

Safeguarding adults

Your responsibilities

Categories of abuse

Your role as alerter

Information sharing

Capacity and consent

Pressure Ulcer Categories/Grading

The Mental Capacity Act (MCA) 2005

- Decision-making flowchart
- Best-interest decision-making flowchart

Deprivation of Liberty Safeguards (DoLS)

- Decision-making flowchart

Prevent and Channel

Resources

Notes:



A series of horizontal dotted lines spanning the width of the page, intended for writing notes.

Your responsibilities

Safeguarding adults

All staff within health services have a responsibility for the safety and wellbeing of patients and colleagues.

Living a life that is free from harm and abuse is a fundamental human right of every person and an essential requirement for health and wellbeing.

Safeguarding adults is a fundamental part of patient safety and wellbeing and the outcomes expected of the NHS. Safeguarding adults is also integral to complying with legislation, regulations and delivering cost-effective care.

These cards should be used by you as a guide, should you have a safeguarding concern, and should always be used alongside your organisation's and local multi-agency policy and procedures.

Definition of an adult at risk

A person aged 18 years or over; who may be in need of community care services by reason of mental or other disability, age or illness; and who is, or may be, unable to take care of themselves, or unable to protect themselves against significant harm or exploitation.

NB: Throughout this publication we have used the term 'patient' to refer to patients and clients.

Your responsibilities when you have safeguarding concerns:

- Assess the situation and whether emergency services required
- Ensure the safety and wellbeing of the individual
- Establish what the individual's views and wishes are about the safeguarding issue and procedure
- Maintain any evidence and follow internal procedures for reporting incidents/risks
- Remain calm and try not to show any shock or disbelief
- Listen carefully and demonstrate understanding by acknowledging regret and concern that this has happened
- Inform the person that you are required to share the information, explaining what information will be shared and why
- Make a written record of what the person has told you, using their words or what you have seen, as well as your actions

Your responsibilities

Duty of care

You have a duty of care to your patients/service users, your colleagues, your employer, yourself and the public interest. Everyone has a duty of care. It is not something that you can opt out of.

The Health Professions Council standards state:

'a person who is capable of giving their consent has the right to refuse treatment. You must respect this right. You must also make sure they are fully aware of the risk of refusing treatment, particularly if you think there is a significant or immediate risk to life.'

Duty of care can be said to have reasonably been met where an objective group of professionals consider:

- All reasonable steps have been taken
- Reliable assessment methods have been used
- Information has been collated and thoroughly evaluated
- Decisions are recorded, communicated and thoroughly evaluated
- Policies and procedures have been followed

- Practitioners and managers have sought to ascertain the facts and are proactive.

You should always treat every individual with dignity and respect to ensure that they feel safe in services and empowered to make choices and decisions.

Ensure that significant others, for example a family member, friend or advocate, are involved to support the individual where appropriate.

However, it is important to recognise that whilst an individual with capacity has the right to refuse care for themselves, the duty of care extends to considering where others may be at risk and action is needed to protect them.

Whistle blowing

Always act whenever abuse is suspected, including when your legitimate concern is not acted upon. Whistle blowers are given protection under the Public Interest Disclosure Act 1998.

Your responsibilities

You have a responsibility to follow the six safeguarding principles:

Principle one: Empowerment

Presumption of person-led decisions and consent.

Adults should be in control of their care and their consent is needed for decisions and actions designed to protect them. There must be clear justification where action is taken without consent, such as lack of capacity or other legal or public interest justification. Where a person is not able to control the decision, they will still be included in decisions to the extent that they are able. Decisions made must respect the person's age, culture, beliefs and lifestyle.

Principle two: Protection

Support and representation for those in greatest need.

There is a duty to support all patients to protect themselves. There is a positive obligation to take additional measures for patients who may be less able to protect themselves.

Principle three: Prevention

Prevention of harm or abuse is a primary goal.

Prevention involves helping the person to reduce risks of harm and abuse. Prevention also involves reducing risks of neglect and abuse occurring within health services.

