Safeguarding Adults Policy and Procedure

V6

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Contents

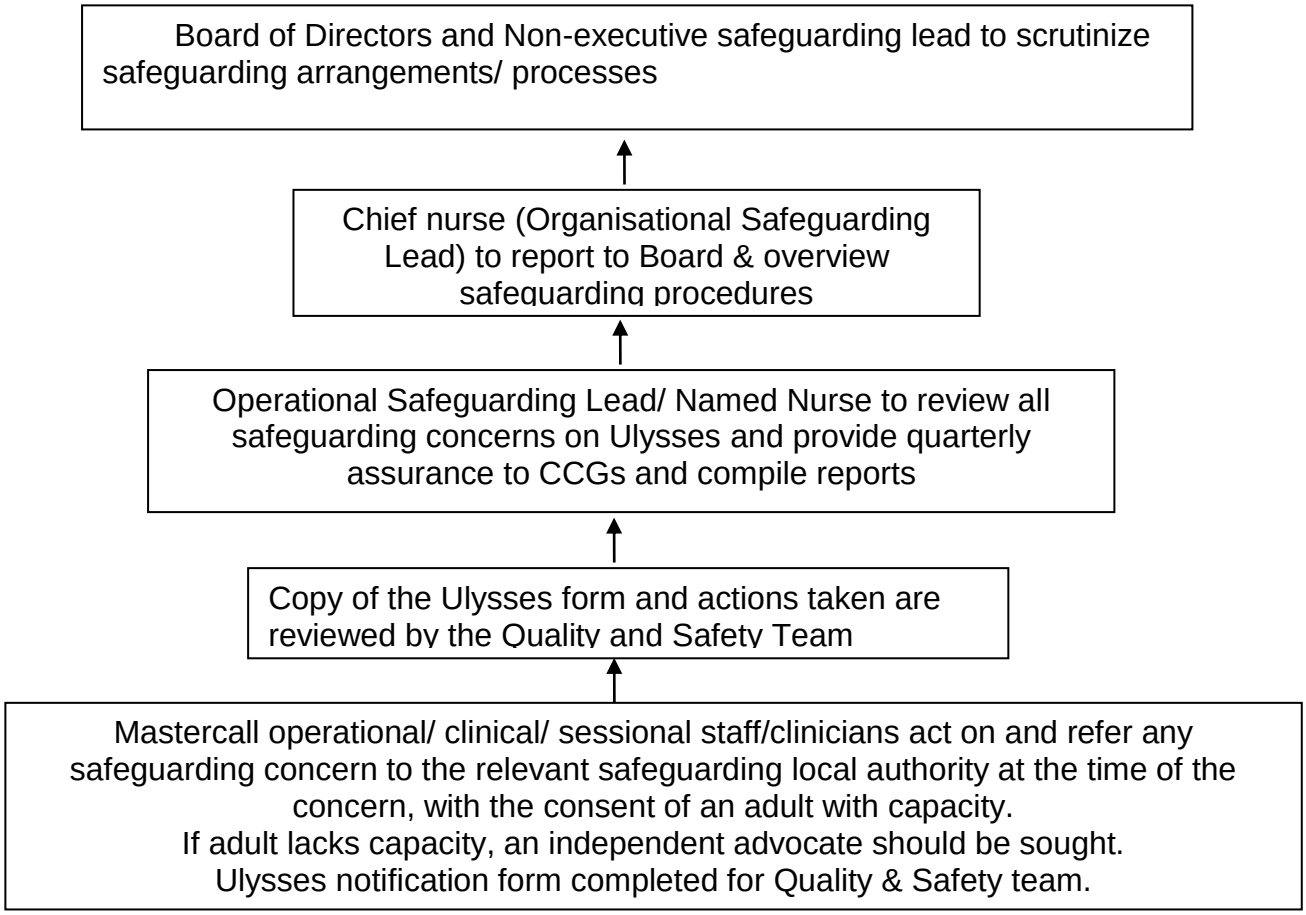
1 Introduction

This policy summarises the requirements on all members of staff in relation to the safeguarding of adults who may have care and support needs, and who may be at risk of abuse or neglect. It is supported by detailed procedures for the protection of vulnerable adults during and out of hours.
It is the aim of the Government that everyone has the right to:

- Live their life free from violence, fear and abuse.
- Be protected from harm and exploitation.
- Self-determination/ independence, which involves a degree of risk.

1.1 Mastercall Lines of Reporting and Responsibility

Lines of Reporting and responsibilities (See flowchart above)



All Staff should follow the above framework for reporting any causes for concern relating to adults. Concerns requiring an immediate action should follow the emergency action algorithm (see appendix 2).

The Director and Board level lead for Safeguarding is the Chief Nurse. The Director level lead takes overall responsibility for the organisational Safeguarding strategy and all matters relating to the Safeguarding of Adults for Mastercall Healthcare. The Board lead provides information and

assurance to the CCG that standards outlined on the Safeguarding audit are met. Where any audit standard is not met, the Board lead is responsible for ensuring that action plans are in place to address any gaps.

The nominated operational lead is the Safeguarding Lead for Adults and Children. This person deputises for the Director Level lead when necessary and ensures that the Safeguarding Adult policy is implemented by all Heads of Department/ Service leads. This person produces an annual report based upon the organisational strategy to present to the Chief Nurse and Board of Directors. The operational safeguarding lead liaises with the Designated Nurses for Safeguarding within the CCGs and also with any other appropriate individuals with regard to the sharing of information where a Safeguarding report has been raised.

Reports of cause for concern are reviewed by the safeguarding lead or named Doctor, once they have been received through the Ulysses reporting system.
The quality and safety team receive reports of cause for concern and ensures that these are referred to the safeguarding lead, named nurse or doctor for appropriate action and follow up.

Recording safeguarding referrals provides an audit trail which can be also be used for trend analysis, training needs analysis etc. If the reporter provides an email address they will automatically receive an acknowledgement from Ulysses and will receive feedback where appropriate.

1.2 Scope of the policy

This policy refers to all employees and those working on behalf of Mastercall Healthcare who may come into contact with adults during the course of their work.

The policy and procedures also seek to ensure the human rights of vulnerable people are upheld in accordance with the Human Rights Act 1998 and they are empowered to make decisions for themselves wherever possible.

This policy should be read in conjunction with other key documents:

- Mental Capacity Act 2005: Code of Practice (Department for Constitutional Affairs 2007)
- Department of Health (2009) No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse. DH. London.
- The Care Act (2014)
- Human Rights Act (1998)
- Data Protection Act (1998)

Online access to the local and Greater Manchester Safeguarding Partnership policies and procedures can be found at:

- http://greatermanchesterscb.proceduresonline.com/chapters/contents.html

2 Background

The Care Act 2014

The Care Act 2014 came in to force in April 2015. The Act builds on recent reforms and replaces some previous areas of law to provide a coherent approach to adult social care in England and thus legislates for safeguarding adults at risk of abuse or neglect. The following six principles apply to all organisations involved in the provision of health and social care:

Six key principles underpin all adult safeguarding work

Empowerment – People being supported and encouraged to make their own decisions and informed consent.
"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."

Prevention – It is better to take action before harm occurs.
"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."

Proportionality – The least intrusive response appropriate to the risk presented.
"I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."

Protection – Support and representation for those in greatest need.
"I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."

Partnership – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."

Accountability – Accountability and transparency in delivering safeguarding.
"I understand the role of everyone involved in my life and so do they."

Mastercall staff must understand what constitutes abuse in adults, how to recognise abuse and how to respond to concerns. This will include:

- knowing about different types of abuse and neglect and their signs;
- supporting adults to keep safe;
- knowing who to tell about suspected abuse or neglect; and
- supporting adults to think and weigh up the risks and benefits of different options when exercising choice and control.

In providing a healthcare service, Mastercall Healthcare is committed to ensuring that all patients receive the best possible care and treatment within the resources available and that all statutory and legal requirements are met, and that the welfare of all adults is paramount at all times.

All staff should have access to appropriate safeguarding training and should be able to recognise abuse, and to respond and refer to appropriate services without delay. Local Safeguarding Partnerships reinforce the message that all professionals need to be aware of their safeguarding responsibilities.

This policy should also be seen in the context of the Caldicott Guardian Policy which stresses the need to maintain confidentiality yet reminding staff that the sharing of the right information at the right time to the right people is fundamental to good safeguarding practice.

