Safeguarding Webinar 2

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NHS
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Lincolnshire CCG Safeguarding Team

Specialist safeguarding support
for Lincolnshire CCG and Primary Care

Call: 01522 309317

(Monday to Friday 09:00 – 17:00)

Secure Email: SWLCCG.safeguarding1@nhs.net

(checked daily Mon-Fri)

https://lincolnshireccg.nhs.uk/about-us/safeguarding/federated-safeguarding-team/

The team is made up of the Named and Designated Professionals in Safeguarding and Safeguarding Specialists for children and adults

AIMS & OBJECTIVES

- Training requirements in Primary Care
- Identifying Safeguarding Concerns in Adults
- Legal frameworks, MCA, DOLS
- Difficult situations
- FGM
- SG Adults; GP referrals
- Resources

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TRAINING REQUIREMENTS FOR PRIMARY CARE

RCGP document: a great summary of training requirements:

Royal College of General Practitioners

RCGP supplementary guide to safeguarding training requirements for all primary care staff

1.0 Introduction

This document is an RCGP supplement to, and should be used in conjunction with, the following Intercollegiate Documents (ICD):

- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. Fourth edition: January 2019 (1)
- Adult Safeguarding: Roles and Competencies for Health Care Staff. First edition: August 2018 (2)

It is intended to give a 'quick glance' summary of the safeguarding training requirements for all who work in a primary care setting (clinical and non-clinical staff) which includes NHS, private, virtual and any other setting where primary health care is delivered.

https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/child-safeguarding-toolkit.aspx

	Level 3 Core	Level 3 requiring additional knowledge, skills and competencies
Staff groups	• Pharmacists* • Foundation level doctors	• GPs • GP practice safeguarding leads • GP registrars • Practice nurses • Advanced nurse practitioners • Paramedics
Adult Safeguarding **INITIAL** training requirement in the first 12 months of taking up a Level 3 post	Minimum of 8 hours	Minimum of 8 hours
Adult Safeguarding **REFRESHER** training requirement over 3 years	Minimum of 8 hours	Minimum of 8 hours
Child Safeguarding **INITIAL** training requirement in the first 12 months of taking up a Level 3 post	Minimum of 8 hours	Minimum of **16** hours
Child Safeguarding **REFRESHER** training requirement over 3 years	Minimum of 8 hours	Minimum of **12** hours **with the exception of GP Practice Safeguarding Leads** who will require **16** hours
Total safeguarding **REFRESHER** training requirement over 3 years	Minimum of **16** hours	□ For all professionals in this group **except** GP Practice Safeguarding Leads: Minimum of **20** hours □ GP Practice Safeguarding Leads: Minimum of **24** hours

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3.0 Education and Training

Education and training at all levels should be at least 50% participatory (1,2). Participatory training involves a level of interaction. A record of training can be kept by using the Education, training and learning activity logs in the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff, Appendix 4.

Inter-professional and inter-organisational training is encouraged in order to share best practice, learn from serious incidents and to develop professional networks.

Examples of Participatory education and training:

- Attending face-to-face training
- Group case discussion
- Reflection on the learning from a case the professional has been involved in and how this learning has been applied to their practice
- Webinars
- Attendance at safeguarding forums e.g. GP Practice Safeguarding Lead forums.

WHERE TO ACCESS TRAINING:

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- Level 3 training provided by CCG SG Team via Microsoft Teams
- Recent document: Level 3 Safeguarding Training Package *
- e-learning:
  - LSCP website (free) - https://www.lincolnshire.gov.uk/safeguarding/lscp/3?documentId=258&categoryId=20076
    - Child safeguarding refresher
    - Adult safeguarding refresher
    - Prevent
    - Trafficking and modern slavery
    - CSE
  - e-learning for health https://www.e-lfh.org.uk/programmes/safeguarding-children/
  - Home office FGM training https://www.fgmelearning.co.uk
  - Medical Protection free MCA/DOLS training https://www.medicalprotection.org/uk/articles/mental-capacity-act-online-learning-course

https://www.rcn.org.uk/professional-development/publications/pub-007366

Adult Safeguarding: Roles and Competencies for Health Care Staff

First edition: August 2018

INTERCOLLEGIATE DOCUMENT

https://www.rcn.org.uk/professional-development/publications/pub-007069

Appendix of Intercollegiate Document contains learning logs such as this one, to help record your learning:

