Safeguarding Adults Policy

Version	V6.3
Supersedes:	All previous versions
Date Ratified by Board:	November 2012 (original policy)
Reference Number:	PC24POL24
Title & Department of originator:	Quality & Patient Safety
Title of responsible committee/department:	Quality & Workforce Committee
Effective Date:	September 2019
Next Review date:	September 2022
Target audience:	All PC24 Personnel
Impact Assessment Date:	November 2012
Summary	To make all PC24 personnel aware of the procedure if they suspect any vulnerable adults that they come into contact with is being abused.

Version	Date	Control Reason	Title of Accountable Person for this Version
V3.0	Jan 2017	Review of policy. This policy supersedes previous versions.	Director of Nursing
V3.1	Feb 2018	This policy supersedes previous versions. Page 4, policy will be reviewed is 3 years, not 2. Page 8, TNA updated.	Director of Nursing

V3.2	Mar 2018	Information added for Sefton primary care staff	Director of Nursing
V4.0	Nov 2018	Information added for St Helens Extended Access services	Director of Nursing
V5.0	August 2019	Re formatting and movement some sections for ease of use. Section 9.9.4 information added regarding coding and submission of FGM data to the DOH	Safeguarding Medical Lead Safeguarding Medical Lead
V6.0	March 2020	Addition of 9.10 and updated training in 19.2	
V6.1	September 2020	Addition of Warrington CCG Safeguarding referral information.	Deputy Director of Nursing
V6.2	March 2021	Review of Safeguarding information to new CCG areas and updates to Clinical Leads in Appendix 3.	Deputy Director of Nursing
V6.3	June 2021	Update to Appendix 3, best practice processes and addition of 6.5.	Safeguarding Clinical Lead

Reference Documents	**Electronic Locations (Controlled Copy)**	**Location for Hard Copies**
See Section 19	Primary Care 24 Intranet / Policies/Governance Risk/ Policies	**Policy File, Wavertree Headquarters**

Consultation: Committees / Groups / Individual	**Date**
Associate Director of Nursing, Director of Nursing, Quality Governance Group, Quality and Workforce Committee	**Sept 2019**

PRIMARY CARE 24
SAFEGUARDING ADULTS POLICY

	Adult – Referral form to complete	Adults - Referral	Adults - Out of Hours Advice
Liverpool (Careline)	No form available	0151 233 3800	0151 233 3800
Sefton, Southport and Formby (MASH)	No form available	0345 140 0845	Monday to Thursday after 5.30pm, Friday after 4pm, weekends: Emergency Duty Team 0151 934 3555
St Helens (First Response Team)	No form available	01744 676767	0345 050 0148
Halton (Social Care)	https://halton.me/safeguarding-adults-alert-form/	0151 907 8306	Monday to Thursday after 5pm Friday after 4:30pm Weekends: Emergency Duty Team 0345 0500 148
Knowsley (MASH)	https://forms.knowsley.gov.uk/AdultSafeguarding	0151 443 2600	0151 443 2600
Warrington Adult Social Care	No form available	01925 443322	01925 444400

Please discuss any queries with your Manager or contact the PC24 Quality & Patient Safety Team on 0151 254 2553. For queries during the out of hours period please contact the Shift Manager on 0151 221 5837. A clinician is expected to draw on safeguarding training and clinical judgement, or contact social care directly, if only non-clinical support is available.

In the event of any changes to relevant legislation or statutory procedures this policy will be automatically updated to ensure compliancy without consultation. Such

changes will be communicated.

CONTENTS

1.1. PURPOSE

1.1 This Policy aims to make all personnel aware of the procedure if they suspect any Vulnerable Adults that they come into contact with have been or are being abused.

1.2 Primary Care 24 (PC24) is committed to a best practice which safeguards Vulnerable Adults irrespective of their background and which recognises that an adult may be abused regardless of their age, gender, religious beliefs, racial origin or ethnic identity, culture, class, disability or sexual orientation.

1.3 The first priority should always be to ensure the safety and protection of Vulnerable Adults. To this end it requires all personnel, to recognise and take responsibility to act on any suspicion of abuse or neglect and to pass on their concerns to a responsible person / agency.

1.4 PC24 is committed to implementing this policy; the protocols it sets out for all employees, and will provide in-house learning opportunities and make provision for appropriate Vulnerable Adults training to all employees. This policy will be made accessible to employees via the PC24 intranet and reviewed no later than 3 years from date of ratification.

1.5 It addresses the responsibilities of all employees. It is the role of the Safeguarding Lead to brief the personnel on their responsibilities under the policy. Failure to adhere to this policy could lead to dismissal or constitute gross misconduct.

1.6 To achieve safe practice, all personnel need to be able to:

- Describe their role and responsibility
- Describe acceptable behaviour
- Recognise signs of abuse
- Ensure PC24 systems work well to minimise missing vital information or delay in communication
- Describe what to do if worried about an adult
- Respond appropriately to concerns or disclosures of abuse
- Minimise any potential risks to vulnerable adults

1.7 Safeguarding Vulnerable Adults is a fundamental goal for PC24. This policy has taken into account legislative and government guidance requirements and other internal policies and CCG Local Safeguarding Adult Frameworks.

2.0 SCOPE OF THE POLICY

This policy applies to all PC24 personnel, including temporary and agency staff.

3.0 RAISING CONCERNS – Primary Care 24 AND OUT OF HOURS

3.1 During office hours, if you require additional support or advice on whether to make a referral regarding a Vulnerable Adult, you should discuss initially with your manager. If they are unavailable, or more support is required, please contact the Quality and Patient Safety Team on 0151 254 2553. This team may then involve the Director of Nursing (Safeguarding Lead) to support you with this decision making process.

3.2 During Out of Hours, if an individual identifies a safeguarding concern and would like to discuss this, the Shift Manager on duty should be contacted (0151 221 5837). The call will then be directed to the Manager or Director on call for advice and support when:

- Personnel are concerned regarding a Vulnerable Adult in the community setting and they need to discuss any issues or general concerns regarding that adult.
- Problems relating to treatment that makes the individual additionally vulnerable.
- Where there is a potential for other people to be at risk, due to the concern you may have, it is important to discuss the matter with the appropriate person. This will allow a rapid appraisal of the situation to be made, as other agencies and Safeguarding leads may need to be contacted.
- If the member of personnel is unsure whether to make a Safeguarding referral.
- Concerns are regarding a PC24 member of personnel.

3.3 If a clinician has identified a safeguarding concern, and there are no managers or directors with a clinical background available, then the clinician is expected to draw on their own safeguarding training and use clinical judgement to determine if social care should be contacted (for advice or for a referral). If there is any doubt, taking steps towards a referral is recommended. If a clinician is not sure which local authority they are working in, they should refer to Appendix 3.

3.4 If a referral is the preferred outcome, the referrer is expected to use reasonable effort to discuss this with the vulnerable adult. Concerns should be shared with, and explained to, the vulnerable adult, and the vulnerable adult's consent to make a referral to social care should be sought. These discussions should not take place if the staff member's personal safety may be compromised.

3.5 Where there are concerns about a vulnerable adult's capacity to consent, lack of consent (for someone with capacity), or it is not possible to discuss with the vulnerable adult at all, this should be clearly documented in the patient's notes. Any discussion that has resulted in an agreement and consent from the patient should also be documented. If a staff member's personal safety may be compromised by documenting in patient-held notes, then documenting on PC24 records will suffice.

3.6 A flowchart of best practice including assessing capacity and seeking consent can be found in appendix 4 and 5. There are occasions when acting in a patient's best interest

(when there is no capacity) or acting without consent is acceptable. This should be clearly documented, and if required, discussed with appropriate members of PC24 team.

3.7 If a safeguarding concern is identified, the identifying individual is responsible for completing the referral. A clinical concern should never be delegated to a non-clinician to complete the referral.

3.8 Where a Safeguarding referral has been made by a member of PC24 ensure you report the incident on the Datix Risk Management System that same day. This is appropriate to delegate to another member of the team. The Head of Service information can be found in Appendix 3.

3.9 Upon receipt of the Datix, the patient's usual GP practice will be informed of the safeguarding referral made by PC24 via letter.

3.10 In exceptional circumstances, if you feel your position may be compromised, you may wish to remain anonymous, however please inform your relevant Liverpool Careline, Knowsley Access Team and Halton, St Helens Clinical Adult social care that you are happy for the investigating social worker to contact you for clarity of information if required.

3.11 Best Practice as outlined above can be found in Appendix 6.

4.0 IF THE INCIDENT IS A CRIME

If the incident is a crime or you consider that an adult is at immediate risk you must contact Merseyside Police by dialling **999** (non-emergency **101).**

4.1 Making a Hate Crime referral

Hate Crime should be reported to Merseyside Police on 101 or 999 if there is immediate danger. In addition where the individual may need additional support or services the Safeguarding referral process should be applied. A referral should be made to the Local Authority for an assessment.

