NHS
Fareham and Gosport
and South Eastern Hampshire
Clinical Commissioning Groups

Safeguarding Adults Policy
Version 5

Version Control

Version	Section Amended	Date	Requested by	Actioned by
2	Minor amendments to pan Hampshire policy to prepare for approval by South Eastern Hampshire and Fareham and Gosport CCGs.	14th March 2014		Julia Barton
3	Minor amendments to reflect removal of Hampshire Vulnerable Person's Committee from CCG safeguarding governance structures.	26th August 2014		Julia Barton
4	Updated to reflect the Care Act (2014)	April 2016		Pauline Dorn
5	Updated links to policies and addition of reference to the risk management framework	August 2017		Pauline Dorn

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Author:	Pauline Dorn Head of Vulnerable Adults and Safeguarding Fareham and Gosport and South Eastern Hampshire CCGs
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Policy statement:	The CCG has a responsibility to ensure there are effective safeguarding arrangements for services which they commission, including effective systems for reporting abuse and neglect. It must ensure that the safeguarding of vulnerable adults is central to the quality agenda, with that all staff employed by the CCG are aware of their individual responsibilities. Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. (DH, 2014)
Equality Analysis Completed?	This document includes a section about Equality Analysis (previously called Equality Impact Assessment), the aim being to encourage and support policy developers to demonstrate 'due regard' to the Equality Act 2010. This will be achieved if all new policies are assessed for equality impact at an early stage, and records kept of the equality analysis process and any actions identified.
Approved by:	Joint Quality Assurance Committee
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SAFEGUARDING ADULTS POLICY

Contents

SAFEGUARDING ADULTS POLICY

1. INTRODUCTION & PURPOSE

1.1 This policy sets out the Clinical Commissioning Groups' (CCGs') responsibility for safeguarding adults as an NHS body, and defines the responsibilities of every member of staff working in the CCG.

1.2 The introduction of The Care Act 2014 provides a clear legal framework for how Clinical Commissioning Groups work in partnership with other public services to protect adults at risk, placing Adult Safeguarding on the same statutory footing as children.

1.3 Local authorities have the lead responsibility for the co-ordination of the safeguarding adult's process. In order to ensure consistency of approach across the local authorities within Hampshire and Isle of Wight, a county wide safeguarding adults policy has been developed by Local Authorities, the NHS, and Hampshire Constabulary. The multiagency policy can be found at

http://www.hampshiresab.org.uk/wp-content/uploads/February-2017-Multi-Agency-Safeguarding-Adults-Policy-and-Guidance-2nd-Edition-December-2016-v3_HF000013546093.pdf

1.4 This policy has been prepared to support the multiagency policy and procedures. No individual agency's statutory duty can be delegated to another and all internal policies must be in accordance with the multiagency policy.

1.5 NHS Fareham and Gosport and South Eastern Hampshire Clinical Commissioning Groups (the CCGs) encourage an open culture to ensure clear understanding between partners at a local level when other agencies such as the local authority and Care Quality Commission need to be involved in the safeguarding of adults. Promoting the health and well-being of those who are at risk of being abused or neglected in the services commissioned including the needs of the wider health and social care community.

1.6 Safeguarding means protecting a person's right to live in safety, free from abuse and neglect. As commissioners we must demonstrate the aims of adult safeguarding:

a) To prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
b) To safeguard individuals in a way that supports them in making choices and having control in how they choose to live their lives
c) To promote an outcomes approach in safeguarding that works for people resulting in the best experience possible

d) To raise public awareness so that professionals, other staff and communities as a whole play their part in preventing, identifying and responding to abuse and neglect.

