

Inspector's Handbook

Safeguarding

February 2018

Currently under review to late 2019

The Care Quality Commission is the independent regulator of health and adult social care in England.

Our purpose

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

Our values

- Excellence – being a high-performing organisation
- Caring – treating everyone with dignity and respect
- Integrity – doing the right thing
- Teamwork – learning from each other to be the best we can.

This handbook has been updated since the June 2016 version

The main changes are:

- Updated legislation and statutory guidance
- Updated terms reflecting changes in CQC teams
- Inspector responsibilities added (p. 11)
- Much of the text has been moved to the appendices to reduce the volume of the handbook
- Unregistered Provider text provided (p. 16)
- My Portfolio and Insight information included (p. 22)
- Included Next Phase KLOEs and prompts regarding safeguarding
- Examples provided for poor delivery of care, complaints and safeguarding (Appendix 9)
- Updated appendices
- Removed section on completing an IMR (Independent Management Review) as this will now be managed through the safeguarding committee
- CQC position statement on child safeguarding training and expectations of providers (p. 17)
- Clarified statutory notification guidance (Appendix 10)
- Updated guidance on managing requests for SAR/SCR (Safeguarding Adults Review/Serious Case Review) (Appendix 11)
- Information about Modern slavery and human trafficking (Appendix 12)

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Please note: links to our Intranet pages are not accessible externally, so these have been removed. Places where links have been removed are marked in the document “[link removed]”.

Foreword

All people and organisations that come into contact with children or adults using health and care services have a responsibility to help keep them safe from abuse and neglect. CQC takes this responsibility seriously and plays a vital role in helping ensure children and adults who use regulated services are protected by the people and organisations that provide them with a health or social care service. This is part of our statutory duties to protect and promote the health, safety and welfare of people who use health and social care services.

This Handbook is for Inspectors, Registration Inspectors and others, who, on a daily basis, use information, knowledge, skill and professional judgement to assess how well providers are keeping people who use their services safe from harm, abuse and neglect. The Handbook was developed in co-production with CQC staff in all inspectorates and from around the country to bring together in one place key elements of information, advice, guidance and support to help CQC continue to improve our performance and respond to safeguarding effectively, efficiently and consistently. In doing so, we will help improve the lives of people using services and the quality and safety of those services.

We, along with our partners in the health and social care sectors, need to be ever vigilant to make sure that care providers and people that work for them create, operate and maintain environments, systems and processes in which risks to people's health, safety and welfare are effectively prevented or identified and acted on promptly in order to keep them safe from abuse and neglect.

Our strategy 'Shaping the future' sets out our ambition for a more targeted, responsive and collaborative approach to regulation, so more people get high-quality care. It set out four priorities:

- **Encourage improvement, innovation and sustainability in care**
- **Deliver an intelligence-driven approach to regulation**
- **Promote a single shared view of quality**
- **Improve our efficiency and effectiveness**

We have incorporated these shared priorities into this updated Handbook and hope you will find it a useful resource.

Ursula Gallagher

Deputy Chief Inspector PMS (London) and Lead Nurse
CQC Lead for Safeguarding

Introduction

Safeguarding is everyone's business whatever their role in CQC. Whilst this handbook aims to support inspectors and registration inspectors to deal effectively, efficiently and consistently with concerns and issues about safeguarding, it may be regarded as a source of reference for all staff wishing to improve their own understanding and quality of performance.

The Handbook contains:

- Up-to-date material in terms of end to end processes and practice to help inspectors understand what they need to know and do about safeguarding in a range of circumstances.
- Links to relevant CQC and external guidance on specific safeguarding practice and issues.

It also:

- Sets out the legislative background to safeguarding children and adults
- Defines what safeguarding is
- Explains the roles of partner organisations and how they link with CQC's role
- Sets out how other teams in CQC help support safeguarding work
- Complements but does not duplicate the Adult Social Care and Health Handbooks
- Is supported by the safeguarding page (internal link removed) on the Intranet
- Has been developed in co-production with staff across all sectors and areas of the organisation
- Reflects what staff said they wanted in a Safeguarding Handbook

The Handbook aims to align with sector handbooks, focusing on issues relevant to safeguarding. The main structure of the Handbook follows that of the operational model: Register; Monitor; Inspect; Rate.

As far as possible, the Handbook aims to be a one-stop shop to support all staff. Should you be affected by issues around safeguarding, abuse or neglect, support is available from your buddy, line manager, human resources and the employee assistance programme (internal link removed) on the intranet.

We hope that the Safeguarding Handbook provides you with the information you need to help you in fulfil your responsibilities in CQC. If you have any questions please contact CQC National Advisors Safeguarding via the dedicated mailbox: (link removed).

Roles and responsibilities

CQC's roles and responsibilities in safeguarding

The statement of CQC's roles and responsibilities for safeguarding children and adults (2017) should be read in conjunction with this handbook.¹

CQC's Safeguarding Governance structure is as follows:

- Safeguarding Committee reporting to CQC's Executive Team and represented across sectors
- DCI Safeguarding Lead (Chair of Safeguarding Committee)
- National Advisors Safeguarding

Our primary safeguarding responsibilities can be described at a high level as:

1. Ensuring providers have the right systems and processes in place to make sure children and adults are protected from abuse and neglect
2. Working with other inspectorates to review how health, education, police, and probation services work in partnership to help and protect children and young people and adults from harm
3. Holding providers to account and securing improvements by taking enforcement action
4. Using intelligent monitoring, where we collect and analyse information about services, and responding to identified risks to help keep children and adults safe
5. Working with local partners to share information about safeguarding.

These responsibilities are explained in more detail in pages 7-14 of the Safeguarding Statement.

If you have any questions about safeguarding, please contact (internal link removed).

CQC is **not** responsible for conducting safeguarding investigations or enquiries – that is for the relevant Local Authority or the police.

We do not routinely attend Safeguarding Adult Boards (SABs) or Local Safeguarding Children's Boards (LSCBs), although we may share information and intelligence to help them and safeguarding teams conduct enquiries. Engagement with these Boards is at a local level, with local partners liaising with one another to agree

¹ http://www.cqc.org.uk/sites/default/files/20150710_CQC_New_Safeguarding_Statement.pdf

involvement and attendance so that there is a joined-up approach. CQC recognises that LSCB's are going through a period of change and therefore this section will be updated as soon as we are notified of the scale of those changes.

Where we are asked to, and where we have a regulatory role, we fully engage with Serious Case Reviews (SCRs) and Safeguarding Adults Reviews (SARs), sharing information to learn lessons where things have gone wrong in protecting children and adults from harm, abuse or neglect.

Under our approach to inspection, safeguarding sits in the "Is the service safe?" key question. During Registration safeguarding key questions and evidence will be gathered at the assessment stage to show whether or not a provider can satisfy us as to their compliance should registration be granted.

During inspection, each sector uses KLOEs and prompts to enable information and evidence to be gathered to show whether or not the service is meeting the fundamental standards.

In addition, the Fundamental Standards regulation on safeguarding² reflects the importance of human rights related to mental health legislation. The regulation contains specific provisions to protect people detained under mental health legislation from inappropriate use of restraint, as well as to ensure consent to care and treatment.

Information about safeguarding or safeguarding issues may emerge in responses to any of the 5 key questions, the KLOEs or prompts or during a registration assessment.

Inspection Manager and Registration Manager's responsibilities

With regard to safeguarding, the Inspection and Registration Manager's role includes ensuring that CQC staff are appropriately trained and supported to perform their role effectively and to a good standard of quality.

Managers should ensure that their staff team are managing safeguarding records in line with the Key Performance Indicators for Safeguarding and take appropriate action when they do not. The emphasis for the KPIs is to ensure that when CQC are told about abuse or neglect, we take the right action at the right time and that we record accurately and consistently what we do.

Managers also have an overview of safeguarding activity in their team. They monitor Management Information reports to help identify themes and trends in their area or

² Reg 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

within services and where particular issues may require additional resources to resolve.

They provide advice and support to Inspectors when required to ensure CQC are taking the correct regulatory approach and that people are protected.

Role of the Concerns Team

The Concerns team is based within the National Customer Service Centre and handles all concerning information received via phone, email/web form and post. This includes safeguarding information from members of the public, other statutory bodies, information from whistle blowers and complaints from patients detained under the Mental Health Act. The team also refer Safeguarding Alerts to the Local Authority Safeguarding Team.

The Concerns Team do not make judgements but undertake an initial assessment (triage) of any information of concern received using a decision making tool and associated guidance. All information of concern is processed onto CRM and handed over to an Inspector/Inspector Manager within 24 hours of receipt.

