Safeguarding Adults Policy and Procedure

The latest version of this document is on the 'policies and procedures' site. If it is printed or saved to another location, please check the 'date reviewed' with the version on the policies and procedures site.

Applies to:	All staff and volunteers, Trustees, people on work experience and students				
Owner:	Zoe Capon	**Approver:**	Clare Barton	**Date reviewed:**	Sept 2025
Reviewed by:	Clare Marks, Amanda Wilkins, Sarah Ireland				
Summary of changes:	Policy rewrite				

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1. Statement

St Margaret's adheres to the Somerset ICB policies and the Multi Agency framework made in 2023 Multi Agency - Joint Safeguarding Adults Policy Somerset - June 2023. This St Margaret's Hospice policy details the key points, internal responsibilities and procedures that guide our practice within the system wide policy in adherence to the Somerset Safeguarding Adults Board Guidance - Guidance for Safeguarding Adults in Somerset.

St Margaret's has a specific role and responsibility in relation to safeguarding and a duty to safeguard and promote the welfare of all adults at risk, with whom they have contact. This includes patients, families, adults and children under the care of hospice, staff, volunteers, people on work experience, students, trustees, donors, supporters and the public. It is a general safeguarding policy that covers both clinical and non-clinical safeguarding practice.

Safeguarding means protecting a person's right to live in safety, free from abuse and neglect. The processes employed are designed to minimise the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including where appropriate, having regard to their views, wishes, feelings and beliefs in deciding any action (Care and Support Statutory Guidance (DoH) Department of Health March 2016.

Although not all staff and volunteers have direct contact with adults (patients, their families or public) within their role, it is important that all understand safeguarding issues so that they are able to identify a person who is at risk of abuse and know how to respond and act accordingly.

2. Scope of Policy (Purpose)

To provide the key points of guidance of how to recognise potential abuse and what actions to take accordingly, if abuse it is thought to be occurring or has occurred.

To safeguard individuals in a way that supports them to make choices and have control in how they choose to live their lives "Making Safeguarding Personal" Care Act 2014 –see reference Making Safeguarding Personal - Guide 2014.pdf

The policy should be used in conjunction with the Somerset ICB and Somerset Safeguarding Adults policies and details the key points and provides local procedures within the wider policies.

- ICB Somerset Safeguarding Adults Policy - Safeguarding Adults - NHS Somerset ICB
- Somerset Safeguarding Adults Policy - Policy and procedure

This policy and its procedures are in line with the Care Act 2014, includes clear lines of accountability and describes core roles and responsibilities to help and protect adults with care and support needs who are experiencing, or are at risk of, abuse or neglect because of those needs.

Local authorities have a lead role in coordinating local safeguarding activity and St Margaret's has a legal and moral duty to work in partnership with other agencies in safeguarding adults at risk.

Providers must have robust safeguarding procedures in place to protect individuals from abuse and harm. This includes:

- Immediate action to protect individuals if abuse is suspected.
- Thorough investigation of incidents.
- Cooperation with local safeguarding authorities and the police if necessary.
- Training staff to recognise and respond to potential safeguarding issues.

Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, enforced by the **Care Quality Commission (CQC)**, sets out the legal requirements for staffing in health and social care services in England. It requires providers to ensure that they have enough staff who are suitably qualified, competent, skilled, and experienced to meet the needs of the people always using their services. This includes having systems in place to determine appropriate staffing levels and skill mix, and to continuously review and adapt them in response to changing needs. Staff must receive appropriate induction, training, supervision, and appraisals, and be supported in their professional development, including obtaining further qualifications and maintaining registration with relevant professional bodies. Providers must not obstruct staff from meeting professional standards. While the CQC cannot prosecute for breaches of Regulation 18, it can take regulatory action, including refusing registration if providers fail to comply.

Read the full Regulation 18 guidance on the CQC website

3. Key Principles

The following seven key principles, as set out in national Safeguarding Adults documents - most recently the Care and Support Statutory Guidance (2014) must underpin all adult safeguarding work:

- **Empowerment** – People should be supported and encouraged to make their own decisions and give informed consent without coercion, by being helped to choose the care and support that best enables them to meet their goals.

- **Prevention** – It is better to act before harm occurs. St Margaret's is committed to prioritising the prevention of abuse in all its services, ensuring all sites have robust procedures in place for dealing with incidents of abuse when they occur.

- **Proportionality** – Adults have the right to have their decisions respected, even if this involves risks being taken in respect of the individual. If an individual has capacity to make their own decisions, in relation to safeguarding concerns, it is essential to protect these rights. Assessment of an individual's capacity in relation to making decisions should be reviewed on a case-by-case basis to protect the individual.

- **Protection** – The greatest need should be supported and represented as soon as any concerns of possible abuse are raised. The safety of the individual or group must be the primary consideration.

- **Partnership** – Local services should work with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

- **Abuse** - St Margaret's will work closely with the relevant Local Authority to provide an effective multi-agency approach to the prevention, detection, and investigation of abuse.

- **Accountability** – There must be accountability and transparency. All staff must work within the framework of the law and safeguarding procedures should be seen as an integral part of working practices in all services

Refer to appendix - A1. Useful Contact Details.docx for any safeguarding concerns.