Principle four: Proportionality

Proportionality and least intrusive response appropriate to the risk presented.

Responses to harm and abuse should reflect the nature and seriousness of the concern. Responses must be the least restrictive to the person's rights and take account of the person's age, culture, wishes, lifestyle and beliefs. Proportionality also relates to managing concerns in the most effective and efficient way.

Principle five: Partnerships

Local solutions through services working with their communities.

Safeguarding adults will be most effective where citizens, services and communities work collaboratively to identify, respond and prevent harm and abuse.

Principle six: Accountability

Accountability and transparency in delivering safeguarding.

Services are accountable to patients, public and to their governing bodies. Working in partnership also requires being open and transparent with partner agencies about how safeguarding responsibilities are being met.

(The role of Health Service Practitioners, DH, 2011)

Categories of abuse

1. Categories of abuse

Physical, psychological/emotional, sexual and sexual exploitation, financial, neglect, discrimination and institutional.

Physical: assault, rough handling, unreasonable physical restraint.

Psychological/emotional: bullying, intimidation, verbal attack or other behaviour that affects the wellbeing of an individual.

Sexual and sexual exploitation: any non-consenting sexual act or behaviour.

Financial: theft, fraud, misappropriating funds i.e. when using a person's money for self-gain or gratification.

Neglect: a person's wellbeing is impaired and care needs are not met, breaching duty of care.

Discrimination: psychological abuse that is racist, sexist or linked to a person's sexuality, disability or age.

Institutional: Observed lack of dignity and respect in the care setting, rigid routine, processes/tasks organised to meet staff needs, disrespectful language and attitudes.

2. Significant harm

"Harm should be taken to include not only ill treatment, but also the impairment of, or avoidable deterioration in, physical or mental health; and the impairment of physical, intellectual, emotional, social, or behavioural development" Law Commission, 1995.

3. Radicalisation

The processes by which people come to support violent extremism and, in some cases, join terrorist groups.

4. Other

a) *Domestic abuse and self harm* need to be considered as possible indicators of abuse and/or contributory factors.

b) *Tissue damage, pressure ulcers and moisture damage* may also be indicative of physical neglect, abuse or failed duty of care.

See Guidance on Pressure Ulcer Categories and Grading card.

c) Local multi-agency guidelines may also provide guidance with regards to *honour based violence and trafficking*.

If in doubt contact your nominated lead for adult safeguarding.

Your role as alerter

Your role as 'alerter' in the safeguarding process

The 'alerter' raises a safeguarding concern within their own agency following policy and procedures.

This concern may result from something that you have seen, been told, or heard.

Assessment

Your assessment should be holistic and thorough, considering the patient's emotional, social, psychological and physical presentation as well as the identified clinical need. You need to be alert to:

- Inconsistencies in the history or explanation
- Skin integrity, hydration or personal presentation, e.g. if the person is unkempt
- Delays or evidence of barriers in seeking or receiving treatment
- Evidence of frequent attendances to health services or repeated failure to attend
- Environmental factors, eg. signs of neglect
- Reactions and responses of other people with the patient
- Cultural differences and the patient's views and wishes should be respected

Key Questions

- Is the patient vulnerable or at risk as defined under 'No Secrets' or in local multi-agency policy and procedures?
- Is immediate protection required?
- Does the patient have capacity for the decision required?
- Are they able to give informed consent or is action needed in their best interests?
- Is any action that is being considered proportionate to the risk identified?
- Are there valid reasons to act, even without the patient's consent? For example, where others are at risk or to address a service failure that may affect others.
- Has a crime been committed and should the police be informed?
- Do you need to preserve any evidence?
- Are there others at risk? e.g. children or other adults

Make a referral to Safeguarding Children where necessary.

A holistic assessment should be carried out at the initial contact on admission and on discharge, in both community and acute settings.

