Safeguarding Adults and Children from Risk of Abuse Policy	
Post holder responsible for Policy Document	Ruth Wills – Head of Inpatient Services & Clinical Quality
Policy Guardian/ Author	Ruth Wills – Head of Inpatient Services & Clinical Quality
Department responsible for Procedural Document	Clinical Quality Team
Intended audience. Who is this policy intended for?	All staff
Contact details	01392 688022 clinicalqualityteam@hospiscare.co.uk
Date of original document	June 2019
Equality Impact Screening performed	Yes
Ratifying body and date ratified	Ann Rhys, Dr Jenny Hayes and Jayne Bramley November 2022 SMT February 2023
Review date (and frequency of further reviews)	Annually
Expiry date	~~December 2023~~ extended to March 2024 *(to allow for full organisational review)*
Date document becomes live	November 2022
Dissemination plans	Shared at Clinical Team Leaders & via organisational comms

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		**Evidence Provided**	
Patient Experience		Incidents reviewed monthly at Patient Experience and Safety Group (PES) and CD LIN	✓
Safety		Incidents reviewed monthly at Patient Experience and Safety Group (PES) and CD LIN	✓
Assurance Framework		Quality and Assurance Improvement Committee (QAIC) quarterly and Annual Board report	✓
Monitor/Finance/Performance			X

CQC Regulations/Outcomes		Contributes to safe effective and well led KLOEs	✓
Other (please specify):			
Strategic Plans and Roadmaps Clinical Roadmap 2021 - 2024			
Note: This document has been assessed for any equality, diversity or human rights implications ✓			

Controlled document
This document has been created following the Hospiscare policy on procedural documents. It should not be altered in any way without the express permission of the author or their representative.

Full History		**Status: Final**	
Version	**Date**	**Author**	**Reason**
1	June 2019	Tina Naldrett – Director of Clinical Services and Safeguarding Lead	Final
1.1 – 1.3	Mar - Oct 2020	Judy Vick – Clinical Practice Development Lead	*1.1* - Extension. *1.2* - Childrens flowchart added. *1.3* - Appendix 3.
1.4	Apr 2022	Ruth Wills – Clinical Quality and Infection Prevention & Control Lead Nurse	Review – a complete rewrite to include new guidance
1.5	Nov 2022	Ruth Wills – Head of Inpatient Services & Clinical Quality	Update to escalation of concerns flowchart

Associated Hospiscare Policies/ Procedural documents:	Please note this replaces the Child Protection Policy and correlates to; Recruitment Policy; Volunteer Recruitment Policy; Speaking up raising a concern and whistle blowing; Mental Capacity Act Policy; Consent Policy; Clinical Record Keeping Policy
Legislative Requirement/ Best practice reference:	Mental Capacity Act 2005; Charities Commission in the December 2017 policy document "Strategy for dealing with Safeguarding issues in charities"; NHS England Safeguarding Policy 2015. Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019 (Jan)
Key Words:	Safeguarding, risk, abuse, adults, children
In consultation with and date: Ann Rhys, Dr Jenny Hayes, Ruth Wills and Jayne Bramley, November 2022	
Contact for Review:	Ruth Wills – Head of Inpatient Services & Clinical Quality
Executive Lead/Board Chair Signature:	

1. Reason for the policy

Best practice √
Legal compliance √
Regulatory compliance √
Good governance √
Risk mitigation √

In light of recent issues within other charities, Hospiscare has reviewed its safeguarding arrangements and this policy now includes best practice, as outlined by the Charities Commission (CC) in the December 2017 policy document "Strategy for dealing with safeguarding issues in Charities" and the NHS England Safeguarding Policy 2015. To comply with this guidance the CC recommends that charities review the suitability, robustness and effectiveness of their processes and policies in relation to safeguarding but also in relation to staff safety and staff conduct more broadly. The data protection officer undertakes an annual audit of charitable activity which goes to Board for sign off In addition to the annual clinical report.

2. Statement of Policy

Hospiscare's vision is to ensure that those in need receive outstanding end of life care, in the place of their choice.

Our mission – To provide compassionate, expert end of life care to those in need – before, during and after death. Together with our local community, we make everyday matter.

We aim to provide the best possible service in line with our values:

- ✓ Compassionate
- ✓ Respectful
- ✓ Professional
- ✓ Inclusive

Hospiscare policies and procedures will be developed, approved and reviewed within a consistent framework. This document describes that framework which includes the governance process and the format of policies and procedures.

Safeguarding adults and children at risk of abuse is underpinned by these values and is integral to Hospiscare's service delivery.

To support effective safeguarding it is Hospiscare's policy to have a clear and robust approach to safeguarding in four key areas:

- Leadership, culture and values
- Law, regulation and the statutory framework
- Capacity and capability in Hospiscare to implement safeguarding procedures
- Clarity about responsibilities and reporting, accountability and transparency

Safeguarding adults at risk at Hospiscare is everyone's responsibility and therefore, awareness and training for everyone, appropriate to their job role will be provided.

Adults and children at risk may include service users, their carers and families, Hospiscare staff, volunteers, supporters and customers. This list is not exhaustive

This policy:

- Clarifies safeguarding legislation and the charity's responsibilities and obligations
- Covers definitions about safeguarding: What is Safeguarding and when it applies
- Describes how safeguarding is monitored and governed within the charity
- Describes what to do if a staff member or volunteer has a concern, or a concern is reported by another interested party
- Describes how safeguarding incidents should be recorded and reported
- Describes what training is required

3. Definitions

Abuse is defined as:

- A violation of individuals' human and civil rights by others' (*No Secrets* (2000)

Safeguarding is defined as the:

- Prevention of harm and abuse through provision of high quality care
- Effective response to allegations of harm and abuse, in line with the local multi-agency procedures (see page pages 9 and 10: Alerting others to safeguarding concerns)

Adults and children at risk

The term 'adult at risk' has been used in this policy to replace 'vulnerable adult'. This is because the term 'vulnerable adult' may wrongly imply that some of the fault for the abuse lies with the abused adult. Children at risk is also the new terminology to describe an 'at risk child'.
An adult at risk under the Care Act 2014 applies to an adult, aged 18 or over, who:

- has needs for care and support (whether or not the local authority is meeting any of those needs) and
- is experiencing, or at risk of, abuse or neglect and
- as a result of those care and support needs, is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

The person's need for additional support to protect themselves may be increased when complicated by additional factors, such as physical frailty brought on by old age or other circumstances, such as acute and / or chronic illness, impaired mental capacity and physical or learning disabilities. Children at risk can take a range of different forms. It is any action by another person (adult or child) that causes harm to a child. It can may include but not restricted to; physical abuse, emotional abuse, sexual abuse or neglect.

