University Hospital of North Staffordshire NHS
NHS Trust

Policy No. (C36)
Protection of Adults from Abuse and Neglect who have Care and Support Needs

The following personnel have direct roles and responsibilities in the implementation of this policy:

- **All Trust Staff**

Version:	**7**
Ratified By:	**Quality and Safety Forum**
Date Ratified:	**December 2016**
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Trust Contact:	**Senior Nurse Safeguarding**
Executive Lead:	**Chief Nurse**

Version Control Schedule

Final Version	Issue Date	Comments
V1	Jan 2004	
V2	Sep 2006	
V3	Nov 2008	
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V5	September 2013	Policy reviewed and approved by Compliance Steering Group, Quality and Safety Forum and Executive Committee.
V6	May 2015	Updated with new flow charts and referral details
V7	December 2016	

University Hospitals of North Midlands NHS
NHS Trust

Statement on Trust Policies to be included in all policies

Staff Side and Trade Unions
The University Hospitals of North Midlands NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way in which we provide services to the public and the way in which we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

Equality and Diversity
The University Hospitals of North Midlands aims to promote equality and diversity and value the benefits this brings. It is our aim to ensure that all staff feel valued and have a fair and equitable quality of working life.

Equality Impact Assessment
The organisation aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. The Equality Impact Assessment tool is designed to help you consider the needs and assess the impact of your policy.

Information Governance
Any Trust policy which impacts on or involves the use and disclosure of personal information (patient or employee) must make reference to and ensure that the content of the policy is comparable with the relevant statutory or legal requirement and ethical standards

Data Protection Bill, General Data Protection Regulations (GDPR) and the NHS Code of Confidentiality
GDPR replaces the EU Data Protection Directive of 1995 and supersedes the law of member states that were developed in compliance with the Data Protection Directive 95/45/EC. Its purpose is to protect the "right and freedom" of natural persons (i.e. livening individuals) and to ensure that personal data is not processed without their knowledge, and, wherever possible, that it is processed with their consent.

Processing includes holding, obtaining, recording, using and disclosing of information and applies to all forms of media, including paper and images. It applies to confidential patient information but is far wider in its scope, e.g. it also covers personal records

Whiles GDPR applies to both patient and employee information, the Confidentiality Code of Practice (COP) applies only to patient information. The COP incorporates, the requirements of GDPR and other relevant legislations together with the recommendations of the Caldicott report and medical ethics considerations, in some cases extending statutory requirements and provides detailed specific guidance.

Freedom of Information Act 2000
The Freedom of Information Act 2000 (FOIA) is an Act which makes legal provision and creates a legal gateway and timetable for the disclosure, to the public, of the **majority** of corporate information held (but not necessarily created) by this Trust. The Trust has a legal responsibility to proactively provide a large amount of information to the public and to pro-actively respond to specific requests for information. Information will not be disclosed when the Trust can claim legal exemption. Any non-disclosure must be conveyed in writing; quoting the relevant exemption together with signposting to internal and external methods of compliant. Locally, guidance on the DPA, FOIA and COP can be obtained from the Information Governance Manager or the Caldicott Guardian.

Mental Capacity Act

Any Trust policy which may affect a person who may lack capacity should comply with the requirements of the Mental Capacity Act 2005 (MCA)

The MCA and its associated Code of Practice provides the framework for making decisions on behalf of individuals

who lack the mental capacity to do these acts or make these decisions for themselves. Everyone working with and/or caring for adults who lack capacity, whether they are dealing with everyday matters or life-changing events in the lives of people who lack capacity must comply with the Act.

In a day to day context mental capacity includes making decisions or taking actions affecting daily life – when to get up, what to wear, what to eat etc. In a legal context it refers to a person's ability to do something, including making a decision, which may have legal consequences for the person lacking capacity, or for other people.

The Code provides guidance to all those working with and/or caring for adults who lack capacity, including family members, professionals and carers. It describes their responsibilities when acting or making decisions with, or on behalf of, individuals who lack the capacity to do this for themselves. In particular, it focuses on those who will have a duty of care to a person lacking capacity and explains how the legal rules set out in the Act will work in practice.

The Health Act: Code of Practice for the Prevention and Control of Health Care Associated Infections
The purpose of the Code is to help NHS bodies plan and implement how they can prevent and control HCAI. It sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean, safe environment, where the risk of HCAI is kept as low as possible. Failure to observe the Code may either result in an Improvement Notice being issued by the Care Quality Commission, or in the Trust being reported for significant failings and placed on 'Special Measures'.

The Code relates to healthcare provided by all NHS bodies. Each NHS body is expected to have systems in place sufficient to comply with the relevant provisions of the Code, so as to minimise the risk of HCAI to patients, staff and visitors.
The Trust Board must have an agreement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks.

Effective prevention and control of HCAI must be embedded into everyday practice and applied consistently by all staff.

Human Rights
The Trust is committed to the principles contained in the Human Rights Act. We aim to ensure that our employment policies protect the rights and interests of our staff and ensure that they are treated in a fair, dignified and equitable way when employed at the Trust.

Sustainable Development
The University Hospitals of North Midlands NHS Trust (UHNM) is committed to demonstrating leadership in sustainability and has a Trust Board approved Sustainable Development Management Plan (SDMP): Our 2020 Vision: Our Sustainable Future which sets out the route to developing a world-class healthcare system that is financially, socially and environmentally sustainable.

There are three 'Key Priorities' to aim for by 2020. With the help of employees, key partners and other stakeholders the trust will embed opportunities to:

1. Reduce our environmental impact, associated carbon emissions and benefit from a healthier environment;
2. Improve the resilience of our services and built environment as a result of severe environmental and climatic changes;
3. Embed sustainable models of care and support our local community to be well-connected, healthy, resilient, independent and managing their lives in a positive way.

The SWITCH campaign is designed to achieve these priorities. It is relevant to all departments and all members of staff. The focus is on using resources sustainably in order to provide better patient care, improve health and our working environment.

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1. INTRODUCTION

1.1 This guidance has been produced to complement the Staffordshire and Stoke on Trent Safeguarding Adult Safeguarding Enquiry Procedures April 2016.

The University Hospitals of North Midlands NHS Trust works closely with partners to implement and monitor the joint policy to ensure its compliance with the Care Act (Department of Health 2014).

1.2 This Policy should be read in conjunction with:

- Trust Policy No RM07 An Organisation-wide Policy for the Management of Untoward Incidents Including Serious Untoward Incidents.
- Trust Policy No C43 Policy and Procedures for Obtaining Consent (including the application of the Mental Capacity Act 2005) Trust Policy No CO5 Policy for the Discharge / Transfer of Adult Patients
- Trust Policy No RE01 Multidisciplinary Health Records
- Trust Policy No RM02 Policy & Procedure for Handling Complaints
- Trust Policy No HR01 Disciplinary Policy and Procedure
- NMC (2015) The Code: Professional standards of practice and behaviour for Nurses and Midwives. NMC (2012) Midwives Rules and Standards
- NMC (2009) Advice for Record Keeping
- Staffordshire and Stoke-on-Trent Safeguarding Adult Safeguarding Partnership Enquiry Procedures (April 2016) Trust Policy No C23 Trust Policy for managing the risks associated with Safeguarding Children
- Disability and the Equality Act 2010
- Discharge Policy C05
- Policy C33 Use and Reduction of Restrictive Interventions including the use of Clinical Holding.
- Trust Policy C37 Dealing with Domestic Abuse
- SSASPB Escalation Policy
- SSASPB Information Sharing Guidance for Practioners (2015)

An “Equality Impact Assessment” has been completed and no actual or potential discriminatory impact has been identified relating to this document.

2. POLICY STATEMENT

2.1 The University Hospitals of North Midlands NHS Trust is a member of Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board which promotes the safety and protection of adults at risk in Staffordshire and Stoke on Trent in line with the Care Act (2014). It sets out definitions of abuse and vulnerability: it outlines our principles and our commitment to a multi-agency approach to the prevention and investigation of abuse.

2.2 The University Hospitals of North Midlands is stating its intention to fulfil their obligations as identified in the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board Terms of Reference. Partnership obligations include:

- Promoting the work of the Partnership including compliance with both the Adult Safeguarding Policy & Procedures and the Mental Capacity Act / Deprivation of Liberty Safeguards.

- Committing representatives to participate in Partnership meetings
- Ensuring that the staff, with the appropriate level of seniority, attend the relevant Partnership meetings.
- Actively participating in Partnership meetings
- Ensuring staff attend learning development opportunities
- Providing information that assists in making the governance arrangements for the Partnership effective.

3. SCOPE

3.1 This policy applies to all staff working within the University Hospital of North Midlands NHS Trust regardless of contract type. It also applies to those who are employed by the contracted agencies of the Trust including; independent contractors, students on placement and volunteers.

3.2 The employees of the University Hospitals of North Midlands will work alongside other agencies to ensure compliancy within the Safeguarding of Adults Policy in Stoke-on-Trent and Staffordshire, to ensure adherence by all staff to the flowchart of actions regarding the protection of adults at risk who have care and support needs (Appendix 2). If a member of staff becomes aware of an incident that falls within these guidelines they should report in accordance to trust policy RM07 – An Organisation wide policy for the Management of untoward Incidents including serious untoward incidents by completing a DATIX.

4. DEFINITIONS

Sister / Charge nurse
Sister / Charge nurse will apply to the registered practitioner who has 24 hour responsibility for the ward / department.

Adult with care and support needs

The adult safeguarding duties under the Care Act 2014 apply to an adult aged 18 years or over who:

has needs for care and support (whether or not the local authority is meeting any of those needs and;

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

Abuse is defined as:

Abuse includes physical, sexual, emotional, psychological, financial/material, neglect/ acts of omission, discriminatory and organisational abuse, domestic abuse, modern slavery and self-neglect. Abuse may consist of a single act or repeated acts. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.

Harm - Not only ill-treatment (including sexual abuse and forms of ill-treatment that are not physical) but also the impairment of, or an avoidable deterioration in physical or mental health and the impairment of physical, intellectual, emotional, social or behavioural development.

Ill treatment Section 44 of the Mental Capacity Act (MCA) 2005 introduced a new offence of ill treatment of a person who lacks capacity by someone who is caring for them or acting as a deputy or attorney for them. That person can be guilty of ill treatment if they have deliberately ill-treated a person who lacks capacity, or been reckless as to whether they were ill-treating the person or not. It does not matter whether the behaviour was likely to cause, or actually caused, harm or damage to the victim's health.

MAPPA (multi-agency public protection arrangements) statutory arrangements for managing sexual and violent offenders.

MARAC (multi-agency risk assessment conference) the multi-agency forum of organisations that manage high-risk cases of domestic abuse, stalking and 'honour'- based violence.

