14 It is the responsibility of ategi as the employer or provider agency to decide if a member of staff or Shared Lives Carer should be suspended or subject to other management action.

12.15 An investigation in this context usually has four elements:

i. to establish the facts about the incident/s where abuse is alleged or suspected
ii. to assess the care and support needs of the person
iii. to determine who is responsible/ culpable and what action is recommended in relation to them
iv. to review the management of the service and make recommendations for improvement.

12.16 The 'investigating officer' will present a written report to the Head of Operations who must discuss with the Head of Quality Assurance and Compliance and the CEO who will discuss the recommendations with the Quality Committee.

Follow up from a Strategy Discussion/Meeting

12.17 Where the strategy discussion/meeting concludes that no further action is needed, the person at risk of abuse of neglect and/or the referrer should be informed.

12.18 There are a number of possible outcomes that may result from a strategy discussion/meeting and these depend on the nature and circumstances of the disclosure. There may be more than one strategy discussion/meeting and therefore this stage could take anything from a week to several weeks, depending on the outcome of certain investigations.

12.19 Strategy discussion/meeting outcomes may include:

- no further action to be taken
- a protection action plan be implemented to safeguard or reduce the risk to the victim or other persons at risk of abuse or neglect
- police investigation
- an adult protection Case Conference may be called so that the circumstances of the case can be formally reviewed and further action taken if necessary
- a non-criminal internal investigation by; Social Services, Health, CIW, CQC or the service provider (ategi)

12.20 ategi representatives may be invited to attend all or part of the strategy discussion/meeting. In some circumstances we will not be invited and a separate meeting will be arranged.

Adult Protection and Support Orders (Wales)

12.21 The Social Services and Well-being (Wales) Act 2014, Section 127 provides for Adult Protection and Support Orders (APSOs), the purpose of which is to:

- enable the authorised officer, and any other person accompanying the officer, to speak in private with a person suspected of being an adult at risk
- enable the authorised officer to ascertain whether that person is making decisions freely; and
- enable the authorised officer properly to assess whether the person is an adult at risk and to make a decision as required by section 126(2) of the Social Services and Well-being (Wales) Act 2014 on what, if any, action should be taken.

12.22 APSOs can be made by a justice of the peace if satisfied that:

- the authorised officer has reasonable cause to suspect that a person is an adult at risk
- it is necessary for the authorised officer to gain access to the person in order properly to assess whether the person is an

adult at risk and to make a decision on what, if any, action should be taken
- making an order is necessary in order to fulfil the purposes set out in section 127(2); and
- exercising the power of entry conferred by the order will not result in the person being at greater risk of abuse or neglect.

12.23 APSOs are designed to enable vulnerable adults to express their views independently to an authorised officer where there is reason to believe they are at risk of abuse or neglect. However, an APSO may not be appropriate if:
- the granting of an APSO might leave the individual at greater risk
- other less interventionist approaches have not been considered; and
- the use of a Domestic Violence Protection Order1 where the wrong-doer may be removed from the property may provide better protection for the victim.

12.24 Consideration will be given to the need to inform other persons affected by the order, for example where there are shared living arrangements within a domestic setting such as supported accommodation.

12.25 Section 127(6)(b) of the Act states that an APSO may include a condition providing for the authorised officer to be accompanied by another specified person. The list below is not exhaustive (section 127(3) allows a constable to attend so they are not listed below as an accompanying person). Their inclusion in an agreed order does not necessarily mean that they must accompany the authorised officer on a visit.

Examples of such a person who might be included:
- the key worker (social worker or health care worker)
- domiciliary care worker
- advocate (statutory or non-statutory)
- family member or close friend
- best interest assessor
- general practitioner; or
- an approved mental health professional under the Mental Health Act 1983.

12.26 An authorised officer may request an ategi staff member, Shared Lives Carer or volunteer to accompany them as part of the APSO. Their role may vary but will include:
- to ensure that any interview with the person suspected of being at risk is conducted fairly

- to provide expert knowledge and experience on specific matters (e.g., capacity);
- to advocate on behalf of the person;
- to share their existing knowledge of the person;
- to build a rapport with the person;
- to allow the authorised officer to jointly investigate concerns with, for example, a key worker, a police officer, health professional or Office of the Public Guardian; and
- to assist communication with the adult (or any other member of the household), for example, an interpreter in British Sign Language, lip speaker, Makaton communicator, deaf-blind communications interpreter or a language interpreter.

12.27 Where an ategi staff member or Shared Lives Carer accompanies an authorised officer as part of the APSO, they will alert the DDSL and record the details of their role in the safeguarding records for the individual.

Assessment of a chid under the Children Act 1989

12.28 Following acceptance of a referral by the local authority children's social services, a social worker will lead a multi-agency assessment under Section 17 of the Act. Local authorities have a duty to ascertain the child's wishes and feelings and take account of them when planning the provision of services. Assessments should be carried out in a timely manner reflecting the needs of the individual child, as set out in the statutory guidance, Working Together to Safeguard Children, 2018.

12.29 Where information gathered during an assessment (which may be very brief) results in the social worker suspecting that the child is 'suffering or likely to suffer significant harm', the local authority should hold a strategy discussion to enable it to decide, with other agencies whether it must initiate enquiries under Section 47 of the Children Act 1989.

12.30 ategi staff members and Shared Lives Carers if requested to attend a multi-agency meeting or contribute to the statutory processes under Section 17 or Section 47, will do so and ensure information is recorded accurately and in a timely manner in the ategi safeguarding MIS.

13. Whistleblowing

13.1 The Public Interest Disclosure Act 1998 introduced protection for workers from reprisals for disclosing information in the public

interest. It emphasises the importance that the role 'whistle-blowing' can play in deterring and detecting malpractice and abuse of children and adults at risks.

13.2 ategi will promote practical arrangements for whistle-blowing to enable all trustees, managers, staff and Shared Lives Carers to voice their concerns, made in good faith, without fear of repercussion. Any person who uses the 'whistleblowing' procedure will be made aware that their employment rights are protected.