Inspector responsibilities

An Inspector's core function with relation to safeguarding includes

- Assessing and interpreting safeguarding information provided prior to an inspection.
- Conducting inspections and ensuring safeguarding is an integral part of the inspection
- Asking the right questions to elicit the assurances required that people are safe from harm and neglect
- Collecting and corroborating evidence to be able to show that service users are safe
- Reporting what they find

Provider responsibilities

Within the regulatory framework, the responsibilities of providers of services with regards to safeguarding are clear:

1. To put in place and operate effectively systems, processes, policies, procedures and training to help ensure children and adults who use services are safeguarded from the risk of or actual abuse and neglect
2. To comply with accepted national guidance on staff competencies in line with their role
3. To be aware of the Mental Capacity Act (2005) and the meaning of consent
4. To provide levels and a quality of service that meet all the requirements of the relevant safeguarding regulatory framework for the service they provide
5. To remedy any shortcomings found in safeguarding practice in their service to help reduce risks to people who use the service
6. To learn and apply learning from any safeguarding incident to help strengthen safeguarding in the future
7. To refer incidences of abuse or potential abuse to local authority safeguarding teams
8. To notify CQC of safeguarding incidents in accordance with regulations by completing a statutory notification at the time the abuse is identified
9. To co-operate with safeguarding enquiries

Local Authority responsibilities

Under section 42 of the Care Act 2014, Local Authorities **must** make enquiries regarding an adult in their area if certain criteria are met. The Local Authority must have reasonable cause to suspect that the adult:

(1) (a) has needs for care and support (whether or not the authority is meeting any of those needs),

(b) is experiencing, or is at risk of, abuse or neglect, **and**

(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

(2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.³

Enquiries made under this section of the Act are mandatory and known as **section 42 enquiries**

³ <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1>

What if the criteria are not met?

Where the criteria are **not** met or not all the criteria are met, the Local Authority has discretion to conduct an enquiry. This may be to learn lessons or for other reasons. However, these enquiries are not mandatory, so are known as **other enquiries**

The legislative background and role of local authorities in safeguarding children and adults is set out in [Appendix 1](#)

Definition of safeguarding

Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It's fundamental to high-quality health and social care.⁴

Scope of safeguarding

Children

England, Wales, Northern Ireland and Scotland each have their own guidance for organisations to keep children safe. They all agree that a child is anyone who is under the age of 18 years.

Local authorities have overarching responsibility for safeguarding and promoting the welfare of **all** children and young people in their area. Even so, everyone and every agency who comes into contact with children and families has a role to play.

Adults

For adults, the scope of safeguarding is limited to adults with care and support needs, whether or not the local authority is aware and who, because of these needs, are unable to protect themselves from abuse and neglect or the risk of abuse and neglect. For safeguarding principles and definitions see [Appendix 2](#).

Abuse

All safeguarding work aims to protect children and adults from abuse and neglect. Guidance points out that we should not limit our view as to what constitutes abuse or neglect as they take many forms. The circumstances of each case should always be taken into account. Exploitation is a common theme in these types of abuse and neglect.

A full definition of an adult at risk along with a range of different types of abuse that may affect adults is at [Appendix 3 and 4](#).

Full definitions of a vulnerable child along with a range of different types of abuse that may affect children is in [Appendix 5](#)

⁴ <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/safeguarding-people>

Register

Registration inspection

The Registration Inspector's role is to assess a provider's suitability to carry on a regulated activity and to assess a managers' suitability and fitness to manage the regulated activities applied for i.e. CQC and people who use services they provide can have confidence in them and trust they will comply with the law and provide safe services.

Before services come into regulation, they must first be registered. A key part of the registration process involves registration inspectors undertaking a site visit to gather and assess information and evidence about a provider's ability to meet the relevant Regulations. This occurs for most, but not all, new applications and variations. In planning site visits and fit person interviews, registration inspectors may contact local inspectors to seek information, including safeguarding information and other intelligence. As safeguarding information is restricted on CRM, prompt responses to information requests are appreciated to inform interviews and visits.

Registration inspectors also interview nominated individuals and those applying to be registered as managers to consider their fitness for registration. Registration is an ongoing process and providers may apply to vary their registration at any time after being registered. Once registered, the service enters the scheduling process for inspection in the relevant sector.

The Registration Handbook published August 2017 contains guidance for registration inspectors.

Regarding safeguarding, registration inspectors may review documentary evidence such as safeguarding policies and procedures, for example.

The registration visit record contains a number of prompts about Safeguarding under Regulation 13 (the Fundamental Standard on safeguarding service users from abuse and improper treatment [Appendix 6](#)). These should help you gather evidence, including documentary evidence, to show how the provider meets or plans to meet this Fundamental Standard.

Witnessing abuse or neglect during an inspection

If you are a registration inspector and you witness abuse or neglect during a site visit to conduct a fit person interview or to a new provider who is not yet registered with us, you should gather and record as much evidence as possible. Note, however, that it is for the LA and/or police to conduct any enquiries.

Then contact the Concerns Team and ask them to create a safeguarding record in CRM and make a safeguarding referral. You can do this by sending an email to (internal link removed). You will be able to monitor the progress of the alert as the registration application is processed. Guidance on handling information and risk in unregistered providers is here (internal link removed).

The above also applies if you witness abuse or neglect in an unregistered service. The only difference will be that there will be no registration application.

If you witness abuse or neglect when assessing variations to a condition to a registration or variation of a manager's registration, the expectation is that the registered person would take immediate action to refer the issue to the local authority and/or police. If the registered person is implicated or refuses to do so, you will need to ensure that the local authority and/or police are informed and can do this through the Concerns team via the process set out in the two examples above.

Unregistered Providers (URP's)

In the case of URP's, the Concerns Team at NCSC do not risk assess the content of enquiries meaning they do not sift out or respond to safeguarding issues that might be part of the information received.

The Concerns team will instead pass the enquiry on to the relevant Registration Manager (RM), with an email notification that the enquiry contains a safeguarding element, and leave it to the RM to decide whether a safeguarding referral should be raised with the local authority whilst the URP is investigated.

If the RM decides that a safeguarding referral does need to be raised with the Local Authority, the RM should email (internal link removed) providing the ENQ number and the details, requesting NCSC to make the referral.

Monitoring and information sharing

A number of KLOEs in all 5 Key Questions have safeguarding aspects. Links to KLOEs, prompts and characteristics are below:

Healthcare

[Healthcare KLOEs prompts and characteristics](#)

Adult Social Care

[ASC KLOEs prompts and characteristics](#)

Managing safeguarding information

This section aims to help you manage information about safeguarding that you may receive internally or from external sources.

The majority of information about safeguarding enters CQC through NCSC. This can be via phone, email, post, web form. This includes the important feedback we get from the public and people using care services through the web form “share your experience”. The information is assessed by the Concerns Team, processed on CRM, flagged as an alert or concern and referred to Inspectors or Inspection managers within 24 hours of receipt.

Statutory Notifications on abuse are received by email, post or via the online provider portal by the Information Sharing team in NCSC and passed to the relevant Inspector.

The accurate classification of safeguarding alerts and concerns in CRM provides assurance that we take the right action at the right time about abuse and neglect and informs our management information. **These records should only be reclassified when they are incorrect.**

Statutory notifications They should only be reclassified where the provider has failed to make a referral to the local authority, which will happen by exception since this is the purpose of the notification. In all cases where records are incorrectly reclassified NCSC will revert to the original enquiry type.

Note that reclassification of records affects our management information, the data that we publicise internally and externally. If this is inaccurate we cannot assure ourselves that we have taken the appropriate and/or timely action.

In addition, inspectors may receive safeguarding information through a number of other routes, such as directly from local authorities, external bodies such as HMIP or Ofsted, or when conducting inspections and speaking to people using services, their families or staff.

See Factors to consider on receiving safeguarding information ([Appendix 7](#))

Factors to consider when making decisions after receiving information about abuse or neglect

This guidance describes the factors that inspectors should take into account when making decisions about safeguarding information. You can use it when you receive relevant information about regulated services and refer to national safeguarding principles ([Appendix 8](#)). You may also find it helpful to refer to the flowchart on recording safeguarding [link removed]

Safeguarding training

CQC staff training materials are available via the internal Education and Development site [link removed].

Safeguarding children training position statement

Roles and competencies for child safeguarding training are outlined in ‘*Safeguarding children and young people: roles and competences for health care staff INTERCOLLEGIATE DOCUMENT Third edition: March 2014*⁵. This guidance sets out ‘minimum training requirements’, emphasising the importance of maximising flexible learning opportunities to acquire and maintain knowledge and skills, drawing upon lessons from research, case studies, critical incident reviews and analysis, and serious case reviews.

