Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

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The WWL Way

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AT ALL TIMES, STAFF MUST TREAT PATIENTS WITH RESPECT AND UPHOLD THEIR RIGHT TO PRIVACY AND DIGNITY.

1 INTRODUCTION

1.1 Wrightington Wigan and Leigh NHS Teaching Hospitals (WWL) as with all other NHS bodies, has a statutory duty to ensure that it has arrangements in place to safeguard and promote the welfare of adults at risk of abuse. This policy is designed to support WWL staff in ensuring that their practice is in line with the Care Act 2014.

1.2 The Care Act 2014 defines safeguarding as protecting an adult's right to live in safety, free from abuse and neglect. The act sets out a legal framework for how local authorities and other agencies should protect adults at risk of abuse or neglect. The Care Act put adult safeguarding on a legal footing with each Local Authority required to set up a Safeguarding Adults Board (SAB) with core membership from the Local Authority, the Police and NHS (specifically Clinical Commissioning Groups).

1.3 The Care Act 2014 defines an "Adult at Risk" as someone over the age of 18 who has care and support needs.

1.4 Everyone has the right to live in safety, free from harm, abuse, and neglect. Abuse and neglect can occur anywhere; in a person's home, a public place, while you are in hospital, attending a day centre or in a Care Home.

1.5 Whether you work with adults or not, all staff (clinical or non-clinical) have a duty of care to report their concerns to the correct authority within agreed timescales. Vulnerable adults are people aged 18 or over who may need care services by reason of mental health or other disability, age, or illness or who may be experiencing abuse or neglect and are unable to protect themselves from harm.

1.6 Whilst the Trust acknowledges there is different supporting legislation in relation to safeguarding children and safeguarding adults, the Trust have adapted an integrated life course approach. This is sometimes referred to as a 'Think Family' approach and involves services working with both adults and children taking into account the whole family circumstances and responsibilities.

1.7 A 'Think Family' approach encourages staff to consider a child or adult at risk as part of a family whilst keeping the child or adult at risk at the centre of the care provided. This means considering the needs of the individual in the context of their relationships and their environment. 'Think parent, think child, think family' is therefore the guiding principle for this way of working.

1.8 Safeguarding concerns for children may be related to their parent's ability to meet their basic needs. Parents may have for example mental health issues or challenges with substance misuse which may impact on their parenting capacity and ability to meet the needs of their children. Sometimes adults at risk can be parents or have caring responsibilities and therefore the needs of their dependents need to be considered from safeguarding perspective. Regardless of whether staff work predominantly with children or adults at risk, safeguarding statutory responsibilities require the consideration of the needs of all. The Children Act (1989, 2004) is clear that the child's welfare is paramount in all situations.

2 POLICY STATEMENT

2.1 This policy aims to ensure that WWLFT complies with relevant legislation and guidance regarding safeguarding adults at risk of harm, abuse, or neglect. All staff have a duty and are required to promote the well-being of adults and where there are adult protection concerns, to act to safeguard them.

2.2 This policy supersedes any previously identified policy for safeguarding adults at risk within the Trust.

3 KEY PRINCIPLES

3.1 The Care Act 2014 sets out several principles that provide a basis for the care and support system including safeguarding:

3.2 **Protect from abuse and neglect –** professionals and partner agencies should consider how resources can be pierced together to protect people from abuse and neglect.

3.3 **Right to freedom** – every person must be legally protected where the right to liberty is concerned.

3.4 **Promoting well-being** – applies in all cases where the Trust undertakes a care and support function or decision making in the context of adult safeguarding.

3.5 **Provision of support** – enabling individuals to achieve their desired outcomes, which should be agreed with the professionals supporting them and guiding them through the safeguarding process.

3.6 **Assumption that individuals –** are best placed to make judgements about their own well-being. Robust mental capacity assessments must ne undertaken in order that capacity is assessed at all stages of the safeguarding process.

3.7 **Respect of people's views and wishes** – this is critical to "making safeguarding personal". View of people's belief systems, past wishes, thoughts, and feelings must be taken into consideration to form part of the process outcomes.

3.8 **Foster a preventative approach** – every effort must be made to avert crisis management with appropriate consideration made to assess risk factors throughout the safeguarding process.

3.9 **Participation of the individual** – this must be given due consideration throughout the safeguarding process with people being allowed to voice their thoughts, wishes and opinions.

3.10 **Empowerment** – is the principle that adults should be in control of their lives and consent is needed for decisions and actions designed to protect them.

4 TRUST SAFEGUARDING GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

4.1 The Trust is required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of adults in our delivery of services. Safeguarding is embedded at every level in the Trust and there are effective governance arrangements as detailed below.

4.2 The Chief Nurse is the Board Executive lead for safeguarding children and safeguarding adults at risk, however the Chief Executive retains overall statutory responsibility. The Trust

Safeguarding Team sits within the Corporate Division and reports directly to the Deputy Chief Nurse.

4.3 Safeguarding is overseen by the Safeguarding Effectiveness Group chaired by the Chief Nurse which is held quarterly. The Head of Safeguarding and Named Nurses have direct access to the Chief Executive and Chief Nurse as required, for example to discuss serious incidents, Safeguarding Adult Reviews, Brief Learning Reviews and agree statutory safeguarding reports.

4.4 Key Trust senior leaders are statutory members of Wigan Safeguarding Adult Board, Community Safety Partnership and the Health and Wellbeing Board.