4. Making a Safeguarding Referral about a Concern

See the following guidance for different types of referrals and the process on how to make a safeguarding referral:

Concern/Referral	Appendix Link
Domestic abuse	A3 Domestic abuse referral pathway A4 Domestic abuse - what to look out for and how to make a referral
Referring patients, clients and families	A5 Safeguarding adults referral flowchart for abuse of or by patients, clients, and their families
Referring a concern in relation to the public in retail or fundraising activities	A6 Procedure for abuse of or by the public in retail or in fundraising activity
Suspected abuse of a staff member or volunteer, trustee or student	A7 Procedure if suspected abuse of a trustee, staff member, volunteer or student
Known abuse by a staff member, volunteer, trustee or student	A8 Where there is known abuse by a trustee, staff member, volunteer or student
Modern slavery	A14 How to report a concern related to modern slavery

5. Responsibility/Accountability

Trustees	• The Board of Trustees has a proactive duty and responsibility to safeguard and promote the welfare of the organisation, its staff, volunteers and patients and protect their rights to receive the Hospice's services or work within the Hospice in safety, free from abuse, harassment and neglect. • The Board of Trustees is responsible for oversight and assurance of the organisations framework, policy, practice and procedure in relation to safeguarding adults and children. • There is a safeguarding trustee link on the Trustee board.
Chief Executive Officer	• Chief Executive Officer (CEO) has accountability for the safe policy, practice and framework for safeguarding of both individuals and the organisation. These responsibilities are delegated to the Designated Safeguarding Lead. The Chief Executive Officer has overall responsibility for patient safety and wellbeing ensuring that there are effective risk management processes within the Hospice which meet all statutory requirements and manages this together with the DSL. The CEO is responsible for ensuring that safeguarding procedures are followed. • Has devolved responsibility for the safe policy, procedure, framework, and practice in relation to safeguarding within the organisation. • Will ensure CQC is informed appropriately of any safeguarding concerns raised.
Designated Safeguarding Lead (DSL)	• Accountable for the process, policy and procedure around safeguarding within the Hospice. Delegating responsibility and tasks as appropriate. • Ensures that the safeguarding policies for protecting patients and families are current and fit for purpose. • Ensures all staff, volunteers, and contractors are aware of these policies. • Supports the Safeguarding team in the process within the Hospice. Provide an expert source of knowledge as required. • Guides staff as appropriate in handling safeguarding issues. • Ensures all staff have regular, role-appropriate safeguarding training. • Ensures that staff are informed of changes in policies or legislation.

	• Stays updated on legislation and ensures the Hospice meets statutory requirements. • Regularly reviews safeguarding practices to maintain high standards. • Keeps accurate records and report trends to leadership and relevant governing bodies.
Director of People	• Ensures relevant post holders and volunteers new to the organisation are checked through the Disclosure and Barring Service (DBS) process in line with employment policies. • Ensures that where staff members are implicated as alleged perpetrators of abuse that correct disciplinary procedures and reporting processes are followed. • Ensures that organisational HR policy and procedure is fit for purpose and reviewed regularly every two to three years
Clinical Safeguarding Lead (CSL)	• The Lead is owner of the safeguarding policy and its review 3 yearly or more often in response to changes in training and legislation. • Manages and delegates responsibility regarding the safeguarding inbox which allows access to timely advice and support. • Works with DSL to maintain the statutory and mandatory training compliance. • Advises and supports and promotes the safeguarding agenda within the hospice. • Manages and delegates responsibility regarding safeguarding cases, concerns, queries and process • Coordinates with social services, healthcare providers and law enforcement to manage cases. • Advises, supports and promotes the safeguarding agenda within the hospice.
Social workers	• Have delegated responsibility to manage the safeguarding inbox, take cases, make submissions to adult safeguarding. • Promote safeguarding throughout the organisation. • Document and raise concerns.
Education Team	• Works with the DSL and CSL to ensure training in relation to safeguarding is appropriate and fit for purpose and in line with statutory and contractual expectations. • Ensures relevant training in relation to safeguarding is available, updated and completion monitored (95 percent compliance target). • Ensures staff and volunteers undertake relevant safeguarding training as part of the induction programme and in line with the mandatory and statutory training policy. • Ensures on-going training and access to operational guidelines are available to support staff in practice.
Line Managers	• Ensure staff attend relevant mandatory training sessions and are released from duties to do so. • Are accountable for service compliance with statutory and mandatory training: 95% compliance (SMH), 85% (ICB) set as standard. • Use supervision and appraisal meetings to ensure staff attend and understand the training offered in relation to safeguarding. • Inform the education team if any further development and training needs identified for staffing regarding safeguarding. • Ensure staff understand issues of consent and confidentiality and recognise the principle of sharing information on a 'need to know basis' only. • Ensure concerns raised are reported to the safeguarding lead or most senior member of staff. • Ensure staff have the time and space to attend training.
All Staff (including	• Attend training provided, remain compliant with statutory training and responsible for own knowledge and skills in safeguarding.

bank and volunteers)	• Read and understand the policy and discuss with the line manager or a senior manager if they do not understand what is expected of them. • Follow the safeguarding procedure and raise any suspicion or concern about safeguarding with the line manager or the most senior member of staff on duty/ manager on call and the safeguarding lead. Maintain a professional curiosity where there is any level of concern. • Fact-find and report only, and do not undertake an investigation. • Must report all incidents of suspected or actual harm of vulnerable adults or children to the safeguarding inbox. • Keep factual confidential notes of the concern, describing what happened, with date, times and what was said by who, written at the time of the concern or as soon as practically possible after the event. • Ensure that any actions and plan are documented on SystmOne where the concerns are related to patient care.
Head of Income Generation	• Ensures that the Fundraising and Marketing team, staff and volunteers, operate in line with good practice and the guidance, laid out in the chartered institute of fundraising document: "Treating Donors Fairly – Guidance for Fundraisers: Responding to the Needs of People in Vulnerable Circumstances and Helping Donors make Informed Decisions". Chartered Institute of Fundraising - Treating donors fairly (16th July 2021)

NB. Please refer to Appendix A9 - Matrix for Training Safeguarding Levels - Dec 2024 to view the different requirements of training depending on your Job role.

6. Key Definitions and Information

A vulnerable adult is known as an 'adult at risk' if they are aged 18 or over and may be unable to protect themselves from harm or exploitation due to factors as disability, illness, or the effects of ageing.