The intercollegiate document states that:

To protect children and young people from harm, all healthcare staff must have the competences to recognise child maltreatment and to take effective action as appropriate to their role. It is the duty of employers to ensure that those working for them clearly understand their contractual obligations within

⁵ [https://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20%2002%20%20%20%20%20\(3\).pdf](https://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20%2002%20%20%20%20%20(3).pdf)

the employing organisation, and it is the responsibility of employers to facilitate access to training and education which enable the organisation to fulfil its aims, objectives and statutory duties effectively and safely.

The document describes 5 levels of competency:

- *Level 1: All staff working in health care settings*.*
- *Level 2: All non-clinical and clinical staff who have any contact with children, young people and/or parents/carers.*
- *Level 3: All clinical staff working with children, young people and/or their parents/carers and who **could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person** and parenting capacity where there are safeguarding/child protection concerns.*
- *Level 4 specialist roles - named professionals.*
- *Level 5 Specialist roles - designated professionals.*

**This means all healthcare settings, including those that do not treat children*

Level 4 and 5 specialist roles refer to the statutory roles at level 4 i.e. Named Doctors, Nurses or Midwives for safeguarding children and young people or level 5 Designated doctors or nurses for safeguarding children and young people

All providers of NHS funded health services including NHS trusts, NHS foundation trusts and public, voluntary sector, independent sector and social enterprises require level 4 and level 5 specialist roles and should identify a named doctor and a named nurse (and a named midwife if the organisation provides maternity services) for safeguarding.

In the case of NHS 111, ambulance trusts and independent ambulance providers, there should be a minimum of one level 4, a named professional.

GP practices should have a lead and deputy lead for safeguarding, who should work closely with named GPs. Named professionals have a key role in promoting good professional practice within their organisation, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place.

Key principles when assessing child safeguarding arrangements

The intercollegiate document is a guidance document and while the level of safeguarding training is a good indication as to how well the provider responds to safeguarding concerns, it is not the sentinel indicator of good child safeguarding arrangements in an organisation. The organisation needs to demonstrate that they have a 'comprehensive safeguarding system' underpinned by policies, effective risk

assessments, and high profile leadership as well as quality assured training and that they know that these are consistently in place.

1. We need to equally apply the regulations and the associated policy frameworks across all sectors
2. We need to use '*Working Together to Safeguard Children*' (2015)⁶ and the intercollegiate guidance to be assured that providers have made the appropriate risk assessments for children's safeguarding.
3. Risks and expectations of child safeguarding training and competencies are the same across all sectors. All staff working in a care setting should be given a mandatory induction, which includes familiarisation with child protection responsibilities and procedures to be followed if anyone has any concerns about a child's safety or welfare.

The job titles used in the health and care sector are becoming ever more complicated and difficult to map against current wording in guidance. Instead we need to consider the following:

- Can the provider demonstrate they have considered the roles of different members or groups of staff and determined which members of staff is required to have which level of children's safeguarding training? If the level of training does not align with the intercollegiate guidance, (specifically where they are deciding to use a lower level of training) can the provider demonstrate how they know that their staff are competent to deal with a safeguarding issue and that their system effectively identifies risk and prevents harm?
- How does the leadership and culture of the organisation support a culture of openness and encourage staff to think the unthinkable and come forward with concerns?
- Are providers able to demonstrate examples of safeguarding referrals and the impact that their processes have made?

If on investigation, it then does not seem like staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role, then we should be looking at more than just whether they need additional training, but at all aspects of the system described.

We would also expect as in all our sectors that the method and expectations of training was properly designed, delivered and evaluated, and whilst there is room for some element of on-line training this is not a substitute for face to face training especially discussion of case studies and personal cases.

⁶ <https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>

Adult safeguarding training

A requirement of the statutory guidance to the Care Act is that health and social care staff will have undertaken training in safeguarding adults.

All providers should ensure their staff are trained and competent to safeguard adults at risk.

We await the publication of the Intercollegiate document “Safeguarding Adults: Roles and Competencies for healthcare staff” and will update this handbook once it is published.

The National Competency Framework for Safeguarding Adults⁷ (developed by Bournemouth University) is a widely used framework within social care.

The aim of this document is to outline the competencies within the workforce which staff and volunteers in care services should possess to ensure the safety and protection of adults at risk of or experiencing abuse and/or neglect (adult at risk). It helps organisations use identifiable standards to measure staff competencies.

What to look for on Registration and inspection

Training is only one element of the wider safeguarding system and therefore inspection teams should ensure there is evidence of the actual effectiveness of the training within the overall provider system. For example, how is training applied and what outcomes are or will be achieved? What do staff say about their safeguarding training and experience.

Guidance on Information sharing

Information sharing is an essential tool to help protect the safety and welfare of people who use services, to help ensure our efficiency and effectiveness as a regulator and to help other public bodies perform their duties and functions.

The document on the Intranet ‘guidance on sharing information’ (internal link removed) builds on the advice in our ‘Code of practice on confidential personal information’ (internal link removed) to set out the circumstances in which information can and should be shared.

The guidance points out when you may need to exercise caution, particularly around sharing confidential personal information - which is that which relates to and identifies an individual. It stresses that in order to share confidential personal

⁷ <http://www.ncpqsw.com/publications/national-competency-framework-for-safeguarding-adults-comprehensive-and-concise/>

information the purpose of disclosing that information must provide a legal basis for doing so.

It is important to remember that decisions to share confidential information should always be recorded. Sometimes a decision not to share, perhaps as an individual has objected, should also be recorded.

If you are unsure about whether to share information having consulted the guidance, please contact (internal link removed) for advice.

NCSC decision making tool

As part of the Responding to Concerns Programme, an electronic Decision Making Tool was developed with inspector input to support a more effective way of identifying the appropriate category for the information received.

The Tool uses a set of rule-based questions to reach a set of pre-determined priority levels. It uses the same CRM Categories of Enquiry Types as the previous tool (Safeguarding alert; Safeguarding concern; Whistle blowing; Complaint about provider). In addition, we have broadened the range of priority levels that are assigned to information of concern (see the table below). These indicate the seriousness of the information received and the speed of any action that inspectors need to take, as well as the relevant KPI(s).

The 'prioritisation rationale' is intended as a guide to the seriousness associated with the concern and actions that an Inspector might take, For example:

- For safeguarding (priority 1 and 2) the prioritisation rationale mirrors the actions and timeliness dictated by the KPI's (KPI 2 and 3)
- Where no safeguarding actions are required (priority 3 and 4) this information is considered for a future inspection – the CRM Category and prioritisation rationale reflects this.
- As NCSC triage any information on an individual basis, and without the wider context and knowledge of the service, sometimes the Inspector or Inspection Manager may feel that an incorrect category has been applied. In these circumstances, the Inspector or Inspection Manager should change the CRM record to the appropriate category. NCSC always appreciate feedback from Inspection colleagues to support their learning and development. If anything is re-categorised, please email the details and reasons to the (internal link removed) mailbox.

Information from Children's Services Inspection and Health and Justice Teams

You may also need to take into account information from the Children's Services Inspection (CSI) team and Health & Justice team. This is shared as follows:

Information regarding issues affecting children in regulated services will be included in information about the relevant provider. Risks to children must be taken into account when planning your inspections. Where safeguarding issues emerge during a review involving the CSI team, senior managers in the area where the review is taking place will be informed. If concerns are systemic, these will be raised with the relevant Inspection Manager.

Information from Health and Justice Inspections about individual health providers will either be conveyed directly to the relationship holder or assimilated into the general information held by CQC centrally.

Safeguarding information routes to inspectors

Inspectors receive information from a variety of routes including

- National Reporting and Learning System
- NCSC via CRM or phone
- Notifications
- Inspection
- External bodies (e.g. LA, HMIP)
- Whistle-blowing
- Service users/public
- Thematic reports

Safeguarding records and tools

The NCSC Concerns Team process all safeguarding information that comes into CQC and create a safeguarding record.

Where safeguarding information has been raised through a Statutory Notification of abuse, an enquiry will be created, categorised and the inspector notified of this.

NHS Trusts fulfil their responsibility in completing a Statutory Notification by reporting through the National Reporting and Learning System (NRLS). Those notifications categorised as moderate or severe are highlighted to inspectors.

CRM: creating, completing and navigating safeguarding records

Guidance about creating and completing a safeguarding record on CRM is (internal link removed)

The link below takes you to a video made by the Sector Support Team to demonstrate how to navigate safeguarding records on CRM and to help ensure work is picked up in Management Information.

