

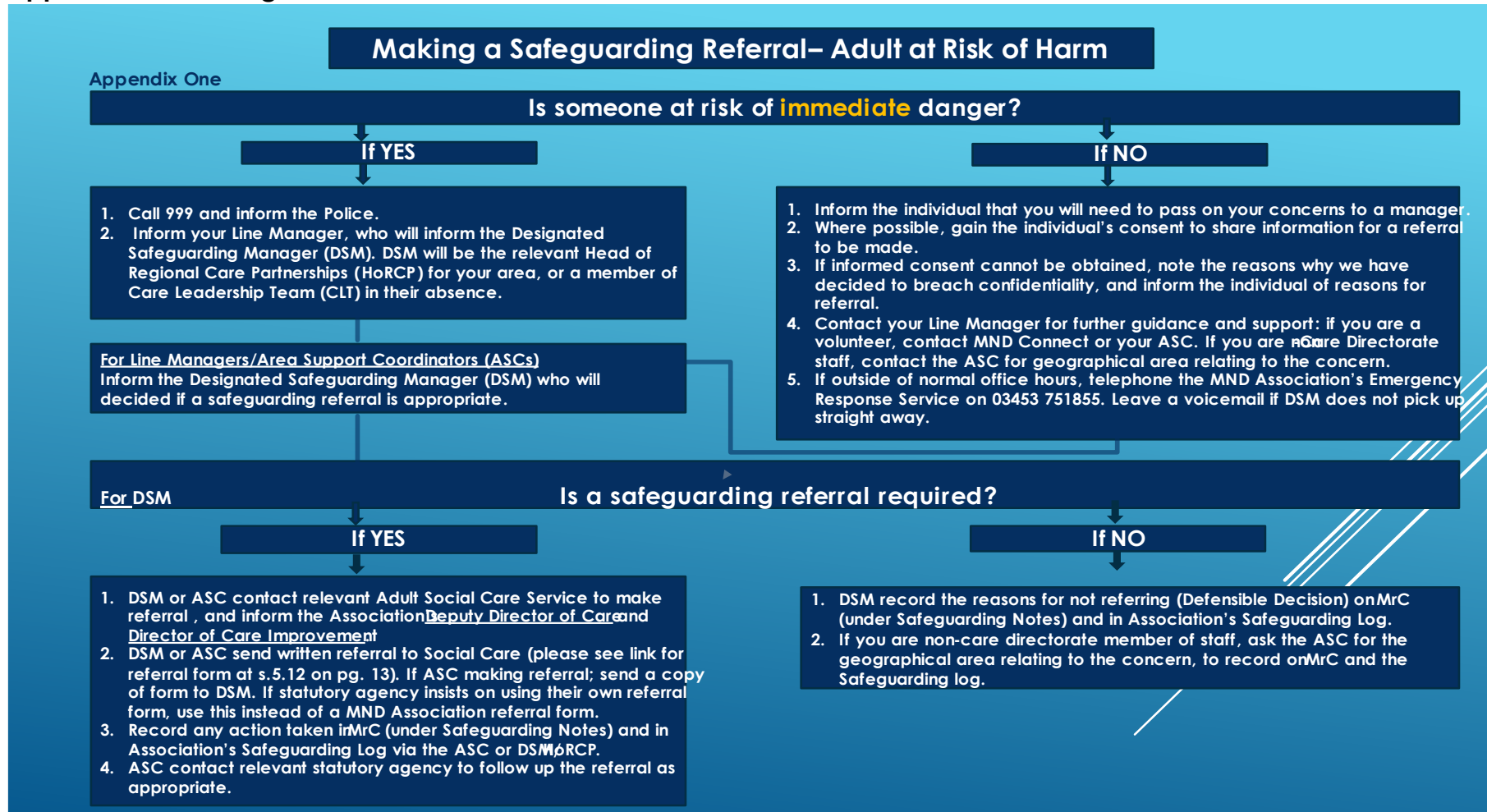
Appendices and Glossary

Safeguarding Adults at Risk of Harm Policy

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Appendix 1 – Making a Referral Flowchart



Appendix 2

Legal and Policy Context – Adults at Risk of Harm

There are several key pieces of legislation which set out the framework for all agencies working with adults at risk. In summary these are:

The Care Act 2014 (updated March 2016) England

The legal framework for the Care Act 2014 is supported by Department of Health statutory guidance which provides information and guidance about how the Care Act works in practice. The guidance has statutory status which means that there is a legal duty to have regard to it when working with adults with needs of care and support and carers.

On 10th March 2015 the Department of Health published the refreshed edition of the Care and Support statutory guidance, which supports implementation of part 1 of the Care Act 2014 by local authorities, the NHS, the police and other partners. The new edition supersedes the version issued in October 2014. It takes account of regulatory changes, feedback from stakeholders and the care sector and developments following the postponement of social care funding reforms 2020.

The Care Act only covers England; there are separate laws covering Wales and Northern Ireland. There is a separate guide for implications of the Social Services and Well-being (Wales) Act 2014, which came into force in Wales in April 2016.

The Act places new duties on Local Authorities bringing several key areas together including

- Assessments and eligibility for service users and carers
- Duties and powers of a Local Authority to meet needs
- **Safeguarding**
- Charging for services and assessing financial resources
- Provider failure, and
- Support and market oversight

Under the Act, Local authorities have a new duty that will require them to establish a more comprehensive information and advice service for people in their area about care and support for adults and support for their carers. This includes, amongst other things, **information about how to raise concerns about a person's safety or wellbeing.**

With regard specifically to safeguarding, the Local Authority must arrange, where necessary, for an **independent advocate** to support and represent an adult who is subject to a safeguarding enquiry or a Safeguarding Adult review (SARs). Effective safeguarding is seeking to promote 'rights' as well as physical safety. If an enquiry needs to start urgently, an advocate need not be in place but needs to be appointed as soon as possible

Mental Capacity Act 2005

The legal framework provided by the Mental Capacity Act 2005 is supported by a code of practice which provides guidance and information about how the Act works in practice. The code has statutory force, which means that certain categories of people have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves

Government Statement of Policy on Adult Safeguarding (HM Government 2013)

This document outlines the Government's policy on safeguarding adults at risk of abuse and neglect. It includes the statement of principles for Local Authority Social Services and housing, health, the police and other agencies to use, both for developing and assessing the effectiveness of their local safeguarding arrangements. It also describes, in broad terms, the outcomes for safeguarding adults, both for individuals and organisations.

