NHS
Castle Point and Rochford
Clinical Commissioning Group

Safeguarding Adults Policy

Version:	3.0
Ratified by:	Governing Body
Date ratified:	30/03/2017
Name of Director Sponsor:	Tricia D'Orsi, Chief Nurse
Name of originator/author:	Sarah Jane Ward, Deputy Chief Nurse/Safeguarding Adult Lead
Name of responsible committee/individual:	Quality & Governance Committee
Date issued:	30/03/17
Review date:	31/03/2020
Target audience:	CCG Staff and Members

Contents

Appendices:

1.0 Introduction

1.1. This policy sets out Castle Point and Rochford Clinical Commissioning Group (CCG) responsibility for safeguarding adults as an NHS body, and defines the responsibilities of every member of staff working in the CCG.

1.2. The Care Act 2014 states that workers across a wide range of organisations must be vigilant about adult safeguarding concerns in all walks of life including, amongst others in health and social care, welfare, policing, banking, fire and rescue services and trading standards; leisure services, faith groups, and housing. Therefore, the first priority of all staff should always be to ensure the safety and protection of vulnerable adults. It is the responsibility of all staff to act on any suspicion or evidence of neglect and pass on their concerns to a responsible person or agency. All staff working in the CCG are expected to report suspected or actual cases of abuse, and where appropriate to participate in the safeguarding process.

1.3. This policy outlines the internal processes for Castle Point and Rochford CCG employees to adhere to; whilst supporting the co-operation between the Essex Adult Safeguarding Board (ESAB) and our Statutory Partners, Essex County Council, Essex Police. We believe this policy represents a true multi agency process - comprehensive in its approach to procedures and compliant with both legislation and best practice and applies to all agencies working with adults at risk of harm and abuse in Castle Point and Rochford.

1.4 The Southend, Essex and Thurrock (SET) and Essex Safeguarding Adult Board policies and operational procedures are the main policy documents and should be read in conjunction with this policy.

1.5. Castle Point and Rochford CCG promotes;

Safeguarding is everybody's business, and everybody's responsibility.
Doing nothing is not an option.

1.6 CCGs have statutory responsibilities of their own in relation to safeguarding adults at risk and this document should be read in collaboration with other national and local guidance such as;

- SET Safeguarding Adults Guidelines The Southend, Essex & Thurrock (SET) Safeguarding Adults Guidelines Version 4.1 – August 15

http://www.essexsab.org.uk/Portals/68/Professionals/SET%20Safeguarding%20Guidelines%20%20-%20V4.1%20Aug%202015.pdf

- ESAB Safeguarding Policy

http://www.essexsab.org.uk/en-us/professionals/reportingconcerns.aspx

- The Care Act Statutory Guidance, Department of Health, 2014

- Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework, NHS England, 2015

- Mental Capacity Act Code of Practice, Office of the Public Guardian, 2014

- Note on Deprivation of Liberty Safeguards (DoLS) judgments of the Supreme Court, Department of Health, 2014

- Department for Constitutional Affairs. 2007. *Mental Capacity Act (2005) Code of Practice.* London. TSO.

- Ministry of Justice. 2008. *Deprivation of Liberty Safeguards (2007). Code of Practice.* London. TSO.

- The Stationary Office. 2005. Mental Capacity Act. Code of Practice. London. TSO.

- DH, 2010. Clinical Governance and Adult Safeguarding; an integrated process. London. TSO.

- NHS England, 2013. Serious Incident Framework.

- HM Government, 2015. Prevent Duty Guidance: for England and Wales. London. COI.

2.0 Aim of the Policy

2.1. The aim of this policy is to ensure that all members and employees of Castle Point and Rochford CCG:

- Promote the wellbeing, security and safety of vulnerable people consistent with their rights, capacity and personal responsibility, and prevent abuse occurring wherever possible;

- Understand the process for reporting Adult safeguarding incidents and concerns;

- Use integrated governance systems for reporting to ensure that the process of reporting, investigation and subsequent action, is as effective as possible in achieving good outcomes for vulnerable patients and service users;

- Use the safeguarding principles to shape the strategic delivery and commissioning of services within Castle Point and Rochford CCG

- Complies with The Care Act 2014 and the Mental Capacity Act 2005

3.0 Scope and Definitions

3.1 NHS Castle Point & Rochford CCG

The CCG is defined as NHS Castle Point & Rochford Clinical Commissioning Group responsible for commissioning health services for the population of Castle Point & Rochford.

3.2 The Care Act does not give a definition of "adults at risk" but instead states that Safeguarding duties apply to an adult who:

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

3.3 The local authority are responsible for co-ordinating the response to a safeguarding adults concern, and health services and the police are the two main partner agencies working with the local authority to respond to abuse and neglect.

3.4 The CCG must have clear lines of accountability which are reflected in its governance arrangements, and arrangements in place to co-operate with the Local Authority in the operation of the Essex Safeguarding Adults Board (see Appendix 1)

3.5 The CCG has a safeguarding adults lead and lead for the Mental Capacity Act (MCA) supported by relevant policies and training.

3.6 Health services have a responsibility to protect adults and therefore all staff in the CCG and all contracted services have a responsibility to;

a) Raise concerns, allegations and incidents in relation to safeguarding adults in a timely manner.

b) Alert adult services in the local authority of the concerns as per the SET Safeguarding Adult Guidelines

c) Contribute to the safeguarding process, including contributing to safeguarding adults investigations where requested to do so.

d) All CCG managers and contractors are responsible for raising awareness of safeguarding adults with their staff, ensuring they attend the relevant training and follow this policy.

3.7 This policy uses the term ‘patient’ to include the range of descriptions used to describe the relationship between staff and people who receive services from the NHS and the local authority.

3.8 This policy uses the term “adult” to describe any person aged 18 years or over.

4.0 Categories of Abuse

4.1 Care Act Definitions

The ‘Care Act 2014’ specifies ten categories of abuse, which are addressed in further detail in Appendix 2. These being:

- Physical
- Domestic
- Sexual
- Psychological
- Financial or Material
- Modern Slavery
- Discriminatory
- Organisational
- Neglect or acts of omission
- Self-Neglect

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

4.2 Other Forms of Abuse

It is acknowledged that other types of abuse are not directly referenced in the ten categories of abuse set out by the Care Act 2014.

