Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Stakeholder	Document	Page No	Line No	Comments	Developer's response
BASW Cymru	Guideline	4	1	Are you able to identify that you have only included legislation/guidance/data etc from England but the other nations have relevant data, guidance and legislation? This would make this guidance more relevant and applicable to all 4 nations. You wouldn't necessarily need to identify what this is, but just a comment reflecting on this fact.	Thank you for your comment. NICE guidelines are commissioned specifically for England. Whilst the devolved administrations can adopt/adapt the guidelines it is not possible to include links or references to legislation or statutory guidance used outside of England.
BASW Cymru	Guideline	8	11	We feel that there should be a specific recommendation Care Home policies should also reflect the needs of the individuals that they are providing care for, and therefore their policies may need to be audio, braille, signs/pictures etc as well as homes ensuring that they discuss this policy using appropriate language with their residents and documenting that this has occurred.	Thank you for your comment. A reference to the Accessible Information Standard and the requirements this has in terms of consideration of communication and support needs has been added.
BASW Cymru	Guideline	9	15	Should there be something included here about how whistleblowers can access support. Important to recognise this fact. It's easy to say that whistleblowers shouldn't be victimised, but you need to say how this can be achieved.	Thank you for your comment. Whilst the committee agree that support for whistleblowers is important, the aim of this recommendation is to make it clear that organisations should not treat whistleblowers unfairly (or terminate their employment) as a result of their disclosures, and that doing so is illegal. After further discussion, the committee agreed that the recommendations in sections 1.8, 1.9 and 1.10 cover the issue of support and the reference to support has been deleted from this recommendation.
BASW Cymru	Guideline	13	3	I wonder, especially in the light of Covid 19, whether this timescale of 6 weeks is achievable. Are we setting care homes up to fail by this short time span?	Thank you for your comment. The committee discussed at length the timescale within which mandatory training should be completed by new staff (see evidence review H for details). The committee felt that specifying 'no later than 6 weeks' was an appropriate limit, particularly as this aligns with other guidance such as that from the RCN (Adult Safeguarding: Roles and competencies for Health

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					Care Staff 2018). The committee recognise the impact which Covid-19 has had on care homes and were mindful of this when discussing this timescale.
BASW Cymru	Guideline	13	13	I am concerned that, while I agree with mandatory training (for Safeguarding) as well as other area, there needs to be a reflection of how this is paid for in the contracts care providers have with commissioners, including additional income to the care homes by commissioners.	Thank you for your comment. Whilst the committee acknowledges the costs of safeguarding training, the provision of mandatory induction training is required under section 14.225 of the care and support statutory guidance and is reflected in CQC standards. These recommendations are intended to reflect best current practice, and the committee took care to draft recommendations which they believe to be achievable in the current climate..
BASW Cymru	Guideline	14	1	I am really concerned about the whole area of training you have stipulated. There will be some care homes who do not have the skills to enable this depth of training to happen, nor the funds to purchase this level of training from other sources. Shouldn't there be training that is offered by the commissioner that should cover these requirements.	Thank you for your comment. NICE guidelines are intended to reflect best practice and the committee took care to draft recommendations which they believe to be achievable in the current climate. They aimed not to be too prescriptive to ensure that responses to their recommendations can be proportionate, for example, in smaller organisations where resourcing may be difficult and to offer flexibility in how staff understanding can be supported.
BASW Cymru	Guideline	19	1	I believe that this is unlikely to occur as many of the care homes don't even carry out formal exit interviews. Are we setting them up to fail?	Thank you for your comment. The committee drafted this recommendation with the intention of promoting exit interviews as best practice. However they recognise that care homes may use different methods to gather this information and exit interviews are now included as an example only.
BASW Cymru	Guideline	33	6	This could also cause difficulties if a non-criminal investigation is needed.	Thank you for your comment. This recommendation has been amended to highlight that this may cause issues for any future investigation; not only those of the police.
BASW England	Comments form Q1	General	General	**1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why.** Embedding learning: requires commitment to lifelong learning by all within the organisation, seeing the relevance and that being viewed positively and	Thank you for your comment and providing this feedback. The committee agree that embedding learning is challenging and needs a concerted and proactive approach and drafted a number of recommendations relating to this in sections on induction and training in care homes, and care home culture, learning, and management. Whilst the

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				as part of the job and service provided. Requires a value based approach to recruitment and retention, strong leadership and a culture where people living at the care home are actively encouraged to be involved in designing and delivering learning and provide feedback – culture where people are valued and listened to. Requires being open to challenge and being prepared to change. May create increase in number and type of concerns being raised, whistleblowing and exposure of poor practice Care home staff population can be a transient workforce so this can be hard to achieve with an unstable team or frequent change in home manager. Strategic Partnership working- Different/competing priorities, resource constraints, lack of shared understanding and commitment to safeguarding adults and to supporting care homes, trust issues, defensive practice or reluctance to accept or shared responsibility- "the Local Authority deals with safeguarding". There is constant changing with staffing as the investment is not always there to recruit and retain staff, as a result a constant training/learning culture is required. There needs to be a focus on person centred practice within homes and all taking responsibility for safeguarding, this will only be achieved with effective/open leadership. For care home managers and staff: Supporting and enabling decision making and ensuring the least restrictive option and is in the person's best interests can prove challenging to uphold	committee recognise the impact that recruitment and retention can have on culture and learning in the care home, funding is not within the scope of this guideline. The committee also recognise the difficulties that can arise in strategic partnership working, however this guideline focuses on safeguarding practice in care homes. Whilst the recommendations refer to this issue where it relates to the care home context, for example, recommending that SABs seek assurances that local partners are working together to support residents; partnership working more broadly is not within the scope of the guideline. The committee were mindful of the importance of person-centred practice when drafting their recommendations and include details regarding the 6 core principles of safeguarding, Making Safeguarding Personal, and the Care Act, 2014 in their recommendations where applicable. The issues you raise in relation to this, as well as your comments on the time required for care home staff (and regulators) to understand the guideline will be considered by NICE where relevant support activity is being planned. Best interests decision-making is covered by NICE guidance on Decision-making and mental capacity.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				Best interests Making Safeguarding personal – what does this mean and how does this work locally? Care homes struggle to understand: what action will be taken in response to concerns raised and who by in the context of Making Safeguarding personal How widely understood is the well-being principle of the Care Act 2014? The guidance is lengthy so this will have an impact as staff will need to have protected time to understand the document, this will require support from managers within organisations. There will be considerable impact on all concerned in the process of safeguarding, not least in reading and inwardly digesting all aspects of the guidance, but particularly in training for all staff - making time available for those undergoing the training, but also in making sure that there enough training services to meet the needs of staff at all levels. There will also be an impact on reviewing bodies - CQC, CCGs (were CHC provision is involved) and SSDs to ensure that all aspects of the guidelines are being put into operation.	
BASW England	Comments form Q2	General	General	**2. Would implementation of any of the draft recommendations have significant cost implications?** Most, if not all of them. The document is lengthy and, at times, pithy. If its implementation requires, extra personnel input, this will cost money to ensure the quantity and quality of staff. Views expressed highlight that it is a distinct disadvantage that the Government keeps postponing publishing proposals for the funding of social care as this needs to be on a par with that of the NHS.	Thank you for your comment and providing this feedback. The committee recognise the impact that care funding and delivery structures, and workforce planning can have on safeguarding outcomes, however these are not within the scope of the guideline.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

BASW England	Comments form Q3	General	General	**3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)** Existing practical resources should always be used to their best advantage. I have a feeling that this is not always the case, but have no direct evidence. The National Initiative I would like to see is that in respect of social care funding (as above). We can always learn from others and can benefit from examples of good practice. For me the onus is on reviewing bodies like the CQC to provide and highlight these. At a more local level CCGs and SSDs could also do more to share with all what they feel is good within their areas. The guideline has many good things in it. Although many of these are not new, it is important that they are brought again to the notice of relevant parties, in equal measure to those who are new to the profession or have been well established in it for many years. Accessible information available in the place where they live, opportunities to talk about/discuss/explore issues and share experiences. Knowing who to talk to about concerns and issues and culture of trust, respect and openness.	Thank you for your comment and providing this feedback. The committee recognise the impact that funding and delivery structures can have on preventative work and care quality, however these issues are not within the remit of NICE With regards to your comments on sharing best practice, the committee drafted a number of recommendations designed to support care home staff in developing their understanding of safeguarding, particularly in relation to the role which local authorities and SABs can play in this, for example recommending that they "…share recommendations and key learning from Safeguarding Adults Reviews with key stakeholders (including care home providers, staff, residents and their families and carers)." The committee acknowledge that some of their recommendations overlap with previous guidance or that produced by other organisations, they agreed to include them because there is variation in practice across the sector (an issue that this guideline was designed to address). They too hope that by restating this content here it will support *all* practitioners to work effectively within the wider safeguarding framework. The committee agree that accessible information is an important issue in care homes and have included details relating to this in a number of instances. For example, recommending that safeguarding policies "… are in line with Accessible Information Standard requirements to meet the communication support needs of individual residents." They also make recommendations regarding the type of support that should be offered to a resident when a safeguarding issue occurs, for example in the section entitled 'Working with the resident at risk during a safeguarding enquiry'.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					The committee also agree that 'open' cultures and clear lines of communication and accountability are essential in promoting effective safeguarding practice, and drafted a number of recommendations relating to this which they believe will support care homes to work more effectively and improve outcomes for residents.
BASW England	Comments form Q4	General	General	**4. The recommendations in this guideline were developed before the coronavirus pandemic. Please tell us if there are any particular issues relating to COVID-19 that we should take into account when finalising the guideline for publication.** The pandemic is exposing great inequality in impact and in human rights protection across the UK. The pressures arising from the pandemic and the difficulties in responding to these run the risk of undermining entitlements, reducing rights and removing safeguards. The starkest expressions of this are in the inequality of access to protection from abuse and neglect, access to treatment to sustain life, and the unequal and devastating death rates in our society. This guideline needs to ensure that people living in care homes continue to receive access to advocacy and that the voices of people and families are listened to heard and represented in relation to any safeguarding issues. There needs to be strategic focus on safeguarding in care homes but due to covid- 19 and other high profile priorities this is not always the case. Covid-19 context- what change has this brought?	Thank you for your comment and providing this feedback. The committee recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes, illustrating how essential safeguarding is in care homes. The committee have discussed their recommendations in light of Covid-19 and have attempted to mitigate against its impacts wherever possible, for example the list of potential indicators of organisational abuse ('physical signs and lack of openness to visitors') now incorporate details on closure to outside scrutiny; details which were added in response to concerns in the sector regarding Covid-19 restrictions. However, the committee acknowledge that learning from the pandemic may need to inform any future updates of the recommendations. NICE publish products related to their response to COVID-19 here https://www.nice.org.uk/covid-19#sle which are being updated regularly and we will flag any relevant areas to the COVID-19 guideline team. The guideline makes a number of references to human rights issues, for example, the context section of the guideline refers to Articles 3, 5, and 8 of the Human Rights Act and also includes text from the Care Act statutory guidance which emphasises that restrictions on a persons' rights or freedoms must be kept to a minimum when attempting to protect them from abuse or neglect. Similarly, the

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				Limited external oversight, restrictive practices without authorisation, lack of contact between people and families, lack of 3rd oversight in terms of decisions making, risks assessment and managements, strategies, how are reportable incidents such as medication errors being concerned-change in local processes – impact? Ability to cope with changing needs, high rates of infection, low morale, deaths of people and staff, the quality of person centred care being received, Staffing levels and quality- do care staff know the people they are looking after, Dignity and respect how being maintained, infection control, Contingency arrangements, End of Life care, inappropriate and unlawful DNACPR, access to health care-routine and emergency, emotional support to staff, people and families, culture of home and organisation. Care Homes and their staff and residents have suffered disproportionately from the Covid pandemic - lack of testing for both, lack of PPE, indiscriminate discharge from Hospital without finding out if they had Covid and irrespective of whether or not they had symptoms: all this compared adversely with the support (in principle anyway) given to the NHS. The delayed requirement to isolate leaving Homes' management to fend for themselves in terms of day to day precautions and decision making. In the event of the pandemic continuing, and particularly if there is a second spike these failings have to be rectified. However, this has to be tempered with common sense when it comes to residents and their wishes (if they are able to express them and can understand the consequences) and/or perceived needs. For example in respect of contact with relatives (if the latter agree), as long as it does not endanger other residents in particular, or other	committee recognise the impact that Covid-19 has had on external scrutiny of care homes and the indicators of organisational abuse ('physical signs and lack of openness to visitors') now also in-corporate details on closure to out-side scrutiny; and the committee believe that these will help to emphasise that there is no justification for blanket bans on external visitors. The committee also agree that access to advocacy remains vital in the context of the pandemic. The guideline includes a number of recommendations that emphasise the importance of communication support for care home residents, as well as an example indicator of discriminatory abuse relating to access to advocates. The committee hopes that the inclusion of these issues will emphasise the importance of advocacy and encourage care home managers and providers to find ways in which to overcome barriers that have arisen to this in 2020. The guideline includes excessive or unjustified use of restrictive practices and inappropriate administration of medication, and non-compliance with infection control as example indicators of organisational abuse. Medications management in care homes is covered more broadly in NICE guideline SC1 Medications management in care homes https://www.nice.org.uk/guidance/sc1/chapter/1-Recommendations Whilst the committee agree that the impact of Covid-19 has been especially challenging for care homes; issues such as transmission rates within care homes, discharges from hospitals, access to PPE and testing, reviews of DoLS, and staffing levels are not within the scope of this guideline, however as we have noted above your comments on

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				persons in general, and appropriate precautions are undertaken. Throughout the pandemic, care homes have been disadvantaged due to a lack of focus, issues with hospital discharges, no solutions for PPE issues, restricting family contact, issues with testing, stopping reviews/DoLs assessments etc. No real solution focused practice or support, staffing difficulties etc.	these issues will be referred to the COVID-19 guideline team.
BASW England	Comments form Q5	General	General	**5. We would particularly welcome your comments on the visual summaries developed alongside this guideline on individual and organisational indicators of abuse and neglect.** Indicators of individual abuse and neglect: Helpful to have a visual summary but think there needs to be more about the three-point test which is applied at the point of concern being referred to Local Authority. This will help care homes to understand why some things progress to enquiry and some don't. Indicators of organisational abuse and neglect: again helpful to have a flow chart to follow and what to do is clear, what I think could be clearer is the language. Does it pass plain and simple language test? Thinking about the audience which includes a range of people are words like "governance" widely understand? Could this lead to concerns not being reported through lack of clarity? For both visuals, people would need to be signposted to their local services in order for action to be taken. Other thoughts	Thank you for your comment and support for the visual summaries. The guideline recommends that local authorities should clearly communicate to care homes their decisions regarding s42 enquires (e.g. whether a s42 will be initiated and why or why not this will happen). In addition, the committee also drafted recommendations that emphasise that care home managers should work to ensure that staff understand learning from s42 enquiries (as well as other instances of safeguarding work, from relatively minor issues resolved within the care home to serious events that have resulted in a SAR). However, the process of conducting a s42 enquiry is not within scope for this guideline and practitioners should refer to guidance from ADASS/LGA on this. Links to resources published by ADASS/LGA have also been added into the guideline at various points, including with specific reference to conducting a s42 enquiry. The committee were careful to use plain and simple language in their recommendations, and the lists of indicators have been edited to provide clarity and simplify the text as much as possible. In addition, an easy read version of the guideline will be produced.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				Training should be regulation for care staff in relation to common conditions - e.g. Dementia, CVA, Parkinsons, MS - but it should also be available in respect of less common ones and include how to recognise these, where to source help and support, etc. Training should focus on emotional and mental health needs of residents as well as physical care, and for managers should focus on support for staff as well as care of residents. To ensure appropriateness of placement there should be ongoing assessment and review of residents, and staff, especially senior staff should know how to recognise when this is needed. Not all residents are appropriately placed initially, especially if they are self -funders. Such people should be able to receive a care assessment from Social Services to assist in the admission process. This is particularly needful for patients in Hospital where consideration should also be given to a CHC assessment. Although Nursing Home staff do tend to be aware when a resident may qualify for CHC funding - in any case this should be picked up by the 6 monthly FNC review (though possibly not always) - this is less so in residential homes and a system should be established to rectify this. Mental Capacity Assessments and DoLS (in its current or amended form) should be used appropriately as part of the safeguarding process and the safeguards they provide should be understood in the context of human rights and as a positive way of supporting people.	With regards to your suggestions regarding the content of training, whilst the committee agree that condition-specific knowledge is essential to good quality health and social care, this guideline focuses on safeguarding practice and as such recommendations on more broader training content is not within scope for this guideline. However, in the list of potential indicators of organisational abuse the committee felt that it was important to include the example of care that is not person-centred. Similarly, although decisions regarding care placements are not within the scope of the guideline, the committee included the following example in potential indicators of organisational abuse: "… the care home admits or accepts referrals for residents that staff do not have the skills to care for …" Referrals and assessment for CHC funding are also out of scope for this guideline. The committee also agree that the Mental Capacity Act and DoLS are fundamental to the provision of effective and safe care. Although mental capacity and restrictive practices are not within the scope of this guideline, the committee agreed to include references to the Human Rights Act and the Mental Capacity Act wherever possible. For example, the context section of the guideline refers to Articles 3, 5, and 8 of the Human Rights Act and also includes text from the Care Act statutory guidance which emphasises that restrictions on a persons' rights or freedoms must be kept to a minimum when attempting to protect them from abuse or neglect.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					The introductory text also includes reference to the importance of considering mental capacity, noting that where this is a concern the safeguarding guideline should be used in conjunction with NICE's Decision-making and mental capacity guideline. In addition, the guideline recommends (when responding to potential indicators of abuse or neglect) that practitioners: - follow the principles of Making Safeguarding Personal, take into account mental capacity, and take actions that are guided by the wishes of the resident.
Berkshire West, Buckinghamshire, and Oxfordshire CCGs	Comments form Q1	General	General	**Question 1:** The recommendations for the Safeguarding Adult Boards (SAB) will be a challenging change in practice in evidencing the accountability function of the Safeguarding Adult Boards in the guidelines. Their role and the governance processes involved in the SAB partnerships is one of scrutiny and holding to account not being the accountable party. Commissioners would be the accountable party for assurance. CCG Designated Leads are working to capacity within the SAB as core members, they also work with Local Authority partners to deliver on the challenging business plans and thus increase and focus in this function, whilst important will impact on the capacity and CCG workforce to deliver. The Health and Wellbeing boards should be considered in this section as accountable for challenging and supporting practice change, being held to account by the SAB partners. This differentiation is needed in the guidance. Please note that our SABs will be providing consultation comments as separate organisations which the Designates will input too as part of a multi-agency response.	Thank you for your comment and providing this feedback. The committee have amended a number of the recommendations for Safeguarding Adults Boards (SAB) to make it clearer that these boards have a strategic oversight role and as such are often not taking forward actions themselves but are seeking assurances that local authorities, other commissioners and representative organisations on the board are. For example, the guideline now recommends that SABs should seek assurances that clear lines of communication are in place between commissioners, the Regulator and safeguarding leads; that they include issues relating to safeguarding adults in care homes as part of their strategic planning and in their annual report and that they ensure that learning is shared about safeguarding adults reviews. The committee recognise that SABs are differently organised, funded and resourced in different regions and therefore agreed recommendations that reflected that flexibility whilst still being clear about the particular actions that are always the responsibility of the SAB.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Berkshire West, Buckinghamshire, and Oxfordshire CCGs	Comments form Q1	General	General	**Question 1** The area of commissioning clearly provides reference to both health and social care commissioning and demonstrating multi agency learning and protocols hence a reference here to local safeguarding procedures for standards of care or serious concerns frameworks would be useful. In addition, this commissioning function for health may be a challenge for some CCGs in structuring their resources and demonstrating contract and quality assurance arrangements for the care homes. There is no connections being made to the Long term plan and integrated care systems (ICSs) and integrated care partnerships (ICPs that would support the coordination of care and treatment for the older population of the area. Similarly we would like to suggest that a reference to the primary care enhanced scheme to support the interface between community teams, primary care and care homes.	Thank you for your comment and providing this feedback. The committee recognise the impact that care funding and delivery structures can have on safeguarding outcomes, however these issues are not within the scope of this guideline.
Berkshire West, Buckinghamshire, and Oxfordshire CCGs	Comments form Q2	General	General	**Question 2** Whilst local CCGs are making progress working with LA to build a partnership approach to quality and preventative approaches including training support there is a financial impact of commissioning resources to implementing preventative and proactive support to care homes for health. The detail of training and the need of this will impact on homes to deliver and be complaint; also the resources to deliver that training in a local area will impact on training providers and partners. The primary care enhanced scheme to support the interface between primary care and care homes reference in the accountability and responsibility.	Thank you for your comment and providing this feedback. The committee recognise the impact that funding and delivery structures can have on preventative work and care quality, however these issues are not within the remit of NICE. The committee recognise that there may be some resource implications associated with their recommendations on training but they hope that their emphasis on the mandatory nature of some safeguarding training (as set out by the Care Act, 2014) and the risks to care home residents of not providing staff with this training will support care home managers and providers to find ways in which to overcome these. In addition, the committee were mindful of these implications when drafting their recommendations and avoided being overly prescriptive in order to ensure that care homes can take a proportionate response (e.g. smaller providers).

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Berkshire West, Buckinghamshire, and Oxfordshire CCGs	Comments form Q3	General	General	**Question 3** The guideline is a large document and from our CCG experience this will be a challenge for all multi agency partners to digest and thus it would be helpful to create a practical resources pod cast explaining the summary of the guidance with subtitles. Furthermore, there are some paragraphs within the document that could potentially be amalgamated. For example: 1.3.11 Care home managers should make sure there are regular opportunities for all staff to share best practice in safeguarding, including learning from Safeguarding Adults Reviews. 1.2.14 Incorporate recommendations and other information from Safeguarding Adults Reviews into training as quickly as possible after the reports publish.	Thank you for your comment and providing this feedback. Your comments will be considered by NICE where relevant support activity is being planned. With regards to your comment on the amalgamation of recommendations, the guideline as a whole has been edited for clarity and to ensure that concepts are not repeated. However, the recommendations to which you refer relate to two distinct issues. The first recommendation relates to the concept of care home 'culture' and is intended to encourage care home managers to foster an environment in which best practice and lessons from SARs are discussed openly between staff on a very regular basis. The second recommendation refers to more formal learning programmes delivered on a less frequent basis. As such, the committee did not feel that it would be appropriate to merge these two recommendations.
Berkshire West, Buckinghamshire, and Oxfordshire CCGs	Comments form Q4	General	General	**Question 4** The recommendations in this guideline were developed before the coronavirus pandemic. We would like to suggest that a reference is made within the Guideline to COVID 19 (or any other national crisis) requesting contractual arrangements that include evidence of robust business continuity plans, mutual aid, development of local networks and access to the residents requiring additional care and support.	Thank you for your comment and providing this feedback. The committee have discussed their recommendations in light of Covid-19 and have attempted to mitigate against its impact wherever possible, and have added details relating to this in some recommendations, for example, the list of potential indicators of organisational abuse ('physical signs and lack of openness to visitors') now incorporate details on closure to outside scrutiny; details which were added in response to concerns in the sector regarding Covid-19 restrictions. However, contractual arrangements or issues relating to financial sustainability are not within the remit of NICE.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

British Geriatrics Society	Guideline	General	General	A very well written document that would be very much welcomed to raise awareness and reduce abuse and neglect in our care homes.	Thank you for your comment and your support.
British Geriatrics Society	Guideline	12	1	All temporary workers should have completed safeguarding training and be updated prior to being accepted for working in a care home. The recommendation as presently written provides a loophole that could allow temporary workers not complete the training by moving between care homes every 6 weeks.	Thank you for your comment. The committee have added another recommendation in the section on training to clarify that care home managers should seek assurance from agencies they contract with, that all contract staff working in the care home have completed mandatory safeguarding training .
British Geriatrics Society	Guideline	16	2	Please consider making training available as online with no F2F requirement to make it as easy as possible for people to do the training. Provide it in levels with level 1 being basic and for all and further levels depending on roles with the highest level being for care home managers. Within the elearning package provide FAQs and there should be an assessment at the end of each level all online with a pass mark of 80% as a minimum. Also provide an email where people can email a query/question related to the training.	Thank you for your comment. The committee spent a great deal of time discussing how best to deliver training. The committee's recommendations relating to training are based on a systematic review which did not identify any quantitative evidence comparing the effectiveness of different modes of training and provided only limited evidence in relation to cost-effectiveness. However, the committee acknowledged that there is anecdotal evidence of concerns about e-learning, and that these reflect their own concerns; particularly in relation to the absence of human interaction and opportunities for discussion. As a result, the committee agreed that it was appropriate to recommend that face-to-face training should be used wherever possible, but also to recommend that e-learning could be used if it was not possible to provide face-to-face training. The committee also agreed to clarify that face-to-face training should include the use of virtual platforms, which they believe will help to mitigate against the challenges that have occurred as a result of Covid-19 (as well as potential resourcing issues). Details regarding issues such as pass rates and support for specific e-learning packages are not within the remit of NICE.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

British Geriatrics Society	Guideline	43	20	Consider including a statement about having virtual meetings as a default as it facilitates faster set up of meetings and attendance easier with F2F only if necessary	The committee did not review evidence relating to the format of meetings about safeguarding concerns and their recommendations do not therefore include details on this. The evidence which the committee did review suggested that there can often be a lack of trust amongst the interested parties and their recommendations therefore focus on the importance of communication about decisions taken, particularly with the resident about whom the concern has been raised. The committee believe that this focus will help to ensure that meetings remain effective and transparent regardless of format.
British Geriatrics Society	Visual summary - Indicators of individual abuse and neglect	General	General	Consider expanding on each item here as people may not be aware of what each covers. May be more important to give more space on the visual to these items and reduce the space and content for the other sections.	Thank you for your comment. The visual summaries are supposed to be summaries of key sections within the main guideline and as such only include main headings. The lists of what each cover are in the main guideline and we will try and ensure that the visual summary is clear about that and that direct links are provided to help users with easy access to these.
Care England	Evidence Review A	General	General	As mentioned in the comments on the guideline above we suggest that this is read again in light of Covid-19 and the breaches of Article 8 rights which exist in some care homes, and which cause immense distress to residents and those who care for them in their families and networks. There is a real risk that, even when the pandemic is less pressingly awful, restrictions will continue: this has happened already, when infection levels fell greatly during the summer of 2020, yet too many care homes still felt unable to offer visits despite government guidance on how to make these work.	Thank you for your comment. A reference to Article 8 of the Human Rights Act has been added to the context section of the guideline as well as a paragraph from the Care Act statutory guidance which emphasises the importance of these issues: “Effective safeguarding is about seeking to promote an adult’s rights to security, liberty and family life, as well as about protecting their physical safety and taking action to prevent the occurrence or re-occurrence of abuse or neglect. Any restriction on the individual’s rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary.” The committee recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes. The committee have discussed their recommendations in light of

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					this and have attempted to mitigate against the impact of Covid-19 wherever possible, although learning from the pandemic may inform any future updates of the recommendations. NICE have published products related to their response to COVID-19 here which are being updated regularly. We will flag any relevant areas to the COVID-19 guideline team.
Care England	Evidence Review B	General	General	We very much liked the linked theme maps, figures 1 and 2, because of the positive messages for practice improvement in the second theme map. We suggest incorporating these into the guideline text as well, to meet this important aim.	Thank you for your comment and support. Unfortunately it is not possible to incorporate these into the guideline document itself however all of the recommendations will be published on the NICE website as part of a 'pathway' linking to other relevant guidance and this will include these items.
Care England	Evidence Review H	General	General	We recognise the thoroughness of the research methods used here but suggest that, as pointed out in comment 5, the changes that were already under way re a move to virtual platforms and a blended learning model have been speeded up greatly by Covid-19. Perhaps this, and the pace of current change, should be accepted in the introduction to this review. It now seems clear that face to face training is neither the best in terms of outcome nor the most economically justifiable way to embed learning: this is in light of rapid improvement in the technology even during 2020.	Thank you for your comment. After lengthy discussions regarding the delivery of training the committee agreed to clarify that face-to-face training should include the use of virtual platforms. The committee agreed that this should mitigate against the challenges that have occurred as a result of Covid-19 (as well as potential resourcing issues). The definition (found in the 'terms used' section of the guideline) includes the following text: "It may take place with participants all in the same room, or by using video or telephone conferencing. It may include online materials, but participants are able to ask questions, discuss, reflect on current practice and use case studies and examples."
Care England	Guideline	General	General	Care England welcomes this guidance, while suggesting further emphasis to certain areas, for example, the relationship between the empowering ethos of the HRA and the MCA, on the one hand, and adult safeguarding on the other, which leads to tensions in practice between protection and enabling autonomy. This is particularly worrying during Covid-19, with too many providers feeling unsupported by DHSC guidance when they want to enable residents' face to face contact with relatives, leading to excessively risk-averse practice such as	Thank you for your comment and support. The committee agree that striking a balance between empowerment and protection is essential to effective safeguarding practice and agreed to include references to the Human Rights Act and the Mental Capacity Act where relevant to emphasise this. For example, the context section of the guideline refers to Articles 3, 5, and 8 of the Human Rights Act and also includes text from the Care Act statutory guidance which

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				blanket bans on visitors and visits out of the home for residents. Despite saying that funding is not routinely considered, another area that should be highlighted is the toxic effect of a poor relationship within a local authority between the adult safeguarding teams and the adult social care commissioning practice, which leads to economic consequences for providers and residents: Note that this is cultural rather than being a function of commissioning funding, and should be considered in this guideline since it leads to staffing problems and high turnover which exacerbate the risks of neglect and abuse by poorly trained or motivated staff.	notes that restrictions on a persons' rights or freedoms must be kept to a minimum when attempting to protect them from abuse or neglect. In addition, the guideline recommends (when responding to potential indicators of abuse or neglect) that practitioners: - follow the principles of Making Safeguarding Personal, take into account mental capacity, and take actions that are guided by the wishes of the resident. The committee also recognise the impact that Covid-19 has had on external scrutiny of care homes and the indicators of organisational abuse ('physical signs and lack of openness to visitors') now also incorporate details on closure to outside scrutiny. The committee believe that these will help to emphasise to care homes that there is no justification for blanket bans on external visitors. The committee are aware that there can sometimes be tensions between local authority safeguarding and commissioning teams. Whilst they are also concerned about the effects this can have on providers and in turn on care quality, internal relationships in local authorities are not within the scope of this guideline. There are a large number of references throughout the guideline about mental capacity and the Mental Capacity Act. The introduction/context section includes the following statement "… When a care home resident lacks capacity, this guideline should be used in line with the NICE guideline on decision making and mental capacity …" and includes a link to that guideline.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Care England	Guideline	7	22	There is a significant omission here of the importance of Article 8 rights to a private and family life, which, supported by MCA statutory principle 3, emphasises the rights of a person to make 'unwise decisions with capacity': this is culturally too often ignored in social care and needs reinforcing.	Thank you for your comment. A reference to Article 8 of the Human Rights Act has been added to the context section.
Care England	Guideline	7	22	To the list of HRA Articles, add Article 8, which is the one most often egregiously breached by Safeguarding Adults professionals; emphasise Article 8 rights throughout the guideline.	Thank you for your comment. A reference to Article 8 of the Human Rights Act has been added to the context section.
Care England	Guideline	7	26	The reference to the MCA should be stronger than just 'informed by…' 'used in line with'. The MCA is the essential framework for decisions about intervening in the life of anyone who might lack capacity to consent to what is proposed. We suggest adding the statutory MCA code of practice and changing to 'informed and imbued by the statutory principles of…'	Thank you for your comment. There are a large number of references throughout the guideline relating to mental capacity and the Mental Capacity Act. The context section of the guideline includes the following statement: "When a care home resident lacks capacity, this guideline should be used in line with the NICE guideline on decision making and mental capacity …" and includes a link to that guideline. NICE guidance does not repeat recommendations in different guidelines but the NICE website allows for users to follow pathways between sets of recommendations that are helpful for them.
Care England	Guideline	12	006 - 0015	To the useful factors that a SAB needs to work to, add the need to avoid any suggestion of the 'presumption of guilt' that care providers too often recount experiencing. Allegations of course must be taken seriously but the support (here and on page 43, see below) needs balancing to reflect that not all allegations are made in good faith or correctly understood.	Thank you for your comment. The committee agrees that 'presumption of guilt' can be challenging (an issue highlighted by the research evidence) and drafted recommendations in sections 1.7 and 1.10 with this issue in mind.
Care England	Guideline	16	General	References to face to face training appeared somewhat old-fashioned compared with virtual platforms, before Covid-19, given the expense in time, money and resources. Now this presumption	Thank you for your comment. After lengthy discussions regarding the delivery of training the committee agreed to clarify that face-to-face training should include the use of virtual platforms. The committee agreed that this should mitigate against

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				of the superiority of face-to-face does seem an un-justifiable supposition.	the challenges that have occurred as a result of Covid-19 (as well as potential resourcing issues). The definition (found in the 'terms used' section of the short guideline) includes the following text: "It may take place with participants all in the same room, or by using video or telephone conferencing. It may include online materials, but participants are able to ask questions, discuss, reflect on current practice and use case studies and examples."
Care England	Guideline	17	044 - 019	Most important in putting training into practice is to ensure that policies, protocols and recording tools promote the best practice that has been learned in training.	Thank you for your comment. The committee agreed that the importance of embedding learning from training and encouraging knowledge sharing and open discussions should be given particular emphasis in the guideline.
Care England	Guideline	22	General	Recording: see note 6 above and reinforce its message here. **Comment 6:** Most important in putting training into practice is to ensure that policies, protocols and recording tools promote the best practice that has been learned in training.	Thank you for your comment. The committee agreed that the importance of embedding learning from training and encouraging knowledge sharing and open discussions should be given particular emphasis in the guideline.
Care England	Guideline	23	General	The word 'behaviours' depersonalises the individ-ual: consider 'manifestations (or indicators, or signs) of distress' or similar. You might also use the example of toothache, that is known to elicit real distress, food refusal, hiding from view etc. – and note that failure to recognise pain from treata-ble conditions, siting the manifestation within the cared-for person, is a clear indicator of neglect or abuse. See comment 17.	Thank you for your comment. The committee added the phrase 'signs of distress' but also in-cluded reference to 'behaviours' for clarity.
Care England	Guideline	26	2	In discussion of self-neglect it is essential to refer-ence the MCA.	Thank you for your comment. The guideline in-cludes a reference to the Mental Capacity Act in the section entitled 'How it relates to legislation, statutory guidance and other NICE guidelines'. Recommendation 1.4.10 specifically covers the is-sue of capacity and self-neglect and a link to the guideline on Decision-making and mental capacity (NG108) is included here.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Care England	Guideline	27	23	Rephrase 'when capacity is unclear…' by referring to the MCA: nobody has to prove they have capacity, which seems perhaps implied here nor of course is 'capacity' global; there needs some evidence that a person might lack capacity in order to trigger an essential assessment of their decision and time specific capacity.	Thank you for your comment. The list of potential indicators of sexual abuse have been edited and details regarding marriage have been added. Further information regarding a residents right to engage in sexual activity if they have the mental capacity to consent has also been added, and the 'suspect' indicators have been separated accordingly.
Care England	Guideline	28	24	If there is a possibility of someone marrying or engaging in sexual activity without relevant capacity, this is a criminal matter and should be referred urgently for determination; worth highlighting this. Decisions vary in who can ever make them; nobody can make a decision to marry if someone lacking capacity to decide whether or not to do this. Similarly with e.g. abortion.	Thank you for your comment. The list of potential indicators of sexual abuse have been edited and details regarding marriage have been added. Further information regarding a residents right to engage in sexual activity if they have the mental capacity to consent has also been added, and the 'suspect' indicators have been separated accordingly.
Care England	Guideline	35	14	A good point; but further emphasise that a good care provider is the one who does raise safeguarding concerns, openly and candidly, rather than the one who never does! See page 46 line 28, where this point might be reiterated.	Thank you for your comment and support. The committee feel that this recommendation provides a clear enough position on this issue and NICE guidelines do not reiterate points for emphasis.
Care England	Guideline	36	General	Whether s.24 enquiry is needed or not, consider support also for care provider staff in managing the outcomes.	Thank you for your comment. These recommendations have been amended to include that where a s42 enquiry is *not* initiated the local authority should "…discuss what other support is needed with the care home and the resident, and provide advice and support to help improve outcomes for the resident."
Care England	Guideline	40	11	Add a reminder that a person lacking capacity accused of abusing someone is entitled under certain circumstances to the support of an independent mental capacity advocate (IMCA) even when they have relatives or friends.	Thank you for your comment. The example of advocacy has been added as a potential form of support for a resident who is accused of abusing someone and may lack capacity.
Care England	Guideline	43	General	We welcome the positive and collegiate tone of this area of the text, but see also comment 4 re p.12.	Thank you for your comment and support for this section. The committee agrees that 'presumption of guilt' can be challenging (an issue highlighted by the research evidence) and drafted recommendations in sections 1.7 and 1.10 with this issue in mind.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Care England	Guideline	46	28	See comment 12 and consider a repeated reminder of this point. **Comment 12** - A good point; but further emphasise that a good care provider is the one who does raise safeguarding concerns, openly and candidly, rather than the one who never does! See page 46 line 28, where this point might be reiterated.	Thank you for your comment. Whilst the committee agree that this is a key issue, it is not NICE style to repeat the same recommendations in different sections of the guideline.
Care England	Guideline	49	23	See comment 8 and consider cross-referring this important point.	Thank you for your comment. Whilst the committee agree that this is a key issue, it is not NICE style to repeat the same recommendations in different sections of the guideline.
Care England	Guideline	50	7	Continuation of comments 8 and 17. **Comment 8:** The word 'behaviours' depersonalises the individual: consider 'manifestations (or indicators, or signs) of distress' or similar. You might also use the example of toothache, that is known to elicit real distress, food refusal, hiding from view etc. – and note that failure to recognise pain from treatable conditions, siting the manifestation within the cared-for person, is a clear indicator of neglect or abuse. See comment 17. **Comment 17:** See comment 8 and consider cross-referring this important point.	Thank you for your comment. The committee added the phrase 'signs of distress' but also included reference to 'behaviours' for clarity.
Care Quality Commission	Guideline	4	2 &11-16	For info - The link refers to CQC State of Care 2018/19 – the link takes you to the new State of care report 2019/20, which has only recently been published. The link on line 12 also goes to the 2019/20 state of care page but refers to the CQC's 2019 report – is the following listed data from the 2018/19 report? Suggest clarifying, which report is indicated.	Thank you for your comment. We have changed the links and the references throughout the context section to reference the recently published State of care report 2019-20. We have removed all references and links to the 2018-19 report.
Care Quality Commission	Guideline	4	6-7	States 'Provide services for people who stay for shorter periods, **including as day visitors**. This is	Thank you for your comment. The guideline only covers care homes as registered and regulated by the CQC. So although some of those registered

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				sometimes referred to as respite care or short break services.' For info – CQC do not regulate day centres that people visit during the day only. https://www.cqc.org.uk/sites/default/files/20151230_100001_Scope_of_registration_guidance_updated_March_2015_01.pdf - See page 21 flowchart re regulated activity – personal care. Although we do note sometime people do go into care homes for care in the day. Suggest review of the scope of registration, and what CQC categorise as care homes settings (note these provide the regulatedactivity for accommodation for persons who require nursing or personal care) CQC do register short break and respite care services were people stay overnight.	care homes may also provide services for day visitors (and we have stated that) there is no implication that the scope of the guideline extends to cover day centres. The 'terms used in this guideline' section includes a definition of 'care homes as: Residential care homes (with or without nursing care) that are registered with and regulated by the Care Quality Commission.
Care Quality Commission	Guideline	5	9-28	This section contains a list of guidance. Given the need for the guideline covers: - The difference between safeguarding issues and poor practice - When and how to make safeguarding referrals to the local authority We would highlight recent guidance developed by the LGA https://www.local.gov.uk/understanding-what-constitutes-safeguarding-concern-and-how-support-effective-outcomes	Thank you for your comment. The list of guidance in the context section contains guidance that was assessed as part of Evidence Review C. Although the new LGA guidance was published too late (sept 2020) to be included in the evidence review, and so could not be included on the list you refer to, the committee agreed it was helpful to include a number of links to resources on the MSP website throughout the guideline. These links will lead people to the new published resource.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Care Quality Commission	Guideline	9	15-18	States, 'Be aware that whistleblowers including residents are protected by law.' Residents are not classed as whistleblowers. Whistleblowers are employees of the service. Please see attached guidance documents that set out how we define whistleblowers at CQC, and our role in engaging with whistleblowers. https://www.cqc.org.uk/sites/default/files/documents/20131107_100495_v5_00_whistleblowing_guidance_for_providers_registered_with_cqc.pdf https://www.cqc.org.uk/sites/default/files/20200420_Whistleblowing_quick_guide_final_update.pdf Consider signposting to PIDA here as you reference 'protected by law'.	Thank you for your comment. We have updated the recommendations in the section about whistleblowing policies and procedures and we have also changed a number of other recommendations that refer to whistleblowing. We have: - Removed reference to family, friends and other residents being able to use whistleblowing policies. - Emphasised that in line with legislation these policies and procedures are for staff. - We have added reference to volunteers due to recent case law (2019) http://rva.org.uk/article/whistleblowing-protection-for-volunteers/ which implies protection for volunteers also. - We have also added a couple of links to the CQC quick guide below https://www.cqc.org.uk/sites/default/files/20200420_Whistleblowing_quick_guide_final_update.pdf - We did not think that a reference to PIDA was needed within the recommendations themselves although this has been referenced in the evidence review
Care Quality Commission	Guideline	10	1-3	As above reference for pg 9 given to residents and families being afraid of the repercussions. Residents and families would use the concerns or complaints procedure within the service or raise safeguarding concerns. They are not whistleblowers. Through the document – the role of provider's complaints process (for people who use services and their families), and the ombudsman is not clear. From our perspective, this is really critical this is clear throughout.	Thank you for your comment. We have reviewed all references to the ombudsman and CQC and clarified that complaints go to the ombudsman and feedback to CQC – apart from when this is whistleblowing (staff and volunteers only) and we have also linked to the CQC whistleblowing quick guide.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				https://www.cqc.org.uk/sites/default/files/documents/how_to_complain_about_a_health_or_soc_care_service_large_print_20110906_0.pdf https://www.cqc.org.uk/get-involved/share-your-experience/peoples-experience-care-what-we-want-know-why	
Care Quality Commission	Guideline	12	20-21	For information only, our guidance is not prescriptive about timescales between training or what it should contain: Our guidance for providers on meeting the regulations also asks providers to have due regard to the following guidance: 'As part of their induction, staff must receive safeguarding training that is relevant, and at a suitable level for their role. Training should be updated at appropriate intervals and should keep staff up to date and enable them to recognise different types of abuse and the ways they can report concerns.' However, staff have to be able to identify, and respond appropriately, see the link below: https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-13-safeguarding-service-users-abuse-improper#guidance We don't have any type of document that sets out exactly what organisations need around training in adult social care. This is perhaps clearer in health.	Thank you for your comment. We have included a reference to this document in our rationale and impact about the training recommendations. Based on the evidence, their experience and on various existing guidance including the Care Act statutory guidance and the Intercollegiate document published by the RCN the committee agreed the recommendations about training and induction requirements which are aimed at all care home staff, but (as indicated) would need to be tailored with regards to the level and detail of the content for different roles.
Care Quality Commission	Guideline	33	16-22	Reporting suspected abuse and neglect	Thank you for your comment. We have changed the reference here (section: reporting suspected abuse and neglect) so it links to the CQC whistleblowing helpline for staff and volunteers only. This

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				This states 'if you do not feel confident reporting within the organisation, contact… and CQC are listed. This currently reads as if we have equal weighting to the LA, which we don't – For safeguarding the local authority is the first point of contact. Consider splitting our role out and adding this later. Re the whistleblowing helpline – as comments before this would only apply to staff . Consider the target audience here.	recommendation is aimed at all people when they are reporting suspected abuse or neglect within a care home i.e. to managers or a safeguarding lead. The recommendation says that if people do not feel confident reporting in the home they should contact the local authority directly themselves or a whistleblowing helpline. At the beginning of section 1.4 we have now included some text to say that sections 1.4, 1.5 and 1.6 (this section) apply to ALL people.
Care Quality Commission		34	3-8	Advocacy – This reads as though the care home has responsibility for people having access to an advocate. Consider clarifying the local authority has the responsibility to provide this were needed. See Care Act statutory guidance	Thank you for your comment. Reference to advocacy has been deleted from this section after further discussion by the committee as they felt that the recommendation was not sufficiently clear. They wished to emphasise the importance of supporting the communication needs of the resident; however more formal requirements for advocacy are not needed in advance of a safeguarding referral being made. So it is clearer now that the LA has responsibility to provide this following a referral being made. See section 1.8.
Care Quality Commission	Guideline	38	14-16	At end of safeguarding enquiries there is a reference to CQC 'gives them the information needed to decide whether they wish to take further action (for example with the CQC)' Please note this is outside of the scope of CQC. We do not have any remit in taking further action either around people's complaints or the outcome of safeguarding investigations. We welcome feedback about people's experiences to inform our regulatory response. The guidance	Thank you for your comment. We have changed this recommendation to read "give them the information needed to decide whether they wish to take any further action (for example, to inform the Care Quality Commission or make a complaint to the Local Government and Social Care Ombudsman). We have also made a number of other amendments in different places in the guideline to emphasise that the CQC will not process individual complaints. But we have pointed staff and volunteers towards the CQC whistleblowing quick guide.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				does require clarification about our role as a regulator. Please refer to our guidance documents about our role and how we respond to concerns about care. As raised above the guidance document doesn't currently explain the complaints system in care homes, which often picks up quality of care issues that are at a lower level than abuse and neglect. https://www.cqc.org.uk/sites/default/files/documents/how_to_complain_about_a_health_or_soc_care_service_large_print_20110906_0.pdf https://www.cqc.org.uk/get-involved/share-your-experience/peoples-experience-care-what-we-want-know-why https://www.cqc.org.uk/get-involved/share-your-experience/because-we-all-care	
Care Quality Commission	Guideline	46	10-19	This refers to 'regulatory standards' and 'Care Quality Commission quality standards' Please can you look to align with CQC language – There are the regulations (minimum legal requirement), and then our key lines of enquiry we use to gather evidence, and the rating characteristics we apply to determine service rating. Consider looking at our guidance for adult social care providers to use our terminology as this is what providers will recognise. https://www.cqc.org.uk/guidance-providers/adult-social-care/how-we-monitor-inspect-regulate-adult-social-care-services	Thank you for your comments. We have amended the organisational abuse indicators in recommendation 1.12.2 about not meeting contractual or regulatory requirements to tie in more clearly with CQC language and terminology, national regulations and fundamental standards. We have included reference to the key lines of enquiry, national regulations and fundamental standards. The committee did discuss the CQC closed culture work and made some amendments to the indicators about "physical signs and lack of openness to visitors" to include more indicators of closed cultures. This is also highlighted in the care home culture section of the guideline. We have also changed the heading.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				The heading of organisational abuse didn't align with the text in this section. The reference to surveys etc didn't fit well. Suggest consider our - Closed culture work https://www.cqc.org.uk/publications/themes-care/our-work-closed-cultures	
Care Quality Commission	Guideline	49	17-26	For indicators starting with 'consider' For this section, we thought the audience was unclear – it reads as though this is targeted at a person using the service, or their relative – and we thought the 2 weeks reference would align with a complaint being raised with the provider about a quality of care issue. This needs to be really clear that it is about quality of care not 'suspect' abuse – concern if this is misunderstood could lead to delay in a safeguarding referral taking place.	Thank you for your comment. We have added text at the beginning of section 1.4 indicators to be clear that the recommendations in 1.4, 1.5 and 1.6 really do apply to everyone who may come into contact with care home residents. The recommendations are about the immediate actions that should be taken by anyone who considers or suspects abuse or neglect in a care home and the things to consider when reporting this to a care home manager or safeguarding lead. We have added a similar note to the beginning of section 1.12 which is about indicators of organisational abuse. We have also made some changes to one or two of the recs to be clear that actions to take if you 'consider' abuse or neglect may ultimately result in the issue being escalated into 'suspect' actions, which would require a referral to the local authority without delay.
Care Quality Commission	Guideline	64	19-27	CQC standards cover basic training This links to a 2014 joint signed off piece with ADASS and others but actually doesn't cover our view on training. Consider using a more relevant link	Thank you for your comment. We have included a reference to this document in our rationale and impact about the training recommendations. Based on the evidence, their experience and on various existing guidance including the Care Act statutory guidance and the Intercollegiate document published by the RCN the committee agreed the recommendations about training and induction requirements which are aimed at all care home staff.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-13-safeguarding-service-users-abuse-improper#guidance	The content of the mandatory training requirements in the NICE guideline should be seen as basic training content for all staff, but (as indicated) would need to be tailored with regards the level and detail of the content for different roles.
Care Quality Commission	Visual Guidelines		Both	These could cause confusion as it is important providers follow their local safeguarding policies and procedures.	Thank you for your comment. The visual summaries have been amended and are linked directly from the guideline now. They simply duplicate the pathway of recommendations within the guideline
City Health Care Partnership	Guideline	10	6	How will this work in practice, thinking about large care homes with multiple units. Will there be an expectation to have a safeguarding lead in each unit?	Thank you for your comment. This recommendation is intended to emphasise the importance of ensuring that there is oversight of safeguarding work within the care home or organisation and that all staff are aware of who has this responsibility. The committee feel that it is appropriate for providers to make decisions regarding the 'coverage' of safeguarding leads.
City Health Care Partnership	Guideline	10	17	How regular? Does this need to identify a specific time frame and who will be responsible for ensuring that this is actioned? E.G CQC/Commissioners	Thank you for your comment. This recommendation has been edited to make it clear that care homes should audit their own care records *in addition* to external audits by bodies such as the CQC; however, as they did not review evidence on this, the committee did not feel that it was appropriate to specify a timeframe because different types of records may need to be audited at different times depending on the nature of the content. The important message the committee wanted to communicate in the rec is that this should be done as part of normal record keeping practice
City Health Care Partnership	Guideline	13	3	'as soon as possible' is very subjective, should this not be completed during induction to ensure understanding and consolidation of learning prior to working independently? Without this there is an element of risk which will need to be mitigate against.	Thank you for your comment. The committee discussed at length the timescale within which mandatory training should be completed by new staff (see evidence review H for details). The committee felt that specifying 'no later than 6 weeks' was an appropriate limit, particularly as this aligns with other guidance such as that from the RCN (Adult Safeguarding: Roles and competencies for Health Care Staff 2018).

