Safeguarding Policy

Public

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21/11/2023	V8	Added review cycle and date Amended escalation Added section escalation for allegations against colleagues Re-ordered definitions, key

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24/3/24	V8.1		responsibilities Added Accessibility, Training, and Equality Impact Assessment sections Amended Local Leads, Caldicott Guardian listing, escalation process wording, wording changes from Trustees.

Adjoining or Referenced Policies, Procedures, Guidance
Whistleblowing Policy
Child Protection Policy
Missing Persons Policy
Incident, Accident and Near Miss Policy
Safer Recruitment Policy
Caldicott Policy
MH Crisis Management Policy

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1. Accessibility

At Social Interest Group (SIG), we are keen that everyone has equitable access to our policies and procedures as needed. If you need this policy in a different format, please contact the author via **enquiries@socialinterestgroup.org.uk**
The policy is available to all staff via the intranet and to other key stakeholders via our website; **www.socialinterestgroup.org.uk**.

2. Scope

Safeguarding residents and participants, their children, and all colleagues, volunteers and the wider community is fundamental to every aspect of Social Interest Group's service delivery. To ensure our continued commitment to safeguarding, the Group is committed to ensure a pro-active approach through implementing Psychologically Informed Environments and Trauma Informed support and care. This policy sets out our approach, internal framework and flows of escalation and reporting in line with relevant legislation (see Appendix 1) and the Six Principles of Safeguarding; Partnership, Accountability, Empowerment, Prevention, Proportionality and Protection.

3. Key Definitions

3.1 Colleagues

For the avoidance of doubt, where colleagues are referred to, this is acknowledged to include both permanent employees and bank workers, agency workers, volunteers, consultants, self-employed/contractors where applicable, work experience individuals, internships, and other placements. This is not meant to indicate employment rights where none exist.

3.2 Residents and Participants

For the purpose of this policy reference to either residents, participants and members indicates someone for whom we are providing support or a service and includes:

- Any tenant or client in accommodation owned or managed by the SIG (the Group) and its subsidiaries.
- Any person receiving outreach and or floating support (including in prison or hospital).
- Someone enquiring about or applying for our services.
- This policy is also relevant to those who have previously received our services.

3.3 Adult at Risk

Any person who uses, works in or visits a service, site or office in the Group has the potential to be an 'adult at risk'. This will include but not be limited to participants, colleagues, family and friends of participants, etc. It is possible that information may come to light around safeguarding concerns for adults at risk who do not access SIG services. SIG colleagues are expected to follow safeguarding

procedures for anyone they encounter, or incidents/allegations reported to them as per this policy.

Adult at risk (The Care Act section 42) means anyone over 18 years old who:

i. Has care and support needs.
ii. Is experiencing, or is at risk of, abuse and neglect; and
iii. As a result of those care and support needs, is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Further information around assessing whether someone has 'care and support needs' as defined by the Act can be found in Appendix 2.

3.4 Safeguarding

The Health and Care Act 2022 statutory guidance defines safeguarding as 'protecting an adult's right to live in safety, free from abuse and neglect'.

Any of our colleagues may come into contact with people inside and outside of work who they have a safeguarding concern about; people who are at risk of harm. Safeguarding means protecting people from harm including physical, emotional, sexual, financial harm and neglect. Safeguarding adults at risk is about people and organisations working together to prevent and stop both the risks and experience of abuse and neglect, whilst 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.

NOTE Risks around becoming involved in terrorism through radicalisation are reported through separate mechanisms from safeguarding; see section 11; Prevent.

NOTE Risks around self-harm and suicidal ideation are mental health clinical risks and should be escalated through your local Mental Health Clinical Care teams or NHS emergency services.

3.5 Abuse

Abuse is a violation of a person's human and civil rights by any other person. It is where someone does something (or omits to do something) to another person which puts them at risk of harm and impacts on their health and wellbeing. There are many different types of abuse which we must be alert to, for example:

Physical abuse	Emotional / psychological abuse	Sexual abuse
pain injury, harm	insults, bullying, threats, humiliation and ridicule	any sexual activity carried out without continued consent from the individual
Financial / material abuse	**Organisational abuse**	**Modern slavery**
theft, fraud, extortion (including legal documents such as wills)	professionals and organisations abusing their power, data or cultural influence systematically	people working in forced conditions or not in line with basic rights
Discriminatory abuse	**Neglect / self neglect**	**Domestic abuse**
being treated differently based on any of the 9 protected characteristics **Under the Equality Act of 2010**	someone or you denying basic rights including hygiene, self-care, warmth, food etc	use of power, control, and coercion over romantic partners and / or family members

Further information about specific forms of abuse; modern slavery, sexual abuse and consent, the protected characteristics within discriminatory abuse, cuckooing and female genital mutilation can be found in Appendix 3.

3.6 Mental Capacity

Legally there is a presumption of capacity unless the adult demonstrates otherwise (Mental Capacity Act 2005). If someone has a mental health issue or difficulty this does not mean they don't have the capacity to understand information and process it to come to an informed decision. If the vulnerable adult is judged to have capacity and does not want to report abuse this wish must be respected as the law recognises the right to 'make an unwise decision' (see Appendix 4: Mental Capacity). Exceptions to this are when there is a public duty to report, a crime has been committed, or there is a coercive or controlling relationship involved; seek advice from your Local Safeguarding Lead. Any adult at risk will always have their privacy, dignity, independence and choice respected at all times and they should be able to freely determine their own lives, make their own choices and take risks except when they do not have capacity to do so.

