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## SAFEGUARDING ADULTS AT RISK POLICY

### Version 5.0

<b>Version</b>	<b>5</b>
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Ratified by	Trust Policy and Strategy Group 03/05/2018 Executive management Committee
Date	
Author	Nuala Waide Associate Director for Safeguarding Adults and Children
Lead Director	Chief Nurse
Name of Responsible Individual or Committee	BHT Safeguarding Committee
Consultation/s	<ul style="list-style-type: none"> <li>• BHT Safeguarding Committee</li> <li>• Chief Nurse</li> <li>• Medical Director</li> <li>• Associate Medical Directors</li> <li>• Divisional Chief Nurses</li> <li>• Head of Patient Safety and Litigation</li> <li>• Matrons and Lead Nurses</li> <li>• Nurse Consultants</li> <li>• Information Governance Manager</li> <li>• SDU Leads</li> <li>• AHP Leads</li> <li>• Freedom to Speak up Guardian</li> <li>• Safeguarding Team</li> <li>• Safeguarding Committee</li> <li>• BSAB Business Manager</li> <li>• Business Manager BCC Safeguarding Adults Team</li> <li>• Head of Safeguarding BCC</li> <li>• Detective Chief Inspector, Protecting Vulnerable People, Thames Valley Police</li> <li>• BCC Joint Mental Capacity Act Coordinator and Deprivation of Liberty Safeguards Lead</li> </ul>
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Equality Impact Assessment	11/04/2018

**To be used and read in conjunction with the Buckinghamshire Safeguarding Adult Board Multi-Agency Policy and Procedures**

**DOCUMENT HISTORY**

**Safeguarding Adults Policy and Procedures**

<b>Version</b>	<b>Issue</b>	<b>Reason for change</b>	<b>Authorising body</b>	<b>Date</b>
1	0	New Policy Author: Catherine Brown, Quality Standards Information Facilitator	Ratified: Governance Committee	12/10/07
2	0	Taken in to account: The new 2008 organisational and governance structure within the Trust, <ul style="list-style-type: none"> <li>• The creation of a county-wide Safeguarding Board, and Trust Safeguarding Steering Group</li> <li>• New reporting and compliance monitoring procedures</li> <li>• A revised Trust Equality Impact Assessment</li> </ul> Author: Ian Waddell, Deputy Operations Manager, Medicine for Older People & Neurology	Re-issued	9/3/10
3	0	Formal Review Author: Celia Thomson, Named Nurse for Safeguarding Adults	Healthcare Governance Committee	8/5/12
4	0	Formal Review Author: Geraldine Cowley, Lead Nurse for Safeguarding Adults, <i>Version 4 has taken into account: The integrated organisational and governance structure within the Trust with the Community Services The creation of a county-wide Safeguarding Board, and Trust Safeguarding Steering Group New reporting and compliance monitoring procedures A revised Trust Equality Impact Assessment</i>	Trust management Committee (TMC)	6/3/15
5	1	Extensive review of policy Author Nuala Waide, Associate Director of Safeguarding Version 5 is a complete revision of the policy to ensure greater clarity and simplicity. Key changes include: <ul style="list-style-type: none"> <li>• Policy reflects recent updates in legislation, including Care Act 2014; Serious Crime Act 2015; Modern Slavery Act 2015 and emphasises Trust duties in respect of these</li> <li>• New information included about</li> </ul>	Executive Management Committee (EMC)	11/05/2018

		<p>“making safeguarding personal”, Think Family, transitions, and adult’s rights to advocacy</p> <p>More information for staff to support them in challenging poor practice and also raising concerns via the Freedom to Speak Up Guardian. considered</p>		
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## Associated Trust Documents

BHT Ref	Title	Location/Link
BHT Pol 117	Mental Capacity Act & Deprivation of Liberty Safeguards Policy	BHT Intranet Register of Trust-wide policies, Sheet 84
BHT Pol 225	Prevent Policy	BHT Intranet Register of Trust-wide policies, Sheet 212
BHT Pol 149	Safeguarding Children Policy	BHT Intranet Register of Trust-wide policies, Sheet 17
BHT Pol 243	Mental Health Act Administration Policy and Procedure	BHT Intranet Register of Trust-wide policies, Sheet
BHT Pol 014	Chaperone Policy	BHT Intranet Register of Trust-wide policies, Sheet 15
BHT Pol 024	Consent to Examination and Treatment Policy	BHT Intranet Register of Trust-wide policies, Sheet 27
BHT Pol 215	Adult Mortality Review Process	BHT Intranet Register of Trust-wide policies, Sheet 202
BHT Pol 007	Being Open & Duty of Candour	BHT Intranet Register of Trust-wide policies, Sheet 8
BHT Pol 031 (HR18)	Dignity & Respect at Work Policy	BHT Intranet Register of Trust-wide policies, Sheet 35
BHT Pol 209	Managing Allegations Against Staff Policy	BHT Intranet Register of Trust-wide policies, Sheet 194
BHT Pol 206	Professional & Personal Boundaries Policy	BHT Intranet Register of Trust-wide policies, Sheet 191
BHT Pol 128	Recruitment and Selection Policy & Procedure	BHT Intranet Register of Trust-wide policies, Sheet 108
BHT Pol 092	Raising Concerns Policy & Procedure	BHT Intranet Register of Trust-wide policies, Sheet 127
BHT Pol 032	Discipline Policy & Procedure	BHT Intranet Register of Trust-wide policies, Sheet 37
BHT Pol 128	Recruitment and Selection Policy and Procedure	BHT Intranet Register of Trust-wide policies, Sheet 108
BHT Pol 051	Information Governance Policy (Data Protection Policy & Information Management & Technology (IM&T) Security Policy: Incorporated)	BHT Intranet Register of Trust-wide policies, Sheet 53

## Acknowledgements

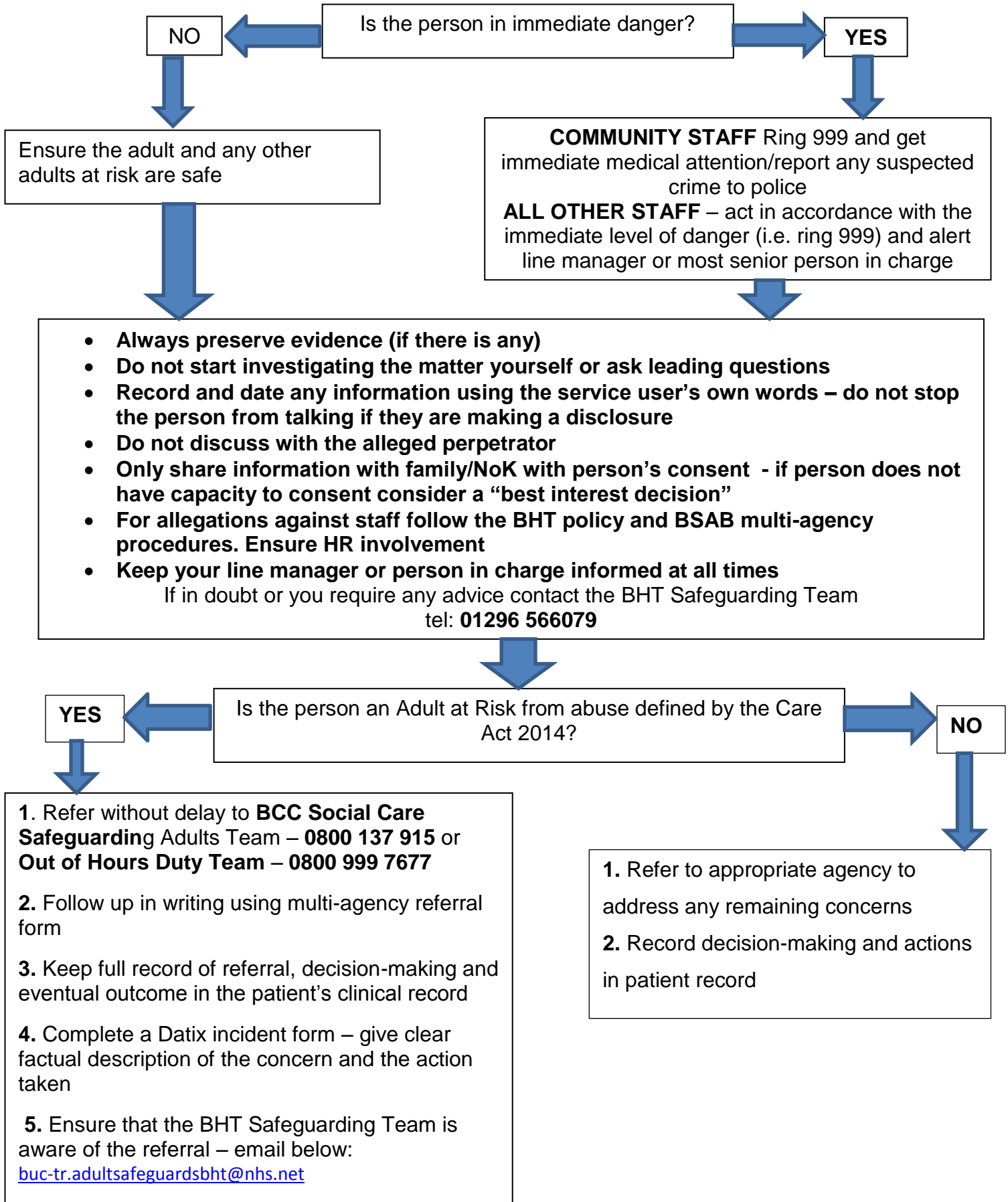
Thanks are given to the North West Dignity Leads Network which has generously allowed BHT to use the “Challenging Poor Practice” training module that they developed.

## CONTENTS

<b>Section No</b>	<b>Title</b>	<b>Page No</b>
	Document History	2
	Associated Documents	4
	Acknowledgements	4
	BHT Adult Safeguarding Flowchart	7
<b>1.</b>	<b>INTRODUCTION</b>	<b>8</b>
<b>2.</b>	<b>PURPOSE</b>	<b>8</b>
<b>3.</b>	<b>DEFINITIONS</b>	<b>8</b>
<b>4.</b>	<b>ROLES AND RESPONSIBILITIES</b>	<b>10</b>
	<b>4.1</b> Trust Board	<b>10</b>
	<b>4.2</b> Chief Executive	<b>10</b>
	<b>4.3</b> Chief Nurse	<b>10</b>
	<b>4.4</b> Associate Director for Safeguarding Adults and Children	<b>11</b>
	<b>4.5</b> Corporate Safeguarding Team	<b>11</b>
	<b>4.6</b> Human Resources	<b>11</b>
	<b>4.7</b> Divisional Leads	<b>11</b>
	<b>4.8</b> Service Delivery Unit (SDU) Leads and Matrons	<b>11</b>
	<b>4.9</b> Senior Sisters, Charge Nurses, and Lead Allied Health Professionals	<b>12</b>
	<b>4.10</b> All Staff	<b>12</b>
<b>5.</b>	<b>STANDARDS, KEY PRINCIPLES AND LEGISLATION - SAFEGUARDING</b>	<b>12</b>
	<b>5.1</b> The fundamental objectives of adult safeguarding	<b>13</b>
	<b>5.2</b> Wellbeing	<b>14</b>
	<b>5.3</b> Making Safeguarding Personal	<b>14</b>
	<b>5.4</b> Mental Capacity Act	<b>15</b>
	<b>5.5</b> Capacity and Consent	<b>16</b>
	<b>5.6</b> Assessing Capacity	<b>16</b>
	<b>5.7</b> Deprivation of Liberty Safeguards	<b>16</b>
	<b>5.8</b> Determining the Adult's Best Interests	<b>17</b>
	<b>5.9</b> Overriding the Wishes of the Adult	<b>17</b>
<b>6.</b>	<b>RECOGNISING AND RESPONDING TO ABUSE</b>	<b>18</b>
	<b>6.1</b> Safeguarding Adults Threshold Tool	<b>18</b>
	<b>6.2</b> Categories and Definitions of Abuse	<b>18</b>
	<b>6.3</b> Criminal Offences and Adult Safeguarding	<b>21</b>
	<b>6.4</b> Hate Crime	<b>22</b>
<b>7.</b>	<b>HOW TO REPORT CONCERNS OF ADULT ABUSE</b>	<b>22</b>
	<b>7.1</b> Reporting Concerns of Adult Abuse to Adult Social Care	<b>22</b>
	<b>7.2</b> Reporting Concerns of Adult Abuse to the Police	<b>23</b>
	<b>7.3</b> Referring concerns of Self-Neglect to the Risk Assessment Multi-Agency Panel (RAMP)	<b>24</b>
	<b>7.4</b> Reporting Concerns about Domestic Abuse	<b>25</b>
	<b>7.5</b> Reporting suspected modern slavery	<b>25</b>
	<b>7.6</b> Reporting PREVENT Concerns	<b>26</b>
	<b>7.7</b> Reporting Concerns to Trust Managers	<b>27</b>
<b>8.</b>	<b>MANAGING ALLEGATIONS AGAINST MEMBERS OF STAFF</b>	<b>27</b>
<b>9.</b>	<b>INFORMATION SHARING</b>	<b>29</b>
<b>10.</b>	<b>POSSIBLE RESPONSE TO AN ADULT ABUSE REFERRAL</b>	<b>30</b>
	<b>10.1</b> Immediate Response – No Enquiry	<b>30</b>
	<b>10.2</b> Strategy Discussion/Meeting	<b>30</b>
	<b>10.3</b> Safeguarding Adult Investigation	<b>31</b>
	<b>10.4</b> The Adult's Rights to Advocacy	<b>32</b>
	<b>10.5</b> Escalating Concerns	<b>32</b>
	<b>10.6</b> Challenging Poor Practice and Raising Concerns	<b>32</b>
<b>11.</b>	<b>SAFEGUARDING ADULT REVIEWS (SARs)</b>	<b>33</b>
<b>12.</b>	<b>THINK FAMILY</b>	<b>34</b>
<b>13.</b>	<b>DUTIES TO CARERS</b>	<b>35</b>

<b>14.</b>	<b>TRANSITION FROM CHILD TO ADULT SERVICES</b>	<b>35</b>
<b>15.</b>	<b>STAFF TRAINING AND SUPPORT</b>	<b>36</b>
	<b>15.1 Training</b>	<b>36</b>
	<b>15.2 Support for Staff Involved in Safeguarding Adult Cases</b>	<b>36</b>
<b>16.</b>	<b>EQUALITY AND DIVERSITY STATEMENT</b>	<b>37</b>
<b>17.</b>	<b>CONSULTATION AND REVIEW PROCESS</b>	<b>37</b>
<b>18.</b>	<b>MONITORING THIS POLICY</b>	<b>37</b>
<b>19.</b>	<b>REFERENCES AND ASSOCIATED LEGISLATION</b>	<b>39</b>
<b>20.</b>	<b>GLOSSARY OF TERMS</b>	<b>40</b>
	<b>APPENDICES</b>	
Appendix 1	GUIDELINES – SPOTTING THE POTENTIAL FOR AND IDENTIFYING ABUSE	41
Appendix 2	ADVICE FOR STAFF – how to respond to disclosures of abuse	45
Annex 1	Equality Impact Assessment	48

**BHT Adult Safeguarding Flowchart**  
**Concern, Allegation, Disclosure or Suspicion of Abuse**  
**Alerter/first person dealing with the situation**



## 1. INTRODUCTION

*Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.*

Department of Health 2017

Safeguarding adults is everybody's business and everybody has the right to live a life that is free from harm and abuse. Buckinghamshire Healthcare NHS Trust (BHT) has a statutory duty to ensure that all people who use its services are protected from abuse and that their rights are upheld. The Trust is committed to promoting an organisational culture which prevents abuse and will ensure that its services are delivered in a safe environment and that the prevention of abuse is explicitly promoted by means of transparent standards of care and rigorous monitoring.

