Humber Teaching
NHS Foundation Trust

SAFEGUARDING ADULTS POLICY AND PROCEDURES (N-024)

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1. INTRODUCTION

This latest revision of the policy builds on the Care Act 2014, other changes in legislation and government statutory guidance. It also takes into account learning from best practice and embodies the Making Safeguarding Personal approach. Humber Teaching NHS Foundation Trust recognises its responsibility to prevent the abuse of adults at risk. All employees have a duty of care to safeguard those in their care. Safeguarding is everybody's business; with professionals, citizens and communities playing their part in preventing, detecting and reporting neglect and abuse. Safeguarding adults at risk is a fundamental part of patient safety and wellbeing and an expected outcome of the NHS. Healthcare professionals have a key role in safeguarding adults, firstly in the identification of abuse, harm and neglect, and secondly responding appropriately to it. Safeguarding adults is integral to complying with legislation, regulations and delivering effective safe care.

From April 2015 the Care Quality Commission (CQC) guidance Essential Standards of Quality and Safety and the 28 outcomes that it contains were replaced in its entirety with "Raising Standards putting people First" Strategy 2013-2016 which asks:

- Are we safe?
- Are we caring?
- Are we effective?
- Are we well led?
- Are we responsive to individual needs?

These measures were introduced as part of the government's response to the Francis Inquiry's recommendations and are intended to help improve the quality of care and transparency of providers by insuring that those responsible for poor care can be held to account.

The CQC published 13 fundamental standards, although the entire standards are relevant the most appropriate ones in respect of this policy include:

- Service users must be treated with dignity and respect at all times
- Person Centred Care
- Service users must not be given unsafe care or treatment
- Service users must not suffer any form of abuse or improper treatment
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2. SCOPE

This policy applies to all employees of the Trust, including any agency staff, students, trainees, volunteers, clinical attachments, apprentices, seconded staff and all other staff on placement within the Trust.

The policy compliments the Kingston upon Hull and East Riding of Yorkshire Multi-agency Policy, Procedures and Practice Guidelines (2018) for the protection of adults and the North Yorkshire Joint Multi Agency Safeguarding Adults Policy and Procedure 2018

3. POLICY STATEMENT

Safeguarding adults from harm is a core duty of Humber Teaching NHS Foundation Trust. This document provides staff guidance to ensure that the principles of safeguarding adults are embedded in all aspects of the Trust practice.

The Trust recognises that:

- Staff have an obligation to work in partnership to protect adults at risk of abuse
- Adults can be at risk of abuse and neglect whilst in our care

- The abuse of adults constitutes a clear infringement of human and civil rights and in many cases may be a criminal offence

All staff have a duty to empower our service users and to protect them. Our service users should be in control of their care and their consent is needed for decisions and actions designed to protect them. There must be clear justification where action is taken without consent, such as lack of capacity or other legal or public protection.

The Trust's Humber Safeguarding Team will provide support and advice to staff involved in issues relating to safeguarding adults (Appendix 1). Where staff experience significant and lasting distress, it may be appropriate to encourage them to access support as outlined in the Trust's policy on supporting employees involved in traumatic and/or stressful incidents, complaints or claims.

Concerns raised to the relevant Local Authority Safeguarding Adults Team will be made using the approved documentation (access to copies of relevant forms can be found on the Trust Intranet site).

4. DUTIES AND RESPONSIBILITIES

Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework (NHS England 2015) sets out clearly the safeguarding roles, duties and responsibilities of all organisations in the NHS. The Care Act 2014 is the legislation that gives duties to all organisations including the NHS. Safeguarding adults at risk is core business for the organisation. All staff have responsibilities to safeguard those in our care.

4.1. Director of Nursing, Allied Health and Social Care Professionals

The director of nursing allied health and social care professionals is accountable and responsible for ensuring that the Trust's contribution to safeguarding adults is discharged effectively.

4.2. Trust Board and Directors

The board and directors are responsible for the discharging of duties in relation to safeguarding of adults in the Trust. The board is responsible for reviewing and maintaining an effective system of internal control, including systems and resources for managing all types of risks associated with safeguarding adults.

4.3. Executive Director Lead

The executive director lead for safeguarding adults is the director of nursing, allied health and social care professionals and is responsible, along with the chief executive, for ensuring that the Trust discharges its duties in relation to safeguarding adults.

4.4. Humber Safeguarding Team (Internal)

- Has the responsibility to ensure that the safeguarding adults policy is in harmony with local, regional and national guidance
- To ensure staff have access to professional support and guidance when dealing with safeguarding issues or concerns
- To work with Trust staff to help them achieve their competencies to work with adults in a safe way
- To ensure staff and service users have access to information to support their decision-making processes
- To offer debriefing and supervision to staff and staff groups
- To work in partnership with the Local Authority Safeguarding Adults Teams (External) and Boards

- To provide training in relation to safeguarding adults, Prevent and Mental Capacity Act in line with the Intercollegiate Document 2018
- To develop and implement a strategic safeguarding adults audit plan

4.5. Clinician/Practitioner

The clinician/practitioner is responsible for considering adults at risk in the assessment process and to make appropriate referrals when safeguarding concerns are identified.

4.6. Charge Nurses/Team Leaders

Charge nurses and team leaders will ensure that this policy is readily accessible and that all the staff they manage are familiar with the contents and their responsibilities. They will ensure that staff are released to undertake statutory safeguarding training.

4.7. All Staff

Staff are required to be familiar with this policy and to comply with it at all times. Safeguarding adults is everybody's responsibility. Staff have a responsibility to raise a safeguarding concern when they are suspected or identified. Staff should ensure they attend statutory training.

5. AIMS

The aims of adult safeguarding are:

- Stop abuse and neglect wherever possible
- Prevent harm and reduce the risk of abuse or neglect to adults with supports and care needs
- Safeguard adults in a way that supports them in making choices and having control about how they want to live
- Promote an approach that concentrates on improving life for adults concerned
- Raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect
- Provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or wellbeing of an adult
- Address what has caused the abuse or neglect

(Care Act 2015 14.11)

6. CONTEXT

6.1. The Care Act 2014

The Care Act 2014 applies to adults (aged 18 and over) who:

- have 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.

