Safeguarding Adults Policy and Reporting Procedure for

East Coast Community Healthcare CIC staff

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Issued: August 2016
Review Date: August 2018

DOCUMENT CONTROL SHEET

Name of Document:	**Safeguarding Adults at Risk of Abuse and Neglect Policy**
Description of document	This policy sets out to establish a system which in conjunction with Norfolk Multi-Agency Safeguarding Adults Policy and Procedures and the Suffolk Adult Safeguarding Policy And Operational Guidance (Part 1 & 2) will enable prevention as well as provide a clear process for recognising, reporting and responding to incidents of adult abuse and/or neglect.
Version:	**7**
Date of this version:	**August 2016**
Produced by:	**Safeguarding Team: East Coast Community Healthcare CIC**
Reviewed by:	**Virtual Policy Review Group**
Associated Documents	Norfolk Multi Agency Safeguarding Adults Policy Norfolk Multi Agency Safeguarding Adults Procedures Suffolk Adult Safeguarding Policy and Operational Guidance (Part 1 & 2) ECCH Mandatory Training Policy ECCH Record Keeping Standards ECCH Incident Management Policy ECCH SUI Policy ECCH Consent Policy ECCH Mental Capacity Policy ECCH Deprivation of Liberty Policy ECCH PREVENT Policy
CQC Regulation	Regulation: 9, 10, 11, 12, 13, 17, 20
Synopsis and Outcomes of Consultation Undertaken:	
Synopsis and Outcomes of Equality & Diversity Impact Assessment	**No adverse impact**
Ratified by (committee):	**Integrated Governance Committee**
Date ratified:	**August 2016**
Distribute to:	**All ECCH staff, NHS Great Yarmouth & Waveney Clinical Commissioning Group and stakeholders**
Date due for review:	**August 2018 or earlier in light of new legislation or guidance**
Enquiries to:	**Safeguarding Lead/Named Nurse**

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INTRODUCTION

This policy applies to all East Coast Community Healthcare CIC (referred to as ECCH) staff (including temporary, bank and locum staff). In addition this policy applies to any providers commissioned or contracted by ECCH.

Within this policy 'adult' refers to an individual aged 18 years or over.

Under Section 42 of the Care Act 2014, Safeguarding duties apply to an adult who meets the following **three stage test:**

- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

An adult who meets the above criteria is referred to as an 'adult at risk'. Safeguarding duties also apply to family carers experiencing intentional or unintentional harm from the adult they are supporting or from professionals and organisations they are in contact with.

Previous references to 'Vulnerable Adult' have been replaced by the new term 'Adult at risk'. Chapter 14 of the Care Act 2014 Statutory Guidance, upon which the fundamental principles of this policy are based, has replaced the 'No Secrets' Guidance (DH 2000).

The Care Act Guidance can be found at:

https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation

STATEMENT OF COMMITMENT

Safeguarding adults is a responsibility for all staff, doing nothing is not an option.

ECCH recognises that the protection of adults at risk of abuse and neglect is paramount and that all staff working for ECCH have a duty of care whilst individuals are in its care. Furthermore, all service users have the right to feel safe and protected from any situation or practice that results in them being harmed or at risk of harm.

ECCH is committed to proactively promoting the safety, health, wellbeing and protection of all adults in its care in order that they can achieve their maximum potential. ECCH staff will proactively prevent abuse and neglect occurring and respond appropriately if abuse/neglect are identified, suspected or disclosed.

ECCH staff will work in partnership with other agencies, patients and their carers on the issues of safeguarding adults at risk. Staff should be alert to vulnerability and actively consider, by continuous and rounded assessment, how they can reduce the risk of harm occurring in the first instance.

ECCH follows the procedures and protocols of the Norfolk and Suffolk County Council as lead agencies in protecting adults and the policies and guidance issued by Norfolk and Suffolk Safeguarding Adults Boards (SAB).

In order to support the above, ECCH as an organisation and its staff will:

- Actively work within the agreed multi-agency framework of the Norfolk and Suffolk Safeguarding Adults Boards.
- Endeavour to provide safe and effective delivery of services that facilitate the prevention and early detection of abuse and/or neglect.
- Where preventative strategies fail, ensure all staff respond effectively to such abuse and/or neglect.
- Actively support the rights of the individual to lead an independent life based on self-determination and personal choice.
- Recognise the on-going duty of care to service users who perpetrate abuse and facilitate any necessary action to address abusive behaviour.
- Maintain effective dialogue to ensure collaboration between agencies, including sharing information as appropriate in line with the Norfolk & Suffolk Information Sharing Protocol to safeguard adults at risk.
- Fully contribute to safeguarding assessments and concerns of abuse and/or neglect in accordance with the joint policy and operational procedure.
- Contribute fully to Safeguarding Adult Reviews (SAR) as necessary or required by the Safeguarding Adults Boards.
- Have robust systems in place so that staff are familiar with the Safeguarding Adults Policy and Procedure and the need for a proactive approach to prevent abuse and neglect.
- Collect data to enable monitoring and analysis of information, in accordance with good practice and government requirements.
- Audit and evaluate practice, and provide reports as required to the appropriate bodies, to ascertain how well ECCH is fulfilling its responsibilities to safeguard adults.
- Adhere to rigorous recruitment practices to deter those who actively seek vulnerable people to exploit or abuse.
- Have a workforce development plan in place that includes appropriate competencies for staff and volunteers in relation to safeguarding adults work.
- Ensure proactive links are maintained with other systems designed to protect other groups (e.g. Domestic Violence and Child Protection).

AIM OF THIS POLICY

This policy aims to explain the responsibilities all employees have for safeguarding adults and identify the procedures by which his must be done. To this end all employees of ECCH must:

- Promote the wellbeing, security and safety of adults at risk consistent with their rights, capacity and personal responsibility, and prevent abuse or neglect occurring wherever possible.

- Understand the process for reporting safeguarding adult incidents and concerns
- Use the safeguarding principles to shape the strategic and operational delivery of services in ECCH.
- Use the established governance system to ensure the process of reporting, investigation and subsequent action is as effective as possible in achieving good outcomes for adults at risk.
- Comply with The Care Act 2014, 'No Secrets' Guidance (2000), the Care Quality Commission's Essential Standards of Quality and Safety Outcomes Framework (2009), and ECCH's quality and risk policies and procedures.

RATIONALE

This Policy and reporting procedure has been informed by the following documents and standards:

Relevant Documents

The Care Act 2014 requires that all agencies have policies and procedures in place to effectively respond to known or suspected abuse of adults at risk.

The Norfolk and Suffolk Social Services joint policies and operational procedures are the main policy documents and should be read in conjunction with this policy.

These documents can been found at:

http://www.norfolksafeguardingadultsboard.info/assets/NSAB-Policy/NSAB-Multi-Agency-POLICY-SEPT2015-FINAL1.pdf

and

http://www.suffolkas.org/assets/Publications/Policies-and-Procedures/Safeguarding-Policy-Home-Page/Suffolk-Safeguarding-Adults-Policy-and-Operational-Guidance.pdf

Additional reference to and use has been made of the following documents:

- the eleven good practice standards in the Association of Directors of Social Services 'Safeguarding Leads' - A National Framework of Standards for Good Practice (2005);
- Chapter 14 of the Care Act 2014 on safeguarding service users from abuse and/or neglect.
- Department of Health (2011) Safeguarding Adults: The Role of Health Service Practitioners.

Relevant Standards

This policy and reporting procedure has been produced to support the following standards:

- Care Quality Commission (2010): Essential standards of quality and safety Outcome 7

The context of Safeguarding Adults
In 2000, the Home Office produced a guidance document called 'No Secrets' which recognised the vulnerability of some adults and offered guidance to professionals providing community care services to them and their carers.

No Secrets states that:

> *All vulnerable adults are to be protected from abuse and supported in seeking treatment and redress in the event that they have been abused. Agencies and organisations will work co-operatively on the identification, investigation, treatment and prevention of abuse of vulnerable adults.*

The No Secrets guidance was further strengthened as it reflected The Human Rights Act 1998, which underpinned the duty on public agencies to intervene proportionately to protect the rights of citizens. These rights included:

- Article 2: the right to life
- Article 3: freedom from torture (including humiliating and degrading treatment) and
- Article 8: the right to family life (one that sustains the individual)

Further protection has been afforded to vulnerable adults through the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009.

All staff working with adults at risk should have an understanding of these Acts and incorporate the principles into their everyday professional practice.

Following the Francis Report (2013), the Care Act 2014 has placed safeguarding adults and Safeguarding Adult Boards on a statutory basis, with duties to cooperate over the supply of information and rights to access to advocacy.

The Care Act 2014 created a duty of candour on providers about failings in hospital and care settings with a new offence for providers of supplying false or misleading information, in the case of information they are legally obliged to provide.

KEY PRINCIPLES

ECCH will adhere to the Government agreed safeguarding principles that provide a basis to achieve good outcomes for patients:

Principle 1 – Empowerment: Presumption of person led decisions and consent.

Principle 2 – Protection: Support and representation for those in greatest need.

Principle 3 – Prevention: Prevention of neglect, harm and abuse is the primary objective.

Principle 4 – Proportionality: Proportionate and least intrusive response to the risk presented.

Principle 5 – Partnership: Local solutions through services working in their communities.

Principle 6 – Accountability: Accountability and transparency in delivering safeguarding.

In additional to the above application of this policy must be informed by the good practice principles listed in Appendix 1.

KEY DEFINITIONS AND CONCEPTS

The purpose of safeguarding adults at risk is to prevent, detect and manage the risk of abuse or neglect of an adult, particularly where there is an increased level of vulnerability (either permanent or transitory).

Abuse
Abuse is:

> '…*the violation of an individual's human and civil rights by any other person or persons'* (Department of Health, 2000, 2.3).

In giving substance to the statement above, staff are reminded to give consideration to a number of factors including:

> '*Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.*' (Department of Health, 2000, 2.6).

Abuse occurs in all sections of society and there should be no discrimination because of assumptions about class, gender, age, disability, sexual orientation, race, religion, culture or eligibility for services.

Abuse concerns the misuse of power, control and/or authority and can be perpetrated by an individual, a group or an organisation. It may be intentional or unintentional

It is important to remember that any adult can become vulnerable to abuse and neglect, at any time.

Safeguarding Alert
A safeguarding alert is when a member of staff informs their senior colleague/supervisor/manager and/or the Safeguarding Team of an allegation or suspicion of actual or potential abuse or neglect.

When an alert becomes a referral: An alert becomes a referral when a 'concern' about a person is deemed to be a 'risk of potential abuse' and requires further enquiry by way of a referral for safeguarding procedures to take effect. At this point, the MASH will have decided that it meets the Safeguarding Threshold.

Safeguarding Referral
A safeguarding referral is when a member of staff takes the concern about the suspected or actual abuse/neglect of an adult at risk outside of the organisation to Adult Social Services (lead agency) for further investigation.

Significant harm
There is no definition of the degree of abuse of an adult at risk that requires intervention. However, in determining how serious or extensive abuse or neglect must be to justify intervention, No Secrets (DH 2000) suggests that a useful starting point can be found in

Who Decides? Building on the concept of 'significant harm' introduced in the Children Act (1989), the Law Commission suggested that harm:

> 'should be taken to include not only ill-treatment (including sexual abuse and forms of ill-treatment which are not physical), but also the impairment of physical or mental health; and the impairment of physical, intellectual, emotional, social or behavioural development.'
>
> (Who Decides? Lord Chancellor's Department 1997)

Adult at risk
An adult at risk is defined as:

> *Any person aged 18 or over and at risk of abuse or neglect because of their needs for care and support, and is experiencing, or is at risk of, abuse or neglect, and as a result of those needs is unable to protect him or herself against the abuse or neglect or the risk of it.*
>
> The Care Act 2014

Staff are reminded that vulnerability is not a rigid concept and applies to a wide range of disabilities and situations, including those adults at risk because of their caring role or family responsibilities. 'Safeguarding adults' highlights the range of adults at risk, including those experiencing domestic violence, substance misuse, honour based violence and homelessness.

The intent of the abuse or neglect is likely to inform the type of response. For example, it is important to recognise unintentional abuse or neglect and this may include considering the impact of stress on a carer's ability to care for another person.

Depending on the circumstances the appropriate response where unintentional abuse takes place could be a support package for a carer, but in another circumstance in which safeguarding concerns arise from harm suffered as a result of abuse/neglect which was intended to cause harm then it would be necessary to consider whether to refer the matter to the police to consider whether a criminal investigation would be required or appropriate.

Section 42 Enquiry
The Section 42 Enquiry is carried out by the person/s designated to do so within the agency/ies or organisation/s assigned to investigate. The investigator organises and collects information about the concern and the context in which it happened in order and produces a report with recommendations.