5.0 REFERRAL PROCESS

5.1 Social Services are the statutory body for investigating all referrals.

5.2 See below chart for information on referral pathways

	Adult – Referral form to complete	Adults - Referral	Adults - Out of Hours Advice
Liverpool (Careline)	No form available	0151 233 3800	0151 233 3800
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Sefton – Staff working within the **Sefton GP practices** must follow the South Sefton Clinical Commissioning Group Safeguarding Children & Adults at risk Policy, found at: http://nww.southseftonccg.nhs.uk/Library/CCG_&_locality/Policies/South%20Sefton%20Safeguarding%20Policy%20V8.pdf

St Helens - Staff working in St Helens must follow the St Helens Council guidance for Safeguarding Adults: found at: https://www.sthelens.gov.uk/social-care-health/adults/safeguarding-adults/

5.3. If you have any problems making a referral contact your line manager or the Safeguarding Lead. Out of hours, contact the PC24 Shift Manager or PC24 Director on call when out of hours) for any support or assistance.

6.0 DESCRIPTION OF INVESTIGATION PROCESS – GP OOH AND URGENT CARE

- When a referral has been received by the accepting point (Liverpool Careline, Knowsley Access Team, and Halton Adult social care) it is sent to the appropriate area team for Liverpool, Knowsley and Halton Council.
- Referrals will also be screened by the Local Authority.

6.1 The referrer should receive confirmation from the Local Authority to acknowledge receipt of the referral. After the initial referral, the member of personnel may be involved in the subsequent stages of a Safeguarding Adults Enquiry. The extent of involvement will depend on a number of things, including:

- Role and responsibilities.
- Involvement in reporting the incident or concern.
- Relationship with the alleged victim(s).
- Relationship with the person who is alleged to have committed the abuse.

- The Local Authority will then co-ordinate the investigation depending on the nature of the referral and whether there are patterns arising from the same establishments.
- A strategy meeting may be called to plan the investigation.
- Personnel may be required to attend the strategy meeting as part of the multi-disciplinary team involved.
- In cases where the individual has not attended a strategy meeting before or feel they require support, the Safeguarding Lead will attend to support the individual through this process. If the Safeguarding Lead is not available to attend then a Clinical representative will attend the meeting.

6.2 All reports of suspected abuse will be investigated by Social Services and/or the Police. In some cases an investigation may be passed back by Social Services to the organisation where the incident occurred. The outcomes of any investigation will be shared with Social Services with an action plan formulated as required.

6.3 What happens after the report is made depends on:

- The nature and seriousness of the alleged abuse.
- The general circumstances of the alleged abuse and its implications.
- The alleged victims' circumstances and their relationship to the person who is alleged to have abused them.
- The number of people and agencies involved.
- The alleged victims' mental capacity.

6.4 On completion of the investigation the referrer may receive a letter to inform them that the investigation has concluded. The details of the case or information regarding whether the concerns or allegations are substantiated will not be given to the referrer. Any information received that shows the Safeguarding allegations were unsubstantiated should be documented in the patient's records to ensure a complete

record. Where there are 'patient held' records, if the original allegation was documented and if it remains safe to do so, the information regarding the allegation being unsubstantiated should also be documented.

6.5 **Safeguarding Adult Review** (SAR)

The Care Act 2014 states that Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult.

PC24 is committed to engaging with this process and will consider cases we become aware of for referral. Staff continue to be encouraged to log all safeguarding concerns on Datix and the Safeguarding Team will consider those that may need referral to a SAR.

The referral form can be accessed on the Merseyside Safeguarding Adults Board website (www.merseysidesafeguardingadultsboard.co.uk) recognizing that it is important to involve the person, family and/or friends in the SAR process. More information can be found on the website.

7.0 ALLEGATION AGAINST MEMBERS OF PERSONNEL

7.1 Where an allegation of abuse has been made regarding a PC24 member of personnel, the incident policy should be followed and a referral made to the Local Authority Designed Officer.

7.2 For complaints relating to a patient's treatment by a PC24 personnel, refer to the Primary Care 24 Complaints Policy on the intranet.

8.0 RECORDING THE INCIDENT

8.1 Where there are allegations or reports of abuse you must record what was said by the person who disclosed the information as soon as possible after the event. Ensure you keep a record of the incident using the PC24 Datix Risk Management system. Record:

- What was said?
- What was seen?
- Who you contacted?
- Actions taken.
- Rationale for decision making.

What not to do:

- **Do not** question the person about the incident.

- **Do not** ask the person questions relating to the incident such as Who, What, Why, Where or When.
- **Do not** promise to keep secrets.
- **Do not** make promises you cannot keep.
- **Do not** contact the alleged abuser.
- **Do not** be judgemental.
- **Do not** gossip about the incident.
- **Do not** touch or move anything in the room.

8.2 **The 'One Chance Rule'**

The primary concern is for the safety of the victim. Staff may only get one chance to talk to the victim (eg due to the nature of forced marriage). Staff should consider the following:

What to do:

- Ensure the victim is seen in a safe and private place.
- See the victim on their own, if an interpreter is required take steps to ensure the interpreter is not connected with the individual or the community.
- Risk assess and discuss a safety plan.
- If the victim is under 18 years old refer to Child Safeguarding procedures.
- If the victim is over 18 years old refer to Adult Safeguarding procedures.
- Establish a safe way of contacting the victim, document any information given in relation to perpetrators, potential/immediate risks and any current contacts with agencies.
- Consider the need for immediate protection and placement away from the family.

What not to do:

- Attempt to mediate.

9.0 GOOD PRACTICE SPECIFIC TO SEFTON PRACTICES

A safeguarding poster will be displayed in all rooms, clinical and administration, to make it clear who is the practice safeguarding lead (appendix 7)

9.1 Domestic Abuse

- All administration staff should respond to concerns that a patient may be a victim of domestic abuse by discussing this with the practice safeguarding lead, another clinician or the practice manager.
- Clinical staff should exercise professional curiosity and include questions about domestic abuse during consultations.
- Those who have been victims of domestic abuse should have this coded on their problem list, even if the relationship has now ended. Those who have had

previous relationships where domestic abuse has featured, are at risk of developing new relationships with domestic abuse.

- All clinicians should feel empowered to ask an accompanying partner/friend/relative to leave the consultation to give the opportunity for the clinician to consult their patient alone. It is good practice to always check who is with the patient, recording their presence in the notes, and their name.
- An alert may be appropriate to prompt future clinicians to the history of domestic abuse. A subtle message (e.g. 'consider seeing this patient alone' with a reference to the date that domestic abuse is coded in the problem list) is more appropriate than an alert about domestic abuse that an accompanying person may read.
- Contact details for clinicians supporting someone in a domestic abuse scenario can be found in appendix 2.

9.2 Deprivation of Liberty (DOLs)/Community Treatment Orders (CTOs)

- These should be coded on the problem list.
- If a member of the administration team is responsible for letters and coding, or new registrations, they should be aware that these legal orders should be brought to the attention of the practice safeguarding lead or the practice manager.
- The practice manager or practice safeguarding lead should keep a record of those with Deprivation of Liberty safeguards, and those on Community Treatment Orders. This list should be reviewed periodically and the notes of these individuals should also be reviewed. If there is any cause for concern, or there has been a long period of time without review, consider contacting the individuals and offering a review.

9.3 Adults with learning difficulties

- All adults with learning difficulties should have this coded on their records, which enters them onto a register to be offered an annual health review. This may be appropriately completed by a member of the nursing team.
- The main carers and the next of kin details may be appropriate to record in the records. If applicable, consent to record this information should be sought from the individual.
- When an individual presents with a carer or relative, the name of the accompanying person should be recorded in the notes.
- Appendix 4 & 5 may help with issues of consent or capacity.

9.4 Female Genital Mutilation (FGM)

- If a female discloses that she has had FGM in the past, this should be coded.
- If the patient is still under 18, the clinician is obligated to inform the police, even if the FGM occurred many years earlier, or in another country. Further information about this mandatory reporting can be found in gov.uk literature online.

- The practice should report via Datix whenever an individual reports a background of FGM. PC24 wil submit data about patients with FGM to the Department of Health via a Clinical Audit Platform every quarter.

9.5 Dementia

- Efforts should be made to discuss end of life care, opinions on resuscitation and seek consent to discuss care with a named individual, while the patient retains capacity. Ideally these conversations should happen in the presence of family, friends or carers to smooth the path for later conversations towards the end of life.
- Where consent is given to discuss care with a named individual, an alert should be added with the contact details of this individual.
- Appendix 4 & 5 may help with issues of consent or capacity.

9.6 Mental health

- The practice will have a system in place to identify prescriptions that have not been collected. If there are concerns about any of the individuals who have not collected prescriptions, these must be brought to the attention of the safeguarding lead.
- Admissions to psychiatric wards must be coded individually, rather than grouped together under diagnosis.

9.7 Working with those who do not speak English

- An independent translator should always be offered.
- If a patient chooses to use a family member or friend, this is at the discretion of the GP, based on their relationship with the patient and their family, and only if the medical questioning will not cause embarrassment or non-disclosure of symptoms, and if there is no question of domestic abuse, or traditional malpractice. A child under 18 should never be used to translate for a family member.
- When an individual who does not speak English approaches reception, including to register with the practice, the administration team must make every effort to communicate effectively, including offering the use of language line by a receptionist.