NOTE: When there is a child at risk there is a duty to report regardless of the parent, guardian, carer or other adult's view; see Safeguarding Children Policy for further information.

3.7 Psychologically Informed Environments

Creating a Psychologically Informed Environment (PIE) is to create a safe environment where participants and residents feel safe and have opportunities to lead happier, healthier lives; this approach is central to our work and therefore to our safeguarding practice. It covers.

- The physical and social environment
- The training and support given to staff.
- The psychological framework – or understanding.
- The relationships within the service
- How outcomes are measured and evaluated
- Reflective practice

3.8 Trauma Informed Care

Trauma Informed Care (TiC) is a strengths-based framework that recognises the complex nature and effects of trauma and promotes resilience and healing. This approach is central to our work and therefore to our safeguarding practice.

- Safety – creating spaces that promote a sense of safety.
- Trust – providing clear and consistent information.
- Choice – providing options for support and interventions.
- Collaboration – maximising opportunities to work together with our participants and residents, families, networks and communities.
- Empowerment – building on each person's strengths and experiences.

3.9 Professional Curiosity

Professional curiosity is where we explore and proactively try to understand what is happening within a family or for an individual, rather than making assumptions or taking a single source of information and accepting it at face value. It has been recognised as a key part of safeguarding practice in several Safeguarding Adults Reviews and is a central part of our safeguarding approach within the Group.

SIG is committed to creating an environment that responds to disclosures of abuse in the following ways:

Physical & Social Environment	The training and support given to staff	The psychological framework – or understanding

Ensuring that we utilise our environments to the best of our ability to ensure private and confidential places exist to allow Residents & Participants to open up about potential abuse/neglect	Training on TiC and person centred care in order to build trust, facilitating disclosure of information to inform safeguarding activity (see also Training; section 12)	Understanding that abuse/allegations of abuse are part of the person and are not seen in isolation. SIG understands that when working with Adults at Risk colleagues should be focused on strengths and solution focused approaches
The relationships within the service	**How outcomes are measured and evaluated**	**Reflective practice**
The service has a positive environment that allows all staff, managers, Residents & Participants and the wider community to feel safe, secure and validated through transparency, honesty and continued learning	Ensuring that safeguarding is first and foremost in our minds and that outcomes never take precedent over the wellbeing and safety of Residents & Participants, staff and the wider public.	The service ensures that a culture exists of reflective practice through regular supervisions, group reflective practice meetings, training to supervisors and protected time to ensure continued development and learning

4. Roles and Responsibilities

4.1 All colleagues

Safeguarding is everyone's business, and all colleagues will demonstrate a professional curiosity where there are any signs that there may be a safeguarding concern. Everyone has a duty to escalate, and report concerns with the guidance of their Local Safeguarding Lead (or any of the Safeguarding Team, in their absence; see Appendix 5), and to refer to the Local Authority where appropriate. They must maintain their own knowledge of safeguarding as it applies to their role and to participate in reflective practice. All colleagues are expected to comply with and are accountable for following this policy and procedure but are also safeguarded through its intentions and process. Any member of this group or their partners who is considered an adult at risk will have additional reasonable adjustments put in place to support them. All colleagues supporting participants and delivering assessments and Risk Assessments must ensure that risks of abuse, neglect and exploitation of people are integral in

the assessment and planning process. All colleagues are required to report safeguarding concerns as per the Incident, Accident and Near Miss Policy published on the intranet.

4.2 Local Safeguarding Leads

The role of the Safeguarding Leads (see Appendix 5) is to provide an immediate, knowledgeable point of escalation and advice for our colleagues, and they in turn have support from each other and from the Designated Safeguarding Lead and Safeguarding Coordinator. They are responsible for responding to requests for advice and assisting in decision making, and to guide the process of external referral. Safeguarding Leads have additional access to training and resources, and Safeguarding Practice Reviews to ensure confidence and competence in their role. Local Safeguarding Leads are responsible for building relationships with their Local Safeguarding Adults Boards (LSABs).

4.3 Safeguarding Co-Ordinator

The Safeguarding Coordinator is a member of the Audit and Compliance Team and co-ordinates the development, training, and function of the Leads as a team. They also maintain a central record of Safeguarding alerts made by services and track these, facilitating escalation to CEO and other stakeholders and closure as required. They can deputise for the Designated Safeguarding Lead during leave and play a key role in organising and facilitating the AINMs review meetings and Safeguarding Practice Reviews which provide a space for reflection on action taken by SIG or other stakeholders around Safeguarding Alerts. Where appropriate and necessary they can further escalate matters of concern to external stakeholders where they feel risk continues to be present, and appropriate mitigations are not in place, with the support of the Designated Safeguarding Lead and wider Leadership Team.

4.3 Designated Safeguarding Lead

The Director of Compliance, Risk and Audit is the Designated Safeguarding Lead for SIG and the subsidiaries. The Designated Safeguarding Lead has responsibility for the strategic direction of Safeguarding policy and practice throughout the organisation and supplies a monthly report to the Leadership Team and a quarterly report to the Trustees. They support and assist the Safeguarding Coordinator in all aspects of their Safeguarding responsibilities.

