MEYERCLINIC

# Safeguarding Adults Policy and Procedures

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| Policy Lead | Dr Annelize Meyer |
| Version No. | 5 |
| Date of issue | July 2025 |
| Date to be reviewed | July 2026 |
| **Not controlled once printed** | |

## Introduction

Meyer Clinic's aim in implementing this policy is to ensure that staff understand their responsibilities in relation to safeguarding and the prevention of any form of abuse of any patient, thus enabling them so to live in a safe and non-threatening environment, free of any abuse.

To achieve this aim, it is essential that all staff are fully aware of what constitutes abuse in order that they can identify abuse by being further aware of what to look for. Staff must also be fully aware of how to report concerns, recognise the importance of doing so immediately and understand the procedures through which to do this. This policy provides the information staff will require to fulfil their duties and obligations in respect to the safeguarding patients.

All staff have a responsibility to be vigilant with regard to the indicators of abuse and Meyer Clinic proactively encourages a culture of raising all concerns, whether or not these result in being reportable safeguarding events. Staff members can be assured that they will not be penalised for reporting the possibility of abuse provided this is done without malice.

**The relevant local authority safeguarding policy is recognised in all of our services and will be referred to in conjunction with this policy.**

**Emergency services support is to be sought if risk is imminent to a person or if an individual assessing is unsure of the risk to a person.**

**Meyer Clinic's** Local Authority Safeguarding Team details are **located via their website - Raise a concern about an adult - West Sussex County Council**

**To report an urgent concern that requires a same day response, please call the Adult Social Care out of hours manager on 033 022 27007.**

A referral MUST be made immediately to the local authority safeguarding team based on where the adult at risk is located.

## Policy Statement

Meyer Clinic has a legal responsibility to prevent adults from abuse, harm or neglect (including self-neglect) and to act positively to report concerns.

We will take all reasonable steps to prevent harm, to protect people and to respond appropriately when harm does occur.

## Scope

This policy and the procedures apply to all staff, including workers and independent sub-contractors.

Meyer Clinic are required to have a Safeguarding Lead responsible for guiding and supporting staff when dealing with the safeguarding of adults.

**The Safeguarding Lead for Meyer Clinic is Dr. Annelize Meyer.**

**Contact Number: 01243 771 455**

## Procedures

As a part of our commitment, Meyer Clinic will adhere to the 6 key principles of safeguarding outlined in the Care Act 2014:

- **Empowerment**
- **Prevention**
- **Proportionality**
- **Protection**
- **Partnership**
- **Accountability**

**Empowerment** - Empowerment is the principle that adults should be in control of their lives and consent is needed for decisions and actions designed to protect them.

The purpose of safeguarding is to enable people to live a life free from abuse and neglect. It is, therefore, vital that if an individual has mental capacity and is able to make their own decisions that they maintain control of their life and that professionals support their decision-making throughout the process. This includes:

- Working towards the outcomes the individual wants.
- Listening to the individual and ensuring their voice is heard.
- Taking actions with an individual's consent, unless there is a clear justification for acting contrary to their wishes, such as for reasons of public interest or a lack of mental capacity.
- Ensuring the individual receives support to participate in all decisions about them (e.g., with the support of friends/family/advocacy, personal assistants, translators etc.) and due regard is given to issues of accessibility and equality and diversity.
- Enabling individuals to make informed decisions (e.g., sharing assessments of risk, sharing information on available support options to reduce those risks and providing support to weigh up risks and solutions).
- Respecting the choices and decisions that individuals make.
- Allowing individuals to change their mind if their views or circumstances change or simply, if they just change their mind.

In the event that an individual is without the mental capacity to make a particular decision for themselves, a Best Interests Meeting should take place and a decision should be made in the best interest of the individual and within the framework of the Mental Capacity Act 2005 and Code of Practice. The individual should continue to be the involved to the fullest extent possible in the decision-making process and any decisions made must recognise their wishes, feelings, beliefs and values and ensure that they are appropriately represented.

**Protection** - Safeguarding Adults procedures provide a framework by which adults can be supported to safeguard themselves from abuse, or are supported and protected, where they are unable, for reasons of mental capacity, to make decisions about their own safety.

Assessments of mental capacity and best interest decisions, in relation to those without mental capacity, must always be within the legal framework of the Mental Capacity Act and Code of Practice. Protection encompasses each and every person's duty of care and/or moral responsibility to act upon suspicions of abuse, within the context of this procedure, and ensure that adults at risk as citizens receive the protection afforded them in law.

**Prevention** - Prevention of abuse is the primary goal, and members of the public, agencies, service providers, individual employees or volunteers and communities all have a role in preventing abuse from occurring. Prevention involves promoting awareness and understanding and supporting people to safeguard themselves from the risk of abuse. This includes helping people to identify and make informed decisions about risks and develop forward plans that keep them safe.

