Safeguarding Adults Policy

Division: *Trust-Wide*
Document No: *CG134*

Specific staff groups to whom this policy directly applies	Likely frequency of use	Other staff who may need to be familiar with policy
All staff and volunteers working in NBT who have contact with patients, whether adult or child. All staff and volunteers who have contact with the general public whilst employed at NBT.	Regular	External Staff working in NBT. NBT contractors and Staff working under a Service Level Agreement.

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Summary of changes since the previous version	Update on team and Trust-wide processes and responsibilities Updates on leadership titles and roles Update on legislation

1. Executive summary

1.1. The latest revision of this policy develops from the Care Act (2014), other safeguarding legislation and government statutory guidance.

1.2. All staff have a duty of care to recognise and take action to prevent the abuse or neglect of adults at risk. Safeguarding is everybody's business with all professionals, members of the community and system partners having a key role in the identification of and response to abuse, harm, or neglect.

1.3. Safeguarding Adults is integral to the compliance of related legislation and regulations to deliver safe and effective care.

1.4. Safeguarding adults from harm is a core responsibility of North Bristol NHS Trust and this document provides guidance and support to staff in their safeguarding responsibilities and to ensure safeguarding principles are embedded in all areas of Trust practice.

1.5. Safeguarding Adults is fundamentally to ensure that the principles and duties around this growing evidence-based agenda are applied holistically and consistently, and consideration is always given using a contextual, trauma informed, Think Family and Strength Based approach.

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2. Purpose of the policy

2.1. The policy is intended for use by staff employed by or working on behalf of North Bristol NHS Trust. The aim is to ensure there are clear and robust processes in place to meet its statutory and mandatory requirements around safeguarding adults across the organisation. It will guide staff in supporting adults at risk of abuse or neglect or their families who access the Trusts services and will guide staff in accessing relevant systems and procedures to manage the risks associated with safeguarding adults and adult protection.

3. Scope of the Policy

3.1 This Policy is based on both national legislation and policy and local guidance and policy and is applicable to all staff employed by the Trust, all volunteers, those working with the Trust under a service level agreement and independent contractors and services hosted by the Trust.

All personnel working for or on behalf of North Bristol NHS Trust are expected to comply with this policy. The purpose of the policy is to guide practice and help raise awareness of the recognition of abuse and neglect of adults at risk, to minimize the risk of abuse and neglect and to ensure that should abuse or neglect come to the attention of Trust staff they know what to do.

4. Definition of terms

4.1. Adult safeguarding is defined as protecting an adult's right to live in safety, free from abuse and neglect. Adult safeguarding 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 ensuring the adult's wellbeing is promoted including having regard to their views, wishes, feelings and beliefs in deciding on any action.

The aims of adult safeguarding are to:

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

4.2 **The Care Act 2014** defines that adult safeguarding duties apply to adults over 18 years old who:

- Has needs for care and support (whether the local authority is meeting any of those needs); **and**
- Is experiencing **or** at risk of, abuse or neglect; **and**
- As a result of their care and support needs are unable to protect themselves from either the risk or experience of abuse or neglect.

The processes and procedures outlined within this document are underpinned by The Care Act 2014 (The Act). The Act was introduced in 2014 and gave statutory status to Safeguarding Adults, which means that staff now have a duty to safeguard adults, and not simply a responsibility. It has brought about some significant changes to the Safeguarding Adults agenda. The Act also introduced a change to terminology. A Vulnerable Adult is now referred to as an Adult at Risk. The perpetrator is now known as a 'Source of Harm.'

Section 42

Whilst Local Authorities retain the lead in respect of Safeguarding Adults procedures, the Act has placed a legal duty on organisations outside the Local Authority, including Healthcare providers and the Police. The Act requires Local Authorities to make enquiries, or cause others to do so, if it believes that an adult is at risk of or experiencing abuse or neglect. This means that health care providers may be requested to be involved in safeguarding investigations and have a duty to do so under Section 42 of the Care Act (2014).

Partnership Working

The responsibility for co-ordination of Safeguarding Adults work remains with the Local Authority. However, the Care Act makes it clear that the operation of procedures is a collaborative one. All organisations working with adults at risk now use the multi-agency approach. Staff, therefore, have a duty to work effectively in partnership with other key agencies, including voluntary and statutory agencies.

Safeguarding Adult Reviews (SAR) and Domestic Homicide Reviews (DHR)

Safeguarding Adults Boards (SABs) and Partnerships must arrange a Safeguarding Adults Review (SAR) under Section 44(1), (2) and (3) of the Care Act (2014) when an adult in its area dies, or suffers serious harm, because of known or suspected abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult.

SABs are free to arrange for an SAR in other situations outside these criteria, where it is believed that there will be value in doing so. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults and can include exploring examples of good practice.

The purpose of a Safeguarding Adults Review is not to apportion blame, but to establish if there are lessons to be learnt to prevent such situations happening again, and to share those lessons across the organisations. Any case that potentially meets the threshold for a review will be referred to the local SAB for consideration. The need for a review will be determined by the local SAR panels. The Trust has a duty as a partner agency of the Safeguarding Adults Boards to contribute to enquiries and to implement recommendations when SARs (Safeguarding Adult Reviews) are completed. The findings from SARs are shared by members of the Integrated Safeguarding Team through a variety of routes including Safeguarding Committee, mailshots, intranet page, reflective supervision and the Safeguarding Operational Group.