4.5 Quarterly reports regarding safeguarding are provided to the Trust Quality and Safety Committee.

4.6 The Trust has the following identified safeguarding adult roles in line with the 'Adult Safeguarding: Roles and Responsibilities Intercollegiate Document (2018):-

4.6.1 Named Nurse Safeguarding Adults
4.6.2 Named Midwife Safeguarding
4.6.3 Named Doctor Safeguarding Adults
4.6.4 An identified Mental Capacity Act and Deprivation of Liberty Safeguards Lead

4.7 Safeguarding assurance is provided to Commissioners and the Wigan Safeguarding Adult Board as required in line with statutory responsibilities.

4.8 An Annual Safeguarding Adult Report is provided to the Trust Board and shared with Commissioners and the Wigan Safeguarding Adult Board.

5 ROLES AND RESPONSIBILITIES

5.1 Chairperson

The key responsibilities of the role of the Chairperson are:

5.1.1 To ensure that the role and responsibilities of the Governing Body in relation to safeguarding are met.
5.1.2 To promote a positive culture of safeguarding within Trust Board and the wider Trust through assurance that there are procedures for; safer recruitment, rehabilitation of offenders, duty of candour, corporate manslaughter, unlawful deprivation, and whistle blowing. As well as appropriate policies for safeguarding, and that these are being followed.
5.1.3 To ensure that staff and patients are aware that the organisation takes safeguarding seriously and will respond to concern about the welfare of children and adults at risk of abuse.
5.1.4 To ensure that there are robust governance processes in place to provide assurance on safeguarding.
5.1.5 To ensure child and adult safeguarding policies and procedures work effectively together
5.1.6 To ensure good information from and between the Trust Board and senior management on safeguarding.
5.1.7 To provide constructive challenge to, and scrutiny of, the Trust safeguarding systems.
5.1.8 To have oversight of the discharge of legal obligations relating to MCA, Deprivation of Liberty Safeguards (Liberty of Protection Safeguards anticipated to replace DOLS in April 2022) and adult safeguarding.

5.2 **The Chief Executive**

5.2.1 The Chief Executive must provide strategic leadership, promote a culture of supporting good practice regarding safeguarding within the Trust and promote a culture of learning and professional curiosity, and collaborative working with other agencies.

5.2.2 The Chief Executive takes overall responsibility for safeguarding strategy and policy with additional leadership being provided at Trust Board level by the Chairperson and the Executive Director with the lead for safeguarding.

5.2.3 The Chief Executive should ensure that Named Safeguarding Professionals have direct access as required so that matters requiring escalation can be brought to their attention.

5.2.4 To ensure that the role and responsibilities of the Trust Board in relation to safeguarding are met.

5.2.5 To ensure that the Trust adheres to relevant national guidance and standards for safeguarding.

5.2.6 To have oversight of the Human Resources safeguarding duties relating to a safe workforce and protecting the public from harm, with oversight to safer recruitment, rehabilitation of offenders, whistleblowing, duty of candour, corporate manslaughter, unlawful deprivation, and other duties that impact on the safety of the organisation and the public.

5.2.7 To have an Executive Director lead for safeguarding.

5.2.8 To have oversight of the legislation relevant to the Trust activities and have strategic oversight in relation to implementation, review, service delivery, risks management and planning.

5.2.9 To ensure the Trust participate in and contributes to the Wigan Safeguarding Adult Board.

5.2.10 To ensure the identification of strategic risks and ability to ensure that these are mitigated across the system.

5.2.11 To lead with a strong culture of safeguarding throughout the Trust.

5.2.12 To ensure that Safeguarding Team are resourced to support and respond to the demands of safeguarding effectively.

5.2.13 To ensure that an effective safeguarding training and supervision strategy is resourced and delivered.

5.2.14 To ensure and promote appropriate, safe, multi-agency/inter-agency partnership working practices and information sharing practices operate within the Trust.

5.3 **Executive Director for Safeguarding**

5.3.1 The nominated Executive Director for Safeguarding is the Chief Nurse who takes responsibility for safeguarding issues. The Executive Director for Safeguarding reports to the Trust Board regarding the Trust's compliance with its statutory responsibilities in relation to safeguarding.

5.3.2 The Chief Nurse is the nominated representative for the Trust in the Wigan Safeguarding Adult Board.

5.3.3 They provide leadership in the long-term strategic planning for safeguarding across the Trust supported by the Named Safeguarding Professionals.

5.3.4 Named Safeguarding Professionals should have regular, direct access to the Executive Director for Safeguarding to provide expert advice and support for safeguarding matters.

5.3.5 The Executive Director for Safeguarding must ensure that Named Safeguarding Professionals are included in all key Trust and wider safeguarding partnership decision making.

5.3.6 To ensure that safeguarding is positioned as core business in strategic and operating plans and structures.

5.3.7 To oversee, implement and monitor the ongoing assurance of safeguarding arrangements.
5.3.8 To ensure the adoption, implementation and auditing of policy and strategy in relation to safeguarding.
5.3.9 To ensure the appointment of Named Safeguarding Professionals.
5.3.10 To support the Named Safeguarding Professionals to implement safeguarding arrangements.
5.3.11 To ensure that there is a programme of training, safeguarding supervision and mentoring to support those with responsibility for safeguarding.
5.3.12 To work in partnership with Commissioners, Local Authorities, and the Police to secure high quality, best practice in safeguarding.
5.3.13 To ensure the identification of strategic risks and ability to ensure that these are mitigated across the Trust.
5.3.14 To provide strategic guidance to staff assigned to lead on MCA and safeguarding adults at risk.
5.3.15 To ensure the voice of the adult is heard in service delivery and development to ensure making safeguarding personal.
5.3.16 To assure Commissioners and other strategic bodies representing safeguarding in relation to safe procedures within the organisation, risk management, governance arrangements, auditing of services and monitoring of staff leading on safeguarding within the Trust.
5.3.17 To ensure that serious incidents relating to safeguarding are reported immediately and managed effectively.