(Care Act 2015, 14.2)

Other legislation remains valid with regards safeguarding adults; including the Human Rights Act (1998), Equality Act (2010), Mental Health Act (1983, amended 2007), Mental Capacity Act (2005) Safeguarding Vulnerable Groups Act (2012). In April 2021 the Domestic Abuse Act gained royal

accent, there are key changes to the legislation including a new statutory definition of domestic abuse and support for victims, for further guidance please see the Domestic Abuse policy.

The CQC guidance in Identifying and responding to Closed Cultures is embedded throughout the Trust safeguarding processes, noting how to identify, recognise and manage concerns within settings.
https://www.cqc.org.uk/sites/default/files/20200623_closedcultures_guidance.pdf

Kingston upon Hull, East Riding of Yorkshire and North Yorkshire local authorities have statutory duties regarding safeguarding of adults and remain the lead agency with regard safeguarding adults. The Trust's policy will work in accordance and in collaboration with these local authority teams. An Easy Read version of the Care Act is also available at
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/365345/Making_Sure_the_Care_Act_Works_EASY_READ.pdf

The full Care Act guidance is available at
https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

The Care Act statutory safeguarding guidance, chapter 14 issued by the Department of Health, can be accessed via this link to Hull Safeguarding Board website at
http://safeguardingadultshull.com/articles/Care_Act_documents/35

The Multi-Agency Policy, Procedures and Practice Guidelines for the Protection of Adults in Hull and the East Riding (2015) document outlines the process and principles that underpin the protection of adults at risk. This policy is consistent with the multi-agency document and supports the principles embedded in the procedures and practice guidance sections.

The following six principles (Care Act 2015 14.13) apply to all sectors and settings including care and support services and underpin all adult safeguarding work:

Empowerment – People being supported and encouraged to make their own decisions and informed consent.	"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens"
Prevention – It is better to take action before harm occurs.	"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help"
Proportionality – The least intrusive response appropriate to the risk presented.	"I am sure that the professionals will work in my interest, and I see them and they will only get involved as much as needed"
Protection – Support and representation for those in greatest need.	"I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want"
Partnership – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.	"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to help get the best results for me"
Accountability – Accountability and transparency in delivering safeguarding.	"I understand the role of everyone involved in my life and so do they".

6.2. Mental Capacity Act 2005/ Deprivation of Liberty Safeguards

This section sets out the work that should be under taken and must be considered throughout adult safeguarding concerns

The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who lack capacity to make decisions for themselves; and establishes a framework for making decisions on their behalf, The Mental Capacity Act outlines five statutory principles that underpin the work with adults who lack mental capacity:

- A person must be assumed to have capacity unless it is established that he/she lacks capacity;
- A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success;
- A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision;
- An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his/her best interests;
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Where a person has capacity any care and treatment will require their consent. For people who have an impairment or disturbance of the mind that impacts on their ability to exercise their capacity and to make their own decisions, the MCA (2005) requires that practitioners consider and make all reasonable adjustments that would allow the person to make their own decisions.
Please refer to the Trust Mental Capacity and Best Interests Policy which is available on the intranet.

The DoLS provides a legal framework for hospitals and care homes to lawfully deprive patients or residents in their care of their liberty; DoLS consideration in assessing whether an incapacitated person is deprived of their liberty focuses on:

- Is the patient under constant supervision and control?
- Is the patient not free to leave?
- What is their objective situation overall?
- Please refer to the Trust's Mental Capacity 2005 and DoLS Policy via this link.

Mental Capacity (Amendment Act) 2019 Liberty protection Safeguards

At the time of writing this policy, the above legalisation had not been implemented into practice. The Liberty Protection Safeguards (LPS) is expected to come into force in April 2022. The amendments establishes a new process for authorising arrangements enabling the care and treatment of people, to which the person lacks capacity to consent and which give rise to a deprivation of liberty within the Article 5(1) of the European Convention on Human Rights (ECRC).

6.3. Think Family

The 'Think Family' strategy aims to improve outcomes for children, young people and families with additional needs by coordinating the services they receive from the local authority and its partner agencies. The strategy specifically refers to parents with a mental health difficulty and parents with a long-standing limiting illness, disability or infirmity. Working Together to Safeguard Children (2018) makes specific reference to professionals being particularly alert to the potential need for early help and intervention for a child who is living in a family where there is substance misuse, adult mental health problems and domestic violence.
Both Think Family and Working Together (2018) recognise the need for agencies to share information in order to safeguard children and young people and this requirement is made more explicit in the recently published 'Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers' (2018). The Care Act 2014

again refers explicitly to the need for appropriate and timely information sharing when undertaking assessments and developing plans which consider the needs of the whole family. Indeed the practice guidance; The Care Act and Whole Family Approaches 2015 identifies that all practitioners need to Think Family and Get the Whole Picture, if they are to make the whole family approach "a reality".

6.4. Multi-Agency Public Protection Arrangements

Multi-Agency Public Protection Arrangements (MAPPA) are the statutory arrangements for managing sexual and violent offenders. Responsible Authorities (including Police, National Probation Service and Prisons) have a duty to ensure that the risks posed by these offenders are assessed and managed appropriately (see Appendix 5).

www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2

7. DEFINITIONS

The following are categories of harm as outlined in the Care Act 2014.Staff should be mindful that there are many different forms of abuse, staff are therefore advised that discretion is required when deciding what action is taken to safeguard an 'Adult at Risk'. The following are taken from the Ann Craft Trust, which can be accessed via:

https://www.anncrafttrust.org/resources/types-of-harm/

1. **Organisational** –This includes neglect and poor care within an organisation or specific care setting, such as a hospital or care setting, or in relation to care provided in one's own home. Organisational abuse can range from one off incidents to ongoing ill treatment. It can be through neglect or poor professional practice as a result of structure, policies, processes and practices within an organisation.
2. **Discriminatory** – Discrimination is abuse that centres on a difference or perceived difference, particularly with respect to race, gender, disability, or any of the protected characteristics of the Equality Act.
3. **Sexual** – This includes 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.
4. **Financial or Material** – This includes theft, fraud, internet scamming, and coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions. It can also include the misuse or misappropriation of property, possessions, or benefits.
5. **Physical** – including hitting, slapping, pushing, kicking, misuse of medication, misuse of restraint, or inappropriate sanctions.
6. **Emotional or Psychological** – This includes threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation, or withdrawal from services or supportive networks.
7. **Neglect or acts of omission** – including acts of omission**,** commission, discharging too early, ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, food, drink and heating.
8. **Self-Neglect** – This covers a wide range of behaviour, but it can be broadly defined as neglecting to care for one's personal hygiene, health, or surroundings. An example of self-neglect is behaviour such as hoarding.
9. **Modern Slavery** – This includes slavery, human trafficking, and 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.
10. **Domestic Violence** – Any incident or pattern of incidents of controlling, coercive, threatening

behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexual orientation. The abuse can encompass, but is not limited to: psychological, physical, sexual, economic and emotional forms of abuse (Domestic Abuse Act 2021)