13.3 Managers, staff members and Shared Lives Carers will be supported in this individual responsibility to bring matters of concern to the attention of senior management and/or relevant external agencies. This is particularly important where the welfare and safety of children and adults is at risk.

13.4 ategi will:

- Ensure they have appropriate whistle-blowing policies in place
- Ensure that they have clear procedures for dealing with allegations against staff, Shared Lives Carers and volunteers.
- Encourage and support all trustees, managers, staff and Shared Lives Carers to report any behaviour by colleagues that raises concern regardless of source.

13.5 All Safeguarding concerns raised via the 'whistle-blowing' pathway must be referred to the Head of Operations, Head of Quality and Compliance and the Chief Executive Officer for consideration and assessment.
(See Staff Safe Practice Handbook for more information)

13.6 National Whistleblowing Helpline - the NHS whistle-blowing helpline was extended in 2012 to staff and employers in the social care sector. The helpline number is 08000 724 725 and further information can be found on the website.

14. Recruitment and Selection

14.1 The company is aware of its responsibility for ensuring that it carries out appropriate safer recruitment practices for all positions within the organisation. The Safeguarding Vulnerable Groups Act 2006 requires the ategi to carry out specific vetting checks (Enhanced DBS and Barred List Check were appropriate) and to verify references obtained for shortlisted candidates if they are to perform 'regulated activity'. i.e., work closely with adults at risk and/or children.

14.2 The recruitment and selection of all trustees, managers, staff and Shared Lives Carers will comply with current legislation and safeguarding guidance. This means that all new positions will clearly state in the vacancy advertisement and candidate information pack the need to undergo and clear an Enhanced DBS disclosure check as part of the pre-employment checks.

14.3 For further information on ategi's approach to safer recruitment and selection of trustees, managers, staff and Shared Lives Carers refer to the Safer Recruitment Policy and Procedures document.

15. Complaints

15.1 All complaints that are received about the conduct or behaviour of ategi's trustees, managers, staff or Shared Lives Carers will be dealt with according to the organisation's Complaints Policy and Procedure.

15.2 If a complaint is identified as a potential safeguarding concern, then the Safeguarding Policy and Procedures will be followed.

16. Monitoring and Quality Assurance

16.1 ategi is committed to striving for excellence in the provision of all its services. We do this by actively monitoring and reviewing the safeguarding systems in place. We use an electronic recording system to capture all relevant data that supports the evidencing and monitoring of compliance in safeguarding.

16.2 This mechanism is a crucial and integral part of the monitoring and quality assurance systems which contributes to the management and governance of safeguarding policies, procedures and practices.

16.3 It is the responsibility of the Quality Committee to:

- review the safeguarding policy and procedures annually to ensure they continue to reflect legislation and guidance and submit to the board of trustees for approval
- ensure all trustees, managers, staff and Shared Lives Carers confirm they have received, read, understand and agree to adhere to the safeguarding policy and procedures (Appendix E)

- oversee an effective system for safeguarding across ategi, with particular focus on: service user safety, staff safety and wider health & safety requirements
- oversee the effectiveness of the care practice and ensure ategi maintains compliance with the Care Quality Commission' and Care Inspectorate Wales' fundamental standards of quality & safety.

17. Linked ategi Policies and Procedures

17.1 This safeguarding policy and supporting procedures are linked to the following policies, procedures and documents and therefore staff should read this in conjunction:

- Code of Conduct
- Complaints Policy
- Lone Working Policy and Procedures
- Managing Safeguarding Allegations Policy
- Reflective Supervision
- Safer Practice Handbook
- Safer Recruitment Policy and Procedures
- Serious Incident Reporting Policy and Procedures
- Training and Development Policy
- Whistleblowing Policy

18. Underpinning Legislation and Guidance

- All Wales Child Protection Procedures, 2008
- Anti-Social Behaviour, Crime and Policing Act 2014
- Care Act 2014 – HM Government
- Care and Support - Statutory Guidance on Implementation of the Care Act 2014
- Children Act 1989
- Children Act 2004
- Children and Social Work Act 2017
- Counter-Terrorism and Security Act 2015
- Data Protection Act 2018
- Domestic Abuse (Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015
- Domestic Abuse Act 2021 and statutory guidance
- Equality Act 2010 and guidance
- Forced Marriage (Civil Protection) Act 2007

- Information Sharing – advice for practitioners 2018
- Mental Capacity Act- Code of Practice 2005
- Mental Capacity (Amendment) Act 2019 (LiPS)- delayed to 2021
- Mental Health Act 1983 as amended by Mental Health Act 2007 and Welsh Mental Health Act 1983: Code of Practice Revised 2016
- Modern Slavery Act 2015
- Safeguarding Vulnerable Groups Act 2006 (as amended by the Protection of Freedoms Act 2012)
- Safeguarding Vulnerable Groups Act 2006
- Sexual Offences Act 2003
- Social Services and Well-being (Wales) Act 2014 and Guidance Working Together to Safeguard People
- The United Nations Convention on the Rights of the Child 1991
- The United Nations Principles of Older Persons 1991
- The Voyeurism (Offences) Act 2019
- What to do if you're worried a child is being abused 2015
- Working Together to Safeguard Children - HM Government 2018

Appendix A:

ategi Safeguarding Concern Form

Name of Adult (or child)						
Address						
Contact Number						
Day/Date/Time				**D.O.B.**		
Name of staff member, Shared Lives Carer noting the concern	**Name**					
	Contact Details					
Service Area	**Shared Lives (Bucks)**		**Shared Lives (Haringey)**		**Shared Lives (South Glos)**	
	Shared Lives (Wales)		**Supported Living**		**Visiting Support**	

Please indicate the type of abuse suspected (please tick more than one if appropriate):			
Physical		**Financial/Material**	
Sexual		**Self-Neglect**	
Neglect/acts of omission		**Domestic Abuse**	
Emotional/ Psychological		**Modern Slavery**	
Discriminatory		**Organisational**	
Criminal Exploitation		**Child Sexual Exploitation**	
Location of the incident or event that is the subject of the concern:			
Details of the concern/incident - *Include clear and factual outline of the concern being raised with dates, times, people and places, and any witnesses where appropriate. (Please use additional sheets if required)*			

Where is the adult or child now in relation to the source of harm or alleged abuser?