Education, training and learning activity log – level 3

You will need to keep accurate records and document the following on an ongoing and continual basis:

- type of education, training and learning eg, online learning, course attendance, group case discussion, independent learning
- topic, a brief description and key points of learning activity
- the number of learning hours in total and the number of **participatory learning hours** (interacting with other professionals eg conference, meeting or training course). Record separately for adults and children or record proportionally as appropriate

Date	Type of education training and learning activity (specify*)	Topic and key points of learning activity	Number of hours ADULTS	Participatory hours ADULTS	Number of hours CHILDREN	Participatory hours CHILDREN

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IDENTIFYING SAFEGUARDING CONCERNS

ADULT SAFEGUARDING - TYPES OF ABUSE

- Physical abuse – including assault, hitting, slapping, pushing, misuse of medication, restraint
- Domestic violence – including psychological, physical, sexual, financial
- Emotional abuse
- Sexual abuse – including rape, indecent exposure, sexual harassment, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting
- Psychological abuse – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, isolation or unreasonable withdrawal of services or support
- Financial or material abuse – including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions
- Modern slavery – encompasses slavery, human trafficking, forced labour, domestic servitude.
- Discriminatory abuse – including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion
- Organisational abuse – including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice
- Neglect and acts of omission – including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services
- Self-neglect – this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding

WHO IS AT RISK?

An adult at risk19 is defined as any person aged 18 years and over who:

- Has needs for care or support (whether or not the Local Authority is meeting those needs; and
  - Is experiencing, or at risk of, abuse and neglect; and
  - 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.

Appendix 3 – Definition of an adult at risk

An adult at risk (*as defined in the Care Act 2014*) safeguarding duties apply to an adult who:

- **has needs for care and support (whether or not the local authority is meeting any of those needs) 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 either the risk of, or the experience of abuse or neglect.**

Elderly and frail

- ill-health
- physical disability
- Impairment e.g. stroke.

Personality disorder

- inability to recognise consequences of behaviour,
- particularly in cases of '**self-neglect**' which results in harm to themselves whether physical or psychological

Learning disability,

- learning difficulty
- Autism or Asperger's.
- Communication difficulties, either verbal or in reasoning or being able to understand if something is bad or wrong.
- Particularly vulnerable and can be targeted and exploited financially or sexually.

Physical disability

- Rely upon others for assistance through care and support.
- To be an adult at risk they would have to be in a position of being unable to protect themselves from those delivering care or from others.
- Wheelchair users for example, living independently and being assisted with personal care are not an adult at risk unless unable to protect themselves as above.

Long term illness and conditions (e.g. Parkinson's disease or Chronic Obstructive Pulmonary Disease)

- We are concerned about those who are isolated or have communication difficulties or who are reliant on others on a day to day basis.

Mental health needs,

- Includes dementia.
- Fluctuating mental capacity
- Difficulty in recognising what is happening to them
- Inability to consent to what is happening or to tell someone else.

Alcohol or substance misuse

- Resulting in poor living conditions or risks associated with the people they live
- They may live on the street, become incapacitated and therefore unable to assess risks or give consent.

Sensory impairment

- Not all people with a sensory impairment would be considered an adult at risk,
- There would be a need for support as a result of other disability/illness/impairment – the sensory loss is an additional vulnerability

SIGNS OF ABUSE – WHAT TO LOOK FOR?

- Becoming quiet and withdrawn
- Being aggressive or angry for no obvious reason
- Looking unkempt, dirty or thinner than usual
- Physical signs of abuse, such as bruises, wounds, fractures and other untreated injuries
- The same injuries happening more than once
- Not wanting to be left on their own or alone with particular people
- Being unusually light-hearted and insisting there's nothing wrong
- Changes in their normal character, such as appearing helpless, depressed or tearful or conversely they may display the opposite extremes.

WHAT CAN MAKE YOUR PATIENTS MORE AT RISK?