Where the adult at risk has mental capacity to undertake an interview, they are usually the first person to be interviewed as part of the Section 42 Enquiry. The safety of the adult is paramount. Their confidentiality will be respected, except where information needs to be shared to protect them or others (duty of care overrides right to confidentiality). See Information Sharing section.

As part of the Initial Enquiry there will be active consideration, in consultation with the police and in some cases with legal services, of the potential use of relevant legislation. The police will make a decision as to whether an Achieving Best Evidence interview is necessary; this should be carried out as soon as possible.

TYPES AND POSSIBLE INDICATIONS OF ADULT ABUSE AND NEGLECT

ECCH has adopted the categories of abuse and neglect referred to in the Care Act 2014 to aid understanding and reporting of abuse and neglect (see Appendix 2 for more information): The categories are:

- Physical
- Sexual
- Psychological/Emotional
- Financial or Material
- Discriminatory
- Neglect or acts of omission*
- Institutional/Organisational
- Self Neglect

* Under the *Mental Capacity Act 2005* wilful neglect and ill treatment become a criminal offence.

In addition to the types of abuse defined in the Care Act 2014, there are also a range of related issues that may lead to abuse or neglect of an adult at risk.

These include:

- Domestic abuse/violence
- Radicalisation
- Forced marriage
- Female Genital Mutilation (FGM)
- Honour based violence
- Adult sexual exploitation
- Modern day slavery
- Hate Crime

Whilst there are specific pathways to manage these issues, where the person at risk meets the criteria for adult safeguarding, a safeguarding adult referral should always be considered. Advice on managing these complex cases should be sought from the ECCH Safeguarding Team.

It is recognised that an individual may suffer more than one type of abuse or neglect and there is overlap between different types of abuse/neglect.

Some general indicators which may suggest abuse and/or neglect include:

- Appearing frightened, stressed, agitated, withdrawn or subdued
- Unexplained changes in behaviour or mood
- Dehydration, malnourishment
- Unusual weight gain or loss
- Poor sleep patterns
- Fear of leaving/going home
- Money or possessions going missing
- Making inappropriate comments
- Unkempt or neglected appearance, inappropriate/soiled clothing
- seeking shelter or protection
- unexplained reactions towards particular settings
- frequent or regular visits to the GP, or hospital casualty department, or hospital admissions
- frequent or irrational refusal to accept investigations or treatments for routine difficulties
- inconsistency of explanation
- Evidence of improper use of medication
- Unexplained injuries (bruises, cuts, burns, wounds)

For more details see Appendix 2.

Detailed information and guidance on all aspects relating to Safeguarding Adults can be accessed on ECCHO by referring to the 'Safeguarding' Section.

MAKING SAFEGUARDING PERSONAL

Safeguarding should be person-led and outcome focused, engaging the adult at risk in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. In most cases this can only happen by making sure people get the care and support that they need. It is also important that the people who care for them also get this support and recognition. Most importantly it is about listening and providing the options that permit individuals to help themselves.

The Care Act 2014 makes it explicit that the adult at risk must be at the centre of the safeguarding process. People who are subject to safeguarding procedures have the right to be involved as fully as possible in all aspects of the process. People should be given relevant information (including ECCH or multi-agency safeguarding leaflets) and assisted to identify and negotiate what outcomes they want and influence the process that professionals follow throughout the safeguarding process.

Any person making a report of abuse/neglect should be listened to, their information acted upon, and wherever appropriate they should be informed about the outcome. People should also be informed of their rights to advocacy, including potential access to an Independent Mental Capacity Advocate (IMCA) where relevant to assist them in being actively involved in leading their own safeguarding assessments and planning.

The adult at risk and their families have the right to advice, support for human rights, protection of the law, access to the civil and criminal justice system, and access to independent translation services (non family), victim support services and advocacy services, in order to support their voice being heard in the safeguarding adult process.

The safeguarding process should be experienced as empowering and supportive – not as controlling and disempowering.

SAFEGUARDING ADULT BEST PRACTICE GUIDANCE MATRIX

The East Anglia and Essex Adult Safeguarding Forum 'Adult Safeguarding Best Practice Guidance' document provides guidance to assist staff in making decisions about safeguarding adults within their organisations (See Appendix 3 for information on Safeguarding Adults Best Practice Guidance Matrix).

TRAINING

All ECCH staff must attend Safeguarding Adult basic awareness training at induction. This training is a mandatory requirement and must be updated every three years.

In addition ECCH will:

- ensure all staff receive publications and information to aid alerting and referring adult abuse/neglect concerns
- ensure that relevant staff with management responsibilities receive additional training. The aim of additional training has two functions:

    1. to enable staff with management responsibilities to embed prevention and adult safeguarding in their services and work practices

    2. to support managers who have responsibility for supervising staff/volunteers in the on-going investigation of alleged abuse or neglect of adults at risk.

RESPONSIBILITIES

Achieving positive outcomes for adults subject to abuse and/or neglect or suspected of being at risk of harm or abuse/neglect is dependent on everyone carrying out their responsibilities. The specific responsibilities for Heads of Service, the Safeguarding Lead/Named Nurse, the Deputy Named Nurse Safeguarding Adults, individual members of staff and the Education and Training department are set out in Appendix 4.

CAPACITY AND CONSENT

Any intervention to protect an adult at risk must be carried out with the consent of the adult concerned, unless they are unable to give consent or their consent is over-ridden by a duty to protect them and/or others.

Therefore all interventions by ECCH staff must be:

- lawful
- proportionate to the risk
- respectful of the wishes of the person at risk

Where an adult lacks the capacity to safeguard themselves, other people (and this may include ECCH staff) will need to make those decisions.

If ECCH staff are taking actions and/or decisions to keep an individual, who lacks the capacity to safeguard themselves, safe they will:

- act in a way that is necessary to promote the adult at risk health or well-being or to prevent deterioration to their quality of life
- ensure that an appropriate level of safety is provided for an adult at risk if an intervention is put in place
- ensure that the ascertainable past and present wishes and feelings of the adult concerned are taken into account. And that those wishes were not made as a result of undue influence
- ensure that the adult at risk is encouraged and supported to the fullest extent possible to participate in any decision made which affects them.

In considering whether to disclose information staff should consider the merits of each case however, certain considerations will need to be taken in all cases:

- extent of the information which is to be disclosed – it will be easier to justify disclosure of demographic data or the fact that someone attended a clinic rather than detailed health information

- the nature and impact of the crime or harm justifying the disclosure - it will be easier to justify disclosure of information relating to a physical attack against a person than it would be for shoplifting

- whether the disclosure is for detection or prosecution of crime or harm to others or whether it is preventative - it may be more justifiable to disclose information to support prosecution in relation to a crime that has occurred than to prevent a crime which has not yet occurred

Individuals will be assumed to have the capacity to make informed decisions, unless there is clear evidence to the contrary. Adults at risk should be supported to make their own decisions based on an awareness of the choices available.

In cases where there is evidence that an adult lacks capacity to make specific decisions, where appropriate, provision will be made to find a suitable independent person to represent their 'best interest'.

In all instances where a person demonstrates a lack of capacity in relation to a specific area or decision, everything which is done by ECCH staff must be based upon an assessment of that person's best interests (see the ECCH Mental Capacity Act 2005 Policy for more information).

CULTURAL AWARENESS AND ADULT SAFEGUARDING

When providing services to people from minority groups such as those from the Travelling Community and minority ethnic groups, it is important to acknowledge that any failure to recognise their cultural, religious and ethnic diversity may be interpreted as abuse, since it denies the individual their own personal history and identity. It is also important to be aware of the racism and discrimination that people from minority ethnic communities may have experienced and to try and work proactively to meet the individual's needs. Discrimination such as racism at either an organisational, personal or societal level can make identification and disclosure, referral and response difficult for the abused person, their family carers and social networks.

Relevant issues may be:

- Previous experience of racism or discrimination
- Reluctance to approach public authorities about any issue, due to distrust or fear
- Anxiety about having to deal with officials in English, which may not be a preferred or first language

Language difficulties and lack of familiarity with local procedures may lead to a reliance on family members to act as intermediaries in everyday life.

Disclosure about a family member may therefore be all the more difficult for that individual. Good practice would promote the use of an independent interpreter or translator or trusted advocate. Care should be taken to ensure that a supporter such as this is aware of the importance of confidentiality both within the client relationship and between the client and their community.

The intricate and complex nature of extended family relationships can exacerbate the need for the adult at risk to have an opportunity to talk openly in private; therefore, where possible, every effort should be made to speak to the person in an appropriate setting.

RECEIVING A DIRECT DISCLOSURE OF HARM, ABUSE OR NEGLECT

Guidance on how staff should respond if they receive a direct disclosure of harm, abuse or neglect is given in Appendix 5.

PROCEDURE WHEN ABUSE/NEGLECT IS DISCLOSED OR SUSPECTED

Staff must always take any concern seriously, however insignificant it may seem.

Staff do not have to witness the actual abuse or neglect before making an alert. Always make an alert, regardless of whether the harm was intentional or unintentional.

When abuse/neglect is disclosed/suspected staff are advised to:

- treat the allegation seriously and keep an open mind
- remain calm and listen carefully
- be sympathetic, supportive and non-judgemental
- gather as much information as possible without asking any leading questions (use words like 'tell, explain, describe')
- not press for more information as this may be done during a subsequent investigation
- Be aware of the need to protect, and not contaminate evidence
- Ask the person what they would like to do about what has happened
- reassure the person that actions will be taken
- Ensure the person is safe - If there is an immediate threat contact emergency services.
- Consider - are there any other people (including children) at risk?

ECCH staff **must not** investigate the allegation/suspicion themselves. Once a referral has been received, Adult Social Services and where appropriate the Police will investigate further.

Staff should not:

- Contact or confront the person you think is responsible for the abuse/neglect
- destroy or move any possible evidence
- start to investigate the situation

Further guidance on how staff should respond to suspected abuse or neglect is given in Appendix 6.

Staff are reminded of their responsibilities to protect any possibility of forensic evidence if the disclosure refers to a recent incident (see Appendix 7 - Preserving Evidence).

WHAT CONSTITUTES 'ABUSE' AND NEGLECT?

The seriousness or extent of abuse/neglect is often not clear when anxiety is first expressed. As already stated, it may be a one-off incident or multiple events.

Once reported, Social Services will take the lead in co-coordinating an investigation, including making a judgment on the level of intervention required, based on the details of the case.

If in doubt, staff must '*err on the side of caution'* and alert and discuss their concerns with a colleague.

MAKING A REFERRAL OF ALLEGED, SUSPECTED, ACTUAL OR POTENTIAL ABUSE / NEGLECT

The safeguarding adult alerting and referral procedure is set out in Appendix 6. **This process MUST be followed by all staff.**

The ECCH Safeguarding Team can be contacted during office hours (9 – 5) for advice and support, but all staff should ensure their line manager is informed of their intention to do this.

The alerting and referral procedure involves the following steps:

Step 1
Adult abuse/neglect is disclosed or suspected

Step 2
Check if the adult at risk is in immediate danger and/or needs urgent medical attention. Check if urgent Police / Ambulance presence is required. Check if anyone else is at risk (child or adult).

If the answer is yes to any or all of the above questions, the member of staff must call 999 and take steps to ensure the immediate safety and welfare of the alleged victim and protect any forensic evidence (see Appendix 7).

After contacting the Police and ambulance service for immediate assistance, a safeguarding referral to Social Services must be made as set out below at Step 4.

Step 3 ***Alerting***
If the adult at risk is not in immediate danger, the staff member must *alert* at the first opportunity a senior colleague/supervisor/manager and/or the Safeguarding Team about their concerns.

In making an assessment of the need for a safeguarding referral the following factors should be considered:

- the vulnerability of the individual
- the nature and extent of the abuse/neglect

- the length of time it has been occurring
- the impact on the individual
- the risk of repeated or increasingly serious acts involving this or other adults deemed at risk.

For advice and guidance in office hours (9-5) contact the Safeguarding Team. Outside of office hours contact ECCH's On-Call Manager or Social Services. See Appendix 10 for contact details.

Step 4
To make a referral, ring Norfolk **or** Suffolk County Council (see Appendix 10 for contact telephone numbers).

See Appendix 9 for a checklist of what information to include in the referral.

In deciding which authority to contact, the location of the alleged or suspected abuse/neglect is the deciding factor, e.g. an individual who is an inpatient in Suffolk discloses abuse/neglect by a family member at their home address in Norfolk, in this case the referral is made to Community Services, Norfolk Social Services.

Step 5
The staff must enter in the patient record details of the safeguarding referral and all future discussions/actions in relation to the safeguarding concern.

For services using patient-held records, see the Record Keeping section on page 18.

Step 6
A DATIX Incident Form ***must*** be completed by the member of staff who made the safeguarding alert / referral and submitted in the normal way (via the Datix system).