4. Scope:

This policy covers all Hospiscare employed staff and / or volunteers working in all areas of the charity and its subsidiaries. If actions are required by specific teams, this is referred to in the policy.

5. Responsibilities

The Chief Executive Officer is responsible for ensuring all polices have gone through the correct organisational procedure.

Board and Trustees are responsible for ensuring they meet their obligations, as laid out by the Charity Commission (CC) and the Care Quality Commission (CQC). Trustees must report to the CQC any safeguarding issues, serious incidents, complaints or allegations as they occur and any which have not previously been disclosed. Failure to do so may be considered misconduct and / or mismanagement and may be a breach of trustees' duties (CC Guidance 2018).

The Board has nominated a lead trustee for safeguarding This trustee will work with the Clinical Director, who is Hospiscare's current Safeguarding Lead, to review all alerts.

Staff or volunteers who have concerns about safeguarding should, in the first instance, contact their line manager and the safeguarding lead or their deputy, and email the safegurding@hospiscare.co.uk inbox with any queries. If they still have concerns they can contact the Chief Executive, Chair of Trustees or any Trustee.

Directors: The Clinical Director is responsible for ensuring the revised policy is communicated to staff/ volunteers who work with patients, families and carers. The Clinical Director has executive responsibility for safeguarding reporting to the Quality Assurance and Improvement Committee and the Board.

The other organisation Directors are responsible for ensuring that their staff are aware of, and comply with, this policy and any regulatory obligations as set out in it.

Line Managers are responsible for ensuring that their staff are signposted to the policy and that they work within the guidance it contains, and they are aware of their requirements around training.

Staff and volunteers: it is the responsibility of all staff to be aware of the content of this policy and work to the policy.

Learning and Development Team is responsible for developing and implementing training modules to support this policy, and to report quarterly to QAIC.

6. The aims of safeguarding and making safeguarding personal

There are six principles that underpin adult safeguarding and apply to all sectors and settings. The principles should inform the ways in which professionals engage with people at risk of abuse, harm or neglect

- **Empowerment** – personalisation and the presumption of person-led decisions and informed consent.
  'I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens.'
- **Prevention** – it is better to take action before harm occurs
  '*I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.'*
- **Proportionality** – Proportionate and least intrusive response appropriate to the risk presented
  'I am sure that the professionals will work for my best interests, as I see them and they will only get involved as much as needed'
- **Protection** – Support and representation for those in greatest need
  'I get help and support to report abuse. I get help to take part in the safeguarding process to the extent to which I want and to which I am able'
- **Partnership** – local solutions through services working with their community. Communities have a part to play in preventing, identifying, 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 to get the best result for me'
- **Accountability** – Accountability and transparency in delivering safeguarding
  '*I understand the role of everyone involved in my life'*

A personalised approach to safeguarding means:

- enabling safeguarding to be done with, and not to , people
- Working with people to set safeguarding outcomes which have meaning to them
- Practice that focuses on achieving meaningful improvement to peoples circumstances rather than just an investigation and conclusion
- To prevent harm and reduce the risk of abuse to adults with care needs
- To safeguard individuals in a way that supports them in making choices and having control on how they live their lives
- To promote an outcomes based approach in safeguarding that works for people resulting in the best experience possible
- To raise public awareness so that professionals, staff and communities as a whole play their part in preventing, identifying and responding to abuse, harm and neglect.

(Adass, 2018)

7. Mental Capacity

The assessment of mental capacity is primarily applicable to clinical services but should be borne in mind in respect to any potential adults at risk, for example when accepting a donation.

The presumption is that adults have the mental capacity to assess their own safety, how they live their lives and the risks they want to take. This should be honoured and respected.

Issues of mental capacity and ability to give informed consent are central to actions and decisions made by Hospiscare in relation to safeguarding adults at risk.

Circumstances may result in the person lacking mental capacity to make a specific decision at the time it needs to be made. In relation to clinical services a Mental Capacity Assessment will be made by the Clinician and where appropriate, an IMCA (Independent Mental Capacity Advocate) provided (The Mental Capacity Act 2005).

A 'best interest' decision should be made by the multi-disciplinary team with a patient representative or IMCA view taken into consideration. The ultimate decision and responsibility about a patient's safety lies with the Medical Clinician in charge of their care. See the Mental Capacity Act (MCA) guidance for additional information and Hospiscare policy.

In relation to non-clinical services, advice may be sought from the Clinical Director who is the Safeguarding Lead.

For information regarding Deprivation of Liberty (DOLs) please see section 12

8. Categories of Abuse

8.1 Categories of Abuse for Adults at Risk

Abuse can be:

Physical: Slapping, pushing, kicking, rough handling, misuse of medication or restraint.

Sexual: Rape, sexual assault or sexual acts to which the adult at risk has not consented to, could not consent to, or was put under pressure into consenting. This can include 'non-contact' sexual acts such as indecent exposure, online abuse, and non-consensual pornographic activities

Psychological: Verbal assault or intimidation, emotional abuse, threats of harm or abandonment, denying choices or wishes.

Financial: Theft, fraud, exploitation and pressure in connection with wills, property, possessions or benefits. This can include 'cuckooing' where a person's property is taken over and used for illegal activities

Neglect and acts of omission: Ignoring medical or physical care needs, failure to provide

access to appropriate health or social care, withholding necessities of life, such as medication, food, fluids or heating.

Discriminatory: Motivated by discriminatory and oppressive attitudes towards race, gender, cultural backgrounds, religion, sexual orientation and age (known as protected categories under the Equality Act (2010).

Organisational: Within a healthcare environment by carers, either by an isolated incident of poor or unsatisfactory care being given, persuasive ill treatment or gross misconduct.

Modern slavery: Including slavery, human trafficking, forced labour and domestic servitude. https://www.rcpch.ac.uk/resources/child-modern-slavery-human-trafficking-guidance

Domestic violence: any incident or pattern of incidents of controlling, coercive, threatening behavior, honour based behavior, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality (Gov.uk, 2013). This type of abuse includes Female Genital Mutilation (FGM).

Self-neglect: This covers a wide range of behaviours neglecting to care for one's personal hygiene, health or surrounding and can include behavior such as hoarding and non-attendance at necessary health/dental appointments. Considerations must be given to others, the wider community, mental capacity legislation and whether this gives rise to a safeguarding concern

8.2 **PREVENT**

The PREVENT programme is designed to safeguard people in a similar way to safeguarding processes and protect people from gang activity, drug abuse, and physical and sexual abuse. The counter terrorism and security act (2015) introduced a duty on the NHS in England, Wales and Scotland 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 will meet, and treat people who may be drawn into terrorism, and therefore professionals need to be able to identify early signs of radicalisation in line with the PREVENT framework.