A Domestic Homicide Review (DHR) is a review that looks into the circumstances around a death related to domestic abuse or violence. Similar to a SAR, the purpose is to establish learning around how professional agencies worked together to safeguard victims. Domestic Homicide Reviews became law from April 2011 and are either commissioned by the local Community Safety Partnership (CSP) or through the local Safeguarding Adults Partnership. Domestic Homicide Reviews are the overall responsibility of the Home Office.

In Bristol, the Keeping Bristol Safe Partnership are responsible for reviewing Domestic Homicide referrals and commissioning Domestic Homicide Reviews on behalf of the Home Office. The local partnerships have the option of commissioning a non-statutory review if the circumstances around the death do not meet Home Office criteria for a statutory DHR, but there is a suspected local learning opportunity or good practice identified.

4.3 **Abuse:**

The Care Act (2014) statutory guidance lists 10 types of abuse but states that professionals must not limit their view of what constitutes abuse or neglect to those types, or the different circumstances in which they can take place. These are:

- Physical abuse
- Domestic abuse
- Sexual abuse
- Psychological or Emotional abuse
- Financial or material abuse
- Modern slavery
- Discriminatory abuse

- Organisational or institutional abuse
- Neglect and acts of omission
- Self-neglect

4.4 Abuse can consist of a single or repeated act(s); it can be intentional or unintentional or result from a lack of knowledge. It can affect one person, or multiple individuals. Professionals and others must be vigilant in looking beyond single incidents to identify patterns of harm. To see these patterns, it is important that information is recorded and appropriately shared.

4.5 Patterns of abuse and neglect vary and include:

- Serial abuse, where the perpetrator seeks out and 'grooms' individuals by obtaining their trust over time before the abuse begins – sexual abuse or exploitation commonly falls into this pattern, as do some forms of radicalization and financial abuse.
- Long-term abuse in the context of an ongoing family relationship such as domestic abuse between partners or family members, or persistent psychological abuse.
- Opportunistic abuse, such as theft, occurs because money has been left lying around.
- Situational abuse, for example because a Carer has difficulties themselves affecting their ability to adequately meet a person's needs. These could be debt, alcohol, or mental health related, or the specific demands resulting from caring for another person.

4.6 Abuse may become known because of a disclosure by the adult at risk; it may be observed by others or be considered a possible cause of a patient's injuries, behaviour, or other problems.

4.7 **Who might abuse?**

Anybody can abuse. Abusive relationships involving two or more adults also exist. The abuser is frequently, but not always, known to the adult they abuse and can include spouses/partners, other family members, neighbours or friends, acquaintances, paid staff or professionals, volunteers and strangers, or people who deliberately groom and exploit adults they perceive as more vulnerable to abuse.

4.8 **Where might abuse occur?**

Abuse can happen anywhere, for example:

- The person's own home (whether living alone, with relatives, or others).
- Day or residential centres.
- Supported housing.
- Work settings.
- Educational establishments.
- Care homes.

- Clinics or hospitals.
- Prisons.
- Via the internet or social media.
- Other places in the community.

4.9 **Why abuse may occur?**

Abuse can occur for many reasons. The risk is known to be greater when:

- The person is socially isolated.
- A pattern of family violence exists or has existed in the past.
- Drugs or alcohol are being misused.
- Relationships are placed under stress.
- The abuser or victim is dependent on the other (for finance, accommodation, or emotional support).

Where services are provided, abuse is more likely to occur where staff are:

- Inadequately trained.
- Poorly supervised and managed.
- Lacking support.
- Working in isolation

4.10 **Safeguarding Principles**

This policy and associated procedures are based on the six principles of safeguarding that underpin all adult safeguarding work. These are:

- Empowerment: Adults are encouraged to make their own decisions and are provided with support and information.

- Prevention: Strategies are developed to prevent abuse and neglect that promote resilience and self-determination.

- Proportionate: A proportionate and least restrictive and intrusive response is made balanced with the level of risk.

- Protection: Adults are offered ways to protect themselves, and there is a coordinated response to adult safeguarding.

- Partnerships: Local solutions are sought through services working together within their communities.

- Accountable: Accountability and transparency in delivering a safeguarding response.

4.11 Making Safeguarding Personal

The aim of Making Safeguarding Personal is to ensure that safeguarding is person-led, Trauma Informed, Strength Based and outcome-focused. It engages the adult in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice, and control; as well as improving their quality of life, wellbeing, and safety. It is an approach that sees people as experts in their own lives. The Trust will work with adults and their families (and their advocates or representatives if they lack capacity) to identify the outcomes they want to achieve; with partner agencies and services contribute to developing a range of clear, well-defined and appropriate responses that focus on supporting the adult to meet their desired outcomes and reduce the risk of recurrence of abuse; document clearly in the persons record what has been agreed and who is responsible for each action.

The Trust is committed to developing effective joint working with partners in health and social care organisations across the Integrated Care System (ICS). This document is for internal use; staff must also refer to the relevant multiagency Safeguarding Adult Board (SAB) and Partnership policies for Safeguarding Adults available on the Integrated Safeguarding Team webpage here.

All staff have a duty to empower patients and to protect them from abuse, harm, or neglect. Patients should have control of their care through consent. There must be a clear justification where action is taken without consent such as lack of capacity or other legal or public protection.