Prevention also refers to the actions of organisations to ensure they have systems in place that minimise the risk of abuse. Prevention is associated with a broad range of responsibilities and initiatives, each associated with making safeguarding adults a core responsibility within the context of providing high quality services.

**Proportionality** - The principle of proportionality relates to the responsibility to ensure that responses to safeguarding concerns are proportional to assessed risk and the nature of the allegation/concern. Proportionate decisions need to take into account the principles of empowerment and protection.

This principle of proportionality is also encompassed within the Mental Capacity Act; where an individual lacks mental capacity to make a particular decision, decisions must be made in the individual's 'best interests'. This includes the responsibility to consider if the outcomes can be achieved in a way that is 'less restrictive of the person's rights and freedoms'.

**Partnership** - Partnership means working together to prevent and respond effectively to incidents or concerns of abuse, to support the adult at risk in making informed decisions

about identified risks of harm and helping them to access sources of support that keep them safe.

Partnership also includes working with relatives, friends, unpaid carers or other representatives, such as advocates as partners, as appropriate, to achieve positive outcomes for the adult at risk. Partnership also means working cooperatively with other agencies to prevent, investigate and end abuse. Statutory, private, voluntary and specialist or mainstream services and their representatives should be considered partners within this procedure.

**Accountability** - The principle of accountability involves transparency and decision making that can be accounted for. This involves each individual and Company fulfilling their duty of care, making informed defensible decisions, with clear lines of accountability. It involves companies, staff (and volunteers) understanding what is expected of them, recognising and acting upon their responsibilities to each other, and accepting collective responsibility for safeguarding arrangements.

To meet our commitment, we will:

- ensure that everyone that works with us, for us or on our behalf is familiar with this policy and has access to the required documents
- monitor the implementation of this policy and take any steps that are required to improve our practices
- ensure that effective procedures are in place for responding to complaints, concerns and allegations of suspected or actual abuse
- ensure that there are appropriate risk assessments in place
- ensure safe recruitment procedures including ID Checks, references and DBS checks are followed for every position we recruit to
- all individuals that work for us now or in the future, in any capacity, will be trained to Level 1 in Safeguarding, with clinical staff being trained to Level 2 and the Safeguarding Lead being trained to Level 3.

## Types of abuse

Abuse is the violation of an individual's human and civil rights. Abuse can be self-inflicted or inflicted by another person or persons. In the context of safeguarding, it is used to refer to any knowing, intentional or negligent act by another that causes harm or a serious risk of harm to another. The Care Act recognises ten categories of abuse experienced by adults as follows, although it is important to also recognise that cyber bullying, forced marriage, mate crime and radicalisation can also apply to adults:

**Physical abuse** - Use of physical force or mistreatment of one person by another, which may or may not result in actual physical injury; physical injuries which have no satisfactory explanation or where there is a definite knowledge or reasonable suspicion that the injury

was inflicted with intent, or through lack of care, by the person having custody, charge or care of that person. This could include:

- Hitting
- Slapping
- Pushing
- Rough Handling
- Exposure to heat or cold temperatures
- Forced feeding
- Denial of treatment
- Restraint
- Misuse of medication
- Not being assisted to the toilet when needing to go
- Or other inappropriate sanctions

Possible indicators of physical abuse include:

- History of unexplained falls or minor injuries.
- Unexplained bruising in well protected areas, on the soft parts of the body or clustered as from repeated striking.
- Unexplained burns in an unusual location or of an unusual type.
- Unexplained fractures to any part of the body that may be at various stages in the healing process.
- Unexplained lacerations or abrasions.
- Slap, kick, pinch or finger marks.
- Injuries/bruises found at different stages of healing or such that it is difficult to suggest an accidental cause.
- Injury shape similar to an object.
- Untreated medical problems.
- Weight loss due to malnutrition or dehydration; complaints of hunger.
- Appearing to be over medicated.

**Sexual Abuse -** Any behaviour which is unwanted or takes place without consent or understanding. Sexual abuse can take many forms and may include:

- Non-contact sexual activity
- Pornographic photography
- Indecent exposure
- Stalking
- Grooming
- Harassment
- Unwanted teasing or innuendo
- Unwanted touching
- Penetration of the human body with fingers, penis or objects

Possible indicators of sexual abuse could include:

- A change in usual behaviour for no apparent or obvious reason.
- Sudden onset of confusion, wetting or soiling.
- Withdrawal, choosing to spend the majority of time alone.
- Overt sexual behaviour/language by the vulnerable person.
- Self-inflicted injury.
- Disturbed sleep pattern and poor concentration.
- Difficulty in walking or sitting.
- Torn, stained and/or bloody underclothes.
- Love bites.
- Pain or itching, bruising or bleeding in the genital area.
- Sexually transmitted urinary tract/vaginal infections.
- Bruising to the thighs and upper arms.
- Frequent infections.
- Severe upset or agitation when being bathed/dressed/undressed medically.