The Trust has a zero tolerance of abuse and must uphold the requirements set out in the Care Quality Commission (CQC) standard 13 on safeguarding services users from abuse and improper treatment. The Trust also upholds national legislation and policy guidance aimed at safeguarding adults from harm caused by abuse.

BHT endorses and promotes the principles outlined within the BSAB policy and procedures and fully supports partnership working to enable the safeguarding of people of all ages and from all backgrounds.

## 2. PURPOSE

The aim of this policy is to safeguard adults by providing clear direction to staff in respect of their duties and the supporting legislation and guidance; "staff" includes contracted services and volunteers. The policy sets out the responsibilities of all Trust staff to safeguard adults from abuse and underlines the principle that safeguarding is everybody's business.

BHT staff must read this policy in conjunction with the BSAB Multi Agency Policy and Procedures. The policy applies to people aged eighteen years of age and above; if there is a concern about a person under the age of eighteen staff must refer to the BHT Safeguarding Children Policy.

## 3. DEFINITIONS

**Abuse** - Abuse is mistreatment by any other person or persons that violates a person's human and civil rights. It may occur by either an act, or a failure to act, that results in an absence of respect for an individual's safety, privacy, dignity and cultural background.

Abuse of adults can be broadly defined under the following categories:

- Physical
- Psychological
- Sexual
- Neglect
- Self-neglect
- Financial
- Discriminatory
- Organisational
- Domestic abuse
- Modern Slavery



Staff must not limit their view of what constitutes abuse or neglect as they can take many forms and the circumstances of the individual case must always be considered. For further detail regarding these categories of abuse go to section 6 of this policy.

**Adult at risk** The Care Act 2014 states that safeguarding duties apply to any person aged 18 years and above who:

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

**Advocacy** The Care Act 2014 extended the right for eligible people to have independent advocacy to help them be actively involved in their care and support process, including their:

- Care assessments
- Care and support planning
- Care and support reviews
- Safeguarding enquiries
- Safeguarding adult reviews (previously known as serious case reviews).

**Caldicott Guardian** - a senior person within the Trust who is responsible for protecting the confidentiality of service-user information and enabling appropriate information sharing, who works in an advisory capacity and provides a focal point for confidentiality and information sharing issues.

**Duty to cooperate** The Care Act 2014 says that local authorities must cooperate with each of their relevant partners, and each relevant partner must cooperate with the local authority in the exercise of their functions relating to adults with care and support needs. The Act sets out 5 aims of co-operation between partners which are relevant to care and support, although it must be noted that the purposes of co-operation are not limited to these matters:

- promoting the wellbeing of adults needing care and support and of carers;
- improving the quality of care and support for adults and support for carers (including the outcomes from such provision);
- smoothing the transition from children's to adults' services;
- protecting adults with care and support needs who are currently experiencing or at risk of abuse or neglect;
- identifying lessons to be learned from cases where adults with needs for care and support have experienced serious abuse or neglect.

**Multi-Agency Safeguarding Hub (MASH)** – co-locates or virtually connects professionals from a range of agencies, with the key aim of ensuring the speedy and comprehensive sharing of information to enable robust decision-making aimed at protecting Adults at Risk in a timely and effective manner.

**Public interest** - means the interests of the community as a whole, or a group within the community or individuals.

**Public Interest Test** refers to the process a health care professional (HCP) must use to decide whether to share confidential information without consent. It requires consideration of the competing public interests e.g. the public interest in protecting people at risk of abuse, promoting their welfare or preventing crime and disorder and the public interest in maintaining public confidence in the confidentiality of public services, and to balance the risks of not sharing against the risk of sharing.

**Section 42 Enquiry** of the Care Act 2014 requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

## **Vulnerability**

The Care Act discourages the use of the term “vulnerable adult”, preferring instead the terminology “Adult at Risk” (see definition above). It is still advisable however to recognise that certain factors increase a person’s vulnerability and may render them more susceptible to being abused.

Some, but not all people with a learning or physical disability, mental health concerns or who are elderly may be vulnerable. Previous experience of abuse, communication difficulties or a lack of capacity may also be features in a person’s life which may increase the possibility of them being vulnerable to abuse.

A person who is in need of care from BHT services because of illness, frailty or the need for hospital admission may be vulnerable. They may be in need of assistance with personal care, be dependent in some way on services, have a specific ill health condition, or may be disadvantaged by obstacles to effective communication. All these circumstances are recognised as constituting risks that imply possible vulnerability in the individual which could make them an Adult at Risk as defined by the Care Act 2014.

## **4 ROLES AND RESPONSIBILITIES**

The Trust recognises and upholds its duties and responsibilities to safeguard adults for abuse as set out in the Care Act 2014 and its supporting Statutory Guidance. The Trust fully embraces the principle that safeguarding adults is everybody’s responsibility as embodied below.

### **4.1 Trust Board**

The Trust Board has overall responsibility for implementing a robust system of risk management within the Trust that enables the delivery of safe and effective care and ensures that Adults at Risk of harm from abuse are safeguarded. These responsibilities include:

- setting safeguarding adults within the organisation’s strategic objectives;
- ensuring Board level leadership and senior management commitment to safeguarding adults;
- ensuring there are structures in place and clear lines of accountability which include having in place named individuals with specific responsibility for safeguarding adults, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS);
- ensuring an overall policy is in place;
- supporting a culture which places prevention of harm and the wellbeing of service users at the centre of all Trust activities and enables safeguarding issues to be identified and addressed;
- ensuring the appointment of and easy access for staff to a Freedom to Speak Up Guardian;
- monitoring, auditing and evaluating the effectiveness of the safeguarding service.

### **4.2 Chief Executive**

Ultimate responsibility for safeguarding within the organisation sits with the Trust Chief Executive Officer (CEO). As the accountable officer, the chief executive must ensure that responsibility for Safeguarding Adults is delegated to an appropriate Executive Lead

### **4.3 Chief Nurse**

As nominated Executive Lead, the Trust Chief Nurse must ensure that robust systems and processes are in place for safeguarding adults. The Executive Lead for safeguarding adults is responsible for:

- providing executive leadership;
- providing assurance about the governance of safeguarding to the Trust Board, BSAB, commissioners, partner organisations and regulators;
- attending or designating a suitable alternative to attend at all relevant BSAB meetings;
- ensuring that the Trust is represented on BSAB sub committees and task and finish groups;

- ensuring that there are effective procedures in place for managing allegations of abuse against staff;
- ensuring that safeguarding is integral to patient care;
- ensuring that regular reports about safeguarding are presented to the BHT Quality Committee Trust Board.

#### **4.4 Associate Director for Safeguarding Adults and Children**

The AD for Safeguarding takes a strategic lead for safeguarding across the organisation, supports the Executive Lead for Safeguarding and has responsibility for leading and supporting the BHT Corporate Safeguarding Team.

#### **4.5 Corporate Safeguarding Team**

The Safeguarding Team supports Trust staff and the organisation to fulfil their obligations to work effectively in order to prevent harm, abuse, and neglect, and to act positively to protect all people who are at risk of abuse. This is done by:

- the delivery of evidence based training which complies with national guidance;
- the provision of safeguarding supervision and advice for staff;
- building effective relationships with key partners – both internal and external to the Trust;
- supporting Trust divisions in their safeguarding work and responsibilities;
- working in partnership with LA social care safeguarding teams in supporting information sharing as partners within the Buckinghamshire MASH.

#### **4.6 Human Resources**

The Trust HR function has a central role in safeguarding people from abuse as follows:

- to ensure that safe and effective selection and recruitment procedures are in place that are able to identify candidates who may be unsuitable to work with vulnerable people in accordance with Home Office guidance as set out by the Disclosure and Barring Service (DBS);
- to ensure that appropriate disciplinary investigation and procedures are in place to deal appropriately with a member of staff who may act abusively towards a patient or other person;
- to provide advice on the management of staff/volunteers who have had allegations made against them - this may include providing advice on disciplinary processes as well as supportive measures available for the member of staff/volunteer concerned;
- to ensure that the appropriate local and national bodies are informed when staff are suspended or dismissed due to a safeguarding concern or allegation;
- to ensure that there is a policy in place which supports staff to raise concerns and that there is an agreed process to support staff reporting poor practice;
- to ensure a commitment to staff training at all levels.

#### **4.7 Divisional Leads**

The Divisional Chairs, Divisional Directors and Divisional Chief Nurses are responsible for ensuring that the requirements of this policy to safeguard adults are managed within their division and that staff are aware of and implement those requirements. The leads will ensure that monthly safeguarding reports are provided for the Trust Safeguarding Committee;

#### **4.8 Service Delivery Unit (SDU) Leads and Matrons**

SDU Leads and Matrons Managers are responsible for ensuring that their staff are aware of the Trust Safeguarding Adults policy and are trained at an appropriate level for their roles. They will offer support to those reporting abuse and direct them to other sources of support accordingly.

They must ensure that the level of responsibility for each staff member is explicit as a statement in all job descriptions to meet the expectations of each individual role.

SDU Leads and Matrons Managers will provide good clinical leadership and demonstrate high professional standards which are paramount to the provision of safe care and the prevention of abuse. They will also take a leading role in the investigation of incidents arising from safeguarding issues.

#### **4.9 Senior Sisters, Charge Nurses, and Lead Allied Health Professionals**

It is the role of the Senior Sister, Charge Nurse and Lead for AHPs to locally implement this policy. They must make provision for mechanisms to be in place to ensure that their staff have read and understood the policy and to ensure that it forms part of induction for new staff. Any non-compliance with the policy must be investigated and addressed immediately and if necessary, a Datix incident form completed.

#### **4.10 All Trust Staff**

All employees (including bank & agency staff), volunteers and contractors are required to adhere to the policies, procedure and guidelines of the Trust, including their roles and responsibilities under this policy. All BHT staff must:

- read and comply with this policy;
- all clinical staff in particular must familiarise themselves with the BSAB Multi-Agency Safeguarding Adults Procedures – see link below:  
<http://www.buckinghamshirepartnership.gov.uk/safeguarding-adults-board/information-for-professionals/> ;
- work effectively to prevent harm, abuse, and neglect, and act positively to protect adults at risk;
- work at all times within the guidelines of their professional codes of conduct and the policies of the Trust to prevent abuse through any act or omission or poor professional practice whether or not this may be intentional;
- undertake and keep updated in mandatory safeguarding training.

### **5. STANDARDS, KEY PRINCIPLES AND LEGISLATION - SAFEGUARDING**

Safeguarding adults from abuse, neglect and improper treatment is a core duty of the Trust. The legal responsibilities placed on BHT to safeguard adults are set out in the Care Act 2014 and its associated Care and Support Statutory Guidance. The Care Act sets out a clear legal framework for how local authorities along with partner agencies, must protect adults at risk of abuse or neglect.

BHT works in partnership with Buckinghamshire County Council (BCC) and other agencies as part of a wider inter-agency approach to ensure effective safeguarding across our local communities.

Safeguarding service users from abuse and improper treatment is one of the CQC's fundamental standards. To meet the requirements of Regulation 13 BHT must have a zero tolerance approach to abuse, unlawful discrimination and restraint. This includes:

- neglect
- subjecting people to degrading treatment
- unnecessary or disproportionate restraint
- deprivation of liberty.

The CQC states that abuse and improper treatment includes care or treatment that is degrading for people and care or treatment that significantly disregards their needs or that involves inappropriate recourse to restraint. For these purposes, 'restraint' includes the use or threat of force, and physical, chemical or mechanical methods of restricting liberty to overcome a person's resistance to the treatment in question.

The Care Act (sections 42-47) places on a statutory footing, the safeguarding obligations which previously were largely contained in the No Secrets statutory guidance. The Trust and its staff must adhere to the safeguarding duties set out in the Care Act 2014 and associated Statutory Guidance - see link below:

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

The Care Act places a duty on statutory organisations (including healthcare organisations) to have in place effective arrangements safeguard adults and the Statutory Guidance requires that organisations must always promote the adult's wellbeing in their safeguarding arrangements.

HCPs must work with the adult to establish what being safe means to them and how this can best be achieved. HCPs must not advocate 'safety' measures that do not take account of individual well-being, as defined in Section 1 of the Care Act.