3 Definition of Abuse

Within this policy, the term abuse refers to:

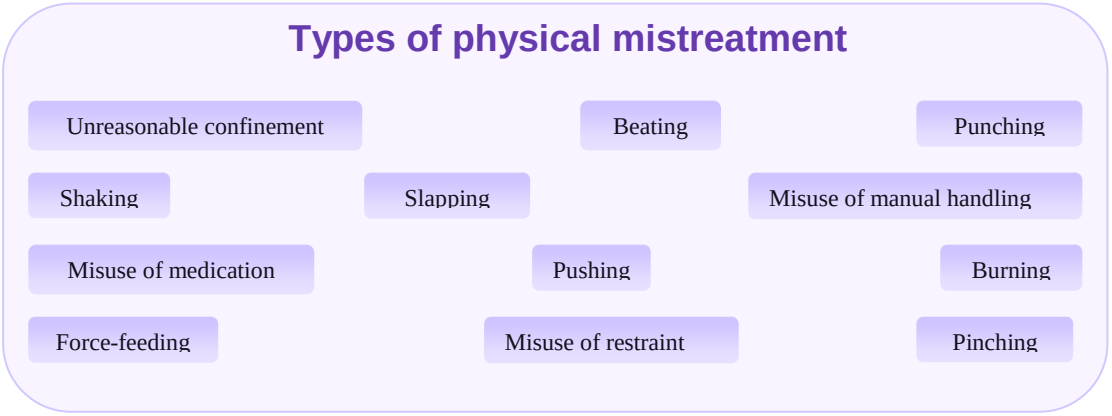
‘An act or omission by another person that causes significant harm to the physical, emotional or social well-being of a vulnerable person.’

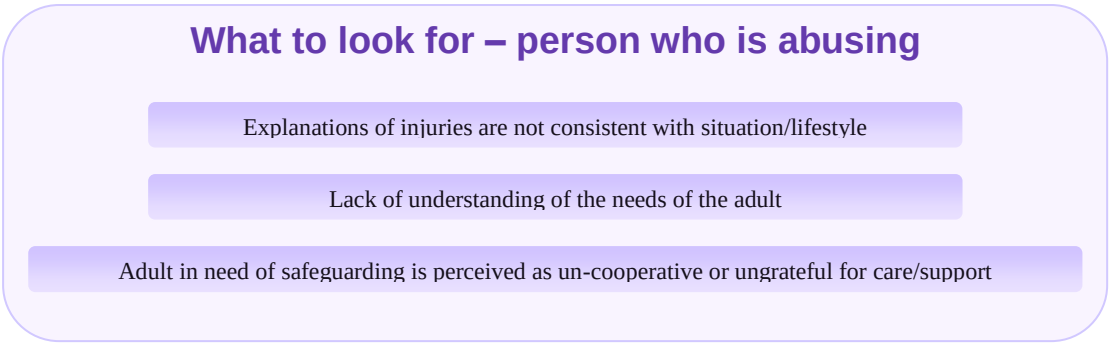
Abuse is the violation of an individual’s human and civil rights by any other person. Abuse may consist of single or repeated acts. It may be physical, verbal or psychological, or neglect. It may be an act or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.

3.1 Types of abuse:

Abuse and neglect include:

3.1.1 Physical abuse – is the physical mistreatment of one person by another which may or may not result in physical injury.





3.1.2 Sexual abuse - Sexual abuse involves forcing or enticing an individual to take part in sexual activities, including prostitution, whether or not s/he is aware of what is happening.

Types of sexual abuse

- Serial abuse over a long period of time after identifying a person perceived as vulnerable
- Assault by penetration (of mouth, vagina, anus by any body-part or any object)
- Use of offensive or suggestive language
- Abuser exposing genitals
- Forcing the person to watch/look at pornography
- Full sexual intercourse
- Rewards for sexual acts
- Rape (penetration of mouth, vagina, anus with penis)
- Sexual activity with a mentally disordered person
- Abuser touching victim's body
- Sexual relationships instigated by those in a position of trust

What to look for - signs of being abused

- Recoiling from physical contact
- Genital discharge
- Fear of males or females
- Persistent and inappropriate sexual behaviour especially in the presence of certain persons
- Torn, stained or bloody garments
- Not consenting to or understanding sexual activity
- Sudden use of offensive sexual language
- Bruising / lacerations to upper thighs
- Recurring genital irritation
- Unexplained sexually transmitted diseases
- Disclosure
- Pronounced overly affectionate behaviour
- Pregnancy
- Unusual difficulty walking

What to look for – person who is abusing

- Personal care tasks taking significantly longer to perform than usual
- Use of offensive or suggestive sexual language
- Over enthusiastic in carrying out personal care tasks, working alone with adults
- Openly showing favouritism and/or the giving of gifts for no apparent reason

3.1.3 Psychological abuse - Emotional, psychological and mental abuse are often closely linked terms that can be used interchangeably. It may involve the use of intimidation, indifference, hostility, rejection, threats, humiliation, shouting, swearing or the use of discriminatory and/or oppressive language.

Types of psychological abuse

- Gross restriction of freedom
- Person's access to personal hygiene and toilet restricted
- Threat to withdraw care/support
- Withholding of security and affection
- Name-calling
- Humiliation or ridicule not treating with respect
- Denial of the opportunity for privacy
- Threat of institutional care
- Provoking fear of violence
- Shouting and swearing
- Adult's choices, opinions and wishes being neglected/rejected
- Use of bribes or threats

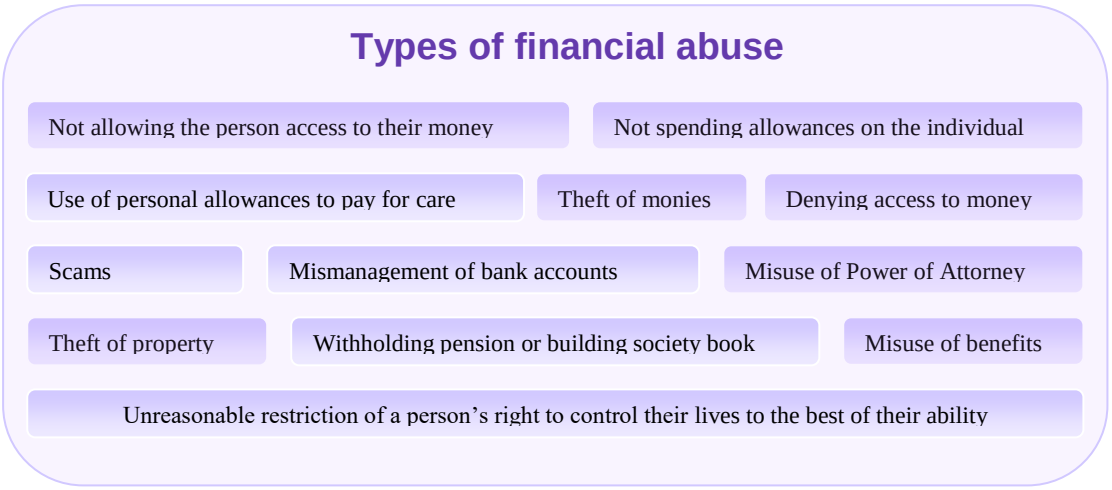
What to look for - signs of being abused

- Stress and / or anxiety in response to certain people
- Displays compulsive behaviour
- Withdrawn, unresponsive and displays overly compliant behaviour
- Disclosure
- Reduction in skills and concentration
- Lack of trust particularly with significant others
- Changes in sleep pattern
- Frightened of specific individuals
- Lack of self esteem

What to look for - person who is abusing

- Withholding affection
- Denial of social and cultural contact
- Discriminatory comments
- Denial of reasonable requests
- Use of abusive language or shouting
- Denying privacy
- Lack of understanding of the needs of the adult
- Ignoring the person
- Use of threats
- Adult in need of safeguarding is perceived as un-cooperative or ungrateful for care/support

3.1.4 Financial or material abuse - is the misappropriation or misuse of money / assets, or transactions to which the person could not consent, or which were invalidated by intimidation / deception. It can include not allowing the person access to their money, not spending allowances on the person, misuse of power of attorney, theft of money or property, or scams.



3.1.5 Neglect / Acts of omission: is behaviour that results in the persistent or severe failure to meet the physical and/or psychological needs of an individual in their care.