**Psychological/emotional abuse** - Psychological or emotional abuse is behaviour that is psychologically harmful or inflicts mental distress.

- Threats
- Bribes
- Coercion
- Ridicule
- Humiliation
- Provoking fear
- Intimidation
- Negating choices, wishes or self-esteem
- Causing isolation or overdependence

Possible indicators of psychological or emotional abuse include:

- Ambivalence about carer.
- Fearfulness expressed in the eyes; avoids looking at the carer, flinching on approach.
- Deference.
- Overtly affectionate behaviour to alleged perpetrator.
- Insomnia/sleep deprivation or need for excessive sleep.
- Change in appetite.
- Unusual weight gain/loss.
- Tearfulness.
- Unexplained paranoia.
- Low self-esteem.
- Excessive fears.
- Confusion.
- Agitation.

**Financial abuse** - Actual or attempted theft fraud or burglary. Misappropriation or misuse of money, property, benefits, material goods or other asset transactions which the person did not or could not consent to or which were invalidated by intimation coercion or deception – this could include:

- Withdrawal of benefits
- Wills
- Property inheritance
- Withholding of money due to the person
- Exploitation
- Embezzlement

Possible indicators of financial abuse include:

- Unexplained or sudden inability to pay bills.
- Unexplained or sudden withdrawal of money from accounts.
- Individual lacks belongings or services, which they can clearly afford.
- Lack of receptiveness to any necessary assistance requiring expenditure, when finances are not a problem (although the natural thriftiness of some people should be borne in mind).
- Extraordinary interest by family members and other people in the vulnerable person's assets.
- Power of Attorney obtained when the vulnerable adults is not able to understand the purpose of the document they are signing.
- Recent change of deeds or title of property.
- Carer only asks questions of the worker about the individual's financial affairs and does not appear to be concerned about the physical or emotional care of the person.
- The person who manages the financial affairs is evasive or uncooperative.
- A reluctance or refusal to take up care assessed as being needed.
- A high level of expenditure without evidence of the individual benefiting.
- The purchase of items which the individual does not require.
- Personal items going missing from the home.
- Unreasonable and/or inappropriate gifts.

**Institutional/organisational abuse** - Organisational or institutionalised abuse can occur in any organisation when the routines in use force individuals to sacrifice their own needs, wishes or preferred lifestyle to the needs of the institution or service provider.

Abuse may be a source or risk from an individual or by a group of staff members embroiled in the accepted custom, subculture and practice of the institution or service. It involves the collective failure of an organisation to provide safe appropriate services and includes failure to ensure necessary preventative or protective measures are in place. Possible indicators of institutional or organisational abuse include:

- May be reflected in an enforced schedule of activities.

- Limiting of personal freedom.
- Control of personal finances.
- A lack of adequate clothing.
- Poor personal hygiene.
- A lack of stimulating activities.
- A low quality diet.
- Anything which treats the individual as not being entitled to a 'NORMAL' life.

Institutions may include residential and nursing homes, hospitals, day centres, sheltered housing schemes and group or supported housing projects. It should be noted that all organisations and services, whatever their setting, can have institutional practices which can cause harm to vulnerable adults.

The distinction between abuse in institutions and poor care standards is not easily made and judgements about whether an event or situation is abusive should be made with advice from appropriate professionals and regulatory bodies.

**Neglect** - Can be both physical and emotional. Neglect occurs when a person deliberately withholds or fails to provide, appropriate and adequate care and support which is required by another person. It may be through a lack of knowledge or awareness, or through failure to take reasonable action given the information and facts available to them at the time.

Neglect of a Duty of Care or the breakdown of a care package may also give rise to safeguarding issues, for example where a care provider is unable/unwilling to meet the assessed needs. Possible indicators of neglect include:

- Poor condition of accommodation.
- Inadequate heating and/or lighting.
- Poor physical condition of person (e.g., ulcers, pressure sores etc.).
- Individual's clothing in poor condition (e.g., unclean, wet, etc.).
- Malnutrition.
- Failure to give prescribed medication or appropriate medical care.
- Failure to ensure appropriate privacy and dignity.
- Inconsistent or reluctant contact with health and social agencies.
- Refusal of access to callers/visitors.

**Wilful neglect and ill-Treatment** - Wilful neglect means the deliberate failure to do something that was a duty, often with an element of recklessness. It does not require any proof of any particular harm or distress or proof of the risk of harm.

Ill-treatment involves deliberate conduct which ill-treats a person who lacks mental capacity to make the relevant decisions, whether or not it causes any harm to them. Ill-treatment also involves a guilty mind, with the abuser having an appreciation that he or she was inexcusably or recklessly ill-treating the person.