5.4 The Trust Board and Directors

5.4.1 The Trust Board and Directors must ensure appropriate scrutiny of the organisation's safeguarding performance.
5.4.2 All Trust Board Members must be trained to level 1 in safeguarding children and adults and must know the common presenting features of abuse and neglect and the context in which it presents to healthcare staff.
5.4.3 In addition, Trust Board Members should understand the statutory role of the NHS Providers in safeguarding including partnership arrangements, policies, risks, and performance indicators; staff's roles and responsibilities in safeguarding; and the expectations of regulatory bodies in safeguarding.
5.4.4 Essentially the Trust Board will be held accountable for ensuring the services they deliver are high quality, evidence-based care and people are seen in appropriate environments, with the right staff, who share the same vision, values and demonstrate expected behaviours.

5.5 Head of Safeguarding

5.5.1 The Head of Safeguarding (HoS) leads and co-ordinates the Safeguarding Team which contributes to the strategic development of safeguarding children and adults at risk within all settings in the Trust and which enhances multi-agency/partnership working.
5.5.2 The HoS is responsible to the Deputy Chief Nurse and is accountable to the Chief Nurse. They work in partnership with Commissioners, the Wigan Safeguarding Adult Board, Wigan Safeguarding Children Board; Local Authorities and other agencies, to ensure that the Trust fulfils all its statutory responsibilities in relation to safeguarding.
5.5.3 Ensuring that all legislative, regulatory, and national guidance relating to safeguarding is adhered to and reported on as appropriate.
5.5.4 Providing oversight to confirm all safeguarding practice across the organisation is evidence based, ensuring best practice is supported by validated research.
5.5.5 Providing the Trust with a quarterly and annual report which details all relevant safeguarding operational activity and compliance with NHS Provider safeguarding
5.5.6 Statutory responsibilities in partnership in the Named Safeguarding Professionals.

5.5.7 Line management of the Trust Safeguarding Team.
5.5.8 The completion of any safeguarding Key Performance Indicators, Safeguarding Contractual Standards, Section 11 Safeguarding Audits, Commissioner Assurance documents, etc.
5.5.9 Oversee the completion of any NHS Serious Investigations related to safeguarding and responding to complaints where safeguarding is a feature.
5.5.10 Escalation and oversight of identified safeguarding risks.
5.5.11 Identification and escalation of serious safeguarding incidents.
5.5.12 Oversee and ensure statutory responsibilities in relation to the Care Act 2014 are met.

5.6 **Named Professionals for Safeguarding Adults**

5.6.1 Named Professionals for Safeguarding Adults (including the Named Nurse, Named Midwife and Named Doctor) are safeguarding roles which are required by every NHS Provider as per the Intercollegiate document – Adult Safeguarding: Roles and Competencies for Health Care Staff August (2018).
5.6.2 The responsibilities of the Named Safeguarding Professionals are as follows:
5.6.3 Contributes as a member of the Safeguarding Team to the development of strong internal safeguarding adult at risk policy, guidelines, and protocols.
5.6.3 Able to effectively communicate local safeguarding knowledge, research, and findings from audits, challenge poor practice and address areas where there is an identified training/development opportunity.
5.6.4 Facilitates and contributes to Trust safeguarding audits, multi-agency audits and statutory inspections.
5.6.5 Works with the Safeguarding Team and partners in other agencies to conduct safeguarding training needs analysis, and to commission, plan, design, deliver and evaluate single and inter-agency training and teaching for staff in the Trust.
5.6.6 Undertakes and contributes to Brief Learning Reviews (BLRs), Local Case Reviews, Safeguarding Adult Reviews (SARS), Domestic Homicide Reviews (DHRs) and undertake chronologies, and the development of action plans using a root cause analysis approach where appropriate.
5.6.7 Co-ordinates and contributes to implementation of action plans and the learning following the above reviews with the Safeguarding Team.
5.6.8 Provides advice and information about safeguarding to the Trust, both proactively and reactively – this includes the Board, Directors, and Senior Managers.
5.6.9 Provides specialist advice to practitioners, both actively and reactively, including clarification about Trust policies, legal issues, and the management of adult at risk cases.
5.6.10 Provides safeguarding supervision and leads or ensures appropriate reflective practice is embedded in the Trust to include peer review.
5.6.11 Participates in sub-groups, as required, of the Wigan Safeguarding Adult Board.
5.6.12 Lead and oversee the safeguarding quality assurance and improvement processes.
5.6.13 Undertakes risk assessments of the Trust's ability to safeguard adults at risk.
5.6.14 Have an advanced knowledge of relevant national and international issues, policies, and implications for practice.
5.6.15 Have an advanced knowledge and understanding of Trust structures to be able to challenge and advocate within policies and procedures and practice for safeguarding.
5.6.16 Understand the commissioning and planning of safeguarding health services.
5.6.17 Know about the professional and experts' role in the court process and support staff in the writing of court reports.
5.6.18 Know how to implement and audit the effectiveness of safeguarding services on an organisational level against current national guidelines and quality standards.