### 5.1 The fundamental objectives of adult safeguarding are to:

- **Prevent abuse or neglect wherever possible** - Service provision must be person-centred and of a high quality with a focus on outcomes, inclusion and wellbeing. When people become increasingly isolated and cut off from families and friends, they become extremely vulnerable to abuse and neglect. Trust staff must be observant so that they can make early, positive interventions with individuals and families to prevent the deterioration of a situation or breakdown of a support network.
- **Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs** - Staff must be trained and supported to know how to identify and report abuse and ensure that interventions aimed at minimising harm are put in place in a timely way. Adults with care needs must be made aware of their rights to assessment and support and to protection from harm caused by abuse or neglect.
- **Safeguard adults in a way that supports them in making choices and having control about how they want to live** - Staff must work with adults to enable them to make choices about how they live their lives and what being safe means to them. When an enquiry into abuse and neglect is required, the adult should always be involved from the beginning, and their views and wishes taken into account unless there are exceptional circumstances that would increase the risk of abuse. If the adult has substantial difficulty in being involved, and where there is no one appropriate to support them, then the local authority must arrange for an independent advocate to represent them for the purpose of facilitating their involvement.
- **Promote an approach that concentrates on improving life for the adults concerned** - Staff must promote the wellbeing of adults with whom they work. This means taking account of the adult's wishes, feelings and beliefs so that they can be in control of their own care; it also includes making safeguarding personal. When a concern about abuse is raised, any safeguarding enquiries must be handled in a sensitive and skilled way to ensure that distress to the adult is minimised, and to support the adult to realise the outcomes they want and to reach a resolution or recovery.
- **Raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect** - The Trust will cooperate with BSAB and partner agencies in developing communications strategies.
- **Provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult** - The Trust will provide information about safeguarding on its internet site so that people identify how to raise concerns about the safety or wellbeing of an adult with care and support needs..
- **Address what has caused the abuse or neglect** - The Trust will promote an organisational culture which places prevention of harm and the wellbeing of service users at the centre of all Trust activities. This will be achieved through ensuring organisational structures support good clinical leadership so that high professional standards are always applied in the provision of care.

Effective adult safeguarding involves working *with* adults who have care and support needs to keep them safe from abuse or neglect. **The following 6 principles underpin all safeguarding adult work:**

**1. Empowerment** – People being supported and encouraged to make their own decisions and informed consent.

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

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

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

**3. Proportionality** – The least intrusive response appropriate to the risk presented.

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

**4. Protection** – Support and representation for those in greatest need.

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

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

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

**6. Accountability** – Accountability and transparency in delivering safeguarding.

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

## 5.2 Wellbeing

The “wellbeing principle” is a guiding philosophy of the Care Act 2014 and it puts the individual’s wellbeing at the heart of care and support. BHT staff must always work on the assumption that an adult is best placed to judge their own wellbeing.

Care and support must put people in control of their care wherever possible, and wellbeing must be promoted at every stage of the care pathway. Taking this approach enables identification of how care and support could best help the adult achieve their identified outcomes.

Wellbeing is described as:

- personal dignity (including treatment of the individual with respect);
- physical and mental health and emotional wellbeing;
- protection from abuse and neglect;
- control by the individual over day-to-day life (including over care and support provided and the way it is provided);
- participation in work, education, training or recreation;
- social and economic wellbeing;
- domestic, family and personal;
- suitability of living accommodation;
- the individual’s contribution to society.

In carrying out its care and support functions, BHT must always act to promote wellbeing.

## 5.3 Making Safeguarding Personal

The Care Act’s statutory guidance asks Local Authorities (LAs) to put into practice the Making Safeguarding Personal (MSP) “person-led” and “outcome-focused” approach to adult protection. This involves practitioners identifying and seeking to achieve, as far as possible, the preferred outcomes of the adult at risk, through the adult safeguarding process

BHT is committed to the principles of making safeguarding personal and requires staff to work with an adult to establish what being safe means to them and how that can be best achieved. Staff must not promote “safety” measures that do not take account of individual well-being.

A key principle of MSP is to engage the person in a conversation about how best to respond to their safeguarding situation in a way that enhances their involvement, choice and control as well

as improving quality of life, wellbeing and safety. The purpose is to ensure that the adult experiences the safeguarding process as being empowering and supportive.

The need to protect people from abuse and neglect is a key principle of wellbeing and the Care Act 2014 puts great importance on making safeguarding personal. This means that in any safeguarding situation the wellbeing of an adult at risk must be promoted, and their wishes and feelings always taken into account.

Staff must always assume that an adult has capacity to make their own decisions and must do everything possible to support them to do so. This is a key tenet of the Mental Capacity Act 2005 (MCA) as well as being fundamental to individual wellbeing and making safeguarding personal. Where an adult is found to lack capacity to make a decision then any action taken, or any decision made on their behalf, must be made in their best interests.

In any safeguarding situation Trust staff must:

- Work with an adult (and their advocates or representatives if they lack capacity) from the outset in order to identify the outcomes they want to achieve.
- Review with the adult at the end of safeguarding activity to what extent their desired outcomes have been achieved.
- Record and monitor the results in a way that can be used to inform practice and account to the respective Safeguarding Adults Boards.
- Develop a range of robust and appropriate responses that focus on supporting adult to meet their desired outcomes and reduce the risk of or recurrence of abuse.

Any safeguarding concerns raised about an adult who has care and support needs must be reported (see section 7 of this policy below) so that a decision can be made about whether it is necessary to carry out a safeguarding inquiry. This process must always include the adult about whom there are concerns, so that their wishes and preferences can be acted on as far as is possible and in keeping with the principles of 'Making Safeguarding Personal'.

#### **5.4 Mental Capacity Act (2005)**

The MCA protects and empowers individuals, aged 16 and over who may lack the mental capacity to make their own decisions about their care and treatment. Trust staff must understand and always work in line with the Mental Capacity Act (MCA) 2005 so as to help adults to manage risk in ways that put them in control of decision making wherever possible. People must always be assumed to have capacity to make their own decisions and be given all practicable help before anyone treats them as not being able to do so.

The MCA provides the legal framework that empowers adults who may lack capacity to make decisions about their lives, including decisions about their care and support and safeguarding concerns. The mental capacity of an adult must always be a consideration in all safeguarding adult work. Wherever there is doubt about the capacity of an adult, a capacity assessment must be undertaken and recorded. The requirement to apply the MCA in adult safeguarding situations supports duties in respect of MSP.

The MCA created the criminal offences of ill-treatment and wilful neglect in respect of people who lack capacity. The offences can be committed by anyone responsible for that adult's care and support including paid staff, family carers as well as people who have the legal authority to act on that adult's behalf (i.e. persons with power of attorney or Court-appointed deputies). Such offences are punishable by fines or imprisonment of up to five years.

For further clarification about mental capacity issues, please refer to the MCA 2005 Code of Practice – link below:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/224660/Mental\\_Capacity\\_Act\\_code\\_of\\_practice.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224660/Mental_Capacity_Act_code_of_practice.pdf)

For more detailed guidance and information about how to work within the legislation please refer to the BHT MCA & DoLS Policy.

## 5.5 Capacity and Consent

As part of its safeguarding duties the Trust and its staff must adhere to the principles of the MCA 2005 and its Code of Practice

All safeguarding responses must adhere to the principles of the MCA 2005, which states that ‘a person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success.’ This means that an adult must be assumed to have the capacity to make decisions unless it is established otherwise.

Adults at Risk must be supported to make their own decisions based on an awareness of the choices available. Where there is evidence that an adult lacks the capacity to make a particular decision, then all decisions must be made in accordance with the best interest principles – see below.

## 5.6 Assessing Capacity

An assessment of a person’s capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general. A person is considered unable to make a decision if they cannot do one or more of the following things:

- understand the information given to them that is relevant to the decision;
- retain that information long enough to be able to make the decision;
- use or weigh up the information as part of the decision-making process;
- communicate their decision – this could be by talking or using sign non-verbal communication methods and can include simple muscle movements such as blinking an eye or squeezing a hand.

If a person lacks capacity in any of these areas, then this represents a lack of capacity (see Mental Capacity Act 2005: Code of Practice:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/497253/Mental-capacity-act-code-of-practice.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf))

Where a person is assessed as lacking capacity, and there is no one suitable to help make decisions such as family members or friends, or where there are concerns that these individuals may pose a risk to the adult concerned, then an independent mental capacity advocate (IMCA) must be appointed to represent the interests of the Adult at Risk. See also section 10.4 of this policy on the Adult’s Rights to Advocacy.

Contact details of the IMCA services for each local authority are available from the link below:

<https://www.scie.org.uk/mca/imca/find>

## 5.7 Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) were introduced as an amendment to the MCA and came into force on 1 April 2009. The MCA allows restraint and restrictions to be used, but only if they are shown to be in a person's best interests and only if the person will be deprived of their liberty in a care home or hospital.

The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom and set out a process that hospitals and care homes must follow if they believe it is in the person's best interests to deprive a person of their liberty in order to provide a particular care plan..

Whether someone is deprived of their liberty depends on the person's specific circumstances. A large restriction may sometimes in itself be a deprivation of liberty or sometimes a number of small restrictions added together will amount to a deprivation of liberty. What needs to be assessed is the amount of control that the care home or hospital has over the person.

a deprivation of liberty occurs when:

- a person is under continuous supervision and control in a care home or hospital, and
- is not free to leave, and
- the person lacks capacity to consent to these arrangements.



BHT staff must ask the LA if they can deprive a person of their liberty. This is called requesting a standard authorisation. Following a referral from BHT staff, it is then the role of BCC Adult Social Care as the Supervisory Body to arrange for assessments to ensure the deprivation of liberty is in the person's best interests.

The role of the LA to act as a supervisory body for DoLS imposes upon it a more general duty to act as a human rights champion for those adults who might lack capacity to agree to actions taken by others.

For more detailed guidance and information about how to work within the legislation please refer to the BHT MCA & DoLS Policy.

### **5.8 Determining the Adult's Best Interests**

The MCA is designed to protect those who lack capacity by ensuring that decisions made on their behalf are made in their best interests. The decision maker must always consider the least restrictive alternative.

Where an adult lacks capacity, the HCP must consider many important elements which include:

- involving the person in the decision as much as possible;
- trying to identify any issues the person would take into account if they were making the decision themselves, including religious or moral beliefs – these would be based on views the person expressed previously, as well as any insight close relatives or friends can offer;
- considering if it's likely the adult could regain capacity at a later stage and whether it would be safe or appropriate to wait until this may happen;
- the appointment of an IMCA.

### **5.9 Overriding the Wishes of the Adult**

There are occasions when the HCP may need to consider whether to override the expressed wishes of the adult. As set out above, the first priority in any safeguarding action is to ensure the safety and wellbeing of the adult at risk. It is also a key principle of the Care Act 2014 that people must be in control of their own care and can refuse any supportive interventions. In practice, these two elements can be difficult to balance and there may be some occasions when an HCP must intervene and take safeguarding action regardless of the adult's wishes.

A person's mental capacity (see above) must always be considered in relation to any adult safeguarding concern, however the issues at hand can be challenging, particularly where it appears that an adult has capacity for making specific decisions that nevertheless place them at risk of being abused or neglected.

It is important to always balance the adult's wishes alongside wider implications such as whether a criminal offence may have taken place, the level of risk, or the risk of harm to others including any children.

There may also be occasions where a practitioner has doubts about the validity of decisions made by the adult because of concern about undue influence or coercion. Where this is suspected, consideration must be given as to whether the adult's choices can be taken at face value and support may be required to help a person make a decision free of coercive influence.

HCPs who have serious or escalating concerns about the welfare of an adult who has capacity but may be at risk of harm from abuse, must consider a referral to the BSAB Risk Assessment Multi-Agency Panel (RAMP) – see section 7.3 below on how to report a concern of adult abuse.

A new offence of coercive and controlling behaviour in intimate and familial relationships was introduced into the Serious Crime Act 2015. The offence will impose a maximum 5 years imprisonment, a fine or both – please see link below.

<https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship>

In certain circumstances the Courts can exercise their authority and overrule a person's apparent wishes, even if that person has the capacity to take the decision. This is not to remove, but to

restore choice and control, enabling the person to make a free and informed decision free from undue influence of coercion.

Where decisions are made to override an adult's wishes, clear written records must be made as to the reason for doing this. Such decisions must be made in conjunction with other HCPs or agencies involved in the adult's care. Any uncertainties regarding how to proceed with a safeguarding adult concern must be addressed either via supervision or discussion with a line manager or through consultation with a member of the Trust Safeguarding Team.

## **6. RECOGNISING AND RESPONDING TO ABUSE**

Abuse is mistreatment by any other person or persons that violates a person's human and civil rights; it may include poor care practices and may also involve criminal acts. Incidents of abuse may be a one-off or may be multiple and may affect more than one person; several types of abuse may be happening simultaneously.

Patterns of abuse vary and include:

- serial abuse, in which the perpetrator seeks out and 'grooms' individuals. Sexual abuse sometimes falls into this pattern as do some forms of financial abuse;
- long-term abuse, in the context of an on-going family relationship such as domestic violence between spouses or other closely connected people, or persistent psychological abuse;
- opportunistic abuse such as theft, occurring because money or jewellery has been left lying around.

BHT expects that all staff know how to recognise and respond to abuse (see Appendices 1 & 2 of this policy) and how to report their concerns (see section 6 below). Any HCP or other staff member who recognises a concern about an Adult at Risk has a duty to formally raise that concern in accordance with BSAB multi-agency policy and procedures. This will enable enquiries to be instigated so that a decision can be made to decide what, if any, action must be taken to protect the adult at risk.

Whilst abuse may sometimes be unintentional, the key focus must be on the harm caused to the adult at risk and the effect on their wellbeing, health or development. Repeated incidents of poor care may be indicative of more serious problems and could point towards organisational abuse, so it is important to look beyond single incidents or individuals and identify patterns of harm.

Where there are concerns of abuse immediate action must always be taken to safeguard the Adult at Risk and then to refer the concerns to the BCC Social Care Safeguarding Adult Team in the Multi Agency Safeguarding Hub (MASH) in accordance with BSAB Multi-Agency Policy and Procedures. Where the alleged abuse involves a possible crime, then the police must always be involved. For more information see section 7.2 below on how to report concerns of adult abuse.