Your role as alerter

Communication

- Consider use of communication aids or language line if required to involve the patient
- Take account of individual differences
- Listen carefully, remain calm and try not to show shock or disbelief and acknowledge what is being said
- Do not ask probing or leading questions that may affect credibility of evidence
- Be open and honest and do not promise to keep a secret
- Seek consent to share information if the patient has capacity and if this does not place you or them at increased risk
- You may share information without consent if it is in the public interest, in order to prevent a crime or to protect others from harm

Refer to your own organisation's policy procedures and multi-agency information sharing protocol for further information.

Reporting

- Report concern following your safeguarding adult policy and procedures
- Make a clear and concise referral without delay, ensuring that the person reading it will understand the key issues
- Concern about a colleague should be raised through your organisation's procedures for managing allegations against staff or whistleblowing policy

Remember that you are accountable for what you do or choose not to do.

Recording

- You are accountable for your actions or omissions
- To demonstrate transparent and defensible decision making, make legible, factual, timely and accurate records of what you do, when and why. e.g capacity assessment completed, best interest decisions made and any restraint required.

Information sharing

Where there are safeguarding concerns staff have a duty to share information.

It is important to remember that in most serious case reviews, lack of information sharing can be a significant contributor when things go wrong.

Information should be shared, with consent, wherever possible.

A person's right to confidentiality is not absolute and may be overridden where there is evidence that sharing information is necessary to support an investigation or in best interests, e.g. in the interests of public safety, police investigation or implications for regulated services.

- 1. Remember that the Data Protection Act is not a barrier to sharing information**, but provides a framework to ensure that personal information about living persons is shared appropriately.
- 2. Be open and honest** with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
- 3. Seek advice** if you are in any doubt, without disclosing the

identity of the person where possible.

- 4. Share with consent where appropriate** and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgment, that lack of consent can be overridden in the public interest. You will need to base your judgment on the facts of the case.
- 5. Consider safety and wellbeing** and base your information sharing decisions on considerations of the safety and wellbeing of the person and others who may be affected by their actions.
- 6. Ensure sharing of information is proportionate, relevant, accurate, timely and secure:** Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date and is shared in a timely fashion and securely.
- 7. Keep a record** of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom, when, for what purpose and in what format.

Information sharing

Any information disclosed should be:

- clear regarding the nature of the problem and purpose of sharing information
- based on fact, not assumption
- restricted to those with a legitimate need to know
- relevant to specific incident
- strictly limited to the needs of the situation at that time
- recorded in writing, with reasons stated

Further guidance is available from:

- local multi-agency Information Sharing Protocols
- best practice guidance to maintain confidentiality and compliance with the Data Protection Act 1998
- Caldicott Guardian and Information Governance lead for your organisation

Sharing data when someone lacks mental capacity

Can the patient give consent to disclosure of information?

You have a responsibility to explore approaches to help them understand.

In some instances the individual will not have the capacity to consent to disclosure of personal information relating to them. Where this is the case, any disclosure of information needs to be considered against the conditions set out in the Data Protection Act 1998 and the Mental Capacity Act (2005).

Capacity and consent

In establishing the ability and capability to consent to care and treatment, the following must be taken into account and documented:

- There is a relevant assessment of capacity
- The assessment is specific to the relevant decision and time, eg - "John lacks capacity" might raise concern without explaining for what and when
- All reasonable and appropriate steps have been taken to empower/maximise capacity
- An appropriate range of disciplines have been involved
- Family and carers have been involved appropriately
- Regular review is provided for

It is acceptable to ask questions or ask for further guidance and reassurance. For example:

- if it is not clear who has made, or is making, the assessment of capacity or best interests
- if family, carers or others may be seeking to override the views of others
- If you disagree with the decision or have concern that the MCA and/ or policy is not being followed

Best interest

If the patient is not able to consent or refuse treatment, there is a duty to make a best interest decision about whether to treat the patient.

You must:

- Involve the person who lacks capacity
- Have regard for past and present wishes and feelings, especially written statements
- Consult with others who are involved in the person's care
- Not discriminate

It is not acceptable to do nothing.

It is your responsibility to make sure you know how to contact your local safeguarding adults lead.