The Care Act 2014 statutory guidance lists 10 types of abuse, but states that local authorities should not limit their view of what constitutes abuse or neglect to those types, or the different circumstances in which they can take place. A person with capacity may also be at risk. A person's vulnerability depends on their circumstances and environment, and each case must be considered individually.

For abuse and events that take place when a patient is in the community it may be difficult to ascertain if a person has capacity or is vulnerable. It is important that any suspicion of abuse is highlighted, and advice sought to support actions and decision making.

6.1 The aims of adult safeguarding policy, practice and procedure is to:

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

6.2 Potential Abusers

Anybody can abuse. Mutually abusive relationships involving two or more adults also exist. The abuser is frequently, but not always, known to the adult they abuse and can include spouses/partners, other family members, neighbours or friends, acquaintances, paid staff or professionals, volunteers and strangers, as well as people who deliberately exploit adults they perceive as vulnerable to abuse. This can include all staff members. Abuse can happen anywhere and, in any setting, including those in which care is being delivered.

6.3 Types of Abuse

- **Physical Abuse**

Includes assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.

- **Sexual Abuse**

Includes rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, sexual assault or any sexual act that the adult has not consented to or was pressured into consenting to.

- **Female Genital Mutilation (FGM)**

FGM is a procedure where the female genital organs are injured or changed and there is no medical reason to do so. It is frequently a very traumatic and violent act for the victim and can cause harm in many ways. The practice can cause severe pain and there may be immediate and/or long-term health consequences, including mental health problems, difficulties in childbirth, causing danger to the child and mother, and/or death.

FGM is a criminal offence – it is child abuse and a form of violence against women and girls and should be treated as such. It is illegal in England and Wales under the Female Genital Mutilation Act 2003. As amended by the Serious Crime Act 2015, the Female Genital Mutilation Act 2003 - Fact sheet FGM now extends to cover the following:

- Failure to protect a girl from the risk of FGM is an offence.
- Extra-territorial authority over offences of FGM committed abroad by UK nationals and those habitually (as well as permanently) resident in the UK
- Lifelong anonymity for victims of FGM
- FGM Protection Orders which can be used to protect girls at risk.
- A mandatory reporting duty which requires specified professionals to report known cases of FGM in under 18s to the police.

All cases of identified FGM should be reported to the Somerset Safeguarding service - 3 – FGM – An introduction who will provide advice, guidance and signposting to relevant specific support agencies.

See these initial steps, in line with the Appendix 15 - FGM Safeguarding Pathway provided by the (DPHSC) Department of Health & Social Care.

If you suspect FGM and the individual is over 18 years of age, then you should complete a safeguarding risk assessment: Appendix 15d. FGM risk assessment templates.

N.B Please know that if you feel there is an FGM reason for concern with any individuals, you will need to contact the safeguarding lead in the first instance, who will recommend process of action. Standard practise is for the Designated Safeguarding Lead to complete this form and notify the police through 999/101).

See additions useful guidance from the Department of Health –
FGM - Safeguarding and Risk Assessment for Health Professionals
A15c. FGM Mandatory Reporting – the professional duty

- **Emotional and Psychological Abuse**

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

- **Financial or Material Abuse**

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

- **Discriminatory Abuse**

Including forms of harassment slurs, or similar treatment or because of any protected characteristics which include race, gender identity, age, disability, sexual orientation or religion.

- **Neglect and Acts of Omission**

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

- **Self-Neglect**

This covers a wide range of behaviours which results in neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

- **Hate & Mate Crime**

Five categories of hate crimes are recognised by the law based on:
- Race
- Religion
- Incapacity
- Sexual orientation
- Identity transgender

Any offence may be prosecuted as a hate crime if the perpetrator possesses either of the following:
- Displayed animosity against others based on their sexual orientation, gender identity, disability, race or religion.

Or
- Been motivated by hostility based on race, religion, disability, sexual orientation or transgender identity

Anyone can be a victim of more than one type of hate crime. These crimes are covered by legislation (Crime and Disorder Act 1998 and section 66 of the Sentencing Act 2020) - Sentencing Act 2020 which allows prosecutors to apply for an uplift in sentence for those convicted of a hate crime.

- **Organisational Abuse**

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

- **Religious Abuse**

Harassment, humiliation, spiritual abuse and religious violence are examples of abuse committed in the name of religion. Religious abuse can occur in any religion or faith and can be sustained by religious leaders or other members of a religious community.

Examples of religious abuse include the use of religious teachings as an excuse for mistreatment, the imposition of harmful religious rules and practices, the ostracisation or humiliation of people who do not follow religious norms, the use of religious authority to control or manipulate others, and the denial of access to necessities like medical care in the name of religion.

Religious abuse can cause psychological trauma, emotional pain, loss of faith and even bodily harm, among other severe and enduring repercussions on both individuals and communities. It is critical that people and religious communities recognise the warning signs for spiritual abuse and take action to stop it.

See the documents below (also listed in the Appendix Links at the end of this document) for reporting a safeguarding referral and reference to hate crime in relation to religious abuse:

A10 - Somerset Safeguarding Adult Board, Adult Safeguarding, Risk Decision Making Tool
A17 - Reporting a Hate Crime - Somerset
A17a - Reporting a hate crime flow chart

- **Domestic Violence**

Includes psychological, physical, sexual, financial and emotional abuse, as well as so-called 'honour' based violence.

Please see the following appendix for further information and how to make a referral:

A3. Domestic Abuse Referral Pathway
A4 - Domestic Abuse - What to look out for and how to make a Referral.docx

- **Modern Slavery, trafficking, and exploitation**

Encompasses slavery, human trafficking, forced 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.