Step 7
If the Safeguarding Team has not already been informed it is the responsibility of the member of staff who has made the safeguarding referral to do this as soon as possible but always within 24 hours of the referral. Out-of-hours the On-Call Manager ***must*** be informed that a referral has been made.

Step 8
If not updated by Social Services on the outcome of the referral it is the responsibility of the member of staff who made the referral to follow this up.

For Norfolk: If not updated on the outcome of the safeguarding referral after 48 hours the member of staff must ring back to request an update.

For Suffolk: If not updated on the outcome of the safeguarding referral after 72 hours the member of staff must ring back to request an update from the Senior Safeguarding Practitioner (see Appendix 10 for contact details).

All follow-up actions must be recorded in the patient record.

The member of staff must inform the ECCH Safeguarding Team of any updates / developments.

Step 9
A Strategy Meeting is part of the safeguarding adult procedures.

If invited to attend a Strategy Meeting the referring staff member must make every effort to attend. As the referrer it is very important that you attend as you will have important information about the individual and their circumstances. If the referrer is unable to attend (annual leave or sick leave) the ECCH Safeguarding Team must be advised of this at the first opportunity so alternative arrangements can be discussed.

Only in exceptional circumstances would non-attendance at a Strategy Meeting be acceptable for staff working normally. For guidance on what is understood to be exceptional circumstance speak with the ECCH Safeguarding Team.

RECORD KEEPING

High quality record keeping in accordance with ECCH record keeping standards is essential in safeguarding adult work.

ECCH staff must ensure that their actions, communications and information they give and receive are recorded contemporaneously in the correct documentation.

ECCH staff need to identify the correct place and method of documentation with their line manager to ensure an audit trail of decision-making in safeguarding adult cases.

The following must be recorded in the patient record:

- the nature of the disclosure/concern
- where consent was given to make the safeguarding referral. If consent was not given on what basis was the referral made
- time the referral was made
- any other action taken to protect the adult at risk (including others if necessary) and
- the full name of the person receiving the referral.

All entries ***must*** start with the prefix 'SGA – [dash]'. The prefix ***must*** be in capital letters.

If a safeguarding referral was NOT made at this time this must be recorded in the patient record giving reasons why.

For services using patient-held records a new separate set of records must be started. These records are to be held in accordance to ECCH Record Keeping standards at the staff member's base.

SAFEGUARDING CONCERNS INVOLVING A MEMBER OF ECCH STAFF 'WHISTLEBLOWING' – RAISING AND ESCALATING CONCERNS

If the allegation of abuse/neglect concerns a member of ECCH staff, the staff member raising the concern must follow ECCH's 'Whistleblowing Policy' and speak directly with the Safeguarding Team at the first opportunity.

ECCH will always act on such concerns when raised. However, ECCH has a specific duty to act when they are about:

- Inappropriate care given to a patient(s), client(s) or resident(s)
- Unlawful conduct
- Financial malpractice
- Dangers to the public or the environment
- Other behaviour inappropriate to ECCH's policies

When raising an adult abuse or neglect concern, no distinction should be made between staff and other persons. The adult at risk's wellbeing is paramount.

If the allegation concerns the staff member's manager (e.g. they are implicated or colluding with the alleged abuse/neglect) the member of staff must raise the alert directly with the Safeguarding Lead. See Appendix 8 for details.

CONFIDENTIALITY AND INFORMATION SHARING

Information held by ECCH about an individual is subject to the legal 'duty of confidence' and should not normally be disclosed without the consent of the persons who have provided the information or who are the subjects of the information.

The Care Act 2014 states that the government expects organisations to share information about individuals who may be at risk from abuse or neglect.

A key aspect of protecting an adult at risk is striking a balance between the right to confidentiality and the right to be protected from harm. The purpose of information sharing in the context of safeguarding an adult at risk is to provide an effective service or protect a person from harm, danger, abuse and neglect.

Staff are reminded that confidentiality ***must never*** be confused with secrecy.

In the context of safeguarding an adult at risk the public interest in maintaining confidentiality can be overridden by the public interest to protect vulnerable persons. This may include information sharing with the adult at risk, referrer, family members and other agencies where appropriate.

When receiving a request to share information for the purposes of safeguarding an adult at risk staff must take the following steps:

1. Clarify the identity/person making request and why they require the information.

2. Check and call them back to confirm they are who they say they are.

3. Clarity what information is being requested.

4. Clarity with whom this information may be shared with other than the person making the request.

5. Record all conversations etc. in the patient's record.

In addition to the above actions ECCH staff ***must*** abide by the following 'Seven Golden Rules' for information sharing:

1. **Remember that the Data Protection Act 1998 is not a barrier to sharing information** but provides a framework to ensure that personal information about people 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 the information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

3. **Seek advice if you are in doubt,** without disclosing the identity of the person where possible. Contact ECCH's Caldicot Guardian, (Director of Quality and Primary Care); or the Safeguarding Team for advice.

4. **Share with consent where appropriate** and respect the wishes of those who do not consent to share confidential information. **You may still share information without consent if, in your judgement, that the lack of consent may 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.

Staff are reminded of their responsibilities under:

- The Public Interest Disclosure Act (1998). This supports all workers' rights to disclose evidence under a range of important circumstances
- The Data Protection Act 1998 provides a framework to ensure that personal information is shared appropriately.

If the adult at risk does not have capacity to consent, is disclosure in their best interest? Information disclosed or seen cannot be withheld where this compromises safety. The disclosure of information in these circumstances needs to be managed professionally and sensitively.

If contacted by a colleague from a partner agency (e.g. police, social services) for information about an adult at risk staff should <u>always</u>:

- Never make a disclosure decision on your own, always discuss it with a senior colleague/your manager.

- Ask for the caller's main switchboard number.
- Ring main switchboard, confirm identify of caller and ask for contact details.
- Confirm appropriate response with your senior colleague/manager.
- Contact caller, check if the person is entitled to the information and share information on a 'need to know' basis.

In relation to safeguarding an adult at risk, information must be shared as timely as possible – do not delay a response.

Staff are reminded that the Duty of Confidence exists beyond death.

ABUSE BY ANOTHER ADULT AT RISK

Where the person causing the harm is also an adult at risk, the safety of the person who may have been abused is paramount.

If the carer of an adult at risk has any of the following problems, it may increase the risk and likelihood of an abusive situation:

- alcoholism
- mental illness
- stress
- chronic fatigue
- frequent medical consultation

However, ECCH may also have responsibilities towards the person causing the harm. The person causing the harm may themselves be eligible to receive an assessment and care. In this situation it is important that the needs of the adult at risk who is the alleged victim are addressed separately from the needs of the person causing the harm.

It will be necessary to reassess the adult allegedly causing the harm. This could involve participating in a network meeting with partner agencies.

MARAC (MULTI AGENCY RISK ASSESSMENT CONFERENCE)

MARAC is a formal multi-agency meeting to consider and safely plan for the highest risk victims of domestic abuse, their children and adults at risk living in the household. The purpose of MARAC is for partner agencies to attend and share relevant and proportionate information on those victims identified as being at a 'high' level of risk of serious harm or homicide and thereafter jointly constructing a management plan to provide professional support to all those at risk within the family.

The purpose of MARAC is to:

- Share relevant information to increase the safety, health and well being of victims – adults and their children;
- Determine whether the perpetrator poses a significant risk to any particular individual or to the general community;

- Construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm;
- Reduce repeat victimisation;
- Improve agency accountability; and Improve support for staff involved.

ECCH nominated individuals who will have access to the information provided at MARAC, and attend MARAC on behalf of ECCH are; Safeguarding Lead/Named Nurse and the Deputy Named Nurse Safeguarding Children/Adults.

Information shared at MARAC will be kept in a confidential and appropriately restricted manner and must not be shared with other agencies without the permission of the agencies attending that MARAC.

To raise MARAC concerns and to report issues contact the ECCH Safeguarding Team.

RADICALISATION – THE PREVENT STRATEGY

Radicalisation is not included as an abuse type in the Care Act 2014 Guidance. It is however important to include it within this policy to raise awareness and provide operational guidance to staff. The Prevent Strategy (Home Office 2011) recognises that the presence of key vulnerabilities such as Learning Disabilities, autism or Mental Health problems can increase an individual's susceptibility towards radicalisation and to be influenced by extremism.

Prevent is part of the Government's counter-terrorism strategy which aims to identify individuals who may be susceptible to exploitation into violent extremism by radicalisers. Prevent focuses on ensuring that vulnerable individuals are safeguarded from being drawn into extremism or terrorism. The Department of Health has worked with the Home Office to develop guidance for healthcare organisations to implement Prevent local, called 'Building Partnerships, Staying Safe.'

All ECCH staff have a responsibility to help the organisation to fulfil its obligation to minimise risks by identifying individuals who may be prone to exploitation or influence from violent extremism by following the Prevent programme.

Healthcare workers have the potential to:

- meet and treat someone who is succeptible to radicalisation.
- receive information that allows them to correctly identify signs that someone has been or is being drawn into terrorism.
- prevent someone from becoming a terrorist or supporting terrorism as it is substantially comparable to safeguarding in other areas.
- identify people who could be considered to be "at risk".

A workshop to raise awareness of Prevent (WRAP) is available to all ECCH staff to provide a better understanding of Prevent, reporting procedures, multi-agency counter terrorism arrangements and indicators of what makes someone vulnerable or susceptible to radicalisation.

Example indicators that an individual may be engaged with an extremist group, cause or ideology include:

- Increasingly spending time in the company of other suspected extremists;
- Changing their style of dress or personal appearance to accord with the group;
- Their day to day behaviour increasingly centred around an extremist ideology, group or cause;
- Loss of interest in other friends and activities not associated with the extremist ideology, group or cause;
- Possession of material or symbols associated with an extremist cause (e.g. the swastika for far right groups);
- Attempts to recruit others to the group/cause/ideology; or
- Communications with others that suggest identification with a group/cause/ideology.

Example indicators that an individual has an intention to use violence or other illegal means include:

- Clearly identifying another group as threatening what they stand for and blaming that group for all social or political ills;
- Using insulting or derogatory names or labels for another group;
- Speaking about the imminence of harm from the other group and the importance of action now;
- Expressing attitudes that justify offending on behalf of the group, cause or ideology;
- Condoning or supporting violence or harm towards others;
- Plotting or conspiring with others.

NB. The examples above are not exhaustive and vulnerability may manifest itself in other ways. There is no single route to terrorism nor is there a simple profile of those who become involved. For this reason, any attempt to derive a 'profile' can be misleading. It must not be assumed that these characteristics and experiences will necessarily lead to individuals becoming terrorists, or that these indicators are the only source of information required to make an appropriate assessment about vulnerability.

Anyone who has concerns about someone who may be at risk of exploitation or influence from violent extremism should take action as per the Prevent Flowchart in Appendix 11.

Further advice and guidance can be obtained from the Safeguarding Team and the ECCH Prevent Policy on ECCHO.

Any concerns re the above issues need to be reported through the ECCH Prevent Lead within the Safeguarding Team.

HONOUR BASED VIOLENCE (HBV)

The terms "honour crime", "honour based violence" or "*izzat*" embrace a variety of crimes of violence (mainly but not exclusively against women) and behaviours, where a person is being punished by their family and/or community.

The individual is being punished for actually, or allegedly, undermining what the family or community believes to be the correct code of behaviour. By showing that they have not been properly controlled to conform, the individual brings “shame” or “dishonour” on the family.

HBV is associated with issues such as dress code, choice of friends, fear of or actual forced marriage, career choice, relationships with members of the opposite sex and kissing in public. Such issues impact upon a family’s honour and therefore can lead to violence and abuse. Examples of HBV may include murder, unexplained death (suicide), controlling sexual activity, domestic abuse (including psychological, physical, sexual, financial or emotional abuse), child abuse, rape, kidnapping, false imprisonment, threats to kill, assault, harassment and forced abortion.

This list is not exhaustive. Such crimes cut across all cultures, nationalities, faith groups and communities. They transcend national and international boundaries.

"Honour Based Violence" can be distinguished from other forms of violence, as it is often committed with some degree of approval and/or collusion from family and/or community members.

Forced marriage is a marriage in which one or both spouses do not or (in the case of some adults with learning or physical disabilities) cannot consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and/or emotional pressure. *An arranged marriage is very different to a forced marriage and the two should not be confused*. An arranged marriage is an established tradition where a spouse is suggested by the families of the prospective bride and / or groom; however, the choice to go ahead with the marriage remains with the bride and groom.

When considering issues of concern related to honour based violence, members of staff need to be aware of the ‘one chance’ rule. That is, they may only have one chance to speak to the potential victim and thus only one chance to save a life.

