

Managing Safeguarding Allegations Against Staff: Policy and Procedure

NHS England and NHS Improvement



**Document Title:
Managing Safeguarding Allegations Against Staff: Policy
and Procedure**

Version number: 3

First published: 27th March 2014

Updated: 25 March 2019

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1 Introduction

- 1.1 This policy provides a framework for managing allegations against NHS England & NHS Improvement staff that indicate that a child, young person or adult at risk is believed to have suffered, or is likely to suffer, significant harm. It also applies to cases where a staff member is behaving in a way that suggests they are unsuited to working with these groups of people.
- 1.2 This policy is focused on the management of risk, based on an informed assessment of harm and abuse. Definitions of harm can be found in [Safeguarding Children and Young People](#), [Adult Safeguarding: Roles and Competencies for Health Care Staff \(August 2018\)](#) and the [Care Act \(2014\)](#).
- 1.3 This policy should be read alongside the relevant NHS England & NHS Improvement policies relating to safeguarding individuals, and policies for the identification, management and support of primary care practitioners. Consideration must also be given to contractors whose performance gives cause for concern.

2 NHS England and NHS Improvement: commitments and values

- 2.1 The NHS Constitution establishes the principles and values of the NHS in England and the rights of patients, members of the public, and staff. It sets out the commitments of the NHS, together with the responsibilities that the public, patients and staff owe to one another, to ensure that the NHS operates fairly and effectively.
- 2.2 As a publicly-funded NHS body, and in line with the Constitution, NHS England & NHS Improvement aspires to the highest standards of excellence and professionalism in the leadership and management of the organisation, the people it employs, and the education, training and development they receive.

3 Application and scope

- 3.1 This policy applies to all NHS England & NHS Improvement staff, and anyone working on behalf of, or undertaking work for, or volunteering for, NHS England & NHS Improvement. It applies to all employees and contractors of NHS England & NHS Improvement, including:
 - GPs
 - dental practitioners
 - pharmacists
 - optometrists
 - secondees into and out of the organisation
 - volunteers, as defined by the NHS

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- students
- honorary appointees
- trainees
- contractors
- temporary workers, including locum doctors and those working on a bank or agency contract
- staff registered as performers on the National Performers' List.

3.2 For ease of reference, all employees and workers who fall into these groups are referred to as 'staff' in this document.

3.3 The policy covers allegations made against staff both within and outside their NHS England & NHS Improvement duties, such as in their private life, including:

- the commitment of a criminal offence against, or related to, a child, young person or adult at risk;
- a failure to work collaboratively with social care agencies when an issue about the care of a child, young person or adult at risk for whom they have caring responsibilities, is being investigated;
- behaving towards a child, young person or adult at risk in a way that suggests they are unsuitable to work with them;
- the commitment of domestic violence or abuse, or the failure to ensure that a vulnerable individual is protected from the impact of such violence or abuse; and
- abuse against someone closely associated with a member of staff, such as a partner, or a member of the family or household.

3.4 Although managing safeguarding allegations against staff is covered by the Children Acts (1989/2004), this Policy also applies to vulnerable adults at risk of harm or abuse as per the Care Act (2014). [Working Together to Safeguard Children \(2018\)](#) states that all statutory organisations should have a procedure for managing allegations against staff.

4 Managing allegations: Immediate actions

4.1 The regions will need to understand their local multi-agency policies and procedures for managing allegations, in conjunction with the NHS England and NHS Improvement Accountability and Assurance Frameworks.

4.2 Three separate actions must be considered when an allegation is made:

- enquiries and assessment by child/adult social care, into whether a child/young person/adult at risk of harm or abuse is in need of protection
- a police investigation of a possible criminal offence
- disciplinary action (including suspension).