How to progress a safeguarding record (internal link removed).

My portfolio

In terms of seeing all safeguarding records in one place, most inspectors have access to the safeguarding dashboard through 'my portfolio' which allows you to see all records for services you are responsible for (some Registration inspectors do not have access to this function).

You can view different types of information about safeguarding for your portfolio of locations at different levels of detail to suit your needs.

Management Information reports on safeguarding are also available to help you understand safeguarding activity in, for example, a particular local authority over a period of time or how quickly action has been taken. These are accessible through the Dashboard. To access from CRM opening page, click on the "Service Analytics" tab under the Saved Queries white box and then on the Safeguarding tab. The following list of reports should then appear. These can be actioned clicking the relevant tabs to the right of "Safeguarding Landing Page" [link removed]

Insight

We have developed CQC Insight to monitor the quality of care. We have specific Insight tools for the different health and care sectors.

CQC Insight:

- incorporates data indicators that align to our key lines of enquiry for that sector
- brings together information from people who use services, knowledge from our inspections and data from our partners
- indicates where the risk to the quality of care provided is greatest
- monitors change over time for each of the measures
- points to services where the quality may be improving

Inspection planning

A range of data about safeguarding is available to help you plan your inspection. This data can vary between Inspection Directorates and different service types. The following section outlines what is available to inspectors for each different sector.

Acute and Specialist NHS Trusts

In the acute sector, information that feeds into the Provider Information Request (PIR) focuses on mandatory training and additional training for paediatrics. It will also seek information on the safeguarding lead is for adults and children, so that they may be interviewed by the inspector. There is a section on the governance arrangements for safeguarding, at all levels. In addition the PIR asks to supply all the Safeguarding referrals in the previous 12 months, broken down by adults vs children and core service. Another section covers FGM and sexual exploitation data. Qualitative information is contained in NRLS data, which may point to safeguarding incidents, but currently the large volume of items makes systematic analysis unmanageable. High level statistics are available about the number of NRLS incidents.

Ambulances RPIR will be finalised in the near future and also contain safeguarding incident information.

Further information is available here (internal link removed).

Adult Social Care

Safeguarding volumes for locations within your portfolio are analysed and displayed on the Adult Social Care Insight dashboard, available through CRM Service Analytics. Further detail regarding safeguarding incidents including the additional

relevant information fields is available by downloading an Information Pack for a location.

Questionnaires for people using services in, for example, Community Services, ask people to agree or disagree with a number of statements about the service, including “I feel safe from abuse and or harm from my care and support workers”. This is also available by downloading an Information Pack for a service.

Further information on CQC Insight for Adult Social Care is available here (internal link removed) and further information regarding Information Packs here (internal link removed).

Mental Health and Community Services

For Mental Health and Community Services, the RPIR will contain the same data as described for acute sector. Information from Insight is available for Mental Health services on, for example, the deaths of patients detained under the Mental Health Act, incidents of assault and self-harm among inpatients and a monthly breakdown of the number of safeguarding and whistleblowing enquiries over the last 12 months.

Further information is available here (internal link removed).

Primary Medical Services

The number of safeguarding and whistleblowing enquiries over the last 12 months, and the text where applicable, are currently available in the GP practice and dental practice pre-inspection data packs. CQC is exploring the potential inclusion of safeguarding and whistleblowing enquiries in a practice history/timeline of key events section of the GP Insight monitoring dashboard”

Further information is available here (internal link removed).

Inspection

Site visit

Visits to provider locations

Use the relevant Site Visit guidance for your sector and type of service where appropriate (internal links to each sector have been removed)

Identifying risks of abuse or neglect during an inspection

At a basic level, risks to children and adults using services are higher where systems and processes are weak and staff are not clear or do not know what to do when a safeguarding situation presents. You will therefore need to check what systems and processes are in place and how robust they are.

Some questions to consider:

- Do staff know how to identify and report abuse and neglect?
- What training in safeguarding has been carried out and when? Has this been updated to take into account any changes to safeguarding laws or procedures? How has training improved staff practice and had a positive impact on people using the service?
- Regarding Mental Health, is consent to care and treatment always sought in line with legislation and guidance? Are staff aware of the differences between lawful and unlawful restraint practices and how to apply for an authorisation to deprive a person of their liberty?
- What safeguarding incidents have occurred since the last inspection? How were they handled? How timely was the response?
- Are there any themes that show certain types of incidents have happened more than once? What evidence is there to show this: records, notes, action plans?
- How has learning from previous incidents led to changes and improvements in safeguarding?

Some factors to consider

- Safeguarding is a mandatory prompt within KLOE's
- What does the intelligence and information tell you about levels of risk? Are they low or have they increased?
- What is the provider's track record with regard to safeguarding in terms of alerts, notifications, responses, co-operation and learning?
- How will this be shared with Registration Inspectors when new Registered Manager and variation applications are being assessed?

- What safeguarding issues or activity have there been since the last inspection? Note that this needs to be considered in the context of the location in question – increased information may not by itself mean a greater risk, it could mean a more open culture or awareness training in safeguarding. This could be a positive indicator, and not necessarily a negative one.
- Are any safeguarding themes evident that you need to explore? If so, consider how you will do this, what evidence you may need to seek and who you may need to speak with to obtain and corroborate evidence.
- Do you need to include a specialist in your inspection?
- Has this inspection been moved forward for any reason?
- If you need to make a safeguarding alert during your visit, do you have the local authority details with you e.g. in your phone?

If you witness abuse or neglect when on a site visit the expectation is that the registered person would take immediate action to refer the issue to the local authority and/or police. If the registered person is implicated or refuses to do so, you will need to ensure that the local authority and/or police are informed and can do this through the Concerns team via the process set out in the two examples above.

Witnessing abuse or neglect during an inspection

If you witness a safeguarding incident during a site visit:

- inform the manager or senior person on duty (unless they are implicated); and
- take action to keep the person/people safe (providing it is safe for you to do so).

The provider is responsible for notifying the local authority (and where an offence may have occurred, the police) and they should do so immediately. You will want to make sure that CQC is notified by the provider that they have notified the LA and police. It is for the LA and/or police to conduct any investigation.

You should only act as an alerter to local authorities and police forces where providers have refused to do so, or are directly implicated in the abuse themselves.

Inspectors should not await the outcome of Police investigations prior to entering premises for the purpose of inspection if there are grounds to do so. To request that NCSC refers an alert to the LA, send an email to: (internal link removed).

Mental Capacity and Deprivation of Liberty Safeguards

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

Examples of people who may lack capacity include those with dementia, a severe learning disability, brain injury, a mental health condition, a stroke or who is unconsciousness caused by an anaesthetic or sudden accident.

However, just because a person has one of these conditions does not necessarily mean they lack the capacity to make a specific decision.

Someone can lack capacity to make some decisions (for example, to decide on complex financial issues) but still have the capacity to make other decisions (for example, to decide what items to buy at the local shop).

The deprivation of liberty safeguards were introduced to provide a legal framework around the deprivation of liberty. Further information is available at ([internal links removed](#)).

MCA and children

The Mental Capacity Act (2005) safeguards the human rights of people who might (or might be assumed to) lack mental capacity to make decisions, in particular about consenting to proposed care and treatment. The act applies to those aged 16 years and above.

Chapter 12 particularly applies to young people

- *12.14 If a young person has capacity to agree to treatment, their decision to consent must be respected. Difficult issues can arise if a young person has legal and mental capacity and refuses consent – especially if a person with parental responsibility wishes to give consent on the young person’s behalf. The Family Division of the High Court can hear cases where there is disagreement. The Court of Protection has no power to settle a dispute about a young person who is said to have the mental capacity to make the specific decision.*

[Mental Capacity Act Code of Practice](#)

Mental Health Act: information from SOADs and MHA reviewers

We monitor the use of the Mental Health Act as applied to adults and children, to protect the interests of people whose rights are restricted under the Act. We do this in three main ways:

- Checks made by an independent expert, known as a Second Opinion Appointed Doctor (SOAD), which look at treatment, such as prescribing medicines, without the consent of patients.
- The work of the Mental Health Act reviewers, who visit patients detained in hospital and meet with them in private to find out about their experiences.
- A discretionary role in investigating complaints from patients subject to the Mental Health Act.

Mental Health Act (MHA) reviewers and/or Second Opinion Appointed Doctors (SOADs) may witness a suspected, or actual, safeguarding incident or receive safeguarding information as part of their work. The MHA reviewer or SOAD must immediately bring this to the attention of the manager or provider of the service, unless they are directly implicated in the concerns. The primary responsibility to make a safeguarding referral lies with the provider. MHA reviewers should then inform the relevant Inspection Manager by telephone that a concern has been raised, and note this in their visit report. SOADs should telephone the SOAD operations manager and note that a concern has been raised in their visit report. Inspectors are responsible for the subsequent management of the safeguarding information and assessing its relevance to the provider meeting the Fundamental Standards Regulations.