11. Other types of harm that are also relevant to safeguarding adults:

7.1. Prevent

The Trust, as with all other NHS bodies, has a statutory duty to ensure that it makes arrangements to protect, safeguard and promote the welfare of children, young people and adults at risk and support the Home Office Counter Terrorism strategy CONTEST.

This includes a specific focus on Prevent (preventing violent extremism / radicalisation). Throughout this document, safeguarding children, young people and adults at risk includes those vulnerable to violent extremism/ radicalisation. The key legislative framework includes: The Counter Terrorism Act 2015, The Children Act 1989 (2004), Working Together to Safeguard Children (2015), No Secrets (2000), The Crime and Disorder Act (1998), Health and Social Care Act (2008) and the Care Act (2014).

The Trust has a policy specific to Prevent which is reinforced through training with all clinical staff.

7.2. Female Genital Mutilation

Female Genital Mutilation (FGM) is a collective term for procedures, which include the removal of part or all of the external female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterization for cultural or other non-therapeutic reasons.

FGM is illegal in the United Kingdom, even if someone is taken overseas to undergo FGM it is still a crime in the UK if it has been done by a UK national or on a UK national. Failure to protect a girl from FGM can also result in prosecution.

The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life. The procedure is typically performed on girls aged between 4 and 13, but in some cases, it is performed on new-born infants or on young women before marriage or pregnancy (see Appendix 3). Trust staff are required to complete a Datix when any adult discloses that they have had the procedure carried out. The safeguarding children policy should be referred to when there are FGM concerns relating to a child.

8. PROCEDURES

Safeguarding individuals at risk covers a wide spectrum of activity from prevention through to joint multi-agency responses where neglect, harm and abuse occur. The Trust's workforce is uniquely placed to identify any potential safeguarding risk and/or concern. The Trust does not tolerate neglect and/or poor professional practice. Poor practice or neglect may take the form of isolated incidents of inadequate or unsatisfactory professional practice through to pervasive ill treatment or gross misconduct.

Repeated instances of poor care may be an indication of more serious problems (institutional abuse).

- Be aware and receptive to signs of harm, neglect and abuse. Look beyond first impressions
- Help service-users express what is happening to them. Recognise patterns of concern
- Help service-users to voice what they want to happen
- You have a duty to report any concerns about care provided by other individuals and/or agencies external to the Trust

A stepped approach will be used to respond to a concern to safeguard an individual at risk (Appendix 2). There are key stages in responding to safeguarding related issues. There must be a clear audit trail of all discussions held, decisions made and actions taken, especially when making a reasoned decision about whether to refer through multi-agency procedures or not.

One of the hardest decisions for staff is whether to raise a concern. There is a real danger of staff tolerance growing with continued exposure to seemingly minor issues.

This can lead to complacency and a potential acceptance of behaviour that would not be tolerated in other settings. It can result in incidents not being placed into the multi-agency context when this would be the expected course of action. Therefore, it is important to record all incidents and monitor trends so that repeated or targeted incidents are identified and that **referrals are made when abuse occurs or is alleged**.

8.1. Action to be taken if someone Reports and/or Discloses Abuse of a Person with Care and Support Needs

All staff have a responsibility to report all concerns regarding any form of abuse or suspected abuse. This is not isolated to the care and support delivered by individuals or your teams within the Trust, it is far broader. Staff must consider the holistic care or support the individual(s) at risk receives. This might involve another organisation or a member of the public or family.

The local authority safeguarding team will take all concerns seriously. They will as far as possible try to protect staff anonymity. It does not matter if the allegation is in doubt or proven to be wrong, because safeguarding an individual at risk is your priority.

8.2. Immediate Action

On occurrence of an incident of alleged abuse staff will follow the stepped approach to ensuring the persons immediate safety and medical welfare (Appendix 2).

Staff must inform their manager or designated person (unless they are the alleged abuser – if this is the case then support should be sought directly from another manager (out of hours – contact the on-call manager), your teams safeguarding link person and/or the Humber safeguarding adults team (Monday-Friday office hours – HNF-TR.SafeguardingHumber@nhs.net) for advice (Appendix 1).

The manager or the designated person will make a decision whether to use the safeguarding referral route or an alternative route. If they are in any doubt, they should refer through the safeguarding route. There must be a clear documented audit trail of all discussions, decisions made and actions taken. All safeguarding decisions must be recorded on the safeguarding tab within the Lorenzo system, any safeguarding concern made to the local authority must be followed up with a Datix with the form or reference number attached.

8.3. Historical Disclosures

If a person discloses historical abuse and is agreeable to sharing this information including the potential perpetrator, gain their clear consent and report this directly to the appropriate local authority safeguarding team. Ensure all information is clearly documented within the safeguarding tab.

There may be times where a person will not want to disclose historical concerns initially; however this may be explored through therapeutic intervention.

If the person does not consent to sharing their disclosure wider to allow for investigation but they have given a potential perpetrators name, you can share the perpetrators name **ONLY** with the Protection of Vulnerable People Unit (PVPU) on 101.

If there is a wider concern that the person who has been alleged to have caused harm to that person, is in contact with other adults at risk, children or young people, or works in a position of trust, the information MUST be reported to the Local Authority Safeguarding Team or via the Police on 101 as a matter of public interest.

In all cases inform the Trust safeguarding team.

8.4. Decision to Raise a Concern with the Local Authority

The decision to raise a concern is a key step in the safeguarding referral process (Appendix 3).