4.4 SIG Leadership Team

SIG Leadership Team (made up of the Directors of each department within the SIG Group and CEO) have a responsibility to monitor all allegations of abuse and gain an oversight of all Safeguarding activity through monthly reports from the Designated Safeguarding Lead. They will constructively challenge the safeguarding team on their activity and approach where appropriate, and will ensure the

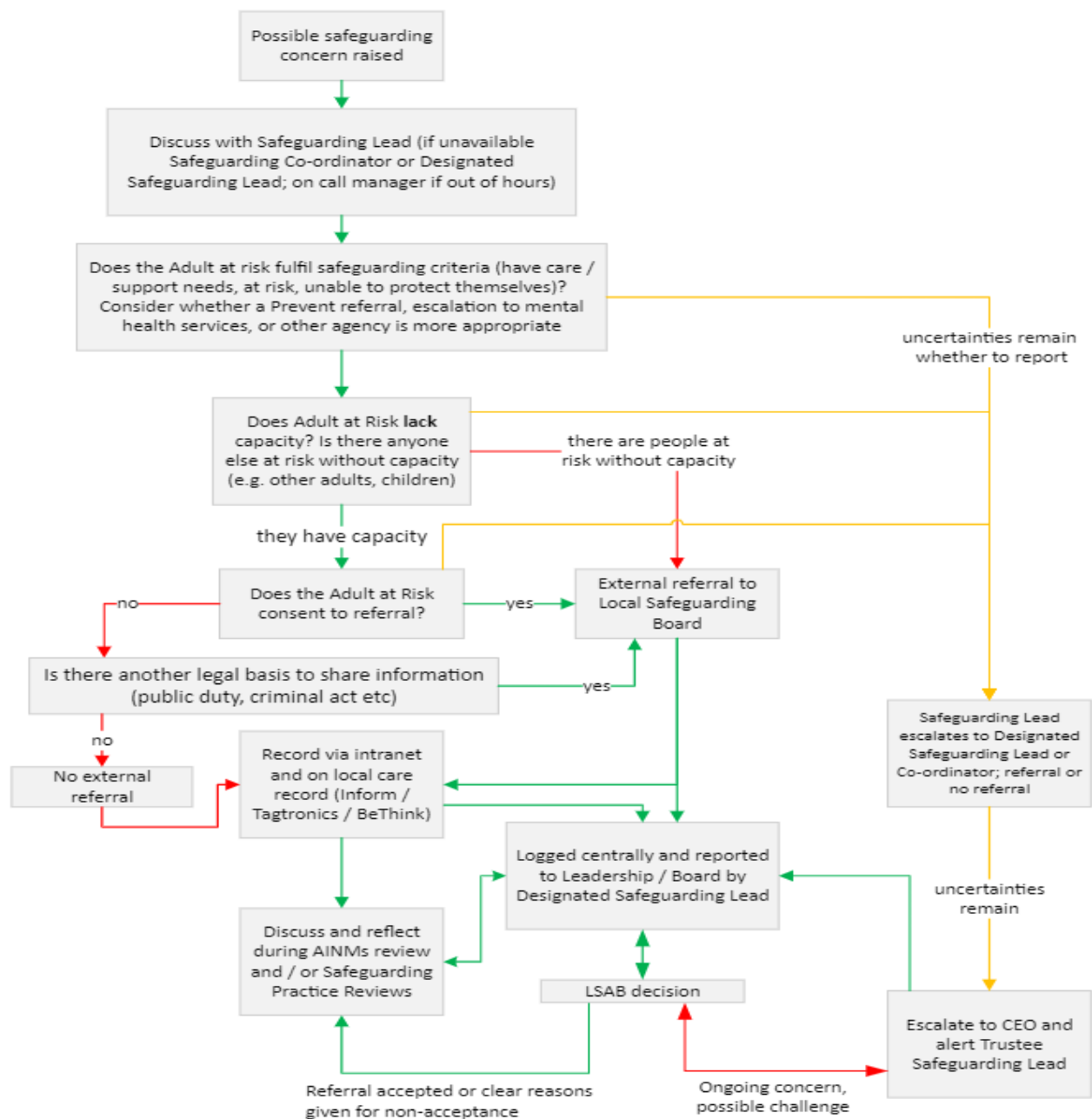responsiveness of operational teams to advice from LSABs.

4.2 SIG Board of Trustees

The Board of Trustees has a designated safeguarding lead whose responsibility it is to oversee the charities compliance with its policy and legal duties regarding safeguarding. They will act as a point of escalation for the Designated Safeguarding Lead as required but specifically where there are allegations against colleagues, situations where there are particularly difficult conflicts regarding whether to report, and in instances where reports are rejected by the local authority, and we are looking to challenge due to significant and ongoing concern.

5. Managing a safeguarding concern

The flow chart below demonstrates how Safeguarding concerns are raised internally, escalated appropriately, and reported both internally and externally. Follow this step by step to manage your safeguarding concern. A quick reference process is available at Appendix 6.