Human Trafficking: Human trafficking is the process by which individuals are exploited through force, fraud or coercion. It typically involves:

Sex Trafficking	Forcing individuals to engage in commercial sex acts against their will.

Labour Trafficking	Forcing individuals to work in various industries, such as agriculture, construction or domestic work, under exploitative conditions.
Organ Trafficking	The illegal trade of human organs, where individuals are coerced or deceived into giving up their organs or have them forcibly taken from them.

Other types of abuse and exploitation: Exploitation involves the unfair treatment of individuals to benefit from their work or resources. This can occur in various forms, such as:

Economic Exploitation	Economic exploitation denotes the mechanism through which individuals, groups or nations derive unjust advantages from the labour, resources or economic endeavours of others, frequently resulting in disparities. This concept underscores the capacity of dominant entities to manipulate and control less powerful counterparts within diverse economic interactions, thereby revealing profound power disparities within the global framework. Labor Rights encompass the legal entitlements and safeguards provided to employees, designed to guarantee equitable treatment, safe working environments, and appropriate remuneration within the labour market.
Cuckooing	Cuckooing occurs when professional criminals target the homes of vulnerable adults, taking control of their property to exploit it for criminal purposes. Typically, the criminal befriends the victim and establishes a relationship to gain access to their home. **There are various forms of cuckooing, including:** • Using the property to deal or store drugs • Using the property for sex work • Taking over the property as a place to live This is not an exhaustive list but a guide to the sort of behaviour which could give rise to a safeguarding concern, as set out in the Care and Support Statutory Guidance document Care and support statutory guidance - GOV.UK. More information can be found in Somerset policies and St Margaret's statutory training for more information.

7. Risk Of Suicide

St Margaret's work in partnership with the National Suicide Prevention Alliance (NSPA), represented by MIND, Somerset which is delivered countywide, and focuses on supporting and improving support for those in Somerset who are at risk of suicide, bereaved or affected by suicide.

As an organisation that has engaged with individuals who are grieving and those impacted by loss, we strive to foster closer connections with our patients and their families. Our objective is to offer responsible guidance, enhance awareness and facilitate reporting on suicide prevention.

If you have any suicide concerns or referrals please refer to the Assessment and Management Policy for Individuals Expressing or Acting on Suicidal Intent. Alternatively if immediate action is needed please call 999.

8. PREVENT

The PREVENT programme is part of the UK Government strategy aimed at preventing individuals from becoming involved in terrorism or supporting Extremists' causes. It is a crucial element in safeguarding communities from radicalisation and extremist influences.

The Channel Panel is the multi-agency mechanism that oversees and co-ordinates PREVENT interventions in Somerset. The Panel has a statutory basis under the terms of the Counter Terrorism and Security Act 2015 Counter-Terrorism and Security Act - GOV.UK.

8.1 Objectives of the PREVENT programme are:

- To challenge ideology and tackle those that support terrorism and extremism.
- Safeguarding and support: protect vulnerable individuals from being drawn into terrorism through early intervention and support.
- To promote community collaboration: Working with sectors and institutions to ensure they can identify and support individuals at risk of radicalisation.

8.2 Radicalisation - Involves an adult at risk (vulnerable adult) being specifically targeted, groomed or radicalised to take part in, assist with or promote potential terrorist or extremist activities.

Signs of Radicalisation:

- Behavioural changes: withdrawal from family and friends, increased secrecy and changes in appearance or behaviour.
- Ideological shifts: adopting extreme views, expressing support for violence or showing intolerance towards other groups.
- Social changes: associating with new social groups that espouse radical beliefs or spending excessive time online with extremist content.
- Communication changes: use of coded language, increased use of extremist rhetoric or abrupt changes in communication patterns.

9. Reporting Safeguarding Concerns

Staff and volunteers have a duty to report any allegation or suspicions of abuse, current or historical and should follow the Safeguarding Adults at Risk Procedure.

Any concerns about potential abuse should be highlighted through the most appropriate route depending on the person who is at risk of abuse. The following four pathways in Appendices A5, A6, A7 and A8 should guide staff and volunteers to escalate concerns:

Referring Patients, Clients and Families	A5 - Safeguarding Adults' Referral Flowchart for Abuse of or by Patients, Clients, and their Families
Referring a concern in relation to the Public in Retail or Fundraising activities	A6 - Procedure for Abuse of or by the Public in Retail or in Fundraising Activity
Suspected Abuse of a Staff member or Volunteer, Trustee or Student	A7 - Procedure if Suspected Abuse of a trustee, Member of Staff, Volunteer or student
Known abuse by a Staff member, Volunteer, Trustee or Student	A8 - Where there is KNOWN abuse by a trustee, staff member, volunteer or student

The Adults Safeguarding Risk Decision Making Tool (2019) from the Somerset Safeguarding Adults Board should be referred to for guidance:

Where abuse, current or historical, has been alleged or is suspected, St Margaret's safeguarding lead or most senior member of staff must be notified, and they will identify who will report to Adult Social Care/Children's Social Care after an initial investigation to collect the facts. Initial contact with adult social care is by telephone but must be followed up by encrypted email or in writing within two working days. Where there is doubt regarding the capacity of a vulnerable adult, please refer to the Consent Policy and Consent Procedure.

Where intervention by an agency is not required, or deemed not to be required by Adult Social Care, the situation should be monitored by staff with regular assessments of patient and contact with the family and others involved in the care of the patient, if appropriate, and reported to the safeguarding lead. All information must be appropriately documented on the SystmOne safeguarding concern task window and will include an update on actions put in place and other agencies involved.

This may include concerns regarding care within the hospice, in the patient's home or other institutions that have become apparent during an assessment or during conversations with outside contacts such as family, carers or the primary health care team.

10. Documentation

Accurate and full documentation must take place in a contemporaneous manner, avoiding the use of abbreviations. This ensures transparency and continuity of information for the safety of the person concerned.