Safeguarding – roles and responsibilities in health and social care services (Department of Health, Local Government Association, ADASS, NHS Confederation, Association of Chief Police Officers 2013)

This guidance provides clarity about the roles and responsibilities of the key agencies involved in adult safeguarding. The aim is to ensure that the right things are done by the right people at the right time, working within their own agency and with partners

Information Sharing Guidance (Department of Health)

This guidance supports good practice in information sharing by offering clarity on when and how information can be shared legally and professionally, to achieve improved outcomes. This guidance will be especially useful to support early intervention and preventative work where decisions about information sharing may be less clear than in safeguarding situations.

Commissioning for Better Outcomes (Department of Health, Local Government Association, ADASS, Think Local, Act Personal)

This guidance outlines standards to support a dynamic process of continuous improvement and, through self-assessment and peer review, to challenge commissioners and their partners, to strengthen and innovate to achieve improved outcomes for adults using social care, their carers, families and communities. The standards have been designed to reflect the improvements that experience has shown are needed, to support the transformation to social care to meet people's reasonable aspirations, and to support the implementation of the Carers Act 2014.

Prevention in Safeguarding (Social Care Institute of Excellence, 2011)

This guidance outlines a range of methods of preventing the abuse of adults at risk of harm, from public awareness campaigns through to approaches that empower the individual to be able to recognise, address and report abuse. It examines policy and practice guidance and examples of emerging practice.

Making Safeguarding Personal – a toolkit for responses (Local Government Association, 2015)

The toolkit is set out in a modular format with a summary of key areas – ranging from models, theories and approaches to areas of specialism that safeguarding practitioners need to be aware of. It can be used as a practitioner guide for pointers on how to respond to individual cases, or as a starting point resource for service development.

Gaining access to an adult suspected to be at risk of abuse or neglect – a guide for social workers and managers in England (SCIE, 2014)

This guide clarifies existing powers and legal options relating to access to adults suspected to be at risk of abuse or neglect where access is restricted or denied. Throughout the guide there are links to information on the relevant legislation and case law.

Social Services and Well-Being (Wales) Act 2016

This Act came into force in Wales in April 2016 and is a new law for improving the well-being of people who need care and support, and carers that need support. The Act changes the way in which people's needs are assessed and the way services are delivered – people will have more say in the care and support they receive. It also promotes a range of help available within the community to reduce the needs for formal, planned support. This includes stronger powers to keep people safe from abuse and neglect. The Act builds on the policy set out in *Sustainable Social Services for Wales: A Framework for Action*.

Regulation and Inspection of Social Care (Wales) Act 2016.

MND Association – Appendices for Safeguarding Adults Policy – updated in Feb 2023 – V2.0
AMENDED FOR 4POLICIES previously V6.0

This Act builds upon the success of regulation on Wales and reflects the changing world of social care. It places service quality and improvement at the heart of the regulatory regime and strengthens protection for those who need it

Adult Safeguarding Policy (Northern Ireland) (2015). *Replaces Part 1 of 'Safeguarding Vulnerable Adults: Reg Adult Protection Policy and Guidance' September 2006.*

The intention of this policy is improve safeguarding outcomes for all adults who are at risk of harm through abuse, exploitation or neglect and is relevant to organisations across all sectors which provide services to or work with adults at risk

General Data Protection regulation (GDPR)

The GDPR is a regulation that came into force in May 2018 and standardises data protection law across all 28 EU countries and imposes strict new rules on controlling and processing personally identifiable information – it replaces the 1995 EU Data Protection Directive.

Appendix 3

Recording Guidance for Adults at Risk of Harm

All records pertaining to adult and children's safeguarding must be recorded in the Association CRM system – known as MrC, as well as in the Association's Safeguarding Log. Obviously, much of the information we will record is of a sensitive nature and so permissions to enter or view information are restricted to those that have access to this area of MrC and the Log. Those with permissions to make or view a 'safeguarding note' in MrC include Area Support Coordinators (ASCs), MND Connect and Care Leadership Team (CLT).

A safeguarding note needs an accurate chronology.

The times of the phone calls we receive or when we were otherwise made aware of a potential safeguarding concern and the calls and actions that we subsequently make or do, are crucial in providing an audit trail to show that we dealt with a safeguarding or potential safeguarding alert in a timely fashion.

Appendix 4

Guidance for managing allegations against staff and volunteers who work / or provide a service for adults or children at risk of harm in the MND Association

- 1.1 **N.B.** Staff/Volunteers should be aware that contact outside of their working arrangements between staff and adults and/or children at risk, is considered inappropriate ([See appendix 8 – A Guide to the General Principles of Safe Practice](#))
- 1.2 If you become aware of a member of staff/volunteer, who works for The MND Association, and have concerns that they have:
- Behaved in a way that has harmed an adult/child/young person at risk, or may have harmed an adult, child/young person;
 - Possibly committed a criminal offence against or related to an adult/child/young person at risk; or
 - Behaved towards an adult/child/young person at risk in a way that indicates s/he may be unsuitable to work with groups at risk of harm.

Such concerns should be referred to a Line Manager within the MND Association promptly. If a Director/Deputy Director is suspected of abuse, this should be reported to the Chief Executive. If a Trustee or the CEO is suspected of abuse this should be reported to the Chair of Trustees, supported by the Director of Care Improvement. If the Chair of Trustees is suspected of abuse this should be reported to the Charity Commission. The Line Manager should discuss their concerns with the **Local Authority Designated Officer for allegations (LADO)** or **Designated Adult Protection Officer (DAPO)** in NI

The behaviours described above fall into the category of significant harm, (physical, sexual, emotional abuse and/or neglect). A Line Manager must take care to ensure the correct criteria have been met. Where there is no evidence of actual or possible significant harm, The MND Association should discuss possible disciplinary action of the staff member with the appropriate manager within their directorate.

- 1.3 All such allegations that reach the category of significant harm should be referred to the **Local Authority Designated Officer for allegations** who

provides advice and guidance to employers and voluntary organisations, liaises with the police and other agencies and monitors the progress of cases to ensure that they are dealt with as quickly as possible. The Designated Officer for allegations will offer advice on the management of the process and will arrange for a Strategy Discussion to be held, if required.

- 1.4 The Designated Officer for allegations is not the investigating officer. The Designated Officer for allegations should be approached prior to a decision on suspension of the staff member. If there is the possibility of a criminal investigation then the police, external commissioner (where appropriate), must be consulted before the person who is the subject of the allegation is informed. It is important to consider any previous allegations. Those undertaking any investigations need to be alert to any patterns, which may suggest abuse could be widespread.