**Most indicators of the other types of abuse may also indicate wilful neglect or ill-treatment so these two offences should always be considered with each allegation.**

**Self-neglect** - Self-neglect is failing to care for one's personal hygiene, health or surroundings in such a way that causes, or is likely to cause significant physical, mental or emotional harm or substantial damage to or loss of assets. Self-neglect differs from the other forms of abuse because it does not involve a perpetrator. Self-neglect can happen as a result of an individual's choice of lifestyle or the person may have a mental health condition, such as depression, poor physical health, cognitive difficulties or misuse substances. Possible indicators of self-neglect include:

- Living in grossly unsanitary conditions that could endanger health and wellbeing.
- Grossly inadequate self-grooming or personal care.
- Inappropriate or inadequate clothing.
- Maintaining an untreated illness, disease or injury or lacking eyeglasses, dentures, hearing aids etc.
- Being malnourished or dehydrated to such an extent that, without intervention, the individual's physical or mental health is likely to be severely impaired.
- Creating hazardous living conditions that will likely cause serious harm to the individual or others or cause substantial damage to or loss of assets, such as severe hoarding, improper wiring, infestation and lack of indoor plumbing or heating.
- Managing one's assets in a manner that is likely to cause substantial damage to or loss of assets.

**Domestic Abuse** – Domestic abuse is the abuse of one person within an intimate or family relationship. It can be the repeated, random or habitual use of intimidation to control, coerce or threaten a person. The abuse can encompass, but is not limited to physical, emotional, psychological, financial, sexual, honour-based violence, female genital mutilation or forced marriage.

Domestic abuse can also involve the abuse of a person at risk. Safeguarding procedures only apply in this instance where the person:

- has needs for care and support and
- is experiencing, or at risk of, abuse or neglect and
- as a result of those care and support needs is unable to protect themselves from abuse or neglect or the risk of abuse or neglect.

Possible indicators of domestic abuse include:

- Intense or irrational jealousy or possessiveness expressed by the partner or reported by the person at risk.
- Reluctance to speak or disagree in the presence of their partner.
- Often accompanied by an "over protective" partner, preventing professionals obtaining the accurate picture of what is happening.

- History of depression, anxiety, self-harm or suicide attempts.
- History of alcohol or drug abuse.
- Appearance of low self-esteem.

**Honour-based violence** - Honour Based Violence (HBV) is a crime of incident which has or may have been committed to protect or defend the honour of a family or community. It is a collection of practices used to control behaviour within families or other social groups, to protect perceived cultural and religious beliefs and/or honour. Such violence can occur when a relative has shamed their family and/or community by breaking their honour code. Possible indicators of honour-based violence include:

- Seeming under the control and influence of others and relying on others to communicate on their behalf.
- Often accompanied by an "over protective" partner or family member, preventing professionals obtaining the accurate picture of what is happening.
- Reluctance to speak or disagree in the presence of their partner or family member.
- Isolation from the community.
- History of depression, anxiety, self-harm or suicide attempts.
- History of alcohol or drug abuse.
- Appearance of low self-esteem.

**Female Genital-Mutilation** - Female Genital Mutilation (FGM) is sometimes referred to as female circumcision. It refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. This practice is illegal in the UK. Possible indicators of Female Genital-Mutilation include:

- Genital scarring.
- Frequent Urinary Tract or Pelvic Infection.
- Difficulty in passing urine.
- Impaired sexual function.
- Complications in pregnancy and/or childbirth.
- Post-Traumatic Stress Disorder, flash backs or anxiety.

**Modern Slavery -** Modern Slavery encompasses human trafficking, domestic servitude and forced labour. 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. Possible indicators of Modern Slavery include:

- Marked isolation from the community.
- Seeming under the control and influence of others and relying on others to communicate on their behalf.
- Restricted freedom of movement.
- Unusual travel times.
- Unfamiliarity with the local neighbourhood.
- Signs of other forms of abuse, such as looking malnourished, unkempt or withdrawn.

- Few or no personal effects.
- No identification documents.
- Fear of law enforcement.

**Discriminatory Abuse and Hate Crime** - Discriminatory abuse is abuse targeted at a perceived vulnerability or on the basis of prejudice including racism or sexism, or based on a person's impairment, origin, colour, disability, age, illness, sexual orientation or gender.

Hate Crime can be one-off or multiple *criminal* offences that are perceived, by the person at risk or any other person, to be motivated by hostility or prejudice based on a person's vulnerability or perceived vulnerability. They can manifest as the other types of abuse, including physical, sexual, financial, neglect and psychological abuse. Examples can include:

- Hate mail
- Verbal or physical abuse
- Criminal damage to property
- Target of distraction burglary, bogus officials or unrequested building/household services

Possible indicators of discriminatory abuse and/or hate crime are the same as those outlined above for other types of abuse.

**Mate Crime** - Mate Crime is the premeditated exploitation, abuse or theft from people with a Learning Disability, by those they consider as their friends. However, it also applies to older adults, for example, those with a mental health problem or sensory impairment.