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

City Health Care Partnership	Guideline	13	007 - 010	There may be implications in being able to effectively tailor training to staff roles from a multi-agency perspective from health and social care as there are some differences between the intercollegiate and Bournemouth guidance for safeguarding training.	Thank you for your comment. A number of stakeholders also expressed concern over this recommendation and having discussed it further the committee agreed to remove it from the final version of the guideline.
City Health Care Partnership	Guideline	13	13	Is this realistic?	Thank you for your comment. NICE guidelines are intended to reflect best practice and to reduce variations in quality across the sector. The committee drafted recommendations which they believe to be achievable within the current climate.
City Health Care Partnership	Guideline	14	2	Who will set the standard for mandatory training as there are differences between the Intercollegiate and Bournemouth documents? Will there be identified differences between Nursing and Residential Care Home requirement's?	Thank you for your comment. Mandatory training for safeguarding is required to fulfil section 14.225 of the care and support statutory guidance. The committee agreed that it was not appropriate for the this guideline to include detail about professional standards and competencies for different health and practitioner roles in relation to safeguarding, instead referring to the intercollegiate document as a guide for certain roles.
City Health Care Partnership	Guideline	15	3	How can the reflection be evidenced? What are the timescales required to evidence it?	Thank you for your comment. The committee did not feel that it was appropriate to be prescriptive regarding evidence of reflective learning and timescales.
City Health Care Partnership	Guideline	16	2	Agree that training should be face to face and need to ensure that the option of e learning because face to face is not available does not become an easy option (staff absence etc).	Thank you for your comment. The committee's recommendations relating to training are based on a systematic review which did not identify any quantitative evidence comparing the effectiveness of different modes of training and provided only limited evidence in relation to cost-effectiveness. However, the committee acknowledged that there is anecdotal evidence of concerns about e-learning, and that these reflect their own concerns; particularly in relation to the absence of human interaction and opportunities for discussion. As a result, the committee agreed that it was appropriate to recommend that face-to-face training should be used wherever possible, but also to recommend

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					that e-learning could be used if it was not possible to provide face-to-face training. The committee also agreed to clarify that face-to-face training should include the use of virtual platforms, which they believe will help to mitigate against the challenges that have occurred as a result of Covid-19 (as well as potential resourcing issues).
City Health Care Partnership	Guideline	16	20	This should also include access to the IT equipment	Thank you for your comment. The committee believe that this is implicit in the recommendation and is part of standard practice for managers.
City Health Care Partnership	Guideline	17	6	Be specific about what the quality check and sample is	Thank you for your comment. The committee agreed that it is appropriate for care home managers to make decisions on these issues.
City Health Care Partnership	Guideline	17	8	What is the specific time frame? Does on site mean where training is delivered or at the workplace?	Thank you for your comment. This recommendation has been edited so that it is clear that training is completed in an agreed timeframe - and the reference to being delivered on-site has been removed.
City Health Care Partnership	Guideline	18	6	How will this be evidenced?	Thank you for your comment. Whilst the evidence which the committee reviewed suggested that managers have an important role to play in modelling safeguarding best practice, it did not include details on how this could be checked. The committee did not therefore feel that it was appropriate to be prescriptive with regards to how to evidence that care home managers and safeguarding leads are leading by example.
City Health Care Partnership	Guideline	19	1	From experience care homes do not undertake exit interviews so how will the information be gathered?	Thank you for your comment. The committee drafted this recommendation with the intention of promoting exit interviews as best practice. However they recognise that care homes may use different methods to gather this information and exit interviews are now included as an example only.
City Health Care Partnership	Guideline	20	1	How can care home providers factor the time in to enable this to be effective for all staff and it is unlikely the care home would be provided with SAR	Thank you for your comment. NICE guidelines are intended to reflect best practice and the committee drafted recommendations which they believe to be achievable in the current climate; however, they

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				details for learning unless they were involved in the SAR process.	recognise that this may not always be possible and feel that the use of the word 'regular' ensures that this does not place too great a burden on care home managers. The committee also drafted recommendations specifying that SABs should take a proactive role in fostering learning from SARs where possible.
City Health Care Partnership	Guideline	21	12	This is unrealistic	Thank you for your comment. The committee have amended a number of the recommendations that referenced Safeguarding Adults Boards (SABs) to make it clearer that boards have a strategic oversight role and as such are often not taking forward actions themselves but are seeking assurances that local authorities, other commissioners and representative organisations on the board are. The committee agreed to remove as a result and incorporated aspects of this into a recommendation relating to training. This recommends that SABs (and their subgroups and partners) should encourage care home providers to arrange opportunities for staff and residents to learn together from recent SARs.
City Health Care Partnership	Guideline	22	2	This needs to be more specific about what information is to be shared and with which staff	Thank you for your comment. Whilst the evidence which the committee reviewed aligned with the committees own views on the importance of information sharing in relation to safeguarding practice, there was limited information about what should be shared and with whom. The committee did not therefore feel that it was appropriate to be prescriptive with regards to this recommendation.
City Health Care Partnership	Guideline	22	9	How regular is regularly? Annually/quarterly How will this be achieved and who will ensure the mangers are competent to review the records	Thank you for your comment. The committee did not feel that it was appropriate to specify at what interval records should be reviewed as no evidence was identified which focused on this issue. Whilst the committee were keen to emphasise that this should be done regularly, they felt that this should be decided at the local level, and that it is also appropriate that decisions about which staff

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					have the competency to carry this work out are made at this level.
City Health Care Partnership	Guideline	23	21	This is too vague what level of information should be provided and in what format? Leaflets? Posters? Information pack?	Thank you for your comment. As the committee did not review evidence relating to this issue they could not be prescriptive with regards to information formats.
City Health Care Partnership	Guideline	31	1	Unless the safeguarding lead is the alleged perpetrator	Thank you for your comment. The recommendation now includes the following qualifier "… unless they are implicated in the alleged abuse…"
City Health Care Partnership	Guideline	32	7	Also consider the safeguarding lead and the Multi Agency Safeguarding Hub (MASH)	Thank you for your comment. This recommendation covers the immediate steps to be taken when abuse or neglect is suspected and as such they focus on working with the individual at risk. Notifying the safeguarding lead is covered in the section on reporting suspected abuse or neglect.
City Health Care Partnership	Guideline	32	22	Also consider Mental Capacity and Best interests and Public Interest at this point	Thank you for your comment. Reference to advocacy has been deleted from this section after further discussion by the committee as they felt that the recommendation was not sufficiently clear. They wished to emphasise the importance of supporting the communication needs of the resident; however more formal requirements for advocacy are not needed in advance of a safeguarding referral being made. So it is clearer now that the LA has responsibility to provide this following a referral being made. See section 1.8.
City Health Care Partnership	Guideline	34	15	This needs to be more clear regarding the relationship of trust of the alleged perpetrator and the resident	Thank you for your comment. The committee agreed to add some detail to the recommendation to make it clearer that this was about the presence of a 'power imbalance' between the alleged abuser and resident.
City Health Care Partnership	Guideline	38	7	Would the Police investigation take precedence over the Section 42 and therefore	Thank you for your comment. It is not within the scope of the guideline to specify how police investigations or section 42 enquiries are undertaken.
City Health Care Partnership	Guideline	38	24	Is this referring to Independent Mental Capacity Advocate or a general advocate such as a friend?	Thank you for your comment. This recommendation includes reference to both general advocates and independent advocates appointed when this is required via legislation e.g. the Mental Capacity Act.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

City Health Care Partnership	Guideline	39	15	How is this achievable?	Thank you for your comment. This recommendation has been edited to clarify that this is the responsibility of local authorities and commissioners rather than SABs.
City Health Care Partnership	Guideline	45	24	Should include when policies are not being implemented	Thank you for your comment. The committee agree that this is an important issue to consider and it has been added to the list of potential indicators of organisational abuse or neglect.
City Health Care Partnership	Guideline	49	12	Purposely silenced or deactivated call bells when client is not aware of this	Thank you for your comment. This has been added as an example as suggested.
City Health Care Partnership	Guideline	49	22	Should think link with the care homes complaints procedure	Thank you for your comment. The committee preferred not to link this to the complaints procedure but instead included 2 weeks as an example of a reasonable timescale to respond.
City Health Care Partnership	Guideline	51	10	How can this be embedded and evidence this as from experience, learning from enquires and SAR's are rarely shared with care homes?	Thank you for your comment. The committee drafted recommendations earlier in the guideline about the importance of SABs and local authorities sharing this information with care homes.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	General	General	In line with our approach to full consultation with SAB members on the NICE guidelines, one of our Lay Members has provided feedback specific to the COVID-19 pandemic, highlighting the potential concerns for quality assurance of care provision and specifically how this may be compromised during COVID, whilst locally this is addressed it is useful to share that feedback as part of this consultative activity'. Age groups are another feature of that feedback with reference 'older' groups those with care and support needs covers all adults over the age of 18 and a broad range of needs e.g. Learning Disability. The size and complexity of the guidance for providers/care home managers has also been flagged.	Thank you for your comment. The committee recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes. The committee have discussed their recommendations in light of this and have attempted to mitigate against the impact of Covid-19 wherever possible, although learning from the pandemic may inform any future updates of the recommendations. NICE have published products related to their response to COVID-19 here which are being updated regularly. We will flag any relevant areas to the COVID-19 guideline team. The committee understand that the population of people living in care homes is very diverse. In the section entitled 'the purpose of this guideline' the committee have emphasised that the guideline covers *all* care home residents (including those attending for the day). Whilst the committee acknowledge that a large number of people living in care homes may have very specific needs; no

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					evidence (meeting the inclusion criteria for the systematic reviews underpinning the guideline) was identified which focused on safeguarding practice in relation to these groups of people and the committee did not therefore feel able to make targeted recommendations. However, they were mindful of the 6 core principles of safeguarding and Making Safeguarding Personal when drafting recommendations and took care to ensure that the recommendations are not discriminatory. In addition, an Equality Impact Assessment of the guideline and recommendations has been carried out to ensure that people with more specific needs are not disadvantaged. With regards to the size and complexity of the guideline, for the purposes of transparency it is necessary to make all of the guideline documents and review work available at the same time. However, once the guideline has been finalised it will be published on the NICE website as part of an interactive 'pathway' (which also links to other relevant guidance) making it more easy to use and navigate.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	General	General	Safeguarding champions is a good approach, and the initiative is being taken forward locally. This may not be able to be put in place across all providers/areas due to potential resource implications.	Thank you for your comment and support. The committee wanted to be clear that safeguarding champions are staff already working within the care home, with good knowledge of safeguarding policy and procedure - but who are appointed as champions of safeguarding within the care home as part of their substantive role. This is clear in the 'terms used in the guideline. As such there would be minimal resource implications.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	General	General	Training is in place - No we just ask to see evidence of certificated safeguarding training not annually the only one we ask for annually is moving and handling Annual training is not required, the LSAB stance is	Thank you for your comment. These recommendations have been edited to clarify that care homes should assess knowledge of safeguarding on an annual basis rather than provide training every year.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				repeat 3 yearly unless key legislative changes take place, that is not to say that the 'provider' should be proactively ensuring that there staff remain up-skilled and knowledgeable as they have a responsibility to safeguard like any other agency	
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	General	General	(Face to face training recommendation may need to be adapted in current circs…) Most do e learning	Thank you for your comment. After lengthy discussions regarding the delivery of training the committee agreed to clarify that face-to-face training should include the use of virtual platforms. The committee agreed that this should mitigate against the challenges that have occurred as a result of Covid-19 (as well as potential resourcing issues). The definition (found in the 'terms used' section of the short guideline) includes the following text: "It may take place with participants all in the same room, or by using video or telephone conferencing. It may include online materials, but participants are able to ask questions, discuss, reflect on current practice and use case studies and examples."
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	General	General	Not sure how easy it is for homes to incorporate SAB review findings into training? We would need to assist .Homes tend to buy training privately not carry out their own which would also make this difficult	Thank you for your comment. NICE guidelines are intended to reflect best practice and the committee drafted recommendations which they believe to be achievable. They hope that these recommendations will encourage care homes and providers to request that trainers include this type of information, given that it is publicly available.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	2	16	1.2.11 I would support this. Face to face is best by a long way. eLearning has it's limitations	Thank you for your support.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	2	17	Aspirational	Thank you for your comment. NICE guidelines are intended to reflect best practice and to reduce variations in quality across the sector. The committee drafted recommendations which they believe to be achievable within the current climate.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	2	18	OK in theory but Aspirational	Thank you for your comment. NICE guidelines are intended to reflect best practice and to reduce variations in quality across the sector. The committee drafted recommendations which they believe to be achievable in the current climate.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	8	5	1.1.1 Support this element. The LSAB business unit have devised a policy template to be consulted upon for use by all agency types in developing internal policy, however, that is with the caveat that it should be in keeping with locally agreed multiagency policy.	Thank you for your support for this recommendation.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	8	10	1.1.2 A reasonable requirement – there should be checks to see if it's accessible	Thank you for your comment and support for the recommendation. The committee agree that accessibility is key and ensured that this was clearly set out in the recommendation itself.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	8	General	There may be some difficulty in Care Homes aligning policy with local arrangements if subject to their own organisations, policy/procedures/templates developed nationally.	Thank you for your comment. This recommendation has been edited to clarify that whilst care homes and providers must have an overarching safeguarding policy and procedure in place to meet the requirements of the Care Act; however local arrangements should be considered when implementing this.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	9	1	1.1.3 Would probably require an IT response	Thank you for your comment. The committee agree that this may be an issue and have added details to the relevant rationale and impact section to highlight potential technological implications.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	9	4	1.1.4 There is a training implication	Thank you for your comment. The committee agree that this may be an issue and have added details to the relevant rationale and impact section to highlight potential training implications.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	9	7	1.1.5 Guidance for this should be in the policies and procedures	Thank you for your comment. The committee agree that this is an important point and feel that this is covered in the recommendations relating to safeguarding policies and procedures.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	9	10	Should be part of the policy and procedures.	Thank you for your comment. The committee agree that whistleblowing should be central to safeguarding procedures and drafted the recommendation on this basis.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	9	12	1.1.7 I never heard of an external whistle blowing service. There will be a cost implication to consider.	Thank you for your comment. The committee acknowledge that not all care homes will be able to establish an external whistleblowing service which is why the committee have only recommended that care homes consider this. The committee also

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					added a new recommendation stating that care home providers "… should have a clear procedure setting out how anyone can report a whistleblowing concern. This process must specify who people can contact, and how (for example the local authority or the Care Quality Commission)."
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	10	1	1.1.9 Support should come through the whistle blowing service and/or the local authority	Thank you for your comment. Whilst the committee agree that support for whistleblowers is important, the aim of this recommendation is to make it clear that organisations should not treat whistleblowers unfairly (or terminate their employment) as a result of their disclosures, and that doing so is illegal. After further discussion, the committee agreed that the recommendations in sections 1.8, 1.9 and 1.10 cover the issue of support and the reference to support has been deleted from this recommendation.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	10	14	1.1.13 There is a training implication / cost	Thank you for your comment. The committee agree there are links to training requirements here and have added a link to section 2 of the recommendations which covers training and induction.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	10	17	1.1.14 Good. Care home records are a major issue. Not sure how we could achieve this. Aspirational!	Thank you for your comment and support. NICE guidelines are intended to reflect best practice and to reduce variations in quality across the sector. The committee drafted recommendations which they believe to be achievable within the current climate.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	11	6	1.1.16 Would require provider forums, newsletters, training	Thank you for your comment. The committee did not wish to be prescriptive with regards to the methods through which this should be done.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	11	General	Local Authorities responsibilities will be difficult to meet if placements are 'out of area', a care home in an area may not have a contract with the host authority with residents being placed by other authorities or self-funding.	Thank you for your comment. Whilst the committee acknowledge that 'out of area' placements may have monitoring implications; these recommendations are intended to reflect best practice. This recommendation specifically places the onus on local authorities to ensure that providers are meeting their statutory and contractual duties regardless of placement location. As this recommendation is

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					aimed at commissioners it is not possible to reference self-funders in this particular instance; however the committee were mindful of the issues that people who self-fund their own care may face in relation to safeguarding in care homes and drafted all recommendations with these in mind.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	12	2	1.1.18 The board has a clear oversight function and is not operational, and policy and procedures already make that clear and any new revision will echo, the SAB would not require that level of detail in terms of safeguarding leads for care homes and/or providers. This is an operational issue and not for the board This is not a strategic function to do this and operational. Not sure how this will be achieved is it social care, safeguarding leads or SAB business unit	Thank you for your comment. This recommendation has been edited to clarify that SABs should seek assurances that clear lines of communication are in place between commissioners, the Regulator and safeguarding leads; rather than the detailed knowledge suggested by the original text.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	12	6	1.1.19 What recommendations does this refer to? If the inference is that it relates to Safeguarding Adult Reviews, then likely it is relevant, if this relates to consultation for board strategic plans then possible to carry out undertake survey activity (which will include consideration of capacity for business units and not all will be structured the same). Is there something here for Care Quality Commission role too and regulatory standards. The CQC is their regulatory body, not be part of this. The only area I can see relevant is SARs How would this work? Surveys? Membership? Chair Role? If membership how would the SAB ensure a broad representation, and that one provider	Thank you for your comment. This recommendation has been edited to clarify that SABs may consider commissioning such training but are not required to provide it themselves. The committee expects that these recommendations may arise as a result of SARs, but do not wish to imply that SARs would be the only source of learning. The committee is not able to make recommendations to the CQC but they hope that this section will be useful to all regulatory bodies.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				type is not given precedence over another, inclusivity would be an issue, just on numbers alone, and currently that input is sought via SAB representation at provider forums. Would this be through a representative group or questionnaire?	
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	12	10	1.1.20 A fundamental role of the SAB anyway and oversight is to seek assurance of safeguarding intervention/enquiries. It can be picked up through board usual audit activity and through the 'outcomes data' of national returns, or does this relate to specific support such as the role of advocacy? This is done via performance reporting and agency assurance reports This is aspirational – would be ideal if achievable. Partners would have to build this into their own organisational processes.	Thank you for your comments. This recommendation has been edited to clarify that SABs should seek assurances from their partners that this responsibility is being met rather than the level of involvement that may have been suggested by the original text.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	12	12	1.1.21 The SAB annual report requirements and contributions related to the statutory and relevant partners, if this alludes to providers as a relevant partner, this would sit better with commissioners, who are informed of local provision. Sheer numbers of providers across areas would make this difficult to achieve, the SAB has no power to request submissions/contributions, which would impact upon the SAB being able to discharge that recommendation. Not practical or necessary. Is it practical, or required. This could be done as a collective via commissioning teams and the interface with providers.	Thank you for your comment. This section has been edited to clarify that SABs should include matters relevant to safeguarding in care homes in their annual report rather than the wider consultation with care homes suggested by the original text.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				Is this a representative group, and how would identify fairly and with inclusivity.	
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	12	15	1.1.22 The SAB already has an escalation process in place for Care Homes/staff to escalate issues of dispute/disagreement and it follows learning from a Mental Health Homicide Review and to resolve disputes/disagreements and escalate. This needs further clarity as to whether any proposed escalation model encompasses adults/families or those that are unhappy with the process/outcome, if so is this is duplicating the Adult Social Care Ombudsmen guidance and complaint. Opportunity to provide clarity in policy revisions. These processes are in place and should be standard. Can be done through professional challenge. Is it asking if we need an appeals process for safeguarding outcomes instead of or prior to a judicial review.	Thank you for your comment. This recommendation has been edited to clarify that SABs should ensure that escalation procedures are relevant to care homes rather than establish new processes as suggested by the original text.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	12	20	1.2.2 The question is – is it this their training or local authority or SAB training. Either way it should be compliant.	Thank you for your comment. This relates to training provided by the care home or provider.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	12	General	Safeguarding Boards may not be aware of all establishments in their area, processes for accurately collating and maintaining this information have proved difficult therefore engaging directly with all homes and safeguarding leads may prove difficult to achieve. Nor should the SAB know of every establishment this will sit with commissioners' roles in the SAB being sighted of issues.	Thank you for your comment. This recommendation has been edited to clarify that SABs should seek assurances that clear lines of communication are in place between commissioners, the Regulator and safeguarding leads; rather than the detailed knowledge suggested by the original text.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	13	1	This is aspirational. How do you ensure agency staff are trained who may come in for one shift to cover sickness? It would mean that they would have to use the same people if available.	Thank you for your comment. NICE guidelines are intended to reflect best practice and to reduce variations in quality across the sector. The committee drafted recommendations which they believe to be achievable within the current climate. However, the committee have included a new recommendation to clarify that whilst care home managers must ensure that agency staff working at the home have completed the necessary safeguarding training for their role, and that they understand the local safeguarding policy and procedure, care home managers are not themselves responsible for arranging or providing this.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	13	6	SABs should consider organising mandatory training for care homes - training provision is already in place for providers to access free via the SAB, and the SAB is not in a position to dictate/enforce with individual providers/employers, commissioners include contractual clauses re training etc. Opportunities in place via commissioners for safeguarding champions training Tailor training for each member of staff – the SAB already draws upon competency frameworks such as the Bournemouth Competencies and NHS Intercollegiate document, this happens as well as drawing on Skills for Care etc and commissioners role in supporting providers. A training network/group is in place to ensure that we capture health and social care elements. There is not a requirement under the Care Act. This would be ideal but who would pay for it. Could care home pay a levy for the LA and/or LSAB to provide it centrally.	Thank you for your comment. These recommendations have been edited to clarify that SABs should seek assurance from their partners regarding training (rather than provide or commission this themselves) to ensure that it has been developed on a multi-agency basis and reflects the level of responsibility for each role/level.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	13	13	1.2.5 Aspirational. Cannot see it happening	Thank you for your comment. NICE guidelines are intended to reflect best practice and to reduce variations in quality across the sector. The committee drafted recommendations which they believe to be achievable within the current climate.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	13	17	1.2.6 Very aspirational this is a high staff turn around industry	Thank you for your comment. NICE guidelines are intended to reflect best practice and to reduce variations in quality across the sector. The committee drafted recommendations which they believe to be achievable within the current climate. The committee also included an additional recommendation to ensure that the financial burden of training agency staff did not always fall on care homes: " Care home managers must ensure that agency staff working at the home have completed the necessary safeguarding training for their role, and that they understand the local safeguarding policy and procedure. "
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	14	2	1.2.7 Yes I would agree	Thank you for your support.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	14	10	National guidance on the differences between poor practice and abuse/neglect aimed at the care home sector to supplement training would be welcomed. Our experience is that despite training this distinction is not easily grasped by providers as evidenced in the referrals that they make to the Local Authority. A move to improve knowledge and awareness of providers to reduce inappropriate reporting is welcomed.	Thank you for your comment and support.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	14	General	We do not assess training content of providers programmes, we do not have the knowledge to determine if training is adequate for every setting, therefore we ensure its certificated and therefore the training body is accountable. Also we do not see training content (not accessible to us) only evidence a course has been completed.	Thank you for your comment. We have edited these recommendations to clarify that SABs should seek assurances from their partners regarding the quality and content of training but are not required to provide or evaluate training themselves.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				LSAB training is reviewed by partners prior to rollout, the LSAB can not dictate the source of training for providers but does compare against nationally recognised frameworks to ensure it is fit for purpose. The LSAB training therefore meets competencies.	
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	15	3	1.2.8 Aspirational	Thank you for your comment. NICE guidelines are intended to reflect best practice and to reduce variations in quality across the sector. The committee drafted recommendations which they believe to be achievable within the current climate.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	15	6	1.2.9 Aspirational	Thank you for your comment. NICE guidelines are intended to reflect best practice and to reduce variations in quality across the sector. The committee drafted recommendations which they believe to be achievable within the current climate.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	15	10	1.2.10 Good content	Thank you for your support.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	19	8	1.3.8. Very important – all of it	Thank you for your comment and for your support for this recommendation.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	20	10	1.3.12. I would support this and have it fed back to the SAB	Thank you for your comment and for your support for this recommendation.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	20	General	P20 – need to be careful about asking people for safeguarding experiences – must be done sensitively. Is recording of this etc expected? It means tailoring training which may be seen as an additional burden by many – though it is a good idea. Is a compromise highlighting these and asking for them to be shared with staff in meetings etc? We have started highlighting cases which have gone to court in the newsletter which is powerful for example.	Thank you for your comment. The committee agree that asking people about their experiences should always be done carefully, sensitively, and with regard to data protection principles. However, they believe that the experiences of care home residents are a key source of information that can facilitate learning, although they felt that it is appropriate to allow individual care homes/providers to make decisions on how these experiences should be shared.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	21	9	This should go without saying	Thank you for your comment. The committee agreed that it was important to make a clear recommendation that local partnership agreements should cover "… the indicators of abuse and neglect that should result in safeguarding action (based on the indicators in this guideline)". This is because there is a range of guidance relating to indicators of abuse and neglect; however where this guideline recommends that indicators should be included in local partnership agreements, it refers specifically to these indicators.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	21	12	1.3.15 – 1.3.18. The SAB should arrange opportunities for staff and residents to learn together – why? some of this is captured through national return and outcomes met? SAB has attempted survey activity for a number of years with limited success, SAB Chair has included in work programme opportunities to meet with client groups to gain valuable insight and feedback. Providers receive bulletins /briefings from the SAB Individual learning reflection at the debrief stage Everybody's responsibility to safeguard, should providers not be proactive in acting on any learning internally, and from mechanisms such as compliments/comments and complaints and ensure that learning is embedded in any in-house messages and/or in-house training? Worth-while maybe in a forum setting	Thank you for your comment. The committee have amended a number of the recommendations that referenced Safeguarding Adults Boards (SABs) to make it clearer that boards have a strategic oversight role and as such are often not taking forward actions themselves but are seeking assurances that local authorities, other commissioners and representative organisations on the board are. The committee agreed to remove as a result and incorporated aspects of this into a recommendation relating to training. This recommends that SABs (and their subgroups and partners) should encourage care home providers to arrange opportunities for staff and residents to learn together from recent SARs.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	22	2	Sharing records of safeguarding actions with other staff would need to be carefully actioned considering GDPR and implications if perpetrator information is included	Thank you for your comment. This recommendation has been edited to suggest that this should be done 'as necessary' to ensure that data protection requirements can be considered.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	22	2	1.3.19 Supported.	Thank you for your comment and your support for this recommendation.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	22	General	1.4 Onwards. This is OK and fairly standard practice and has been for years. Good to see that they have not fallen into the trap of asking for consent to refer. There should be some inclusion that when there is a crime police should comply with the victim's code of practice and obtain a victims personal statement.	Thank you for your comment. Recommendations relating to police procedure are not within scope of this guideline.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	24	21	Health and social care staff may not have contact with residents and families of self-funders, this information would surely be best provided by care homes on admission.	Thank you for your comment. This issue is beyond the scope of the guideline.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	27	17	This should be expanded to include any sexual activity with any person (including partner/husband/wife) where mental capacity may be in question. This should not just be about consent.	Thank you for your comment. The list of potential indicators of sexual abuse have been edited and details regarding marriage have been added. Further information regarding a residents right to engage in sexual activity if they have the mental capacity to consent has also been added, and the 'suspect' indicators have been separated accordingly.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	35	3	1.7.5 The report should include all relevant information which should be factual and as accurate as possible. E.g. exact Time and date of incident. Full identifying details name date of birth etc. Details of who witnessed what. Use a template if available The LSAB training reinforces factual recording and separating opinion, it also makes clear the onus upon agencies to ensure the accuracy of information and uses exemplars to support. The LSAB has no power to dictate how providers access training and in what format or source which naturally means there will be disparity so this tool may serve to standardise practice for providers. This is not 'new' it should be happening.	Thank you for your comment. The committee did not want to go into this level of detail about what a report should contain. The committee agreed that guidance is best left to local authorities to set out what they would need and the format of this.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	37	19	1.8.6 SABs and LA's should have auditing processes in place….monitor how residents/advocates included in safeguarding enquiries – The SAB has and continues to undertake advocacy survey activity and reports are submitted to SAB.	Thank you for your comment and support. This recommendation has been edited to clarify that SABs should ensure that LAs have these processes in place; rather than both LAs and SABs having their own processes.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				Review of audits is planned. Social Care also undertake a range of quality assurance activity and report internally through Senior Management discussions. Equally, the Care Act makes clear in Section 43 (4) that the SAB may do anything which appears to it to be **necessary or desirable** for the purpose of achieving its objective. Schedule 2 of the Care Act 2014 outlines it is for 'each' SAB area to determine its own arrangements, resources etc, there will be different approaches in each SAB area and resource(s) to what they can achieve and what will be a priority.	
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	39	14	1.8.14 SABs should monitor whether care homes are telling residents about advocacy and criteria for accessing – why? Should it not be considered anyway for enquiries? How would that take place? E.g. a survey? Have any resources needed and/or implications for SAB and their units been considered for this recommendation? Potential for the key worker to pick it up at assessment and review and feedback to SAB in some way (surveys?). how advocates are involved in the management of safeguarding concerns – this is identified in the point above page 37 (19, 1.8.6) serves as a helpful prompt for SAB to revisit regularly and for consistency.	Thank you for your comment. This recommendation has been edited to clarify that this is the responsibility of local authorities and commissioners rather than SABs.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	43	General	It's not clear but reads as an assumption that all safeguarding enquiries involve meetings.	Thank you for your comment. The committee believe that this heading is sufficiently clear. It does not imply that all enquiries will involve meetings but it does make recommendations about meetings if and when they are held.
County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	44	9	This is well put not many people understand this. It looks like this section fits into our executive/organisational safeguarding process.	Thank you for your comment and support.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

County Durham Safeguarding Adults Inter-Agency Partnership	Guideline	47	General	Staffing indicators on P47 may need to be a bit more flex during pandemic as may be high absence levels, reliance on temp staff, higher turnover.	Thank you for your comment. The committee recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes. The committee have discussed their recommendations in light of this and have attempted to mitigate against the impact of Covid-19 wherever possible. As these are a 'consider abuse or neglect' indicators (i.e. one *possible* explanation) the committee believe that this provides sufficient flexibility, however, learning from the pandemic may inform any future updates of the recommendations. NICE have published products related to their response to COVID-19 here which are being updated regularly. We will flag any relevant areas to the COVID-19 guideline team.
Dementia UK	Evidence Reviews	General	General	A general comment about the challenges of service provision during COVID-19 outbreak (e.g. General Practitioner clinical oversight, paucity and variance in face to face assessments) and how this may impact on safeguarding policies and procedures.	Thank you for your comment. The committee recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes. The committee have discussed their recommendations in light of this and have attempted to mitigate against the impact of Covid-19 wherever possible, although learning from the pandemic may inform any future updates of the recommendations. NICE have published products related to their response to COVID-19 here which are being updated regularly. We will flag any relevant areas to the COVID-19 guideline team.
Dementia UK	Evidence Reviews	General	General	A general comment about the paucity of research within the field of safeguarding and how to implement best practice across systems to inform guidelines and training requirements. There are clearly significant financial implications for this work but given the vulnerabilities of this group and the dichotomous nature of the provision of services to care home population, as opposed to those living in the community, this is a key priority.	Thank you for your question. NICE takes the research recommendations forward in the sense that they liaise with the research community to ensure they are addressed. NICE does this by communicating research recommendations to researchers and funders. In particular, NICE works closely with the NIHR (including the SSCR) and NETSCC to prioritise research recommendations from across the programme of NICE guidelines, meeting regularly to monitor progress on carrying out and funding research from NICE research recommendations. NICE will work in exactly this way to promote

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					the funding and commissioning of research that will address the gaps identified by the committee for this guideline.
Dementia UK	Guideline	General	General	Thank you for the opportunity to feedback on this important and relevant document. The following comments aim to support and strengthen the safeguarding adults in care homes recommendations.	Thank you for your support.
Dementia UK	Guideline	General	General	We suggest strengthening the overall tone of the recommendations to be more consistently person centred, particularly relevant for people living with dementia who are a high proportion of nursing and residential care home residents. Words used to talk about dementia can have a significant impact on how people with dementia are viewed and treated in our community. See: https://www.dementia.org.au/sites/default/files/resources/dementia-language-guidelines.pdf	Thank you for your comment. The committee agree that person-centred care is central to effective safeguarding, particularly for those with more complex needs such as people with dementia. The committee were mindful of this when writing recommendations and putting the person at the centre of all safeguarding decision making is a common thread throughout all the recommendations. Unfortunately, there was an absence of evidence on safeguarding in relation to specific groups (such as people with dementia), that met pre-specified inclusion criteria, which made it difficult for the committee to make targeted recommendations, however they were mindful of the 6 core principles of safeguarding and Making Safeguarding Personal when drafting recommendations and took care to ensure that the recommendations are not discriminatory. In addition, an Equality Impact Assessment of the guideline and recommendations has been carried out to ensure that people with more specific needs are not disadvantaged. In addition, a number of recommendations emphasise the importance of support for communication, particularly in relation to people who may have difficulties communicating verbally and the importance of considering non-verbal indicators of abuse or neglect, such as unexplained changes in a residents' behaviour.
Dementia UK	Guideline	General	General	There is evidence of the impact of COVID-19 on the health and social care workforce and we believe that this has a wider implication for care	Thank you for your comment. The committee recognises the significant impact which Covid-19 has had on the care sector in general and on individual

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				home residents. E.g. recent findings from the pilot phase of the Coronavirus (COVID-19) Infection Survey, England, Wales and Northern Ireland report that nursing and care home workers have a higher positive COVID-19 infection rate than those working in non-patient facing roles. We believe that this means that the care home workforce capacity and expertise in safeguarding (and other issues) is challenged. See: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/datasets/coronaviruscovid19infectionsurveydata/2020	care homes. The committee have discussed their recommendations in light of this and have attempted to mitigate against the impact of Covid-19 wherever possible, although learning from the pandemic may inform any future updates of the recommendations. NICE have published products related to their response to COVID-19 here which are being updated regularly. We will flag any relevant areas to the COVID-19 guideline team.
Dementia UK	Guideline	General	General	A general comment to acknowledge the escalating acuity of need in care homes due to an ageing population and complexity of health and social care needs. This relates to the role of the wider health and social care system to enable and support safeguarding best practice.	Thank you for your comment. The committee acknowledge that the population of people living in care homes have a wide and complex range of health and social care needs. Unfortunately, there was an absence of evidence on safeguarding in relation to specific groups that met pre-specified inclusion criteria, which made it difficult for the committee to make targeted recommendations, however they were mindful of the 6 core principles of safeguarding and Making Safeguarding Personal when drafting recommendations and took care to ensure that the recommendations are not discriminatory. In addition, an Equality Impact Assessment of the guideline and recommendations has been carried out to ensure that people with more specific needs are not disadvantaged.
Dementia UK	Guideline	General	General	We are concerned over the lack of and consistent definition of nursing home and residential care homes in the recommendations. We believe that consistent use of language and definitions for nursing and residential homes is important because of e.g. expectations of provision of care, workforce skill mix and ratios as well as the co-ordination of care services with care homes. See	Thank you for your comment. All recommendations are aimed at nursing and residential care homes and the guideline is consistent in its use of the term care homes, which is defined in the glossary as "Residential care homes (with or without nursing care) that are registered with and regulated by the Care Quality Commission."

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				Sanford, A.M., Orrell, M., Tolson, D., Abbatecola, A.M., Arai, H., Bauer, J.M., Cruz-Jentoft, A.J., Dong, B., Ga, H., Goel, A. and Hajjar, R., 2015. An international definition for "nursing home". Journal of the American Medical Directors Association, 16(3), pp.181-184. O'Neill, D., Briggs, R., Holmerová, I., Samuelsson, O., Gordon, A.L. and Martin, F.C., 2020. COVID-19 highlights the need for universal adoption of standards of medical care for physicians in nursing homes in Europe. European Geriatric Medicine, 11(4), pp.645-650.	
Dementia UK	Guideline	General	General	We are concerned about the challenges in implementation of the recommendations into practice e.g. training, education, supervision and mentorship as well as workforce capacity to attend or deliver. The care home sector includes individual as well as multiple providers and there is evidence of care home work being viewed as low status as well as the transient nature of the workforce limiting mandating and registration of training and/ or qualifications. Equally there remains a paucity of Quality Assurance and guidelines in relation to taught content of courses/ agreed minimum standards The COVID-19 outbreak has highlighted the importance of supporting best practice within and from care homes especially in the infrastructure around them. See: Gordon, A.L., Goodman, C., Davies, S.L., Dening, T., Gage, H., Meyer, J., Schneider, J., Bell, B., Jordan, J., Martin, F.C. and Iliffe, S., 2018. Optimal healthcare delivery to care homes in the UK: a realist evaluation of what supports effective working to improve healthcare outcomes. Age and ageing, 47(4), pp.595-603.	Thank you for your comment and providing this feedback. The committee drafted recommendations which they believe to be achievable in the current climate. Whilst they acknowledge that smaller providers may face greater challenges in implementing some of these recommendations; NICE guidelines are intended to reflect best practice. Where possible, the committee have built flexibility into the recommendations to avoid placing too great a burden on smaller providers. The committee recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes. The committee have discussed their recommendations in light of this and have attempted to mitigate against the impact of Covid-19 wherever possible, although learning from the pandemic may inform any future updates of the recommendations. NICE have published products related to their response to COVID-19 here which are being updated regularly. We will flag any relevant areas to the COVID-19 guideline team.
Dementia UK	Guideline	General	General	We believe it would be helpful in the recommendations to strengthen more the needs of people living	Thank you for your comment. The committee acknowledge that the population of people living in

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				in care homes with learning disabilities, severe and enduring mental health problems, autism etc. especially in relation to training needs and the evidence base.	care homes is diverse and that there are a wide and complex range of health and social care needs. However, only limited evidence was identified which focused on safeguarding practice in relation to specific groups of people such as people with learning disabilities or autism. This made it difficult for the committee to draft targeted recommendations, however, the committee were mindful of the 6 core principles of safeguarding and the Making Safeguarding Personal programme when drafting their recommendations and referenced issues such as accessible communication wherever possible. In addition, an Equality Impact Assessment of the guideline and the recommendations has been carried out to ensure that people with more specific needs are not disadvantaged.
Dementia UK	Guideline	General	General	We recommend acknowledging the distinctions between the roles and responsibilities of nursing staff and unregistered social care staff within the context of care home provision. It is also noted that there is no mention of their code of practice, regulatory body, whistleblowing policy etc. within the guidance. See: Devi, R., Goodman, C., Dalkin, S., Bate, A., Wright, J., Jones, L. and Spilsbury, K., 2020. Attracting, recruiting and retaining nurses and care workers working in care homes: the need for a nuanced understanding informed by evidence and theory. Age and Ageing.	Thank you for your comment. The committee did not feel it was possible to go into this level of detail about each and every workforce area that come into contact with care homes, given the scope of the guideline. The guideline is focused mainly on actions for care homes themselves and those coming across indicators of abuse and neglect within them.
Dementia UK	Guideline	General	General	Much of the references to Quality Assurance activity is via social care provision. It is unclear how social care staff can Quality Assurance clinical activity in relation to safeguarding issues. We suggest this is more explicit within the guidance. This relates to not both internal and external care home	Thank you for your comment. Service organisation in relation to preventative safeguarding work and the interaction between health and social care quality audit, inspection and control is not within the scope of this guideline.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				processes, as failings in the wider health care systems or workers may be a causal factor of safeguarding failings	
Dementia UK	Guideline	General	General	We recommend highlighting the routes for raising safeguarding concerns if care home providers believe that other services are putting their residents at risk e.g. not funding appropriate placements, paucity of health care services (particularly relevant during COVID-19 outbreak) or seeking transition to alternative accommodation in event of being unable to meet a residents needs for example. See: Gage, H., Dickinson, A., Victor, C., Williams, P., et al (2012). Integrated working between residential care homes and primary care: A survey of care homes in England. BMC Geriatrics, 12, 71.	Thank you for your comment. Service organisation in relation to preventative safeguarding work and the interaction between health and social care quality audit, inspection and control was not within the scope of this guideline. However, the guideline includes a number of individual and organisational level indicators or abuse and neglect which cover some examples of the issues you are raising here.
Dementia UK	Guideline	General	General	We are mindful of the importance of quality and quantity in regulatory inspection monitoring and measuring health care delivery in care homes and recommend that inspection processes should strongly reflect safeguarding quality assurance measures.	Thank you for your comment. The committee agree that regulatory inspection is key to ensuring that safeguarding is effective. Whilst it is not within the remit of NICE to write recommendations for the CQC this guideline is partly intended to support care homes to meet quality criteria set out by the CQC. We have now included a statement about this at the end of the context section of the guideline.
Dementia UK	Guideline	General	General	We suggest that mechanisms to improve healthcare provision to care homes (e.g. Enhanced Health Care in Care homes within NHS Long Term plan), and multi-professional care models (e.g Dutch case management model) is an area that requires further exploration for the recommendations. See: Vroomen, J.M., Van Mierlo, L.D., van de Ven,	Thank you for your comment. Service organisation in relation to safeguarding work and the interaction between health and social care was not within the scope of this guideline.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				P.M., Bosmans, J.E., van den Dungen, P., Meiland, F.J., Dröes, R.M., van Charante, E.P.M., van der Horst, H.E., de Rooij, S.E. and van Hout, H.P., 2012. Comparing Dutch case management care models for people with dementia and their caregivers: The design of the COMPAS study. BMC health services research, 12(1), pp.1-10.	
Dementia UK	Guideline	General	General	A general comment to recognise the increase in the use of technology during COVID-19 outbreak – in particular consideration should be given to its relevance, benefits and challenges in video conferencing for assessments, interventions and e.g. best interest meetings and family conferences.	Thank you for your comment. The committee recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes. The committee have discussed their recommendations in light of this and have attempted to mitigate against the impact of Covid-19 wherever possible, although learning from the pandemic may inform any future updates of the recommendations. NICE have published products related to their response to COVID-19 here which are being updated regularly. We will flag any relevant areas to the COVID-19 guideline team.
Dementia UK	Guideline	4	4	We notice that the data predominately focusses on people of 65 years plus living in nursing and residential care homes. Whilst the majority of residents in nursing and residential care homes are of this age range, there remains an important minority of younger people living in care homes with e.g. young onset dementia or learning disabilities. We suggest that the particular considerations for them and safeguarding should have a stronger presence in the recommendations.	Thank you for your comment. The committee acknowledge that the care home sector is very diverse and that the population of people living in them have a wide and complex range of health and social care needs. Whilst the absence of safeguarding specific evidence made it difficult for the committee to make recommendations relating to specific groups of people, they were mindful of the 6 core principles of safeguarding and the MSP framework when drafting recommendations and took care to ensure that the recommendations are not discriminatory. In addition, an Equality Impact Assessment of the guideline and recommendations has been carried out to ensure that people with more specific needs are not disadvantaged.
Dementia UK	Guideline	4	24	We suggest it would be helpful to make more visible the link to the evidence for these statements	Thank you for your comment. The guidelines follow NICE style criteria and links to the evidence reports are included in the rationale and impact sections of the guideline

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Dementia UK	Guideline	10	20	We suggest that that another option rather than care home managers to give feedback about safeguarding issues may be necessary as residents, carers, families and friends may wish to choose another person or agency.	Thank you for your comment. The committee agree that residents, and carers, family and friends of residents may wish to provide feedback to individuals who are not care home managers. However, as the scope of the guideline is limited to safeguarding in care homes this recommendation focuses only on the actions that care home managers should take. Feedback through other channels is covered in the recommendations relating to policies and procedures (i.e. whistleblowing).
Dementia UK	Guideline	16	1	We suggest that the term 'blended learning' should be incorporated to reflect the combination of e-learning, online discussions and seminars as well as face to face events. This is particularly relevant following the COVID-19 outbreak, where ways of teaching and learning have had to adapt to social distancing requirements.	Thank you for your comment. After lengthy discussions regarding the delivery of training the committee agreed to clarify that face-to-face training should include the use of virtual platforms. The committee agreed that this should mitigate against the challenges that have occurred as a result of Covid-19 (as well as potential resourcing issues). The definition (found in the 'terms used' section of the short guideline) includes the following text: "It may take place with participants all in the same room, or by using video or telephone conferencing. It may include online materials, but participants are able to ask questions, discuss, reflect on current practice and use case studies and examples." The committee did not wish to use the term 'blended learning'
Dementia UK	Guideline	16	20	Our experience in care homes is that access to Wi-Fi, electronic devices and time is a consistent barrier to training and education and suggest that the recommendations should reflect this.	Thank you for your comment. The committee agrees that these issues are important and acknowledge that there may be barriers to the provision of training within individual care homes (see evidence review H for details on the committees discussion) however the recommendations are intended to set out best practice.
Dementia UK	Guideline	17	14	Line management and reflective/clinical supervision are not necessarily one and the same – we suggest consistent, distinctive use of line management or reflective/clinical supervision in this section of the recommendation e.g. is distinct in sentence in section 1.3.4., but not clear in page 17, line 14.	Thank you for your comment. The recommendation does not stipulate that the example of 'supervision sessions' be provided as part of line management

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Dementia UK	Guideline	19	14	We suggest staff should be trained rather than encouraged to look out for changes in the mood and behaviour of residents, because this might indicate abuse or neglect.	Thank you for your comment. This recommendation was drafted in response to the committees' views regarding an 'open' culture. Training to recognise abuse or neglect is covered in the section on induction and training in care homes.
Dementia UK	Visual summary – Indicators of organisational abuse and neglect	General	General	We are unclear what the last bullet point means (lack of physical signs and openness) in the visual summary in the Indicators that should lead you to 'consider' abuse or neglect. We suggest it might be helpful to make this clearer (e.g. does it refer to the physical environment?). We also wondered if it could be made clearer that the organisation abuse concerns are related to other organisations rather than the care home in the visual summary section: Indicators that should lead you to 'suspect' abuse or neglect: Residents repeatedly cannot access medical/dental care. We are also mindful that an increase of reporting of safeguarding concerns maybe also the response to stronger safeguarding awareness, training, procedures or processes.	Thank you for your comment. This is an error and should have read "Physical signs and lack of openness to visitors". We will ensure that these indicator headings are clearer in the summaries when published.
Department of Health and Social Care (DHSC)	Guideline	68	018 - 023	The guideline acknowledges that in order to be compliant with the recommendations, care homes could see an increase in requests for training and retraining practitioners, the need to utilise external training, the need for recording information, and additional time that would need to be afforded to staff to ensure they are trained well, with a potential increase in demands for support, for example speech and language therapists. While the department supports promoting good practice and adherence to guidance that currently exists, the department wants to stress the importance of not placing further burdens on care homes and local authorities which may also have cost implications, and of not contradicting existing	Thank you for your comment. We can reassure you that the committee has worked hard to draft and more recently review the recommendations to ensure they are not in conflict with existing legislation or statutory guidance and indeed in some cases the recommendations are based on a review of other (non- statutory) health and social care guidance relating to abuse, neglect and safeguarding. Where this is the case, it is clearly described in the guideline.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				guidance. The Department understands that responses from safeguarding partners including CQC will provide detail on where there may be duplication.	
Department of Health and Social Care (DHSC)	Guideline	General	General	The Department is committed to the safety of individuals who are at risk of, or are experiencing, abuse and neglect in care homes. These individuals should be safeguarded, and any risk of harm removed, in accordance with existing legislation. Whilst the department welcomes efforts to emphasise the importance of safeguarding in care homes, we would invite NICE to consider a temporary pause to progressing this guideline to publication. Based on discussions with the sector, it is clear that the sector requires more time to consult on this guideline and advise on its content to ensure it is up-to-date and accurate. We understand that sector partners will be providing detailed responses on the content. As the commissioner, DHSC would also welcome the opportunity to discuss the guideline with NICE leads and review the initial commission which we understand originated from DHSC in 2018. Subject to the above, the department would also be grateful for consultation on the full amended version of the guideline before proceeding to publication.	Thank you for your comment. We have received and responded to detailed responses from sector partners and welcome the opportunity to discuss the amended version of the guideline with the DHSC before publication
Department of Health and Social Care (DHSC)	Guideline	057 - 091		The Care Act and the supporting statutory guidance sets out the expectations for Safeguarding Adults Boards and local authorities on their safeguarding duties without being overly prescriptive. Local safeguarding adult policies will also have their own referral routes, guidance and contact details and the department would want NICE to acknowledge this in order to avoid duplication. The department notes that local authorities and care homes may take marginally different approaches than what has been recommended,	Thank you for your comment. The recommendations within the guideline are aimed mainly at care home managers and staff but were also intended to be of use to residents, as well as family members and other visitors who may witness a safeguarding issue. Whilst the committee have included some recommendations for local authorities, as well as SABs, CCGs and other commissioners, they recognise that requirements for local authorities are set out clearly in statutory guidance and in a number of resources provided by ADASS

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				which nonetheless still align with the Care Act, the statutory guidance and other legal frameworks. The guidelines need to contextualise the recommendations and align with roles of practitioners and those who will be taking the recommendations forward in practice.	and the LGA. This guideline is not intended to duplicate any of these resources, but instead to complement these by making recommendations on the policies, leadership styles and care home cultures that promote effective safeguarding practice. The guideline then presents two action orientated decision-making pathways covering the steps to take before a s42 referral is made. It covers some aspects of communication and support while enquiries are underway and the importance of shared learning from enquiries but not the conduct of the s42 enquiry itself. The recommendations are clear where a certain person or organisation needs to take an action. It is NICE style to keep recommendations succinct as they are being read by busy people who need to find information quickly.
Department of Health and Social Care (DHSC)	Guideline	056 - 057	09 - 019	The department recognises that there are recommendations for further research which indicates, while there may be some evidence to support the recommendations, NICE would want to see further research carried out in the areas listed. The department would want to know what the expectations are to carry out the further research and whether this would be something that the NICE would take forward.	Thank you for your question. NICE takes the research recommendations forward in the sense that they liaise with the research community to ensure they are addressed. NICE does this by communicating research recommendations to researchers and funders. In particular, NICE works closely with the NIHR (including the SSCR) and NETSCC to prioritise research recommendations from across the programme of NICE guidelines, meeting regularly to monitor progress on carrying out and funding research from NICE research recommendations. NICE will work in exactly this way to promote the funding and commissioning of research that will address the gaps identified by the committee for this guideline.
Department of Health and Social Care (DHSC)	Guideline	4	21	NICE identifies that there is a lack of clarity within care homes in identifying the difference between safeguarding issues and poor practice, and when and how to make safeguarding referrals to the local authority. The department notes that there is a range of guidance and resources to support indi-	Thank you for your comment. The guideline is intended to help practitioners to identify the difference between a serious safeguarding issue and issues that may be safeguarding issues but also crossed over into areas of poor practice - and should be addressed internally by the care home in the first instance (there are various exceptions and

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				viduals to spot signs of abuse and neglect, including the Care and Support Statutory guidance (2014). Some of which, NICE and the advisory committee for NICE have used to inform the guidelines which provides a cohesive combination of these resources.	checks and balances to this set out within the guideline). The sets of 'consider' and 'suspect' indicators are designed to help with those judgements (this model was also used in the child abuse and neglect NICE guideline). The guideline recommends that all 'suspect' indicators are referred to the Local Authority to decide whether the three statutory criteria are met and whether a section 42 Enquiry or other investigation is needed. 'Consider' indicators are intended to result in action within the care home to rectify the issue. However, the recommendations are also intended to encourage the care home to seek advice from the local authority if they are not sure whether a referral should be made. The committee also added a number of recommendations encouraging local authorities to support care homes to develop staff understanding in relation to the differences between poor practice and a safeguarding concern. The recommendations within the guideline are aimed mainly at care homes and the people who work within them, but were also intended to be of use to residents, as well as family members and other visitor who may witness a safeguarding issue. Whilst the committee have included some recommendations for local authorities, as well as adult safeguarding boards, CCGs and other commissioners, they recognise that requirements for local authorities are set out clearly in statutory guidance and in a number of resources provided by ADASS and the LGA. This NICE guideline is not intended to duplicate any of these, but instead was designed to complement these by making recommendations on the policies, leadership styles and care home cultures that promote effective safeguarding practice (sections 1-3). The guideline then presents two action orientated decision-making pathways covering the steps to take before a

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					s42 referral is made. It covers some aspects of communication and support while enquiries are underway and the importance of shared learning from enquiries but not the conduct of the s42 enquiry itself.
Department of Health and Social Care (DHSC)	Guideline	68	14	The department recognises that while this guideline is not mandatory it will set a precedent for best practice and there likely will be an expectation that the guidance would be considered by care homes and local authorities. The Department would therefore be grateful for reassurance that this guideline will not be setting a new legal standard for care homes and local authorities and that there will not be legal implications where they operate under the Care Act (2014) and other statutory frameworks, but do not choose to adopt the recommendations within the guideline.	Thank you for your comment. The committee are clear that the core legal duty for adult safeguarding is found in section 42 of the Care Act 2014. The guideline complements (and does not replace) statutory duties and good practice in the Care Act and other relevant legislation and guidance. Where appropriate the recommendations cross refer to these and they also endeavour to support stakeholders in their compliance. There will be no legal implications from failing to follow the guideline except where the recommendations are based on existing legal requirements and indirectly if CQC incorporate elements of this guideline in their inspection processes.
Greater Manchester Clinical Network for Safeguarding Adults	Evidence Review A	006	031	We are concerned that this recommendation does not include which health experts will medically examine if physical abuse has occurred as a result of wilful neglect, self-neglect or other types of abuse that needs to be clinically verified. In the comparison section consideration needs to be given to health experts to verify abuse which only should be by a medical or forensic expert with relevant training in safeguarding adults. This needs to be throughout the document. Little evidence of research carried out from a clinical point of view in care homes for safeguarding adults throughout the document. i.e. when does a quality issue become a safeguarding issue / incident. Overall the document reads well.	Thank you for your comment. It is not clear exactly what your comment refers to, however the page and line number quoted suggest that it relates to the summary of the protocol (PICO) tables. These are not recommendations, but an explanation of the methods which were used to search for, analyse, and review the data presented to the committee. The review questions (which were initially devised through engagement with stakeholders and were further refined through committee discussion) were: What indicators should alert people to abuse in care homes? and What indicators should alert people to neglect in care homes? As such this did not allow for consideration of data relating to which professionals are involved in the 'verification' of abuse or neglect. It was not therefore possible for the committee to make recommendations in relation to this.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Greater Manchester Clinical Network for Safeguarding Adults	Evidence Review C	General	General	Little mention of the importance of relevant training and clinical safeguarding supervision. But generally well written.	Thank you for your comment and support. The question which this review was designed to answer was 'What tools and ways of working support effective or accurate recognition and reporting of safeguarding concerns in care homes?' As such, it would not capture data relating to the importance of training and clinical safeguarding supervision. Training is covered in evidence review H (with the committee's recommendations listed in section 1.2 of the guideline). Clinical safeguarding supervision was not identified as a key research question at the scoping stage (which included engagement with stakeholders); however evidence on supervision more generally was included in a number of reviews, and recommendations relating to this issue can be found in sections on induction and training in care homes, and care home culture, learning and management.
Greater Manchester Clinical Network for Safeguarding Adults	Evidence Review E	General	General	Well written.	Thank you for your support.
Greater Manchester Clinical Network for Safeguarding Adults	Evidence Review F	General	General	Well written – pleased to see the quality agenda embedded and the potential impact on safeguarding incidents.	Thank you for your support.
Greater Manchester Clinical Network for Safeguarding Adults	Evidence Review F	General	General	It might worth considering the role of NHSE and designated safeguarding nurses /professionals / safeguarding executive leads as system leaders.	Thank you for your comment. Systems leadership is not within the scope of this guideline.
Greater Manchester Clinical Network for Safeguarding Adults	Evidence Review G	General	General	Well written.	Thank you for your support.
Greater Manchester Clinical Network for Safeguarding Adults	Evidence Review H	General	General	Well written.	Thank you for your support.
Greater Manchester Clinical Network for Safeguarding Adults	Evidence Review I	General	General	Is it worth mentioning how preventative safeguarding activity is carried out to prevent abuse in the first place? How will this data be captured? For example preventing level 3 or 4 pressure ulcers, financial exploitation that does not hit section 42's? it's an opportunity to help providers demonstrate	Thank you for your comment. The committee agrees that preventative safeguarding work is essential and recognise the high quality work that providers do in this area, however, this is not within scope for the guideline. However, the committee hopes that care homes and providers will find the

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				the high quality work that takes place to prevent abuse in the first place. – Overall a well-written section.	indicators of organisational abuse and neglect to be a useful tool to enable them to further strengthen their preventative safeguarding activities.
Hesley Group Ltd	Guideline	044 - 048	General	This area has been a crucial part of our own organisational learning recently – individual patterns mixed systemically with whole service reviews and alerts. These four pages - Again the need for healthy scepticism and open-mindedness about cultures developing either to fill a void in the organisation or as a result of a structure designed to mislead by leadership for their own ends. The evidence is often there to be seen of the right questions are asked of the right people and inquirers bear in mind the possibility of abuse (consider) Quality oversight needs to triangulate evidence provided by managers of good practice and the capacity to drill down into the culture of the service. Culture where questions are accepted by staff and managers as being standard practice and a positive thing, will encourage them to ask questions too.	Thank you for your comment and feedback. The committee hope that the indicators of organisational abuse can be used for preventative safeguarding work also.
Hesley Group Ltd	Guideline	040 - 042	013	Indicates training needs & support for managers to develop skills.	Thank you for your comment. Whilst, the guideline makes recommendations about the skills and training for safeguarding, the training needs for managers to support staff during an enquiry are very specific and outside the scope of the guideline
Hesley Group Ltd	Guideline	12	017 - 021	Concerns that recommendations are based on the expertise and experience of a small number of people rather than supported by evidence.	Thank you for your comment. The committee's recommendations are based on the best available evidence, as well as their own experiences, with a systematic review underpinning each question