What good safeguarding looks like

The following text is provided for information and offers helpful characteristics

From the ASC characteristics of Good for KLOE S1:

- People are consistently safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination.
- The service has effective safeguarding systems, policies and procedures and manages safeguarding concerns promptly, using local safeguarding procedures whenever necessary. Where required, investigations are thorough. There is a consistent approach to safeguarding and matters are always dealt with in an open, transparent and objective way.
- Where the service is used by children, staff take a preventative approach to safeguarding and are aware of relevant risk factors and triggers. They discuss any concerns with managers and colleagues, and the service works with people, their families and external agencies to promote children's safety and prevent abuse. Child protection practice and arrangements are aligned with local safeguarding arrangements. The service's culture, staff induction, training and supervision arrangements successfully promote a child-centred approach to safeguarding.
- The service's proactive approach ensures that human rights are not breached or violated. Where there needs to be a decision to balance rights, for example a person's right to freedom and the rights of that person or others to be free from harm, decisions are taken in people's best interests.
- All staff have a comprehensive awareness and understanding of abuse and know what to do to make sure that people who lack voice are protected, including when experiencing harassment or abuse in the community.
- People know about the service's safeguarding policy. They know what to do and feel comfortable raising concerns about their own or other people's safety. People

who raise concerns receive sympathetic support and appropriate information. There are no recriminations; it is seen as a normal and desirable part of day-to-day practice.

From the Healthcare characteristics of Good for KLOE S1:

There are clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse, using local safeguarding procedures whenever necessary.

These:

- are reliable and minimise the potential for error
- reflect national, professional guidance and legislation
- are appropriate for the care setting and address people's diverse needs
- are understood by all staff and implemented consistently
- are reviewed regularly and improved when needed.

Staff have received up-to-date training in all safety systems, processes and practices.

Safeguarding adults, children and young people at risk is given sufficient priority.

Staff take a proactive approach to safeguarding and focus on early identification.

They take steps to prevent abuse or discrimination that might cause avoidable harm, respond appropriately to any signs or allegations of abuse and work effectively with others, including people using the service, to agree and implement protection plans.

There is active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations, including when people experience harassment or abuse in the community.

After inspection

Although safeguarding itself is not rated individually for any service, information and evidence about safeguarding helps feed in to ratings for mainly the Safe and Effective domains.

This chapter focuses on bringing the evidence together and reporting your findings.

Follow-up and reporting

It is important that you draw together all your evidence about safeguarding so that you can present a fully-evidenced picture of safeguarding in that service. Evidence may emerge from response to your questions in any of the 5 domains, not just the Safe domain.

Some issues to consider

- Do you have all the evidence about safeguarding that you need?
- Has the evidence been corroborated?
- How will you best reflect the views of people you spoke with, particularly people using the service, their families, carers, friends or representatives? What does safeguarding look like from their perspective?
- Have you identified any breaches of Regulation 13 (Safeguarding Fundamental Standard)? If so, what is our regulatory response going to be? The Enforcement Handbook [\(internal link removed\)](#) will help you reach a decision.
- Is any other regulatory activity required?
- Is there a need for a Management Review Meeting (MRM)? Do colleagues from other Inspection Directorates need to take part? If so, who will lead and how will actions be joined up? You should have received training on the CRM processes for recording MRMs.
- Are there issues that the local authority and /or service commissioners and/or police need to be aware of?

Reporting templates

Reporting templates may include a sub-headed section to report on safeguarding. This will contribute to your overall rating of the Safe domain and, for services where people may be detained under the Mental Health Act or subject to Deprivation of Liberty Safeguards, the Effective domain.

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⁸ <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance>

⁹ <https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>

Appendix 1– Legal background to safeguarding children and adults

Safeguarding children

The main legal framework for safeguarding children is contained in two pieces of legislation: the Children Act 1989 and the Children Act 2004. The requirements of these Acts and other related and relevant legislation are described in the Government guidance, [Working Together to Safeguard Children 2015¹⁰](#)

Local Authorities have lead responsibility in their areas for safeguarding children. They also have a number of legal functions. For example, Local Authorities must establish a Local Safeguarding Children Board¹¹ for their area.

Note that although CQC is not named as one of the statutory members of LSCBs, we may have a role in attending relevant meetings or assisting where, through our regulatory activity, we could act with other partners to address poor care.

Local Safeguarding Children Board (Currently undergoing a period of change. The handbook will be updated when these changes are finalised)

Statutory objectives¹²:

- (a) To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
- (b) To ensure the effectiveness of what is done by each such person or body for those purposes

Membership of LSCB (as note above)

Legislation¹³ sets out that a LSCB must include at least one representative from the local authority and the authorities below:

District councils (where they exist) Chief Officer of police Cafcass

Youth Offending Team NHS England and CCGs

National Probation Service and Community Rehabilitation Companies

NHS Trusts and NHS Foundation Trusts, where all or the majority of services are in the local authority area

¹⁰

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf

¹¹ Section 13, Children Act 2004

¹² Section 14, Children Act 2004

¹³ Section 13 Children Act 2004

Governor or director of any secure training centre in the area

Governor or director of any prison in the area which ordinarily detains children

Serious Case Reviews (as note above)

Serious Case Reviews are required under legislation¹⁴ where the LSCB **must** review serious cases in certain circumstances and advise the Board and partners of lessons which have been learned. The criteria for conducting a review are:

- (a) Abuse or neglect of a child is known or suspected; and
- (b) Either – (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child

Guidance recommends that even where one of the criteria is not met, as SCR **should always be carried out** where a child has died in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or secure children's home. This also applies where a child dies was being detained under the Mental Health Act 1983 or where a child aged 16 or 17 was the subject of a deprivation of liberty order under the Mental Capacity Act 2005.

Guidance also suggests that where the above criteria are not met, a review should still be considered where the review will thoroughly, independently and openly investigate the issue. The final decision to conduct a SCR rests with the Chair of the LSCB.

Further, areas of good practice should also be reviewed so that lessons can be shared and embedded.

Safeguarding adults

Local Authorities have a lead responsibility for safeguarding adults in their area. They also have a number of legal functions. For example, they must establish a Safeguarding Adults Board¹⁵ for their area.

Legal Framework

Implemented in April 2015, the Care Act 2014 gave safeguarding adults a legal framework for the first time.

The Statutory Guidance to the Care Act (2014)¹⁶, updated 2017 includes, from paragraph 14.7 onwards, guidance about safeguarding adults at risk of abuse and neglect. This includes:

¹⁴ Regulations 5(1)(e) and 5(2) of the Local Safeguarding Children Boards Regulations 2006

¹⁵ Section 43(1), Care Act 2014

- definitions of what safeguarding adults is;
- how to spot certain defined types of abuse;
- reporting and responding to abuse and neglect;
- criminal offences relating to safeguarding adults;
- safeguarding duties and which organisations they apply to;
- the role of Local Authorities and multi-agency working;
- safeguarding enquiries
- Safeguarding Adults Boards and Safeguarding Adults Reviews.

Safeguarding Adults Board

The statutory objectives¹⁷ of a Safeguarding Adults Board are:

- (a) To help and protect adults in the Local Authority area who have care and support needs (whether or not the Local Authority is meeting those needs), and
- (b) Who is experiencing, or at risk of, abuse or neglect, and
- (c) As a result of those needs, is unable to protect themselves against the abuse or neglect or the risk of it.

Membership of SAB

Legislation requires the Local Authorities which set up the SAB to be represented on it. In addition, the Clinical Commissioning Groups and the chief officer of police in the LA area must be represented.

Other organisations may be invited to attend, if appropriate, depending on the focus of the work. This may include CQC, representatives of local health and social care providers, local Healthwatch, fire and ambulance services [the latter two are normally full members of SABs].

Safeguarding Adults Review

A SAB **must conduct** a SAR involving an adult in its area who has care and support needs if:

- (i) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult; **and either:**

¹⁶ <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1>

¹⁷ Section 43(2), Care Act 2014

- (ii) The adult has died, and the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected abuse or neglect at the time the adult died); or
- (iii) The adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect

The local authority does not need to have been meeting the care and support needs of the adult in question for it to conduct a SAR.

The SAB **may** carry out an SAB for adults in their area who do not meet the above criteria but where they believe that learning will result which will help protect adults in future.