8.3 **Categories of Abuse for Children at Risk**

All staff who come into contact with children and young people have a responsibility to safeguard and promote their welfare and should know what to do if they have concerns about safeguarding/child protection issues. This responsibility also applies to staff working primarily with adults. Staff in these settings need to be aware that any adult may pose a risk to children due to their health or behaviour.

Categories of abuse to children are similar to that of adults and are outlined below:

Physical Abuse: Actual or likely physical injury to a child, or young person, under the age 18, or failure to prevent physical injury.

Sexual Abuse: This may involve forcing or enticing a child to take part in sexual activity, resulting in actual or likely sexual exploitation of a child or young person. The child

may be dependent or developmentally immature. This category of abuse would include FGM.

Emotional Abuse: Severe or persistent emotional maltreatment or rejection, likely to cause severe and persistent adverse effect on the emotional and behavioural development of a child.

Neglect: The persistent or severe failure to meet a child's basic physical and / or psychological needs, or the failure to protect a child from exposure to danger or neglect, resulting in impairment of the child's health or development.

Historical Abuse: There may be occasions when an adult will disclose abuse (either sexual or physical) which occurred in the past, during their childhood. This information needs to be treated in exactly the same way as a disclosure or suspicion of current child abuse. The reason for this is that the abuser may still represent a current risk to children.

Staff and volunteers will be made aware of the potential signs of child abuse; common indicators include:

Physical signs such as hand-slap marks, bruising in unusual areas, bruised eyes or bite marks.

- Poor physical care and inadequate hygiene, inappropriate dress or failure to seek appropriate healthcare.
- A child's behaviour may also indicate that they have been abused, e.g. fear of adults or of a certain adult when they approach them, a display of aggressive behaviour or deliberate self-harm.

There is no one definite sign, symptom or injury. A series of minor events can be just as damaging as any one event.

9. Responding to safeguarding concerns at Hospiscare

The Hospiscare Safeguarding and PREVENT Lead is the Clinical Director; the Deputy Safeguarding Lead is the Head of Community & Supportive Care.

Staff and volunteers will be trained to understand the importance of alerting and reporting safeguarding concerns. If, at any stage, staff and volunteers require support, they may discuss their concerns with a line manager and / or email the organisation's Safeguarding Lead on safeguarding@hospiscare.co.uk

When being told about someone who feels they are being abused, listen carefully to what you are being told and only ask questions for clarification, not probing. Do not promise confidentiality but reassure them that they will be kept safe.

If abuse is observed, then make a record as soon as possible of the facts and report as described in the policy.

In clinical teams, a written/ electronic record should be made in the medical or nursing notes, including a body map if required. This needs to be done as close to the disclosure as is feasible, in order to have the details as factual as possible. It should be signed and dated and a Vantage incident report made. This information should then be shared with the safeguarding lead or deputy. If required the safeguarding lead will escalate to Devon County Council (DCC) safeguarding team. All safeguarding reports are logged and shared and reviewed at the Patient Experience and Safety meeting.

What to do if Hospiscare Safeguarding Lead or Deputy are not contactable
On the rare occasion where the Safeguarding Lead and Deputy are unavailable, please contact Rowcroft Hospice on 01803 210800 and ask for Jo Anthony (Safeguarding Lead) or her Deputy who will advise.

9.1 Alerting others to safeguarding concerns raised at Hospiscare

What to do if the threat is urgent
The severity of threat to the individual should be assessed and immediate measures put in place to reduce risk. If potential threat is of a criminal offence and risk is high, then the police should be alerted via (9) 999; the police have a safeguarding team. If this is for an IPU patient and is out of hours, inform the doctor on call and Clinical on call who will inform SMT on call if required.
If the concern relates to a non-clinical area alert the relevant director in working hours or the SMT person on call out of working hours. (See non clinical safeguarding concerns flowchart Appendix 2).

What to do if the threat is not urgent
If the alleged abuse is not an imminent threat, it should be reported to the Line Manager and they will decide whether to alert the relevant authorities in consultation with Hospiscare's Safeguarding Lead or, in their absence, the Chief Executive Officer or another member of the SMT.

With reference to alerts relating to patients; if it is about a patient in IPU the doctor and/or ward manager in charge should be informed. If the alert relates to a patient in the community the GP will be informed.

9.2 Reporting
If it is decided that the incident or allegation falls within this Safeguarding Policy,

Hospiscare will contact:

Adults at risk - Care Direct, the Adult Safeguarding Team at Devon County Council (DCC) on **0345 6000 388** or email customerservicecentrecaredirectteam-mailbox@devon.gov.uk (to raise a safeguarding alert. If it is professional advice that is required, this can be accessed from the Duty Officer on **0345 6000 388**.

Children at risk - call the Devon Safeguarding Children's number on 0345 155 1071 or email mashsecure@devon.gov.uk. There is also a Devon Childrens service online 'request for support' form available to complete, which can be found here.

Some categories of abuse may be regarded as a criminal offence and in these cases DCC will inform the police.

Hospiscare will discuss next steps with DCC and a lead person at DCC and at Hospiscare will be identified. Hospiscare will then be guided by DCC.

It is important to ensure that all the facts are documented at the time of the telephone call and that this record can be accessed by the lead person identified by Hospiscare within 24 hours.

All safeguarding issues should be reported to Hospiscare's Safeguarding Lead via safeguarding@hospiscare.co.uk. Allegations of abuse by staff or volunteers at Hospiscare will independently trigger an internal investigation.

The person raising the allegation of abuse should be kept informed of the process of events, as assessed appropriate for them, by the above Hospiscare personnel.

In addition to being reported to DCC, the CQC should be alerted. Raising a safeguarding concern is a statutory notification required by the CQC under 'abuse or allegations of abuse concerning a person who uses the service'. This notification should be completed via their website, by the Safeguarding Lead. The Director of Workforce Development should be informed if the allegation is against an employee.

The alert should be reported to Hospiscare's Board of Trustees via the QAIC, if the concern is internal to Hospiscare for example, one of our own staff or volunteers. If the Trustees consider it to be a significant incident it should be reported to the Charity Commission in accordance with the December 2017 guidance.

9.3 Devon County Council (DCC) Safeguarding Adults Escalation Protocol

DCC has a formal agreement and commitment between two or more parties on a common response to specific issues, events or circumstances. The aim of this protocol is to resolve professional disagreements relating to the safety of adults at risk, escalating any concerns that may arise, if issues are not viewed as being dealt with satisfactorily.