In your opinion does the alleged abuser pose a risk of harm to others?	Yes	No
If yes, please describe the risk and names of others potentially at risk from this concern.		

In your opinion does the adult or child have any vulnerability or communication difficulties? *(i.e., a physical or mental impairment or illness - give details)*		
Is the adult or child aware that the concern is being reported? *If no why?*	Yes	No
Are you aware if a Safeguarding concern has been made about this person before?		
Yes	No	Not Known
Is the adult or child involved with any other agencies?		
Yes	No	Not Known
If YES provide details		
Have you completed a Body Chart? (Please tick and complete)	YES – attached	No – why?

This form once completed should be emailed directly to your

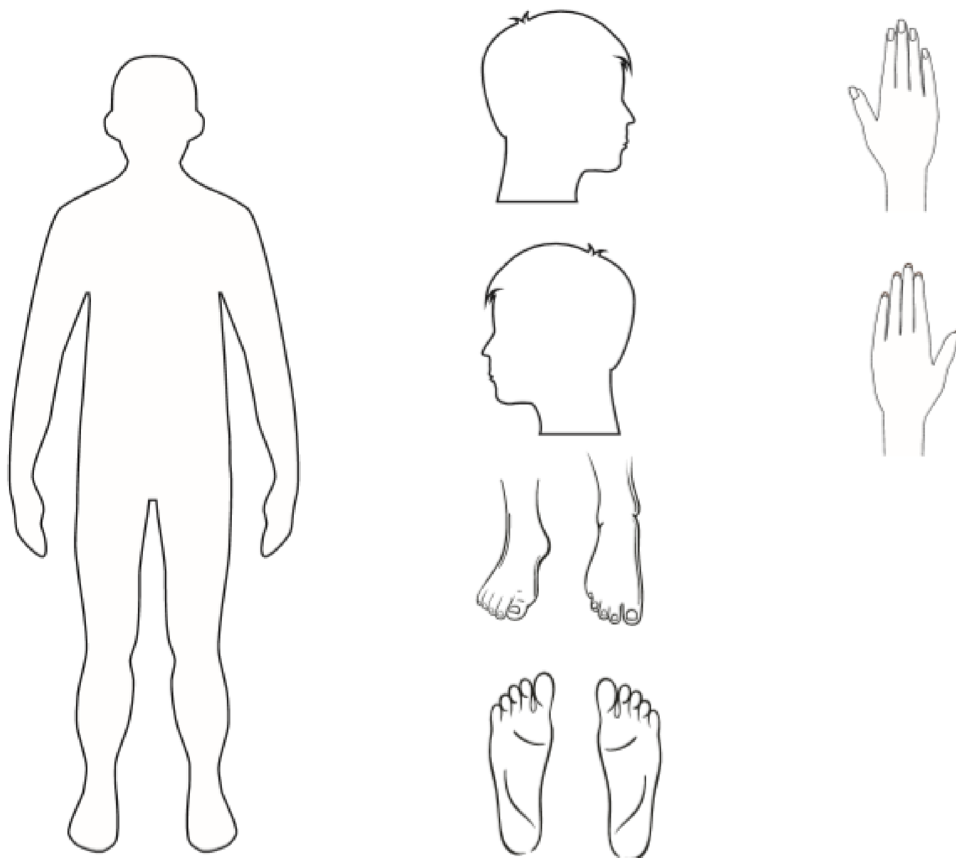
Deputy Designated Safeguarding Lead in your Service Area, following which you should confirm with them that they have received it.

Actions Taken by Deputy Designated Safeguarding Lead			
Date	**Person taking action**	**Action taken**	**Signature**

Safeguarding Concern Form - Body Chart

Name of adult (or child):	**Day/Date/Time**
Name of person completing form	**Service Area**

This chart must be sued together with the Safeguarding Concern Form
You should show clearly the located of your concern and label with a number and a brief description e.g., "1. Burn about 4cm" on the Safeguarding Concern Form refer to the injury using the same number and description.



Notes

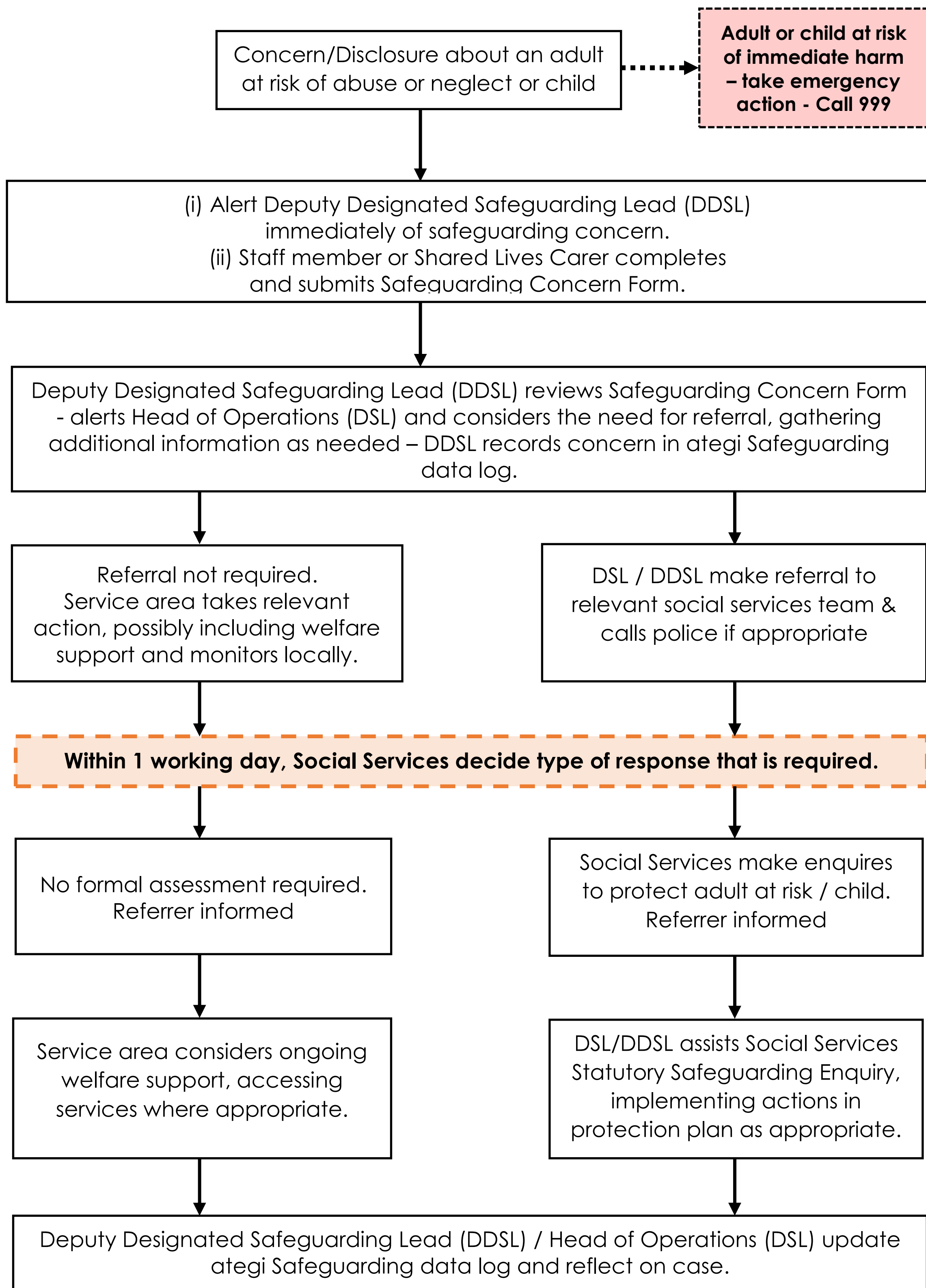
Guidance on completing the ategi Safeguarding Concern Form