Types of neglect

- Wilful failure to intervene, or consider the implications of non-intervention in behaviour which is dangerous to the individual concerned or to others
- Failure to use agreed risk-taking procedures resulting in the person taking unnecessary risks
- Inadequate care in hospital/residential settings
- Denying access to services or advocacy
- Withholding affection or communication
- Withholding food/drinks/heat/light/clothing
- Withholding of aids, e.g. hearing aids, spectacles, walking aids
- Inadequate furnishings
- Limiting choice
- Not providing access to medical care or giving personal care

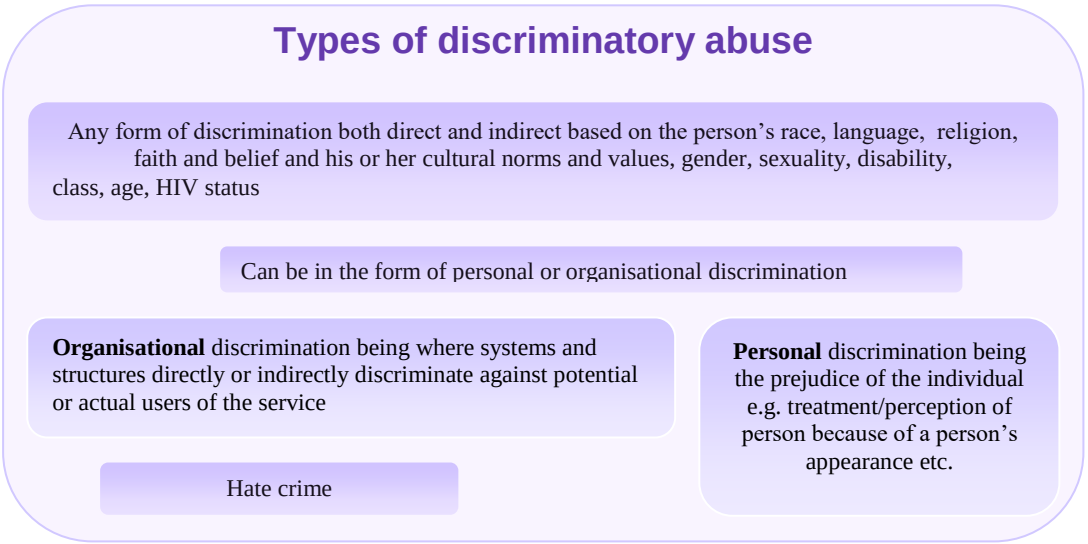
What to look for - signs of being abused

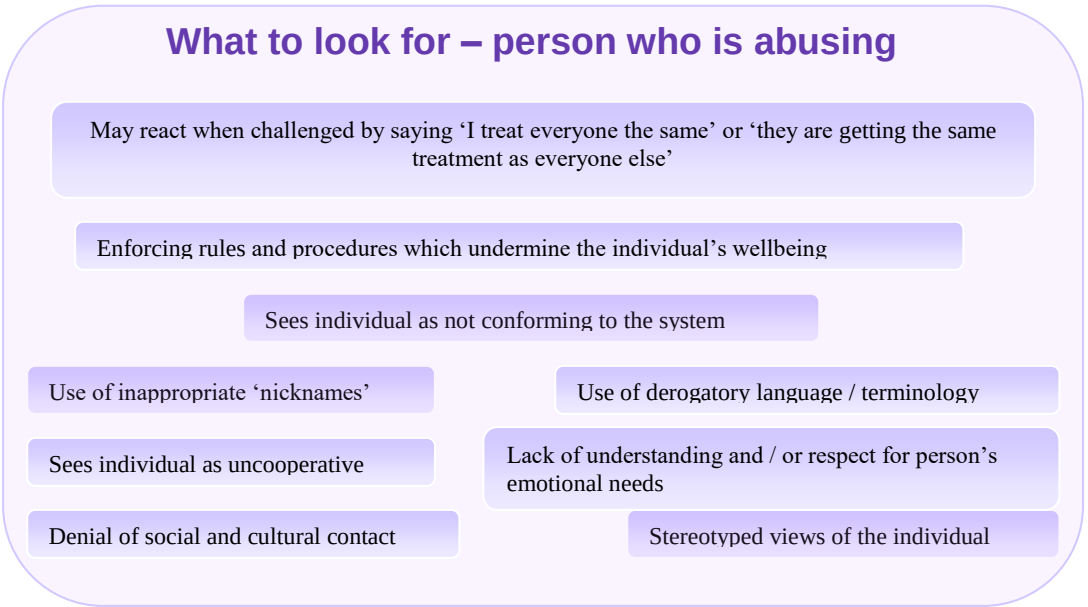
- Depression / fear
- Person is isolated
- Continence problems
- Dehydration
- Unkempt look
- Person not allowed visitors or phone
- Person locked in room
- Demanding e.g. food and / or drink
- Access to personal hygiene and toilet is restricted
- Deterioration of health
- Pressure ulcers
- Complaints of pain or discomfort
- Sleep disturbance
- Disclosure by person using service
- Low self-esteem
- Unexplained accidents
- Exposed to inappropriate stimuli
- Disclosure

What to look for – person who is abusing

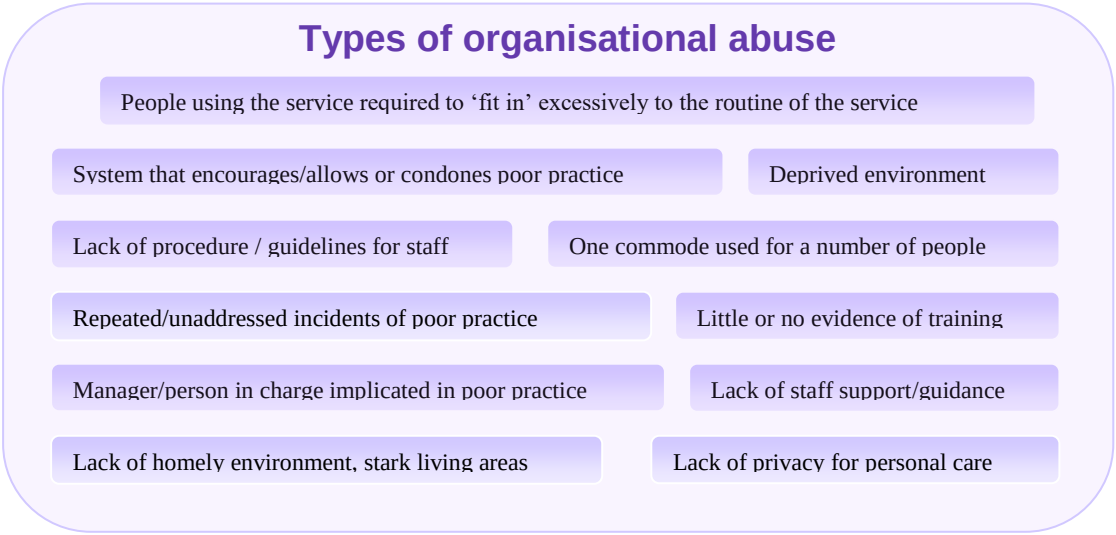
- Seemingly uncaring attitude and cold detachment from individual
- Frequent failure to report individual's progress to others
- Denying individual's requests
- General lack of consideration toward the needs of the individual
- Individual perceived as uncooperative or ungrateful for care / support given
- Denying others, including health and social care professionals, access to the individual

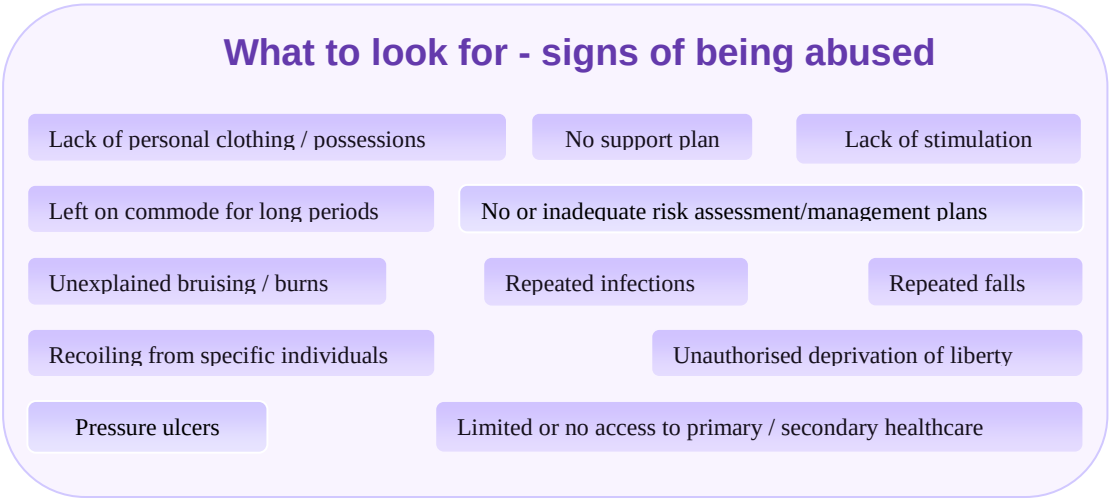
3.1.6 Discriminatory abuse - This includes some forms of harassment, slurs or similar unfair treatment relating to race, gender and gender identity, age, disability, sexual orientation, or religion.