It is important for staff to be aware of triggers and warning signs which may be apparent in HBV cases. These can include:

- Truancy
- Decline in performance or punctuality
- Withdrawal from education
- Not authorised to attend extra curricular activities
- Self harm / attempted suicide
- Eating disorders
- Depression
- Isolation
- Substance misuse
- Family disputes
- Running away
- Female genital mutilation
- Lack of money – financial control

INITIAL RESPONSE TO REPORTS / SUSPICIONS OF HONOUR BASED VIOLENCE IDENTIFICATION

A victim of HBV will have overcome immense cultural barriers to have reported HBV. A report may be made by a friend of the victim. Any member of staff having a concern about HBV must raise this immediately with their line manager and if safe to do so with the victim and ensure the victim's safety appropriately.

Staff must take seriously the threats to the victim's safety and offer support.

Staff must ensure they speak to the victim alone to discover who is 'safe' to speak in front of; doing this in another room may not be sufficient to encourage a victim to speak freely so alternatives may need to be considered.

Staff must not make any assumptions based upon culture; many cultures have extensive differences in small areas.

HBV: IMMEDIATE SAFEGUARDING CONCERNS

In all cases when responding to reports of HBV, the victim's immediate safety must be the overriding concern and ECCH staff must take the following steps:

- **Do not** turn the victim away
- **Do not** approach the victim's family or community leaders – this could heighten risk to the victim
- **Do not** share information with anyone without the express consent of the victim
- **Do not** attempt any form of reconciliation or mediation with the family.

If the victim is a child, contact the Deputy Named Nurse Safeguarding Children immediately for advice and guidance. Tel: 07917 262261

If the victim is an adult, contact the Deputy Named Nurse Safeguarding Adults immediately for advice and guidance. Tel: 07766 307261

HBV: RECORDING OF INFORMATION

Obtain as much information as possible concerning the risk to the victim. The DASH Risk Assessment Checklist (see Appendix 12) should be used as an initial risk indicator. A fuller risk management plan will be conducted later by specialist personnel.

If an interpreter is required ***always*** use a professional service, ***never*** use a friend, family member or member of the local community. Always brief and debrief the interpreter to ensure you are passed all information that the victim discusses and that the interpreter is clear on the need for confidentiality. Consider the gender of the interpreter, and if the victim is comfortable with this arrangement.

Ensure a full record is kept of who is aware of the incident (circle of knowledge), what information has been received by ECCH and from where, what options are discussed for immediate safeguarding, and what action is agreed.

HBV: SHARING AND GATHERING INFORMATION

In all cases where HBV is reported or suspected, the incident must be brought to the attention of the line manager as soon as possible.

Staff ***must*** ensure confidentiality – communities may present with concerns which seem genuine in an attempt to obtain information on what has been reported / where the victim is. Consider requesting a block on incident recording systems to protect the victim.

POSTHUMOUS REFERRALS

Where a safeguarding adult concern is raised regarding a deceased person (for example where the circumstances around the death are suspicious or allegations are made regarding issues of neglect, financial abuse or the proceeds of the estate) staff should make a safeguarding referral as though the person were still alive.

ECCH SAFEGUARDING COMMITTEE

Work to deliver ECCH's ongoing commitment to safeguarding individuals in its care will be supported by a safeguarding committee (SC). The SC will have its own terms of reference and will report to the Integrated Governance Committee (IGC). The role of the SC is to focus on any area of activity considered relevant to taking forward the safeguarding agenda within the organisation. Representatives from safeguarding children and adults (commissioning) will be invited to attend meetings of the SC at regular intervals, no less than once a quarter. The presence of commissioning representatives is to provide external scrutiny of the organisation's work to safeguard children, young people and vulnerable adults.

FAILURE TO ACT BY ECCH STAFF

Any member of ECCH staff found to have wilfully neglected their responsibilities as set out in this policy to raise a concern and/or make a referral about actual or potential harm or abuse/neglect to another individual may be subject to investigation of their actions/inactions and where appropriate be subject to ECCH's disciplinary procedure.

MONITORING ARRANGEMENTS

Monitoring of this policy will be established through audit in adherence to the requirements of the organisation's clinical governance arrangements. Staff's knowledge and compliance with the Policy will be through staff appraisals, and Staff Performance Development Reviews (PDRs). Compliance with this policy will be communicated to the general public via the Freedom of Information (FOI) procedure and through appropriate documents.

REFERENCES AND BILIOGRAPHY

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EAEASF (2015) *Adult Safeguarding Best Practice Guidance for NHS Services in East Anglia and Essex*. East Anglia and Essex Adult Safeguarding Forum.

Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry*. The Stationary Office: London.

National Domestic Violence Helpline - 0808 2000 247
http://www.nationaldomesticviolencehelpline.org.uk/

SCC (2004) *Vulnerable Adults Protection Committee: Inter-agency Policy, Procedures and Staff Guidance.* Suffolk County Council.

SCC (2008) *Adult Safeguarding Policy and Operational Guidance.* Suffolk County Council.

Suffolk Police website - Domestic Violence & Abuse Information:
http://www.suffolk.police.uk/safetyadvice/domesticabuse/whatisdomesticabuse.aspx

APPENDIX 1- KEY PRINCIPLES OF ECCH SAFEGUARDING ADULTS POLICY

In the application of this policy all staff must use the following good practice principles:

- Any vulnerable adult can be at risk of abuse and has a right to protection from abuse
- All reports of abuse will be treated seriously
- Staff who are working to protect an adult from the risk of abuse will make the dignity, safety and wellbeing of that individual a priority in their actions.
- All adult safeguarding work should aim to enable and support the maximum decision-making capacity of adults who experience abuse.
- The person who may be experiencing abuse should be given information, properly accessible to them, about the adult safeguarding process.
- Those who have experienced abuse will be offered the choice and support to participate, or have their views included, in all forums that are making decisions about their lives.
- Those who have or may be experiencing abuse should be offered contact with independent advocacy services.
- Information will only be shared with the person's consent or where there is an overriding justification (for example, to protect the individual from significant harm, to protect others from risk, to prevent a crime and on a need-to-know basis).
- The wishes of the person who may be experiencing abuse will be respected, unless there is a responsibility to override them. An individual's wishes cannot undermine ECCH's or an individual professional's legal duty to act eg if a crime has been committed.
- All decisions taken by ECCH staff about a person's life must be reasonable, proportionate and justified. Where ECCH staff have a duty to intervene to reduce risk, then that intervention should be proportionate to the risk facing the person.
- Any intervention in a person's life, including immediate protection and its outcome, should match the wishes, where known, of that person as closely as possible.
- ECCH and its staff will activity support and participate in the multi-agencies approach as detailed in the procedures and protocols of the Norfolk Local Authority and Suffolk Local Authority.
- Continuous feedback from staff and service users will be sought to improve of this policy and reporting procedure.

APPENDIX 2 - TYPES OF ABUSE / NEGLECT

An individual, a group or an organisation may perpetrate abuse. Most often the perpetrator is someone whom the adult already knows, such as a partner, a relative, a neighbour, a care worker, a social worker, a doctor, a nurse or another service user.

Abuse may take place in any setting. It may be domestic violence, harassment or hate crime.

As a result of abuse, harm is done which results in psychological, physical or emotional damage to a person from which they will need care and support to recover.

Physical abuse
Physical abuse is defined as the non-accidental infliction of physical force that results in bodily injury, pain or impairment.

Examples of behaviour include:
hitting, pushing, slapping, scalding, shaking, pushing, kicking, burning, scalding, pinching, hair pulling, poisoning, misuse of medication, unexplained inquiry, restraint (e.g. double sheeting, tying people up, clothes too tight, locked doors), use of inappropriate sanctions, inappropriate application of techniques or treatments, involuntary isolation or confinement, misuse of medication.

Note: inadvertent physical abuse may also arise from poor practice, e.g. poor manual handling techniques (see also neglect).

Some physiological processes/medical conditions can cause changes which are hard to distinguish from some aspects of physical abuse.

Possible signs and symptoms of physical abuse include:

- any injury not fully explained by the history given; injuries inconsistent with the lifestyle of the person; bruises and/or welts on body;
- clusters of injuries forming regular patterns burns (friction, rope or electric appliance)
- multiple fractures
- lacerations or abrasions
- marks on body
- misuse of medication

Sexual abuse
Sexual abuse is defined as direct or indirect involvement in sexual activity without valid consent. Consent to a particular activity may not be given because:

- a person has capacity and does not want to give consent
- a person lacks capacity and is therefore unable to give consent
- a person feels coerced into activity because the other person is in a position of trust, power or authority.

Examples of behaviour include:
Rape (vaginal and anal), sexual assault or sexual activity which the vulnerable adult does not want, could not consent to or was pressured into consenting including prostitution, pornography, masturbation, inappropriate touching, fondling, kissing, oral sex or sexualised language.

It is a person's human rights to have a sexual relationship with another person, of whatever sex, if they are able to understand what they are doing and both parties want this to occur.

Some possible signs and symptoms of sexual abuse include:

- significant change in behaviour (sexual or attitude)
- pregnancy
- wetting or soiling
- poor concentration
- withdrawn
- depressed
- unusual difficulty in walking or sitting
- torn, stained or bloody underclothing
- bruises (thighs or upper arms), unexplained marks
- bleeding, pain or itching in genital area
- STD & UTI vaginal infection
- severe upset/agitation when given personal care
- fluctuation of mood changes
- pain, bruising or bleeding in genital or anal areas

Emotional/psychological abuse

Emotional/psychological abuse is defined as the use of threats, humiliation, bullying, swearing and other verbal conduct, or any other form of mental cruelty that results in mental or physical distress. It includes the denial of basic human and civil rights, such as self-expression, choice, privacy and dignity. It can be verbal and non-verbal harassment.

Examples of behaviour include:

- humiliation
- blaming
- controlling
- intimidation
- coercion
- harassment
- deliberately misrepresentation of a person's behaviour or views
- infantilisation (treating an adult as if they were a child)
- 'cold-shouldering'
- isolating a person
- withholding pleasurable foods, activities, social contacts
- withdrawal from services or supportive networks.

Some possible signs and symptoms of psychological abuse include:

- withdrawal
- depression
- cowering and fearfulness
- sudden changes in behaviour
- deliberate self-harm

Financial or material abuse

Financial or material abuse is defined as the unauthorised and improper use of funds, property or any resources belonging to an individual.

Those who financially abuse may be people who hold a position of trust, power, and authority or has the confidence of the vulnerable adult.

Examples of behaviour include:

- theft
- fraud
- exploitation
- pressure in connection with wills, property inheritance or financial transactions
- misuse or misappropriation of property, possessions or benefits.

Some possible signs and symptoms of financial or material abuse include:

- unexplained sudden inability of vulnerable adult to pay bills or maintain lifestyle
- unusual or inappropriate bank account activity
- withholding money
- recent change of deeds or title of property
- unusual interest shown by family or other in the person's assets
- person managing financial affairs is evasive or uncooperative
- misappropriation of benefits and/or use of the person's money by other members of the household
- fraud or intimidation in connection with wills, property or other assets

Discriminatory abuse

Discriminatory abuse is defined as harassment, slurs or similar treatment because of a person's race, gender, age, culture, religion, ability, or choice of sexual partner. Not providing a person with the food, clothing, skin care, washing arrangements or worship that they require unequal treatment, verbal abuse, inappropriate use of language, slurs, harassment, deliberate exclusion.

Neglect and acts of omission

Neglect and acts of omission are defined as the repeated deprivation of assistance that the vulnerable adult needs for important activities of daily living, including a failure to intervene in behaviour which is dangerous to the vulnerable adult or to others, ie poor manual handling techniques.

Omission result in the quality of an individual's life being impaired because of an inability to respond appropriately to an individual's needs. This may relate to passive acceptance, or lack of awareness of inappropriate behaviour displayed by an individual. It can happen where there is a lack of will, strength or knowledge to deal with the situation.

Under the Mental Capacity Act 2005 wilful neglect and ill treatment became a criminal offence.

Example of neglect can include:

- ignoring medical or physical care needs
- failure to provide access to appropriate health and social care or educational services, e.g. failing to make sure that someone's eyes, ears, teeth and feet are checked regularly
- the withholding of essentials, such as medication, adequate nutrition and heating and information re sexual and reproductive health
- careless as well as deliberately poor care; for example: withholding assistance to use the toilet, not changing continence pads or failure to keep a vulnerable person warm and comfortable.

Some possible indicators of neglect include:

- poor hygiene
- malnutrition
- inappropriate clothing
- broken skin

Self-neglect

Self-neglect differs from the other forms of abuse listed here because it does not involve a perpetrator. The Care Act 2014 includes discussion of self-neglect and defines this by a wide range of behaviours including failing to care for one's personal hygiene, health or surroundings in such a way that causes, or is reasonably likely to cause significant physical, mental or emotional harm or substantial damage to or loss of assets. Self-neglect falls into the Safeguarding Adults remit when the adult meets the requirements of the three stage test.