The General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) set specific standards for documentation, particularly in the context of safeguarding. We also have staff who adhere to the Social Work England, HCPC and BACP standards for safeguarding.

Accurate and thorough documentation is critical in safeguarding vulnerable individuals and ensures that proper care and actions are taken.

This list provides a concise guide for compliance with GMC and NMC standards in safeguarding documentation:

GMC Standards for Doctors: - Safeguarding statement - GMC

1. Record Safeguarding Concerns:
   - Detail reasons for concerns.
   - Note information shared with other healthcare professionals/agencies.
   - Document actions taken, including referrals or colleague discussions.
   - Record outcomes of referrals or interventions.
2. Record Information Sharing:
   - Include details of what was shared, with whom, and why.
   - Follow confidentiality guidelines (GMC's Confidentiality: Good Practice in Handling Patient Information)
3. When sharing patient info for safeguarding, document:
   - What information was shared and why.
   - Who it was shared with.
   - Consent or legal basis for sharing without consent.

NMC Standards for Nurses and Midwives - Read the Code online - The Nursing and Midwifery Council

1. Maintain Clear, Accurate Records:
   - Ensure records are complete, accurate, and relevant.
   - Document events as soon as possible (contemporaneously).
2. Document Safeguarding Steps:
   - Record safeguarding concerns raised.
   - Note any discussions with colleagues or other parties.

11. MARAC - High-Risk Domestic Abuse Victims

MARAC - Multi-Agency Risk Assessment Conference (MARAC)

This is a meeting where information about high-risk domestic abuse victims (those at risk of serious harm or murder) is shared between local agencies such as the police, social services, health services, housing and domestic violence services.

The Purpose of MARAC:

- To create a comprehensive safety plan for high-risk victims.
- To ensure all relevant agencies are aware of the risks and can coordinate their actions to support the victim.
- To manage and reduce the risk posed by the perpetrator.

Referral process

Victims are usually referred to a MARAC by any professional (police officer, healthcare worker, social worker etc.) who believes they are at high risk of harm.

The referral is typically based on a risk assessment tool, such as the DASH (Domestic Abuse, Stalking, and Harassment and Honour-Based Violence) Risk Identification Checklist.

If an individual within St Margaret's care is thought to be at high risk of domestic abuse, the risk assessment and the referral to MARAC will be made by CSL or DSL.

Please see more information in the following appendices:

A13 - DASH Risk Assessment and Guidance
A13a - Safe Lives Dash risk Checklist
A13b. Dash Risk Checklist for High-Risk cases of domestic Abuse, Stalking and Violence

12. Consent and Mental Capacity

12.1 Clinical Safeguarding – Patients and Families

The Care and Support Statutory Guidance states that the priority in safeguarding should always be the safety and well-being of the adult. Making Safeguarding Personal is a person-centred approach which encourages adults to make their own decisions and to be provided with the support and information that empowers them to do so. The approach recognises that adults have a general right to independence, choice and self-determination including control over information about themselves. Staff should strive to deliver effective safeguarding consistently within these principles.

It is essential in adult safeguarding to consider whether the adult can give consent in all aspects of their lives. If they are able, their consent should be sought.

Adults may not give their consent to the sharing of safeguarding information for several reasons. For example, they may be unduly influenced, coerced or intimidated by another person, they may be fearful of

reprisals, they may fear losing control, they may lack trust in statutory services or fear their relationship with the abuser will be damaged.

Reassurance and appropriate support can help to change their view on whether it is best to share information, and staff should consider the following approaches:

- Explore the reasons for the adult's objections – what are they concerned about.
- Explore the concern and why you think it is important the information is shared.
- Tell the adult with whom you may be sharing the information with and why.
- Explain the benefits, to them or others, of sharing information – could they access better help and support.
- Discuss the consequences of not sharing the information – could someone come to harm.
- Reassure them that the information will not be shared with anyone who does not need to know.
- Reassure them that they are not alone, and that support is available to them.

If, after this, the adult refuses intervention to support them with a safeguarding concern or requests that information about them is not shared with other safeguarding partners, in general their wishes should be respected. However, there are several circumstances where staff can override such a decision, including if the adult lacks the mental capacity to make that decision. This requires formal mental capacity assessment and recording must be properly explored and recorded in line with the Mental Capacity Act. Other circumstances include:

- Emergency or life-threatening situations which may warrant sharing of relevant information with the emergency services without consent.
- If there is an aspect of public interest, e.g. not acting will put other adults or children at risks, sharing the information could prevent a serious crime.
- If there is a duty of care on a particular agency to intervene, e.g. the police if a crime has been/may be committed.
- The risk is unreasonably high.
- Staff are implicated.
- There is a court order or other legal authority for acting without consent.

It is important to keep an accurate and complete record of the decision-making process and what, if any, information was shared in such situations. Staff should seek advice from managers in line with St Margaret's policy before overriding the adult's decision, except in emergencies. Managers should make decisions based on whether there is an overriding reason which makes it necessary to act without consent, and whether this is proportionate because there is no less intrusive way of ensuring safety. Legal advice should be sought where appropriate. If the decision is to act without the adult's consent, then unless it is unsafe to do so, the adult should be informed that this is being done and the reasons why.

If none of the above apply and a decision is taken not to share safeguarding information with other safeguarding partners, or not to intervene to safeguard the adult, then the following applies:

- Support the adult to weigh up the risks and benefits of different options.
- Ensure that they are aware of the level of risk and outcomes.
- Offer to arrange for them to have an advocate.
- Offer support for them to build confidence and self-esteem, if necessary.
- Agree on and record the level of risk the adult is taking.
- Record the reasons for not intervening or sharing information.
- Regularly review the situation.
- Seek to build trust to enable the adult to better protect themselves.