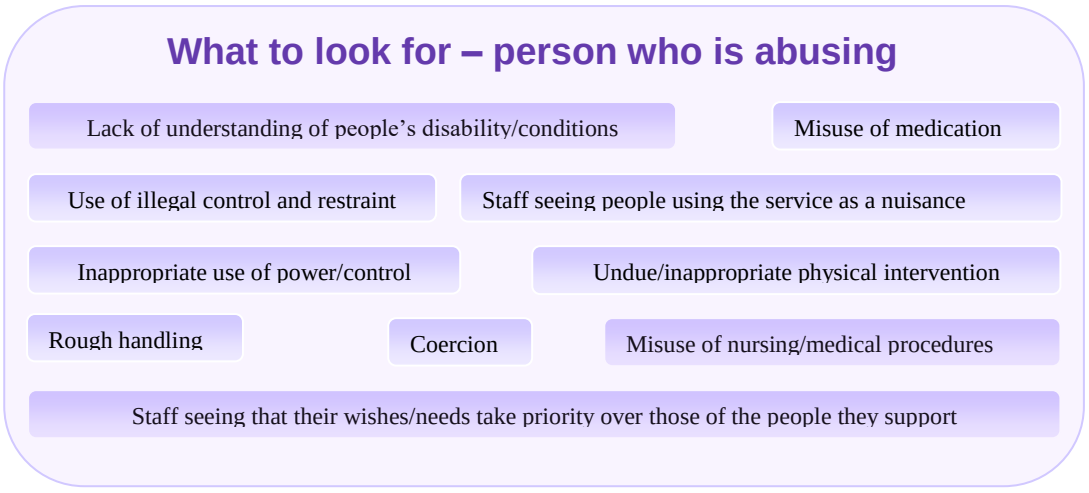




3.1.7 Organisational abuse – is repeated incidents of poor professional practice or neglect or inflexible services based on the needs of providers rather than the person receiving the services.







3.1.8 Modern Slavery – Modern slavery encompasses 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. Although a large number of active organised crime groups are involved in modern slavery, it must be remembered that individual opportunistic perpetrators can also commit such acts.

The damage to the individual, by being used as a commodity for the profit of others, can be difficult to comprehend and thus we all have a role in preventing vulnerable people from being exploited and providing enhanced support as part of an overall response.

Under section 52 of the Modern Slavery Act 2015, there is a duty to notify the Secretary of State about suspected victims of slavery or human trafficking. It also requires that where a specified public authority to which the Section applies has reasonable grounds to believe that a person may be a victim of slavery or human trafficking, it must notify the Home Office.

Mastercall's statement on modern slavery and human trafficking:

Mastercall recognises we have an obligation to prevent slavery and human trafficking and will do all in its power to prevent slavery and human trafficking within our Organisation.

Modern slavery can take many forms including the trafficking of people, forced labour, servitude and slavery. Mastercall takes our responsibility extremely seriously. Our recruitment processes ensure our recruitment team and human resources department are alert to the signs of exploitation, in order that we may take the necessary action promptly and effectively should it be identified. Sectors affected include, but are not limited to, operational staff and clinical staff and GPs.

This statement focuses specifically on Mastercall' s compliance with the Modern Slavery Act 2015 (the Act) and highlights the steps we take to ensure there is no slavery or human trafficking occurring within the organisation or any suppliers.

In regards to Mastercall staff, if it is suspected that a patient or member of staff could be a victim of slavery then staff should call 101 and report it to the Police.

Further advice can be found via the Modern Slavery Helpline on 0800 0121 700 or via www.modernslavery.co.uk. Referrals can also be made via the latter using the online form or by contacting **The Modern Slavery Coordination Unit at Greater Manchester Police** via;

Traffickingandslavery@gmp.police.uk1 856 1736 / 0161 856 5136

National referral mechanism guidance: adult (England and Wales)
Please use the link below to the National Referral Mechanism (NRM) which is a framework for identifying and referring potential victims of modern slavery and ensuring they receive the appropriate support.
https://www.gov.uk/government/publications/human-trafficking-victims-referral-and-assessment-forms/guidance-on-the-national-referral-mechanism-for-potential-adult-victims-of-modern-slavery-england-and-wales

3.1.9 Exploitation– either opportunistically or premeditated, unfairly manipulating someone for profit or personal gain.

3.1.10 Self-Neglect - covers a wide range of behaviour; neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. Self-neglect it is also defined as the inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and wellbeing of the individual and sometimes to their community.

Indicators of self-neglect may be:

- living in very unclean, sometimes verminous, circumstances
- poor self-care leading to a decline in personal hygiene
- refusing necessary help from health and/or social care in relation to personal hygiene and care
- poor diet or nutrition
- having poor personal hygiene, poor health/sores or long toe nails
- poorly maintained clothing
- isolation
- failure to take medication
- hoarding large numbers of pets
- neglecting household maintenance and therefore creating hazards or fire risks.

The Care Act 2014 formally recognises self-neglect as a category of abuse. However, there is no single operational definition of it. The Care Act does, however, make it clear that it does come within the statutory definition of abuse or neglect if the individual concerned has care and support needs and

is unable to protect him or herself. Adults who self-neglect can now be supported through intervention under safeguarding adult procedures.

Self- neglect is a difficult issue to address in practice, not least because people who self-neglect may not see that they are living with self-neglect. There are questions of personal choice and how to provide help and support to someone who may not want it. In addressing self-neglect under this policy and procedure the response must be proportionate to the risk of harm to the individual. If someone has capacity to decide not to accept care and support, then generally this must be respected unless there is a wider public interest to intervene (e.g. where their actions are affecting other vulnerable persons) or they are being unduly influenced or at risk to their life. An example of this would be where hoarding is a problem, and in these cases the local fire service may need to be informed.

3.1.11 Domestic Abuse - Is any incident or pattern of incidents of controlling, coercive, threatening behaviours, violence or abuse between those who are, or have been, intimate partners or family members regardless of gender or sexuality.

Controlling behavior is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behavior.

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. It has been widely understood for some time that coercive control is a core part of domestic violence. It is important to recognise coercive control as a complex pattern of overlapping and repeated abuse perpetrated within a context of power and control.

Mastercall Healthcare is committed to promoting the safety of everyone who experiences domestic abuse and are well placed to provide information, support and where appropriate, referral to other services.

In England and Wales 7.5% of women and 4.3% of men will suffer domestic violence in any given year (Crime Survey of England and Wales, 2016/2017).

Each year since 1995, nearly 50% of all women aged 16 and over who were murdered in England and Wales, were killed by their partner or ex-partner, with 12% of men being murdered by similar agents.

On average the police receive an emergency call relating to domestic abuse every 30 seconds.

Perpetrators, and experiencers of abuse, may be women or men but, especially in cases of severe and repeated violence and sexual assault, there is a greater preponderance of male on female abuse.

Pregnancy is a time when domestic abuse is more likely to start or escalate with 15% of women reporting violence during a pregnancy.

Staff procedure

All staff, whether contracted or non-contracted, should be aware of the need to provide an environment and receptiveness that allows for comfortable disclosure of domestic violence from all patients. In addition, they should understand the statutory reporting requirements, the need for good record keeping, and the rules governing the sharing of information with other agencies.

Mastercall Healthcare is committed to the preservation of the safety of all staff, and where such staff feel that an abusive partner is a risk to them, or any other member of staff's family safety within or out with the workplace, then the police should be called.