4.12 Organisational Abuse

The Care Act Guidance defines Organisational or institutional abuse as:

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 because of the structure, policies, processes, and practices within an organisation. Not all abuse that occurs within care services will be organisational; some incidents between adults or actions by individual members of staff may occur without any failings on the part of the organisation. Organisational abuse refers to those incidents that derive to a significant extent from an organisation's practice and culture (particularly reflected in the behavior and attitudes of managers and staff) policies and procedures.

Concerns relating to organisational abuse and neglect must be reported to the relevant Divisional Director of Nursing and the Chief Nursing Officer or

Deputy Chief Nursing Officer, and the Integrated Safeguarding Team. Staff can speak to 'Freedom to Speak Up' Guardians if further advice around raising concerns is needed.

An initial risk assessment must be carried out as soon as the allegation is made to decide if urgent action is required such as suspending individual members of staff, closing the ward/department, or removing patients to a place of safety. This is the responsibility of the Divisional Director of Nursing. When there is a choice of actions consideration of patient care and safety must be the guiding priority, so the least disruptive intervention is selected.

Allegations of Organisational Abuse or Neglect are taken extremely seriously and will result in increased external scrutiny and reputational impact. All allegations will be reported to the Local Authority and the Care Quality Commission.

Please also refer to the Keeping Bristol Safe Partnership (KBSP) multi-agency Organisational Abuse Policy.

4.13 **Female Genital Mutilation**

There is no requirement for automatic referral of adult women with FGM (Female Genital Mutilation) to adult social services or the police. Professionals must be aware that any disclosure may be the first time that a woman has ever discussed her FGM with anyone. A referral to the police must not be an automatic response for all adult women who are identified as having had FGM; cases must be individually assessed. The Trust Safeguarding team must be informed for any woman who is also an adult at risk. An adult woman who has had FGM may also be an indicator that others in the family, including female children, may be at risk of FGM. There is a mandatory requirement to refer children who are at risk of, or have had, FGM, as a child protection referral. There is also a specialist form within the Careflow record that must be completed by the clinician who identifies the FGM or receives the disclosure from the woman.

In all cases above, if the person is an adult at risk as defined by the Care Act you must also make a safeguarding adult's referral.

If there are female children in the home, please seek additional advice from the Named Nurse for Safeguarding Children or the Lead Midwife for safeguarding for guidance on information sharing for child safeguarding.

4.14 **Modern Slavery**

Includes slavery, human trafficking, forced and compulsory labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive, and force individuals into a life of abuse, servitude, and inhumane treatment. Many active organised crime groups are involved in modern slavery. But it is also committed by individual opportunistic perpetrators. Contemporary slavery takes various forms and

affects people of all ages, genders, and backgrounds. Modern slavery can involve people trafficked into the UK or adults who are UK or European Union residents.

Modern Slavery should be considered if a person is:

- Forced to work - through mental or physical threat.
- Owned or controlled by an 'employer', usually through mental or physical abuse or the threat of abuse.
- Dehumanized, treated as a commodity, or bought and sold as 'property.'
- Physically constrained or has restrictions placed on his/her freedom of movement.

Human trafficking involves the act/s of recruiting, transporting, transferring, harbouring, or receiving a person using force, coercion, or other means; for the purpose of exploiting them.

If an identified victim of modern slavery and /or human trafficking is also an adult with care and support needs, the response will need to be coordinated under adult safeguarding processes.

Due to the significant links with organised crime that trafficking and modern slavery often have the police are the lead agency in managing responses to all adults who are the victims of human trafficking. There is a national framework to assist in the formal identification and help to coordinate the referral of victims to appropriate services, known as the National Referral Mechanism (NRM). The NRM was introduced in 2009 to meet the UK's obligations under the Council of European Convention on Action against Trafficking in Human Beings. At the core of every country's NRM is the process of locating and identifying "potential victims of trafficking." Further guidance is available here.

From 31st July 2015 the NRM was extended to all victims of modern slavery in England and Wales following the implementation of the Modern Slavery Act 2015. If you have concerns that a patient is a victim of trafficking or modern slavery, seek support from a senior colleague and the integrated safeguarding team. Speak to the person alone in an area that cannot be overheard and if needed to facilitate clear communication use a professional interpreter.

Possible Indicators:

Signs of several types of slavery and exploitation are often hidden, making it hard to recognize potential victims. Victims can be any age, gender, ethnicity, or nationality. Whilst by no means exhaustive, this is a list of some common signs:

- The adult is not in possession of their legal documents (passport, identification, and bank account details) and they are being held by someone else.
- They are accompanied outside their address; they are not permitted to go

out alone.

- The adult perceives themselves to be in debt to someone else or in a situation of dependence.
- The adult has old or serious untreated injuries, and they are vague, reluctant, or inconsistent in explaining how the injury occurred.
- The adult looks malnourished, unkempt, or appears withdrawn
- The adult has few personal possessions and often wears the same clothes
- What clothes they do wear may not be suitable for their work.
- The adult is withdrawn or appears frightened, unable to answer questions directed at them or speak for themselves and/or an accompanying third party speaks for them.
- If they do speak, they are inconsistent in the information they provide, including basic facts such as the address where they live
- They appear under the control/influence of others, appear unfamiliar with where they live or where they work.
- Fear of authorities

Please see **Appendix 1** for guidance.