1.7 There are fundamental requirements for effective safeguarding in the delivery of NHS care:

a) The Clinical Commissioning Groups have responsibility to assure the quality and safety of the organisations with whom contracts are held, and ensure that those contracts have explicit clauses that hold the providers to account for preventing and dealing promptly and appropriately with any example of abuse and neglect
b) To prevent safeguarding incidents arising through the provision of high quality NHS funded care. This includes the NHS Outcomes Framework which sets out the high-level national outcomes that the NHS should be aiming to improve, inclusive of standard 5 - Treating and caring for people in a safe environment; and protecting them from avoidable harm.
c) To ensure effective responses where harm or abuse occurs through multi agency adult safeguarding policies and procedures.

1.8 In discharging these CCG statutory duties / responsibilities account must be taken of:

- Safeguarding Adults. Multi-Agency Policy, Guidance and Toolkit. Hampshire, Isle of Wight Portsmouth and Southampton (2015) http://www.hampshiresab.org.uk/wp-content/uploads/February-2017-Multi-Agency-Safeguarding-Adults-Policy-and-Guidance-2nd-Edition-December-2016-v3_HF000013546093.pdf
- NHS Accountability and Assurance Framework (2015)
- Department for Constitutional Affairs. 2007/ Mental Capacity Act (2005) Code of Practice. London. TSO.
- Ministry of Justice. 2008. Deprivation of Liberty Safeguards (2007). Code of Practice. London. TSO.
- The Stationary Office. 2005. Mental Capacity Act. Code of Practice. London. TSO.
- DH, 2010. Clinical Governance and Adult Safeguarding; an integrated process. London. TSO.
- NHSCB, 2015. Serious Incident Framework. https://improvement.nhs.uk/uploads/documents/serious-incidnt-framwrk.pdf
- DH, 2011. Building Partnerships. Staying Safe. The health sector contribution to HM Government's Prevent Strategy. London. COI.
- NHS Outcomes Framework 2016/17
- NHS Five Year Forward View (2014)

2. SCOPE & DEFINITIONS

2.1 The Local Authority are responsible for co-ordinating the response to a safeguarding adults concern, and health services and the police are the two main partner agencies working with the Local Authority to respond to abuse and neglect.

2.2 The CCGs must have clear lines of accountability which are reflected in its governance arrangements, and arrangements in place to co-operate with the Local Authority in the operation of the Safeguarding Adults Board

2.3 The CCGs have a safeguarding adults lead and lead for the Mental Capacity Act (MCA) supported by relevant policies and training.

3. PROCESS/REQUIREMENTS

3.1 Principles of safeguarding adults

The Care Act (2014) outlines six key principles underpin all safeguarding adults work:

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

3.2 Vulnerability

This policy uses the term ‘patient’ to include the range of descriptions used to describe the relationship between staff and people who receive services from the NHS and the Local Authority.

3.2.1 An adult at risk is someone of 18 years or over who is, or may be in need of community care services by reason of mental or other disability, age or illness, and who is unable to take care of him/herself, or unable to protect him/herself against significant harm or exploitation. The term community care services includes all social and health care

services provided in any setting or context. An adult at risk's vulnerability is determined by a range of interrelated factors which include personal characteristics, factors associated with their environment and situation, and social factors.

3.2.2 The vulnerability of an adult at risk is related to how they are able to make informed choices and protect themselves from harm, free from duress, pressure, or undue influence of any sort, and protect themselves from abuse, neglect and exploitation. An adult at risk may therefore be a person who for example;

- Is elderly and frail due to ill health, physical disability or cognitive impairment
- Has a learning disability
- Has a physical disability or sensory impairment
- Has mental health needs including dementia or a personality disorder
- Has a long term condition
- Misuses substances or alcohol
- Is a carer such as a family member who provides personal assistance and care to adults and is subject to abuse
- Is unable to demonstrate the mental capacity to make a decision and are in need of care and support

3.2.3 Abuse is a violation of an individual's human rights and civil rights by any other person or persons. It can take many forms. Abuse can be a single event or repeated events, or, as in the case of neglect, may be an on-going process over time. Abuse can be the result of deliberate intent, negligence or ignorance, or as a result of poor practice.