Possible safeguarding concern raised

Discuss with Safeguarding Lead (if unavailable Safeguarding Co-ordinator or Designated Safeguarding Lead; on call manager if out of hours)

Does the Adult at risk fulfil safeguarding criteria (have care / support needs, at risk, unable to protect themselves)? Consider whether a Prevent referral, escalation to mental health services, or other agency is more appropriate

uncertainties remain whether to report

Does Adult at Risk **lack** capacity? Is there anyone else at risk without capacity (e.g. other adults, children)

there are people at risk without capacity

they have capacity

Does the Adult at Risk consent to referral? — no — yes → External referral to Local Safeguarding Board

Is there another legal basis to share information (public duty, criminal act etc) — yes

no

No external referral

Record via intranet and on local care record (Inform / Tagtronics / BeThink)

Safeguarding Lead escalates to Designated Safeguarding Lead or Co-ordinator; referral or no referral

Logged centrally and reported to Leadership / Board by Designated Safeguarding Lead

uncertainties remain

Discuss and reflect during AINMs review and / or Safeguarding Practice Reviews

LSAB decision

Escalate to CEO and alert Trustee Safeguarding Lead

Referral accepted or clear reasons given for non-acceptance

Ongoing concern, possible challenge

SIGs commitment to becoming a Psychologically Informed Environment means that any learning, reflections and issues from safeguarding cases in those reports will be fed back to staff and Residents & Participants in a timely manner to ensure a culture of transparency, safety and continued learning.

6. Safeguarding allegations against colleagues

Safeguarding allegations may be raised against colleagues (whether employed, volunteer, or agency etc) by participants, colleagues, or third parties. Where staff have concerns, they should speak to the relevant Service Manager and Safeguarding Lead immediately. If they are unavailable or implicated in concerns, or if for any reason they cannot approach them, the Safeguarding Co-ordinator or Designated Safeguarding Lead should be contacted urgently; out of hours, the on-call process should be followed.

For the safety of and protection of everyone including the colleague who has had allegations raised against them they will be removed from contact with participants and / or alleged victims as far as SIG is able to influence, whilst the allegations are reviewed. To agree this an urgent meeting (one working day) will be convened involving a member of the People and Culture Team, a member of the Compliance Team, the local Safeguarding Lead and Service Manager, and may include Head of Service, Director of Operations or EDI Programme Manager to agree.

- Next steps and appropriate support to be in place for the colleague with allegations against them.
- Whether a safeguarding referral is warranted or what information must be gathered first
- Any other internal or external communications which may be required.
- Who will lead the safety review and timeframes for actions.

Allegations involving colleagues are always escalated to the Trustee Safeguarding Lead. A quick reference guide to this process can be found in Appendix 7.

Alternatively, the Whistleblowing Process may be followed; see Whistleblowing Policy.

7. Historic Abuse

Not all abuse that is disclosed will be occurring or have just occurred. Someone may open up about incidents that may have happened months or years ago. If that is the case, then consider the following:

Evidence: Take what the person says seriously but do not explore past the key details	Can someone still be at risk? Is there a name of a person who could be harming further people? (i.e., a person who is being accused of child abuse who	What does the service user want? With it being historic, is the person ready to get support for this? If not, is there other services that can support the	Build support: If the person wants to disclose, support the person to be clear what they want and to go to the police to report it.

	works with children). If so, act immediately by calling 999	person?	

If a historic abuse allegation is made, follow the normal safeguarding process immediately after the disclosure is made to ensure appropriate action is taken.

It may also be appropriate to review the Missing Persons Policy and Whistleblowing Policy dependent on the nature of the allegation.

8. How to respond when a Safeguarding allegation is made

Remain calm	Take what the person says seriously	Clarify understanding but do not ask detailed/ leading questions	Reassure the person that they were right to tell you
Do not make promises of secrecy	Be open and honest: explain you may have to share concerns with others	Immediately record in writing using their words. Never summarised	Get help, support and reflection from your colleagues and/or your manager

8.1 Limited Re-traumatisation
When someone discloses to you neglect or abuse, it is important to engage them using a Trauma Informed Care approach. Some of the key areas to avoid include:

Lack of privacy when disclosing	Asking them overly personal questions	Making them feel powerless or controlled	Making them feel people are in authority over them	Violating their personal space (e.g. hugging)
Demonstrating your own discomfort discussing the disclosure	**Reacting in a way or making promises leading to 'betrayal' by professionals**	**Making them feel knowledge is being held back by professionals**	**Making them feel their voice and wants are not being listened to**	**Making them feel disbelieved**

Ensure that after the person has opened about the disclosure, the chance of re-traumatisation is limited through:

Checking in on how safe that person is feeling	Understanding what support they have	Assisting in finding support if they do not feel they have any	Agreeing when to follow up to ensure ongoing wellbeing	Encouraging self-soothing and grounding techniques if they feel any re-traumatisation

8.2 The Impact on You: Vicarious Trauma

The term vicarious trauma, sometimes also called compassion fatigue, is the term that describes the phenomenon generally associated with the "cost of caring" for others.

Vicarious trauma is the emotional residue of exposure from working with people. This happens when you hear people's trauma stories and become witnesses to the pain, fear, and terror that trauma survivors have endured. Vicarious trauma is not 'burn out' which can happen over time, instead it is a state of tension and preoccupation of the experience described by Residents & Participants.