Please see appendices 3 and information at:
DSAP Escalation Protocol V.04 - final.docx (sharepoint.com)

10. Staff Support:

Raising a safeguarding concern can affect the staff and volunteers involved. Managerial support should be given throughout and beyond the event and an appropriate referral for external support can be made if it is assessed that this would be beneficial. If a whole team are involved a facilitated debrief can be offered. Open and regular communication with the manager and staff involved should continue for as long as is necessary.

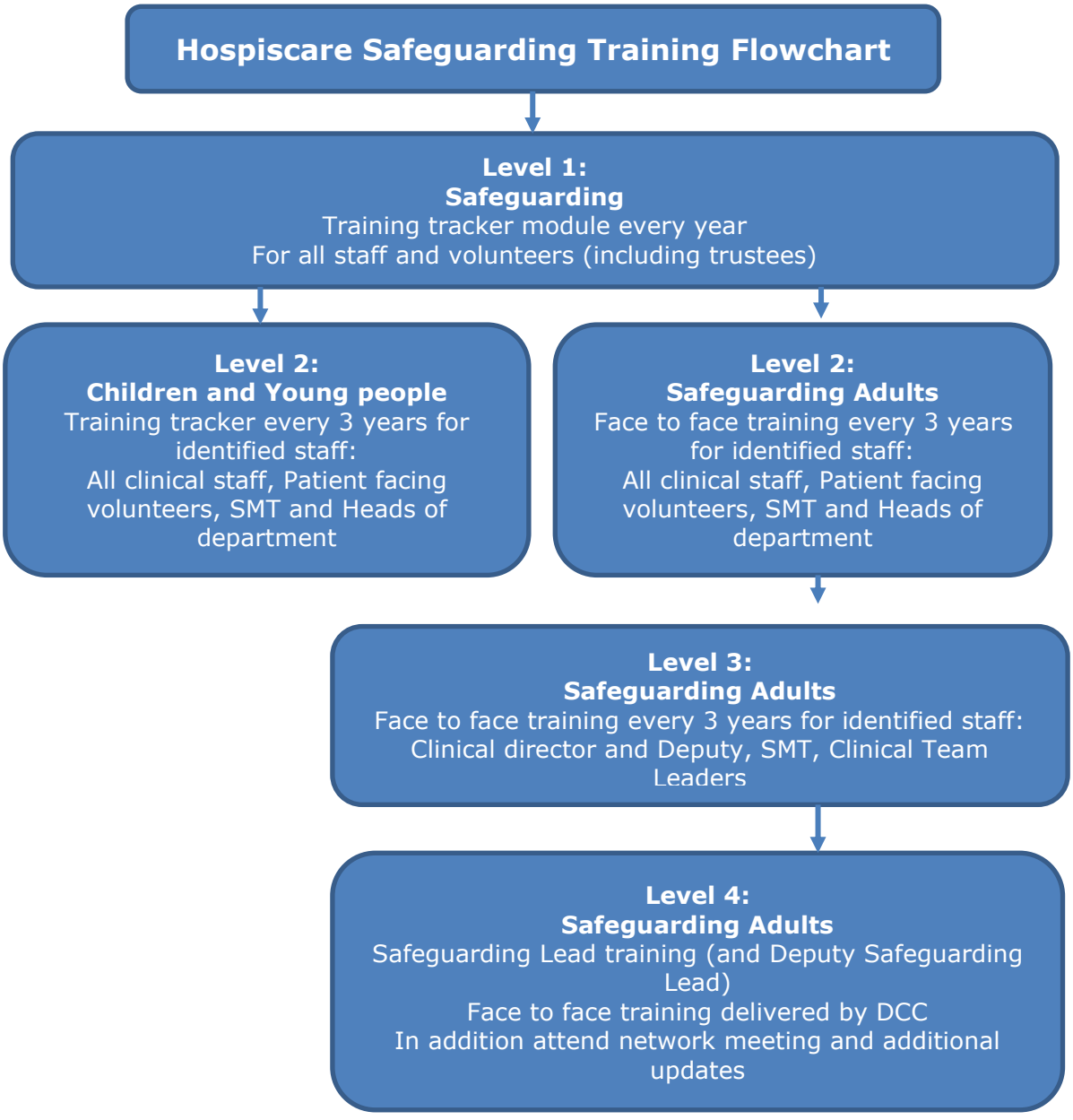
11. Governance of Safeguarding Issues

Hospiscare's Safeguarding Lead will log all issues and report them to the Patient Experience and Safety Group, including those outside clinical areas. The log and action plans

associated with incidents will be reviewed monthly. An annual report will be submitted to QAIC and, via that committee, to the Board of Trustees. The Safeguarding Lead will report to Hospiscare's regulators.

12. Safeguarding Training at Hospiscare

All staff and volunteers, in all areas and in all roles within the organisation, will require safeguarding training as a statutory obligation under the Charity Commission and guidance from the inter-collegiate document.
The flowchart below outlines the training expectations of Hospiscare staff and volunteers regarding safeguarding for both adults and children



The flowchart above reflects our risk assessment outcome, proportionate to the exposure adults and children have to our staff and volunteers. This policy notes the CQC expectation

that organisations should be working towards the implementation of this framework in a timely manner.

All staff and volunteers are required to complete the training tracker Safeguarding Level 1 module within the first two weeks of appointment. A record of who is required to do so is held by the Learning and Development team. Volunteer (including trustees) safeguarding compliance information is held by the volunteer team. This information is periodically shared with line managers. Staff will be required to do repeat training at the level appropriate to their role.

13. Deprivation of Liberty Safeguarding (DoLS):

The Mental Capacity Act ensures that people who lack mental capacity are only deprived of their liberty if:

- it is in their best interest
- there is no other way to keep them safe, to give them care or treatment they need.

DoLS provides protection to people in a healthcare setting who have a mental disability and do not have the capacity to decide whether or not they wish to remain there, to receive treatment or care.

An application to Devon District Council (DDC) must be made by Hospiscare IPU senior staff for authorisation from the local authority (Devon County Council) to deprive someone of their liberty, if they believe it is in their best interest.

Depriving a person of their liberty is a **statutory notification requirement of the CQC** and full details of the application and its outcome must be completed, via their website, by the most senior nurse involved.

Depriving someone of their liberty includes:

- Use of restraint, including sedating a person or sending them to somewhere they do not wish to go to
- Staff taking complete and effective control over the care and movement of a person for a significant length of time
- Staff refusing to discharge someone when relatives or friends have requested it
- Restrictions that lead a person to lose relationships with relatives or friends
- Continuous supervision and control of a person that results in them not being able to do what they want or go where they want to.