3.3 Risk Factors

There are certain risk factors and situations that may place people at particular risk of being abused. The presence of these factors does not automatically mean that abuse will result, but it may increase the likelihood.

3.3.1 The list below is not exhaustive and other risk factors may place people at particular risk;

- Where there is a relationship, there is usually a dependence of the person at risk on the person carrying out the abuse who may be a care giver/partner, relative, friend, volunteer or someone who is employed to care. In some cases the person carrying out the abuse may be an adult at risk themselves.
- Abuse in domestic settings often occurs in the context of long-standing poor relationships and/or carer stress. In some of these cases, someone carrying out abuse may themselves be or have been maltreated by the person they are caring for.

3.4 Categories of Abuse

The following categories of abuse are now widely accepted and used in safeguarding practice;

- **Physical:** Deliberately inflicting pain, physical harm or injury including hitting, punching, slapping, pushing, kicking, misuse of medication, inappropriate restraint or inappropriate sanctions.

- **Sexual:** rape and sexual assault or sexual acts to which the adult at risk has not consented, or could not consent or was pressurised into consenting.

- **Psychological**: emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or support networks.

- **Financial or material:** theft, fraud, exploitation, pressure in connection with Wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

- **Neglect or acts of omission:** intentionally or unintentionally ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life such as medication, adequate nutrition and heating.

- **Discriminatory**: this can manifest itself in any of the above ways and frequently will include a combination of types of abuse. What differentiates it from other categories is that the abuse is motivated by prejudice. It can also be caused by people being negligent or can stem from ignorance, in which case the abuser may not be aware of the abusive effect of their actions. This type of discrimination against the individual is often because he or she is perceived to belong to a specific group; this may be gender, sexual orientation, race religion or disability, among others.

- **Domestic Abuse**: Psychological, physical, sexual, financial, emotional abuse and so called ‘honour’ based violence.

- **Organisational abuse**: Neglect and poor care practice within a care setting such as a hospital or care home or in relation to care provided in someone’s own home ranging from one off incidents to on-going ill-treatment. It can be neglect or poor practice as a result

of the structure, policies, processes and practices within a care setting.

- **Modern Slavery:** Encompassing slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

- **Self-Neglect:** Covers a wide range of behaviour including neglecting to care for one's personal hygiene, health or surroundings and behaviour such as hoarding.

3.5 **Contexts in which abuse might take place**

3.5.1 **Domestic Abuse**: Domestic violence is defined as 'any incident of threatening behaviour, coercive control, violence or abuse between adults who are, or whom have been, intimate partners or family members regardless of gender or sexuality' that forms part of a pattern of coercive or controlling behaviour. Family members include mother, father, son, daughter, brother, sister and grandparents whether directly related, in-laws and step-family (Association of Chief Police Officers, 2004).

3.5.2 **Hate Crime**: Hate crime is defined as any crime that is perceived by the victim, or any other person, to be racist, homophobic, transphobic or due to a person's religion, belief, gender identity or disability. This definition is based on the perception of the victim or anyone else and is not reliant on evidence.

3.5.3 **Mate Crime**: Mate crime happens when someone is faking a friendship in order to take advantage of a vulnerable person. Mate crime is committed by someone known to the person. They might have known them for a long time or met recently. A 'mate' may be a 'friend', family member, supporter, paid staff or another person with a disability.

3.5.4 **Forced Marriage**: Forced marriage is a term used to describe a marriage in which one or both of the parties are married without their consent or against their will. A forced marriage differs from an arranged marriage, in which both parties consent to the assistance of their parents or a third party in identifying a spouse.

3.5.5 **Honour Based Violence**: Honour based violence is a crime or incident which has, or may have been committed to protect or defend the honour of the family and/or community. It is a collection of practices which are used to control behaviours within families or other social groups to protect perceived cultural and religious beliefs and/or honour. Such violence can occur when perpetrators perceive that a relative has

shamed the family and/or the community by breaking their honour code.