Self-neglect can happen as a result of an individual's choice of lifestyle or the person may have:

- depression or other mental health condition,
- poor physical health,
- cognitive difficulties
- substance misuse

Possible indicators of self-neglect

- Living in grossly unsanitary conditions which endangers health and wellbeing
- Grossly inadequate self-grooming or personal care and/ or inappropriate or inadequate clothing.
- Maintaining an untreated illness, disease or injury or lacking eyeglasses, dentures, hearing aids, etc.
- Being malnourished or dehydrated to such an extent that, without intervention, the adult's physical or mental health is likely to be severely impaired
- Creating severely hazardous living conditions that will likely cause serious physical harm to the adult or others or cause substantial damage to or loss of assets, such as severe hoarding, improper wiring, lack of indoor plumping or heating, infestation
- Managing ones assets in a manner that is likely to cause substantial damage to or loss of assets

If someone who is considered to be self neglecting is also considered to have capacity, they are entitled to refuse care, treatment and other health and social care recommendations.

For people where there is evidence of entrenched self-neglect but who are considered to have capacity, it is important that staff discuss with the Safeguarding Team to consider a coordinated approach to a multi-agency forum.

If a person does not have capacity to weigh up choices and to understand their potential consequences of self-neglect then the law allows interventions to be made to protect them from risk. If staff have these concerns they must be escalated to the ECCH Safeguarding Team.

Mental capacity can be assessed as an individual's ability to:

- **understand** information given to them to make a particular decision
- **retain** the information long enough to be able to make the decision
- **use or weigh up** the information to make the decision
- **communicate** their decision (by any means).

Self-harm
The scope of this policy does not include issues of risk associated with deliberate self-harm. However, it may be appropriate to address the concerns by raising an Safeguarding Alert if:

- The self-harm appears to have occurred due to an act(s) of neglect or inaction by another individual or service.
- There appears to be a failure by regulated professionals or organisations to act within their professional codes of conduct.
- Actions or omissions by third parties to provide necessary care or support where they have a duty either as a care worker, volunteer or family member to provide such care/ support.

Organisational / Institutional abuse
Organisational (Institutional) abuse can occur in any setting where things are arrange to suit staff instead of the user of the service, so it can even occur in someone's own home. Abuse can happen as a result of:

- poor care standards and practice
- inadequate staffing so that corners are cut because of the lack of time
- rigid routines which don't allow any choice
- a lack of training and awareness
- poor supervision

Examples of behaviour include:
inflexible routines set around the needs of staff rather than individual service users, e.g. requiring everyone to eat together at specified times, bathing limited to times to suit staff, no doors on toilets. These can arise through lax, uninformed or punitive management regimes. The behaviour is cultural, and not specific to particular members of staff.

Modern Slavery encompasses:

- Domestic Servitude - Employees working in private homes are forced or coerced into serving and/or fraudulently convinced that they have no option to leave.
- Sex Trafficking - Women, men or children that are forced into the commercial sex industry and held against their will by force, fraud or coercion.
- Forced Labour - Human beings are forced to work under the threat of violence and for no pay. These slaves are treated as property and exploited to create a product for commercial sale.
- Bonded Labour - Individuals that are compelled to work in order to repay a debt and unable to leave until the debt is repaid. It is the most common form of enslavement in the world.
- Child Labour - Any enslavement (whether forced labor, domestic servitude, bonded labor or sex trafficking) of a child.
- Forced Marriage - Women and children who are forced to marry another without their consent or against their will.

Staff should discuss with the Safeguarding Team and refer to the DASH Risk Assessment which can be found on http://www.dashriskchecklist.co.uk/index.php?page+dash-2009-model-for-practitioners

Any concerns about slavery, human trafficking, forced labour and domestic servitude must be reported to the police.

Domestic Abuse
The UK government's definition of domestic violence is:

> "*any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to psychological, physical, sexual, financial, emotional*."

Examples of domestic abuse

- Physical - Shaking, smacking, punching, kicking, presence of finger or bite marks, starving, tying up, stabbing, suffocation, throwing things, using objects as weapons, female genital mutilation (FGM), 'honour violence'.
- Physical effects are often in areas of the body that are covered and hidden (ie breasts and abdomen).
- Sexual - Forced sex, forced prostitution, ignoring religious prohibitions about sex, refusal to practise safe sex, sexual insults, sexually transmitted diseases, preventing breastfeeding.
- Psychological - Intimidation, insulting, isolating a woman from friends and family, criticising, denying the abuse, treating her as an inferior, threatening to harm children or take them away, forced marriage.
- Financial - Not letting the victim work, undermining efforts to find work orstudy, refusing to give money, asking for an explanation of how every penny is spent, making her beg for money, gambling, not paying bills.
- Emotional - Swearing, undermining confidence, making racist remarks, making a woman feel unattractive, calling her stupid or useless,eroding her independence.

Staff need to refer to the ECCH Safeguarding Team and refer to the DASH Risk Assessment:
http://www.dashriskchecklist.co.uk/index.php?page+dash-2009-model-for-practitioners

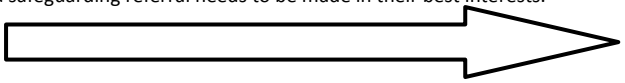
APPENDIX 3 - SAFEGUARDING ADULTS BEST PRACTICE GUIDANCE MATRIX

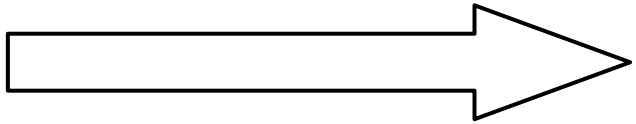
The matrix below contains examples of concerns with an indication of which safeguarding level they may fit into. The examples outlined are not an exhaustive list and do not provide an absolute definition. There will be cases that do not fit easily into a specific level and advice should be sought from your organisation's Adult Safeguarding Lead if there is any query as to which level a concern should be placed in. If in doubt and no expert safeguarding advice is available, complete a Safeguarding Adults referral.

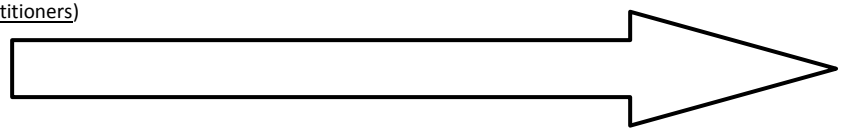
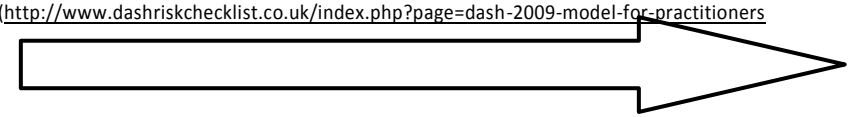
In addition all concerns must be reported in line with your organisation's internal escalation processes.

Every patient has the right to have their concerns reported through the correct procedures; this may include a safeguarding referral. If a patient does not have capacity to make this decision you must consider whether a safeguarding referral needs to be made in their best interests.

Type of Abuse	NOT SAFEGUARDING NORMAL CARE MANAGEMENT ISSUES	NOT SAFEGUARDING SERVICE IMPROVEMENT / QUALITY ISSUES	SAFEGUARDING REFERRAL MAY BE REQUIRED CONTACT YOUR SAFEGUARDING LEAD FOR DISCUSSION	SAFEGUARDING REFERRAL REFERRAL TO POLICE SHOULD BE CONSIDERED	SAFEGUARDING REFERRAL REFERRAL TO POLICE REQUIRED
PHYSICAL (FALLS)	• Isolated incident (risk assessment reviewed, associated care plan in place. • Risk assessment and associated care plan in place but is not being followed. There is no harm to the patient.	• One patient experiencing recurring falls whilst in a care setting or receiving care services (risk assessment reviewed, care plan reviewed, appropriate referral made to relevant health professional) and no harm has occurred • One off fall of more than one patient within the same care setting and no harm has occurred	• Fall where serious harm occurs whilst in receipt of care (e.g. fractured long bone). Consider referral as a serious incident if this meets the framework criteria.	• Fall causing serious or significant harm to person, leading to the need for medical intervention where there has been previous concerns identified • Previous concerns identified but not addressed by organisation • Insufficient prevention measures in place such as training, supervision & auditing • Numerous falls affecting more than one person from the same care setting or care provider requiring medical treatment.	• One fall causing catastrophic harm to one person possible-hospitalisation / irreparable damage / death where there has been previous concerns identified • Insufficient prevention measures for care providers in place such as training, supervision & auditing.
PHYSICAL	• Staff error causing no/little harm, e.g. superficial skin friction mark • Minor events that still meet criteria for 'incident reporting'	• Isolated incident involving service user on service user • Inexplicable very light marking found on one occasion	• Inexplicable marking or lesions, burns, cuts or grip marks on a number of occasions • Accumulation of minor injuries on one patient or within one working area e.g. ward, care home	• Inappropriate restraint • Inexplicable fractures/injuries to any part of the body that may be at various stages in the healing process	• Assault • Grievous bodily harm/assault leading to significant harm, irreversible damage or death

Type of Abuse	NOT SAFEGUARDING NORMAL CARE MANAGEMENT ISSUES	NOT SAFEGUARDING SERVICE IMPROVEMENT / QUALITY ISSUES	SAFEGUARDING REFERRAL MAY BE REQUIRED CONTACT YOUR SAFEGUARDING LEAD FOR DISCUSSION	SAFEGUARDING REFERRAL REFERRAL TO POLICE SHOULD BE CONSIDERED	SAFEGUARDING REFERRAL REFERRAL TO POLICE REQUIRED
PHYSICAL (PRESSURE ULCERS)	• Pressure damage with no evidence of neglect OR failure to provide adequate care or pressure relieving equipment. • Patient has capacity and makes an informed decision to decline treatment. A pressure ulcer develops.	• Pressure damage that meets the threshold of a serious incident should be reported. As part of the SI process, the following questions must be considered: 1. Has there been rapid onset and /or deterioration of skin integrity? 2. Has there been a recent change in medical condition e.g. skin or wound infection, other infection, pyrexia, anaemia, end of life care that could have contributed to a sudden deterioration of skin condition? 3. Have reasonable steps been taken to prevent skin damage? 4. Is the level of damage to the skin disproportionate to the patient's risk status for skin damage? e.g. low risk of skin damage with extensive injury. 5. Is there evidence of poor practice or neglect?	• Patient not risk assessed with regards to pressure ulcers risk and management and harm occurs • Failure to provide suitable pressure relieving equipment and harm occurs • Failure to follow the advice of clinical specialists and harm occurs • Pressure ulcers that have been investigated through the SI process and have found to be preventable AND the 5 questions outlined in box 2 have been considered. If this affects more than one patient, <u>Organisational Abuse should be considered</u>	As box 3. If this affects more than one patient, <u>Organisational Abuse should be considered</u>	• Patient not risk assessed with regards to pressure ulcers risk and management leading to catastrophic harm/possible hospitalisation/irreparable damage/death • Failure to provide suitable pressure relieving equipment / follow the advice of clinical specialists leading to catastrophic harm/possible hospitalisation/irreparable damage/death If this affects more than one patient, Organisational <u>Abuse should be considered</u>
MEDICATION	• Adult does not receive prescribed medication (missed/wrong dose) on one occasion and no harm occurs • Minimal harm to one person but robust prevention measures in place such as training, supervision & auditing	• Recurring missed medication or administration errors in relation to one service user that cause no harm and no on-going concerns • Prevention measures in place such as training, supervision and auditing	• One off medication error to more than one person - no harm caused • Recurring missed medication or errors that affect more than one adult and/or result in harm • Medication error causing serious or significant harm to person, leading to the need for medical intervention • Previous concerns identified / on-going ineffectiveness • Insufficient prevention measures in place such as training, supervision & auditing • Appearing to be over medicated	• Deliberate maladministration of medications • Covert administration without proper medical supervision	• Recurring errors ,or an incident of deliberate Maladministration, that results in ill-health or death. • Catastrophic harm to more than one person leading to hospitalisation/long term effects/death
SEXUAL	Every patient has the right to have their concerns reported through the correct procedures; this <u>may</u> include a safeguarding referral. If a patient does not have capacity to make this decision you must consider whether a safeguarding referral needs to be made in their best interests. 		• Isolated incident when an inappropriate sexualised remark is made to an adult and no or little distress is caused • Verbal sexualised teasing that causes offence NB: The individual should be offered a referral to the police	• One off or recurring sexualised touch or isolated/recurring masturbation without consent • Attempted penetration by any means (whether or not it occurs within a relationship)without consent • Sexual harassment • Sexualised relationship between staff and a service user	• Sex in a relationship characterised by authority, inequality or exploitation, e.g. staff and service user • Sex without consent/rape • Being made to look at pornographic material without consent • Being subject to indecent exposure