Mastercall Healthcare will ensure that information about domestic abuse, 'honour' based violence, FGM and forced marriage is available in public areas and in also in private areas such as male and female toilets. This will show local and national helpline numbers. Information on services across Greater Manchester can be found on www.endthefear.co.uk ,

The issue of domestic abuse should never be raised unless the person/ victim is alone and staff should explain about confidentiality, its limits, and when information may be shared with other agencies.

If there is reason to suspect children or adults (with care and support needs who cannot protect themselves) are at risk of harm, safeguarding must take precedence over confidentiality. Under Section 115 of the Crime and Disorder Act 1998, information should be passed to another agency where there is significant risk of harm to the person, his/her children or somebody else if information is not passed on.

In keeping with general Mastercall Policy, all staff should keep thorough and accurate records regarding any such consultations
Such notes should include

- Ethnicity, where relevant.
- Relationship to perpetrator and name of perpetrator.
- The presence of children in the household.
- Nature of abuse/injuries (using body map)
- Description of all kinds of abuse experienced and reference to specific incidents.
- First episode? Recurrent? How often?
- Any enhanced risk factors?
- Actions taken and information given.

Staff experiencing domestic abuse should refer to the “Supporting Staff Living with Domestic Abuse” policy.

3.1.12 Forced Marriage - is “a marriage conducted without the valid consent of one or both parties, where duress is a factor”. Forced marriages are a form of domestic abuse and are dealt with as such by the police.

Forced marriages are where one or both persons involved get forced into a marriage that they do not want to enter and do not consent to the marriage. Forced marriage is not the same as arranged marriage. In an arranged marriage, people always have a choice about whether they get married or not.

Because forced marriage is illegal, it can happen in secret and can also be planned by parents, family or religious leaders. It may involve physical abuse, sexual abuse or emotional abuse and some element of duress is involved.

It is felt that males may still be a reluctant to report to the police that they have been forced into a marriage. The Anti-Social Behaviour Crime and Policing Act 2014 makes it a criminal office to force someone to marry.

How can the police help?

All agencies want to encourage potential victims and those already in a forced marriage to seek support and help from the police. There are specialist officers who can deal with the issues who will help and support people throughout the process.

Reporting a Forced Marriage: Mastercall Healthcare will recognise and respect the victim’s wishes, respect confidentiality, establish lines of communication and provide appropriate support and guidance via a number or recognised support agencies.

Staff can encourage the reporting of a forced marriage via the normal means of communicating with GMP listed on the contact us page.

In addition, there are Specialist Domestic Abuse Investigators and Community Race Relations Officers on each division by calling 0161 872 5050. Karma Nivarna is a UK charity that supports victims and survivors of forced marriage and honour-based abuse – 0800 599 9247.

Forced marriages are a legitimate issue to report to the police. The Police will support and protect the victim and investigate criminal offences.

Situations whereby a forced marriage may come to the attention of the police include:

- An individual who fears they may be forced to marry.

- A report by a third party of an individual having been taken abroad for the purpose of a forced marriage.
- An individual who has already been forced to marry a spouse who comes from overseas.

Mastercall understands that many victims do not want to criminalise family members and may be reluctant to call the police, but we should encourage those abused in this way to do so if this is the only way to get out of the situation.

The Forced Marriage Unit Foreign and Commonwealth Office are also available to help and advice and they can be contacted on 0207 008 0151. In particular, the FCO can help to repatriate victims back to this country if they have been forced into a marriage abroad.

3.1.13 So called 'Honour' Based Violence (HBV) - is where the person is being punished by their family or their community. They are being punished because of a belief, actual or alleged, that a person has not been properly controlled and does not conform to family/community norms, thus bringing 'shame' or 'dishonour' of the family. 'HBV' is a crime or incident, which has or may have been committed with the intention of protecting or defending the honour of the family and/or community members. (ACPO 2007.)

All practitioners working with victims of forced marriage and HBV need to be aware of the **'one chance'** rule. That is, they may only have **one chance** to speak to a potential victim and may only have **one chance** to save a life.

HBV may include murder, fear of or actual forced marriage, controlling sexual activity, domestic violence and abuse (including psychological, physical, sexual, financial or emotional), kidnapping, false imprisonment, assault, harassment and forced abortion. This list is not exhaustive. Isolation is one of the biggest problems facing those trapped in, or under threat of violence.

These crimes cut across all cultures, nationalities, faith groups and communities. They transcend national and international boundaries; they are violations of human rights and there is no 'honour' in the commission of them. Offences of Honour Based Violence are prosecuted under the specific offence committed e.g. common assault, grievous bodily harm, harassment, kidnap, rape and murder.

Alerts that may indicate 'honour'-based violence may include issues of domestic violence, concerns about forced marriage, enforced house arrest and missing persons. If a concern is raised through a Safeguarding Adults referral, and there is a suspicion that the adult is the victim of honour-based violence, there should be early consultation with the specialist police officers in the Public Protection Investigation Unit (PPIU).
For further information go to:

Independent Choices – women's domestic violence helpline for Greater Manchester 0161 636 7525

http://www.cps.gov.uk/legal/h_to_k/honour_based_violence_and_forced_marriage/

3.1.14 Female Genital Mutilation (FGM) - involves procedures that include the partial or total removal of the external female genital organs for non-medicinal reasons. The practice is extremely painful and has serious health consequences, both at the time when the mutilation is carried out, and in later life.

The age at which girls undergo FGM varies. The procedure may be carried out when the female is new-born, during childhood or adolescence, just before marriage or during the first pregnancy. However, the majority of cases of FGM are thought to take place between the ages of five and eight and therefore girls within that age bracket are at a higher risk.

FGM is illegal in the UK. It is an offence for UK nationals or permanent UK residents to carry out FGM abroad or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the procedure is legal. Any woman that wishes to report FGM to the police should be supported to do so.

If a woman discloses that FGM has been committed and she does not want this to be reported please offer FGM support (see below).

Further help/Support services

Greater Manchester Victims' Services

www.gmvictims.org.uk or Support Line 0161 200 1950

The Guardian Project – a free service covering the whole of Greater Manchester. It provides care and support for women who may be at risk from, or who have been victims of, female genital mutilation – 07449 651 677

HM Government multi agency guidelines can be found at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97857/FGM.pdf

3.1.15 Human trafficking is organised crime often with an international element, with the exploitation of human beings for profit at its heart. It is an abuse of basic rights, with organised criminals preying on vulnerable people to make money.

Adult victims may travel willingly, in the belief that they are destined for a better life, including paid work, and may start their journey believing they are economic migrants, either legally or illegally. They may also believe that the

people arranging their passage are merely facilitators, helping with their journey, rather than people who aim to exploit them. In other cases, victims may start their journey independently and come to rely on facilitators along different stages of their journey to arrange papers and transportation.

Traffickers use threats, force, coercion, abduction, fraud, deception, abuse of power and payment to control their victim. And most traffickers are organised criminals.

Human trafficking and modern slavery are forms of abuse. Children are recruited, moved or transported and then exploited, forced to work or sold.
People can be trafficked for:

- sexual exploitation
- benefit fraud
- forced marriage
- domestic servitude such as cleaning, childcare, cooking
- forced labour in factories or agriculture
- criminal activity such as pickpocketing, begging, transporting drugs, working on cannabis farms, selling pirated DVDs and bag theft.

Many people are trafficked into the UK from abroad, but they can also be trafficked from one part of the UK to another.

Practical guidance for practitioners can be found at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181550/Human_Trafficking_practical_guidance.pdf

3.2 What is Adult Safeguarding?

Adult safeguarding is about protecting a person's right to live safely, free from abuse and neglect. It is the promotion of the welfare of individuals and refers to the activity that is undertaken to protect specific adults who are at risk of harm or abuse as described in the Care Act 2014 and which may affect an individual at different times during their lives.

People who may be at risk of harm or abuse include:

- People with a physical disability
- People who are physically frail
- People who have a severe illness
- People who have a sensory impairment
- People who have a learning disability
- People who have a mental health problem
- People with dementia
- People who misuse drugs or alcohol
- People with other care of support needs who might not be able to protect themselves as a result of those needs.

3.3 The Mental Capacity Act

Mental Capacity assessment is fundamental to supporting and protecting adults at risk from abuse. It applies to individuals who are 16 and over and provides a legal framework to empower people to make decisions about themselves, or for professional or care providers who have to make decisions on behalf of individuals who lack the mental capacity to make specific decisions at a specific time, themselves. They should offer the least restrictive option.