- Impairment of mental capacity
- Communication difficulties
- Physical dependency
- Low self-esteem
- Experience of abuse (including childhood)
- Poor physical and/or mental health
- Social isolation
- Poverty
- Being a carer

LEGAL FRAMEWORK

- CARE ACT (2014)

- **New definition of who needs safeguarding**
  - *People with care and support needs who may be in vulnerable circumstances*
  - *Those at risk of abuse or neglect by others and unable to protect themselves*
- **Creates a legal framework for key organisations with adult safeguarding responsibilities to work together**
  - *safeguarding adults boards with health, police and social care as key participants*
  - *duty to carry out safeguarding reviews when an adult dies, suffers permanent harm or has reduced capacity or quality of life in the context of abuse or neglect*
  - *duty on local authorities to ensure services are safe and dignified*
  - *key principles of empowerment, proportionality, prevention, protection, partnership and accountability*

LEGAL FRAMEWORK

- Human Rights Act and relevance to Safeguarding adults:
  - The right to life (article 2)
  - The right to not be tortured or treated in an inhuman or degrading way (article 3)
  - The right to liberty and security (article 5)
  - The right to respect for private and family life and home life (article 8)
- GMC guidance:
  - Good Medical Practice – stresses the need for doctors to protect patients and take prompt action if patient safety, dignity or comfort is or may be compromised.

MENTAL CAPACITY ACT - MCA

WHY DO WE HAVE THE MCA?

- It protects the rights of people to make decisions for themselves where they are able
- It makes it clear who can make decisions, in which situations and how they should do this
- It helps people to plan ahead for a time when they may lack capacity
- It guides who should be consulted and their authority
- It provides protection to professionals providing care

MCA STATUTORY PRINCIPLES

1. Presume capacity (not *in*capacity)
2. Empower people to make their own decisions
3. An unwise decision does not necessarily mean lack of capacity
4. Decisions must be in the person's best interests
5. Look for the least restrictive option that meets the person's need.

THE 2 STAGE TEST

Stage 1:

Is there an impairment of, or disturbance in the functioning of, the mind or brain?

Stage 2:

If so, does this mean that the person cannot make a specific decision at the time it needs to be made, even with help, enabling and empowerment?

FOUR STEPS TO (FUNCTIONAL) STAGE 2 – CAN THE PERSON:

1. Understand relevant, suitably-presented information about the specific decision (including what would happen if they refuse to decide)

2. Retain the information, for long enough to

3. Use and weigh it to reach a decision, and then

4. Communicate that decision by any possible means.

If a patient is not able to do <u>any</u> of the four steps they are deemed to lack capacity for that specific decision

BEST INTERESTS DECISION-MAKING

- Might the person regain capacity? Can the decision wait?
- Involve the person in the decision: explore past and present views, culture, religion, attitudes, anything else relevant to this person
- Consult interested family and friends (or IMCA if required)
- Do not make stereotyping assumptions
- Try to find the least restrictive option that meets the need
- Weigh and balance options = best interest decision.

INDEPENDENT MENTAL CAPACITY ADVOCATES (IMCAS)

Who needs an IMCA?

1. A person is facing a major decision eg. about serious medical treatment or where to live;

and

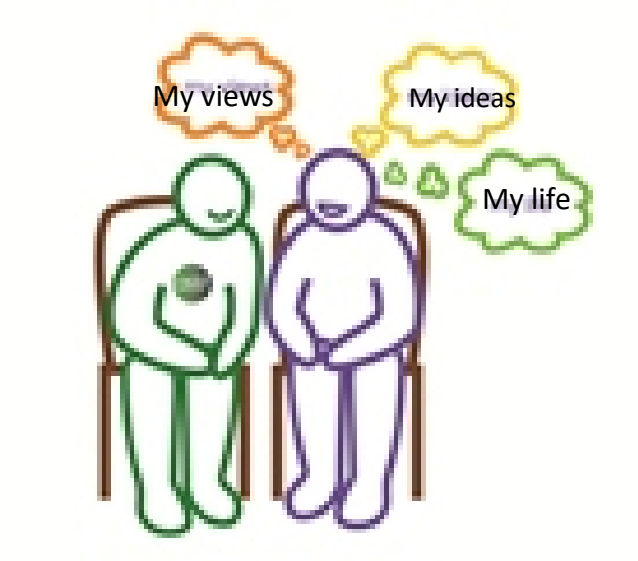
2. Lacks mental capacity to make this decision;

and

3. has nobody apart from paid carers (or 'professional' LPA/Deputy only for finances and property) to be involved in this decision.

