



St Wilfrid's Hospice

Safeguarding Adults Policy and Procedure

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1. Key points about this policy

- All staff and volunteers have a responsibility to raise a safeguarding concern without delay if they witness or are told about alleged abuse or suspect abuse, with your line manager or other senior members of the multi-disciplinary team.
- All disclosures and concerns must be acted on, however vague, in a timely manner.
- This includes concerns regarding a colleague (employee or volunteer) having abused an adult.
- A social worker must be consulted and involved with all concerns.
- Detailed recording every step along the way is essential.
- The responsibility for decisions whether to make a safeguarding referral to Adult Social Care lies with the multi-disciplinary team in consultation with the Safeguarding Lead.
- All activities under safeguarding need to be underpinned by the Care Act Guidance notion of 'making safeguarding personal'. This means that St Wilfrid's safeguarding activities will be person-led and outcome-focussed.

2. Does this policy have any impact on equality and inclusion?

There is assessed impact, please see Appendix One.

In more detail

3. What is this policy about?

Overarching policy statement

St Wilfrid's Hospice recognises that it has fundamental responsibilities in relation to keeping all those who have contact with the organisation safe from harm in the broadest sense. This includes the patients and families, adults and children under the care of the hospice. It includes the deceased. It also includes staff and volunteers, donors and supporters, the public and our community.

We recognise that keeping safe from harm in the broadest sense requires whole-organisation commitment, underpinned by the organisation's values. Our aim is to foster a broad culture of safe from harm with a focus on prevention and shared awareness, based on sound governance.

In the hospice's understanding whole-organisation safeguarding spans both adult and children safeguarding for the hospice's patients and families (referred to as 'clinical' safeguarding within the organisation) as well as non-clinical aspects such as sound HR practices or facilities management to keep people from harm.

What this policy is about

This policy focusses on the particular area of safeguarding adults as a crucial part of whole-organisation safeguarding. St Wilfrid's recognises and respects that living a life in safety, free from abuse and neglect is a fundamental right of every adult. Safeguarding adults is an integral part of patient and family care.

This policy and procedure aims to ensure that:

- The needs, interests and human rights of adults experiencing, or at risk of abuse or neglect are respected and upheld
- Proportionate, timely, professional and ethical responses are made
- All decisions and actions are taken in line with the Mental Capacity Act (2005).

Safeguarding adults covers a spectrum of activity from prevention and early intervention through to multi- agency responses where harm and abuse has occurred. St Wilfrid's is committed to working together with relevant partner agencies to protect and support adults experiencing, or at risk of abuse or neglect whilst empowering and supporting people to make their own choices. St Wilfrid's recognises that successful responses need multi-agency and multi-disciplinary approaches.

The organisation's main function is to draw the attention of the relevant statutory body to instances where safeguarding has been identified as a concern. Staff and volunteers have a responsibility to act as early as possible on concerns or allegations that an adult is at risk of or experiencing abuse or neglect. The organisation will ensure that all staff and volunteers have an awareness of this policy and know how to follow relevant procedures. In addition, staff will be expected at all times to act within their professional codes of conduct in relation to safeguarding adults.

There is a separate policy concerning Child Protection and Safeguarding.

4. What are the different responsibilities under this policy?

The **Chief Executive** holds ultimate accountability for adherence to the policy and procedure, ensuring that reasonable resources are made available for its implementation.

The **Registered Manager** is responsible for ensuring this document is compliant with statutory legislation and implemented into practice. The Registered Manager has a duty to report relevant safeguarding events to the CQC.

The Safeguarding Lead, supported by the hospice social workers, is responsible for providing advice, expertise, support and training for hospice staff and volunteers on safeguarding queries and concerns and for promoting a culture within the hospice that encourages staff and volunteers to voice any concerns and provides support for staff and volunteers when concerns are expressed. The Safeguarding Lead is also responsible for ensuring safeguarding concerns are reported to Adult Social Care as relevant and appropriate.

Line Managers are responsible for informing and educating all existing employees, volunteers and contractors with practising privileges about the requirements of the document and dealing with any immediate concerns.

All **employees, volunteers and contractors with practising privileges** are responsible for adherence to the policy and procedure. Where the term "staff", "employee" or "volunteer" is

used in this document this includes contractors with practising privileges (see Practising Privileges Policy for definition).

Governance structure for whole-organisation safeguarding, including adult safeguarding

The **Board of Trustees** is responsible for overarching oversight of whole-organisation safeguarding (see over-arching policy statement, section 3), with the aim to protect from harm all people who come into contact with the charity. It is guided in this by Charity Commission guidance. The Board approves the key policies related to clinical safeguarding, *Safeguarding Adults* and *Child Protection and Safeguarding*. The Board is responsible for fostering an organisational culture that enables the bringing of safeguarding concerns to light and for these to then be addressed.

The **Trustee Safeguarding Lead** acts as a key liaison point and critical friend between the Board of Trustees and the Safeguarding Committee, with reference to external developments and best practice. They are elected by the Board of Trustees.

The **Safeguarding Committee** is a Board of Trustees sub-committee. It is responsible for providing assurance to the Board regarding highest standards of whole-organisation safeguarding practice in a continuous cycle of improvement. The Committee monitors related performance and brings any concerns to the attention of the hospice leadership team and the Board. In doing so, the Committee has regard to the Care Quality Commission's key questions and to national and local health and social care policy and guidance.

The Safeguarding Committee is comprised of the Trustee Safeguarding Lead who chairs the committee, the Hospice CEO and the hospice's designated Safeguarding Lead. Minutes of Safeguarding Committee meetings are presented at Board meetings where Board members have the opportunity to question and comment on matters arising from those minutes.

5. Putting the policy into practice

5.1. Scope

This document refers to safeguarding all adults aged 18 and over under the care of St Wilfrid's, including patients, carers and family members, on hospice premises and in their own homes. It includes the bereaved.

For young adults just over 18 staff should be mindful of age of maturity and the potential need for transitional safeguarding considerations.

5.2. Principles and Values

The organisation works in accordance with the key principles of the Care and Support Statutory Guidance (issued under the Care Act 2014, October 2014) and in particular:

- **Empowerment** - St Wilfrid's will aim to support and encourage people to make their own decisions regarding safeguarding decisions and to give informed consent.
- **Prevention** - St Wilfrid's will aim to take action before harm occurs.