Signs and Symptoms can include:

Having difficulty talking about feelings	Anger/ irritation	Startle effect/ being jumpy	Addictions: alcohol, food, gambling, etc	Sleep difficulties	Worried you are not doing enough	Diminished joy
Feeling trapped in your job	Not getting satisfaction from your job	Intrusive thoughts of trauma	Feeling of hopelessness	Blaming others	Black & white thinking	Dissociative thinking

Unfortunately, you cannot always stop the above effects, but you can limit the damage by identifying the effects of Vicarious Trauma and taking active steps to limit the impact of it and learn from the experience. SIG commitment to maintaining a Psychologically Informed Environment means that the following are available to staff:

SIG commitment to staff:	Creating a safe space for all	Allowing an environment where reflective practice happens	Providing an Employee Assistance Programme (24hr telephone support)	Providing effective supervision to all colleagues by trained supervisors	PIE Utilising any opportunity to continue to build PIE into day-to-day activities

Your individual commitment:	Ensure you take your breaks and being honest on what you can achieve	Ensure you utilise supervision and reflective practice for continued development	Use your manager and colleagues for support and continued wellbeing	Remember that you are human, and this can happen to anyone!

All colleagues are expected to use their supervision sessions with their supervisors to reflect and explore vicarious trauma, or if more immediate support is required talk to Line Manager and trained colleagues to access this at the right time.

9. Safer Recruitment

Safer Recruitment is a key part of our Safeguarding framework at SIG and covers mechanisms for checking applicants employment history and against Disclosure and Barring Service records, as well as discouraging those who pose a threat to vulnerable adults by being open about our policies, procedures and checks throughout the application process. Please refer to our Safer Recruitment

policy and procedure for full details.

10. Information Sharing and Data Protection in Safeguarding

Information sharing is governed by the General Data Protection Regulation (GDPR) however there are a specific set of principles governing the sharing of data in cases where contexts such as Safeguarding is a concern; the Caldicott Principles (see Caldicott Policy for details). If you are unsure about whether you should be sharing information or how much to share you should consult with the organisation's Caldicott Guardian. Multi-agency working, and working within partnerships with other organisations is a key part of SIG's role in safeguarding.

11. Prevent

This is a specialist area of safeguarding provided for by the Counter Terrorism and Security Act 2015. It places a duty on 'specified authorities' (including the NHS, Local Authorities, and Probation Service) to have 'due regard to the need to prevent people from being drawn into terrorism'. As we deliver services on behalf of specified authorities we too come under this duty.

The Prevent Strategy was published by government and deals with all forms of terrorism and non-violent extremism. Extremism is defined as 'vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs'. Radicalisation is the process by which vulnerable people may be drawn or groomed into extremism, and terrorism is the acts of violence which may be associated with extremist ideologies.

People often become vulnerable to radicalisation when they:

- Don't have a strong sense of identity and feel confused about where they fit in or belong.
- Feel under threat either personally or as part of their community.
- Feel angry or wronged about events like conflicts or terrorist incidents in the UK or abroad.
- Experience mental ill health, bereavement, loss of job or home.
- Experience racism, bullying or discrimination.
- Have family breaking down.
- Feel 'left behind'.

Clues to watch for which might indicate radicalisation in someone include:

- A change in behaviour
- Changing their circle of friends
- Isolating themselves from family and friends
- Talking as if from a scripted speech
- Unwillingness or inability to discuss their views.
- Sudden disrespectful attitude towards others
- Increased levels of anger

- Increased secretiveness, especially around internet use
- Accessing extremist material online
- Using extremist or hate terms to exclude others or incite violence.
- Writing or creating artwork promoting violent extremist messages

There is a Prevent Team in every local area combining local authority and police team expertise. 'Channel' is the multi-agency safeguarding programme which offers help and guidance to people who may be at risk of being drawn into extremist related activity. Referrals should always be escalated to the Prevent Lead of the organisation; at the Social Interest Group this is the Director of Compliance, Risk and Internal Audit, however if for any reason you think there is an immediate credible threat you should call 999 for a police response.

12. Training and monitoring

SIG will provide mandatory training on Safeguarding both children and adults at induction and then at two yearly intervals after that. This mandatory level will be monitored and reported on to Leadership Team by the Learning and Development Partner in the People and Culture Team. The Safeguarding Team (Local Safeguarding Leads, Safeguarding Coordinator, Designated Safeguarding Lead and Trustee Safeguarding Lead) will receive additional training from external providers aimed specifically at their competencies and requirements. The Safeguarding Team will hold regular CPD and supervision sessions (Safeguarding Practice Reviews) to share and maintain best practice across the organisation. Learning will be disseminated to frontline teams via their Safeguarding Leads.

Safeguarding referrals will be monitored by the Safeguarding Coordinator and Designated Safeguarding Lead for quality and specificity. Both referrals and concerns raised will be monitored in AINMs review meetings via the Safeguarding log kept by the Audit and Compliance team. There will also be an annual safeguarding audit testing the effective roll out of this policy.