Pressure Ulcer Grading

Adapted from EPUAP/NPUAP 2009

EPUAP - Category/Grade 1

- Non-blanchable erythema of intact skin: persistent redness in light pigmented skin
- Discolouration of the skin: observe for a change of colour as compared to surrounding skin. In darker skin, the ulcer may be blue or purple
- Warmth, oedema, induration or hardness as compared to adjacent tissue may also be used as indicators, particularly on individuals with darker skin.
- May include sensation (pain, itching).



SUPERFICIAL

EPUAP System - Category/Grade 2

- Partial thickness skin loss involving epidermis, dermis or both.
- Presents clinically as an abrasion or clear blister.
- Ulcer is superficial without bruising*
- Check for moisture lesion.



*Bruising appearance and blood filled blister would indicate deep tissue injury.

EPUAP - Category/Grade 3

- Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon and muscle are not exposed.
- May include undermining and tunneling.
- The depth varies by anatomical location (bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and grade 3 ulcers can be shallow.
- In contrast area of significant adiposity can develop extremely deep grade 3 pressure ulcers.
- Bone/tendon is not visible or directly palpable.



Plus: Unclassified PU – now Grade 3

- Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, grey, green, brown, black, eschar) in the wound bed. Until enough slough is removed to expose the base of the wound, the true depth cannot be determined; but it will be either grade 3 or 4.
- Stable eschar (dry, adherent, intact without erythema or fluctuance) on the heels serves as 'the body natural (biological) cover' and should not be removed.
- Should be documented as grade 3 until proven otherwise.



EPUAP – Category/Grade 4

- Full thickness tissue loss with exposed bone (or directly palpable), tendon.
- Often include undermining and tunneling.
- The depth varies by anatomical location (bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and grade 4 ulcers can be shallow
- Grade 4 ulcers can extend into the muscle and/or supporting structures (eg fascia, tendon or joint capsule).



DEEP

Moisture Lesions

- Redness or partial thickness skin loss involving the epidermis, dermis or both caused by excessive moisture to the skin from urine, faeces or sweat.
- These lesions are not usually associated with a bony prominence.
- They can however be seen alongside a pressure ulcer of any grade.



The Mental Capacity Act (MCA) 2005

Five principles that underpin the Mental Capacity Act 2005:

In order to protect those who lack capacity, and to enable them to take part as much as possible in decisions that affect them, the following statutory principles apply:

1. You must always assume a person has capacity unless it is proved otherwise
2. You must take all practicable steps to enable people to make their own decisions
3. You must not assume incapacity simply because someone makes an unwise decision
4. Always act, or decide, for a person without capacity in their best interests
5. Carefully consider actions to ensure the least restrictive option is taken

Assessment of capacity:

Follow the two-stage test for capacity:

Stage one: Does the person have an impairment of the mind or brain (temporary or permanent)?

If Yes:

Stage two: Is the person able to:

- understand the decision they need to make and why they need to make it?
- understand, retain, use and weigh information relevant to the decision?
- understand the consequences of making, or not making, this decision?
- communicate their decision by any means (i.e. speech, sign language)?

Failure on any point may indicate lack of capacity.

How to act in someone's best interests:

- Do not make assumptions about capacity based on age, appearance or medical condition
- Encourage the person to participate as fully as possible
- Consider whether the person will in the future have capacity in relation to the matter in question
- Consider the person's past and present beliefs, values, wishes and feelings

Continued over...

The Mental Capacity Act (MCA) 2005

- Take into account the views of others – i.e. carers, relatives, friends, advocates
- Consider the least restrictive options

A best interests checklist will be available as part of local policy and procedure.

What else do you need to consider?

MCA code of practice:

Professionals and carers must have regard to the code and record reasons for assessing capacity or best interests. If anyone decides to depart from the code they must record their reasons for doing so.

Lasting Power of Attorneys (LPA) and Advance Decision (AD):

Is there a valid and current LPA or AD in place?

The Independent Mental Capacity Advocacy (IMCA):

The Mental Capacity Act sets up IMCA services to help vulnerable people who lack capacity and are facing important decisions - including serious healthcare treatment. The service can help where there are no family or friends, apart from paid carers, who can be consulted as part of making a best interest decision.