1.5 **Internal Reporting Requirements**

Allegations must be reported to a Care Director and appropriate HR Business Partner. The Director must make a referral to the Local Authority Designated Officer for allegations who is contactable through Adult/Children's Services, and also notify the Head of HR and the appropriate Senior Manager (Director of Care Improvement). The Head of HR should inform the Insurance Manager. Such information should then be confirmed in writing.

For more information see the '[A Guide to the General Principles of Safe Practice](#)' in [Appendix 8](#)

- 1.6 If Social Care and/or the Police decide to carry out an investigation, it may be possible that they will advise the Association to suspend the member of staff, whilst enquiries are carried out. The MND Association could also invoke its disciplinary procedure.

The MND Association will not carry out an investigation unless Social Care and the Police decide it is appropriate for them to do so.

1.7 **Less Serious Allegations**

In some instances, allegations may be made against a member of staff, which do not immediately fall into the category of significant harm but are nevertheless a cause for concern. Where this occurs, the appropriate Line Manager and HR Business Partner must be informed, and the procedures outlined below must be followed. If following allegations against The MND Association staff a subsequent adult safeguarding or child protection investigation by Social Care/ Police results in no further action, the MND

Association may nevertheless still need to process the matter through internal Disciplinary or Capability procedures.

1.8 **Primary Consideration must be given to:**

- Supporting the adult/child or young person at risk, the person making the allegation and the member of staff/volunteer involved;
- Reaching a decision about suspension without prejudice of the member of staff involved ([see the Association's Disciplinary procedure](#))

If the member of staff has contact with adults and/or children at risk of harm, as part of their work with the MND Association all contact should stop, and their suspension should be considered. Suspension should be seen as a neutral act which is designed both to protect adults/children at risk and the staff member concerned.

Allegations against employees/volunteers may also be raised through the [Grievance procedures, Complaints Procedures and/or Managing Concerns about Volunteers Policy](#). They may also arise in Disciplinary Proceedings. If this is the case Adult Safeguarding and/or Child Protection Procedures must take precedence and other procedures will be suspended whilst the safeguarding investigation takes place. Staff raising concerns will be supported in line with the [Whistle-Blowing Policy](#).

1.9 **Decision Making**

Once a referral has been made to the Designated Officer for allegations the Local Safeguarding Adults/Children Board procedures for 'Allegations against staff, volunteers and carers' will be followed. In general, the following process will be taking place, if the allegation appears to have some foundation, and there is reason to believe that an adult/child at risk is suffering or is likely to suffer significant harm. A Strategy Discussion will be arranged by The Local Authority Designated Officer:

- If the allegation is such that it is clear to the Designated Officer for allegations that investigations by police and/or enquiries by Adult/Children's Social Care are not necessary The Designated Officer for allegations will discuss the next course of action with appropriate manager within The MND Association;
- Where there is disagreement about the course of action to be followed The Designated Officer for allegations should make the final decision, which will be guided by what is in the best interests of the adult/child/young person at risk;

- The Designated Officer for allegations must keep and maintain appropriate records which ensure there is a chronology of discussions, decisions and actions taken.

1.10 **Strategy Discussion**

A Strategy meeting should be organised by The Local Authority Designated Officer for allegations when the outcome of the referral and assessment indicates that there is cause to suspect that an adult/child at risk has suffered, or is likely to suffer significant harm.

The Strategy Discussion should take as its focus the suspected/actual risk posed by the adult about whom there are concerns/allegations. In addition, records relating to adults/children and young people at risk associated with investigations should note details of the nature of the enquiries/investigation and its outcome.

The adult/child/young person at risk should receive support. Staff members and, volunteers should receive support through the mechanisms within The MND Association. However, the police, and other relevant agencies must be consulted before informing a person who is the subject of allegations, which may possibly require a criminal investigation.

6.11 **Substantiated Allegations**

Where concerns are confirmed, relevant information must be passed by the MND Association Care Director to the [Disclosure and Barring Service](#) (DBS) and the appropriate regulatory and professional bodies.

6.12 **Procedures**

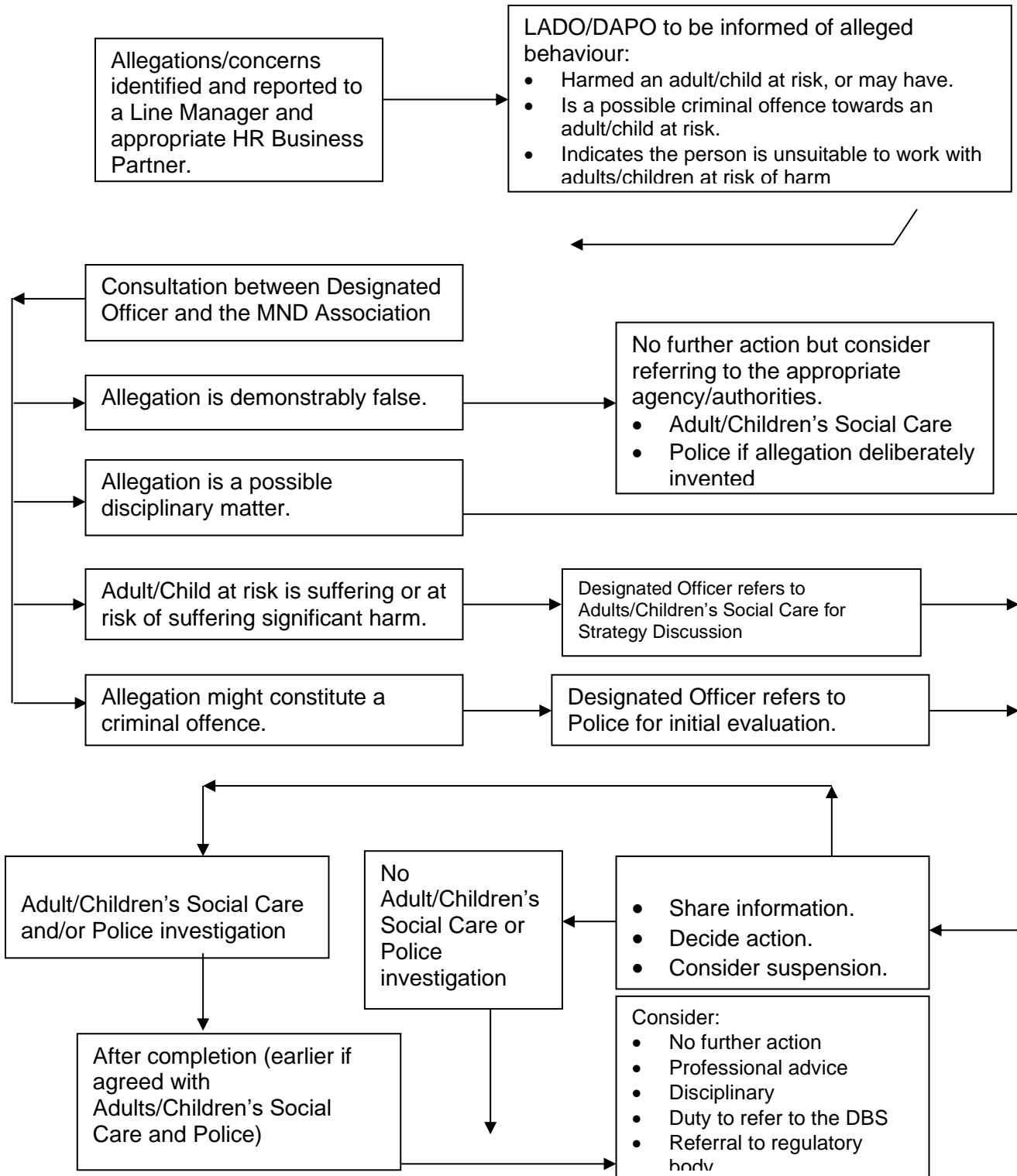
Where a member of staff resigns prior to the conclusion of an adult safeguarding or child protection investigation or disciplinary action relating to a safeguarding issue, or is dismissed as a result of a safeguarding investigation or disciplinary action, the investigation must be completed and the findings recorded on their personnel file as well as referred to the DBS.