4.15 **Homelessness – Duty to Refer**

The Homelessness Reduction Act 2017 introduced the ‘duty to refer’ and this came into force on the 3rd of April 2018. Under the new duties in the Act, local housing authorities will now offer individuals who are homeless or threatened with homelessness a greater package of advice and support. The Act should mean more people get the help they need earlier, to prevent them from becoming homeless in the first place. Health services who provide inpatient or Emergency Department services now have a legal duty to refer patients they consider may be homeless or threatened with homelessness to a local housing authority. The referring professional must have the person’s consent. The patient will need to decide which local housing authority they are referred to, mirroring the way people choose which local housing authority to seek help from when approaching directly for housing assistance.

If NBT considers that a patient may be homeless or threatened with homelessness or if the patient made a positive disclosure to a member of staff that they were homeless or at risk of homelessness, the service would be required to ask the individual if they would like to be referred to a Local Housing Authority.

Service users may be patients, or other individuals for whom the health service exercises a function.

The Act defines an individual as threatened with homelessness if they are likely to become homeless within 56 days. However, the Department of Health and Social Care encourages health services to refer individuals that may be at risk of homelessness as early as possible to maximize the opportunities to prevent homelessness.

The following factors would indicate that an individual may be threatened with homelessness and should be enquired about:

- problems with debt, particularly rent or mortgage arrears
- problems with a property owner, being threatened with eviction or served notice to leave
- being a victim of domestic abuse, or other forms of violence, threats, or intimidation
- approaching discharge from hospital, armed forces, or release from custody, with no accommodation available
- having previously been in care, the armed forces or in prison

Further information can be found here.

4.16 **Prevent Violent Extremism and Radicalisation (PREVENT Duty)**

North Bristol NHS Trust is committed to operating a zero-tolerance approach to all those who abuse or neglect adults or children, including staff and the public, and that all suspected cases of exploitation or radicalisation of patients will be communicated and acted upon. Trust services and staff members need to be able to recognise signs of any form of radicalisation and extremism and be confident in raising concerns for the correct people within the Trust. For guidance, please see Policy CG-217 on Link.

4.17 **Domestic Abuse Act (2021)**

North Bristol NHS Trust is committed to operating a zero-tolerance approach to all who abuse or neglect adults or children and will ensure that all suspected cases where there is risk of Domestic Abuse will be explored and necessary appropriate action taken. Trust services and staff members need to be able to recognise their responsibilities in identifying potential Domestic Abuse, understand risk factors, signs, and indicators, and be confident in discussing this with relevant other individuals or agencies. For information see Policy CG-205.

Staff must ensure they know the standard procedure of response when Domestic Abuse is suspected or identified. Staff must have an awareness of the context underpinning the wider agenda and new legislation, and how these impact patients (and their families) who access NBT (North Bristol NHS Trust) services and must ensure they access all training offers relating to Domestic Abuse, commensurate to their role

5. Roles and responsibilities

5.1 Responsibilities of Clinical Managers, Consultants and Senior Staff Senior staff identifying or receiving a report of suspected abuse or neglect, where an adult with care and support needs who cannot protect themselves from harm, must ensure the following:

- The immediate safety of the individual and other patients/staff

- Inform the Trust Integrated Safeguarding Team by completing a referral on Careflow Connect (see below process)
- Ensure the patients consultant is aware of the allegation
- Establish and record the facts of the allegation or disclosure
- Consider the possible need for a medical examination/medical photography
- Where the patient has mental capacity discuss with them sharing information with them close family/friends/support network
- Where the patient lacks capacity to decide on information sharing consider sharing with family/friends in their best interests
- Consider the need for a Mental Capacity Act Assessment
- Consideration of the possible need for an “Independent Medical Capacity Advocate” (IMCA)
- Consider evidence of a crime having been committed meaning the police will need to be informed
- Support for the wider care team around the patient particularly inexperienced staff, volunteers, or newly registered practitioners

When abuse is suspected a referral to the Integrated Safeguarding Team must be completed

5.2 Responsibilities of Divisional Management Teams

It is the role of the Divisional Management Teams to ensure that all safeguarding processes are robust in their area and that mandatory safeguarding and Mental Capacity Act and DoLS training compliance is within the Integrated Care Board (ICB) compliance levels within the Quality Standards Contract. The Divisional Director of Nursing or Deputy (as delegated) for each division will act as a Designated Lead for safeguarding and they will be responsible for ensuring investigations and enquiries are managed and for monitoring the safeguarding process within their division. They will attend, or delegate to an appropriate deputy specific safeguarding meetings with the local authority as requested by the Integrated Safeguarding Team Leaders. This role must be delegated to a named individual during all periods of absence and ongoing safeguarding situations communicated clearly.

5.3 Role of Patient Safety and Complaints Departments

The Patient Safety Team will share any incident reports which come to light which may be considered related to or about to adults at risk with the Integrated Safeguarding Team for an assessment of the need for a formal safeguarding referral. In cases of serious safeguarding concerns an investigation may be carried out under the Safeguarding Adults Board (SAB) multi-agency safeguarding procedures.

The Complaints Department will share any complaints which may relate to alleged abuse or neglect with the Integrated Safeguarding Team for an assessment of the need for a safeguarding referral. A record of the referral is recorded as part of the process using the relevant electronic reporting system.

In situations where a safeguarding referral is required the Local Authority Lead will include the complaints officer in the safeguarding process to ensure that the complaint is addressed in a timely way.

Divisional Quality Leads have a responsibility to share safeguarding information as relevant with the team.