9.8 Carers

- A practice will code those who act as carers for family and friends, and record this on their problem list. This will prompt clinicians to consider additional health and social needs they may have as carers, including in the context of urgent/emergency health care needs.
- Individual practices need to consider how to support and improve the experience of carers as they access health care for themselves and the individual they care for.

9.9 Self Neglect

- Relationship building is the cornerstone of working with those who appear to be neglecting aspects of their own self-care.
- Clinicians should expect to persist and commit to shared goals made with the individual and should refer to the Self Neglect guidance found through the following link: www.merseysidesafeguardingadultsboard.co.uk/self-neglect-2/. A one page summary can be found in appendix 8.

9.10 Use of IMCAs (Independent Mental Capacity Advocates)

- Where an individual lacks capacity an IMCA may be required as a legal safeguard for specific important decisions; including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person in the decision-making process. Essentially they make sure that the Mental Capacity Act 2005 is being followed.
- IMCAs are required to produce a report for the person who instructed them. In most cases this should be provided to the decision maker before the decision is made. People who instruct IMCAs must pay attention to any issues raised by the IMCA in making their decision.
- Full documentation should be made in the patient's notes at every stage, including the final outcome of any best interest meeting.

10.0 GOOD PRACTICE SPECIFIC TO OOH/PCS/EXTENDED ACCESS/PATHFINDER ADVICE

10.1 Learning Disabilities

- The clinician is encouraged to consider capacity and consent for each aspect of the diagnosis, explanation and management plan, remembering that capacity can vary depending on the scenario.
- The adult may be encouraged to include a carer or family member in the consultation, and the name of an accompanying carer or relative should be recorded in the notes.
- Where there is concern for the individual, the clinician should refer to the flowcharts in the appendices 4 & 5, and if necessary seek further advice.
- The patient's usual GP should be informed of the contact.

10.2 Sensory impairment (deaf, blind, multiple impairments)

- When possible, clinicians should clarify with the patient how they would prefer to communicate. Exercising 'professional curiosity' to explore the individual's limitations should mitigate against misunderstanding.
- During urgent care appointments, when a British Sign Language translator is unlikely to be available quickly, it may be necessary to use a family member or friend to translate. This is firstly to triage the consultation to ensure patient safety. If the consultation is not an emergency (threat to life) and appears to have potential for embarrassment or partial information sharing is a concern,

the clinician should end the consultation and seek an alternative source of translation. A child should never be used to translate.

10.3 Non-English speakers

- An independent translator should always be offered. During urgent care appointments, this is likely to be via Language Line.
- When an individual contacts urgent care by phone, and telephone interpreting services are unavailable, it may be necessary to offer the patient an UCC appointment when this may not otherwise have been the triage outcome. This ensures independent translating via Language Line and a safer patient experience.

10.4 Homeless groups

- Those who are homeless and/or in addiction (prescribed or illegal) are more vulnerable to abuse from others, more likely to be victims of crime, and be more likely to have associated illnesses, disease or comorbidity.
- Careful consideration should be given to physical health, putting aside prejudice if they are frequent attenders of urgent care services, and treating the individual on their history for that presentation.
- Where there are no physical health needs, the clinician may wish to consider social signposting, and whether there are specific safeguarding concerns to discuss with the individual.

10.5 Those in addiction

- See section 10.4 for overlap
- The clinician should be aware of common drugs of abuse available on prescription. If a clinician is unsatisfied with a history following a request for medication, or if there is a special patient note from a patient's GP requesting that medication is not prescribed, then the request should be rejected.

10.6 End of Life

- PC24 is committed to a positive end of life experience for patients and their loved ones, and will respond in a timely manner to all requests for contact.
- If there is any evidence of neglect or abuse towards the palliative patient, the clinician is expected to respond to this as to any other vulnerable adult, including if the abuse has happened as a result of lack of awareness/education from the family, or through exhaustion from carers.
- The family should be involved in the decision to contact social services, and where possible, contact should be framed as a positive solution to the difficulties faced by the palliative patient.
- Recognition that emotions often run high during palliation, and this may be directed towards clinical staff, particularly if a referral to social care is required. The clinician should seek advice and support from service leads.

10.7 Mental illness

- Supporting those with mental illness during transient contact in urgent care scenarios is essentially about ensuring safety, and may also be about signposting.
- The clinician should refer to the capacity and consent flowcharts (appendices 4 & 5).

10.8 Self Neglect

- Relationship building is the cornerstone of working with those who appear to be neglecting aspects of their own self-care, even if meeting the individual for a very short amount of time.
- Clinicians should aim to negotiate 'quick wins' with an individual until able to hand over to the patient's usual GP.
- Clinicians should refer to the Self Neglect guidance found through the following link: www.merseysidesafeguardingadultsboard.co.uk/self-neglect-2/. A one page summary can be found in appendix 8.

11.0 GOOD PRACTICE SPECIFIC TO INTERMEDIATE CARE

11.1 Frailty

- A definition according to British Geriatrics Society: a state of increased vulnerability to poor resolution of homoeostasis after a stressor event. It is characterised by low energy, slow walking speed and reduced strength. It may be associated with physical or mental impairment, but can also be noted in the absence of any long term condition.
- Working within an MDT, PC24 are committed to identifying frailty, safeguarding vulnerability and co-ordinating ongoing care together.

12.0 GOOD PRACTICE SPECIFIC TO ASYLUM PRACTICE

12.1 Working with those who do not speak English

- See section 9.7
- Clinicians should be aware of the influence of traffickers in the lives of asylum seekers, and be very wary of using an accompanying adult to translate.

12.2 Female Genital Mutilation (FGM)

- See section 9.4

12.3 Mental Health

- If an individual's mental health is grounds for concern, recognising that asylum seekers are often isolated, permission will be sought to share information with the accommodation providers, particularly in the interests of safety (for themselves or others). The minimum amount of information will be shared. In these instances, the close relationship with the accommodation providers can often safeguard the individual, who has no other advocate.

12.4 Victims of modern slavery/trafficking/honour based violence/forced marriage/FGM

- If an individual discloses they remain at risk of any other above while living in initial accommodation, the Asylum Practice is committed to raising this with the accommodation providers to ensure that their safety is given a priority. The practice will advocate for the patient being moved accommodation as soon as possible, ideally that day.
- Any threat, or new disclosure of harm, will be taken seriously and the individual will be supported to contact the police, or put in touch with a support organisation that can help them access the police if needed.

12.5 MDT

- Individuals who are considered to be particularly vulnerable will be discussed as a team at the monthly MDT as part of the safeguarding standing agenda item.

13.0 DEFINITIONS OF ABUSE

13.1 For the purpose of this Policy the following definition of abuse applies.

Abuse is any behaviour towards a person that deliberately or unknowingly causes him or her harm, endangers their life or violates their rights. The term **harm** may become more commonly used than abuse.

13.2 **Definitions**

The following definitions have been agreed and adopted as workable definitions for use within PC24.

A **vulnerable adult** is any person aged 18 years or over who is or may be in need of health or social services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.

The term **'adult at risk'** may be used to replace 'vulnerable adult'. This is because the term 'adult at risk' focuses on the situation causing the risk rather than the characteristics of the adult concerned.

Mental Capacity is the ability to make a decision by understanding, retaining and weighing up the consequences of the decision, then effectively communicating this decision.

13.3 Abuse may be;

Physical: occurs when injuries are inflicted or the health/development of the person is severely impaired.

Neglect: can be physical e.g. lack of food or drink, and /or emotional e.g. restriction of movement by removal of mobility aids.

Sexual abuse: occurs when the person is involved in sexual activity to which they have not consented or, given their level of mental capacity, do not truly comprehend.

Psychological abuse: can involve intimidation, humiliation, threatening behaviour, causing fear.

Financial abuse: is common and takes many forms, the most frequent being when,

- someone who is supposed to be buying basic essentials is not doing so
- a vulnerable person is persuaded to withdraw savings

Spiritual abuse: inappropriate use of religious belief or practice through misuse of authority and repentance discipline, oppressive teaching, obtrusive healing/deliverance ministries. Includes the denial of rights to faith and religious practice.

Discriminatory abuse describes repeated, on-going or widespread discrimination which leads to,

- significant harm
- unequal health or social care
- breaches in civil liberties
- failure to protect

Institutional abuse happens when the routines, culture and practice of an institution or service provider force service users to sacrifice their own needs to that of the institution. This may include actions that fit in to several of the categories listed above but which take place as standard practice.

Hate Crime is any incident which may or may not constitute a criminal offence, which is perceived by the victim or other person as being motivated by prejudice or hate. The crime or incident may be targeted at someone or a family due to:

- Race
- Disability
- Gender
- Age
- Religion
- Sexual Orientation
- Transgender

Domestic abuse: Any of the above abuse, but taking place between current or ex-partners, or other family members, when both parties are over the age of 16. It includes partners of different or same gender, and between child and parent.

Forced Marriage

Forced marriage is a marriage conducted without the valid consent of one or both parties where some element of duress is a factor. Duress can include physical pressure, threatening behaviour, abduction or imprisonment, isolation, emotional, psychological, financial abuse and control. The United Nations views forced marriage as a form of Human Rights abuse. The practice of forced marriage is not confined to one culture or one religion and can happen regardless of race, religion, disability, age, sexuality and gender.