Multi-agency Safeguarding Hub (MASH)- The MASH is a building hosted by Staffordshire Police**,** where a number of statutory agencies have co-located their staff to facilitate information-sharing and shared risk assessment and planning in connection with the abuse of vulnerable people. Partners who are currently based at the MASH include Staffordshire County Council, Stoke-on-Trent City Council, North Staffordshire Combined Healthcare NHS Trust, Staffordshire and Stoke-on-Trent NHS Partnership Trust, South Staffordshire and Shropshire NHS Foundation Trust and the National Probation Service. The MASH serves children as well as adults.

Potential Source of Risk - Any individual who is believed to be responsible for, or implicated in, the abuse of an adult. This may include relatives and family members, professional staff, paid care workers, volunteers, other service users, neighbours, friends and associates, people who deliberately exploit vulnerable people and strangers. In these procedures this term will apply equally to people who are believed to have abused an adult irrespective of whether the abuse was done intentionally or unintentionally.

Safeguarding Enquiry - The process undertaken in accordance with the duty under section 42 of the Care Act 2014 to establish the facts of the case; ascertain the adult's views and wishes; assess the needs of the adult for protection, support and redress and how they might be met ; protect the adult from the abuse and neglect, in accordance with the wishes of the adult; make decisions as to what follow-up action should be taken with regard to the person or organisation responsible for the abuse or neglect; and enable the adult to achieve resolution and recovery. The duty to make enquiry lies with the local

authority but it can 'cause enquiry to be made' by other agencies and consideration will be made on a case by case basis as to who the appropriate person would be to undertake the enquiry.

Wilful neglect an intentional or deliberate omission or failure to carry out an act of care by someone who has care of a person who lacks capacity to care for themselves. Section 44 of the Mental Capacity Act (MCA) makes it a specific criminal offence to wilfully ill-treat or neglect a person who lacks capacity.

5. ROLES AND RESPONSIBILITIES

5.1 NHS Provider Trusts

- **To work in accordance with the Care Act (2014)**

- To work in accordance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009, and the Care Quality Commission (Registration) Regulations 2009
- To ensure the optimum safety of patient/clients and organisational commitment to recognising and responding to vulnerability
- To report all instances of possible abuse in line with these procedures.
- To report significant incidents to CQC as required by regulations.
- To contribute information and specialist skills, knowledge and resources to an enquiry.
- To lead and manage investigations where they work as part of a multi-disciplinary team with social care responsibilities and functions (e.g.
- CMHT – see responsibilities listed under Local Authority Social Care).
- To contribute to the assessment of mental capacity or mental health of adults at risk of abuse / neglect and of alleged abusers where they too are at risk
- To attend and contribute to Enquiry Discussions, Enquiry Reviews and Outcomes Conferences
- To produce reports for the above as requested
- To contribute to clinical assessments and provide specialist advice regarding standards of clinical care.
- To ensure that where complaints, disciplinary or serious untoward incident (SUI) investigations relate to possible abuse, these investigations take place within the framework of these procedures.
- To implement the DoLS provisions of the Mental Capacity Act 2005 as required of a Managing Authority.
- To make referrals to the Disclosure & Barring Scheme or to professional bodies where necessary

5.2 The Executive Committee is responsible for:

Providing ratification of this policy, in accordance with Trust Policy G01.

5.3 The Quality and Safety Forum is responsible for:

Providing approval of this policy.

5.4 As Executive Lead for this policy, the Chief Nurse is responsible for:

- Ensuring that it is reviewed, in accordance with national guidance and within the agreed timescales.
- Ensuring that it is approved by the Quality and Safety Forum.

- Ensuring that it is ratified by the Executive Committee.
- Ensuring that implementation of this policy is monitored and any risks associated with the implementation are included in the Risk Register and managed appropriately.
- Ensuring that all relevant staff are aware of this policy and receive relevant training.
- Ensuring appropriate representation at the Strategic Group of the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board

5.5 **The Deputy Chief Nurse is responsible for:**

- Monitoring the occurrence of reported abuse to adults at risk and reporting this to the Quality Safety Forum ensuring lessons learnt from safeguarding referrals are shared across the organisation.
- Ensuring there is appropriate representation at all the sub groups of the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board.
- Attending the Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board meetings.

5.6 **The Associate Chief Nurses (ACN) are responsible for:**

- Attending the Trust Safeguarding Steering Group
- The monitoring of patterns and trends in safeguarding referrals.
- Supporting the Deputy Chief Nurse to ensure lessons learnt are shared and practice changed where required.
- Ensuring that their Divisions are 90% compliant with Level 1 Adult Safeguarding Training.
- Identifying appropriate Senior Nurses to undertake Section 42 Enquiries

5.7 **The Matron is responsible for:**

- Ensuring all the Sisters / Charge Nurses are aware and have an understanding of the policy.
- Undertake Section 42 Enquires as instructed by their ACN
- Are involved in Safeguarding meetings as required.
- To produce reports as requested by the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership to contribute towards Serious Case Reviews.
- To support staff in attending level 1 safeguarding training
- Attend Trust Adult Safeguarding Working Group

5.8 **The Senior Nurse Safeguarding is responsible for:**

- The setting, monitoring and maintenance of robust safeguarding adult arrangements and training programmes.
- Contribute to collaborative interagency working and quality assurance frameworks for safeguarding.
- Provide expert clinical leadership and direction for the safeguarding of adults a risk within the UHNM.
- Provide supervision and support to all staff re safeguarding adults particularly the complexities of statutory requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Advising UHNM on its duties for Safeguarding Adults at Risk as stipulated by government strategy and national, regional and local guidance.

5.9 **Adult Safeguarding Nurse**

- To be accessible to front line staff for advice and guidance with regards to Trust policy and inter-agency adult protection procedures.
- Attend designated partnership groups.
- Manage enquiries of alleged abuse against the Trust ensuring that all allegations are timely captured on the Trust database and shared with the appropriate ACN.
- Facilitate and deliver training in safeguarding adults

5.10 **The Sister / Charge Nurse is responsible for:**

- Ensuring all staff on the ward, particularly those who take charge are aware of the referral process.
- Ensuring all staff complete the mandatory training relating to the recognition of abuse and the adult at risk.
- To be aware of agency whistle-blowing procedures and use them where appropriate.
- To assist with enquires of alleged abuse.

5.11 **All staff employed by the University Hospital of North Staffordshire are responsible for:**

- Maintaining the safety of patients and clients in their care
- Providing accurate documentation with regard to the referral of a safeguarding concern.
- Following the flowchart of actions in Appendix 1. in order to prevent abuse to adults at risk within the Trust. The flowchart provides a clear structure within roles/responsibilities and actions to be undertaken by every employer within the statutory multi agency partnership for the population of Stoke on Trent and Staffordshire.
- Following the procedure in cases of suspected adult abuse / neglect in Appendix 2.
- To provide care and treatment that promotes the adult's choice and autonomy as far as this is possible.
- To work in compliance with policies and procedures that promote the safety of the adult at risk (e.g. medication, moving & handling, management of violence & aggression).
- To work in compliance with the principles of the Mental Capacity Act 2005.
- To be aware of how to recognise and report possible abuse / neglect.
- To report all instances of possible abuse immediately in accordance with these procedures.
- To contribute to and co-operate with adult safeguarding enquiries where necessary or when requested to do so.

6. EDUCATION/TRAINING AND PLAN OF IMPLEMENTATION

All staff should complete mandatory training which provides signposting to Safeguarding Adults (as outlined in the TNA in HR53 Statutory and Mandatory Training Policy). All Qualified Nurses, Midwives, Doctors and Allied Health Professionals will need to attend Level 1 Adult Safeguarding Training.

Training should be held in the staff personal record, ideally within ESR.

7. MONITORING AND REVIEW ARRANGEMENTS

7.1 Monitoring Arrangements

Regular monitoring will take place to give assurance to the Executive Committee that there is compliance against the policies and procedures for Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board. This will include:

- Incident reporting
- Audit of compliance to policy and procedures.
- Case file reviews
- Reports will be submitted to the Quality and Safety Forum through the Trust Safeguarding Steering Group
- Monitoring of Deprivation of Liberty Safeguards.
- Completion of CCG Dashboard
- Performance reports presented to Adult Safeguarding Working Group

7.2 Review

The Chief Nurse is responsible for ensuring that this policy is reviewed 3 years from date of ratification, unless national legislation indicates a requirement to review sooner.

8. REFERENCES

Department Of Health (2014) Care Act Home Office London

Department of Health (2010) Clinical Governance and Adult Safeguarding - An Integrated Process

National Patient Safety Agency (2010) National Framework for Reporting and Learning from Serious Incidents requiring investigation

Appendix 1

PROCEDURE IN CASES OF SUSPECTED ADULT ABUSE / NEGLECT

The patient must be kept fully informed throughout the entire process. All adults who are at risk have the right to make choices even those that leave them at risk. However, if capacity to make a decision is impaired or where there is clear evidence that a criminal offence has been committed, the right to choices may not be paramount.

1.1 **Trust Process for suspected adult abuse alerts/referrals**:

- After ensuring the person is in no immediate danger, staff should verbally inform their line manager instantly, who will then inform the Matron, directly if appropriate. Out of hours; it must be reported to the Clinical Site Manager, who will make a decision whether the Trust on call manager should be informed either at that time or at 09:00 hours the next working day, dependent on the nature of the incident. The Site Manager is to support staff in the process of initiation of a referral.

- If physical or sexual abuse has just occurred or is still occurring, then the staff discovering the incident, should inform the Police immediately. When it appears that there may have been a criminal offence, evidence of abuse should be kept safe and free from contamination e.g. all clothing is bagged. The responsibility for initiating action then rests with the Police; **NB** a safeguarding concern still needs to be raised with the Local Authority where the abuse is believed to have taken place.

- A referral can be initiated by any member of staff; however, it should be discussed with the Nurse in Charge. The referral should be made immediately or within 24 hours to the Local Authority where the abuse is believed to have taken place by **telephone**. Incidents occurring out of hours should be referred to the Social Care & Health Emergency Duty Team and Police as required. A Datix should also be completed immediately following the incident or its discovery.

  Note: Royal Stoke only – if abuse occurs within the Royal Stoke University Hospital then the Hospital Social Care Team can be contacted.

- Adult Safeguarding Nurse should be contacted in office hours. Out of hours details of alert/referral to be E-mailed to the Adult Safeguarding Nurse and the Senior Nurse Safeguarding.

- Witness statements should be written by the person receiving information and collected straight away whilst the details of the incident are uppermost in the minds of all the relevant staff. The nurse in charge should organise this process and keep statements together in readiness should an enquiry be undertaken. When recording any disclosure, record the actual words used by the person. Any physical injuries should be recorded on a Body Map (Appendix 2)

- During working hours, the Consultant responsible, and Matron must be informed of the referral. Incidents occurring out of hours should be discussed with a middle grade doctor and the Site Manager to ensure that the incident has been effectively dealt with and contained. Throughout the process the safety and welfare of the patient is paramount and must be maintained.