- 4.3 The safety of the child, young person or adult at risk is of paramount importance, and immediate action may be crucial in safeguarding an investigation. Where there is concern that other individuals may be at risk of harm or abuse, this must be reported immediately.
- 4.4 Reputational issues must be managed appropriately, in discussion with the relevant communications team.
- 4.5 All staff must be familiar with referral procedures for the protection of children and adults at risk. A concern must be reported to a staff member's line manager, who should take advice from the regional or central safeguarding lead. See Appendix 2 for a flowchart of this process.
- 4.6 All LSCBs and SABs have their own websites, which set out their safeguarding policies and procedures. In addition, each Local Authority has a Local Authority Designated Officer (LADO) to act on its behalf in investigating allegations - a role cited in the Savile investigations as critical for working in partnership with the NHS. The LADO should be informed of all allegations, in line with local safeguarding procedures.
- 4.7 A Serious Incident Report of an allegation against a member of staff should be managed using [Strategic Executive Information System \(StEIS\)](#) methodologies.
- 4.8 It is crucial that no action taken by NHS England & NHS Improvement to manage an allegation will jeopardise an external investigation, such as a criminal investigation.

5 Procedure for reporting and managing allegations: NHS England directly employed staff and performers

- 5.1 Every effort must be made to maintain confidentiality, and manage communications effectively, whilst an allegation is being investigated. Any information-sharing must comply with the requirements of data protection legislation¹, the Human Rights Act and the common law duty of confidence.
- 5.2 Please refer to section 7 about the Disclosure and Barring Service (DBS).
- 5.3 Each NHS England & NHS Improvement region, and the central support team, will have a Nominated Safeguarding Senior Officer (NSSO) who will lead and co-ordinate investigations - and be of sufficient seniority to make decisions - on behalf of NHS England. Where there is no-one in this role, the Regional Chief Nurse will act as the point of contact to identify and appoint the NSSO.
- 5.4 The NSSO should ensure (if appropriate) that a child protection/adult at risk referral is made (or has been made) to the relevant social care team and,

¹ The EU General Data Protection Regulation and Data Protection Act 2018

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where necessary, the police, using the appropriate reporting form. The referral must be put in writing to child/adult social care by the reporting individual within 24 hours, or on the next working day (in the case of a weekend).

- 5.5 Where the issue relates to a child, the NSSO will liaise with the LADO, to agree on the information that needs to be shared with other geographical areas. The LADO can be contacted through the local Social Care team or the LSCB contact lead.
- 5.6 Immediate issues of investigation and management of the employee should be discussed and agreed at this time, including what information should be passed to the staff member concerned.
- 5.7 Where the issue relates to an adult, the NSSO will discuss the case and allegations with the relevant adult social care department manager and the police, to decide which agency should lead the investigation.
- 5.8 The NSSO will work with HR and the staff member's line manager, to decide whether suspension is appropriate during the period of investigation. HR will advise whether the NHS England & NHS Improvement disciplinary procedure is to be followed, or, in the case of a performer subject to the Performers' List regulations, which procedure should be followed. HR advice will be pertinent to all staff, regardless of their employment status with NHS England & NHS Improvement.
- 5.9 The NSSO should ensure the Director of the relevant regional or central safeguarding team is informed about the allegation.
- 5.10 Following notification to child/adult social care and/or the police, the NSSO should undertake an internal Strategy Planning Meeting, to decide how to manage the allegation. The following people should attend:
 - the NSSO
 - the LADO
 - the staff member's line manager
 - a senior member of staff from the Directorate or region concerned
 - the Safeguarding Lead for the area covered
 - a senior member of staff from the relevant regional or national support centre
 - appropriate members of the HR team
 - an appropriate designated professional, to act as safeguarding expert.
- 5.11 The Strategy Planning Meeting will:
 - consider what further contact is required with regional staff, local police, and/or child/adult social care
 - nominate a member of the investigation team as the link person
 - establish whether the child/young person/adult at risk of harm or abuse is safe from any further risk of harm or abuse