- **Proportionality** - St Wilfrid's will aim for the least intrusive response appropriate to the risk presented.
- **Protection** - St Wilfrid's will seek to support and represent those in greatest need.
- **Partnership** - St Wilfrid's will aim for strong multi-agency partnership working in relation to any safeguarding issues.
- **Accountability** - St Wilfrid's will aim for accountability and maximum transparency in delivering safeguarding.

St Wilfrid's subscribes to the Care Act Guidance notion of '**making safeguarding personal**'. This means that St Wilfrid's safeguarding activities will be person-led and outcome-focussed. St Wilfrid's will engage the person concerned 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 quality of life, safety and wellbeing (wellbeing is the underlying guiding principle of the Care Act 2014). St Wilfrid's recognises that adults have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances. Staff will work with adults to establish what being safe and wellbeing means to them and how this can be best achieved.

Professional curiosity needs to be at the heart of safeguarding. It is about practitioners seeking to explore and understand what is happening in someone's life, rather than making assumptions or accepting what they are told at face value. It involves looking out for signs that things are not right and seeking out the evidence of what is really happening.

5.3. Definitions

5.3.1 Adults experiencing, or at risk of abuse or neglect

The Care Act replaces previous definitions of 'vulnerable adults'. The Care Act Guidance (para 14.2) states that safeguarding duties "apply to an adult who:

- Has needs for care and support (whether or not the local authority is meeting any of those needs) and
- Is experiencing, or is 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 adult experiencing, or at risk of abuse or neglect will hereafter be referred to as the adult throughout this document.

The adult *may* be a person who is frail due to ill health. St Wilfrid's patients *may* be at particular risk due to their debilitating illnesses. Vulnerability *may* increase as people become more ill, because they may be increasingly unable to safeguard themselves. They and the people around them *may* not realise or accept their increasing vulnerability. People who are ill *may* be more susceptible to coercion and undue influence and at risk of abuse from within their family or also healthcare professionals, including St Wilfrid's staff, because of their dependence on them for care and support.

However, just because a person is old or frail or has a disability they are not inevitably at risk of abuse and neglect. The vulnerability of the adult is related to how able they are to make and exercise their own informed choices free from duress and pressure and to protect themselves from abuse, neglect and exploitation. Vulnerability is determined by a range of interconnected factors, including personal characteristics, situational factors and social factors.

Risk issues and safeguarding do not only apply to patients. The patients' carers and other family members may be adults experiencing, or at risk of abuse or neglect due to their own particular circumstances.

5.3.2 Who abuses and neglects adults

Anyone can carry out abuse or neglect. The persons alleged to be causing harm are frequently known to the adult and in a position of trust and power. A St Wilfrid's patient may be an adult experiencing or at risk of abuse or neglect. However, at the same time the patient may also be an alleged perpetrator of harm to another adult, for example, their carer. Such harm can be intentional, or it may well be unintentional, in the context of struggling to care and being cared for. Likewise, people in a professional or commercial relationship with the adult (for example, staff of external agencies or St Wilfrid's own staff) can be alleged perpetrators of harm.

5.3.3 Abuse

Abuse may be:

- A single act or repeated acts
- Affect one person or more
- An act of neglect or a failure to act
- Patterns of abuse vary and include serial abusing, long-term abuse and opportunistic abuse.

Intent is not an issue at the point of deciding whether an act or a failure to act is abuse; it is the impact of the act on the person and the harm or risk of harm to that individual.

Some abusive acts are crimes and informing the police must be a key consideration.

5.3.4 Types of Abuse

Physical Abuse - including hitting, pushing, pinching, shaking, misusing medication, scalding, the misuse or illegal use of restraint, inappropriate sanctions, exposure to heat or cold and not giving adequate food or drink.

Physical (and psychological/emotional) abuse may include cultural forms of abuse, for example, honour-based violence, forced marriage, female genital mutilation (FGM), abuse linked to embedded social norms, spiritual or religious beliefs.

FGM is illegal in the UK and is not required by any religion. It is a very traumatic and violent act, causing harm to women and girls. The age at which FGM is carried out varies, it may be shortly after birth, during childhood, adolescence, just before marriage or during a woman's first pregnancy. Specific guidance is provided (see list of references) on how to respond if you suspect FGM has occurred or may occur.

Sexual Abuse - including the direct or indirect involvement of the adult in sexual activity or relationships which they do not want or have not consented to, they cannot understand and lack the mental capacity to be able to give consent to, they have been coerced into because the other person is in a position of trust, power or authority.

Psychological/Emotional Abuse - behaviour that has a harmful effect on the person's emotional health and development or any form of mental cruelty which results in:-

- Mental distress
- The denial of basic rights such as self-expression, privacy and dignity
- Negating the right to make choices and undermining self-esteem
- Isolation and over-dependence.

This includes threats of harms or abandonment, being deprived of social or any other sort of contact, humiliation, blaming, controlling, intimidation, coercion and bullying.

Financial or Material Abuse - is the use of a person's property, assets, income, funds or resources without their informed consent or authorisation. It includes theft, fraud, exploitation, undue pressure in connection with wills, property and inheritance, the misuse of property and the misuse of an enduring power of attorney or a lasting power of attorney.

Neglect and Acts of Omission - is the failure of any person who has responsibility for the care or custody of an adult to provide the amount and type of care that a reasonable person would be expected to provide. It includes ignoring medical or physical needs, failing to allow access to appropriate health and social care services and withholding the necessities of life such as medication, adequate nutrition, hydration or heating.

This includes neglect by a partner organisation such as a hospital or care home which the hospice becomes aware of, overlapping with the category of organisational abuse. In such instances the hospice has a duty to act under safeguarding principles even though the alleged abuse may have occurred under the care of another institution.

Neglect can be intentional or unintentional. **Unintentional neglect** could result from a carer failing to meet the needs of the adult because they do not understand the needs of the person, may not know about services available or because their own needs prevent them from being able to give the care the person needs. It may also occur if the individuals are unaware of or do not understand the possible effect of the lack of care.