Each of these areas are covered elsewhere within this policy, these being:

- Prevent
- Honour Based Violence
- Female Genital Mutilation
- Forced Marriage
- Hate Crime
- Human Trafficking

5.0 CCG Responsibilities

5.1 Safeguarding Principles

NHS Castle Point & Rochford CCG has signed up to, and accepts the principles laid down within the Care Act 2014 and the Southend Essex Thurrock (SET) Safeguarding Adults Guidelines. These include:

- Taking action to identify and prevent abuse from happening.
- Responding appropriately when abuse has or is suspected to have occurred.
- Ensuring that the agreed safeguarding adults procedures are followed at all times, these are available at http://www.essexsab.org.uk/Portals/68/Professionals/SET%20Safeguarding%20Guidelines%20%20-%20V4.1%20Aug%202015.pdf
- Providing support, advice and resources to staff in responding to safeguarding adult issues.
- Informing staff of any local or national issues relating to safeguarding adults.
- Ensuring staff are aware of their responsibilities to attend training and to support staff in accessing these events.
- Ensuring staff have access to appropriate training.
- Ensuring staff have access to appropriate consultation and supervision regarding safeguarding adults.
- Considering how diversity, beliefs and values of people who use services may influence the identification, prevention and response to safeguarding concerns.
- Ensuring that information is available for people who use the services and family members on how to raise a concern. For example ASK SAL safeguarding adults across Essex helpline. ASK SAL leaflets are available from info@asksal.org.uk in different languages and formats. For more information see www.asksal.org.uk.
- Also available is: The Silver Line which is a free confidential helpline providing information, friendship and advice to older people, open 24 hours a day, every day of the year. For more information, leaflets and posters see http://www.thesilverline.org.uk/
- Ensuring that all employees who come in contact with adults have a Disclosure and Barring Service (DBS) check in line with the requirements of the Independent Safeguarding Authority Vetting and Barring Scheme.
- Ensuring that all staff are aware of their responsibilities to inform the Chief Nurse of all safeguarding concerns

5.1.2 Castle Point and Rochford CCG will adhere to the statutory safeguarding principles that provide a foundation to achieve good outcomes for patients;

- **Empowerment** - People being supported and encouraged to make their own decisions and informed consent.

  "I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."

- **Prevention** – It is better to take action before harm occurs.

  "I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."

- **Proportionality** – The least intrusive response appropriate to the risk presented.

  "I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."

- **Protection** – Support and representation for those in greatest need.

  "I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."

- **Partnership** – Local solutions through services working with their communities.

  "I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."

- **Accountability** – Accountability and transparency in delivering safeguarding.

  "I understand the role of everyone involved in my life and so do they."

5.1.3 All individuals, regardless of age, ability, race, gender, sexual orientation, faith or beliefs should have the greatest possible control over their lives

5.1.4 People should be able to live as independently as possible and to make informed decisions about their own lifestyles, including the opportunity to take risks if they choose to do so, without fear of harm or abuse from others. It should be acknowledged that these decisions may be viewed as unsafe or unwise and must be heeded if a person has the capacity to make the specific decision. 'A person is not to be treated as unable to make a decision merely because he makes an unwise decision' (Mental Capacity Act 2005 (MCA))

5.1.5 People have a right to express their wishes and priorities and to be personally involved when plans are made for their care. Every effort should be made to enable people to express their wishes in a way that is appropriate for them

5.1.6 In any intervention to reduce risk or respond to immediate danger, care should be taken to ensure the least possible disruption to people's lives. Every effort

will be made to ensure that the vulnerable adult(s) who have allegedly been abused, or witnessed such abuse, or their nominated representative will be involved as much as practically possible with the procedures in this document and be supported throughout the process

5.2 Responsibilities within the CCG

5.2.1 The CCG Accountable Officer is accountable for safeguarding adults in Castle Point and Rochford CCG

5.2.2 The Chief Nurse is the delegated accountable and responsible officer for safeguarding adults in Castle Point and Rochford CCG.

5.2.3 Castle Point and Rochford CCG shares the seat at the ESAB with a rotation agreed by the Chief Nurses of the Essex CCG's.

5.2.4 Castle Point and Rochford CCG is a member of the ESAB Health Executive Forum Group which is core and central to the governance arrangements of the agenda for adults (and children).

5.2.5 The Deputy Chief Nurse is the Lead for Safeguarding Adults will represent Castle Point and Rochford CCG at the NHS E regional safeguarding forum and other local safeguarding meetings.

5.2.6 The Deputy Chief Nurse/Lead for Safeguarding Adults will provide leadership and safeguarding advice to the CCG. The Deputy Chief Nurse and the Quality and Patient Safety Senior Nurses will represent the CCGs at operational safeguarding meetings, overarching safeguarding meetings, and strategic working groups in partnership with other agencies.

5.2.7 The CCG has a responsibility to learn from incidents and in addition will conduct trend and thematic analysis of incidents and ensure learning has taken place. The CCG will ensure all commissioned services learn from safeguarding adult's incidents and trend analysis, improving services for patients.

5.2.8 The CCG will report relevant Serious Incidents Requiring Investigation to the Essex Safeguarding Adults Board and ensure that providers report in the same way.

5.2.9 The CCG has a responsibility to ensure that commissioned services are meeting their safeguarding adults (including the provisions of the MCA/DoLS) responsibilities through regular reporting, the SIRI process, clinical visits, and hard and soft intelligence. This includes ensuring they respond and share responses to requests from the ESAB i.e. "Section 11" audit.

5.2.10 The CCG will ensure that provider governance arrangements cover fundraising by celebrities and any access to premises by them, any privileges, and their use and value in relation to fundraising. The CCG should also ensure

that the culture within commissioned services encourages concerns to be raised and that these and any incidents of whistleblowing in relation to the sexual abuse of patients, staff and visitors are robustly investigated and managed.

5.2.11 In some circumstances where satisfactory arrangements to protect an adult cannot be established, legal remedy using the Court of Protection is needed. When this is necessary, the CCGs will support the use of legal processes.

5.3 Lead for Safeguarding Adults (previously known as Designated Adult Safeguarding Manager (DASM))

The Lead for Safeguarding Adults will support all activity required to ensure that the organisation meets its responsibilities in relation to safeguarding adults. The Lead for Safeguarding Adults will offer support and advice to the CCG Governing Body member responsible for adult safeguarding. The Lead for Safeguarding Adults will ensure the regular provision of training to the staff and CCG Governing Body of the CCG. The Lead for Safeguarding Adults will be a source of expertise and advice to those working in the CCG. He or she will be able to advise the local authority, police and other organisations on health matters in relation to adult safeguarding.