So Called Honour Based Violence (HBV)

So Called Honour Based Violence (HBV) is where the person is being punished by their family or their community. They are being punished because of a belief, actual or alleged, that a person has not been properly controlled enough to conformity and therefore is seen to have brought 'shame' and 'dishonour' on the family.

Carers: anyone, including children and adults, who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. Exhaustion, stress, frustration, and poor knowledge of needs, may lead to intentional or unintentional poor care. Domestic abuse may also feature from a vulnerable adult directed towards their carer.

13.4 An '**Alerter**' is anyone who suspects that a patient / service user or other vulnerable adult is being or has been abused, anyone who has concerns, hears an allegation or disclosure of any type.

For further guidance please refer to the independent Safeguarding authority, the link can be found by clicking below:
http://www.isa.homeoffice.gov.uk/Default.aspx?page=523

13.5 An individual, a group, or an organisation may perpetrate abuse**. Abuse** concerns the misuse of power, control and /or authority and can manifest itself as:

- Domestic violence, sexual assault or sexual harassment.
- Racially or religiously motivated assaults.
- Discrimination and oppression.
- Institutional abuse.

Those more at risk may fall into the following categories:

- Receives personal or nursing care/support to live independently in his or her home or care home.
- Receives any health or social services.
- Has a substantial learning, physical or communication difficulty or disability.

- Has a physical or mental illness, chronic or otherwise, including addiction to alcohol or drugs.
- A substantial reduction in physical or mental capacity due to advanced age or illness.

13.6 All employees within Primary Care 24 have a vital role in promoting the safety and protection of vulnerable adults.

14.0 CONFIDENTIALITY

14.1 It is PC24's Policy that all patients and members of PC24 personnel should be able to expect that information given to any member of staff within PC24 will be held in a secure and confidential manner and will not be divulged to others without their consent except in the following circumstances:

- It is with the consent of the individual.
- A Court Order.
- Necessary in the public interest including the protection of a child or other vulnerable adult.
- Assuring and improving quality of care and treatment (e.g. clinical audit).
- Investigating complaints or potential legal claims.

14.2 Any member of personnel staff who is in doubt should consult their Head of Service or the Safeguarding Lead for their support and advice.

15.0 REQUEST FOR INFORMATION / RECORDS

15.1 When information or records are requested this request should be referred to the PC24 Company Secretary.

15.2 Records will be released only when third party information has been withdrawn from the records. In some cases it may be agreed that a summary report of healthcare input will be supplied to the relevant parties rather than the full records being released.

15.3 Requests for records should be made in writing and sent to the Company Secretary who has the PC24 responsibility for Information Governance. Where information is requested by another organisation via a telephone conversation, information should not be given until this has been discussed with the Director of Nursing or Medical Director and an assessment made of the most appropriate way in which to respond. For telephone conversations see the Primary Care 24 Confidentiality and Data Protection Policy (PC24POL1) located on the Intranet for further guidance.

15.4 If the patient's consent has not been obtained another valid reason for release should be provided i.e. a copy of a court order, or other legal justification for release. This should be discussed with the Company Secretary who has the PC24 responsibility for Information Governance, Senior Information Risk Officer (SIRO) and Safeguarding Lead (Director of Nursing) prior to release.

16.0 THE INVOLVEMENT OF STAFF FROM OTHER ORGANISATIONS

Where several organisations are involved with the individual, or a crime is suspected, the investigation will be multi-agency. An investigation and any Safeguarding Adult plan could involve Social Services, Police, Health Professionals, the Care Quality Commission and provider agencies (e.g. residential homes, supported housing, domiciliary care and day centres).

Other considerations:

Domestic Abuse

In addition to the individual who may disclose incidents of domestic abuse, staff should consider whether there are children or vulnerable adults that may require a safeguarding referral following an incident/report of domestic abuse.

17.0 IMPLEMENTATION OF THIS POLICY

17.1 This policy will be displayed on the staff intranet and promoted within PC24. New employees will be made aware of the policy on induction.

Clinical/Medical Leads will ensure that all healthcare professionals are aware of and how to access this policy.

17.2 Monitoring Compliance

The effectiveness of this policy must be routinely monitored to ensure that the objectives of the policy are met. Compliance and effectiveness of this policy will be monitored by a combination of:

- Monitoring against this policy via the Quality & Patient Safety department who will note and report the number of safeguarding incidents/complaints reported through the Datix Risk Management system.
- Service Delivery Units will be required to monitor local compliance against this policy at an operational level which includes reporting incidents through the Datix Risk Management System.
- Safeguarding mandatory training for all staff.
- Annual performance review of all staff.

17.3 Policy Review

This policy will be reviewed within 1 year of implementation and every 3 years

thereafter or sooner if there is a change in policy or organisational change.

17.4 Breaches of policy

This policy is mandatory. Where it is not possible to comply with the policy, or a decision is taken to depart from it, this must be notified to the PC24 Safeguarding Lead so that the level of risk can be assessed and an action plan can be formulated.

18.0 RESPONSIBILITIES

18.1 Board of Directors

Primary Care 24 Board is responsible for ensuring that the Primary Care 24 fulfils the requirements of adult safeguarding, safeguarding contracted standards and regulation standards via scrutiny of the assurance and performance reports submitted to the appropriate Board sub-Committees.

18.2 The Director of Nursing

The Director of Nursing acts as the Primary Care 24 Safeguarding Lead and is responsible for:

- Ensuring Safeguarding of Vulnerable adults activity and compliance is reported to PC24 Board via relevant Committees.
- Is responsible for ensuring Caldicott Principles are followed in relation to safeguarding and information sharing.
- Has overall responsibility for the content of all serious case review submissions in line with the local safeguarding adults board regulations (2006) where Primary Care 24 have been involved.
- Has strategic responsibility for safeguarding development within PC24
- Reporting to and advising the Executive Management Team and the Board on all matters relating to safeguarding
- Provision of specialist advice and support to staff in relation to adult safeguarding issues where possible and or direct to appropriate level of specialist safeguarding lead for advice
- Representing the PC24 at appropriate external safeguarding meetings.
- Board responsibility for safeguarding in PC24
- Responsibility for liaising with external stakeholders and the sharing of information where appropriate
- Responsibility for producing safeguarding reports for relevant committees and the PC24 Board
- Responsibility for the contributing to Serious Case review (SCR) and Domestic Homicide in partnership with Clinical Commissioning Safeguarding Leads
- Review Domestic homicide reports (DHR) and co-ordination of requests for information for legal cases
- Where required attend case conferences and court hearings on behalf of PC24
- Promote compliance with safeguarding policy and procedures

- Ensuring the process for Learning Lessons from Serious Case Reviews and other safeguarding related incidents becomes embedded within Safeguarding and Incident Learning Procedures
- Ensuring that PC24 has in place a process to provide support for staff who have been involved in safeguarding incidents.

18.3 Associate Directors, Heads of Service, Medical/Nursing Clinical Leads

- Ensure appropriate monitoring and reporting mechanisms are developed, reviewed and communicated to PC24 Executive Management Team.
- Responsibility for making appropriate recommendations to ensure that the Services remain compliant with safeguarding policy, procedure and practice
- Ensure the process for Learning Lessons from Serious Case Reviews and other safeguarding related incidents becomes embedded within the Directorates and Incident Learning Procedures.

18.4 All Personnel

PC24 personnel must take appropriate action if they suspect or know a vulnerable adult is being abused or is likely to come to significant harm.

It is a professional duty to refer concerns appropriately and failure to act on concerns is a breach of the Adult Safeguarding Policy and Procedures and could result in further harm or death to the patient. This is important even if other agencies are involved in the incident. The Police and other agencies are expected to raise their concerns separately.

- Personnel of PC24 are responsible for the safety and well-being of patients and have a duty of care for those patients who are less able to protect themselves from harm, abuse or neglect. This also includes 'avoidable harm' which may be caused to a patient for example through inappropriate positioning, moving or handling.
- It is the responsibility of all Primary Care 24 Personnel to be familiar with the Safeguarding Adults Policy and Procedures, and to implement them when abuse is known or suspected.

18**.5** Where there is disagreement between staff whether or not to refer, staff must be aware of their individual duty to protect vulnerable people and to make the referral. Junior staff may wish to discuss a difference of opinion with senior staff, or a Clinical Lead from the relevant Service.

18.6 Raising a Concern (Whistle Blowing):

Primary Care 24 recognises the importance of building a culture that allows all employees to feel comfortable about sharing information in confidence and with a lead person regarding concerns they have about a colleague's behaviour. This will also include behaviour that is not linked to abuse but that has pushed the boundaries beyond acceptable limits. Open honest working cultures where people feel they can

challenge unacceptable colleague behaviour and be supported in doing so, help keep everyone safe.

18**.7** Any queries on the application or interpretation of this Policy must be discussed with the author of this document prior to any action taking place.

19**.0 STAFF TRAINING**

19.1 Those working with adults must take part in clinical governance including holding regular case discussions, training, and education and learning opportunities. They include e-learning but also personal reflection and scenario based discussion, drawing on case studies and lessons from research, critical event analysis, analysis of feedback, complaints, which can be included in appraisal.