Self-neglect - is included in the Care Act Guidance as a type of abuse and neglect. It is defined as the inability (intentional or non-intentional) to maintain a socially and culturally accepted

standard of self-care with the potential for serious consequences to the person's health and wellbeing. It includes a wide range of behaviours such as neglecting to care for one's personal hygiene, health or surroundings and declining essential support without which health and safety needs cannot be met. It includes behaviour such as hoarding. It should be noted that self-neglect may not prompt follow through under safeguarding by the Local Authority. An assessment will be made on a case-by-case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. For further information see <https://sussexsafeguardingadults.procedures.org.uk/pkoox/sussex-safeguarding-adults-procedures/sussex-multi-agency--to-support-adults-who-self-neglect#s2894>

Discriminatory Abuse - exists when values, beliefs or culture result in a misuse of power that denies opportunity to some groups or individuals. It can be motivated by discriminatory and oppressive attitudes towards age, gender, sexuality, disability, religion, class, culture, language, race or ethnic origin.

Organisational Abuse - is the mistreatment, abuse or neglect of an adult by a regime or individuals within settings and services which these adults live in or use. It occurs when routines and systems result in poor or inadequate standards of care and poor practice.

Domestic Violence - is defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between adults who are or have been intimate partners or family members regardless of gender or sexuality. Domestic abuse is rarely a one-off incident and should instead be seen as a pattern of behaviour. It occurs across society, regardless of age and gender, but statistically consists mainly of violence by men against women. There is a strong correlation between domestic violence and child abuse. It includes 'honour' based violence.

5.3.5 Related issues

The following are also covered under safeguarding:

Modern slavery – encompasses slavery, human trafficking, forced labour and domestic servitude. The true extent and nature of modern slavery in Sussex is not presently known as this crime remains largely invisible to the general public.

Hate crime or incidents - any incident that is perceived by the victim, or any other person, to be racist, homophobic, transphobic or due to a person's religion, belief, gender identity or disability. It should be noted that this definition is based on the perception of the victim or a third party witnessing the incident. Such incidents may constitute a criminal offence. Anyone can be a victim of hate crime or incidents regardless of race, age, disability, sexuality or gender.

Mate crime - when a person is harmed or taken advantage of by someone they thought was their friend. Surveys indicate that people with disabilities can often become the targets of this form of exploitation.

'Honour' based violence - may be committed when family members feel that dishonour has been brought to their family. Women are predominantly (but not exclusively) the victims, and the violence is often committed with a degree of collusion from family members and/or the community.

Forced marriage - this is the term used to describe a marriage in which one or both of the parties is married without their consent or against their will. A forced marriage differs from an arranged marriage, in which both parties consent to the assistance of their parents or a third party in identifying a spouse.

Abuse by children - If a child or children is/are causing harm to an adult, this will be dealt with under this Safeguarding Adults Policy.

Radicalisation - refers to the processes by which people come to support violent extremism. The government's **Prevent** programme (part of the counter-terrorism strategy CONTEST) puts a legal duty on organisations such as the hospice to seek to protect individuals who are vulnerable to exploitation from those who work to get people to support or commit acts of violence. Preventing someone from becoming a terrorist or supporting terrorism is no different from safeguarding vulnerable individuals from other forms of exploitation. The hospice's Prevent policy therefore sits alongside the hospice's Adults Safeguarding Policy and the Safeguarding Children's Policy. Concerns under Prevent are managed by adhering to the general safeguarding procedures below.

6. Procedures

6.1 Raising a concern within the hospice

Safeguarding is everybody's business. Anybody may see abuse taking place, be told about alleged abuse or suspect abuse.

Raising a concern refers to the duty of all staff and volunteers to inform their line manager of a concern that an adult:

- Has been harmed, abused or neglected or
- Is being harmed, abused or neglected
- Is at risk of being harmed, abused or neglected.

A concern may arise from:

- A direct disclosure by the adult
- A concern raised by others using the service, a carer or a member of the public
- An observation of the behaviour of the adult or of the behaviour of another person towards the adult.

6.1.1. Responsibilities of the person raising the concern

6.1.1.1. Taking immediate action

All staff and volunteers must take immediate action if they witness an actual incident of abuse.

They must make an immediate evaluation of risk and take steps to ensure that the adult is not in immediate danger.

There may be an urgent need for medical treatment, or where there is immediate risk of harm urgent action may be needed to protect the person. Depending on circumstances, this may involve calling the police and/or an ambulance. It may be necessary to remove the adult to a safe place or encourage the perpetrator to leave the premises.

As far as possible any such actions should be taken in consultation with and with support by line managers and other senior staff.

It may be possible to challenge the person who is abusing the adult but staff and volunteers should not put themselves in any danger.

Where relevant, any evidence of, for example the person's physical condition, their clothing, property should be preserved.

6.1.1.2. Acting on a concern or disclosure

Actual incidents of abuse in the presence of staff or volunteers are relatively rare. Far more frequently staff and volunteers will be told of behaviour that might be abuse and/or they will pick up on other clues (e.g., bruising, a person appearing unusually timid).

When responding to an adult making a disclosure, staff and volunteers should assure them that they are taking them seriously, listen carefully and get as clear a picture as possible. Staff and volunteers are not expected to undertake an investigation at this point, however, they may ask some very basic clarifying questions (e.g., "when did you say this happened?").

Staff and volunteers must act on all disclosures and concerns, however vague. This includes disclosures and concerns where the adult concerned states that they do not want any action to be taken.

Promises of absolute confidentiality cannot be given when told a disclosure. Staff and volunteers should explain that they have a duty to tell their manager and that the concerns may be shared with others who could have a part to play in protecting them.

Staff and volunteers should reassure the adult concerned that they will be involved in decisions about what will happen.

6.1.1.3. Informing a manager

Disclosures and concerns should be reported to a line manager or relevant senior members of the multi-disciplinary team without delay. Out of hours the senior clinical manager on-call needs to be informed.

This includes concerns regarding a colleague (staff or volunteer) having abused an adult. If the concern is that a manager has abused an adult a Director must be informed.

6.1.1.4. Making a record

Incidents, disclosures and concerns must be clearly recorded at the earliest opportunity in the electronic patient record and if appropriate through the incident reporting process. With regards to relatively vague concerns in particular, recording must be factual, not speculative (e.g., record behaviour observed or quote what has been said). Follow-through action (e.g., report to line manager) and any further plans must be recorded. Staff and volunteers with no access to the electronic patient record should write a paper record. This needs to be dated and signed and then scanned onto the electronic patient record.

The place to record any of the above in the electronic patient record is the dedicated *safeguarding template*. It will pull together, in one place, a history of all entries related to safeguarding. This is crucial in terms of the multi-disciplinary team's ongoing awareness and oversight in relation to safeguarding issues for the person concerned.