13. Equity Impact Assessment

EIA Questions	Answer and mitigations
Who is affected by this policy?	All colleagues, volunteers and contractors, participants and residents, and family, friends and acquaintances of colleagues.
Who is intended to benefit and	All the above are intended to benefit as they are in contact with people who know what to look for when someone

how?	might be being abused and how to raise concerns effectively and in their best interests.
Could there be a different impact or outcome for some groups?	It is possible that some groups are impacted by social or perceived stereotypes, as people make assumptions when thinking about certain aspects of safeguarding or abuse, for example domestic abuse victims are more likely to be women, certain ethnic groups have a higher level of honour based violence, etc. This will be mitigated by the chain of escalation, and CPD and supervision sessions creating the space to question, explore and identify assumptions.
Does this policy / procedure include making decisions based on individual characteristics, needs or circumstances?	The policy explicitly includes only those over aged 18. There is a need to base safeguarding decisions on certain needs (care and support needs as defined by the Care Act).
Are relations between different groups likely to be affected by what you are doing? Will it favour one group or deny opportunities to others?	The policy does not intend to impact relations between different groups, or to favour / deny opportunities to any group. There is a risk that known biases in certain types of safeguarding can lead to erroneous assumptions being made; to be mitigated by the chain of escalation, and CPD and supervision sessions creating the space to question, explore and identify assumptions, as above.
Is there any specific, targeted action to promote equality? Is there a history of unequal outcomes?	The mitigations above will be targeted to promote an equitable approach.

Appendix 1: Legislation

Legislation is available to protect our Residents & Participants, ourselves and the wider community. Do not be afraid to use in line with Evidence Based Practice:

1.1 Care Act 2014: The act helps to improve people's independence and wellbeing through limiting the impact and exposure to abuse and neglect. It makes clear that local authorities must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support. It replaced 'No Secrets' 2000.

1.2 Mental Capacity Act 2005: The Mental Capacity Act (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over.

1.3 Equality Act 2010: The Act legally protects people from discrimination in the workplace and in wider society. It replaced previous anti-discrimination laws with a single act.

1.4 Children and Families Act 2014: This aims to ensure that children, young people and their families are able to access the right support and provision to meet their needs.

1.5 Children's Act 1989/2004: The act allocates duties to local authorities, courts, parents, and other agencies, to ensure children are safeguarded and their welfare is promoted. The Act is to promote co-ordination between multiple official entities to improve the overall well-being of children. The 2004 Act also specifically provided for further vulnerabilities, such as disabled children.

1.6 Sexual Offences Act 2003: This act aimed to include more offences described as sexual offences and a greater focus on consent.

1.7 Forced Marriage Act 2007: is an act that seeks to assist victims of forced marriage, or those threatened with forced marriage, by providing civil remedies. Those at risk can apply for a Forced Marriage Protection Order (FMPO) to stop the marriage taking place.

1.8 Prevent Strategy 2011: The purpose of *Prevent* is to stop people from becoming terrorists or supporting terrorism. This includes countering terrorist ideology and challenging those who promote it, supporting individuals who are especially vulnerable to becoming radicalized, and working with sectors and institutions where the risk of radicalization is assessed to be high.

1.9 GDPR/Data Protection Act 2018: The General Data Protection Regulation ("GDPR") came into force on the 25 May 2018. It is a European law which governs what we can and cannot do with people's personal data. The UK has supplemented this further with the Data Protection Act 2018 to safeguard people's data/information.

2.0 The London Multiagency Adult Safeguarding Policy and Procedures

2.1 The Human Rights Act (1998)

Appendix 2: Using the Care Act 2014 to assess 'care needs'

The Care Act is the key piece of legislation when safeguarding adults; we must be able to demonstrate that the person is an 'Adult at Risk'. However, sometimes we can make a referral that does not result in the outcome we feel is acceptable for the abuse/neglect the person has suffered/suffering from. To help us make the best possible referrals and to challenge any decision we do not feel is appropriate, please use the below guidance.

2.1 Care Act Assessment

The local authority must carry out an assessment if a person appears to have care and support needs, regardless of their nature or level (section 9). They must then decide whether the person's needs are eligible to be met (section 13) when judged against the national eligibility criteria and whether there is a duty (section 18/20) to meet them.

- Local authorities must assess anyone who appears to have **any level of needs for care and support**.
- Assessment is not a **gateway to services but an intervention in its own right. It is a crucial way to help a person understand their needs and how they can be met.**
- For the assessor they must establish the full extent of the needs, including those currently met by a carer. **This so called 'carer blind' aspect** of assessment is new. It aims to ensure that the entirety of a person's needs are identified.

An assessment should **identify:**

- Clearly define and evidence care and support **needs.**
- What outcomes the individual is looking to achieve to maintain or improve their **wellbeing**
- How care and support might help in achieving those **outcomes**
- Draw on personal, community and family **assets** to promote independence.

2.2 Safeguarding Boards should also ensure that they are:

- Person centred, involving the individual and **any person** they might want involved.
- Establish the **total extent** of the needs, **going beyond the presenting need** and assessing the **impact on wellbeing** and the individual's desired outcome.
- If necessary, the LA must use supported decision making.
- Eligibility can only be decided **after** an assessment.

2.3 Eligibility Criteria

The adult's needs arising from or related to a physical or mental impairment or illness. Importantly with respect to the housing sector, the LA should base their judgement on the assessment of the adult and a formal diagnosis should not be required (Care Act Statutory Guidance 6.105).

As a consequence of being unable to achieve these outcomes there is, or there is likely to be a **significant** impact on the adult's **wellbeing**.

The key is to establish a need that arises from a physical or mental impairment or illness. A mental impairment could cover a mental health condition (whether that condition is diagnosed or not), brain damage such as Wernicke–Korsakoff syndrome, or autism and related conditions.