The Care Act also requires members of SAB to co-operate and contribute to a SAR to help identify lessons to be learned and to apply those lessons to future cases.

What SCRs/SARs are not

SCRs/SARs are not used to investigate how someone may have died or suffered significant harm, or who was responsible – coroners and the justice system are responsible for that. Neither are they used to apportion blame.

Appendix 2: Safeguarding principles

Below are a number of set principles which apply to safeguarding children and adults. Inspectors and managers should always take these principles into account when making decisions.

Children

In Working Together to Safeguard Children (March 2015), currently being updated, two key principles are set out which should underpin all effective safeguarding arrangements for children in every local area:

Safeguarding is everyone's responsibility: for services to be effective, each professional organisation should play their full part; and

A child-centred approach (see below): for services to be effective they need to be based on a clear understanding of the needs and views of children.

A child-centred approach¹⁸

Effective safeguarding systems are child-centred. Failings in safeguarding systems are too often the result of losing sight of the needs and views of the children within them, or placing the needs of adults ahead of the needs of children.

Safeguarding and promoting the welfare of children means (in terms of Working Together guidance):

- Protecting children from maltreatment
- Preventing impairment of children's health and development
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to have the best outcomes

Children want to be respected, their views to be heard, have stable relationships with professionals built on trust and to have consistent support provided for their individual needs. This should guide the behaviour of professionals. Anyone working with children should see and speak to the child; listen to what they say; take their views seriously; and work with them collaboratively when deciding how to support their needs.

A child-centred approach is supported by the United Nations Convention on the Rights of the Child – it protects the rights of the child and provides a child-centred

¹⁸ Working Together to Safeguard Children 2015 pp 9-10

framework for the development of services. It is also supported by domestic legislation such as the Children Act 1989 which requires local authorities to have due regard to the child's wishes when deciding what services to provide and the actions to take to protect children; and the Equality Act 2010 which promotes equality of opportunity and the elimination of discrimination.

Adults

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.

In the Care and Support Statutory Guidance to the Care Act (updated February 2017), the government set out six principles (see below) which underpin all safeguarding work for adults. These principles apply across all sectors and settings.

The principles are accompanied by examples of statements from people who use services to help explain how they can be applied in practice. This helps to make safeguarding personal.

Empowerment – people being supported and encouraged to make their own decisions and informed consent.

“I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens.”

Prevention – It is better to take action before harm occurs.

“I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.”

Proportionality – The least intrusive response appropriate to the risk presented

“I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed.”

Protection – Support and representation for those in greatest need

“I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want.”

¹⁹ <https://www.gov.uk/government/publications/care-act-statutory-guidance>

Partnership – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting abuse and neglect.

“I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me.”

Accountability – Accountability and transparency in delivering safeguarding.

“I understand the role of everyone involved in my life and so do they.”

Making Safeguarding Personal²⁰

The 6 principles of adult safeguarding set out in the Care and Support Statutory Guidance emphasise the importance that all safeguarding partners take a broad community approach to establishing adult safeguarding arrangements. Critically, organisations should recognise that safeguarding arrangements are there to protect individuals.

For local authorities and partners, Making Safeguarding Personal²¹ is a shift in culture and practice that builds on what is already known about what makes safeguarding effective from the point of view of the person who is safeguarded. The approach sees people as experts in their own lives and involves working with them to understand what outcomes they wish, how that can be achieved and seeing how the results match people’s wishes. Outcomes should become embedded in practice so the focus on outcomes is constant. In brief, it is a move from a process supported by conversations to a series of conversations supported by a process.

MSP therefore seeks to achieve:

- A personalised approach that enables safeguarding to be done with, not to, people
- Practice that focuses on achieving meaningful improvement to people's circumstances rather than just on ‘investigation’ and ‘conclusion’
- An approach that utilises social work skills rather than just ‘putting people through a process’
- An approach that enables practitioners, families, teams and SABs to know what difference has been made

²⁰ Statutory Guidance to the Care Act 2014 p233

²¹ Making Safeguarding Personal Guide (LGA, ADASS) 2014

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.

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

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.

- The vulnerability of an adult at risk is related to being able to make and carry out informed choices (consent) free from pressure or undue influence.
- The risk of harm will be affected by how well they are able to protect themselves from abuse or neglect.

Consider older people living in the community with no close friends or family; people in residential or nursing care or in mental health hospitals with no family or professional contacts such as a social worker; and those in receipt of dementia services who may possess an added vulnerability of fluctuating mental capacity in either being able to understand if something is wrong or to know how or who to tell about it.

The more dependent and isolated an individual is, the greater the associated risks.

Appendix 4: Types of abuse and neglect: Adults ²²

- **Physical abuse** – including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.
- **Domestic violence** – including psychological, physical, sexual, financial, emotional abuse; so called ‘honour’ based violence.
- **Sexual abuse** – including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, 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, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.
- **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, or the misuse or misappropriation of property, possessions or benefits.
- **Modern slavery** – encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.
- **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 as a result of the structure, policies, processes and practices within an organisation.
- **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, the withholding of the necessities of life, such as medication, adequate nutrition and heating
- **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.

²² <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance>

Appendix 5: Types of abuse and neglect: Children ²³

- **Abuse** – a form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others (e.g. via the Internet). They may be abused by an adult or adults, or another child or children.
- **Physical abuse** – a form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child
- **Emotional abuse** – the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or “making fun” of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child’s developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.
- **Sexual abuse** – Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.
- **Neglect** – The persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:
 - provide adequate food, clothing and shelter (including exclusion from home or abandonment);
 - protect a child from physical and emotional harm or danger;
 - ensure adequate supervision (including the use of inadequate care-givers); or
 - ensure access to appropriate medical care or treatment.

²³ <https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>

Appendix 6: Regulation 13: Fundamental standard on Safeguarding

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Safeguarding service users from abuse and improper treatment

13.—(1) Service users must be protected from abuse and improper treatment in accordance with this regulation.

(2) Systems and processes must be established and operated effectively to prevent abuse of service users.

(3) Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

(4) Care or treatment for service users must not be provided in a way that—

(a) includes discrimination against a service user on grounds of any protected characteristic (as defined in section 4 of the Equality Act 2010) of the service user,

(b) includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint,

(c) is degrading for the service user, or

(d) significantly disregards the needs of the service user for care or treatment.

(5) A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

(6) For the purposes of this regulation, “abuse” means -

(a) any behaviour towards a service user that is an offence under the Sexual Offences Act 2003(1),

(b) ill-treatment (whether of a physical or psychological nature) of a service user,

(c) theft, misuse or misappropriation of money or property belonging to a service user, or

(d) neglect of a service user.

(7) For the purposes of this regulation, a person controls or restrains a service user if that person—

(a) uses, or threatens to use, force to secure the doing of an act which the service user resists, or

(b) restricts the service user's liberty of movement, whether or not the service user resists, including by use of physical, mechanical or chemical means.

Appendix 7: Factors to consider on receiving safeguarding information

On receipt of information about safeguarding, inspectors should consider:

Urgency – how serious is the issue? Is a person in imminent danger of being abused or neglected? Is this a safeguarding alert or concern? Has another agency (local authority/police) been informed? If information is received from NCSC Concerns team, it will have been allocated a priority level – you will first need to consider whether you agree with this assessment, and take action in line with the KPIs (see below).

Confidentiality – if the person making the alert has not agreed to have their details passed on, record this decision and delete their identity details from the alerter/informant fields in the safeguarding record. When NCSC generate a referral, information is extracted automatically from the safeguarding record so if any contact details are present they will pull through into the referral document which is sent to the local authority [see [Information Sharing](#)].

In some circumstances it may not be possible to pass on the safeguarding information without identifying the referrer (for example, where only a very limited number of people would have known about the issue or where you consider it imperative for the local authority safeguarding team to know the referrer's identity in order to be able to properly investigate and protect people from harm). In those cases, this decision should be recorded and the referrer should be informed of our decision and reasons, if it is possible to do so.

Where the safeguarding referral comes from a professional, you should consider whether they are acting as a 'whistle-blower' and, if so, follow the relevant process and guidance for handling whistle-blowers' concerns. Professionals should understand and follow the appropriate safeguarding processes and, other than in exceptional circumstances, should not expect confidentiality in doing so

Questions to ask – check the factors to consider when making decisions after receiving information about abuse or neglect ([Appendix 8](#)) [not an exhaustive list of factors, so be led by the nature of the issue and the evidence you need to gather].

Context – consider the other information and intelligence you have or know about the provider, location or service. What does the new information tell you? Does the sum of the intelligence mean a regulatory response is required? If so, what response is appropriate? Or is the information not serious enough to require an immediate response but something to take into account in the future, adding to the overall picture about a provider/service?