6.1.2. Responsibilities of the person receiving the report of a concern - Line Managers, Senior Members of the Multi-Disciplinary Team (MDT) and Senior Clinical Manager On-Call

6.1.2.1. Follow-through by the MDT and Decision to Make a Referral to Adult Social Care

Line managers or relevant senior members of the multi-disciplinary team receiving a report of an incident, disclosure or concern, however vague and uncertain, must ensure that the matter is discussed at the earliest opportunity by the multi-professional team or appropriate members of it.

This discussion should lead to a decision regarding the most appropriate follow-through. This may range from 'no action at this point but keep under review' for vague concerns to supporting immediate needs or a decision to make a safeguarding alert to statutory services.

The hospice Social Worker (or in their absence, the Hospice Safeguarding Lead, the Deputy Safeguarding Lead or another senior clinician) must be involved in all such MDT discussions.

The Hospice Safeguarding Lead (or in their absence the Deputy Safeguarding Lead or another senior clinician) needs to be consulted regarding all safeguarding decisions and before action is taken, unless, on reflection by the MDT (including the social worker), a concern is deemed minor, unfounded and clearly not requiring any follow through other than keeping the matter under review.

Out of hours, in the absence of MDT colleagues required for an MDT discussion and also in the absence of the Safeguarding Lead, the Senior Clinical Manager On-Call will need to take responsibility for making decisions in the light of risk and urgency. The decision will need to address whether the matter can wait until MDT discussion and consultation with the Safeguarding Lead become possible or whether an immediate referral to statutory services is

necessary. In making this decision the Senior Clinical Manager On-Call may seek advice from the Medical Consultant On-Call. If in any doubt at all the decision should be to refer to statutory services. A Social Worker and the Safeguarding Lead need to be brought up to date with any safeguarding issues which have arisen and were dealt with out of hours at the earliest opportunity. It is the social worker's responsibility to then look through the referral made out of hours, using their specialist knowledge in the area of safeguarding, and if relevant to follow through with Adult Social Care e.g., clarifying information or providing additional information, in liaison with their MDT colleague who made the original referral.

6.1.2.2. Speaking to the adult

It is usually appropriate for a relevant member of the MDT or the social worker to speak to the adult before matters are taken further. The following should be considered:

- Getting the person's view on what has happened and what they want done about it
- Giving them information about the safeguarding process and how this could help to make them safer
- Supporting them to ask questions about issues of confidentiality
- Explaining that they will be kept informed.

Accessible Information Needs should be considered and responded to as appropriate. Where relevant help with translation should be offered.

If it is felt that the adult may not have the mental capacity to understand the relevant issues and to make a decision, issues should nevertheless be explained to them as far as possible, given the person's communication needs. They should be given an opportunity to express their wishes and feelings.

It is important to establish whether the adult has the capacity to make decisions in relation to this matter. It should be assumed that the adult has capacity unless they have clearly been assessed as not having capacity. In the event of no capacity, relevant decisions and actions must be taken in the person's best interests. For further details see the hospice Mental Capacity Policy and Procedure.

Hospice patients in particular may have fluctuating capacity. Their physical condition may cause confusion or drowsiness. Acute illness, severe pain, medication and distress can all have a temporary effect on their capacity to make decisions. It should be considered whether it is possible to defer asking them to make decisions about a safeguarding concern or allegations until they are more alert and able to respond.

6.1.2.3. Deciding whether or not to make a safeguarding referral to Adult Social Care

The following factors should be considered when deciding whether to make a referral:

- Does the person have capacity?
- How vulnerable is the adult?
- What is the nature and extent of the abuse?
- Is it a real or potential crime?

- How long has it been happening? Is it a one-off incident or a pattern of repeated actions?
- What is the impact on the individual?
- What is the risk of repeated or increasingly serious acts of abuse?

If in doubt a safeguarding referral to the statutory services must always be completed (unless an adult with capacity does not consent – see 6.1.2.5). It is *not* St Wilfrid's role to determine whether the referral meets safeguarding thresholds. The Local Authority is the lead agency in relation to safeguarding. The Local Authority safeguarding team will decide whether criteria are met. This means some referrals will not be followed through by the statutory services as active cases.

The responsibility for decisions whether to make a referral lies with the MDT in consultation with the Hospice Safeguarding Lead.

6.1.2.4. Getting the consent of the adult at the referral stage

It is essential to consider whether the adult is capable of giving informed consent to a referral. If they are, their consent should be sought. Consideration should be given as to whether they are free from constraint (for example are they acting under duress).

Where an adult with capacity has made a decision that they do not want a referral to the statutory services made and there are no public interest or vital interest considerations (see below), their wishes must be respected. The person must be given information and have the opportunity to consider all the risks and fully understand the likely consequences of that decision over the short and long term.

Consent should *not* be sought if doing so would:

- Place the adult at increased risk of serious harm
- Prejudice the prevention, detection or prosecution of a serious crime, or
- Cause an unjustified delay.

6.1.2.5. Making a decision to refer without consent

If consent has been withheld or consent was not sought for the reasons above a decision to refer must nevertheless be made *if* there is an overriding public or vital interest.

This includes situations where:

- Other people are at risk
- The person thought to be the cause of the risk has care and support needs and may also be at risk
- A serious crime has been committed
- Staff are implicated
- Coercion is involved.

6.1.2.6. Making a referral in the context of incident management

Where an incident has caused harm or has the potential for the adult or other adults to be harmed or to be at risk of abuse or neglect, information regarding this should always be shared with the Local Authority. 'Harm' means a negative or detrimental impact on a person's emotional, physical or mental wellbeing. This may be different for each person.

The views and wishes of the adult should always be sought in such cases, however, this does not override the professionals' responsibilities for passing information to the local authority.

Pressure ulcers. Please refer to the Pressure Ulcer Prevention and Management Policy and Procedure for guidance with regards to applying safeguarding principles to the assessment and management of pressure ulcers. There is detailed Department of Health & Social Care guidance (Safeguarding adults protocol; pressure ulcers and raising a safeguarding concern, March 2024) on the interface between pressure ulcers and safeguarding.

Medication errors. For detailed guidance as to when safeguarding criteria might apply to medication errors see the hospice Medication Error Policy and Procedure.