Staff should also be alert to the potential abuse of an adult at risk by an attorney or deputy. If staff have concerns about the actions of an attorney acting under a registered Enduring Power of Attorney (EPA) or Lasting Power of Attorney (LPA), or a Deputy appointed by the Court of Protection, they should contact the ASC Safeguarding team and follow The Safeguarding Adults at Risk Procedure.

12.2 Mental Capacity

The presumption in the Mental Capacity Act 2005 (MCA) 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 consider the ability of adults to make informed choices about how they wish to live their lives and the risks they are willing to take. This includes their ability to understand the implications of their situation and to act themselves to prevent abuse and to participate fully in decision-making about interventions.

The MCA 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. It applies to anyone over 16 who is unable to make some or all decisions for themselves. All decisions taken in the adult safeguarding process must comply with the Act. It is essential in any safeguarding enquiry that the mental capacity of those involved is clarified at the outset.

The MCA outlines five statutory principles that underpin the work with adult who may lack mental capacity:

1. A person must be presumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to decide unless all practicable steps to help them do so have been taken without success.
3. A person is not to be treated as unable to decide merely because they make an unwise decision.
4. An act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Most adults requiring additional safeguards are likely to be people who lack the mental capacity to make decisions about their care and support needs.

It is always important to establish the mental capacity of an adult who is at risk of abuse or neglect should there be concerns over their ability to give informed consent to:

- Planned interventions and decisions about their safety.
- Their safeguarding plan and how risks are to be managed to prevent future harm.

The MCA says that '...a person lacks capacity in relation to a matter if at the material time he/she is unable to decide for him/herself in relation to the matter because of an impairment of, or disturbance in the functioning of the mind or brain.' Further a person is unable to decide if they are unable to:

- Understand the information relevant to the decision.
- Retain that information long enough for them to make the decision, or
- Use or weigh that information as part of the process of making the decision, or
- Communicate that decision (whether by talking, using sign language or by any other means such as muscle movements, blinking an eye or squeezing a hand).

Where there are disputes about a person's mental capacity or the best interests of an adult is deemed to be at risk, and these cannot be resolved locally, legal advice should be sought about whether an application to the Court of Protection is required.

If a person has capacity but is deemed to not be able to make informed decisions because of elevated levels of coercion and control and are deemed to be at elevated levels of harm consideration should be given to the inherent authority of the Court of Protection. This refers to the capacity to make determinations and directives aimed at safeguarding individuals who, while not covered by the Mental Capacity Act 2005, remain vulnerable and have impaired decision-making capabilities. This jurisdiction empowers the court to act in circumstances where individuals face risks stemming from the conduct or negligence of others, frequently in contexts related to safeguarding.

The inherent jurisdiction of the Court of Protection holds significant implications for patients, including the following:

- **Protection from Harm:** The court possesses the authority to intervene and shield patients from potential dangers, particularly in instances where they do not fulfil the criteria established by the Mental Capacity Act 2005 yet remain at risk. Safeguarding Rights: The court plays a crucial role in ensuring that patients' rights are upheld, especially in circumstances where they may be vulnerable to undue influence or exploitation.

- **Decision-Making Support:** In cases where a patient is unable to make specific decisions due to either temporary or permanent impairments, the court can assume the responsibility of making those decisions to prioritise the patient's welfare.

- **Intervention in Abuse Cases:** The court is empowered to act in situations where there is substantiated evidence of abuse, neglect, or exploitation, thereby providing legal protections for the patient.

- **Legal Orders:** The court has the capacity to issue various legal orders, including restraining orders against individuals who may pose a threat to the patient.

This jurisdiction is intended to address the deficiencies in statutory protections, ensuring that vulnerable individuals receive the necessary support and safeguarding.

13. Deprivation of Liberty Safeguards (DoLS) and Safeguarding

Clinical Safeguarding – Patients

Deprivation of liberty safeguards (DoLS) applies to patients we care for. DoLS applies when a patient has a mental disorder, is 18 years old or over, and who does not possess the mental capacity to agree to their care arrangements. It ensures that any restriction of their liberty is conducted in their best interests and is legally sanctioned. In a domestic environment, it is essential for both staff and patients to recognise the following points:

- **Continuous Supervision and Control:** A patient who is subject to continuous supervision and control and is not permitted to leave may be deemed to be deprived of their liberty.

- **Legal Authorisation:** Any restriction of liberty must receive authorisation from the Court of Protection to confirm its legality. In the absence of such authorisation, the deprivation is deemed unlawful.

- **Best Interests:** The care arrangements must prioritise the patient's best interests and be essential to avert harm.

- **Representation:** Patients are entitled to legal representation and the support of an Independent Mental Capacity Advocate (IMCA) to safeguard their rights.

- **Challenging Decisions:** Patients and their representatives possess the right to contest any deprivation of liberty in the Court of Protection.

St Margaret's staff must consider if DoLS applies to any patients they care for and ensure that all care arrangements adhere to these safeguards. For more information. Refer to the DoLS Policy.

Remember, any DoLS referrals sent to Adult Social Care must also be sent to the safeguarding inbox so that it can be recorded and logged.

14. Safer Recruitment

Recruitment and Selection of Staff

St Margaret's has a comprehensive recruitment and selection policy, linked to our safeguarding policy. This commitment to safeguarding is highlighted in all job advertisements, publicity materials, recruitment websites and candidate information packs.

Our recruitment process is designed to rigorously assess each candidate's commitment to our safeguarding principles. We aim to deter, reject or identify individuals who may pose a risk to patients or who are otherwise unsuitable for working with them.

Examples include:

- The Head of Human Resources maintains a record that tracks the issue of Disclosure and Barring Service (DBS) certificates for all volunteers, staff, and trustees.
- Pin registrations are checked by HR.
- HR receive alert notices regarding names (and/or known pseudonyms) of people of interest from the CDLIN for reference and keep a log on a spreadsheet held by HR.