The Act is intended to be enabling and supportive of people who lack capacity, not restricting or controlling of their lives. It aims to protect people who lack capacity to make particular decisions, but also to maximise their ability to make decisions, or to participate in decision-making, as far as they are able to do so.

It makes it clear who can take decisions, in which situations, and how they should go about this. It enables people to plan ahead for a time when they may lack capacity. The Act covers major decisions about someone's property and affairs, healthcare treatment and where the person lives, as well as everyday decisions about personal care, where the person lacks capacity to make the decisions themselves.

The Act's confirms in legislation that it should be assumed that an individual (aged 16 or over) has full legal capacity to make decisions for themselves (the right to autonomy) unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made.

This is known as the presumption of capacity. The Act also states that people must be given all appropriate help and support to enable them to make their own decisions or to maximise their participation in any decision-making process.

The fundamental philosophy of the Act is to ensure that any decision made, or action taken, on behalf of someone who lacks the capacity to make decision or act for themselves is made in their Best Interests.

The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling.

The Act strengthens the right to be protected from harm if someone lacks capacity and introduces the Section 44 offence of ill treatment or wilful neglect of someone who lacks capacity.

There are five 'statutory principles' - the values that underpin the legal requirements in the Act. The five statutory principles are:

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

4. 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/her best interests.
5. Before any action is taken, or any decision is 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.

No individual can be protected by the Mental Capacity Act from making a bad decision.

The fundamental philosophy of the Act is to ensure that any decision made, or action taken, on behalf of someone who lacks the capacity to make decision or act for themselves is made in their Best Interests.

In July 2018, the government published a Mental Capacity (Amendment) Bill, which passed into law in May 2019
It replaces the Deprivation of Liberty Safeguards (DoLS) with a scheme known as the Liberty Protection Safeguards (although the term is not used in the Bill itself).
Key features of the Liberty Protection Safeguards (LPS) include:

- In line with the Law Commission's suggestion they start at 16 years old. Deprivations of liberty have to be authorised in advance by the 'responsible body'.
    - For NHS hospitals, the responsible body will be the 'hospital manager'.
    - For arrangements under Continuing Health Care outside of a hospital, the 'responsible body' will be their local CCG (or Health Board in Wales).
    - In all other cases – such as in care homes, supported living schemes etc. (including for self-funders), and private hospitals, the responsible body will be the local authority.
    - For the responsible body to authorise any deprivation of liberty, it needs to be clear that:
    - The person lacks the capacity to consent to the care arrangements
    - The person has a mental disorder
- The arrangements are necessary to prevent harm to the cared-for person, and proportionate to the likelihood and seriousness of that harm.
-

In order to determine this, the responsible body must consult with the person and others, to understand what the person's wishes and feelings about the arrangements are.

An individual from the responsible body, but not someone directly involved in the care and support of the person subject to the care arrangements, must conclude if the arrangements meet the three criteria above (lack of capacity; mental disorder; necessity and proportionality).

Where it is clear, or reasonably suspected, that the person objects to the care arrangements, then a more thorough review of the case must be carried out by an Approved Mental Capacity Professional.

Where there is a potential deprivation of liberty in a care home, the Act allows care home managers – if the local authority felt it was appropriate - lead on the assessments of capacity, and the judgment of necessity and proportionality, and pass their findings to the local authority as the responsible body. This aspect of the Act has generated some negative comment, with people feeling that it might lead to insufficient independent scrutiny of the proposed care arrangements.

Safeguards once a deprivation is authorised include regular reviews by the responsible body and the right to an appropriate person or an IMCA to represent a person and protect their interests.

As under DoLS, a deprivation can be for a maximum of one year initially. Under LPS, this can be renewed initially for one year, but subsequent to that for up to three years.
Again, as under DoLS, the Court of Protection will oversee any disputes or appeals.
The new Act also broadens the scope to treat people, and deprive them of their liberty, in a medical emergency, without gaining prior authorisation.

The target date for implementation has not been confirmed. Prior to then, a revised MCA Code of Practice will be published

In the case of a best interest decision, it must be ensured that any existing Advanced Decisions to Refuse Treatment (ADRT), Attorney or Court Deputy is identified, and that the process used is clearly recorded in the notes. Further advice can always be sought from the senior clinician on call for Mastercall.

3.4 Mental Capacity Act Code of Practice

The Code is intended to give detailed guidance to professionals and informal carers about their responsibilities under the Mental Capacity Act. It cannot cover every situation but is intended to explain the principles behind the Act and the important concepts introduced by it.

The Code is a statutory (legal) document and a number of people who work with people who may lack capacity have an obligation to have regard to its contents.

This mainly consists of people working in a paid or professional capacity (including researchers) or acting in one of the formal roles that the Act creates including Attorneys under LPAs, a Court-appointed Deputy and Independent Mental Capacity Advocates (IMCAs).

3.5 Independent Mental Advocates (IMCA)

The Act states that people must be given all appropriate help and support to enable them to make their own decisions or to maximise their participation in

any decision-making process. The role of Mental Capacity Advocate was created for this purpose.

The Independent Mental Capacity Advocate (IMCA). Information for referring an individual to an IMCA can be found at http://www.advocacyexperience.com/

Whether a person has mental capacity to make a particular decision or not, has to be considered on an individual basis in the light of the circumstances at the time. It is not something to consider once, which then applies across all decision making. The act confirms that individuals should be presumed to have capacity unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made.

An IMCA **must** be instructed, and then consulted, for people lacking capacity who have no-one else to support them, other than paid staff in relation to decisions proposing:

serious medical treatment
long term change of accommodation or
in hospital for 28 days or longer

3.6 Attending Deaths in the Out of Hours

If the death is expected, the registered GP has completed the relevant special notes or Statement of Intent, and we have no suspicions about the circumstances of the death then we can issue a pronouncement of death and ask the family to organise undertakers etc. If the death is unexpected then the Police should be called and treated in the same way as any unexpected deaths.

4 Our Responsibility

All Staff have a responsibility towards an adult who is at risk of harm, or abuse to:

- Ensure that their welfare and wellbeing is a primary concern.
- Be fully compliant with the law
- Report any concerns at the time via Ulysses, safeguarding referral, or complete a cause for concern form if Ulysses is not available
- Contact in hours, or out of hours, adult social care team (see app 2)
- If requires immediate action, contact the Police via 999

All staff must attend annual mandatory updates in Safeguarding adults at risk of abuse or harm.

Mastercall acts as part of a jigsaw ensuring that communication between care teams, patients, carers and other care services are maintained, supported and protect all patients.

4.1 Duty to refer

Any cause for concern relating to an adult at risk of harm or abuse should be reported to the Quality and Safety (Q&S) team using the Safeguarding reporting template in Ulysses. If the Ulysses system is offline for any reason, the original paper reporting mechanism can also be used to report concerns for a person's welfare (see appendix 1).

Where an adult with capacity to make an informed decision about their own safety does not want any action taken, this does not override a professional's responsibility to raise a safeguarding concern and to share key information with relevant professionals e.g. where others are at risk, a criminal offence has been committed etc.

If there appears to be significant risk to the adult, and no one else, consideration would need to be given to whether their wishes should be overridden. The adult's wishes should not stop professionals from fulfilling their responsibilities in relation to duty of care regarding appropriate sharing of information.

In these situations, the adult must always be:

- advised about what information will be shared, with whom and the reasons for this
- advised that their views and wishes will be respected as far as possible by the local authority or other agencies in relation to any response they may have a duty to make
- provided with information regarding what happens when a local authority is advised of a safeguarding concern
- assured by the professional passing this information to the local authority, that their lack of consent to the information being shared, and their views and wishes regarding actions they do or do not want taken in relation to the situation as far as it affects them directly, will also be explained to the local authority.

In the case of sexual assault, the Police should be called and care taken to preserve forensic evidence (i.e. ensure the patient does not bathe, change clothes etc. prior to a medical examination).

Where an offence may have been committed

If it is suspected that an offence may have been committed, there should always be a conversation with the adult regarding whether they wish the police to be involved.

If the adult does not want the police to be involved, this does not override a professional's responsibility to share information regarding a potential, or actual, offence with them.