Type of Abuse	NOT SAFEGUARDING NORMAL CARE MANAGEMENT ISSUES	NOT SAFEGUARDING SERVICE IMPROVEMENT / QUALITY ISSUES	SAFEGUARDING REFERRAL MAY BE REQUIRED CONTACT YOUR SAFEGUARDING LEAD FOR DISCUSSION	SAFEGUARDING REFERRAL REFERRAL TO POLICE SHOULD BE CONSIDERED	SAFEGUARDING REFERRAL REFERRAL TO POLICE REQUIRED
FINANCIAL	All allegations of financial abuse should be discussed with the safeguarding team to establish if harm has been caused and a referral is required. 		• Adult's monies kept in a joint bank account – unclear arrangements for equitable sharing of interest • Adult denied access to his/her own funds or possessions • Staff/carers personally benefit from the support they offer service users, e.g. accrue 'reward points' on their own store loyalty cards when shopping • Adult not routinely involved in decisions about how their money is spent or kept safe – capacity in this respect is not properly considered	• Misuse/misappropriation of property, possessions or benefits by a person in a position of trust or control • Personal finances removed from adult's control	• Fraud/exploitation relating to benefits, income, property or will • Theft
NEGLECT (CLINICAL CARE PLANS)	• Person centred, evidence-based clinical care plan in place and being followed. Linked to appropriate risk assessment. NOT regularly reviewed but no harm occurs	• Clinical care plan not person centred, not linked to appropriate risk assessment. No harm. If this affects more than one patient consideration must be given to organisational abuse.	• Poor quality clinical care plans affecting one patient, causing harm or distress. • Previous concerns about clinical care plans not addressed locally.	• Poor quality clinical care plans leading to harm or distress to more than one patient – consideration must be given to possible organisational abuse	• Poor quality clinical care plans leading to catastrophic harm to one person possible-hospitalisation / irreparable damage / death • Poor quality clinical care plans causing significant harm to more than one person • Previous concerns identified significant concerns • Insufficient prevention measures in place such as training, supervision & auditing
NEGLECT (DISCHARGE FROM A CLINICAL SETTING)	• Deterioration of patient due to medical condition – all support services in place	• Poor discharge planning from a clinical setting leading to inconvenience but no harm or distress.	• Poor discharge from clinical setting leading to support services not being set up. Causes harm or distress to patient.	• Poor discharge planning from a clinical setting, failure to refer patient to appropriate support services, leading to significant harm.	• Poor discharge planning from a clinical setting, failure to referred patient to appropriate support services, leading to catastrophic harm/possible hospitalisation/irreparable damage/death
ORGANISATIONAL	CATEGORY INTENTIONALLY LEFT BLANK	• Lack of stimulation/opportunities for people to engage in social and leisure activities • Patient's views not sought, patient not involved in care planning process. • Denial of individuality and opportunities for patients to make informed choices and take responsible risks • Clinical care-planning documentation not person-centred	• Rigid/inflexible routines • Patients' dignity is undermined, e.g. lack of privacy during support with personal care needs • Continued concerns over culture of organisation • Clinical care-planning documentation not person-centred, advice given to organisation but no improvements made • Organisation does not have policies or practices that recognise or deal with safeguarding issues.	• Bad practice unreported and going unchecked • Unsafe and unhygienic living environments in a care setting	• Staff misusing their position of power over patients • Over-medication and/or inappropriate restraint used to manage behaviour within an institutional setting • Widespread, consistent ill treatment within an institutional setting
DISCRIMINATORY	• Isolated incident when an inappropriate prejudicial remark is made to an adult and no or little distress is caused	• Care planning fails to address an adult's diversity associated needs for a short period • Isolated incident of teasing motivated by prejudicial attitudes	• Inequitable access to service provision as a result of a diversity issue • Recurring taunts • Recurring failure to meet specific needs associated with diversity	• Being refused access to essential services • Denial of civil liberties, e.g. voting, making a complaint • Humiliation or threats	• Hate crime resulting in injury/emergency medical treatment/fear for life • Hate crime resulting in serious injury or attempted murder/honour-based violence

Type of Abuse	NOT SAFEGUARDING NORMAL CARE MANAGEMENT ISSUES	NOT SAFEGUARDING SERVICE IMPROVEMENT / QUALITY ISSUES	SAFEGUARDING REFERRAL MAY BE REQUIRED CONTACT YOUR SAFEGUARDING LEAD FOR DISCUSSION	SAFEGUARDING REFERRAL REFERRAL TO POLICE SHOULD BE CONSIDERED	SAFEGUARDING REFERRAL REFERRAL TO POLICE REQUIRED
PSYCHOLOGICAL	CATEGORY INTENTIONALLY LEFT BLANK	• Isolated incident where adult is spoken to in a rude or other inappropriate way – respect is undermined, but little or no distress is caused	• Treatment that undermines dignity and damages esteem • Denying or failure to recognise an adult's choice or opinion • Frequent verbal outburst • Withholding of information to disempower	• Humiliation • Emotional blackmail (threats of abandonment/harm) • Taunts or verbal outbursts that cause distress	• Denial of human rights/civil liberties • Prolonged intimidation • Vicious personalised verbal attacks
DEPRIVATION OF LIBERTY SAFEGUARDS	CATEGORY INTENTIONALLY LEFT BLANK	• Isolated incident of DoLs application not made in timely manner or conditions not being complied with • Isolated incident of a more restrictive method of control being used than is necessary	• Lack of policy or practices that recognise deprivation of liberty issues If this affects more than one patient, organisational abuse should be considered	• Restriction of liberty repeatedly unreported	• Restriction of liberty so significant that evidence of neglect or physical harm has occurred as described in the above categories
SELF-NEGLECT	• Patient has capacity and is making own choices about self-care	• Care plans do not appropriately support interventions to manage risk of self-neglect • Risks of self-neglect are not explored with the patient	If the patient does not have capacity and there is perceived harm or they are refusing interventions to prevent harm, this should be discussed with your organisation's safeguarding lead	If the organisation's approach to self-neglect is of concern, Organisational Abuse should be considered	If the organisation's approach to self-neglect is of concern, Organisational Abuse should be considered
DOMESTIC ABUSE	Refer to DASH risk assessment (http://www.dashriskchecklist.co.uk/index.php?page=dash-2009-model-for-practitioners) 			• Sexual, emotional, financial, or physical abuse from family members • Sexual, emotional, financial, or physical abuse from intimate or previously intimate partner	• Forced marriage • "Honour" violence
MODERN SLAVERY	NB: consideration of the safety of all members of the household or family MUST be made Discuss with safeguarding lead and refer to DASH risk assessment (http://www.dashriskchecklist.co.uk/index.php?page=dash-2009-model-for-practitioners  There is also a national Modern Slavery Helpline: 08000 121 700			CATEGORY INTENTIONALLY LEFT BLANK	• Any concerns about slavery, human trafficking, forced labour and domestic servitude must be reported to the police

APPENDIX 4 - RESPONSIBILITIES – INDIVIDUAL SERVICES

Each **Head of Service** within ECCH is required to:

- Ensure all staff have completed Safeguarding Adults training.
- Ensure all staff are given copies of the reporting protocol in diary card format. Diary cards can be obtained from the Safeguarding Team.
- Ensure all staff know how to seek advice on a safeguarding adult matter.
- Ensure all staff know how to make a safeguarding referral to the lead agency (Social Services).
- Identify staff who will need targeted awareness training beyond that contained in basic awareness training. Any additional training needs will be brought to the attention of the Safeguarding Team in the first instance.
- Identify staff required to receive enhanced training (i.e. those with management responsibilities in abuse/neglect cases) and bring this to the attention of the ECCH Safeguarding Team in the first instance.
- Ensure that all temporary and locum staff known how to report safeguarding adult concerns.
- Ensure that all staff have access, or know how to access information about safeguarding adults from the relevant Safeguarding Adult Board website.
- Ensure the that the safeguarding protocol (in poster format) is displayed prominently on all staff notice broads.
- Ensure that the contact details for the ECCH Safeguarding Team are displayed prominently on *all* staff notice broads.
- Ensure staff's knowledge and compliance with this Policy is examined and recorded as part of appraisals and Staff Performance Development Reviews (PDRs).

Safeguarding Lead/Named Nurse and the Deputy Named Nurse Safeguarding Adults

The ECCH Safeguarding Lead/Named Nurse and the Deputy Named Nurse Safeguarding Adults will:

- provide expert, evidence-based clinical leadership on all aspects of the Safeguarding Adults agenda to ECCH
- ensure that there are systems and processes in place for the protection of adults at risk across ECCH**,** working with partner agencies in line with Department of Health standards and legislation

- ensure the development and implementation of a ECCH plan for Safeguarding Adults that ensures the contribution to safeguarding is in line with national policy and guidance, is consistent across Great Yarmouth & Waveney and co-ordinated with Norfolk & Suffolk County Councils

- work in collaboration with the Norfolk and Suffolk Safeguarding Adults Boards and their sub groups and in line with jointly agreed local safeguarding adult policies

- maintain links with the commissioning body to assured them that the service is meeting its requirements to safeguarding adults

- maintain links into the Norfolk and Suffolk Safeguarding Adult Boards through identified representatives with the directorates.

All Staff

All ECCH staff (including temporary and locum staff) have the following responsibilities:

- to be vigilant to the possibility/presence of abuse and neglect of an adult at risk.

- to take seriously any allegation or suspicion of actual or potential abuse, however insignificant it may seem.

- to alert their senior colleague/supervisor/manager immediately or at the first opportunity of all allegations or suspicions/concerns of actual or potential abuse or neglect.

- to make a safeguarding adult referral if required.

- to seek whatever support they feel they need from their senior colleague/supervisor/manager and/or the Safeguarding Team.

- to follow the alerting/reporting procedure as in Appendix 4

- to complete a ECCH Datix Incident Form if required (available via Datix)

- to make a clear and factual record of the disclosure and actions taken. If patient-held records are used, staff must start a separate set of records to be held securely in the office

- to attend the safeguarding Strategy Meeting if required. If unavailable to attend, they must inform the ECCH Safeguarding Team at the first opportunity. If the ECCH Safeguarding Team is unavailable the member of staff will be directed to the appropriate designated person.

- to actively contribute to outcomes/protection plan.

- to ensure all relevant colleagues are informed of any actions appropriate to their service under the outcomes/protection plan.

- to actively support Adult Social Services and/or the Police in the investigation of adult abuse or neglect

If in doubt, staff should always alert/refer and not assume someone else already has. Failing to do so is a failure in their duty of care.

Training and Education Department

The Training and Education department will ensure that:

- there are a sufficient number of Safeguarding courses throughout the year
- records of all staff attending training are maintained and accurate
- provide information on safeguarding adult activity as and when requested

Multi-Agency Safeguarding Hub (MASH)

The lead role for the coordination of Safeguarding Adults alerts and referrals lies with the MASH. The main advantage of the MASH is that professionals can share the information their agency may have on an adult at risk immediately in a way that is confidential, proportionate and secure.

Sensitive and confidential information will never leave the 'safety' of the MASH team but it will help inform decision making. Adult and Community Services staff within the MASH pass on these decisions and information to the Adult Protection Team or clusters for enquiry or other relevant input as necessary.

Adult Protection Team (APT)

The Adult Protection Team's main role is to undertake Section 42 Enquiries where there is reasonable cause to suspect abuse has occurred. The APT primarily investigates allegations of abuse that have been given a medium or high risk rating by the MASH (with neighbourhood clusters investigating lower risk allegations).

The APT aims to provide a professional, proportionate social work service to adults at risk who are subject to Section 42 Enquiries in often complex and challenging situations. They will support adults at risk to complete and implement customer focused protection plans where appropriate.

The APT also has responsibility for guiding practitioners in cluster teams with Section 42 Enquiries when required alongside offering support to other agencies with safeguarding issues relating to adults at risk.