Duty of Candour. If you become aware of a duty of candour matter, consideration must be given to making a safeguarding referral, in line with the Duty of Candour policy and procedure.

6.1.2.7. Making a referral post-death

Safeguarding can be relevant post-death. If you believe that the death of a person with care and support needs is related to (or may be related to) abuse or neglect that they were experiencing (or could have been experiencing) you must raise a concern under safeguarding with a line manager (see 6.1.1.3).

Safeguarding concerns in the lead up to death, not necessarily believed to be a contributory factor to the death, also need to be followed through, particularly where the interests of other people are at stake.

Particular attention needs to be given to informing any family members of such safeguarding referrals, given the context of the recent death of their loved one. Not informing family members should only be agreed in exceptional circumstances, in consultation with the Safeguarding Lead.

6.1.2.8. Recording of follow up and decisions

Any discussions or decisions by the MDT, or following consultation with the hospice Safeguarding Lead, rationale for decisions and subsequent plans must be recorded on the electronic patient record.

Decisions and the rationale for these decisions need to be recorded particularly carefully where it has been agreed:

- Not to take action as informed consent withheld or

- To act despite withheld consent.

6.2 Making a referral and recording of concerns and alerts

A safeguarding referral is the direct reporting of an allegation, concern or disclosure to the local authority who acts as the lead agency with regards to safeguarding.

The timing of the referrals must reflect the level of perceived risk but should usually be within one working day of the recognition of risk.

Adult Safeguarding referrals can be made by email from a secure nhs.net email address to Health & Social Care Connect hsc@eastsussex.gov.uk or alternatively by phoning **Health & Social Care Connect tel. 0345-60-80-191** (Option 2).

If emailing a safeguarding referral, then a copy of the email must be copied onto the electronic patient record. If phoning the referral through then a detailed record of the referral conversation must be made on the electronic patient record, including who the referral was for, what type of abuse, nature of concern, additional information given.

Adult Safeguarding referrals can also be completed online using the Adult Portal link within the East Sussex County Council website <https://new.eastsussex.gov.uk/social-care/worried/report>

Before using the Adult Portal you will need to register an email address. Using an nhs.net email address will be more secure as the staff member completing the referral may be sent email updates once Adult Social Care have processed the referral. Where the Adult Portal route is used, a pdf of the referral needs to be created and a copy of this saved before submitting the referral to the Adult Portal. The pdf must then be scanned onto the electronic patient record.

If Adult Social Care needs to be contacted out-of-hours due to the urgency of the safeguarding concerns, then their Emergency Duty Service can be contacted on the same Health & Social Care Connect number and option above.

The hospice social workers can make referrals on behalf of the MDT or advise their MDT colleagues how to go about doing so. It is often helpful if the person most directly involved (the person who has witnessed abuse or spoken directly to the person at risk) makes the call to Adult Social Care as accurate and detailed information is crucial. This can be decided on a case-by-case basis.

There may be occasions when the hospice is advised that another organisation or individual has already made a safeguarding referral to the local authority. However, if the hospice has identified its own concerns, it should not rely on the concerns already having been referred by others. A separate referral needs to still be completed by the hospice.

Where MDT colleagues have completed and sent the referral without social worker involvement (for example out of hours) it is then the social workers' responsibility to look through the referral sent at the earliest opportunity, using their specialist knowledge in the area of safeguarding, and if relevant to follow through with Adult Social Care for example clarifying information or providing additional information, in liaison with their colleague.

In addition, matters may need to be reported to the police where a crime has been committed or is suspected. Adult Social Care are usually able to advise whether this will be necessary or not.

Safeguarding referrals to Adult Social Care and/or the police need to be reported to the CQC if the alleged abuse involves any of the hospice services, or if the alleged abuse took place in the hospice. It is the responsibility of the Hospice Safeguarding Lead to make the Registered Manager aware in each instance. Notifications to the CQC need to be submitted by the Registered Manager or if not available by the Safeguarding Lead or deputy. Where care is CHC funded the CHC team needs to be informed that a referral has been made.

In addition, matters may need to be reported to the Charity Commission where the hospice or an individual member of staff is thought to be the cause of risk. This reporting to the Charity Commission will be undertaken by the CEO. If individual registered staff members are implicated there may be a need to refer to health and social care professional regulators.

All safeguarding concerns, whether a safeguarding referral has been made or not, need to be recorded by the Social Workers on the 'Safeguarding Concerns & Alerts Summary' spreadsheet located in the Safeguarding Steering Group folder. In the social workers' absence recording to be undertaken by the Safeguarding Lead or Registered Manager.

6.3 When safeguarding referrals meet the local authority safeguarding criteria for their involvement

Locally agreed multi-agency procedures detail the roles and responsibilities of each agency in responding and acting when safeguarding referrals meet the Local Authority safeguarding criteria for their involvement. If the Local Authority reasonably suspects that an adult is, or is at risk of, being abused or neglected they must follow through with an enquiry. An enquiry can range from a conversation with the adult to much more formal multi-agency plans.

The Local Authority as the lead agency can require provider organisations such as St Wilfrid's to carry out enquiries. The St Wilfrid's Safeguarding Lead or other appropriate senior members of the clinical team will follow through at the Local Authority's request.

The St Wilfrid's Hospice Social Workers and/or other clinical staff may need to continue to play a role in multi-agency planning meetings or discussions, Enquiry and Outcome review meetings and safeguarding plans and reviews of the safeguarding plan.

6.4 Referrals which do not meet the local authority's safeguarding threshold

It is not unusual for the Local Authority to decide that a referral does not meet the criteria and their threshold for follow-through as an active safeguarding case. The Local Authority will only get involved with the most serious cases. Nevertheless concerns expressed will remain on the Local Authority's records and add to a fuller picture should further referrals be made to them.

6.5 Hospice responsibility following a safeguarding referral to Adult Social Care

As detailed above (6.3 and 6.4) the Local Authority is the lead agency regarding safeguarding. However, the hospice remains responsible for closely monitoring situations and staying involved after a referral to Safeguarding has been made. The hospice social workers, in liaison with the Safeguarding Lead, should seek updates from the Adult Social Care safeguarding team whether the referral is being taken forward into an enquiry or not. The frequency of such checking on progress needs to be determined by the perceived level of risk. Where the hospice does not agree with the Adult Social Care Safeguarding Team's decision not to take a case forward into safeguarding or to close a case to safeguarding it is the hospice's responsibility to make a case for re-consideration and if deemed necessary to escalate concerns.