The flow chart below summarises the Designated Officer for allegations arrangements for each Local Authority. Further details of allegations management procedures are available within the Local Safeguarding Adult/Children Board Procedures.

Please see flowchart diagram below: '[Allegations against Adults Working with or Providing a Service for adults, children and young people at risk of harm](#)'

6.13 Flowchart: Allegations against Adults Working with or Providing a Service for adults, children and young people at risk of harm.

Local Authority Designated Officer for Allegations (LADO)/ Designated Adult Protection Officer (DAPO) in NI



Appendix 5

Recording: General Principles

The following are general principles to be followed to ensure accurate, detailed and clear record keeping:

- All concerns about an adult, child or young person at risk of harm must be fully recorded on the case file within MrC, under 'safeguarding note' within 5 working days.
- Case files should only contain information relevant to a particular child/young person or adult at risk from harm and their family. The record should clearly state whether the information recorded is fact, third party information or professional opinion.
- Those supervising staff and volunteers who are involved in safeguarding adults, children and/or young people at risk must document their discussion about that individual or family in their one to one supervision and this must be recorded on the case file in MrC. The file must be kept up to date.
- All information relating to an adult/child/family at risk must be held securely in one place.
- All records should conform to the requirements of GDPR and the Human Rights Act (1998). Information shared within The MND Association must be "on a need to know" basis. Information disclosed to another agency must be in the public interest, and is divided into two categories:
 - 1) Information about children/young people in need of protection and:
 - 2) Information about life-threatening harm to an adult.
- Remember any file may be accessed by a Court of Law in Care and/or Criminal proceedings. Staff and volunteers may be called upon to give evidence in court and the importance of clear, accurate but detailed case notes cannot be overemphasised.
- The [Case Recording Policy](#) must be adhered to at all times.

Appendix 6

Guide to the General Principles of Safe Practice within the MND Association

- Keeping children/young people and adults at risk safe from harm is fundamental to our work and overrides all other considerations, including GDPR. See section 5.21 in the safeguarding policy for details about when to breach confidentiality and informed consent
- All staff and volunteers must understand their role in safeguarding children/young people and adults at risk from harm.
- Concerns expressed by children, young people and adults at risk from harm about their safety and well-being must be listened to and taken seriously by all staff and volunteers. Such concerns must be discussed with and passed on to Line Managers.
- **All staff and volunteers must be aware that it is not their role or responsibility to investigate allegations of abuse or neglect.**
- **All concerns about the possible abuse, neglect or care of children, young people and adults at risk from harm should be reported to the appropriate authorities/agency or, in situations of emergency, to the police.**
- All staff and volunteers must understand that keeping children/young people and adults at risk safe from harm requires professionals and others to share information and concerns (as set out in 'Working Together to Safeguard Children 2015, the Protection of Freedoms Act 2012 and the Vulnerable Groups Act 2006).
- **Any concerns about children, young people or adults at risk from harm must be fully and appropriately recorded. See *Recording – General principles*.**
- Contacts outside of normal working hours between staff/volunteers and children/young people or adults at risk are considered inappropriate (unless it is part of a piece of planned and agreed work with children/young people and/or adults at risk) and can only take place with the prior agreement of the appropriate Line Manager. In addition, written parental consent (where applicable) of the child concerned will be required. Overnight stays by children/young people and adults at risk in the homes of staff and volunteers are inappropriate under any circumstances.

- Allegations that a MND Association member of staff or volunteer has caused harm to a child or adult at risk from harm must be immediately reported to the Line Manager
- Allegations of past historical abuse must be referred to the Director of Care Improvement and Head of HR.
- Through its [Safer Recruitment and Selection policy and procedures](#), the MND Association endeavours to ensure that people unsuitable to work with adults, children and young people at risk of harm are not employed.
- All staff and volunteers who have direct contact with adults, children and young people, at risk, will require a [Disclosure and Barring Service](#) check.
- Managers in every work setting in the MND Association should take all steps necessary to promote safer environments for adults at risk, children in need and children suffering or likely to suffer significant harm. Staff and volunteers must feel able to raise concerns with their line managers. If a Line Manager fails to respond to an employee or volunteers concerns regarding adult/child safeguarding, the employee or volunteer must feel free to contact the next manager up the line without prejudice. Adults, children and young people at risk of harm should feel safe enough to share their fears and problems with those they are working with and be made aware of the MND Association's Complaints Procedures. [Please refer to the Association's Whistle Blowing Policy.](#)
- Staff and volunteers may be on their own with adults, children and young people at risk. Where lone working is unavoidable, staff should agree working protocols with colleagues and line managers, and develop appropriate risk assessments to maximise safe practice. This should be regularly reviewed ([See Lone Working Policy](#)).

Appendix 7

Data Protection

Compliance with the General Data Protection Regulations 2018 is a pre-requisite to all our work. The GDPR is a regulation that came into force in May 2018 and standardises data protection law across all 28 EU countries and imposes strict new rules on controlling and processing personally identifiable information – it replaces the 1995 EU Data Protection Directive. Like its predecessor, the Data protection Act 1998, it provides clear guidance as to the exemption status of information concerning the protection and safeguarding of both adults and children at risk of harm. Please refer to our [Data Protection Policies](#) in full.