All personnel require adult safeguarding mandatory training as part of induction. This should then be renewed every three years.

19.2 Training Needs Analysis

	Requirements	**Delivery Method**	**Staff Group**	**Recording**	**Strategic & Operational Responsibility**
Safeguarding Adults Level 1	Minimum 2 hours over 3 years (Total combined with children = 4 hours in 3 years)	50% participatory (face to face training/group discussion) 50% non-participatory (e-learning)	Reception, admin, domestic staff, drivers	Training database	Director of Nursing and Executive Safeguarding Lead
Safeguarding Adults Level 2*	Minimum 4 hours over 3 years (Total combined with children = 8 hours in 3 years)	50% participatory (face to face training/group discussion) 50% non-participatory (e-learning)	Practice managers, reception managers, safeguarding administrators, healthcare assistants	Training database	Director of Nursing and Executive Safeguarding Lead
Safeguarding Adults Level 3*	Minimum 8 hours over 3 years (Total combined with children = 20	50% participatory (face to face training/group discussion) 50% non-participatory	GPs, Practice Nurses, ANPs, Clinical Pharmacists, GP registrars	Training database	Director of Nursing and Executive Safeguarding Lead

	hours in 3 years)	(e-learning)			

* This can be accessed via Protected Learning Time events held locally or delivered by CCGs.

19.3 Recruitment of Staff – Minimum Criteria

The minimum safety criteria for safe recruitment of all staff that work for PC24 are:

- have been interviewed
- have 2 references that have been followed up
- have DBS service check appropriate to role
- Satisfactory medical and health clearance

20.0 EQUALITIES & HEALTH INEQUALITIES

20.1 EQUALITY AND DIVERSITY

The population Primary Care 24 serves is diverse and includes areas of high deprivation. Children and adults from all cultures are subject to abuse and neglect. All children and adults have a right to grow up and live safe from harm. In order to make sensitive and informed professional judgments about the needs of children (including their parents' capacity to respond to those needs) and the needs of adults at risk, it is important that professionals are sensitive to differing family patterns and lifestyles that vary across different racial, ethnic and cultural groups. Professionals need to be aware of the broader social factors that serve to discriminate against black and minority ethnic populations. Working in a multi- cultural society requires professionals and organisations to be committed to equality in meeting the needs of all children and adults at risk and to understand the effects of harassment, discrimination or institutional racism, cultural misunderstandings or misinterpretation.

The assessment process should maintain a focus on the needs of the individual child or adult at risk. It should always include consideration of how the religious beliefs and cultural traditions influence values, attitudes and behaviours and the way in which family and community life is structured and organised. Cultural factors neither explain nor condone acts of omission or commission that place a child or adult at risk of significant harm. Professionals should be aware of and work with the strengths and support systems available within families, ethnic groups and communities, which can be built upon to help safeguard and promote their welfare. See Appendix 1.

20.2 EQUALITIES AND HEALTH INEQUALITIES STATEMENT

PC24 is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and

performance requirements and will mainstream equality and diversity principles through its policies, procedures and processes. This policy has been implemented with due regard to this commitment. To ensure that the implementation of this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact analysis conducted where necessary. PC24 will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

21.0 PERSONAL INFORMATION STATEMENT

PC24 is committed to an environment that protects personal information aspects in the development of any policy. When proposing change there is a new requirement for policy writers to investigate when the personal information aspect of the policy complies with the data protection principles in Schedule 1 of the Data Protection Act 1998. All individuals with responsibility for reviewing/writing policies should consider Privacy Impact Assessment compliance.

This policy complies with the Data Protection Act 1998, therefore no Privacy Impact Assessment is necessary.

22.0 RELATED GUIDANCE AND POLICIES

22.1 This Policy should be read in conjunction with the following PC24 policies:

- Training and Development Policy (PC24POL17)
- Primary Care 24 Confidentiality and Data Protection Policy (PC24POL1)
- Primary Care 24 Complaints Policy (PC24POL34)
- Primary Care 24 Disciplinary Policy, (PC24POL14)
- Primary Care 24 Policy for Managing Incidents & Serious Incidents (PC24POL32).

The following statutory, non-statutory, best practice guidance and the policies:

22.2 Statutory Guidance

- Department for Constitutional Affairs (2007) *Mental Capacity Act 2005: Code of Practice.* London: TSO.
- HM Government (2009) *The Right to Choose: multi-agency statutory guidance for dealing with forced marriage.* Forced Marriage Unit: London.
- Ministry of Justice (2008) *Deprivation of Liberty Safeguards Code of Practice to supplement Mental Capacity Act 2005.* London: TSO.
- Home Office (2015) Counter Terrorism and Security Act.
- Home Office (2015) Mandatory Reporting of female Genital Mutilation – procedural information.

22.3 Non-Statutory Guidance

- Department of Health (June 2012) *The Functions of Clinical Commissioning Groups* (updated to reflect the final Health and Social Care Act 2012).
- NICE (2014) Domestic violence and abuse: multi-agency working http://www.nice.org.uk/guidance/ph50

22.4 Best Practice Guidance

- Department of Health (2009) *Responding to domestic abuse: a handbook for health professionals*
- Ending violence against women and girls. March 2014. www.gov.uk/government/policies/ending-violence-against-women-and-girls-in-the-uk
- Department of Health (2010) *Clinical governance and adult safeguarding: an integrated approach.* Department of Health
- Department of Health (2006) *Mental Capacity Act Best Practice Tool.* Gateway reference: 6703

END OF POLICY

	Appendix 1 Equalities & Health Inequalities Screening
	Appendix 2 Domestic Abuse Contact Details
	Appendix 3 PC24 services
	Appendix 4 Consent
	Appendix 5 Determining Capacity
	Appendix 6 Best Practice
	Appendix 7 Example Safeguarding Poster
	Appendix 8 Self Neglect Summary
	Appendix 9 Knowsley Mental Health Contact Numbers

Appendix 1

Equalities and Health Inequalities – Screening Tool

Name of Policy: Safeguarding Adults Policy
Date of Ratification: February 2018

Introduction

The purpose of this Screening Tool is to help you decide whether or not you need to undertake an Equality and Health Inequalities Analysis (EHIA) for your project, policy or piece of work. It is your responsibility to take this decision once you have worked through the Screening Tool. Once completed, the Head of your SDU or the Quality & Patient Safety Team will need to sign off the Screening Tool and approve your decision i.e. to either undertake an EHIA or not to undertake an EHIA.

The Quality and Patient Safety Team can offer support where needed. It is advisable to contact us as early as possible so that we are aware of your project.

When completing the Screening Tool, consider the nine protected characteristics and how your work would benefit one or more of these groups. The nine protected characteristics are as follows:

1. Age
2. Disability
3. Gender reassignment
4. Marriage and civil partnership
5. Pregnancy and maternity
6. Race
7. Religion and belief
8. Sex
9. Sexual orientation

A number of groups of people who are not usually provided for by healthcare services and includes people who are homeless, rough sleepers, vulnerable migrants, sex workers, Gypsies and Travellers, Female Genital Mutilation (FGM), human trafficking and people in recovery. Primary Care 24 will also consider these groups when completing the Screening Tool:

The **guidance** which accompanies this tool will support you to ensure you are completing this document properly. It can be found at: http://extranet.Primarycare24.co.uk/

Equality and Health Inequalities: Screening Tool

A	General information
A1	Title: **Safeguarding Adults Policy** What is the title of the activity, project or programme?
A2.	What are the intended outcomes of this work? Please outline why this work is being undertaken and the objectives.

A3.	Who will be affected by this project, programme or work? Please identify whether the project will affect staff, patients, service users, partner organisations or others. **The purpose of this policy is to make all PC24 personnel aware of the procedure if they suspect any vulnerable adults that they come into contact with is being abused.**		
B	**The Public Sector Equality Duty**		
B1	Could the initiative help to reduce unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics (see above)?		
	Yes	No	Do not know
	Summary response and your reasons: **This is an organisational policy and the policy equally applies to all PC24 personnel**		
B2	Could the initiative undermine steps to reduce unlawful discrimination or prevent any other conduct prohibited by the Equality Act 2010? If yes, for which of the nine protected characteristics? If yes, for which of the nine protected characteristics?		
	Yes	**No**	Do not know
	Summary response and your reasons: **This is an organisational policy and the policy equally applies to all PC24 personnel**		
B3	Could the initiative help to advance equality of opportunity? If yes, for which of the nine protected characteristics?		
	Yes	No	Do not know
	Summary response and your reasons: **All nine characteristics as the policy equally applies to all PC24 personnel**		
B4	Could the initiative undermine the advancement of equality of opportunity? If yes, for which of the nine protected characteristics?		
	Yes	**No**	Do not know
	Summary response and your reasons: **This is an organisational policy and it equally applies to all PC24 personnel**		
B5	Could the initiative help to foster good relations between groups who share protected characteristics? If yes, for which of the nine protected characteristics?		
	Yes	No	Do not know