Establish a need. Physical or mental impairment or illness		Identify at least two outcomes that the person is unable to achieve		Show a significant impact on a person's wellbeing	=	A successful referral resulting in an eligible need being identified

2.4 Eligibility questions

- Is unable to achieve the outcome without assistance.
- Is able to achieve the outcome without help but to do so causes significant pain, distress or anxiety.
- Is able to achieve the outcome without assistance but doing so endangers others.
- Is able to achieve the outcome without assistance but takes significantly longer than would be normal. **(Care Act Statutory Guidance 6.106)**

2.5 The Care Act clearly defines nine outcomes that everyone in our society has the right to:

1. Managing and maintaining nutrition
2. Maintaining personal hygiene
3. Managing toilet needs
4. Being appropriately clothed
5. Being able to make use of the home safely
6. Maintaining a habitable home environment
7. Developing and maintaining family or other personal relationships
8. Accessing and engaging in work, training, education or volunteering
9. Making use of necessary facilities or services in the local community including public transport and recreational facilities or services
10. Carrying out any caring responsibilities the adult has for a child

The Care Act also discusses the impact of not receiving desired outcomes on their wellbeing. They define wellbeing as:

- personal dignity
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over their day-to-day life
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal domains
- suitability of the individual's living accommodation
- the individual's contribution to society.

Further details can be found in the Care Act Guidance, ch14.

Appendix 3: Further Details on Types of Abuse

3.1 Modern Slavery

Slavery is an umbrella term for activities involved when one person obtains or holds another person in compelled service. Someone is in slavery if they are:

- forced to work through mental or physical threat.
- owned or controlled by an 'employer', usually through mental or physical abuse or the threat of abuse.
- dehumanised, treated as a commodity or bought and sold as 'property'.
- physically constrained or have restrictions placed on his/her freedom.

The following definitions are encompassed within the term 'modern slavery' for the purposes of the Modern Slavery Act 2015.

- 'slavery' is where ownership is exercised over a person.
- 'servitude' involves the obligation to provide services imposed by coercion.
- 'forced or compulsory labour' involves work or service extracted from any person under the menace of a penalty and for which the person has not offered himself voluntarily
- 'human trafficking' concerns arranging or facilitating the travel of another with a view to exploiting them.

Signs can include:

- No identification on the individual as it has been taken off them by the perpetrators.
- Threats of being returned to country of origin, told that no one will believe them or that they are in the wrong and will face punishment.
- Having no access to money
- Being paid money but given less than the minimum wage
- Not realising they are slaves.
- Living in cramped conditions or others being forced to live with them

3.2 Sexual Abuse and Consent

Any kind of sexual activity that happens without consent is illegal. This includes suggestive comments, showing people sexual images, touching, and groping as well as sexual activity. Consent can be given and then retracted. And just because someone didn't say 'no', that doesn't mean they've consented. People we work with may not be clear on this and may not be aware they have been a victim of a sexual assault. Some areas to consider when supporting people:

- Did both parties participate freely and readily?
- What was the body language? Did they feel too scared to say no but their body language was closed off?
- Being too intoxicated on drugs/alcohol means they cannot consent.
- Someone who is asleep, or unconscious cannot consent.
- Capacity matters: mental health issues, learning disabilities, head injuries. If someone cannot communicate the decision, understand the consequences or understand choice then they cannot consent.
- People have the right to withdraw consent at any time. Once consent is withdrawn for anything, the behaviour must stop.

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3.3 Protected Characteristics: Discriminatory Behaviours

In line with the Equality Act 2010, no one should be treated any differently based on the following:

Age

Disability

Gender reassignment

Marriage/Civil Partnership

Pregnancy & Maternity

Race

Religion/ belief

Sex

Sexual Orientation

If someone is treated differently based on these protected characteristics it is counted as Discriminatory Abuse.

3.4 Cuckooing

This is when an adult at risk has their property taken over by individuals, usually organised crime gangs for the purpose of the distribution/supply of drugs. This is often linked to 'County Lines' where organised crime gangs utilise national networks to distribute drugs, crossing local authority boundaries and therefore making targeted responses challenging. If you suspect this, speak to your manager and inform the police.

3.5 Female Genital Mutilation

FGM is the practice of deliberately cutting, injuring or changing a female's genitalia with no medical reason. It is often practiced due to cultural reasons, but it is illegal (Female Genital Mutilation Act 2003) and can cause considerable physical and emotional pain both in the short-term and the long-term. This usually occurs in childhood, but adults may disclose this has happened to them. If this occurs, it is important you support the person in getting support and help them understand what happened to them was illegal and that support is available.

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Appendix 4: Mental Capacity Act 2005

4.1 Two stage assessment:

1. Is the person unable to make the decision in question at the time it needs to be made?
2. Is this inability as a result of an impairment of, or disturbance in the functioning of the mind or brain?

4.2 Four stage capacity test:

1. Does the person have an **understanding** of the key points of the decision that needs to be made, and why they need to make it? Do they understand the likely consequences of making the decision, or not making it?
2. Is the person able to **use and weigh** the information relevant to the decision?
3. Is the person able to **retain** the information relevant to the decision for long enough to make the decision?
4. Is the person able to **communicate** the decision by any means?

If a person is unable to do one or more of these things, they are considered unable to make the decision. Do not feel the pressure to make any final decision unless you are worried about immediate risks (i.e. a heavily intoxicated service user). Utilise your evidence to work with your colleagues, your manager and mental health services so that the person receives the best outcome possible.