3.5.6 **Female genital mutilation**: This involves procedures that include the partial or total removal of the external female genial organs for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life.

3.5.7 **Human trafficking**: This refers to the recruitment, transportation, transfer, harbouring or receipt of persons, by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or position of vulnerability, or giving or receiving payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.

3.5.8 **The Prevent Agenda**: Contest is the UK's counter-terrorism strategy that aims to reduce the risk we face from terrorism so that people can go about their lives freely and with confidence. The Prevent strategy is one work stream within this agenda and it aims to stop people becoming terrorists or supporting terrorism. Prevent is different from the other work streams as it operates in the pre-criminal space. Prevent is about supporting and protecting those people that might be susceptible to radicalisation, ensuring that individuals are susceptible to radicalisation.

3.5.8.1 There is no single profile of a terrorist and it is not about race, religion or ethnicity. The many contacts staff have with people through their work in the NHS mean that they may well come across someone who is being exploited for terrorism. There are factors which can make individuals susceptible to the terrorist message, including factors personal to the individual, such as low self-esteem and rejection, and external factors such as foreign policy and group identity.

3.5.8.2 Radicalisation is a process and not an event and at points through the process it is possible to intervene. Frontline staff in the NHS can potentially make a difference to supporting and redirecting individuals who are being exploited in this way.

3.5.8.3 If a member of staff thinks that a person is being radicalised, the information must be passed to the Head of Vulnerable Adults and Safeguarding who has received the necessary training from the Department of Health, will ensure the referral via the regional co-ordinator is made promptly and will also attend any multi-agency meetings (Channel Panel) to decide how to best support the individual.

3.6 **Points to consider**.

3.6.1 The categories of abuse are not mutually exclusive and many situations involve a combination of types of abuse. Any or all of these categories of abuse may be perpetuated as a result of deliberate intent, negligence or ignorance.

3.6.1.1 Abuse causes significant harm and distress to the person. It may consist of a single act or repeated acts over a period of time. It may be caused by action or by failure to act, or by neglect. It may be intentional or unintentional.

3.6.1.2 In some instance the abuse may have happened over a long period of time and may only recently have been suspected or disclosed.

3.6.2 Where abuse or neglect involves someone under 18 years of age, the CCGs' Safeguarding Children policy should be followed. Where there is a situation of adult abuse, and there are children in the household, the children's safety must also be considered. Where there is child abuse in a household, and an adult at risk also resides in the household, consideration of risk to the vulnerable adult should also be given.

3.6.3 The wishes of the person who has experienced abuse are central to the safeguarding adult's process. Adults at risk need to be listened to and what they have to say should be taken seriously. They have a right to privacy, to be treated with dignity and respect and supported and enabled to live as independently as possible.

3.7 **Mental Capacity Act**.

3.7.1 In accordance with the Mental Capacity Act (2005) there is a presumption of mental capacity unless an assessment under the Act shows otherwise. The act defines someone who lacks capacity as '*a person who lacks the capacity to make, or take, a particular decision for themselves at the time the decision needs to be taken'*. Therefore assessments of capacity must be decision specific. The statutory principle aims to protect people who lack capacity and to help them take part, as much as possible, in decisions that affect them. The act provides statutory principles which are;

- A person must be assumed to have capacity unless it is established that s/he lacks capacity.
- A person is not treated as unable to make a decision unless all reasonable practicable steps to help her/him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because s/he makes an unwise decision.

- An act done, or decision made, under the act for or on behalf of somebody who lacks capacity must be done, or made, in their best interests.
- Before the act is done, or the decision made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

3.7.2 A person is considered unable to make a decision if they cannot;

- Understand the information about the decision to be made ('relevant information').
- Retain that information in their mind.
- Use or weigh that information as part of the decision making process, or
- Communicate their decision (by talking, using sign language or other means).