5.7 **Safeguarding Team**

5.7.1 The Trust Safeguarding Team is operationally line managed by the Named Nurses for Safeguarding and their key responsibility is to support the Named Nurse in delivering the above statutory responsibilities.
5.7.2 Providing advice, support, and safeguarding supervision to frontline staff.
5.7.3 Operate a daily Safeguarding Team duty system to support frontline staff with any safeguarding queries or concerns.
5.7.4 Manage and action the safeguarding components of the Hospital Information System (HIS) including oversight of referrals to the Safeguarding Team.
5.7.5 Deliver single agency and multi-agency safeguarding training.
5.7.6 Work within the Escalation Policy of the Wigan Safeguarding Adult Board.
5.7.7 Support the development of safeguarding policies, procedures, and guidance.
5.7.8 Support the Named Nurse in Brief Learning Reviews (BLRs), Local Case Reviews, Safeguarding Adult Reviews (SARS), Domestic Homicide Reviews (DHRs).

5.8 **Line Managers**

5.8.1 Line Managers are responsible for ensuring
5.8.2 Safeguarding responsibilities are reflected in all job descriptions for the staff that they manage, relevant to their job role.
5.8.2 That staff are compliant with mandatory safeguarding training in line with Trust policy as art of annual Professional Development Reviews.
5.8.3 Any staff in contact with adults through the course of their normal duties are trained in accordance with their role. They should be alert to the potential indicators of abuse and know how to act on those concerns. They should also be aware of the Wigan Safeguarding Board Policies.
5.8.4 They follow safeguarding procedures in relation to managing allegations against staff. Any allegations against staff members should be brought to the attention of the Head of Safeguarding and Named Nurses so that appropriate referrals can be made to the Local Authority Designated Officer (LADO) for matters to safeguarding children; and for matters relating to safeguarding adults can be made in line with Persons in a Position of Trust (PIPOT) processes.

5.9 **Medical Staff, Dentists, Registered Nurses, Allied Health Professionals, Midwives and Health Visitors**

All Medical staff, Dentists, Registered Nurses, Allied Health Professionals, Midwives and Health Visitors are professionally accountable for the standard of care they provide to patients via the General Medical Council and Nursing and Midwifery Council, (GMC 2012, NMC, 2008) and for care delegated and subsequently provided by non-registered staff. The relevant professional Codes of Conduct all place duties and responsibilities upon registrants in relation to adult safeguarding and are consistent with this policy.

5.10 **Individual Staff Members**

5.10.1 Every member of staff working with patients has a responsibility to act and a duty to report actual or suspected abuse, harm, or neglect, or if they have a concern that there is a risk of harm, neglect or abuse may take place, to their line manager in the course of their work, in a timely manner.
5.10.2 Individual Staff Members should:
5.10.3 Be alert to the potential indicators of abuse for adults and know how to act on those concerns in line with Trust policy, Wigan Safeguarding Adult Board policies.
5.10.4 Complete mandatory safeguarding training, in line with Trust policy, to ensure their competency in this area and contribute, as requested, to the multi-agency safeguarding processes.
5.10.5 Understand the principles of confidentiality and information sharing in line with local and government guidance.

5.10.6 Must respond appropriately to safeguarding concerns and make appropriate and timely referrals Must respond appropriately to requests by Social Care and other agencies regarding safeguarding.

5.10.7 Seek support and guidance from the Trust Safeguarding Team in a timely manner when they are unclear or unsure of the appropriate action in relation to adult safeguarding concerns.

5.10.8 Be familiar with Trust safeguarding policies and procedures and how to access them.

6 FREEDOM TO SPEAK UP

6.1 All Trust staff have a responsibility to disclose suspected 'malpractice' or concerns about the organisation. Although there is currently no legal definition, 'whistleblowing' has come to be accepted as the disclosure by an employee of confidential information which relates to some danger, fraud or other illegal or unethical conduct connected with the workplace. These concerns made in relation to the organisation or the employees of the organisation.

6.2 It has been recognised that actively encouraging staff to raise concerns about health care, probity, and quality matters responsibly and without delay ensures that the interests of patients are always put first.

6.3 The Public Interest Disclosure Act (PIDA) 1998 ensures protection for employees who have concerns about the organisation they work for if staff are acting in good faith, reasonably believe that the matter being disclosed is either happening now, took place in the past, or is likely to happen in the future and is making a 'qualifying disclosure'.

6.4 The Trust Freedom to Speak Up Policy should be followed if staff become aware of any such concerns. Where staff are concerned about matters of a safeguarding nature they should consult with the safeguarding team or approach the Freedom to Speak up Guardian.

7 THE AIM OF ADULT SAFEGUARDING

7.1 To stop, wherever possible abuse or neglect.

7.2 To prevent, wherever possible, harm and reduce the risk of abuse or neglect to adults with care and support needs.

7.3 To safeguard adults in a way that supports them in exercising their choice and having control as to how they want to live.

7.4 To promote a safeguarding approach that focuses on improving the quality of life for the adult concerned.

7.5 To raise public awareness of safeguarding in order that communities, alongside professionals, play their part in preventing, identifying, and responding effectively to abuse and neglect.