APPENDIX 5 - RESPONDING TO A DIRECT DISCLOSURE OF HARM OR ABUSE

Do:

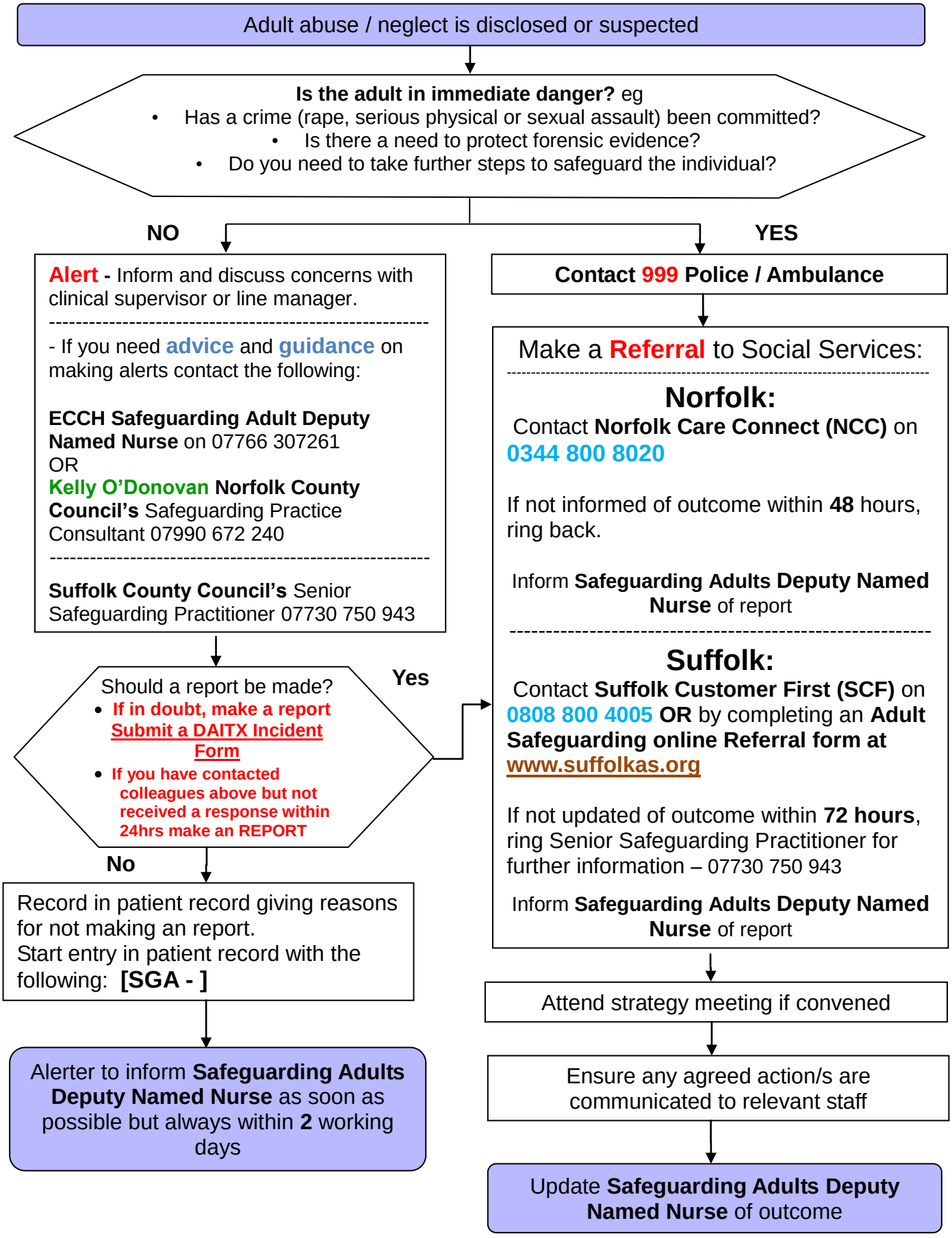
- remain calm and try not to show any shock or disbelief;
- listen very carefully to what you are being told;
- demonstrate a sympathetic approach by acknowledging regret and concern that this has happened to them;
- reassure the person by telling them:
  - they have done the right thing by sharing the information with you;
  - you are treating the information seriously;
  - the abuse is not their fault (if the information is being shared by the 'victim');
- be aware of the possibility of forensic evidence if the disclosure refers to a recent incident; (see **Preserving Evidence)**;
- explain that you are *required* to share the information with your line manager/team leader and/or the Safeguarding Adults Lead, but not with other staff or service users.
- reassure the person that any further investigation will be conducted sensitively and with their full involvement, wherever possible;
- reassure the person that steps will be taken to support and, where appropriate, protect them in the future;

- alert your line manager and the Safeguarding Adults Lead, or the person acting in this role in their absence, immediately;
- refer to ECCH's 'Whistleblowing Policy' or contact the Safeguarding Adult Lead if you believe that management within your organisation are implicated or colluding with the alleged abuse, or are not taking it seriously;
- make a written record of what the person has told you; (see **Record Keeping);**
- bear in mind that you may feel the need to air your feelings about what you have reported. Your line manager will advise you about available support;

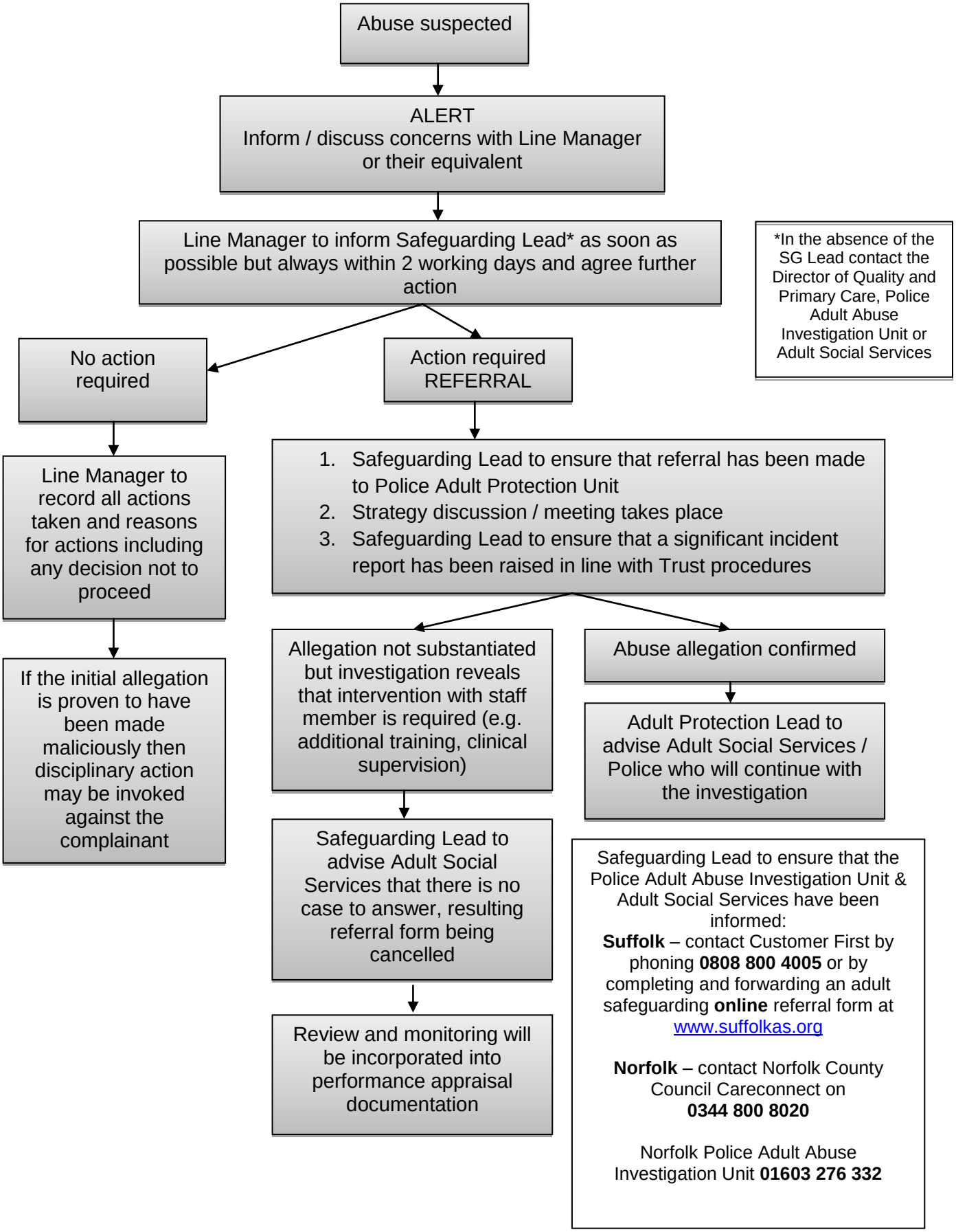
Do Not:

- stop someone who is freely recalling significant events; allow them to share whatever is important to them;
- ask questions or press the person for more details (this may be done during any subsequent investigation, so it is important to avoid unnecessary stress and repetition for the person concerned). This may also invalidate any evidence if required for a prosecution;
- promise to keep secrets;
- make promises you are unable to keep;
- contact the alleged 'perpetrator' or alleged 'victim' (unless you have no choice because they make contact with you);
- be judgmental (e.g. '*why didn't you try and stop them?*');
- break the confidentiality agreed between the person disclosing the information, yourself and your line manager/Safeguarding Adults Lead. Do not talk to anyone else about the information shared with you (e.g. 'It's awful, you'll never guess what I've just been told').

APPENDIX 6 - SAFEGUARDING ADULTS – SUSPECTED ADULT ABUSE: STAFF GUIDE



APPENDIX 7 - ALLEGATION OF ABUSE AGAINST A MEMBER OF STAFF



Appendix 8 Checklist of what to include in a Safeguarding Adults Referral:

- Name of person being referred
- Gender/Address/age & DoB/language/race/cultural background
- Details of vulnerable adult's physical and or mental disability or illness / details of any communication difficulties
- Is an interpreter required?
- Place/date/time of alleged abuse
- Type and description of alleged abuse – physical – sexual – psychological – financial/material exploitation – neglect or acts of omission – discriminatory – institutional abuse/poor professional practice
- What was observe/exactly what was said - can a verbatim quote be given? [do not change the alleged victim's own words]
- Is the vulnerable adult at risk from – an individual, a group, an organisation?
- Details of alleged abuser (name & address) if known/Does the alleged abuser know a referral is being made?
- Was the incident witnessed?
- Have there been previous concerns regarding this person? If so what?
- Whether consent has been obtained for the referral, and if not the reasons eg the vulnerable adult lacks mental capacity or there is an overriding public interest (where other vulnerable adults are at risk)
- What actions have been taken to assist the vulnerable adult at this time?
- Referrer's relationship to victim
- Referrer's contact details

Appendix 9 Preserving Evidence

Whilst staff efforts to preserve evidence may be vital, the first concern is the immediate health and wellbeing of the victim.

When Police involvement is required following suspected physical or sexual abuse, they are likely to be on the scene quickly. To enable the Police to investigate effectively, it is *imperative* that vital evidence is preserved. For the short time before the Police arrive, what staff do or do not do can make a vital difference. Remember:

- Where possible, leave things as they are. If anything has to be handled, keep this to a minimum. Do not clean up. Staff should not touch anything they do not have to.

- Leave weapons where they are unless they are handed to you. If staff have to receive them, take care not to destroy fingerprints. Do not wash anything or in any way remove fibres, blood etc.

- If staff are handed any items of possible interest, e.g. a weapon, put them in separate paper bags which must be sealed and given unopened to a Police Officer. Note on the bags what is contained and store in a secure place.

- Only where necessary (if they are un-wearable), change and preserve the clothing and footwear of the victim. Handle these as little as possible and store them in separate sealed bags. Hand the sealed bags to a Police Officer.

- Preserve anything used to comfort or warm a victim, e.g. a blanket.

- Note in writing the state of the clothing of both the victim and the alleged perpetrator. Note the injuries in writing. Make full written notes on the conditions and the attitudes of the people involved in the incident.

- Care should be exercised that there is no cross-contamination between the victim and the alleged perpetrator. Therefore, members of staff attending to the victim should not have any contact with the alleged perpetrator and vice versa.

- Note and preserve any obvious evidence such as footprints or fingerprints.

- Secure the room and do not allow anyone to enter until the police arrive.

- Any written record relating to the incident or its surrounding circumstances should be preserved and made available to the Police.

- In addition, in the case of sexual abuse, the following apply:

- It is crucial for both the victim and the alleged perpetrator to be medically examined for forensic evidence at the earliest opportunity. Whilst respecting the wishes of the victim, they should be discouraged from washing or bathing until such time as an examination has been undertaken.

- Try not to have any person in physical contact with both victim and alleged perpetrator as cross-contamination can destroy evidence. This may be difficult if you are alone on duty and need to comfort both parties, but be aware that any one touching both the victim and the alleged perpetrator will cross-contaminate.

- Preserve bedding where appropriate.

- Note and preserve any bloody items.

- Preserve any used condoms.

- In any instance where a victim is seriously injured and is taken to hospital, ask that a sample of blood be taken before any transfusion, as a transfusion will invalidate any evidence in relation to blood.

Methods of Preservation

- For most things, use clean brown paper, a clean brown paper bag or a clean envelope if possible. If using an envelope, do not lick it to seal.

- For liquids, use clean glassware.

- For knives and other metal objects, use a polythene bag.

- For fire damaged materials, use a nylon bag.