3.7.3 It is the right of adults who have the capacity to make a decision to make their own choices irrespective of how unwise their decision is construed. However, where a crime is suspected or there is a serious risk of harm to that person or another person, relevant agencies should be informed and the concerns investigated.

3.7.4 Where adults lack the capacity to make certain decisions to safeguard them, other people will need to make those decisions. At these times, all staff will act in accordance with the **Best Interests Decisions** as described in the Mental Capacity Act Code of Practice (2005). The decision making process for major decisions will be recorded on the Hampshire County Council Mental Capacity Act Toolkit documentation and held in the patient record.

3.7.5. All staff in the Continuing Care Team will have received training in the application of the Mental Capacity Act in clinical practice.

3.8 Deprivation of Liberty Safeguards (DOLS) (2007)

3.8.1 These safeguards protect people who lack capacity to make decisions about care or treatment and who need to be cared for in a restricted way. The aim of the safeguards is to ensure;

- That people are given the care they need in the least restrictive manner.
- That decisions being made suit the needs of the adult at risk
- Safeguards are in place
- The provision of rights to challenge unlawful detention against the person's will are appropriate.

3.8.2 The **supervisory body** for the deprivation of liberty is the Local Authority (of residence), and where people consider they need to deprive somebody of their liberty, they will need to apply to the local authority. Hospitals and care homes remain the **managing authorities** for compliance with the Deprivation of Liberty Safeguards and must comply with the legislation. The CCGs' will oversee these responsibilities in providers of NHS funded care.

3.9 Information Sharing/ Making Safeguarding Personal

3.9.1 It is important that all involved remain confident that their personal information is kept safe and secure and that practitioners maintain the privacy rights of the individual, whilst sharing information to deliver better services. It is important that practitioners can share information appropriately as part of their day-to-day practice and do so confidently. It is important that practitioners keep a record of their decision and the reasons for it. Record what has been shared, with whom and for what purpose.

Be open and honest with the person (and/or their family where appropriate) at 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. Ref Making Safeguarding Personal

Professionals will wish to refer to specific advice from their Professional Body regarding information sharing e.g.

http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality_64_66_sharing_information.asp

http://www.nmc-uk.org/nurses-and-midwives/advice-by-topic/a/advice/confidentiality/

3.9.2 Making Safeguarding Personal is a shift in culture and practice in response to what we know now about what makes safeguarding more or less effective from the perspective of the person who is being safeguarded. It is about having conversations with people about how we might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. It is about collecting information about the extent to which this shift has a positive impact on people's lives. It is a move from a process supported by conversations to a series of conversations supported by a process. By agreeing, negotiating and recording their desired outcomes, working out with them (and their representatives or advocates if they lack capacity) then the best outcomes for the individual can be realised.

3.9.3 Where safeguarding adults investigations are complete, and the remaining issues to be addressed constitute a quality concern and do not reach the safeguarding threshold, these issues may be transferred to the Clinical Quality Review Meeting (CQRM) for the provider for on-going monitoring. Where independent providers are not monitored via CQRM process the ongoing quality monitoring will be carried out in collaboration with Hampshire County Council.

3.10 Death by Fire

3.10.1 It is clear from local and national statistics that vulnerable adults are at higher risk of death from fire in their own homes. On many occasions, these people are known to health and social care professionals. The Hampshire Fire and Rescue Service work jointly with health and social care to provide home fire safety checks for vulnerable adults and will provide equipment where appropriate. This is a key priority for the LSAB and the CCG has a key role in highlighting the importance of this agenda.

3.11 Risk Management Framework

The use of the 4LSAB risk management framework is recommended for cases that are below the threshold for a statutory safeguarding process but where levels of risk are high and a multi-professional approach is required.