Specific responsibilities of the CCG Lead for Safeguarding Adults will include:

- Responsibility for the oversight of individual complex cases.
- Co-ordination where allegations are made, or concerns raised, about a person, whether an employee, volunteer or student, paid or unpaid.
- Promoting partnership working and keeping in regular contact with their counterparts in partner organisations.
- Assessing and highlighting the extent to which their own organisation and those it commissions prevents abuse and neglect taking place.
- Ensuring that the CCG patient facing services (such as CHC team) have
- appropriate recording systems that provide clear audit trails about decision making and recommendations in all processes relating to the management of adult safeguarding allegations.
- Support and advise commissioners, NHS England and public health on adult safeguarding within contracts and commissioned services and in securing assurance from providers that they have effective safeguarding arrangements in place.
- Provide advice to commissioned services.
- Understand and embed the routes of referral for adults at risk across the health system.
- Provide an safeguarding advisory role to the CCG representative on the Essex Safeguarding Adults Board (ESAB), and supporting the CCG ESAB member.
- Take a lead for health in working with the ESAB to undertake safeguarding adult reviews and take forward any learning for the health economy.
- Provide support to Essex County Council in regard to health expertise in safeguarding cases.

- The Lead for Safeguarding Adults needs to have a broad knowledge of healthcare for older people, those with dementia, learning disabilities, mental health issues and/or care leavers.

5.4 Role of the CCG in the prevention of abuse

The primary driver of the safeguarding adult agenda is prevention of harm to vulnerable adults. The CCG is committed to ensuring that patients are protected from abuse and neglect will be embedded in the following mechanisms:

- Commissioning high quality services.
- Ensure safeguarding adult arrangements are robust within all commissioned services.
- Considering the impact on vulnerable adults when commissioning and decommissioning services.
- Engaging in the multi-agency process when safeguarding concerns arise in the services the CCG commissions working with partner agencies.
- Raising safeguarding concerns in line with the ESAB/SET guidance, linking to the Serious Incident Policy where appropriate.
- Monitoring the quality of services ensuring the triangulation of data.
- Rigorous recruitment practices including all permanent staff, NHS approved agency workers, locums and other temporary staff, students, trainees and volunteers.
- Empowering individuals with information about their rights within well publicised complaints and feedback mechanisms.
- Participating fully as required in Safeguarding Adults Reviews/Domestic Homicide Reviews and other investigations to ensure that recommendations from Safeguarding Adults Reviews/Domestic Homicide Reviews and other Safeguarding Adults investigations are used to inform CCG's when commissioning/decommissioning services.
- To ensure the recommendations from Safeguarding Adults Reviews/Domestic Homicide Reviews and other large scale investigations are embedded within commissioned services.
- To ensure that systems are in place to monitor providers and ensure that necessary learning is embedded in to practice.
- To ensure complaints and concerns are screened for safeguarding adults issues acknowledging that care quality lapses may well constitute a safeguarding adults concerns.

5.5 Staff Responsibility in the CCG

Although staff working within a CCG do not provide direct care to patients, the nature of their work may identify risks during the course of their role, for example:

- Direct observation during visits to providers of care
- Conversations with patients, families and staff from provider organisations

- Complaints and patient experience feedback
- Incident reports and serious incident reports
- Audits which identify lapses in care quality
- Concerns raised through whistleblowing
- CQC reports
- Soft intelligence about providers
- Concerns when patients are transferred from one setting to another about their previous care
- Commissioning and decommissioning services which will impact on vulnerable adults
- Quality data may highlight concerns about staffing, not meeting acceptable standards of care/service provision
- Staff should also be conscious of the fact that they may become aware of safeguarding issues who are known to/cared for by colleagues.

5.5.1 Managers have the additional responsibilities to:

- ensure that all their own staff members have adequate and appropriate training for their roles and responsibilities within adult safeguarding in line with the SET Training Strategy.
- provide support and advice to all staff when dealing with adult safeguarding issues and to provide support, advice and resources to enable the Safeguarding Adults Lead to fulfil their role.
- provide a safe environment in which to work and receive services, without fear of reprisal in accordance with the Whistleblowing Policy.
- encourage an atmosphere of openness so that staff can approach them with any concerns regarding adults.
- ensure that safeguarding adults becomes fully integrated into NHS systems.

The CCG should be mindful that there is also an expectation on commissioning support services to work with us in achieving the above. As such, these services should be well informed of expectations and performance should be monitored for assurance and to ensure learning is transferred in to improved practice.

It is the responsibility of **everyone** to recognise suspected or actual abuse and to take appropriate action in line with the procedures in this document.

6. Capacity and Consent

6.1 Two of the overriding principles in Safeguarding Adults are capacity and consent:

The Care Act stipulates that organisations should always promote the adult's wellbeing in their safeguarding arrangements.

It emphasises that people have complex lives, being safe is only one of the things they want for themselves and that professionals should work with the adult to establish what being safe means to them and how that can be best achieved.

Professionals and other staff should not be advocating “safety” measures that do not take account of individual well-being.

Whenever possible every effort must be made to obtain the consent of an adult to report abuse taking into consideration the definitions of the Mental Capacity Act (2005). However when there is a duty of care due to the adult not having the capacity to protect him / her the matter must be discussed with the Safeguarding Adults Lead in the CCG (for CCG staff and members) to determine how best to proceed.

Any patient affected by abuse, who has capacity, should be consulted regarding whether or not they wish action to be taken in relation to their own situation.
However, their response will be viewed in the context of the need for any intervention in order to protect other service users and / or staff from harm or risk of harm. If the individual does not wish to report the abuse a discussion must take place with the Safeguarding Adults Lead in the CCG (for CCG staff and members) regarding the appropriate course of action to safeguard other service users, staff and whether it is in the public interest.

Therefore:

6.1.2 Any intervention to protect an adult 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 or others.

6.1.3 All interventions must be:

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

6.2 Choices and Risk

Sometimes attempts to justify a person’s right to make choices about their lifestyle, may involve risk e.g. where an adult is left in a situation which could leave them in serious risk of abuse. Decisions about risk at this level should never be taken by individual staff but should be discussed through a properly constituted professionals meeting where risk assessments are considered. If there is a concern that a person does not understand the decisions they are making and the consequences of what they are doing then there may be a need to carry out a Mental Capacity Assessment.

6.3 Mental Capacity Act (2005)

Mental Capacity Act Guidance must be followed.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224660/Mental_Capacity_Act_code_of_practice.pdf.

or http://www.essexsab.org.uk/Portals/68/MCA%20Policy%20Oct%202016.pdf

6.3.1 In accordance with the Mental Capacity Act (2005) there is a presumption of mental capacity unless an assessment under the Act shows otherwise. The act defines someone who lacks capacity as 'a person who lacks the capacity to make, or take, a particular decision for themselves at the time the decision needs to be taken'. Therefore assessments of capacity must be decision specific. The statutory principle aims to protect people who lack capacity and to help them take part, as much as possible, in decisions that affect them. The act provides statutory principles which are;

- A person must be assumed to have capacity unless it is established that she/he lacks capacity.
- A person is not treated as unable to make a decision unless all reasonable practicable steps to help her/him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because she/he makes an unwise decision.
- An act done or decision made, under the act for or on behalf of somebody who lacks capacity must be done, or made, in their best interests.
- Before the act is done, or the decision made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

6.3.2 A person is considered unable to make a decision if they cannot:

- Understand the information about the decision to be made ('relevant information').
- Retain that information in their mind.
- Use or weigh that information as part of the decision making process, or
- Communicate their decision (by talking, using sign language or other means).