7.6 To provide information and support in accessible ways to help adults understand the different forms of abuse, and how to raise a concern about the safety or wellbeing of an adult.

7.7 To investigate allegations of abuse and neglect of adults at risk ensuring that robust protection plans are in situation.

7.8 To act in such a manner as to protect an adult's right to live in safety, free from harm and abuse (Care Act 2014).

8 RECOGNITION OF ABUSE

8.1 WHAT IS ABUSE?

8.1.1 It should be recognised that the term “abuse” can be subject to wide interpretation and that, when determining whether abuse is taking place, consideration will need to be given to a range of factors. “Abuse is a violation of an individual’s human and civil rights by any other person or persons”.

8.1.2 Abuse may consist of:

8.1.2.1 A single act or repeated acts.
8.1.2.2 It may be physical, psychological, or emotional.
8.1.2.3 An act of neglect or omission to act.
8.1.2.4 Occur when a person is persuaded to enter a financial or sexual transaction to which they have not, or cannot, consent.
8.1.2.5 Abuse may be deliberate or unintentional or result from lack of knowledge.

8.2 CATEGORIES OF ABUSE

The main categories of adult abuse are:-

8.2.1 Physical
8.2.2 Sexual Abuse
8.2.3 Sexual Exploitation
8.2.4 Psychological Abuse
8.2.5 Financial or Material Abuse
8.2.6 Neglect and Acts of Omission
8.2.7 Discriminatory Abuse
8.2.8 Organisational Abuse
8.2.9 Domestic Abuse
8.2.10 Modern Slavery
8.2.11 Female Genital Mutilation (FGM)
8.2.12 Self-Neglect
8.2.13 County Lines
8.2.14 Mate Crime

8.3 **Physical Abuse:** This can include but is not limited to assault, hitting, slapping, pushing, misuse of medication, restraint, or inappropriate physical sanctions.

8.4 **Sexual Abuse:** This can include but is not limited to rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, sexual assault, and sexual acts to which the adult has not consented or was pressured into consenting.

8.5 All sexual activity involving professionals with individuals for whom they care or know to be vulnerable is contrary to professional standards. It is abusive and will often result in disciplinary proceedings. This can cause harm to the adult at risk and damage the trust between that professional and the adult. An imbalance of power is often a feature in a relationship between professional involved in the care or treatment of an adult. It is the responsibility of the professional to be aware of the imbalance of power and to maintain clear boundaries.

8.6 **Sexual Exploitation:** Involves the sexual abuse of an adult in exchange for attention, affection, food, drugs, shelter, protection, other necessities and/or money and could be part of a seemingly consensual relationship. The person being exploited may believe their abuser is their friend, boyfriend, or girlfriend. The abuser may:-

8.6.1 Physically or verbally threaten the victim.
8.6.2 Take indecent pictures of them and circulate to others and be violent toward them.
8.6.3 Try to isolate them from friends and family.
8.6.4 Possible signs of sexual exploitation include:

8.6.4.1 Unexpected or unexplained changes in behaviour.
8.6.4.2 Sudden withdrawal from social activities.
8.6.4.3 Cutting off ties with friends and family.
8.6.4.4 Fixation with a new mobile phone and a desire to hide who they are talking to.
8.6.4.5 Sexual abuse such as bruising, injury or sexually transmitted diseases.

8.6 **Psychological Abuse:** This can include but is not limited to 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.

8.7 **Financial or Material Abuse:** This can include but is not limited to theft, fraud, internet scamming, exploitation, 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.

8.8 **Neglect or Acts of Omission:** This can include but is not limited to 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.

8.9 **Discriminatory Abuse:** This can include but is not limited to discrimination on grounds of race, gender and gender identity, age, disability, sexual orientation, religion and other forms of harassment, slurs, or similar treatment.

8.10 **Organisational Abuse:** This can include but is not limited to neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to ongoing ill treatment. It can be through neglect or poor professional practice because of the structure, policies, processes, and practices within an organisation.

8.11 **Domestic Abuse:** A definition of Domestic Abuse is currently being developed as part of the 2020 Domestic Abuse Bill. The Bill will create, for the first time, a cross-government statutory definition of domestic abuse, to ensure that domestic abuse is properly understood, considered unacceptable and actively challenged across statutory agencies and in public attitudes.

8.12 Women's Aid define domestic abuse as an incident or pattern of incidents of controlling, coercive, threatening, degrading and violent behaviour, including sexual violence, in most of cases by a partner or ex-partner, but also by a family member or carer. It is very common. In the majority of cases, it is experienced by women and is perpetrated by men.

8.13 Domestic abuse can include, but is not limited to, the following:-
8.13.1 Coercive control (a pattern of intimidation, degradation, isolation and control with the use or threat of physical or sexual violence).
8.13.2 Psychological and/or emotional abuse.
8.13.3 Physical or sexual abuse.
8.13.4 Financial or economic abuse.

8.13.5 Harassment and stalking.
8.13.6 Online or digital abuse.

8.14 The Government definition, which is not a legal definition, includes so called 'honour' based abuse, including FGM and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

8.15 Domestic violence and abuse rarely exists in isolation. The impact of living with adult violence has detrimental emotional and psychological effects on children and it is also a potential indicator for other forms of harm. It is closely associated with substance misuse, homelessness, and mental health.