4. ROLES & RESPONSIBILITIES

4.1 Role of the CCG in the prevention of abuse:

The primary driver of the safeguarding adult's agenda is prevention of harm to vulnerable adults. The CCG is committed to ensuring that people are protected from abuse and neglect and this will be embedded in the following mechanisms;

- Commissioning high quality services.
- Ensure safeguarding adults arrangements are robust within all commissioned services.
- Considering the impact on vulnerable adults when commissioning and decommissioning services.
- Engaging in the multi-agency process when safeguarding concerns arise in the services the CCG commissions working with partner agencies.
- Raising safeguarding concerns in line with the multiagency policy, linking to the Serious Incident Policy and where appropriate.
- Monitoring the quality of services ensuring the triangulation of data.

- Ensuring rigorous recruitment practices including all permanent staff, NHS approved agency workers, locums and other temporary staff, students, trainees and volunteers.
- Empowering individuals with information about their rights within well publicised complaints and feedback mechanisms.
- Participating fully as required in Statutory Reviews under section 44 of the Care Act (2014) and other investigations.
- Ensuring recommendations from Statutory Reviews and other large scale investigations are embedded within commissioned services.
- Ensuring incidents, complaints and concerns are screened for safeguarding adults issues acknowledging that care quality lapses may well constitute a safeguarding adults concern.

The CCGs' act as the lead commissioner for a range of NHS commissioned services both within and outside their geography. Where concerns arise, they will act in partnership with the Local Authority and other partners in the safeguarding adult's agenda to contribute to any necessary investigation and actions. This includes commissioning and funding any independent reviews which may be necessary. Where the CCGs' commission NHS care outside of their geographical areas they may need to consider partnerships in addressing the issues affecting these services.

4.2 The role of CCG staff

Although staff working for a CCG do not provide direct care to patients, the nature of their work may identify risks during the course of their role e.g.;

- Direct observation during visits to providers of care
- Conversations with patients, families and staff from provider organisations
- Complaints and patient experience feedback
- Incident and serious incident reports
- Audits which identify lapses in care quality
- Concerns raised through whistleblowing
- Reports from regulators e.g. CQC
- Soft intelligence about providers
- Concerns when patients are transferred from one setting to another about their previous care
- Commissioning and decommissioning services which will impact on vulnerable adults
- Quality data may highlight concerns about staffing, not meeting acceptable standards of care/service provision
- Staff should also be conscious of the fact that they may become aware of safeguarding issues who are known to/cared for by colleagues.

4.3 The following table makes explicit the responsibilities of individual CCG staff;

Party	Key Responsibilities
Chief (Accountable) Officer	• Is accountable for ensuring the CCGs' contribution to safeguarding adults. • Delegates their responsibility for the leadership and management of the safeguarding adults function to the Chief Quality Officer
Chief Quality Officer/Chief Nurse	• Ensures safeguarding roles and responsibilities of all staff (directly employed and contracted) are clearly stated and included in staff induction training and at regular intervals as appropriate to the role of the member of staff. • Ensures all contracted services have a robust safeguarding adults policy and procedure in place. • Ensures safeguarding roles and responsibilities are explicit in all job descriptions and through a CCG statement on the website. • Ensures safeguarding adults is integral to clinical governance and quality arrangements. • Ensures the CCG works in partnership with the Local Safeguarding Adults Board. • Represents the CCG as a statutory member of the Hampshire Safeguarding Adults Board. • Maintains relationships with other key organisations including the Local Authority and Police Service.
GP Executive Lead for Quality	• Represents CCG membership GP practices on safeguarding adult issues • Advises on safeguarding adult policies, procedures and training for primary care settings • Ensures there is effective dissemination of safeguarding adult guidance and policies to primary care • Receives regular briefings via the Hampshire Safeguarding Adults Team on cases within the CCG's boundaries • Provides leadership for safeguarding adults, particularly in primary care.
Executive lead for clinical governance	• Ensures robust governance processes are in place. • Ensures safeguarding adults is integral to all clinical governance processes in the CCG.
CCGs Head of Vulnerable Adults and Safeguarding	• Day to day responsibility for responding to safeguarding adults concerns in NHS commissioned services. • Ensures appropriate training for staff is available and provided. • Prepares an annual report for the CCG. • Presents regular briefing reports to the Quality Assurance Committee and Quality Operational Group • Provides consultancy, leadership and oversight of safeguarding adults activity. • Sustains robust partnerships with the Local Authority and the police, and other partner agencies.