Judgement – use your professional judgement in deciding action to take and how best to respond to the information received [refer to framework of KPIs and mandatory actions]

Support – if you are not sure about a specific course of action, or want to check your thinking about a safeguarding issue, ask your manager or buddy for assistance.

Taking action – action should be taken within the framework of the KPIs for safeguarding alerts and concerns (internal link removed).

Appendix 8: Factors to consider when making decisions after receiving information about abuse or neglect

1. Making decisions – factors to consider

a. When I first receive information about abuse or neglect

- (i) What is happening, has happened, or is alleged to be happening or have happened?
- (ii) Did any person experience, or were they put at risk of, abuse or neglect?
- (iii) Are any other people at risk of abuse or neglect?
- (iv) Has medical attention been sought?
- (v) Is/are the alleged victim/s safe now?
- (vi) Does any other statutory agency know about the incident or event?
- (vii) If they do not know, do I need to tell them?
- (viii) If they do know, are they acting on the information?

b. The person using the service

- (i) What are the person's wishes about how the information should be dealt with?
- (ii) Does the person lack capacity to make decisions relevant to the information and their own safety and wellbeing?
- (iii) If the person lacks capacity, who is representing them?
- (iv) Can the person advocate for themselves?

c. The alleged incident or event

- (i) What is the actual or potential nature and impact on the person of the actual or possible abuse or neglect?
- (ii) Might other agencies have information that could affect our judgement/assessment about the impact and likelihood of abuse or neglect, or the wishes of the person where these are not known?
- (iii) If the likelihood and/or impact of abuse or neglect is low, are there other concerns that when considered together suggest the person is or may be at higher risk of abuse or neglect?
- (iv) Is there evidence or reasonable cause to suspect negligence, incompetence or recklessness as the cause of abuse or neglect?
- (v) Is it likely to be a Police matter?

d. The location and provider

- (i) Are there themes and trends – is this a recurring pattern for the location and/or provider? Is it part of a bigger picture?
- (ii) What other relevant information do we already have about the location and/or provider (for example, other concerns, existing or other

safeguarding concerns, notifications, previous or ongoing enforcement action)?

- (iii) What is the provider's capacity and capability to respond appropriately?

As services vary between sectors and regions, inspectors will need to use informed judgement based on intelligence, evidence and available information to help them decide on future action.

2. Next steps

NCSC will triage information and send you an alert (already referred) or a concern. Once you have considered the factors in section (c) above, you need to consider the next steps.

- (a) Do you need to share this information with anyone e.g. Corporate Provider Team?
- (b) Does the immediate action taken adequately ensure the safety and welfare of the relevant person/people? If not, what other action may be required?
- (c) Do you or others need to begin any regulatory processes?

3. Strategy Meetings

The local authority should keep us informed of actions relating to safeguarding issues about regulated providers. We may be invited to a strategy meeting to discuss the incident(s) and where action will be agreed by the LA and others. It is for inspectors to exercise their professional judgement, seeking advice from your buddy or line manager as appropriate. Please consider that unless at this early stage we are planning to take some action, there should not be a need to attend a strategy meeting, however we do need to receive minutes and there should be a conversation with the LA about our level of involvement to ensure we are aware of all facts and evidence.

Appendix 9: Examples: Poor delivery of care, complaints and safeguarding

Examples of poor delivery of care

- Concerns raised by family member that V1 losing weight and the home not taking any action to improve. Alleged lost 4kg since admitted to home from hospital in April 2016.

People lose weight for many reasons it is not solely an indication that someone has been neglected. The reasons for the weight loss should be explored and the local authority will determine whether there was neglect involved and follow due process.

- Faxed referral received from (deleted) Ambulance Service. Concerns were raised by the crew who attended the person at the home as agency staff knew little about the service user. Also concerned medical treatment was delayed and person's care notes were not up to standard

These issues are about the provider's administration and management of someone's care, they do not indicate abuse/neglect.

- MT is currently nursed in bed and a very frail lady. During CQC Inspection it was observed that MT was being fed in her bed by a member of the domestic team and her feet were noted to be tightly squashed against the footboard of the bed. Mt requires pressure care due to potential breakdown on her feet due to ongoing /healing pressure ulcer

This is an example of poor oversight of care and the inspector also noted that the matter was dealt with at the time. A domestic member of staff helping someone to eat is not in itself an issue unless (and this has not been indicated) the individual required particular care when eating that only a trained member of staff would be able to provide.

Examples of complaints

- Standards of care for relative; not involved with BI decisions about care; care from bed as appropriate chair not available. Concerns regarding the quality care being provided to relative in care home.

There is no indication here of abuse but concern about the care package.

- Caller has a cousin in the care home who is a stroke victim a week ago her Medication was stopped, caller does not know why medication has been stopped. She is doubly incontinent

There is no indication here of abuse, there may be valid reasons for medication being stopped which would have been a clinical GP decision.

- Issues regarding staff training, staff shortages, staff not turning up for work and management of care agency

These are concerns about staffing and are a complaint about the provider, no indication that any issues have led to abuse or neglect

Examples of safeguarding issues

- Witnessed during CQC inspection ED being assisted with meal whilst remaining in a reclining position. ED had not been repositioned between 06:30 to 14:10. Ed had not been given food or drink until 13:25, staff stated that son usually comes to assist ED with their lunch

There is a risk of choking; neglect; not repositioning; reliant on relative to help with eating.

- Falsifying controlled drugs sheets, manual handling without training, not washing residents properly and lack of cleanliness.

Risks of inappropriate use of medication, potential for harm due to residents not receiving correct medication or dosage at the right time; Poor manual handling can result in serious injury; lack of personal care is neglect.

- Allegation by person using service that staff hit and tipped drink over them

Example of physical abuse by staff member.

Appendix 10: Clarification on statutory notifications of abuse

STATUTORY NOTIFICATIONS FOR INCIDENTS OR ALLEGATIONS OF ABUSE UNDER REGULATION 18 OF THE CARE QUALITY COMMISSION (REGISTRATION) REGULATIONS 2009

What is Regulation 18?

Regulation 18 puts registered persons under a statutory duty to notify the Commission without delay of certain specified incidents. Under 18(2)(e), registered persons must notify CQC without delay of any abuse or allegation of abuse in relation to a service user.

What falls within the definition of 'abuse' under Regulation 18?

Regulation 18(5) (b) of the Care Quality Commission (Registration) Regulations 2009 defines 'abuse' in relation to a service user as:

- (i) sexual abuse,
- (ii) physical or psychological ill-treatment,
- (iii) theft, misuse or misappropriation of money or property, or
- (iv) neglect and acts of omission which cause harm or place at risk of harm.

What is a statutory notification?

A statutory notification is one set out legislation. Registered persons are required by statute to notify CQC in certain specific situations and if they fail to do so, they will be committing a criminal offence.

When is a registered person under a duty to send us a statutory notification in relation to safeguarding and abuse?

If there is 'abuse' as defined above and the abuse occurred or is alleged to have occurred

- (i) whilst services are being provided in the carrying on of a regulated activity, or
- (ii) as a consequence of the carrying on of a regulated activity, the registered person must send CQC a statutory notification without delay.

How CQC interprets abuse under Regulation 18

If there is 'abuse' as defined above and the **abuse occurred or is alleged to have occurred**

- (i) whilst services are being provided in the carrying on of **that registered person's** regulated activity, or

- (ii) as a consequence of the carrying on of **that registered person's** regulated activity, the registered person must send CQC a statutory notification without delay.

How CQC interprets allegations of abuse under Regulation 18

CQC interprets this as abuse that has **allegedly occurred**

- (i) whilst services are being provided in the carrying on of **that registered person's** regulated activity, or
- (ii) as a consequence of the carrying on of **that registered person's** regulated activity

It does not mean where and when the allegation of abuse was made.

What happens if a registered person fails to send CQC a statutory notification when one is required?

That registered person will be committing a criminal offence.

So, if a registered person witnesses or is told about abuse occurring as part of someone else's regulated activities (a GP may ask a patient about bruising to their face to be told by that patient that they were assaulted by their dentist), is that registered person required to send us a statutory notification?

No because the alleged abuse has not occurred whilst that registered person is providing **his** regulated activities or as a consequence of **his** carrying on of regulated activities.

Doesn't that mean that lots of incidents of abuse are unlikely to reach CQC?

Just because a registered person is not required to make a statutory notification, it doesn't mean they are not under another duty to other relevant bodies to report that abuse.

What about incidents that are not a statutory notification?