WHY AN IMCA

- Independent
- Provide information; support & represent the person in best interest discussions
- Raise questions and challenge decisions if not in the person's best interest
- May take issues to Court of Protection

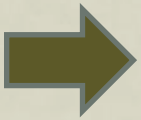


DOLS (DEPRIVATION OF LIBERTY SAFEGUARDS)

- The European Convention on Human Rights; the source of the law on DoLS:

- DoLS ensures people who cannot consent to their care arrangements are protected if those arrangements deprive them of their liberty.
- Arrangements are assessed to check they are necessary and in the person's best interests.
- A **deprivation of liberty** occurs when: 'The person is under continuous supervision and control and is not free to leave'

AUTHORISING DEPRIVATION OF LIBERTY

Where Deprivation of Liberty is occurring or anticipated within a hospital or care home		Hospital or care home must apply for a authorisation to the Local Authority DoLS assessment service
Where Deprivation of Liberty occurs outside of a hospital or care home and is 'imputable to the state'		Authorisation must be sought by the Court of Protection

- Article 5 of the Human Rights Act states that 'everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty [unless] in accordance with a procedure prescribed in law'.

- The Deprivation of Liberty Safeguards is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who **lacks capacity to consent to their care and treatment** in order to **keep them safe from harm**.

TO DEPRIVE THESE PATIENTS OF THEIR LIBERTIES, A MEDICAL PROFESSIONAL HAS TO STATE THAT THE PATIENT IS 'OF UNSOUND MIND'.

-

- The term 'unsound mind' is required by law: Courts can only accept this legal phrase

- As GP's we are in a good position to say that a patient has a medical condition which affects their ability to make decisions or affects their cognitive functioning; and we can therefore also give our **opinion** on whether they are or are not of 'unsound mind' because of this.

- The MHA defines a mental disorder as ‘any disorder or disability of the mind’. Although the Act does not define these terms any further, conditions falling within this definition (and which may therefore result in a patient being classified as of ‘unsound mind’) **may include** conditions such as:

- dementia
- personality and behavioural changes due to brain injury and damage
- mental and behavioural disorders due to psychoactive substance use or schizophrenia
- learning disabilities

CHESHIRE WEST LANDMARK CASE

- A Supreme Court judgement in March 2014 made reference to the 'acid test' to see whether a person is being deprived of their liberty, which consisted of two questions:
- Is the person subject to continuous supervision and control? *and*
- Is the person free to leave? – with the focus being not on whether a person seems to be wanting to leave, but on how those who support them would react if they did want to leave
- If someone is subject to that level of supervision, and is not free to leave, then it is almost certain that they are being deprived of their liberty.

Each case must be considered on its own merits, but in addition to the two 'acid test' questions, if the following features are present, it would make sense to consider a deprivation of liberty application:

- frequent use of sedation/medication to control behaviour
- regular use of physical restraint to control behaviour
- the person concerned objects verbally or physically to the restriction and/or restraint
- physically stopping a person from doing something which could cause them harm
- removing items from a person which could cause them harm
- holding a person so that they can be given care, support or treatment
- bedrails, wheelchair straps, restraints in a vehicle, and splints
- the person having to stay somewhere against their wishes or the wishes of a family member

PRACTICE EXAMPLE:

- Claire has an acquired brain injury. She lives in supported housing. She has impaired executive functioning and awareness of risk as a result of her brain injury.
- Claire is happy in her placement and has a good relationship with carers.
- She lacks insight into her condition and has been assessed as having poor road safety, decision making and planning and for her safety requires supervision outside of home.
- She has previously left the house alone and was found wandering near a busy road.
- To reduce risks to her safety a decision is made to install keypads on external doors so that she cannot leave unsupervised.
- (application is made to the Court of Protection)

Nigel's surgery 10: GPs and the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

Categories: Organisations we regulate

This mythbuster has been updated in light of a ruling by the Supreme Court in March 2014 and to clarify the disclosure of records to attorneys acting under a Lasting or Enduring Power of Attorney.

GPs and their staff (and all providers of health and social care) should have a good understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) to ensure that they can act in a patient's best interest.

This mythbuster provides a reminder of the principles of MCA, including:

- When to appoint an independent mental capacity advocate (IMCA)
- Lasting power of attorney (LPA)
- Court of protection.

It then details how the application of DoLS has changed following a Supreme Court Judgement in March 2014.

About Nigel Sparrow

Nigel is our Senior National GP Advisor and Responsible Officer.