Full documentation is available on the Hospiscare Intranet, which aids the decision making process and advice and support can be sought from the DDC Deprivation of Liberty Safeguarding Team (DoLS) directly via 01392 381676 or by emailing dols@devon.gov.uk

Full documentation regarding this decision (or discussion that resulted in the decision not to report, with rationale) should be made in the Hospiscare electronic patient record.

Please refer to the emergency legislation regarding Deprivation of Liberty during the COVID-19 pandemic.

14. Safe Recruitment of Hospiscare Employees and Volunteers

- Recruitment of employees will follow the Hospice Recruitment and Selection Policy and Procedure
- Recruitment of volunteers will follow the Volunteer Recruitment Policy and Procedure
- All staff in patient-facing roles will be subject to an Enhanced Disclosure and Barring Service check
- All staff in roles that include a regulated activity will be subject to an Enhanced Disclosure and Barring Service check, including barred lists
- Any external staff or official visitors will not be allowed any contact with the patients, without the continued presence of a member of Hospice staff. Visiting professionals such as opticians and chiropodists can see patients without a chaperone when they have signed in and confirmed their professional registration
- Staff are encouraged to use the Speaking-up Policy (Whistle Blowing) to raise concerns

15. Monitoring compliance with and the effectiveness of the Policy

Key performance indicators comprise:

- An annual report at QAIC and the Board of Trustees
- Number of questions and referrals to safeguarding@hospiscare.co.uk
- Number of safeguarding referrals escalated to DCC
- 100% completion of new employees/volunteers of safeguarding training tracker within first month of employment
- 95% completion of the safeguarding training tracker level 1 – annually
- Quarterly safeguarding newsletter to be produced and distributed across the organisation
- Complaints and incident reports will be examined to highlight any issues and actions to modify and reduce risk

The monitoring compliance will be through reporting to the QAIC.

16. Equality Impact Assessment

There is now a tool at *Appendix 5*.

17. References and Information resource:

Charities Commission December 2017 Strategy for Dealing With Safeguarding Issues in Charities:
https://www.gov.uk/government/publications/strategy-for-dealing-with-safeguarding-issues-in-charities/strategy-for-dealing-with-safeguarding-issues-in-charities

Domestic violence:
https://www.rcn.org.uk/professional-development/publications/pub-005985

NHS England Safeguarding Policy 2015:
https://www.england.nhs.uk/wp-content/uploads/2015/07/safeguard-policy.pdf

Devon Safeguarding Board 2018:
https://new.devon.gov.uk/devonsafeguardingadultsboard/
https:new.devon.gov.uk/devonsafeguarding/

Department of Health Mental Capacity Act 2005 and Code of Practice 2017:

https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

Department of Health No Secrets 2000:

https://www.gov.uk/government/publications/no-secrets-guidance-on-protecting-vulnerable-adults-in-care

Safeguarding Children Information for Devon:

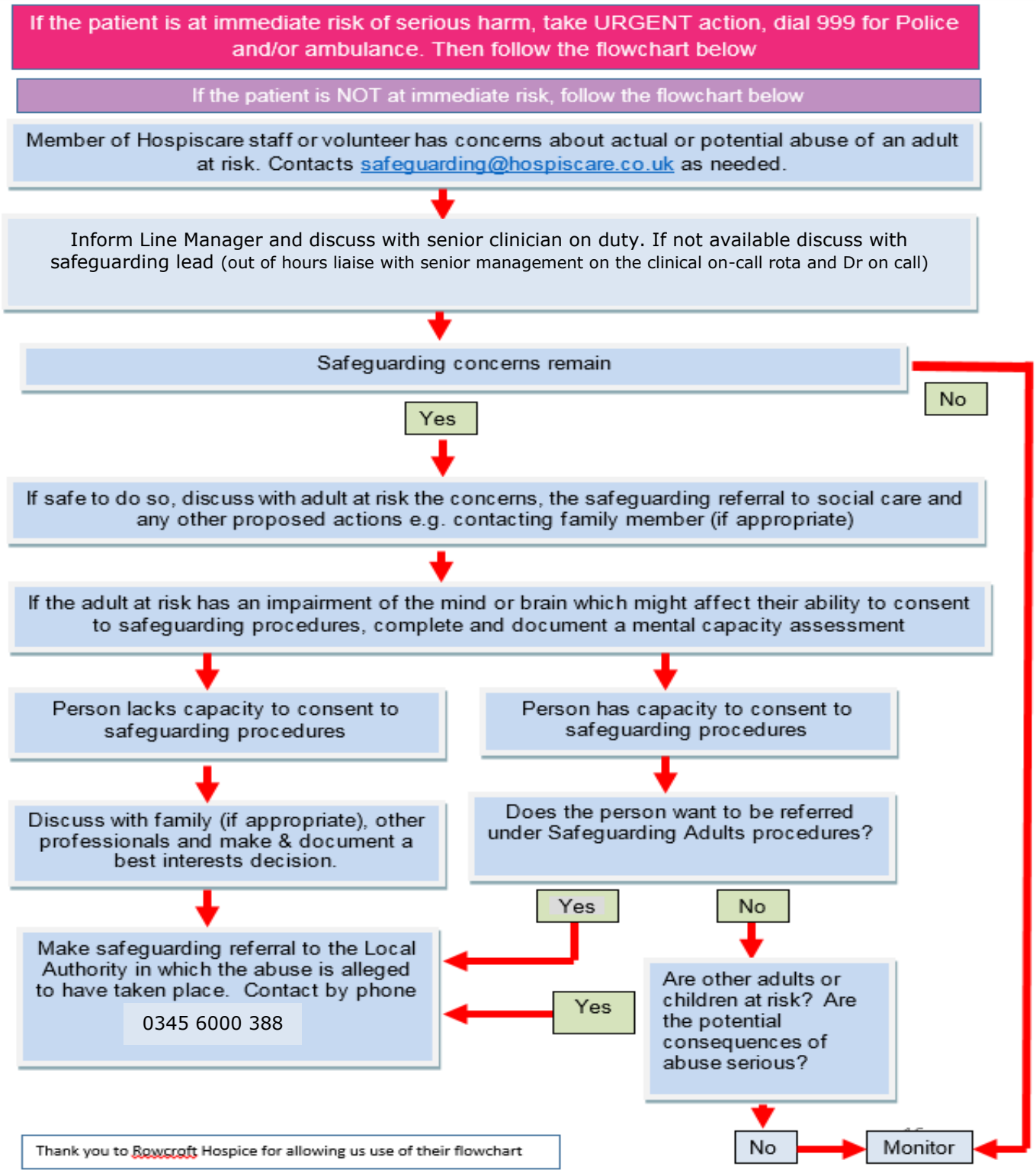
https://www.devonchildrenandfamiliespartnership.org.uk/

Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (Jan 2019)

www.safeguardingassociatesforexcellence.co.uk/wp-content/uploads/2019/01/2019-Intercollegiate-document.pdf

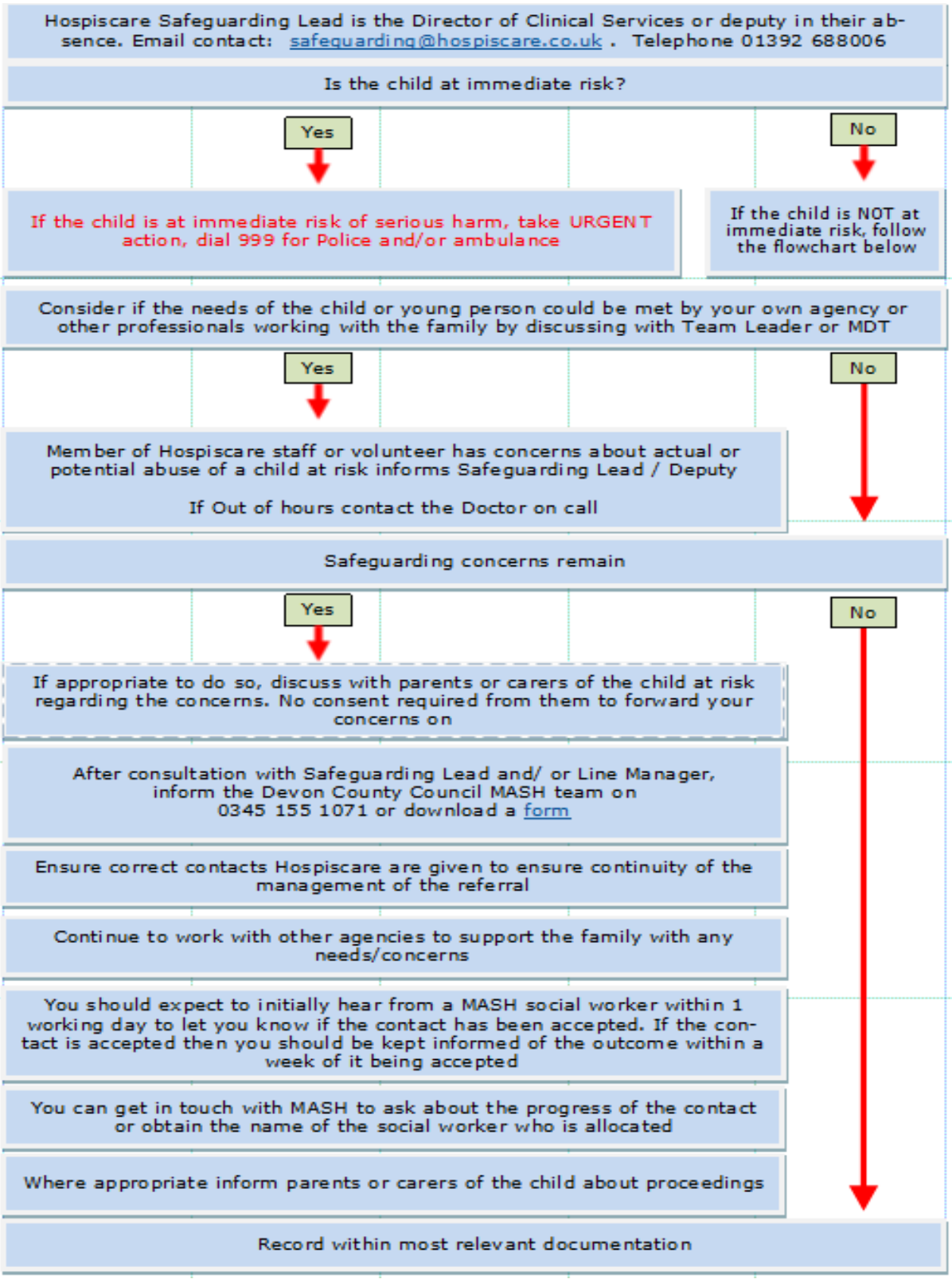
Appendix 1

Safeguarding Adults Referral Flowchart



Thank you to Rowcroft Hospice for allowing us use of their flowchart

Safeguarding Children Referral Flowchart



Appendix 2 – Non clinical escalation of concerns flow chart

If the person is at immediate risk of serious harm, take URGENT action, dial 999 for Police and/or ambulance. Then follow the flowchart below

If the person is NOT at immediate risk, follow the flowchart below

Inform Line Manager and discuss if necessary with Senior Manager on duty. If allegation involves a member of staff or volunteer, please contact senior manager and/or safeguarding lead who will advise and liaise with HR. For other support or clarity, liaise with Safeguarding Lead

Member of Hospiscare staff or volunteer has concerns about actual or potential abuse of an adult at risk. Contacts safeguarding@hospiscare.co.uk This inbox is monitored Mon-Fri 09:00-17:00. **Out of hours** call SMT on-call

Safeguarding concerns remain

Yes

No

If related to mental health concerns encourage to speak to GP
If concern level HIGH, contact Mental Health First Aider

If related to safeguarding of individual
Encourage them to speak with GP or trusted professional

If risk to others i.e. children, speak with Safeguarding Lead for advice/ escalation to DCC

Speak with Safeguarding Lead, if concern continues

Does the person want to be referred to Adult Safeguarding?

Safeguarding Lead will decide if referral needed and will consider person's ability to consent

Yes

No

Consider speaking with NOK, other professional colleagues & make best interest decision supported by Safeguarding Lead

Is the person or another at risk?

Yes

Make a referral to DCC Safeguarding Team

Monitor & encourage to seek ongoing help

Appendix 3

Hospiscare Clinical Documentation Flowchart

Hospiscare staff member is aware of a pre-existing concern that has been raised for a patient.

Complete first section of Safeguarding window on patient electronic record to alert colleagues to the relevant details of this

Hospiscare employee raises a safeguarding concern as per procedure/process

Complete patient electronic record Safeguarding window and inform safeguarding@hospiscare.co.uk so that the appropriate CQC notification is made

Hospiscare employee is aware that an external colleague/agency has made a safeguarding concern for a Hospiscare patient currently within our service

Complete patient electronic record Safeguarding window and inform safeguarding@hospiscare.co.uk so that the appropriate CQC notification is made

Appendix 4

Safeguarding Adults Escalation Protocol

A protocol is a formal agreement and commitment between two or more parties on a common response to specific issues, events or circumstances.

The aim of this protocol is to resolve professional disagreements relating to the safety of adults at risk, escalating any concerns that may arise, if issues are not viewed as being dealt with satisfactorily.