It can encompass other types of abuse, such as physical, psychological, sexual or financial. Examples can include being physically harmed for the amusement of others, having benefits or food stolen or being coerced into crime or prostitution. Possible indicators of mate crime include:

- As with indicators for other types of abuse (e.g., physical, sexual, psychological or financial).
- Subservient behaviour and constant seeking approval of so called "friends".

**Radicalisation** - Radicalisation is the process by which a person comes to support terrorism and forms of extremism leading to terrorism. Radicalisation is not officially classed as a type of abuse, however, it is important to include it to raise awareness.

Key vulnerabilities such as Learning Disabilities, Mental Health problems or autism can increase an individual's susceptibility towards radicalisation and to be influenced be extremism (Home Office, 2011). Possible indicators of radicalisation include:

- Changing style of dress or personal appearance to fit in with a group.
- Day to day behaviour increasingly centred around an extremist ideology, group or cause.

- Attempts to recruit others to the group/cause/ideology.
- Condoning or supporting violence towards others.
- Plotting or conspiring with others.
- Using insulting or derogatory names or labels for another group.
- Expressing attitudes that justify offending on behalf of the group, cause or ideology.

## 3-Stage Test

Under section 42 of The Care Act 2014, safeguarding duties apply to an adult who meets the following three stage test**:**

**1. Has needs for care and support (whether or not the local authority is meeting any of those needs) and**

**2. Is experiencing, or at risk of, abuse or neglect and**

**3. As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.**

An adult who meets these criteria is referred to as "an adult at risk". Safeguarding duties also apply to family carers experiencing intentional or unintentional harm from the adult they are supporting or from professionals and organisations that they are in contact with.

## Adults at Risk

Safeguarding adults means:

- protecting the rights of adults to live in safety, free from abuse and neglect
- working together to prevent and stop both the risks and experience of abuse or neglect
- making sure that the adult's wellbeing is promoted including, keeping them at the centre of any decision and taking full account of their views, wishes, feelings and beliefs
- recognising that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances and therefore, of any potential risks to their safety or wellbeing.

### If you suspect an adult is at risk of abuse

Where an individual believed to be at risk of abuse is encountered or if an individual discloses or discusses potential abuse with you, it should be recognised that the

individual may be describing abuse, albeit not explicitly. You must stay calm and show empathy, reassuring them that the information is being treated seriously. Following the identification of a safeguarding concern, staff are responsible for:

- assessing the situation and determining whether emergency intervention is required
- ensuring the safety and wellbeing of the individual
- establishing the individual's views and wishes on the safeguarding issue
- maintaining evidence and clear documentation
- reporting the incident(s)/risk(s) to the Safeguarding Lead
- remaining calm and not showing any shock or disbelief
- listening carefully and with understanding, by acknowledging regret and concern over what has happened
- informing the individual that information will be shared and why.

It is essential to ensure that the individual at risk of abuse remains at the centre and involved in the safeguarding process, accounting for the views wishes, feelings and beliefs and individuals should be offered to have a family member, friend or advocate, if appropriate and desired, to be present during any discussions on safeguarding. Staff will have been considered to have reasonably met their duty of care when:

- all reasonable steps have been taken
- reliable assessment methods have been used
- information has been collated and thoroughly evaluated
- decisions have been recorded, communicated and thoroughly evaluated
- policies and procedures have been followed
- actions are proactive and facts are confirmed.

Any assessment of any safeguarding concern should be holistic and thorough considering the individual's emotional, social, psychological and physical presentation as well as the identified clinical need. When discussing/assessing a safeguarding issue with an individual:

- be open and honest and do not promise to keep a secret
- seek consent to share information if the individual has capacity and if this does not place you, them or others at an increased risk
- share information without consent if it is in the public interest in order to prevent a crime or protect others from harm
- make a clear and concise referral
- do not delay unnecessarily
- concerns about a colleague should be raised through the Whistleblowing Policy.

Be aware of the possibility of forensic evidence if the disclosure refers to a recent incident. If there is a possibility that forensic evidence exists, preserve the evidence. Do not clean it up.

### Safeguarding referrals

All safeguarding concerns must be immediately raised to the Safeguarding Lead who will review and consider whether a safeguarding referral is appropriate. Where there is any doubt, the Safeguarding Lead should discuss this further with suitable colleagues before making a decision.

Before making a safeguarding referral, the Safeguarding Lead should ensure the patient fits the statutory criteria for an adult at risk (as defined under the 3-Stage Test section of this Policy) and assess their mental capacity to consent to the referral (see Meyer Clinic's Mental Capacity Act and DoLS Policy for further information). If a patient lacks capacity to make a decision about a safeguarding referral, it is acceptable to refer them in their 'best interests'. An individual of capacity has the right to refuse consent, in this situation the risk of doing so must be fully explained.