Nigel's surgery:

Clearing up some common myths about our inspections of GP and out-of-hours services and sharing agreed guidance to best practice.

More from Nigel's surgery

You can view the list of all issues in three ways:

- Nigel's surgery: latest updates
- Nigel's surgery: listed by key question
- Nigel's surgery: numerical list

LIBERTY PROTECTION SAFEGUARDS (LPS):

- In July 2019, the Government published a Mental Capacity (Amendment) Bill which will see DoLS replaced by the Liberty Protection Safeguards (LPS). Key features of the Liberty Protection Safeguards (LPS) include:
- In line with the Law Commission's suggestion they start at 16 years old (current DoLS applies to those >18)
- Deprivations of liberty have to be authorised in advance by the 'responsible body'.
  - For NHS hospitals, the responsible body will be the 'hospital manager'.
  - For arrangements under Continuing Health Care outside of a hospital, the 'responsible body' will be their local CCG.
  - In all other cases – such as in care homes, supported living schemes etc. (including for self-funders), the responsible body will be the local authority.
- For the authorisation of any deprivation of liberty, it needs to be clear that:
  - The person lacks the capacity to consent to the care arrangements
  - The person has a mental disorder
  - The arrangements are necessary to prevent harm to the cared-for person, and proportionate to the likelihood and seriousness of that harm.