6.3.3 It is the right of adults who have the capacity to make a decision to make their own choices irrespective of how unwise their decision is construed. However, where a crime is suspected or there is a serious risk of harm to that person or another person, relevant agencies should be informed and the concerns investigated.

6.3.4 Where adults lack the capacity to make certain decisions to safeguard them, other people will need to make those decisions. At these times, all staff will act in accordance with the Best Interests Decisions as described in the Mental Capacity Act Code of Practice (2005). The decision making process for major decisions will be recorded and held in the patient record. In doing so they will:

- act in a way that is necessary to promote the vulnerable adult's health or well- being or to prevent deterioration to their quality of life
- ensure that an appropriate level of safety is provided for a vulnerable adult if an intervention is put in place
- ensure that the ascertainable past and present wishes and feelings of

the vulnerable adult concerned are taken into account. And that those wishes were not made as a result of undue influence

- ensure that the vulnerable adult is encouraged and supported to the fullest extent possible to participate in any decision made which affects them.

For supporting patients whom have; no capacity; no family; no identified carers; or if it is felt that the family and carers are not acting in the best interests of the patient an Independent Mental Capacity Advocate should be contacted through:

Telephone: 0300 330 5499

Email: imca@voiceability.org

Write to: IMCA, VoiceAbility, Mount Pleasant House, Cambridge CB3 0RN

6.3.5. All staff in the Continuing Health Care Team (CHC) will have received training in the application of the Mental Capacity Act in clinical practice.

More information for MCA &DoLS can be found: http://www.essexsab.org.uk/en-gb/professionals/mcaanddols.aspx

7. Deprivation of Liberty Safeguards (DoLS)

7.1 These safeguards protect people who lack capacity to make decisions about care or treatment and who need to be cared for in a restricted way. The aim of the safeguards is to ensure:

- That people are given the care they need in a less restrictive manner.
- That decisions being made suit the needs of the adult at risk
- Safeguards are in place
- The provision of rights to challenge unlawful detention against the person's will are appropriate.

7.2 Where the deprivation of liberty is in CQC Registered Domiciles, such as Hospitals, Nursing Homes and Residential Homes, it is the responsibility of the provider to make an application to the supervisory body. The supervisory body for the deprivation of liberty is the local authority (of residence), and where people consider they need to deprive somebody of their liberty, they will need to apply to the local authority. Hospitals and care homes remain the managing authorities for compliance with the Deprivation of Liberty Safeguards and must comply with the legislation.

7.3 Where the deprivation of liberty in imputable to the state (CCG) and occurs in the patient's own home or supporting living, then the responsibility to seek authorisation for this deprivation falls directly on the commissioning authority. As such, CCG's must have systems and processes in place, to identify patients who are subject to a deprivation of liberty and, where appropriate, to seek authorisation from the Court of Protection.

8. Confidentiality and information sharing.

8.1 The Care Act 2014 places duties to co-operate over the supply of information on relevant agencies. Similarly 'No Secrets' (DOH 2000) states that: the government expects organisations to share information about individuals who may be at risk from abuse.

8.2 Confidentiality must never be confused with secrecy.

8.3 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.

8.4 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 vulnerable adult, referrer, family members and other agencies where appropriate.

8.5 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 and abuse.

8.6 Clarify the identity/person that is making the request and why they require the information. Check and call them back to confirm they are who they say they are.

8.7 Follow the **Seven Golden Rules** for information sharing;

1. **Remember that the Data Protection Act 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 either:

   - CCG Caldicot Guardian/Chief Nurse – 01268 464592
   - CCG Deputy Caldicot Guardian/Deputy Chief Nurse – 01268 464598
   - CCG Information Governance Team - 01268 594531

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 judgment, that the lack of**

consent may be overridden in the public interest. You will need to base your judgment 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.

9. Making a safeguarding adult referral, of alleged, suspected, actual or potential abuse.

(Useful contact numbers Appendix XX)

9.1 The safeguarding adult alerting and referral process can be found at http://www.essexsab.org.uk/en-gb/professionals/reportingconcerns.aspx
This process must be followed by all staff.

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

9.3 If the adult is in immediate danger and/or needs urgent medical attention staff must call 999 and take steps to ensure the immediate safety and welfare of the alleged victim and protect any forensic evidence. A safeguarding referral to Social Services must also be made.

9.4 If the adult is not in immediate danger, the staff member must alert at the first opportunity a senior colleague/supervisor/manager and/or their Safeguarding Adults Lead about their concerns.

9.5 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
- 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 vulnerable adults.

9.6 For advice and guidance contact Social Care (0345 6037630) or the CCG Nursing and Quality Senior Nurses NHS Castle Point and Rochford CCG, Pearl House, 12 Castle Road, Rayleigh, SS6 7QF, tel: 01268 464508

9.7 To make an Adult protection referral, ring Social Care Direct 0345 6037630 or out of hours - 0345 606 1212 and complete a SETSAF 1 Safeguarding Adult Concern Form and send as per the instructions on the form http://www.essexsab.org.uk/en-gb/professionals/reportingconcerns.aspx

9.9 Appendix XX is a guidance checklist of what information will be required when making a referral.

9.10 CCG CHC team must enter in the CHC records for NHS Funded care patients or maintain relevant file note details of the safeguarding referral and all future discussions/actions in relation to the safeguarding concern. (see Appendix 7)

9.11 Consideration should be made as to whether the incident meets the criteria for raising a serious incident.

9.12 Inform the lead for Safeguarding Adults and the line manager, as soon as possible after the event or during if further advice is required.

10. Strategy Meetings

10.1 Strategy Meetings are part of the safeguarding adult procedures. If invited to attend a Strategy Meeting the referring staff member must make every effort to attend. It is very important that the referrer attends as they will have important information about the individual, their circumstances and the concern identified. If the referrer is unable to attend for any reason an alternative relevant attendee must be identified, this should be discussed with the lead for safeguarding adults to assure suitable representation is available.