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				Glad that systemic nature of abuse enfolded in organisational culture is spoken of as is the need for on the job evaluation of the impact of a training event. Whilst we as an organisation have the benefit of ongoing training face to face, without the recommended joining together for delivery, small services would find face to face delivery by a registered manager economically unviable.	identified at the scoping stage of guideline development. These two recommendations were drafted on the basis of evidence which suggested that there was a lack of understanding regarding safeguarding practices amongst some care home staff and that this can lead to inconsistent care. The committee believe that these two recommendations reflect best practice, and as mandatory training is required by the Care Act and is reflected in CQC standards, the committee did not feel these recommendations represented a significant change in practice. Although the committee recommend that training should be conducted face-to-face, they recognise that this may present challenges for smaller providers, and therefore agreed to specify that 'face-to-face learning' also includes training delivered virtually, for example through telephone or video conferencing.
Hesley Group Ltd	Guideline	18	6	Whilst the Registered Manager should model such practices this needs to be quality assured throughout services as recent experience has taught us that it is possible to be duped.	Thank you for your comment. Whilst the committee recognises that individuals may sometimes be dishonest about their level of knowledge and expertise, this recommendation was drafted to emphasise the importance of leadership. Quality assurance of care home managers practice is encompassed in a number of recommendations such as those in the sections on care home safeguarding policy and procedure and care home culture, learning and management.
Hesley Group Ltd	Guideline	19	8	Scrutiny of Registered Manager *practice* by the wider organisation needs to be integral to safeguarding people and expected by manager. We have experienced negative outcomes from the risk of accepting *results based* judgements without triangulation	Thank you for your comment. The committee agree that the use of a wide range of information is essential to safeguarding practice. The committee agree that oversight of care home managers practice is essential and drafted the recommendations relating to policies and procedures, care home culture, and indicators of abuse with this in mind.
Hesley Group Ltd	Guideline	22	12	Consider (i.e. bear in mind the possibility) as well as Suspect Safeguarding may help here in. Risk of developing constantly negative suspicious	Thank you for your comment. The committee have defined the meaning of the terms 'consider' and ''suspect' in the context of this guideline and have

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				culture as a result needs to be dealt with by organisations – need to get balance right so we get healthy scepticism and open-mindedness.	set out clear courses of action for both sets of indicators. The 'consider' indicators encourage action to be taken within the care home to address the issue - without necessarily involving the local authority. It is hoped that this will help care homes with person centred care and the continuous improvement of the care and support offered.
Hesley Group Ltd	Guideline	37	6	Vital is the need to identify best person particularly if the individual lacks capacity to make decisions about the safeguarding process and needs specialist support to understand what is happening in other formats – the guide refers to SLT support for example. Important to emphasise that the use of “best interests” decisions under MCA doesn’t take away the right to be informed even if there is lack of capacity Helpful – capacity is an issue with most of the people we support and we may need reminding of the relationship between safeguarding and MCA from time to time.	Thank you for your comment and support. The guideline references the Mental Capacity Act on p8 and notes that where a resident may lack capacity these recommendations should be used in conjunction with the Decision making and mental capacity guideline (NG108).
Lancashire county council	Guideline	General	General	The main concerns we receive are in relation to inadequate care plan and personalised care plans. Concerns around medication management for residential and nursing care homes. There are often concerns about residents who are at risk of falls and suffer significant injuries as a consequence of this, often there are repeated falls and these are seen in isolation rather than reflecting on if actions are working, not working. There are often issues about meaningful activities within care homes. Another area of concern is good leadership and development of positive learning cultures within care homes. The consultation mentions that there should be safeguarding leads within organisation which is	Thank you for your comment and support. The committee agree that these are important issues, however it was not within the remit of this guideline to make recommendations on these specifically. The guideline does include absence of a care and support plan and failure to adhere to a care and support plan as potential indicators of neglect; lack of meaningful activities as a potential indicator of organisational abuse, and inappropriate administration of medication as a potential indicator of neglect or physical abuse; and medications management is covered in more detail in NICE guideline SC1 Medications management in care homes. Whilst falls are not included specifically as a potential indicator, the guideline includes the following

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				very positive, however, I would suggest that there needs to be recognition of the work that the safeguarding leads need to do to improve the safeguarding atmosphere in the home by sharing real life examples or learning through safeguarding adults reviews.	text as a potential example: "… suspect neglect … when residents … are not kept safe from everyday hazards or dangerous situations." The committee also agree that care home culture, leadership, training and continuous learning are all important aspects of developing a positive environment for safeguarding, issues that are incorporated into the list of potential indicators of organisational abuse. The committee have also drafted a number of recommendations intended to promote an 'open' culture within care homes (see the section entitled 'Care home culture, learning, and management') and they agree that learning from SARs is an important component of this, an issue covered in recommendations for care home managers, commissioners, and SABs.
LGA/ ADASS	Evidence Review C	General	General	The Agree 11 assessment of the framework. Making decisions on the duty to carry out Safeguarding Adults enquiries Suggested framework to support practice, reporting and recording https://www.local.gov.uk/sites/default/files/documents/25.130%20Making%20Decisions%20on%20the%20duty_06%20WEB.pdf There are some issues with the way the framework is conveyed here and these should be addressed (notwithstanding the rider that you acknowledge the Agree 11 tool doesn't quite 'fit' with the frameworks you are citing). Comments include (not exhaustive): This was deliberately not set out as 'guidance' because the guidance is the care and support statutory guidance. It is as it says a framework to support understanding and decision making.	Thank you for your comment. The committee accept that your publication was not designed as guidance as such and indeed the authors of some of the other publications might say the same about theirs. The term was used in the context of review C to provide a generic description of the documents, which on the whole provided guidance, advice or support for stakeholders on certain aspects of safeguarding practice. An explanation of the way in which the terms 'guidance' was used has now been added to the final version of the guideline.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				You call it guidance You say…This guidance is aimed at sectors and organisations involved with referrals of safeguarding adults concerns. The Agree 11 assessment of the framework. Making decisions on the duty to carry out Safeguarding Adults enquiries Suggested framework to support practice, reporting and recording https://www.local.gov.uk/sites/default/files/documents/25.130%20Making%20Decisions%20on%20the%20duty_06%20WEB.pdf There are some issues with the way the framework is conveyed here and these should be addressed (notwithstanding the rider that you acknowledge the Agree 11 tool doesn't quite 'fit' with the frameworks you are citing). Comments include (not exhaustive): This was deliberately not set out as 'guidance' because the guidance is the care and support statutory guidance. It is as it says a framework to support understanding and decision making. You call it guidance You say…This guidance is aimed at sectors and organisations involved with referrals of safeguarding adults concerns.	
LGA/ ADASS	Evidence Review C	027	005 - 009	**This says… The committee were aware that there may be uncertainty about what should and should not be reported as a safeguarding**	Thank you for your comment with which the committee concur. The section of evidence review C to which you refer has been edited to reflect the fact that the recommendation was made in order to

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				enquiry under the S42 duty or an 'other' safeguarding enquiry. Based on the evidence and their own expertise and experience, the committee therefore recommended placing the responsibility on the local authority to decide in a timely fashion whether the referral meets the legal criteria for a section 42 enquiry **This is not a rec of the committee it is in the legislation in S42. This is a LA decision.** **The decision for others to make is whether it is a safeguarding concern and the evidence doc rightly indicates the value of conversations. Refer to concerns framework https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal and for enquiries** **https://www.local.gov.uk/sites/default/files/documents/25.130%20Making%20Decisions%20on%20the%20duty_06%20WEB.pdf**	emphasise the legislative requirements about the local authority's response to a safeguarding referral. We have made a number of edits to the recommendations to be clearer and we have also further emphasised within the guideline that the decision as to whether to proceed with a s42 enquiry sits with the LA and we have also included a link to MSP resources about decision making re enquiries on the LGA website.
LGA/ ADASS	Evidence Review C	56	General	Who the framework is aimed at…It is actually aimed primarily at the decision maker as to what constitutes an enquiry (This is the LA) but with relevance across sectors (because understanding of the decision making after they refer a safeguarding concern may support their own practice and decision making in considering safeguarding concerns). It is made clear on p.5 that the framework on enquiries would connect with one on concerns. This one on concerns would aim to support understanding of what constitutes a sg concern across the range of organisations and sectors. NICE was advised of the forthcoming concerns framework (published Sept 2020, referred to	Thank you for your comment and for highlighting some of the details missing from our original analysis of the LGA/ADASS document (Making decisions on the duty to carry out Safeguarding Adults enquiries. Suggested framework to support practice, reporting and recording. London: Association of Directors of Adult Social Services 2019). Evidence review C has now been revised to highlight the intended audience, as per your advice. We note that page 5 describes further planned work related to the framework but it was not clear from that information that the 2019 work represented an 'update' of the framework itself, rather a related piece of work.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				above) and invited to contribute. Your data relating to recognition of safeguarding concerns. This is misinterpreted because this is about what gets reported to NHS digital as a safeguarding (S42 enquiry) Not what gets referred to the Local Authority. The column on summary of data is unhelpful in parts as it relies on a misunderstanding by the reviewer of what and who the enquiries framework is aimed at. Rigour of development (0%) Details were not provided on the methods used to develop the guidance. Yes they are…through three national workshops where 160 staff were represented. You say too…It was unclear whether the guidance had been externally reviewed by experts prior to its publication (although the authors did state that the document had been reviewed from a legal perspective) It includes in the acknowledgements a list of critical readers, so this is inaccurate.	We have also revised the data extracted from the framework, removing reference to reporting and NHS digital requirements, which we hope is now a more accurate representation. Any resulting changes to the themes have also been made. We have also updated our description of the rigour of development to provide examples of the various sources for the framework. Although this includes the fact that feedback was provided by a group with a range of backgrounds we are not sufficiently confident that this would be considered 'external review' according to the terms of the AGREE II instrument, which states that reviewers should be not have been involved in the guideline development group. It's also unclear what methods the group used to guide their feedback and how the information was used to inform the development or redrafting of the framework. We nevertheless acknowledge that the affiliations of the group are clearly stated as is the objective of their feedback (to improve quality). On this basis we have slightly adjusted the rating for this domain and in turn to the overall score for the document itself.
LGA/ ADASS	Evidence Review C	11	General	The enquiries framework has in part been misunderstood. On p 11 you refer to Topics with relevant findings and you highlight Reporting • reporting procedure. Whilst the framework is about what gets reported in the Safeguarding Adults Collection (NHS Digital), then decision making behind that on what constitutes a safeguarding enquiry. Has there been a confusion with reporting meaning referring a concern to the LA perhaps?	Thank you for highlighting this. This review has been edited and references to reporting (e.g. in relation to SAC/NHS Digital) have been removed.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

LGA/ ADASS	Evidence Reviews	General	General	Some of your evidence refers to thresholds and three-part test (in respect of S42(1) Care Act. In our workshops on enquiries and concerns, and in the enquiries framework, we have said why these terms are not acceptable. This is because these terms imply that an individual must pass a test or cross a threshold to get help. This is counter to person centred and best practice.	Thank you for your comment. In the interests of transparency, the development team report the data and findings as they are presented in the original research; however the committee were careful not to use these terms in their recommendations.
LGA/ ADASS	Guideline	General	General	Recommendations under heading Local authorities, clinical commissioning groups, and other commissioners . Again, see https://www.local.gov.uk/sites/default/files/documents/25.169%20Practical%20examples%20of%20Making%20Safeguarding%20Personal%20from%20commissioners%20and%20providers%20of%20health%20and%20social%20care%20WEB.pdf and https://www.local.gov.uk/sites/default/files/documents/25.142%20Making%20Safeguarding%20Personal_03%20WEB.pdf The recommendations on p11 put too much emphasis on assurance and insufficient on mutual learning and dialogue across providers and commissioners. The two lines in rec 1.1.16 go a little way on this but it also is about conversations and a two way learning process. The LGA/ADASS briefings talk about this, reflecting the voice of 160 providers and commissioners at workshops. See p 12 column two in https://www.local.gov.uk/sites/default/files/documents/25.142%20Making%20Safeguarding%20Personal_03%20WEB.pdf which refers to the need for 'equality amongst voices…willingness to listen…atmosphere where honest conversations can take place about challenges….'	Thank you for your comment. The recommendations you refer to on page 11 focus specifically on the actions that local authorities, clinical commissioning groups and other commissioners should take. These are preceded by recommendations targeted towards care homes and providers, and followed by a set of recommendations aimed at SABs. On the basis of the evidence they reviewed and their expertise, the committee agreed that it was necessary to write recommendations that are specific to each group in order to improve safeguarding practice in care homes. However, the majority of the recommendations suggest specific actions which care homes and care home managers should take as this is where the committee agreed greater support was needed. However, the guideline also contains a large number of recommendations emphasising that organisations need to work together and the role of SABs in ensuring this happens.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				It talks about the responsibility of commissioners to disseminate a clear vision and values. An emphasis on learning from experience by empowering staff and service users to raise issues.	
LGA/ ADASS	Guideline	General	General	A recommendation might be included about ensuring appropriate engagement with care providers and commissioners in Safeguarding Adults Reviews. In general more emphasis could be placed on creating a culture of working together and empowering people to speak out. Modelling transparency, listening, honesty, openness all of which support effective safeguarding.	Thank you for your comment. The guideline includes a number of recommendations emphasising the importance of creating a collaborative environment that empowers people to speak out. Sections 1.1 to 1.3 in particular, focus on of those areas (such as policy and procedure, induction and training, and 'open' cultures and supportive leadership) that help to build this type of environment. The guideline did not include a review focusing on the conduct of SARs and the committee were therefore not able to make detailed recommendations relating to this. However, recommendations have been included which emphasise the role that SABs play in sharing learning from SARs with care homes and local partners, and care homes dissemination of learning to staff through induction, training, team and one to one meetings.
LGA/ ADASS	Guideline	General	General	***Indicators of abuse.*** *However, alongside lists of examples of what constitute different types of abuse we suggest cross referencing to 'Understanding what constitutes a safeguarding concern and how to support effective outcomes; Suggested multi-agency framework to support practice, recording and reporting' Available late Sept 2020 on https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal This gives definitions of abuse/neglect; care and support needs and safeguarding concern (p17-21)* *The framework (LGA/ADASS) for decisions on safeguarding concerns also provides a set of 15*	Thank you for your comment. The committee agree that the issue of 'tests' or 'thresholds' has proven challenging in practice. However, the committee agreed that the intention behind them as well as the guidance accompanying them needed to be clarified. Whilst the guideline recommends that all 'suspect' indicators are referred to the Local Authority to decide whether the three statutory criteria are met and whether a section 42 Enquiry or other investigation is needed and the 'consider' indicators are intended to result in action within the care home to rectify the issue, the recommendations are also intended to encourage care homes to seek advice from the local authority if they are at all unsure whether a referral should be made. The

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				core messages (pages 8-10) that might be adopted to support shared understanding, consistency and accountability in deciding what is a safeguarding concern. On page 28 this framework says: *'There is a wide range of local protocols to support decisions on what is or is not a safeguarding concern. These local protocols often offer extensive lists of specific examples of what might constitute a safeguarding concern and many of these relate to provider settings.* *These examples are helpful to an extent but greater emphasis on core ingredients to be applied in each decision, would add value to these protocols. The core messages in this framework can form a basis to help local protocols to achieve this, so that they offer support in in every set of circumstances. There are helpful examples of practice support …(from Oxfordshire and in appendix 4). Whilst none of the protocols offered to date reflect all the core messages in this framework, each illustrates a particular strength and, together with this framework can inform the basis for local development.* *The Oxfordshire Safeguarding Adults Board decision making support matrix69* *For example: encouraging consultation with the local authority in some, not all, situations on whether to refer a safeguarding concern; supporting legal literacy in practice; indicating other possible pathways through which issues might be addressed if not through safeguarding; recognising the importance of recording what on the surface may not be identified as significant concerns, towards enabling identification of patterns of concerns that*	committee also added a number of recommendations to encourage local authorities to support care homes to develop staff understanding in relation to the differences between poor practice and a safeguarding concern. The committee acknowledge that a number of resources on this issue exist, these lists were intended to highlight to practitioners some of the key areas of concern with the aim of reducing variability across the sector. The committee welcome the recent publication (Sep 2020) by LGA/ADASS entitled "Understanding what constitutes a safeguarding concern and how to support effective outcomes; Suggested multi-agency framework to support practice, recording and reporting". This document was published after the end of the development phase for this guideline however the committee agreed to formally consider its contents to determine whether it had implications for the recommendations which the committee had already drafted. After careful consideration, the committee concluded that the framework does not conflict with the recommendations in this guideline. However, they agreed that it was appropriate to include a link to this, and other resources published on the Making Safeguarding Personal web pages, published by ADASS and LGA.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				taken together might constitute a safeguarding concern. *(See for example www.osab.co.uk/wp-content/uploads/OSAB-Threshold-of-Needs-Matrix-December-2018-MASTER.pdf)* *This getting away from lists of what is a concern and 'thresholds' or 'tests' that staff must apply is important … towards an approach that applies a set of core components for the decision making.*	
LGA/ ADASS	Guideline	General	General	The descriptions regarding sexual & intimate relationships are unclear and could be discriminatory. In 1.4.13 – move up: Have a sexually transmitted infection, become pregnant change Have a sexual relationship with another person, and capacity to consent is unclear for either person Are involved in a sexual act with another person, and consent from either person is unclear Add in consider psychological abuse if resident is not supported to maintain contact with people important to them, including during lockdown periods if resident is denied the right to develop intimate relationships, where they have the capacity to understand what is entailed, and the ability to consent themselves and be aware whether their partner is also consenting. Ref: https://www.39essex.com/cop_cases/a-local-authority-v-jb-2/	Thank you for your comment. The list of potential indicators relating to sexual abuse have been edited for clarity and to ensure that they are not discriminatory. Further details have also been added regarding a resident's right to engage in sexual activity if they have the mental capacity to consent. The committee believe that failure to enable contact with family or friends is most appropriate to the indicators of neglect (please see the following indicator: "… do not have opportunities to interact with other people, either virtually or in person." The indicators of organisational abuse ('physical signs and lack of openness to visitors') now also incorporate details on closure to outside scrutiny; details which were added in response to concerns in the sector regarding Covid-19 restrictions. The committee believe that denial of the right to engage in intimate relationships is covered by the following indicators of psychological abuse: "… are denied a choice on any occasion (for example, around activities of daily living or freedom of movement) … are denied unsupervised access to others …" This issue is also covered by the following indicator of organisational abuse: "… the care home does not comply with Mental Capacity Act require-

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				'98. the Mental Capacity Act and the Court of Protection do not exist in a vacuum. They are part of a system of law and justice in which it is recognised that sexual relations between two people can only take place with the full and ongoing consent of both parties' Discussions about intimate relationships need to include concepts of understand consent (both for the person who is your client, and the other person.	ments on deprivation of liberty and liberty protection safeguards." In addition, the start of the section listing potential indicators of sexual abuse recommends that practitioners should be aware that "… residents have the right to engage in sexual activity if they have the mental capacity to consent …", and readers are directed to the NICE guideline on decision making and mental capacity for more information.
LGA/ ADASS	Guideline	General	General	Tell the person you have a responsibility to report etc… This is described slightly differently elsewhere (because sharing isn't automatic where the person doesn't consent). including in the new LGA/ADASS framework 'Understanding what constitutes a safeguarding concern and how to support effective outcomes; Suggested multi-agency framework to support practice, recording and reporting' Available late Sept 2020 on https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal See flow chart page 7. Includes: Are you concerned that an adult is at risk of or is experiencing abuse or neglect? What types of abuse or neglect are concerned about? Have you had a conversation with the adult about the concerns? Have you sought the views and wishes of the adult? Then asks that vital interests of the person or public interest issues be taken into consideration in deciding whether to share even where the person declines consent.	Thank you for your comment. The committee are aware of the recent LGA/ADASS publication (Sep 2020) "Understanding what constitutes a safeguarding concern and how to support effective outcomes; Suggested multi-agency framework to support practice, recording and reporting". It is not clear which part of the guideline you are commenting on, but if your query relates to situations in which a resident does not want a safeguarding concern to be reported, this is covered at the start of the section listing potential indicators of abuse and neglect. . This recommendation has also been refined to clarify that action must still be taken and that a referral should be made if appropriate, especially if there is a risk to other residents (e.g. if the alleged abuser is someone in a position of trust at the care home). Discussions with the resident and the person raising the concern are covered further in sections relating to information gathering and confidentiality, and responding to reports of abuse or neglect.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				Ditto on p34 line 6/7. Making Safeguarding Personal is not about walking away if a person says 'no thanks.' But….there are legal principles that need to be applied if their wishes are to be overridden see MSP Myths and Realities.(LGA/ADASS, 2019) https://www.local.gov.uk/myths-and-realities-about-making-safeguarding-personal	
LGA/ ADASS	Guideline	General	General	It isn't helpful to abbreviate or tailor the core definitions to care homes, but they should be based closely on the legislation and guidance. Please refer to the two frameworks…for enquiries. You could provide links and page refs. https://www.local.gov.uk/sites/default/files/documents/25.130%20Making%20Decisions%20on%20the%20duty_06%20WEB.pdf and concerns https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal	Thank you for your comment. We have referenced various guidance including ADASS and LGA guidance within the guideline and used it as part of the evidence base for writing the recommendations. We have also added references to the Making Safeguarding Personal resources at various points throughout the guideline including in the context section and we have added a recommendation linking to the Making Safeguarding Personal resources for more information about section 42 enquiries
LGA/ ADASS	Guideline	General	General	Whilst you make reference to SARs in the text you do not refer to the statutory requirement or criteria for SARs at the start of the document. Nor do you define SARs in your glossary. We think this would be helpful.	Thank you for your comment. A definition of a Safeguarding Adults Review (SAR) has been added to the glossary. This includes reference to the statutory requirements outlining when a SAR should be conducted.
LGA/ ADASS	Guideline	General	General	This was deliberately not set out as 'guidance' because the guidance is the care and support statutory guidance. It is as it says a framework to support understanding and decision making. You call it guidance You say…This guidance is aimed at sectors and organisations involved with referrals of safeguarding adults concerns.	Thank you for your comment. The committee acknowledge that this publication was not designed as 'guidance'. The term was used in the context of evidence review C to provide a generic description of the documents which were included for analysis, as on the whole they provide guidance, advice or support for stakeholders on certain aspects of safeguarding practice.
LGA/ ADASS	Review C	General	General	*Clarity of presentation (10%) Statements are presented but are somewhat vague. The different options are not discussed, and the key statements*	Thank you for your comment. The focus of the quality assessment using the AGREE II instrument was each individual document or 'guidance'.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				are not easily identifiable. It seems the reviewer has not looked at the appendices which show a great deal of detail on different methodologies and challenges. Also, this is included in the workshop slides. All documents are on the LGA website. *Applicability (11%) again, the reviewer says the guidance did not present a systematic discussion of facilitators and barriers to the guidance or advice for implementation. There was some discussion on how the statements can be put into practice, but this was limited . . . Both appendices and main document contain case studies and tips on putting principles into practice etc.*	Where appendices were also clearly available on the landing page or via hyperlinks from the document itself these were also considered. Having revisited the framework, we have located the link to LGA website and then on to the appendices and have therefore been able to revise the assessment of 'clarity of presentation'.
LGA/ ADASS	Guideline	General	General	National networks SAB Chairs response: First, we would like to respond to say that the consultation period is extremely short and as such we have been unable to respond comprehensively to the whole document. Thus, we are adding our comments to the consultation responses by the SAB Business Managers Network and to the consultation responses by ADASS/ LGA Many national and local issues arose and are ongoing through COVID with some studies looking at this in terms of protecting the safety of residents from infection. No doubt these guidelines will need updating to incorporate the learning from them The consultation document is very comprehensive and a concern we would like to register, is that because of the detail including the links included within the document, Care Home Managers may find the guidance difficult to use, given the breadth of their responsibilities Many of the matters included within the Guidance	Thank you for your comments. All registered stakeholders were given advance notice of the start and finish dates for the consultation but we do recognise the challenge of responding and are very grateful to your organisation for the time taken in doing this. The committee also recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes. The committee have discussed their recommendations in light of this and have attempted to mitigate against the impact of Covid-19 wherever possible, although learning from the pandemic may inform any future updates of the recommendations. NICE have published products related to their response to COVID-19 here which are being updated regularly. We will flag any relevant areas to the COVID-19 guideline team. The committee recognise that care home managers are busy people which is why NICE recommendations are designed to be succinct and action orientated, and it is not necessary to read the background documents in order to understand the

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				are already clearly stated in the Care Home Regulations and where Registered Managers will have clarity from CQC. In addition whilst you refer to the large number of people, especially Older people in care homes, you make no reference to the very differing needs and abilities of all those living in Care homes, or Care Home size. You will appreciate that these will range from young people over 18 with mental health problems, often in very small registered care homes, care homes for those with learning disabilities and those with dementia. Some will be units with 80+ beds. The approach to safeguarding balancing with differing considerations of risk and plans to support people to maintain independence. You state that: There is wide variation in the way Safeguarding Adults Boards operate and communicate with care homes. The recommendations should lead to greater consistency. Safeguarding Adults Boards should not need additional resources, but some will need to change the way they work. If they are not already doing so, they will need to promote a positive culture and encourage greater collaboration between their members and partner organisations, especially care homes. SABs do not have huge resources and often have small teams of people to support them e.g. one or two staff. The recommendations to SABs assume that there are resources to deliver against them. SAB Chairs generally work 2-3 days per calendar month. The Care Act clearly defines the responsibility of SABs to have strategic responsibility for bringing together senior leaders from partner organisations to deliver improvements and not to undertake the operational detail other than that stated	content of a recommendation. The committee see it as positive that you judge the guideline to be comprehensive. The recommendations will also be easier to access when they are in web format and the issues more searchable. Whilst the committee acknowledge that some of these issues are covered in other guidance they agreed to include them because there is variation in practice across the sector (an issue that this guideline was designed to address), and are confident that these align with the Care Home Regulations and the CQC inspection framework. The committee acknowledge that the care home sector is very diverse and that the population of people living in them have a wide and complex range of health and social care needs. Unfortunately, there was an absence of evidence (meeting pre-specified inclusion criteria) on safeguarding relating to specific groups of people, such as younger people with mental health difficulties, or people (of any age) with a learning disability. This made it difficult for the committee to make targeted recommendations, however they were mindful of the 6 core principles of safeguarding and Making Safeguarding Personal when drafting recommendations and took care to ensure that these are not discriminatory. In addition, an Equality Impact Assessment of the guideline and recommendations has been carried out to ensure that people with more specific needs are not disadvantaged. With regards to the role of SABs, the committee recognise that boards are organised, funded and resourced differently and therefore agreed recommendations were flexible whilst still being clear

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				within the relevant sections of the Care Act The lead responsibility for communicating with Care Homes lies with Commissioners from Local Authorities and the NHS and indeed also with CQC.	about specific actions that are always the responsibility of the SAB. The committee have therefore amended a number of the recommendations relating to Safeguarding Adults Boards (SAB) to make it clearer that these boards have a strategic oversight role and as such are often not taking forward actions themselves but are seeking assurances that local authorities, other commissioners and representative organisations on the board are. With regards to the recommendation relating to communication with care homes, this has been edited to clarify that SABs should seek assurances that clear lines of communication are in place between commissioners, the Regulator and safeguarding leads in care homes or at a provider organisation.
LGA/ ADASS	Guideline	General	General	National networks SAB Chairs response: First, we would like to respond to say that the consultation period is extremely short and as such we have been unable to respond comprehensively to the whole document. Thus, we are adding our comments to the consultation responses by the SAB Business Managers Network and to the consultation responses by ADASS/ LGA Many national and local issues arose and are ongoing through COVID with some studies looking at this in terms of protecting the safety of residents from infection. No doubt these guidelines will need updating to incorporate the learning from them The consultation document is very comprehensive and a concern we would like to register, is that because of the detail including the links included within the document, Care Home Managers may find the guidance difficult to use, given the breadth of their responsibilities	Thank you for your comments. All registered stakeholders were given advance notice of the start and finish dates for the consultation but we do recognise the challenge of responding and are very grateful to your organisation for the time taken in doing this. The committee also recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes. The committee have discussed their recommendations in light of this and have attempted to mitigate against the impact of Covid-19 wherever possible, although learning from the pandemic may inform any future updates of the recommendations. NICE have published products related to their response to COVID-19 here which are being updated regularly. We will flag any relevant areas to the COVID-19 guideline team.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				Many of the matters included within the Guidance are already clearly stated in the Care Home Regulations and where Registered Managers will have clarity from CQC. In addition whilst you refer to the large number of people, especially Older people in care homes, you make no reference to the very differing needs and abilities of all those living in Care homes, or Care Home size. You will appreciate that these will range from young people over 18 with mental health problems, often in very small registered care homes, care homes for those with learning disabilities and those with dementia. Some will be units with 80+ beds. The approach to safeguarding balancing with differing considerations of risk and plans to support people to maintain independence. You state that: There is wide variation in the way Safeguarding Adults Boards operate and communicate with care homes. The recommendations should lead to greater consistency. Safeguarding Adults Boards should not need additional resources, but some will need to change the way they work. If they are not already doing so, they will need to promote a positive culture and encourage greater collaboration between their members and partner organisations, especially care homes. SABs do not have huge resources and often have small teams of people to support them e.g. one or two staff. The recommendations to SABs assume that there are resources to deliver against them. SAB Chairs generally work 2-3 days per calendar month. The Care Act clearly defines the responsibility of SABs to have strategic responsibility for	The committee recognise that care home managers are very busy which is why NICE recommendations are designed to be succinct and action orientated, and it is not necessary to read the supporting information in order to understand the content of a recommendation. The committee see it as positive that you judge the guideline to be comprehensive. The recommendations will also be easier to access when they are in web format and the issues more searchable. Whilst the committee acknowledge that some of these issues are covered in other guidance they agreed to include them because there is variation in practice across the sector (an issue that this guideline was designed to address), and are confident that these align with the Care Home Regulations and the CQC inspection framework. The committee acknowledge that the care home sector is very diverse and that the population of people living in them have a wide and complex range of health and social care needs. Unfortunately, there was an absence of evidence on safeguarding (meeting pre-specified inclusion criteria) in relation to specific groups of people such as younger people with mental health difficulties, or people (of any age) with a learning disability). This made it difficult for the committee to make targeted recommendations, however, they were mindful of the 6 core principles of safeguarding and Making Safeguarding Personal when drafting recommendations and took care to ensure that these are not discriminatory. In addition, an Equality Impact Assessment of the guideline and recommendations has been carried out to ensure that people with more specific needs are not disadvantaged. With regards to the role of SABs, the committee

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				bringing together senior leaders from partner organisations to deliver improvements and not to undertake the operational detail other than that stated within the relevant sections of the Care Act The lead responsibility for communicating with Care Homes lies with Commissioners from Local Authorities and the NHS and indeed also with CQC.	recognise that SABs are organised, funded and resourced differently and therefore drafted recommendations that reflected these differences whilst still being clear about those specific actions which are always the responsibility of the SAB. The committee have therefore amended a number of the recommendations relating to Safeguarding Adults Boards (SAB) to make it clearer that these boards have a strategic oversight role and as such are often not taking forward actions themselves but are seeking assurances that local authorities, other commissioners and representative organisations on the board are. With regards to the recommendation relating to communication with care homes, this has been edited to clarify that SABs should seek assurances that clear lines of communication are in place between commissioners, the Regulator and safeguarding leads in care homes or at a provider organisation.
LGA/ ADASS	Guideline	012 - 017	General	From page 12 the section on Induction and training in care homes The emphasis here is on formal learning and the approach is somewhat mechanistic/procedural. Whilst this is important, the workshops for commissioners/providers led by LGA/ADASS in 2019/20, which produced two short briefings https://www.local.gov.uk/sites/default/files/documents/25.169%20Practical%20examples%20of%20Making%20Safeguarding%20Personal%20from%20commissioners%20and%20providers%20of%20health%20and%20social%20care%20WEB.pdf and https://www.local.gov.uk/sites/default/files/documents/25.142%20Making%20Safeguard-	Thank you for your comment. The committee agree that leadership, culture and continuous learning are all important in creating a positive environment for safeguarding and included recommendations about this in section 3 - care home culture, learning and management. It is not NICE style to repeat the same recommendations in different sections of the guideline. It will be easier for users to jump between sections once it is published on the NICE website. The committee discussed the CQC closed cultures work in their final meeting and agreed to make additions to the organisational abuse indicators in section 1.12 around physical signs and lack of openness to visitors.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				ing%20Personal_03%20WEB.pdf heard from commissioners and providers alike that leadership and cultures that allow for reflection amongst staff are crucial and that the underpinning value base for effective safeguarding is a crucial part of development. This seems to be missing in this section. This is covered to some extent in the next section pages 17/18 so perhaps a clear link between the two is required. Also, a link to pages 19/20 the care homes culture link would be helpful. The LGA/ADASS resource 'Making Safeguarding personal. What might 'good' look like for health and social care commissioners and providers (Dec 2017) on pages 14-16 sets out some key components which are not included in this section of the NICE draft guidance. We consider that these are crucial and suggest reference is made to them, This should include that there is reference in the LGA/ADASS resource to the need for learning amongst commissioners as well as their part in seeking assurance of the impact of learning through contract monitoring. Also, the LGA/ADASS resource refers to the need to make reference to acting on factors (evidence in research) that enable and inhibit the transfer of learning into practice. This includes organisational support to put values into practice. It would be helpful to include information on risks in closed environments, what they are and what to do if concerned. (especially regarding neglect and isolation) refer to ADASS 'Closed Environment' 2020 This section should include understanding of concepts of involvement in decision making, regardless of mental capacity – i.e. always take people's perceptions into consideration.	The committee have also now included a number of additional references to the Making safeguarding Personal resources published by LGA and ADASS throughout the guideline.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

LGA/ ADASS	Guideline	005	011	NICE was aware that the framework (relating to understanding what constitutes a safeguarding concern) that goes hand in hand with the framework on 'Making decisions on the duty to carry out safeguarding enquiries' (LGA/ADASS) has been under development over the past 12 months. The fact that this work is in two parts was stated in the enquiries framework. The concerns framework is of direct relevance to this NICE guideline. It needs in my view to be cross referenced and some aspects of it integrated (such as definition of a safeguarding concern).	Thank you for your comment. The committee acknowledge the recent publication (Sep 2020) by LGA/ADASS of "Understanding what constitutes a safeguarding concern and how to support effective outcomes; Suggested multi-agency framework to support practice, recording and reporting". The committee have reviewed the new LGA/ADASS guidance in the context of the points you raise and do not believe that the two sets of guidance contradict each other, especially as the NICE guideline is focused mainly on decision making in the context of the care home, before a referral is made. The committee also wanted to emphasise that LAs frequently receive inappropriate referrals an issue which the NICE guideline is intended to address will help people make informed. The NICE guideline includes a reference to the LGA/ADASS document in the context section (as well as a hyperlink. References to this guidance are also included in evidence review C where further details regarding the committee's views in relation to these issues can be found.
LGA/ ADASS	Guideline	005	011 - 020	Reference is made to Association of Directors of Adult Social Services, Local Government Association 11 (2019) Making decisions on the duty to carry out Safeguarding Adults enquiries. ADASS & the LGA are <u>also</u> about to publish briefings on referring Safeguarding Concerns (S42.1 Care Act) This would be usefully referred to.	Thank you for your comment The committee have referred to this document in the context section of the guideline and included a hyperlink. References to this guidance are also included in evidence review C where further details regarding the committees' views in relation to these issues can be found.
LGA/ ADASS	Guideline	005	General	There are two recent Making Safeguarding Personal briefings (LGA/ADASS) for commissioners and providers of health and social care, published in Oct 2019 and July 2020. NICE colleagues attended the workshops that formed a basis for these briefings. The briefings arose from 4 workshops in total so represent input from experience and best practice of around 160 health and social	Thank you for your comment and for sharing this information

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				care providers and commissioners. These too are highly relevant to this work, especially as the NICE guideline underlines its intention to make 'recommendations on what works'. The briefings developed from the workshops, with around 160 commissioners and providers, shared examples of 'what works.' The relevant documents are 'We can do this well' and 'We are doing this well'. See: https://www.local.gov.uk/sites/default/files/documents/25.169%20Practical%20examples%20of%20Making%20Safeguarding%20Personal%20from%20commissioners%20and%20providers%20of%20health%20and%20social%20care%20WEB.pdf and https://www.local.gov.uk/sites/default/files/documents/25.142%20Making%20Safeguarding%20Personal_03%20WEB.pdf	
LGA/ ADASS	Guideline	006	002	The guideline says: 'The core legal duty for adult safeguarding is found in section 42 of the Care Act 3 2014. This places a statutory duty on local authorities to conduct an enquiry when …' The title of the guideline and its broader intention to… make 'action-orientated recommendations to improve safeguarding for residents of care homes' would indicate the need to broaden this interpretation of how the guideline relates to legislation. It would seem appropriate at least to refer to the sections of the Care Act that are headed Safeguarding adults at risk of abuse or neglect so S42-47 but in particular 42-44. Also S1 and 2 (wellbeing and prevention). Advocacy too S67 and 68.	Thank you for your comment. The committee have added some further detail and references to the legislation in the context section, including about human rights, as referenced in the Care Act statutory guidance. There are also some additional references to legislation and related guidance in the recommendations themselves
LGA/ ADASS	Guideline	008	General	Policies and procedures section/recommendations. These appear to reflect a narrow view on safeguarding adults, which is primarily about responding to incidents/concerns. Whilst lines 1-3 on p9 talk about identifying patterns there is no further	Thank you for your comment. It is true that the scope of the guideline is largely focused on identifying abuse and neglect and responding to and managing safeguarding concerns. However, the development of the guideline has been informed throughout by the Making Safeguarding Personal

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				reference in this section to prevention/early intervention. Safeguarding is as much about prevention (identifying signs that individuals may be at risk of abuse and providing a climate in which safeguarding issues are less likely arise and things can be picked up and raised as issues, such as quality issues) as it is about intervening where there is abuse. Recent LGA/ADASS publications on MSP for commissioners and providers (LGA, 2019 and 2020 cited above) do pick up on the need to engage with the person as the guidance does. However, there is also a strong emphasis on prevention and early intervention; on cultures and leadership that encourage positive partnership and parity of esteem so that team relationships encourage early sharing of concerns and everyone feels able to challenge. Staff as well as service users need to be empowered to raise issues. Every voice counts. The LGA/ADASS briefings also underline the need for workforce and workplace development to support putting procedures into practice. This I think should be in your list of requirements. See https://www.local.gov.uk/sites/default/files/documents/25.169%20Practical%20examples%20of%20Making%20Safeguarding%20Personal%20from%20commissioners%20and%20providers%20of%20health%20and%20social%20care%20WEB.pdf and https://www.local.gov.uk/sites/default/files/documents/25.142%20Making%20Safeguarding%20Personal_03%20WEB.pdf These two documents and an earlier one for commissioners/providers in 2017 (following link) https://www.local.gov.uk/sites/default/files/documents/25.27%20-%20CHIP%20Making%20Safeguarding%20Personal%3B%20What%20might%20%E2%80%98good%E2%80%99%20look%20like%20f.-2.pdf indicate the relevance for effective safeguarding of best practice in ***all*** of the CQC five core regulatory	programme, and the six core principles of safeguarding as set out in the Care Act statutory guidance, particularly in relation to the preventative aspect of safeguarding work. Further details on this are provided in the context section of the guideline. The committee were especially keen to emphasise the principle of prevention in recommendations relating to the promotion of an 'open' and reflective care home culture that enables staff highlight safeguarding concerns and challenge poor practice. The principle of prevention also underpins man y other recommendations, for example those relating to learning relating to learning from safeguarding incidents to manage or reduce risk.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				components; namely that when making safeguarding personal, providers and commissioners are "well-led, caring, effective, safe and responsive." This 2017 publication (LGA/ADASS) gives examples under each of the five core CQC components of what helps to safeguard people. (see p12-13).	
LGA/ ADASS	Guideline	012	002	**National networks SAB Chairs response:** It is not the responsibility of SABs to know the operational detail of who the leads are in care homes – this is the responsibility of partners' Commissioning and Operational services. Every SAB has a website and it is partners' responsibility (Commissioners) to draw attention, to all care home providers, about the SAB website and how contact can be made with SABs.	Thank you for your comment. The committee have amended a number of the recommendations that referenced Safeguarding Adults Boards (SAB) to make it clearer that these boards have a strategic oversight role and as such are often not taking forward actions themselves but are seeking assurances that local authorities, other commissioners and representative organisations on the board are. In this instance, the recommendation has been edited to clarify that clear lines of communication are in place between commissioners, the Regulator and safeguarding leads; rather than the detailed knowledge suggested by the original text.
LGA/ ADASS	Guideline	12	6	**National networks SAB Chairs response:** It is not the responsibility of SABs to undertake this work, generally. However, partners will engage with Care Homes in undertaking their responsibilities and specifically SABs would engage with a care home or groups of care homes where a specific action is made from a safeguarding Adult Review (SAR), relevant learning or learning event.	Thank you for your comment. This section has been edited to emphasise the specific role that SABs should play in disseminating recommendations and learning from relevant SARs; rather than the wider engagement suggested by the original text.
LGA/ ADASS	Guideline	012	010 - 011	**National networks SAB Chairs response:** This is the responsibility of those undertaking the enquiry and SABs will have oversight of this and will be key in addressing the issues set out in 'Making Safeguarding Personal' and expecting partners to demonstrate how this is delivered. This responsibility is already set out for SABs within the Care Act 2014, and its regulations and guidance.	Thank you for your comments. This recommendation has been edited to clarify that SABs should seek assurances from their partners that this responsibility is being met rather than the than level of involvement that may have been suggested by the original text.
LGA/ ADASS	Guideline	012	012 - 014	**National networks SAB Chairs response:** This is impractical and if offered as widely as suggested would lead to Annual Reports encumbered with a	Thank you for your comment. This section has been edited to clarify that SABs should include matters relevant to safeguarding in care homes in

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				lot of detail. However, it might be more appropriate for the suggestion for all SABs to have a mechanism, through its partners, as appropriate to local issues and partner feedback, to enable improved engagement with care homes which facilitates wider understanding and improved practice in relation to safeguarding e.g. regular reports from heath and social care commissioners.	their annual report rather than the wider consultation with care homes suggested by the original text.
LGA/ ADASS	Guideline	012	015 - 016	**National networks SAB Chairs response:** Safeguarding Adults Boards will usually have escalation procedures, generally applied and not specific to care homes. These will be on the Board's website.	Thank you for your comment. This recommendation has been edited to clarify that SABs should ensure that escalation procedures are relevant to care homes rather than establish new processes as suggested by the original text.
LGA/ ADASS	Guideline	13	006 - 012	National networks SAB Chairs response: All SABs do have detailed strategy and policy setting out the training requirements of staff in all partner organisations at the appropriate level and most apply some resource to this, though in the majority of cases the detail of training is delegated to partner organisations. It is important to note that most SABs do not have specific budgets, so any training has to be prioritised by partner agencies depending on local needs. Care Homes are required by CQC to provide safeguarding training to their own staff and managers which would include multi agency work.	Thank you for your comment. These recommendations have been edited to clarify that SABs should seek assurance from their partners regarding training (rather than provide or commission this themselves) to ensure that it has been developed on a multi-agency basis and reflects the level of responsibility for each role/level.
LGA/ ADASS	Guideline	015	003	1.2.8 – checking training is completed is important regardless of whether it happens on site or not. Might be better to say 'staff should be given time during their working day to complete training, and its impact should be assessed.'	Thank you for your comment. This recommendation has been edited to clarify that it relates to checks that training has been completed in an agreed timeframe. Details relating to training being completed on site have been deleted.
LGA/ ADASS	Guideline	018	General	*Line management and supervision* section. The tone of this could be less hierarchical. This is a two-way engagement where each learns and develops from the other. Not simply managers doing unto staff. This is reflected on p 19 lines 1-3 but only in exit interview context. This should be encouraged *all the time*.	Thank you for your comment. This is covered in recommendations relating to care home culture.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

LGA/ ADASS	Guideline	019	General	*Care Home Culture section* A mention of values based recruitment perhaps?	Thank you for your comment. Whilst the committee agree that values based recruitment can be an effective tool, this is not an issue specific to the remit of safeguarding and as such is out of scope for this guideline.
LGA/ ADASS	Guideline	020	020	*Multi agency working* section…begins 'Care homes should…' This is a joint responsibility and perhaps better to say…there is a joint responsibility across .(all partners) to build positive relationships of trust and work together etc.… All have a responsibility in all of these aspects in this section.	Thank you for your comment. The committee agree with you and have therefore clarified that this was their original intention by editing the recommendation to say that care homes, local authorities, clinical commissioning groups and other local agencies should work together.
LGA/ ADASS	Guideline	021	012	**National networks SAB Chairs response:** This is not the responsibility of SABs unless there is specific learning from a SAR or specific locally commissioned learning event. This is a responsibility of Commissioning and Operational services in partner organisations.	Thank you for your comment. The committee have amended a number of the recommendations that referenced Safeguarding Adults Boards (SABs) to make it clearer that boards have a strategic oversight role and as such are often not taking forward actions themselves but are seeking assurances that local authorities, other commissioners and representative organisations on the board are. The committee agreed to remove as a result and incorporated aspects of this into a recommendation relating to training. This recommends that SABs (and their subgroups and partners) should encourage care home providers to arrange opportunities for staff and residents to learn together from recent SARs.
LGA/ ADASS	Guideline	021	12	This is not the responsibility of SABs, unless there is specific learning from a SAR or specific locally commissioned learning event. This is a responsibility of Commissioning and Operational services in partner organisations.	Thank you for your comment. The committee have amended a number of the recommendations that referenced Safeguarding Adults Boards (SABs) to make it clearer that boards have a strategic oversight role and as such are often not taking forward actions themselves but are seeking assurances that local authorities, other commissioners and representative organisations on the board are. The committee agreed to remove as a result and incorporated aspects of this into a recommendation relating to training. This recommends that

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					SABs (and their subgroups and partners) should encourage care home providers to arrange opportunities for staff and residents to learn together from recent SARs.
LGA/ ADASS	Guideline	021	21	**National networks SAB Chairs response:** We do not believe that there would be the time, or whether it would be particularly useful to share Board Minutes & Reports with care home staff. However, Care Homes must share the outcomes of relevant Safeguarding Adult Reviews with their staff in a way that leads to learning and improvements in practice.	Thank you for your comment, which the committee discussed at length. Ultimately they decided to leave the recommendation as it stands because it already makes it clear that managers would only share relevant information with staff.
LGA/ ADASS	Guideline	034	17	The new LGA/ADASS framework on safeguarding concerns, available late Sept 2020 on https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal suggests that this decision may not be able to be taken at this stage/may cause delay so the framework states clearly that only a) and b) in S42 (1) Care Act need to be fulfilled before reporting as a concern to the Local Authority. The LA will then work with the referrer to answer this criteria c) in S42(1) as to whether the person is able to protect themselves.	Thank you for your comment. The committee agreed to remove this recommendation, because although the intention was not to imply that it was up to the referrer whether a section 42 enquiry should be undertaken, the committee recognised that it could cause confusion. Instead, the guideline recommends that the indicators (in conjunction with the other recommendations in these sections) are used to decide whether a safeguarding referral should be made
LGA/ ADASS	Guideline	035	002	Suggest cross referencing to the new Understanding what constitutes a safeguarding concern and how to support effective outcomes; Suggested multi-agency framework to support practice, recording and reporting' Available late Sept 2020 on https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal This gives definitions of abuse/neglect and care and support needs and safeguarding concern This may help.	Thank you for your comment. The committee acknowledged the recent publication (Sep 2020) by LGA/ADASS of "Understanding what constitutes a safeguarding concern and how to support effective outcomes; Suggested multi-agency framework to support practice, recording and reporting". The committee have though referred to it in the evidence report discussions and in the context section of the guideline and included a link.
LGA/ ADASS	Guideline	035	11	1.7.7 This single point of access for referrals and advice should be available 24/7. Urgent matters should be reported when they are first identified, (i.e. if the person is at immediate or imminent risk), whereas less urgent referrals can be made the	Thank you for your comment. This recommendation is focused on the ability to seek expert advice, and does not refer to an urgent referral emergency contact line. It is intended to encourage care

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				next working day. (for example, where an event has occurred, but the person is safe and not immediate action is needed.)	homes to proactively ask for advice regarding safeguarding in less 'urgent' situations (for example, to help decide whether a referral should be made at all).
LGA/ ADASS	Guideline	035	017	1.7.9 This should be changed to reflect the fact that it is professionals who make these assessments, rather than the organisations they work for.	Thank you for your comment. The committee felt that it was most appropriate to refer to the local authority/organisation as a whole to reflect their statutory responsibilities, rather than specify the individual roles that might be involved, particularly as this may vary between local authorities.
LGA/ ADASS	Guideline	036	001	Ideally the LA will discuss with the care home rather than just tell them. There should be a dialogue, although it is the decision of the LA.	Thank you for your comment. Whilst the committee agree that local authorities should engage and actively discuss safeguarding practice with care homes wherever possible, they felt that it was not appropriate to suggest this in this instance as there is a risk that this could jeopardise or interfere with the investigation.
LGA/ ADASS	Guideline	037	4	What they would like to achieve and how? How they would like to be involved?	Thank you for your comment. The committee are confident that this recommendation is sufficiently clear as it is currently written.
LGA/ ADASS	Guideline	037	019 - 021	**National networks SAB Chairs response:** This is good and should be happening in line with Making Safeguarding Personal protocols.	Thank you for your comment and support. This recommendation has been edited to clarify that SABs should ensure that LAs have these processes in place; rather than both LAs and SABs having their own processes.
LGA/ ADASS	Guideline	38	11	Earlier reference to advising referrers where an enquiry does not take place, how any risks are being addressed/ mitigated. This should probably go in here too?	Thank you for your comment. Risk management in cases where a S42 does not take place is included in a recommendation in section 7.
LGA/ ADASS	Guideline	38	11	Not just feedback to resident but to provider of care too (but in line with data protection requirements). This is the responsibility of the local authority and SABs will and do monitor this in performance data.	Thank you for your comment. The committee agree that feedback to care providers is key. As this is the responsibility of LAs, and SABs monitor this through performance data; the committee did not feel that it was necessary to include a recommendation stating this.
LGA/ ADASS	Guideline	038	017	*Enquiry lead… should ask the resident at risk:* Suggest this should include 'whether/how/ to what extent they wish to be involved . . .	Thank you for your comment. The committee believe that this is implicit in the recommendation;

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					and the text has been edited a number of times to ensure that it is succinct.
LGA/ ADASS	Guideline	039	014 - 018	Possibly a further point is that SABs (and commissioners of advocacy) should collate broader concerns, for example arising from non-statutory (community) advocacy carried out in the local area. See new resource ' Strengthening the role of advocacy in Making Safeguarding Personal' LGA/ADASS https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal	Thank you for your comment. This recommendation has been edited to clarify that this is the responsibility of local authorities and commissioners rather than SABs. SAB collation of wider concerns is covered in section 1.2.
LGA/ ADASS	Guideline	039	015 - 018	**National networks SAB Chairs response:** This is the responsibility of the local authority and SABs will and do monitor this in performance data.	Thank you for your comment. This recommendation has been edited to clarify that this is the responsibility of local authorities and commissioners rather than SABs.
LGA/ ADASS	Guideline	40	15	Use of *under investigation* as a term. This is pre-Care Act language … suggest subject to or party to a safeguarding enquiry. On this page and going forward in the report.	Thank you for your comment. These sections have been edited using the phrasing you suggest.
LGA/ ADASS	Guideline	40	015 - 020	Exclusion from investigation – a better example would be excluding a potential abuser, rather than data protection, as this may encourage staff not to include a family member 'due to data protection rules'. Add a reference to the fact that both a victim and abuser may be entitled to advocacy support via the IMCA service.	Thank you for your comment. The example of data protection has been removed from this recommendation. Entitlement to advocacy support via the IMCA service is covered in the section on support during an enquiry.
LGA/ ADASS	Guideline	040	16	1.9.1 – consider whether the staff member about whom the enquiry is made should be working away from the resident the concerns are about or be suspended from work if the concerns are serious, and others may be at risk.	Thank you for your comment. Whilst the committee agree that this is an important consideration, this recommendation relates to support for the staff member concerned and the committee did not feel that it was appropriate to include this detail.
LGA/ ADASS	Guideline	44	General	Add a sub heading related to Covid, for example: Organisational Abuse during the Covid Period Consider when: • lockdown measures are applied disproportionately, and alternative ways of maintaining contact (including facilitating 'face to face' meetings virtually or in person) are not supported.	Thank you for your comment. The committee recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes. The committee have discussed their recommendations in light of this and have attempted to mitigate against the impact of Covid-19