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- review the action already undertaken to ensure the safety of the victim
 - decide on the internal investigation strategy
 - make a referral to the appropriate professional body, e.g. GMC or NMC, if applicable. This referral could be made prior to any HR investigation, dependent on how serious the allegations are on the clinician
 - decide how to present the allegations to the staff member concerned, and – in agreement with child/adult social care and the police - what information should be passed to the staff member
 - decide how the investigation process will be managed, ensuring that NHS England & NHS Improvement performance procedures are followed
 - decide how the child/adult at risk of harm or abuse, or their nominated parent/guardian/nominated carer making the allegation, is to be kept informed of progress in the investigation
 - ensure that the incident has been reported on the [StEIS system](#)
 - ensure that relevant information is shared with the senior management team
 - decide on the frequency and format of review meetings needed to manage the investigation and its resulting actions.
- 5.12 The police and/or social care should be consulted when they are involved in any on-going investigation, and/or when criminal proceedings are pending.
- 5.13 The staff member's line manager should be asked to provide appropriate support to the individual, and keep them regularly informed, while the case is on-going. Further support may also be provided by Occupational Health.
- 5.14 The sharing of information must not 'contaminate' any on-going NHS England or NHS Improvement, police or child/adult social care investigations. Confidentiality must be maintained at all times, and any information-sharing must comply with the requirements of data protection legislation, the Human Rights Act and the common law duty of confidence.
- 5.15 The NHS England or NHS Improvement Communications Team will advise on the handling of any media queries regarding an allegation.

6 Procedure for reporting and managing allegations: Non-directly employed staff

6.1 The [2015 report by Kate Lampard QC](#) on the Jimmy Savile investigations gives clear guidance for dealing with allegations against non-directly employed staff. It states that such allegations must be shared with the individual's employer or employing body at the earliest opportunity.

For example:

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- Allegations against contracted staff including GPs, optometrists, dentists and pharmacists should be managed according to the Performers' List policies and procedures.
 - Allegations made against agency workers must be reported to the appointing agency and referred to NHS England or NHS Improvement Procurement.
 - Allegations made against workers employed by external contractors should be referred to the contractor and the relevant lead body in NHS England or NHS Improvement responsible for managing the service level agreement with the contractor.
 - Allegations made against workers seconded from another employer to NHS England & NHS Improvement, or embedded with NHS England & NHS Improvement but employed elsewhere, should be reported to the relevant employer.
 - Allegations made against volunteers undertaking duties for, or on behalf of, NHS England or NHS Improvement must also be reported to the voluntary body concerned.
 - Allegations made against workers engaged under a contract for services should be referred to NHS England or NHS Improvement Procurement.
- 6.2 Special safeguarding arrangements are in place in relation to patient and public participation within NHS England & NHS Improvement, including for Patient and Public Voice (PPV) partners. [Safeguarding: Patient and Public Participation](#) has full guidance on safeguarding policy for these groups.
- 6.3 A NSSO should be appointed, and undertake the duties set out in sections 5.2 to 5.9 above. Appendix 2 outlines the process to be followed.
- 6.4 The NSSO will need to engage with the relevant parties outlined above to decide how the allegation should be managed. This is likely to be a complex process, and the NSSO should take early advice from local safeguarding.
- 6.5 It is recommended that a meeting is held between NHS England & NHS Improvement and the other party/parties at the earliest opportunity, noting the responsibility to report issues to the police and/or social care teams within 24 hours of the allegation being received. These parties should attend the strategy meeting.
- 6.6 For contracted staff, such as GPs, the local performance manager should be informed so that the case can be reviewed and investigated. Cases may need to be referred to the performance group and the GMC.
- 6.7 In addition to the above procedures, NHS England & NHS Improvement must consider how to manage any allegation connected with, or relevant to, the duties that a staff member undertakes with NHS England & NHS Improvement. Such allegations also need to be reported to, and escalated by, the lead NHS England & NHS Improvement manager, as appropriate.

- 6.8 Assumptions should not be made that another party has referred the matter to the police or relevant other body. Evidence must be provided promptly, and if this is not forthcoming, the designated NSSO should refer the matter on behalf of NHS England & NHS Improvement, and advise the other party/parties accordingly.