Team and senior managers within the Trust must be informed of any action taken in respect of reporting abuse; this is especially important in respect of informing the police. HCPs must always inform or seek advice from their managers before contacting the police (unless the situation is an emergency, in which case always dial 999).

### **6.1 Safeguarding Adults Threshold Tool**

In order to assist staff to assess the seriousness of their safeguarding concern about an adult, the Safeguarding Adults Threshold Tool has been developed (see link below). This document guides practitioners in assessing the level of risk associated with their concern. The tool is not intended to replace professional judgment but to empower staff to comply with their responsibilities under the Care Act 2014.

<http://www.buckinghamshirepartnership.gov.uk/media/4919754/BSAB-Threshold-Document.pdf>

### **6.2 Categories and Definitions of Abuse**

The Care Act 2014 and associated Care and Support Statutory Guidance describes 10 categories of adult abuse. The section below sets out the different types and patterns of abuse

and neglect and the different circumstances in which they may take place. This is not intended to be an exhaustive list but an illustrative guide as to the sort of behaviour which could give rise to a safeguarding concern. See Appendix 1 of this policy for more comprehensive information about how to recognise.

**Physical abuse including:**

- assault
- hitting
- slapping
- pushing
- misuse of medication
- restraint
- inappropriate physical sanctions

**Psychological abuse including:**

- emotional abuse
- threats of harm or abandonment
- deprivation of contact
- humiliation
- blaming
- controlling
- intimidation
- coercion
- harassment
- verbal abuse
- cyber bullying
- isolation
- unreasonable and unjustified withdrawal of services or supportive networks

**Sexual abuse including:**

- rape
- indecent exposure
- sexual harassment
- inappropriate looking or touching
- sexual teasing or innuendo
- sexual photography
- subjection to pornography or witnessing sexual acts
- indecent exposure
- sexual assault
- sexual acts to which the adult has not consented or was pressured into consenting

**Neglect (and acts of omission including):**

- ignoring medical, emotional or physical care needs
- failure to provide access to appropriate health, care and support or educational services
- the withholding of the necessities of life, such as medication, adequate nutrition and heating

**Self-neglect**

This covers a wide range of behaviour including neglecting to care for one's personal hygiene, health or surroundings and also behaviour such as hoarding. It should be noted that self-neglect may not necessarily prompt a safeguarding (section 42) enquiry, especially where an adult is recognised to have capacity to make decisions about lifestyle choices.

HCPs working with cases of suspected self-neglect must not work alone. Support and advice must be sought from the individual's line manager and/or multi-disciplinary team (MDT), and/or the Trust Safeguarding Team so that a robust care and support plan can be established. Regular clinical and safeguarding supervision must be sought in respect of the management of complex and difficult cases and all advice on the course of action to follow must be recorded in the adult's clinical record.

When a HCP has concerns about self-neglect the BSAB Self Neglect toolkit (see link below) provides a useful guide to assessing risk and making decisions on when a referral to BCC Social Care Safeguarding Adults Team in the MASH will be necessary.

<http://www.buckinghamshirepartnership.gov.uk/safeguarding-adults-board/professional-resources/self-neglect/>

There may come a point when HCPs are no longer able to do support the adult's choices without external support. In such situations HCPs who have serious or escalating concerns about the welfare of an adult who is self-neglecting yet has capacity, must, with the guidance of the line manager or MDT, consider a referral to the BSAB RAMP – see section 7.3 below on Reporting a Concern of Abuse.

**Financial or material abuse including:**

- theft
- fraud
- internet scamming
- coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions
- the misuse or misappropriation of property, possessions or benefits

**Discriminatory abuse including forms of:**

- harassment
- slurs or similar treatment because of:
  - race
  - gender and gender identity
  - age
  - disability
  - sexual orientation
  - religion

**Organisational abuse**

Including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

Incidents of abuse may be one-off or multiple, and affect one person or more. HCPs must look beyond single incidents or individuals to identify patterns of harm. Repeated instances of poor care may be an indication of more serious problems and of what we now describe as organisational abuse. In order to see these patterns it is important that information is recorded and appropriately shared.

**Domestic abuse/violence**

Domestic abuse is a significant cause of serious harm or death and constitutes a considerable proportion of overall crime. Because domestic abuse causes considerable problems to individuals and to society so it is vitally important that it is tackled and its victims made safe.

People may experience domestic abuse regardless of their gender, ethnicity, religion, sexuality, class, age or disability. It may also occur in a range of different relationships including heterosexual, gay, lesbian, bi-sexual and transgender, as well as within families. Whilst both men and women can be victims of domestic abuse, women are much more likely to be victims than men.

The cross-government definition of domestic violence and abuse is:

*Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.*

This can encompass but is not limited to the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional
- harassment
- stalking
- female genital mutilation (FGM)
- so-called 'honour' based abuse
- forced marriage
- controlling and/or coercive behaviour

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Effective safeguarding is achieved when agencies share information to obtain an accurate picture of the risks and then work together to ensure the safety of the adult at risk is prioritised – please see section 7.4 below for how to refer a concern of domestic abuse.

### **Modern slavery**

Modern slavery is a serious and brutal crime in which people are treated as commodities and exploited for criminal gain. It encompasses:

- slavery
- human trafficking
- forced labour and domestic servitude
- sexual exploitation
- traffickers and slave masters using whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment

Modern slavery victims can often face more than one type of abuse and slavery, for example if they are sold to another trafficker and then forced into another form of exploitation.

Traffickers or modern slavery facilitators can select victims from amongst vulnerable groups, for example, people with:

- substance misuse issues;
- debts, in their country of origin or as a result of their illegal migration;
- mental health problems;
- learning disabilities.

A common factor of trafficking is that the trafficker will present a scenario in which the potential victim can improve the quality of their life and that of their family. Vulnerable people are often targeted as being easier to coerce into a situation where they can be manipulated.

The scale of modern slavery in the UK is significant and there have been year on year increases in the number of victims identified. The Home Office has estimated that in 2013 there were between 10,000 and 13,000 potential victims of modern slavery in the UK.

### **6.3 Criminal Offences and Adult Safeguarding**

If, as part of a safeguarding allegation, a crime is suspected, then the police must always be informed and should investigate (see Section 7.2 below on how to report concerns of adult abuse). Where there are any doubts about whether the allegation may be criminal, the Trust Safeguarding Team must be consulted for advice and if necessary they will contact the police. NB — where a member of staff thinks a crime is happening now, then they must call the police now.

Statutory guidance (see link below) states that early involvement of the police ensures that they are able to preserve evidence and have a better opportunity to safeguard the individual who may have suffered harm and hold the alleged offender to account. Line managers and senior Trust personnel who are in charge at the time must always be informed whenever police are called by a staff member in relation to a safeguarding concern. The Chief Nurse who is the Trust's executive lead for safeguarding must always be informed of such events.

Whilst the police investigation takes priority over other enquiries, a multiagency approach must also be agreed to ensure all the interests and views of the person are considered throughout and an appropriate plan is agreed and put in place.

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

#### **6.4 Hate Crime**

Some issues of adult abuse must also be considered in the context of hate crime legislation. The term 'hate crime' can be used to describe a range of criminal behaviour where the perpetrator is motivated by hostility or demonstrates hostility towards the victim's disability, race, religion, sexual orientation or transgender identity.

These aspects of a person's identity are known as 'protected characteristics'. A hate crime can include verbal abuse, intimidation, threats, harassment, assault and bullying, as well as damage to property. The perpetrator can also be a friend, carer or acquaintance who exploits their relationship with the victim for financial gain or some other criminal purpose.

Several serious case reviews in recent years have identified anti-social behaviour and hate crimes towards vulnerable individuals.

### **7. HOW TO REPORT CONCERNS AND ALLEGATIONS OF ADULT ABUSE**

Staff must remain vigilant to all signs of abuse or neglect as set out in section 6 above and Appendix 1 of this policy. Anyone can witness or become aware of information suggesting that abuse and neglect could be occurring.

Abuse may come to the attention of an HCP or any other staff member through:

- a disclosure, allegation or complaint by a patient about their care or treatment by paid carers, professionals, family members, friends, strangers or other individuals;
- a disclosure, allegation or complaint raised by a third party;
- an observation relating to a person's practice or behaviour towards an Adult at Risk;
- concern about changes in behaviour or the wellbeing of an Adult at Risk;
- a build-up of concerns over a period of time.

Regardless of how the concern comes to light, it is imperative that once someone becomes aware of the possible abuse of an Adult at Risk, immediate action is taken to safeguard the adult and report the abuse.

In order to ensure the immediate safety of the adult, it is essential that information about the allegation is not shared with the person alleged to have committed the abuse.

#### **7.1 Reporting concerns of Adult Abuse to Adult Social Care**

All concerns must be reported to the BCC Social Care Safeguarding Adults Team in the MASH. Concerns can be reported by telephone in the first instance using contact information below:

**During office hours**

09:00 – 17:30 Monday to Thursday

09:00 – 17:00 on Friday

**Tel: 0800 137915**

**Outside office hours**  
Emergency out of hours  
**Tel: 0800 9997677**

Concerns must be followed up in writing using the BSAB Safeguarding Multi-Agency Adult Referral Form – see link below.

<http://www.buckinghamshirepartnership.co.uk/safeguarding-adults-board/how-to-report-abuse/>

It is expected that the person who has received information about, or noticed possible abuse must raise the concern. Some junior or non-clinical staff members in particular may need guidance on how to do this. Help and support will be available from line managers, senior/duty managers, the Trust Safeguarding Team or the BCC Social Care Safeguarding Adults Team.

**The process for securely submitting a safeguarding adult referral is as follows:**

1. Complete a safeguarding adult referral form; this should ideally be done with the consent of the adult who is thought to have suffered harm, but lack of consent does not prevent the referral being undertaken.

**Key points to consider:**

- Try to establish what the adult wants as an outcome of the referral;
  - Inform the adult that you are carrying out the referral and say what might happen next;
  - Do not inform the person/people alleged to have caused harm of the referral.
2. Send the completed referral form to the Referrals Coordinator at BCC Adult Social Care and mark **FAO Adult MASH** (multi agency safeguarding hub). Please use the secure email address below:  
[secure-safeguardingadults@buckscc.gcsx.gov.uk](mailto:secure-safeguardingadults@buckscc.gcsx.gov.uk)
  3. At the same time as submitting the referral to Adult Social Care, staff must also send a copy to the BHT Safeguarding Adult Team using the secure email address below:  
[buc-tr.adultsafeguardsbht@nhs.net](mailto:buc-tr.adultsafeguardsbht@nhs.net)

**7.2 Reporting concerns of Adult Abuse to the Police**

Everyone is entitled to the protection of the law and access to justice; all victims of abuse must be informed of their right to report an allegation to the police. The police have a lead responsibility for investigating any criminal offences committed against an Adult at Risk. In all situations where an adult has possibly been abused and a crime may have been committed, the first consideration must always be the person's safety and respect for their dignity and rights (see also section 6.3 above).

**In non-urgent situations** the police can be contacted using the **101 telephone number**. Any discussion with the police, including a crime reference number assigned to the case, must be recorded in the clinical record. The Chief Nurse and Safeguarding Team must also be made aware.

**In emergency situations** contact the police using the **999 telephone number** and record this fact in the clinical record. Inform line manager, senior/duty managers, the BHT Safeguarding Team and Trust Chief Nurse.

It is essential that any actions taken by BHT staff do not increase risk to the adult or compromise an investigation. It is vital that the accounts of any adults at risk, witnesses and suspects are obtained in a way that does not affect their admissibility in the courts. If there are any doubts about this the Trust Safeguarding Team must be consulted so that discussion with the police for advice as to the best course of action can take place.

Where an allegation of crime is made it is important to abide by the following key principles:

- Let the adult know who will be informed, and offer support;

- Do not make promises that may not be kept regarding confidentiality. If there is evidence of a serious crime or other factors are involved, then it is your duty to share the information;
- Do not speak about the allegation to the person alleged to have caused the harm without checking with the police first;
- Only ask questions to establish what has happened, to find out if the adult or another person is at immediate risk of harm and to establish the basic facts;
- Do not ask leading questions, but do not stop someone from speaking whilst they are disclosing what has happened, as this may convey a message that they are doing something wrong;
- Keep a record of what is said and use the exact words of the person involved and note the time, date and location of any recording;
- Record the physical appearance of any individual/s involved and note any damage or other relevant information regarding to the surrounding environment;
- Take steps to preserve evidence where possible and explain to the police what you have done. It is equally important to tell them if you have moved or touched something that might be relevant;
- Consider other individuals who may be involved in the situation and could also be potential victims – please see section 12 re “Think family”.

By observing these simple rules you will assist the victim and ensure that evidence is obtained in a professional manner and that any criminal prosecution will not be jeopardised.

Some adults may choose not to pursue a criminal allegation but the police will continue to secure and preserve evidence and a crime report will still be recorded. Whilst adults have a right to make decisions about their lives, in some circumstances the wishes of the Adult at Risk may be overridden if concerns persist about their own safety or that of others.

Other than investigating a crime, the involvement of the police can be of additional benefit such as obtaining victim support, or enabling the police to invoke specific protective actions which may apply to the situation, for example a Domestic Violence Protection Orders (DVPO).

### **7.3 Referring concerns of Self-Neglect to the Risk Assessment Multi-Agency Panel (RAMP)**

The RAMP aims to support adults who meet the Care Act safeguarding criteria and who are resident in Buckinghamshire and the practitioners who work with them.