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				• There is a lack of contact with external professionals, or disproportionate limitations on their visiting. (for example, BIAs, Social Workers, Nurses or GPs are denied access)	wherever possible, although learning from the pandemic may inform any future updates of the recommendations. NICE have published products related to their response to COVID-19 here which are being updated regularly. We will flag any relevant areas to the COVID-19 guideline team.
LGA/ ADASS	Guideline	52	1	It would be helpful to add something here rather than just the link. It is a very significant area of learning and response. Perhaps something like reflecting on the core values and leadership of the organisation and the impact of these and what needs addressing in this context. Readers may skip links rather than accessing them.	Thank you for your comment. We have kept the link as is because it is NICE style not to repeat things in different aspects of the guideline, but we can look at whether the link between this section and the earlier culture, learning and management section could be given greater prominence when the guideline is set out on the NICE website.
LGA/ ADASS	Guideline	55	004 - 014	Definitions of safeguarding concern and safeguarding enquiry. The following is problematic. It would be helpful to use the same definitions as appear in the LGA/ADASS frameworks (2019/2020) and in the NHS digital Safeguarding Adults Collection, which in turn rely on S42 Care Act 2014. This states that S42(1)This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) (a) has needs for care and support (whet her 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 (whether under this Part or otherwise) and, if so, what and by whom. For a safeguarding concern, the framework says that …'This framework suggests therefore that where it appears that criteria a and b of s42(1) are met and the referring worker/ organisation believes	Thank you for your comment. The committee have carefully defined the terms concern, referral and enquiry in the glossary in line with the Care Act and recommendations within the guideline, to make the actions required very clear at each stage. This is also reflected in the 2 visual summaries. The glossary defines a concern as a: "…. consideration, suspicion or indication of abuse or neglect of a resident, or residents within a care home. Anybody who works in, lives in or visits the home may have a safeguarding concern, either because of something they have seen or because of something they were told. All safeguarding concerns should be responded to in line with this guideline. The glossary defines referral in the following way: If abuse or neglect is suspected this must be reported to the local authority. This is called making a safeguarding referral. Finally, safeguarding enquiry is defined in the glossary as per the definitions in the Care Act, 2014 and accompanying statutory guidance.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				that the circumstances amount to a safeguarding concern a referral is made to the local authority'. A and b are 'has needs for care and support etc.… and then is at risk of …experiencing abuse or neglect… The definitions of abuse and neglect and care and support needs are expanded upon in section 3 of this framework. For safeguarding enquiry that enquiries framework says, 'From the point at which the three statutory criteria (and alongside this an understanding that there is 'reasonable cause to suspect') are met then there is a duty under S42(2) to undertake an enquiry. All activity from that point will constitute an enquiry under the S42(2) duty. S42(2) supports an understanding that activity attached to that duty to make enquiries is required – to inform the decision on what action needs to be taken and by whom.	The guideline recommends that all 'suspect' indicators are referred to the Local Authority to decide whether the three statutory criteria are met (with a link to the '3 point test' included) and whether a section 42 Enquiry or other investigation is needed. 'Consider' indicators are intended to result in action within the care home to rectify the issue. However, the recommendations are also intended to encourage the care home to seek advice from the local authority if they are not sure whether a referral should be made. The committee also added a number of recommendations encouraging local authorities to support care homes to develop staff understanding in relation to the differences between poor practice and a safeguarding concern. The s42 enquiry process itself is not within the scope of this guideline and practitioners should refer to relevant ADASS/LGA and other related guidance with regards to these details. This guideline only covers recommendations around the information and support needs of care homes, care home staff, residents at risk and alleged perpetrators while enquiries are taking place and as well as some principles around meetings and information sharing during an enquiry – not detailed guidance about how enquiries should be conducted. The committee acknowledged the recent publication (Sep 2020) by LGA/ADASS of "Understanding what constitutes a safeguarding concern and how to support effective outcomes; Suggested multi-agency framework to support practice, recording and reporting". The committee have though referred to it in the evidence report discussions and in the context section of the guideline and included a link.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					The committee have looked through and discussed the new LGA/ADASS guidance in the context of the points you raise and do not believe the two sets of guidance are at odds with one another, especially as the NICE guideline is focused mainly on decision making in the context of the care home, before a referral is made. The committee also wanted to emphasise that LAs frequently receive inappropriate referrals and that the NICE guidance will help people make informed decisions about whether to make a referral to the local authority or take another course of action.
LGA/ ADASS	Guideline	057	012 - 018	In the section on recommendations for research and on Embedding learning from Safeguarding Adults Reviews, you need to refer to the research already undertaken by Professors Suzy Braye & Michael Preston-Shoot on Self Neglect and in learning from SARs.(Please also see their forthcoming National review undertaken with Research in Practice (forthcoming LGA/ADASS publication).	Thank you for your comment. Details in relation to the work by Braye, et al. have been added to this research recommendation. Please see evidence review H ('why this is important') for further details.
LGA/ ADASS	Guideline	91	005 - 008	Section 43, Care Act 2014, outlines that SABs are responsible for coordinating and ensuring the effectiveness of what partner agencies do when helping and protecting adults who have care and support needs, are experiencing or at risk of abuse and neglect, and because of their needs are unable to protect themselves. Schedule 2 further specifies that this responsibility requires publication of both a strategic plan and an annual report. Commissioning and disseminating the outcomes of Safeguarding Adult Reviews (SARs) (section 44) is a further responsibility that aims to enhance the effectiveness of single agencies and multi-agency partnership working in preventing and protecting adults from abuse and neglect. The statutory guidance for implementation of the	Thank you for your comment. The role of SABs in sharing learning and ensuring that partner agencies are helping and protecting adults with care and support needs is covered in section 1.2 of the guideline, and the guideline is not intended to duplicate requirements set out in the Care Act, 2014 or the accompanying statutory guidance.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				Care Act 2014 (DHSC, 2018) elaborates these responsibilities, in so doing mirroring to some degree the aforementioned research. The statutory guidance refers to prevention of abuse and neglect, development of policies, guidance and strategies, for example about counteracting discrimination and balancing people's confidentiality with the duty to protect, and promotion of multi-agency training. SABs are also responsible for overseeing and holding partners to account for the quality, responsiveness and effectiveness of adult safeguarding services. This might be done through analysis and interrogation of data, and the use of self-audits and peer review. Integral to this oversight and improvement agenda is the development of collaboration, monitoring progress against stated intentions through annual reports. The statutory guidance requires SABs to identify mechanisms for monitoring and reviewing the implementation and impact of policies and training. Crucially, for the purposes of this article, what is meant by impact is left undefined.	
LGA/ ADASS	Guideline	91	005 - 008	Section 43, Care Act 2014, outlines that SABs are responsible for coordinating and ensuring the effectiveness of what partner agencies do when helping and protecting adults who have care and support needs, are experiencing or at risk of abuse and neglect, and because of their needs are unable to protect themselves. Schedule 2 further specifies that this responsibility requires publication of both a strategic plan and an annual report. Commissioning and disseminating the outcomes of Safeguarding Adult Reviews (SARs) (section 44) is a further responsibility that aims to enhance the effectiveness of single agencies and multi-agency partnership working in preventing and protecting adults from abuse and neglect. The statutory guidance for implementation of the	Thank you for your comment. The role of SABs in sharing learning and ensuring that partner agencies are helping and protecting adults with care and support needs is covered in section 1.2 of the guideline, and the guideline is not intended to duplicate requirements set out in the Care Act, 2014 or the accompanying statutory guidance.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				Care Act 2014 (DHSC, 2018) elaborates these responsibilities, in so doing mirroring to some degree the aforementioned research. The statutory guidance refers to prevention of abuse and neglect, development of policies, guidance and strategies, for example about counteracting discrimination and balancing people's confidentiality with the duty to protect, and promotion of multi-agency training. SABs are also responsible for overseeing and holding partners to account for the quality, responsiveness and effectiveness of adult safeguarding services. This might be done through analysis and interrogation of data, and the use of self-audits and peer review. Integral to this oversight and improvement agenda is the development of collaboration, monitoring progress against stated intentions through annual reports. The statutory guidance requires SABs to identify mechanisms for monitoring and reviewing the implementation and impact of policies and training. Crucially, for the purposes of this article, what is meant by impact is left undefined.	
LGA/ ADASS	Guideline	91	015 - 020	APPENDIX 1 Research on the governance of adult safeguarding[3] has scoped SAB responsibilities in detail, identifying seven core functions: Strategic planning; Setting standards and issuing guidance; Quality assurance; Promoting participation; Awareness raising; Capacity building and training, and Relationship management. 8.5.1.2. The statutory guidance[4] mirrors to some degree the aforementioned research. It refers to prevention of abuse and neglect; development of	Thank you for your comment. The role of SABs in sharing learning and ensuring that partner agencies are helping and protecting adults with care and support needs is covered in section 1.2 of the guideline, and the guideline is not intended to duplicate requirements set out in the Care Act, 2014 or the accompanying statutory guidance.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				policies, guidance and strategies, and promotion of multi-agency training. SABs are encouraged to develop effective links with other key local partnerships. SABs are also responsible for overseeing and holding partners to account for the quality, responsiveness and effectiveness of adult safeguarding services. This might be done through analysis and interrogation of data, and the use of self-audits and peer review. Integral to this oversight and improvement agenda is the development of collaboration, monitoring progress against stated intentions through annual reports. The statutory guidance requires SABs to identify mechanisms for monitoring and reviewing the implementation and impact of policies and training, with a particular emphasis given to self-neglect. Crucially, what is meant by impact is left undefined.	
Lincolnshire Safeguarding Adults Board	Guideline	12	10	This is an operational matter. Safeguarding Adult Boards may seek assurance about the quality of Sec 42 enquires in relation to Making Safeguarding Personal and how generally enquiries are progressed.	Thank you for your comments. This recommendation has been edited to clarify that SABs should seek assurances from their partners that this responsibility is being met rather than the level of involvement that may have been suggested by the original text.
Lincolnshire Safeguarding Adults Board	Guideline	12	12	This recommendation is not practical, but as highlighted above Lincolnshire Care Association are part of our partnership board and as such will see and disseminate the annual report as necessary. Through the partnership board they have the opportunity to comment on the report and also the development of future strategy.	Thank you for your comment. This section has been edited to clarify that SABs should include matters relevant to safeguarding in care homes in their annual report rather than the wider consultation with care homes suggested by the original text.
Lincolnshire Safeguarding Adults Board	Guideline	12	15	The board has its own escalation policy for all partners to follow and therefore there is no requirement for a separate one to be developed.	Thank you for your comment. This recommendation has been edited to clarify that SABs should ensure that escalation procedures are relevant to care homes rather than establish new processes as suggested by the original text.
Lincolnshire Safeguarding Adults Board	Guideline	12	2	Clinical Commissioning Group/Commissioners of providers should be responsible for knowing who the safeguarding leads are.	Thank you for your comment. This recommendation has been edited to clarify that SABs should seek assurances that clear lines of communication

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				This should perhaps say that Safeguarding Adult Boards should ensure that Clinical Commissioning Group /Commissioners have procedures in place to clearly identify safeguarding leads within care/residential homes and that Safeguarding Adult Boards should support the Clinical Commissioning Groups in educating safeguarding leads and raising awareness. E.g. safeguarding ambassadors process (a local initiative) instigated by Clinical Commissioning Groups.	are in place between commissioners, the Regulator and safeguarding leads; rather than the detailed knowledge suggested by the original text.
Lincolnshire Safeguarding Adults Board	Guideline	12	6	This should be considered as part of the normal board consultation and communication process. Obviously the dissemination of learning from Safeguarding Adult Reviews which may be relevant to care homes will take place. Lincolnshire has excellent relations with the Lincolnshire Care Association who represent the majority of our care homes and Lincolnshire Care Association are part of Lincolnshire Safeguarding Adults Board being a member of the partnership board.	Thank you for your comment. The committee drafted the recommendation with the aim of reducing variation in practice across the sector.
Lincolnshire Safeguarding Adults Board	Guideline	13	6	It would be difficult to mandate training for private organisations but our safeguarding board does offer a range of multi-agency training available to all partners free of charge. The board also supports the Clinical Commissioning Group led initiative of safeguarding ambassadors which provides individuals with a greater awareness of safeguarding and lessons learnt from relevant Safeguarding Adult Reviews. The independent board chair attends these sessions.	Thank you for your comment. We have edited these recommendations to clarify that SABs should seek assurance from their partners regarding training (rather than provide or commission this themselves) to ensure that it has been developed on a multi-agency basis and reflects the level of responsibility for each role/level. Thank you for sharing this example of good practice, we will pass this information on to the NICE implementation team.
Lincolnshire Safeguarding Adults Board	Guideline	15	6	This would be difficult to achieve with the current resourcing and funding available to Safeguarding Adult Boards.	Thank you for your comment. This recommendation has been edited to clarify that translations of key concepts or specific phrases should be provided if necessary rather than translations of all resources related to safeguarding. The committee

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					acknowledge that there may still be resource implications associated with this but they believe this recommendation to be achievable within the current climate.
Lincolnshire Safeguarding Adults Board	Guideline	20	20	There is no requirement for a separate partnership as described as within the Lincolnshire Safeguarding Adults Board care homes are represented through Lincolnshire Care Association. There is already a quality assurance meeting between the Clinical Commissioning Groups, Local Authority and Lincolnshire Care Association to monitor and support the sector and this should be seen as best practice. Lincolnshire Care Association are also signed up to our Safeguarding Adult Boards information sharing agreement.	Thank you for your comment. This recommendation has been edited to clarify that it relates to the importance of all local agencies working together to establish local arrangements, rather than the suggestion that a separate partnership or arrangement needs to be established.
Lincolnshire Safeguarding Adults Board	Guideline	21	12	Safeguarding Adult Boards do arrange opportunities for professionals to learn from Safeguarding Adult Reviews and other enquiries. It is not their responsibility to inform residents as described in this recommendation.	Thank you for your comment. The committee have amended a number of the recommendations that referenced Safeguarding Adults Boards (SABs) to make it clearer that boards have a strategic oversight role and as such are often not taking forward actions themselves but are seeking assurances that local authorities, other commissioners and representative organisations on the board are. The committee agreed to remove as a result and incorporated aspects of this into a recommendation relating to training. This recommends that SABs (and their subgroups and partners) should encourage care home providers to arrange opportunities for staff and residents to learn together from recent SARs.
Lincolnshire Safeguarding Adults Board	Guideline	21	18	The role of Safeguarding Adult Boards is to seek assurance that safeguarding arrangements are effective. Performance information provided to the board should highlight where there are any areas of specific concerns and where there are working with Lincolnshire Care Association, Clinical Commissioning Groups and the Local Authority as a board we can ask for further specific assurance.	Thank you for your comment. The committee agreed to edit this recommendation for the final version of the guideline and it now encourages care homes to participate in safeguarding adults boards arrangements for sharing experiences about managing safeguarding concerns.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Lincolnshire Safeguarding Adults Board	Guideline	37	19	Agree with this recommendation and this should be a focus for all Safeguarding Adult Boards.	Thank you for your comment and support. This recommendation has been edited to clarify that SABs should ensure that LAs have these processes in place; rather than both LAs and SABs having their own processes.
Lincolnshire Safeguarding Adults Board	Guideline	39	14	This is a wider more general issue about advocacy use across safeguarding. It is not the role of Safeguarding Adult Boards to monitor the care homes specifically, rather the role of Clinical Commissioning Groups and Care Quality Commission to ensure standards are met. Safeguarding Adult Boards seek assurance through the commissioners.	Thank you for your comment. This recommendation has been edited to clarify that this is the responsibility of local authorities and commissioners rather than SABs.
MENCAP	Comment form Q3	General	General	**Q3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)** As a large care provider we have set up an internal safeguarding panel with a range of people from across the organisation involved, and an independent chair. Here is a link to a short case study on it (note: this is a few years old and the panel has further developed since it was written eg. there is now an independent chair, there have been audits and the work of the panel has continued to develop etc: https://www.scie.org.uk/safeguarding/adults/introduction/highlights#mencap	Thank you for your comment and providing this example. Your comments will be considered by NICE where relevant support activity is being planned.
MENCAP	Comment form Q4	General	General	COVID-19 issues to be considered re: this guideline We think there are a number of specific issues relating to COVID-19 that need to be taken into account when finalising this guideline. It is recognised that people in care homes have	Thank you for your comment and providing this feedback. The committee recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				been badly affected by COVID-19. Issues to consider include: size of care homes and factors that have contributed to transmission, access to testing, PPE, low staffing levels (staff sick or isolating) and neglect of basic care needs and health needs – many of the issues that have been raised in the media. There has also been a lot of concern about reduced oversight during COVID - lack of visits (including family visits), reduced involvement of other external professionals, reduced CQC inspections during the pandemic. All this has put people at greater risk of abuse and neglect. As mentioned earlier, there are also implications for type of training and how meetings are conducted etc eg. face to face vs online. We suggest a specific COVID section is added to the guidance.	The committee have discussed their recommendations in light of this and have attempted to mitigate against the impact of Covid-19 wherever possible, although learning from the pandemic may inform any future updates of the recommendations. NICE have published products related to their response to COVID-19 here which are being updated regularly. We will flag any relevant areas to the COVID-19 guideline team. Whilst management of transmission, PPE, testing, and staffing levels are not within the scope of this guideline, the committee recognise the impact that Covid-19 has had on external scrutiny of care homes and the indicators of organisational abuse ('physical signs and lack of openness to visitors') now also incorporate details on closure to outside scrutiny. The committee believe that this will help to emphasise that there is no justification for blanket bans regarding external visitors. Non-compliance with infection control policies is also included in the list of potential indicators of organisational abuse. With regards to training, after lengthy discussions regarding delivery methods the committee agreed to clarify that face-to-face training should include the use of virtual platforms. The committee agreed that this should mitigate against the challenges that have occurred as a result of Covid-19 (as well as potential resourcing issues). The definition (found in the 'terms used' section of the guideline) includes the following text: "It may take place with participants all in the same room, or by using video or telephone conferencing. It may include online materials, but participants are able to ask questions, discuss, reflect on current practice and use case studies and examples."

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					The committee did not review evidence relating to the format of meetings relating to safeguarding concerns and their recommendations do not therefore include details on this. The evidence which the committee did review suggested that there can often be a lack of trust amongst the interested parties and their recommendations therefore focus on the importance of communication about decisions taken, particularly with the resident about whom the concern has been raised. The committee believe that this focus will help care homes to ensure that meetings remain effective and transparent regardless of format.
MENCAP	Guideline	General	General	Audience of the guideline - The document says the guideline is for: Care home providers, managers, staff and volunteers, Other health and social care practitioners working with adults in care homes, Health and social care commissioners of residential care for adults, Local authorities and Safeguarding Adults Boards, Adults living in care homes, their families, friends, carers and advocates, and the public. Each of the people above will have different roles and responsibilities linked to the guideline. Whilst everyone has a responsibility for safeguarding, the responsibilities of particular individuals and agencies will be greater, or more nuanced, and should be reflected as such through the guideline. It says one audience is adults living in care homes and their families. However, the guideline in its current form is not accessible for people with learning disability and/or autism and others. We would like to see mention of an Easy read version of the final guideline being produced and/or it made clear that providers, LAs, CCGs, SABs need to offer this. It is also really important that adults living in care	Thank you for your comment. The committee note your concerns regarding the differing roles and responsibilities of practitioners involved in safeguarding and the intended audience for the guideline. When there is a specific practitioner or agency that should take action as a result of a particular recommendation this has been clarified either in the introductory text or within the recommendation itself. If there is flexibility in who should take action it is NICE style to draft a generic recommendation to allow for organisations to respond proportionately. Your comments about implementation of the guideline will be considered by NICE where relevant support activity is being planned. Both care home residents and family members of care home residents have been involved in the development of the guideline as members of the guideline committee.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				homes, including working-age adults with a learning disability, and their families have been involved in the development of the guidance. Have there/ will there be focus groups/ consultation directly with these groups? (This will require production of accessible materials etc.)	
MENCAP	Guideline	General	General	Generally the impetus of this guidance falls too much on 'self-checking'. We don't think it recognises the important role that external agencies play in safeguarding, particularly in cases of organisational abuse.	Thank you for your comment. The guideline focuses on safeguarding practice in care homes and as such the majority of recommendations relate to the work of care homes themselves (and care home managers in particular). The committee agree that external oversight is essential and drafted recommendations for local authorities and commissioners as well as SABs to cover this. Although the work of regulatory bodies is not within scope of the guideline the committee drafted recommendations relating to the indicators of abuse and neglect which can be used by anyone.
MENCAP	Guideline	General	General	When reading this guideline what comes across is a large, older persons' care home, people in uniforms and a very structured environment...It needs to be made explicit that care homes vary considerably in size and style. It would be helpful if the guideline explained the different types/ models of care homes as this is relevant to safeguarding and could make some care homes riskier settings than others. For example: • Different size care homes • May have internal health professionals (less reliance on community health team – less involvement from external professionals) • May not have internal health professionals and there may be an overstretched community health team which means there are long delays for health input • Part of a big organisation with quality assurance framework etc coming from the wider organisation (not those directly working in a particular care home)	Thank you for your comment. The committee acknowledge that the care home sector is very diverse and that the population of people living in them have a wide and complex range of health and social care needs; however, identification of risk factors was not within the scope of the guideline. Whilst the absence of safeguarding specific evidence made it difficult for the committee to make recommendations relating to specific groups of people, they were mindful of the 6 core principles of safeguarding and the Making Safeguarding Personal programme when drafting recommendations and took care to ensure that the recommendations are not discriminatory. In addition, an Equality Impact Assessment of the guideline and recommendations has been carried out to ensure that people with more specific needs are not disadvantaged.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				• It could be a standalone care home that is not part of a large provider. • Is it isolated/ in a remote area, or not.	
MENCAP	Guideline	General	General	*"The terms 'consider' and 'suspect' are used to define the extent to which an indicator suggests abuse or neglect, with 'suspect' indicating a stronger likelihood of abuse or neglect." - Given that all indicators are highlighted as 'not proof of abuse or neglect in their own right',' is it necessary to provide this separation between indicators? We think the distinction between 'consider' and 'suspect' is not clear, meaning referrals may not be made when they should. This feels risky.* *We think that the idea that people are always trying to consider if there is abuse and/or neglect is important, but the risk of having these as indicators may mean that they could reduce the significance of these and under-report. There needs to be a clear guide that people concerned need to talk to the safeguarding lead about their concerns.* *'Some behavioural and emotional indicators of abuse and neglect may be due to non-recent… violence'.* *'Some indicators of abuse and neglect can be similar to behaviours arising from other causes...This is particularly important for residents who do not communicate using speech.'* *The wording of the above (lines 7-16) is concerning. It should be made extremely clear that no amount of previous trauma, and/or no existent condition should ever be suggestive that a thorough investigation is not necessary, or be utilised as an excuse for indicators to be ignored. Indeed, people who have been previously abused, or have particular needs, may be more susceptible to abuse*	Thank you for your comment. The guideline recommends that all 'suspect' indicators are referred to the Local Authority to decide whether the three statutory criteria are met and whether a section 42 Enquiry or other investigation is needed. 'Consider' indicators are intended to result in action within the care home to rectify the issue. However, the recommendations are also intended to encourage the care home or the person with the concern to seek advice from the local authority if they are not sure whether a referral should be made. The committee also added a number of recommendations encouraging local authorities to support care homes to develop staff understanding in relation to the differences between poor practice and a safeguarding concern. The committee believe the recommendations in the guideline will result in more timely and appropriate referrals being made and create a better shared understanding about what is a serious safeguarding concern and what is poor practice. The text you refer to regarding behaviours arising from other causes has been amended to clarify that it relates to behaviours that are 'signs of distress' and includes references to trauma and adverse childhood events. This section also includes the following caveat: "However, the possibility of abuse or neglect should always be considered as a cause of behavioural and emotional indicators, even if they are seemingly explained by something else" to be absolutely clear that abuse and neglect should always be considered or suspected.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				and/or neglect. The wording is also concerning as it assumes that people with learning disabilities and/or autism use behaviours that are challenging – that these emerge from them and do not have an environmental cause. The recognition that trauma has been part of many people's histories is important to make, but that this needs good therapeutic support is the key message. *'If the indicators relate to a past incidence of abuse or neglect, and the resident is currently in a safe environment, someone who has a positive relationship with the resident should find out what support (if any) they would like." - This should be confirmed following a thorough investigation.* *If people are traumatised from past events this needs to be taken very seriously and the person should have their needs addressed. It is recognised that many people with LD have been traumatised by their experience in the care system e.g. those who have been shut away in inpatient units experiencing high use of restrictive interventions etc. It is important their psychological needs are not neglected. They will often be dependent on others to ensure they are able to access the right support for these needs. This must happen to ensure that neglect of people's emotional and psychological needs is not occurring on top of abuse.* *It says that when responding to all indicators of abuse and neglect to follow the principles of the MSP framework. There is an external weblink to further information about MSP but we think there should be more about MSP within the guideline and the LA responsibility to help with this. It needs to be clearer what following the principles of MSP might look like when responding to all the indicators of abuse and neglect.*	

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

MENCAP	Guideline	General	General	It will often be people outside a care home who may spot signs of abuse and neglect – as recognised in the Care Act guidance: Spotting signs of abuse and neglect Workers across a wide range of organisations need to be vigilant about adult safeguarding concerns in all walks of life including, amongst others in health and social care, welfare, policing, banking, fire and rescue services and trading standards; leisure services, faith groups, and housing. GPs, in particular, are often well-placed to notice changes in an adult that may indicate they are being abused or neglected. Findings from serious case reviews have sometimes stated that if professionals or other staff had acted upon their concerns or sought more information, then death or serious harm might have been prevented. The following example illustrates that someone who might not typically be thought of, in this case the neighbour, does in fact have an important role to play in identifying when an adult is at risk. - CARE ACT STATUTORY GUIDANCE It feels important to have a proper section in this NICE guidance that is clearly aimed at external professionals- and what their role is here, and how they should act on indicators they spot. It would also be helpful to have a specific section aimed at families of residents and what their role is here, and how they can act on indicators they spot.	Thank you for your comment. The committee agree that visitors to a care home may often be well-placed to identify areas of concern. The introduction to the lists of potential indicators now includes text clarifying this (explicitly stating that they are relevant to everyone). The committee did not believe that it was appropriate to create separate lists for professionals and family or friends of care home residents as this creates duplication and risks confusion. However, the recommendations covering immediate actions to take do provide information on how to act if you do not work in the care home.
MENCAP	Guideline	General	General	Re: gathering information 'Give the resident the chance to speak freely about what has happened. Use simple and open questions, and ask in a non-leading way. Write down what they tell you, in their own words' – It needs to be clear who is responsible for both	Thank you for your comment. In section 6 of the guideline the actions are aimed at whoever witnessed the possible abuse or neglect. It is about the immediate actions that should be taken when gathering information before reporting to the safeguarding lead (or to others depending on circumstances).

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				gathering and reporting information about safeguarding concerns remembering that the guidance is currently aimed at a large group of individuals and organisations. Indeed, the responsibilities of this whole section need to be assigned.	
MENCAP	Guideline	General	General	There doesn't seem to be a section in the guidance on how agencies share information early on to prevent abuse or the role of external agencies in spotting abuse in care homes. There seems to be too much reliance on the care home to do this.	Thank you for your comment. The committee agree that preventative safeguarding work is essential, however, as it often overlaps with care quality improvement it is not within the scope of this guideline and so the committee were unable to go into detail about this. However, the guideline makes a number of references to the 6 key principles of safeguarding (including prevention), for example, in recommendations relating r to the content of mandatory training. It is also covered indirectly in the possible indicators of individual and organisational level abuse and neglect. The guideline recommends that an understanding of these indicators is included in mandatory training and link to the training section has now been added. With regards to the role of external oversight, the guideline focuses on safeguarding practice in care homes and as such the majority of recommendations relate to the work of care homes themselves (managers in particular). However, the committee agree that external oversight is essential and drafted recommendations for local authorities and commissioners as well as SABs to cover this. Although the work of regulatory bodies is not within the scope of the guideline the committee drafted recommendations relating to potential indicators of abuse and neglect which can be used by anyone.
MENCAP	Guideline	General	General	*'providing extra support to cover absences as part of the enquiry and to help staff continue providing consistent and high-quality care.'* –It should be clear there will be cost implications for LAs where LAs are funding placements in care homes.	Thank you for your comment. The rationale and impact section of the guideline includes details relating to potential resource impacts, however as this is an example of best practice the committee agreed that it should be included despite this possible impact.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

MENCAP	Guideline	26 - 30	General	Re: physical abuse. 'have their activity limited by misuse of medication, or covert administration when not medically authorised' - this language could be clearer, limiting activity can be as extreme as limiting someone's ability to walk, talk or stand through the use of medication. Arguably, there should be a full section for abuse using medication given the various forms this can take, and the seriousness of potential consequences. Re: sexual abuse: what is the difference between sexualised and highly sexualised behaviour, and why is only 'highly sexualised' behaviour deemed a possible indicator when undertaken by the person (where it is recognised as a change in behaviour). Re: psychological abuse: 'are deliberately and systematically isolated by other residents and/or staff' – this should include being isolated FROM family members, friends or professionals. E.g. in Atlas care homes, residents were routinely isolated from professionals and relatives by way of hiding the various injuries they had sustained, and removing their ability to report issues about their mistreatment. Keeping people and agencies at 'arms length' in 'closed cultures' is an indicator of potential abuse in and of itself. Re: discriminatory abuse: the guidance should reflect that people may be isolated from social, community and religious activities in order to hide signs that abuse or neglect are taking place, to restrict access to people who may raise concerns, or to whom individuals may raise concerns themselves.	Thank you for your comment. The committee agree that inappropriate administration of medication is a serious concern however they believe that the recommendations are they currently written are sufficiently clear on this issue; and this is covered in the list of examples relating to potential indicators of physical abuse and those relating to organisational abuse. NICE have also produced guidance on this more broadly (please see SC1 Medications management in care homes) The committee agree that 'closed cultures' are an important issue and drafted the list of potential indicators of organisational abuse with this in mind (please see the section entitled 'physical signs and lack of openness to visitors'). The committee also agree that isolation from preferred activities is concerning and included a potential indicator relating to this in the discriminatory abuse section ("suspect discriminatory abuse when residents … are not provided with the support they need, for example, relating to their religious or cultural beliefs …"
MENCAP	Guideline	40 - 41		It would be helpful to give clarity about the expectations of how to "manage" suspected abusers. There is an implication that they are suspended (this is included as when people are returning form	Thank you for your comment. The committee did not feel they were able to add any further detail to the recommendations already included about supporting staff subject to a safeguarding enquiry, although they recognise this is a complex area. "If

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				suspension) but this is not the only route to managing allegations, and this needs to be clear.	they are suspended from work" is included as an example for one of the recommendations and it is not assumed that all staff subject to an enquiry would be suspended.
MENCAP	Guideline	4	Context	*'(residential care homes and nursing homes) provide support to around 410,000 older people' – There also needs to be a reference to working-age disabled adults. If they are not included in this figure then there needs to be another figure for this group. It would also be helpful to also include a figure for the number of people with a learning disability and/or autism in care homes as well. These different groups have different needs so it is important to recognise the range of adults we are talking about (i.e. it is not just older people in care homes).* *We would like to see a NICE guideline focusing on safeguarding in other settings as well – e.g. supported living, as well as inpatient settings.* *People with a learning disability (including those with high support needs) will often live in supported living rather than care homes. Here, there can be similar features to care homes such as a number of people living together etc, as well as different features. It is crucial there are robust safeguarding practices in supported living settings as well. Supported living may include support of people both with a regulated activity (where people have personal care) and where there is no regulatory oversight.*	Thank you for your comment. The scope of the guideline is defined in the introductory sections. This includes details on the population covered by the guideline which is defined as 'all adult residents of care homes'. Care homes are defined in the 'terms used in this guideline' section as residential care homes (with or without nursing care) that are registered with and regulated by the Care Quality Commission." It is NICE style to keep guidelines brief and to the point because they are aimed at busy people and as such the committee did not feel it was necessary to list the types of care home and types of provision as you suggest. The committee acknowledge that the care home sector is very diverse and that the population of people living in them have a wide and complex range of health and social care needs. Unfortunately, there was an absence of evidence on safeguarding in relation to specific groups of people such as people with a learning disability. This made it difficult for the committee to make targeted recommendations, however, they were mindful of the 6 core principles of safeguarding and the Making Safeguarding Personal framework when drafting recommendations and took care to ensure that the recommendations are not discriminatory. In addition, an Equality Impact Assessment of the guideline and recommendations has been carried out to ensure that people with more specific needs are not disadvantaged.
MENCAP	Guideline	4	General	The guideline says that safeguarding procedures and practice vary at the local level. It says 'In particular, care homes often struggle to understand: the difference between safeguarding issues and	Thank you for your comment. The committee hope that the guideline will reduce inconsistencies in practice. Although it is up to local authorities and safeguarding adult boards to set their own local ar-

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				poor practice, when and how to make safeguarding referrals to the local authority.' We think it is also important to explain that LA safeguarding policies vary, with different reporting thresholds, and also the application of these policies vary, which is concerning. See Action for Elder report: 'A patchwork of practice'. As a care provider for people with a learning disability working across multiple LAs this can mean that we get a different response from different LAs, but where we are operating within the same management chain. LAs are an important audience for this guideline – as there should be consistency between LAs.	rangements the committee hope that local authorities will use the guideline to develop a shared understanding with care homes about when a safeguarding referral should be made. A note has been added to the opening of section 4 (indicators of abuse and neglect) to this effect. This reads: " Local authorities may wish to adapt and incorporate them as part of their referral guidance or criteria."
MENCAP	Guideline	8	General	It would be helpful if guideline made reference to requirement for health and social care services to follow the Accessible Information Standard (AIS) (this is likely to include the need to produce easy read information for people with a learning disability, and other ways to ensure the communication needs of people in care homes are met).	Thank you for your comment. A reference to the Accessible Information Standard and the requirements this has in terms of consideration of communication and support needs has been added.
MENCAP	Guideline	9	General	It says 'Care homes and care home providers should have systems in place to track and monitor incidents, accidents, disciplinary action, complaints and safeguarding concerns, to identify patterns of potential harm.' It is also very important local authority safeguarding, commissioners, the SAB, police, CQC – also have systems in place to information share, track safeguarding referrals, complaints that come to them, other intelligence – to identify patterns of potential harm and help prevent abuse in care homes (Numerous Safeguarding Adults Reviews have findings and recommendations relevant to this eg. Atlas Care homes Safeguarding Adults Review: https://www.devonsafeguardingadultspartnership.org.uk/about/safeguarding-adult-reviews/	Thank you for your comment. Whilst the committee agree that these organisations should also have systems in place, they felt that as the range of stakeholders involved may vary at the local level it was unhelpful to attempt to list all relevant organisations in this recommendation.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

MENCAP	Guideline	10	General	*"Be aware that care home staff and residents (and their families and carers) may be afraid of the repercussions of whistleblowing, and this can prevent them from identifying and reporting abuse and neglect.'* *The guideline does not say what action this should translate into. For example it should be made clear that organisations have a responsibility to reassure people that they can safely raise concerns without consequence to the individual.* *We suggest this point is split up – so there is a focus on the issue that care home staff may be afraid of repercussions, and in another point there is a focus on the issue that residents and their families may be afraid of repercussions.* *It is important organisations reassure people that they can safely raise concerns without consequences to the individual, and this should be communicated in ways that are accessible to residents with a learning disability and their families, eg. easy read document. Unfortunately we hear from numerous families on our helpline and in campaign work that there can be repercussions if they raise concerns about the care of their loved one. For example, in response, they may find safeguarding concerns raised against them (the family), this can lead to involvement and communication with families being reduced, which can lead to the resident being more at risk.*	Thank you for your comment. The committee believe that this section as a whole covers the actions that should be taken, however the recommendations relating to whistleblowing policy and procedure also emphasise the role of care home managers and providers in ensuring that whistleblowers are not victimised or face negative consequences as a result of their disclosures.
MENCAP	Guideline	10	General	*"Care homes and care home providers should: have a safeguarding lead and make sure everyone knows who this is, what they do, how to contact them, and who to speak to if they are unavailable.'* *Perhaps there could be a link to the definitions section here or even the definition wording for*	Thank you for your comment. We have included a link to the definition of 'safeguarding lead' in the terms used section of the guideline. We have also included reference to CQC in this section. We have added further detail in the indicators of organisational abuse that relate to CQC quality assurance systems. We have also referenced CQC

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				'safeguarding lead' could be included at this point in the guideline as well. It doesn't say anything about the competencies/ skills/ training of the safeguarding lead – it may be helpful to make reference to the competencies that CQC ask for in their approval of a registered manager. *'Care homes should regularly audit care records and ensure that they are complete and available, in case they are needed if a safeguarding concern is raised.' - It would be helpful if the guideline makes reference to Quality Assurance systems as expected by CQC (which covers standalone homes and multi-location providers).*	in a number of places in the guideline and included a paragraph in the context section about CQC and NICE guidelines.
MENCAP	Guideline	11	General	It needs to be clear that LAs, CCGs and other commissioners need to be fulfilling their own responsibilities around safeguarding e.g. conducting safeguarding enquiries, making safeguarding personal, ensuring advocates are involved where needed etc. Not just about ensuring care homes are fulfilling their statutory and contractual safeguarding responsibilities. LAs need to make sure they are tracking what is happening in care homes and looking at complaints that come to them, CQC ratings, information from police – working with other agencies and the SAB. This is important for both their safeguarding and commissioning responsibilities. It says 'Commissioners should: ensure that care homes are maintaining records about safeguarding, make record-keeping responsibilities clear as part of contract management.' - It should be made clear that commissioners should not be commissioning services that fail to adequately meet their safeguarding responsibilities. (Note: one of the indicators of abuse is 'the care home does not have	Thank you for your comment. The committee agree with the point you make and in the final version of the guideline made this clearer by simplifying the first for local authorities to suggest that they (and other commissioners) should ensure all care homes they work with are fulfilling their statutory responsibilities and contractual responsibilities. It is therefore explicit that care homes would not be commissioned if they fail in this regard.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				policies and procedures covering: safeguarding, whistleblowing, complaints"	
MENCAP	Guideline	14	General	*'how to recognise the differences between poor practice and abuse and neglect'* – training should cover how both of these (poor practice & abuse/neglect) should be addressed . It gives a process for abuse/ neglect but not poor practice. It may lead to people reducing suspected abuse to an issue of practice if the difference in not well understood (may reduce reporting).	Thank you for your comment. The scope of the guideline is safeguarding rather than poor practice and the committee felt that it was appropriate to emphasise the distinction here.
MENCAP	Guideline	14	General	'The 6 core principles of safeguarding and the Making Safeguarding Personal framework' – not just what they are but what these mean in practice should be covered. The MSP framework is referred to throughout the guideline but it would be beneficial to understand how the framework will be used to produce 'outcomes' for people i.e. for people to be encouraged to talk about their experiences to help shape policy changes if necessary. Often people with a learning disability are underrepresented so it would be good to see this addressed - how professionals will engage to learn from people with a learning disability who have been involved in safeguarding processes.	Thank you for your comment. The committee agree that practical application of the 6 core principles is key; however, they feel that this is implicit to the recommendation. The committee were also mindful of this when drafting recommendations relating to the evaluation of training (see for example section 1.2) and felt that these will help care home managers to ensure that staff are able to put their learning into practice and avoid the risk of 'tick box' training.
MENCAP	Guideline	19	General	*'Care home managers should encourage staff to discuss care home culture, learning and management in relation to safeguarding in exit interviews when leaving employment with the care home.'* – The guideline should make clear that this should be encouraged in supervision, team meetings etc.(not just exit interviews).	Thank you for your comment. This is covered by the recommendation that care home managers should ensure there are opportunities for staff to share best practice or challenge poor practice. The recommendation gives team meetings or one to one supervision as examples of when this could take place.
MENCAP	Guideline	20	General	Maybe it could be suggested that SABs take a role in sharing findings from local SARS (and SARs from other local areas across the country where relevant, e.g. high profile ones) with care homes and care providers, including what has been done to implement findings from previous SARs. As part of its remit to help prevent abuse and neglect.	Thank you for your comment. The first point you make is covered in recommendations regarding the role of safeguarding adults boards. The committee agrees with the second issue you raise, and the recommendation has been amended to instead refer to staff 'who work alone or who get very little direct oversight (for example night staff)'. The third

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				'(Staff) who get very little supervision' – this shouldn't be the case. These are registered locations and there are standards that CQC have about this that providers must meet, so all should be supervised to meet these regulations. 'Care home managers should ask for feedback about safeguarding from residents (and their families, friends and carers) and other people working in care homes.' – This should include asking them how they have been involved and if the level of involvement has been in line with their wishes.	issue you raise is covered by the recommendations about supporting people through a safeguarding enquiry.
MENCAP	Guideline	21	General	*'Care homes should work with the LA, CCGs and other local agencies to establish a local strategic partnership agreement about safeguarding adults in care homes that covers…' – it is essential this establishment of a local strategic partnership agreement is led by the LA (it may not happen if it is not clear who has responsibility for establishing it).* *'Care home managers and providers should share their experiences of managing safeguarding concerns with Safeguarding Adults Boards, so that other care homes and providers can learn from this'. This should link to what is said on page 21: 'Safeguarding Adults Boards should arrange opportunities for staff and residents to learn together from recent experiences of safeguarding' – so that it is clear 'how' this will happen (and it would be good for this to include some good practice examples of how SABs are doing this). It would also be helpful for the guideline to say that LAs must also learn from experiences of safeguarding and understand what might be getting in the way of effective safeguarding e.g. long delays in LA getting back to providers, social care cuts which are putting people at risk etc. Important opportunity for all partners to learn.*	Thank you for your comment. This recommendation has been edited to emphasise the importance of team working by stating that care homes, local authorities, clinical commissioning groups and other local agencies should work together to establish local partnership arrangements. They felt this helped to clarify that it is not always local authorities who must lead this and that this will instead vary according to local arrangements. In relation to your second point, the committee removed the recommendation that safeguarding adults boards should arrange opportunities for staff and residents to learn together and instead added details to a recommendation on training to clarify that safeguarding adults boards should encourage care home providers to do this. They also edited the other recommendation to which you refer to emphasise the importance of a joint approach to sharing experiences. In the final version of the guideline this recommendation now suggests that care home managers and providers should participate in safeguarding adults board's arrangements for sharing experiences about managing experiences in care homes.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

MENCAP	Guideline	24	10	Re: The lists of Indicators (individual and organisational) – we think some sort of chart and/or separate document is needed as it is confusing and hard to read having long lists in the middle of the document. It does feel that the distinction between what is 'consider' and what is 'suspect' is not clear. Many of the examples in the 'consider' list are concerning (for example, many of the indicators in the 'consider neglect if' section are almost certainly signs of neglect, i.e: "do not have access to food and drink in line with their dietary needs"). The approach, in separating 'consider' and 'suspect' serves to water down the seriousness of such concerns. The guideline needs to better explain how these lists reflect the Care Act and how the indicators link with local safeguarding policies (threshold for reporting). It feels like multiagency partnerships could use the lists to refine and develop local safeguarding policies – but at the moment the indicators feel very aimed at care homes. Care homes will be making decisions about referrals using local safeguarding policies.	Thank you for your comment. We will consider whether additional charts would be useful as part of implementation activities. Further explanatory text has been added to the introduction to the indicators to clarify how they should be used in the context of other recommendations. It is also important to note that action *must* always be taken whether the indicator is 'consider' or 'suspect'. Further details regarding the committees discussion of the evidence and relevant legislation is included in evidence review C.
MENCAP	Guideline	12 – 13	General	This is a section that is particularly relevant when considering the impact of COVID-19 (face to face training Vs digitised training). The guideline could say there needs to be some consideration of the need to accommodate training in both modes, but a recognition that this is followed up with reflection as part of supervision, meetings etc. 'Care homes should give staff protected time for induction and mandatory safeguarding training. They should ensure that staff have enough time to read and understand the induction and training materials and improve their knowledge and confidence	Thank you for your comment. The guideline definition of face-to-face embraces training delivered on virtual platforms and the committee agreed that this should mitigate against the challenges that have occurred as a result of Covid-19. It is not within the scope of the guideline to include recommendations about job descriptions and employment contracts but it is hoped that these recommendations will be picked up by employers and contractors.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				about safeguarding.' - It is important this is included within contracts i.e appropriate time for training and reflection for staff etc. is costed in.	
MENCAP	Guideline	34	009 - 016	*'When a safeguarding concern has been reported to you, look at the broader context rather than assessing it in isolation. Take into account: if any other people (including children) are at risk as well...between the resident and alleged abuser.'* - Again, none of the above should be used to remove or reduce the investigation of incidents without absolute certainty that it is safe to do so.	Thank you for your comment. These factors are supposed to contribute to an individual assessment of the situation. It does not negate the clear instruction that if abuse or neglect is suspected a referral should be made to the local authority.
MENCAP	Guideline	43	General	*'Local authorities should be aware of the reputational impact on the care home's business (for example, on recruitment, resourcing and financial losses), and ensure that their actions are timely and proportionate'. – we agree it is absolutely crucial that the LAs actions are timely and proportionate and there is speedy completion - primarily so that the people and/or others do not continue to be put at risk of abuse and neglect and there can be swift learning but also for the members of staff who may be suspended, this links to the cost as while someone is suspended there is a need to continue to offer the same level of support. Where safeguarding continues for months it has an impact on all of these.* *'Local authorities should share the outcomes of safeguarding enquiries with commissioners, so that they can incorporate the findings into their own decisions (for example, whether to lift a placement embargo)' –* *It would be helpful for the guideline to give more information about 'placement embargoes'. What happens in this situation? Who is made aware of the placement embargo/ what information shared, with which agencies and how. We are aware of sit-*	Thank you for your comment and support for this recommendation. In relation to your second point, the committee agree that communication of placement embargoes is an important and complex question; however, these recommendations focus on safeguarding practice within care homes and this question is not within the scope of this guideline.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				uations where local commissioners don't use particular care services because of concerns, however, out of area commissioners do use these services. This can mean that people are ending up in risky services and are likely to be more at risk as they are out of area. What support is put in place to increase oversight (eg. ensure there are more robust safeguarding investigations and inspections etc). The Atlas Care homes SAR has a finding/recommendation around this issue.	
MENCAP	Guideline	44	General	*'Keep the resident at risk informed about the outcome of the meetings'* – this suggests the resident at risk and their family have not been involved in the meeting. As mentioned above, need to know what the expectation should be if individuals and/or families do want to be involved. Are policies and process flexible enough to be in line with MSP principles?	Thank you for your comment. The committee agree that policies and processes should be in line with the principles of Making Safeguarding Personal. This is emphasised at the first recommendation in this section which suggests that "Only exclude people from a meeting if this is in accordance with the safeguarding policy. If people have to be excluded from a safeguarding meeting, explain why and give them a chance to share their views in another way."
MENCAP	Guideline	44	General	<u>Indicators of organisational abuse and neglect</u> The separation between this and the personal abuse section is stark despite their inherent links. The first indicator of organisational abuse is usually personal abuse, (e.g. in Winterbourne View, personal abuse was suspected and reported before investigation proved organisational abuse.) That the first sign of organisational abuse is usually personal abuse should be reflected as an indicator of organisational abuse in its own right. The definition of organisational abuse is fairly unclear: "Organisational abuse (also known as institutional abuse) is distinct from other forms of abuse or neglect, because it is not directly caused by individual action or inaction. Instead, it is a cumulative consequence of how services are man-	Thank you for your comment. The committee agree that an incident of abuse or neglect of an individual can often be the first sign of a wider organisational or institutional problem. The committee did discuss the CQC guidance on 'closed cultures', however it was not possible to include in these lists as it focuses on the risks associated with 'closed cultures' rather than guidance on how to identify and report instances of abuse or neglect (and was therefore not included in the evidence review underpinning these lists). However, the committee did add additional details to their lists of potential indicators regarding 'physical signs and lack of openness to visitors.' After careful consideration, the committee do not believe that this document conflicts with their recommendations or lists of potential indicators.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				aged, led and funded." - It should be clear the institutional abuse does usually manifest itself at the personal level. 'Some aspects of organisational abuse may be hidden (closed cultures)' – this is not our understanding of the term 'closed culture'. We would suggest a different definition is given and it would be helpful if it could link to the CQC closed culture indicators guidance. https://www.cqc.org.uk/sites/default/files/20191104_closedcultures_supportinginformation_full.pdf We also think it would be helpful to have more about closed cultures within this NCIE guidance. Re: consider organisational abuse: it should be clear whose responsibility it is to 'check' for signs versus coming across them. The 'consider' and 'suspect' sections are bureaucracy based, though signs could be just as 'personal' as in all other circumstances. There should be something about the capability of managers and pathways reflected in this section, particularly given cases such as Winterbourne View and Atlas Care homes where complicity of management has been proved. Signs of organisational abuse may be more nuanced than the bureaucratic signs highlighted in this section. Indeed, different people will see different signs dependent on their relationship with the person, the service or the organisation involved. It is therefore important to differentiate between the different audience groups when discussing and highlighting indicators. The responsibilities to look for, and see, signs should be assigned.	