Safeguarding Lead may be requested to attend a Professional meeting to discuss a referral, the lead will determine if there is a health element relating to the safeguarding, if there is no evidence it will be determined that attendance is not required.

11. Disclosure of information in the Public interest (Whistle blowing) Guidelines.

11.1 Staff who work with adults, commission services for them or receive feedback about the care that they receive, have an individual responsibility to raise concerns with someone who has the responsibility to take action when they consider a patient/client has not been treated appropriately. Castle Point and Rochford CCG will always act on such concerns when raised. In particular they have a specific duty to act when concerns 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 the safety and wellbeing of patients

Staff are required to follow Castle Point and Rochford CCG Freedom to speak up raising concerns (whistleblowing) Policy for the NHS)

12. Domestic Violence

12.1 Where concerns are identified relating to a patient who is experiencing or perpetrating domestic abuse, an assessment to the level of risk to the individual or those within the household should be undertaken using the DASH risk assessment tool. The lead for safeguarding adults should be consulted to assist and advise with this process. Where a high level of risk and imminent danger is suspected the police should be contacted in order to seek help.

12.2 When a DASH risk assessment indicates high a risk a referral should be made to the Essex Multi Agency Risk Assessment Team/Conference MARAT/C. A MARAT/C is a formal multi agency meeting to consider safety plans for the individual, their children and vulnerable adults living in the household.
The objectives of the MARAT/C are:

- To work collaboratively using a multi-agency risk assessment process to improve risk assessment and safety planning, intervention and review for adults and children at high level risk of significant harm or death as a result of domestic abuse
- To use agency information to inform risk to determine if an adequate safeguarding plan is in place with the victim and children
- To ensure any on-going risk posed by perpetrators is addressed within safety planning for the victim and children
- To ensure high risk domestic abuse incidents are discussed at a Southend MARAC within 14 days of the referral into the MARAT
- To ensure MARAC meetings are focused and purposeful to improve quality of information and risk management
- To ensure multi-agency action plans are reviewed when required

12.3 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.

12.4 In cases where a victim or perpetrator of domestic abuse has children, advice should be sought from the CCG Safeguarding Children Team. If a child is suffering or likely to suffer significant harm a referral should be made to Childrens Social Care and if appropriate the police, in accordance with the SET Safeguarding and Child Protection Procedures.

12.5 Further information and advice can be found in the CCG Domestic Abuse Workplace Policy

13. Prevent

13.1 Prevent is an emerging programme which aims to identify individuals who may be susceptible to exploitation into violent extremism by radicalisers. Violent extremists often use persuasive rationale and charismatic individuals to attract people to their cause. The aim is to attract people to their reasoning, inspire new recruits and embed their extreme views and persuade vulnerable individuals of the legitimacy of their cause. The aim of Prevent is to stop people from becoming terrorists or supporting terrorism.

The objectives of the strategy are to:

1. Respond to the ideological challenge of terrorism and the threat we face from those who promote it.

2. Prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support.

3. Work with sectors and institutions where there are risks of radicalization which we need to address.

13.2 Any concerns related to staff or service users, who may be at risk of radicalisation, need to be reported through the lead for safeguarding adults

13.3 The CCG will ensure that commissioned services comply with the requirements of the Prevent Duty Guidance 2015 and NHS E Prevent Training and Competencies Framework 2015.

13.4 The Prevent lead for the CCG is the Deputy Chief Nurse/Safeguarding Adult Lead

More information can be found:
http://www.essexsab.org.uk/en-gb/typesofabuse/radicalisation.aspx

14. Honour Based Violence/Abuse

14.1 Violence and abuse in the name of honour covers a variety of behaviours (and crimes), where a person is being punished by their family and/or community for a perceived transgression against the 'honour' of the family or community.

14.2 Issues such as: dress code, choice of friends, forced marriage, career choice, relationships with members of the opposite sex, kissing in public and false imprisonment; are issues which impact upon a families honour and therefore can lead to violence and abuse.

14.3 Practitioners 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.

14.4 All front line staff should contact safeguarding immediately to discuss their concerns and raise a referral;

Contact Essex Police on 101 or 999 if an emergency.
Further information and contacts can be found at: http://www.essexsab.org.uk/en-gb/typesofabuse/honourbasedabuse.aspx

15. Female Genital Mutilation (FGM)

15.1 Female genital mutilation (FGM), also known as female circumcision or female genital cutting, is defined by the World Health Organisation (WHO) as "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons".

15.2 FGM prevalence; more than 28 countries practise FGM. http://www.who.int/reproductivehealth/topics/fgm/prevalence/en/ http://nationalfgmcentre.org.uk/world-fgm-prevalence-map/

15.3 FGM is carried out for cultural and social reasons within families and communities. For example, it is often considered a necessary part of raising a girl properly, and as a way to prepare her for adulthood and marriage. FGM is often motivated by the belief that it is beneficial for the girl or woman. Many communities believe it will reduce a woman's libido and discourage sexual activity before marriage.

15.4 FGM is illegal in the UK. It is also illegal to arrange for a child to be taken abroad for FGM. If caught, offenders face a large fine and a prison sentence of up to 14 years.

15.5 Section 5B of the Female Genital Mutilation Act 2003 introduced a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report 'known' cases of FGM in under 18s which they identify in the course of their professional work to the police. The duty has applied from 31 October 2015 onwards.

This might occur if either:

- There is a disclosure by a girl under 18 years that an act of FGM has been carried out on her; or
- Physical signs that appear to show that an act of FGM has been carried out on a girl under 18 years are observed and there is no reason to believe that the act was necessary for the girl's physical or mental health or for the purposes connected with labour or birth.

15.5 If you are worried about someone who is at risk of FGM or has had FGM, you

must share this information with your Adult or Child Safeguarding Lead and report to the Police. It is then the Police responsibility to investigate and co-ordinate with other agencies to protect any girls or women involved.

https://www.england.nhs.uk/wp-content/uploads/2016/12/fgm-pocket-guide-v5-final.pdf

16. Forced Marriage

16.1 A forced marriage is: *"A marriage conducted without the valid consent of one or both parties, where duress is a factor".* Forced marriages are a form of domestic abuse and are dealt with as such by the police. Forced marriages are where one or both persons involved get forced into a marriage that they do not want to enter and do not consent to the marriage. Sometimes it is parents forcing their child to get married or sometimes it can be the extended family or community.

16.2 It can happen between people in this country or between someone from this country with someone abroad. Forced marriages happen in all communities. We are aware it happens all over and we want to encourage particular communities to understand that this is force and to be confident enough to report to the police.

16.3 Forced marriage is primarily, but not exclusively, an issue of violence against women. Most cases involve young women and girls aged between 13 and 30 years, although there is evidence to suggest that as many as 15 per cent of victims are male.