There will be occasions where the test for a statutory notification is not met, but where nonetheless a registered provider of regulated activities has concerns about the quality, safety and service user experience in another regulated activity. In these situations providers would be expected to demonstrate what action they had taken including discussing with colleagues, discussing with commissioners and using the safeguarding alerts and concerns processes to alert the CQC if concerns persist or they are concerned that no action is being taken.

Appendix 11: How we should deal with Safeguarding Adults Reviews and Serious Case Reviews

Purpose

This section sets out the policy and background of Safeguarding Adults Reviews (SARs) and Serious Case Reviews for children (SCRs). It explains how SARs/SCRs should be dealt with by CQC.

Introduction

We recognise that we have a role to play in SARs/SCRs and the learning that comes from them when they relate to a service we regulate. The policy context and statutory bases for SARs and SCR are different.

What is a Safeguarding Adults Review/Serious Case Review?

A SAR/SCR is used where an adult or child at risk has died or where they have suffered significant injury or harm. The aim of the SAR/SCR is to openly and critically examine each agency's involvement in the case and to establish whether there are lessons to be learnt. Reviews also consider how local professionals and agencies work together to safeguard adults and children at risk. They are also used to inform and improve local safeguarding children and adults practice, as well as to review the effectiveness of agencies' safeguarding policies and protocols. SARs/SCRs produce an overview report with recommendations for future action.

What SARs/SCRs are not

SARs/SCRs are not used to investigate forensically how someone may have died or suffered significant harm, or the criminality aspects – coroners and the justice system are responsible for that. Neither are they used to apportion blame.

When should a SAR be undertaken?

Under the Care Act 2014²⁴ a Safeguarding Adult Board (SAB) **must** undertake a SAR when there is reasonable cause for concern about how the SAB, its members or other bodies with relevant functions worked together to safeguard the adult in its area with needs for care and support **and**

- (i) the adult died and the SAB knows or suspects the death resulted from abuse or neglect; or
- (ii) the adult is alive and the SAB knows or suspects the adult experienced significant abuse or neglect

SABs **may** undertake a SAR for any other case involving an adult in its area.

²⁴ S44 Care Act 2014

In both of the above circumstances, it does not matter whether or not the local authority was meeting the adult's care and support needs, the key factor is that the adult had those needs.

When should a SCR be undertaken? (Changes to LSCB's and SCR's are underway with the result that this information will be updated)

Local Safeguarding Children's Boards (LSCBs) **must** always undertake a SCR and advise the local authority and Board partners of lessons to be learned when:

- (i) abuse or neglect of a child is known or suspected **and**
- (ii) either -
 - a. the child has died; **or**
 - b. the child has been seriously harmed and there is cause for concern about how the authority, LSCB partners or other relevant persons have worked together to safeguard the child

A SCR **should** always be carried out when a child dies in certain circumstances:

- (i) in police custody
- (ii) on remand or following sentencing
- (iii) in a Young Offender institution
- (iv) in a secure training centre or secure children's home
- (v) where the child is detained under the Mental Health Act 2005

A SCR **may** be carried out where a case does not meet the above criteria, or where the LSCB wishes to review where good practice occurred and it could be shared and embedded.

What is our role in SARs and SCRs?

The Safeguarding Adults Board or Local Safeguarding Children's Board will decide when to undertake a Review. They will establish a Review Panel which is generally made up of members from the SAB/LSCB. They will then agree the terms of reference for the review with clear timescales.

Although we have no formal role on safeguarding Boards – and would therefore not sit on the review panel – we may have a role to play in two circumstances:

- (i) co-operating with the Review by contributing knowledge, intelligence and information²⁵
- (ii) when we are asked to be involved in a Review (for example, we may be involved where an adult or child using a service we regulate experiences abuse)

²⁵ S45(1) Care Act 2014

Learning lessons from SCRs and SARs

It is vital that lessons are learned from SCRs and SARs and then applied by the relevant agency or agencies involved. The respective safeguarding board will appoint an independent chair to oversee the Review, this person may also author the Review Overview report; in some cases an independent author may also be appointed. The Chair and author lead the Review and determine input from each agency- this may include asking agencies to complete an Individual Management Review (IMR).

The Chairs are independent of the SAB or SCB and their overview report should be independent and evidence clear findings and recommendations. The Review report will be based upon a collation of evidence from each of the IMRs submitted and there will be a chronology of actions taken by each agency, all brought together in one place.

How CQC learns and communicates lessons from SCRs and SARs

The Safeguarding Committee has operational and oversight responsibility for the commissioning, review and approval of IMRs provided by CQC and draft SAR reports where our previous involvement makes this necessary. The National Advisors Safeguarding will work closely with inspectors, managers and teams to provide support and expert guidance to ensure that the process is delivered in line with the agreed governance process. As well as assuring the quality of our contribution, the process of review by the Safeguarding Committee will ensure that CQC is able to identify recurring themes or actions that may apply more widely.

Appendix 12: Modern Slavery and Human Trafficking

Modern Slavery is the term used within the UK and is defined within the Modern Slavery Act 2015. The Act categorises offences of Slavery, Servitude and Forced or Compulsory Labour and Human Trafficking.

These crimes include holding a person in a position of slavery, servitude forced or compulsory labour, or facilitating their travel with the intention of exploiting them soon after.

Although human trafficking often involves an international cross-border element, it is also possible to be a victim of modern slavery within the United Kingdom. For example, a care home was found to be used to traffic women into the UK. The women were working long hours in poor conditions, had no identity documents and were being exploited.

It is possible to be a victim even if consent has been given to be moved.

Children cannot give consent to being exploited therefore the element of coercion or deception does not need to be present to prove an offence.

[Modern Slavery Human Trafficking Unit \(MSHTU\)](#) plays a central role in leading the National Crime Agency's fight against serious and organised crime.

Types of Human trafficking

There are several broad categories of exploitation linked to human trafficking, including:

- Sexual exploitation
- Forced labour
- Domestic servitude
- Organ harvesting
- Child related crimes such as child sexual exploitation, forced begging, illegal drug cultivation, organised theft, related benefit frauds etc
- Forced marriage and illegal adoption (if other constituent elements are present)

Find out more about the different [types of exploitation](#) by cutting and pasting the link into your Internet browser.

Identifying victims

Some of the vulnerable groups most frequently targeted by traffickers:

- People from impoverished and low income households or with debts
- Women and children
- Ethnic minorities, indigenous people, hill tribes, refugees and illegal migrants

- People with low levels of education or learning disabilities
- Young people running away from home or care
- People with substance misuse issues
- People with mental health problems

Report crimes of modern slavery

In the first instance the point of contact for all modern slavery crimes should be the local police force.

If you hold information that could lead to the identification, discovery and recovery of victims in the UK, you can contact the Modern Slavery Helpline 08000 121 700.

For more information visit www.unseenuk.org

References and links to further guidance

Children

[Safeguarding children and young people from sexual exploitation](#)

[Safeguarding children who may have been trafficked](#)

[Forced marriage](#)

[Safeguarding children from abuse linked to faith or belief](#)

[Safeguarding children from female genital mutilation](#)

[Radicalisation - Prevent Strategy](#)

[Radicalisation - Channel guidance](#)

Guidance from external sources

[Meeting the needs of young people with learning disabilities who experience or are at risk of sexual exploitation](#) Barnardo's and Comic Relief (2015)

Adults

[RCGP safeguarding adults at risk of harm toolkit](#)

[Violence and aggression - short term management in mental health and community health settings](#) NICE (May 2015)

[Skills for Care Safeguarding care certificate workbook](#) – identifying signs of abuse and neglect, (pp4-6)

[Multi-agency Statutory Guidance on Female Genital Mutilation](#)

This multi-agency guidance on female genital mutilation (FGM) should be read and followed by all persons and bodies who are under statutory duties to safeguard and promote the welfare of children and vulnerable adults. It replaces [female genital mutilation: guidelines to protect children and women \(2014\)](#)

[Home Office Dept Education Guidance Mandatory Reporting of Female Genital Mutilation](#)

This guidance concerns the mandatory reporting duty for FGM. It requires regulated health and social care professionals and teachers to report known cases of FGM in under 18-year-olds to the police. The FGM duty came into force on 31 October 2015.

Controlling or Coercive Behaviour in an Intimate or Family Relationship:
[Home Office Guidance](#)

SCIE: Adult safeguarding [here](#)

ADASS: Directors of Adult Social Services [here](#)

Disclosure and Barring Service [here](#)

Mental Capacity Act 2005 [here](#)

Multi-agency Public Protection Arrangements (MAPPA) guidance [here](#)

Home Office: Strategy to end Violence to Women and Girls 2016-2020 [here](#)