Emergency Situations

There may not always be time in emergency situations for full investigation and consultation. In such situations, there should be no liability for acting in the reasonable belief that someone lacks capacity, where what you do is reasonably believed to be in their best interests (MCA s5). This can include restraint if need be, if it is proportionate and necessary to prevent harm (MCA s6), and even "a deprivation of liberty", if this is necessary for "life sustaining treatment or a vital act", while a Court Order is sought if need be (MCA s4B).

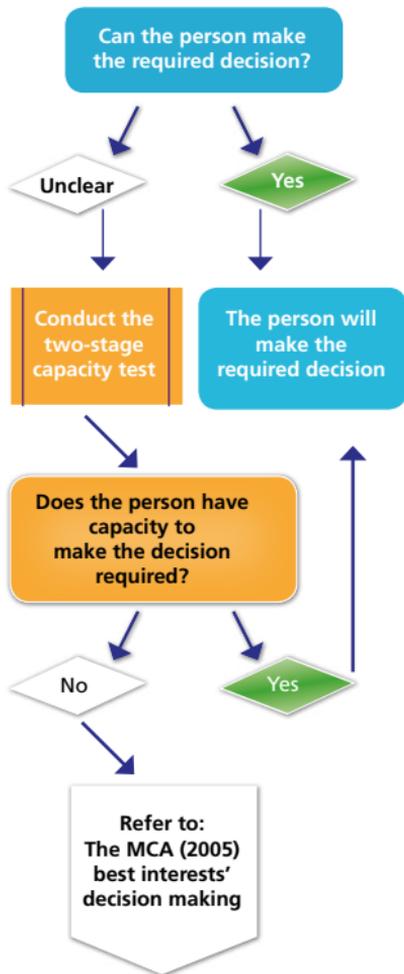
Where to find guidance

The full text of the Act and the code of practice is available at:

www.dca.gov.uk/legal-policy/mental-capacity/mca-cp.pdf

MCA (2005) decision-making flowchart

All adults should be presumed to have capacity unless the opposite has been demonstrated. Consent must be obtained by the person undertaking the procedure and is specific to the decision to be made.



Refer to the five principles of the MCA:

- A presumption of capacity
- Individuals being supported to make their own decisions
- Unwise decisions
- Best interests
- Least restrictive option

The two-stage capacity test:

Stage one. Is there an impairment of, or disturbance in the functioning of the person's mind or brain? If so,

Stage two. Is the impairment or disturbance sufficient that the person lacks the capacity to make the particular decision?

Can the person:

- Understand the information relevant to the decision,
- Retain that information,
- Weigh that information as a part of the process of making a decision and
- Communicate their decision (whether by talking, using sign language or any other means)?

(Person must demonstrate all four functions above to be deemed as having capacity for the required decision-making.)

The best-interest checklist:

When making a decision in someone's best interests one must:

- Involve the person as much as possible
- Find out the person's wishes and feelings
- Consult people who know the person well
- Consider all relevant information
- Avoid making the decision if it is likely that the person might regain capacity
- Think about what would be the least restrictive option

and must not:

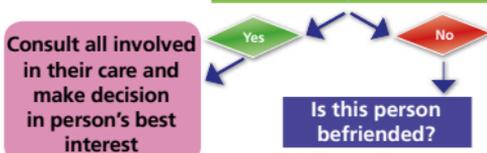
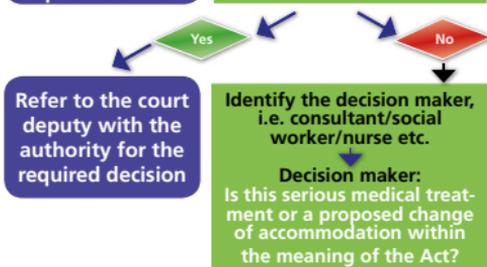
- Make assumptions based on the person's age, appearance, condition or behaviour
- Make a decision involving life-sustaining treatment that is motivated by a desire to end the person's life.