Additionally, if the patient refuses consent for a safeguarding referral the Safeguarding Lead must consider whether there is an overriding public interest that outweighs individual patient confidentiality, for example, other people could be at risk, a possible crime has been committed or there is a risk to the health and safety of others.

Where the adult at risk criteria does not apply, a patient with capacity refuses consent and there is no overriding public interest disclosure a safeguarding referral may not be appropriate. In these instances, the Safeguarding Lead and treating staff should consider any other actions required to support the needs of the adult or other actions, such as complaints processes, training needs or regulatory action if appropriate.

Please see the flow chart in **Appendix 1** for further information.

## Information Sharing

Information sharing between organisations is essential to safeguard adults at risk of abuse, neglect and exploitation. In this context 'organisations' mean not only statutory organisations but also voluntary and independent sector organisations, housing authorities, the police and Crown Prosecution Service, and organisations which provide advocacy and support.

Decisions about what information is shared and with whom will be taken on a case-by-case basis by the Registered Manager in line with Meyer Clinic's Patient Confidentiality and Information Governance Policies.

A record must be kept of all decisions made in relation to information sharing, whether the information is shared or not. If a decision has been made to share information, a record must be kept of what was shared, with whom and for what purpose. Any information disclosed should be:

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

## Radicalisation and the Prevent strategy

Under Section 26 of the Counter-Terrorism Security Act 2015, healthcare professionals have a duty to have 'due regard to the need to prevent people from being drawn into terrorism'. The Prevent strategy aims to reduce the threat of terrorism by preventing people from becoming terrorists or supporting terrorism and has three strategic objectives:

- respond to the ideological challenge of terrorism and the threat we face from those who promote it
- prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support
- work with sectors and institutions where there are risks of radicalisation that we need to address.

Meyer Clinic will ensure that all staff understand and can comply with this duty through the implementation of mandatory prevention of radicalisation training. Staff will be expected to demonstrate:

- that they know what measures are available to prevent people from becoming drawn into terrorism
- how to challenge the extremist ideology associated with terrorism
- how to understand obtain support for individuals who may be being exploited by radicalising influences.

As a part of this strategy staff are also responsible for being:

- aware of their professional responsibilities in relation to the safeguarding of adults
- familiar with Meyer Clinic's protocols, policies and procedures
- aware of who to contact to discuss any safeguarding concerns
- aware of the processes and support available following raising a concern
- aware of the current patient practice for confidentiality (see the Confidentiality Policy for further information).

Changes to an individual's behaviour indicative of potential radicalisation should be assessed for their reliability and significance by considering any:

- parental/family reports of unusual changes in behaviour, friendships or actions and requests for assistance
- patients / staff accessing extremist material online
- use of extremist or hate terms to exclude others or incite violence.

If staff are concerned that an at-risk individual is being exploited, they should raise their concern with the Registered Manager and/or the Safeguarding Lead who will then consider referral to the relevant Local Authority or Regional Prevent Coordinator. Factors that can contribute toward an individual's vulnerability and subsequent risk of radicalisation include:

- Identity crisis: radicalisers can exploit adolescents/at-risk adults who may feel uncomfortable with their place in society and disconnected from their family and/or heritage by providing a sense of purpose or feelings of belonging.
- Personal crisis: can result in a sense of isolation, making an individual vulnerable to radicalisation.
- Personal circumstances: individuals who feel their aspirations are likely to be undermined may translate into a generalised rejection of civic life and an adoption of violence as a symbolic act.
- Criminality: where an at -risk individual becomes involved in a group that engages in criminal activity are more likely to be drawn into terrorist related activity.
- Grievances: the following may play an important part in the early indoctrination of at-risk individuals:
    - a misconception and/or rejection of UK foreign policy
    - distrust of western media reporting
    - perceptions that UK government policy is discriminatory (e.g., counter-terrorist legislation).
- Other factors:
    - ideology and politics
    - provocation and anger (grievance)
    - need for protection
    - seeking excitement and action
    - fascination with violence, weapons and uniforms
    - youth rebellion
    - seeking family and father substitutes
    - seeking friends and community
    - seeking status and identity.

## Staff Conduct

Meyer Clinic will not tolerate any staff member worker or other person engaged to support or provide services to, or on our behalf to have:

- behaved in a way that has harmed, or may harm, an at-risk adult
- possibly committed a criminal offence against, or related to, an at-risk adult

- behaved towards an at-risk adult in a manner that may indicate they are unsuitable to work in a position of trust.

Any staff member identified to behave in such a way as to indicate one or more of the above statements, either within their work or as a consequence of actions within their personal life, may be subject to disciplinary action. Identification of such incidents can come from various different sources. Meyer Clinic will take prompt action to investigate any allegations made and will take any actions necessary to protect individuals and those that work with us, for us, and on our behalf.