The RAMP is a multi-agency panel designed to support practitioners and service users where aspects of an individual’s lifestyle are being potentially or actually harmful to their wellbeing. The panel supports practitioners working with Adults at Risk in the following ways:-

- To consider a variety of options for supporting individuals
- Improved support for practitioners
- Identification of risk at an earlier opportunity
- A proportionate, coordinated, effective and timely response
- Improved outcomes for the adult with care and support needs
- Create wider understanding of the nature of care and support needs in Buckinghamshire

Referrals for consideration by RAMP regarding adults with care and support needs must be directed to BCC Social Care Safeguarding Adults Team in the MASH (see link below to locate referral form). RAMP referrals will be managed in the MASH and the following decisions may be made:-

- That immediate protective measures are required – action by Adult Social Care Safeguarding or the police; the case will not proceed to RAMP at this time;
- That there is evidence within the referral of actions already taken to engage and support the Adult at Risk which have had limited or no effect - in this situation the RAMP referral will be forwarded to RAMP administrator.

[RAMP Referral Form](#)



It is the responsibility of the staff member raising the concern to ensure that they receive feedback in relation to the outcome of their concern in order to establish that the adult at risk has been effectively safeguarded. The outcome must be documented in the clinical record and the adult's views about the safeguarding process must also be documented stated (see section 9 below).

#### **7.4 Reporting Concerns about Domestic Abuse**

When completing a safeguarding adult referral for BCC Social Care Safeguarding Adults Team in relation to domestic abuse, consideration must be given to the completion of a Domestic Abuse Stalking and Harassment (DASH) Risk assessment form – see link below:

<https://www.buckscc.gov.uk/media/4508591/dash-with-guidance.pdf>

Completion of the DASH form enables the HCP to ascertain the severity of domestic abuse and therefore whether a referral to Buckinghamshire Multi-agency Risk Assessment Conference (MARAC) is also required.

The Buckinghamshire MARAC is part of a coordinated community response to domestic abuse incorporating representatives from statutory, community and voluntary agencies working with victims/survivors, children and the alleged perpetrator. The MARAC aims to:

- Share information to increase the safety, health and well-being of victims/survivors – adults and their children
- Determine whether the alleged perpetrator poses a significant risk to any particular individual or to the general community
- Construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm
- Reduce repeat victimisation
- Improve agency accountability; and
- Improve support for staff involved in high-risk domestic abuse cases.

The aim of the form DASH Risk assessment form is:

- To help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence.
- To decide which cases should be referred to the MARAC and what other support might be required. A completed form becomes an active record that can be referred to in future for case management.
- To offer a common tool to agencies that are part of the MARAC process and provide a shared understanding of risk in relation to domestic abuse, stalking and 'honour'-based violence.
- To enable agencies to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides and 'near misses', which underpins most recognised models of risk assessment.

See link below for access to Buckinghamshire resources in relation to domestic abuse and MARACs:

<https://www.buckscc.gov.uk/services/community/community-safety/domestic-abuse-resources-for-professionals/guidelines-for-professionals>

#### **7.5 Reporting suspected modern slavery:**

Where there are concerns that an individual may be a victim of modern slavery, a safeguarding adult referral form must be completed and sent to BCC Social Care Safeguarding Adults Team (please see section 7.1 above). In addition to this, an additional referral in accordance with the National Referral Mechanism (NRM) must also be completed – please see below for details on how to do this. A Datix incident form must also be completed.

People who are thought to be victims of modern slavery are entitled to help and protection from the UK Government. They may be unwilling to come forward to law enforcement or public protection agencies, not seeing themselves as victims, or fearing further reprisals from their abusers. Victims may also not always be recognised as such by those who come into contact with them.

Local support for victims is available from the Rahab Project – please see link below:

<http://www.themustardtree.org/rahab>

Where a suspected victim is admitted to any BHT in-patient unit, care must be taken regarding who is visiting the patient; advice about this can be taken from the police or any other agency that may be involved in supporting the patient. When the patient is discharged, this must be done in accordance with multi-agency advice and in such a way that the patient is kept safe from harm. Do not permit a visitor to discharge the patient; if there is a risk of this happening the Trust Security Team must be alerted along with the police. If a patient at risk disappears from an in-patient setting, the Trust Missing Persons Policy must be invoked.

In 2009 the UK government set up the NRM to which potential cases are referred and through which victims can access relevant support. This mechanism has been reinforced and encompassed into legislation in the form of the Modern Slavery Act 2015.

Frontline staff (also called first responders) may have concerns that modern slavery has taken place: they don't need to be certain that someone is a victim. Where appropriate urgent health needs must be met and the case must then be referred to the NRM so that a competent authority can fully consider the situation.

From 1 November 2015, specified public authorities (including NHS Trusts) are required to notify the Home Office about any potential victims of modern slavery that they encounter in England and Wales. Completing the NRM form (please see link below) is sufficient to satisfy this duty to notify as long as all of the sections marked with a † are completed.

[National referral mechanism form: adult \(England and Wales\)](#)

Adults will only be accepted into the NRM if the consent section of the form has been completed. Informed consent requires that the potential victim have the NRM, the referral process, and potential outcomes, clearly explained to them.

If the potential victim does not want to be referred to the NRM, then an MS1 form (please see link below) must be completed and sent to [dutytonotify@homeoffice.gsi.gov.uk](mailto:dutytonotify@homeoffice.gsi.gov.uk). The MS1 form can be anonymous.

[Form: duty to notify the Home Office of potential victim of modern slavery](#)

Detailed Home Office guidance for frontline staff is available from the link below:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/509326/victims-of-modern-slavery-frontline-staff-guidance-v3.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/509326/victims-of-modern-slavery-frontline-staff-guidance-v3.pdf)

Further information on human trafficking can be found at:

<http://www.nationalcrimeagency.gov.uk/about-us/what-we-do/specialist-capabilities/uk-human-trafficking-centre>

## **7.6 Reporting PREVENT Concerns**

Prevent is part of the Government's counter- terrorism strategy. The aim of Prevent is to reduce the threat to the UK from terrorism by preventing vulnerable people (including children) from becoming terrorists or supporting terrorism. This is a safeguarding concern.

A safeguarding adult referral must be made to the BCC Social Care Safeguarding Adults Team (please see section 7.1 above) and any subsequent decision regarding whether to make a referral to the Channel (de-radicalising) programme will be made in conjunction with local police.

Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) places a duty on certain bodies (including NHS Trusts) that in the exercise of their functions they must have "due regard to the need to prevent people from being drawn into "terrorism".

Healthcare staff are well placed to recognise individuals who are vulnerable and may be susceptible to radicalisation by extremists or terrorists. This is a fundamental duty of care and falls within the Trust's safeguarding responsibilities. All healthcare staff must be trained to ensure that they can identify the possible signs that someone has been, or is being, drawn into terrorism.

A concern that an individual may be vulnerable to radicalisation does not necessarily mean that they are thought to be a terrorist; this simply means that there are concerns that they may be being exploited by others. Staff who have such concerns must inform their line manager in the first instance and subsequently the Trust Safeguarding Team.

Where there are urgent concerns that an individual is presenting as an immediate terrorist risk to themselves, others or to property this must be reported to:

- **The National Counter Terrorism Hotline on 0800 789321**
- **or**
- **The police using the 999 number**

Additional guidance about Prevent issues is available from the Trust Prevent Policy.

### **7.7 Reporting Concerns to Trust Managers**

BHT staff must ensure that all adult safeguarding referrals, both to Adult Social Care (MASH) and the police, are reported to the manager in their clinical area, to the site team and the Trust Safeguarding Team. In the case of a serious allegation which may also require that the police are notified alongside the completion of the safeguarding adult referral, line managers, senior/duty managers, the Trust Safeguarding Team and the Chief Nurse must be made aware. Please also see section 8 below regarding management of allegations against staff.

## **8. MANAGING ALLEGATIONS AGAINST MEMBERS OF STAFF**

Staff are reminded that they have a responsibility to maintain appropriate professional boundaries at all times in their relationship with patients as well as their relatives or carers in accordance with the Trust Professional & Personal Boundaries Policy. Staff are expected to carry out the complete range of care for patients as per the individualised care plan, but must exercise their professional judgement for specific tasks and situations. Any member of staff who feels uncomfortable or considers a task to be inappropriate in the given circumstances, must ask someone else to be present or to take over.

Trained staff are responsible for care delegated to untrained staff and must give due consideration to an adult's vulnerability as well as the task and circumstances.

The Care Act 2014 states that "It is important that all partners are clear where responsibility lies when possible abuse or neglect is carried out by employees or in a regulated setting such as a hospital. It is the first responsibility of the employing organisation to act on allegations against staff.

When a concern or allegation is raised which may indicate that a member of Trust staff has behaved in a way that has harmed or may have harmed an Adult at Risk, this must always be taken seriously and must be investigated. The concern raised may relate to the staff member's work within the Trust or their activities outside of the work place.

Where the allegation is of a criminal nature, the police must always be informed (see sections 6.3 and 7.2 above). Patients must be made aware of their rights to inform the police of any allegation they may make about a staff member.

Whenever an allegation of abuse is made about an employee who is working with Adults at Risk, Trust staff must abide by BSAB People in a Position of Trust (PiPoT) Policy and Guidance for Managing Allegations against Staff who Work with or Care for Adults at Risk – see link below.

This guidance must be followed when an allegation is made that an employee may have:

- Behaved in a way that has harmed, or may have harmed a child, young person or Adult at Risk;
- Possibly committed a criminal offence against, or related to an Adult at Risk or a child; or

- Behaved towards an Adult at Risk or a child in a way that indicates s/he is unsuitable to work with Adults at Risk.

<http://www.buckinghamshirepartnership.gov.uk/safeguarding-adults-board/information-for-professionals/persons-in-positions-of-trust/>

Staff who become aware of an allegation against a member of staff must always escalate this information to line managers, senior/duty managers and the Trust Safeguarding Team so that the appropriate action can be taken to:

- Immediately put in place safety plans for the adult against whom the alleged abuse has occurred as well as for other adults in the environment;
- Alert the BCC Social Care Safeguarding Adults Team and/or the police as explained in sections 7.1 and 7.2 above;
- Report the allegation using the Datix incident reporting system;
- Report to the Named Senior Officer within the Trust - this is the Executive Lead for Safeguarding who is the Chief Nurse – or deputy;
- Inform the Adults Local Authority Designated Officer (ALADO) who is responsible for the management and oversight of all allegation against staff cases in Buckinghamshire – this will usually be undertaken by the Named Senior Officer or deputy;
- Appoint a Designated Officer – usually a senior manager – to work collaboratively with other agencies and take appropriate action as agreed to ensure that any allegation of abuse is dealt with fairly, quickly and consistently and to ensure that support is provided to the member of staff who is subject to the allegation;
- Seek advice from the Trust Human Resources (HR) Team;
- Inform the CQC;
- Inform the Buckinghamshire Clinical Commissioning Group (CCG);
- Ensure that the BSAB policy and guidance is followed.

A management planning meeting/discussion will take place which will agree what immediate action to take, how to manage an internal investigation of an allegation against staff and who should lead the investigation. As the executive lead for safeguarding and as such, the senior manager for managing allegations of abuse against staff, the Chief Nurse must always be informed of these events. An internal investigation will only take place if this is considered safe or appropriate; the police will take a lead in a criminal investigation and the Trust will proceed as guided by the police.

The member of staff about whom the allegation has been made will be informed of the allegation and any agreed action following the management planning meeting/discussion. If the person is a member of a trade union or professional association they should be advised to seek support from that organisation. A referral to the Trust Wellbeing Service for the staff member must be considered.

The management planning meeting/discussion will agree who will maintain contact with the staff member. It is also required that the employee will be:

- Treated fairly and honestly;
- Supported to understand the processes involved;
- Informed of the potential outcomes of the investigation.

Consideration must always be given to invoking Disciplinary Procedures which may include suspension and/or referral to the Disclosure and Barring Service (DBS).

The LA may well be reassured by the employer's response so that no further action by them is required. However, a local authority would have to satisfy itself that an employer's response has been sufficient to deal with the safeguarding issue and if not will undertake any enquiry of its own and any appropriate follow up action (e.g. referral to CQC, professional regulators etc.).

Following consultation with HR and the Trust Safeguarding Team, it may be appropriate in some cases to move the person against whom the allegation is made to a non-care position or to another location under full supervision and pending the outcome of any investigation. If this is considered to be appropriate the full supervision must be provided at a level whereby the alleged

perpetrator is not, and cannot be, alone with adults at risk and cannot pose any risk to them. Taking this course of action will depend on the full circumstances of the individual case.

If it is decided that a member of staff who has been temporarily redeployed or excluded can return to their substantive post, the Trust's Named Senior Officer or deputy, together with HR, will consider how best to facilitate this. Most staff will benefit from help and support to return to work after a very stressful experience. A phased return and/or the provision of a mentor may be appropriate. It should also be considered how the employee's contact with the Adult at Risk who made the allegation can best be managed.

Where an allegation is determined to be unfounded the Trust must refer the matter to the BCC Social Care Safeguarding Adults Team for them to determine whether the Adult at Risk may be in need of services or may have been abused by someone else. In the rare event that the allegation is shown to be deliberately invented or malicious, the Police should be asked to consider whether any action may be appropriate against the person responsible.

On the conclusion of any investigation and any related disciplinary proceedings, the adult about whom the concern was raised and/or their family/carer will be informed of the outcome and what, if any, action has been taken. If disciplinary action has been taken the details of this cannot be disclosed. This will happen prior to the employee's return to work if they have been temporarily redeployed or excluded from the workplace. The details of how this will happen will be agreed at the final reconvened management planning meeting/discussion if held, and if not, with the ALADO.

## **9. INFORMATION-SHARING**

The General Data Protection Regulation (GDPR) which is enforceable from 25<sup>th</sup> May provides the legislative context governing what and how information can be shared, and in what circumstances. The Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.

Responsible information sharing plays a key role in enabling services to protect victims of adult abuse, and in extreme cases save lives. Articles 2 and 3 of the Human Rights Act 1998 place an obligation on public authorities to protect people's rights to life and their freedom from torture, inhumane and degrading treatment. Meeting these obligations requires lawful information sharing.

Confidentiality is a serious consideration for all public services; however within the confines of safeguarding arrangements information can usually be shared safely. It is always good practice to try to gain the consent of the Adult at Risk before sharing any information relating to safeguarding. If consent is refused professionals must apply the public interest test; that is, considering whether the public interest in maintaining confidence in confidentiality is outweighed by the public interest in protecting a child at risk of significant harm or serious harm to an adult.