Party	Key Responsibilities
	• Takes part in Serious Case Reviews and other safeguarding adults (SGA) investigations as required in line with section 42 and section 44 of the Care Act. • Works in partnership with safeguarding adults leads in provider services and the Local Authority. • Works in collaboration with the Continuing Health Care Team.
CCGs' Quality Team Clinical Quality Facilitator (for Safeguarding Adults)	• Works closely with all partners and key agencies on SGA issues. • Supports the Head of Vulnerable Adults and Safeguarding in relation to SGA training, investigations and procedures • Leads on section 42 enquiries as required. • Supports primary care in development of reports relating to safeguarding adult reviews in line with section 44 of the Care Act. • Drafts reports and collates information and intelligence from a number of sources about safeguarding adult issues. • Supports with providing and presenting reports at relevant committees. • Monitors provider compliance with SGA requirements and CQC registration. • Supports the development of the SGA function in primary care.
All Staff	• Will be alert to the potential indicators of abuse or neglect of vulnerable adults and know how to act on concerns and follow the appropriate timescales. • Attend relevant training and maintain the skills to recognise abuse, neglect or exploitation and how to report this as per policy. • Seek advice from the safeguarding adults team if unsure how to act in response to concerns about a vulnerable adults. • Escalates issues to senior managers should disagreement arise in relation to how a safeguarding issue is being handled. • Keep contemporaneous records in accordance with professional and organisational policy.

5.0 GOVERNANCE ARRANGEMENTS

5.1 The following table makes explicit the roles and responsibilities of groups/committees overseeing the safeguarding adults agenda;

Party	Key Responsibilities
The Wessex Area Team	• Ensures oversight of the CCGs' arrangements for safeguarding adults.
CCGs' Governing Bodies	• Receive assurance that management and accountability structures support safe and effective services in accordance with statutory guidance, national and local guidance for safeguarding adults.
Hampshire Safeguard Adults Board (HSAB)and Health Sub Group	• CCG Representatives at this group are responsible for cascading information to/from the HSAB and CCGs' Joint Quality Operational Group and Quality Assurance Committee.

5.2 The Chief Accountable Officer has delegated the responsibility for Safeguarding Adults to the Chief Quality Officer in Fareham and Gosport and South Eastern Hampshire CCGs.

5.3 The CCGs Chief Quality Officer is a member of the Hampshire Safeguarding Adults Board (HSAB) and business subgroup.

5.4 The Head of Vulnerable Adults and Safeguarding will represent the CCGs at the following subgroups of the HSAB: Health subgroup, Learning and Review, Quality Assurance, Policy implementation group and additionally the Wessex regional safeguarding forum. The Chief Quality Officer chairs the workforce development sub group of the HSAB.

5.5 The CCGs have a responsibility to learn from incidents and in addition will conduct trend and thematic analysis of incidents and ensure learning has taken place. The CCGs will ensure all commissioned services learn from safeguarding adult's incidents and trend analysis, improving services for patients.

5.6 The CCGs will report relevant Serious Incidents Requiring Investigation to the Hampshire Safeguarding Adults Board and ensure that providers report in the same way.

5.7 The CCGs have a responsibility to ensure that commissioned services are meeting their safeguarding adults (including the provisions of the MCA/DoLs) responsibilities through regular reporting, the Serious Incident (SI) process, clinical visits, and hard and soft intelligence.