	Summary reasons: **This is an organisational policy and it equally applies to all PC24 personnel**		
B6	Could the initiative undermine the fostering of good relations between groups who share protected characteristics? If yes, for which of the nine protected characteristics?		
	Yes	**No**	Do not know
	Summary response and your reasons**:** **This is an organisational policy and it equally applies to all PC24 personnel**		
C	**The duty to have regard to reduce health inequalities**		
C1	Will the initiative contribute to the duties to reduce health inequalities?		
	Could the initiative reduce inequalities in access to health care for any groups which face health inequalities? If yes for which groups?		
	Yes	**No**	Do not know
	Summary response and your reasons: **This is an organisational policy and it equally applies to all PC24 personnel**		
C2	Could the initiative reduce inequalities in health outcomes for any groups which face health inequalities? If yes, for which groups?		
	Yes	**No**	Do not know
	Summary response and your reasons: **This is an organisational policy and it equally applies to all PC24 personnel**		
D	Will a full Equality and Health Inequalities Analysis (EHIA) be completed?		
D1	Will a full EHIA be completed? Bearing in mind your previous responses, have you decided that an EHIA should be completed? Please see notes. Please place an X below in the correct box below. Please then complete part E of this form.		
	Yes	Cannot decide	**No**
E	Action required and next steps		
E1	If a full EHIA is planned: Please state when the EHIA will be completed and by whom. Name: Date:		

E2	If no decision is possible at this stage: If it is not possible to state whether an EHIA will be completed, please summarise your reasons below and clearly state what additional information or work is required, when that work will be undertaken and when a decision about whether an EHIA will be completed will be made. Summary reasons: Additional information required: When will it be possible to make a decision about an EHIA?
E3	If no EHIA is recommended: If your recommendation or decision is that an EHIA is not required then please summarise the rationale for this decision below. Summary reasons: This policy has been consulted on by the Quality & Patient Safety Tem. There is no negative impact with respect to the characteristics as defined by the Equality Act.

F	*Record Keeping*		
Lead originator:	Director of Nursing	Date:	02.02.2018
Director signing off screening:	Director of Nursing	Date:	02.02.2018
Directorate:	Quality & Patient Safety	Date:	
Screening published:	Staff intranet	Date:	February 2018

Appendix 2

Domestic Violence and Abuse Support

Liverpool

LDAS (Liverpool Domestic Abuse Services)	0151 263 7474
SLDAS (South Liverpool Domestic Abuse Services)	0151 494 2222
The Ruby Project (hospital referral only - RLUBHT/UHA)	0151 286 6159
RASA (Rape & Sexual Abuse - current and historical sexual abuse)	0151 558 1801
Safe Place (Sexual Health Referral Centre)	0151 295 3550
WHISC (Women's Health Information and Support Centre Liverpool)	0151 707 1826
MDVS (Merseyside Domestic Abuse Services)	0151 709 8770

Sefton

SWACA (Sefton Women and Children's Aid)	0151 922 8606
RASA (Rape & Sexual Abuse - current and historical sexual abuse	0151 558 1801

Knowsley

The First Step (Knowsley Domestic Abuse Services)	0151 548 3333

Wirral

Wirral Family Safety Unit	0151 604 3567

St Helens

Helena - Refuge and Helpline	01925 220 541

Merseyside Helplines

Savera UK – (BAMER support for domestic abuse)	0800 107 0726 / 0151 709 6586
Worst Kept Secret	0800 028 3398

FOR PROFESSIONALS ONLY

IDVA (Independent Domestic Violence Advocate) 0151 330 2014, I@localsolutions.org.uk

MARAC Officers (Maria Curran & Jayne O'Toole) 0151 233 7013, marac@liverpool.gcsx.gov.uk

MASH (Multi Agency Safeguarding Hub) 0151 233 2320, Liverpool.mash@merseyside.pnn.police.uk

Refuge

To refer into refuge you ring housing options (Liverpool) or refuge directly

Liverpool

Housing Options (Careline)	0151 233 3000
North Liverpool refuge (Fae House)	0151 207 1511
South Liverpool refuge (Grace House)	0151 734 1074
Amadudu BME refuge Liverpool	0151 734 0083

Sefton	0151 922 8606
Knowsley	0151 546 1567
Wirral	0151 643 9766
St. Helens	01925 220541
National	0808 802 0300

National Support and information

National Domestic Violence Helpline 0808 2000 247, www.nationaldomesticviolencehelpline.org.uk

National Centre for Domestic Violence (Legal advice and support) 0800 970 2070, www.ncdv.org ,

Rights of Women (Legal advice for women on domestic & sexual violence) 020 7251 6577, www.rightsofwomen.org.uk

Mankind Initiative 01823 334244 (support for men suffering domestic abuse)

Respect 020 7549 0578 (men's helpline and perpetrator programme)

Stonewall 020 7593 1850 (LGBT information and advice line)

Imkaan 020 7842 8525 (black feminist organisation dedicated to addressing violence against women and girls)

February 2017

Appendix 3

PC24 Directory of Services

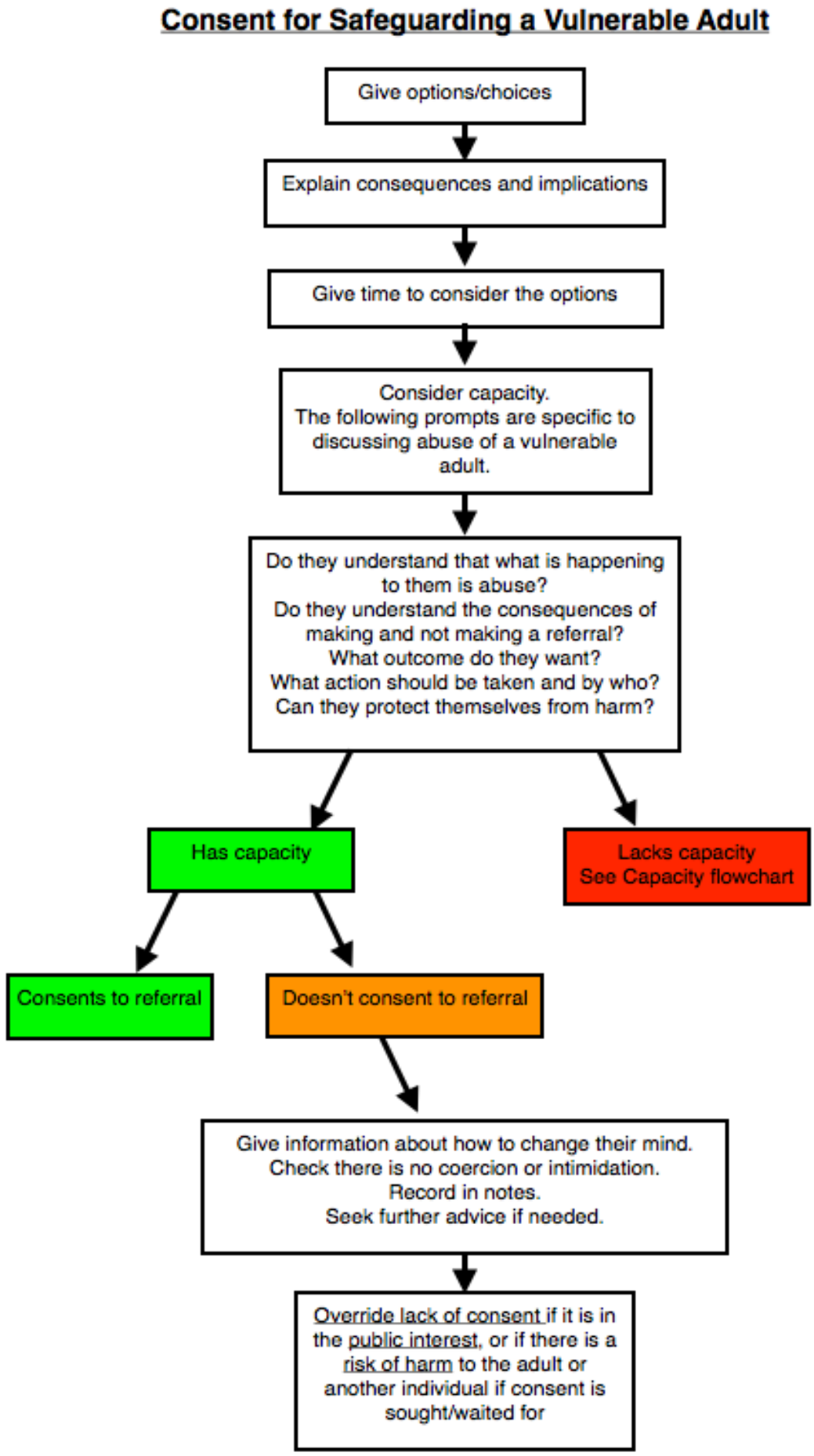
Location	Clinical Lead for Service	Service Manager	CCG Policy	Local Authority for Referral	PC24 Advice/ Support
Primary Care, Sefton GP					
Crossways, Waterloo	Dr Daniel Ellis	Claire Linnan	South Sefton CCG	Sefton Social Care	9-5 Director of Nursing, Paul Kavanagh-Fields 5-6:30 Shift Manager (call centre)
Crosby Village	Dr Daniel Ellis	Claire Linnan	South Sefton CCG	Sefton Social Care	9-5 Director of Nursing, Paul Kavanagh-Fields 5-6:30 Shift Manager (call centre)
Litherland Practice	Dr Daniel Ellis	Claire Linnan	South Sefton CCG	Sefton Social Care	9-5 Director of Nursing, Paul Kavanagh-Fields 5-6:30 Shift Manager (call centre)
Maghull Practice	Dr Daniel Ellis	Claire Linnan	South Sefton CCG	Sefton Social Care	9-5 Director of Nursing, Paul Kavanagh-Fields 5-6:30 Shift Manager (call centre)
Netherton Health Centre	Dr Daniel Ellis	Claire Linnan	South Sefton CCG	Sefton Social Care	9-5 Director of Nursing, Paul Kavanagh-Fields 5-6:30 Shift Manager (call centre)