It is important that this Safeguarding Concern Form and accompanying Body Map is fully completed in a timely manner.
The details are important and in order to help the Deputy Designated Safeguarding Lead in your Service Area respond and refer appropriately you should follow the guidance below.

- Enter all the admin details including date of birth (this will be asked for when a safeguarding referral is made to either Social Services or the police)
- Include full names (not initials)
- Make sure the concern is given in detail using the words of the adult or child who the concern is about
- Don't report what other people have told you – they must write their own Safeguarding Concern Form
- Only write about one adult or child on each form
- Remember that concern forms may be used in court cases and inquests as primary documents – so they must be complete, legible and accurate
- Make sure you use the ategi Safeguarding Concern Form to record your concern. Do not use any other forms or simply a piece of paper. Writing on other forms can cause confusion and errors
- If you jotted your notes down on a piece of paper whilst talking with the adult or child or immediately afterwards, you should attach these to the completed form
- If you cannot access a copy of the Safeguarding Concern Form then contact your Deputy Designated Safeguarding Lead or the Head of Quality and Safeguarding soon as you are able to who will supply the form for you
- Once completed the Safeguarding Concern Form should be emailed to safeguarding@ategi.co.uk
- Please alert your Deputy Designated Safeguarding Lead to the safeguarding concerns as soon as possible. It can take several hours to deal with even urgent concerns and the earlier we start the better
- Finally, ensure you sign, date and time the form.

Appendix B

ategi - How to respond to a Safeguarding Concern or Disclosure Flowchart


Concern/Disclosure about an adult at risk of abuse or neglect or child
Adult or child at risk of immediate harm – take emergency action - Call 999
(i) Alert Deputy Designated Safeguarding Lead (DDSL) immediately of safeguarding concern.
(ii) Staff member or Shared Lives Carer completes and submits Safeguarding Concern Form.
Deputy Designated Safeguarding Lead (DDSL) reviews Safeguarding Concern Form - alerts Head of Operations (DSL) and considers the need for referral, gathering additional information as needed – DDSL records concern in ategi Safeguarding data log.
Referral not required. Service area takes relevant action, possibly including welfare support and monitors locally.
DSL / DDSL make referral to relevant social services team & calls police if appropriate
Within 1 working day, Social Services decide type of response that is required.
No formal assessment required. Referrer informed
Social Services make enquires to protect adult at risk / child. Referrer informed
Service area considers ongoing welfare support, accessing services where appropriate.
DSL/DDSL assists Social Services Statutory Safeguarding Enquiry, implementing actions in protection plan as appropriate.
Deputy Designated Safeguarding Lead (DDSL) / Head of Operations (DSL) update ategi Safeguarding data log and reflect on case.

ategi Named Designated and Deputy Designated Safeguarding Leads

Role	Name	Telephone	Email
DSL – Head of Operations			
DDSL – Head of Quality and Compliance			
DDSL – Shared Lives – Bucks			
DDSL – Shared Lives – Haringey			
DDSL – Shared Lives – South Glos			
DDSL – Shared Lives – Wales			
DDSL – Supported Living			
DDSL – Visiting Support			

Information Sharing to Safeguard Adults at Risk and Children

Appendix C

Preserving Evidence following a Safeguarding Concern or Disclosure

- Your first concern is the safety and welfare of the abused person.

01

REMEMBER GDPR & DATA PROTECTION ACT 2018 and human rights law are not barriers to justified information sharing, but provide a framework to ensure personal information about living individuals is shared appropriately.

02

BE OPEN AND HONEST with the individual (and/or their family were appropriate) from the outset about why, what, how, and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

03

SEEK ADVICE from the DDSL/DSL, your line manager or governance lead, if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.

04

SHARE INFORMATION WITH CONSENT WHERE POSSIBLE, and respect where possible the wishes of those who do no consent to having their information shared. You may share information without consent if, in your judgement, there is a lawful basis to do so, such as a safeguarding concern. Base your judgement on the facts of the case.
When sharing or requesting information from someone, be clear of the basis you are doing so. Be mindful an individual might not expect information to be shared.

05

CONSIDER SAFETY AND WELL-BEING: base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions.