16.4 Forced marriage itself is not a criminal offence; however the offences associated to a forced marriage are a criminal offence. Where someone has been forced to marry then inevitably there will be some element of criminality.

16.5 Perpetrators, usually parents or family members could be prosecuted for offences including conspiracy, threatening behaviour, assault, kidnap, abduction, theft of the individuals personal belongings (often official documents such as a passport), threats to kill, imprisonment and murder

16.6 Often victims do not feel that they can report the matter to the police or even walk out of the marriage, as they would disgrace their family's honour.

16.7 If you are worried about someone who is at risk of Forced Marriage or has been victim of Forced Marriage, you must share this information with your Adult or Child Safeguarding Lead and report it to the Police. It is then the Police responsibility to investigate and co-ordinate with other agencies to protect any girls or women involved.

Contact details: https://www.gov.uk/stop-forced-marriage
Forced Marriage Unit
fmu@fco.gov.uk
Telephone: 020 7008 0151
From overseas: +44 (0)20 7008 0151

Monday to Friday, 9am to 5pm
Out of hours: 020 7008 1500 (ask for the Global Response Centre)

17. Hate Crime

17.1 A hate crime is an act that is committed against any person or group that is motivated by an individual or group offender's hostility and prejudice based upon:

- Disability
- Race, ethnic origin or nationality
- Religion
- Sexual orientation
- Transgender (Gender orientation)
- Alternative lifestyle

17.2 Offences include things like name calling, verbal abuse, bullying , harassment, spitting, physical attacks, damage to property, graffiti, written notes, emails and text messages

17.3 If you are worried about someone who is experiencing Hate Crime, you must share this information with your Adult or Child Safeguarding Lead and report to the Police. It is then the Police responsibility to investigate and co-ordinate with other agencies to protect any individuals involved.

18. Human Trafficking/Modern Slavery

18.1 Human Trafficking is a part of the Safeguarding agenda because it involves the exploitation of vulnerable adults and children it is considered to be a key element of the NHS Safeguarding agenda

18.2 Human Trafficking is *"the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation."*

18.3 Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs."

18.4 Human trafficking is international organised crime, with the exploitation of human beings for profit at its heart. It is an abuse of basic rights, with organised criminals preying on vulnerable people to make money.

18.5 Adult victims may travel to the UK willingly, in the belief that they are destined for a better life, including paid work and may start their journey believing they are economic migrants, either legally or illegally. They may also believe that the people arranging their passage and papers are merely

facilitators, helping with their journey, rather than people who aim to exploit them. In other cases, victims may start their journey independently and come to rely on facilitators along different stages of their journey to arrange papers and transportation.

18.6 Traffickers use threats, force, coercion, abduction, fraud, deception, abuse of power and payment to control their victim. And most traffickers are organised criminals

18.7 The greatest numbers of adult victims come to the United Kingdom from:

- China,
- South East Asia, and
- Eastern Europe

18.8 If you are worried about someone who may have been victim of Human trafficking, you must share this information with your Adult or Child Safeguarding Lead and the Police. It is then their responsibility to investigate and co-ordinate with other agencies to protect any individuals involved. A referral will be undertaken by the police in to the National Referral Mechanism.

For more information:
http://www.essexsab.org.uk/en-b/typesofabuse/modernslavery.aspx
https://www.gov.uk/government/publications/how-to-report-modern-slavery/how-to-report-modern-slavery

19. Sharing Information and Lessons Learnt

19.1 The lead for safeguarding adults will report regularly to the CCG on activity that they have managed within our locality; this will be included within the reporting systems to the Governing Body and Castle Point and Rochford CCG Quality and Governance Committee.

19.2 Castle Point and Rochford CCG will also regularly share information and lessons learnt from information on quality, safety and safeguarding performance via its internal bodies and systems and within the SET wide safeguarding health meetings.

20 Supporting Families

20.1 All members of staff have a responsibility to safeguard and promote the welfare of children. A child is defined as anyone under the age of 18 years. Where safeguarding and health concerns (e.g. mental ill health of incapacity) are identified in adult who are parents/carers an assessment should be made on the actual or potential impact on their children.

20.1 The Safeguarding Children Team can provide support and advice to safeguard children. Contact information and safeguarding children procedures can be found on the CCG website

http://castlepointandrochfordccg.nhs.uk/members-area/safeguarding/safeguarding-children

20.3 More information and advice on how to make a referral to the Family Operations Hub (this includes children's social care) can be found on

http://www.escb.co.uk/en-gb/workingwithchildren/concernsaboutthewelfareofachild.aspx

21 Monitoring, Review and Archiving

21.1 Monitoring

The Safeguarding Adults Board as part of its remit ensures that there are effective safeguarding arrangements in Castle Point & Rochford and monitor how robust safeguarding arrangements are through their auditing process.

The Safeguarding Boards have clear roles and responsibilities and may request that a 'Serious Case Review' be convened.

Reports on Safeguarding Adults will be presented bi-monthly to the Quality and Performance Committee and to the CCG Governing Body.

The Safeguarding Adults Policy should be reviewed/updated every three years or sooner if there is significant local or legislative change e.g. transfer of responsibilities.

21.2 Review

The safeguarding adults lead will review the policy as national guidance and legislation or local SET procedures are changed or 3 yearly.

Staff will be informed by CCG internal communications of any changes to the policy.

21.2 Archiving

The Head of Performance and Corporate Services will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: NHS Code of Practice 2009.

21 Equality Impact Assessment Statement

NHS Castle Point and Rochford CCG is committed to carrying out a systematic review of all its existing and proposed policies to determine whether there are any equality implications. The policy applies to all groups. This policy has been assessed using the former CCG's Equality Impact Assessment framework and identified as having the following impact/s upon equality and diversity issues:

Age	Disability	Gender	Gender Reass.	Sexual Orient.	Religion	Preg./ Mat.	Race	Marital Status	Total Points	Impact
0	0	0	0	0	0	0	0	0	0	0

Points

3 – This area has a high relevance to equalities

2 – This area has a medium relevance to equalities

1 – This area has a low relevance to equalities

0 – This area has no relevance to equalities

Scoring

13-21 points – High Impact

7-12 points – Medium Impact

0-6 points – Low or No Impact

Safeguarding Adult policy encompasses all adults and the Safeguarding Children and Young People encompasses all children , young people and their families

22. Version Control

Policy Title:

Version	Date issue/review	Author Name and title	Comment
3.0	January 2017	Sarah Jane Ward- Deputy Chief Nurse/safeguarding Adults Leads	Version 2 reviewed and changed to reflect changes to local and national legislation and updates

Appendix 1

Types of abuse

This section considers the different types and patterns of abuse and neglect and the different circumstances in which they may take place. This is not intended to be an exhaustive list but an illustrative guide as to the sort of behaviour which could give rise to a safeguarding concern.