Where there is doubt about deciding whether the public interest justifies disclosing confidential information without consent, HCPs and other Trust staff must consider seeking advice from a line manager, Caldicott Guardian, the Trust Information Governance Lead or the Trust Safeguarding Team. Where an HCP or other staff member decides to share confidential information without consent, this must be explained to the Adult at Risk unless to do so would put them at further risk of harm.

When an Adult at Risk discloses that abuse is happening, absolute assurances about confidentiality cannot be given, even if the adult has capacity to make informed decisions. There will be cases where sharing some information without consent is necessary to enable professionals to reach an informed decision about whether further information should be shared or action should be taken.

The Care Act Statutory Guidance emphasises the need to share information about safeguarding concerns at an early stage. This is to enable all agencies and individuals involved with the adult's care to effectively assess the risk of harm and to be confident that the adult is not being unduly

influenced, coerced or intimidated and is aware of all the options. It is good practice to inform the adult about any action being taken unless doing so would increase the risk of harm.

A concern about adult abuse must always be raised to the BCC Social Care Safeguarding Adults Team in the MASH (see section 7 above) in accordance with local procedure; all information shared, including any completed concern forms, must be stored in the adult's clinical record.

If the decision is to share, this must be done in a proper way which means:

- Share only the information which is necessary and for the purpose for which it is being shared;
- Share the information only with the person or people who need to know;
- Check that the information is accurate and up-to-date;
- Share it in a secure way;
- Establish with the recipient whether they intend to pass it on to other people, and ensure they understand the limits of any consent which has been given;
- Inform the person to whom the information relates, and, if different, any other person who provided the information but only if it is safe to do so.

Staff must always record all decisions about whether or not they have shared information and the reasons for doing so. This record must include what information has been shared and with whom, and whether disclosure was made with or without consent.

## **10. POSSIBLE RESPONSE TO AN ADULT ABUSE REFERRAL**

When responding to a safeguarding adult concern, the aim must always be that the right outcome is achieved for the individual concerned. If the risk of harm is significant and/or immediate, adults at risk must be protected straightaway and the concern raised without delay.

Section 42 of the Care Act 2014 requires that local authorities must make enquiries, or cause others to do so, if it is believed that an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

On receipt of a safeguarding adult referral it is the responsibility of the manager of the investigating team within the BCC Social Care Safeguarding Adults Team in the MASH to decide whether to initiate an enquiry under these procedures.

### **10.1 Immediate Response – No Enquiry**

It may be immediately decided that the threshold to initiate a safeguarding adult enquiry under the Multi-Agency Safeguarding Adults Procedures is not met when

- the adult at risk is not an adult who is covered by these procedures;
- the situation does not involve abuse, neglect or exploitation;
- significant harm has not been caused.

**or**

- the Adult at Risk has the mental capacity to make an informed choice about their own safety and they choose to live in a situation in which there is risk or potential risk and there are no public interest concerns or other vital interest considerations.

### **10.2 Strategy Discussion/Meeting**

Once a decision has been made to initiate an enquiry, information is gathered promptly via a multi-agency strategy discussion within the MASH. This discussion can be conducted by telephone to ensure that information can be gathered and assessed in a timely way.

It is the responsibility of the MASH investigating team manager to determine whether advocacy is required (see section 10.4 of this policy), to convene and chair the strategy discussion or meeting and ensure that minutes are taken and circulated. Detailed guidance about strategy discussions and meetings can be found within the BSAB Multi Agency Safeguarding Procedures.

A strategy discussion or meeting must take place before any investigation is started. During this stage organisations, for example a care provider or the police in the case of a possible crime, may be carrying out their own enquiries or investigations. These should be co-ordinated with the section 42 enquiry, but may be linked by information gathering and sharing.

It may be necessary to suspend internal enquiries where the police request such action, or where the organisation is unable to progress due to competing priorities between civil and criminal proceedings. For example a disciplinary hearing may not be possible until the conclusion of a police investigation in order not to prejudice any possible prosecution.

The strategy discussion/meeting will:

- share the information currently available about the Adult at Risk and their situation;
- consider whether a capacity assessment is required;
- evaluate the risk faced by the Adult at Risk;
- decide if an investigation is needed under the safeguarding adults procedures;
- identify the members of an investigation team;
- agree the multi-agency investigation plan;
- agree a safeguarding plan;
- coordinate the collection of information about the alleged abuse or neglect;
- identify individual(s) to liaise/support the Adult at Risk and family/carer during the investigations (this could be a worker from the investigating team or someone who knows the adult well, (for example, care or support staff));
- decide if the Adult at Risk requires a medical examination from a general practitioner (GP), the accident and emergency service or a forensic medical examiner (the police will advise);
- identify an alternative and appropriate response to the concern if an investigation is not required;
- agree an investigation plan and a safeguarding plan pending a case conference (reconvened safeguarding strategy meeting) or
- in serious cases agree the immediate safeguarding plan pending a face to face strategy meeting.

The outcomes of a strategy discussion/meeting will be one of the following:

- to continue with the safeguarding adults investigation;
- no further action required under safeguarding adults procedures;
- to continue action with other procedures.

### **10.3 Safeguarding Adult Investigation**

The purpose of the investigation is to:

- determine if abuse has taken place;
- re-evaluate risk;
- reassess the capacity of the Adult at Risk;
- safeguard the Adult at Risk and reduce the risk of further abuse;
- ensure the Adult at Risk's physical and emotional condition is assessed and treated;
- obtain an assessment of the incident and the family circumstances, including the identification of facts which may have caused/contributed to the abuse;
- achieve the best/most sensible outcome for all concerned;
- collect evidence for any appropriate legal proceedings;
- evaluate the need for a more comprehensive social and health assessment.

Agreement must be reached about respective roles and responsibilities of organisations during the investigation/enquiry, including agreement on lead responsibilities, specific tasks, cooperation, communication and the best use of skills. Depending on the specific circumstances the lead role in carrying out a safeguarding adult investigation may be delegated to a member of BHT staff.

HCPs and other BHT staff will be expected to share information for the purpose of a safeguarding adult investigation in accordance with the guidance set out in section 9 of this policy – please see above.

It is the responsibility of BHT staff who have made a safeguarding adult referral to ensure that they receive an outcome of the referral and to record the outcome in the adult's clinical record.

For full details about how investigations are conducted please refer to the BSAB Multi Agency Procedures.

#### **10.4 The Adult's Right to Advocacy**

The Care Act requires that each local authority must arrange for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them.

Where it is considered appropriate, an adult must be supported during an assessment, a carer's assessment (including any children assessments), the preparation of the care and support plan and any safeguarding review.

The right to advocacy must always be considered at every stage of the safeguarding process and consideration given to whether the person at risk would benefit from the support of an independent advocate to express their views. This includes considering the requirement to provide a statutory Independent Mental Capacity Advocate (IMCA) – see link below on how to find a local IMCA service:

<https://www.scie.org.uk/mca/imca/find>

There are two types of non-statutory advocacy that can be commissioned. These are:

**Instructed advocates** who take instructions directly from the person and can support at meetings and with communication. If the person decides they do not require the support of an advocate then support will be withdrawn.

**Non-instructed advocates** who work with people who may lack capacity or have severe communication challenges. A non-instructed advocate will work with the person and those around them. An independent report will be produced that will ask relevant questions and can support the safeguarding decision-making process.

See link below to find non-statutory advocacy services in Buckinghamshire:

<https://www.pohwer.net/Pages/Category/our-services>

Any decision or consideration given to instruct an advocate of whatever type must be recorded. It is important that all people involved in the safeguarding adult process are aware of which type of advocate is representing the person and supporting them to express their views.

#### **10.5 Escalating Concerns**

Where there are any concerns that a safeguarding case has not been managed in accordance with local procedures these must be escalated as follows:

- discuss with line manager or within the local team in the first instance;
- talk to the relevant investigating team manager;
- discuss with the Trust Safeguarding Team;
- where there is no satisfactory outcome the issue of concern will be escalated to the Trust Executive Director (Chief Nurse) and ultimately to the BSAB;
- record every decision to act or not to act and keep the Trust Safeguarding Team informed.

#### **10.6 Challenging Poor Practice and Raising Concerns**

BHT staff must always feel able to express their concerns about the abuse of Adults at Risk as set out in this policy. These concerns must be expressed without fear of recrimination and staff must be able to believe that their concerns will be welcomed as a positive contribution to the overall standard of care within the Trust.



BHT supports its staff who identify a concern relating to poor practice and which may result in harm to patients or others; staff are positively encouraged to speak out about any concerns they may have. The best and most effective way to do this, wherever possible, is to tackle poor practice immediately or “in the moment”. The link below to a training resource on how to do this may be helpful to some staff:

[https://www.dignityincare.org.uk/assets/Challenging\\_Booklet\\_low\\_res.pdf](https://www.dignityincare.org.uk/assets/Challenging_Booklet_low_res.pdf)

Whilst a culture of speaking up is instilled throughout the organisation, not all staff will feel comfortable in tackling concerns directly. Staff are therefore encouraged to raise concerns with their line manager or clinical lead, or with the Trust Safeguarding Team if speaking to a line manager is not possible.

Where staff do not feel comfortable in raising concerns as suggested above, the Trust’s **Freedom to Speak up Guardian** (FTSUG) is available to support staff to raise their concerns safely. This role has been created as part of a national network following the Francis Inquiry into the failings in care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009.

Staff must be able to raise concerns with confidence; the role of the FTSUG enables staff anxieties to be dealt with swiftly and ensures a better experience for all concerned. Speaking to the FTSUG is shown to reduce personal stress, enables a more local resolution to be achieved and with allows better implementation of learning back into practice.

Not every concern needs to be the subject of a formal process and the Trust FTSUG sees every concern raised as an opportunity to learn and improve patient safety and the quality of care. Whether staff are working in a clinical or non-clinical role, whenever they have a concern they are able to share it safely with the support of the FTSUG.

Staff wanting to raise concerns in confidence can call Tracey Underhill, the Trust’s Freedom to Speak up Guardian on the dedicated phone line:  
**01296 316027** or **07768612590**

## 11. SAFEGUARDING ADULT REVIEWS

The Care Act 2014 places a statutory responsibility on Safeguarding Adults Boards to commission Safeguarding Adults Reviews (SARs) in certain specified situations.

BSAB must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

BSAB must also arrange a SAR if an adult in its area has not died, but the Board knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

BSAB is free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support. SARs should reflect the six safeguarding principles set out in section 5.1 of this policy.

The aims of a SAR are to:

- seek to determine what the relevant agencies and individuals involved in the case might possibly have done differently in order to have prevented harm or death;
- learn lessons from the case and apply the learning to future cases in order to prevent similar harm occurring again;
- generate findings and recommendations which are of practical value to each organisation and professional involved;

- provide answers for families and friends of adults who have died or been seriously abused or neglected.

The following principles should be applied by BSAB and their partner organisations to all reviews:

- there must be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews must be proportionate according to the scale and level of complexity of the issues being examined;
- reviews of serious cases must be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith; and
- families must be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

In setting up a SAR, BSAB must also consider how the process can dovetail with any other relevant investigations that are running parallel, such as a child serious case review (SCR) or domestic homicide review (DHR), a serious incident (SI) investigation, a criminal investigation or an inquest. An SI report produced by the BHT may contribute to the SAR process.

Consideration must be given to how all parallel investigations can be managed with a SAR in the most effective manner possible so that organisations and professionals can learn from the case - for example, considering whether some aspects of the reviews can be commissioned jointly so as to reduce duplication of work for the organisations involved.

## 12. THINK FAMILY

When considering the wellbeing of any adult, services and professionals need to respond to the crucial context of family. A family focus must be considered alongside, not instead of, the provision of individual care. A comprehensive assessment will take into account the circumstances in which adults live and their caring responsibilities, as well as their individual wellbeing.

Personal stress factors and risks do not necessarily seriously affect an adults parenting or caring capacity, however it is important to recognise that many families face multiple problems which can have a compounding effect. People living in these families are disproportionately more likely to experience poor outcomes.

Factors to consider include:

- poverty;
- debt;
- unemployment;
- lack of supportive family and social networks;
- crime and experience of the criminal justice system;
- poor housing or homelessness;
- antisocial behaviour;
- drug and alcohol problems;
- mental health concerns;
- learning disabilities;
- physical health concerns;
- relationship problems and breakdown;
- domestic abuse.

In order to better understand the whole picture of an adult's circumstances it is important to consider asking family-related questions at first and subsequent contacts such as:

- Who else lives in your house?

- Who helps with your support and who else is important in your life?
- Does anyone have lasting power of attorney for your health and care and/or your finances?
- Is there anyone that you provide support or care for?
- Is there a child in the family (including stepchildren, children of partners or extended family)
- Does any parent need support in their parenting role?

Working with adults who live with multiple problems can be challenging and it may not be possible to easily change all the adversities which they and their families experience. However it may be possible to reduce the negative effects and promote protective factors through keeping a focus on individual and family strengths and resilience.

It is important to recognise the impact that individual family members can have on one another. The behaviour of children, for example, can have a large impact on their parents' circumstances and behaviours, as well as vice versa. Whilst children can be a source of motivation to curb risk-taking behaviours, they can also be a trigger for challenges and stresses within the family; for example having a child with a disability and/or complex health needs can lead to particular strains on a family.

A whole-family approach may frequently necessitate joint working across a wide range of local partnerships in order to enable services to be coordinated. The sharing of information with other key agencies through agreed referral processes must always be considered. HCPs must always remain aware and be prepared to intervene when there is concern that a child or another Adult at Risk is suffering or is likely to suffer harm.

### **13. DUTIES TO CARERS**

The Care Act 2014 recognises that carers can be eligible for support in their own right. The threshold is based on the impact their caring role has on their wellbeing. BHT staff must give due consideration to the fact that carers have recognition within the Care Act so that they can be effectively supported and safeguarded.

As part of the assessment and support planning process for the carer and, or the adult they care for, BHT staff must give consideration as to whether support can be provided that removes or mitigates the risk of abuse to the carer as well as the adult in need of care and support.