MCA (2005) best-interest decision-making flowchart

The person is assessed as not having the capacity to make a required decision

Have arrangements been made for incapacity?

Has the person made an advanced decision relevant to the required decision?



The decision maker:

- Must ensure that the proposed action/treatment is in the best interests of the person.
- The decision maker needs to check if there is an Advance Decision (AD), Lasting Power of Attorney [LPA] or Deputy or if there is a friend/carer of person nominated by the person to consult.
- Advance Decision must be relevant to this decision.

Best-interest-checklist

The decision maker must:

- Consult with all relevant others, i.e. the person, medic/GP, carers, Allied Health Professionals, social care staff, Advocate/IMCA, or people who know the person well, i.e. LPA or Deputy or Enduring Power of Attorneys
- Identify the views of all relevant people in the person's life
- Not make assumptions about a person's best interests based upon the person's age, or appearance, condition or any aspect of their behaviour
- Consider all the relevant circumstances relating to the decision in question
- Involve the person as fully as possible
- Ensure that if the decision concerns the decisions relating to life-sustaining treatment, the decision maker must not be motivated by a desire to bring about death
- Be able to justify and evidence their decision making
- Ensure that other least restrictive options are always explored (complete best interests decision record).

A formal best interests meeting is not always needed. It is important that consultation has taken place and the decision maker follows the guidance above with all relevant others and this is documented on the agreed paperwork.

Record keeping: it is important that you accurately record and evidence any decisions made with regards to best interests.

Deprivation of Liberty Safeguards (DoLS)

What are they?

The Deprivation of Liberty Safeguards 2009 (DoLS) are an amendment to the Mental Capacity Act 2005. They provide a legal framework to protect those (over 18 years) who lack the capacity to consent to the arrangements for their treatment or care.

For example, by reason of dementia, learning disability or brain injury and where levels of restriction or restraint used in delivering treatment or care (for the purpose of protection from risk or harm) are so extensive as to potentially be depriving the person of their liberty.

Deprivation of Liberty Safeguards go beyond the actions permitted under section five of the Mental Capacity Act (MCA) 2005.

Who do they apply to?

The safeguards only apply to people who:

- lack capacity to consent to care/treatment they receive
- are over 18 years of age
- receive care in a hospital or a care home setting and the care they receive deprives them of their liberty
- are not detained under the Mental Health Act

If a person is being deprived of their liberty and they are not in a care home or hospital, their care can only be authorised through the Court of Protection.

Deprivation of Liberty Safeguards (DoLS)

What you need to know

- Sometimes Deprivation of Liberty (DoL) is required to provide care and treatment and protect people from harm, but every effort should be made to prevent DoL by making provision to avoid placing restrictions
- If DoL cannot be avoided, it should be for no longer than is necessary
- Where the Safeguards apply, there is a legal duty on the hospital or care home to request that the commissioner of care, or local authority, authorise the depriving of someone's liberty for a limited period of time
- A major part of preventing DoL is minimising any restraint. Restraint must be appropriate, proportionate and in the patient's best interests