When considering if a safeguarding concern needs to be completed, staff must consider Section 42 (1) Care Act 2014, three duties:

a) does the person have needs for care and support (whether or not the authority is meeting any of those needs)
b) are they experiencing, or at risk of, abuse or neglect, and
c) as a result of those needs are they unable to protect himself or herself against the abuse or neglect or the risk of it.

Staff need to document their decision making process, if they require support or advice they should contact the Local Authority Safeguarding Adults team or internally the Humber Safeguarding team for additional guidance.

It is possible to manage some potential safeguarding concerns internally. The key is robust documented evidencing of all discussion, decisions made and action taken. There must be evidence that a safeguarding adult's referral has been considered and a clear rationale to the decision not to refer.

For example:

- One-off disagreements between two service users, where neither vulnerable adult was harmed or is considered to be particularly vulnerable to the other
- Staff believe the incident is a one off, isolated minor incident where no harm has been caused
- The incident involves actions such as shouting at each other, but where there is deemed to be an equal power relationship

It is extremely important in all situations to recognise that the victim might consider the behaviour or action to be a form of abuse. There must be clear concise evidence that safeguarding was considered.

When using your professional judgement to determine whether an incident is reported to the local authority safeguarding adults team/ Police, you may find it useful to consider the following:

- The consequences to the alleged victim and the equality of the relationship between the alleged perpetrator and the alleged victim
- The ability of the alleged victim to consent
- The mental capacity of the alleged perpetrator to understand the consequences of their decision to act in the way that is alleged
- The intent of the alleged perpetrator
- The frequency of this and similar allegations regarding the alleged perpetrator
- Please see Appendix 6 Patient on Patient Guidance

You **must** refer if:

- The alleged victim considers the actions against them to be abusive
- The alleged victim or carer is distressed, fearful or feels intimidated by the incident
- You believe that there is a deliberate attempt to cause harm or distress
- Incidents are repetitive and targeted to either the adult or others
- The action resulted in a physical injury
- A crime has been committed
- The incident involves a member of staff

This list is by no means exhaustive – in any situation where you feel abuse has occurred, a referral must be submitted to the relevant local authority safeguarding adults team.

In the decision-making process, you must evidence the following:

- Why does this adult(s) need safeguarding – what are the risks?
- What actions need to be taken to reduce that risk?
- Do they consent to this action?
- Are others potentially at risk?

All adults identified at risk of abuse will be listened to and taken seriously in an appropriate manner. Adults have a right to privacy, to be treated with dignity and respect. Adults have the right to lead their own lives and have their rights upheld, regardless of ethnic origins, gender, sexuality, disability, age, religious or cultural background and beliefs.

8.5. Making Safeguarding Personal (MSP)

MSP is a national approach to promote responses to safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is seeing the person as experts in their own life and working with them to identify the outcomes they want, the aim to enable them and support recovery. MSP emphasises the importance of person centred approach, adopting the principle ‘no decision without me’.

Making Safeguarding Personal

8.6. Gaining Consent

When a decision has been made to complete a concern to the local authority staff must gain informed consent from the adult at risk (informed consent applies when a person can be said to have given consent based on a clear appreciation and understanding of the facts, and the implications and consequences of an action).

Staff will assume a person has capacity unless proven otherwise (section 7 – Mental Capacity Act 2005). Adults with capacity have a right to make their own choices irrespective of how unwise their decision is.

If an individual with capacity makes an unwise decision, there will be clear documented evidence of the advice and any recommendations made or actions taken to reduce future risk(s).

8.6.1. What if they do not/ cannot consent

Some service-users are unable to complain about abuse or consent to raise a concern to the local authority safeguarding adult team.
You will always ask the person their preferred course of action. There are occasions when staff can override a person’s wishes:

- Public protection concerns (other people are at risk)
- Best interest decisions – no mental capacity to make an informed decision

If the decision is to act without the adult's consent, then unless it is unsafe to do so, the adult should be informed that this is being done and why. Where staff have made the decision to share the information staff must ensure that all decision making is evidenced within the safeguarding tab.

Further information can be found in the Social Care Institute for Excellence adult safeguarding.

[Safeguarding adults: sharing information | SCIE]

8.7. Completing a Concern

If there is any doubt, complete a concern and submit to the relevant local authority safeguarding adult team.

The referral process is simple (Appendix 3):

- The full detail of the safeguarding incident is to be recorded on the concern form. You must ensure that the detail is comprehensive and it reflects the actual incident and/or allegation. Any discussion, decisions made or any actions taken to protect the individual must be documented. Send a copy of the completed concern to the relevant local authority safeguarding adult Team (Appendix 1)
- Complete a Datix. Attach a copy of the concern form and send to the Trust's risk management team.

Copies of these documents are to be kept/filed (paper) and/or scanned (electronic) in the safeguarding tab/confidential section of the service-user record.

8.7.1. Recording in service-user record

If the incident is service-user sensitive before investigation, then document that there is a safeguarding concern or an allegation has been made in the relevant section of records. Document that a concern has been completed and submitted to the relevant local authority safeguarding adult team and a Datix has been completed and submitted to the Trust's risk management team.

If staff contact the internal Humber Safeguarding Team, a log of the discussion will be held in the safeguarding database, a safeguarding practitioner will send the member of staff a copy of the discussion to add to the person's record.

8.8. Information Sharing

As part of inter-agency working, agreement on the sharing of information is required. There are a number of key points relating to the importance both of confidentiality and of disclosing confidential information when necessary to support a safeguarding or criminal investigation. This is also reiterated in the Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (NHS England) and the Care Act 2014.

- Information must be shared on a "need to know" basis, and only when it is in the 'best interest' of the vulnerable adult
- Confidentiality should not be confused with secrecy
- Informed consent should be obtained but, if this is not possible and other vulnerable adults are at risk, it might be necessary to override this requirement
- Principles of confidentiality designed to safeguard and promote the interests of service users should not be confused with those designed to protect the management interests of an organisation.

Staff in handling and disclosing personal information must adhere to the seven principles of sharing

information.