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				Some of the signs highlighted e.g. lack of policies and procedures should lead to questions about how/ why services were commissioned in the first place, there must be an inherent responsibility for commissioners to commission appropriately and to utilise existent information to minimise potential for abuse/neglect. Perhaps this list of organisation abuse is one that should be aimed at CQC to check against?	
MENCAP	Guideline	51	General	The title should perhaps be 'learning from safeguarding of adults in care homes' – so that it is very clear that the audience for this isn't only care home managers. There is lots of learning for everyone involved in safeguarding e.g. care home staff and care providers, LAs, police, commissioners, safeguarding SAB, community professionals.	Thank you for your comment. The committee agree that all practitioners involved in safeguarding should proactively seek opportunities for learning, however the focus of this guideline is safeguarding practice within care homes and these recommendations specifically relate to the processes through which care homes (managers and staff) can learn from safeguarding concerns, referrals and enquiries.
MENCAP	Guideline	36 – 37	General	On page 36 they flag the need for an enquiry lead to be identified. What are the skills of this lead... in particular what are their skills in relation to the "client group"... this is important as form P37 onwards they are identified as needing to engage with the person who the referral is about but there is little about how this will be done and how this could be known to be successful. 'Involve the resident at risk, and their family or an appropriate advocate, throughout the enquiry process, in line with their wishes and mental capacity, unless their exclusion can be justified (for example, because of data protection requirements)' – we would suggest the example of data protection is removed. Perhaps data protection issues could be referred to elsewhere in the guidance as we are not sure it has the right impact here and could be unhelpful. We are hearing too many situations	Thank you for your comment. The committee has defined the role of the enquiry lead in the glossary however the guideline cannot include details about the skillset needed for this role because the s42 enquiry process more broadly is not within the scope of this guideline. With regards the reference to 'data protection requirements' the committee agree with you and this example has been removed. With regards to the definition of 'involve' the committee was unable to specify further but a number of examples in the guideline will give a good steer about what this means in practical terms. Again we were unable to go into detail about who is making referrals for advocacy because it depends at what point the concern or referral or enquiry is being discussed. We have tried to refer to

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				where families are being excluded or not given important information and being told it is because of 'data protection' without further explanation. It would be better for the guideline to say something along the lines of 'data requirement protections' should never be used as a blanket excuse to exclude the resident or family, there would have to be very robust reasons for any 'exclusion' that went against the wishes of the person and their family. The person should be included in line with MSP principles. What does 'involve' mean and who is doing this? – Greater clarity would be helpful including e.g. what is the expectation re: involvement in safeguarding meetings (where a person wants to attend). We often hear that people and families are not involved, that professionals meet separately etc.) Does involvement also mean being sent draft minutes of the meeting (in an accessible format) and given the opportunity to correct them? This links to the point above about how involvement is done and the skills of the enquiry lead. Our experience as a care provider is that LA engagement with the person who a referral is about is currently limited and that we are often used as a proxy to check that people are happy with the outcomes. It should also be clearer in the guideline who is making referrals for advocacy where (to ensure this is done/ not missed). It should also be highlighted the importance of the LA ensuring there is adequate advocacy provision in the area, as a lack of available advocates may have an impact on speed of action. Information about what residents in care homes and their families should be able to expect in terms	advocacy throughout the guideline where an action is needed. Finally, the committee agree that Safeguarding Adults Boards should ensure that local authorities have auditing processes in place to monitor how residents and their advocates are included in safeguarding enquiries and made a recommendation regarding this.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				of involvement in safeguarding is perhaps something SABs could do – monitor, but also set out expectations etc.	
MENCAP	Visual Summary	General	General	1-page visual summaries on Indicators of abuse Comments on these are similar to comments on the main guideline – please see above. Note: in the Indicators of individual abuse visual summary it doesn't actually include 'indicators', just types of abuse. It is not clear who the visual summaries are aimed at - care worker, the care home manger, other professionals? - and whose responsibility it is to do the things listed.	Thank you for your comment. The visual summaries are aimed at all the audiences listed in the opening section of the guideline.
Methodist homes (MHA)	Guideline	8	7	As an organisation covering all of England, Scotland and Wales it would not be possible to have a policy that is in line with all local safeguarding arrangements as each Local authority differ slightly. Allowance must be given for an overarching policy that organisations can have which reflects the Health and Social Care Act.	Thank you for your comment. This recommendation has been edited to clarify that care homes and providers must have an overarching safeguarding policy/procedure in place to meet the requirements of the Care Act; however local arrangements should be considered when implementing this.
Methodist homes (MHA)	Guideline	8	13	Is there a difference between 'accessible' and display? We have leaflets and anyone can request a policy at any time. The concern would be overrun notice boards that are cluttered and information not easy to read.	Thank you for your comment. The recommendation has been edited to clarify that this relates to accessibility and that individuals can ask to read a specific policy.
Methodist homes (MHA)	Guideline	68	18	For a large organisation covering England, Scotland, Wales, e-learning has been a preferred method of delivery. There is only one Safeguarding Lead so face-face within all services would not be possible and Local Safeguarding teams do not always deliver training. Enhanced e-learning would be preferable but a national programme would be desirable which would aim for a consistent level of knowledge for all.	Thank you for your comment. After lengthy discussions regarding the delivery of training the committee agreed to clarify that face-to-face training can be provided via virtual platforms. They also agreed that it may not always be possible to provide face-to-face training and that in these circumstances it may be appropriate to provide e-learning instead. The committee agree that national consistency is essential and drafted their recommendations regarding the content of training with this in mind.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

National Care Forum	Guideline	4	21	Regional differences in LA safeguarding team requirements of care home managers for reporting contributes to care home reporting poor practice issues as mentioned below. It is not as clear cut as the context given here that care homes struggle to understand the difference between poor practice and safeguarding issues. LAs in some areas expect everything to be reported to them including poor practice as their thresholds and reasons for reporting often overrule a care home manager making a balanced decision on what should and what should not be a safeguarding referral.	Thank you for your comment. The guideline is intended to help practitioners to identify the difference between a serious safeguarding issue and potential safeguarding issues that can also be understood as poor practice, which should be addressed internally by the care home in the first instance (although a number of exceptions and checks and balances to this are set out within the guideline). The sets of 'consider' and 'suspect' indicators are designed to support these judgements (a model previously developed as part of the NICE guideline on child abuse and neglect). The guideline recommends that all 'suspect' indicators are referred to the Local Authority to decide whether the three statutory criteria are met and whether a section 42 Enquiry or other investigation is needed. 'Consider' indicators are intended to result in action within the care home to rectify the issue. However, the recommendations are also intended to encourage the care home to seek advice from the local authority if they are not sure whether a referral should be made. The committee also added a number of recommendations to encourage local authorities to support care homes to develop staff understanding in relation to the differences between poor practice and a safeguarding concern. The recommendations within the guideline are aimed mainly at care homes and the people who work within them, but were also intended to be of use to residents, as well as family members and other visitor who may witness a safeguarding issue. Whilst the committee have included some recommendations for local authorities, as well as adult safeguarding boards, CCGs and other commissioners, they recognise that requirements for local authorities are set out clearly in statutory guidance and in a number of resources provided by ADASS and the LGA. This NICE guideline is

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					not intended to duplicate any of these, but instead was designed to complement these by making recommendations on the policies, leadership styles and care home cultures that promote effective safeguarding practice. The guideline then presents two action orientated decision-making pathways covering the steps to take before a s42 referral is made. It covers some aspects of communication and support while enquiries are underway and the importance of shared learning from enquiries but not the conduct of the s42 enquiry itself.
National Care Forum	Guideline	5	5	In the section below the one sector not named as having any input in to this document is any care sector organisation or representing body for care providers, such as any member of the Care Provider Alliance. Given that the impact directly relates to care providers, there needs to be a future clearer connection with the sector.	Thank you for your comment. As part of our consultation activities we have engaged directly with the Care Provider Alliance, which brings together the main national associations representing independent and voluntary adult social care providers in England, and a number of these organisations as well as a range of independent care providers have individually responded to this consultation. The guideline itself recommends active engagement between local authorities (and other commissioners) and care homes as a means of improving knowledge and understanding of safeguarding practice. Your comments will also be considered by NICE where relevant support activity is being planned.
National Care Forum	Guideline	6	7	We agree that there is variance at a local level – however, this is invariably by LA safeguarding teams and their inconsistencies in reporting requirements, i.e. using the point made below as to why all potential suspected cases are reported to them for them to decide. This does result in referrals for poor practice being confused with an actual suspected safeguarding issue. This is as a result of what has been requested of the care home, not necessarily as a result of not understanding the difference as in the points above.	Thank you for your comment. The guideline is intended to help people to make decisions making about whether a safeguarding referral to the local authority should be made. The following text has been added to the introduction of section 4 (indicators): “Local authorities may wish to adapt and incorporate them as part of their referral guidance or criteria. The guideline recommends that all 'suspect' indicators are referred to the Local Authority to decide whether the three statutory criteria are met and whether a section 42 Enquiry or other investigation

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					is needed. 'Consider' indicators are intended to result in action within the care home to rectify the issue. However, the recommendations are also intended to encourage the care home to seek advice from the local authority if they are not sure whether a referral should be made. The committee also added a number of recommendations to encourage local authorities to support care homes to develop staff understanding in relation to the differences between poor practice and a safeguarding concern.
National Care Forum	Guideline	12	1	The role of the Adult Safeguarding Boards in mandatory training is considered within the consultation and this would be a positive step where it describes this being undertaken on a multi-disciplinary basis. Whilst this is evident in some areas already it is not consistent. The way each Local Authority operates both in terms of process and their approach is uneven, especially for members who cover several regions. This is true both in terms of when and how to make a safeguarding referral. We would like to see a move to greater consistency of approach by Adult Safeguarding Boards and would ask that this is considered.	Thank you for your comment and support. The committee drafted this recommendation with the intention of reducing unwarranted variation across the sector.
National Care Forum	Guideline	12	2	It would be helpful as the guidance suggests that Adult Safeguarding Boards know who the safeguarding leads are in care homes and how to contact them. Our members state that Adult Safeguarding Boards need to help care home managers in building capacity to engage with Boards, both in terms of training and ease of engagement. We would welcome further consideration of this in the guidance and to build upon the recognition in the document that Boards will need to change the way they work to make this most effective.	Thank you for your comment. This recommendation has been edited to clarify that SABs should seek assurances that clear lines of communication are in place between commissioners, the Regulator and safeguarding leads; rather than having the detailed knowledge suggested by the original text. The role of SABs in building capacity and fostering engagement are covered in section 1.2.
National Care Forum	Guideline	13	1	The training responsibility for agency staff lies with the employing agency – care providers should check and be assured that this has been completed to a good standard.	Thank you for your comment. The committee have included a new recommendation to clarify that whilst care home managers must ensure that agency staff working at the home have completed

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					the necessary safeguarding training for their role, and that they understand the local safeguarding policy and procedure, care home managers are not themselves responsible for arranging or providing this.
National Care Forum	Guideline	13	3	More broadly there is a concern that there is no bench mark standard for safeguarding training therefore allowing for inconsistency across the sector. We would advocate that all safeguarding training is NICE guidance compliant to ensure consistency across the sector.	Thank you for your comment. The committee recognise that there are inconsistencies across the sector and drafted their recommendations regarding the content of training with this in mind. The core objective of NICE guidance is to reduce variation and reduce inconsistency and the committee believe that their recommendations will improve outcomes for care home residents.
National Care Forum	Guideline	13	7	We are aware that in Wales LAs offer free or very nominal cost mandatory training to care providers locally, shared with LA staff training already in place – this worked well and ensured consistent training and messages relating to the specific LA requirements for reporting etc	Thank you for this information. We will share this information with the NICE implementation team.
National Care Forum	Guideline	22	14	It would be helpful if LA safeguarding teams worked with care home providers to be assured and allow care homes to decide on the 'consider' and 'suspect' indicators as this is usually where some confusion is rise dover what should / should not be a referral. This is not a lack of understanding as mentioned above but lack of consistency of approach across LA Safeguarding teams approach	Thank you for your comment. The committee agree with you and this is why they agreed upon two levels of possible indicators of abuse and neglect - consider and suspect. The guideline recommends that all 'suspect' indicators are referred to the Local Authority to decide whether the three statutory criteria are met and whether a section 42 Enquiry or other investigation is needed. 'Consider' indicators are intended to result in action within the care home to rectify the issue. However, the recommendations are also intended to encourage the care home to seek advice from the local authority if they are not sure whether a referral should be made. The committee also added a number of recommendations encouraging local authorities to support care homes to develop staff understanding in relation to the differences between poor practice and a safeguarding concern.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

National Care Forum	Guideline	35	17	LAs do points 17 onwards to varying degrees, so would be good to have national guidance aimed at LA safeguarding teams to monitor and encourage consistent approach in using judgements	Thank you for your comment. As an implementation issue this is outside the scope of this guidance, however this will be flagged to the implementation team at NICE. In addition, ADASS and the LGA have recently published a framework relating to this (https://www.local.gov.uk/sites/default/files/documents/25.168_Understanding_what_constitutes_a_safeguarding_07.1.pdf).
National Care Forum	Guideline	41	20	The amount of additional time and responsibility put on the care home manager to implement this. In larger organisations there may be L&D department and other support avenues to assist with implementing the recommendations in this report, even though it will undoubtedly mean additional costs: and none of the recommendations could be argued are not valid and will improve raising awareness and dealing with safeguarding issues. However, in a smaller organisation we are unclear how, on a practical level they will manage to implement this without external practical and financial support.	Thank you for your comment. NICE guidelines are intended to reflect best practice and the committee drafted recommendations which they believe to be achievable through using existing resources differently. However, the committee took care to avoid being too prescriptive and placing unsustainable requirements on smaller organisations; and they expect that implementation will need to be proportionate to the resources available in many cases.
National Care Forum	Guideline	43	19	There is much emphasis on what the care home provider must do during the process from referral to sharing lessons learned and very little on the safeguarding enquiry process, which can take a long time to complete. It will be interesting to see how the LA safeguarding boards ensure that care home managers and providers are kept up to date as in 1.11.2 below, and informed of the outcome and reasons behind it. Most of the open safeguarding events reported by members are sitting there for a number of months as providers try and chase LA safeguarding outcomes – there is little communication to the care home manager or provider form the Chair of safeguarding enquiries and it is difficult to find out outcomes, if closed let lone any reasons for decisions	Thank you for your comment. The guideline includes recommendations regarding the importance of local authorities and SABs sharing learning. Recommendations regarding the process of conducting an enquiry are not within the scope of this guideline. Practitioners should refer to relevant ADASS/LGA and other related guidance with regards to these details. This guideline only covers recommendations around the information and support needs of care homes, care home staff, residents at risk and alleged perpetrators *while* enquiries are taking place as well as some principles around meetings and information sharing while enquiries are taking place – not detailed guidance about how enquiries should be conducted.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Newcastle Safeguarding Adults Board	Evidence Reviews	General	General	We are not sure how helpful it is to share these documents for consultation as we assume these have been used as the evidence base for development of the guideline. Perhaps sharing these for information would be better as this makes the consultation feel more complex, especially given the very short timeframe. Consultation of the guideline is probably sufficient unless we have misinterpreted the use of these documents (if so then perhaps some consultation guidance notes would have been helpful?)	Thank you for your comment. NICE guidelines are based on the results of systematic reviews which are presented to a committee of experts who use these (and their own expertise) to draft recommendations. Transparency is central to this process and this is why such a wide range of documents are made available at the same time. The committee recognises the challenge of responding in a relatively short space of time and are very grateful to your organisation for the time taken in doing this.
Newcastle Safeguarding Adults Board	Guideline	General	General	We have an overall concern about the timing of the consultation and the ability for people to be able to respond fully. In particular, care homes will have found it extremely difficult to respond to the consultation when they are having to manage Covid-19 related issues. During the middle of this consultation, our area has seen a rise in infections and additional restrictions being put in place.	Thank you for your comments. The committee recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes. All registered stakeholders were given advance notice of the start and finish dates for the consultation but we do recognise the challenge of responding and are very grateful to your organisation for the time taken in doing this.
Newcastle Safeguarding Adults Board	Guideline	General	General	We are unsure whether the guidelines add any value to existing resources for care homes around safeguarding adults. The guidelines repeat much of what is already in CQC regulations, the care and support statutory guidance and local multi-agency safeguarding adults policy and procedures. Conversely, we worry that further guidance in this area has the potential to cause risk by providing mixed or confused messages, We feel that many of the recommendations and advice are already covered in these documents in some way. At times the guidelines appear to confuse roles and responsibilities for certain areas – e.g. what might be a commissioner responsibility versus what might be a SAB responsibility. Our preference would be that there is more emphasis on directing care homes to	Thank you for your comment. The committee acknowledge that there are some issues in their recommendations which are covered by other guidance; however, they agreed to include them here because there is variation in practice across the sector (an issue that this guideline was designed to address). They are confident that where there is overlap with existing guidance (such as the CQC inspection framework), the recommendations align well with these. In addition, many of the recommendations drafted by the committee relate to areas in which less guidance is available, for example in relation to indicators of organisational abuse and neglect, and the specific actions that should be taken when raising concerns.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				local multi-agency policy and procedures which reflect local practice and arrangements, rather than trying to re-write these here.	The committee agree that there were some issues regarding the distinction between the responsibilities of SABs and local authorities (a concern raised by other stakeholders). The recommendations relating to SABs have now been edited to make it clearer that they hold a strategic role providing oversight, and that rather than taking action themselves, they should instead seek assurances from local authorities (or other commissioners), and local partners that this work is being carried out. The first recommendation covering safeguarding policies and procedures has been edited to clarify that whilst care homes and providers must have an overarching safeguarding policy and procedure in place to meet the requirements of the Care Act; local arrangements should be considered when implementing this.
Newcastle Safeguarding Adults Board	Guideline	General	General	We question the rationale for singling out care homes from other health and social care providers in producing this guidance. Is the intention to produce guidance for home care providers, NHS providers etc?	Thank you for your comments. NICE guidelines are developed based on priority areas identified by the Department of Health and Social Care where guidance is most needed, and this guideline was commissioned in response to concerns regarding variation in safeguarding practice in care homes.
Newcastle Safeguarding Adults Board	Guideline	4	General	The tone in the “context” and the “need for the guideline” sections feels quite negative towards care homes. Our experience is that care home providers have a good understanding of safeguarding adults procedures, they know where to seek advice and they are good at making safeguarding adult referrals when they need to. Our concern to section 42 enquiry conversion rate from care home providers is high, demonstrating they are making appropriate safeguarding adults referrals.	Thank you for your comment. These sections are included to clearly justify and explain why public money has been spent on the development of the guideline and why practitioners should follow the actions that are recommended. The guideline was commissioned in response to inconsistencies in safeguarding practice, and these sections will necessarily need to highlight specific areas in which these were identified. Further details on this can be found in the guideline scope.
Newcastle Safeguarding Adults Board	Guideline	10	6	Our experience is that safeguarding leads within care homes are the care home managers.	Thank you for your comment. The committee agreed that it is acceptable for care home managers to take on the role of safeguarding lead. This recommendation was intended to emphasise that

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					care homes/providers should identify an individual who has oversight of all safeguarding work and that all staff should be aware of who this person is, how to contact them, and what to do if they are not available. The committee acknowledge that there may sometimes be concerns regarding the practice of care home managers and drafted recommendations such as those relating to external whistleblowing services (see section 1.1)with this issue in mind.
Newcastle Safeguarding Adults Board	Guideline	12	2	This is an unrealistic recommendation – SABs would liaise with Commissioners to contact care homes. SABs do not manage contact lists for safeguarding leads in any sector, operational staff in LAs might have a list of key contacts in care homes, but as above the general rule is to contact the manager of the establishment. As a SAB, we strive to ensure that anyone (professional or public) knows how to contact our SAB.	Thank you for your comment This recommendation has been edited to clarify that SABs should seek assurances that clear lines of communication are in place between commissioners, the Regulator and safeguarding leads; rather than the detailed knowledge suggested by the original text.
Newcastle Safeguarding Adults Board	Guideline	12	6	We support this recommendation (but probably already covered in care and support statutory guidance).	Thank you for your comment and support.
Newcastle Safeguarding Adults Board	Guideline	12	10	We feel this would read better as “SABs should receive **assurance** on how care home residents are supporting during safeguarding enquiries” – however as above, we would necessarily view this as a care home specific issue but would probably consider is as part of broader work on Making Safeguarding Personal.	Thank you for your comments. This recommendation has been edited to clarify that SABs should seek assurances from their partners that this responsibility is being met rather than the level of involvement that may have been suggested by the original text.
Newcastle Safeguarding Adults Board	Guideline	12	12	Would suggest removing this specific recommendation – it is too prescriptive and is covered by the broader “engagement” in paragraph 1.1.19.	Thank you for your comment. This section has been edited to clarify that SABs should include matters relevant to safeguarding in care homes in their annual report rather than the wider consultation with care homes suggested by the original text.
Newcastle Safeguarding Adults Board	Guideline	12	15	Not sure why this is a specific recommendation. All SABs will have escalation re disputes covered in their multi-agency policy and procedures. We are	Thank you for your comment. This recommendation has been edited to clarify that SABs should ensure that escalation procedures are relevant to

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				not aware of any specific difficulties in escalating disputes with care homes.	care homes rather than establish new processes as suggested by the original text.
Newcastle Safeguarding Adults Board	Guideline	13	1	We agree that safeguarding training should be mandatory as part of inductions. We think 6 weeks is too long a time frame for someone to have completed some basic safeguarding training if they are working in care homes.	Thank you for your comment. The committee discussed at length the timescale within which mandatory training should be completed by new staff (see evidence review H for details). The committee felt that specifying 'no later than 6 weeks' was an appropriate limit, particularly as this aligns with other guidance such as that from the RCN (Adult Safeguarding: Roles and competencies for Health Care Staff 2018).
Newcastle Safeguarding Adults Board	Guideline	13	6	Most SABs (including ourselves) have a multi-agency training strategy. We are fortunate to be able to provide some multi-agency training free of charge and this is well attended by care home staff. For providers who choose to deliver in-house training (something SABs do not have the power to prevent and in fact many statutory partners deliver in-house training) we have a local competency framework and offer to quality assure any in-house training.	Thank you for your comment. These recommendations have been edited to clarify that SABs should seek assurance from their partners regarding training (rather than provide or commission this themselves) to ensure that it has been developed on a multi-agency basis and reflects the level of responsibility for each role/level.
Newcastle Safeguarding Adults Board	Guideline	14	2	We think this presents an opportunity to introduce training levels and the RCN Safeguarding Adults Roles and Competencies framework document could be translated to provide this as many of the roles would be broadly comparable. This could provide better consistency for competencies across the sector and would align to training requirements for nursing staff in care homes. As above, we have a local competency framework but it would be helpful (for all sectors) if there was consistency nationally.	Thank you for your comment. These sections set out the essential components of mandatory and further training. The committee discussed the RCN competencies framework document when drafting these recommendations (see evidence review H) and agreed that it was not therefore necessary to make more detailed recommendations on the content of further training. The committee hope that these recommendations will help to reduce inconsistencies across the sector.
Newcastle Safeguarding Adults Board	Guideline	15	10	The items listed in this section should not constitute further training but should be a basic requirement e.g. how to ask about abuse and neglect in a sensitive and non- judgemental manner, signs and indicators of organisational abuse and neglect. A tiered approach to training with role specific levels (As per RCN Competencies) would ensure that	Thank you for your comment. These sections set out a tiered approach and are intended to cover the essential components of both mandatory and further training. The committee discussed the RCN competencies framework document when drafting these recommendations (see evidence review H)

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				these issues are included as necessary per role and not an addition for all staff.	and agreed that as this provided more detail it was not therefore necessary include detail on this here.
Newcastle Safeguarding Adults Board	Guideline	18	16	Feedback should be provided whether positive or negative to ensure staff are competent and learn from their experience of responding to safeguarding adults concerns.	Thank you for your comment. The committee agree that both positive and negative feedback is essential and 'positive' has now been deleted from this recommendation.
Newcastle Safeguarding Adults Board	Guideline	19	20	This requirement is ambiguous as "regular" will be open to interpretation and perhaps needs to be linked specifically to team meetings and supervision e.g. ensuring these are standard agenda items.. It is particularly important though that SABs ensure that learning from relevant SARs i.e. relevant to the care provided in care homes and service is disseminated to care homes and that… Care Home Managers are required to ensure learning from local SARs which is circulated to them is effectively shared with staff in the home. Where necessary Care Home managers must ensure that where learning requires a change to practice in the home that this is implemented and monitored/evaluated.	Thank you for your comment. The committee agreed that it is appropriate for 'open' interpretation of this issue; however, the recommendation has been edited to include team meetings as an example. The role which SABs play in disseminating learning is covered in sections 1.2.
Newcastle Safeguarding Adults Board	Guideline	20	10	Asking about experience of safeguarding can only apply to people who have been involved in a safeguarding process and should be part of that process i.e. care homes consulting people following conclusion of a case as directed by the person coordinating the safeguarding adults enquiry. More general surveys about experiences of safeguarding adults would be the responsibilities of SABs.	Thank you for your comment. The committee believe that care home managers should seek feedback regarding all 'levels' and areas of safeguarding work, including preventative work, and the care homes management of concerns and referrals, rather than only seeking feedback when a safeguarding enquiry takes place.
Newcastle Safeguarding Adults Board	Guideline	20	20	SABs have partnership and information sharing agreements in place with local commissioners which clearly apply to services commissioned by those agencies. There isn't a need to establish additional partnership or information sharing agreements.	Thank you for your comment. This recommendation has been edited to clarify that it relates to the importance of all local agencies working together to establish local arrangements, rather than the suggestion that a separate partnership or arrangement needs to be established.
Newcastle Safeguarding Adults Board	Guideline	21	18	We think this is a SAB responsibility to seek experiences from relevant sectors where they see it as a requirement, e.g. because of a local issue. Links to paragraph 1.1.19 around engagement and	Thank you for your comment. The recommendation has been edited to emphasise the role of both care home managers and providers, and SABs.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				would be covered by this. If felt that it needed to be included, then perhaps it would be better worded as …should **be encouraged** to share their experiences of…	
Newcastle Safeguarding Adults Board	Guideline	21	21	Minutes of SAB meetings are generally confidential. We produce summary minutes which are publicly available. We would look to target specific information from the SAB that is of relevance to care homes, rather than them generically sharing minutes from the SAB meetings.	Thank you for your comment. The intention of this recommendation is to emphasise the role that care home managers and providers play in sharing learning from SAB meetings. The committee agree that only relevant information from SAB summary minutes should be shared and include this caveat in the recommendation.
Newcastle Safeguarding Adults Board	Guideline	22	11	We don't understand why some categories of abuse have been left out of the guidance – it seems as though it has been decided some categories are not applicable ? The evidence review does not include some categories such as neglect and acts of omission and self neglect? We would suggest that we do not tailor these to what we think should apply to a care home setting, instead the guidance needs to reflect a fully inclusive list as set out in the Care Act otherwise we risk giving staff conflicting messages.	Thank you for your comment. Neglect and acts of omission are covered by the list of potential indicators relating to individual abuse and neglect, and to organisational abuse. Please see review C for details of the evidence and committee decisions relating to these lists.
Newcastle Safeguarding Adults Board	Guideline	34	3	This section is too simplistic and assumes that the resident has capacity - Many Care home residents as we know do not have capacity and this can make them more susceptible to abuse in the first instance. Mental capacity is a huge issue and needs to be appropriately reflected in the guidance.	Thank you for your comment. The recommendations in this section have now been edited to include further references to communication support, and the Mental Capacity Act. There are a large number of references throughout the guideline about mental capacity and the Mental Capacity Act. The introduction/context section includes the following statement "…When a care home resident lacks capacity, this guideline should be used in line with the NICE guideline on decision making and mental capacity …" and includes a link to that guideline. NICE guidance does not repeat recommendations in different guidelines but the NICE website allows for users to follow pathways between sets of recommendations that are helpful for them.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Newcastle Safeguarding Adults Board	Guideline	34	17	This paragraph appears to suggest that the only reason a person may not be able to protect themselves is due to a person's mental capacity to make decisions. There could be other reasons such as physical ability to remove themselves from the situation, perpetrator risks and behaviour, control and coercion.	Thank you for your comment. The committee agreed to remove this recommendation, because although the intention was not to imply that it was up to the referrer whether a section 42 enquiry should be undertaken, the committee recognised that it could cause confusion. Instead, the guideline recommends that the indicators (in conjunction with the other recommendations in these sections) are used to decide whether a safeguarding referral should be made
Newcastle Safeguarding Adults Board	Guideline	35	6	This section is a repetition of the care and support statutory guidelines and is information that is covered in local policy and procedures.	Thank you for your comment. The committee believes that whilst the guideline aligns with the care and support statutory guidance it builds on and supports this information rather than duplicating it. It is designed for a wide audience but specifically with people who work in care homes in mind.
Newcastle Safeguarding Adults Board	Guideline	36	1	This is a repetition of the care and support statutory guidance, local procedures and additional guidance produced around Making Safeguarding Personal. This should not be different for people in care homes or any other setting.	Thank you for your comment. The committee do not believe that this recommendation implies that existing safeguarding guidance or policies and procedures do not apply to care homes. They believe that this is an issue in which there is unwarranted variation in practice and the recommendation (and the guideline as a whole) is intended to address this inconsistency.
Newcastle Safeguarding Adults Board	Guideline	45	9	There is general lack of clarity on who this section is aimed at – the general public, carers, managers, local authority staff. E.g. 1.12.12 is probably an LA responsibility as part of the S42 enquiry but other paragraphs appear to be aimed at others?	Thank you for your comment. Like the indicators of individual abuse this section is for anyone who works in, visits or is a resident in a care home - unless otherwise stated - and is aligned with the audiences set out on page 1 of the guideline.
Newcastle Safeguarding Adults Board	Guideline	45	General	The use of the concept of "consider" and "suspect" abuse is new to us. On first consideration we find that it could lead to confusion and the potential for care homes to try and manage/investigate concerns themselves when they should in fact be reported on a multi-agency basis. As outlined above, we feel care homes have a good understanding of what issues they do and do not need to report. We have also produced local guidance (like many other SABs) to try and offer additional pointers on	Thank you for your comment. The guideline is intended to help people to make decisions about whether a safeguarding referral to the local authority should be made. The following text has been added to the introduction of section 4 (indicators): "Local authorities may wish to adapt and incorporate them as part of their referral guidance or criteria." The guideline recommends that all 'suspect' indicators are referred to the Local Authority to decide

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				issues where there might be more grey areas – e.g. medication errors, skin damage and falls.	whether the three statutory criteria are met and whether a section 42 Enquiry or other investigation is needed. 'Consider' indicators are intended to result in action within the care home to rectify the issue. However, the recommendations are also intended to encourage the care home to seek advice from the local authority if they are not sure whether a referral should be made. The committee also added a number of recommendations to encourage local authorities to support care homes to develop staff understanding in relation to the differences between poor practice and a safeguarding concern.
Newcastle Safeguarding Adults Board	Guideline	49	18	Does not address what the person should do if the care home manager is perceived to be a part of the problem.	Thank you for your comment. Details have been added to explain that where this is the case it may be appropriate to raise the matter with the group manager, regional manager, owner or board of trustees.
Newcastle Safeguarding Adults Board	Visual summary -Indicators of individual abuse and neglect	General	General	This document we assume aims to set out a visual flowchart to aid staff at a glance but we think the differentiation between 'consider and 'suspect' abuse is not clear and helpful. In our experience many safeguarding concerns start off with a consider approach as at the outset the need to safeguard is not always clear. However, in these circumstances we would always suggest that ensuring the person is safe should be paramount yet its not included here but is included in the section 1.6 immediate actions? The difference between consider and suspect abuse is a subtle one and may not be helpful in all cases. We would suggest further work on this visual to clarify with perhaps one clearer route for staff?	Thank you for your comment. We will try and make this clearer on the visual summaries to help users of the guidance and ensure that safety of residents is emphasised for both types of indicators. The committee also included a recommendation at the beginning of this section in the main guideline to say that if "… a resident is in immediate danger or if there is a risk to other residents (for example if the alleged abuser is someone in a position of trust): • follow immediate actions to take if you suspect abuse or neglect and • report suspected abuse or neglect (see recommendation 1.6.13) as soon as is practical." The committee agree that any indications that the resident is not safe and is in immediate danger should automatically result in following the 'suspect' abuse or neglect pathway of action.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Newcastle Safeguarding Adults Board	Visual summary -Indicators of Organisational abuse and neglect	General	General	As above but section 1.12 is very input focussed and does not look at outcomes or consider patients /resident focussed issues. In the section 'Consider' issues listed e.g. Mismanagement of safeguarding concerns , Inadequate staffing, Poor quality of care are clear safeguarding referrals if there has been a direct impact upon the care of patients /residents. But the flow chart flows through to raising concerns and awaiting a response (time to be agreed by the person (potentially 2 weeks). In some situations this would be wholly unacceptable and does not consider an appropriate assessment of risk. This also places responsibility for quality improvement on the alerter which in some situations may be very junior members of staff or members of the public – is this something we would want to happen?	Thank you for your comment. The committee did not wish to write detailed recommendations about managing organisational level concerns, referrals or support through enquiries because these are dealt with so differently depending on the region and the nature of the concern. They did however want to include sets of indicators so that people knew when they should raise concerns either with the care home or report something directly to the local authority. The committee agreed that 2 weeks was a reasonable amount of time for care homes to respond after something has been raised with them and the guideline is clear that if there is no evidence that a concern has been acted upon the person should raise the level of concern to 'suspect', and contact the local authority.
NHS England and Improvement	Guideline	General	General	We are concerned that there is no reference to coronavirus. In particular, what the impact will be on not seeing family and friends, for example the additional stresses upon people's mental health and also that covid-19 may make care homes more closed to outside scrutiny. (RD)	Thank you for your comment. The committee recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes. The committee have discussed their recommendations in light of this and have attempted to mitigate against the impact of Covid-19 wherever possible, although learning from the pandemic may inform any future updates of the recommendations. NICE have published products related to their response to COVID-19 here which are being updated regularly. We will flag any relevant areas to the COVID-19 guideline team. Recommendations relating to organisational abuse ('physical signs and lack of openness to visitors') now incorporate details on closure to outside scrutiny; details which were added in response to concerns in the sector regarding Covid-19 restrictions.
NHS England and Improvement	Guideline	General	General	We are concerned the guidelines do not make reference to the importance of not having blanket policies and decisions for everyone in a care home, for example DNACPR recommendations must be made on an individual basis. (RD)	Thank you for your comment. This is covered under recommendations relating to possible indicators of organisational abuse ("… residents do not receive person-centred care ...")

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

NHS England and Improvement	Guideline	General	General	We are concerned the guidance does not stress the importance of working in co-production with care home residents, including on how they are supported to keep themselves and others safe, being residents as 'experts of their own lives'. We noticed an omission in co-producing the organisational safeguarding policies and processes. (RD)	Thank you for your comment. The guideline currently recommends that safeguarding policies and procedures should be based on the principles of collaborative working and the committee believe that this implies the inclusion of residents themselves.
NHS England and Improvement	Guideline	General	General	In regard to the section on recognising the signs of abuse, the guidance should include greater emphasis upon recognising that people will have different ways of showing distress, including, maybe, behaviour that other people find challenging. (RD)	Thank you for your comment. The committee agree that care home residents are likely to express their distress in a wide variety of ways. The introduction to the section listing potential indicators of abuse or neglect emphasises this, and behavioural indicators are specifically listed as examples throughout these lists. See for example, "Consider neglect when residents … uncharacteristically refuse or are reluctant to engage in social interaction ..."
NHS England and Improvement	Guideline	General	General	We suggest the guidance adds a greater focus on trauma informed care and on providing support after an incident and on staff recognising that people with a learning disability and autistic people may have experienced abuse before. We also suggest the guidance acknowledges the need to recognise traumatised families and the importance of the family unit and working with families. (RD)	Thank you for your comment. The committee agree that trauma informed care is vital. The possibility of prior experience of abuse is referred to in the introduction to the lists of potential indicators of abuse or neglect. The importance of trauma focused care after an incident(s) of abuse or neglect is covered under the section on support for the resident during an enquiry where the committee recommend that care homes should provide practical and emotional support both during and after the conclusion of an enquiry and that referral to specialist support (e.g. psychological) should be considered.
NHS England and Improvement	Guideline	4	4	This line only references older people. We suggest including a statistic about the number of younger adults in care homes. (RD)	Thank you for your comment. We discussed this with the committee but we were unable to agree a suitable statistic to add and the committee felt this was better left as it was.
NHS England and Improvement	Guideline	23	18	Acknowledging that abuse may be perpetrated by family members, carers and care home staff – important to recognise how much more difficult potential disclosures may be in such settings, so the	Thank you for your comment. The committee agree and have included various references within the guideline about alleged perpetrators who are persons in positions of trust, (care home staff, managers and also family members). With regards

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				need for increased vigilance and the importance of an open culture. (RD)	to the issue of an open culture, the sections on induction and training, and on culture, leadership and management include recommendations aimed at facilitating this. This is also reflected in the indicators of organisational abuse which include closed cultures as examples.
NHS England and Improvement	Guideline	24	14	We recommend the inclusion of this line: … or given someone else's clothes to wear (RD)	Thank you for your comment. This has been added as an example.
NHS England and Improvement	Guideline	56	General	Key recommendations for research – it would be important these were prioritised for funding so we can get the evidence base that is needed to inform practice. (RD)	Thank you for your question. NICE takes the research recommendations forward in the sense that they liaise with the research community to ensure they are addressed. NICE does this by communicating research recommendations to researchers and funders. In particular, NICE works closely with the NIHR (including the SSCR) and NETSCC to prioritise research recommendations from across the programme of NICE guidelines, meeting regularly to monitor progress on carrying out and funding research from NICE research recommendations. NICE will work in exactly this way to promote the funding and commissioning of research that will address the gaps identified by the committee for this guideline.
NHS England and Improvement	Guideline	69	13	In order to test awareness of safeguarding, we suggest that there is a section regarding value-based recruitment/recruitment in general. (RD)	Thank you for your comment. Whilst the committee agree that values based recruitment can be an effective tool, this section of the guideline relates to the evaluation of training provided to staff who are already employed in care homes.
NHS England and Improvement	Visual summary – Indicators of organisational	General	General	For someone who wishes to report (whistleblow), it does not reflect the support or 'protection' they could/might need. We suggest considering the inclusion of this or signposting. (RD)	Thank you for your comment. The visual summaries only include some of the information within the guideline and they do not include sections 1-3 which focus more on care home policies, procedures, culture, and training. The section covering policies and procedures also include information about whistle blowing and the legal protections afforded to whistleblowers. Although it is not possible to include all of this detail in the visual summary, we will consider how best this can incorporate

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

	abuse and neglect				some of the underpinning principles (such as whistleblowing) from sections 1-3
NHS England and Improvement	Guideline	General	General	Mentioning of modern slavery would strengthen this; not specifically about the safeguarding of individual patients but around organisational safeguarding issues and relating to staffing. (JH)	Thank you for your comment. The committee agree that the issue of modern slavery is relevant to care homes and have included examples relating to this in the list of potential indicators of organisational abuse (staffing).
NHS England and Improvement	Guideline	General	General	Didn't see anything specific about Lampard Recommendations - although written for NHS Trusts, point 9.5 in the recommendations states that for good practice other organisations may wish to consider these (JH)	Thank you for your comment. Whilst the committee recognise the importance of the report to which you refer, this guideline focuses specifically on safeguarding practice in care homes, and the Lampard and Marsden report would not have been included in the systematic reviews on which this guideline is based.
NHS England and Improvement	Guideline	General	General	Safe recruitment seemed light in general; Disclosure and Barring Service (DBSs) important	Thank you for your comment. The committee agree that 'safe' recruitment practices are important and have included examples relating to this (and DBS specifically) in the list of potential indicators of organisational abuse (staffing). Recruitment in relation to preventative safeguarding is not within the scope of the guideline.
NHS England and Improvement	Guideline	General	General	Training - I think that adhering to the intercollegiate documents for adult safeguarding should be included. For that matter, the intercollegiate document for children too - as children visit homes etc (Think Family approach). (JH)	Thank you for your comment. The guideline includes recommendations relating to mandatory and further training. The committee discussed the RCN competencies framework/intercollegiate document when drafting these recommendations (see evidence review H) and agreed that it was not therefore necessary to include further details on these issues here. Consideration of risks to children is covered in recommendations relating to the reporting of potential abuse or neglect.
NHS England and Improvement	Guideline	General	General	Cannot recall reading anything re Persons in a Position of Trust; mention should be made (JH)	Thank you for your comment. The committee agree that consideration of power imbalances is a key part of effective safeguarding practice and included details relating to this in their recommendations on responding to abuse and neglect.
NHS Southampton City CCG	Comments form Q1	General	General	**1. Which areas will have the biggest impact on practice and be challenging to implement?**	Thank you for your comment and support for the guideline. As part of our consultation activities we

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				Please say for whom and why. • The guidance is positive and timely providing a consistent message and approach to safeguarding adults within a sector which has a wide variation in safeguarding practice and procedures at a local level. • Effective engagement with the care home sector is essential as part of the consultation across all "sizes and types" of care homes to ensure that the outcome of the consultation is successful and achievable. • Support and engagement with providers in relation to quality improvement in safeguarding understanding and practice will have the greatest impact.	have engaged directly with the Care Provider Alliance, which brings together the main national associations representing independent and voluntary adult social care providers in England and a number of these organisations as well as a range of independent care providers have responded to this consultation.
NHS Southampton City CCG	Comments form Q2	General	General	**2. Would implementation of any of the draft recommendations have significant cost implications?** Proposals within the consultation may be seen as additional responsibilities and requirements that may not currently sit with the provider. This may be seen by many as requiring additional financial implications and therefore evidence of best practice solutions has to be available to support the sector move forward with new statutory responsibilities These may cause some challenges for Boards – see an example of local Board at the end of this document	Thank you for your comment and providing this feedback. It is not clear to which recommendations your comments on financial implications refer however it may be of note to you that the recommendations relating to SABs have now been edited to make it clearer that they relate to the strategic and oversight role which SABs play, and emphasises that rather than taking action themselves, SABs should instead seek assurances from local authorities, or other commissioners and local partners that this work is being undertaken. The committee are confident that the edited recommendations no longer have the financial implications suggested by the original text. With regards to the rest of the recommendations, the committee do not believe that these will have a significant financial impact however they agree that best practice resources can be a valuable implementation tool and your comments will be considered by NICE where relevant support activity is being planned.
NHS Southampton City CCG	Comments form Q3	General	General	**3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of**	Thank you for your comment and providing this feedback. The committee agree that good communication between care homes and SABs is key and

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				good practice.) • Care home rep on Safeguarding Adults Board able to act as conduit information flow back between wider care home sector forum • Providers work together within the sector to identify Speak Out advocates who can be utilised by any worker within any provider. CCG / LA could ensure additional support with training etc.	have emphasised this in their recommendations for SABs, for example, recommending that they include issues relevant to care homes in their annual report and consider care homes when undertaking strategic planning. The committee agree that greater focus on raising safeguarding concerns would be positive. Whilst sector-wide initiatives are not within the remit of this guideline, the committee drafted their recommendations on care home culture with this issue in mind, for example when recommending that support be provided through 'safeguarding champions' as a means of encouraging people to raise concerns.
NHS Southampton City CCG	Comments form Q4	General	General	**4. The recommendations in this guideline were developed before the coronavirus pandemic. Please tell us if there are any particular issues relating to COVID-19 that we should take into account when finalising the guideline for publication** • Delegation of clinical functions from community nursing teams to care home staff has been significant during Covid, to include insulin administration, simple dressings, management of medicines dosage on sliding scales etc. There is a need to review how care homes can be supported in accessing competency-based training for this and support for ongoing maintenance of competency and good governance, where these roles and functions are retained.	Thank you for your comment and providing this feedback. The committee recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes. The committee have discussed their recommendations in light of this and have attempted to mitigate against the impact of Covid-19 wherever possible, although learning from the pandemic may inform any future updates of the recommendations. NICE have published products related to their response to COVID-19 here which are being updated regularly. This includes a shared learning resource on delegation of clinical tasks as part of end of life care delivery, which may be of interest to you. The committee emphasise the importance of safeguarding training that is tailored to the responsibilities and duties of the staff who undertake it however training in relation to the broader issue of clinical tasks is not within scope of this guideline. This is in part covered in NICE guideline Managing medicines in care homes SC1 (see for example '

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					Care home staff administering medicines to residents') however this issue will also be flagged to the COVID-19 guideline team.
NHS Southampton City CCG	Guideline	9	010 - 014	Need to provide solutions to external whistleblowing options rather than an additional financial responsibility for care home to provide. Could explore joined up approach across locality and care homes with Speak Out champions. Continued awareness raising in sector of available support already accessed. CQC or ICU/CCG. Could explore collaboratively identifying/funding a sector wide speak up guardian from within or external to the sector who understands the sector in great depth. Will need good governance arrangements.	Thank you for your comment. The committee acknowledge that not all care homes will be able to establish an external whistle blowing service which is why the committee have only recommended that care homes consider this. The committee also added a new recommendation stating that care home providers "… should have a clear procedure setting out how anyone can report a whistleblowing concern. This process must specify who people can contact, and how (for example the local authority or the Care Quality Commission)."
NHS Southampton City CCG	Guideline	10	005 - 009	Suggest that further clarity is made in final document regarding the different aspects of safeguarding work. Different safeguarding leads can create confusion and working in silos. Potential for leads with oversight from overarching safeguarding lead. Suggest a number of Safeguarding leads rather than leads for aspects of safeguarding work as they may see an issue in isolation	Thank you for your comment. This recommendation has been edited to clarify that there should be an overarching safeguarding lead role providing oversight of safeguarding work within the care home or organisation.
NHS Southampton City CCG	Guideline	10	014 - 016	Need to explicitly state that safeguarding roles and responsibilities need to be understood in terms of both preventive as well as in response to incidents/risk of harm/abuse.	Thank you for your comment. The committee agree that preventative safeguarding work is essential, however, as it often overlaps with care quality improvement it is not within the scope of this guideline and so the committee were unable to go into detail about this. However, the guideline makes a number of references to the 6 key principles of safeguarding (including prevention), for example, in section 2 where these principles are referenced with regards to the content of mandatory training. It is also covered indirectly in the possible indicators of individual and organisational level abuse and neglect in sections 4 and 12. The

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					guideline suggests that an understanding of these indicators is included in mandatory training. A link to the training section has now been added.
NHS Southampton City CCG	Guideline	10	General	Positive approach toward whistleblowing within this sector. But need to support that any sector wide speak up guardian is supported in their CPD pertaining to this role and has access to supervision externally to the sector for objective reflection and support.	Thank you for your comment. Whilst the committee agree that whistleblowing is a key issue in health and social care, recommending a sector wide oversight/guardian role is not within the scope of this guideline.
NHS Southampton City CCG	Guideline	11	002 - 005	Needs clarification whether this is a recommendation for safeguarding specific quality visits outside of safeguarding processes and in addition to routine quality visits which include safeguarding as an integral component.	Thank you for your comment. This recommendation has been edited for clarity.
NHS Southampton City CCG	Guideline	11	006 - 009	Currently learning for care home sector from reviews etc is facilitated through joint forums. Positive comment which will require additional consideration and support from commissioning leads to coordinate process / opportunities for sharing of learning in a more robust way, A sector specific training offer tailored to the care home setting would be different to the multiagency approach commonly on offer but is a worthy consideration and worthy of formal commissioning.	Thank you for your comment and support. The committee did not wish to be prescriptive with regards to the methods through which this should be done.
NHS Southampton City CCG	Guideline	12	001 - 012	Would require significant awareness raising as to the role and function of the boards prior to any of this taking place. Strengthen role of safeguarding leads through additional communications and working with the safeguarding adult board. Need to consider the impact that this may have upon the post holder who is often the registered manager and holds a wide portfolio. Challenges of changes and maintaining safeguarding register within the board business team. These functions and representations by the sector	Thank you for your comment. The committee have amended a number of the recommendations that referenced Safeguarding Adults Boards (SAB) to make it clearer that these boards have a strategic oversight role and as such are often not taking forward actions themselves but are seeking assurances that local authorities, other commissioners and representative organisations on the board are. In relation to communication with care home safeguarding leads, the guideline now recommends that SABs should seek assurances that clear lines of communication are in place between commissioners, the Regulator and safeguarding leads

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				on Boards are already in place in some areas, caution needs to be that these are sector elected members who can be objective and adequately represent the differing elements of residential care, in order to be successful in such a leadership role. There is a need to be specific about who they are representing, are we referring to residential care homes and nursing homes or do we mean supported living accommodation too or specialist LD residential care?	check that local authorities and CCGs have clear lines of communication in place with care homes.
NHS Southampton City CCG	Guideline	13	001 - 005	What about maintenance or service staff who are short term contract individuals or visiting professionals.	Thank you for your comment. The committee have included a new recommendation to clarify that whilst care home managers must ensure that agency staff working at the home have completed the necessary safeguarding training for their role, and that they understand the local safeguarding policy and procedure, care home managers are not themselves responsible for arranging or providing this.
NHS Southampton City CCG	Guideline	15	016 - 018	Need to include training pertaining to intimate and sexual behaviours by or involving those who lack capacity.	Thank you for your comment. The guideline includes a list of potential indicators of sexual abuse, which makes reference to capacity issues, and the recommendations relating to training suggest that these are included as an essential component of mandatory and further training.
NHS Southampton City CCG	Guideline	18	General	Need to include/consider role of proprietors who can influence culture within care homes, what about their need for understanding with safeguarding as they often influence practice within residential care teams and management.	Thank you for your comment. Proprietors are included by use of the term 'care home providers' throughout the guideline. Their role in shaping care home culture is referenced in the recommendation about promoting a care home culture in which safeguarding is openly discussed and in which support for people raising concerns is readily available.
NHS Southampton City CCG	Guideline	21	012 - 020	The Safeguarding Adults Board (SAB) should offer additional learning opportunities and enhance communication and awareness with the sector however will present challenges regarding existing resources within boards. Potential best practice solutions may already be options. support this but	Thank you for your comment. The committee have amended a number of the recommendations that referenced Safeguarding Adults Boards (SABs) to make it clearer that boards have a strategic oversight role and as such are often not taking forward actions themselves but are seeking assurances

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				responsibility has to remain with the home and assurance sought by the SAB.	that local authorities, other commissioners and representative organisations on the board are. The committee agreed to remove as a result and incorporated aspects of this into a recommendation relating to training. This recommends that SABs (and their subgroups and partners) should encourage care home providers to arrange opportunities for staff and residents to learn together from recent SARs.
NHS Southampton City CCG	Guideline	21	General	Important messages to embed best practice across the sector and raise awareness of the work of the Safeguarding Adults Board and vice versa. Walkabouts to services by Board members could promote and facilitate this as part of an ongoing promotion programme.	Thank you for your comment. This is the kind of co-operation and shared learning the committee had in mind when they made this recommendation.
NHS Southampton City CCG	Guideline	23	007 - 009	Need to include wording to “trauma” to this paragraph.	Thank you for your comment. References to trauma and adverse childhood experiences (ACEs) have been included in this section.
NHS Southampton City CCG	Guideline	26	25	Need to include “injuries can be self-inflicted”	Thank you for your comment. The committee discussed this and agreed that self harm in itself would not indicate a safeguarding issue. However, a safeguarding concern could result if there was failure to respond to this behaviour, to review care plans, or arrange help in face of this behaviour.
NHS Southampton City CCG	Guideline	31	1	Clarification whether this is the Designated Professional in the CCG or designated safeguarding lead in the care home?	Thank you for your comment. We have edited this to clarify that this refers to the safeguarding lead, removed the phrase 'designated' and added a link to the glossary definition of safeguarding lead.
NHS Southampton City CCG	Guideline	35	011 - 013	Disagree with this comment. The requirement to have a single point of contact for care homes to seek expert advice is not practical due to challenges with other sectors also wanting a single point of access. Also the risk of an individual in that role losing ability to think across the wider system. Prefer to have a single point of access for all agencies and practitioners.	Thank you for your comment. This recommendation has been edited to clarify that there should be a single contact point for all local agencies rather than one which is specific to care homes.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

NHS Southampton City CCG	Guideline	39	014 - 018	This will require additional data reporting to SAB from all homes. Will be a positive to raise awareness of the service and support for residents. Need to ensure simple reporting process in place and captured within data system easily or potential that it will not get reported. It would be helpful to report when advocacy is provided by family, as this might identify providers who rarely commission the support of an IMCA and may be utilising families for ease rather than with the best interest of the individual in mind.	Thank you for your comment. This recommendation has been edited to clarify that this is the responsibility of local authorities and commissioners rather than SABs.
NHS Southampton City CCG	Guideline	42	General	Positive to strengthen work in relation to section 42 in care homes.	Thank you for your comment and support.
NHS Southampton City CCG	Guideline	43	016 - 018	This would be a good opportunity to encourage/promote/require Local Authorities to share provider specific information about the referral and outcomes for all safeguarding enquiries across the sector, as a routine report with all commissioning bodies.	Thank you for your comment. The committee hopes that these recommendations will encourage such practices.
Oxfordshire Safeguarding Adults Board	Guideline	8	5	These are nearly all currently requirements as part of the CQC inspection framework so it would be expected that care homes already understand these requirements and have them in place. The Board has some concerns over the requirement for non-Board partners to follow Board procedures. The procedures are developed with all the Board partners and are signed up to by senior staff in those organisations. There isn't a practical way for the 150+ care home providers to input into the development of or to sign up to the Board procedures, which goes against the care act guidance on how SABs should develop procedures regarding those they impact upon.	Thank you for your comment. The committee acknowledge that some of these issues are covered in other guidance, however they agreed to include them here because there is variation in practice across the sector (an issue that this guideline was designed to address). The committee agree that there may be practical barriers in involving providers to this extent however, and have therefore edited this recommendation to clarify that whilst care homes and providers must have an overarching safeguarding policy and procedure in place to meet the requirements of the Care Act; local arrangements should be considered when implementing this.
Oxfordshire Safeguarding Adults Board	Guideline	12	2	"SABs should ensure that they know who the safeguarding leads are in care homes and care home providers, and how to contact them. They should	Thank you for your comment. This recommendation has been edited to clarify that SABs should seek assurances that clear lines of communication

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				ensure that safeguarding leads are clear about how to contact the Board." There isn't a single operational team within Oxfordshire who would know this level of detail about every care home and care home provider within the county. The expectation that the Safeguarding Board, which is a very small pool of staff, could hold and maintain and up-to-date list of all these is impracticable and would interfere with the Board Support staff's role to support the actual strategic partnership work of the Board.	are in place between commissioners, the Regulator and safeguarding leads; rather than the detailed knowledge suggested by the original text.
Oxfordshire Safeguarding Adults Board	Guideline	12	6	"SABs and sub-groups to the Board should engage with care homes (including care home providers, staff, residents and their families and carers), to ensure that the Board's recommendations for them are useful and appropriate." Oxfordshire does have representation from the local care home provider associations on its sub-groups. However, as these representatives are first to say, the associations by no means cover all providers in the county (less than 60%), cannot speak on behalf of the 120+ care providers operating in the County and will only provide their view based on their organisation and specialism. These are private companies who are ultimately in competition with others in their sector so they do not have an established history of working together or any pre-existing relationship with eachother.	Thank you for your comment. This recommendation has been edited to emphasise the key role that SABs should play in disseminating recommendations and learning from relevant SARs; rather than the wider engagement suggested by the original text.
Oxfordshire Safeguarding Adults Board	Guideline	12	10	"SABs should ensure that partner organisations are working together to support residents during safeguarding enquiries."	Thank you for your comments. This recommendation has been edited to clarify that SABs should seek assurances from their partners that this re-