- The initial interview with the source of risk should be conducted by the outside agency – I.e. Social Care Team.

What to do when abuse is disclosed by an Adult at risk

Do	Don't
Listen carefully, stay calm and make notes of what they say using their own words.	Question, put pressure on the person for more details, start your own investigation or take photographs.
Be aware that medical evidence may be needed.	Act in a way that may prevent the person talking about the abuse in future.
Reassure the person that the information will be treated seriously.	Promise to keep secrets.
Help the person to understand that whatever has happened is not their fault.	Make any promises that you may not be able to keep (e.g. 'It won't happen again').
Explain the referral process and that others will need to be made aware.	Question the alleged abuser.
Explain that the matter will have to be referred or even if they do not consent but that their wishes will be made clear if this happens.	Agree not to refer because the Adult withholds consent.
Make the referral immediately.	Wait to discuss with colleagues or gather more information.

Also refer to Appendix 2 – Flow chart for cases of Suspected Adult Abuse

1.2 **When the (alleged) source of risk is a member of staff in addition to 1.1**

- When a patient, member of public or staff makes an allegation that they have witnessed or suspect abuse by a member of staff, a written statement from the person making the allegation must be completed immediately if possible.

- The allegation needs to be passed on to the senior member of staff on duty who will liaise with the Matron/Associate Chief Nurse/Deputy ACN, in hours and the clinical site manager out of hours.

- Matron/Associate Chief Nurse/Deputy ACN should discuss the allegation with the Deputy Chief Nurse for on-going advice and support. Human Resources will be contacted by the Deputy Chief Nurse / ACN as appropriate. Out of Hours the Clinical Site Manager should liaise with the Trust on-call manager for on-going advice. An initial fact finding investigation will need to be undertaken; this would be undertaken by the Matron for the area or Site Manager out of hours. The initial outcome of the investigation must be reported to the Deputy Chief Nurse / ACN within 12 hours.

- The requirement of a safeguarding referral should be considered and made if necessary at this point. A Datix should be completed.

- Where an allegation of sexual / physical abuse is made the Police must be contacted immediately. Legal advice should be taken from the Police as to whether an internal investigation should proceed.

- Should an internal investigation be undertaken then the member of staff is entitled to have an accredited Professional/Trade Union representative or workplace colleague with them for the interview and must be informed that statements may be used in a disciplinary procedure and that as a result of the safeguarding referral being made that statements may be required by the Police.

- The Matron (or site team for out of hours) will undertake an initial risk assessment. Action must be taken immediately to remove any threat of harm to the patient or patients. The suspension of the individual/s concerned will be considered in accordance with the Trust's Disciplinary Policy. Where a person is not suspended consideration must be given to whether that person should continue to practice/work in the clinical environment for the duration of the fact finding event. Advice may be obtained from Human Resources.

- Within 12 hours of the allegation being made, the Fact Finding Officer will have completed an initial investigation.

- A summary of the investigation and the recommendations should be brought to the attention of the Deputy Chief Nurse / ACN.

- Where the Fact Finding officer recommends, following discussion with the Deputy Chief Nurse / Senior Nurse Safeguarding / ACN, that a formal safeguarding referral is not required a decision will be made, with the agreement of the Fact Finding Officer and Human Resources, as to whether any untoward incident has occurred and whether this requires further internal investigation within the disciplinary procedure and/or root cause analysis.

- Whilst a criminal investigation is being undertaken any internal Trust investigation should not proceed without legal advice being sought from Human Resources or the Police Team investigating. The Police will advise when the Trust is able to interview the alleged source of risk so as not to contaminate their investigation.

1.3 **Adult Safeguarding Concerns against the Trust**

Adult Safeguarding concerns against the Trust are often around quality of care for example pressure ulcers or lack of nutrition. The concern is not usually against one member of staff, but a ward or department. The Trust will be asked to undertake a Section 42 Enquiry as follows;

1. UHNM can be instructed by the Local Authority (LA) to undertake a Safeguarding Enquiry

2. UHNM Safeguarding Team will Email the ACN to appoint an independent Senior Nurse/Medic to undertake the Enquiry (Investigating Officer - IO). Divisional Governance Manager to be copied into E-mail for reporting i.e. complete Datix

3. IO to undertake the Enquiry and produce a report which demonstrates findings and any recommendations.IO is to forward completed report to ACN for approval.

4. ACN to forward approved report to UHNM Safeguarding Team

5. Safeguarding Team to forward to Local Authority

6. Should the Local Authority wish to undertake an Enquiry Review Meeting then the IO will be invited to attend with a member of the Safeguarding Team to present their findings

7. Outcome of Enquiry determined and fed back to Safeguarding Team by the Local Authority i.e. proven, unproven, partially proven or insufficient evidence.

8. Outcome will be fed back to the ACN by the Safeguarding Team.

9. ACN to share within Division and nominate a representative to feedback to the Safeguarding Working Group for wider learning at UHNM

2. Coroner

If we are aware that one of our patients is subject to an adult safeguarding enquiry then upon death the Doctor must inform the Coroner and advise them of the concerns that have been raised. The Bereavement Officers will also need to be fully aware of the concerns.

Appendix 2

- Ensure the patient is not in immediate danger and the patient is supported
- The alerter should inform their line manager verbally regarding their concerns.
- Note: If a criminal offence is suspected i.e. Physical / Sexual abuse has occured then contact the Police immediately. Ensure any evidence e.g. clothing is kept safe and free from contamination. On-going responsibility and actions in these circumstances will rest with the Police.
- The alerter should telephone their concern through to the Local Authority where the abuse is believed to have taken place:Note: A referral should be completed immediately and within 24 hours.
- Staffordshire County Council - 03456042719
- Stoke on Trent Council - 08005610015
- The alerter should also complete a Datix and inform the Adult Safeguarding Nurse on the next working day by phone or E-mail
- Witness statements should be written and collected straight away whilst the incident is clear and uppermost in all relevant staff(s) minds. When any patient disclosure is recorded this should be recorded detailing the actual words used. Any physical injuries should be recorded on a body map.
- During working hours the patients Consultant and Matron should be made aware of the referral. Incidents occuring out of hours should be discussed with the Site Manager.

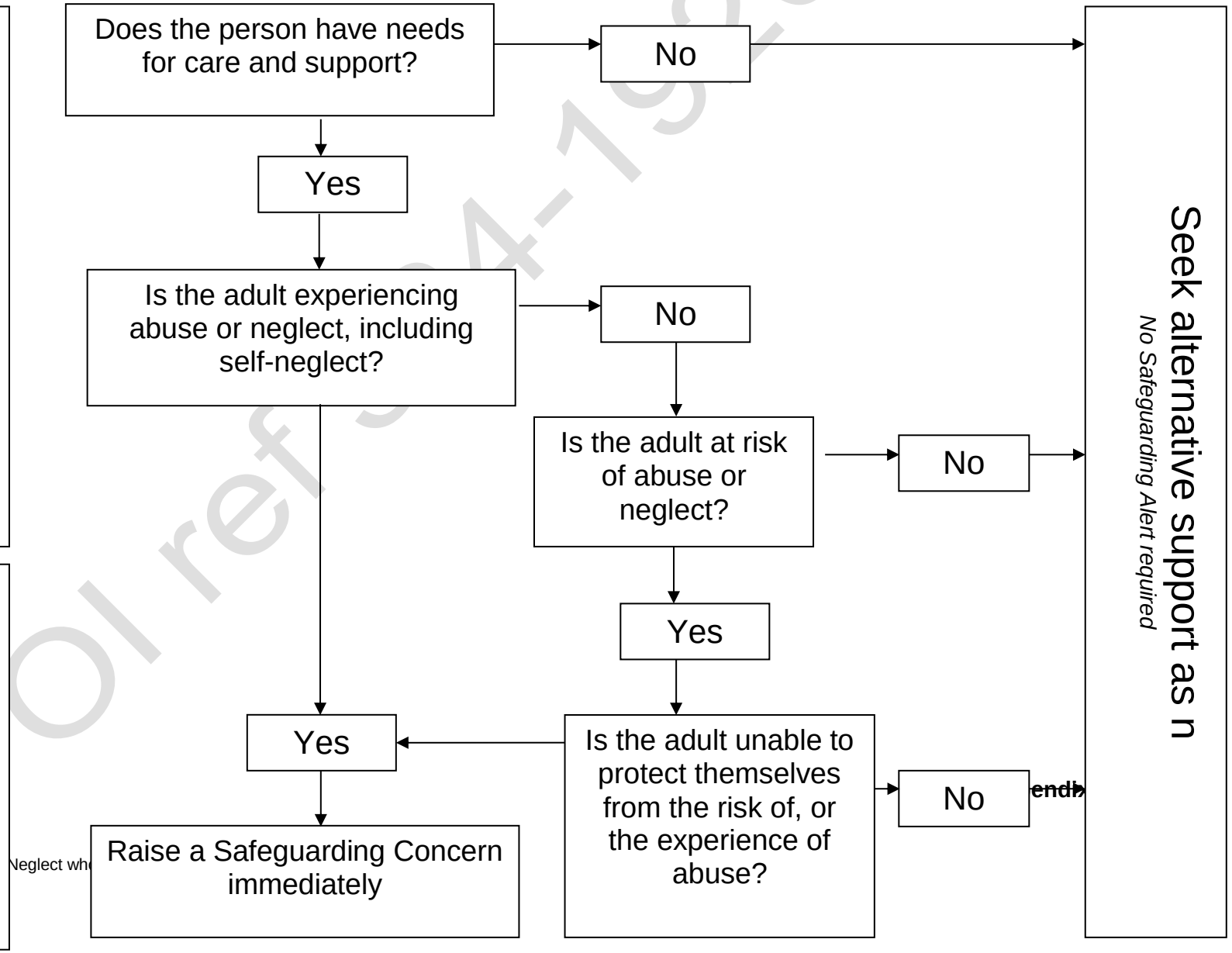
Initial safeguarding decision flow chart

Appendix 3

An adult at risk of abuse or neglect:
has needs for care and support (whether or not the local authority is meeting any of these needs) and;

- *is experiencing, or at risk of abuse or neglect; and*
- *as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect significant harm or exploitation*

Types of abuse:
Physical **Sexual**
Financial **Discriminatory**
Neglect **Self-neglect**
Emotional abuse
Organisational abuse
Domestic abuse
Modern slavery



Appendix 4

How and when to raise a safeguarding concern

Who can raise a safeguarding concern?	Anyone – the adult, Carers, paid staff, volunteers, Inspectors, Police Officers, Health and Safety Officers, etc.
Who decides whether to raise a concern?	The person who believes that abuse may be taking place is the best person to raise the concern and they should take the responsibility for doing so. It is not good practice for that person to delegate this to another agency and this will cause difficulties if that agency has a different view on the incident, especially if they do not themselves believe that abuse has occurred.
How quickly should a concern be raised?	Immediately and always within 24 hours.
Who should be contacted with a concern?	In all cases concerns will be raised with the local authority where the abuse is believed to have taken place: **Staffordshire County Council, Social Care and Health Tel: 0345 604 2719.** **Stoke-on-Trent City Council, Adult Social Care** **Tel: 0800 5610015** Where a crime has taken place or the adult may be in immediate danger contact should be made with Staffordshire Police. **In emergencies using 999 or if less urgent using 101.**
How is a concern raised?	By telephone to the above numbers. Staff who raise a concern may be asked to provide additional written detail and information. Callers will be given a reference number for their own records and to assist with any follow-up queries.