5.8 The CCGs will ensure that provider governance arrangements cover fundraising by celebrities and any access to premises by them, any privileges, and their use and value in relation to fundraising. The CCGs should also ensure that the culture within commissioned services encourages concerns to be raised and that these and any incidents of whistleblowing in relation to the sexual abuse of patients, staff and visitors are robustly investigated and managed.

5.9 In some circumstances where satisfactory arrangements to protect a vulnerable adult cannot be established, legal remedy using the **Court of Protection** is needed. When this is necessary, the CCGs will support the use of legal processes and the associated costs.

5.10 In some cases it is appropriate to seek an independent investigation into a safeguarding concern. This may be required if it is considered that there is any conflict of interest or where the CCGs desire an external investigation. Whenever this is undertaken it will always remain within the remit of the Hampshire multi-agency safeguarding adult processes. Where this is required the CCG will support this and bear the associated costs.

6. TRAINING

6.1 All CCG staff will receive basic training in safeguarding adults as part of their induction and will complete the on-line e learning every three years for safeguarding adults as part of their mandatory training. The safeguarding adults team will provide bespoke training for groups of CCG staff as required.

6.2 Safeguarding adults training will be delivered in line with the Hampshire multi-agency learning and development strategy for safeguarding adults.

7. REPORTING A CONCERN

7.1 If the situation presents a threat to life and limb, the police should be called. For all other concerns, incidents and allegations, these must be reported to the Local Authority as the co-ordinating authority. The referral should be made within 4 hours of the incident. To alert a concern the following Local Authority contact numbers should be used:

- **Hampshire County Council: 0300 555 1386**
- **Portsmouth City Council: 023 9268 0810**
- **Southampton City Council: 023 8083 3003**

7.2 In all cases if anyone is unsure about a safeguarding concern, they should contact the CCG safeguarding adults' team at Fort Southwick for advice. The CCG team should be informed of all cases that are reported to the Local Authority by a member of CCG staff.

7.3 The concern and the referral must be recorded on the CCGs' incident system by the person reporting the concern.

7.4 The line manager of the person reporting the concern should be informed when the concern is in relation to a patient/service user in a commissioned service, or in relation to a member of staff within the CCGs.

8. EQUALITY ANALYSIS

This policy seeks to promote and support equality for vulnerable groups

9. REVIEW

This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed after twelve months and thereafter on a bi-annual basis or following change in key guidance or legislation.

8. REFERENCES AND LINKS TO OTHER DOCUMENTS

NHSCB, 2013. Safeguarding Vulnerable People in the Reformed NHS. Accountability and Assurance Framework. NHS Commissioning Board.

Care Act (2014)

Ministry of Justice, 2008. Deprivation of Liberty Safeguards. Code of Practice. London. TSO.

Department for Constitutional Affairs. 2007. Mental Capacity Act 2005.The Mental Capacity Act. Code of Practice. London. TSO.

Local Government Documents – Making Safeguarding Personal 2014

APPENDIX 3: POLICY IMPLEMENTATION IMPACT ASSESSMENT (*To be completed and attached to any policy submitted to an appropriate committee for consideration and approval)*

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

Manpower	**WTE**	**Recurring £**	**Non-Recurring £**
Operational running costs			
Additional staffing required - by affected areas / departments			
Totals:			

Staff Training Impact	**Recurring £**	**Non-Recurring £**
Affected areas / departments e.g. 10 staff for 2 days		
Totals:		

Equipment and Provision of Resources	**Recurring £***	**Non-Recurring £***
Totals:		

Accommodation / facilities needed	
IT Hardware / software / licences	
Medical equipment	
Stationery / publicity	
Travel costs	
Utilities e.g. telephones	

APPENDIX 3: POLICY IMPLEMENTATION IMPACT ASSESSMENT Cont.

Process change Rolling replacement of equipment	
Equipment maintenance	
Marketing – booklets/posters/handouts, etc	
Totals:	

*Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:	
Signature & date of financial accountant:	
Funding / costs have been agreed and are in place:	
Signature of appropriate Executive or Associate Director:	