7 Disclosure and Barring Service (DBS)

- 7.1 As an employer of staff in a 'regulated activity', NHS England and, where appropriate, NHS Improvement has a legal duty to refer concerns to the DBS in accordance with the [Safeguarding Vulnerable Groups Act 2006](#).
- 7.2 Managers must report concerns to their local HR team, who should seek advice from their Regional Safeguarding Lead and the NHS England safeguarding team, england.nursingandqualitycntw@nhs.net or directly through the Head of Safeguarding.
- 7.3 A staff member of NHS England & NHS Improvement must be referred to the Disclosure and Barring Service if:
- they have been permanently removed from 'regulated activity' through dismissal or permanent transfer, or
 - they would have been removed or transferred if they had not left, resigned, retired or been made redundant, *and if*
 - they are believed to have engaged in 'relevant conduct' (i.e. been involved in an action or inaction that has harmed a child or vulnerable adult, or put them at risk of harm), *or*
 - they have satisfied the 'harm test' (i.e. no action or inaction was found to have occurred, but a significant risk remains that it could occur), *or*
 - they have received a caution or conviction for a 'relevant offence' (i.e. involving automatic barring, either with or without the right to make representations).

See Appendix 1 for detailed information on 'relevant conduct'.

- 7.4 When an allegation is made, it is important to investigate thoroughly, to establish whether or not it has foundation. This will inform any decision to dismiss or remove the individual from regulated activity. An investigation must always be completed, even if the staff member leaves NHS England & NHS Improvement in the meantime.
- 7.5 The DBS has no investigative powers and bases its decisions on the evidence supplied to it. It is therefore essential that an investigation is as detailed as possible, in order to provide as much evidence as possible.
- 7.6 If additional information becomes available after a referral is made, this should also be provided to the DBS.

- 7.7 Following an investigation, if it is decided that the individual can return to regulated activity, there may not be a legal duty to make a referral.
- 7.8 The duty to make a referral may not be triggered by temporary suspension and depends on whether there is sufficient information to meet the referral criteria. However, a person may be suspended where an allegation has been made and an investigation is pending.
- 7.9 The website [Making barring referrals to the DBS](#) offers comprehensive guidance, as well as a [DBS barring referrals flowchart](#). NHS England's & NHS Improvement's Disciplinary Policies provide information on the procedures to be followed.
- 7.10 The best way to make a referral is with the DBS [secure online referral form](#), which includes on-screen guidance. Help and advice are also available from the DBS on 03000 200 190.

8 Record-keeping

- 8.1 The NSSO is responsible for ensuring records are kept of the following:
- the nature of the allegation or concern
 - who was interviewed, what statements and notes were taken, and when
 - any records that were seen and reviewed
 - the actions considered and the justification for specific decisions, including suspension and any actions taken under the NHS England or NHS Improvement Disciplinary Policy
 - the alternative actions that were explored
 - minutes and actions of all meetings that took place.
- 8.2 This information will be held until the individual concerned reaches the age of 79, or until 6 years after their death, whichever is longer (in accordance with NHS England & NHS Improvement [Documents and Records Management policy](#)). A record-keeping checklist is provided in Appendix 3.
- 8.3 All records should be saved in a secure area, not on personal drives. Folders should be restricted to appropriate personnel on the shared drive.
- 8.4 It is important that:
- files are named appropriately
 - a retention period is applied
 - records are saved in an agreed area, and security measures applied, since they will contain personal information
 - emails are stored securely: emails can constitute records, and therefore form a critical part of the investigation.

- 8.5 All organisations that process personal data are required to comply with the Data Protection Act 2018 and EU General Data Protection Regulation (GDPR). This came into force in May 2018 and strengthens personal data protection for all individuals within the European Union – and in the UK, after Brexit. The [GDPR Guidance](#) published by the Information Governance Alliance contains useful information on how the GDPR applies to the processing of personal data by health and social care organisations.

9 Post-investigation review

- 9.1 Following the completion of the initial investigation, the NSSO will lead a review of the case and any actions taken.
- 9.2 Recommendations from the review will be implemented, and information disseminated to the appropriate people, both within the organisations and to local safeguarding forums.
- 9.3 The staff member concerned should be fully supported throughout their integration back into the workplace once the investigation is complete if this is appropriate. The staff member may be offered on-going support through Occupational Health.