Seaforth Village Practice	Dr Daniel Ellis	Claire Linnan	South Sefton CCG	Sefton Social Care	9-5 Director of Nursing, Paul Kavanagh-Fields 5-6:30 Shift Manager (call centre)
Thornton Practice	Dr Daniel Ellis	Claire Linnan	South Sefton CCG	Sefton Social Care	9-5 Director of Nursing, Paul Kavanagh-Fields 5-6:30 Shift Manager (call centre)
Intermediate Care					
Knowsley	Dr Tatiana Tchikhiaeva	Gemma Kearns	Knowsley CCG	Knowsley MASH	9-5 Mon-Fri Director of Nursing, Paul Kavanagh-Fields OOH Shift Manager (call centre)
Other					
Asylum Service	Dr Jon Reynolds	Julie Omar	NHSE	Liverpool Careline	9-5 Mon-Fri Director of Nursing, Paul Kavanagh-Fields
Out of Hours					
UCC Old Swan	Dr Jon Reynolds	Julie Omar	Liverpool CCG	Liverpool Careline	Shift Manager (call centre)
UCC Runcorn	Dr Sharmila Armitage	Dominique Fearis	Halton CCG	Halton Social Care	Shift Manager (call centre)
UCC RLUH	Dr Jon Reynolds	Julie Omar	Liverpool CCG	Liverpool Careline	Shift Manager (call centre)
UCC UHA	Dr Jon Reynolds	Julie Omar	Liverpool CCG	Liverpool Careline	Shift Manager (call centre)
UCC Huyton	Dr Tatiana Tchikhiaeva	Gemma Kearns	Knowsley CCG	Knowsley MASH	Shift Manager (call centre)
UCC Lowe House, St Helens	Dr Tatiana Tchikhiaeva	Gemma Kearns	St Helens CCG	St Helens First Response Team	Shift Manager (call centre)

UCC Bath Street	Dr Sharmila Armitage	Vicky Gorman	Warrington CCG	Warrington MASH	Shift Manager (call centre)
Out of Hours Triage (including NWAS Pathfinder) and Home Visits, as per address of patient					
Primary Care Streaming					
UHA	Dr Jon Reynolds	Julie Omar	Liverpool CCG	Liverpool Careline	10-5 Director of Nursing, Paul Kavanagh-Fields 5-7 Shift Manager (call centre)
RLUH	Dr Jon Reynolds	Julie Omar	Liverpool CCG	Liverpool Careline	11-5 Director of Nursing, Paul Kavanagh-Fields 5-7 Shift Manager (call centre)
GP Extended Access					
Childwall	Dr Jon Reynolds	Julie Omar	Liverpool CCG	Liverpool Careline	Shift Manager (call centre)
Townsend	Dr Jon Reynolds	Julie Omar	Liverpool CCG	Liverpool Careline	Shift Manager (call centre)
Abercromby	Dr Jon Reynolds	Julie Omar	Liverpool CCG	Liverpool Careline	Shift Manager (call centre)
Garston	Dr Jon Reynolds	Julie Omar	Liverpool CCG	Liverpool Careline	Shift Manager (call centre)
Millennium Centre	Dr Tatiana Tchikhiaeva	Gemma Kearns	St Helens CCG	St Helens First Response Team	Shift Manager (call centre)
Rainford	Dr Tatiana Tchikhiaeva	Gemma Kearns	St Helens CCG	St Helens First Response Team	Shift Manager (call centre)
Rainhill	Dr Tatiana Tchikhiaeva	Gemma Kearns	St Helens CCG	St Helens First Response Team	Shift Manager (call centre)
Woodside	Dr Tatiana Tchikhiaeva	Gemma Kearns	St Helens CCG	St Helens First Response Team	Shift Manager (call centre)

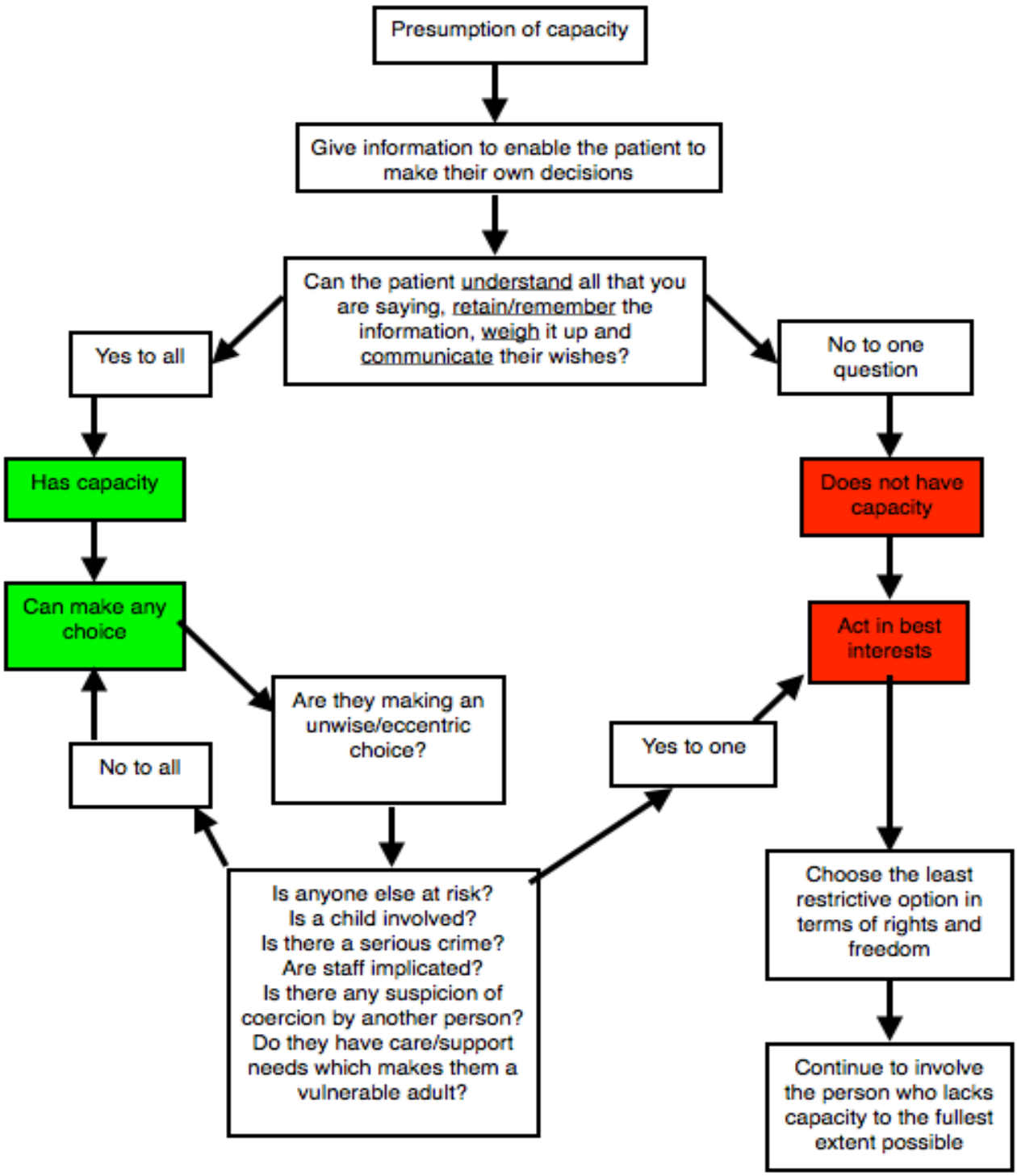
Huyton	Dr Tatiana Tchikhiaeva	Gemma Kearns	Knowsley CCG	Knowsley MASH	9-5 Director of Nursing, Paul Kavanagh-Fields 5-8 Shift Manager (call centre)
Kirkby	Dr Tatiana Tchikhiaeva	Gemma Kearns	Knowsley CCG	Knowsley MASH	9-5 Director of Nursing, Paul Kavanagh-Fields 5-8 Shift Manager (call centre)
Halewood	Dr Tatiana Tchikhiaeva	Gemma Kearns	Knowsley CCG	Knowsley MASH	9-5 Director of Nursing, Paul Kavanagh-Fields 5-8 Shift Manager (call centre)
Whiston	Dr Tatiana Tchikhiaeva	Gemma Kearns	Knowsley CCG	Knowsley MASH	9-5 Director of Nursing, Paul Kavanagh-Fields 5-8 Shift Manager (call centre)
Triage, as per address of patient					