What information should be included when raising the concern?	**Personal details** of the adult (name, date of birth, address, gender, race, faith, culture and current whereabouts). Name, address, contact number of the person raising the concern, and their relationship to the adult. **Full description of the abuse** that is believed to have taken place including where and when it occurred. **All known details of the potential source of risk** (name, address, date of birth, gender, current whereabouts and relationship to the adult). **Details of any harm caused to the adult**. Perception of continuing risks. **Immediate action** taken or required to protect the adult. **Details of other people** who may be at risk of harm. **Details of any action already taken** (e.g. call to emergency services, crime number, and protection measures.) **Details of agencies involved** with the adult. **Whether the adult is aware** of the concern being raised. **Whether the adult has agreed** to the concern being raised. **Any known views or wishes of the adult** regarding possible outcomes. **The views of the person raising the concern** about what needs to happen next. **Any information that relates to the mental capacity** of the adult in relation to their ability to protect themselves from harm. **Any known language or communication needs** (e.g. need for an interpreter or intermediary).
What if the adult does not wish for the concern to be raised?	Where there is a risk of harm to the wellbeing of the adult or to others, a potential offence or disciplinary issues the concern should be raised but it must be made clear what the adult's view on this is.
What feedback will be given on concerns that have been raised?	People raising a concern should be given information regarding the status of the concern they have raised. The extent of this feedback will depend on various things (e.g. the relationship they have with the victim, confidentiality issues and the risk of compromising an investigation). It should normally be possible to advise people whether their concern has led to a section 42 enquiry.

Appendix 5

Physical Abuse

Physical abuse includes assault, hitting, slapping, pushing, kicking, misuse of medication, being locked in a room, inappropriate sanctions or force-feeding, inappropriate methods of restraint and unlawfully depriving a person of their liberty.

Possible indicators:

- Unexplained in inappropriately explained injuries;
- Adults exhibiting untypical self-harm;
- Unexplained cuts or scratches to mouth, lips, gums, eyes or external genitalia;
- Unexplained bruising to the face, torso, arms, back, buttocks, thighs in various stages of healing. Collections of bruises that form regular patterns which correspond to the shape of an object or which appear on several areas of the body;
- Unexplained burns on unlikely areas of the body (e.g. soles of the feet, palms of the hands, back), immersion burns (from scalding in hot water/liquid), rope burns, burns from an electric appliance;
- Unexplained or inappropriately explained fractures at various stages of healing to any part of the body;
- Medical problems that go unattended;
- Sudden and unexplained urinary and/or faecal incontinence. Evidence of over/under-medication;
- Adult flinches at physical contact;
- Adult appears frightened or subdued in the presence of particular people;
- Adult asks not to be hurt;
- Adult may repeat what the person causing harm has said (e.g. 'Shut up or I'll hit you');
- Reluctance to undress or uncover parts of the body;
- Person wears clothes that cover all parts of their body or specific parts of their body;
- An adult without capacity not being allowed to go out of a care home when they as to;
- An adult without capacity not being allowed to be discharged at the request of an unpaid carer/family member

Domestic Abuse

Domestic abuse includes psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence.

In 2013, the Home Office announced changes to the definition of domestic abuse:

- Incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse… by someone who is or has been an intimate partner or family member regardless of gender or sexuality
- Includes: psychological, physical, sexual, financial, emotional abuse; so call 'honour' based violence; Female Genital Mutilation; forced marriage
- Age range extended down to 16.

Many people think that domestic abuse is about intimate partners, but it is clear that other family members are included and that much safeguarding work that occurs at home is, in fact, concerned with domestic abuse. This confirms that domestic abuse approaches and legislation can be considered safeguarding responses in appropriate cases.

Family members are defined as: mother, father, son, daughter, brother, sister and Grandparents, whether directly related, in-laws or step-family.

Forced marriage is a term used to describe a marriage in which one or both of the parties are 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.

In a situation where there is concern that an adult with care and support needs is being forced into a marriage they do not or cannot consent to, there will be an overlap between action taken under the forced marriage provisions and the adult safeguarding process. In this case action will be co-ordinated with the police and other relevant organisations. The police must always be contacted in such cases as urgent action may need to be taken.

The Anti-social Behaviour, Crime and Policing Act 2014 means it is now a criminal offence to force someone to marry. In addition, the Forced Marriage (Civil Protection) Act 2007 may be used to obtain a Forced Marriage Protection Order as a civil remedy.

Honour-based violence is a crime, and referring to the police must always be considered. It has, or may have been committed when families feel that dishonour has been brought to them. 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. Many of these victims will contact the police or other organisations. However, many others are so isolated and controlled that they are unable to seek help.

Adult safeguarding concerns that may indicate honour-based violence include domestic violence, concerns about forced marriage, enforced house arrest and missing person's reports. If an adult safeguarding concern is raised, and there is a suspicion that the adult is victim of honour-based violence, referring to the police must always be considered as they have the necessary expertise to manage the risk.

Female genital mutilation (FGM) involves procedures that intentionally alter or injure female genital organs for non-medical reasons. The procedure has no health benefits for girls and women. The Female Genital Mutilation Act (FGMA) was introduced in 2003 and came into effect in March 2004. The Act makes it illegal to practise FGM in the UK or to take girls who are British nationals or permanent residents of the UK abroad for FGM whether or not it is lawful in another country. It also makes it illegal to aid, abet, counsel or procure the carrying out of FGM abroad.

Sexual Abuse
Sexual abuse including, rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts to which the adult has not consented or was pressured into consenting.

It includes penetration of any sort, incest and situations where the person causing harm touches the abused person's body (e.g. breasts, buttocks, genital area), exposes his or her genitals (possibly encouraging the abused person to touch them) or coerces the abused person into participating in or looking at pornographic videos or photographs. Denial of a sexual life to consenting adults is also considered abusive practice.

Any sexual relationship that develops between adults where one is in a position of trust, power or authority in relation to the other (e.g. day centre worker/social worker/residential worker/health worker etc.) may also constitute sexual abuse (see section on position of trust).

Possible indicators:

- Adults has urinary tract infections, vaginal infections or sexually transmitted diseases that are not otherwise explained;
- Adult appears unusually subdued, withdrawn or has poor concentration;
- Adult exhibits significant changes in sexual behaviour or outlook;
- Adult experiences pain, itching or bleeding in the genital/anal areas;
- Adults underclothing is torn, stained or bloody;
- A woman who lacks the mental capacity to consent to sexual intercourse becomes pregnant;
- Sexual exploitation.

The sexual exploitation of adults with care and support needs involves exploitive situations, contexts and relationships where adults with care and support needs (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of performing sexual activities, and/or others performing sexual activities on them.

Sexual exploitation can occur through the use of technology without the person's immediate recognition. This can include being persuaded to post sexual images or videos on the internet or a mobile phone with no immediate payment or gain, or being sent such an image by the person alleged to be causing harm. In all cases those exploiting the adults have power over them by virtue of their age, gender, intellect, physical strength, and/or economic or other resources.

Psychological Abuse

Psychological abuse includes 'emotional abuse' and takes the form of threats of harm, or abandonment, deprivation of contact, humiliation, rejection, blaming, controlling, intimidation, coercion, indifference, harassment, verbal abuse (including shouting or swearing), cyber bullying, isolation or withdrawal from services or support networks.

Psychological abuse is the denial of a person's human and civil rights including choice and opinion, privacy and dignity and being able to follow one's own spiritual and cultural beliefs or sexual orientation.

It includes preventing the adult from using services that would otherwise support them and enhance their lives. It also includes the intentional and/or unintentional withholding of information (e.g. information not being available in different formats/languages etc.).

Possible indicators

- Untypical ambivalence, deference, passivity, resignation;
- Adults appears anxious or withdrawn, especially in the presence of the alleged abuser;
- Adults exhibits low self-esteem;
- Untypical changes in behaviour (e.g. continence problems, sleep disturbance);
- Adults is not allowed visitors/phone calls;
- Adults is locked in a room/in their home;
- Adults is denied access to aids or equipment (e.g. glasses, dentures, hearing aid, crutches, etc.);
- Adult's access to personal hygiene and toilet is restricted;
- Adult's movement is restricted by use of furniture or other equipment;
- Bullying via social networking internet sites and persistent texting

Financial or Material Abuse

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

Possible indicators

- Lack of heating, clothing or food;
- Inability to pay bills\unexplained shortage of money;
- Lack of money, especially after benefit day;
- Inadequately explained withdrawals from accounts;
- Unexplained loss/misplacement of financial documents;
- The recent addition of authorisation signatories on an adult's accounts or cards
- Disparity between assets/income and living conditions;
- Power of attorney obtained when the adult lacks the capacity to make this decision;
- Recent changes of deeds/title of house or will;
- Recent acquaintances expressing sudden or disproportionate interest in the adult and their money;
- Service user not in control of their direct payment or individualised budget;
- Mis-selling/selling by door-to-door traders/cold calling;
- Illegal money-lending

Modern Slavery

Modern Slavery encompasses 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.

A large number of active organised crime groups are involved in modern slavery. But it is also committed by individual opportunistic perpetrators.

There are many different characteristics that distinguish slavery from other human rights violations, however, only one needs to be present for slavery to exist.

Someone is in slavery if they are:

- 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;
- dehumanised, treated as a commodity or bought and sold as 'property';
- physically constrained or has restrictions placed on his/her freedom of movement.

Contemporary slavery takes various forms and affects people of all ages, gender and faces.

Human trafficking involves an act of recruiting, transporting, transferring, harbouring or receiving a person through a use of force, coercion or other means, for the purpose of exploiting them.

If an identified victim of human trafficking also an adult with care and support needs, the response will be co-ordinated under the adult safeguarding process. The police are the lead agency in managing responses to adults who are the victims of human trafficking.

There is a national framework to assist in the formal identification and help to co-ordinate the referral of victims to appropriate services, known as the National Referral Mechanism.