10 Monitoring

- 10.1 The National Safeguarding Steering Group will monitor compliance with this policy, through the Regional Safeguarding Leads.
- 10.2 The Head of Safeguarding is responsible for the monitoring, revision and updating of this policy, on behalf of the Chief Nursing Officer (CNO) and will update the CNO on its implementation.
- 10.3 This policy will be monitored regularly to ensure that it complies with equality and diversity requirements.

11 Equality and health inequalities analysis

- 11.1 Promoting equality and addressing health inequalities are important to NHS England and NHS Improvement. In developing this policy, we have:
- considered the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the [Equality Act 2010](#)) and those who do not share it
 - considered the need to reduce inequalities between patients in access to, and outcomes from, healthcare services, and in ensuring that

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services are provided in an integrated way where this might reduce health inequalities.

Appendix 1:

Definitions of 'at risk', 'harm' and 'relevant conduct'

Definition of people at risk

Safeguarding means protecting a person's right to live in safety, free from abuse and neglect. All staff within NHS England & NHS Improvement have a responsibility to safeguard people in their care, but extra care must be taken to protect those who are least able to protect themselves. Children and young people, and vulnerable adults, can be at particular risk of abuse or neglect.

A child is a person aged under 18 years; young people aged 16 or 17 who are living independently are still defined as 'children'.

A vulnerable adult is someone who may be in need of care because of a physical, learning or other disability, or because of their age or an illness. This definition also applies to an adult who is unable to take care of him or herself properly, or who is unable to protect him or herself from significant harm or exploitation.

Some groups of people are particularly vulnerable to harm and exploitation, and it is important that their needs are carefully considered:

- those with disabilities
- those living away from home
- asylum seekers
- children and young people in hospital
- children in contact with the youth justice system
- victims of domestic abuse
- those who may be singled out due to their religion or ethnicity
- those who may be exposed to violent extremism.

Definitions of harm: Children

Physical harm

Physical harm is defined as physical contact that results in discomfort, pain or injury. It may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm.

Supplying drugs to children, or the use of inappropriate or unauthorised methods of restraint, also fall under this definition.

Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces or causes, illness in a child. This situation is commonly described as 'factitious illness by proxy' or 'Munchausen syndrome by proxy'.

Emotional and psychological harm

Emotional harm is defined as action or inaction by others that causes mental anguish. It involves the persistent emotional maltreatment of a child, which causes severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person.

Such harm may feature age or developmentally inappropriate expectations being imposed on a child. These can include interactions that are beyond the child's development capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction.

Emotional harm may also involve witnessing aggressive, violent or harmful behaviour towards another individual (e.g. domestic violence). It may also involve serious bullying, frequently causing a child to feel frightened or in danger, exploitation or corruption.

Some level of emotional harm is involved in all types of maltreatment of a child (e.g. grooming, harassment, or inappropriate emotional involvement), though it may occur alone.

Sexual harm and exploitation

Sexual harm is defined as any form of sexual activity involving a child under the age of consent. It involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening.

Such activities may involve physical contact, including penetrative (e.g. rape, buggery or oral sex) or non-penetrative acts. They may also include non-contact activities, such as involving children in the looking at, or production of, pornographic material, causing them to watch sexual activities, or encouraging them to behave in sexually inappropriate ways.

Downloading child pornography, taking indecent photographs of children, and sexualised texting, are all forms of sexual harm.

Neglect and acts of omission

Neglect is a persistent failure to meet a child's basic physical and/or psychological needs, which is likely to result in serious impairment of the child's health or development.

Neglect may occur during pregnancy as a result of maternal substance abuse.

Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment)
- protect a child from physical and emotional harm or danger
- ensure adequate supervision and/or adequate care-givers
- ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Female Genital Mutilation (FGM)

Female genital mutilation (FGM) is a procedure where the female genitals are deliberately cut, injured or changed, without medical justification. It is also known as 'female circumcision' or 'cutting', and by other terms such as initiation, infibulation, sunna, gudniin, halalays, tahur, megrez and khitan.