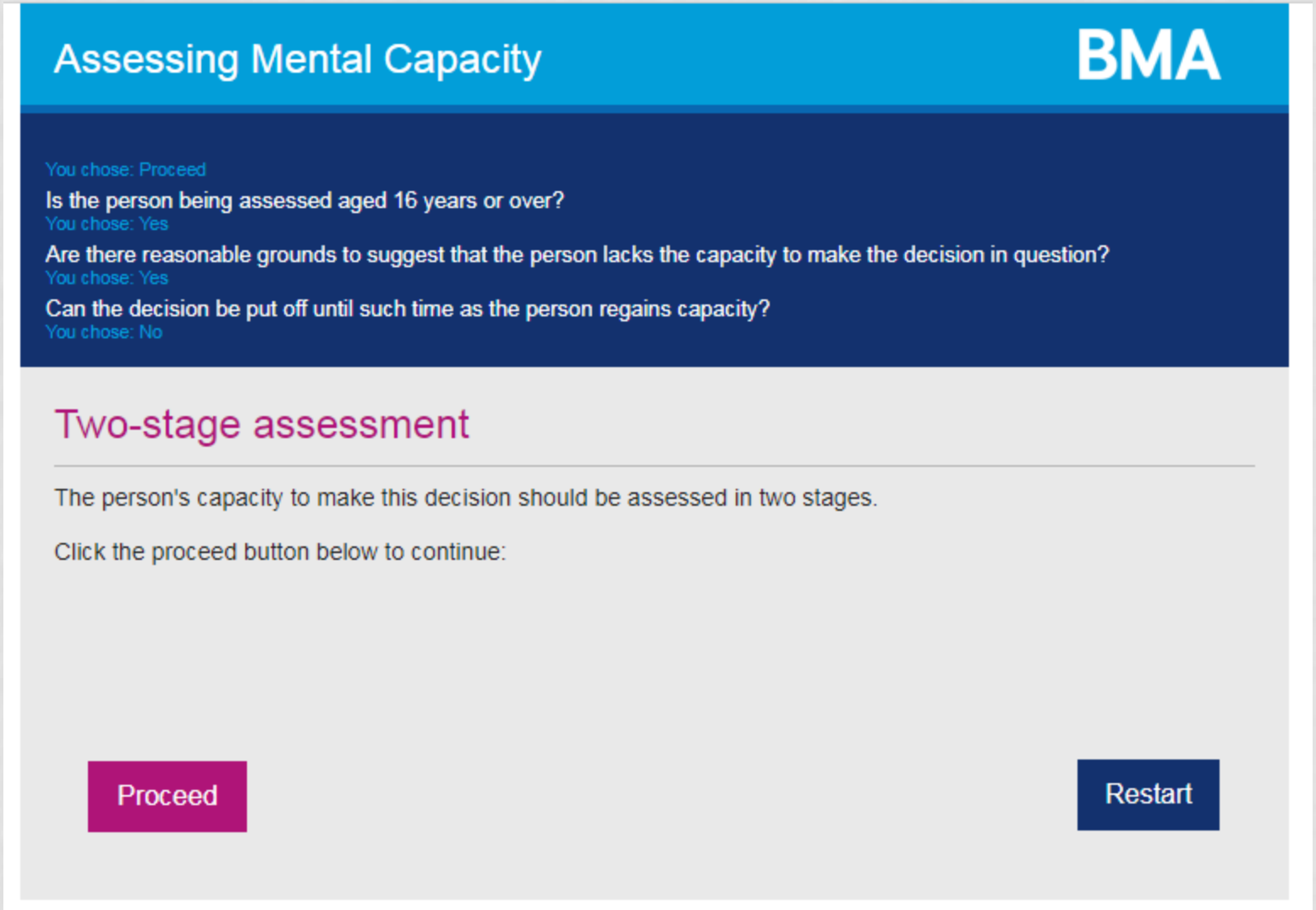
SIMPLIFIED DOLS VS LPS

DoLS

1. Assessment of care needs by multi-disciplinary team.
2. Placement.
3. Is this a Deprivation of Liberty?
4. Application to Supervisory Body.
5. 6 assessments by DoLS professionals.
6. Supervisory Body authorises - up to 1 year.
7. 1 year later = the whole process must start again from scratch.
8. Or, person moves = the whole process must start again from scratch.

LPS

1. Assessment of care needs by multi-disciplinary team.
2. Is this a Deprivation of Liberty?
3. Placement.
4. Responsible Body obtains 3 assessments, 2 of which can potentially rely on existing assessments.
5. Responsible Body authorises (potentially) 1 year, then renewal for 1 year, then renewal 3 years.
6. Or, person moves, so long as the move was predicted and included in the original care plan, the authorisation goes with them.


Assessing Mental Capacity
BMA
You chose: Proceed
Is the person being assessed aged 16 years or over?
You chose: Yes
Are there reasonable grounds to suggest that the person lacks the capacity to make the decision in question?
You chose: Yes
Can the decision be put off until such time as the person regains capacity?
You chose: No
Two-stage assessment
The person's capacity to make this decision should be assessed in two stages.
Click the proceed button below to continue:
Proceed
Restart

DIFFICULT SCENARIOS – CONSENT?

- Information sharing?
- An adult lacks the capacity to consent, but it is in their best interests
- The Adult has capacity but may be under duress or being coerced
- A potential / actual criminal offence is suspected
- Where there may be a significant risk of harm to a third party.
- The alleged abuser may have care and support needs so may also be at risk
- Abusive adult in position of authority in relation to other vulnerable adults or children
- A legal authority has requested the information

FGM

- All procedures that involve partial or total removal of external genitalia, or other injury to the female organs for non-medical reasons
- Immediate and long term consequences, both physical and psychological
- FGM is carried out mainly among specific ethnic populations in Africa and parts of the Middle East and Asia
- UNICEF estimates that over 200 million girls and women worldwide have undergone FGM

Justifications given for FGM

The justifications given for the practise are multiple and reflect the ideological and historical situation of the societies in which it has developed. Reasons include:

- Custom and tradition;
- Preservation of virginity/chastity;
- Social acceptance, especially for marriage;
- Hygiene and cleanliness;
- Increasing sexual pleasure for the male;
- Family honour;
- A sense of belonging to the group and conversely the fear of social exclusion;
- Enhancing fertility.

Consequences of FGM

Depending on the degree of mutilation, FGM can have a number of short-term health implications:

- Severe pain and shock;
- Infection;
- Urine retention;
- Injury to adjacent tissues;
- Immediate haemorrhaging;
- Death.

Long-term implications can entail:

- Extensive damage of the reproductive system;
- Uterus, vaginal and pelvic infections;
- Cysts and neuromas;
- Complications in pregnancy and child birth;
- Psychological damage;
- Sexual dysfunction;
- Difficulties in menstruation and urination;.

In England and Wales - The prevalence of FGM in England and Wales is difficult to estimate because of the hidden nature of the crime. However, a 2015 study estimated that:

- Approximately 60,000 girls aged 0-14 were born in England and Wales to mothers who had undergone FGM (see **Annex B: of Multi Agency Statutory Guidance on Female Genital Mutilation (HM Government,)**
- Approximately 103,000 women aged 15-49 and approximately 24,000 women aged 50 and over who have migrated to England and Wales are living with the consequences of FGM. In addition, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM.