06

NECESSARY, PROPORTIONATE, RELEVANT, ADEQUATE, ACCURATE, TIMELY AND SECURE: ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those who need to have it, is accurate and up-to-date, shared in a timely manner and securely.

07

KEEP A RECORD of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose. If you decide not to share, record your reason why.

However, your efforts to preserve evidence may be vital.

- When Police involvement is required, they are likely to be on the scene quickly. Preservation of evidence is crucial if the Police investigation is to be effective.
- What you **DO OR NOT DO** in the time whilst you are waiting for the Police to arrive may make all the difference.

The following checklist aims to help you to ensure that vital evidence is not destroyed. **In situations of physical and/or sexual assault:**

a) If the abused client has a physical injury and it is appropriate for you to examine, always obtain their (or parent's) consent first.
b) Do not touch what you do not have to. Wherever possible leave things as they are. Do not clean up, do not wash anything or in any way remove fibres, blood etc. If you do have to handle anything at the scene keep this to a minimum.
c) Do not touch weapons unless they are handed directly to you. If this happens, as before, keep handling to a minimum. Place the items/weapons in a clean, dry paper bag.
d) Preserve the abused client's clothing and footwear, do not wash or wipe them. Handle them as little as possible.
e) Preserve anything that was used to comfort the abused person, for example, a blanket.
f) Secure the room, do not allow anyone to enter unless strictly necessary to support you or the abused client and/or the alleged perpetrator, until the Police arrive.

Following allegations of physical and/or sexual assault, consideration will be given to organising a medical examination of the abused person and the alleged perpetrator.

The decision to carry out an examination will be taken during strategy discussion/meeting. Any examination will be carried out by a Forensic Medical Examiner who will be contacted by the Police.

If a medical examination is required:

a) Ensure that no one has physical contact with **both** the abused person and the alleged perpetrator as cross-contamination can destroy evidence. You may have to comfort both the abused person and the alleged perpetrator, e.g., if the alleged perpetrator is a person we support. You need to be aware that cross-contamination can easily occur.
b) Where appropriate, protect bedding avoid washing.
c) Preserve any bloodied items.
d) Preserve any used condoms.

Methods of preservation:

a) For most things use clean brown paper, if available, or a clean brown paper bag or a clean envelope. If you use an envelope do not lick it to seal.
b) For liquids use clean glassware.
c) Do not handle items unless necessary to move and make safe.

It is acknowledged that completion of all of the above tasks may not be possible in a traumatic situation - you are urged to do the best that you can.

Appendix D

Safeguarding Adults that are particularly vulnerable

All trustees, managers, staff and Shared Lives Carers should be aware that 'vulnerability' and 'risk of harm' is increased when other factors are present in abuse cases. Additional safeguarding and protection may be needed for adult at risks when one or more of these factors are involved.

The following check list should be used by trustees, managers, staff and Shared Lives Carers to assess risks and check care plans to inform immediate actions that may be required to promote the welfare and safeguard the adult at risk.

- Lack of capacity to make decisions
- Abuse by partner/family member – power relationship
- Abuse by carer – power relationship
- Repeat incidents
- Alcohol and/or Substance dependence/misuse
- Dominant Race/culture issues
- Dependence on one person for care
- Isolation or withdrawal from services or support networks
- Low self esteem
- Mental illness/confusion
- Lack of capacity/dementia
- Intimidation/threats/harassment
- Physical disability/lack of mobility
- Decreased ability to communicate
- People employing their own personal assistants- no CRB checks needed
- Unsafe environments

All references to risk assessments and the identification of any factors that increase risks should be recorded alongside safeguarding concerns and the information made available to statutory services at time of referral.

Adults with Mental Health or Learning Disabilities

Autism

Autism is experienced differently by individuals, but there are three areas of difficulty which are commonly used to describe the condition, and are also used in the criteria when diagnosing autism. These are known as the 'triad of impairments'. While people may experience different degrees of impairment for each part of the triad, people with autism experience the following:

- difficulties with social interaction – finding it hard to understand, communicate and recognise how other people are feeling.

- difficulties with social communication – struggling with verbal and non-verbal language
- difficulties with social imagination – finding it hard to imagine what others are thinking or alternatives to their own routines.

As a result, people with autism typically struggle with the rules of social engagement, such as when to speak, when to laugh and when to empathise. While many people with autism have good language skills, others will speak little or not at all, though this does not mean they cannot communicate in other ways. Autistic people typically prefer communication to be simple and clear.

Many autistic people also have the following.

- Sensory sensitivity – over- or under-sensitivity to things such as light, sound, touch and heat, or certain tastes, textures or smells.
- Problems with motor skills, proprioception or balance.
- A need for structure – imposing their own routines in order to help make sense of the world and alleviate anxiety; such routines can sometimes become obsessive behaviours and rituals.
- narrow interests – a very close interest in a particular topic or pastime, often becoming extremely knowledgeable in it.
- A focus on detail – this is also a strength which can enable high levels of achievement in certain fields. However, it can also inhibit understanding of the 'bigger picture' in relationships and contexts.
- Mild difficulties in one area of the triad and severe difficulties in another.
- Skills and needs that fluctuate from day to day and moment to moment.
- Learned strategies which mask their difficulties, or carers who help to mediate difficulties so well that they are not initially apparent to a professional assessing them.

It is important to note that impairment in the area of 'social imagination' does not mean that people with autism lack imagination and creative talent. The spectrum nature of the condition and the idiosyncrasy of some people's needs mean it is imperative that service providers and practitioners do not over-generalise (SCIE)

Some people with autism are able to live relatively independent lives but others may need a lifetime of specialist support. People with autism may also experience some form of sensory sensitivity or under-sensitivity, for example to sounds touch, tastes, smells, light or colours.

Asperger syndrome is a form of autism. People with Asperger syndrome are often of average or above average intelligence and generally have fewer problems with speech than other people on the spectrum. This can make them more vulnerable as while they might appear very able, this appearance can conceal their level of social naivety.

ategi recognises that adults with mental health or learning disabilities such as autism and Asperger syndrome can be extremely vulnerable both within a service setting and within the community.