Appendix 8

Media Consent

Please refer to the Association's guidelines on consent participating in media such as photography and video recording

Appendix 9

Acceptable Use Policy for Mobile Phones, Cameras, Tablets and other Digital Portable Devices

The MND Association recognises that staff may need to have access to mobile phones whilst working with adults, children and young people at risk. However, there have been a number of concerns raised by Local Authorities and nationally through Serious Case Reviews regarding the use of mobile phones and other digital devices.

Such concerns are mainly based around:

- Staff being distracted from their work with service users;
- The use of mobile phones and other digital devices around adults, children and/or young people;
- The inappropriate use of mobile phones.

Please see our [policy on acceptable use of mobile phones and cameras](#) for more information.

Appendix 10

Duty of Care to All MND Association Staff and Volunteers

Dealing with issues concerning the protection and safeguarding of adults and children/young people at risk of harm can be difficult and distressing. All staff and volunteers have access to regular and structured one to one staff supervision or volunteer support groups. In addition, staff also have access to a free personal counselling helpline. If you need to contact the helpline the details are: 0808 802 6262.

Appendix 11

Safeguarding Adults Reviews (SAR)

The Care Act states that the safeguarding adults board must arrange a

safeguarding adults review in some circumstances, e.g. if an adult with care and support needs dies, as a result of abuse or neglect and there is concern about how one of the members of the safeguarding adults board acted. Reviews are about learning lessons for the future so that all organisations involved can improve as a result.

Each UK nation has its own terminology for carrying out and sharing the learning from reviews.

The Chief Executive can be required to conduct an Individual Management Review or contribute in a specified manner requested by the Local Safeguarding Adults Board, as a result of the death of or serious injury to an adult at risk, who is/was a service user of the MND Association.

The Chief Executive may delegate the responsibility of co-ordinating the Review to the Head of HR and/or the Director for Care Improvement.

Purpose of the Review

The specific objectives of the management review will be to establish the following:

- Whether the MND Association Safeguarding Adults at Risk of Harm procedures were followed;
- Whether the Local Safeguarding Adults Board, for the specific area, interagency procedures were followed;
- Whether the case suggests that there is an urgent need to review those procedures in the light of lessons learnt;
- Whether any other action is needed;
- Any practice learning, which needs to be disseminated throughout The MND Association.

This will require that the following main tasks be carried out:

- Identification and reading of file material;
- Interviews of key practitioners and managers
- Establishment of factual chronology;
- Assessment of whether decisions and actions taken in the case were in line with the organisation's policies and procedures;
- Determination of what services were provided following the decisions and actions in the case;
- Recommendations for action in the light of the Review findings.

Who will conduct the review?

A senior manager with relevant knowledge and experience, who has had no involvement with the adult at risk or the family, and who has no management responsibility for the case, will conduct the Review.

The Review will be conducted separately from any disciplinary or criminal proceedings related to the case. Those conducting the review will have access to all relevant records.

All relevant staff will be interviewed. Staff involved will be given the opportunity to comment on the factual accuracy of the Review report before it is shared outside of the MND Association.

The result of the Management Review, or any other specified contribution will be submitted to the SCR Panel of the LSAB that requested a Review Report from the Chief Executive.

What can be learnt from the review?

Are there lessons from the review for the way in which the MND Association works to safeguard adults at risk and to promote their welfare? Is there good practice to highlight as well as ways in which practice can be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies, resources?

Recommendations for action

What action is to be taken and by whom? What outcomes should these actions be about, and how will management review whether they have been achieved?

- Responsibility for co-ordinating the Individual Management Review Report, for ensuring that it is written to an appropriate standardised format and adheres to necessary timescales as set down by the SCR panel rests with the Head of Safeguarding;
- A report concerning any involvement of The MND Association in a SCR will need to be made to the Standards Committee;
- The Director for Care Improvement has responsibility for presenting the report to the Standards Committee;
- Any outcomes arising from the Review Report concerning practice learning and their implementation will be the responsibility of the person with a lead for safeguarding in the organisation (Director of Care Improvement).

Appendix 12

Domestic Homicide Reviews

The cross-government definition of domestic violence and abuse is: any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- Psychological;
- Physical;
- Sexual;
- Financial;
- Emotional.

It often involves controlling and coercive behaviour and issues such as forced marriage may affect young people.

The definition has recently been changed to encompass young people in the age group 16 – 17.

When someone has been killed as a result of domestic violence (domestic homicide) a review should be carried out. Professionals need to understand what happened in each homicide and to identify what needs to change to reduce the risk for future tragedies. A similar process to Serious Case Reviews (see 14 above) will take place and the same MND Association procedure applies.

Appendix 13

Responding to Reports of Historical/ Past Abuse

Any staff member receiving an allegation of past abuse from a former service user should act in accordance with the following:

Action to Safeguard

15.1 Adults who may have been abused as children may have waited to tell their stories for many reasons. There may be fear of reprisal, alleged abusers may have some form of control over the alleged victim and there is often a strong sense of guilt and foreboding about actions that may be taken after reporting.

- 15.2 It is, therefore, absolutely vital that the member of The MND Association staff receiving the first contact should ensure that the alleged victim feels safe enough to provide good quality information about the alleged abuse, including as far as possible, details of the alleged abuser(s) and the context of the abuse. This first contact is critical to the process of safeguarding in ensuring alleged perpetrators are tracked, there is appropriate liaison with the police and child protection agencies, and steps are taken to provide relevant help and support to alleged victims of historical abuse.
- 15.3 All initial contacts should be recorded and the Director of Care Improvement must be informed immediately if an allegation of past/historical abuse is made. The lead for Safeguarding will direct all subsequent action on behalf of MND Association including referral to or liaison with The Police and Social Care.
- 15.4 **Confidentiality and Information Sharing**

Adults who disclose alleged past/historical abuse are entitled to have their information treated with great respect and sensitivity. However, as in all matters of child protection, this must not interfere with any processes aimed at protecting children or young people from harm or bringing alleged perpetrators of abuse to justice. From the outset of all contacts it will be vital to explain to alleged victims of abuse that all information will be dealt with sensitively and held confidentially but this will not preclude information sharing with relevant agencies in order to secure the safety of all children/young people and adults at risk from abuse.