8.16 If staff identify or suspect domestic abuse they should consult the following documents:

8.16.1 The Trust policy in relation to Domestic Abuse titled 'Domestic Abuse, Forced Marriage, so called 'Honour' Based Abuse and Female Genital Mutilation' which can be found on the Trust Intranet:
8.6.2 Trust SOPs in relation to Domestic Abuse.

8.17 Staff who identify potential victims of domestic abuse should contact the Trust Safeguarding Team for further advice and support. The Safeguarding Team includes hospital based Independent Domestic and Sexual Violence Advisors (IDSVAs). The hospital IDSVAs also work with and support staff members experiencing Domestic Abuse.

8.18 The Trust Safeguarding Team can help staff to determine whether a referral to a Multi-Agency Risk Assessment Conference (MARAC) is required. MARAC is a multi-agency information sharing meeting for those victims who have been identified by local partner agencies as being high risk victims of domestic abuse. It works on the basis that the initial safeguarding has already taken place and that all agencies that need to be involved already are.

8.19 The MARAC is an opportunity for all agencies to share information which might identify further risk to the victim, develop a multi-agency action plan to address any outstanding risks, with timescales, leads for all partners to be aware of activity.

8.20 **Modern Slavery:** This can include but is not limited to slavery, human trafficking, forced labour and domestic servitude, coercion, and deception to force individuals into a life of abuse, servitude, and inhumane treatment.

8.21 **Female Genital Mutilation (FGM):** FGM is a procedure where the female genital organs are injured or changed and there is no medical reason for this. 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.

8.22 The age at which FGM is carried out varies enormously according to the community. The procedure may be carried out shortly after birth, during childhood or adolescence, just before marriage or during a woman's first pregnancy

8.23 FGM is a criminal offence – it is child abuse and a form of violence against women and girls, and therefore should be treated as such. Cases should be dealt with as part of existing structures, policies and procedures for safeguarding.

8.24 There are, however, particular characteristics of FGM that front-line health professionals should be aware of to ensure that they can provide appropriate protection and support to those affected.

8.25 If staff identify or suspect FGM they should consult the following documents:-

8.25.1 The Trust policy in relation to FGM titled 'Domestic Abuse, Forced Marriage, so called 'Honour' Based Abuse and Female Genital Mutilation' which can be found on the Trust Intranet
8.25.2 Trust SOPs in relation to FGM
8.25.3 Multi-Agency Statutory Guidance on Female Genital Mutilation

8.26 **Self-Neglect:** This can include but is not limited to a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. There will be those situations where usual attempts to engage the person with necessary support have been unsuccessful, and a significant risk of harm remains. It will also often, but not always, be those cases where a multi-agency response is required to respond effectively to the concerns.

8.27 **County Lines:** Is criminal exploitation where adults at risk are manipulated to sell drugs. **Cuckooing** is a practice associated with county lines where people take over a person's home and use the property to facilitate exploitation. It takes the name from cuckoos who take over the nests of other birds. There are different types of cuckooing: using the property to deal, store or take drugs. It sees dealers using both physical and emotional threats to establish a base for selling drugs in someone's home.

8.28 **Mate Crime:** Mate Crime is defined as the exploitation, abuse, or theft from any person at risk from those they consider to be their friends. Those that commit such abuse or theft are often referred to as 'face friends'.

8.29 People with disabilities, particularly those with learning disabilities, are often the targets of this type of crime. In some cases, victims of mate crime have been badly harmed or even killed.

8.30 There are different forms of mate crime, for example:-

8.30.1 Theft/financial abuse. The abuse might demand or ask to be lent money and then not pay it back. The perpetrator might misuse the property of the adult.
8.30.2 Physical assault/abuse. The abuser might hurt or injure the adult.
8.30.3 Harassment or emotional abuse. The abuser might manipulate, mislead, and make the person feel worthless.
8.30.4 Sexual assault/abuse. The abuser might harm or take advantage of the person sexually.

8.31 Multiple forms of abuse may occur in any situation for example, in an on-going relationship or when attending a service or provider of care which may affect an individual or multiple service users at any one time. This makes it important to look beyond single incidents or breaches in standards, to underlying dynamics and patterns of harm. Any or all these types of abuse may be perpetrated as the result of deliberate intent, specific targeting of adults at risk, or negligence which may be deliberate or unintentional.

9 WHO MIGHT ABUSE?

9.1 Anyone can be a perpetrator of abuse. Abuse can occur in any relationship and may involve an individual, a group or an organisation. This includes a wide range of people such as 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 including people employed in or occupying positions of trust.

9.2 An abusive relationship often includes the misuse of power by one person over another and is most likely to take place in situations where one person has power over another. For example, where one person is dependent on another for their physical care or due to a power relationship in society (between a professional worker and a service user).

10 WHERE MIGHT ABUSE OCCUR?

10.1 Abuse can take place anywhere, including:-

10.1.1 In the person's own home or the home of their family or friends.
10.1.2 In public places/the community.
10.1.3 Place of work/colleges of further education.
10.1.4 In any care setting: hospital, clinic, care home.
10.1.5 Criminal justice system.

11 MENTAL CAPACITY ACT

11.1 The Mental Capacity Act (MCA) 2005 and the Mental Capacity (Amendment) Act 2019 (MCAA) set out who can, and how to, make decisions relating to care and treatment for those who lack capacity to make such decisions. The MCAA covers decisions relating to finance, social care, medical care and treatments, research, and everyday living decisions, as well as planning for the future.