Possible indicators:

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

- Adult is not in possession of their legal documents (passport, identification and bank account details) and they are being held by someone else;

- 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
- They have few personal possessions and often wear 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, rarely interact or appear unfamiliar with their neighbourhood or where they work. Many victims will not be able to speak English
- Fear of authorities
- The adult perceives themselves to be in debt to someone else or in a situation of dependence.

Environmental indicators

- Outside the property there are bars covering the windows of the property or they are permanently covered on the inside. Curtains are always drawn. Windows have reflective film or coatings applied to them. The entrance to the property has CCTV cameras installed. The letterbox is sealed to prevent use. There are signs the electricity may have been tacked on from neighbouring properties or directly from the power lines?
- Inside the property – access to the back rooms of the property is restricted or doors are locked. The property is overcrowded and in poor repair.

Discriminatory Abuse

This includes discrimination on the grounds of race, faith or religion, age, disability, gender, sexual orientation and political views, along with racist, homophobic or ageist comments or jokes, or comments and jokes based on a person's disability or any other form of harassment, slur or similar treatment. Hate crime can be viewed as a form of discriminatory abuse, although will often involve other types of abuse as well. It also includes not responding to dietary needs and not providing spiritual support. Excluding a person from activities on the basis they are 'not liked' is also discriminatory abuse.

Possible indicators

Indicators for discriminatory abuse may not always be obvious and may also be linked to acts of physical abuse and assault, sexual abuse and assault, financial abuse, neglect, psychological abuse and harassment, so all the indicators listed above may apply to discriminatory abuse.

- An adult may reject their own cultural background and/or racial origin or other personal beliefs, sexual practices or lifestyle choices.
- An adult making complaints about the service not meeting their needs.

Organisational Abuse

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

Organisational abuse is the mistreatment, abuse or neglect of an adult by a regime or individuals in a setting or service where the adults lives or that they use. Such abuse violates the person's dignity and represents a lack of respect for their human rights.

Organisational abuse occurs when the routines, systems and regimes of an institution result in poor or inadequate standards of care and poor practice which affect the whole setting and deny,

restrict or curtail the dignity, privacy, choice, independence or fulfilment of adults with care and support needs.

Organisational abuse can occur in any setting providing health or social care. A number of inquiries into care in residential settings have highlighted that organisational abuse is most likely to occur when staff:

- receive little support from management;
- are inadequately trained;
- are poorly supervised and poorly supported in their work;
- receive inadequate guidance;

or where there is:

- Unnecessary or inappropriate rules and regulations;
- Lack of stimulation or the development of individual interests;
- Inappropriate staff behaviour, such as the development of factions, misuse of drugs or alcohol, failure to respond to leadership;
- Restriction of external contacts or opportunities to socialise.

Neglect and Acts of Omission

These include ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, social are or educational services, and the withholding of the necessities of life such as medication, adequate nutrition and heating. Neglect also includes a failure to intervene in situations that are dangerous to the person concerned or to others, particularly when the person lacks the mental capacity to assess risk for themselves.

Neglect and poor professional practice may take the form of isolated incidents or pervasive ill-treatment and gross misconduct. Neglect of this type may happen within an adult's own home or in an institution. Repeated instances of poor care may be an indication of more serious problems. Neglect can be intentional or unintentional.

Possible Indicators

- Adults has inadequate heating and/or lighting;
- Adult's physical condition/appearance is poor (e.g. ulcers, pressure sores, soiled or wet clothing);
- Adult is malnourished, has sudden or continuous weight loss and/or is dehydrated;
- Adult cannot access appropriate medication or medical care;
- Adult is not afforded appropriate privacy or dignity;
- Adult and/or carer has inconsistent or reluctant contact with health and social services;
- Callers/visitors are refused access to the person;
- Person is exposed to unacceptable risk.

Self-neglect

Self-neglect covers a wide range of behaviour, neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. Self-neglect is also 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 health and well-being of the individual and sometimes to their community.

Indicators of self-neglect may be:

- living in very unclean, sometimes verminous, circumstances;
- poor self-care leading to a decline in personal hygiene;
- poor nutrition;
- poor healing/sores;

- poorly maintained clothing;
- long toenails;
- isolation
- failure to take medication;
- hoarding large numbers of pets;
- neglecting household maintenance;
- portraying eccentric behaviour/lifestyles

NOTE: Poor environments and personal hygiene may be a matter of personal or lifestyle choice or other issues such as insufficient income.

Location of Abuse
Abuse can take place 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/hospitals;
- prisons;
- other places in the community.

Who Might Abuse?
Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the adult with care and support needs. A wide range of people may harm adults. These include:
- a spouse/partner;
- an adult with care and support needs;
- other family members;
- neighbours;
- friends;
- local residents;
- people who deliberately exploit adults they perceive as vulnerable to abuse;
- paid staff or professionals; and
- volunteers and strangers.

A lot of attention can be paid to targeted fraud or internet scams perpetrated by complete strangers, however, it is far more likely that the person responsible for abuse is known to the adult and is in a position of trust and power.

Mental Capacity
The presumption in the Mental Capacity Act 2005 is that adults have the mental capacity to make informed choices about their own safety and how they live their lives. Issues of mental capacity and the ability to give informed consent are central to decisions and actions in adult safeguarding. All interventions need to take into account the ability of adults to make informed choices about the way they want to live and the risks they want to take. This includes their ability:
- to understand the implications of their situation and to take action themselves to prevent abuse;
- to participate to the fullest extent possible in decision-making about interventions.

The MCA 2005 provides a statutory framework to empower and protect people who may lack capacity to make decisions for themselves and establishes a framework for making decisions on

their behalf. This applies whether the decisions are life-changing events or everyday matters. All decisions taken in the adult safeguarding process must comply with the Act.

The Mental Capacity Act (MCA) states that if a person lacks mental capacity to make a particular decision then whoever is making that decision or taking any action on that person's behalf must do this in the person's best interests.

The person who has to make the decision is known as the 'decision-maker', and depending on the decision to be made this may be a carer responsible for the day-to-day are (including both care staff, relatives or friends), or a professional such as a doctor, nurse or social workers where decisions about treatment, care arrangements or accommodation have to be made.

Appendix 6

Advice to staff who receive a disclosure of abuse

People who become aware of abuse or the risk of abuse should:	**Why is this important for the adult?**
Ensure the immediate safety of the adult. If there is an injury appropriate health care should be arranged (e.g. an ambulance, visit to Accident and Emergency Department).	*Immediate protection and health care is provided.*
If a suspected crime has just occurred or is still occurring then the Police should be informed immediately by ringing 999.	*Criminal investigation can begin immediately.*
Ensure that any evidence of abuse is kept safe and free from contamination to avoid interference with the investigation. This would especially apply to clothing and bedding where there has been a sexual assault but also to documentary evidence in other situations.	*Evidence is secure and the adult will have the option of making a complaint.*
Refer the incident / abuse to Social Care.	*Social Care support can be offered as part of the investigation.*
Record all details of the abuse concerns clearly and factually as soon as possible. When recording any disclosure then record the actual words used by the adult. If there are any visible injuries these should be recorded on a Body Map.	*A clear record exists of the adult's initial comments and injuries. The adult will be able to see what is recorded about them and might have a better understanding of what has occurred.*

Do	**Don't**
Listen carefully, stay calm and make notes of what they say using their own words.	Question, put pressure on the adult for more details, start your own enquiry or take photographs.
Be aware that medical evidence may be needed.	Act in a way that may prevent the adult talking about the abuse in future.
Reassure the adult that the information will be treated seriously.	Promise to keep secrets.
Help the adult to understand that whatever has happened is not their fault.	Make any promises that you may not be able to keep (e.g. 'It won't happen again').
Explain the referral process and that others will need to be made aware.	Question any person who is a potential source of risk.
Explain that the matter will have to be referred on even if they do not consent but that their wishes will be made clear if this happens.	Agree not to refer because the adult withholds consent.
Make the referral immediately.	Wait to discuss with colleagues or gather more information.

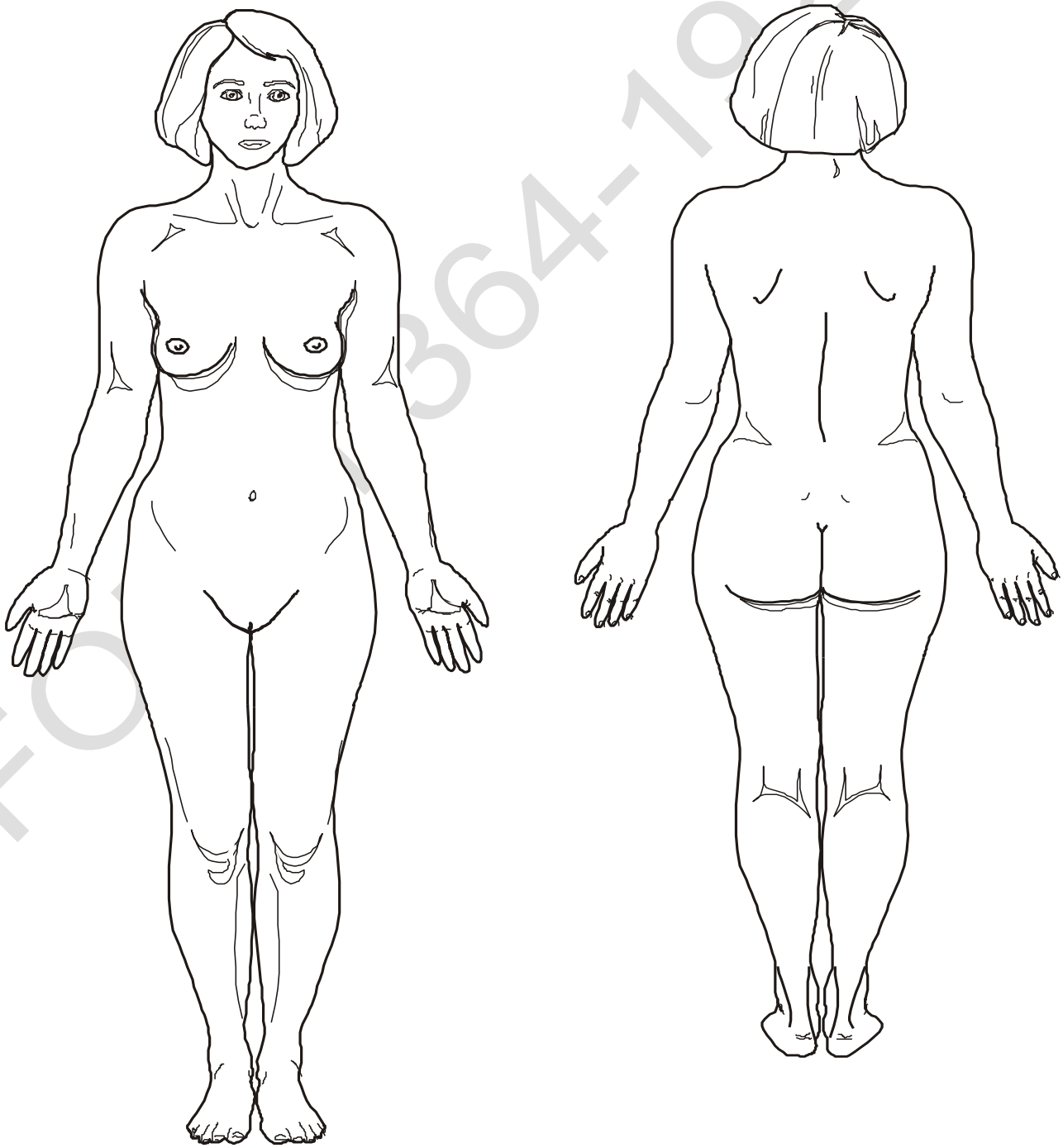
BODY MAP1 (Female) **Appendix 7**

Name of adult: ……. Date of birth……..