As outlined above, as a result of their difficulties with social imagination, people with autism are often unable to properly interpret other people's intentions. They can take written and spoken words to be literal truth without discriminating or probing further and taken advantage of as a result. It should also be highlighted that an adult with autism can be very isolated as a result of their condition, leaving them more open to abuse. Three-quarters of adults with autism either do not have any friends or find it hard or very hard to make friends. Fifty-six per cent have been bullied or harassed as adults.

All service users with autism should be entitled to a person-centred plan. This will ensure not only that they are better understood by staff, Shared Lives Carers, volunteers and social workers, but also that they are supported to develop their own skills to keep healthy and safe.

For more information go to: http://www.autism.org.uk/

Adults with Serious Health Problems- (End of Life issues)

Whatever the diagnosis, people in later life should have access to high quality palliative care services (including pain management) which supports physical, psychological and spiritual needs, respects personal choice (including where advance directives are made) and maintains dignity.

This may include the practical and emotional support to die at home, whenever that is an individual's preference should adopt a palliative care approach; this should be integrated with curative treatment and care where appropriate. It should also consider the support of spiritual care so that spiritual needs at the end of life can be built into all aspects of care.

People approaching the end of their life are a very special group of clients. They can be of any age, from any background, and have one or more of a variety of illnesses. Adults who have an advanced or progressive illness such as those listed below may eventually come to the end of life as a direct result of one or more of these illnesses:

- advanced cancer
- heart failure
- chronic obstructive pulmonary disease
- stroke
- multiple sclerosis
- motor neurone disease
- Parkinson's disease

- Huntington’s chorea
- any end stage organ failure; or
- dementia

Everyone affected by a life-threatening illness is entitled to receive the best care towards the end of their life. This approach may enable some people to choose to stay at home, enable family and friends providing the caring to be supported right through the illness and into the future when they are bereaved, enable care services involved to be highly responsive to changing needs, and make sure dignity is maintained at all times.

Adults with Dementia

The term 'dementia' is used to describe the symptoms that occur when the brain is affected by specific diseases and conditions. Symptoms of dementia include loss of memory, confusion and problems with speech and understanding. The most common cause of dementia is Alzheimer’s disease where the chemistry and structure of the brain changes, leading to the death of brain cells.

ategi acknowledges that a person with dementia is still a unique and valuable human being, despite their illness. It is very important that all staff treat people with dementia with respect to help the person to feel valued so they feel good about themselves. When a person with dementia finds that their mental abilities are declining, they often feel vulnerable and in need of reassurance and support. Health care staff together with family and friends need to do everything they can to help the person to retain their sense of identity and feelings of self-worth.

ategi staff, Shared Lives Carers or volunteers should ensure that anyone involved in the caring of a person with dementia has as much background information as possible, as well as information about the current situation. This information should be sought from the client and family during the first contact with details recorded on the client’s individual record.

A clear plan will assist in helping staff to:

- Avoid activities or situations in which the person is more likely than not to fail, as this can be humiliating. Simple, enjoyable and manageable tasks are key
- Split activities into small steps so the completion of a part of a task feels like a sense of achievement
- Encourage self-respect and pride in their appearance, and compliment them on how they look.
- Try not to correct what the person says to you. Value the importance of any communication and what a person is saying rather than its accuracy.

For more information go to: http://www.alzheimers.org.uk/

Adults with a Drug or Alcohol Dependency

Substance misuse and abuse for adult at risks can mean many things. It includes the use of drugs that can change your mood, such as alcohol, tranquilizers, or illegal drugs. Substance misuse also includes "risky drinking" or unsafe use of medications. Any substance misuse or abuse can cause serious health problems and problems with family and friends, money, and the law.

Risky drinking is when someone drinks alcohol in ways that may not have caused problems yet, but may cause problems if the same drinking pattern is kept up. For some people, this can mean drinking more than the recommended amounts. For some older adults with certain health problems or who take certain medications, this can mean drinking any alcohol.

Drinking alcohol or using medications unsafely can make many physical and mental health problems worse. Some of the physical conditions that are made worse by drinking alcohol are liver disease, cardiovascular disease, diabetes, ulcers and other gastrointestinal problems, and sleep problems. Alcohol can also make it harder for doctors to correctly diagnosis some medical conditions as well as slowing the healing process from injuries.

Some mental health conditions can place a person in greater danger of developing problems with alcohol or other drugs. Some of these include depression, memory or thinking problems, and anxiety. For example, an older person who is depressed may start to drink more, which makes the depression get worse and increases the risk of developing a serious problem with alcohol. Alcohol can make the symptoms of dementia, such as memory loss or trouble concentrating, get worse.

Some dementia type illnesses are caused by alcohol dependency (e.g., Korsakoff's syndrome) where the symptoms include memory loss, invented memories, and loss of interest. Warning Signs of Alcohol or Medication-Related Problems

- Anxiousness or irritability (feeling worried or "crabby")
- Memory loss (trouble remembering things)
- New problems making decisions
- Difficulty concentrating or paying attention
- Lack of interest in usual activities
- Sadness or depression
- Mood swings (happy one minute, sad or angry the next)
- Chronic pain (pain that doesn't go away)
- Problems with money or the police
- Falls, bruises, burns

- Incontinence (can’t control urinating, wetting the bed)
- Headaches
- Dizziness
- Poor hygiene (not combing hair, bathing)
- Poor nutrition, changes in eating habits (eating junk food only)
- Out of touch with family and friends
- Suicidal thoughts (wanting to kill yourself)
- Strange response to medication

Managers should also seek advice from the relevant medical professional if they have any such concerns about a service user or the Head of HR and OD in the case of an ategi Charity staff member, Shared Lives Carer or volunteer.

For more information go to: http://www.addaction.org.uk/

Adults who Self-Neglect

Helping those who neglect themselves can prove an impossible task even for experienced social workers let alone ategi staff, Shared Lives Carers or volunteers. It is important for staff, Shared Lives Carers or volunteers to explore the immediacy of serious harm in these cases, e.g., a diabetic saying that they are going to stop taking their insulin. Professional medical advice may be required in some cases to assist in this assessment.