Similarly, the hospice may re-refer to Adult Social Care with a new referral when new concerns arise.

6.6 Follow-through for patients and clients not under the care of an MDT

Some patient and client groups under St Wilfrid's are not cared for by an MDT. This currently includes some outpatients and the bereaved. In terms of the above process the concern needs to go to the line manager who, unless concerns are very minor, should call an 'ad hoc MDT' by involving the St Wilfrid's Social Worker and other relevant MDT members. All other follow-through as above.

6.7 Safeguarding concerns involving the person thought to be the cause of risk known to the adult in a professional capacity

Where safeguarding concerns are identified involving alleged abusers known to the adult in a professional capacity as employees or volunteers in the service of St Wilfrid's, the Registered Manager must be informed at the earliest opportunity.

An initial internal review will be conducted. The first responsibility to act lies with the employing organisation as provider of the service, i.e., St Wilfrid's Hospice. The Hospice Safeguarding Lead must be consulted regarding appropriate action to protect the adult from harm. All discussions and decisions must be documented.

Where the internal review concludes that concerns are serious, the alert process as in 6.2 will be followed. The referrals will be made by the Hospice Safeguarding Lead and/or Registered Manager. Actions need to be taken in line with the Sussex Safeguarding Adults Procedures for managing allegations against People in Positions of Trust.

<https://sussexsafeguardingadults.procedures.org.uk/pkotl/sussex-safeguarding-adults->

Where concerns arise regarding alleged abuse by professionals from any health or social care agency external to St Wilfrid's Hospice, the Hospice Safeguarding Lead together with relevant MDT staff and/or Directors will consider appropriate action, including possible safeguarding referrals.

6.8 Safeguarding referrals raised for hospice patients or carers by external professionals

Where staff become aware that a safeguarding referral has been made for one of our patients or carers by external professionals or where they become aware of any other safeguarding related activities by external professionals in relation to one of our patients or carers this should be recorded on the electronic patient record and the hospice social workers should be made aware to ensure joint-up working. Social workers should add those cases also to the Safeguarding Log.

6.9 Information sharing

Information sharing between organisations is essential to safeguard adults at risk. St Wilfrid's Hospice will share information regarding an adult at risk with other relevant agencies in line with the UK GDPR (UK General Data Protection Regulation 2018) and relevant hospice policy and procedure. The following principles must apply:

- Information will only be shared on a 'need to know' basis when it is in the interest of the adult.
- Confidentiality must not be confused with secrecy.
- Staff and volunteers must not give assurances of absolute confidentiality.
- Where an adult has refused consent to information being disclosed staff must consider whether there is an overriding public interest that justifies information sharing.
- Decisions about what information is shared and with whom will be taken on a case-by-case basis.

Caldicott Two Review (April 2013) establishes the following principle regarding information sharing: *"The duty to share information can be as important as the duty to protect patient confidentiality"*.

7. Equality and diversity

In pursuing safeguarding concerns St Wilfrid's will take account of equality and diversity issues. While acknowledging that the safeguarding of an individual is paramount, St Wilfrid's will strive to ensure that the manner in which concerns are followed through does not inadvertently discriminate against any groups based on their race, disability, gender, age, sexual orientation, religion and belief.

8. Safeguarding risk management

The hospice's risk management framework requires an operational risk register to be maintained by all clinical and non-clinical departments. Safeguarding is a key consideration

on these registers. The Safeguarding Committee monitors safeguarding risks on a regular basis.

9. Continuous learning and improvement

9.1. Ongoing review of safeguarding concerns and alerts

A systematic review of all clinical safeguarding concerns and alerts is undertaken by the Safeguarding Lead with key clinical staff. Details of each case and outcomes of each review are recorded on the 'safeguarding log'. Lessons learnt from the reviews are shared with the Safeguarding Committee and others as appropriate, with changes to practice as relevant.

9.2. Safeguarding Adult Reviews (SARs)

Under the 2014 Care Act, Safeguarding Adult Boards (SABs) are responsible for a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult. A SAR must also be conducted where the adult has not died but where the SAB knows or suspects that the adult has experienced serious abuse or neglect.

St Wilfrid's has a duty to participate fully in any SAR, at the request of the local SAB, with the Board of Trustees reviewing outcomes and considering any learning accordingly.

9.3. Learning from external sources

In addition, in a process of continuous improvement, the hospice seeks to learn and update practice from external sources such as the local Safeguarding Adults Board, national case studies and published SARs (both local and national) as well as through peer learning with other hospices within the Sussex Collaborative.

10. Audit Plan

Adherence to this policy and procedure will be monitored through the Clinical Governance process and through reviews against relevant standards.

11. Related hospice policies and procedures:

Accident, Incident and Near Miss Policy and Procedure

Code of Conduct Policy and Procedure

Complaints Policy and Procedure

Data Security and Protection Policy

Disciplinary Policy

Disclosure and Barring Service (DBS) Policy

Duty of Candour Policy and Procedure

Health Record Keeping Policy and Procedure

Medication Error Policy and Procedure

Mental Capacity Policy and Procedure
 Pressure Ulcer Prevention and Management Policy and Procedure
 Prevent Policy and Procedure
 Role and Responsibility of Registered Manager Policy
 Speaking up and Raising Concerns Policy and Procedure

12. Training needs:

St Wilfrid's Hospice will ensure that all staff and volunteers, including trustees, receive appropriate induction, training, supervision and continuing support in dealing with safeguarding matters. Training will be appropriate to their level of responsibility and role, in line with the following documents:

- *Skills for Health, UK Core Skills Training Framework, Version 1.4.2*
- *Intercollegiate Document, Adult Safeguarding: Roles and Competencies for Health Care Staff, August 2018*

The mandatory attendance at training will be overseen by the Learning & Development Manager reporting to the Safeguarding Lead. Compliance with training is overseen by the Safeguarding Committee as a responsibility delegated by the Board of Trustees.

13. Policy review:

The document will be reviewed every 2 years or following introduction of any new legislation or significant changes within the organisation.