Name of person completing body map: ……
Date/time of completion: …… Date of incident/injury……..
Contact details of completing person: ……...

The Body Map is to be used by practitioners to record the location, size and number of injuries which may have been caused as a result of abuse or inappropriate care (as a precursor to medical/police photography). Please draw on the body map, in black ink, using the following key to indicate the different types of injury (alphabetic code), and provide brief details for each injury, e.g. measurements of wound, colour of bruise, etc using arrows:

A - Pressure ulcers
B - Bruising
C - Cuts, wounds F - other (specify)
D - Excoriation, red areas (not broken down)
E - Scalds, burns



BODY MAP (Male)

Name of adult: …… Date of birth: ……..……

Name of person completing body map: …… Date/time of completion: …….

Contact details of completing person: ……...

The Body Map is to be used by practitioners to record the location, size and number of injuries which may have been caused as a result of abuse or inappropriate care (as a precursor to medical/police photography).

Please draw on the body map, in black ink, using the following key to indicate the different types of injury (alphabetic code), and provide brief details for each injury, e.g. measurements of wound, colour of bruise, etc using arrows:

A - pressure ulcers

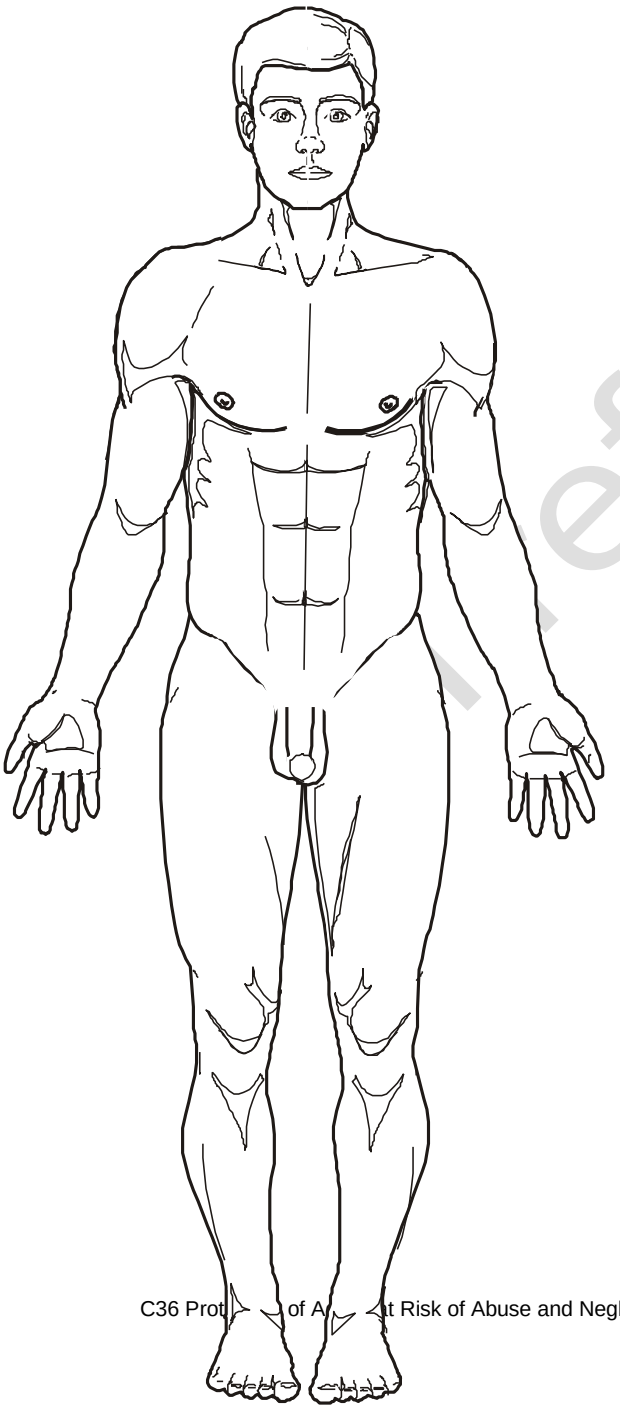
B - bruising

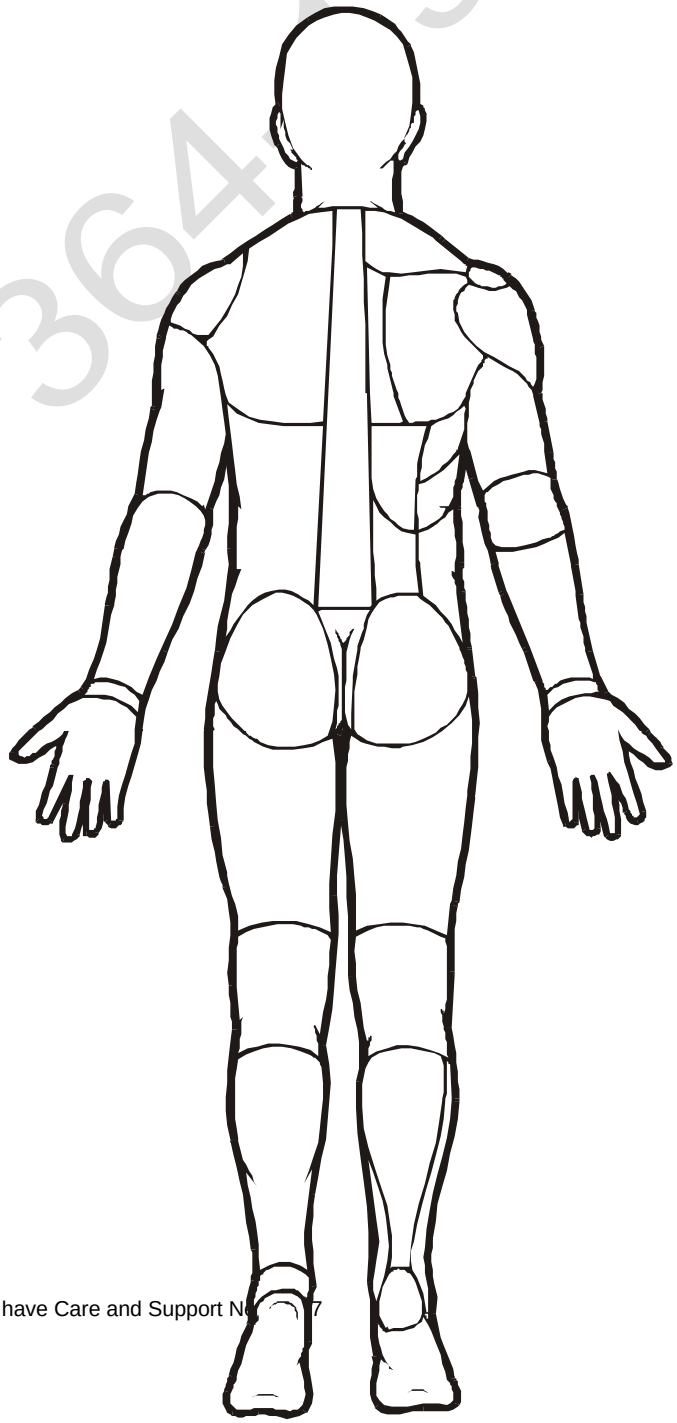
C - cuts, wounds

D - excoriation, red areas (not broken down)

E - scalds, burns

F - other (specify)





Appendix 8

Clinical Governance and Adult Safeguarding- An Integrated Process Terms and Definitions

Event: The term 'event' is used here to signify any incident or occurrence that has the potential to cause harm and/or has caused harm to a person or persons. This might happen as a consequence of an intervention, relating to a piece of equipment and/or as a consequence of the working environment.

SI: Serious Incident requiring investigation is defined as an incident that occurred in relation to NHS funded services and care resulting in; unexpected or avoidable death, permanent harm, a scenario that prevents a provider organisations ability to continue to deliver health care services, a person suffering from abuse, never events and adverse media coverage. (Please refer to the NPSA National Framework for full definition): http://www.npsa.nhs.uk/nrls/reporting/patient-safety-direct/

Complaint: In general use, a complaint is an expression of dissatisfaction. All complaints should always be considered in relation to safeguarding particularly when the complaint involves poor care, poor care culture, neglect or omissions.

Patient Related Incident: A patient incident is an incident that has occurred in an environment where health care is provided. It may be as a result of prescribed or unprescribed care, administration of procedures and interventions. For example 'trips' and 'falls', a medication error, shortage of staff, incorrect procedure, an episode of aggression, unsafe storage of equipment etc.

PET: 'Patient Experience Teams' are being developed in some organisations to help to implement a set of behaviours in the NHS that will improve the emotional experience for patients.

PALs: often diffuse potential complaints and are able to work with teams to identify concerns from the patient/public perspective. Some of the concerns may require a formal report.

Whistle blowing: Whistle blowing policies and procedures are in place to enable staff to raise serious concerns that cannot or have not been addressed through normal line management routes. The issues raised through whistle blowing could be of a clinical nature or about the culture of care.

Significant Event: A significant event is a term used by GP's to describe a positive or negative incident that has occurred in primary care and is similar to a patient incident report.

Safeguarding Team: The safeguarding team varies from organisation to organisation. It could be a team of dedicated posts across health and social care, or a virtual team of people with safeguarding interest and expertise that form part of a local partnership with the safeguarding board at the local authority. Each local authority area has multiagency policies and procedures in place for safeguarding.

NPSA: National Patient Safety Agency is the national reporting and learning service, which provides support, advice and guidance to NHS organisations to promote national learning from serious incidents.

IO: An investigating officer is an appropriate person across health and social care that has the skills and experience to undertake a comprehensive investigation of the incident using the appropriate tools e.g. Root cause analysis, *No secrets* policies and procedures.