RISK FACTORS - FGM

The most significant factor to consider when deciding whether a girl or woman may be at risk of FGM is whether her family has a history of practising FGM. In addition, it is important to consider whether FGM is known to be practised in her community or country of origin and whether there is a positive attitude towards FGM within that culture.

The age at which girls undergo FGM varies enormously according to the community. The procedure may be carried out when the girl is new-born, during childhood or adolescence, at marriage or during a first pregnancy.

Given the hidden nature of FGM, individuals from communities where it takes place may not be aware of the practice. Women and girls who have undergone FGM may not fully understand what FGM is, what the consequences are, or that they themselves have had FGM. Given this context, discussions about FGM should always be undertaken with appropriate care and sensitivity.

It is believed that **FGM may happen to girls in the UK as well as overseas**. Girls of school age who are subjected to FGM overseas are likely to be taken abroad (often to the family's country of origin) at the start of the school holidays, particularly in the summer, in order for there to be sufficient time for her to recover before returning to school.

- A female child is born to a woman who has undergone FGM;
- A female child has an older sibling or cousin who has undergone FGM;
- The family indicate that there are strong levels of influence held by elders and/or elders are involved in bringing up female children;
- A woman/family believe FGM is integral to cultural or religious identity;
- A girl/family has limited level of integration within UK community;
- Parents have limited access to information about FGM /do not know about harmful effects of FGM or UK law;
- A girl confides to a professional that she is to have ‘special procedure’ or to ‘become a woman’;
- A girl talks about a long holiday to a country where the practice is prevalent;
- A family is already known to social care in relation to other safeguarding issues;
- A girl requests help from a teacher or other because she is aware / suspects she is at immediate risk of FGM;
- A girl talks about FGM in conversation, for example, a girl may tell other children about it
- A girl is unexpectedly absent from school;
- Sections are missing from a girl’s Red book; and/or
- A girl has attended a travel clinic or equivalent for vaccinations / anti-malarials.

Department of Health

FGM Safeguarding Pathway

Presentation prompts clinician to suspect/consider FGM e.g. repeated UTI, vaginal infections, urinary incontinence, dyspareunia, dysmenorrhea etc. Also consider difficulty getting pregnant, presenting for travel health advice or patient disclosure (e.g., young girl from community known to practice FGM discloses she will soon undergo 'coming of age' ceremony).

INTRODUCTORY QUESTIONS: Do you, your partner or your parents come from a community where cutting or circumcision is practised? (It may be appropriate to use other terms or phrases)

No – no further action required

Yes

Do you believe patient has been cut?

No – but family history

Yes

Patient is under 18 or vulnerable adult

If you suspect she may be at risk of FGM:

Use the safeguarding risk assessment guidance to help decide what action to take:

- If child is at imminent risk of harm, initiate urgent safeguarding response.
- Consider if a child social care referral is needed, following your local processes.

Patient is under 18

Ring 101 to report basic details of the case to police under Mandatory Reporting Duty.

Police will initiate a multi-agency safeguarding response.

Patient is over 18

Does she have any female children or siblings at risk of FGM?

And/or do you consider her to be a vulnerable adult?

Complete safeguarding risk assessment and use guidance to decide whether a social care referral is required.

FOR ALL PATIENTS who have HAD FGM

1. Read code FGM status
2. Complete FGM Enhanced dataset noting all relevant codes.
3. Consider need to refer patient to FGM service to confirm FGM is present, FGM type and/or for deinfibulation.
   a) If long term pain, consider referral to uro-gynae specialist clinic.
   b) If mental health problems, consider referral to counselling/other.
   c) If under 18 refer all for a paediatric appointment and physical examination, following your local processes.

Can you identify other female siblings or relatives at risk of FGM?

- Complete risk assessment if possible OR
- Share information with multi-agency partners to initiate safeguarding response.

Contact details

Local safeguarding lead:

Local FGM lead/clinic:

NSPCC FGM Helpline: 0800 028 3550

Detailed FGM risk and safeguarding guidance for professionals from the Department of Health is available online

FOR ALL PATIENTS:

1. Clearly document all discussion and actions with patient /family in patient's medical record.
2. Explain FGM is illegal in the UK.
3. Discuss the adverse health consequences of FGM.
4. Share safeguarding information with Health Visitor, School Nurse, Practice Nurse.