Appendix 14

Glossary – Adults

Abuse

Includes physical, sexual, emotional, psychological, financial, material, neglect (including self-neglect), acts of omission, discriminatory and organisational abuse;

- **Physical:** Including hitting, slapping, pushing, kicking, squeezing, shaking, suffocating, punching, drowning, burning/scalding, restraint or inappropriate sanctions.
- **Sexual:** Including rape and sexual assault or sexual acts including activities such as looking at or being involved in the production of pornographic material or watching sexual activities or encouraging individuals to behave in sexually inappropriate ways; to which the adult at risk has not consented, could not consent or was pressured into consenting.

- **Psychological:** Including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation/belittling, name-calling, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.
- **Financial or material:** Including theft, fraud, selling of assets, exploitation, pressure in connection with wills, property or inheritance or financial transactions, the misuse or misappropriation of property, possessions or benefits.
- **Neglect** or acts of omission (including self-neglect): Including ignoring medical or physical care needs, failure to provide access to appropriate health care, social care, education services or misuse of medication, adequate nutrition or heating, leaving in soiled clothes, exposing a person to unacceptable risk, omitting to provide or ensure adequate care and supervision.
- **Discriminatory:** Including racist, sexist behaviour and harassment based on a person's ethnicity, race, culture, sexual orientation, age or disability, and other forms of harassment, slurs or similar treatment.
- **Institutional abuse:** This can sometimes happen in residential homes, nursing homes or hospitals when people are mistreated because of poor or inadequate care, neglect and poor practice that affect the whole of that service.
- **Human and Civil Rights:** the denial of or coercive influence on an individual's rights to be registered to vote; the right to be treated as an equal with dignity and respect; the right to speech and movement (where physically possible).

ABE (Achieving Best Evidence) Interviewer

This applies to **Northern Ireland** only and the interviewer must be social work qualified. They are responsible for planning and conducting interviews with service users who may have been the victim of crime. Interviews are undertaken jointly with the PSNI (Police Service NI) and in accordance with guidance laid out in 'Protocol for Joint Investigation of Adult Safeguarding Cases' and 'Achieving Best Evidence in Criminal Proceedings'.

Adult Protection Gateway Service

This applies to **Northern Ireland** only. Central referral point within the Health and Social Care Trust for all concerns about an adult who is, or may be at risk.

Advocacy

Support to help people say what they want, secure their rights, represent their interests and obtain services they need. Under the Care Act, the local authority must arrange for an independent advocate to represent and support a person

who is the subject of a safeguarding enquiry or a safeguarding adult review if they need help to understand and take part in the enquiry or review and to express their views, wishes, or feelings.

Alert

A concern that a person at risk is or may be a victim of abuse, neglect or exploitation. An alert may be a result of a disclosure, an incident, or other signs or indicators.

Alerter

The person who raises a concern that an adult is being, has been, or is at risk of being abused or neglected. This could be the person themselves, a member of their family, a carer, a friend or neighbour or could be a member of staff or a volunteer.

ASC (Adult Safeguarding Champion)

This applies to **Northern Ireland** only. Provides strategic and operational leadership and oversight in relation to adult safeguarding for an organization or group and is responsible for implementing adult safeguarding policy statement. The ASC is also the main point of contact with HSC Trusts and the PSNI for all adult safeguarding matters.

Assessment

A process to identify the needs of the person and how these impact on the wellbeing and outcomes that they wish to achieve in their day to day life.

Best interests decision

A decision made in the best interests of an individual defined by the Care Act - when they have been assessed as lacking the mental capacity to make a particular decision. The best interest decision must take into consideration anything relevant such as the past or present wishes of the person, a lasting power of attorney or advance directive. There is also a duty to consult with relevant people who know the person such as a family member, friend, GP or advocate.

Care Act 2014

See section on legislation

Care and support needs

The support a person needs to achieve key outcomes in their daily life as relating to wellbeing, quality of life and safety. The Care Act introduces a national eligibility threshold for adults with care and support needs which consists of three criteria, all of which must be met for a person's needs to be eligible.

Care settings or services

Health care, nursing care, social care, domiciliary care, social activities, support setting, emotional support, housing support, emergency housing, befriending and advice services and services provided in someone's own home by an organisation or paid employee for a person by means of a personal budget.

Carer

Unpaid carers such as relatives or friends of the adult. Paid workers, including personal assistants, whose job title may be 'carer', are called 'staff'.

CCG (Clinical Commissioning Group)

These were formally established on 1 April 2013 to replace Primary Care Trusts and are responsible for the planning and commissioning of local health services for the local population.

Central Referral Unit

Is where all referrals to the police are received, risk assessed, graded and allocated for action by the most appropriate police team and/or partner agency.

Clinical governance

The framework through which the National Health Service (NHS) improves the quality of its services and ensures high standards of care and treatment.

Community safety

A range of services and initiatives aimed at improving safety in the community; for example, safer neighbourhoods, anti-social behaviour, hate crime, domestic abuse, PREVENT, human trafficking, modern slavery, forced marriage and honour based violence.

Consent

The voluntary and continuing permission of the person to an intervention based on an adequate knowledge of the purpose, nature, likely effects and risks of that intervention, including the likelihood of its success and any alternatives to it.

Contemporaneous notes

Notes taken at the time of meetings with individuals, telephone calls, visits to premises, during the course of an investigation. These may also be important in the context of giving evidence in legal proceedings.

Community Safety Partnership (CSP)

A strategic forum bringing agencies and communities together to tackle crime within their communities. Community Safety Partnerships (CSPs) are made up of representatives from the responsible authorities, these are Police, police authorities, local authorities, Fire and Rescue authorities, Clinical Commissioning Groups and Community Rehabilitation Companies and the National Probation Service.

CPA (Care Programme Approach)

An approach introduced in England for people with a mental illness, referred to specialist psychiatric services, published by the Department of Health in 1990. This requires health authorities, in collaboration with social services departments, to put in place specified arrangements for the care and treatment of people with mental ill health in the community.

CPS (Crown Prosecution Service)

The government department responsible for prosecuting criminal cases investigated by the police in England and Wales.

CRU (Central Referral Unit)

This applies to **Northern Ireland** only. Central point of referral to PSNI in relation to adult protection based in Belfast.

CJINI (Criminal Justice Inspection Northern Ireland)

This applies to **Northern Ireland** only. An independent legal inspectorate with responsibility for inspecting all aspects of criminal justice system in NI apart from the judiciary.

CQC (Care Quality Commission)

The body responsible for the registration and regulation of health and social care in England. In Wales the body responsible for this is **Care and Social Services Inspectorate Wales** and in NI it is the **Regulation and Quality Improvement Authority**

DASH (Domestic Abuse, Stalking and Harassment and 'Honour' Based Violence)

A risk identification checklist (RIC) which is a tool used to help front-line practitioners identify high risk cases of domestic abuse, stalking and 'honour' based violence.