Appendix 9

1. Domestic Homicide Reviews

Where there has been a domestic homicide the UHNM (NHS) Trust will be approached to see if either the perpetrator or victim were known to any of their services. If either were known to the Trust then the Senior Nurse Safeguarding / Adult Safeguarding Nurse will be invited to attend a Panel meeting with colleagues from other agencies to see if a DHR is required. If a DHR is instigated then a detailed chronology and Individual Management Review (IMR) will be undertaken by an appointed member of UHNM staff.

The basis for the domestic homicide review (DHR) process is to ensure agencies are responding appropriately to victims of domestic violence by offering and/or putting in place suitable support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

The review will also assess whether agencies have sufficient procedures and protocols in place, which were understood and followed by their staff and where there may be a need to improve these procedures.

A DHR should be carried out to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide, and improve service responses for all domestic violence victims and their children, through improved intra and inter-agency working.

Domestic homicide reviews are not inquiries into how the victim died or into who is to blame. That is a matter for Coroners and criminal courts to determine. DHRs are also not a part of any disciplinary enquiry or process. Where information emerges in the course of a DHR suggesting that disciplinary action should be taken, the agency concerned will follow its own internal disciplinary procedures separately to the DHR process.

Appendix 10

Prevent

Prevent is part of the Government's counter terrorist strategy known as CONTEST. Prevent aims to reduce the risk we face from terrorism, by stopping people becoming terrorists or supporting terrorism. The strategy promotes collaboration and co-operation among public service organisations, in order to provide support to vulnerable individuals.

The key objective of the strategy is where there are signs that someone has been or is being drawn into terrorism, the healthcare worker can interpret those signs correctly, is aware of the support which is available and is confident in referring the person for further support. Preventing someone from becoming a terrorist or supporting terrorism is substantially comparable to safeguarding in other areas, include child abuse or domestic violence

- Prevent does not require staff to do anything in addition to their normal roles and responsibilities, but if they are concerned that a vulnerable individual is being exploited, concerns can be raised through the prevent lead. All staff are to have an awareness of the Trust to be followed and this will be included in the Trust induction, mandatory training and staff working in areas at greatest risk will be asked to attend Healthwrap training

- Specific training is available within the Trust on recognising and responding to possible terrorism activity. This is delivered within the Trust by Police Counter Terrorism Advisors and Emergency Planning Leads and entitled "Project Argus".

Appendix 11

Guidance for the Reporting of Genital Mutilation (FGM / Female Circumcision)

Table of Contents

1.0 Purpose

Any staff member within the trust has the potential to influence a woman not to subject their daughter to FGM by emphasising the risks to their health and potential lifelong complications.

This guidance provides information on identifying when a girl (under the age of 18) or women may be at risk of being subjected to FGM and responding appropriately to protect and support them in addition to the correct recording procedures.

2.0 Background

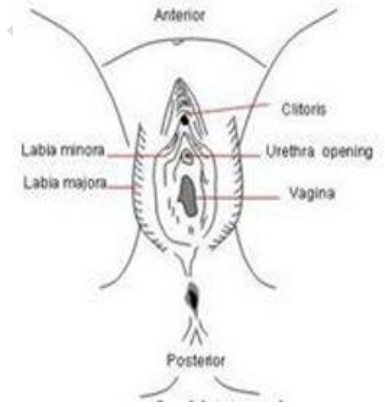
Female Genital Mutilation (FGM), which is also known as female genital cutting, involves any procedure that includes the removal of any part of the female genital organs for cultural or any other non-therapeutic reasons (WHO, 1996).

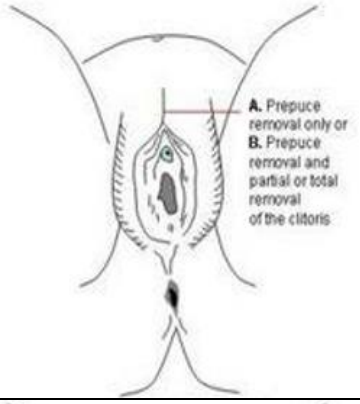
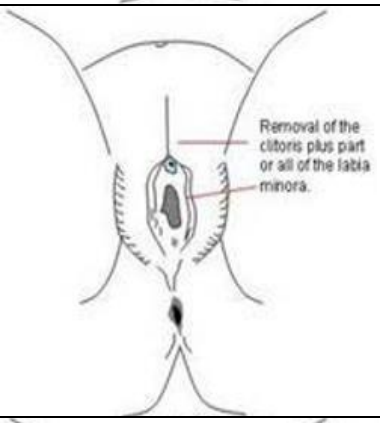
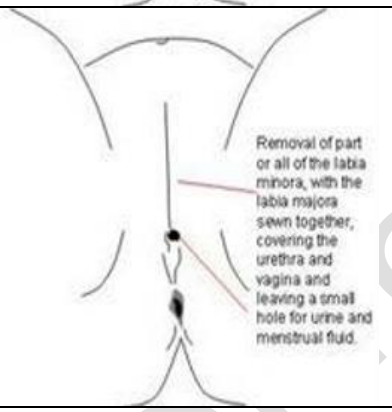
There are many reasons why this custom is still seen as acceptable by those that agree with its practice. It has a positive meaning by enhancing marriageability, improving hygiene and ensuring virginity. They believe that clitoris removal reduces women's promiscuity, which reduces the risk of pre- or extramarital sex and family dishonour (Lockhat, 2004). FGM has become more prevalent within the UK due to an increase in immigration of women from countries where FGM is practiced.

FGM is illegal for females under the age of 18, and must be reported to the police if detected. It is an extremely harmful procedure and has been recognised as a form of child abuse and gender violence against women (DH, 2015).

3.0 Types of FGM

Recognition of the different types of mutilation is important, and were possible recorded accurately within the notes.

Picture	Type	Description
	Normal	

	Type 1 Clitoridectomy	Partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
	Type 2 Excision	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).
	Type 3 Infibulation	Narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.
	Type 4 Unclassified	All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

4.0 Policy for the Reporting of Female Genital Mutilation

If a health care professional during the course of their professional practice comes across the physical findings of FGM in a female they should follow the trust's **FGM flowchart** (appendix 1).

If the female is under the age of 18, then they must inform the police immediately, fill in the **BLUE FGM proforma** (appendix 3), inform the Named Nurse for Child Safeguarding and refer

the child to social services and health care professional (with relevant paediatric experience with FGM).

If discovered in a female who is 18 years or older then they should fill in the **GREEN FGM proforma** (appendix 2), and gather information regarding any female children within the family to identify anyone that might be at risk of this

Health professionals must be familiar with the requirements of the Health and Social Care Information Centre (HSCIC) FGM Enhanced Dataset and explain its purpose to the woman. The requirement for her personal data to be submitted without anonymisation to the HSCIC, in order to prevent duplication of data, should be explained. However, she should also be told that all personal data are anonymised at the point of statistical analysis and publication (RCOG, Green-top Guideline, 2015).

All FGM patients should be offered a referral to the *FGM clinic* (run by Dr Fidelma O'Mahony – Gynaecology) and their details recorded on the relevant data collection form.

The FGM data collection forms will be sent on the last day of the month to the specified data analyst who will upload data to the Department of Health.

5.0 The Law

In 1985 the Prohibition of Female Circumcision Act was passed within UK law stating it is an offence for any person:

> 1) To excise, infibulate or otherwise mutilate the whole or any part of the labia majora or clitoris of another person, or
>
> 2) To aid or abet, counsel or procure the performance of another person of any of those acts on that other person's body.

In 2003 the law was updated (Female Genital Mutilation Act 2003) making it illegal to send children abroad for the purpose of FGM. If found guilty of an offence under this act a person may be imprisoned for up to 14 years.

In 2015, section 74 of the Serious Crime Act (2015) was added to section 5B of the FGM Act 2003 mandating that all health and social care professionals in addition to teachers within England and Wales are required by law to report any 'known' cases of FGM in any under 18 year old which they discover to the police. This duty came into effect on the 31st October 2015.

6.0 Female Genital Mutilation in the UK

It is estimated that approximately 2 million females worldwide undergo a type of FGM each year, with the majority of them being unaware that they are even at risk (FORWARD 2007). There is an estimated 137,000 females in England and Wales who have under gone a type of

FGM, including 10,000 girls under the age of 15 years of age (Macfarlane A and Dorkenoo E, 2014).

It is an offence for anyone (regardless of their nationality and residence status) to perform FGM in the UK or to assist a girl to perform FGM on herself in the UK.

7.0 The Way Forward

Attitudes - It must be appreciated that these women did not choose mutilation. All staff should be aware of the practice and types of female genital mutilation and the adverse effects on women's sexual and reproductive health. Staff should be sensitive to the traditions of the communities where mutilation is practised.

Hospital Services: where FGM is confirmed by observation or disclosure then referral for on-going psychological support should be offered.

Identification of any female children/grandchildren/nieces/siblings should be done and safeguarding initiated. Liaison with Professionals involved with these children is also required e.g. Health Visitor/GP/School Nurse. Referral to Children's Social Care may be necessary

8.0 Safeguarding Children and Adult Issues

Professional Leads Named Midwife/Lead Nurse Safeguarding Adults /Named Nurse Safeguarding Children must be informed of any cases of suspected FGM.

Child aged under 18. Any disclosure of FGM or confirmation during examination in a child should be treated as child abuse and reported to the police using 101. Any suspicion of intended or actual FGM for a child under aged 18 years must be referred to Children's Social Care. Social Care will conduct a Section 47 enquiry and formulate a Child Protection Plan for any female children at risk.

Any suspicion of an Adult 18+ of intended or actual FGM, the alleged victim should be managed by a person with specialist knowledge and understanding wherever possible with regards to their welfare, risk assessment and monitoring. If you are concerned that a person 18+ who has care and support needs is at risk of FGM then an adult safeguarding referral should be made (Policy C36).

FGM is a crime and if you have reason to believe a vulnerable person i.e. child or adult is in immediate and serious risk of harm, or that a crime has been committed call the Police on 999.

Staff must ensure that all Safeguarding paperwork relating to the patient is kept under lock and key, with very limited access. All records should comply with the organisational policies on managing records of domestic incidents/safeguarding.

9.0 Support Services

The NSPCC has launched a free 24-hour helpline which will provide advice and support to protect UK children from female genital mutilation (FGM).

The Female Genital Mutilation helpline, 0800 028 3550 and at FGMhelp@nspcc.org.uk , is a free 24/7 service staffed by trained counsellors offering advice and support to anyone worried about female genital mutilation (FGM). The free 24-hour helpline on 0800 028 3550 and at FGMhelp@nspcc.org.uk is for anyone concerned that a child's welfare is at risk because of female genital mutilation and are seeking advice, information or support. Though callers' details can remain anonymous any information that could protect a child from abuse will be passed to the police or social services

10.0 Training and Resources

All new Trust staff shall have safeguarding training during induction. That training should make reference to this policy.