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.

1. **Physical Abuse** – including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.

   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

2. **Domestic Violence** – including psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence.

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

   Refer to appendix 8 for advice on management of sexual abuse incidents.

   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.

   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

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

   Some possible signs and symptoms of psychological abuse include:

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

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

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

   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

6. **Modern Slavery** – encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

7. **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, and deliberate exclusion.

8. **Organisational Abuse** – including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

   Organisational abuse can occur in any setting where things are arranged 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 behavior 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.

9. **Neglect and Acts of Omission** – including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

   Some possible/indicators of neglect include:
   - poor hygiene
   - malnutrition
   - inappropriate clothing
   - broken skin

10. **Self-Neglect** – this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

    Self-neglect on the part of an adult at risk will not usually lead to the initiation of adult safeguarding procedures unless the situation involves a significant act of commission or omission by someone else with established responsibility for an adult's care. Other assessment and review procedures, including risk assessment procedures, may prove a more appropriate intervention in situations of self-neglect.

Appendix 2 Castle Point and Rochford CCG Safeguarding Assurance

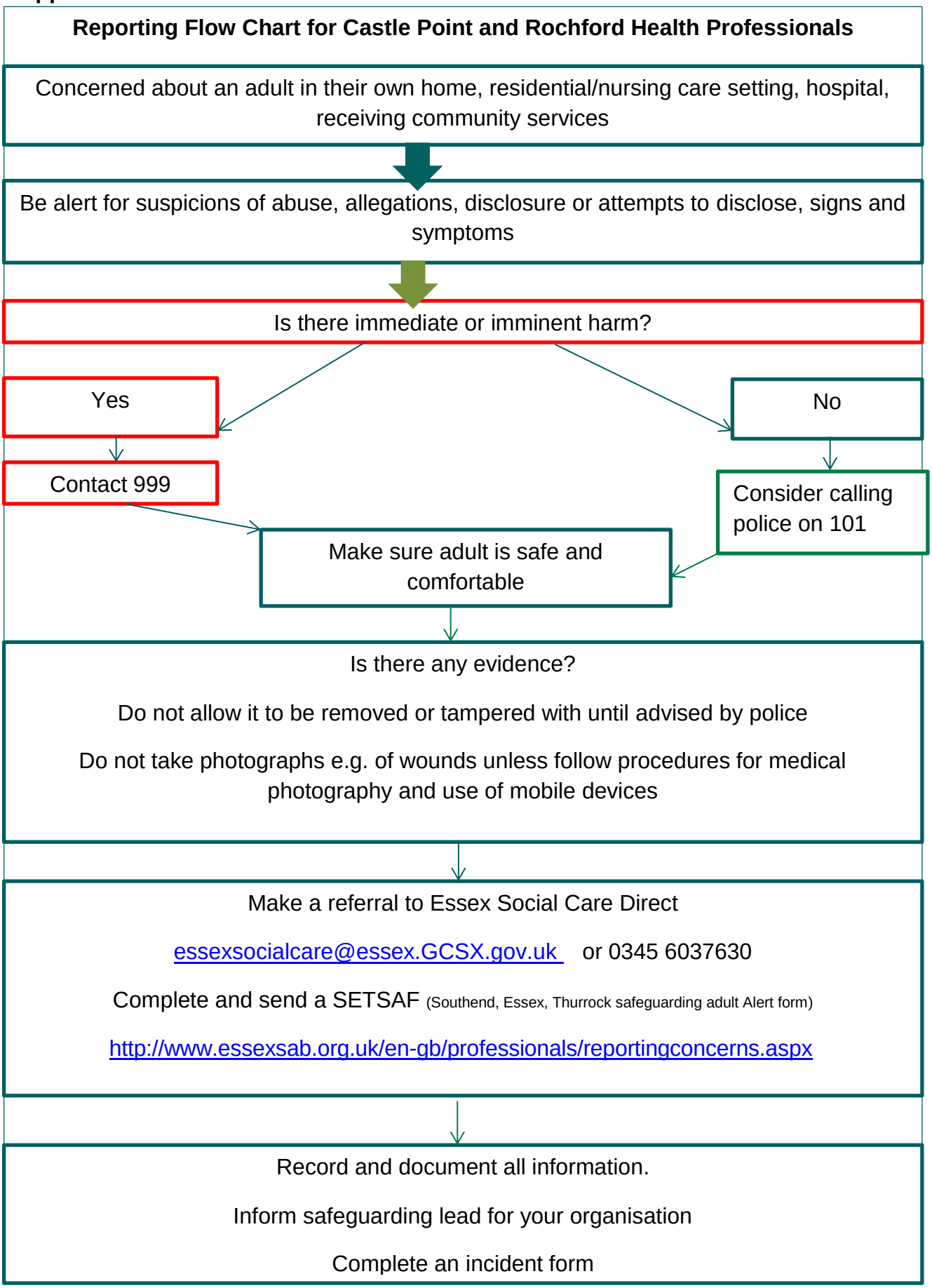
Reporting	**Director of Commissioning Operations (DCO)Team NHS England via Quality Surveillance Group**	
Reporting	**CCG Governing Body**	
Reporting	**Quality and Governance Committee**	**Essex Safeguarding Adults Board Inc. Health Executive Forum, Domestic Abuse Board**
	CCG Chief Nurse- (Executive lead)	
Analysis & correlation	**Deputy Chief Nurse/Lead for Safeguarding Adults & Nursing & Quality Team Safeguarding Adults Training Mandatory for All staff, Commissioning & procurement Processes Monthly meetings with chief nurses**	

Source of Information/ intelligence
CHC Care Home Quality Meeting
Feedback from CHC, SIs, Pressure Ulcers, Complaints, Quality Team Visits
Regional Implementation Network - e.g.DoLS MCA, Prevent
NHS East Region Safeguarding Adults forum
Local Essex Information sharing Meetings
Regional Multiagency Safeguarding Meeting
Pan Essex Information Sharing Meeting
Provider Organisations CQRG – SEPT, SUHFT, Private & NHS Hospitals
Informal Communication with GPs, Community Nurses etc.