DBS (Disclosure and Barring Service)

The government body established in 2012 through the Protection of Freedoms Act and the merger of two former organisations, the Criminal Records Bureau and the Independent Safeguarding Authority. The DBS is designed to help employers make safer recruitment decisions and prevent unsuitable people from working with adults at risk of harm.

The DBS search police records and barring lists of prospective employees and issue DBS certificates. They also manage central barred lists of people who are known to have caused harm to adults with needs of care and support.

Defensible decision making

Providing a clear rationale based on legislation, policy, models of practice or recognised tools utilised to come to an informed decision. This decision is based on the information known at that particular time and it is important to accurately and concisely record the decision-making process, in order to explain how and why the decision was made at that time.

Designated Adult Safeguarding Manager:

The person responsible within an organisation for the management and oversight of individual complex cases and coordination where allegations are made or concerns raised about a person, whether an employee, volunteer or student, paid or unpaid.

Designated Adult Protection Officer (DAPO)

This applies to **Northern Ireland** only. Person responsible for the management of each referral received by the HSC Trust. DAPOs will be in place in both within the Adult Protection Gateway Service and within core service teams.

DoLS (Deprivation of Liberty Safeguards)

Measures to protect people who lack the mental capacity to make certain decisions for themselves which came into effect in April 2009 as part of the Mental Capacity Act 2005 (England and Wales), and apply to people in care homes or hospitals where they may be deprived of their liberty. In NI, The Mental Capacity Act (Northern Ireland) 2016 makes reference to DoL.

Domestic violence and abuse

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to psychological, physical, sexual, financial and emotional abuse.

Controlling behaviour 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 behaviour.

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.

Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family (Home Office 2012).

Domestic Homicide Reviews

Statutory reviews commissioned in response to deaths caused through domestic violence. They are subject to the guidance issued by the Home Office in 2006 under the Domestic Violence Crime and Victims Act 2004. The basis for the domestic homicide review (DHR) process is to ensure agencies are responding appropriately to victims of domestic abuse offering and/or putting in place suitable support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

Duty of Candour

A requirement on all health and adult social care providers registered with the Care Quality Commission (CQC) to be open with people when things go wrong. The duty of candour means that providers have to act in an open and transparent way in relation to service user care and treatment.

Family Group Conferences (FGC)

An approach used to try and empower people to work out solutions to their own problems. A trained FGC coordinator can support the person at risk and their family or wider support network to reach an agreement about why the harm occurred, what needs to be done to repair the harm and what needs to be put into place to prevent it from happening again.

Harm

Involves ill treatment (including sexual abuse and forms of ill treatment which are not physical), the impairment of, or an avoidable deterioration in, physical or mental health and/or the impairment of physical, intellectual, emotional, social or behavioural development.

Hate crime

Any crime that is perceived by the victim, or any other person, to be racist, homophobic, transphobic or due to a person's religion, belief, gender identity or disability.

Health and Wellbeing Board

A statutory, multi-organisation committee of NHS and local authority commissioners, coordinated by the local authority which gives strategic leadership across the local authority area regarding the commissioning of health and social care services.

Human trafficking

The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the

giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.

Independent Mental Capacity Advocate (IMCA)

Established by the Mental Capacity Act 2005, IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions, including decisions about where they live and serious medical treatment options.

IMCAs are mainly instructed to represent people where there is no one independent of services (such as a family member or friend) who is able to represent the person. However, in the case of safeguarding concerns IMCAs can be appointed anyway (i.e. irrespective of whether there are friends or family around and irrespective of whether accommodation or serious medical treatment is an issue).

Local Safeguarding Adults Board (LSAB)

A statutory, multi-organisation partnership committee, coordinated by the local authority, which gives strategic leadership for adult safeguarding, across the local authority. A LSAB has the remit of agreeing objectives, setting priorities and coordinating the strategic development of adult safeguarding across its area (England and Wales)

In NI, the **Northern Ireland Adult Safeguarding Partnership (NIASP)** and **Local Adult Safeguarding Partnerships (LASPs)** provide this strategic function and in wales it is the **National Independent Safeguarding Board**

Making Safeguarding Personal (MSP)

An approach to safeguarding work which aims to move away from safeguarding being process driven and instead, to place the person at risk at the centre of the process and work with them to achieve the outcomes they want.

MAPPA (Multi Agency Public Protection Arrangements)

Statutory arrangements for managing sexual and violent offenders.

MARAC (Multi Agency Risk Assessment Conference)

A multi-agency forum of organisations that manage high risk cases of domestic abuse, stalking and 'honour' based violence.

MASH (Multi Agency Safeguarding Hub)

A joint service made up of Police, Adult Services, NHS and other organisations. Information from different agencies is collated and used to decide what action to take. This helps agencies to act quickly in a coordinated and consistent way, ensuring that the person at risk is kept safe.

Mate Crime

A form of exploitation which occurs when a person is harmed or taken advantage of by someone they thought was their friend.

Mental Capacity

Refers to whether someone has the mental capacity to make a decision or not. The Mental Capacity Act 2005 and the code of practice outlines how agencies should support someone who lacks the capacity to make a decision.

NIASP (Northern Ireland Adult Safeguarding Partnership)

The regional multi-agency, multi-disciplinary partnership that brings together representatives from organisations and communities of interest who have a significant contribution to make to adult safeguarding

NISCC (Northern Ireland Social Care Council)

Independent regulatory body for NISC workforce, established to increase public protection and regulating standards of training and practice for social care workers

No Delay

The principle that safeguarding responses are made in a timely fashion commensurate with the level of presenting risk. In practice, this means that timescales act as a guide in recognition that these may need to be shorter or longer depending on a range of factors such as risk level or to work in a way that is consistent with the needs and wishes of the adult.

PALS (Patient Advice and Liaison Service)

A NHS service created to provide advice and support to NHS patients and their relatives and carers.

Public interest

A decision about what is in the public interest needs to be made by balancing the rights of the individual to privacy with the rights of others to protection.

Office of the Public Guardian (OPG)

The administrative arm of the Court of Protection and supports the Public Guardian in registering enduring powers of attorney, lasting powers of attorney and supervising Court of Protection appointed deputies.

PREVENT

The Government strategy launched in 2007 which seeks to stop people becoming

terrorists or supporting terrorism. It is the preventative strand of the government's counter-terrorism strategy and aims to respond to the ideological challenge of terrorism and the threat from those who promote it; prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support and work with sectors and institutions where there are risks of radicalisation that need to be addressed.