11.2 The MCAA applies to all over the age of 16 years, with a presumption that all young people (16 and 17 years of age) and adults can give valid consent to or refuse treatment and introduces the Liberty Protection Safeguards (LPS).

11.3 The LPS provides a new legal provision to authorise arrangements that amount to a deprivation of liberty of people age 16+ in specified circumstances:-

11.3.1 They apply where the person lacks mental capacity to consent to their care or treatment and
11.3.2 It is necessary to deprive them of their liberty to provide them with that care or treatment.
11.3.3 The LPS is anticipated to replace DOLS with effect from April 2022.

11.4 For further advice and guidance regarding the Mental Capacity Act and Deprivation of Liberty Safeguards please refer to the Trust policy regarding the same ( ).

12 PREVENT (Counter Terrorism)

12.1 The healthcare sector is a key partner in delivering the HM Government's Prevent strategy and promotes a non-enforcement approach to support the health sector in preventing people becoming radicalised. Healthcare staff are well placed to recognise individual's, whether patients or staff, who may be vulnerable and therefore more susceptible to radicalisation by violent extremists or terrorists. It is fundamental to our "duty of care" and falls within our safeguarding responsibilities.

12.2 WWL is committed to safeguarding and supporting vulnerable individuals, including staff who may be at risk of being radicalised by violent extremists. WWL will ensure that appropriate systems are in place for staff to raise concerns if they are aware of this form of exploitation taking place and to promote and operate a safe environment where violent extremists are unable to operate.

13 STAFF SUPPORT

13.1 It is common and natural for staff to experience a range of emotions following their involvement in reporting the suspected abuse of a patient and where they have witnessed the abuse. Incidents of suspected abuse can also prove traumatic for those reporting the incident or being involved in the immediate management of the same or indeed the local safeguarding investigation process. Options should be considered and offered to ensure that there are appropriate support, counselling, and de-briefing opportunities available to staff. All executives, managers and staff should be aware of and consider the following support options:

13.1 Support is available from colleagues, clinical lead, and Trust Safeguarding Team.
13.2 Keeping practitioners informed of what is happening and/or going to happen.
13.3 Offering practitioners independent support via the Staff Wellbeing Team.

14 TRAINING

14.1 All Trust staff have a duty to safeguard and protect the welfare of adults at risk of abuse and neglect. Safeguarding training must be undertaken in order that staff members are able to meet safeguarding responsibilities as required for their specific role. The table in Appendix 1 outlines the training required by Trust staff members. Additional information on the content of safeguarding adult training is included within the 2018 Intercollegiate Guidance entitled, “Adult Safeguarding Roles and Competencies for Health Care Staff.

14.2 The Safeguarding Adults Training Needs Analysis is set out in full in Appendix 1 and staff are requested to familiarise themselves with the same.

15 INFORMATION SHARING

15.1 Information sharing between organisations is essential to safeguard adults at risk of abuse, neglect exploitation. In this context ‘organisations’ mean not only statutory NHS Trusts but also voluntary and independent sector organisations, housing authorities, the police and Crown Prosecution Service, and organisations which provide advocacy and support.

15.2 Decisions about what information is shared and with whom is taken on a case-by-case basis. Whether information is shared with or without the consent of the adult at risk, the information shared should be:-

15.2.1 Necessary for the purpose for which it is being shared.
15.2.2 Shared only with those who have a need for it.
15.2.3 Be accurate and up to date.
15.2.4 Be shared accurately.
15.2.5 Be shared securely.

15.3 There are only a limited number of circumstances where it would be acceptable not to share information pertinent to safeguarding with relevant safeguarding partners. These would be where the person involved has the mental capacity to make the decision and does not want their information shared AND:

15.3.1 Nobody else is at risk.
15.3.2 No serious crime has been or may be committed.
15.3.3 The alleged abuser has no care and support needs.
15.3.4 No staff are implicated.
15.3.5 No coercion or duress is suspected.
15.3.6 The public interest served by disclosure does not outweigh the public interest serviced by protecting confidentiality.
15.3.7 No other legal authority has requested the information.

15.4 Further advice and guidance regarding information sharing is available in Appendix 2.

16 CHAPERONING

16.1 Wrightington Wigan and Leigh Teaching Hospital NHS Foundation Trust (WWL) is committed to developing a culture within the organisation that promotes and champions the privacy and dignity of all patients. It is recognised that how care is delivered can directly influence a person's self- image and their contract within the Trust.

16.2 The nature of many health care interventions and treatments, particularly where they involve the breast, genitalia, or rectum, dimmed lights, state of undress or long periods of being touched, can predispose patients to feelings of vulnerability or distress and may also lead to misinterpretation and, on occasions, allegations of abuse. It is recognised that each patient will respond differently to the situations described based on past-experience, individual beliefs, culture, and religion.

16.3 The presence of a chaperone may assist in addressing the needs of both the patient and the health care professional carrying out the intervention. However, caution should be used as their presence may potentially reduce the likelihood of some patients confiding sensitive information to their practitioner. Respect, explanation, consent, and privacy are paramount to ensure a positive patient experience.

16.4 For further advice and guidance regarding chaperoning please refer to the Trust policy in respect of the same (TW10 - 069).

17 HUMAN RIGHTS ACT

Implications of the Human Rights Act have been taken into account in the formulation of this document and they have, where appropriate, been fully reflected in its wording.