14. Compliance with statutory and other requirements:

Care Quality Commission (CQC) - Statement on CQC's roles and responsibilities for safeguarding children and adults, June 2015
 Department of Health, Care and Support Statutory Guidance, issued under the Care Act 2014, chapter 14, March 2016
 Department of Health & Social Care, Safeguarding adults protocol; pressure ulcers and raising a safeguarding concern, March 2024
 East Sussex Safeguarding Adults Board, Safeguarding Adults – Guidance on Raising Concerns about Abuse and Neglect, Appendix Two, Supplementary guidance on when to consider raising a safeguarding concern regarding medication errors
 Sussex Safeguarding Adults Policy and Procedures, Edition 4, January 2019
 Sussex Safeguarding Adults Escalation and Resolution Protocol Document, version 2 (no date)

15. Version control table:

Document Owner:	Patient and Family Support Director		
Approved By:	Board of Trustees	Date Last Approved:	May 2024
Date of Next Review:	May 2026		

Record of Changes		
Date	Version	Changes/Comments

07.08.15	1	
21.04.22	2	
'May 2023	3	
November 2023	4	Minor revisions
May 2024	5	2 yearly review

16. References:

Charity Commission (2 June 2014) *How to report a serious incident in your charity*

Department of Health (2016) *Female Genital Mutilation Risk and Safeguarding*

East Sussex Fire and Rescue Service (July 2018) *Multi-Agency Hoarding Framework, Guidance for Practitioner in East Sussex*

HM Government (2016) *Multi-agency statutory guidance on female genital mutilation*

Intercollegiate Document (August 2018) *Adult Safeguarding: Roles and Competencies for Health Care Staff*

Appendix One - Equality Impact Assessment Tool

The hospice aims to design and implement services, policies and measures that meet the diverse needs of their service, population and workforce, ensuring that none are placed at a disadvantage in relation to others. The Equality Impact Assessment Tool is designed to help staff consider the needs and assess the impact of the policy in this light. Appropriate adjustments should be made to address any barriers to equity of access. This must be completed using the Equality Impact Assessment Guidance.



St Wilfrid's Hospice

Policy and Procedure Title: Safeguarding Adults Date Completed: April 2024

Assessment tool completed by: Name: Andrea Dechamps Job Title: Director of Patient & Family Support

Peer reviewed by: Name: Tara Schrikker Job Title: Associate Director for Quality and Governance

		Yes/ No	Please elaborate on your answer
1.	Does the document/policy affect one group less or more favourably than another on the basis of:		On the basis that the policy includes safeguarding against risks of discriminatory abuse, it can be argued that the policy should have a <u>positive</u> impact on equality and inclusion.
	Race (including ethnicity and nationality) Does the document/policy take into account the needs of people from different groups, if not do you need to make any adjustments?	yes	Acknowledged in 5.1
	Gender (including gender reassignment) Is the language in the document/policy inclusive of trans and non-binary people?	yes	Acknowledged in 5.1
	Culture	yes	Acknowledged in 5.1
	Religion or belief Do people from faith groups experience any specific disadvantage in relation to your document/policy?	yes	Acknowledged in 5.1

	Sexual orientation Is your language inclusive of LGBTQ+ groups?	yes	Acknowledged in 5.1
	Age Are there ways older or younger people may find it difficult to engage with your document/policy?	yes	Acknowledged in 5.1
	Disability Learning disabilities, physical disability, sensory impairment and mental health problems, do you need to consider large print or easy read for the document/policy?	yes	Acknowledged in 5.1
2.	Is there any evidence that some groups will be affected differently by the document/policy?	no	Not specifically in the policy
3.	If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?	no	
4.	Is the impact of the document/policy likely to be negative?	no	
5.	If so, can the impact be avoided?	na	
6.	What alternative is there to achieving the aims of the document/policy without the impact?	na	
7.	Can we reduce the impact by taking different action?	no	

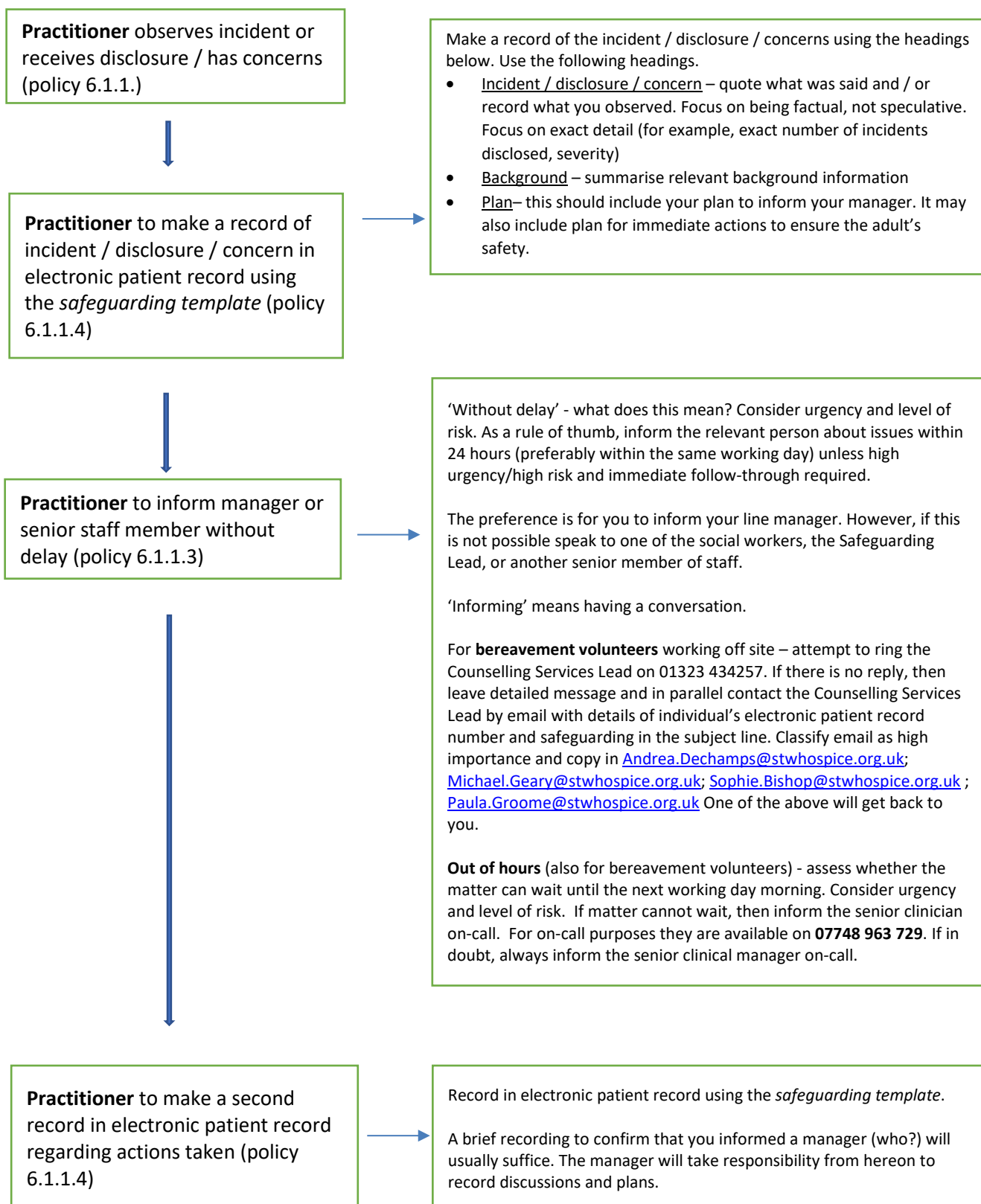
If you have identified a potential discriminatory impact of this document/policy, please [fill out this out](#) with any suggestions as to the action required to avoid/reduce this impact and refer to the Associate Director of People.