It is the preventative strand of the government's counterterrorism strategy, CONTEST.

Prevention

Describes how the care and support system (and the organisations forming part of this system) work to actively promote the wellbeing and independence of people rather than waiting to respond when people reach a crisis point. The purpose of this approach is to prevent, reduce or delay needs escalating.

Protection of property

The duty on the local authority to protect the movable property of a person with care and support needs who is being cared for away from home in a hospital or in accommodation such as a care home, and who cannot arrange to protect their property themselves. This could include their pets as well as their personal property (e.g. private possessions and furniture).

Radicalisation

This involves the exploitation of susceptible people who are drawn into violent extremism by radicalisers often using a persuasive rationale and charismatic individuals to attract people to their cause. The aim is to attract people to their reasoning, inspire new recruits and embed their extreme views and persuade vulnerable individuals of the legitimacy of their cause.

The PREVENT Strategy, launched in 2007, seeks to stop people becoming terrorists or supporting terrorism.

Referral

An alert becomes a referral once it has been assessed and it has been determined that the concerns raised fall within the remit of adult safeguarding arrangements.

Safeguarding

Activity to protect a person's right to live in safety, free from abuse and neglect. It involves people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that their wellbeing and safety is promoted.

Safeguarding activity

Actions undertaken upon receipt of a safeguarding referral. This may include information gathering, holding a safeguarding planning meeting, activities to resolve the risks highlighted, safeguarding review meetings and developing a safeguarding plan with the adult at risk.

Safeguarding support plan

One outcome of the enquiry may be the formulation of agreed action for the adult which should be recorded on their care plan. This will be the responsibility of the relevant agencies to implement.

Safeguarding planning meeting

A multi-agency meeting (or discussion) involving professionals and the adult if they choose, to agree how best to deal with the situation as determined by the views and wishes of the individual.

Safeguarding work

Describes all the work multi-agency partners undertake either on a single agency basis (as part of their core business) or on a multi-agency basis within the context of local adult safeguarding arrangements.

Safeguarding Adult Review (SAR)

A statutory review commissioned by the Local Safeguarding Adults Board in response to the death or serious injury of an adult with needs of care and support (regardless of whether or not the person was in receipt of services) and it is believed abuse or neglect was a factor. The process aims to identify learning in order to improve future practice and partnership working.

Safeguarding enquiry

The action taken or instigated by the local authority in response to a concern that abuse or neglect may be taking place. An enquiry could range from a conversation with the adult, or if they lack capacity, or have substantial difficulty in understanding the enquiry their representative or advocate, prior to initiating a formal enquiry under section 42, right through to a much more formal multi-agency plan or course of action. This is sometimes referred to as a 'section 42 enquiry'.

Self-neglect

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 well-being of the self-neglecters and perhaps even to their community.

Significant harm

The ill treatment (including sexual abuse and forms of ill treatment which are not physical), and impairment of, or an avoidable deterioration in, physical or mental

health, and the impairment of physical, intellectual, emotional, social or behavioral development.

SIRI (Serious Incident Requiring Investigation)

A process used in the NHS to investigate serious incidents resulting in serious harm or unexpected or avoidable death of one or more patients, staff, visitors or members of the public.

Vital interests

A term used in the Data Protection Act 1998 to permit sharing of information where it is critical to prevent serious harm or distress or in life threatening situations.

Willful neglect or ill treatment

An intentional, deliberate or reckless omission or failure to carry out an act of care by someone who has care of a person who lacks capacity to care for themselves.

Appendix 15

Safeguarding After Action Review (AAR) – MND Association internal template

Safeguarding incident After Action Review (AAR)

Action Plan

Objective - Recognising, responding to and recording safeguarding incidents.

5.1

Plan created: January 2023

Plan updated:

Plan Owner:
Nick Goldup

Date/RAG	Action	Action and updates	Who	When	Note
	Enhancing our capability				
	Ensure staff are aware/reminded of the safeguarding telephone number and the out of hours service times.				
	Ensure staff on the rota of the safeguarding out of hours service (Designated Safeguarding Manager) are aware of their responsibilities and actions required if they receive a safeguarding incident related call.				

	Ensure key staff are aware/reminded of our safeguarding policy, where to find it and their role in a safeguarding incident.				
	Ensure volunteers are also equipped with the knowledge and skills to recognise, respond, and record a safeguarding incident.				
	Improving our record keeping				
	Produce case studies on the expected quality of case note completion.				
	Produce guidance for making information available for the police, and other public bodies, to include what documents are part of a likely audit trail.				
	Configure the safeguarding section of MrC to allow viewing and sign off by the Designated Safeguarding Manager of records created, edited, and added to by Area Support Colleagues or others.				
	Raising awareness of our policies				
	Locate an accessible and visible central location for the keeping of our safeguarding and suicide policies. Test solution with key target audiences (e.g ASC colleagues and Support Volunteers) to confirm ease of access and how intuitive they are to find and understand.				

	Review the currently available Safeguarding flow chart and where it best sits within our policy documents, considering whether it should be a standalone document.				
	Extending our response				
	Consider alternative contact methods for those were using the telephone may not be possible or is difficult.				
	Review our process related to escalation of incidents in all circumstances – such as a colleague is not available or can't be reached and so on. To include guidance on the ratification of decisions.				
	Ensure we are clear about what support we can provide to the person with MND and those close to them following an incident, either directly or through signposting to other services. Ensure the audit trail shows if, when and who carried this out.				
	Move beyond responding to and recording safeguarding incidents (postvention) to a greater focus on preventing and early recognition of potential incidents.				
	Expanding our continuous learning/continuous improvement approach				
	If and/or when appropriate, seek the views of those involved (person with MND and those close to them) about our response to the incident.				

	Ensure there is dedicated time at the Safeguarding Board, or a separate meeting, to learn from each response to a safeguarding incident using the After-Action Review process.				
	To compile evidence and make it easily available to those who need to see it, of any learning and/or ideas for improvement. To go beyond learning from each individual incident to more general learning.				
	Produce more generic case studies highlighting good practice in recognising, responding to and reporting safeguarding incidents.				
	Provide workshops, and other methods of learning, for staff and volunteers on dealing with a safeguarding incident.				
	Monitor the take up of suicide prevention training, whilst also recognising the generic nature of the content, and offer further opportunities to develop understanding of the issues of relevance to people with MND.				
	Whilst acknowledging we are not a statutory body, make available more information for people with MND, and those close to them, on their expected quality of care, legal rights and best practice.				