APPENDIX 10 - CONTACT DETAILS FOR MAKING A SAFEGUARDING ADULT REFERRAL

Norfolk	Contact number
To make a Safeguarding Adults referrals contact Norfolk Care Support (NCS)	**0344 800 8020** **If not informed of outcome with 48 hour ring back**

Suffolk	Contact number
To make a Safeguarding Adults referrals contact Suffolk Customer First (SCF)	**0808 800 4005** or completing an Adult Safeguarding online referral form at www.suffolkas.org (Emergency 01473 299699) **If not informed of outcome with 72 hour ring** **Annelli Rooke on 07730 750 943**

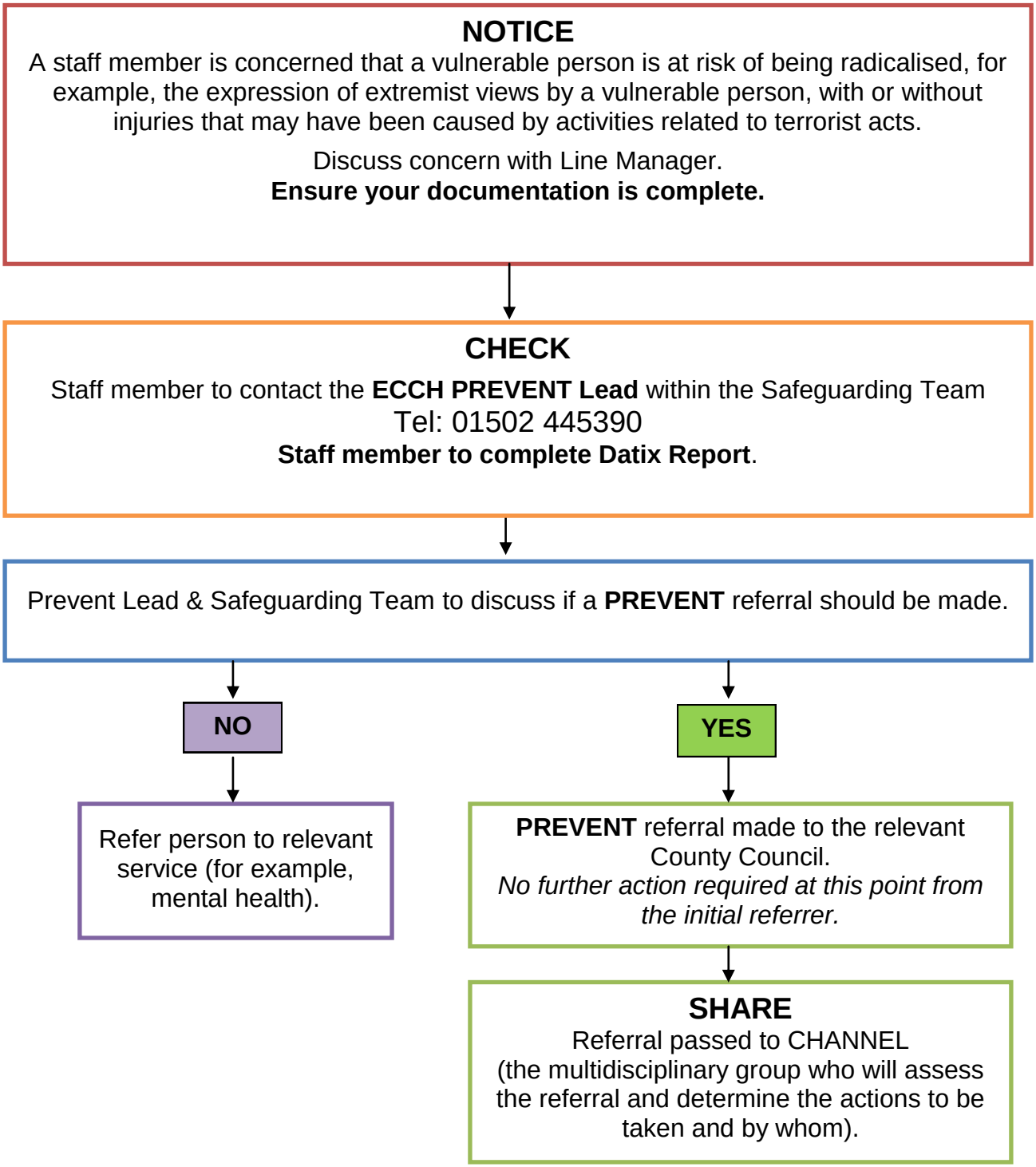
Useful Contact Numbers

Name	Contact details
Safeguarding Lead/Named Nurse ECCH	m: 07771 623950 (office hours) Out of office hours contact ECCH On Call Manager or social services (see above)
NORFOLK **Care Connect** **Norfolk: Police Adult Protection Unit (Eastern Region):**	 0344 800 8020 01603 275784
SUFFOLK **Customer First** Suffolk Police Safeguarding Team The Beeches Victim Care Centre, Lowestoft	 0808 800 4005 (01986) 853 005 (01986) 835 006

<u>APPENDIX 11</u> – PREVENT FLOWCHART

Prevent is part of the Government's counter-terrorism strategy and is aimed at supporting the reduction of racism and inequalities and the promotion of cohesion. Prevent focuses on ensuring that vulnerable individuals are safeguarded from being drawn into extremism or terrorism.

'What to Do' if you suspect someone is being radicalised or self-radicalised into extremist activities:



APPENDIX 12 - ACPO-DASH RISK IDENTIFICATION CHECKLIST (RIC)

Aim of the form:

- To help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence.
- To decide which cases should be referred to MARAC and what other support might be required. A completed form becomes an active record that can be referred to in future for case management.
- To offer a common tool to agencies that are part of the MARAC[1] process and provide a shared understanding of risk in relation to domestic abuse, stalking and 'honour'-based violence.
- To enable agencies to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides and 'near misses', which underpins most recognised models of risk assessment.

How to use the form:

Before completing the form for the first time we recommend that you read the full practice guidance and Frequently Asked Questions and Answers. However please note that Norfolk has agreed to adopt the ACPO DASH, rather than the CAADA-DASH and as a consequence there are three extra questions (10,11,12) relating to children.

Risk is dynamic and can change very quickly. It is good practice to review the checklist after a new incident.

Recommended Referral Criteria to MARAC

1. **Professional judgement:** if a professional has serious concerns about a victim's situation, they should refer the case to MARAC. There will be occasions where the particular context of a case gives rise to serious concerns even if the victim has been unable to disclose the information that might highlight their risk more clearly. ***This could reflect extreme levels of fear, cultural barriers to disclosure, immigration issues or language barriers particularly in cases of 'honour'-based violence.*** This judgement would be based on the professional's experience and/or the victim's perception of their risk even if they do not meet criteria 2 and/or 3 below.
2. **'Visible High Risk':** the number of 'ticks' on this checklist. If you have ticked 14 or more 'yes' boxes the case would normally meet the MARAC referral criteria.
3. **Potential Escalation:** the number of police callouts to the victim as a result of domestic violence in the past 12 months. This criterion can be used to identify cases where there is not a positive identification of a majority of the risk factors on the list, but where abuse appears to be escalating and where it is appropriate to assess the situation more fully by sharing information at MARAC. It is common practice to start with 3 or more police callouts in a 12 month period but this will need to be reviewed depending on the local volume and the level of police reporting.

Please pay particular attention to a practitioner's professional judgement in all cases. The results from a checklist are not a definitive assessment of risk. They should provide you with a structure to inform your judgement and act as prompts to further questioning, analysis and risk management whether via a MARAC or in another way.

[1] For further information about MARAC please refer to the CAADA MARAC Guide 2009 www.caada.org.uk

Name of Victim Case ID No. **Restricted when completed**			Date Time	
Please explain that the purpose of asking these questions is for the safety and protection of the individual concerned. Tick the box if the factor is present ☑. Please use the comment box at the end of the form to expand on any answer. **It is assumed that your main source of information is the victim. If this is <u>not the case</u> please indicate in the right hand column**.	Yes (tick)	No	Don't Know	State source of info if not the victim e.g. police officer
1. Has the current incident resulted in injury? (Please state what and whether this is the first injury.)				
2. Are you very frightened? Comment:				
3. What are you afraid of? Is it further injury or violence? (Please give an indication of what you think (name of abuser(s)...) might do and to whom, including children.) Comment:				
4. Do you feel isolated from family/friends, i.e. does (name of abuser(s) ……..) try to stop you from seeing friends/family/doctor or others? Comment:				
5. Are you feeling depressed or having suicidal thoughts?				
6. Have you separated or tried to separate from (name of abuser(s)….) within the past year?				
7. Is there conflict over child contact?				
8. Does (……) constantly text, call, contact, follow, stalk or harass you? (Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done.)				
9. Are you pregnant or have you recently had a baby? (Within the last 18 months.)				
10. Are there any children, step-children that aren't (…) in the household? Or are there other dependants in the household (i.e. older relative				
11. Has (…) ever hurt the children/dependants?				
12. Has (…)ever threatened to hurt or kill the children/dependants				
13. Is the abuse happening more often?				
14. Is the abuse getting worse?				

Page 2 Cont Tick box if factor is present. Please use the comment box at the end of the form to expand on any answer.	Yes (tick)	No	Don't Know	State source of info if not the victim
15. Does (……) try to control everything you do and/or are they excessively jealous? (In terms of relationships, who you see, being 'policed at home', telling you what to wear for example. Consider 'honour'-based violence and specify behaviour.)				
16. Has (……..) ever used weapons or objects to hurt you?				
17. Has (……..) ever threatened to kill you or someone else and you believed them? (If yes, tick who.) You ☐ Children ☐ Other (please specify) ☐				
18. Has (……) ever attempted to strangle/choke/suffocate/drown you?				
19. Does (……..) do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else? (If someone else, specify who.)				
20. Is there any other person who has threatened you or who you are afraid of? (If yes, please specify whom and why. Consider extended family if HBV.)				
21. Do you know if (……...) has hurt anyone else? (Please specify whom including the children, siblings or elderly relatives. Consider HBV.) Children ☐ Another family member ☐ Someone from a previous relationship ☐ Other (please specify) ☐				
22. Has (…….) ever mistreated an animal or the family pet?				
23. Are there any financial issues? (For example, are you dependent on (…..) for money/have they recently lost their job/other financial issues?)				
24. Has (……..) had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? (If yes, please specify which and give relevant details if known.) Drugs ☐ Alcohol ☐ Mental Health ☐				
25. Has (……) ever threatened or attempted suicide?				

Page 3 Cont. Tick box if factor is present. Please use the comment box at the end of the form to expand on any answer.	Yes (tick)	No	Don't Know	State source of info if not the victim
26. Has (……) ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children? (You may wish to consider this in relation to an ex-partner of the perpetrator if relevant.) Bail conditions ☐ Non Molestation/Occupation Order ☐ Child Contact arrangements ☐ Forced Marriage Protection Order ☐ Other ☐				
27. Do you know if (……..) has ever been in trouble with the police or has a criminal history? (If yes, please specify.) DV ☐ Sexual violence ☐ Other violence ☐ Other ☐				
Total 'yes' responses				

For consideration by professional: Is there any other relevant information (from victim or professional) which may increase risk levels? Consider victim's situation in relation to disability, substance misuse, mental health issues, cultural/language barriers, 'honour'-based systems and minimisation. Are they willing to engage with your service? Describe:

Consider abuser's occupation/interests - could this give them unique access to weapons? Describe:

What are the victim's greatest priorities to address their safety?

Do you believe that there are reasonable grounds for referring this case to MARAC? Yes/No
If yes, have you made a referral? Yes/No

Signed: Date:

Do you believe that there are risks facing the children in the family? Yes/No
If yes, please confirm if you have made a referral to safeguard the children: Yes/No
Date referral made …….

Signed: **Name:**	**Date:**

Any other Comments

APPENDIX 13 - EQUALITY AND DIVERSITY IMPACT ASSESSMENT

Impact Assessments must be conducted for:

- **All ECCH policies, procedures, protocols and guidelines (clinical and non-clinical)**
- **Service developments**
- **Estates and facilities developments**

Name of Policy / Procedure / Service	**ECCH Safeguarding Adults Policy Reporting Procedure**
Manager Leading the Assessment	**Paul Hunter**
Date of Assessment	**10/08/2016**

STAGE ONE – INITIAL ASSESSMENT

Q1. Is this a new or existing policy / procedure / service?

☐ **New**
☒ **Existing**

Q2. Who is the policy / procedure / service aimed at?

☐ **Patients**
☒ **Staff**
☐ **Visitors**

Q3. Could the policy / procedure / service affect different groups (age, disability, gender, race, ethnic origin, religion or belief, sexual orientation) adversely?
☐ **Yes**
☒ **No**
If the answer to this question is NO please sign the form as the assessment is complete, if YES, proceed to Stage Two