If a girl appears to have been recently cut or you believe she is at imminent risk, act immediately – this may include phoning 999.

REMEMBER: Mandatory reporting is only one part of safeguarding against FGM and other abuse.

Always ask your local safeguarding lead if in doubt.

The 2003 Female Genital Mutilation Act makes it illegal for any residents of the UK to perform FGM within or outside the UK. The punishment for violating the 2003 Act carries 14 years imprisonment, a fine or both.

It is also an offence to take a child out of the country in order to carry out FGM.

FGM Protection Orders (FGMPO)

An FGMPO is a civil order which may be made for the purposes of protecting a girl against the commission of an FGM offence – that is, protecting a girl at risk of FGM - or protecting a girl against whom an FGM offence has been committed.

Mandatory Reporting of FGM

Since 31st October 2015, regulated health and social care professionals and teachers in England and Wales have a duty to report to the police 'known' cases of FGM in under 18s which they identify in the course of their professional work.

Health Agency Additional Actions

The FGM Enhanced Dataset Information Standard also instructs NHS acute and mental health trusts and GP practices on how they should submit data about patients who have FGM to the Health and Social Care Information Centre (HSCIC). HSCIC collect and publish anonymised statistics on behalf of the Department of Health and Social Care and NHS England. The information is used nationally and locally to improve the NHS response to FGM and to help commission the services to support women who have experienced FGM and safeguard women and girls at risk of FGM. www.hscic.gov.uk/fgm.

SAFEGUARDING REFERRALS

- You believe that the alleged victim has been subject to abuse or neglect **and** has care and support needs;
- You have spoken to the alleged victim to ascertain relevant facts as well as their views and wishes;
- You are sure that the matter should be referred to Adult Safeguarding rather than to MARAC;
- You have also made a referral to Lincolnshire Police if this is necessary;
- You have put interim measures in place to ensure the safety of the alleged victim;

ADULT'S SAFEGUARDING REFERRAL

Adult safeguarding concern identified: If at immediate danger contact 999
(Seek further guidance from your Safeguarding Lead or CCG Safeguarding team if required)
www.lincolnshirelsab.org.uk

Have you gained the individuals consent to make a Safeguarding Adults referral.
(In specific circumstances it is not required)

Complete Adult safeguarding Concern Form
https://www.lincolnshire.gov.uk/lsab/resources/128846.article

or Telephone - 01522 782155 to undertake referral (out of hours - 01522 782333)

- Share information with relevant professionals, proportionate and accurate
- Clarify any actions you have agreed
- Record keeping

If your referral is not accepted and you do not agree with the decision you have the right to challenge

Version 1.0 : April 2018

Adult Safeguarding Concern

The purpose of submitting this form is to bring the concern to the attention of Lincolnshire County Council Adult Care as part of the LSAB safeguarding procedure.

This form reports a concern of abuse or neglect, or 'reasonable suspicions' of abuse or neglect against an individual who;

- has needs for care and support (whether or not the local authority is meeting any of those needs
- 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 either the risk of, or the experience of abuse or neglect

Completed forms should be returned to: ASC@lincolnshire.gov.uk

Additional resources and supporting guidance for completing this form is available at: https://www.lincolnshire.gov.uk/lsab

Is this concern in relation to suspected Exploitation, Human Trafficking or Modern Day Slavery? *	Choose an item.

REFERRERS DETAILS	
Date:*	Click here to enter text.
Name of Referrer: *	Click here to enter text.
Job Title: *	Click here to enter text.
Agency/Organisation:*	Choose an item.
If a provider, please state name:	gggggg
Address: *	Click here to enter text.

RESOURCES

- Lincolnshire CCG Safeguarding Team: 01522 309317
  Secure Email: SWLCCG.safeguarding1@nhs.net
- Lincolnshire Safeguarding Adults Board – About the LSAB - Lincolnshire County Council
- 20190621_CQC Inspector_Handbook_Safeguarding_update.pdf
- www.e-lfh.org.uk/programmes/female-genital-mutilation
- safeguarding_training_requirements_for_primary_care_rcgp.pdf (gpappraisals.uk)
- Capacity and the law (rcgp.org.uk)
- Mental Capacity Act toolkit (bma.org.uk)
- BMA assessment tool: British Medical Association (synthetix-ec2.com)

QUESTIONS?