FGM is usually carried out on young girls between infancy and the age of 15, most commonly before puberty starts. It is very painful and can seriously harm the health of women and girls. It can also cause long-term problems with sex, childbirth and mental health.

It is estimated that 65,000 girls aged 13 and under are at risk of FGM in the UK. UK communities most at risk include Kenyan, Somalian, Sudanese, Sierra Leonean, Egyptian, Nigerian and Eritrean. Non-African countries that practise FGM include Yemen, Afghanistan, Kurdistan, Indonesia, Malaysia, Turkey, Thailand (South) and Pakistan.

FGM is a form of child abuse and is illegal in the UK. It is a mandatory duty for a regulated healthcare professional to report any concerns they have about a female under 18 years old, and to record when FGM is disclosed or identified as part of NHS healthcare. This is a personal duty: the individual professional who becomes aware of the case must make a report, and the responsibility cannot be transferred.

The Home Office's [Multi-agency Statutory Guidance on Female Genital Mutilation](#) offers comprehensive information on FGM; [Mandatory Reporting of Female Genital Mutilation: procedural information](#) gives guidance on when and how to report a case of FGM.

Relevant conduct: Children

A child is a person under 18 years of age.

Any behaviour involving a child is classed as 'relevant conduct' if it:

- endangers a child, or is likely to endanger a child
- if repeated against, or in relation to, a child, would endanger the child or be likely to endanger the child

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- involves sexual material relating to children (including the possession of such material)
- involves sexually explicit images depicting violence against human beings (including the possession of such material)
- includes any behaviour of a sexual nature involving a child.

A person's conduct endangers a child if it:

- harms a child
- causes a child to be harmed
- puts a child at risk of harm
- makes an attempt to harm a child
- incites another person to harm a child.

A person's conduct satisfies the 'harm test' if they are thought likely to:

- harm a child
- cause a child to be harmed
- put a child at risk of harm
- make an attempt to harm a child
- incite another person to harm a child.

Definitions of harm: Vulnerable adults

Living a life that is free from harm and abuse is a fundamental human right, and essential for health and well-being. The safeguarding of adults is about their safety and well-being, and puts measures in place for those least able to protect themselves.

Physical harm

Physical harm is any physical contact that results in discomfort, pain or injury.

Examples of physical harm include:

- assault, rough handling, hitting, slapping, punching, pushing, pinching, shaking, bruising or scalding
- exposure to excessive heat or cold
- a failure to treat sores or wounds
- inappropriate use of medication (e.g. under- or overuse of medication, or the use of un-prescribed medication)
- the use of inappropriate sanctions
- the unlawful or inappropriate use of restraint or physical interventions
- the deprivation of liberty.

Sexual harm and exploitation

Examples of sexual harm and exploitation can include the direct or indirect involvement of the vulnerable adult in sexual activity or relationships that:

- they do not want or have not consented to
- they cannot understand, and cannot consent to, since they lack the mental capacity
- they have been coerced into because the other person is in a position of trust, power or authority, e.g. a care worker.

Sexual harm can involve bruising or injury to the anal, genital or abdominal area, and the transmission of STD. It also includes inappropriate touching.

Being forced to watch sexual activity is also a form of sexual exploitation.

Psychological and emotional harm

This is behaviour that causes mental distress or has a harmful effect on an individual's emotional health and development. It can include:

- mocking, coercing, bullying, verbal attacks, intimidation or harassment
- demeaning, disrespectful, humiliating, racist, sexist or sarcastic comments, shouting, swearing or name-calling
- excessive or unwanted familiarity
- the denial of basic human and civil rights such as self-expression, privacy and dignity
- negating the right of the vulnerable adult to make choices
- undermining the individual's self-esteem
- isolation and over-dependence that has a harmful effect on the person's emotional health, development or well-being
- the use of inflexible regimes and lack of choice.

Neglect

Neglect occurs when a person's well-being is impaired because his or her care or social needs are not met.

Examples of neglect include:

- the failure to allow access to appropriate health, social care and educational services
- the failure to provide adequate nutrition, hydration or heating, or access to appropriate medication
- ignoring medical or physical needs, e.g. untreated weight loss, or a lack of care that results in pressure sores or uncharacteristic problems with continence
- poor hygiene, e.g. lack of general cleanliness or soiled clothes not being changed

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- the failure to address the vulnerable individual's requests.