5.4 Sharing Information

Information can be disclosed when the adult consents to the sharing of their information and/or when it is in the best interests or of “vital interest” of the adult at risk or other adults who may be at risk of being abused. Whenever possible the adult at risk must be told what information is being shared, who it is being shared with and for what purpose. Even when consent is not required (for example reporting concerns about treatment of adults at risk in a community home setting) it is best practice to explain to the individual why we are sharing a concern or information outside the Trust. Additional advice on information sharing can be sought from the safeguarding team, the Information Governance team, and the Trust Healthcare Legal Department.

5.5 Consent

Is valid only if:

- The patient has the capacity to consent
- The patient has enough relevant information to decide regarding consent
- The decision is given voluntarily
- The person has the right to withdraw consent/change their mind

The ability to give consent and capacity to understand information/situations are crucial issues in determining whether an adult at risk can make decisions relating to abuse and neglect they may have experienced. Staff must assess mental capacity and document this clearly in the patients’ records. Please refer to NBT Mental Capacity Act Policy on Link for more information.

If the patient has mental capacity to consent but does not wish information to be shared regarding risk of harm or abuse, a referral can be made without their consent if there are risks to other people or the concerns relate to a care provider or setting.

These decisions must be documented in the patient’s record and shared with the relevant team involved in the patient’s care.

If they do not have the mental capacity to make this decision, information must be shared in line with a best interest decision made by the professional concerned with their care. This must consider the risk to the person and to other vulnerable individuals.

All staff must exercise professional curiosity by exploring and proactively trying to understand what is happening within an individual's life and always avoid

assumptions. Always be aware of unconscious bias when making decisions around safeguarding adults.

5.6 When a referral to the Local Authority has been made

Following a referral to the Local Authority an adult safeguarding practitioner from one of the local authority teams will liaise with the patient, Carer, relative or IMCA, Integrated Safeguarding Team and relevant staff to plan and agree any actions. Depending on the outcome of an interagency discussion and/or meeting, Trust staff may need to provide additional information, participate in the investigation, assessment, strategy meeting and future protection plan. If it is decided that no local authority services or Police involvement is necessary, the multi-disciplinary team responsible for care will need to decide whether further internal proceedings/investigation are required.

For information around Organisational Safeguarding allegations, please refer to the Keeping Bristol Safe Partnership Organisational Safeguarding Policy.

Standards for record keeping when raising a safeguarding concern are outlined on the Integrated Safeguarding Team intranet webpage.

5.7 Carers

Carers could become involved in a variety of situations requiring a safeguarding response. This includes:

- Witnessing or speaking up about abuse or neglect
- Experiencing intentional or unintentional harm from the adult they support or from professionals or organisations they are in contact with
- Intentionally or unintentionally causing harm or neglect to the adult they support, either as an individual or with others

Members of the multi-disciplinary team will take the contribution of unpaid or family member Carers into consideration when assessing the needs of patients and will ensure that both younger and older carers are offered appropriate help and support. Paid carers can share information to facilitate assessments and care planning, but it must be noted that they cannot be a patient's sole advocate or make decisions on behalf of the patient.

5.8 Recruitment

The Trust uses thorough recruitment practices to protect all patients.

Recruitment procedures must include the rigorous checking of:
- Professional Registration details
- Other professional/educational qualifications/competencies as appropriate other sources as appropriate
- Career or work history
- References including current employer

- Disclosure and Barring Service checks

Disclosure and Barring Service checks will be required for all staff, volunteers, and contractors whose work requires contact with children or adults within the Trust.

For further details about the use of this service and the recruitment of inexperienced staff please refer to HR policies or the advisor for your division based in the People and Transformation team. Details of these can be found on the intranet.

5.9 Poor professional practice and neglect or abuse

The difference between poor practice or standards of care and willful neglect requires careful consideration and judgement. If an adult is dependent on the assistance of others to meet basic needs, continual "poor practice or standards of care" can lead to serious harm or death.

Useful elements in deciding if poor practice has occurred that does not require an adult protection response are to ascertain if the concern:

- is a "one off" incident to one individual
- resulted in no harm
- indicated a need for a defined action to prevent re-occurrence.

Incidents that indicate that poor practice is impacting on more than one adult, that poor practice is recurring and is not a "one off," meets the threshold for adult protection procedures being initiated as these incidents can indicate more widespread "organisational" abuse, please see the Keeping Bristol Safe Partnership website for further information on Organisational or Institutional abuse.

A "one off" incident can indicate a lowering of care standards by health or care providers. Early indications of poor practice must be challenged and can be addressed using other systems, such as care management reviews; complaint investigations; or human resources systems. All of these will ensure that the issue is thoroughly investigated, recorded, resolved, and monitored.

The Care Act states - examples of such concerns could include allegations that relate to a person who works with adults with care and support needs who have:

- behaved in a way that has harmed, or may have harmed an adult or child
- possibly committed a criminal offence against, or related to, an adult or child
- behaved towards an adult or child in a way that indicates they may pose a risk of harm to adults with care and support needs

When a person's conduct towards an adult may have an impact on their suitability to work with children, discuss with the LADO (Local Authority Designated Officer) for advice. Please follow the allegations management

process in the Trust Children's Safeguarding Policy or refer to the Southwest Child Protection Procedures via https://www.proceduresonline.com/swcpp/ for services based outside the Bristol area.