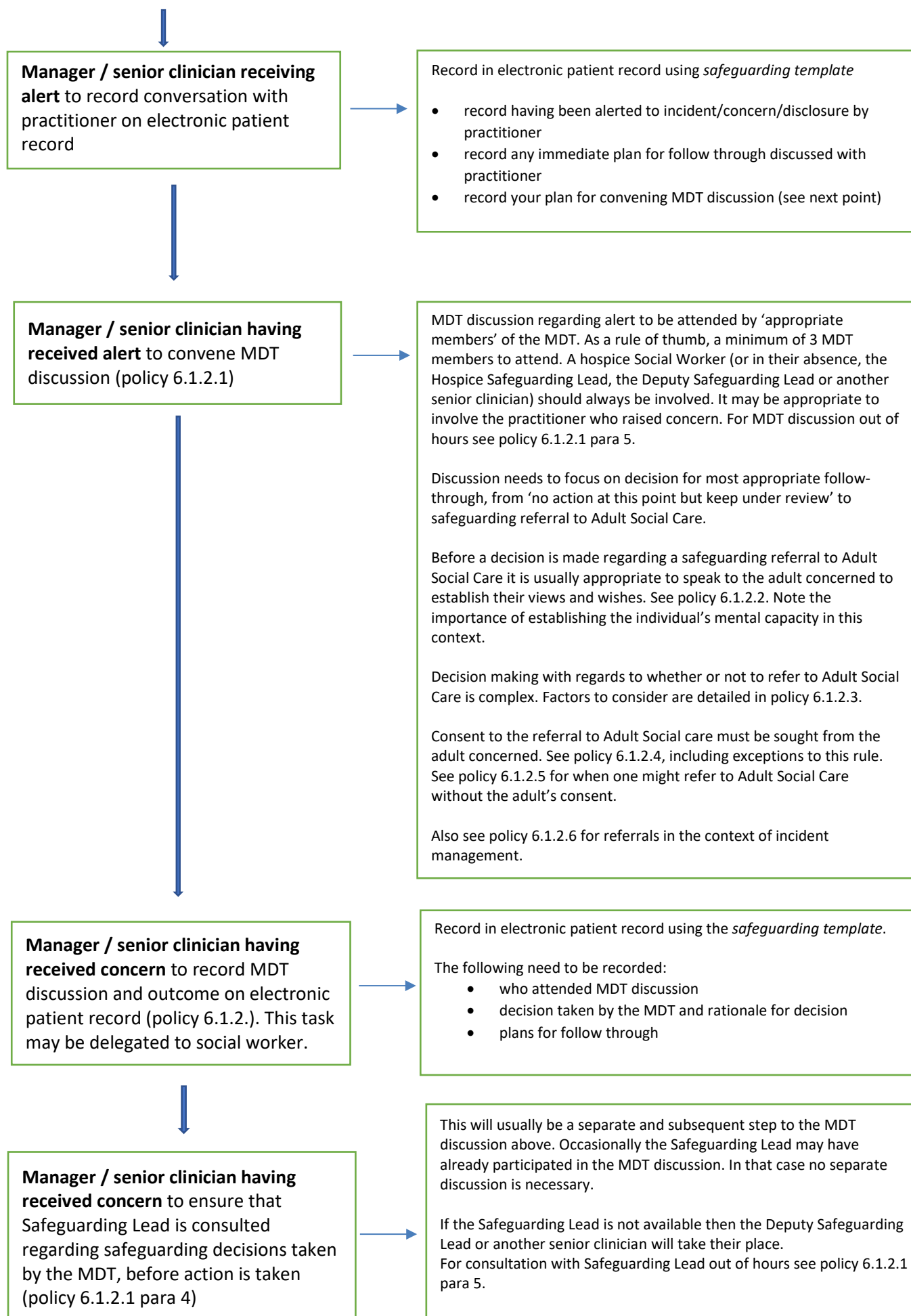
Checked and Signed Off By Name: Tara Schrikker Date: 18.04.24

 Signed: Tara Schrikker

Appendix Two

Adult Safeguarding Process for Patients and Family Members







Safeguarding referral to Adult Social Care to be completed if agreed as the right course of action by MDT and Safeguarding Lead (policy 6.2.)



The timing of referrals must reflect the level of perceived risk but should usually be within one working day of the recognition of risk.

Who will make the referral can be decided on a case-by-case basis. Information on how to refer can be found in policy 6.2.

Consider whether other bodies need to be notified such as police, CQC, Charity Commission – see policy 6.3.3

In parallel to the above process, **social worker** involved in the MDT discussion to update Safeguarding Log with concern after initial MDT discussion and continue to update log as relevant.



Social worker to remain involved with case in an advisory capacity until safeguarding concern no longer relevant. Social worker to continue to take responsibility for updating of log. Safeguarding Lead to initiate review of case and reflection for any learning, together with social worker, once safeguarding concern closed.

If the social worker is not available then the Safeguarding Lead or Deputy Safeguarding Lead will undertake the recording on the Safeguarding Log.