Such situations should always be approached sensitively. The adult should be advised that the police will be contacted and assured that the police will be informed that they do not wish to pursue this matter or speak to the police. It is for the police to determine if they feel it is necessary for them to speak to the adult, or if there is further action they may need to pursue.

Adults who lack capacity to make relevant decisions

If the adult lacks capacity to make informed decisions about the incident, and their ability to maintain their safety, and they do not want a safeguarding concern to be raised, and / or other action to be taken, professionals have a duty to act in their best interests under the Mental Capacity Act 2005.

5 Information sharing

Robust information-sharing is at the heart of safe and effective safeguarding practice. Information sharing is covered by legislation, principally the General Data Protection Act 2018 (GDPR) and the Data Protection Act 2018. The GDPR and the Data Protection Act 2018 introduce new elements to the data protection regime, superseding the Data Protection Act 1998. Practitioners must have due regard to the relevant data protection principles which allow them to share personal information. The GDPR and Data Protection Act 2018 place greater significance on organisations being transparent and accountable in relation to their use of data.

All organisations handling personal data need to have comprehensive and proportionate arrangements for collecting, storing, and sharing information. The GDPR and Data Protection Act 2018 do not prevent, or limit, the sharing of information for the purposes of keeping children, young people and adults safe.
Professionals should refer to specific advice from their professional body regarding information sharing, for instance, the General Medical Council's (GMC's) Ethical Guidance for Child Protection or section 5 of the NMC Code 2015. There is a requirement for professionals to contribute, participate and share information for the purpose of statutory reviews.

Such guidelines are further supported by the Caldicott Principles, updated in 2017. Principle Seven states that the duty to share information can be as important as the duty to protect patient confidentially. It is crucial to understand that sharing information, when there is a need to share it, and a lawful basis for doing so, and maintaining its security and confidentiality, are compatible activities.

6 PREVENT

The Prevent Strategy is a cross-Government policy that forms one of the four strands of CONTEST: the United Kingdom's Strategy for Counter Terrorism. It includes the anti-radicalisation of vulnerable adults and children.

CONTEST, as a counter-terrorism strategy, is organised around four work streams, each comprising a number of key objectives:

- **PURSUE:** To stop terrorist attacks;
- **PREVENT:** To stop people becoming terrorists or supporting terrorism;
- **PROTECT:** To strengthen our protection against a terrorist attack; and
- **PREPARE:** To mitigate the impact of a terrorist attack.

The **PREVENT** programme in the NHS has two key elements:

- responsibility for PREVENT policy/strategy and partnership representation with other Government departments;
- delivery of commitments made in the PREVENT strategy across the healthcare sector.

The PREVENT lead is the operational safeguarding lead. All staff should complete the e-learning module for PREVENT and confirm completion of this by submitting the printed certificate to the HR department

Click here to view the Prevent Training eLearning Channel:

https://www.elearning.prevent.homeoffice.gov.uk/

The e-learning includes information on how Channel links to the government's counter-terrorism strategy (CONTEST) through the Prevent strategy. It also provides guidance on how to identify people who may be vulnerable to radicalisation and how to refer them into the Channel programme. There are case studies to help users understand the process of identifying and referring vulnerable individuals, in addition to providing them with support, and is a good way of providing staff with a fundamental understanding of Channel.

Why is Counter Terrorism part of the Safeguarding agenda in the NHS?
The important 'Prevent' agenda is outlined in the Department of Health

Document Building Partnerships, "Staying Safe – The Healthcare Sector's contribution to HM Government's Prevent Strategy: For Healthcare Organisations"

To ensure that the Prevent agenda is both effective and efficient it was agreed that across NHS England it must be mainstreamed and embedded within existing local safeguarding practices.

The role of the Designated Nurse for Safeguarding Vulnerable Adults, working with other key NHS partners, is to ensure that it is embedded fully into everyday safeguarding activity, including the mandatory training of NHS staff.

What do we mean by the term terrorism?

Although there is no generally agreed definition of terrorism internationally, in the United Kingdom the Terrorism Act 2000 defines terrorism as:

The use or threat of action designed to influence the government or an international governmental organisation, or to intimidate the public, or a section of the public; made for the purposes of advancing a political, religious, racial or ideological cause; and it involves or causes:

Serious violence against a person; serious damage to a property; a threat to a person's life; a serious risk to the health and safety of the public; or serious interference with or disruption to an electronic system.

What do we mean by the term radicalisation?

Radicalisation refers to the process by which a person comes to support terrorism and forms of extremism leading to terrorism. There is no obvious profile of anyone likely to become involved in extremism, or a single indicator of when a person might move to adopt violence in support of extremist ideas.

The process of radicalisation is different for every individual and can take place over an extended period or within a very short time frame.

What do we mean by the term prevention?

Prevention means reducing or eliminating the risk of individuals or groups becoming involved in terrorism. Prevent involves the identification and referral of those susceptible to violent extremism into appropriate interventions. These interventions are aimed to stop the vulnerable being radicalised.

Extremists will always target the vulnerable in a bid to spread their firmly held, but flawed, ideologies. We must tackle them at source and prevent people being brainwashed into terrorism.

Channel Panel

This is a multi-agency panel chaired by the Local Authority to support individuals who have been identified as being groomed into terrorism. The role of the panel is to develop an appropriate support package to safeguard those at risk of being drawn into terrorism based on an assessment of their vulnerability of being at risk of radicalisation. The purpose of the panel is to:

- Assess the nature and extent of that risk
- Develop the most appropriate support plan for the individuals concerned.

The Panel is responsible for managing the safeguarding risk which is in line with other multi agency panels where risk is managed.

PREVENT referrals:

If you are worried about someone being radicalised to be involved in, or to support, violence or terrorism you can report it as follows:

In an emergency, dial: 999.
You can also contact:

• Greater Manchester Police on the non-emergency number: **101 and state channel referral**
• GMP Channel Team: channel.project@gmp.police.uk
• Anti-Terror Hotline: **0800 789 321**
• complete an online referral: https://www.met.police.uk/tua/tell-us-about/ath/possible-terrorist-activity/

7 Homelessness

The health and wellbeing of people who experience homelessness is poorer than that of the general population. The longer a person experiences homelessness, particularly from young adulthood, the more likely their health and wellbeing will be at risk. Co-morbidity (two or more diseases or disorders occurring in the same person) among the longer-term homeless population is not uncommon. The average age of death of a single homeless person is 30 years lower than the general population at 47 years, and even lower for homeless women, at just 43 years.

The legal definition of homelessness is that a household has no home in the UK or anywhere else in the world available and reasonable to occupy. Homelessness does not just refer to people who are sleeping rough. The following housing circumstances are examples of homelessness:

- rooflessness (without a shelter of any kind, sleeping rough)
- houselessness (with a place to sleep but temporary, in institutions or a shelter)
- living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence)
- living in inadequate housing (in caravans on illegal campsites, in unfit housing, in extreme overcrowding)

The causes of homelessness are typically described as either structural or individual, and can be interrelated and reinforced by one another. Causes, and their relationship, vary across the life course.

Structural factors include:

- poverty
- inequality
- housing supply and affordability
- unemployment or insecure employment
- access to social security

Individual factors include:

- poor physical health

- mental health problems including the consequences of adverse childhood experiences
- experience of violence, abuse, neglect, harassment or hate crime
- alcohol and drugs issues
- bereavement
- relationship breakdown
- experience of care or prison
- refugees

For most people who are at risk of, or experiencing, homelessness there isn't a single intervention that can tackle this on its own, at population or at an individual level. Healthcare professionals play an important role, working alongside other professionals to:

- identify the risk of homelessness among people who have poor health, and prevent this
- minimize the impact on health from homelessness among people who are already experiencing it
- enable improved health outcomes for people experiencing homelessness so that their poor health is not a barrier to moving on to a home of their own

Action to prevent and respond to homeless across the life course is essential, these can include:

- reducing the risk of homelessness to children and young people to strengthen their life chances
- enabling working age adults to enjoy social, economic and cultural participation in society
- breaking the cycle of homelessness or unstable housing by addressing mental health problems, and/or drug and alcohol use, and/or experience of the criminal justice system

The Homelessness Reduction Act 2017 (the Act) introduces new duties for local housing authorities to help prevent the homelessness of all families and single people, regardless of priority need. Local housing authorities must offer individuals who are homeless, or threatened with homelessness, a greater package of advice and support. The Act should mean more people get the help they need earlier, to prevent them from becoming homeless in the first place.