NB: When discussing pseudonyms within the framework of safer recruitment, it is crucial to adopt a systematic and methodical approach. The following outlines how to effectively manage and store these pseudonyms:

- **Identification and Designation**: Allocate distinct pseudonyms to individuals participating in the recruitment process to safeguard their identities. For instance, candidates under consideration may be designated as Candidate A, Candidate B, and so on.

- **Documentation:** Keep a secure record of these pseudonyms alongside their actual names. This can be achieved using encrypted digital files or secure physical documentation. It is imperative that access to these records is restricted to authorized personnel only.

- **Purpose and Application:** Clearly articulate the rationale behind the use of pseudonyms. This may include promoting fairness in the recruitment process, ensuring the privacy of individuals, or fulfilling compliance obligations.

- **Connection to Safer Recruitment:** In the realm of safer recruitment, the use of pseudonyms can facilitate the anonymization of candidates during the preliminary stages of recruitment, thereby

reducing bias. Additionally, it serves to protect their personal information throughout the vetting process.

15. Training Requirements

All staff and volunteers receive appropriate induction, training, supervision and support in dealing with safeguarding matters. Training will be in line with the Gov.uk information on the Care Act 2014, Safeguarding Guidance 2024.

Level 1 training	Mandatory for all staff, including volunteers, students, training on induction	Every three years
Level 2 Training	Non-clinical and clinical staff	Every three years
Level 3 Training	Specialist and senior staff	Every three years
Level 4 Training	For Clinical Director, designated safeguarding lead and clinical safeguarding leads	Every three years
Level 5 Training	Clinical Director, designated safeguarding lead	Every three years

When does safeguarding and prevent training need to be updated:
The training matrix held by education and oversighted by the Designated Safeguarding Lead and Clinical Safeguarding Lead; will confirm the Level you will be trained at.
Please see Appendix 9 for the matrix: A9 - Matrix for Training Safeguarding Levels - Dec 2024.

16. Data Protection

Personal identifiable data is collected and processed in accordance with the Data Protection Policy. Data is kept up to date, limited to what is necessary and held securely. Data is only accessed by and shared with those who need it and only used for the purpose it was collected. Data is disposed of in line with the Records and document management policy. See privacy notice on website for more information on the St Margaret's website - St Margaret's | Home Page.

17. Related Hospice Documents

- Whistleblowing and speak up policy and procedure
- Complaints and concerns policy and Complaints and concerns procedure
- Consent policy and Consent procedure
- Data Protection Policy and Data Protection Impact Assessment Policy and Procedure
- Safeguarding Adults at Risk Assessment Form (non-patient)
- Social Media Policy
- DoLS Policy
- Mental Capacity Act Policy and Procedure.docx

18. References

Author/Publication		Date	Title	Source Link
1.	Multi Agency Policy for Somerset	June 2023	Multi Agency Safeguarding Policy - Somerset	Joint Safeguarding Adults Policy FINAL June 2016
2.	Gov.uk	2006	Safeguarding Vulnerable Groups	Safeguarding Vulnerable Groups Act - Legislation.gov.uk
3.	Department of Health – Care Act 2014 -	2014	Care Act 2014	http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
4.	Department of Health Care and Support Gov.uk	Updated 27 September 2024	Statutory guidance - Care and support statutory guidance	Care and support statutory guidance - GOV.UK
5.	SMH - Deprivation of Liberty Safeguards (DoLS) Policy	Reviewed 08/2023	Deprivation of Liberty Safeguards (DoLS) Policy	DOLs policy - DOLs Policy and Procedure.docx
6.	Prevent Duty Guidance England and Wales	2023	Prevent Duty Guidance	Prevent duty guidance: England and Wales (2023) - GOV.UK
7.	CQC – Care Quality Commission UK	June 2015	Statement on the CQCs roles and responsibilities in safeguarding children and adults 2015	CQC Safeguarding Statement
8.	ICB: Joint Safeguarding Adults – Multi Agency Policy	June 2019	Joint Adults Safeguarding Policy ICB	Joint Safeguarding Adults Policy FINAL June 2016
9.	Somerset Safeguarding Adults Board (SSAB)	Policy 2022	Information for Professionals	Information for professionals
10.	Somerset domestic Abuse Service:	2024	Somerset survivors or email ParagonSIDAS@theyoutrust.org.uk	Somerset Domestic Abuse
11.	Multi-Agency Public Protection Arrangements (MAPPA) and Safeguarding	2024	Multi-agency public protection arrangements (MAPPA): Guidance	Multi-agency public protection arrangements (MAPPA): Guidance - GOV.UK SCC Safeguarding Team adults@somerset.gov.uk
12.	General Medical Council – Safeguarding Statement -	Published 17 November 2023	Safeguarding Statement - GMC	Safeguarding statement - GMC
13.	Nursing and Midwifery Council Policy on Safeguarding and Protecting People	Updated Sept 2023	Nursing and Midwifery Council Policy on Safeguarding and Protecting People	nmc.org.uk/globalassets/sitedocuments/safeguarding/safeguarding-policy/
14.	Care Act 2014, Making Safeguarding Personal	2014	Making Safeguarding Personal	Making Safeguarding Personal - Guide 2014.pdf
15.	Chartered Institute of Fundraising	16th July 2021	Treating Donors Fairly 'Responding to the needs of people in vulnerable circumstances'	Chartered Institute of Fundraising - Treating donors fairly