Resultant actions can/may include a staff member being suspended and possibly dismissed. All allegations will be reported to the CQC without delay, as is required. Where the allegation is made against a healthcare professional we will liaise with and report to the relevant professional body.

Additionally, Meyer Clinic has a duty to refer staff member(s) to the Disclosure and Barring Service (DBS) if they have:

a) Satisfied the harm test, i.e., that the Company believes that the staff member may:
   - harm a child or vulnerable adult
   - cause a child or vulnerable adult to be harmed
   - put a child or vulnerable adult at risk of harm
   - attempt to harm a child or vulnerable adult or incite another to harm a child or vulnerable adult.

b) Received a caution or conviction for a relevant offence.

   A relevant offence for the purposes of referrals to DBS is an automatic inclusion offence as set out in the Safeguarding Vulnerable Groups Act 2006 (Prescribed Criteria and Miscellaneous Provisions) Regulations 2009 and the Safeguarding Vulnerable Groups.

   Broadly speaking these offences include all sexual offences, all offences involving children, most prostitution offences and murder. If you are unsure, contact the HR Department for guidance.

If the above conditions have been met and the Registered Manager will conclude that the investigation conducted shows that the staff member(s) concerned has a case to answer, a referral must be referred to DBS.

## Notifications

The Safeguarding Lead is responsible for notifying the CQC, as soon as reasonably possible, of abuse or allegations of abuse concerning a person using the service if any of the following applies:

- the person is affected by abuse
- they are affected by alleged abuse
- the person is an abuser
- they are an alleged abuser.

Not all referrals made to the local authority need to be notified to CQC. The Company is only required to notify CQC of safeguarding incidents where the allegation of abuse is linked to the Company's provision of care. The following mythbuster provides some useful examples of notifying the CQC of safeguarding incidents:

https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-25-safeguarding-adults-risk

## Staff Training

All staff and third parties working or volunteering with Meyer Clinic will be required to undertake an induction that includes mandatory training on the safeguarding of adults as well as the Prevent strategy for radicalisation.

This will then need to be updated at least every 3 years.

## Monitoring

The Senior Leadership Team will receive regular reports from the appointed Safeguarding Lead to include the following content where applicable:

- numbers of staff attending and completing training
- numbers of safeguarding referrals made to the local authority and CQC
- lessons learned and changes effected as a result of safeguarding issues.

## Related Policies

Consent to Treatment for Adults Policy

Staff Training Policy

Equality and Diversity Policy

Information Governance and Record Keeping Policy

Mental Capacity Act and DoLS Policy

Confidentiality Policy

Recruitment Policy

## Legislation and Guidance

Ann Craft Trust: https://www.anncrafttrust.org/resources/a-guide-to-safeguarding-adults/

Care Act 2014

Care Quality Commission: https://www.cqc.org.uk/sites/default/files/20150710_CQC_New_Safeguarding_Statement.pdf

Equality Act 2010

Gov.uk: www.gov.uk/government/publications/safeguarding-adults-the-role-of-health-services

Home Office: Revised Prevent duty guidance: for England and Wales 2023: https://www.gov.uk/government/publications/prevent-duty-guidance/revised-prevent-duty-guidance-for-england-and-wales