18 INCLUSION AND DIVERSITY

This policy document has been assessed against the Equality Impact Assessment Form from the Trust's Equality Impact Assessment Guidance and, as far as we are aware, there is no impact on any protected characteristics.

19 MONITORING AND REVIEW

This document will be reviewed every 3 years as a matter of practice or as and when changes or legislation which affects the document are introduced.

20 ACCESSIBILITY STATEMENT

This document can be made available in a range of alternative formats for example, Braille, Audio CD, and large print. For more details, please contact the HR Department on 01942 77 3766 equalityanddiversity@wwl.nhs.uk

APPENDIX 1

SAFEGUARDING ADULTS TRAINING NEEDS ANALYSIS			
Training	Mandatory	Trust Staff Groups	Training Provision and Frequency
Induction	Yes	All new starters to WWLFT.	Face to Face. On commencement to the Trust – one off signposting session.
Level 1 Safeguarding Adults	Yes	All new starters to WWLFT + all non-clinical staff for example, clerical, porters, and laundry staff.	E-learning (2 hours). Within 6 weeks of commencement to WWFT and repeated every 3 years thereafter.
Level 2 Safeguarding Adults	Yes	All new starters who are clinical staff and that have contact with vulnerable adults + all clinical staff Band 3 and below that have regular contact with vulnerable adults.	E-learning (4 hours). On Induction and re E-learning. Within 6 weeks of commencement to the Trust and every 3 years thereafter peated every 3 years thereafter.
Level 3 Safeguarding Adults	Yes	Clinical staff Band 4 and above for example, all trained Nurses, Doctors and Qualified Therapists working with adults.	Fae to Face (8 hours). Within 6 weeks of commencement to the Trust and every 3 years thereafter.
Domestic Abuse	Yes	All clinical staff Band 4 and above.	Face to Face (4 hours). Within 6 weeks of commencement to the Trust and every 3 years thereafter.
Prevent (Basic)	Yes	All staff.	E-learning. Within 6 weeks of commencement to the Trust and every 3 years thereafter.

Prevent (Intermediate)	Yes	All clinical staff Band 4 and above.	E-learning. Within 6 weeks of commencement to the Trust and every 3 years thereafter
MCA & DoLS	Yes	Health Care Assistants	E-learning. Within 6 weeks of commencement to the Trust and every 3 years thereafter
MCA & DoLS	Yes	All nurse associates; qualified nurses, allied health care professionals	E-learning. Within 6 weeks of commencement to the Trust and every 3 years thereafter

APPENDIX 2

SEVEN GOLDEN RULES FOR INFORMATION SHARING (Information Sharing: HM Government 2015)	
1.	Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.
2.	Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek agreement, unless it is unsafe or inappropriate to do so.
3.	Seek advice if you are in any doubt, without disclosing the identity of the person where possible.
4.	Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, the lack of consent can be overridden in the public interest. You will need to base your judgement on the facts of the case.
5.	Consider safety and well-being. Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.
6	Necessary, proportionate, relevant, accurate, timely and secure. Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up to date, is shared in a timely fashion, and is shared securely.
7.	Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Equality Impact Assessment Form

STAGE 1 - INITIAL ASSESSMENT

For each of the protected characteristics listed answer the questions below using **Y** to indicate Yes and **N** to indicate No	**Sex** (male / female / transgender)	**Age** (18 years+)	**Race / Ethnicity**	**Disability** (hearing / visual / physical / learning disability / mental health)	**Religion / Belief**	**Sexual Orientation** (Gay/Lesbian/	**Gender Re-Assignment**	**Marriage / Civil Partnership**	**Pregnancy & Maternity**	**Carers**	**Other Group**	**List Negative / Positive Impacts Below**
Does the policy have the potential to affect individuals or communities differently in a negative way?	n	N	n	n	n	n	n	n	n	n	n	
Is there potential for the policy to promote equality of opportunity for all / promote good relations with different groups – Have a positive impact on individuals and communities.	y	Y	y	y	y	y	y	y	y	y	y	
In relation to each protected characteristic, are there any areas where you are unsure about the impact and more information is needed?	n	N	n	n	n	n	n	n	n	n	n	**If Yes**: Please state how you are going to gather this information.

Job Title	Named Nurse Safeguarding			**Date**	February 2021

IF 'YES an NEGATIVE IMPACT' IS IDENTIFIED - A Full Equality Impact Assessment STAGE 2 Form must be completed. This can be accessed via:
http://intranet/Departments/Equality_Diversity/Equality_Impact_Assessment_Guidance.asp
Please note: As a member of Trust staff carrying out a review of an existing or proposal for a new service, policy or function you are required to complete an Equality Impact Assessment. By stating that you have NOT identified a negative impact, you are agreeing that the organisation has NOT discriminated against any of the protected characteristics. Please ensure that you have the evidence to support this decision as the Trust will be liable for any breaches in Equality Legislation.

POLICY MONITORING AND REVIEW ARRANGEMENTS

Para	Audit / Monitoring requirement	Method of Audit / Monitoring	Responsible person	Frequency of Audit	Monitoring committee	Type of Evidence	Location where evidence is held
	Rolling monthly review of compliance of in date documents	Project Officer to advise author 6 months in advance of review date and advise CQEC of overall Trust compliance	Project Officer	Monthly rolling programme	CQEC	Monthly compliance report	Team Drive: Director of Nursing/Corporate QEC