Neglect can be intentional or unintentional. Intentional neglect can include:

- wilfully failing to provide care
- wilfully preventing the vulnerable adult from getting the care they need
- being reckless about the consequences of the person not getting the care they need.

Unintentional neglect can include:

- a carer failing to meet the needs of the vulnerable adult because they do not understand their needs
- a carer lacking knowledge about the services that are available
- a carer's own needs preventing them from being able to give the care the person needs
- an individual being unaware of, or lacking an understanding of, the possible effect on the vulnerable adult of a lack of action.

Discrimination

Discrimination exists when values, beliefs or culture result in a misuse of power, or the denial of rightful opportunities, so causing harm.

Any psychological abuse that is racist, sexist, or linked to a person's sexuality, disability, religion, ethnic origin, gender, culture, or age, is discriminatory.

Institutional harm

Examples of institutional harm can include:

- an observed lack of dignity and respect in the care setting
- the enforcement of rigid routines
- processes and tasks being organised to meet the needs of staff rather than those in their care
- disrespectful language and attitudes.

Financial harm

Financial harm is the use of a person's property, assets, income, funds or other resources without their informed consent or authorisation. It includes:

- theft
- fraud
- exploitation
- unauthorised withdrawals of funds from an account
- undue pressure in connection with wills, property, inheritance or financial transactions
- the misuse or misappropriation of property, possessions or benefits

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- the misuse of an enduring power of attorney, or a lasting power of attorney, or an appointeeship.

Domestic violence and self-harm should also be considered as possible indicators of, and/or contributory factors to, harm or abuse.

Relevant conduct: Vulnerable adults

A vulnerable adult is a person aged 18 years or over who is receiving a service or assistance which is classed as regulated activity for adults.

Any behaviour is classed as 'relevant conduct' if it:

- endangers a vulnerable adult or is likely to endanger a vulnerable adult
- if repeated against, or in relation to, a vulnerable adult, would endanger the vulnerable adult or be likely to endanger them
- involves sexual material relating to children
- involves sexually explicit images depicting violence against human beings (including possession of such images)
- is of a sexual nature involving a vulnerable adult.

A person's conduct endangers a vulnerable adult if it:

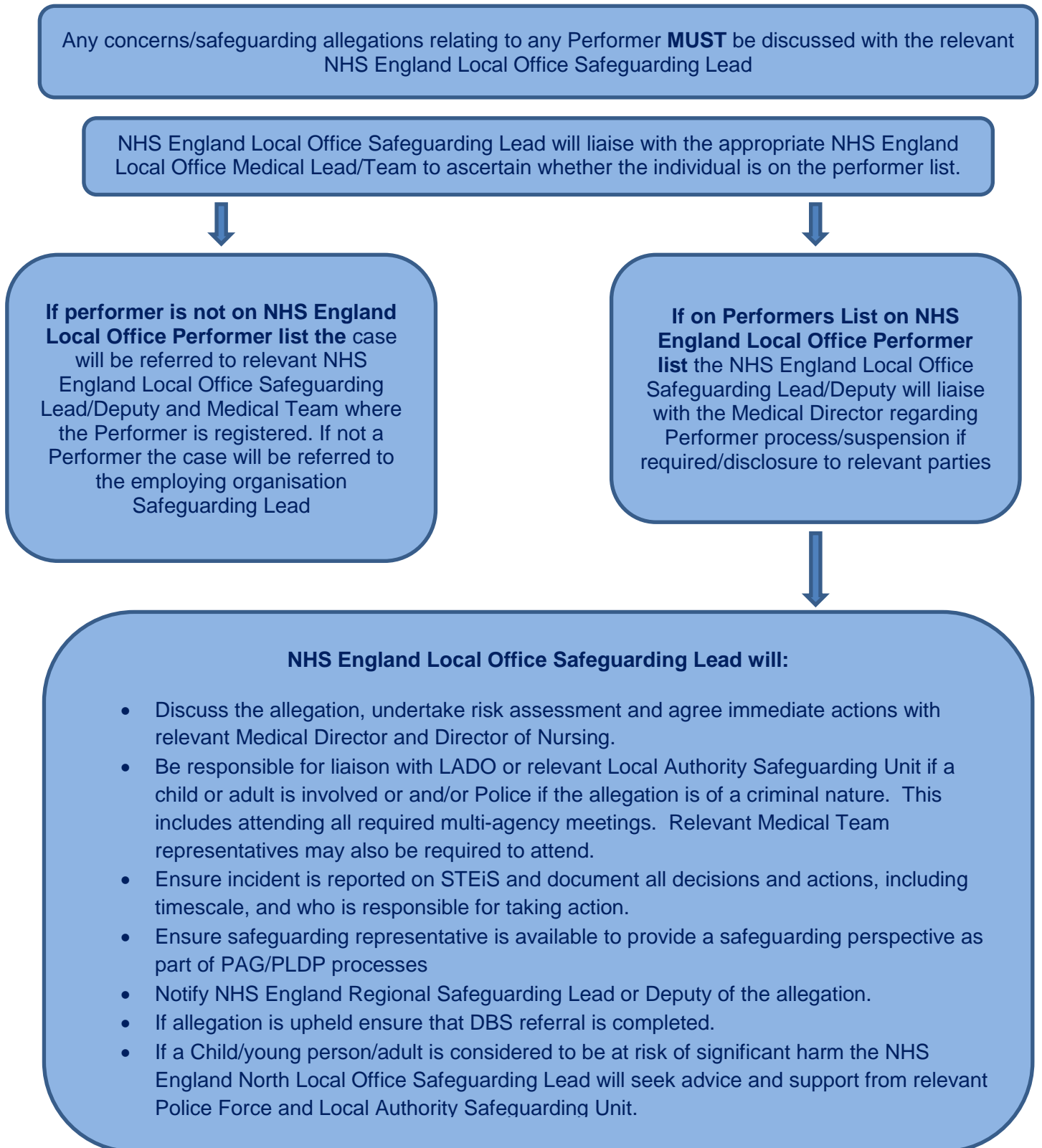
- harms a vulnerable adult
- causes a vulnerable adult to be harmed
- puts a vulnerable adult at risk of harm
- makes an attempt to harm a vulnerable adult
- incites another person to harm a vulnerable adult.

A person's conduct satisfies the 'harm test' if they are thought likely to:

- harm a vulnerable adult
- cause a vulnerable adult to be harmed
- put a vulnerable adult at risk of harm
- make an attempt to harm a vulnerable adult
- incite another person to harm a vulnerable adult.

Appendix 2: Managing Allegations Process Flowchart

Process for managing safeguarding allegations involving Performers



Appendix 3: Record-keeping checklist

The Nominated Safeguarding Senior Officer (NSSO) will be responsible for ensuring that records are kept throughout the investigation of the allegation or concern. This checklist reflects the information needed, but is not exhaustive:

- The nature of the allegation/concern
- Who was spoken to, and when, as part of the process, and what statements/notes were taken
- What records were seen and reviewed
- Why specific decisions/actions were taken, including suspension and any actions taken under the NHS England or NHS Improvement Disciplinary Policy
- The alternative action that were explored
- Minutes and actions of all meetings that take place

This information will be held until the employee reaches the age of 79, or 6 years after death, whichever is the longer period.

Investigation	Key contact	Evidence collected
Clarify and record the nature of the allegation	StEIS completed <input type="checkbox"/> LADO contacted <input type="checkbox"/> Police contacted <input type="checkbox"/> Social Care contacted <input type="checkbox"/> Human Resources contacted <input type="checkbox"/> Performance manager contacted <input type="checkbox"/> Lead Director contacted <input type="checkbox"/>	Date..... Name of contact.....
Statements and notes		Date..... Record where documents are stored
Actions taken Record alternatives considered and why		Date..... Record where documents are stored
Minutes and records of all relevant meetings		Date..... Record where documents are stored