Appendix 4


Consent for Safeguarding a Vulnerable Adult
Give options/choices
Explain consequences and implications
Give time to consider the options
Consider capacity.
The following prompts are specific to discussing abuse of a vulnerable adult.
Do they understand that what is happening to them is abuse?
Do they understand the consequences of making and not making a referral?
What outcome do they want?
What action should be taken and by who?
Can they protect themselves from harm?
Has capacity
Lacks capacity
See Capacity flowchart
Consents to referral
Doesn't consent to referral
Give information about how to change their mind.
Check there is no coercion or intimidation.
Record in notes.
Seek further advice if needed.
Override lack of consent if it is in the public interest, or if there is a risk of harm to the adult or another individual if consent is sought/waited for

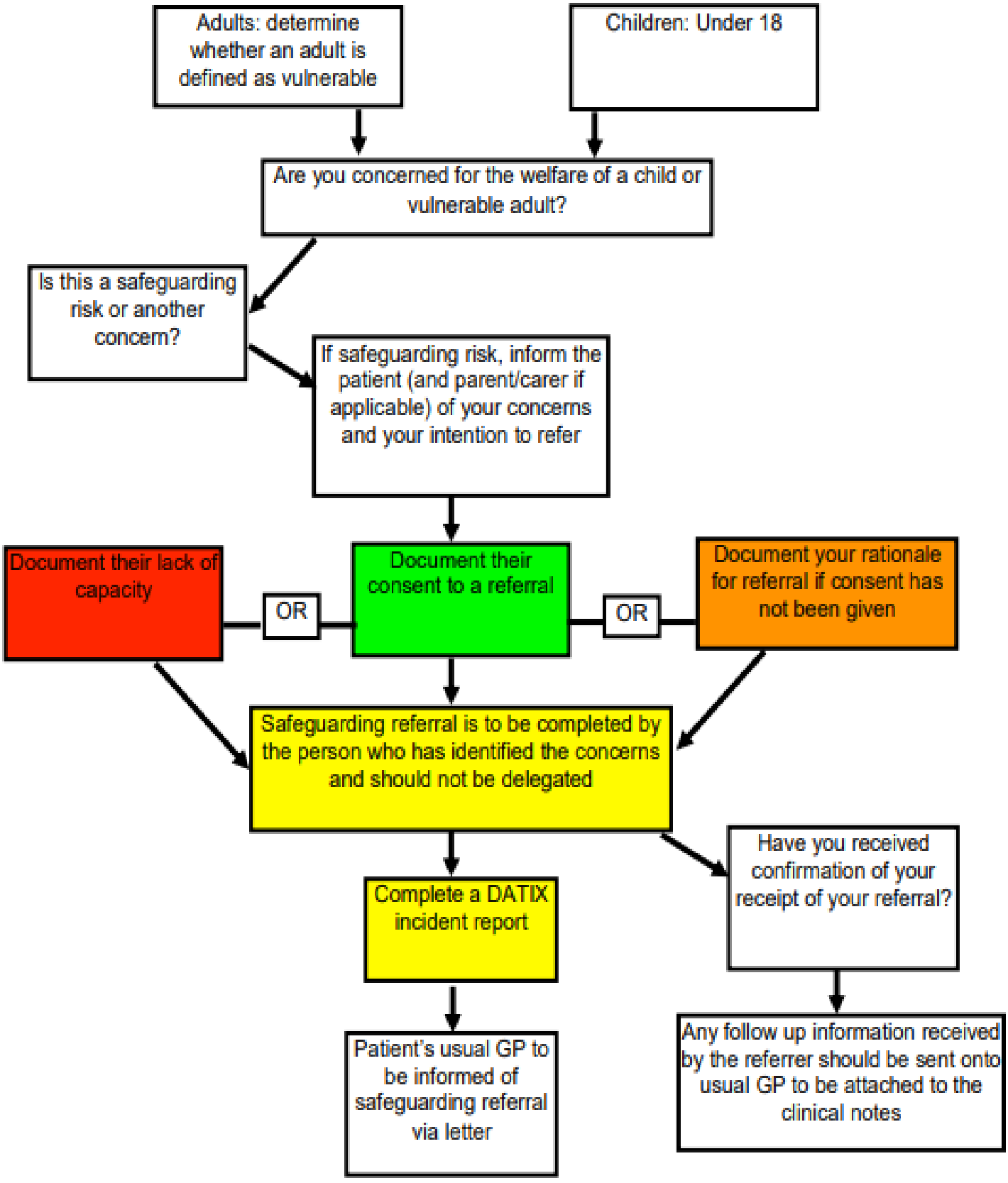
Appendix 5

Determining Capacity



Appendix 6

PC24 Best Practice for Safeguarding Children and Vulnerable Adults



Appendix 7

[NAME] MEDICAL PRACTICE

SAFEGUARDING

PRACTICE LEAD – Dr [NAME]

If Dr [NAME] is not available please share your concerns with another member of the practice clinical team or with the practice manager

Remember safeguarding is everyone's responsibility

ADULT SAFEGUARDING – [LOCAL NUMBER]
CHILD SAFEGUARDING – [LOCAL NUMBER]

For advice on safeguarding children or adults at risk:

PC24 Safeguarding Lead: Paul Kavanagh-Fields (Director of Nursing) – 0151 254 2553

All Safeguarding referrals to be reported via Datix

Appendix 8

Management Guide for Self Neglect

Regardless of the length of likely contact with an individual, **relationship building** is the cornerstone of working with those who appear to be neglecting aspects of their own self-care.
Reinforce **positive** aspects of their life. Be **honest** about your worries for them.
Offer **choices**.
Never promise.

Consider care and support needs, and offer solutions to meet those needs

If an individual refuses to engage…

Consider **capacity** (see other flowchart)
Remember capacity is specific to the single issue or decision

Consider decisional capacity (tell me about something)
and executive capacity (show me how you would do something)
e.g. tell me how you use your blister pack, & show me how you use your blister pack

Assess the risk to the individual

OOH/PCS/Extended Access/Pathfinder

Aim to negotiate 'quick wins' with the individual, until able to pass onto individual's own GP

Sefton Practices/Asylum

Expect persistence and commitment to shared goals with the individual

Seek consent to involve agencies, friends or family

Is there a legal basis to intervene even if an individual has capacity?
Seek advice as needed.

Intervene if:
There is a risk of harm to someone else
A risk of death or serious harm to the individual
A crime has been committed
There is suspicion of coercion by another

Fully document all discussions including:
Capacity in each single issue
Risks and benefits of different options provided
Level of risk when refusing options and possible outcomes of risks
Rationale for not intervening or sharing information
Advocacy and support offered

Suggested agencies:
Social Workers
Psychologists
Community Nurses
GP
Environmental Health
Fire & Rescue Services
Housing Staff
Independent Advocates
Occupational Therapists
Physiotherapists
Police
Probation Case Managers
RSPCA
Voluntary/Community/ Faith Groups

Review regularly and communicate in writing detailing where they can seek help if they change their mind about support

Appendix 9

KNOWLSEY GP RESOURCE - CONTACT LIST	Contact Number	Time Available	Criteria / Notes
Merseycare GP Referrals			
Switchboard	0151 473 0303		
Community Health Teams			
Kirkby	0151 443 4465	0900-1700	
Community Home Resolution Team (aka Mental Health Crisis Service)			
Based at Broad Oak	0151 250 5055 0151 220 5082		If unable to help, go back to Switchboard
North West Boroughs Mental Health Scheme - 24/7	0151 676 5263	24 hrs	Medical or trauma pathfinder amber or below, or suitable MTS outcome (PA or PC), aged 18+, registered with Knowsley GP and currently under care of mental health services. Needs to be able to consent to talk with NW Boroughs Partnership. Crews should state 'NWAS ambulance on scene'.
Knowsley Home Treatment Teams			
Knowsley 24/7	0151 576 5263	24 hrs	If not available will be diverted to on call practitioner who will return call - when available
St Helens	01744 621 688	24 hrs	
Halton	0151 422 6804	24 hrs	
RLUH Switchboard	0151 706 3520	24 hrs	
Aintree Crisis	0151 529 8228	24 hrs	Will need to be on a ward, or assessed at A&E before referral accepted
Waterloo pd Hub via Central Office (Merseycare)	0151 250 3000		Do not take referrals unless patient is assigned a Community Mental Health Team worker
Clock View Access Team	0151 250 5056		
Whiston	0151 676 5263		Access Team
Whiston Switchboard	0151 426 1600	24 hrs	
Rotunda Day Service		Tuesdays	Accepts GP referral **only** on Tuesdays
KNOWSLEY DOMESTIC VIOLENCE SUPPORT SERVICES			
The First Step	0151 548 3333		Can Refer via KMBC MARAC Co-ordinator **0151 443 4608**
Refuge	0808 2000 247		24 hr National Domestic Violence Helpline
Women's Aid	0808 2000 247		
Men's Aid	0333 567 0556		help@mensaid.co.uk