1. **Necessary and proportionate** to the need and level of risk.
2. **Relevant** – only information that is relevant to the purposes should be shared with those who need it.
3. **Adequate** – information should be adequate for its purpose. Information should be of the right quality to ensure that it can be understood and relied upon.
4. **Accurate** – information should be accurate and up to date and should clearly distinguish between fact and opinion. If the information is historical then this should be explained.
5. **Timely** – information should be shared in a timely fashion to reduce the risk of missed opportunities to offer support and protection.
6. **Secure** – wherever possible, information should be shared in an appropriate, secure way. Practitioners must always follow their organisation's policy on security for handling personal information.
7. **Record** – information sharing decisions should be recorded, whether or not the decision is taken to share. If the decision is to share, reasons should be cited including what information has been shared and with whom, in line with organisational procedures. If the decision is not to share, it is good practice to record the reasons for this decision and discuss them with the requester.

For the sharing of information with the police when professionals have concerns, a partnership information form (PIF) should be used. These are available on the Trust intranet.

For further guidance:

- General Protocol for Sharing Information between Agencies, Information Governance Policy
- Access to Health Records Policy

Alternatively, contact the Trust's Caldicott and Data Protection Officer.

8.8.1. Out of Hours

Please contact the on-call director by telephoning 01482 223191.

8.8.2. Police requests for information

Please refer to the Standard Operating Procedure Sharing Personal Data with the Police.

8.9. If a Safeguarding Concern is not agreed

The local authority safeguarding adult team will take all concerns seriously. In some incidents, they may decide not to investigate. The local authority safeguarding adult team will feed back to the referrer the reason and rationale why they have come to this decision. Even in these circumstances, staff must ensure the continual safety of those in our care and protection.

To ensure the continual safety of those individuals at risk staff can take pathway options and/or actions.

- Evaluate existing assessments, care plans and risk tools. Ensure that there is clear documented evidence that this has occurred
- If the existing assessments, care plans or risk tools do not cover the current risk(s) staff must implement new ones to ensure measures have been put in place to reduce future risk
- Staff can consider other referral options (this list is not exhaustive):
    - Care Quality Commission (CQC)
    - Internal within Humber Teaching NHS Foundation Trust – human resources

(capability/disciplinary routes), health and safety, risk management, complaints, Humber Safeguarding Team etc.
- Local authority care management – request review of current care plan, request for a case conference
- NHS continuing care team – request a review
- Local authority health and safety enforcement office – environmental issue or equipment concerns in private and independent residential care homes
- Local Authority Business Unit where are there are concerns about the quality of care with private/independent care providers (domiciliary care or residential)
- Request for a best interest meeting
- Freedom to speak up procedure
- Consider the VARM (Vulnerable Risk Management process East Riding and Hull Safeguarding Adult Board) or the MASM (Multi Agency Self Neglect Meeting – North Yorkshire Safeguarding Adults Board).

https://safeguardingadults.co.uk/Resources/multi-agency-self-neglect-meeting-masm-proforma/

Internal Action

- Complete a Datix form – ensure that the rationale and all discussions held are recorded. This must include the reason why a safeguarding concern was not made. Forward the Datix to the risk management team and ensure that the safeguarding box is ticked.
- Ensure that you have documented your discussion and rationale in the service-user care record on the safeguarding tab.

9. EQUALITY AND DIVERSITY

This policy will reflect anti-discriminatory practice. Any services, interventions or actions must take into account any needs arising from race, gender, age, religion, belief, communications, sensory impairment disability and sexuality. An Equality and Diversity Impact Assessment has been carried out using the Trust-approved EIA. No adverse impact was identified and therefore a full EDIA was not deemed necessary.

10. MENTAL CAPACITY

All staff will ensure that the statutory requirements of the Mental Capacity Act 2005 will be addressed at all times.

1. Assume a person has capacity unless proved otherwise.
2. Do not treat people as incapable of making a decision unless you have tried all practicable steps to help them.
3. Do not treat someone as incapable of making a decision because their decision may seem unwise.
4. When doing things or, taking decisions for people without capacity it must be in their best interests.
5. Before doing something to someone or making a decision on their behalf, consider whether you could achieve the outcome in a less restrictive way.

11. BRIBERY ACT

The Bribery Act 2010 makes it a criminal offence to bribe or be bribed by another person by offering or requesting a financial or other advantage as a reward or incentive to perform a relevant function or activity improperly performed.

The penalties for any breaches of the Act are potentially severe. There is no upper limit on the level of fines that can be imposed and an individual convicted of an offence can face a prison sentence of up to ten years.

For further information see www.gov.uk/government/publications/bribery-act-2010-guidance.

If you require assistance in determining the implications of the Bribery Act please contact the Trust Secretary on 01482 389194 or the Local Counter Fraud Specialist on telephone 0191 441 5936 or email counterfraud@audit-one.co.uk

The Bribery Act applies to this policy.

12. STAFF TRAINING

Safeguarding adult training is mandatory within the Trust. All staff are responsible for their own practice. This includes attendance at appropriate training.

Dependent on 'individual's roles and responsibilities, the level and type of training will vary.

Level 1: The minimum level of competence required of all staff working in the Trust over a three year period. Staff at this level should receive a refresher training equivalent to a minimum of two hours.

A mandatory session of at least 30 minutes duration is included in the general staff induction programme. Level one safeguarding adult training is available online.

Level 2: All staff that have regular contact with patients, their families or carers, or the public, this includes administrators for safeguarding teams. This is the minimum level of competence for all professionally qualified staff. Over a three-year period, professionals at level 2 should receive refresher training equivalent to a minimum of three to four hours.

Training at level 2 will include the training required at level 1 and will negate the need to undertake refresher training at level 1 in addition to level 2. Level two safeguarding adult training is available online.

Level 3: All staff who regularly contribute to supporting adults at risk of harm or abuse and/or their families/carers. Training at level 3 will include the training required at level 1 and 2 and will negate the need to undertake refresher training at levels 1 and 2 in addition to level 3.

Over a three-year period, professionals at level 3 should receive refresher training equivalent to a minimum of eight hours.

Safeguarding Level 3 training is made up of e learning modules and two virtual sessions, all modules must be complete before staff become compliant.

Level 4: Named professionals should attend a minimum of 24 hours of education, training and learning over a three-year period. This should include clinical leadership, appraisal, and supervision training.

Training can be booked online through the training and development centre.