Emergency Department staff shall have enhanced training in the detection and operational management of suspected Female Genital Mutilation.

See the Trust's Mandatory Training Policy.

FGM E-learning package available via the intranet – Smart Card Launcher.

11.0 Audit and Monitoring

Audit of compliance with this guideline will be undertaken on an annual audit basis in accordance with the Clinical Audit Strategy and Policy. The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies.

Key findings and learning points will be disseminated to relevant staff.

The contact details for the FGM leads are detailed below:

Emergency Medicine - Dr Richard Fawcett, Emergency Department, RSUH, Ext: 74757

Obstetrics & Gynaecology -

Paediatrics -

12.0 Equality and Diversity

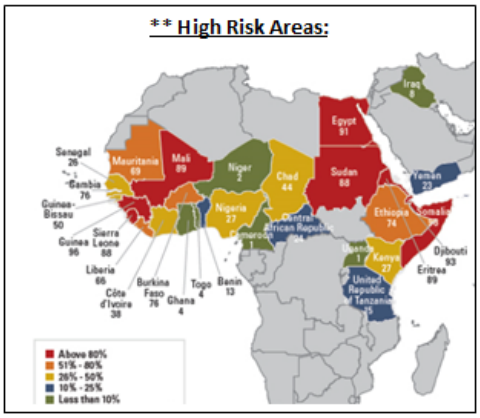
The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

Appendix 1:

University Hospitals of North Midlands NHS
NHS Trust

FEMALE GENITAL MUTILATION (FGM) FLOWCHART

**** High Risk Areas:**



Interaction with a female from a high risk area**/pt admits to FGM

< 18 years old

Are you concerned that a CHILD may have had FGM OR be at risk of FGM?

Use: **FGM REPORTING PRO-FORMA Females under 18 years of age**

The child has told you that they have had FGM.

You have found clinical evidence of FGM

Someone discloses that the girl has had FGM

You consider the girl to be **at risk** of FGM.

Mandatory reporting duty applies

Professional who initially identified the FGM (you) calls 101 police to make a report.

- Record all decisions /actions
- Be prepared to talk to Police.
- Update your local safeguarding lead.

You will have to provide:
- Girl's name, DoB, address
- Your contact details & contact details of your safeguarding lead.

Follow local safeguarding procedures and **refer to children's social care**

IMMEDIATE RESPONSE REQUIRED for identified girl OR another child/other children

Police and social care take immediate action as appropriate

ASSESSMENT OF CASE: Multi-agency safeguarding meeting convened in line with local safeguarding arrangements, including police, social care and health as a minimum.

Health professional (with relevant paediatric competencies) lead on the assessment of the health needs of the child.

Social care and police develop and appropriate pathway.

> 18 year old

FGM found on clinical examination

Female admits to FGM

Use: **Green FGM REPORTING PRO-FORMA for >18 years**

Offer referral to FGM OPD clinic (O&G)

Offer referral for psychological support

Are there any female family members <18

Yes

No

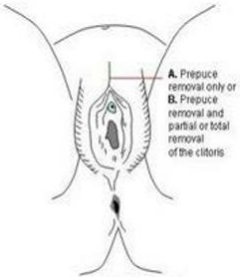
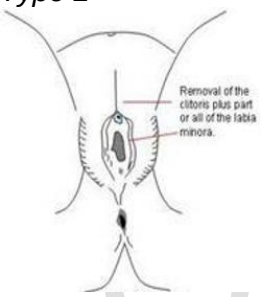
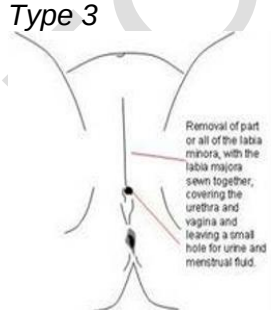
Complete Health Visitor referral form

REMEMBER: Mandatory reporting is only one part of safeguarding against FGM and other abuse. Always ask your local safeguarding lead if in doubt.

Appendix 2

(GREEN) FGM REPORTING PRO-FORMA.

Females 18 years & over

DEPARTMENT		
DATE		
PATIENT DETAILS		
FORENAME		
SURNAME		
DATE OF BIRTH		
POSTCODE		
FGM Type Identified (circle) *Type 1*  *Type 2*  *Type 3*  	Type 1	Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
	Type 2	Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).
	Type 3	Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.
	Type 4	Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.
	9	Not Known.
Deinfibulation Undertaken (Reversal surgery)?	Yes:	No:

Please return to Adult Safeguarding Team, Department of Nursing, Floor 2, Springfield Unit.

Appendix 3 **(BLUE) FGM REPORTING PRO-FORMA**

Females under 18 years of age

HEALTHCARE PRACTITIONER DETAILS		
Name		
Contact Details		
Role		
Place of Work		
Date Form Completed		
GIRLS DETAILS		
Name		
Age / Date of Birth	Age:	DOB:
Address		
FGM Type Identified: 1 2 3 4 9 Please circle appropriate number (see SOP for classification)		
DETAILS OF TRUST'S DESIGNATED SAFEGUARDING LEAD		
Helen Inwood	Deputy Chief Nurse	
Contact Details: Telephone / e-mail	Telephone: 01782 676622	Helen.inwood@uhns.nhs.uk
Place of Work	UHNM, Royal Stoke University Hospital, Springfield Building, Ground Floor, Newcastle Road, Stoke-on-Trent ST4 6QG	
Police Reference Number		
Time and Date	Time:	Date:
Child Protection Contacted (Please Tick One)	Yes:	No
Discussed with Family/Child (Please Tick One)	Yes:	No:

Please return both pages to Child Protection Team & FGM department leads (as per trust SOP)

FEMALE GENITAL MUTILATION.

Regulated Health Professionals are required to report cases of FGM in girls under 18 which they identify in the course of their professional work to the police.

This is a personal duty; the professional who identified FGM/receives the disclosure must make the report.

Within scope of duty

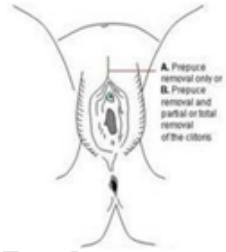
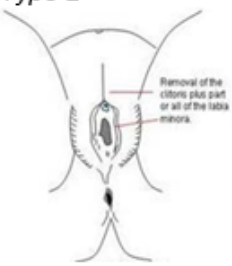
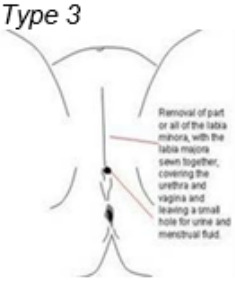
- Girls under 18 who disclose they have had FGM – using all accepted terminology:
  - Cut, Circumcised, Sunna

- When you see signs/symptoms appearing to show she has had FGM:
  - If you have no reason to believe it was for the girl's physical or mental health or for purposes connected with labour or birth.
  - Remember this includes genital piercing and tattoos for non-medical reasons i.e. in abusive context.

Actions

- Telephone the Police on 101, the non-emergency line number.
- Write down the Police reference number.
- Contact Child Protection Team (UHNM) on 79802. Consider "Does the child need urgent medical attention now?"
- Document your actions.

FGM Type

FGM Type Identified (circle) *Type 1*  *Type 2*  *Type 3*  	Type 1	Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
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	Type 3	Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.
	Type 4	Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.
	9	Not Known.

Appendix 4

Traditional and local terms for FGM

Country	Term used for FGM	Language	Meaning
EGYPT	Thara	Arabic	Deriving from the Arabic word 'tahar' meaning to clean/purify
	Khitan	Arabic	Circumcision – used for both FGM and male circumcision
	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
ETHIOPIA	Megrez	Amharic	Circumcision/cutting
	Absum	Harrari	Name giving ritual
ERITREA	Mekhnishab	Tigregna	Circumcision/cutting
KENYA	Kutairi	Swahili	Circumcision – used for both FGM and male circumcision
	Kutairi was ichana	Swahili	Circumcision of girls
NIGERIA	Ibi/Ugwu	Igbo	The act of cutting – used for both FGM and male circumcision
	Sunna	Mandingo	Religious tradition/obligation – for Muslims
SIERRA LEONE	Sunna	Soussou	Religious tradition – obligation for Muslims
	Bondo	Temenee	Integral part of an initiation rite into adulthood – for non Muslims
	Bonde/Sonde	Mendee	Integral part of an initiation rite into adulthood – for non Muslims
	Bondo	Mandingo	Integral part of an initiation rite into adulthood – for non Muslims
	Bondo	Lima	Integral part of an initiation rite into adulthood – for non Muslims
SUDAN	Khifad	Arabic	deriving from the Arabic word 'Khalad' meaning to lower (rarely used in everyday language)
GAMBIA	Kuyango Mandinka Niaka Mandinka Musolula Karoola Mandinka		Meaning the 'affair' but also the name for a shed built for initiates. Cut/weed clean Meaning 'the womens side'/'that which concerns women'
SOMALIA	Gudiniin	Somali	Circumcision used for both FGM and male circumcision
	Halalays	Somali	Deriving from the Arabic word 'halal' i.e. 'sanctioned' – implies purity. Used by Northern & Arabic speaking Somalis.
	Qodiin	Somali	Stitching/tightening/sewing refers to infibulations

Appendix 5

References:

Department of Health (2015). Female Genital Mutilation Risk and Safeguarding Guidance for professionals. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418564/2903800_DH_FGM_Accessible_v0.1.pdf

Foundation for Women's Health, Research and Development (FORWARD) ET AL (2007) a Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales. Available at: http:/www.forwarduk.org.uk/key-issues/fgm/research

Lockhat H. (2004) Female Genital Mutilation: Treating the Tears. London: Middlesex University Press.

Macfarlane, A. J. & Dorkenoo, E. (2014). Female Genital Mutilation in England and Wales: Updated statistical estimates of the numbers of affected women living in England and Wales and girls at risk Interim report on provisional estimates. London: City University London.

Royal College of Obstetricians and Gynaecologists (2015). Green-top Guideline No. 53 Female Genital Mutilation and its management. Accessed from; https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-53-fgm.pdf

World Health Organization (1996). Female Genital Mutilation. Geneva , Switzerland : World Health Organization.

Recourses:

http://www.nspcc.org.uk/Inform/resourcesforprofessionals/minorityethnic/female-genital mutilation_wda96841.html

http://www.nspcc.org.uk/help-and-advice/enquiries/frequently-asked questions_wda83770.html#fgm

Call to End Violence against Women & girls: Action Plan 2014.

www.who.int/reproductivehealth/publications/fgm/en/index.html

Female Genital Mutilation Risk and Safeguarding; Guidance for professionals: DOH March 2015

Mandatory Reporting of Female Genital Mutilation – procedural information: Home Office 201

Leaflets:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/472694/FGM_leaflet.pdf

Home Office online training package: www.fgmelearning.co.uk