Managing the balance between protecting an adult at risk from self-neglect against their right to determine their own fate is a serious challenge for public services. It may be that some adults at risks are unable to understand or agree to help because they lack capacity to make this decision.

When a member of staff, Shared Lives Carer or volunteer identifies that an adult at risk has been subject to:

- serious self-neglect which could result in ‘serious or significant harm’

and

- the adult at risk has capacity to make relevant decisions but has refused essential help without which their health and safety needs cannot be met

and

- the care management process / care plan approach has not been able to mitigate the risk of this ‘serious self -neglect that could result in significant harm’

then you should report such concerns to your Deputy Designated Safeguarding Lead using the ategi Safeguarding Form.

The Deputy Designated Safeguarding lead for your service area will liaise with the relevant local adult Social Services Safeguarding Team by telephone in the first instance followed up in writing using the Local Authority Safeguarding Concern Referral Form.
(See Appendix C for details of the Mental Capacity Best Interest Decision Making Assessment)

Appendix E

Best Interest Decision Making Assessment'

The Mental Capacity Act 2005 and Code of Practice provides a statutory framework to empower and protect people who may lack capacity to make decisions for them self and establishes a framework for making decisions on their behalf. This applies whether the decisions are life-changing events or everyday matters. All decisions taken in the Safeguarding Adults process must comply with the Act.

The Act says that:
… a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or disturbance in the functioning of the mind or brain. Further, a person is not able to make a decision if they are unable to:

- understand the information relevant to the decision or
- retain that information long enough for them to make the decision or
- use or weigh that information as part of the process of making the decision or
- communicate their decision (whether by talking, using sign language or by any other means such as muscle movements, blinking an eye or squeezing a hand).

Mental capacity is time-and decision-specific. This means that a person may be able to make some decisions but not others at a particular point in time. For example, a person may have the capacity to consent to simple medical examination but not to major surgery. Their ability to make a decision may also fluctuate over time.

Principles of the Mental Capacity Act 2005

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

Ill treatment and wilful neglect – Criminal Offence

An allegation of abuse or neglect of an adult at risk who does not have capacity to consent on issues about their own safety will always give rise

to action under the Safeguarding Adults process and subsequent decisions made in their best interests in line with the Mental Capacity Act 2005 and Mental Capacity Act Code of Practice as outlined above.

Section 44 of the Act makes it a specific criminal offence to wilfully ill-treat or neglect a person who lacks capacity. The offences can be committed by anyone responsible for that adult's care and support – paid staff but also family carers as well as people who have the legal authority to act on that adult's behalf (for example, persons with power of attorney or Court-appointed deputies).

These offences are punishable by fines or imprisonment. Ill-treatment covers both deliberate acts of ill-treatment and also those acts which are reckless which results in ill-treatment. Wilful neglect requires a serious departure from the required standards of treatment and usually means that a person has deliberately failed to carry out an act that they knew they were under a duty to perform.

Abuse by an attorney or deputy: If someone has concerns about the actions of an attorney acting under a registered enduring power of attorney (EPA) or lasting power of attorney (LPA), or a deputy appointed by the Court of Protection, they should contact the Office of the Public Guardian (OPG).

Further reading about the role and powers of the OPG and its policy in relation to adult safeguarding.

Capacity and Consent
It is always essential in safeguarding to consider whether the adult at risk is capable of giving informed consent. If they are, their consent should be sought. This may be in relation to whether they give consent to:

- an activity that may be abusive – if consent to abuse or neglect was given under duress, for example, as a result of exploitation, pressure, fear or intimidation, this apparent consent should be disregarded
- a Safeguarding Adults investigation going ahead in response to a concern that has been raised. Where an adult at risk with capacity has made a decision that they do not want action to be taken and there are no public interest or vital interest considerations, their wishes must be respected. The person must be given information and have the opportunity to consider all the risks and fully understand the likely consequences of that decision over the short and long term
- the recommendations of an individual protection plan being put in place
- a medical examination
- an interview
- certain decisions and actions taken during the Safeguarding Adults process with the person or with people who know about their abuse and its impact on the adult at risk.

If, after discussion with the adult at risk who has mental capacity, they refuse any intervention, their wishes will be respected unless:

1. there is a public interest, for example, not acting will put other adults or children at risk
2. there is a duty of care to intervene, for example, a crime has been or may be committed.

Testing Capacity
A single clear four-step test for determining whether a person lacks capacity has been introduced. Because the capacity of some adults may fluctuate and they may or may not be able to make a decision about how to pursue their safety at the time it is needed, the test must be applied in a way that is decision specific. It will help an independent expert or an identified staff member who makes a judgement about whether a person can make a particular decision at a particular time.

In the case of suspected or alleged abuse, ategi staff, Shared Lives Carers or volunteers will need to determine whether the person understands the nature of the concerns and choices facing them. Any issues of power imbalance in the relationship between them and the alleged perpetrator will need to be taken into consideration. The context for such professional decision making would ideally be the strategy discussion.

If every reasonable effort has been made to assist the adult's understanding of the situation and to enable them to communicate their wishes – which may involve commissioning the skills of an advocate or interpreter, and perhaps victim support – and there still is good reason to question the person's capacity or ability to give informed consent, then this test should be applied.

Lack of capacity may be temporary or permanent, and can fluctuate dependent on various things from time of the day or well-being. If a staff member suspects that an adult is:

- Getting upset and frustrated
- Acting out of character
- Changing behaviours/ appearance
- Getting confused
- Taking unusual amount of time to respond to questions

Then it may be that they need help to make a decision.

ANY ategi staff member, Shared Lives Carer or volunteer can assess capacity by using the' 2-part test' below and should also report the need for a capacity test to their line manager or DDSL.

Any consideration, actual testing or outcomes of a mental capacity test must be recorded on the individual service users record.

Anyone assessing someone's capacity in order to make a decision for another person should use the two-stage test of capacity.

Mental capacity is the ability to make a decision. Any assessment should be in two stages:
Part 1:

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?