16.	Ministry of Justice/Home Office	2015	Serious Crime Act 2015, the Female Genital Mutilation Act 2003	Fact sheet FGM
17.	BNSSG Bristol, North Somerset and South Gloucestershire)	9th August 2021	BNSSG Safeguarding Adults Policy	FINAL_BNSSG_Safeguarding_policy_v8_GB_approved.docx
18.	ICB NHS Somerset	Nov 2023	ICB Somerset Safeguarding Adults Policy	Safeguarding Adults - NHS Somerset ICB ICB-Safeguarding-Adults-Policy-2024-fv-2.1-updated.docx
19.	SSAB -Somerset Safeguarding Adults Board	2013	Somerset Safeguarding Adults Policy	Policy and procedure Joint_Safeguarding_Adults Policy FINAL June 2016
20.	Department of Health & Social Care	14 March 2021	Safeguarding Adults: The Role of Health Service Practitioners	Department of HEALTH 24.10.2024
21.	Department of Health & Social Care	Came into force in 2015 Being reviewed in 2024	How to report female genital mutilation: guidance for health professionals	How to report female genital mutilation: guidance for health professionals - GOV.UK
22.	FGM Avon and Somerset Police	1 May 2019	FGM – An introduction CI Leanne Pook FGM lead Avon and Somerset Police	FGM – An introduction
23.	Fiveable Website	2024	Economic Exploitation	Economic Exploitation - (Intro to International Relations) - Vocab, Definition, Explanations | Fiveable
24.	Gov.uk	27 Sept 2024	Statutory guidance & Care and support statutory guidance	Care and support statutory guidance - GOV.UK
25.	Gov.uk	12 February 2015	Counter-Terrorism and Security Act	Counter-Terrorism and Security Act - GOV.UK
26.	BACP Online	2024	Safeguarding and Protecting People	Safeguarding and protecting people
27.	Gov.uk	2005 Updated 2020	Mental Capacity Act	Mental Capacity Act Code of Practice - GOV.UK

Appendix Links:

- A1. Useful Contact Details.docx
- A1a. Safeguarding Organisational Info.png
- A2 - Forms of Domestic Abuse.docx
- A3. Domestic Abuse Referral Pathway.docx
- A4 - Domestic Abuse - What to look out for and how to make a Referral.docx
- A5 - Safeguarding Adults' Referral Flowchart for Abuse of or by Patients, Clients, and their Families.docx
- A6 - Procedure for Abuse of or by the Public in Retail or in Fundraising Activity.docx
- A7 - Procedure if Suspected Abuse of a Member of Staff or a Volunteer.docx
- A8 - Where there is KNOWN abuse by a staff member, volunteer .docx
- A9 - Matrix for Training Safeguarding Levels - Dec 2024.docx
- A10 - Somerset Safeguarding Adult Board, Adult Safeguarding, Risk Decision Making Tool.docx
- A10a. SSAB-Risk-Decision-Making-Tool.docx
- A11 - Flow Chart to support your decision making – when to refer.docx
- A12 - SIDAS Domestic Abuse Referral Form.docx
- A13 - DASH Risk Assessment and Guidance .docx
- A13a - Safe Lives Dash risk Checklist.docx
- A13b. Dash Risk Checklist for High Risk cases of domestic Abuse, Stalking and Violence.pdf
- A14. How to report a concern related to modern slavery.docx
- A15. FGM Safeguarding Development Pathway.jpg
- A15a.Female Genital Mutilation Guidance and Risk and Safeguarding Assessment.pdf
- A15b FGM Mandatory reporting duty – What you need to do poster
- A15c. FGM Mandatory Reporting – the professional duty
- A15d. FGM Professional Guidance Forms
- A16. Safeguarding Concerns Out of Hours.docx
- A17 - Reporting a Hate Crime - Somerset.docx
- A17a - Reporting a hate crime flow chart.pdf

Equity Impact Assessment

An equity impact assessment (EIA) helps us to ensure that our work does not discriminate, or disadvantage individuals or group. This document should be completed each time a policy/procedure is created or reviewed or changes in service specifications and returned to the governance team.

The purpose of this tool is to:

- Identify the equality issues related to a policy, procedure or service.
- Summarise the work done to reduce negative impacts or to maximise benefit.
- Highlight unresolved issues which cannot be removed but will be monitored and set out how this will be done.

Section 1 - Equity Analysis					
Is it likely that the policy/procedure could treat people from protected groups less favourably than the general population?					
Age	☐Yes ☒No	Disability	☐Yes ☒No	Sexual Orientation	☐Yes ☒No
Race	☐Yes ☒No	Gender	☐Yes ☒No	Religion/Belief (non)	☐Yes ☒No
Gender Reassignment	☐Yes ☒No	Pregnancy/ Maternity	☐Yes ☒No	Marriage/ Civil Partnership	☐Yes ☒No
Is it likely that the policy/procedure could affect particular 'Inclusion Health' groups less favourably than the general population? (such as: substance misuse, teenage mums, carers, travellers, homeless, convictions, social isolation, refugees, etc.)					☐Yes ☒No
If you have ticked 'yes' to any of the above, please provide more detail *(if not go to Section 2):*					
In what way are the identified groups adversely affected?					
What has been put in place to mitigate the impact?					
How have you reached this decision? Have you consulted service users? What were their recommendations?					
no					
Why is it right to continue?					
What work will be undertaken to improve the impact on those identified?					
Action		Person responsible		Completion date	
Section 2 - Policies should aim to remove unintentional barriers and promote inclusion:					
Is inclusive language used throughout (relevant/appropriate/non-gender specific)?					☒Yes ☐No
Could there be an adverse impact on an individual's independence or autonomy (e.g. if they require additional support to access the service or comply with policy)?					☐Yes ☒No
If 'Yes', how will you mitigate this risk to ensure fair and equal access?					
Section 3 - External factors					
Is the policy/procedure a result of national legislation which cannot be modified?					☒Yes ☐No
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research/ planned review?)					
The reason for the policy is to update the old policy and make it robust.					

Name	Zoe capon	Date	09/09/25