### **14. TRANSITION FROM CHILD TO ADULT SERVICES**

Transition planning which is person-centred and age and developmentally appropriate is essential to help young people prepare for adulthood. If carried out effectively it can help ensure that risk of experiencing abuse as an adult is minimised.

Structural and cultural differences between children's and adult services can make transition more difficult. Services should therefore work together in an integrated way to ensure a smooth and gradual transition for young people.

Transition planning must start as early as possible so that the young person is helped to understand how to use services. Support after transfer must be aimed at encouraging the young person to engage with services and should explore alternative ways to support their needs if engagement is a problem.

The named worker must be someone with whom the young person identifies they have a meaningful relationship. A practitioner from the relevant adult service should meet the young person before transfer.

The aim of ensuring effective transition to adult life is to improve life experience and outcomes for all children and young people which may include:

- paid employment;
- good health;
- completing exams and moving to further education;
- independent living (choice and control over one's life and good housing options);
- social inclusion (friends, relationships and community).

Detailed guidance on transition to adult care and support can be found in:

- Care Act 2014 Statutory Guidance, chapter 16;  
<https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#contents>
- NICE Guideline 2016, Transition from children's to adults' services for young people using health or social care services.  
<https://www.nice.org.uk/guidance/ng43>

## **15. STAFF TRAINING AND SUPPORT**

### **15.1 Training**

Safeguarding Adult training is a statutory requirement for all staff. An individual employee's role will determine what level of training is required in order to ensure that they are confident and competent to carry out their responsibilities to safeguard adults. The Trust Safeguarding Team is responsible for creating and updating the safeguarding training needs analysis in conjunction with Education, Learning and Development (ELD); the needs analysis sets out what level of training is required by various staff groups and individuals.

Any individual training matrix can be viewed by each Trust member of staff or their line manager via NLMS e-learning on the Learning and Development site on Swanlive. The Trust, supported by the Corporate Safeguarding Team, will ensure that a sufficient number of internal training events are provided and that access to e-learning and external training events is available to staff as appropriate.

Training is provided for all new staff as part of the monthly corporate induction programme. Regular monthly face to face safeguarding training is available to all staff groups. Bespoke training can be provided by the Safeguarding Team on request.

It is the responsibility of individual staff members and their line managers to ensure that training is updated in line with their personal development plans and training Matrix. This will be monitored as part of individual staff appraisal.

### **15.2 Support for Staff Involved in Safeguarding Adult Cases**

It is recognised that staff may find it difficult or stressful when identifying and reporting abuse or being involved in any capacity in a safeguarding adult case. The Trust must consider the potential for distress and psychological trauma to members of staff involved and be prepared to provide support and/or supervision for an individual or team.

Support for staff reporting or working with any incident of abuse against adults can be offered from their line manager, the Trust Wellbeing Service or the Trust Safeguarding Team or any combination of these.

The Trust Safeguarding Team can provide safeguarding advice and/or safeguarding supervision on a 1:1 or group/team basis on request.

Staff who are the subject of an allegation of abuse will also receive support as set out in section 8 of this policy.

## 16. EQUALITY AND DIVERSITY STATEMENT

This policy has been assessed for its impact upon equality. The equality analysis can be seen Annex 1.

Buckinghamshire Healthcare NHS Trust is committed to ensuring that the way we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group.

## 17. CONSULTATION AND REVIEW PROCESS

This policy was circulated for review to:

- Chief Nurse
- Medical Director
- Associate Medical Directors
- Divisional Chief Nurses, Divisional Chairs, Divisional Directors
- Head of Patient Safety and Litigation
- Matrons and Lead Nurses
- Nurse Consultants
- Information Governance Manager
- SDU Leads
- AHP Leads
- Freedom to Speak up Guardian
- Safeguarding Team
- Safeguarding Committee
- CCG Safeguarding Adults Leads
- BSAB Business Manager
- Business Manager BCC Safeguarding Adults Team
- Head of Safeguarding BCC
- BCC Joint Mental Capacity Act Coordinator and Deprivation of Liberty Safeguards Lead

The policy will be reviewed 2 years from ratification or beforehand if there are any significant changes to national or local policy guidance.

## 18 MONITORING THIS POLICY

The Trust Safeguarding Committee and Adults Team will monitor this policy on behalf of the Trust to ensure the effectiveness of the organisation's duties and responsibilities.

Standard/process/issue	Monitoring and Audit			
	Method	By	Committee	Frequency
Referral Audit	Dip sample of 5 completed safeguarding adult referrals to ensure forms have been completed correctly.	Safeguarding Adults Team	BHT Safeguarding Committee	Monthly
Mandatory Training Compliance	Safeguarding Dashboard - to meet CQC targets	Safeguarding Adults Team	BHT Safeguarding Committee	Monthly
Learning from SARS and SIs	Audit safeguarding training & training plans to ensure recommendations are included; Circulation of Trust-wide Learning Notes; Test embedding of	Safeguarding Team	BHT Safeguarding Committee  BSAB Learning and Development Sub Group	Annual Audit Programme

	learning through audit			
Safeguarding Activity	Safeguarding Dashboard	Safeguarding Team	BHT Safeguarding Committee	Monthly
Quality Assurance	BSAB assurance tool	Safeguarding Team	BSAB Quality Assurance Sub-Group	Annual

## 19. REFERENCES

CABINET OFFICE SOCIAL EXCLUSION TASKFORCE (2007), Reaching Out: Think Family: Analysis and themes from the Families At Risk Review, London, TSO

CQC Regulation 13: Safeguarding service users from abuse and improper treatment, <http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-13-safeguarding-service-users-abuse-improper>

DEPARTMENT OF HEALTH, Care and Support Statutory Guidance, <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1> DoH Issued under Care Act 2014

DoH ET AL (2015), The Care Act and Whole-Family Approaches <https://www.local.gov.uk/sites/default/files/documents/care-act-and-whole-family-6e1.pdf>

HMG 1998, Human Rights Act, London TSO

HMG 2005, Mental Capacity Act, London TSO

HMG 2010, Equality Act, London, TSO

HMG 2014, Care Act, London TSO

HMG 2015, Serious Crime Act, London TSO

HMG 2015, Modern Slavery Act, London TSO

HOME OFFICE 2013, Human Trafficking: practical guidance, London, TSO [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/181550/Human\\_Trafficking\\_practical\\_guidance.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181550/Human_Trafficking_practical_guidance.pdf)

HOME OFFICE 2015, Counter Terrorism and Security Act 2015, London, TSO

LOCAL GOVERNMENT ASSOCIATION 2014, Making Safeguarding Personal, London, LGA. <https://www.local.gov.uk/sites/default/files/documents/Making%20Safeguarding%20Personal%20-%20Guide%202014.pdf>

NICE 2016, Transition from children's to adults' services for young people using health or social care services, NICE guideline <https://www.nice.org.uk/guidance/ng43>

## 20. GLOSSARY OF TERMS

<b>AD</b>	Associate Director
<b>AHP</b>	Allied Health Professional
<b>ALADO</b>	Adults Local Authority Designated Officer
<b>BCC</b>	Buckinghamshire County Council
<b>BHT</b>	Buckinghamshire Healthcare NHS Trust
<b>BSAB</b>	Buckinghamshire Safeguarding Adults Board
<b>CCG</b>	Clinical Commissioning Group
<b>CQC</b>	Care Quality Commission
<b>DASH</b>	Domestic Abuse Stalking and Harassment
<b>DBS</b>	Disclosure and Barring Service
<b>DoLS</b>	Deprivation of Liberty Safeguards
<b>DVPO</b>	Domestic Violence Protection Order
<b>FGM</b>	Female Genital Mutilation
<b>FTSUG</b>	Freedom to Speak Up Guardian
<b>GDPR</b>	General Data Protection Regulation
<b>HCP</b>	Health Care Professional
<b>HMG</b>	Her Majesty's Government
<b>HR</b>	Human Resources
<b>IMCA</b>	Independent Mental Capacity Act Advocate
<b>LA</b>	Local Authority
<b>LGA</b>	Local Government Association
<b>MARAC</b>	Multi-Agency Risk Assessment Conference
<b>MASH</b>	Multi-Agency Safeguarding Hub
<b>MCA</b>	Mental Capacity Act
<b>MDT</b>	Multi-disciplinary team
<b>NRM</b>	National Referral Mechanism
<b>PIPOT</b>	People in a Position of Trust
<b>RAMP</b>	Risk Assessment Multi-Agency Panel
<b>SARC</b>	Sexual Assault Referral Centre
<b>SAR</b>	Safeguarding Adult Review
<b>SDU</b>	Service Delivery Unit
<b>SI</b>	Serious Incident



## Appendix 1

### GUIDELINES - SPOTTING THE POTENTIAL FOR AND IDENTIFYING ABUSE

The guidelines are to protect equally both patients and staff

#### Risk Factors for abuse

Adult abuse normally occurs when an adult who is in some way vulnerable is faced with a person or set of circumstances with a potential for harm.

Some factors which may place people at particular risk of being abused are described below. However, the presence of one or more of these factors does not automatically imply that abuse will result, but may increase the likelihood.

#### Factors that contribute to vulnerability of an individual

A person's level of vulnerability may increase or decrease at any given time. A person's ability to manage will depend on these circumstances -

**Power** - In healthcare / care settings all of us become vulnerable –shift in balance of power and responsibility, abuse can occur if power is misused.

**Communication difficulties** vulnerable person finds it hard to communicate wishes and feelings – post CVA, head and neck disease, English not first language, Sensory impairment etc.

**Cognitive Impairment** –such as with learning disability, head injury or dementia; including short term re drug/alcohol use/abuse, post GA or sedative drugs (24 hour rule), mental health issues

**Dependency** – person totally reliant on others for care and support - Physical difficulties or disabilities,

**Isolation** – vulnerable person has little social contact or only with care givers

**Low expectations/self-esteem** –person feels undeserving of care, may have past history of abuse or poor treatment

#### These factors may be thought of as *fertile ground* for abuse:

- Increased dependency of the adult, leading to a high degree of care being required, e.g. immobility, incontinence, assistance with personal tasks.
- Increased family stress leading to a breakdown in communication.
- A history of poor family relationships.
- Living in the same household as a known abuser, a person with a history of violent or aggressive behaviour, alcoholism, drug misuse or sexual offending
- Living in the same household as a person with a recent, severe, frequent or previous pattern of self-harm or violence related to mental health problems.
- People with learning disabilities
- People with physical disabilities
- Increased emotional dependence or isolation
- Increased social isolation
- Financial problems
- Considerable change in a carers lifestyle, e.g. unemployment

#### Indicators of Abuse

The following lists highlight situations or events which may require closer attention. They are purely indicators – the presence of one or more does not confirm abuse. However, a cluster of several indicators may indicate a potential for abuse and hence the need for further assessment.

For ease of use, the indicators have been grouped under a number of headings. Typically, however, an abusive situation will involve indicators **from a number of groups in combination**.

### **Indicators of Physical Abuse or Neglect**

- Unexplained bruises and welts on face, lips, mouth, torso, arms, back, buttocks or thighs in various stages of healing; clusters forming regular patterns, reflecting the shape of an article or on several different surfaces.
- Unexplained burns, especially on soles, palms and back; immersion burns; rope burns; electric appliance burns.
- Unexplained fractures to any part of the body; in various stages of healing; multiple or spinal injuries.
- Unexplained lacerations or abrasions to mouth, lips, gums, eyes, external genitalia.
- Any injury not fully explained by the history given.
- Self-inflicted injury.
- Malnutrition - rapid or continuous weight loss, no evidence of food; dehydration; complaints of hunger.
- Lack of personal care; inadequate or inappropriate clothing; inadequate heating.
- Untreated medical problems.
- Urinary / faecal incontinence.
- Signs of medication misuse (over or under-medication).

### **Sexual Indicators**

- Full or partial disclosure or hints of sexual abuse.
- Urinary / faecal incontinence.
- Poor concentration.
- Unusual difficulty in walking or sitting.
- Torn, stained or bloody underclothing.
- Pain or itching, bruises or bleeding in genital area.
- Sexually transmitted disease / urinary tract or vaginal infections.
- Love bites.
- Significant change in sexual behaviour or outlook.
- Bruising to thighs, upper arms.
- Pregnancy in a person who is not able to consent.