Part 2 - Decision making assessment:

1. Does the person have a general understanding of what decision they need to make and why they need to make it?
2. Does the person have a general understanding of the likely consequences of making, or not making, this decision?
3. Is the person able to understand, retain, use and weigh up the information relevant to this decision?
4. Can the person communicate their decision (by talking, using sign language or any other means)? Would the services of a professional (such as a speech and language therapist) be helpful?

A lack of ability to communicate a decision (at no 4 above) on its own would not demonstrate a lack of capacity this lack of communication. This must be accompanied by either, 1, 2 or 3 above to confirm your assessment of a lack of capacity.

All decisions made on behalf of a service user who lacks capacity will be made in that person's **best interest**, using the common checklist of factors below. If a staff member makes a decision on behalf of a service user then this decision and any capacity test should be recorded on the individual client's record including particular reference to the Best Interest Check List below.

In making serious or complex decisions staff, Shared Lives Carers or volunteers should always seek help from a professional expert or Doctor and contact their DDSL for guidance and support.

Best Interests Check list

Factors to take into consideration when determining 'Best Interests' (Mental Capacity Act, 2005 Section 5; Code of Practice, 5.13)

1. Considering all relevant circumstances – these are circumstances of which the decision maker is aware and those which it is reasonable to regard as relevant.
2. Regaining capacity – can the decision be put off until the person regains capacity?
3. Permitting and encouraging participation – this may involve finding the appropriate means of communication or using other people to help the person participate in the decision-making process.
4. Special considerations for life-sustaining treatment – the person making the best interest decision must not be motivated by the desire to bring about a person's death.
5. Considering the person's wishes, feelings, beliefs and values – especially any written statements made by the person when they had capacity.
6. Taking into account the views of other people – take account of the views of family and informal carers and anyone with an interest in the person's welfare or appointed to act on the person's behalf.
7. Taking into account of the views of any independent mental capacity advocate (IMCA) or any attorney appointed by the person or deputy appointed by the Court of Protection.
8. Considering whether there is a less restrictive alternative or intervention that is in the person's best interests.

Advance Decisions

The Mental Capacity Act 2005 introduced new statutory rules with clear safeguards to enable people to make decisions in advance to refuse care or treatment should they lose capacity in the future. The Act does however stipulate that an advance decision will have no application to any treatment which a doctor considers necessary to sustain life, unless strict formalities have been complied with. Those formalities are that the decision must have been made in writing, and be signed and witnessed. In addition, it must include an express statement that the decision stands 'even if life is at risk'. It should be noted however, that the compulsory treatment provisions of the Mental Health Act 1983 (as amended by the 2007 Act) would override an advance decision which concerns treatment for mental disorder.

This new right impacts on safeguarding work, since any properly drawn-up advance decision may result in health care professionals especially, following a course of action that might in any other circumstances be misinterpreted as neglect or omission.

In all cases where an advance decision is in place, ategi staff, Shared Lives Carers or volunteers providing care and carrying out safeguarding work must seek advice from their line manager or DDSL.

Office of the Public Guardian (OPG)

The OPG was established under the Mental Capacity Act to support the Public Guardian and to protect people lacking capacity by:

- setting up and managing separate registers of lasting powers of attorney, of enduring powers of attorney and of court-appointed deputies
- supervising deputies
- sending Court of Protection visitors to visit people who lack capacity and also those for whom it has formal powers to act on their behalf
- receiving reports from attorneys acting under lasting powers of attorney and deputies
- providing reports to the Court of Protection
- dealing with complaints about the way in which attorneys or deputies carry out their duties.

The OPG also undertakes to notify local authorities, the police and other appropriate agencies when an abuse situation is identified. The OPG's Safeguarding Adult at risks Policy covers any person:

- who has a deputy appointed by the Court of Protection, or
- is the donor of a registered enduring power of attorney or lasting power of attorney, or
- is someone for whom the court authorised a person to carry out a transaction on their behalf under Section 16(2) of the Mental Capacity Act (single orders). This includes young people aged 16 or over who are defined as adults under the Mental Capacity Act.

Involvement

The OPG may be involved in Safeguarding Adult at risks in a number of ways, including: promoting and raising awareness of legal safeguards and remedies, for example, lasting powers of attorney and the services of the OPG and the Court of Protection

- receiving reports of abuse relating to adult at risks ('whistleblowing')
- responding to requests to search the register of deputies and attorneys (provided free of charge to local authorities and registered health bodies)
- investigating reported concerns, on behalf of the Public Guardian, about the actions of a deputy or registered attorney, or someone acting under a single order from the court
- working in partnership with other agencies, including adult care social services and the police.

Court of Protection

The Court of Protection deals with decisions and orders affecting people who lack capacity. The court can make major decisions about health and welfare, as well as property and financial affairs. The court has powers to:

- decide whether a person has capacity to make a particular decision for themselves

- make declarations, decisions or orders on financial and welfare matters affecting people who lack capacity to make such decisions
- appoint deputies to make decisions for people lacking capacity to make those decisions
- decide whether a lasting power of attorney or an enduring power of attorney is valid
- remove deputies or attorneys who fail to carry out their duties.

In most cases decisions about personal welfare will be able to be made legally without making an application to the court, as long as the decisions are made in accordance with the core principles set out in the Mental Capacity Act 2005 and the best interest's checklist and any disagreements can be resolved informally.

However, it may be necessary and desirable to make an application to the court in a safeguarding situation where there are:

- particularly difficult decisions to be made
- disagreements that cannot be resolved by any other means
- on-going decisions needed about the personal welfare of a person who lacks capacity to make such decisions for themselves
- matters relating to property and/or financial issues to be resolved
- serious healthcare and treatment decisions, for example, withdrawal of artificial nutrition or hydration
- concerns that a person should be moved from a place where they are believed to be at risk
- concerns or a desire to place restrictions on contact with named individuals because of risk or where proposed Safeguarding Adults actions may amount to a deprivation of liberty outside of a care home or hospital

Appendix F

ategi Policy Receipt Acknowledgement

By my signature below, I acknowledge that I have received, read, understand, and agree to adhere to the policies and procedures as listed below.

Those policies and procedures include:

Safeguarding Adults and Children at Risk Policy

Name	
Position	
Date	
Signature	