When a person's conduct towards an adult may impact on their safety to work with adults who are unable to protect themselves from harm, a discussion must be had with the Local Authority Officer responsible for considering the suitability of a Person in a Position of Trust (PiPoT). These concerns must be raised with the operational lead for the Integrated Safeguarding Service as a matter of urgency. The Integrated Safeguarding Team Operational Lead will liaise accordingly with relevant parties. The allegation against staff flow chart can assist teams in actions they must follow to complete relevant risk assessments.

All concerns MUST be shared with the Integrated Safeguarding Team, and all must ensure a fair and just culture process can be followed in reviewing any allegation against a member of staff, whilst recognising the statutory process and risk management issues around staff allegations.

If you have non-urgent concerns around a professional or any other person working with adults, and you would like to discuss this prior to reporting to your manager you can contact the Integrated Safeguarding Team, 'Freedom to Speak Up Guardians' or your divisional People Partner who will support you to share your concern appropriately.

5.10 Organisational Abuse

The Care Act Guidance defines Organisational or institutional abuse as:

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 because of the structure, policies, processes, and practices within an organisation. Not all abuse that occurs within care services will be organisational; some incidents between adults or actions by individual members of staff may occur without any failings on the part of the organisation. Organisational abuse refers to those incidents that derive, to a significant extent, from an organisation's practice and culture (particularly reflected in the behavior and attitudes of managers and staff) policies and procedures.

Concerns relating to organisational abuse and neglect must be reported to the relevant Divisional Director of Nursing and the Chief Nursing Officer or Deputy Chief Nursing Officer, and the Integrated Safeguarding Team. Staff can speak to 'Freedom to Speak Up' Guardians if further advice around raising concerns is needed.

An initial risk assessment must be carried out as soon as the allegation is made to decide if urgent action is required such as suspending individual members of staff, closing the ward/department, or removing patients to a place of safety. This is the responsibility of the Divisional Director of Nursing. When there is a

choice of actions consideration of patient care and safety must be the guiding priority, so the least disruptive intervention is selected.

Allegations of Organisational Abuse or Neglect are understandably and correctly taken extremely seriously and will result in increased external scrutiny and contain the risk of sustained reputational impact. All allegations will be reported to the Local Authority and the Care Quality Commission. Please also refer to the Keeping Bristol Safe Partnership (KBSP) multi-agency Organisational Abuse Policy at: Welcome to the Keeping Bristol Safe Partnership website. (bristolsafeguarding.org)

All staff have a duty to ensure they complete the level of safeguarding training commensurate to their role. It is the responsibility of the Divisional Directors of Nursing to ensure their teams are compliant in their safeguarding training. **For training matrix see Appendix 2.**

6. Procedures

6.1 Allegations of abuse

Steps to be taken where an allegation of abuse concerns the actions of a member of Trust staff

Where an allegation concerns the actions of a member of staff it is the duty of all those concerned to report the matter to a Divisional Director of Nursing or equivalent senior manager to ascertain the next steps to be taken. The Chief Nursing Officer or Deputy Chief Nursing Officer in their absence must also be informed. It is important to ensure that any action taken in this circumstance protects the rights and wishes of the adult, protects the rights of the member of staff concerned and enables managers to take appropriate action either on behalf of the adult or in respect of the staff member. Allegations received out of hours must be reported to the on-site Matron or On Call Manager and they will decide whether further escalation out of hours is needed.

The Line Manager (or another senior manager in their absence) of the staff members, in conjunction with the Divisional Director of Nursing and Human Resources, will agree what immediate action and next steps should be taken. This includes discussion with the Chief Nursing Officer or Deputy in their absence at the Executive Incident Review Group to have overview of any ongoing safeguarding adult protection referral that has been made to the Local Authority about a member of staff. The Integrates Safeguarding Team can provide support and expertise around this process.

It is an imperative that any information gathering regarding the alleged abuse does not compromise any police investigation and that the alleged abuser (staff member) is not interviewed until the police led investigation has been completed and the outcome reported back to the relevant senior manager.

Allegations against Agency Staff

Where the allegation of abuse or neglect concerns staff working for the Trust

but employed by an agency the process above must be followed with the addition that the delegated manager or Divisional Director of Nursing or lead for NBT eXtra will notify the agency of the concerns raised and share any actions the Trust carry out.

Contacting the Integrated Safeguarding Team

All Trust staff can report or discuss any safeguarding concern of abuse and/or neglect to the team by the below methods:

- Care Flow Connect
- Email-
- Telephone-
- Team Hours – Monday to Friday (excluding bank holidays) 08:30 -16:30hrs
- Outside of these hours, staff can raise urgent safeguarding concerns that cannot wait until the following working day to the Emergency Duty Team -

Please see **Appendix 3** for referral process flowchart

Useful External Local Authority Contact Numbers

Bristol Adult Social Care
South Gloucestershire Adult Social Care
North Somerset Adult Social Care
Local Authority Emergency Duty Team

Support for Staff

It is acknowledged that staff involved in the care of adults where abuse is disclosed or suspected, may experience feelings of distress. Support can be gained through the Trusts well-being and occupational health services in addition to reflective safeguarding supervision offered by the safeguarding team. All staff are encouraged to access the Integrated Safeguarding team for one-to-one support or general supportive discussion at any time using the contacts above if additional support is needed around distressing cases or situations.

Regular safeguarding supervision to staff who hold a safeguarding adult's caseload can be facilitated and arranged through the Named Professional for Adults. Safeguarding team members will access specialist reflective supervision due to the continual exposure to distressing information and imagery.