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Approved by: Operational Delivery Group, DSAP	Date of approval: 24th February 2020

Acknowledgements

With thanks to Plymouth Safeguarding Adults Board and 4LSAB including Hampshire, Isle of White, Southampton and Portsmouth Safeguarding Adults Boards, whose guidance and protocols for escalation have been adapted to produce this document.

Introduction

1. Introduction

Occasionally, situations arise when workers in one organisation feel that the decision made by a worker from another organisation regarding safeguarding an adult at risk is not appropriate. Working together effectively depends on an open and honest approach between organisations.

A healthy safeguarding system has a culture of respectful, professional challenge both within and between organisations. All workers should feel able to challenge decision-making. It is their right and responsibility, in order to promote the best multi-agency safeguarding practice. Being able to remain open to reviewing a decision and positively accept challenge is equally as important as being able to raise a challenge.

All workers have a professional duty to raise concerns about an individual at risk and all organisations should be mindful to give appropriate support to those raising a concern, as difference in status/experience may affect someone's confidence in reporting.

This protocol provides organisations with the means to raise concerns they have about decisions made by workers from other organisations. It aims to:

- Avoid professional disputes that put adults at additional risk or obscure the focus on the adult at risk.
- Resolve the difficulties within and between organisations quickly and openly.

This protocol is not for:

- Complaints. Workers need to follow their own internal processes for raising a complaint, this may include use of their organisations whistle-blowing process.
- Disagreements internal to one organisation. Workers need to follow their own internal processes to seek resolution about a disagreement within their own organisation.

The Escalation Protocol relates to Safeguarding Adult cases that meet the statutory duties of **The Care Act 2014**. This means the referred adult:

- Has needs for care and support (whether or not the local authority is meeting any of those needs)
- Is experiencing, or is at risk of, abuse or neglect
- 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.

The Escalation Protocol may be useful in cases concerning the following:

- Whether an organisation should take action in relation to a safeguarding concern / enquiry;
- Whether a concern should progress to a safeguarding enquiry;
- Who is the most appropriate professional to lead on a safeguarding enquiry;
- Whether an organisation has taken sufficient action following a safeguarding enquiry;
- If there is disagreement over the sharing of information.

Despite any disputes there must be a strong focus on the adult concerned, what matters most to them, the outcomes they want to achieve and how that may be accomplished. This is at the heart of Making Safeguarding Personal. Adults must be involved in decision-making and where the adult has a 'substantial difficulty' in being involved the support of a suitable person or advocate must be offered.

If a person declines safeguarding support under a S42 enquiry consideration should be given to ways in which the risk to the adult could be managed or mitigated.

2. Principles Underpinning this Protocol

- Partnership: agencies and professionals working effectively together looking for local resolutions at the earliest opportunity to deliver the best outcome for the person.
- Timeliness: responses are timely and ensure the safety of the adult.
- Proportionate: actions taken are proportionate and the least intrusive response to

the risk presented.

3. Stages of the Protocol

In taking action under this protocol it is imperative that the safety of the adult in question must be considered at all times and actions to ensure safety are taken whilst disputes are being resolved.

Additionally, it is important for organisations to ensure that workers involved are included in discussions at each stage of the process. They will be able to provide detail around the issues, information about the person's preferred outcomes and can ensure that well-informed discussions take place.

Due to different organisational structures, organisations may wish to overlay this protocol with appropriate internal roles applicable to each stage.

Stage 1: Workers

Initially, attempts should be taken to resolve the disagreement between the workers involved. This must be completed within two working days. It is important that all available evidence is considered when making decisions and that the rationale for decision making is recorded and fed back as necessary to other workers within organisations. Accountability is, in part, being clear about how and why a particular decision is made. Organisations raising concerns need to be updated on what action has been taken to arrive at a decision.

It is essential that those workers undertaking safeguarding work update and brief their manager on significant information and developments; including disputes. The safety of the adult in question must be considered at all times and actions to ensure safety should be taken.

If resolution cannot be achieved at this stage, then the next stage of this protocol needs to be taken.

Stage 2: Supervisor / Managers

The worker should escalate their concerns to their Supervisor / Manager. The worker should clarify what the disagreement refers to and what their desired outcome of the escalation protocol is.

The Supervisor / Manager must then liaise with the individual of equal authority in the other organisation about the circumstances to resolve the matter. This must be completed within two working days upon receipt of the escalation. The safety of the adult in question must be considered at all times and actions to ensure safety should be taken.

If resolution cannot be achieved at this stage, then the next stage of this protocol needs to be taken.

Stage 3: Organisational Safeguarding Leads or Senior Management

The Supervisor / Manager should escalate their concerns to their Organisational

Safeguarding Lead or Senior Management. The Supervisor / Manager should clarify what the disagreement refers to, what attempts have been made to seek resolution and what their desired outcome of the escalation protocol is.

The Organisational Safeguarding Lead or Senior Manager must then liaise with the individual of equal authority in the other organisation about the circumstances to resolve the matter. This must be completed within two working days upon receipt of the escalation.

The safety of the adult in question must be considered at all times and actions to ensure safety should be taken. This includes ensuring that sufficient safety measures have been put in place for the individual. A multi-agency meeting may be required to review the risks to the individual and create an interim protection plan.

If resolution cannot be achieved at this stage, then the next stage of this protocol needs to be taken.