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				This appears to be an operational issue that would be picked up by the S42 conducted by the Local Authority. The SAB may have a role in assuring itself via the partner agencies that this is being done but it is not for the SAB to ensure this is being done as the Board is not operational.	sponsibility is being met rather than the level of involvement that may have been suggested by the original text.
Oxfordshire Safeguarding Adults Board	Guideline	12	12	"SABs should invite care homes to contribute to the Board's annual report, highlighting achievements, opportunities and challenges in relation to safeguarding." The requirements for a SAB annual report are clearly laid out in the Care Act guidance and this does not include asking non-Board partners for contributions. This risks turning the annual report, which can be a lengthy document, into something that would be incredibly long and unappealing to read.	Thank you for your comment. This section has been edited to clarify that SABs should include matters relevant to safeguarding in care homes in their annual report rather than the wider consultation with care homes suggested by the original text.
Oxfordshire Safeguarding Adults Board	Guideline	12	15	"SABs should establish escalation procedures to resolve any safeguarding disputes with care homes." While we can and do have an escalation policy, this is signed up to by Board Partners. There is no practical way for getting sign up of all 120+ care home providers, who are all private companies that we have no control over. While the requirement for Care Home organisations' safeguarding policies to align with the Board policies should resolve this as an issue the Board is concerned on imposing operational requirements on organisations who have not input on the development of the procedure.	Thank you for your comment. This recommendation has been edited to clarify that SABs should ensure that escalation procedures are relevant to care homes rather than establish new processes as suggested by the original text.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Oxfordshire Safeguarding Adults Board	Guideline	13	1	"no later than 6 weeks after they start" and "refresh the knowledge annually" If SABs are expected to organise the training then organisations will be restricted by the Board's scheduling, they may not be able to meet the 6 week deadline. This is the issue with requiring it to be multiagenc. Internal training within 6 weeks is perfectly reasonable, finding suitable multiagency training within 6 weeks may prove impossible. Refreshing annually is a high requirement, no other workers in health or social care have such a high requirement. The others are only required to refresh their training every three years.	Thank you for your comment. The recommendations relating to SABs have been edited to clarify that SABs should seek assurances from their partners regarding the quality and content of training but are not required to provide or evaluate training themselves. The committee discussed the timescale of mandatory training at length and agreed that 6 weeks was appropriate. The recommendation has also been edited to suggest that knowledge should be assessed, rather than training provided, on an annual basis.
Oxfordshire Safeguarding Adults Board	Guideline	13	6	"SABs should: • consider organising mandatory safeguarding training for staff on a multi-agency basis, working together with related service providers and other health and social care organisations • tailor this training to reflect the safeguarding responsibilities of each member of staff (so staff with more responsibilities receive more comprehensive training)." Currently we do organise safeguarding training within Oxfordshire. However, we have to charge for this service and currently managers within settings attend and they then cascade this training within their organisation. If attending multi-agency safeguarding training becomes a requirement this will massively increase the demand on our service and the SAB do not see how we would be able to	Thank you for your comment. The recommendations relating to SABs have been edited to clarify that SABs should seek assurances from their partners regarding the quality and content of training but are not required to provide or evaluate training themselves.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				meet the need without increasing resourcing and funding. The SAB also think organisations would be unhappy at the cost of sending every member of staff on external training, with this cost likely being passed on to their clients.	
Oxfordshire Safeguarding Adults Board	Guideline	14	2	What training should cover The SAB approve of the clarity offered by what the training should cover as a minimum. However, the guidance is ambiguous on whether this applies to literally all staff or just those staff who deliver care. If this is for all staff, including ancillary staff, then the SAB would consider several of them outside of their role as ancillary staff.	Thank you for this comment. These recommendations have been amended the in the light of comments received to distinguish between training for directly employed staff and agency staff. For the latter it is now recommended that any agency staff member employed to work at the home has completed the necessary safeguarding training for their role and that they understand the local procedures for raising safeguarding concerns. The mandatory training requirements do apply to all employed staff though and that would include ancillary staff, although the level and type of detail required to cover the minimum content for will differ greatly in different types of staff groups and the committee have said that training should and can be tailored for different groups, but the content as listed in the mandatory requirements would apply to all.
Oxfordshire Safeguarding Adults Board	Guideline	15	6	“Mandatory safeguarding training should include an explanation of safeguarding terminology, including translations if needed, for staff who speak English as a second language.” Translating safeguarding training places a large expectation on organisations and the Safeguarding Board. Not only is it time-consuming, it is incredibly costly. It strikes the SAB as disjointed to expect workers to have a sufficient standard of English to work in a	Thank you for your comment. This recommendation has been edited to clarify that translations of key concepts or specific phrases should be provided if necessary rather than translations of all resources related to safeguarding. The committee acknowledge that there may still be resource implications associated with this but they believe this to be achievable within the current climate.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				care home but then to provide additional information in a translated format. If the worker has an insufficient understanding of English then how would they handle a disclosure or understand what they overhear? How would giving them translated information assist them in dealing with those two scenarios.	
Oxfordshire Safeguarding Adults Board	Guideline	20	20	"Care homes should work with the local authority, Clinical Commissioning Groups and other local agencies to establish a local strategic partnership agreement about safeguarding adults in care homes that…" Taking at face value, this is repetitive of expecting Care Homes to align their policies and procedures with those of the Board. Why does this need a separate "local strategic partnership agreement"?	Thank you for your comment. This recommendation has been edited to clarify that it relates to the importance of all local agencies working together to establish local arrangements, rather than the suggestion that a separate partnership or arrangement needs to be established.
Oxfordshire Safeguarding Adults Board	Guideline	21	12	"SABs should arrange opportunities for staff and residents to learn together from recent experiences of safeguarding." Oxfordshire are fortunate in that we already run safeguarding training so this can be incorporated into training. However, we lack the resources (financial and human) to put on further events. The Board would also like to know what is meant by "recent experiences of safeguarding". Whose experience is meant? If this means the day-to-day experience of those going through the safeguarding process, these are not collected in any meaningful way. If it means the experience of professionals and their reflections on safeguarding, we aim to bring this out during training sessions so those who had gone through the process can	Thank you for your comment. These recommendations have been edited to clarify that SABs should seek assurance from their partners regarding training (rather than provide or commission this themselves). The committee believe that the experiences of care home residents (and practitioners) are an important source of learning in relation to safeguarding; however they have edited the recommendation to clarify that SABs should encourage this practice rather than organise it themselves.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				share their experiences. Learning from SARs in incorporated into training.	
Oxfordshire Safeguarding Adults Board	Guideline	21	18	"Care home managers and providers should share their experiences of managing safeguarding concerns with SABs, so that other care homes and providers can learn from this." Care homes have this opportunity whilst attending safeguarding training. Other than this, we do not have the manpower or resources to collect this level of qualitative information from care home managers.	Thank you for your comment. This recommendation has been edited to clarify that care home managers and providers should participate in SAB processes rather than the SAB having to arrange new opportunities as originally suggested by the text.
Oxfordshire Safeguarding Adults Board	Guideline	21	21	"Care home managers and providers should share relevant information from Safeguarding Adults Board meeting minutes and reports with their staff." Apart from the issue of maintaining the up-to-date contact list for all care providers, the Sab believe it would be an unnecessary burden on Care Home Managers to receive unsolicited emails containing minutes and reports for the SAB for them to filter through for relevance. Each meeting probably has in excess of 80 pages of minutes and papers to consider and these range from monthly meetings to quarterly. That's a large amount of extraneous information being sent out and is placing extra burdens on already overworked care home managers.	Thank you for your comment. NICE guidelines are intended to represent best practice and the committee drafted recommendations which they believe to be achievable in the current climate.
Oxfordshire Safeguarding Adults Board	Guideline	39	14	"SABs should monitor: • whether care homes are telling residents about advocacy and the criteria for accessing this and • how advocates are involved in the management of safeguarding concerns."	Thank you for your comment. This recommendation has been edited to clarify that this is the responsibility of local authorities and commissioners rather than SABs.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				The SAB does not see how this could be done within current resourcing. Gathering information and conducting the audits required to offer the assurance would fall outside of what can be managed without an increase in manpower or funding.	
Oxfordshire Safeguarding Adults Board	Guideline	37	19	"SABs and Local Authorities should have auditing processes in place to monitor how residents and their advocates are included in safeguarding enquiries." The SAB support this and already receive this information to our Performance Subgroup	Thank you for your comment and support. This recommendation has been edited to clarify that SABs should ensure that LAs have these processes in place; rather than both LAs and SABs having their own processes.
Oxfordshire Safeguarding Adults Board	Guideline	General	General	As a general point, this guidance was released with very little time to respond during a resurgence of COVID-19. Thought should be given to extending the deadline to ensure organisations effected by the guidance have had ample time to consider.	Thank you for your comment. The committee recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes. All registered stakeholders were given advance notice of the start and finish dates for the consultation but we do recognise the challenge of responding and are very grateful to your organisation for the time taken in doing this.
Oxfordshire Safeguarding Adults Board	Guideline	General	General	Also, the guideline itself it accompanied by a significant body of documentation. Given the time constraints it would be easy to miss things without a dedicated resource to review and compile key points.	Thank you for your comment. A key part of the NICE process is transparency and as such it is important that all supporting evidence is made available at the same time as the guideline and recommendations. All registered stakeholders were given advance notice of the start and finish dates for the consultation but we do recognise the challenge of responding and are very grateful to your organisation for the time taken in doing this.
Oxfordshire Safeguarding Adults Board	Guideline	General	General	Adding to the previous points, the expectation that care home managers, who are the ones most affected by this guidance, have sufficient time and resource to respond to this in a meaningful fashion whilst being very overworked and contending with COVID-19 issues is unreasonable.	Thank you for your comment. A key part of the NICE process is transparency and as such it is important that all supporting evidence is made available at the same time as the guideline and recommendations. All registered stakeholders were given advance notice of the start and finish dates

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					for the consultation but we do recognise the challenge of responding and are very grateful to your organisation for the time taken in doing this.
Oxfordshire Safeguarding Adults Board	Guideline	General	General	Question 1: The recommendations for the Safeguarding Adult Boards (SAB) will be a challenging change in practice in evidencing the accountability function of the Safeguarding Adult Boards in the guidelines. Their role and the governance processes involved in the SAB partnerships is one of scrutiny and holding to account not being the accountable party. Commissioners would be the accountable party for assurance (for those care homes they have a commissioning relationship with). The CQC, who all these organisations are registered with regardless of commissioning, also have a large part to play in assurance. The Health and Wellbeing boards should be considered in this section as accountable for challenging and supporting practice change, being held to account by the SAB partners. The differentiation in the roles of these three needs to be made clear in the guidance.	Thank you for your comment. The recommendations for SABs have been edited to clarify that boards should seek assurances that this work is being carried out by commissioners or local partners, rather than the original level of involvement in operations suggested by some of the original text.
Oxfordshire Safeguarding Adults Board	Guideline	General	General	There is no connection being made to the NHS Long Term plan, the integrated care systems (ICSs) and integrated care partnerships (ICPs) that would support the coordination of care and treatment for the older population of the area.	Thank you for your comment. Whilst the committee agree that integrated care is a key issue it is not within the scope of this guideline.
Oxfordshire Safeguarding Adults Board	Guideline	General	General	There are numerous paragraphs within the document that could be amalgamated.	Thank you for your comment. With regards to the possible amalgamation of recommendations, the guideline as a whole has been edited for clarity

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				For example: 1.3.11 Care home managers should make sure there are regular opportunities for all staff to share best practice in safeguarding, including learning from Safeguarding Adults Reviews. 1.2.14 Incorporate recommendations and other information from Safeguarding Adults Reviews into training as quickly as possible after the reports publish.	and to ensure that concepts are not repeated. However, the recommendations to which you refer relate to two distinct issues. The first recommendation relates to the concept of care home 'culture' and is intended to encourage care home managers to foster an environment in which best practice and lessons from SARs are discussed openly between staff on a very regular basis. The second recommendation refers to more formal learning programmes delivered on a less frequent basis. As such, the committee did not feel that it would be appropriate to merge these two recommendations.
Oxfordshire Safeguarding Adults Board	Guideline	General	General	The recommendations were presumably developed before the coronavirus pandemic. It would be sensible to make a clear reference to safeguarding during COVID-10 (or any other national crisis), requesting contractual arrangements that include evidence of robust business continuity plans, mutual aid, development of local networks and access to the residents requiring additional care and support.	Thank you for your comment. The committee have discussed their recommendations in light of Covid-19 and have attempted to mitigate against its impact wherever possible, and have added details relating to this in some recommendations, for example, the list of potential indicators of organisational abuse ('physical signs and lack of openness to visitors') now incorporate details on closure to outside scrutiny; details which were added in response to concerns in the sector regarding Covid-19 restrictions. However, contractual arrangements or issues relating to financial sustainability are not within the remit of NICE.
RCSE - Faculty of Dental Surgery, British Society of Disability and Oral Health, & British Society of Gerodontology	Guideline	General	General	First it is pleasing that oral hygiene and access to dental care to get a mention in paragraph 1.4.5 as potential areas of neglect. That would need to be taken in context with engagement with dental services and care giver training. It would be helpful to have a specific reference in the main document to ' ensuring that for residents who may lack capacity to make some key decisions about their care there is a standardised location/ format where such capacity decisions and associated best interest decisions are kept and are	Thank you for your comment and support. The guideline also includes inconsistent engagement with external health services as a possible indicator of neglect (see 'suspect neglect'). NICE has also produced guidance on oral health for adults in care homes which may be of interest to you. The committee agree that comprehensive recording of capacity and best interest decisions is essential, however details relating to this are covered in NICE guideline NG108 Decision making and mental capacity which is referenced at the start of

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				readily available to staff.' (when we make a decision under MCA we want that decision to be known while it is still valid, and also potentially used as evidence in future when making a subsequent best interest decision) In the current documentation this could be easily missed by someone only reading the main document.	this guideline (see 'How it relates to legislation, statutory guidance and other NICE guidelines') and in a number of recommendations throughout this guideline.
RCSE - Faculty of Dental Surgery, British Society of Disability and Oral Health, & British Society of Gerodontology	Guideline	24	13	Evidence of neglect and abuse Table 1 Indicators There needs to be a clear example of what constitutes neglect / omissions in relation to oral health. For example, not facilitating oral hygiene, access to dental care such as not arranging check-ups, especially where there is a level of compliance. There should be clear documentation outlining why it has not been possible to facilitate care and what reasonable steps have been taken to support an individual. For those without capacity, there is the balance between abuse and neglect. An example is the individual for whom it is not possible to undertake appropriate personal care without some form of clinical holding. In the document abuse and neglect are mostly lumped into one sentence and the reality for some is somewhere between the two- for example it may be considered neglect if a toothbrush never went near a mouth however difficult it was to achieve. The main document should recognise this challenge and give care homes and carers pointers to resolve such issues. For example contacting local community dental service for help and support.	Thank you for your comment. The committee have not added further detail or examples and feel the examples of indicators already included are adequate. However, they have added oral hygiene and care to this indicator, as well as references to dental care and dentures in the lists of possible indicators of abuse or neglect. It is not possible to go into further details covering *all* possible indicators of abuse and neglect.
RCSE - Faculty of Dental Surgery, British Society of Disability and Oral Health, & British Society of Gerodontology	Guideline	24	13	Rec 1.4.5: Consider neglect when residents: are not supported to present themselves the way	Thank you for your comment. The committee have added a reference to oral hygiene and care to this indicator.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				they would like (for example, oral care, haircuts, makeup and fingernails	
RCSE - Faculty of Dental Surgery, British Society of Disability and Oral Health, & British Society of Gerodontology	Guideline	025	009	Health Care Professionals for example dentists who visit residential homes on a regular/irregular basis may be best placed to spot signs of abuse in residents which may well go unnoticed e.g. orofacial injuries/ altered behaviour patterns. It is their duty to raise concerns if they feel that there is a sign of abuse and it is important that they are made aware of the process for reporting possible cases of abuse. Although specific healthcare professionals are not specified fully in relation to Dentistry, it is implicit in Multi-agency Working.	Thank you for your comment. The committee agree and the lists of indicators and actions in the section "immediate actions to take if you consider/suspect abuse or neglect" are aimed at anyone who may come into contact with care home residents, including visiting health care professionals.
Royal College of General Practitioners	Guideline	General	General	The guideline committee should consider making a recommendation that empowers care home care staff to speak out if they have any concerns relating to the health care and/or social care professional's approach to the care of their residents. An internal process within the care home should highlight that these concerns can be raised and considered by management and, where appropriate, can then be presented to the multiprofessional team. This will be made easier in England with the care home multiprofessional meeting/ward round which will be chaired by a GP, primary care team or elderly care physician, and we recommend a standing agenda item of safeguarding be included.	Thank you for your comment. This issue is covered in the sections relating to whistleblowing policy and procedures and care home culture.
Royal College of General Practitioners	Guideline	General	General	It is essential to recognise the work that care home staff undertake and that they often feel undervalued. The document is written in a style that some may consider accusatory to care home staff and consideration to the words chosen in the document should be reviewed to ensure care home staff reading it feel supported and empowered to carry out the essential role that they have in safeguarding their residents.	Thank you for your comment. The committee agree that care home staff play an essential role in safeguarding and recognise that staff may feel undervalued; issues which they were mindful of when writing recommendations. However, the guideline was commissioned in response to concerns regarding variability in safeguarding practice and is intended to support care home staff to take evidence based actions and reduce inconsistency in practice.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Royal College of General Practitioners	Guideline	9	9	The term whistleblowing has been superseded in most organisations and is now called “speaking up”. Can the committee consider bringing the guidance in line with the national guardians office using the term “freedom to speak up” (https://www.nationalguardian.org.uk/about-the-ngo/) rather than whistleblowing. Whistleblowing as a term is used throughout the document and will need changing throughout.	Thank you for your comment. After further discussion, the committee feel that the term whistleblowing is most appropriate given the wider understanding of the concept across the health and care sector.
Royal College of General Practitioners	Guideline	12	17	• 1.2 Induction and Training All staff should be trained as per the Intercollegiate Documents: Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. Fourth edition: January 2019 Adult Safeguarding: Roles and Competencies for Health Care Staff. First edition: August 2018	Thank you for your comment. These sections set out the essential components of mandatory training. The committee discussed the RCN competencies framework document when drafting these recommendations (see evidence review H) and agreed that it was not therefore necessary to include further details here.
Royal College of General Practitioners	Guideline	20	20	It is essential that care homes work closely with GP surgeries with regard to safeguarding as primary care will hold records relating to the resident that can span many years. GPs lead multi-professional meetings to discuss care home residents and should be added to the list of key members of the multiagency list.	Thank you for your comment. Whilst the committee acknowledge the role of GP surgeries in relation to safeguarding in care homes; it is not possible to list all relevant agencies in the recommendation and the committee felt that the phrase 'other local agencies' would ensure the widest understanding of the recommendation.
Royal College of General Practitioners	Guideline	20	29	It is essential to be aware of the potential abuse by family members / friends in addition to those working within the care home as this could be picked up by staff members and does not appear to be covered in this list.	Thank you for your comment. The explanatory text at the start of the section listing potential indicators of abuse or neglect emphasises that perpetrators of abuse can include family members and friends.
Royal College of General Practitioners	Guideline	26	4	1.4.8 Physical abuse There needs to be an acknowledgement that there is a huge gap in adult safeguarding when it comes to deciding when something is physical abuse in adults. With children, there is a very clear pathway for managing and investigating suspicious about physical abuse/non-accidental injuries – paediatricians are trained to do this role. There is not an	Thank you for your comment. We acknowledge your points and your comments will be considered by NICE where relevant support activity is being planned with partners and key stakeholders. The indicators are aimed at practitioners and lay people and encourage concerns to be raised with safeguarding leads. If the concern was serious the concern would then be raised with the local authority. However, the committee recognise that the indicators listed here can only offer guidance for action

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				equivalent pathway with adults. This gap is acknowledged within safeguarding and NHSE are currently undertaking some work to scope out what needs to be done to plug this gap.	and that other contextual factors are also important, a concept which they built in to these recommendations.
Royal College of General Practitioners	Guideline	29	2	1.4.16 Financial abuse The committee should consider making a recommendation on the need to consider financial abuse when family members appear to not want to fund appropriate care (e.g. due concerns about inheritance).	Thank you for your comment. We have included an example about people not receiving personal allowances, but the committee did not wish to include any further examples as was not clear this was really a safeguarding issue at its core. There may be wider issues about recovery of fees and LAs will have channels for dealing with this.
Royal College of General Practitioners	Guideline	40	10	1.8.21 'Manage the risks between residents while any enquiry takes place.' It would be beneficial to give more detailed guidance on how care homes do this as this is often very complex.	Thank you for your comment. The committee agree that this can be a challenging issue, however as no evidence (meeting pre-specified inclusion criteria) was identified in relation to this, the committee did not feel that it was appropriate to specify the steps that should be taken, except to recommend that care homes should work in collaboration with relevant commissioners.
Royal College of Nursing	Guideline	General	General	The Royal College of Nursing welcomes the opportunity to review and comment on the NICE guidelines for Safeguarding adults in care homes.	Thank you for your comment.
Royal College of Nursing	Guideline	General	General	The use of term section 42, means the guidance is only applicable to England. We accept that NICE guidance is primarily targeted for England, however, the devolved nations may choose to adopt the guidelines and suggest that this should be acknowledged in the terms used.	Thank you for your comment. NICE guidelines are commissioned specifically for England. Whilst the devolved administrations can adopt/adapt the guidelines it is not possible to include links or references to legislation or statutory guidance used outside of England.
Royal College of Nursing	Guideline	General	General	Greater reference to liberty protection safeguards is required.	Thank you for your comment. Although, DoLS are not within scope of the guideline, there are a large number of references throughout to mental capacity and the Mental Capacity Act. The introduction includes the following statement: "… When a care home resident lacks capacity, this guideline should be used in line with the NICE guideline on decision making and mental capacity …" and includes a link to that guideline.
Royal College of Nursing	Guideline	General	General	The COVID-19 pandemic has restriced external visitors (family, friends and professionals) visiting	Thank you for your comment. The committee discussed the impact that Covid-19 has had on care

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				care homes, resulting in less over-sight of practice and support. Some authorites have allocated NHS Funded-Nursing Care to residential clients in 'dual' registered homes to facilitate the nursing care to be delivered within the home. In addition, face-to-face training is also restricted and digital solutions promoted (face-to-face safeguarding training is recommended in this guidance) – https://www.skillsforcare.org.uk/About/News/COVID-19-Essential-training.aspx?utm_source=Website&utm_medium=Homepage%20box&utm_campaign=Essential%20Training?utm_source=Webpage%20&utm_medium=Tracking%20Link&utm_campaign=Essential-Training%20	homes and the ability of residents to receive visitors. Recommendations relating to indicators of organisational abuse ('physical signs and lack of openness to visitors') incorporate details on closure to outside scrutiny; details which were added in response to concerns in the sector regarding Covid-19 restrictions, and the committee believe that these will help to emphasise that there is no justification for blanket bans regarding external visitors. After lengthy discussions regarding the delivery of training the committee agreed to clarify that face-to-face training should include the use of virtual platforms. The committee agreed that this should mitigate against the challenges that have occurred as a result of Covid-19 (as well as potential resourcing issues). The definition (found in the 'terms used' section of the short guideline) includes the following text: "It may take place with participants all in the same room, or by using video or telephone conferencing. It may include online materials, but participants are able to ask questions, discuss, reflect on current practice and use case studies and examples."
Royal College of Nursing	Guideline	General	General	We cannot see reference to the following: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/756243/safeguarding-adults-protocol-pressure-ulcers.pdf https://www.rcn.org.uk/professional-development/publications/pub-007069 https://www.skillsforcare.org.uk/Learning-development/inducting-staff/care-certificate/Care-Certificate.aspx (Safeguarding is a core aspect of this).	Thank you for your comment and the references provided. The guideline refers to the Royal College of Nursing document 'Adult safeguarding: roles and competencies for healthcare staff.' (2018) on page 5. The Department of Health document on pressure ulcers was considered for inclusion in evidence review C however it did not meet the inclusion criteria for the review and did not report data that were appropriate to answer the review question and was therefore excluded (for more information on this please see the protocol and list of excluded studies in evidence review C).

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					The guideline also includes a reference to Skills for Cares' 'What do I need to know about safeguarding adults?' resource. Whilst the committee are aware of the 'Care Certificate' and its significance in the sector, they did not believe that it was necessary to refer to this in the guideline as it does not exclusively focus on adult safeguarding practice in care homes. They were however mindful of the safeguarding adults standard when drafting their recommendations relating to training.
Royal College of Nursing	Guideline	General	General	We think it would be good to refer to the links below in terms of record keeping for nursing homes/ common standards of conduct and behaviour :https://www.nmc.org.uk/standards/code/	Thank you for your comment. As record keeping is only one small part of the guideline the committee did not feel that a reference to the NMC code would be appropriate
Royal College of Nursing	Guideline	14	1	All nursing staff should meet the competencies set out in the Adult Intercollegiate Safeguarding Competencies framework https://www.rcn.org.uk/professional-development/publications/pub-007069	Thank you for your comment. The committee are aware of this document (see evidence review H and took it into account in their discussions on what training should be provided and whether this differed by role. Given the detail provided in this document, the committee did not consider that it was necessary to make detailed recommendations regarding the content of 'further' training for specific groups of practitioners.
Royal College of Nursing	Guideline	17	3	Where staff are registered nurses, they must have access to clinical supervision by other registered nurses and access to an appropriate level of CPD.	Thank you for your comment. Nursing regulations are not within the scope of this guideline.
Royal College of Nursing	Guideline	18	1	There is no mention of clinical or professional leadership in the culture. Many registered care home managers are not clinicians and they must have access to clinical nursing leadership either by their own staff in nursing homes or access to community nursing services.	Thank you for your comment. The committee recognise the importance of leadership however they feel that this issue is covered adequately by recommendations in the section on care home culture, learning and management.
Royal College of Nursing	Guideline	25	3	Sign of neglect are at a very basic level and should include such things such as meaningful activity involving human interaction, upholding human rights.	Thank you for your comment. The committee added the following text to the indicators: "or in activities that are meaningful for them". They have also added further references to human rights in the context section of the guideline.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Royal College of Nursing	Guideline	47	10	1.12.4: Staffing in care homes with nursing staff should be in line with the RCN staff staffing standards.	Thank you for your comment. Staffing levels are not within the scope of NICE guidelines.
Royal College of Nursing	Guideline	49	8	1.12.8: Consideration of human rights breaches such as blanket “no visiting” declarations for care homes.	Thank you for your comment. The committee agree that this is an important issue and details have been added regarding blanket bans on external visitors.
Royal College of Nursing	Guideline	79	8	There should be mention of duty to report staff under the relevant professional codes of conduct.	Thank you for your comment. Duty to report practitioners who may have broken their professional code of conduct is not within the scope of the guideline.
Royal College of Nursing	Visual summaries	General	General	The flowcharts make mention to medical care not nursing care, many safeguarding issues in care homes require access to expert nursing care, nutrition, tissue viability continence.	Thank you for your comment. We have added 'nursing care' to this set of indicators and will also update this on the flowchart you commented on
Royal College of Physicians	Guideline	General	General	The RCP is grateful for the opportunity to respond to the above consultation. We would like to endorse the response submitted by the British Geriatric Society (BGS).	Thank you for your comment.
Royal College of Speech and Language Therapists	Comment form Q1	General	General	**1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why.** Training need to take account of different learning styles/ literacy/ access to IT and/ or face to face. Training needs re other aspects of care – can be difficult in care homes to release staff to attend e.g. communication/ dysphagia training / reasonable adjustments/ specialist training & knowledge around managing conditions e.g. epilepsy/ mental health/ palliative care/ dementia/ challenging behaviour, and more difficult for care agencies. Time for follow up/ checking understanding of learning and implementation – not sure that this is always carried out in practice and may be more difficult when multiple professionals involved with ad-	Thank you for your comment and providing this feedback. The committee agree that training packages need to have flexibility built in to them to take account of issues such as learning styles, literacy levels and technological barriers, and were mindful of these when drafting their recommendations. For example, after lengthy discussions regarding the delivery of training the committee agreed to clarify that face-to-face training should include the use of virtual platforms. The committee agreed that this should mitigate against the challenges that some organisations and care homes may face in arranging training, particularly smaller providers. They also agreed that this will help to overcome the challenges that have occurred as a result of Covid-19. The definition (found in the 'terms used' section of the guideline) includes the following text: "It may take place with participants all in the same room, or by using video or telephone conferencing. It

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				ditional 'care plans'. Robust communication systems around changing care plans/ needs. Audit – essential alongside multiple ways of checking practice/ adherence to care plans.	may include online materials, but participants are able to ask questions, discuss, reflect on current practice and use case studies and examples." The training and induction section also contain recommendations about flexible approaches to learning, including through team meetings and supervision. The committee have also included a recommendation about ensuring that translations of specific terminology are included in training (to ensure that learning is accessible to all staff). The committee also recognise that there can be challenges in releasing staff time for training but they hope that their recommendations emphasising that safeguarding training is mandatory (as specified in the Care Act, 2014) will support care home managers and providers to find ways in which to overcome these. Whilst the committee agree that condition-specific knowledge is essential to good quality care, this is not within the scope of this guideline. However, the committee have emphasised in their recommendations the importance of person-centred care and recommend that the content of training is tailored to the responsibilities and duties of the staff undertaking it. The committee agree that checking staff understanding of training can be difficult and can sometimes be overlooked in a busy care home, and they drafted the recommendations in the section entitled evaluating training with this issue in mind. They also agree that the involvement of multiple practitioners and changes in care plans is an area in which practice varies. The committee have addressed this in their recommendations relating to record-keeping where they emphasise the importance of accuracy and information sharing when documenting safeguarding work. Failure to

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					adhere to care and support plans is also included in the list of potential indicators of neglect.
Royal College of Speech and Language Therapists	Comment form Q2	General	General	**2. Would implementation of any of the draft recommendations have significant cost implications?** • Training access/ staff time release and cover for staff on training. IT to support online learning. • The recommendations will lead to increased demand for speech and language therapy. • In its submission to the Migration Advisory Committee's Full Review of the Shortage Occupation List, the Department of Health and Social Care argued that speech and language therapists should be added to the Shortage Occupation List because the profession is facing a range of pressures including increasing demand, in mental health in particular. • This would require enough speech and language therapists with the skills and knowledge to support this. Speech and language therapists may need to be trained to equip them with additional skills especially around mental capacity and safeguarding (indictors and risks). • Workforce modelling and future planning would need to take this into account.	Thank you for your comment and providing this feedback. The committee recognise that there can be challenges in releasing staff time for training but they hope that their recommendations emphasising that safeguarding training is mandatory (as specified in the Care Act, 2014) will support care home managers and providers to find ways in which to overcome these. The committee also agree that training should be flexible in order to overcome potential practical issues such as IT provision. Whilst this specific issue is not within the scope of the guideline, the committee were mindful of this when making recommendations and avoided being overly prescriptive. Whilst the committee agree that some of their recommendations may lead to an increased demand, many of these are based on requirements in statutory guidance relating to the involvement of the care home resident and the 'empowerment principle'. For example, the Care Act statutory guidance states that when a safeguarding enquiry is underway: "…as far as possible, the adult about whom there is a concern should always be involved ..." As the population of people living in care homes (such as people with learning disabilities and people with dementia) may very often have difficulties in expressing themselves verbally, the committee were in agreement that supporting people to communicate is a fundamental component of effective safeguarding practice. Whilst workforce planning is not within the remit of NICE, your comments will be considered where relevant support activity is being planned.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Royal College of Speech and Language Therapists	Comment form Q3	General	General	**3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)** • Good knowledge re communication strategies to involve service users e.g. reasonable adjustments/ easy read information/ talking mats/ modifying language. • Good access to training/ information on where else to get support/ keeping safeguarding on agenda eg team meetings/ supervisions	Thank you for your comment and providing this feedback. Your comments will be considered by NICE where relevant support activity is being planned. The committee have included recommendations about accessibility of policies and procedures and training to help facilitate this, as well as including a number of examples relating to communication aids and support in the lists of potential of indicators of abuse and neglect. The committee also agree that access to support in relation to safeguarding and keeping this issue 'on the agenda' are essential and drafted the recommendations in the section entitled 'care home culture, learning and management' with this in mind.
Royal College of Speech and Language Therapists	Comment form Q4	General	General	**4. The recommendations in this guideline were developed before the coronavirus pandemic. Please tell us if there are any particular issues relating to COVID-19 that we should take into account when finalising the guideline for publication.** • Access to e-learning and advantages / disadvantages of this • How monitor safeguarding issues when there is less access to care homes and increased video consultation and people may be supported by a carer for a 'video consultation'/ use of technology. How is privacy and confidentiality maintained / supported with emote consultation. • Visits – often restricted access to areas due to infection control issues so visual checks on environment may be reduced	Thank you for your comment and providing this feedback. The committee recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes. The committee have discussed their recommendations in light of this and have attempted to mitigate against the impact of Covid-19 wherever possible, although learning from the pandemic may inform any future updates of the recommendations. NICE have published products related to their response to COVID-19 here which are being updated regularly. We will flag any relevant areas to the COVID-19 guideline team. The committee spent a great deal of time discussing how best to deliver training. The committee's recommendations relating to training are based on a systematic review which did not identify any quantitative evidence comparing the effectiveness

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				• People with communication needs are at greater risk of abuse and neglect as they are unable to express this is taking place. • Decreased access to SLTs/ therapists into care homes during the coronavirus may compound the risks of people with communication needs not being supported to express their concerns leaving them at risk of harm.	of different modes of training and identified only limited evidence in relation to cost-effectiveness. However, the committee acknowledged that there is anecdotal evidence of concerns about e-learning, and that this reflects their own concerns; particularly in relation to the absence of human interaction and opportunities for discussion. As a result, the committee agreed that it was appropriate to recommend that face-to-face training should be used wherever possible, but also to recommend that e-learning could be used if it was not possible to provide face-to-face training. The committee also agreed to clarify that face-to-face training should include the use of virtual platforms, which they believe will help to mitigate against the challenges that have occurred as a result of Covid-19 (as well as potential resourcing issues). The committee also recognise the impact that Covid-19 has had on external scrutiny of care homes and the indicators of organisational abuse ('physical signs and lack of openness to visitors') now also incorporate details on closure to outside scrutiny; and the committee believe that these will help to emphasise that there is no justification for blanket bans regarding external visitors. The committee recognise that many people who live in care homes may have communication needs which mean that they would find it difficult, or even impossible, to verbally disclose if they have been harmed. Whilst no evidence was identified (meeting our inclusion criteria) which specifically reported on safeguarding practice in relation to people with communication difficulties, the committee were in agreement that supporting people to

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					communicate is a fundamental component of effective safeguarding practice. As a result, the committee included a number of non-verbal 'signs' in their lists of possible indicators of abuse or neglect. The introduction to these lists emphasises that the "… possibility of abuse or neglect should always be considered as a cause of behavioural and emotional indicators, even if they are seemingly explained by something else. This is particularly important for residents who do not communicate using speech." The committee agree that access to Speech and Language therapists will likely have become more difficult as a result of the restrictions associated with Covid-19, workforce planning is not within the remit of NICE. However, the committee hope that their emphasis on communication support (reflecting statutory requirements) will encourage providers to focus on this important issue and seek support from local partners wherever possible.
SafeLives	Guideline	General	General	Domestic Abuse / Violence is only referred to twice throughout the guidance which evidences the narrow scope of the document.	Thank you for your comment. The committee have now included the following text at the start of the section listing potential indicators of abuse and neglect to clarify the coverage of domestic abuse in the guideline: "Physical, sexual, psychological and financial abuse may be perpetrated by volunteers, visitors, and family members and carers, as well as by care home staff. When it is perpetrated by someone who is personally connected to the resident, this is considered to be domestic abuse. In some cases, this can be a continuation of past relationships of domestic violence or abuse."
SafeLives	Guideline	General	General	There is no reference to coercive/controlling behaviour which is a crime since 2015 Serious Crime Act and we think this is an important part of the abuse older people can be at risk of in care homes. While the crime only applies if a partner/family member is living with the person they	Thank you for your comment. Coercive or controlling behaviour is covered under the indicators of psychological abuse, and is also referenced in a recommendation relating to reporting a suspected crime. The guideline also includes a list of potential indicators relating to financial and material abuse.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				are using CCB with, the behaviours could still constitute a clear safeguarding risk for that adult and should be identified by staff and carers within the home. In particular financial abuse of older people by partners and adult family members is a key risk.	
SafeLives	Guideline	General	General	Explicit reference to the need for domestic abuse cultural change training should be included in the safeguarding training care home staff receive and the safeguarding lead should have enhanced specialist training on domestic abuse alongside established referral pathways to local specialist domestic abuse services. For an example of cultural change training and the impact it can have on the response to victims of domestic abuse, we would refer you to the DA Matters training for police forces: https://safelives.org.uk/training/police	Thank you for your comment and the example of training you have provided. Section 1.2 specifies what the committee believe to be the essential components of mandatory safeguarding training, including - "how to recognise different forms of abuse and neglect, including organisational abuse and neglect", and "how to act on and report suspected abuse and neglect". The section covering potential indicators of abuse and neglect includes reference to domestic abuse and should therefore be included as an essential component of mandatory training.
SafeLives	Guideline	General	General	All care homes should have a domestic abuse policy which sits alongside the safeguarding policy and which covers employees and residents.	Thank you for your comment. The committee have not recommended a domestic abuse policy in particular but they have now included the following text at the start of the section listing potential indicators of abuse and neglect to clarify the coverage of domestic abuse in the guideline: "Physical, sexual, psychological and financial abuse may be perpetrated by volunteers, visitors, and family members and carers, as well as by care home staff. When it is perpetrated by someone who is personally connected to the resident, this is considered to be domestic abuse. In some cases, this can be a continuation of past relationships of domestic violence or abuse"
SafeLives	Guideline	General	General	We note that many care homes talk of staff and residents as being 'family' and the care home is the residents home. This gives rise to a unique power imbalance which is very similar to many abusive family contexts. While the new statutory definition of domestic abuse does not cover non familial carer relationships, we know from specialist disabled domestic abuse charities such as Stay	Thank you for your comment. The committee have now included the following text in at the start of the section listing potential indicators of abuse and neglect to clarify the coverage of domestic abuse in the guideline: "Physical, sexual, psychological and financial abuse may be perpetrated by volunteers, visitors, and family members and carers, as well as by care home staff. When it is perpetrated by

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				Safe East and DeafHope that in practice, the abuse disabled and older people experience in residential settings can have the same impact as that experienced from family members and partners.	someone who is personally connected to the resident, this is considered to be domestic abuse. In some cases, this can be a continuation of past relationships of domestic violence or abuse."
Sense	Guideline	10	19	At Sense we believe that all source of information is relevant and require recording regarding safeguarding. An additional line needs to be inserted noting; where an individual receives Positive Behaviour Support, all staff have been trained and it is monitored and recorded when any restraint is required. Triangulation of records support the identification of safeguarding concerns which may include, CQC inspection reports, health and safety reviews, medication reviews.	Thank you for your comment. The committee agree that a range of sources should be used in safeguarding practice and drafted recommendations on record keeping with this in mind.
Sense	Guideline	11	5	At Sense to ensure Local authorities and commissioners fulfil their statutory and contractual safeguarding responsibilities through organising quality checks of care homes, that this is included as a part of the service level agreement (contact). We feel that without inclusion in contacts Local authorities may chose not to implement these checks.	Thank you for your comment. This recommendation has been edited for clarity.
Sense	Guideline	12	16	We have noted that PIPOT is not mentioned in the guidelines, we suggest at this line an addition made - Local authorities should provide providers with a Protocol for responding to concerns about a person in a position of trust. (PiPoT) and providers to familiarise themselves with any guidance.	Thank you for your comment. The committee agree that this is important however they felt that this was covered by the recommendations and that it is appropriate that decisions about the use of more detailed protocols can be taken at the local level.
Sense	Guideline	15	21	At Sense we have developed Managers training and guidance booklet on Making safeguarding personal (available on request) to enable managers and staff to support people who have no formal communication and/or communicate differently, to have their outcomes recognised and responded to during safeguarding incidents. The guidance should make reference to providing Making safeguarding personal training to managers.	Thank you for your comment. The committee agree that support for people with communication needs is essential. It is expected that care home managers would receive both mandatory and further training therefore covering both communication needs and the principles of Making Safeguarding Personal. We are unable to link to particular non-NICE guidelines within the recommendations and it is not NICE style to do.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Sense	Guideline	17	2	At Sense all staff receive annual refresher training in the form of questionnaires to ensure competency checks are undertaken annually. Staff additionally every three years complete a eSafeguarding Awareness refresher, where a staff member is not competent in completing this they are then required to complete a face to face safeguarding awareness training. This ensures staffs safeguarding practice is kept up to date with current practice. The guidance should recommend regular refresher training in safeguarding.	Thank you for your comment. The committee agrees that training should be refreshed regularly and included this in their recommendations.
Sense	Guideline	18	11	At Sense we promote safe challenge where staff are enabled to question colleagues practice, this is promoted and staff provided with guidance as part of their initial staff training. To add - Care homes to have a process of safe challenge and encourage staff to question colleagues poor practice and Poor practice is followed up through a rigorous supervision process.	Thank you for your comment. The committee agree that challenging poor practice is essential and drafted several recommendations in the section on care home culture, learning and management with this in mind.
Sense	Guideline	19	8	We believe that Trustees and boards in order to have a full oversight of services should receive annual overviews of safeguarding issues and reflect and assure themselves services are safe. At Sense we introduced an internal safeguarding board which follows this practice has been place since 1999, this system has been replicated by other organisations, and is now recognised good practice.	Thank you for your comment. The committee did not wish to be prescriptive with regards to how this recommendation could be implemented but we will pass this example of best practice to the NICE implementation team.
Sense	Guideline	19	10	As safeguarding is everybody's responsibilities as a minimum Trustees and board members should as a minimum complete safeguarding awareness training, which is refreshed every 3 years, this would be in line with Sense's practice with staff on refreshing safeguarding awareness.	Thank you for your comment. The committee agree about the importance of training for trustees and board members but this is set out in Charity Commission guidance and they did not feel there is a basis on which to include those governance duties within this guideline.
Sense	Guideline	20	6	Sense fully supports the need for discussion on safeguarding practice and links between poor practice and abuse. However this needs to be strengthened as unchallenged poor practice will	Thank you for your comment. The committee agree that challenging poor practice is essential in ensuring an 'open' culture in a care home and

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				become unsanctioned (hidden) culture that leads to abuse as evidenced in recent service disclosures (Wharton Hall).	were mindful of this when drafting the recommendations in section 1.3 as well as recommendations relating to whistleblowing and reporting of safeguarding issues. The list of indicators relating to organisational abuse also include reference to closed cultures.
Sense	Guideline	21	23	At Sense we actively participate in Local authority initiatives which encourage providers to participate is knowledge sharing through groups such as the Birmingham adults safeguarding board partnership, senior staff on local safeguarding boards, and active participation with voluntary organisations directors group (VODG), and the national adult safeguarding network, etc. Participation where possible should be encouraged.	Thank you for your comment. This is the kind of co-operation and shared learning the committee had in mind when they made this recommendation.
Sense	Guideline	22	11	As an organisation we are concerned that the term 'consider' is used, this is at odds that every concern is looked at and is open to interpretation. The examples of 'consider' in neglect should raise serious concerns, singularly may not heighten consideration for neglect, but any as a combination would give serious concern. Having these included as 'consider' provides an option to ignore concerns at an early stage, which are then acted upon until they become a 'suspected' abusive behaviour. The term 'consider' needs to either be removed and all indicators moved to 'suspect' or 'consider' changed to term that encompasses a need to review the persons needs and provided assurance the person is not at risk. Indicators need to be looked at in the round and linking together not seen separate.	Thank you for your comment. The committee agreed that this was unclear and have added a recommendation to suggest that if there are multiple indicators, and at least one is a 'suspect' indicator, you should suspect abuse or neglect and follow that action path. The consider/suspect approach is similar to that used in the Child Abuse and Neglect NICE guideline. The approach guideline recommends that all 'suspect' indicators are referred to the Local Authority to decide whether the three statutory criteria are met and whether a section 42 Enquiry or other investigation is needed. 'Consider' indicators are intended to result in action within the care home to rectify the issue. However, the recommendations are also intended to encourage the care home to seek advice from the local authority if they are not sure whether a referral should be made. The committee also added a number of recommendations encouraging local authorities to support care homes to develop staff understanding in relation to the differences between poor practice and a safeguarding concern.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Sense	Guideline	23	16	As an organisation that supports individuals who may have no formal communication and /or communicate differently we would want to see included 'or use other non-formal communication methods'. We have noted on line 12 the effects of dementia, autism, learning disability … re noted as having an effect on indicators of abuse, this same group and others their communication may not always be through speech. At Sense as part of our training in making safeguarding personal we explore other way people may communicate/disclose abuse in non-formal ways.	Thank you for your comment. This is covered at the end of the paragraph by the text "This is particularly important for residents who do not communicate using speech."
Sense	Guideline	24	11	As an organisation we would like to see added to either the 'Consider' or the 'Suspect' list of examples 'cultural sensitive support not being provided appropriately', as these if not being provided does not recognise individual's equality and diversity needs. This may also be n indicator of organisational abuse.	Thank you for your comment. The committee have added reference to cultural preferences here.
Sense	Guideline	29	20	At Sense for a number of the people we support, money holds limited relevance, however a treasured and valued item or possession that provides a link to a person, memory or acts as a safety/comfort object is a high value to them. As an additional 'suspect' indicator 'have personal items go missing, or constantly lost' needs ot be added to this list of indicators.	Thank you for your comment. This detail has been added as suggested.
Sense	Guideline	32	19	At Sense we have a number of people who are unable to provide a response to any type of formal questioning. The use of 'Achieving Best Evidence' needs to be considered. We have developed guidance on supporting individuals who we support and have examples of how this has been achieved. An addition to this section could include …If the person is unable to formally respond to what happened providers should identify ways of enabling people with non-formal communication to	Thank you for your comment. The committee have added details to the recommendation regarding disclosures from people who do not use verbal communication.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				contribute – through the use of drawing pictures, signed video etc. following achieving best evidence guidance.	
Sense	Guideline	35	3	At Sense we are concerned that the processes seem to jump immediately to a LA investigation, there is a need for a principle of the provider completing investigations. Wherever there is safeguarding concern a referral is made to LA, through strategy meetings and discussion the most appropriate route for investigation is identified.	Thank you for your comment. Recommendations regarding the process of conducting an enquiry are not within the scope of this guideline. Practitioners should refer to relevant ADASS/LGA and other related guidance with regards to these details. This guideline only covers recommendations around the information and support needs of care homes, care home staff, residents at risk and alleged perpetrators while enquiries are taking place as well as some principles around meetings and information sharing while enquiries are taking place – not detailed guidance about how enquiries should be conducted.
Sense	Guideline	35	14	We feel that as part of the openness when a home refers a safeguarding referral an assurance that there is a protection plan in place for the person, to allow time to progress with any investigation.	Thank you for your comment. The committee note that support for the resident is paramount throughout and there is a section about support for the resident while an enquiry is taking place. This section includes reference to putting a protection plan in place.
Sense	Guideline	35	17	As a comment we have noted that 1.7.9 – appears to contradict the consider and suspect principles of 1.5 page 30……	Thank you for your comment. The text "… supported by the recommendations on indicators of individual abuse and neglect …" has been added to this recommendation to make it clear that professional judgement should be used in the context of this guidance.
Sense	Guideline	50	23	With organisational abuse, this is often alerted by either a 3rd party or via a whistle-blower within the organisation, the guidance indicates that the provider will raise a concern directly to the LA. A clearer route needs to be identified. At Sense we make available to staff an external independent confidential whistleblowing contact (concern at work), the guidance needs to reflect providers should have available option for staff to raise organisation abuse via a 3rd party organisation.	Thank you for your comment. There are recommendations regarding whistleblowing policies and procedures earlier in the guideline, including the consideration of an external service. The recommendations in this section do not presuppose who the person is either raising the issue with the care home (under consider) or reporting to the local authority (under suspect) - so it cannot be assumed that it is the provider raising it directly with the LA.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				Additionally, we recommend commenting that - Sharing of information will provide insights into services, this includes CQC inspection reports and notifications, RIDDOR reports, health & safety inspections, care planning meetings, and provider's internal quality checks and allows gathering of soft intelligence. Assimilation of this information helps to identify if there is a provider of risk.	
Shropshire Partners in Care	Guideline	General	General	The comments made by the Safeguarding Adults Board Manager Network (incorporating the responses from the National SAB Chairs Network, noted as SABCN comments) well represent the views of the commentator. In particular comment 7 "SABCN You state that There is wide variation in the way Safeguarding Adults Boards operate and communicate with care homes. The recommendations should lead to greater consistency. Safeguarding Adults Boards should not need additional resources, but some will need to change the way they work. If they are not already doing so, they will need to promote a positive culture and encourage greater collaboration between their members and partner organisations, especially care homes. SABs do not have huge resources and often have small teams of people to support them e.g. one or two staff. The recommendations to SABs assume that there are resources to deliver against them. SAB Chairs generally work 2-3 days per calendar month. The Care Act clearly defines the responsibility of SABs to have strategic responsibility for bringing together senior leaders from partner organisations to deliver improvements and not to undertake the operational detail other than that stated within the relevant sections of the Care Act The lead responsibility for communicating with Care Homes lies with Commissioners from Local Authorities and the NHS and indeed also with CQC".	Thank you for your comment. The committee have amended a number of the recommendations that referenced Safeguarding Adults Boards (SAB) to make it clearer that these boards have a strategic oversight role and as such are often not taking forward actions themselves but are seeking assurances that local authorities, other commissioners and representative organisations on the board are. The committee recognise that SABs are organised, funded and differently and therefore agreed recommendations that reflected that flexibility whilst still being clear about the particular actions that are always the responsibility of the SAB. With regards to the recommendation relating to communication with care homes, this has been edited to clarify that SABs should seek assurances that clear lines of communication are in place between commissioners, the Regulator and safeguarding leads in care homes or at a provider organisation. In relation to the concern regarding the recommendation suggesting that SABs engage with care homes to ensure that SAB recommendations are appropriate and useful to them, this has now been replaced with recommendations suggesting that SABs should incorporate issues related to safeguarding in care homes in to their strategic plans, and that their annual report includes content relevant to safeguarding in care homes.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				Comment 10 from the Safeguarding Adults Board Manager Network (incorporating the responses from the National SAB Chairs Network, noted as SABCN comments) "SABs and sub-groups to the Board should engage with care homes (including care home providers, staff, residents and their families and carers), to ensure that the Board's recommendations for them are useful and appropriate." The Board I work closely with has a Provider membership organisation locally and I represent that organisation on relvent sub groups I don't think it would be appropriate to have lots of providers attending sub groups, we consult with them on maters as required and also have a Safeguarding Adults Forum where such consultation can take place and be fed back to the Board. In addition, NICE guidance cannot conflict with the Care Act and the Care and Support Guidance concerning the role of organisations or safeguarding Adults Boards. In general, the Guidance is very long and in addition to being familiar with the NICE guidance the Care Home Providers need to be working to the legislation, regional policy and local policy as well as organisational internal policy. This could impact on their engagement with the NICE Guidance. The consultation period during Covid-19 is too short I am for instance currently on part time furlough working only 2 days a week instead of 5 and other work has had to be prioritised because of that. I did not get the opportuniyy to finish the comments on the main document - NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE Guideline Safeguarding adults in care	The committee is confident that the guideline and its recommendations do not contradict the Care Act and its supporting guidance. Where relevant, the guideline makes reference to national policies and legislation and recommends that local arrangements should be taken into account when necessary. With regards to the length of the consultation period, the committee recognise the significant impact which Covid-19 has had on the care sector. Whilst, all registered stakeholders were given advance notice of the start and finish dates for the consultation we do recognise the challenge of responding and are very grateful to your organisation for the time taken in doing this.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				homes Draft for consultation, September 2020 due tio time constraints.	
Shropshire Partners in Care	Guideline	General	General	There are already various models for training such as the Intercollegiate document for health. The care provider must be able to determine the training that meets the competency requirements of their teams. Stating that using people with lived experience as being a good effective model for training I wonder how often this has been used for safeguarding asking the person to recount their experience of abuse and neglect and the personal impact that has on a n individual. I realise it is done for other areas of training including domestic abuse and suicide prevention, but you are getting one person's experience at that time and that can vary massively. The success of training can often be in the trainers knowledge, delivery and ability to engage with the learners as opposed to the content alone.	Thank you for your comment. The guideline includes recommendations on the essential components of safeguarding training that should be included in both mandatory and further learning programmes. The committee discussed the RCN competencies framework document when drafting their recommendations (see evidence review H) and agreed that it was not therefore necessary to make more detailed recommendations on the content of further training. The committee hope that these recommendations will help to reduce inconsistencies across the sector. Recommendations on mandatory training and induction have now been edited to clarify that care home managers and providers have responsibility for ensuring that all directly employed staff have completed mandatory safeguarding training no later than 6 weeks after they start. Similarly, there is a recommendation stating that care home managers and providers also have responsibility for ensuring that temporary or agency staff have already completed the safeguarding training necessary for the role they have been asked to take on. With regards to the inclusion of care home residents lived experiences in training for staff, the committee believe that these are an important source of learning. However, they have not commented on the effectiveness of training that incorporates these and have not recommended that this content must be included or presented by an individual resident to a group of staff. They have instead recommended that case studies and specific examples are used to help staff to understand how

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					safeguarding relates to personalised care and protects a residents' human rights The committee agree that the 'success' of training also relies on the abilities and knowledge of the trainer. Whilst this is not within the scope of the guideline the committee did draft a number of recommendations relating to the evaluation of training by care home managers which they believe will discourage the use of poor quality training and trainers, without requiring mangers to determine exactly which component of the training was not effective.
Shropshire Partners in Care	Guideline	General	General	The evidence also suggested that some staff may not embrace training as fully as others, and that potential positive effects of training may be curtailed if managers are unable or unwilling to allow learning to be implemented within the care home and cascaded down to other members of staff. This document enables useful discussion and the role of the manager in providing a positive view on accessing training should be highlighted in the final guidance, the managers are the key to the success of training being embedded in the workplace with pre and post course input needed.	Thank you for your comment. The committee agree that managers have a key role to play in staff learning and development and drafted recommendations in the sections entitled 'Induction and training in care homes' and 'Care home culture, learning, and management' with this in mind.
Shropshire Partners in Care	Guideline	12	10	1.1.21 "SABs should invite care homes to contribute to the Board's annual report, highlighting achievements, opportunities and challenges in relation to safeguarding." This again may not be practical, the members hip organisation Shropshire Partners in Care highlights information about the sector to the Board to include in the annual report, the Board makes the decision about what is included but again this is because we have an established relationship with the Boards in our local area. This may not be the case in some areas.	Thank you for your comments. This recommendation has been edited to clarify that SABs should seek assurances from their partners that this responsibility is being met rather than the level of involvement that may have been suggested by the original text.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Shropshire Partners in Care	Guideline	13	6	1.2.4 Safeguarding Adults Boards should: consider organising mandatory safeguarding training for staff on a 8 multi-agency basis, working together with related service providers 9 and other health and social care organisations 10 • tailor this training to reflect the safeguarding responsibilities of each 11 member of staff (so staff with more responsibilities receive more 12 comprehensive training). The safeguarding Board might influence training in its area but there is no requirement to organise and provide it, how would mandatory training be enforced? In our area we have a sub group that addresses learning and development but does not necessarily provide those options, the local authority does and also private training providers are engaged with he subgroups (Shropshire Partners in Care) to ensure training reflects local safeguarding needs.	Thank you for your comment. These recommendations have been edited to clarify that SABs should seek assurance from their partners regarding training (rather than provide or commission this themselves) to ensure that it has been developed on a multi-agency basis and reflects the level of responsibility for each role/level.
Shropshire Partners in Care	Guideline	16	2	How to conduct training 2 1.2.11 Provide mandatory safeguarding training face-to-face whenever 3 possible. This can be delivered either in person or via virtual platforms. It 4 should be live and interactive and e-learning should only be used when 5 face-to-face training is not possible. Agree face to face is best method, more is being done online presently though to address Covid- 19 requirements for distancing and reducing the spread. This is best if Live virtual training rather than a course with no live time trainer for retention and embedding post course.	Thank you for your comment. The committee's recommendations relating to training are based on a systematic review which did not identify any quantitative evidence comparing the effectiveness of different modes of training and provided only limited evidence in relation to cost-effectiveness. However, the committee acknowledged that there is anecdotal evidence of concerns about e-learning, and that these reflect their own concerns; particularly in relation to the absence of human interaction and opportunities for discussion. As a result, the committee agreed that it was appropriate to recommend that face-to-face training should be used wherever possible, but also to recommend that e-learning could be used if it was not possible to provide face-to-face training.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					The committee also agreed to clarify that face-to-face training should include the use of virtual platforms, which they believe will help to mitigate against the challenges that have occurred as a result of Covid-19 (as well as potential resourcing issues).
Shropshire Partners in Care	Visual Summary - Indicators of organisational abuse and neglect	General	General	Useful but where it says If you consider abuse or neglect • Raise the matter with the care home manager (unless they are believed to be part of the problem), in writing if possible. Explain the impact on residents, or the likely impact if the situation continues. Ask for a response within a specified period of time (for example 2 weeks). • If the manager agrees to make changes, make sure these happen. • After taking these steps, if the situation does not improve, raise your level of concern to 'suspect'. Caution might be needed in terms of the potential for inaction, consideration needs to also be given to the seriousness of the situation and the risks involved. If there is a regional manager maybe they could be involved at that point as well?	Thank you for your comment. These recommendations have been amended to make reference to the group manager, regional manager, owner and board of trustees also. There is more detail within the guideline itself but we will make sure the visual summary reflects these changes
Shropshire Partners in Care	Visual Summary - Indicators of individual abuse and neglect	General	General	Useful.	Thank you for your comment and support.
Slough Borough Council	Guideline	6	4	Adults with care and support needs is part of the criteria for adult safeguarding in the Care Act. It would be clearer to readers that this is a criteria if this point is bullet pointed in the same way as the	Thank you for your comment. We are not sure exactly which lines you are referring to or what you mean by Draft One, but the committee have made a number of changes to the context section since consultation and we hope it reads more clearly