Managers and/or supervisors of staff are responsible for ensuring staff are allocated time to attend training and refreshers in line with the Trust Mandatory and Statutory Training Policy. Safeguarding supervision training should also be undertaken when staff are dealing with Safeguarding cases, this can be agreed through the Humber safeguarding team.

The NHS Safeguarding App has been developed to act as a resource for staff, this is available to download in the appropriate app store searching 'NHS Safeguarding'

13. IMPLEMENTATION

This policy will be disseminated by the method described in the Policy for the Development and Management of Procedural Documents.

The implementation of this policy requires no additional financial resource

14. MONITORING AND AUDIT

Safeguarding vulnerable adults at risk of neglect, harm and abuse is our primary objective. The audit and monitoring of any policy is necessary to ensure that staff deliver a caring culture that prioritises the quality of care, has strong leadership, and a competent and safe workforce. Setting standards and measuring how they are used in day to day care allows services and practitioners to identify concerns about individual patients and early warnings about poor care within their service.

- The policy will be monitored by the Quality and Patient Safety Group
- Copies of the concern forms generated by Trust staff will be attached to the Datix forms and forwarded to Risk Management. These would then be made available to the Trust Safeguarding Lead for monitoring and audit
- All incidents are logged onto Datix and reported to National Patient Safety Agency and the Care Quality Commission

15. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS

National

- The Care Act 2014
- Mental Health Act 1983
- Human Rights Act 1998
- Who Decides? Lord Chancellor's Office 1997
- Care Quality Commission essential standards (Outcome Seven – regulation 11: Safeguarding People who use services from Abuse)
- Youth Justice and Criminal Evidence Act 1999
- Domestic Abuse Act 2021
- CQC Identifying and responding to closed cultures

Mental Capacity Act 2005 (Deprivation of Liberty Safeguarding)

- Safeguarding Vulnerable Groups Act 2006
- National Framework for reporting and learning from serious incidents requiring investigation. National Patient Safety Agency 2010
- Clinical Governance and Adult Safeguarding: An Integrated Process. Department of Health 2010
- Adult social care: A consultation paper. Law Commission 2010
- Safeguarding Adults: The Role of Health Service Practitioners. Department of Health 2011
- Safeguarding adults at risk of harm: A legal guide for practitioners. Social Care Institute for Excellence 2011
- Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework. NHS England 2015

Regional

- Hull Multi Agency Policy Procedures and Practice Guidelines for the Protection of Vulnerable Adults
- East Riding Multi Agency Policy Procedures and Practice Guidelines for the Protection of Vulnerable Adults
- City of York joint multi-agency safeguarding adults policy and procedures

Trust

- Access to Health Records Policy
- Caldicott and Data Protection Policy
- General Protocol for Sharing Information between Agencies (2008)
- Information Governance Policy
- Safe Haven Policy
- Freedom to Speak Up Procedure

Appendix 1: Contact Information

If the incident occurred in Hull, you need to refer to the Hull local authority safeguarding adults team. If it occurred in the East Riding of Yorkshire, you need to refer to the East Riding local authority safeguarding adults team. If the incident occurred in North Yorkshire, you need to refer to the North Yorkshire safeguarding adult team.

If the safeguarding incident occurred outside of area, you would refer to the local authority safeguarding adults team where the incident occurred. For example:

A patient is physically restrained by nursing staff on a general ward in York District Hospital. The patient sustains a fractured arm. They are then discharged into your care with an injury. You would make a referral to the City of York adult safeguarding team.

Local Authority Safeguarding Adults Teams

East Riding of Yorkshire
safeguardingadultsteam@eastriding.gcsx.gov.uk

Hull
www.safeguardingadultshull.com

North Yorkshire
Social.Care@northyyorks.gcsx.gov.uk

You can find up-to-date contact details for all neighbouring Local Authority Safeguarding teams and safeguarding adult concerns on the Humber Teaching NHS Foundation Trust internal intranet under Safeguarding.

Internal support: Humber Safeguarding Team
Humber Safeguarding Team
Humber Teaching NHS Foundation Trust, Beverley Road, Willerby, HU10 6ED
Team email box: HNF-TR.SafeguardingHumber@nhs.net

All contact details are available on the Safeguarding Trust intranet site.

Appendix 2: Stepped Approach

STEP 1

- Remain calm and non-judgmental
- Take whatever action is required to ensure the immediate safety or medical welfare of the adult(s) at risk
- Do not discourage from disclosure and use active listening skills. Give reassurance but do not press for more detail or make promises that cannot be kept. Remain sympathetic and attentive.

STEP 2

- Clarify main facts, summarising what has been disclosed to you
- Explain that you cannot keep information about alleged or suspected abuse confidential and a line manager must be informed
- Remain sensitive
- Seek the person’s consent to share this information
- Consider issues of capacity, consent, best interests and public protection
- Offer future support from yourself or others (key-worker or advocate)

STEP 3

- Take all reasonable steps to ensure that the adult(s) is in no immediate danger of further harm
- Make a complete and accurate record of events as soon as possible. Record facts not opinions. Use person’s own words, record date, time and sign
- Preserve evidence
- Line Manager or other appropriate manager must be informed as soon as possible
- Safeguarding Team
- Remember your Duty of Care

STEP 4

- Ensure that the individual’s care plan(s) and any risk assessments are immediately updated or introduce new ones to reduce any further occurrence
- The alleged abuser should **not** be contacted at this step

Information must always be shared on a need to know basis.
If unsure seek guidance.

- Make sure there is a clear audit trail of all actions taken and decisions made. Including the degree of harm, type of harm, source of harm , did the actions constitute a safeguarding risk, is it an isolated event or is there evidence of a sequence of events, is it an act of intent or omission, what measures can be put in place to reduce or stop the risk?

Appendix 3: Female Genital Mutilation

FGM is a procedure where the female genital organs are injured or changed and there is no medical reason for this. It is frequently a very traumatic and violent act for the victim and can cause harm in many ways. The practice can cause severe pain and there may be immediate and/or long-term health consequences, including mental health problems, difficulties in childbirth, causing danger to the child and mother; and/or death.

The age at which FGM is carried out varies enormously according to the community. The procedure may be carried out shortly after birth, during childhood or adolescence, just before marriage or during a woman's first pregnancy.