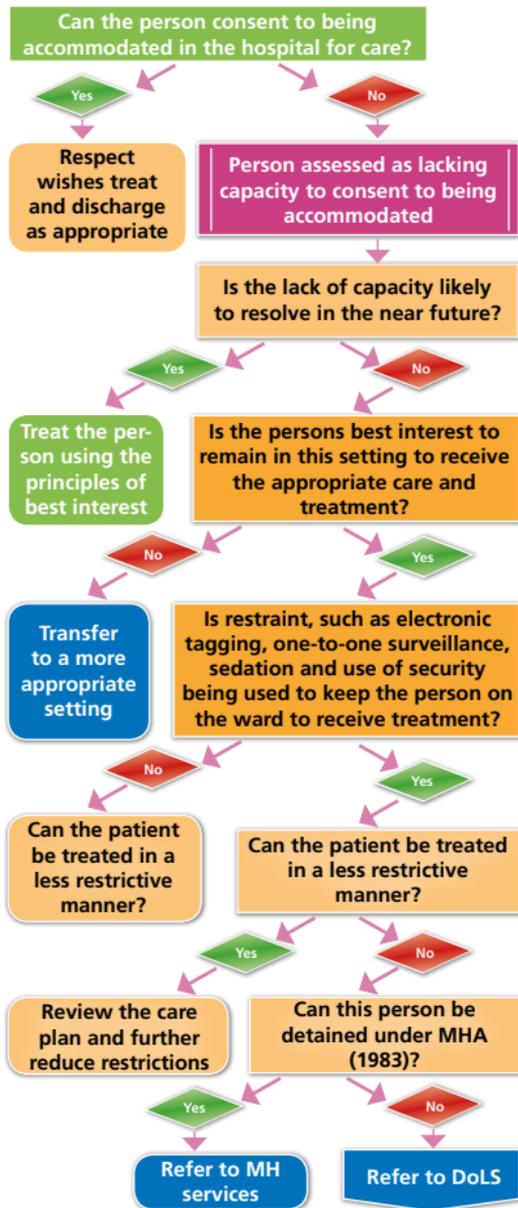
What to do

- If you are worried about a patient in your care who you think might be being deprived of their liberty, consider ways in which you can minimise restrictions
- It is important to act quickly in order to comply with legislation
- Discuss the case with your adult safeguarding lead
- In a community setting you can contact your local authority DoLS team or supervisory body office, who will be able to assist

Please refer to your local DoLS procedures

Deprivation of Liberty Safeguards (DoLS)

decision-making flowchart



The decision maker:

- Must ensure that the proposed action/treatment is in the best interests of the person.
- The decision maker needs to check if there is no Advance Decision (AD), Lasting Power of Attorney (LPA) or Deputy, or if there is a friend/carer of person nominated by the person to consult.
- The AD must be relevant to this decision

Record keeping:

- It is important that you accurately record and evidence any decisions made with regards to best interest.

Mental Capacity Act 2005:

- The person can be treated safely under the wider provisions of the MCA 2005. The person will be supported to make decisions as their mental capacity improves.

Restraint:

- Any form of restraint should prompt consideration of DoLS with an assessment of care where a person may be deprived of autonomy and choice with regards to their care plan.
- The care plan will be agreed by the ward team with the patient where possible, carers or advocate, and reviewed as stated or as circumstances change.

Prevent

Prevent is part of the Government's counter-terrorism strategy known as CONTEST. Prevent aims to reduce the risk we face from terrorism by stopping people becoming terrorists or supporting terrorism.

Healthcare professionals have a key role in Prevent. The strategy focuses on working with vulnerable individuals who may be at risk of being exploited by radicalisers and subsequently drawn into terrorist-related activity. With such vast interaction on a daily basis, there will continue to be occasions where healthcare workers meet and treat individuals who may be open to exploitation by radicalisers.

The key challenge for the health sector is to ensure that, where there are signs that someone has been or is being drawn into terrorism, healthcare workers can interpret those signs correctly, are aware of the support that is available and are confident in referring the person for further support. If you have concerns you should raise these with your organisational Prevent lead or Safeguarding lead.

The DH has developed Prevent guidance and a toolkit for the NHS, private and voluntary health sectors to guide delivery of the strategy at a local level. The documents 'Building

Partnerships, Staying Safe' provide a framework for health organisations to ensure that they are sufficiently structured to manage concerns about vulnerable individuals who may be exploited and drawn into terrorism. The escalation model reflects current safeguarding principals, together with a drive to support vulnerable individuals through closer partnership working across organisations within the public, private and voluntary sector.

Building Partnerships, Staying Safe is available from the Department of Health website at:

<http://www.dh.gov.uk/health/2011/12/guidance-vulnerable-adults/>

In conjunction with the Home Office, the DH has also developed a workshop tailored to the healthcare sector, known as HealthWRAP (Working to Raise Awareness of Prevent). This workshop is used to raise awareness of Prevent as well as the importance of having robust escalation procedures in place within an organisation, alongside partnership sector arrangements.