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				other criteria. Draft One implies that ASC are responsible for safeguarding all adults in their area, whether they have Care and Support needs or not.	now. The committee believe that the text as it is currently written is sufficiently clear.
Slough Borough Council	Guideline	9	6	Police Investigations are the most 'extreme case' It would help if the example of Local Authority or Adult Social Care Enquiry was used here in addition to the Police example as it is the most usual enquiry that evidence is gathered in.	Thank you for your comment. This recommendation has been edited to include local authorities as an example.
Slough Borough Council	Guideline	16	2	F2F training is more challenging during Covid 19. Training using video conferencing is currently more available and should be interactive and give staff the opportunity to ask questions and learn from others.	Thank you for your comment. After lengthy discussions regarding the delivery of training the committee agreed to clarify that face-to-face training should include the use of virtual platforms. The committee agreed that this should mitigate against the challenges that have occurred as a result of Covid-19 (as well as potential resourcing issues). The definition (found in the 'terms used' section of the short guideline) includes the following text: "It may take place with participants all in the same room, or by using video or telephone conferencing. It may include online materials, but participants are able to ask questions, discuss, reflect on current practice and use case studies and examples."
Slough Borough Council	Guideline	19	16	Changes in mood or behaviour should be recorded and reported to line managers. Changes in mood /behaviour should be explored and monitored.	Thank you for your comment. The committee agree that changes in a residents' mood or behaviour should be recorded and shared where possible. This is covered in the section on indicators of abuse and neglect - e.g. "... uncharacteristically refuse or are reluctant to engage in social interaction ..." Recording of such information is covered in the section on record keeping.
Slough Borough Council	Guideline	20	4	The distinction between risk assessment/management (which does not require safeguarding procedures) and safeguarding should also be clear so that the most effective route can be used.	Thank you for your suggestion, which the committee discussed. They concluded that the distinction between poor practice and safeguarding is already addressed in the training section. They also agreed that as risk assessment and risk management are often interpreted differently the recommendation to which you refer is clearer as it is cur-

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					rently written. Risk assessment is part of safeguarding and the committee felt that to make a further distinction could cause more confusion.
Slough Borough Council	Guideline	23	27	This is when a multi – agency risk assessment/management plan would be the appropriate response. If the risks cannot be managed due to ongoing abuse then a Safeguarding Alert may be required.	Thank you for your comment. This recommendation relates to past incidence of abuse or neglect rather than ongoing risk or experience of abuse or neglect. Further text has been added about 'past trauma' in the introduction to this section to clarify this.
Slough Borough Council	Guideline	32	21	For this section staff should proceed with caution in terms of questions if it is suspected that a crime is committed because evidence could be contaminated. Police advice should be sought. Recording anything the resident says without questioning would be helpful as evidence. Questions about the person's immediate health and safety would also be appropriate. This is addressed in another area of the guidance but for clarity should be mentioned here.	Thank you for your comment. This recommendation has been edited to make this clearer and now includes links to the other actions you refer to which are important at this stage
Slough Borough Council	Guideline	34	20	The Care Act Statutory Guidance should be referenced here rather than the MCA. This is because this criteria is about whether the person can/cannot protect themselves due to their care and support needs rather than their mental capacity.	Thank you for your comment. The committee agreed to remove this recommendation, because although the intention was not to imply that it was up to the referrer whether a section 42 enquiry should be undertaken, the committee recognised that it could cause confusion. Instead, the guideline recommends that the indicators (in conjunction with the other recommendations in these sections) are used to decide whether a safeguarding referral should be made.
Slough Borough Council	Guideline	36	27	The local authority will ask for relevant reports and information to be gathered by organisations involved in the person's' care. The authority will also appoint a Safeguarding Manager to the case in addition to the Enquiry Lead.	Thank you for your comment. Recommendations regarding the process of conducting an enquiry are not within the scope of this guideline. Practitioners should refer to relevant ADASS/LGA and other related guidance with regards to these details. This guideline only covers recommendations around the information and support needs of care homes, care home staff, residents at risk and alleged perpetrators *while* enquiries are taking place as well as some principles around meetings and information

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					sharing while enquiries are taking place – not detailed guidance about how enquiries should be conducted. For these reasons the committee only wanted to make reference to the enquiry lead, as local authorities vary with regards how they conduct enquiries and how work in delegated.
Slough Borough Council	Guideline	45	21	The guidance should also reflect that there may be concerns when a manager is always within the home and is perhaps over involved the activities of the care home.	Thank you for your comment. The committee agree that this is an important issue to consider and it has been added to the list of potential indicators of organisational abuse or neglect.
Slough Borough Council	Guideline	53	5	The Local Authority will also appoint a Safeguarding Manager to the case in addition to the Enquiry Lead. The Safeguarding Manager oversees the enquiry, chairs Safeguarding Meetings and provides professional guidance to the Enquiry Lead and partners during the enquiry. Many local Safeguarding Procedures refer to the Safeguarding Manager role and these can be consulted for a full definition. The role scan be entitled Safeguarding Adult Manager or Designated Safeguarding Manager.	Thank you for your comment. Recommendations regarding the process of conducting an enquiry are not within the scope of this guideline. Practitioners should refer to relevant ADASS/LGA and other related guidance with regards to these details. This guideline only covers recommendations around the information and support needs of care homes, care home staff, residents at risk and alleged perpetrators while enquiries are taking place and some principles around meetings and information sharing while enquiries are taking place – not detailed guidance about how enquiries should be conducted. For these reasons the committee only wanted to make reference to the enquiry lead, as local authorities vary with regards how they conduct enquiries and how work is delegated.
Social Care Wales	Guideline	General	General	We welcome this guideline as a helpful and comprehensive document. For implementation in Wales, this guideline would benefit from references to Welsh legislation (some examples below). The guideline needs to contain references to legislation and statutory guidance within the Welsh context to give greater confidence to Welsh practitioners to use it. We are working with the NICE Implementation Facilitator for Wales on a number of projects and are exploring ways to aid implementation in Wales.	Thank you for your comment. NICE guidelines are commissioned specifically for England. Whilst the devolved administrations can adopt/adapt the guidelines it is not possible to include links or references to legislation or statutory guidance used outside of England.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				Acknowledgement of relevant legislation, guidance and frameworks applicable for Wales would greatly help.	
Social Care Wales	Guideline	4	19	Reference to Care Act 2014, only applicable to England. Consider adding an additional reference to Social Services and Wellbeing (Wales) Act 2014.	Thank you for your comment. NICE guidelines are commissioned specifically for England. Whilst the devolved administrations can adopt/adapt the guidelines it is not possible to include links or references to legislation or statutory guidance used outside of England.
Social Care Wales	Guideline	5	26	Helpful reference to Welsh specific practice guidance.	Thank you for your comment and support
Social Care Wales	Guideline	23	5	Reference to care and support statutory guidance issued by Department for Health & Social Care, only applicable to England. Consider adding an additional reference to statutory guidance on safeguarding issued by Welsh Government.	Thank you for your comment. NICE guidelines are commissioned specifically for England. Whilst the devolved administrations can adopt/adapt the guidelines it is not possible to include links or references to legislation or statutory guidance used outside of England.
Social Care Wales	Visual summary: indicators of individual abuse and neglect	General	General	Reference to Section 42 enquiry, only applicable to England. Consider adding an additional reference to s.126 Social Services and Wellbeing (Wales) Act 2014.	Thank you for your comment. NICE guidelines are commissioned specifically for England. Whilst the devolved administrations can adopt/adapt the guidelines it is not possible to include links or references to legislation or statutory guidance used outside of England.
Somerset Safeguarding Adults Board	Guideline	General	General	As a general point, this guidance was released with very little time to respond during a resurgence of COVID-19. Consideration should be given to extending the deadline to ensure organisations effected by the guidance have had ample time to consider it and respond.	Thank you for your comment. The committee recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes. All registered stakeholders were given advance notice of the start and finish dates for the consultation but we do recognise the challenge of responding and are very grateful to your organisation for the time taken in doing this.
Somerset Safeguarding Adults Board	Guideline	General	General	We are concerned that much of the content in relation to Safeguarding Adults Boards (SABs) appears to be based on a misunderstanding of their role and resources, and that this guidance appears to be simultaneously attempting to significantly expand the role of SABs into operational areas in which they currently have no role while, in doing so, diluting the strategic role that is their primary	Thank you for your comment. The committee have amended a number of the recommendations that referenced Safeguarding Adults Boards (SAB) to make it clearer that these boards have a strategic oversight role and as such are often not taking forward actions themselves but are seeking assurances that local authorities, other commissioners and representative organisations on the board are.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				function as defined by the Care Act (2014). We therefore do not believe that this guidance is fit for purpose in relation to its content regarding SABs.	For example, we have said that SABs should seek assurances that clear lines of communication are in place between commissioners, the Regulator and safeguarding leads; that they include issues relating to safeguarding adults in care homes of part of their strategic planning and in their annual report and that they ensure that learning is shared from the findings of safeguarding adults reviews. The committee recognise that SABs are differently organised, funded and resourced in different regions and therefore agreed recommendations that reflected that flexibility whilst still being clear about the particular actions that are always the responsibility of the SAB.
Somerset Safeguarding Adults Board	Guideline	General	General	The guidance is accompanied by a significant body of documentation. Given the time constraints it would be easy to miss things without a dedicated resource to review and compile key points. In particular, the expectation that care home managers, who are the ones most affected by this guidance, have sufficient time and resource to respond to this in a meaningful way whilst contending with COVID-19 issues is unreasonable.	Thank you for your comment. A key part of the NICE process is transparency and as such it is important that all supporting evidence is made available at the same time as the guideline and recommendations. All registered stakeholders were given advance notice of the start and finish dates for the consultation but we do recognise the challenge of responding and are very grateful to your organisation for the time taken in doing this.
Somerset Safeguarding Adults Board	Guideline	General	General	Many of the matters included within the Guidance are already clearly stated in the Care Home Regulations and where Registered Managers will have clarity from the Care Quality Commission (CQC). In addition, no reference is made to the very differing needs and abilities of all those living in care homes, or the large variance in care home size. These will range from care homes specialising in supporting young people over 18 with learning disabilities or mental ill-health to older people with dementia or physical nursing needs. Some will have 80+ beds, others may have 5. The approach to safeguarding will also always need balancing with differing considerations of risk and plans to support people to maintain and where they are able to do so, build, independence.	Thank you for your comment. Whilst the committee acknowledge that some of these issues are covered in other guidance they agreed to include them because there is variation in practice across the sector (an issue that this guideline was designed to address), and are confident that these align with the Care Home Regulations and the CQC inspection framework. The committee agree that the care home sector is very diverse and that the population of people living in them have a wide and complex range of health and social care needs. Whilst the absence of safeguarding specific evidence relating to particular groups of residents made it difficult for the committee to make targeted recommendations, the

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					committee were mindful of the 6 core principles of safeguarding and the importance of Making Safeguarding Personal when drafting their recommendations and took care to ensure that the recommendations do not disadvantage particular groups. In addition, an Equality Impact Assessment of the guideline and recommendations has been carried out to ensure that people with more specific needs are not disadvantaged.
Somerset Safeguarding Adults Board	Guideline	General	General	The draft guidance includes the following statement: There is wide variation in the way Safeguarding Adults Boards operate and communicate with care homes. The recommendations should lead to greater consistency. Safeguarding Adults Boards should not need additional resources, but some will need to change the way they work. We are extremely concerned with this text and the flawed assumptions that it appears to suggest exist within the guidance. SABs do not have huge resources. In Somerset these are limited to one full-time Business Manager (who is also expected to undertake some non-SAB tasks for the Local Authority) and an Independent Chair employed for 30 days per year. The SAB does not have a budget for anything other than their salary costs. While it is true that some SABs do have greater resources, others also have less, and we are not aware of any with the resources to deliver the proposed activities without having make a choice between delivering them and their statutory responsibilities. The Care Act (2014) clearly defines the responsibility of SABs to have strategic responsibility for bringing together senior leaders from partner organisations to deliver improvements and not to undertake the operational detail other than that stated within the relevant sections of the Act.	Thank you for your comment. The committee have amended a number of the recommendations that referenced Safeguarding Adults Boards (SAB) to make it clearer that these boards have a strategic oversight role and as such are often not taking forward actions themselves but are seeking assurances that local authorities, other commissioners and representative organisations on the board are. For example, said the guideline recommends that SABs should seek assurances that clear lines of communication are in place between commissioners, the Regulator and safeguarding leads; that they include issues relating to safeguarding adults in care homes of part of their strategic planning and in their annual report and that they ensure that learning is shared from the findings of safeguarding adults reviews. The committee recognise that SABs are differently organised, funded and resourced in different regions and therefore agreed recommendations that reflected that flexibility whilst still being clear about the particular actions that are always the responsibility of the SAB.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Somerset Safeguarding Adults Board	Guideline	8	5	These are nearly all currently requirements as part of the CQC inspection framework so it would be expected that care homes already understand these requirements and have them in place. We have some concerns over the requirement for non-Board partners to follow Board procedures. The procedures are developed with partners and are signed up to by senior staff in those organisations. However, there isn't a practical way for the 230+ care homes that exist within Somerset to input into the development of, or to sign up to, the Board procedures, which goes against the Care Act guidance on how SABs should develop procedures regarding those they impact upon.	Thank you for your comment. The committee acknowledge that some of these issues are covered in other guidance, however they agreed to include them here because there is variation in practice across the sector (an issue that this guideline was designed to address). The committee agree that there may be practical barriers in involving providers to this extent however, and have therefore edited this recommendation to clarify that whilst care homes and providers must have an overarching safeguarding policy and procedure in place to meet the requirements of the Care Act; local arrangements should be considered when implementing this
Somerset Safeguarding Adults Board	Guideline	12	2	*"SABs should ensure that they know who the safeguarding leads are in care homes and care home providers, and how to contact them. They should ensure that safeguarding leads are clear about how to contact the Board."* *There isn't a single operational team within Somerset who would know this level of detail about every care home and care home provider within the county given the frequency of changes and the simple fact that some providers do not have any contracts with local commissioners. The expectation that the SAB, which it's single member of staff, could hold and maintain and up-to-date list of all these is impracticable and would interfere with the support that they provide to the Board to carry out the actual strategic partnership work of the Board that should be its priority.* *It is not the responsibility of SABs to know the operational detail of who the leads are in care homes – this is the responsibility of partners' Commissioning and Operational services. Most SABs have a*	Thank you for your comment. This recommendation has been edited to clarify that SABs should seek assurances that clear lines of communication are in place between commissioners, the Regulator and safeguarding leads; rather than the detailed knowledge suggested by the original text.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				website and it is partners' responsibility (i.e. Commissioners) to draw attention, to all care home providers, about the SAB website and how contact can be made with SABs.	
Somerset Safeguarding Adults Board	Guideline	12	6	"SABs and sub-groups to the Board should engage with care homes (including care home providers, staff, residents and their families and carers), to ensure that the Board's recommendations for them are useful and appropriate." The proposed guidance suggests and extremely broad requirement on SABs, is unrealistic and would be highly impractical, if not impossible, to deliver across 230+ care homes. Somerset does have representation from the local care home provider association and two significant providers on its Board and, where relevant, subgroups. However, the association by no means covers all providers in the county as it is a paid membership organisation that as independent business some may choose not to join. The two significant providers that are members of the Board cannot speak on behalf of every care home in the County, and will can realistically only provide their view based on their organisation and specialism. It is also not the responsibility of SABs to undertake this work, generally. However, partners will engage with Care Homes in undertaking their responsibilities and specifically SABs would engage with a care home or groups of care homes where a specific action is made from a safeguarding Adult Review (SAR) or other type of learning.	Thank you for your comment. This section has been edited to emphasise the specific role of SABs should play in disseminating recommendations and learning from relevant SARs; rather than the wider engagement suggested by the original text.
Somerset Safeguarding Adults Board	Guideline	12	10	*"SABs should ensure that partner organisations are working together to support residents during safeguarding enquiries."* *This appears to be an operational issue that would be picked up by an enquiry under Section 42 of the*	Thank you for your comments. This recommendation has been edited to clarify that SABs should seek assurances from their partners that this responsibility is being met rather than the level of involvement that may have been suggested by the original text.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				Care Act (2014) conducted by the Local Authority. The SAB does have a role in assuring itself via the partner agencies that this is being done – in Somerset performance in this area is regularly reported to Board's Quality Assurance Subgroup – but it is not for the SAB itself to ensure this is done as the Board is not operational. It should also be noted that, aside from local assurance processes with regard to Making Safeguarding Personal (MSP) that SABs may have in place, quantitative data on this area already forms part of the Safeguarding Adults Collection (SAC) return to NHS Digital.	
Somerset Safeguarding Adults Board	Guideline	12	12	"SABs should invite care homes to contribute to the Board's annual report, highlighting achievements, opportunities and challenges in relation to safeguarding" The requirements for a SAB annual report are clearly laid out in the Care Act (2014) guidance, and this does not include asking non-Board partners for contributions. This risks turning the annual report, which can already be a lengthy document, into something that would be incredibly long, repetitive and unappealing to read if all 230+ care homes in Somerset were to contribute. Logistically the task of requesting, collecting and collating such a large amount of content would also be highly impractical.	Thank you for your comment. This section has been edited to clarify that SABs should include matters relevant to safeguarding in care homes in their annual report rather than the wider consultation with care homes suggested by the original text.
Somerset Safeguarding Adults Board	Guideline	12	15	*"SABs should establish escalation procedures to resolve any safeguarding disputes with care homes."* *In common with most, if not all SABs, we have an escalation policy that is signed up to by Board Partners and describes the process for any organisation to escalate a concern/stuck issue. A separate policy would not be required for care homes as they should be using the same process as any other organisation.*	Thank you for your comment. This recommendation has been edited to clarify that SABs should ensure that escalation procedures are relevant to care homes rather than establish new processes as suggested by the original text.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Somerset Safeguarding Adults Board	Guideline	13	1	"no later than 6 weeks after they start" and "refresh the knowledge annually" If SABs are expected to organise the training then organisations will be restricted by the Board's scheduling, and they may not be able to meet the 6-week deadline. This is an issue with requiring it to be multiagency. Internal training within 6 weeks is perfectly reasonable, finding suitable multiagency training within 6 weeks may prove impossible. Refreshing annually is a high requirement, no other workers in health or social care have such a high requirement. The others are only required to refresh their training every three years.	Thank you for your comment. The recommendations relating to SABs have been edited to clarify that SABs should seek assurances from their partners regarding the quality and content of training but are not required to provide or evaluate training themselves. The committee discussed the timescale of mandatory training at length and agreed that 6 weeks was appropriate. The recommendation has also been edited to suggest that knowledge should be assessed, rather than training provided, on an annual basis.
Somerset Safeguarding Adults Board	Guideline	13	6	"SABs should: • consider organising mandatory safeguarding training for staff on a multi-agency basis, working together with related service providers and other health and social care organisations • tailor this training to reflect the safeguarding responsibilities of each member of staff (so staff with more responsibilities receive more comprehensive training)." We do not, and never have had, a safeguarding training function within the Somerset SAB and therefore do not have the financial or human resources to provide one. In line with our responsibilities under the Care Act (2014) we have developed a training framework that identifies the competencies that different staff groups should have where they are not covered by Intercollegiate Document published by the Royal College of Nursing. We therefore do not have the infrastructure to provide or administer what is being suggested, and	Thank you for your comment. These recommendations have been edited to clarify that SABs should seek assurance from their partners regarding training (rather than provide or commission this themselves) to ensure that it has been developed on a multi-agency basis and reflects the level of responsibility for each role/level.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				even if we did it would need to be provided on a chargeable basis which we believe many organisations would be unhappy about given that they already have in-house functions, and which would simply result in the charge being passed on in the form of higher charges. Our view is that it should not become the responsibility of every SAB to organise mandatory training within current resource levels and that, more fundamentally, responsibility for the training of operational staff cannot sit with a strategic partnership board. It is currently, and should remain, the responsibility of the employing organisation.	
Somerset Safeguarding Adults Board	Guideline	14	2	What training should cover The SAB is supportive of the clarity offered by what the training should cover as a minimum. However, the guidance is ambiguous on whether this applies to literally all staff or just those staff who deliver care. If this is for all staff, including ancillary staff, then the SAB would consider several of them outside of their role as ancillary staff. The training requirements should therefore be further broken down to be clear on what are mandatory minimums for ancillary staff and what are the minimums for care staff. This is the approach we have taken with our own Framework as it is the only practical way to approach the issue.	Thank you for this comment. These recommendations have been amended the in the light of comments received to distinguish between training for directly employed staff and agency staff. For the latter it is now recommended that any agency staff member employed to work at the home has completed the necessary safeguarding training for their role and that they understand the local procedures for raising safeguarding concerns. The mandatory training requirements do apply to all employed staff though and that would include ancillary staff, although the level and type of detail required to cover the minimum content for will differ greatly in different types of staff groups and the committee have said that training should and can be tailored for different groups, but the content as listed in the mandatory requirements would apply to all.
Somerset Safeguarding Adults Board	Guideline	15	6	*"Mandatory safeguarding training should include an explanation of safeguarding terminology, including translations if needed, for staff who speak English as a second language."* *Translating safeguarding training places a large*	Thank you for your comment. This recommendation has been edited to clarify that translations of key concepts or specific phrases should be provided if necessary rather than translations of all resources related to safeguarding. The committee

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				expectation on organisations with responsibility for providing training. Not only is it time-consuming, it is incredibly costly to pay for the expertise to complete this task. *As a general principle, if care staff are expected to deliver care and support to some of the most vulnerable adults in our society, they would be expected to have a sufficient standard of English to interact with the adult, read and understand the care plan and understand their medication regime. Therefore, it would be expected that their standard of English is sufficient for the work around safeguarding. If the worker has an insufficient understanding of English then how would they handle a disclosure? How would they understand what they overheard? How would giving them translated information assist them in dealing with those two scenarios?*	acknowledge that there may still be resource implications associated with this but they believe this to be achievable within the current climate.
Somerset Safeguarding Adults Board	Guideline	20	20	*"Care homes should work with the local authority, Clinical Commissioning Groups and other local agencies to establish a local strategic partnership agreement about safeguarding adults in care homes that…"* *Taking at face value, this is repetitive of expecting Care Homes to align their policies and procedures with those of the Board. Why would this need to be a separate "local strategic partnership agreement"?*	Thank you for your comment. This recommendation has been edited to clarify that it relates to the importance of all local agencies working together to establish local arrangements, rather than the suggestion that a separate partnership or arrangement needs to be established.
Somerset Safeguarding Adults Board	Guideline	21	12	"SABs should arrange opportunities for staff and residents to learn together from recent experiences of safeguarding" The SAB do support learning for professionals in relation to learning from SARs. How this is done would be dictated by local resources and requirements, and in Somerset would usually be based on	Thank you for your comment. The committee have amended a number of the recommendations that referenced Safeguarding Adults Boards (SABs) to make it clearer that boards have a strategic oversight role and as such are often not taking forward actions themselves but are seeking assurances that local authorities, other commissioners and representative organisations on the board are.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				the employer using information produced by the SAB in their training as, as previously stated, the SAB does not have a training function. It would also not be for the SAB to arrange such opportunities for residents, this responsibility would fall to their care providers. Learning from safeguarding experiences outside of SARs could encompass a whole range of things and would be considered the responsibility of the operational teams. For example, if there is a rise in neglect reports from a specific care provider, it would fall to the safeguarding team to work with the care provider on this (potentially under an organisational abuse issue). It should not fall to the SAB to conduct this level of operational learning and would detract from the Board's strategic role. As previously stated, fundamentally, responsibility for the training of operational staff cannot sit with a strategic partnership board.	The committee agreed to remove as a result and incorporated aspects of this into a recommendation relating to training. This recommends that SABs (and their subgroups and partners) should encourage care home providers to arrange opportunities for staff and residents to learn together from recent SARs.
Somerset Safeguarding Adults Board	Guideline	21	18	*"Care home managers and providers should share their experiences of managing safeguarding concerns with SABs, so that other care homes and providers can learn from this." As mentioned in response to other points, the Somerset SAB has limited human resources. Expecting SABs to collect and collate the experience of care home managers in a meaningful fashion would be very time-consuming and resource intensive. Individual experiences also have to be carefully evaluated before use to promote systems-wide change as these can be down to issues between individual providers and the Local Authority safeguarding service, for example, rather than truly indicative of a strategic-level, systems-wide issue.*	Thank you for your comment. The committee recognise that this may be challenging for SABs. The recommendation has been edited to emphasise that the onus for this work is on care home providers and managers.
Somerset Safeguarding Adults Board	Guideline	21	18	*"Care home managers and providers should share relevant information from Safeguarding Adults Board meeting minutes and reports with their staff."*	Thank you for your comment. NICE guidelines are intended to represent best practice and the committee drafted recommendations which they believe to be achievable in the current climate.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				Apart from the issue of maintaining the up-to-date contact list for all care providers, we believe it would be an unnecessary burden on Care Home Managers to receive unsolicited emails containing minutes and reports for the SAB for them to filter through for relevance. We already publish minutes of meetings on our website (redacted to remove any personal information about people who have been invited to speak to the Board about their experiences). However, each meeting will have a significant volume of papers and minutes which we feel would place an unnecessary extra burden on care home managers if they were to be required to read, decide what was relevant to their staff and disseminate. However, care homes must share the outcomes of relevant safeguarding adult reviews with their staff in a way that leads to learning and improvements in practice.	
Somerset Safeguarding Adults Board	Guideline	37	19	*"SABs and Local Authorities should have auditing processes in place to monitor how residents and their advocates are included in safeguarding enquiries."* *The Somerset SAB supports this and has agreed a process with the Local Authority for monitoring this. However, the guidance should be made clearer and explicitly define that it is the LA's role to undertake the auditing process and the SAB's to monitor it's robustness and the data emerging from it as this is an operational function for the LA, and SABs do not have the resources to undertake the level of auditing that would be required to be statistically robust results. For example, based on the number of enquiries undertaken under Section 42 of the Care Act (2014) in Somerset in 2019/20 almost 300 individual audits need to be completed to achieve a minimum 95% confidence level in the results. As far as we are aware no SAB would have*	Thank you for your comment and support. This recommendation has been edited to clarify that SABs should ensure that LAs have these processes in place; rather than both LAs and SABs having their own processes.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				the resources to undertake this level of auditing within its existing human resources. *We therefore that the guidance is changed to:* *Local Authorities should have auditing processes in place to monitor how residents and their advocates are included in safeguarding enquiries. The SAB should have arrangements in place for the monitoring of the robustness of these processes, and of their results.*	
Somerset Safeguarding Adults Board	Guideline	39	14	*"SABs should monitor:* *• whether care homes are telling residents about advocacy and the criteria for accessing this and* *• how advocates are involved in the management of safeguarding concerns."* *This is the responsibility of the local authority not the SAB. It is reported in the SAC return to NHS Digital and we monitor this in performance data.*	Thank you for your comment. This recommendation has been edited to clarify that this is the responsibility of local authorities and commissioners rather than SABs.
Southampton City CCG	Comment form Q1	General	General	1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. • The guidance is positive and timely providing a consistent message and approach to safeguarding adults within a sector which has a wide variation in safeguarding practice and procedures at a local level. • Effective engagement with the care home sector is essential as part of the consultation across all "sizes and types" of care homes to ensure that the outcome of the consultation is successful and achievable. • Support and engagement with providers in relation to quality improvement in safeguarding understanding and practice will have the greatest impact	Thank you for your comment and your support for the guideline. As part of our consultation activities we have engaged directly with the Care Provider Alliance, which brings together the main national associations representing independent and voluntary adult social care providers in England and a number of these organisations as well as a range of independent care providers have responded to this consultation. The guideline itself recommends active engagement between local authorities and other commissioners and care homes to improve knowledge and understanding about safeguarding and how concerns should be dealt with. Your comments will also be considered by NICE where relevant support activity is being planned.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Southampton City CCG	Comment form Q2	General	General	**2. Would implementation of any of the draft recommendations have significant cost implications?** • Proposals within the consultation may be seen as additional responsibilities and requirements that may not currently sit with the provider. This may be seen by many as requiring additional financial implications and therefore evidence of best practice solutions has to be available to support the sector move forward with new statutory responsibilities • These may cause some challenges for Boards – see an example of local Board at the end of this document	Thank you for your comment and providing this feedback. It is not clear to which recommendations your comments on financial implications refer however it may be of note to you that the recommendations relating to SABs have now been edited to make it clearer that they relate to the strategic and oversight role which SABs play and rather than taking action themselves, should instead seek assurances from local authorities, or other commissioners and local partners that this work is being carried out. The committee are confident that the edited recommendations no longer imply the financial burden suggested by the original text. With regards to the rest of the recommendations, the committee do not believe that these will have a significant resource impact however they agree that best practice resources can be a valuable implementation tool and your comments will be considered by NICE where relevant support activity is being planned.
Southampton City CCG	Comment form Q3	General	General	**3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)** • Care home rep on Safeguarding Adults Board able to act as conduit information flow back between wider care home sector forum • Providers work together within the sector to identify Speak Out advocates who can be utilised by any worker within any provider. CCG / LA could ensure additional support with training etc.	Thank you for your comment and providing this feedback. The committee agree that good communication between care homes and safeguarding adults boards (SABs) is key and have emphasised this in their recommendations for SABs, for example, recommending that SABs include issues relevant to care homes in their annual report and consider care homes when undertaking strategic planning. The committee agree that greater focus on raising safeguarding concerns would be positive. Whilst it is not within the remit of this guideline to make recommendations on sector-wide initiatives, the committee drafted their recommendations on care home culture with this issue in mind, for example when recommending that support be provided through ‘safeguarding champions’ as a means of encouraging people to raise concerns.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Southampton City CCG	Comment form Q4	General	General	1. The recommendations in this guideline were developed before the coronavirus pandemic. Please tell us if there are any particular issues relating to COVID-19 that we should take into account when finalising the guideline for publication • Delegation of clinical functions from community nursing teams to care home staff has been significant during Covid, to include insulin administration, simple dressings, management of medicines dosage on sliding scales etc. There is a need to review how care homes can be supported in accessing competency based training for this and support for ongoing maintenance of competency and good governance, where these roles and functions are retained.	Thank you for your comment and providing this feedback. The committee recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes. The committee have discussed their recommendations in light of this and have attempted to mitigate against the impact of Covid-19 wherever possible, although learning from the pandemic may inform any future updates of the recommendations. NICE have published products related to their response to COVID-19 here which are being updated regularly. This includes a shared learning resource on delegation of clinical tasks as part of end of life care delivery, which may be of interest to you. The committee emphasise the importance of safeguarding training that is tailored to the responsibilities and duties of the staff who undertake it however training in relation to the broader issue of clinical tasks is not within scope of this guideline. This is in part covered in NICE guideline Managing medicines in care homes SC1 (see for example ' Care home staff administering medicines to residents') however this issue will also be flagged to the COVID-19 guideline team.
Southampton City CCG	Guideline	1	7	Should this also include the strategies for the prevention of the need to safeguard? Should it also be clear it is for adults aged over 18 and all care groups?	Thank you for your comment. The guideline is clear on page one that it concerns the care of all adults in care homes, as well as who it is for and what it includes. For more information, see the guideline scope on the NICE website. Although the committee agrees that preventative safeguarding work is essential, this was not within the scope of the guideline. However the committee hopes that care homes will use the indicators of organisational abuse and neglect as pointers to preventative safeguarding work.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Southampton City CCG	Guideline	9	10	Need to provide solutions to external whistleblowing options rather than an additional financial responsibility for care home to provide. Could explore joined up approach across locality and care homes with Speak Out champions. Continued awareness raising in sector of available support already accessed. CQC or ICU/CCG. Could explore collaboratively identifying/funding a sector wide speak up guardian from within or external to the sector who understands the sector in great depth. Will need good governance arrangements.	Thank you for your comment. The committee acknowledge that not all care homes will be able to establish an external whistle blowing service which is why the committee have only recommended that care homes consider this. The committee also added a new recommendation stating that care home providers "… should have a clear procedure setting out how anyone can report a whistleblowing concern. This process must specify who people can contact, and how (for example the local authority or the Care Quality Commission)."
Southampton City CCG	Guideline	10	5	Suggest that further clarity is made in final document regarding the different aspects of safeguarding work. Different safeguarding leads can create confusion and working in silos. Potential for leads with oversight from overarching safeguarding lead. Suggest a number of Safeguarding leads rather than leads for aspects of safeguarding work - may see issue in isolation.	Thank you for your comment. This recommendation has been edited to clarify that there should be an overarching safeguarding lead role providing oversight of safeguarding work within the care home or organisation.
Southampton City CCG	Guideline	10	6	It would be beneficial to explain the expectation of the safeguarding lead more clearly, to include training requirements and also supervisory role and the need for supervision.	Thank you for your comment. We have added further details to this section to provide clarity.
Southampton City CCG	Guideline	10	14	Need to explicitly state that safeguarding roles and responsibilities need to be understood in terms of both preventive as well as in response to incidents/risk of harm/abuse.	Thank you for your comment. The committee agree that preventative safeguarding work is essential, however, as it often overlaps with care quality improvement it is not within the scope of this guideline and so the committee were unable to go into detail about this. However, the guideline makes a number of references to the 6 key principles of safeguarding (including prevention), for example, in section 2 where these principles are referenced with regards to the content of mandatory training. It is also covered indirectly in the possible indicators of individual and organisational level abuse and neglect in sections 4 and 12. The guideline suggests that an understanding of these indicators is included in mandatory training. A link to the training section has now been added.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Southampton City CCG	Guideline	10	17	Suggest defining 'regular' or add a timeframe as a minimum?	Thank you for your comment. The committee did not review evidence on this and therefore did not agree that it was appropriate to specify a time-scale. In addition, the committee did not feel that it was appropriate to specify a timeframe because different types of records may need to be audited at different times depending on the nature of the content. The important message the committee wanted to communicate in the rec is that this should be done as part of normal record keeping practice
Southampton City CCG	Guideline	10	General	Positive approach toward whistleblowing within this sector. But need to support that any sector wide speak up guardian is supported in their CPD pertaining to this role and has access to supervision externally to the sector for objective reflection and support.	Thank you for your comment. Whilst the committee agree that whistleblowing is a key issue in health and social care, recommending a sector wide oversight/guardian role is not within the scope of this guideline.
Southampton City CCG	Guideline	11	2	Is this a recommendation for safeguarding specific quality visits outside of safeguarding processes and in addition to routine quality visits which include safeguarding as an integral component	Thank you for your comment. This recommendation has been edited for clarity.
Southampton City CCG	Guideline	11	4	A quality check could be considered in many formats. Is there a way to standardise expectations as to what this incorporates?	Thank you for your comment. This recommendation has been edited for clarity.
Southampton City CCG	Guideline	11	6	Currently learning for care home sector from reviews etc is facilitated through joint forums. Positive comment which will require additional consideration and support from commissioning leads to coordinate process / opportunities for sharing of learning in a more robust way, A sector specific training offer tailored to the care home setting would be different to the multiagency approach commonly on offer but is a worthy consideration and worthy of formal commissioning.	Thank you for your comment and support. The committee did not wish to be prescriptive with regards to the methods through which this should be done.
Southampton City CCG	Guideline	12	1	Would require significant awareness raising as to the role and function of the boards prior to any of this taking place.	Thank you for your comment. The committee have amended a number of the recommendations that referenced Safeguarding Adults Boards (SAB) to make it clearer that these boards have a strategic

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				Strengthen role of safeguarding leads through additional communications and working with the safeguarding adult board. Need to consider the impact that this may have upon the post holder who is often the registered manager and holds a wide portfolio. Challenges of changes and maintaining safeguarding register within the board business team. These functions and representations by the sector on Boards are already in place in some areas, caution needs to be that these are sector elected members who can be objective and adequately represent the differing elements of residential care, in order to be successful in such a leadership role. There is a need to be specific about who they are representing, are we referring to residential care homes and nursing homes or do we mean supported living accommodation too or specialist LD residential care?	oversight role and as such are often not taking forward actions themselves but are seeking assurances that local authorities, other commissioners and representative organisations on the board are. In relation to communication with care home safeguarding leads, the guideline now recommends that SABs should seek assurances that clear lines of communication are in place between commissioners, the Regulator and safeguarding leads check that local authorities and CCGs have clear lines of communication in place with care homes.
Southampton City CCG	Guideline	12	20	What are the expectations about mandatory training? i.e. at what level when compared with the intercollegiate document? Should all staff be trained at the same level (for example housekeeping staff and registered managers).	Thank you for your comment. These sections set out the essential components of mandatory training. The committee discussed the RCN competencies framework document when drafting these recommendations (see evidence review H) and agreed that it was not therefore necessary to include further details here. They also drafted a recommendation aimed at SABs emphasising the importance of ensuring that mandatory training reflects the level of responsibility held by each staff member.
Southampton City CCG	Guideline	13	1	What about maintenance or service staff who are short term contract individuals or visiting professionals – where is this training to be obtained from?	Thank you for your comment. The committee have included a new recommendation to clarify that whilst care home managers must ensure that agency staff working at the home have completed the necessary safeguarding training for their role, and that they understand the local safeguarding policy and procedure, care home managers are

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					not themselves responsible for arranging or providing this.
Southampton City CCG	Guideline	15	6	Who will monitor compliance?	Thank you for your comment. This issue is covered in the recommendations in section 2 however the committee believe that it is appropriate for care home managers to monitor staff learning. Both commissioners and CQC would also have a role in ensuring training happens to required standards.
Southampton City CCG	Guideline	15	16	Need to include training pertaining to intimate and sexual behaviours by or involving those who lack capacity. Change wording from could to should cover.	Thank you for your comment. The guideline includes a list of potential indicators of sexual abuse, which makes reference to capacity issues, and the recommendations relating to training suggest that these are included as an essential component of mandatory and further training.
Southampton City CCG	Guideline	18	General	Need to include/consider role of proprietors who can influence culture within care homes, what about their need for understanding with safeguarding as they often influence practice within residential care teams and management.	Thank you for your comment. Proprietors are included by use of the term 'care home providers' throughout the guideline. Their role in shaping care home culture is referenced in the recommendation about promoting a care home culture in which safeguarding is openly discussed and in which support for people raising concerns is readily available.
Southampton City CCG	Guideline	19	1	How would staff be supported if the safeguarding concerns are about the registered manager?	Thank you for your comment. Reporting safeguarding concerns via an external source is covered in the sections on care home and care home provider roles and responsibilities (whistleblowing), and reporting abuse and neglect.
Southampton City CCG	Guideline	19	13	How would safeguarding champions be different, or work, with safeguarding leads?	Thank you for your comment. Details have been added to the ‘terms used section’ of the guideline to clarify.
Southampton City CCG	Guideline	21	12	The SAB should offer additional learning opportunities and enhance communication and awareness with the sector however will present challenges regarding existing resources within boards. Potential best practice solutions may already be options. support this but responsibility has to remain with the home and assurance sought from the SAB	Thank you for your comment. The committee have amended a number of the recommendations that referenced Safeguarding Adults Boards (SABs) to make it clearer that boards have a strategic oversight role and as such are often not taking forward actions themselves but are seeking assurances that local authorities, other commissioners and representative organisations on the board are.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					The committee agreed to remove as a result and incorporated aspects of this into a recommendation relating to training. This recommends that SABs (and their subgroups and partners) should encourage care home providers to arrange opportunities for staff and residents to learn together from recent SARs.
Southampton City CCG	Guideline	21	General	Important messages to embed best practice across the sector and raise awareness of the work of the Safeguarding Adults Board and vice versa. Walkabouts to services by Board members could promote and facilitate this as part of an ongoing promotion programme	Thank you for your comment. This is the kind of co-operation and shared learning the committee had in mind when they made this recommendation.
Southampton City CCG	Guideline	22	1	Could add a paragraph regarding the storing and retention of records in line with their records retention policy	Thank you for your comment. The committee did not feel that the guideline needed to go into that level of detail about records retention as these policies are complex depending on the data stored and this is beyond the scope of the guideline.
Southampton City CCG	Guideline	23	7	Need to include wording to “trauma” to this paragraph. Reference to ACES may also be beneficial.	Thank you for your comment. References to trauma and adverse childhood experiences (ACEs) have been included in this section.
Southampton City CCG	Guideline	23	12	Add acute and or chronic mental distress	Thank you for your comment. References to trauma and adverse childhood experiences (ACEs) have been included in this section.
Southampton City CCG	Guideline	25	8	Suggest using word malodorous instead of smelly	Thank you for your comment. NICE guidelines prioritise the use of simple and plain language and on balance the committee feel that the original text of this recommendation is the most appropriate.
Southampton City CCG	Guideline	26	10	Consider adding the words ‘this list is not exhaustive’	Thank you for your comment. The phrase 'for example' is used to indicate that the list is not exhaustive.
Southampton City CCG	Guideline	26	25	Need to include “injuries can be self-inflicted”	Thank you for your comment. The committee discussed this and agreed that self harm in itself would not indicate a safeguarding issue. However a safeguarding concern could result if there was failure to respond to this behaviour, to review care plans, or arrange help in face of this behaviour.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Southampton City CCG	Guideline	31	1	Clarification whether this is the Designated Professional in the CCG or designated safeguarding lead in the care home or Local Authority?	Thank you for your comment. This recommendation has been edited to clarify that this refers to the safeguarding lead. The phrase 'designated' has been deleted and a hyperlink to the glossary (where 'safeguarding lead' is defined) has been included.
Southampton City CCG	Guideline	33	1	Offer advocacy or representative support which could include a family or friend	Thank you for your comment. Reference to advocacy has been deleted from this section after further discussion by the committee as they felt that the recommendation was not sufficiently clear. They wished to emphasise the importance of supporting the communication needs of the resident; however more formal requirements for advocacy are not needed in advance of a safeguarding referral being made. So it is clearer now that the LA has responsibility to provide this following a referral being made. See section 1.8.
Southampton City CCG	Guideline	34	9	If there are concerns that children are at risk add in refer to childrens services.	Thank you for your comment. The recommendation specifies consideration of children and requirements to report to the local authority.
Southampton City CCG	Guideline	35	11	Disagree with this comment. The requirement to have a single point of contact for care homes to seek expert advice is not practical due to challenges with other sectors also wanting a single point of access. Also the risk of an individual in that role losing ability to think across the wider system. Prefer to have a single point of access for all agencies and practitioners.	Thank you for your comment. This recommendation has been edited to clarify that there should be a single contact point for all local agencies rather than one which is specific to care homes.
Southampton City CCG	Guideline	35	21	What happens with the Section 42 if a person has died?	Thank you for your comment. The committee did not feel able to write specific recommendations for the very many particular scenarios which people may find themselves in when raising safeguarding concerns and felt that it would go beyond what was reasonable to cover in a guideline of this length and scope to attempt to cover this complex area.
Southampton City CCG	Guideline	36	7	Who completes the Section 42? Often this is the registered manager. Should other people working in the home also be considered for this learning opportunity? How will learning be shared? Who will	Thank you for your comment. Recommendations regarding the process of conducting an enquiry are not within the scope of this guideline. Practitioners

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				complete the Section 42 if there are conflicts of interest?	should refer to relevant ADASS/LGA and other related guidance with regards to these details. This guideline only covers recommendations around the information and support needs of care homes, care home staff, residents at risk and alleged perpetrators *while* enquiries are taking place as well as some principles around meetings and information sharing while enquiries are taking place – not detailed guidance about how enquiries should be conducted.
Southampton City CCG	Guideline	36	7	Need to include responding to Large Scale Enquiries.	Thank you for your comment. Recommendations regarding the process of conducting an enquiry are not within the scope of this guideline. Practitioners should refer to relevant ADASS/LGA and other related guidance with regards to these details. This guideline only covers recommendations around the information and support needs of care homes, care home staff, residents at risk and alleged perpetrators *while* enquiries are taking place as well as some principles around meetings and information sharing while enquiries are taking place – not detailed guidance about how enquiries should be conducted.
Southampton City CCG	Guideline	39	014	This will require additional data reporting to SAB from all homes. Will be a positive to raise awareness of the service and support for residents. Need to ensure simple reporting process in place and captured within data system easily or potential that it will not get reported. It would be helpful to report when advocacy is provided by family, as this might identify providers who rarely commission the support of an IMCA and may be utilising families for ease rather than with the best interest of the individual in mind.	Thank you for your comment. This recommendation has been edited to clarify that this is the responsibility of local authorities and commissioners rather than SABs.
Southampton City CCG	Guideline	42	General	Positive to strengthen work in relation to section 42 in care home.	Thank you for your comment and support.
Southampton City CCG	Guideline	43	16	This would be a good opportunity to encourage/promote/require Local Authorities to share provider specific information about the referral and	Thank you for your comment. The committee hopes that these recommendations will encourage such practices.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				outcomes for all safeguarding enquiries across the sector, as a routine report with all commissioning bodies.	
Southampton City CCG	Guideline	51	General	The importance of learning from home closures secondary to safeguarding processes should also be included, with the recommendation of multi-agency learning events being made.	Thank you for your comment. The committee agree that the closure of a care home can be a key source of learning and drafted recommendations to emphasise the role of SABs in sharing learning with this issue in mind.
Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board	Guideline	General	General	We believe that insufficient consideration has been given to the functioning of the SAB and its resources. Much of what is expected is the responsibility of either the relevant LA or commissioning body. Not all SABs are funded to provide training – ours isn't.	Thank you for your comment. The committee have amended a number of the recommendations that referenced Safeguarding Adults Boards (SAB) to make it clearer that these boards have a strategic oversight role and as such are often not taking forward actions themselves but are seeking assurances that local authorities, other commissioners and representative organisations on the board are. For example, we have said that SABs should seek assurances that clear lines of communication are in place between commissioners, the Regulator and safeguarding leads; that they include issues relating to safeguarding adults in care homes of part of their strategic planning and in their annual report and that they ensure that learning is shared from the findings of safeguarding adults reviews. The committee recognise that SABs are differently organised, funded and resourced in different regions and therefore agreed recommendations that reflected that flexibility whilst still being clear about the particular actions that are the responsibility of the SAB.
Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board	Guideline	8	5	1.1.1. – 1.1.17 Care homes should be aware of these requirements as they are contained within the CQC Inspection Framework and checks against compliance will form part of that process. The only statutory partners prescribed in the Care Act 2014 are the Police, Local Authorities and NHS (Via CCGs). Other partners are arranged locally dependent upon local structures and need. Multi-	Thank you for your comment and providing this feedback. Your comments will be considered by NICE where relevant support activity is being planned.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				agency procedures are produced by the Board for statutory partners and providers in the main. Stoke-on-Trent and Staffordshire have approximately 350 care homes of various resident sizes and consultation with this amount is not practicable.	
Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board	Guideline	12	2	1.1.18 The proposal that Boards 'know who the Safeguarding leads are' in all Care Homes is not feasible, they change so frequently, and maintenance would a disproportionate task to place upon Board administrators. In my particular case there is only myself as Business manager and 1 administrator. There are nearly 350 Care Homes in Stoke-on-Trent and Staffordshire, this would be an impossible task for the SAB and is not relevant for SAB's. LA's have responsibilities towards care homes and would have contacts when needed.	Thank you for your comment. This recommendation has been edited to clarify that SABs should seek assurances that clear lines of communication are in place between commissioners, the Regulator and safeguarding leads; rather than the detailed knowledge suggested by the original text.
Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board	Guideline	12	6	1.1.19 Care homes are not represented in the SSASPB sub-groups. We do, however, have one Board member from an overarching organisation who represents providers who subscribe with them. This is still less than 50% of the total number of providers in the City/County. This organisation can not be expected to represent those providers who don't subscribe to their services.	Thank you for your comment. This section has been edited to emphasise the specific role that SABs should play in disseminating recommendations and learning from relevant SARs; rather than the wider engagement suggested by the original text.
Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board	Guideline	12	10	1.1.20 This is the responsibility of the LA and or their delegate who conduct S42 enquiries and is more operationally focussed than strategic.	Thank you for your comments. This recommendation has been edited to clarify that SABs should seek assurances from their partners that this responsibility is being met rather than the level of involvement that may have been suggested by the original text.
Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board	Guideline	12	12	1.1.21 This is impractical. The SSASPB covers an area with over 350 Care Homes with no one overarching body to contribute on their behalf. It may be possible for there to be a collective input with a focus on a particular item but getting the buy in from all 350 would be impossible and take a great deal of time to pull together. The SSASPB do not	Thank you for your comment. This section has been edited to clarify that SABs should include matters relevant to safeguarding in care homes in their annual report rather than the wider consultation with care homes suggested by the original text.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				ask non-Board members to contribute to the Annual Report.	
Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board	Guideline	12	15	1.1.22 The SSASPB already has its own multi-agency Escalation procedure. Any concerns about safeguarding an individual should be sent to the LA for enquiry, issues about contracts or agreements should be sorted with commissioners in the first instance. It is difficult to see how the Board would get involved in a situation as most should be resolved by the LA or commissioners. If it is a concern about how agencies work together to protect an adult, then they could use the Escalation Procedure if challenge has been unsuccessful. The procedure is available on the Board website.	Thank you for your comment. This recommendation has been edited to clarify that SABs should ensure that escalation procedures are relevant to care homes rather than establish new processes as suggested by the original text.
Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board	Guideline	13	1	1.2.3 The SSASPB are not funded to provide training but seek assurances that the partners do so.	Thank you for your comment. These recommendations have been edited to clarify that SABs should seek assurances from their partners regarding the quality and content of training but are not required to provide or evaluate training themselves.
Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board	Guideline	21	12	1.3.15 We do hold learning events, but these are focussed on the delivery of our strategic priorities or learning lessons from SARs, we have a very small budget from which to do this.	Thank you for your comment. The committee have amended a number of the recommendations that referenced Safeguarding Adults Boards (SABs) to make it clearer that boards have a strategic oversight role and as such are often not taking forward actions themselves but are seeking assurances that local authorities, other commissioners and representative organisations on the board are. The committee agreed to remove as a result and incorporated aspects of this into a recommendation relating to training. This recommends that SABs (and their subgroups and partners) should encourage care home providers to arrange opportunities for staff and residents to learn together from recent SARs.
Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board	Guideline	21	18	1.3.17 It is believed that Care homes have their own networks, or could have their own networks, in which to learn lessons together. They could include our SAB in any distribution. We don't have	Thank you for your comment. The committee recognise that this may be challenging for SABs. The recommendation has been edited to emphasise

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				the administrative support to manage the proposed process.	that the onus for this work is on care home providers and managers.
Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board	Guideline	21	21	1.13.18 The papers for meetings are often many pages long and I believe that these would not be read by Care Home Managers in general. As previously mentioned, we do have a Care Home rep on our Board who is excellent and very participative, but her organisation only represents less than 50% of the total in our area.	Thank you for your comment. The committee drafted recommendations which they believe to be achievable in the current climate. They felt that sharing 'relevant' information (as emphasised in the recommendation) with staff should be possible given that the minutes of SABs are usually made available online.
Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board	Guideline	39	14	1.8.14 The SAB does not have the resource to do this	Thank you for your comment. This recommendation has been edited to clarify that this is the responsibility of local authorities and commissioners rather than SABs.
Sue Ryder	Guideline	1	General	This is an ideal opportunity to include the language of human rights, as the Human Rights Act, 1998 is a foundation law and all other law has to be compatible with it. So when it says: 'This guideline covers keeping adults in care homes safe from abuse and neglect'. It could say: This guideline outlines the human rights of adults in care homes to ensure that their right to life, their right to be free from inhuman and degrading treatment, their right to liberty and their right for private and family life home and correspondence are respected and protected (Articles 2, 3, 5 and 8, Human Rights Act, 1998).	Thank you for your comment. A reference to Article 8 of the Human Rights Act has been added to the context section of the guideline as well as a paragraph from the Care Act statutory guidance which emphasises the importance of these issues: - “Effective safeguarding is about seeking to promote an adult’s rights to security, liberty and family life, as well as about protecting their physical safety and taking action to prevent the occurrence or reoccurrence of abuse or neglect. Any restriction on the individual’s rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary.”
Sue Ryder	Guideline	4	18	We welcome reference to the Care Act, as the primary driver. However, we would want to see more consideration of the Deprivation of Liberty Safeguarding as part of the Mental Capacity Act. Both of these Acts have to be compatible with the UK Human Rights Act	Thank you for your comment. There are a large number of references throughout the guideline about mental capacity and the Mental Capacity Act. The introduction/context section includes the following statement:"… When a care home resident lacks capacity, this guideline should be used in line with the NICE guideline on decision making and mental capacity …" and includes a link to that guideline. NICE guidance does not repeat recommendations in different guidelines but the NICE website allows for users to follow pathways between sets of recommendations that are helpful for them.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					A reference to Article 8 of the Human Rights Act has been added to the context section of the guideline as well as a paragraph from the Care Act statutory guidance which emphasises the importance of these issues: “Effective safeguarding is about seeking to promote an adult’s rights to security, liberty and family life, as well as about protecting their physical safety and taking action to prevent the occurrence or reoccurrence of abuse or neglect. Any restriction on the individual’s rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary.”
Sue Ryder	Guideline	10	1	We would like to see detail of how care homes will protect staff, residents’ families and carers when they raise a concern through the whistleblowing process.	Thank you for your comment. Whilst the committee agree that support for whistleblowers is important, the aim of this recommendation is to make it clear that organisations should not treat whistleblowers unfairly (or terminate their employment) as a result of their disclosures, and that doing so is illegal. After further discussion, the committee agreed that the recommendations in sections 1.8, 1.9 and 1.10 cover the issue of support and the reference to support has been deleted from this recommendation.
Sue Ryder	Guideline	11	2	We would like to see detail of how often the quality checks of care homes need to be completed, i.e. annually.	Thank you for your comment. This recommendation has been edited to remove reference to quality checks.
Sue Ryder	Guideline	13	3	We are concerned that 6 weeks is a long time after induction to complete safeguarding training and would recommend this be reduced.	Thank you for your comment. The committee discussed at length the timescale within which mandatory training should be completed by new staff (see evidence review H for details). The committee felt that specifying 'no later than 6 weeks' was most appropriate.
Sue Ryder	Guideline	13	6	We believe it should be compulsory that Adult Safeguarding Boards organise mandatory training for staff on a multi-agency basis.	Thank you for your comment. Whilst the committee recognises the importance of safeguarding training that is organised on a multi-agency basis they did not feel it was appropriate to make a 'strong' recommendation because of the quality of the evidence on which the recommendation was based.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					See http://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/using-NICE-guidelines-to-make-decisions
Sue Ryder	Guideline	14	General	We recommend referring to intercollegiate guidance on safeguarding training in care homes, as these don't need revising. See, for example, the RCN publications on Adult Safeguarding: Roles and Competencies for Health Care Staff: https://www.rcn.org.uk/professional-development/publications/pub-007069	Thank you for your comment. These sections set out the essential components of mandatory and further training. The committee discussed the intercollegiate guidance when drafting these recommendations (see evidence review H) and agreed that it was not therefore necessary to make more detailed recommendations on the content of further training.
Sue Ryder	Guideline	16	9	We welcome the link that care home staff are 'safeguarding' human rights. Since the Coronavirus Bill, 2020 states on the front page: "European Convention On Human Rights Secretary Matt Hancock has made the following statement under section 19(1)(a) of the Human Rights Act 1998: In my view the provisions of the Coronavirus Bill are compatible with the Convention rights", we have been inundated with requests to provide training on human rights, as this is the first time there has been an explicit link.	Thank you for your comment and support for the recommendation. Further details have been added to the context section and edits made throughout the guideline to reinforce this message.
Sue Ryder	Guideline	18	6	We are concerned that this is too vague. In Sue Ryder we stipulate that all Safeguarding Leads should hold a minimum Level 3 Training Certificate and have completed Prevent training. Prevent is not mentioned here and whilst it might be less obvious that an elderly/in care person might be radicalised, it may still happen.	Thank you for your comment. The purpose of this recommendation is to emphasise that care home managers and safeguarding leads should lead by example and be proactive in their learning. The committee did not intend for the recommendation to list appropriate qualifications for these roles.
Sue Ryder	Guideline	19	13	We welcome the suggestion for appointing safeguarding champions. In relation to whistleblowing in acute NHS trusts, there are now 'speak-up champions', so that anyone can share their concerns. We suggest considering introducing this in care homes.	Thank you for your comment and support for this recommendation. Given the remit of the guidance, the committee feel that 'safeguarding champion' is the most appropriate term to use.
Sue Ryder	Guideline	28	28	We suggest relating freedom of movement to the Human Rights Act and Article 5: The Right to Liberty.	Thank you for your comment. This is covered by the physical abuse indicators. We have also added references to Articles 3, 5,