In England and Wales, criminal and civil legislation on FGM is contained in the Female Genital Mutilation Act 200320 ("the 2003 Act").

FGM is illegal in the UK. For the purpose of the criminal law in England and Wales, FGM is mutilation of the labia majora, labia minor or clitoris.

- FGM is an unacceptable practice for which there is no justification. It is child abuse and a form of violence against women and girls.
- FGM is prevalent in 30 countries. These are concentrated in countries around the Atlantic coast to the Horn of Africa, in areas of the Middle East, and in some countries in Asia.
- It is estimated that approximately 103,000 women aged 15-49 and approximately 24,000 women aged 50 and over who have migrated to England and Wales are living with the consequences of FGM. In addition, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM.
- FGM is a deeply embedded social norm, practised by families for a variety of complex reasons. It is often thought to be essential for a girl to become a proper woman, and to be marriageable. The practice is not required by any religion.

For more detail, please refer to multi-agency statutory guidance on female genital mutilation available on the Safeguarding Intranet page:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/912996/6-1914-HO-Multi_Agency_Statutory_Guidance_on_FGM__-_MASTER_V7_-_FINAL__July_2020.pdf

FGM is illegal in England and Wales under the Female Genital Mutilation Act 2003.

As amended by the Serious Crime Act 2015, the Female Genital Mutilation Act 2003 now includes:

- An offence of failing to protect a girl from the risk of FGM;
- Extra-territorial jurisdiction over offences of FGM committed abroad by UK nationals and those habitually (as well as permanently) resident in the UK;
- Lifelong anonymity for victims of FGM;
- FGM Protection Orders which can be used to protect girls at risk; and
- A mandatory reporting duty which requires specified professionals to report known cases of FGM in under18s to the police.

It is **mandatory** for health professionals to record in the patient's healthcare record (**and inform the safeguarding team data administrator**) if an adult patient has had FGM, whenever it is identified in the course of NHS treatment [including provided in Mental Health Trusts]. (DOH Dec 2014 FGM Prevention Programme: requirements for NHS staff)

Appendix 4: Multi-Agency Public Protection Arrangement

Agencies (including health organisations) have a duty to co-operate and work with the Responsible Authority and have a crucial role to play in reducing risk and protecting the public. It is within this remit that the Trust has a professional duty to share information and notify the Humberside MAPPA Unit of patients who are MAPPA eligible offenders.

Public protection does not rest with any single agency, and as such, MAPPA exists to promote joint working and the sharing of appropriate information. The collaborative nature of MAPPA should not, however, undermine the role of the lead agency in managing the offender/patient in the community, but should assist in ensuring a robust risk management plan designed to protect the public.

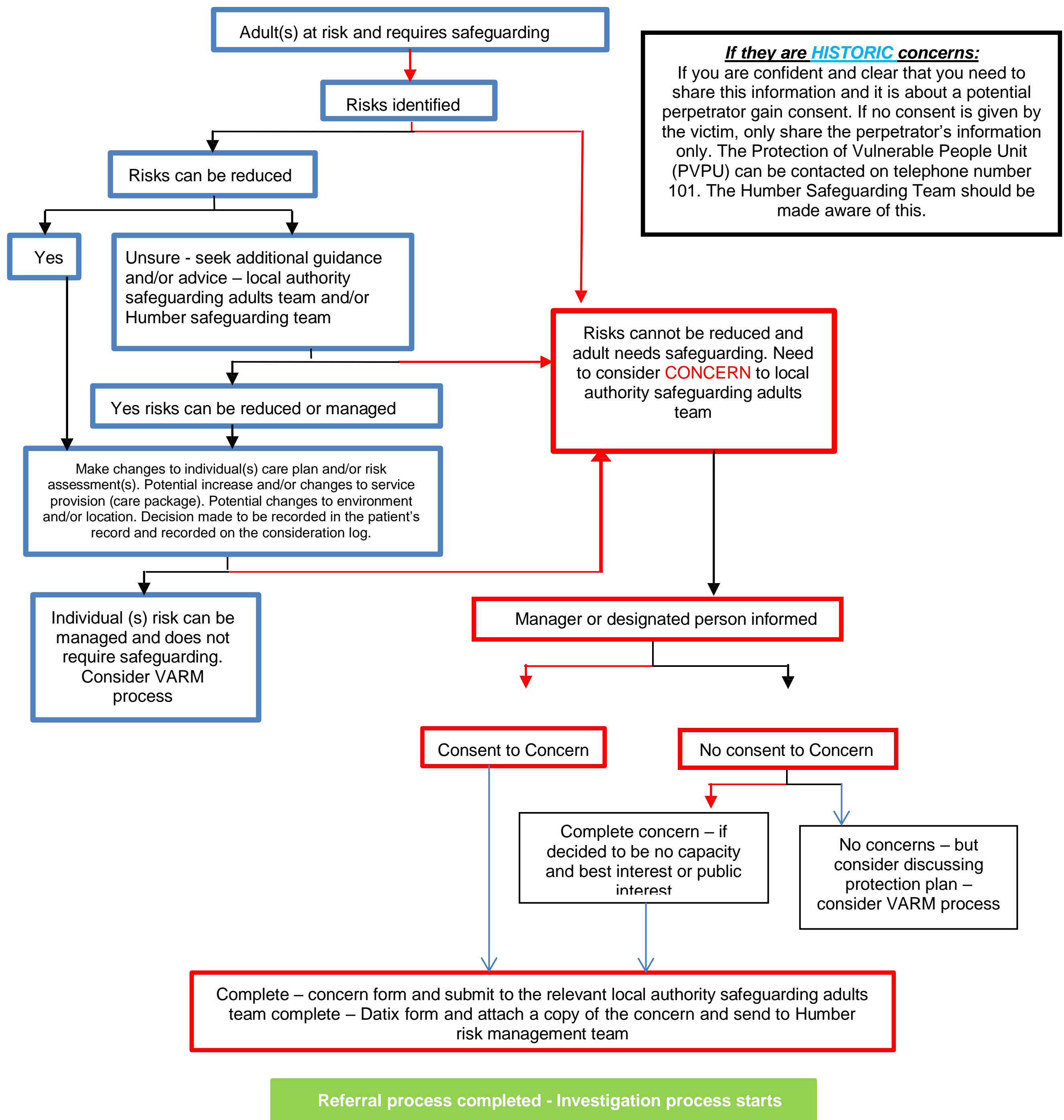
This procedure takes into consideration the guidance issued in December 2013 by the Royal College of Psychiatrists. Although there is a statutory duty to cooperate with MAPPA, health professionals remain bound by patient confidentiality and by their own statutory body's guidelines. When disclosure to MAPPA is being considered initial discussion with the Responsible Clinician should be undertaken.