"An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests"

For further information, the British Medical Association have produced a toolkit:

https://www.bma.org.uk/advice/employment/ethics/mental-capacity/mental-capacity-toolkit

Appendix 5: Contacts List

Designated Safeguarding Lead; Jenny Ralls

Safeguarding Coordinator; Kenny Sehmi

Trustee Lead for Safeguarding; Dylan Kerr

Caldicott Guardian; Adam Moll
Director Level; Angela Henry
Best Practice; Victoria Sweetman
Clinical Support; Muriel Gutu
Peripatetic Service Manager; Titiola Ojuri

Local Safeguarding Leads
Bedford and Luton: Alex Sinclair, Maureen Ryan, Susan Goodland, Sam Smith
Brighton; Janie Pamment, Sam Hull, Belinda Morgan
Croydon; Jacqueline Squire
Brent; Jatin Patel, Amanda Lemuel
Ealing; Kat Lacey, Dominique Woolnough, Catherine Bingham, Mirna Scholey, Shepherd Chikumbindi, Natalie Crank-Burnet
Enfield; Bygid Rahman, Berna Dixon
Kent; Philippa Nancoo, Sharon Hansen (Maidstone), Michael Bourne (Medway)
RBKC; Hadi Khanafer, Dorota Matuszewska, Keisha Dixon, Michael Shaw (SHAP)
Refuge; Helen Sweeney
PCCS; Veronica Claridi
South London; Michael Okoye, Gemma Kagho, Lily Odigie, Janina Ruszczynska, Gloria Olayinka, Osman Kamara, Biola Aleshe
South London Criminal Justice Services; Patrick Owens, Jessica Harker (Brixton), Chelsea Salek-Taghizadeh, Tina Monioro
Havering; Mehmetsalih Torah
Altcourse: Emma Hulme

SAFEGUARDING ESCALATION v1.1

If someone is in immediate danger phone 999 and ask for police

See it

- Are they safe? If you are concerned about an Adult at Risk of Harm you could help stop abuse.
- It is not your responsibility to decide if abuse has happened. **It IS your responsibility to report it to the Safeguarding Lead or Line Manager**.
- Consider whether the Adult at Risk has capacity. Seek consent to make a referral.
- Share your concerns/ information with the local Safeguarding Lead or your Line Manager urgently. If unavailable call Safeguarding Coordinator Kenny Sehmi or Designated Safeguarding Lead Jenny Ralls. When out of hours use the On-Call process.

Report it

- Use the Safeguarding Policy (search the intranet) to guide your discussion with the Safeguarding Lead about whether to make a Safeguarding referral to the local authority.
- If a Safeguarding Alert is appropriate, refer to your local authority as directed by your Safeguarding Lead.

Record it

- Submit an AINMS report regardless of whether you refer externally.
- Make a note on Inform, including risk assessment and include in the handover for the next team regardless of whether you refer externally.

-

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Contact information

Local Safeguarding Lead:

Safeguarding Coordinator: **Kenny Sehmi** 07740 948708

Designated Safeguarding Lead: **Jenny Ralls** 07764 681365

On-Call Manager (out of hours, escalate through the on-call system):

Appendix 7:

ESCALATION FOR ALLEGATIONS AGAINST COLLEAGUES

If someone is in immediate danger phone 999 and ask for police

Everyone
- Any allegation against colleagues (whether employed, volunteer or agency etc) must be reported to the Local Safeguarding Lead and their Service Manager immediately.
- It is not your responsibility to decide if abuse has happened. **It IS your responsibility to report it to the Safeguarding Lead and their Service Manager**.
- Consider whether the Adult at Risk has capacity. Seek consent to make a referral.
- Share your concerns/ information with the local Safeguarding Lead or their Service Manager urgently. If unavailable or if the Service Manager is implicated call Safeguarding Co-ordinator Kenny Sehmi or Designated Safeguarding Lead Jenny Ralls. When out of hours use the On-Call process.
- **Alternatively the whistleblowing process may be followed (see Whistleblowing policy)**

Service Manager

- The colleague should be immediately removed from contact with participants (and / or alleged victims) whilst the allegations are reviewed.
- Alert your Head of Service and Director of Operations
- Convene an urgent meeting (1 working day) with your P&C business partner, a member of the Compliance team, the Local Safeguarding Lead and yourself.

Next Steps

- The meeting will agree:
a. Next steps and appropriate support for your colleague
b. Whether a Safeguarding referral is warranted or what information must be gathered first
c. any other internal escalation / external communications
d. Who will lead the safety review and timeframe

Contact information

Local Safeguarding Lead:

Safeguarding Coordinator: **Kenny Sehmi** 07740 948708

Designated Safeguarding Lead: **Jenny Ralls** 07764 681365

On-Call Manager (out of hours, escalate through the on-call system):

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Appendix 8:

Safeguarding decision making for frontline colleagues

The adult at risk:
- has care and support needs
- is at risk of or is experiencing abuse
- is unable to protect themselves

↓

Does the adult at risk lack capacity? Is there anyone else at risk without capacity (other adults, children)

→ there are people at risk without capacity →

they have capacity ↓

Is there another basis to share information (public duty, criminal act, coercive relationship)

← no ← Does the adult at risk consent to referral? → yes → External referral to local Safeguarding Adults Board

yes →

no ↓

No external referral → Record via intranet and on local care record (e.g. Inform) ←