Please contact your Prevent or Safeguarding lead for further information about awareness raising training.

Prevent - Channel

What is Channel?

Channel is a multi-agency partnership that works with existing safeguarding partnerships and crime reduction panels in order to assess referrals of vulnerable individuals that are at risk of being drawn into terrorism. Channel is administered and coordinated by police, but chaired by the local authority.

Channel is part of the Prevent strand of the Government's Counter Terrorism Strategy CONTEST.

The Channel group provides a mechanism for supporting individuals who may be vulnerable to terrorist-related activity by assessing the nature and the extent of the potential risk, agreeing and providing an appropriate support package tailored to the individual's needs.

What happens with the referral?

- Each referral is screened for suitability. If the referral is not appropriate for Channel an exit strategy will be planned
- Appropriate referrals will go through a preliminary assessment coordinated by the police Channel coordinator
- Partners will be asked to check and report back to the police

Channel coordinator if the vulnerable individual is known to their service and a case profile will be created for the Channel meeting

- The multi-agency panel will convene and be chaired by the local authority, support needs will be identified and action plan will be drafted
- Each case will be reviewed a minimum of every six weeks
- There will be a six-monthly and 12-monthly review for each case

Will the vulnerable person be informed that they have been referred for Channel intervention?

This will depend on individual circumstances. If there is genuine concern that informing individuals of the referral will jeopardise their engagement and increase vulnerability, partners may agree not to inform them, this should be judged on a case by case basis.

How to refer to the Channel programme?

If you have a concern about an individual please refer to your Channel referral protocol which will be held with your organisational Prevent lead or Safeguarding lead.

Resources

For the resources listed below, visit:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124882

- **Clinical Governance and Adult Safeguarding: An integrated process**, (DH, February 2010)
- **Safeguarding Adults: The Role of Health Service Managers and their Boards**, (DH, March 2011)
- **Safeguarding Adults: The Role of Health Service Practitioners**, (DH, March 2011)
- **Safeguarding adults: The Role of NHS Commissioners**, (DH, March 2011)
- **Safeguarding Adults Self-Assessment and Assurance Framework**, (DH, March 2011)
- **Safeguarding Adults and the Role of Health Services: Analysis of the Impact on Equality**, (DH, May 2011)
- **Statement of Government Policy on Adult Safeguarding**, (DH, May 2011)

Further resources:

Protecting adults at risk: see local multi-agency policy and procedures to safeguard adults from abuse.

Adult Safeguarding Resources and Reports from Social Care Institute for Excellence (SCIE):
www.scie.org.uk/adults/safeguarding/index.asp

Safeguarding adults at risk of harm: A legal guide for practitioners:
www.scie.org.uk/publications/reports/report50.pdf

Self-neglect and adult safeguarding: findings from research:
www.scie.org.uk/publications/reports/report46.pdf

Association of Directors of Adult Social Services – Safeguarding Adults Key Documents:
www.adass.org.uk

Adult Safeguarding Knowledge Hub:
<https://knowledgehub.local.gov.uk/group/khub/hub>

Mental Capacity Act 2005 in primary care e-learning toolkit:
www.mcahealth.net

NMC Safeguarding Toolkits:
www.nmc-uk.org/Nurses-and-midwives/safeguarding/

RCN Practice Guidance:
www.rcn.org.uk/development/practice/safeguarding

Key Contacts

Name: Email: Tel:

DoLS/IMCA - Lead

Independent IMCA

Best Interest Assessor

Learning Disability Liaison/Lead

PREVENT Co-ordinator/Lead

Local Authority Adult Safeguarding Lead

Local Authority Contact/Referral Centre

Named Nurse, Child Protection

Named Doctor, Child Protection



South of England

This set of cards was produced in a partnership between NHS Strategic Health Authority Adult Safeguarding Leads, with thanks to the East Midlands Safeguarding Adults Health Network for the original idea and the NHS London Safeguarding Adults Network, MCA and DoLS Flow-chart Working Group.

Sponsored by NHS South of England (East)