### **Psychological Indicators**

- Ambivalence
- Deference
- Passivity
- Resignation
- Fearfulness expressed in the eyes, avoids looking at care giver; flinching on approach
- Emotional withdrawal
- Sleep disturbance
- Low self esteem
- Unexplained fear or defensiveness

### **Social Indicators**

- Physical and mental dependence on a key member of the family
- Poor communication or breakdown in communication
- Considerable change in carers lifestyle, e.g. unemployment, illness
- Negative perception of carer towards dependence of vulnerable person
- Frequent visits to GP or Accident and Emergency Department
- Role reversal – introduction of intimate care
- History of falls and minor ailments
- Provocative behaviour, e.g. wetting, spitting, shouting, exposure
- Apathy of carer/dependant
- Deteriorating health of carer/dependant
- Poor or inappropriate living conditions

- Isolation of household
- Personal history of (drug/alcohol) abuse or violence, either carer or patient
- Family history of abuse
- Financial dependency
- An institution that provides poor quality care
- Increased stress on carer or a sudden nature
- Verbal threats to abandon or harm individual

### **Financial Indicators**

- Unusual or inappropriate bank account activity
- Power of Attorney obtained when person is unable to comprehend
- Recent change of deeds or title of house
- Person lacks belongings or services which they can clearly afford
- Recent acquaintances expressing sudden or disproportionate affection for a person with means
- Carer asks only financial questions of the worker, does not ask questions about care
- Withholding money
- Person managing financial affairs is evasive or unco-operative

### **Discriminatory or Rights Violation Indicators**

- Coercion
- Causing distress to a person by locking in at home, in a car etc.
- No visitors, phone calls or mail allowed
- Inappropriate clothing
- Sensory deprivation, not allowed to have hearing aids, glasses, etc
- Ignoring the persons customary taste in clothes, hairstyles, cosmetics etc
- Ignoring the person's ethnic or cultural needs
- Depriving an individual of ambulatory or cosmetic prostheses
- Restricted access to personal hygiene and toilet
- Lack of respect for the dependant person as an individual
- Carer does not offer personal hygiene, medical care, etc
- Use of furniture and other equipment to restrict movement
- Not providing food consistent with a person's cultural beliefs
- Use of derogatory names or teasing about differences
- Lack of appropriate social contacts
- Not allowing attendance or observance of at religious festivals

### **Neglect Indicators**

- Accommodation dirty, broken or inadequate furnishings
- Inadequate heating
- Inadequate lighting
- Physical condition of person poor, e.g. ulcers, bed sores, etc
- Persons clothing in bad condition, e.g. unclean, wet, etc
- Poor personal hygiene/oral care
- Malnutrition and/or dehydration and weight loss
- Constipation
- Hypothermia
- Failure to give prescribed medication
- Failure to access appropriate medical care
- Failure to ensure appropriate privacy and dignity
- Inconsistent or reluctant contact with health or social agencies
- Refusal of access to callers/visitors
- Failure to visit or engage in social interaction
- Category 3 or 4 pressure ulcers
- Untreated or delay in seeking treatment for medical problem or falls resulting in injury
- Incomplete or inconsistent records of care

## **Modern slavery indicators**

Ask yourself the following questions:

- Is the victim in possession of a passport, identification or travel documents? Are these documents in possession of someone else?
- Does the victim act as if they were instructed or coached by someone else? Do they allow others to speak for them when spoken to directly?
- Was the victim recruited for one purpose and forced to engage in some other job? Was their transport paid for by facilitators, whom they must pay back through providing services?
- Does the victim receive little or no payment for their work? Is someone else in control of their earnings?
- Was the victim forced to perform sexual acts?
- Does the victim have freedom of movement?
- Has the victim or family been threatened with harm if the victim attempts to escape?
- Is the victim under the impression they are bonded by debt, or in a situation of dependence?
- Has the victim been harmed or deprived of food, water, sleep, medical care or other life necessities?
- Can the victim freely contact friends or family? Do they have limited social interaction or contact with people outside their immediate environment?

For more information on modern slavery go to:

<https://www.salvationarmy.org.uk/spot-signs-modern-slavery>

## **Cultural Factors**

Cultural, religious and ethnic differences must be considered when dealing with the protection of adults at risk.

## **Communication**

There should be awareness of the significance of the verbal and non-verbal components of communication. The opportunities for misunderstanding are greatly increased when individuals are from different social and cultural backgrounds. Interpreters should be used when communication is identified as a problem.

## **Religion**

It is important to understand and respect a person's religion – and the implications of adherence to a particular religion on an individual basis. Note should also be taken of religious rituals: for example, the wearing of holy threads or charms, to prevent accident or disease. The removal of these before an operation or an examination can be very upsetting for an individual.

## **Gender Issues**

Gender preferences reflect prevailing cultural attitudes. Wherever possible, for example, Asian women should be offered the opportunity to be examined by a female doctor. If this is not possible, a non-Asian male doctor, who is not part of the culture of the patient, may be more acceptable than a fellow Asian.

Similarly older Muslim men may be unaccustomed to dealing with women in positions of authority, and may be embarrassed by female health workers, especially nurses (Henley 1982).

## **Diet**

Understanding a person's individual dietary habits is important. It is likely that dietary restrictions are linked to religion; for example, Muslim, Sikh and Jewish religions.

To protect the rights, dignity and respect of an individual in a multi-cultural population, other issues to be considered are hygiene, death and bereavement.

## Appendix 2

### ADVICE FOR STAFF – how to respond to disclosures or concerns of abuse

#### If abuse is suspected or alleged, either through observation or information received

#### Do the following

##### Reporting

- Report the abuse to your line manager and fill out the BSAB Safeguarding Multi-Agency Adult Referral Form – see link below and email using secure email as instructed on the form; <http://www.buckinghamshirepartnership.co.uk/safeguarding-adults-board/how-to-report-abuse/>
- Ensure that you as the reporter complete your name and contact details on the form as fully as possible;
- Confirm by phone that BCC Social Care Safeguarding Adults Team in the MASH have received the completed form;
- Inform the Safeguarding Team of your referral;
- Out of hours - inform the site manager and escalate to the senior manager on call.

##### Communicating and helping

Always proceed on the assumption that an allegation or report may be true

- Inform the adult that you are reporting the incident and gain consent, although if consent is not given this is **not** an obstacle to reporting especially if others e.g. children, are at risk;
- Ensure that the patient is safe and protected from any further acts of abuse. If you are unsure about what actions to take seek advice from your Senior Manager and/or Trust Safeguarding Team or Duty Social Worker. If the line manager is unavailable, or is in any way implicated in the suspected abuse then report the concern to a more Senior Manager. An on-call duty manager is always available;
- If a member of Trust Staff is suspected of being the perpetrator of any alleged abuse then this must be reported to the direct Line Manager and the Senior Nurse/Manager on duty so that the appropriate actions are taken;
- Reassure the patient, carer, relative or other source that he/she is acting correctly in informing you. Staff members can refer to the Trust Raising Concerns Policy and/or speak to the Freedom to Speak Up Guardian for further guidance and support;
- Explain the Trust process of reporting and investigating alleged or suspected abuse to the adult;
- Ensure immediate medical attention is obtained (as appropriate);
- If a criminal act is suspected the police may need to be informed – again if unsure seek advice from the Nurse in Charge, manager, duty manager or the BCC Social Care Safeguarding Adults Team.

##### Recording

- Make a written record of the suspected or alleged abuse;
- Quote the Adult at Risk's words (or those of any other source of information) as far as possible;
- Record the date and time that the alleged event was reported;
- Complete a safeguarding adult referral form and share with the Trust Safeguarding Team and store in the adult's clinical record;
- Write a statement where necessary and share with your line manager. It will be used in any subsequent investigations and may be used in subsequent legal action (as applicable).

##### Do not do the following:

- Do not start investigating the abuse yourself;
- Do not press the patient for details. It is not your job to instigate an investigation, but do facilitate such disclosures as the patient or client may spontaneously offer - staff receiving a disclosure must confine questions to: "Tell me...", "Explain..." "Describe..." and must not ask leading questions;

- Do not offer judgements, but do validate the patient's reporter's feelings (without confirming or embellishing the disclosure);
- Do not promise to keep secrets – you have a duty to pass on the information to the appropriate person;
- Do not confront the alleged abuser or alert them to the allegation.

### **If sexual abuse is suspected or alleged**

#### **Do the following**

Follow the procedures above and additionally:

- Discourage the patient from bathing **pending medical examination**. If the patient requests a wash or bath, point out that this may compromise any subsequent forensic examination. Suggest, but do not impose, deferral until examination has taken place. This is particularly important if the police are to be involved;
- Retain evidence such as clothing or bedding;
- Consider seeking the advice of the patient's consultant if there are clinical reasons for doubting the likelihood of an allegation. This may occur when patients have disorders of perception;
- Inform the police;
- Consider a referral to the nearest Sexual Assault Referral Centre (SARC).

#### **Do not do the following**

- Do not automatically discount the allegation because the patient may have disorders of perception;
- Do not contaminate or remove possible forensic evidence.

### **In all cases**

In all circumstances, all decisions, assessments and actions must be recorded in a factual and chronological manner. Any opinions and third party information must be identified as such, and any record must be signed and dated, with time and location.

- Ensure that line managers and senior managers are made aware of any serious allegations, in which case a high level discussion will agree who will share the information with the BCC Social Care Safeguarding Adults Team and police (if appropriate);
- If the concern arises as a result of information received from a member of the public, that person can be offered the opportunity to remain anonymous, but should be advised that if criminal proceedings arise, they may need to give evidence in court;
- If the concern arises from information provided by the patient, it is appropriate to ask the consent of the patient to raise the matter with a senior person within the Trust. However if consent not given this is **not** an obstacle to reporting especially if others e.g. children, are at risk.

### **Advice for the Line Manager**

#### **Do the following**

- Be alert to the signs of abuse and always respond to disclosure;
- On receiving a report or allegation, the Line Manager must act to ensure the relevant information has been obtained to enable him or her to decide that:
  - the person is an Adult at Risk as defined by the Care Act 2014;
  - the allegations come within the definition of abuse;
  - further investigations are required
- Determine the level of risk and take immediate action to safeguard the health and welfare of the Adult at Risk;
- Preserve any evidence;
- Inform the appropriate senior management of the Trust, including the Chief Nurse who is the Trust Executive Lead for Safeguarding;

- Ensure a referral is made to BCC Social Care Safeguarding Adults – this may be by telephone in the first instance, but must be followed up by a written referral;
- Where the abuse is potentially of a criminal nature, then the police must also be informed.
- Inform the Trust Safeguarding Team as soon as is practicable;
- Keep those staff who are involved informed of the actions being taken;
- Ensure the completion of a Trust Datix Incident form.

<b>Division:</b>	<b>Corporate Nursing</b>
<b>Service:</b>	<b>Safeguarding</b>
<b>Title of Proposal:</b>	<b>Policy for Safeguarding Adults</b>
<b>Lead Officer (Author of the Proposal):</b>	<b>AD For Safeguarding</b>
<b>Names of other Officers involved:</b>	<b>Chief Nurse Named Nurse for Safeguarding Adults</b>
<b>Overall Findings: Highlight any risks or key actions</b>	<b>The policy has a positive effect on upholding the rights of all protected characteristics. It promotes positive attitudes to all adults at risk including positive actions to help people with protected characteristics to overcome disadvantages.</b>

### Screening - Initial Assessment

#### Stage – 1

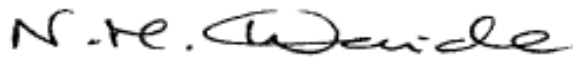
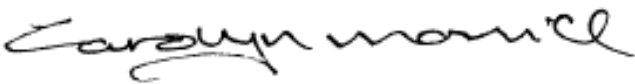
The screening process must be used on all new policies, projects, service reviews and staff restructuring. If you are not able to determine why your proposal has a positive/ negative / neutral affect on patients, services users or staff you will require a more detailed analysis and need to conduct a full equality impact assessment.

<b>Questions</b>	<b>Answers</b>
1. Brief summary of the project/ policy including the main aims and proposed outcomes.	Policy promotes good practice and provides guidance in respect of good practice especially in respect of safeguarding adults at risk of abuse.
2. Could the proposed strategy, policy, service change, or function have a direct or indirect affect on patients,	The remit of the policy is to safeguard the interests of all parties – patients, communities and staff and to ensure that people’s rights are always



<p>service users, staff or local community? Please explain your answer.</p>	<p>upheld.</p> <p>The policy applies to all staff groups who may encounter adults at risk and their carers in the course of their work.</p>
<p>3. Could the proposal have a positive or negative effect on patients, service users, staff or local community by the protected characteristics (age, disability, gender, gender re-assignment, marriage &amp; civil partnership, pregnancy &amp; maternity, race religion or belief, sexual orientation)?</p> <p>Briefly explain your answer by consider each characteristic and state what is the impact on each group.</p>	<p>The policy directs staff to uphold the rights of all patients and their carers including those with any protected characteristics, to be safeguarded from the harm caused by abuse.</p> <p><b>Age</b> – Policy applies to all age people aged over 18 years but also specific guidance is provided in relation to the impact on children who may live with an adult at risk, children transitioning to adult services and children who may be carers.</p> <p><b>Disability</b> – Policy directs staff to take into account any additional needs around disability. It specifically instructs staff in respect of safeguarding and supporting people with disabilities and particularly where mental capacity is identified as being a concern.</p> <p><b>Race</b> – Policy dictates that equal recognition is accorded to all individuals in respect of their safeguarding rights whatever their race.</p> <p><b>Sex</b> – The policy dictates that equal recognition is accorded to all individuals in respect of their safeguarding rights whatever their sex.</p> <p><b>Gender re-assignment</b> – The policy dictates that equal recognition is accorded to all individuals in respect of their safeguarding rights whatever their specified gender identity.</p> <p><b>Marriage and civil partnership</b> – The policy dictates that equal recognition is accorded to all individuals in respect of their safeguarding rights whatever their marital or partnership status.</p> <p><b>Pregnancy and maternity</b> – The policy dictates that pregnancy and maternity do not impede the equal recognition of an individual’s safeguarding rights.</p> <p><b>Religion or belief</b> – The policy dictates that equal recognition is accorded to all individuals in respect of their safeguarding rights whatever religious and cultural beliefs.</p> <p><b>Sexual orientation</b> - Policy dictates that equal recognition is accorded to all individuals in</p>

	respect of their safeguarding rights whatever their sexual orientation.
4. Is there any indication or evidence (including from engagement/consultation with relevant groups) that different groups have or will have different needs, experiences, issues, and priorities in relation to the proposals? Or do you need more information?	The policy takes account of the different needs of particular groups, specifically those who are deemed to be more vulnerable to the harm caused by abuse and those who may lack capacity. The needs of carers, including young carers and children transitioning to adult services are also acknowledged within the policy.
5. What measures are you proposing to take to mitigate /reduce the impact of your proposal for any of the protected characteristics, within patients, service users or staff?	Safeguarding training will incorporate information in respect of the effective application of the policy, including taking into account individual needs so as not to adversely discriminate.
6. Are there any measures that you can take to produce a positive impact for any of the protected characteristics, within patients, service users or staff?	Training of all staff at induction and regularly thereafter (in accordance with national guidance on safeguarding training). Divisional Safeguarding Leads from within Corporate Safeguarding Team allocated to each Division to support staff in their safeguarding practice and reduce the impact of abuse on protected characteristics.
7. <b>As a result of the screening is a full EQIA necessary?</b>	<b>No</b>

<b>Signed off by</b>	
<b>Name of lead officer:</b>	Nuala Waide
<b>Signature &amp; date:</b>	21/02/2018 
<b>Name of Assistant Chief Operating Officer:</b>	
<b>Signature &amp; date:</b>	26/4/18