The Trust has a policy specific to MAPPA.

www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2

Appendix 5: Decision Making and Concerns Pathway

There is an adult(s) at risk (refer to the 3 duties Care Act 2014) Physical, sexual**, organisational, discriminatory, financial or material, emotional or psychological, neglect or acts of omission, self-neglect, Modern Slavery and Domestic Abuse**. You need to put measures in place to safeguard that adult(s). Consider if the act that puts them at risk was intentional or unintentional or was a failure to act you will need to consider the following:



NOTE: When considering risk you still need to consider the degree and intensity of the harm and/or the potential harm. Risks might be managed and the individual(s) is now safe, but you would still make a referral if the potential harm outweighs the current situation – if unclear seek guidance.

Appendix 6: Patient on Patient guidance

Reporting 'patient on patient' adult safeguarding concerns

The aim of this guidance is to provide all staff working on adult inpatient unit's information as to when and how safeguarding concerns should be reported to the Local Authority or Police following an incident on the unit between patients.

Note: The full Safeguarding Adults Policy and Procedure (N-024) is available on the Intranet, this provides detailed guidance on the reporting of concerns to both the Trust Safeguarding Team and the Local Authority Safeguarding Teams.

Capacity and consent

The Mental Capacity Act (MCA) 2005 provides a fundamental safeguard for human rights, and enabled adults to make their own decisions.
When considering safeguarding concerns on inpatient units you must consider the mental capacity of the patient (victim) in relation to reporting the concerns further.

- If a patient has capacity and wishes to report the safeguarding concern, the patient's wishes must be followed.
- If a patient has capacity and does not wish to report the safeguarding concern, the patient's wishes must be respected ***unless*** there is a risk to others. Examples of situations where consent may be overridden include:
    - If another patient is at risk of harm or abuse
    - If you consider others to be at risk of harm or abuse when the patient is no longer on the unit e.g. wider public protection issues involving children and other adults with care and support needs
    - If a crime has been committed
    - If it is in the adults vital interests (a matter of life and death)
    - If the person is being unduly influenced or intimidated to the extent that they are unable to give consent
    - If there is a court order or other legal authority for taking action without consent

If a patient lacks capacity you must consider whether it is in the best interests of the patient to report the safeguarding concern, and if it is, the concern should be reported in the patient's best interests

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Appendix 7: Document Control Sheet

This document control sheet, when presented to an approving committee must be completed in full to provide assurance to the approving committee.

Document Type	Policy – Safeguarding Adults Policy and Procedures		
Document Purpose	To provide guidance and statutory requirements to Trust staff relating to the identification, reporting and management of safeguarding adult issues. .		
Consultation/ Peer Review:	Date:	Group/Individual	
List in right hand columns consultation groups and dates	September 2018	Safeguarding team	
	March 2021	Safeguarding Team, Modern Matrons, Division Leads, CCG Safeguarding Leads	
	July 2021	QPaS	
Approving Committee:	QPaS	Date of Approval:	06/07/21
Ratified at:		Date of Ratification:	
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*	Safeguarding adult training is provided by the Trust to all employees. There are no training requirements related to the implementation of this policy.	Financial Resource Impact	Low
Equality Impact Assessment undertaken?	Yes [✓]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [✓]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below - to be delivered by the Author:*		
	• Policy to be made available on the Trust intranet • Notice of the review of the policy to be disseminated Trust wide. • Update of the policy to be discussed in safeguarding development sessions.		
Monitoring and Compliance:	Compliance with this policy will be monitored within the safeguarding team		

Document Change History:			
Version number/name of procedural document this supersedes	*Type of Change, i.e. review/legislation*	*Date*	*Details of change and approving group or executive lead (if done outside of the formal revision process)*
1.01	*Review and amendments*	*Nov 2010*	*Reviewed and harmonised with ERYPCT*
2.00	*Minor amendment*	*Jan 2012*	*Change of telephone number Hull safeguarding team, appendices added.*
3.00	*Reviewed and amended*	*Nov 2015*	*Updated in line with Care Act and organisational restructure*
4.00	*Review and minor amendment*	*Sept 2018*	*Minor amendment. Updated terminology and contact details. Reference to VARM process and Lorenzo tab*
4.1	*Review and amended*	*March 2021*	*Updated information and guidance* *Updated definitions of risk* *Updated Humber Safeguarding Team details* *Updated Level 3 Safeguarding Training*

Appendix 8: Equality Impact Assessment

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: Safeguarding Adults Policy and Procedures
2. EIA Reviewer (name, job title, base and contact details): Kerry Boughen, Named Nurse (Child)
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? Policy

Main Aims of the Document, Process or Service To provide guidance to Trust staff relating to supporting the development and implementation of the Multi-agency Policy, Procedures & Practice Guidelines. The Trust has agreed to co-operate in an interagency approach aimed at protecting adults at risk of abuse.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group 1. Age 2. Disability 3. Sex 4. Marriage/Civil partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual orientation 9. Gender reassignment	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed? Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	How have you arrived at the equality impact score? a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental Health (including cancer, HIV, multiple sclerosis)	Low	
Sex	Men/Male Women/Female	Low	
Marriage/Civil Partnership		Low	
Pregnancy/Maternity		Low	
Race	Colour Nationality Ethnic/national origins	Low	
Religion or belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Sexual orientation	Lesbian Gay men Bisexual	Low	
Gender reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	

Summary

Please describe the main points/actions arising from your assessment that supports your decision. The policy ensures that there is a fair and consistent approach provided to all patients irrespective of age, race, colour, religion/belief, disability, nationality, ethnic origin, gender, sexual orientation or marital status, domestic circumstances, social and employment status, HIV status or gender reassignment.	
EIA Reviewer: Rachael Sharp	
Date completed: 06.07.2021	Signature: R Sharp