The Act introduces a new duty on specified public services to refer service users they consider may be homeless, or threatened with homelessness, to a local housing authority. The referring service must have the person's consent. The service user will need to decide which local housing authority they are referred to, mirroring the way people choose which local housing authority to seek help from when approaching directly for housing assistance.

The Act defines an individual as "threatened with homelessness" if they are likely to become homeless within 56 days. However, the Department of Health & Social Care encourages health services to refer individuals that may be at

risk of homelessness as early as possible to maximize the opportunities to prevent homelessness.

The basic legal requirement for a referral is the inclusion of the individual's:

- contact details,
- consent, and
- the agreed reason for the referral (i.e. that they are homeless or threatened with homelessness).

8 Allegations against professionals

The vast majority of adults who work with people act professionally, however, some individuals will actively seek employment or voluntary work with children or vulnerable adults, in order to harm them.

All concerns regarding staff practice should be reported to the Organisational Medical Director, the Chief Nurse and the safeguarding lead. Mastercall falls within Greater Manchester and as such is subject to the requirements of the Greater Manchester Safeguarding Partnership (GMSP). GMSP requires Mastercall to comply with their policy when managing allegations against professionals. This policy can be found at:

http://greatermanchesterscb.proceduresonline.com/chapters/p_man_allegations.html

Any allegations involving an external professional e.g. a teacher, carer, a counsellor who works with children need to be shared with Children's Services and/or the Police.

As a professional, you have a responsibility to safeguard adults from harm.

Appendix 1

MASTERCALL HEALTHCARE SAFEGUARDING CONCERN

Only to be used if Ulysses unavailable

PLEASE TICK APPROPRIATE BOX			
CHILD ☐	OR	ADULT ☐	

Full Name of person you are concerned about:		
Call Number:	**Date of concern:**	
Ethnicity of person you are concerned about:	**DOB:**	**Gender of person you are concerned about:**
First Language of person you are concerned about: **Is an interpreter required?** **No** **Yes (if yes, please state language required)**		
Address for person you are concerned about:	**Contact Number:**	
Are there any known health and safety risks within the home? **No** **Yes (if yes, please detail)**		
Has the adult or child you are concerned about got any special needs? **No** **Yes (if yes, please detail)**		
Next of kin information: **Forename:** **Surname:** **Relationship to individual you are concerned about:**	**Address for next of kin:**	
Are there any other key contact people for the child or adult you are concerned about? (e.g. carer, foster carer) **No** **Yes (if yes, please detail)**		

Service Location:	**GP Surgery:**

CONCERN DETAILS

Categories of concern applicable :

Physical abuse
Emotional abuse
Neglect
Sexual abuse
Female Genital Mutilation
Fabricated Illness
Exploitation (including Child Sexual Exploitation, financial abuse)
Forced Marriage
Domestic Violence
Honour Based Violence
Human Trafficking
Mental Capacity
Deprivation of Liberty
Discriminatory abuse
Organisational abuse
Self-neglect
Homelessness
Family support needed

Summary of what are you concerned about why?

Is there an alleged perpetrator of abuse?
No
Yes (please detail)

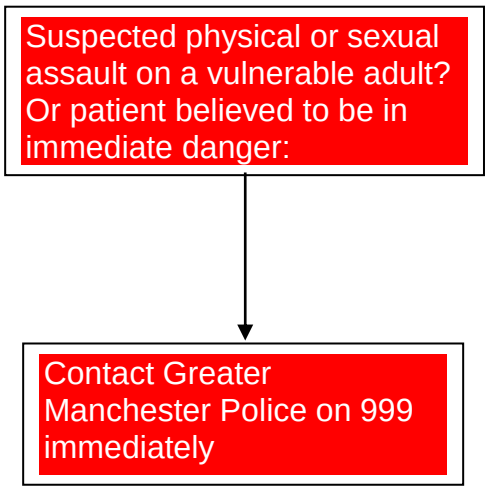
If the concern relates to a professional organisation please provide details (e.g. a care agency)
Name:
Organisation:
Contact Number:

What outcome are your service and the child/family expecting?
What action did you take at the time of your concern? **Police 999 call (please write reference number)** **Police 101 call (please write reference number)** **Referral to Trafford Children's Social Care (name of person spoken to)** **Referral to Trafford Adult's Social Care (name of person spoken to)** **Referral to Trafford Out of Hours Social Care (name of person spoken to)** **Referral to Stockport Children's Social Care (name of person spoken to)** **Referral to Stockport Adult's Social Care (name of person spoken to)** **Referral to Stockport Out of Hours Social Care (name of person spoken to)** **Referral to a support service (Name of service and person spoken to)** **Referral to Housing Department (Name of service and person spoken to)**
Is there any outstanding action required? **No** **Yes (please detail)**
Is the patient aware that you will are sharing this information? **Yes** **No (please state why this has not been discussed)**

Was the patient admitted to hospital? YES/NO	**Details:**
Details of the person reporting: **Name:**	

Role: **Email:** **Date:**
PLEASE SEND THE COMPLETED FORM TO QANDS.MASTERCALL@NHS.NET **OR PUT COMPLETED FORM IN THE QUALITY AND SAFETY TRAY**

Appendix 2: Action to be taken by Clinicians for Urgent/Emergency Safeguarding Referrals



Any other suspected Safeguarding concerns regarding adults at risk of harm or abuse should be reported to Adult Social Care:

CCG/PCT Area	Telephone Number	Out of Hours
Stockport	**0161 217 6029**	**0161 426 5706**
Trafford	**0161 912 5135**	**0161 912 2020**

References and Useful Reading

Department of Health, Home Office (2000) *No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* (issued under Section7 of the Local Authority Social Services Act 1970)

Department for Constitutional Affairs (2007) Mental Capacity Act 2005: Code of Practice, TSO: London

HM Government (2009) *The Right to Choose: multi-agency statutory guidance for dealing with Forced marriage,* Forced Marriage Unit: London

Ministry of Justice (2008) *Deprivation of Liberty Safeguards Code of Practice to supplement Mental Capacity Act 2005,* London TSO

Department of Health (2009) *Responding to domestic abuse: a handbook for health professionals*

Department of Health (2010) *Clinical Governance and adult safeguarding: an integrated approach*, Department of Health

HM Government (2009) *Multi-agency practice guidelines: Handling cases of Forced Marriage,* Forced Marriage Unit: London

The Care Act (2014)

Mental Capacity Act (2005)

Safeguarding Contacts list Rochdale borough: https://www.rbsab.org/UserFiles/Docs/Front%20Door%20Safeguarding%20Contacts.pdf

Stockport Multi Agency safeguarding Adults policy: http://www.stockport.gov.uk/2013/2996/1201778/masshsafeguardingadultsatriskpolicy

Royal College of General Practitioners www.**rcgp**.org.uk/~/media/Files/...76.../CIRC-**Mental**-Capacity-Act-**Toolkit**-2011.ashx

Chief Coroners guidance http://www.coronersociety.org.uk/documents/notifications/2017/march_2017/guidance_no16a_deprivation_of_liberty_safeguards_-_3rd_april_2017_onwards.pdf

Adult safeguarding: roles and competencies for healthcare staff 2019 **https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2018/august/pdf-007069.pdf**

ASSURANCE STATEMENTS

Assurance
The Adult Safeguarding Policy has been uploaded to the 'Information Drive in 'Policies and Procedures' folder (PDF) for all staff to access. The word version is saved in Corporate Drive in the CQC folder under 'Policies and Procedures Original'.

Purpose of policy
To ensure that staff comply with the laws and legislations around Data Protection and NHS code of Practice

Which CQC Standards
Outcome 13 - Safeguarding service users from abuse and improper treatment

How it impacts on patient care

Confidential and sensitive data needs to be securely stored and shared to enable that records are kept safe and that the patients trust us to keep their data.

EQUALITY IMPACT ASSESSMENT TOOL

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes / No	Comments
1.	**Does the policy / guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	N/A	
4.	**Is the impact of the policy / guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	Not known	
6.	**What alternatives are there to achieving the policy / guidance without the impact?**	Not known	
7.	**Can we reduce the impact by taking different action?**	No	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Policy Author, together with any suggestions as to the action required to avoid / reduce this impact.
For advice in respect of answering the above questions, please contact the Policy Author.