Safeguarding team senior leaders are encouraged to ensure regular internal supervision and to seek external independent support arrangements and mutual support including through the Strategic Safeguarding Health System Group (NBT, UHBW, Sirona, ICB and AWP).

7. Monitoring effectiveness

7.1. The table below details the monitoring procedures in order that NBT can be assured that compliance with a policy is being met. It identifies both the processes for monitoring compliance and the actions to be taken where deficiencies and non-compliance are identified. This table must be completed in all policies

7.2. This section describes how the implementation of the policy will be monitored. Audit activity should form part of all policy monitoring; therefore, an audit tool/checklist must be appended (or reference made to a national audit the Trust participates in on a regular basis). The table below should be populated with the key areas currently being monitored in addition to any monitoring criteria as required by regulators such as the CQC (Care Quality Commission). This table can be extended as required.

What will be monitored	**Monitoring/ Audit method**	**Monitoring responsibility (individual/group/ committee)**	**Frequency of monitoring**	**Reporting arrangements *(committee/group the monitoring results are presented to)***	**How will actions be taken to ensure improvements and learning where the monitoring has identified deficiencies**
Training compliance	Attendance rates at safeguarding adults training as per Training Matrix.	Safeguarding Committee	Quarterly	Quality Committee ICB Quality Standard	Recovery plan agreed, escalation to risk register
Allegations against staff	All referrals to be notified to CNO. Safeguarding Team to keep database of referrals and outcomes.	Safeguarding Committee	Quarterly	Quality Committee ICB Quality Standard	Division led action plan reviewed a Safeguarding Committee

8. Associated policies/documents

- Mental Capacity Act 2005 (MCA) and incorporating the Deprivation of Liberty Safeguards (DoLS) Policy CG127
- Consent Policy CG178
- Freedom to Speak Up: Raising Concerns Policy PEO22
- The Prevention and Management of Violence and Aggression Policy HS08
- Domestic Abuse Policy CG205
- Prevent Violent Extremism and Radicalisation Policy CG217
- Safeguarding Children Policy CG197

9. References

Care Act 2014
Counter Terrorism and Security Act 2015
Female Genital Mutilation 2003
Health and Social Care Act 2012
Crime and Disorder Act 1998
Criminal Justice Act 2003
Modern Slavery Act 2015
Health and Social Care Act 2012
Working Together to Safeguard Children 2018
Children Act 1989
NHS Patient Safety Strategy
Serious Violence Act 2022
Domestic Abuse 2021
Mental Capacity Act 2005 and associated Code of Practice Deprivation of Liberty Safeguards and associated Code of Practice
Mental Capacity (Amendment) Act 2019

10. Appendices

Appendix 1

If you are concerned that someone may be the victim of modern slavery or sexual exploitation, or you have suspicions about perpetrators of these crimes you must report it in one of the following ways:

If you think that someone is in immediate danger, call **999**

For non-emergency calls contact Avon and Somerset Police on **101**

Call the Modern Slavery National Helpline on **0800 121 700**

If the Adult has capacity and wishes to report a concern themselves anonymously, they can call Crime stoppers on 0800 555111

In England and Wales people can call The Salvation Army 24-hour confidential Referral Helpline on 0300 3038151 to refer to a potential adult victim of trafficking or to receive advice. This line accepts victim self-referrals.

For actual or potential child victims of trafficking call Bristol First Response: **0117 903 6444**

If the person is an adult at risk as defined by the Care Act, you will be supported to make a safeguarding adult's referral.

If you are a staff member and you have concerns about a patient and you are unsure what to do, please contact the Safeguarding Team, a senior colleague in your department or out of hours the on-call Matron, Clinical Site Management Team, or the Local Authority Emergency Duty Team.