Stage 4: Heads of Service or Nominated Individual of an Organisation

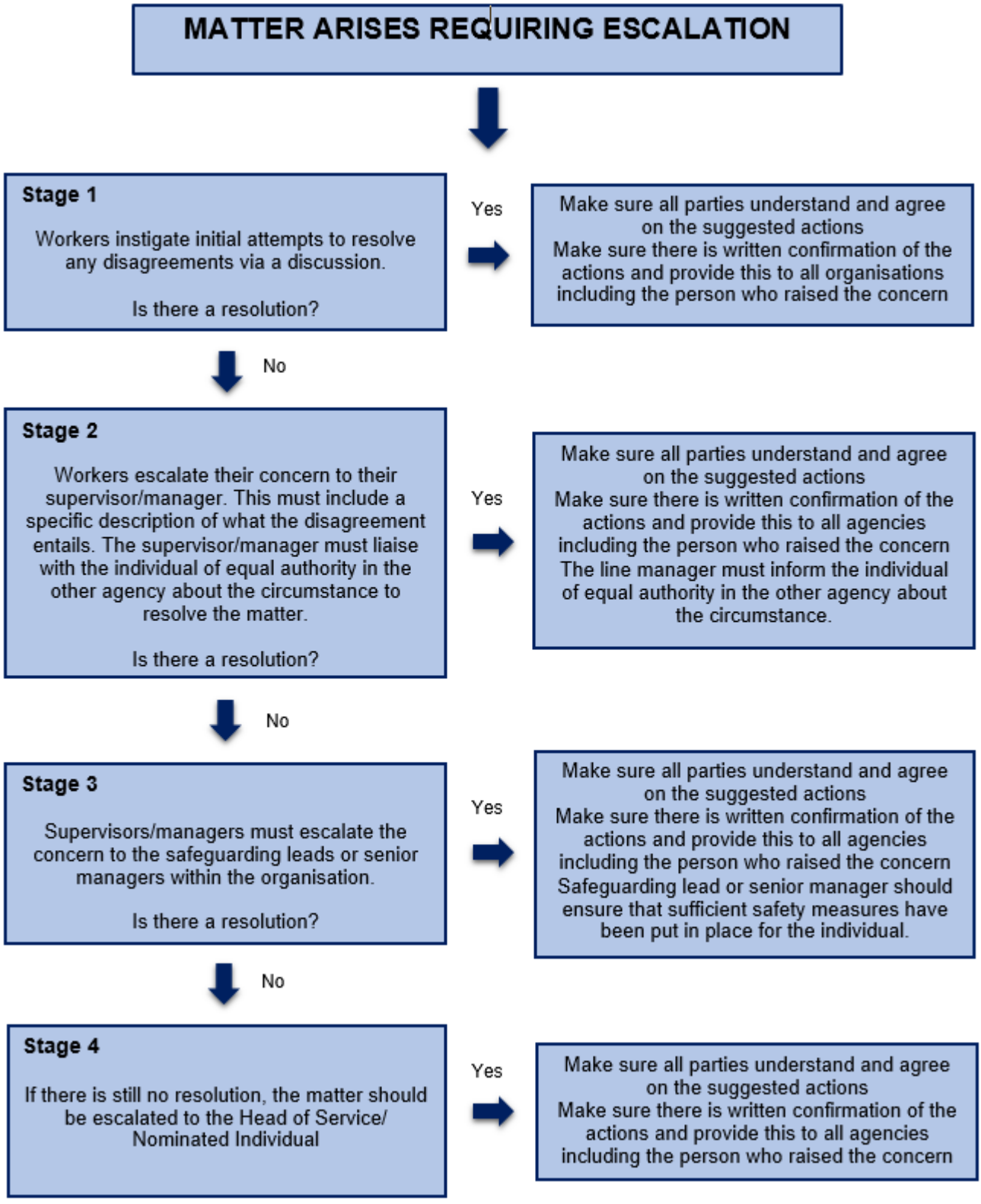
The matter should be referred to the relevant Head of Service or Nominated Individual of the organisations to seek resolution. This must be done within two working days upon receipt of the escalation and the adult at risk's safety should be afforded primacy.

Documenting and Communicating

Actions and decisions must be documented in writing at each stage of the process and must be shared with all the relevant professionals, including the individual who initially raised the concern.

There should be written confirmation between all parties regarding the agreed outcome(s) and how any outstanding issues will be pursued.

All documentation should be made in accordance with the internal processes of each agency.


MATTER ARISES REQUIRING ESCALATION
Stage 1
Workers instigate initial attempts to resolve any disagreements via a discussion.
Is there a resolution?
Yes
Make sure all parties understand and agree on the suggested actions
Make sure there is written confirmation of the actions and provide this to all organisations including the person who raised the concern
No
Stage 2
Workers escalate their concern to their supervisor/manager. This must include a specific description of what the disagreement entails. The supervisor/manager must liaise with the individual of equal authority in the other agency about the circumstance to resolve the matter.
Is there a resolution?
Yes
Make sure all parties understand and agree on the suggested actions
Make sure there is written confirmation of the actions and provide this to all agencies including the person who raised the concern
The line manager must inform the individual of equal authority in the other agency about the circumstance.
No
Stage 3
Supervisors/managers must escalate the concern to the safeguarding leads or senior managers within the organisation.
Is there a resolution?
Yes
Make sure all parties understand and agree on the suggested actions
Make sure there is written confirmation of the actions and provide this to all agencies including the person who raised the concern
Safeguarding lead or senior manager should ensure that sufficient safety measures have been put in place for the individual.
No
Stage 4
If there is still no resolution, the matter should be escalated to the Head of Service/ Nominated Individual
Yes
Make sure all parties understand and agree on the suggested actions
Make sure there is written confirmation of the actions and provide this to all agencies including the person who raised the concern

Appendix 5

Equality Impact Assessment Tool

Name of document	Safeguarding Adults and Children Policy
Department	Clinical Services
Name, job title and contact details of person completing the assessment	Ann Rhys, Clinical Director a.rhys@hospiscare.co.uk
Date completed	28.07.22

The purpose of this tool is to:

- **Identify** the equality issues related to a policy, procedure or strategy
- **Summarise** the work done during the development of the document to reduce negative impacts or to maximise benefit
- **Highlight** unresolved issues with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done

1. What is the main purpose of this document?

This document sets out the following

- Clarifies safeguarding legislation and the charity's responsibilities and obligations
- Covers definitions about safeguarding: What is Safeguarding and when it applies
- Describes how safeguarding is monitored and governed within the charity
- Describes what to do if a staff member or volunteer has a concern, or a concern is reported by another interested party
- Describes how safeguarding incidents should be recorded and reported
- Describes what training is required

2. Who does it mainly affect? *(please insert an "x" as appropriate:)*

Volunteers ☒ Staff ☒ Patients ☒ Other *(please specify)* ☐

3. Who might the policy have a 'differential' effect on, considering the "protected characteristics" below?

(By differential we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)

Please insert an "x" in the appropriate box (x)

Protected characteristic	Relevant	Not Relevant
Age	☐	☒
Disability	☐	☒
Sex – including: Transgender and Pregnancy/ Maternity	☐	☒
Race	☐	☒
Religion/ Belief	☐	☒
Sexual orientation – including: Marriage/ Civil Partnership	☐	☒

4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to *(e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?*

None

5. Do you think the document meets our human rights obligations?

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:
• **Fairness –** how have you made sure it treat everyone justly? • **Respect –** how have you made sure it respects everyone as a person? • **Equality –** how does it give everyone an equal chance to get whatever it is offering? • **Dignity –** have you made sure it treats everyone with dignity? • **Autonomy –** Does it enable people to make decisions for themselves?

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

Please give a brief summary – identifying: The safeguarding policy is an organizational policy which is relevant to all regardless of your identified protected characteristics, and enables human rights incl MCA etc.…

7. If you have noted any 'missed opportunities', or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

"Protected characteristic":	No
Issue:	
How is this going to be monitored/ addressed in the future:	
Group that will be responsible for ensuring this carried out:	