Mental Capacity Act 2005

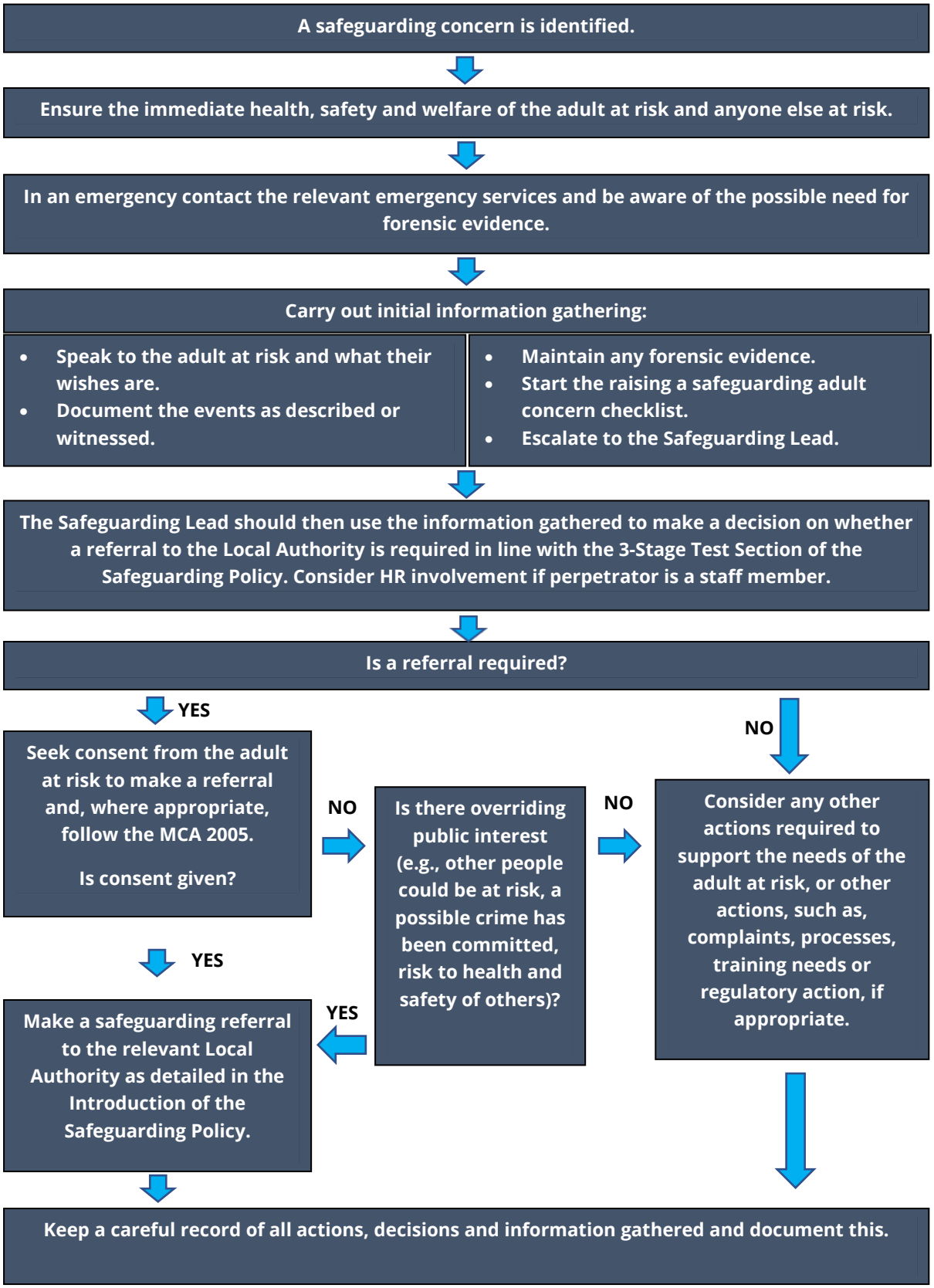
Modern Slavery Act 2015

NHS England: Safeguarding Adults Layout 1 (england.nhs.uk)

NICE Guidance: https://www.nice.org.uk/guidance/health-and-social-care-delivery/safeguarding

Public Interest Disclosure Act 1998

## Appendix 1 – Safeguarding Adults Flow Chart



**Appendix 2**

# Raising a Safeguarding Adult Concern Checklist:

| This checklist is to assist you to have the right information when you are raising a safeguarding adult concern. We know that it is often a stressful conversation and you may forget vital information when you make the call. Do not worry if you do not have all the information below. Concerns will always be considered when some of this information is not available. | |
|---|---|
| | |
| Name of Alerter (You can remain anonymous) | |
| Contact details of Alerter | |
| Relationship to Victim | |
| Organisation of Alerter | |
| | |
| Name (of adult at risk) | |
| Address of Adult | |
| Address, if different, of place of alleged abuse | |
| Contact details of Adult at risk | |
| Details of Category of Vulnerability (Older, frail, Mental Health, Learning Difficulties etc.) | |
| Date of Birth or Age | |
| Gender | |
| Ethnicity | |
| Religion | |
| Capacity and understanding | |
| Communication needs (sensory loss, language, other) | |
| Name of Alleged Perpetrator | |
| Address of Alleged Perpetrator | |
| Date of Birth of Alleged Perpetrator | |
| | |
| Details of Referral - You need to consider the following so that the person taking the referral decision can gain adequate information | |
| Nature of abuse/incident | |
| When did it happen? | |
| Where did it happen? | |
| Was anyone else involved? | |
| Was the incident witnessed? | |
| Have you had previous concerns regarding this person? If so what? | |

| | |
|---|---|
| Does the adult at risk of abuse or neglect know you are making this referral? | |
| What does the person want to happen? | |
| Have you done anything to assist the adult at risk at this time? (What actions have been taken?) | |

## Summary of Review

| | |
|---|---|
| Version | 5 |
| Last amended | July 2025 |
| Reason for Review | Annual review |
| Were changes made? | Yes |
| Summary of changes | Safeguarding Lead contact number now added as per CQC guidance. |
| Next Review Date | July 2026 |
| Version | 4 |
| Last amended | May 2024 |
| Reason for Review | Annual review |
| Were changes made? | Yes |
| Summary of changes | Added section on referrals<br><br>Added section on notifications<br><br>Updated Appendix 1 flow chart<br><br>Removed KLOE compliance section in accordance with CQC's new single assessment framework. |
| Next Review Date | May 2025 |