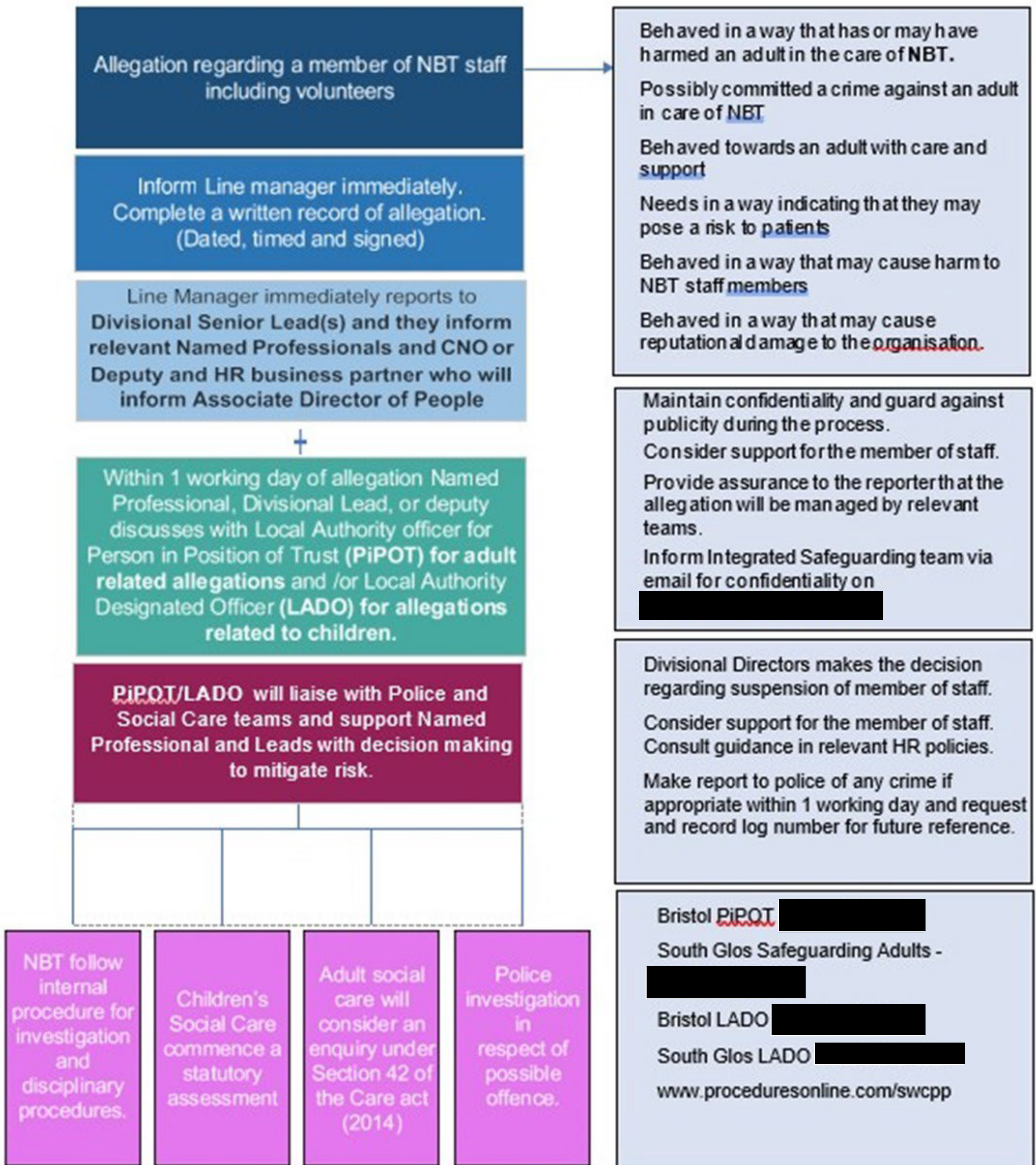
Appendix 2

Adult Safeguarding Training Matrix
The Trust Training Matrix for Adult Safeguarding is based on the recommendations in the Intercollegiate Document for Adults 2018.

Who	What	When	Updating
All staff working in health care settings. All health care staff including, receptionists, administrative staff, caterers, domestic and transport staff, porters, community pharmacist counter staff, peer support workers and maintenance staff, board level executives and non-executives, non-clinical staff working in primary health care settings.	Level 1	At induction, a 30- minute introduction to safeguarding 2 hours combined children and adults safeguarding session via e-learning within 4 weeks of starting role. 3 yearly updates thereafter.	Staff at level 1 should receive refresher training equivalent to a minimum of 2 hours over 3 years.
All practitioners have regular contact with patients, their families or carers, or the public. This includes administrators for safeguarding teams, **health students, phlebotomists, pharmacists**, orthodontists, dentists, dental care professionals, audiologists, optometrists, **nursing associates**, clinical researchers, **allied health professionals**, ambulance staff, staff who work in virtual/online health settings who provide any health care online, **registered nurses, medical staff,** and GP practice managers. Patient Safety Team and Divisional Quality Teams are strongly encouraged to complete level 2 safeguarding training for their role, as directed by their leads and managers.	Level 2	2 – 2.5 hours face to face at induction including MCA and DoLS awareness and practice. 3 yearly update cycle thereafter.	Staff at level 2 should complete learning over a three-year period, professionals at level 2 should receive refresher training equivalent to a minimum of 3-4 hours. (Training at level 2 will include the training required at level 1 and will negate the need to undertake refresher training at level 1 in addition to level 2). Training, education, and learning opportunities should include multi-disciplinary & multi-agency and scenario-based discussion drawing on case studies and lessons from research and audit.

Who	What	When	Updating
Safeguarding professionals and within North Bristol Trust a discreet group of senior staff identified by their managers.	Level 3	For those individuals moving into Level 3 adult safeguarding posts who have yet not attained the relevant knowledge, skills and competence required at level 3 it is expected that within twelve months of appointment additional tailored education will be completed equivalent to a minimum of eight hours of education and learning related to adult safeguarding and have an appropriate supervision in place.	Over a three-year period, professionals at level 3 should receive refresher training equivalent to a minimum of eight hours. Training, education, and learning opportunities should be multidisciplinary and inter-agency. It should be delivered in a manner which encourages personal reflection and may include scenario-based discussion, drawing on case studies, serious case reviews, lessons from research and audit. This should be appropriate to the specialty and roles of the participants.
Specialist roles – Named Professionals This includes lead doctors, heads of adult safeguarding, and named GPs/doctors for organizations commissioning primary care. Named professionals working in provider or commissioning services.	Level 4	Named professionals should participate regularly in support groups or peer support networks for specialist professionals at a local and national level, according to professional guidelines. Named professionals should complete leadership education with a focus on clinical leadership and change management within three years of taking up their post. Training at level 4 will include the training required at levels 1-3 and will negate the need to undertake refresher training at levels 1-3 in addition to level 4.	Named professionals should attend a minimum of 24 hours of education, training and learning over a three-year period. This should include clinical leadership, appraisal, and supervision training.

Appendix 3: Allegations Management Flowchart



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