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					and 8 of the Human Rights Act to the context section of the guideline as well as a paragraph from the Care Act statutory guidance which emphasises the importance of these issues: “Effective safeguarding is about seeking to promote an adult’s rights to security, liberty and family life, as well as about protecting their physical safety and taking action to prevent the occurrence or reoccurrence of abuse or neglect. Any restriction on the individual’s rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary.”
Sue Ryder	Guideline	43	General	We would like to see detail of timescales for when safeguarding investigations need to be completed by.	Thank you for your comment. Recommendations regarding the process of conducting an enquiry are not within the scope of this guideline. Practitioners should refer to relevant ADASS/LGA and other related guidance with regards to these details. This guideline only covers recommendations around the information and support needs of care homes, care home staff, residents at risk and alleged perpetrators while enquiries are taking place as well as some principles around meetings and information sharing while enquiries are taking place – not detailed guidance about how enquiries should be conducted.
Sue Ryder	Guideline	47	27	We have heard from professionals who have visited care homes who do not let residents leave their rooms and are essentially isolating them. Regarding your request of issues relating to COVID-19 that should be taken into account when finalising the guideline for publication, we propose the inclusion of visiting in care home for quality of care and service provision, and the tightening of guidance to protect against this form of restrictive practice. Alternatives to face to face visiting such as virtual visits should also be considered.	Thank you for your comment. The committee recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes. The committee have discussed their recommendations in light of this and have attempted to mitigate against the impact of Covid-19 wherever possible (and have added restrictions on visits - without justification as a possible indicator of organisational abuse), although learning from the pandemic may inform any future updates of the recommendations. NICE have published products related to their response to COVID-19 here which are being updated regularly. We will flag any relevant areas to the COVID-19 guideline team

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Teeswide Safeguarding Adults Board	Guideline	General	General	The Board has a general view that it needs to be clear about what a SABs statutory and strategic responsibilities are and not to cloud these with additional operational issues, there are other mechanisms in place to support this, namely commissioning processes.	Thank you for your comment. The committee have amended a number of the recommendations for SABs to make it clearer that these boards have a strategic oversight role and as such are often not taking forward actions themselves but are seeking assurances that local authorities, other commissioners and representative organisations on the board are. For example, the guideline now recommends that SABs seek assurances that clear lines of communication are in place between commissioners, the Regulator and safeguarding leads; that they include issues relating to care homes as part of their strategic planning and in their annual report and that they share learning from SARs with care homes. The committee recognise that SABs are differently organised, funded and resourced in different regions and therefore agreed recommendations that reflected that flexibility whilst still being clear about those specific actions that are always the responsibility of a SAB.
Teeswide Safeguarding Adults Board	Guideline	8	General	1.1.1 -1.1.17 These are nearly all currently requirements as part of the CQC inspection framework so it would be expected that care homes already understand these requirements and have them in place. The Board has developed inter-agency procedures with their partners which includes those who commission services. However, it would not be practical for care home providers to input into the development of or to sign up to the Board procedures, which goes against the care act guidance on how SABs should develop procedures regarding those they impact upon. In addition, although these guidelines are specific for care home providers, in terms of equity, Boards would have to apply the same principles to other providers of care services and this is also not an option.	Thank you for your comment. The committee acknowledge that some of these issues are covered in other guidance, however they agreed to include them here because there is variation in practice across the sector (an issue that this guideline was designed to address). The committee agree that there may be practical barriers in involving providers to this extent however, and have therefore edited this recommendation to clarify that whilst care homes and providers must have an overarching safeguarding policy and procedure in place to meet the requirements of the Care Act; local arrangements should be considered when implementing this

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Teeswide Safeguarding Adults Board	Guideline	12	10	1.1.20 “SABs should ensure that partner organisations are working together to support residents during safeguarding enquiries.” This is an operational issue and not for SABs. The assurance to board on the effectiveness of safeguarding enquiries would be provided through audit and QA processes.	Thank you for your comments. This recommendation has been edited to clarify that SABs should seek assurances from their partners that this responsibility is being met rather than the level of involvement that may have been suggested by the original text.
Teeswide Safeguarding Adults Board	Guideline	12	12	1.1.21 “SABs should invite care homes to contribute to the Board’s annual report, highlighting achievements, opportunities and challenges in relation to safeguarding.” The requirements for a SAB annual report are clearly laid out in the Care Act guidance and this does not include asking non-Board partners for contributions. This risks turning the annual report, which can be a lengthy document, into something that would be incredibly long and unappealing to read. The purpose of the Annual Report is to set out what the Board’s priorities are and how they have been achieved.	Thank you for your comment. This section has been edited to clarify that SABs should include matters relevant to safeguarding in care homes in their annual report rather than the wider consultation with care homes suggested by the original text.
Teeswide Safeguarding Adults Board	Guideline	12	15	1.1.22 “SABs should establish escalation procedures to resolve any safeguarding disputes with care homes.” It is good practice for Boards to have escalation procedures, but these are generic and not specific to care home providers, it is the responsibility of the LA leading any enquiry to ensure that any professional challenge is dealt with in accordance to policy and procedure.	Thank you for your comment. This recommendation has been edited to clarify that SABs should ensure that escalation procedures are relevant to care homes rather than establish new processes as suggested by the original text.
Teeswide Safeguarding Adults Board	Guideline	12	1.1.19	1.1.19 “SABs and sub-groups to the Board should engage with care homes (including care home providers, staff, residents and their families and carers), to ensure that the Board’s recommendations for them are useful and appropriate.” TSAB do not have representation from care providers at Board	Thank you for your comment. This recommendation has been edited to emphasise the key role that SABs should play in disseminating recommendations and learning from relevant SARs; rather than the wider engagement suggested by the original text.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				or sub-groups, they are represented through commissioners at sub-groups when there are specific and applicable pieces of work being undertaken. It would not be appropriate to have reps at Board or subgroups as they cannot truly represent each providers views.	
Teeswide Safeguarding Adults Board	Guideline	12	General	1.1.18 SABs should ensure that they know who the safeguarding leads are in care homes and care home providers, and how to contact them. They should ensure that safeguarding leads are clear about how to contact the Board." This is not practical, there are insufficient resources within the Board's Business Unit to collate and maintain such records. The emphasis should be on care providers knowing how to access safeguarding teams in the event of a concern and also knowing how to access relevant Board materials that are applicable to their service. Much of this will be achieved through commissioning processes and contract requirements.	Thank you for your comment. This recommendation has been edited to clarify that SABs should seek assurances that clear lines of communication are in place between commissioners, the Regulator and safeguarding leads; rather than the detailed knowledge suggested by the original text.
Teeswide Safeguarding Adults Board	Guideline	13	1	1.2.3 "no later than 6 weeks after they start" and "refresh the knowledge annually" Is attend the right wording? This could be achieved through a workbook, online training or face to face course dependent on how the provider choses to deliver their training. Agree that safeguarding training should be included in induction training within the first 6 weeks. In terms of refreshing their knowledge annually, this may not be achievable, no other workers in health or social care have such a high requirement. The others are only required to refresh their training every three years.	Thank you for your comment. This has been edited to read 'complete' rather than 'attend', and the next recommendation now suggests that knowledge should be assessed, rather than training provided, on an annual basis.
Teeswide Safeguarding Adults Board	Guideline	13	6	1.2.4 "SABs should: • consider organising mandatory safeguarding training for staff on a multi-agency basis, working	Thank you for your comment. These recommendations have been edited to clarify that SABs should

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				together with related service providers and other health and social care organisations • tailor this training to reflect the safeguarding responsibilities of each member of staff (so staff with more responsibilities receive more comprehensive training).” TSAB do provide some multi-agency training and in particular for managers of services which would include Care home managers. However, this is not a statutory requirement and does have massive finance and people resource implications. As long as the wording says consider, we agree with this. In terms of tailoring the training to reflect individual job roles and responsibilities, Boards should have a Training Strategy which outlines the requirements for each level and closely aligning these with the Inter-collegiate document relating to health staff as there are crossovers within the service area.	seek assurance from their partners regarding training (rather than provide or commission this themselves) to ensure that it has been developed on a multi-agency basis and reflects the level of responsibility for each role/level.
Teeswide Safeguarding Adults Board	Guideline	14	2	1.2.7What training should cover Agree with this and applicable to all staff groups.	Thank you for your comment and support.
Teeswide Safeguarding Adults Board	Guideline	15	6	1.2.9 “Mandatory safeguarding training should include an explanation of safeguarding terminology, including translations if needed, for staff who speak English as a second language.” Translating safeguarding training places a large expectation on organisations and the Safeguarding Board. Not only is it time-consuming, it is incredibly costly to pay for the expertise to complete this task. As a general principle, if workers are expected to deliver care and support to some of the most vulnerable adults in our society, they would be expected to have a sufficient standard of English to	Thank you for your comment. This recommendation has been edited to clarify that translations of key concepts or specific phrases should be provided if necessary rather than translations of all resources related to safeguarding. The committee acknowledge that there may still be resource implications associated with this but they believe this to be achievable within the current climate.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				interact with the adult, read and understand the care plan and understand their medication regime. Therefore, it would be expected that their standard of English is sufficient for the work around safeguarding. If the worker has an insufficient understanding of English then how would they handle a disclosure? How would they understand what they overheard? How would giving them translated information assist them in dealing with those two scenarios?	
Teeswide Safeguarding Adults Board	Guideline	20	20	1.3.13 “Care homes should work with the local authority, Clinical Commissioning Groups and other local agencies to establish a local strategic partnership agreement about safeguarding adults in care homes that…” This is duplication, commissioning arrangements will set out the safeguarding requirements for Care Home Providers, there does not need to be a further local partnership agreement, who would manage and co-ordinate this and what is the added value?	Thank you for your comment. This recommendation has been edited to clarify that it relates to the importance of all local agencies working together to establish local arrangements, rather than the suggestion that a separate partnership or arrangement needs to be established.
Teeswide Safeguarding Adults Board	Guideline	21	12	1.3.15 “SABs should arrange opportunities for staff and residents to learn together from recent experiences of safeguarding.” This is outside of the remit of SABs. There may be opportunities for sharing experiences through any training sessions arranged by SABs but this would not extend to residents. Massive resource implications in terms of skill set and finance.	Thank you for your comment. The committee have amended a number of the recommendations that referenced Safeguarding Adults Boards (SABs) to make it clearer that boards have a strategic oversight role and as such are often not taking forward actions themselves but are seeking assurances that local authorities, other commissioners and representative organisations on the board are. The committee agreed to remove as a result and incorporated aspects of this into a recommendation relating to training. This recommends that SABs (and their subgroups and partners) should encourage care home providers to arrange opportunities for staff and residents to learn together from recent SARs.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

Teeswide Safeguarding Adults Board	Guideline	21	18	1.3.17 “Care home managers and providers should share their experiences of managing safeguarding concerns with SABs, so that other care homes and providers can learn from this.” SABs could include this in their annual consultation process. TSAB have a survey which is shared with partners and wider organisations through commissioners and are able to and do do this. TSAB also provide training on ‘managing s42 enquiries’ and provides opportunity for delegates to share their knowledge and experiences.	Thank you for your comment and suggestion. The committee did not feel that it was appropriate to be prescriptive with regards to the methods by which this is done. We will pass this example to the NICE implementation team.
Teeswide Safeguarding Adults Board	Guideline	21	21	1.3.18 “Care home managers and providers should share relevant information from Safeguarding Adults Board meeting minutes and reports with their staff.” We agree with this and support this guideline, although SABs would need to ensure they have appropriate mechanisms in place. TSAB publish Board minutes on their website and also publish a quarterly newsletter with relevant, important information which can be accessed by anyone.	Thank you for your comment and support. The intention of this recommendation is to highlight the proactive role which care home managers and providers should play in sharing this information. In many cases publishing these minutes may be sufficient however the committee agree that this may occasionally require new processes to be established. The role which SABs play in sharing learning is also covered in section 1.1.
Teeswide Safeguarding Adults Board	Guideline	37	19	1.8.6 “SABs and Local Authorities should have auditing processes in place to monitor how residents and their advocates are included in safeguarding enquiries.” TSAB support this and SABs should have mechanisms in place to receive this assurance.	Thank you for your comment and support. This recommendation has been edited to clarify that SABs should ensure that LAs have these processes in place; rather than both LAs and SABs having their own processes.
Teeswide Safeguarding Adults Board	Guideline	39	19	1.8.14 “SABs should monitor: • whether care homes are telling residents about advocacy and the criteria for accessing this and • how advocates are involved in the management of safeguarding concerns.” This should be the responsibility of the commissioning agency not the SAB.	Thank you for your comment. This recommendation has been edited to clarify that this is the responsibility of local authorities and commissioners rather than SABs.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

The Challenging Behaviour Foundation	Guideline	General	General	About the Challenging Behaviour Foundation The Challenging Behaviour Foundation is the only charity in the UK that focusses on children, young people and adults with severe learning disabilities whose behaviour challenges and their families. The charity exists to demonstrate that individuals with severe learning disabilities who are described as having challenging behaviour can enjoy ordinary life opportunities when their behaviour is properly understood and appropriately supported. Challenging behaviour itself is often communication of an unmet need, so understanding the function of behaviour can help to improve the way a person's needs or wishes are understood.	Thank you for your comment and the information you have provided.
The Challenging Behaviour Foundation	Guideline	General	General	Adults with severe learning disabilities are more vulnerable to abuse Individuals with severe learning disabilities are often non-verbal or have little verbal communication and can display behaviour described as challenging. This can make them more vulnerable to abuse, and when abuse does take place it is more likely to go undetected. This needs to be emphasised in the guidance. Individuals with a severe learning disability are at an increased vulnerability to abuse, including sexual abuse, and of this abuse going undetected by authorities because: They have limited communication skills and can be non-verbal; They are likely to require support with personal care Signs of distress are likely to be communicated via challenging behaviours and are seen to be 'the	Thank you for your comment. The committee agree that the safeguarding system has not always provided adequate protection to people with a learning disability. Whilst no evidence was identified (meeting pre-specified inclusion criteria) which included research with people with learning disabilities (focusing on safeguarding), the committee recognise that people with learning disabilities may find it difficult, or even impossible, to verbally disclose that they have been harmed. As a result, the committee included a number of non-verbal 'signs' in their lists of possible indicators of abuse or neglect. The introduction to these lists emphasises that the "… possibility of abuse or neglect should always be considered as a cause of behavioural and emotional indicators, even if they are seemingly explained by something else. This is particularly important for residents who do not communicate using speech." The committee also included provision of communication support in a number of recommendations as they recognise that this is essential to effective safeguarding practice, particularly in relation to

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				person's problem' rather than signs of distress Professionals, health practitioners, CQC inspectors and social workers supporting these individuals may not have the skills or the training to communicate with them We support the mention in the guidance that staff need to be aware that individuals with learning disabilities may display behaviour that could be indicating abuse or neglect has taken place, but might be mistakenly attributed to their disability. However, this needs to be further emphasised. Challenging behaviour displayed by an individual may be communicating distress but used as a reason not to go out, not to have visitors etc. The guidance should indicate a clear responsibility for all care home staff and any other relevant parties to understand the communication styles of each individual they work with and to collaborate with families who know their loved one's behaviours best. Regular communication with family carers is very important. For families, there is currently a lack of clarity about the safeguarding system - how it works and how to navigate through it without any support/ advocacy (something that was raised and included through Ask Listen Do). Care providers should have a responsibility to address this.	people who may be at greater risk of abuse or neglect. Supporting people with learning disabilities to communicate with family or friends is covered in NICE guideline 93 Learning disabilities and behaviour that challenges: service design and delivery (sections 1.2 and 1.3).
The Challenging Behaviour Foundation	Guideline	General	General	Care home environments can increase the risk of abuse taking place and going undetected. Being able to protect this particularly vulnerable group of individuals with a learning disability from harm begins with acknowledging the increased risk and implementation of additional protection, ensuring effective communication, and identifying signs of abuse and following them up. Detection of abuse	Thank you for your comment. Whilst no evidence was identified (meeting pre-specified inclusion criteria) which specifically focused on people with learning disabilities (in relation to safeguarding practice), the committee recognise that people with communication difficulties (including people with a learning disability) may find it difficult, or even impossible, to verbally disclose that they have been

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				hinges entirely on ensuring that staff, social workers, CQC inspectors, GPs, psychiatrists and any other relevant parties know how to communicate effectively with individuals with learning disabilities, particularly those who are non-verbal and to spot signs of abuse, and to respond to concerns raised by family and friends and people who know the person well.	harmed. As a result, the committee included a number of non-verbal 'signs' in their list of possible indicators of abuse or neglect. The committee also included details regarding the importance of communication support where they thought this was particularly important.
The Challenging Behaviour Foundation	Guideline	General	General	Distance from home Adults with learning disabilities can often be in care homes a long way from home and their friends and family. This can make it much harder for families to keep in touch with their relative, making it more likely that abuse will go undetected for longer. In addition, adults with severe learning disabilities may not be able to use communication methods such as phone or zoom. Families often know their relative best and are therefore best placed to notice changes in their behaviour or communication that could indicate abuse has been taking place. Families should be supported to keep in touch with their relative using appropriate means. Although aimed at children and young people, our good practice checklist for local providers (Keeping In Touch With Home, 2016 http://pavingtheway.works/project/wp-content/uploads/2016/07/Keeping-in-touch-with-home-web-version.pdf) provides suggestions for how providers can support families to keep in contact. Distance from home may also result in fewer visits from other professionals such as social workers. The NICE guidance needs to reflect these increased risks for adults with severe learning disabilities whose behaviour challenges in order to make all care home staff aware.	Thank you for your comment. Although support for care home residents to maintain contact with their families and friends is not within the scope of the guideline, the committee agree that their relationship with a care home resident may enable them to more readily identify abuse or neglect; the committee also included details in a number of recommendations regarding the importance of communication support. Further recommendations relating to health and social care for people with learning disabilities can be found on the NICE website. The committee recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes. The committee have discussed their recommendations in light of this and have attempted to mitigate against the impact of Covid-19 wherever possible, although learning from the pandemic may inform any future updates of the recommendations. NICE have published products related to their response to COVID-19 here which are being updated regularly. We will flag any relevant areas to the COVID-19 guideline team.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				Supporting individuals to keep in touch with their relatives is especially important as long as additional restrictions are in place due to Covid 19.	
The Challenging Behaviour Foundation	Guideline	General	General	Medication Adults with learning disabilities are at risk of being inappropriately over-medicated. According to Public Health England "every day about 30,000 to 35,000 adults with a learning disability are taking psychotropic medicines, when they do not have the health conditions the medicines are for." https://www.england.nhs.uk/learning-disabilities/improving-health/stomp/ When looking for signs of misuse of medication that could signify abuse or neglect, care home staff and all professionals need to be aware of the increased risk of inappropriate medication for people with learning disabilities, and the resulting impact on individuals physical health. https://medication.challengingbehaviour.org.uk/	Thank you for your comment. The committee agree that inappropriate administration of medication is a serious concern. This is covered in sections relating to potential indicators of physical abuse, and organisational abuse. Safe administration of medicines is covered more broadly in NICE guidance on medicines optimisation.
The Challenging Behaviour Foundation	Guideline	General	General	Attitude of care staff Individuals with learning disabilities can also be particularly vulnerable to sexual abuse because of the dehumanising attitudes of professionals, staff and the justice system. This needs to be reflected in the guidance. A barrister at the Atlas trials (a review of systematic abuse and neglect, including that of a sexual nature, which took place in a range of sites run by Atlas Care Homes Ltd) described individuals with learning disabilities as having 'canine episodes', and the Brent Safeguarding Adults Review (case of a woman who lived in an Independent Provider service for people with learning disabilities and autism and was found to be HIV positive in March 2016) opens with clear indica-	Thank you for your comment. The committee agree that dehumanising attitudes towards care home residents are unacceptable. Whilst no evidence was identified (meeting our inclusion criteria) which specifically included research with people with learning disabilities, the committee took into account the diverse needs of care home residents (including people with a learning disability) when drafting each of their recommendations, for example, including references to communication support and highlighting the importance of non-verbal indicators of abuse and neglect. They agreed that this was particularly important in relation to sexual abuse and included a number of examples relating to changes in behaviour in this list.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				tions that nobody took the time to learn what Cassie was really like as an individual: 'It is remarkable that in Cassie's many years of residing in long stay hospitals and latterly, at the Independent provider, reveal so little about her […] knowledge of Cassie is primarily based on clinical interpretation and classification and these do not help in deciphering the ways in which she engages with others or with objects'. https://www.brent.gov.uk/media/16411756/adult-b-final-report-nov-2018.pdf This kind of dehumanising attitude of care home staff will no doubt play a role in the perpetration of abuse.	
The Include Project	Guideline	014	21	We are concerned that this recommendation doesn't highlight the need to include talking to residents with cognitive communication difficulties, who are regularly excluded from safeguarding procedures and actions.	Thank you for your comment. The committee agree that consideration of communication difficulties is essential to safeguarding practice. However, they did not feel that it was necessary to specifically refer to this here as this should be covered under the 6 core principles of safeguarding (referenced at the start of this section).
The Include Project	Guideline	15	20	We are concerned that Further Training doesn't include reference to inclusive communication training to facilitate residents' involvement in the safeguarding process.	Thank you for your comment. The committee agree that consideration of communication difficulties is essential to safeguarding practice. This is encompassed under the final bullet point of the training recommendation relating to "… the skills needed to support a resident through a safeguarding enquiry …" as well as the 6 core principles of safeguarding (referenced in section 1.2).
The Include Project	Guideline	24	General	There is evidence that failing to provide appropriate communication support (e.g. access to hi or lo tech AAC is also a form of neglect - it would be wonderful to see this finally highlighted in guidance and could make a significant difference to how care staff view the facilitation of communication.	Thank you for your comment. The committee agreed and included more examples in the indicators about appropriate access to communication aids and support.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

The Include Project	Guideline	28	General	There is evidence that failing to provide people with access to appropriate communication support – effectively silencing them is also a form of psychological abuse – as above.	Thank you for your comment. Access to communication support has been added to the list of potential indicators of neglect.
The Include Project	Guideline	30	General	Communication difficulty is a protected characteristic under the Equality Act. While we appreciate there is not room in this document to list all protected characteristic, this is one which is often forgotten and it would be very helpful to see it highlighted, Especially in view of the fact that there is evidence to show that people with communication needs are at high risk of abuse.	Thank you for your comment. The committee agree that consideration of communication needs is essential and have included reference to this wherever possible, for example, in recommendations 1.4.9 (when to suspect neglect) and 1.7.2 (providing support for communication when responding to safeguarding concerns). Unfortunately, the absence of safeguarding specific evidence made it difficult for the committee to make recommendations relating to particular groups of people (such as those with communication needs), however they were mindful of the 6 core principles of safeguarding and the Making Safeguarding Personal framework when drafting recommendations, and took care to ensure that the recommendations are not discriminatory. In addition, an Equality Impact Assessment of the guideline and recommendations has been carried out to ensure that people with more specific needs are not disadvantaged.
The Include Project	Guideline	32	21	We are concerned that there is no reference of inclusive communication support at this point (e.g. signing / pictorial info / Talking Mats) which may be needed to help the individual reflect and express themselves.	Thank you for your comment. The committee have added details to the recommendation regarding disclosures from people who do not use verbal communication.
The Royal College of Occupational Therapists	Guideline	General	General	The Royal College of Occupational Therapists agrees with all aspects of this draft guideline as it highlights the vital importance of keeping adults in care homes safe from abuse and neglect. The potential indicators of abuse and neglect (by individuals and by organisations) are invaluable, along with the detailing of safeguarding processes from' identifying a concern through to conducting a safeguarding enquiry'. The recommendations on policy, training and care home culture, to help care homes improve staff awareness of safeguarding	Thank you for your comment and support.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				and ensure they are willing and able to report concerns when required is much needed.	
University of East Anglia (School of Health Sciences)	Guideline	General	General	Access to and involvement of advocates in adult safeguarding within care homes may well prove challenging to implement as advocates could require some 'training' about the care home sector, if not already regularly involved in the sector (likely in a number of areas) and may also be in short supply/not widely available.	Thank you for your comment and providing this feedback. Your comments will be considered by NICE where relevant support activity is being planned.
University of East Anglia (School of Health Sciences)	Guideline	General	General	Designation of a member of staff as safeguarding lead is very desirable but may prove difficult, particularly in smaller care home settings. Needs to be clear information about the exact nature and scope of the role, including who to contact in the absence of the lead person (for example, is there a clearly designated deputy who would be available on site when the lead is not working/on-site?).	Thank you for your comment. A definition of safeguarding lead and explanation regarding the role has been added to the 'terms used' section of the guideline. The committee believe that the recommendations in sections 1.4 to 1.6 provide a clear escalation route for raising concerns. The committee agreed that it would be appropriate for individual care homes or providers to make a decision regarding the individual who takes on this role; however the recommendation specifies that care homes should ensure that it is clear who this person is and that staff (or residents and visitors) are clear about how to contact them and who to contact in their absence.
University of East Anglia (School of Health Sciences)	Guideline	General	General	Clarity of procedures/protocol is needed – who in the care home is responsible for contacting the local authority for advice/guidance/making an alert/referral?. Is this the safeguarding lead? Is the care home manager involved in making an alert, or only in the absence of the lead person? Is this, rather the role of the individual staff member who has discovered/witnessed the situation? This all needs to be clear at the level of the care home (or group of care homes if owned by a corporation) and staff will need training and regular updates on this. Contact with the LA for advice and guidance will also need to be negotiated in terms of who/which section the care home make contact with in order to receive appropriate response(s)	Thank you for your comment. Section 1.7 of the guideline makes it clear that in most instances the safeguarding lead would make a referral to the local authority, following information shared with them about alleged abuse or neglect. However, it may be appropriate for another person to do this without involving the safeguarding lead or care home manager, especially if either are implicated in the alleged abuse or neglect.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				and to establish relevant and consistent working relationships.	
University of East Anglia (School of Health Sciences)	Guideline	General	General	Responses of care homes to the pandemic have varied but have included lockdown and isolation of homes, denial of visits by family members and others not deemed essential to the running of the home etc. Virtual/digital visits by social workers and CQC have proved difficult in some instances and protocols need to be developed, particularly as we move to a situation of 'Living with Coronavirus' rather than life post/after Covid-19, which is a long way off from here. This is very important in relation to situations relating to adult safeguarding and concerns about abuse/neglect within care homes – especially given historical evidence of what can occur in closed institutions and the more recent very disturbing reports of high levels of abuse and neglect in C-19 infected care establishments in a number of countries across the world (including Spain, Italy, US and Canada – so clearly affects developed as well as developing countries very significantly and adversely). It is possible that safeguarding situations in care homes across the UK that occurred during or will likely result from the pandemic, particularly in relation to the longer-term consequences, will not be known for a very long-term and that processes relating to safeguarding adults in care homes may need to be re-thought and revised as a result. This will be challenging in relation to guideline development and implementation as there might need to be a revision of the guideline quite soon if the pre-pandemic guideline is issued too soon (or without inclusion of pandemic-related safeguarding guidance).	Thank you for your comment. The committee recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes. The committee have discussed their recommendations in light of this and have attempted to mitigate against the impact of Covid-19 wherever possible, although learning from the pandemic may inform any future updates of the recommendations. NICE have published products related to their response to COVID-19 here which are being updated regularly. We will flag any relevant areas to the COVID-19 guideline team.
University of East Anglia (School of Health Sciences)	Guideline	5	4	We are concerned that this example may imply that only day visitors stay for short periods. Suggest this would be better framed as: for example, short stay/respite residents and day visitors.	Thank you for your comment. The committee agreed to leave this text as it is as they believe that readers will understand what is meant by short breaks and respite care. The example of 'day visi-

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					tors' was included because it is sometimes forgotten that short breaks and respite care also includes very short stays such as these.
University of East Anglia (School of Health Sciences)	Guideline	7	23	It was somewhat surprising that there is no mention in the Guideline (perhaps in sections on mental capacity as well as in this statement) relating to the vulnerable adult/inherent jurisdiction distinction and circumstances, which is likely to affect a number of safeguarding concerns, investigations and potential outcomes	Thank you for your comment. There are a large number of references throughout the guideline about mental capacity and the Mental Capacity Act. The context section of the guideline includes the following statement: "When a care home resident lacks capacity, this guideline should be used in line with the NICE guideline on decision making and mental capacity …" and includes a link to that guideline. NICE guidance does not repeat recommendations in different guidelines but the NICE website allows for users to follow pathways between sets of recommendations that are helpful for them.
University of East Anglia (School of Health Sciences)	Guideline	10	4	We are concerned that there is no mention of training for staff (including managers) on adult safeguarding in this section on roles and responsibilities as care homes should provide/arrange for relevant training, including refresher/update sessions for staff – this could be by signposting to relevant later section but we consider that this should be acknowledged here as a responsibility.	Thank you for your comment. Training for care home staff (all levels) is comprehensively covered in section 1.2. The committee did not feel that it was necessary to refer to training in this section.
University of East Anglia (School of Health Sciences)	Guideline	12	1	There is no mention of the Safeguarding Adults Board responsibility to ensure organisations (including care homes) provide relevant training for staff about adult safeguarding (what it is/what to do if concerns are raised).	Thank you for your comment. Safeguarding training is covered in section 1.2.
University of East Anglia (School of Health Sciences)	Guideline	15	3	Suggest minor amendment to say: individual, team and organisational levels (multiple levels involved so plural needed).	Thank you for your comment. Having discussed your comment, the committee agree that 'organisation level' is correct as 'organisational level' is used to indicate a different tier from individual and team, rather than indication of the number of organisations or level to which this would apply.
University of East Anglia (School of Health Sciences)	Guideline	15	6	Suggest addition to state that training materials/written information should also be provided in other languages for staff if/as necessary.	Thank you for your comment. This recommendation has been edited to clarify that translations of key concepts or specific phrases should be pro-

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					vided if necessary rather than translations of all resources related to safeguarding, as some stakeholders expressed concern regarding the potential resource impacts associated with translation of a wider range of learning material.
University of East Anglia (School of Health Sciences)	Guideline	15	11	Suggest add additional point here about training on how to deal with evidence/how to preserve evidence (initially) and not to compromise evidence unwittingly	Thank you for your comment and suggestion. This has now been added to recommendations relating to the content of mandatory training.
University of East Anglia (School of Health Sciences)	Guideline	16	11	We are concerned that this may suggest an 'opt-out' provision for care homes…Not all Safeguarding Adults Reviews are formally published/released into the public domain. Suggest slight amendment to indicate that recommendations/information from Action Plans that are developed be incorporated (instead of using publication as the marker here)	Thank you for your comment. This has been edited to suggest that recommendations and other learning are incorporated into training 'as quickly as possible after they are available' as not all SARs are published (as you have noted) and ideally this learning would be shared by a SAB in advance of publication.
University of East Anglia (School of Health Sciences)	Guideline	20	7	Suggest add a specific inclusion of night staff here (by use of something like: including night care staff).	Thank you for your suggestion. This has been added to the recommendation.
University of East Anglia (School of Health Sciences)	Guideline	25	6	Suggest add 'or mental capacity' after mental health to indicate that capacity can be related to such situations as cognitive impairment from different causes (and not a mental health condition as such).	Thank you for your comment. This detail has been added as suggested.
University of East Anglia (School of Health Sciences)	Guideline	32	1	We are concerned at the possible implication in this statement that the care home does not have a role in contacting/reporting to the Police and think that this should be clarified. If the person does not wish to contact the police and has capacity to make that decision, there may be a need in a serious (but non-emergency) situation for the care home to make a report in any case. The current statement does not suggest that this could be the case.	Thank you for your comment. This recommendation has been amended as follows to provide clarity: " 1.6.3 If a crime is suspected but the situation is not an emergency, encourage and support the resident to report the matter to the police. If they cannot <u>or do not wish to</u> report a suspected crime (for example, because they have been coerced or lack capacity), report the situation to the police yourself."
University of East Anglia (School of Health Sciences)	Guideline	32	18	It is quite possible that there may be more than one abuser/perpetrator (see increasing levels of evidence on poly-victimisation in abusive situations). We are concerned that this statement does	Thank you for your comment. The committee have considered the use of plural terms for both 'resident' and 'alleged abuser'. They recognise that more than one resident and/or perpetrator may be involved but believe that the recommendations are

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				not acknowledge that there could be multiple abusers in the same abusive incident and suggest that the statement is amended slightly to say something like (…and alleged abuser(s)).	sufficiently clear and feel that it is unlikely that readers would infer from them that cases in which multiple individuals are involved are not covered by the guideline.
University of East Anglia (School of Health Sciences)	Guideline	33	2	See previous point – suggest amend to add (s) after abuser, so reads as abuser(s) to acknowledge possible multiple perpetration.	Thank you for your comment. The committee have considered the use of plural terms for both 'resident' and 'alleged abuser'. They recognise that more than one resident and/or perpetrator may be involved but believe that the recommendations are sufficiently clear and feel that it is unlikely that readers would infer from them that cases in which multiple individuals are involved are not covered by the guideline.
University of East Anglia (School of Health Sciences)	Guideline	33	12	Suggest add slight amendment here as a final sentence: Explain to the person why you need to do this (may be to protect other residents) and what is likely to happen following the reporting (in terms of the process that will likely follow).	Thank you for your comment. These recommendations have been edited for clarity and to make sure they are in keeping with NICE style.
University of East Anglia (School of Health Sciences)	Guideline	34	8	See previous point – suggest add similar final sentence here See point in Example 12 – suggest add (s) to abuser so reads alleged abuser(s	Thank you for your comment. These recommendations have been edited for clarity and to make sure they are in keeping with NICE style.
University of East Anglia (School of Health Sciences)	Guideline	34	16	We are concerned about the potential for confusion between this statement and that which appears above on page 33, lines 16-19. In addition, reporting requirements in care home safeguarding procedures may require the safeguarding lead or care home manager/owner (unless implicated) to make such a referral to the local authority.	Thank you for your comment. The committee have made a number of changes to sections 1.4, 1.5 and 1.6 to ensure that it is clearer which recommendations apply to anybody who may have a safeguarding concern and the point at which that is referred to a senior manager within the care home or the safeguarding lead. We have also made it very clear that the safeguarding lead or manager or whoever is making a referral MUST make the referral if they suspect abuse or neglect.
University of East Anglia (School of Health Sciences)	Guideline	35	3	There is an implication in this section that only one resident will be involved but in fact it is possible that several residents could be affected by abusive	Thank you for your comment. The committee have considered the use of plural terms for both 'resident' and 'alleged abuser'. They recognise that more than one resident and/or perpetrator may be involved but believe that the recommendations are

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				situations by the same individual/individuals. Suggest slight amendment to indicate/acknowledge this through addition of (s) to resident in 36, line 1.	sufficiently clear and feel that it is unlikely that readers would infer from them that cases in which multiple individuals are involved are not covered by the guideline.
University of East Anglia (School of Health Sciences)	Guideline	35	21	As per previous point, more than one resident could be subject of abuse/abusive situations from the same individual/individuals – Suggest add (s) to resident in this sentence.	Thank you for your comment. The committee have considered the use of plural terms for both 'resident' and 'alleged abuser'. They recognise that more than one resident and/or perpetrator may be involved but believe that the recommendations are sufficiently clear and feel that it is unlikely that readers would infer from them that cases in which multiple individuals are involved are not covered by the guideline.
University of East Anglia (School of Health Sciences)	Guideline	36	4	As per previous point, more than one resident could be subject of abuse/abusive situations – Suggest add (s) to resident here and make family plural in next point, line 11.	Thank you for your comment. The committee have considered the use of plural terms for both 'resident' and 'alleged abuser'. They recognise that more than one resident and/or perpetrator may be involved but believe that the recommendations are sufficiently clear and feel that it is unlikely that readers would infer from them that cases in which multiple individuals are involved are not covered by the guideline.
University of East Anglia (School of Health Sciences)	Guideline	36	10	As per previous points, more than one resident could be subject of abuse/abusive situations – Suggest add (s) to resident wherever it appears in this section and also when referring to family amend to families (e.g. line 10).	Thank you for your comment. The committee have considered the use of plural terms for both 'resident' and 'alleged abuser'. They recognise that more than one resident and/or perpetrator may be involved but believe that the recommendations are sufficiently clear and feel that it is unlikely that readers would infer from them that cases in which multiple individuals are involved are not covered by the guideline.
University of East Anglia (School of Health Sciences)	Guideline	37	1	1.8 There appears to be an assumption in this section that only one member of staff will be involved but in fact it is possible that several staff members could be involved in abusive situations (see evidence on poly-victimisation). Suggest slight amendment to indicate/acknowledge this through addition of (s) to	Thank you for your comment. The committee have considered the use of plural terms for both 'resident' and 'alleged abuser'. They recognise that more than one resident and/or perpetrator may be involved but believe that the recommendations are sufficiently clear and feel that it is unlikely that readers would infer from them that cases in which

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				members throughout this section and change person to individual(s) where necessary.	multiple individuals are involved are not covered by the guideline.
University of East Anglia (School of Health Sciences)	Guideline	40	13	1.9 As per previous points, more than one resident could be subject of abuse/abusive situations from the same individual/individuals – Suggest add (s) to resident in this section.	Thank you for your comment. The committee have considered the use of plural terms for both 'resident' and 'alleged abuser'. They recognise that more than one resident and/or perpetrator may be involved but believe that the recommendations are sufficiently clear and feel that it is unlikely that readers would infer from them that cases in which multiple individuals are involved are not covered by the guideline.
University of East Anglia (School of Health Sciences)	Guideline	42	13	As per previous point, more than one resident could be subject of abuse/abusive situations from the same individual/individuals – Suggest add (s) to resident here and alter was to were if necessary in line17.	Thank you for your comment. The committee have considered the use of plural terms for both 'resident' and 'alleged abuser'. They recognise that more than one resident and/or perpetrator may be involved but believe that the recommendations are sufficiently clear and feel that it is unlikely that readers would infer from them that cases in which multiple individuals are involved are not covered by the guideline.
University of East Anglia (School of Health Sciences)	Guideline	44	4	This comment applies to the whole section. There appears to be an assumption in this section that only one member of staff will be involved but in fact it is possible that several staff members could be involved in system-level (organisational) abusive situations. Suggest slight addition to page 45, line 4 to indicate/acknowledge this (For example: It is possible that more than one – or several staff members - could be involved in such abuse….). Also amendments throughout this section as necessary to indicate/acknowledge this through addition of (s) to member so reads staff member(s).	Thank you for your comment. The committee have considered the use of plural terms for both 'resident' and 'alleged abuser'. They recognise that more than one resident and/or perpetrator may be involved but believe that the recommendations are sufficiently clear and feel that it is unlikely that readers would infer from them that cases in which multiple individuals are involved are not covered by the guideline.
University of East Anglia (School of Health Sciences)	Guideline	44	6	As per previous point, more than one resident could be subject of abuse/abusive situations from the same individual/individuals – Suggest add (s) to resident here.	Thank you for your comment. The committee have considered the use of plural terms for both 'resident' and 'alleged abuser'. They recognise that more than one resident and/or perpetrator may be involved but believe that the recommendations are sufficiently clear and feel that it is unlikely that readers would infer from them that cases in which

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					multiple individuals are involved are not covered by the guideline.
University of East Anglia (School of Health Sciences)	Guideline	46	10	This comment applies to the whole section. Consider adding Failure to provide mandatory training for staff in relation to safeguarding, abuse and neglect – and including essential aspects of safety for care of residents (such as medication management, safe handling etc). Although this could be said to be part of Care Quality Commission standards (line 10-11) it appears to be an important indicator and worth stating separately.	Thank you for your comment. This is included as one of the indicators.
University of East Anglia (School of Health Sciences)	Guideline	46	21	1.12.3 This comment applies to the whole section. It is possible that the safeguarding lead could be the one person reporting concerns – this should be acknowledged in some form here. Also a concern could be logged as an employment or disciplinary issue not as safeguarding concern and this should be recognised here.	Thank you for your comment. These examples are included in the list of potential indicators of organisational abuse relating to inconsistent patterns of safeguarding concerns (for example, if all concerns originate from 1 member of staff), and reports of safeguarding concerns made through complaints procedures.
University of East Anglia (School of Health Sciences)	Guideline	46	24	This comment applies to the whole section. We are concerned that there is no mention in this section of concern about possible inadequate, incomplete, possible missing documentation or recording by staff (care plans, daily notes etc). Could appear just before (after) statement on care plans – sentences 8-9. This comment applies to the whole section.	Thank you for your comment. This example is covered by the example of poor or outdated records in the list of potential indicators of organisational abuse.
University of East Anglia (School of Health Sciences)	Guideline	48	28	Suggest addition of something like: ' or equipment is insufficient to meet the needs of residents cared for in the home…' There may not be enough equipment/may not meet the specific needs/requirements for a particular health condition(s).	Thank you for your comment. This has been added as suggested.
University of East Anglia (School of Health Sciences)	Guideline	50	12	An increase in reporting of safeguarding concerns relating to neglect may also be of significant concern (and impact on residents as deleterious). Suggest that this be added in either to this sentence, or as a further statement in this section.	Thank you for your comment. This has been added to the recommendation.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

University of East Anglia (School of Health Sciences)	Guideline	50	30	Two criteria have been specified in previous sentence – suspicion of experience of abuse and neglect and unable to protect self. Suggest amend sentence to: these criteria.	Thank you for your comment. This has been corrected.
University of East Anglia (School of Health Sciences)	Guideline	51	17	Provision of training for the (whole) care home staff team as a group is very important in relation to this section. It may be necessary to provide this at the level of the care home. The statement as it stands suggests multi-disciplinary and multi-agency training but training at the level of care home alone (which might be multi-professional/multi-disciplinary) could be required and provided by existing care home staff, as well as having external facilitation. Could this be clarified here?	Thank you for your comment. Training for care home staff as a group (with multi-disciplinary input) is listed as an example of how culture at the care home 'level' can be changed. Please see the second bullet point of this recommendation.
University of East Anglia (School of Health Sciences)	Guideline	54	21	As per previous points earlier in this response, more than one resident could be subject of abuse/abusive situations from the same individual, or even individuals – Suggest add (s) to resident here.	Thank you for your comment. The committee have considered the use of plural terms for both 'resident' and 'alleged abuser'. They recognise that more than one resident and/or perpetrator may be involved but believe that the recommendations are sufficiently clear and feel that it is unlikely that readers would infer from them that cases in which multiple individuals are involved are not covered by the guideline.
University of East Anglia (School of Health Sciences)	Visual summary B	Box 1	Column 1	Suggest add: lack of/intermittent/inconsistent staff training about safeguarding and what to do about it and including essential aspects of safety for care of residents (such as medication management, safe handling etc). Although this is a regulatory standard this is an important issue that should be raised as separate point (could appear as last point in the first box on this Visual Summary).	Thank you for your comment. These are the headings of 'consider' indicator sections within the guideline - and there are many examples under each within the main guideline. We will make this clearer when published.
University of East Anglia (School of Health Sciences)	Visual Summary B	Box 3	Column 1	Suggest add: what person should do if the care home manager is implicated – who should be contacted in such as instance – this is not specified or clear and needs to be clarified.	Thank you for your comment. This scenario is covered within the main guideline. We will consider how best to include it on the visual summaries.
Warrington Borough Council & Warrington Safeguarding Adults Board	Guideline	General	General	In relation to the recommendations for SAB's: There are a number of concerns regarding the impact of the guidance on the resources and the stra-	Thank you for your comment. The recommendations for SABs have been edited to clarify that boards should seek assurances that this work is

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				tegic capability of the SAB. Several of the recommendations are complex and significant in terms of resource and will take the SAB into a more operational arena than it seems the Care Act envisages. Increasing the direct communication with staff, residents and families (by no means simple given the different audiences) is likely to be confusing and suggests a more operational and hands on role than is feasible given the strain on safeguarding partner agencies and the very limited resources to support SABs. Safeguarding Adult Boards should and do take the strategic lead for the area – we have concerns that some of the recommendations overlap with operational work that is within the remit of partner agencies such as the Local Authority's safeguarding duty, the role of commissioners and the role of Healthwatch. The focus of this guidance, which is helpful, is raising awareness within care homes of safeguarding, on how to recognise, report it and minimise the risk of harm. The concern is that the much more visible role of the SAB which is clearly envisaged needs to confirm the SAB as the overall strategic body. Our concerns are that there will be confusion about where people should report concerns and the difference between the Local Authority lead role and that of the SAB, especially for residents and families, but also amongst care staff. Some of the guidance suggestions are unrealistic and impractical, especially considering the size and capacity of SAB resource. For example, keeping a list for all safeguarding leads within care homes is an impractical task, which has previously been attempted by the Local Authority. The turnover of managers in care settings is a national issue and there are many care homes in a local area, not all commissioned by the Local Authority. Through	being carried out by commissioners or local partners, rather than the original level of involvement in operations suggested by some of the original text.

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				contract management, providers could be instructed to identify a safeguarding lead, however keeping the information up to date would be a challenge and how the SAB would ensure that this is correct would be challenging without additional resource. We feel it is unlikely to be sufficiently productive to justify the investment. There are other ways to communicate and in Warrington there is a Safeguarding Adults Forum which WSAB has in place, as well as a Registered Manager network, where discussions around safeguarding in care homes and the SAB regularly take place. The use of this forum enables the messages from the SAB to be disseminated and for providers and agencies to raise concerns about practice and procedures for the SAB to resolve. The suggestions where engagement is required with staff and residents within care homes and their families would require a myriad of strategies to be effective, and as stated above may lead to confusion as to the role of the SAB and the messages being delivered to both staff and individuals on the mechanism for reporting safeguarding concerns. The roles of Healthwatch and the local advocacy hub in this area of work is considered a more practical way forward locally – both of whom are SAB partners.	
Warrington Borough Council & Warrington Safeguarding Adults Board	Guideline	General	General	Identifying, reporting and undertaking enquiries: Overall our perception is that there is some helpful content but the process is over categorised and over simplified and does not allow for the great range of situations and approaches that the Care Act addresses and that are experienced in safeguarding in care homes work. It also does require resources from all parties that currently it is difficult to envisage being available, particularly in the context of Covid 19. Whilst getting safeguarding in	Thank you for your comment. The committee believes that whilst the guideline aligns with the care and support statutory guidance it builds on and supports this information rather than duplicating it. It is designed for a wide audience but specifically with people who work in care homes in mind. In terms of the pressure on resources the committee drafted recommendations which they believe to be achievable in the current climate, and are intended to reflect best practice, and in many cases

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				care homes right will continue to be a high priority and perhaps more so, it is vital that guidance is realistic and proportionate, and that where resources, staff time and investment is required that it results in impact in the areas required. The guidance should add to and enhance the application of guidance in the Care Act. In some cases, it does not seem to do that and through over simplification could undermine some of the intentions of the Care Act. The signs of abuse and the training content is helpful, however the difference between consider and suspect abuse should not be so rigidly applied when it is followed through to guidance on how to act. We would be very concerned if there were reasons to consider abuse such as 'are addressed rudely or inappropriately' and 'are deliberately and systematically isolated' and these were not reported as safeguarding concerns but instead monitored to see if the problem persists, as the guidance states. Sometimes glimpses of emotional abuse can be one off chances to uncover a systematic pattern – for example in Winterbourne view. The guidance in these areas is too prescriptive and would not work for all staff in all situations and settings e.g. "if you work in a care home address the problem yourself", could be an inappropriate recommendation for some of those situations and some staff where whistleblowing may be the right option. The safeguarding lead is likely to be a role attributed to very different posts in different care provision. It may not be practical for them to have involvement with every resident who has been subject to a safeguarding as suggested in the guidance.	highlight existing legal requirements. You may wish to note that many of the recommendations relating to SABs have now been edited to make it clearer that they relate to the strategic and oversight role which SABs play rather than the detailed operational involvement which the original drafts may have suggested, an issue which a number of stakeholders raised with regards to financial implications. Your comments about resourcing will however be considered by NICE where relevant support activity is being planned. The committee recognises the significant impact which Covid-19 has had on the care sector in general and on individual care homes. The committee have discussed their recommendations in light of this and have attempted to mitigate against the impact of Covid-19 wherever possible, although learning from the pandemic may inform any future updates of the recommendations. NICE have published products related to their response to COVID-19 here which are being updated regularly. We will flag any relevant areas to the COVID-19 guideline team. In relation to your comment about the consider and suspect levels of the indicator recommendations, the committee agreed that the intention behind them as well as the guidance accompanying them needed to be clarified. Whilst the guideline recommends that all 'suspect' indicators are referred to the Local Authority to decide whether the three statutory criteria are met and whether a section 42 Enquiry or other investigation is needed and the 'consider' indicators are intended to result in action within the care home to rectify the issue, the recommendations are also intended to encourage care homes to seek advice from the local authority if they are at all unsure whether a referral should be made. The committee also added a number of recommendations to encourage local authorities to

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

				The Local Authority's role in the Care Act is quite clear. The NICE guidance differs in ways that are not always helpful partly because the two are not expressively linked but at times because they appear to describe something which sounds different e.g. how does the enquiry lead link to the Care Act, where there are, for example, options to cause others to undertake the Section 42 . Currently an enquiry may be conducted by a local authority lead, but with input from the person best placed to discuss with the Adult at Risk who may not be the same person versus the process in the NICE guidance is one in which the enquiry lead asks the resident. It would have been helpful perhaps to consider more the interface between what is a quality concern and what constitutes safeguarding, where a Section 42 is not required at all and a provider internal enquiry is appropriate and when it is appropriate, within a Section 42 to cause the Provider to undertake it.	support care homes to develop staff understanding in relation to the differences between poor practice and a safeguarding concern. The recommendations about whistleblowing policy and procedures in care homes have also been revised, including an emphasis on protection against victimisation and negative consequences as a result of disclosures. With regard to your comment regarding safeguarding leads and their potential involvement with every resident about whom a safeguarding concern has been raised, the committee accept that this may be challenging, for example, in larger care homes, however the intention of this recommendation is to emphasise that a specific individual should have oversight of all safeguarding work and take responsibility for ensuring that all appropriate actions are taken, even if they do not personally undertake this work themselves. In addition, this recommendation has been edited to clarify that this relates to the post of safeguarding lead within an individual care home rather than the provider level post suggested by the original text. In relation to your point about the local authority role and the Care Act 2014, the committee carefully reviewed their recommendations and are content that they do not contradict the legislation. The guideline is intended to promote effective safeguarding practice through action-oriented recommendations about policies, leadership styles and care home culture. The guideline then includes two action orientated decision-making pathways covering the steps to take before a s42 referral is made. It covers some aspects of communication and support while enquiries are underway and emphasises the importance of shared learning from enquiries but the s42 enquiry process itself is not within the

Safeguarding adults in care homes
Consultation on draft guideline - Stakeholder comments table
03/09/2020 – 01/10/2020

					scope of this guideline and practitioners should refer to guidance from ADASS/LGA regarding this. The committee also included a number of recommendations encouraging local authorities to support care homes to develop staff understanding in relation to the differences between poor practice and a safeguarding concern. The guideline recommends that local authorities should clearly communicate to care homes their decisions regarding s42 enquires (e.g. whether a s42 will be initiated and why or why not this is the case). In addition, the committee also drafted recommendations that emphasise that care home managers should work to ensure that staff learn from s42 enquiries (as well as other instances of safeguarding work, from relatively minor issues resolved within the care home to serious events that have resulted in a SAR).