Appendix 3 - Contact Sheet for Safeguarding Adults

Castle Point and Rochford CCG		
For advice and support		
CCG Lead for Safeguarding Adults/MCA/DoLS/Prevent	Sarah Jane Ward	01268 464598 07779 439753
	Non urgent: CPRCCG.safeguarding@nhs.net	
Quality and Patient Safety Senior Nurse- (including safeguarding)	Vicky Cline/Dawn Brown	01268 46454 07855 125183
Caldicott Guardians	CCG Caldicot Guardian/Chief Nurse CCG Deputy Caldicot Guardian/Deputy Chief Nurse CCG Information Governance Team	01268 464592 01268 464598 01268 594531
Local Authority		
Essex County Council Safeguarding Referrals	essexsocialcare@essex.GCSX.gov.uk	0345 6037630
Independent Mental Capacity Advocacy	VoiceAbility imca@voiceability.org	0300 3305499
Police	**For any serious issue/honour based abuse/domestic abuse**	**999** **Non urgent 101**
Sexual Abuse Referral Centre		
Oakwood Place **Brentwood**	Essex.SARC@mountainhealthcare.co.uk	01277 240620 (9am-5pm) *24 hour answer phone* Out of Hours Help Line: 0330 223 0099
Support Lines		
AskSAL Silver Line 24-hour National Domestic Violence Freephone Helpline	***For public to report concerns*** For support for older people	03452 66 66 63. 0800 4 70 80 90 0808 2000 247

Appendix 4


Reporting Flow Chart for Castle Point and Rochford Health Professionals
Concerned about an adult in their own home, residential/nursing care setting, hospital, receiving community services
Be alert for suspicions of abuse, allegations, disclosure or attempts to disclose, signs and symptoms
Is there immediate or imminent harm?
Yes
No
Contact 999
Consider calling police on 101
Make sure adult is safe and comfortable
Is there any evidence?
Do not allow it to be removed or tampered with until advised by police
Do not take photographs e.g. of wounds unless follow procedures for medical photography and use of mobile devices
Make a referral to Essex Social Care Direct
essexsocialcare@essex.GCSX.gov.uk or 0345 6037630
Complete and send a SETSAF (Southend, Essex, Thurrock safeguarding adult Alert form)
http://www.essexsab.org.uk/en-gb/professionals/reportingconcerns.aspx
Record and document all information.
Inform safeguarding lead for your organisation
Complete an incident form

Appendix 5:

GUIDANCE NOTES FOR COMPLETING SET SAF1 (Safeguarding Adults Concern) FORM http://www.essexsab.org.uk/en-gb/professionals/reportingconcerns.aspx

Where safeguard concerns have been identified at stage one & stage two there must be an ongoing and documented RISK MANAGEMENT PLAN or the DASH RISK PLAN (If required) - http://www.essexsab.org.uk/Documents/SETSAFForms.aspx

Introduction
The adult alert form (SET SAF 1) can be used by anyone to begin the adult safeguarding process.

The form should be used to record any specific concerns or incidents that relate directly to the care or welfare of an adult.

The form **must** be used whenever there are concerns that may identify possible abuse against an individual. The form should only be completed in respect of the alleged victim.

It is not to be used to outline generalised non-specific concerns that would normally be addressed through social or care work process and involvement.

Details of the referral must always be recorded accurately and without delay. However *Completion of SET SAF 1 must not delay immediate action being taken where necessary to ensure the safety of the vulnerable adult and the preservation of evidence if it is suspected that a crime has been committed.*

Section 1 – Person you are concerned about
This section is for you to tell us who you are concerned about, it is important to complete as much identification information as possible, as this will help in ensuring that the correct person is identified from the information provided.

Section 2- Current situation and details of the incident/concern(s) being raised
This section of the form is critical to identify if the person or other people remain at risk. In this section it is important to state the actual risk, not unspecified vulnerability i.e. this person could be at risk if someone wanted to take money from them etc – the risk stated must relate directly to the specific concern that has instigated the completion of the SET SAF 1 – for *example where it is alleged that someone has been assaulted by a staff member who is still in contact with the person(s) then this would need to be highlighted as a current risk.*

Details of the concern
This section is for telling us the main reason for the SET SAF 1 and needs to be a factual account or recording of the incident or event. It is important here to specify fact not opinion and will include observations stated by direct witnesses, the alleged victim, the location, time, date and anyone who was involved – including the identification of witnesses who may have been present in the area of the incident. This can be continued

on a separate sheet, but please try to summarise as much as possible to present a clear pen picture of the incident, which may be read by someone who has no knowledge of the alleged victim or the service (if applicable).

Accurate description of injury
Use this section to accurately describe any injuries noted *e.g. yellowing 3cm bruise to underside of left upper arm* etc.

Body Chart Completion
Where appropriate, please include a body chart or forward as soon as possible. (body charts can be found on (page 81)

Doctor informed
Please use these boxes to identify whether or not these actions have been taken.

Actions taken to safeguard the individuals
Please state here actions you have taken to reduce the risk of further incidents, these may include the removal of individual or alleged perpetrator from contact with each other or other parties, contacting other agencies – Police, GPs etc.

Are any other professionals involved in this alert?
Identify which other people (professionals and others) have been made aware of the concern or incident(s), please list names, roles and any reference number.

Name and Police Station for Investigating Officer:
Please obtain the name of the investigating officer, their police station and the Crime Reference Number which is obtained from the police when reporting a crime.

Section 3: Relative/Name of Main Carer
The relative/main carer section should include the person closest to the individual who may need to be contacted about the concerns (unless this person is identified as being part of the concern – if so please identify the person in section 4 of the SET SAF 1).

Section 4- Details of alleged perpetrator
This section is for identifying a person or persons who it is believed has contributed specifically to the incident or concern mentioned the alert relates to. It is important that any person named is as a direct consequence of the specific allegation and identification by the alleged victim or direct witness. It is not for speculation – please complete as much as is known – if this is single name i.e. “John” then please use this, if the person is not known, then please state this. In any incidents where the alleged abuser is a member of staff or resides with the alleged victim, please ensure this information is provided.

If you are aware that the alleged perpetrator holds a position of trust (paid or voluntary), please ensure that you record the details of that position and of the organisation, if known.

Section 5 – Telling us who you are
This section is for the person raising the concern to identify themselves. This part of the

form should identify who this person is, and contact information so that further information can be obtained if required.

In the event that the person does not wish to be identified for reasons of anonymity, while reasonable efforts should be made to encourage the person to give contact information as this may assist in the safeguarding processes, if the answer is still no, then please state this in this section together with a reason if known.

Appendix 6 SET SAF 1 – SAFEGUARDING ADULT CONCERN FORM

http://www.essexsab.org.uk/en-gb/professionals/reportingconcerns.aspx

Service User reference/NHS No: (Swift/PRN/NHS) (if known)	Date Form Completed:

1.Tell us if the concern is for a person or an Organisation: (please complete as much of this as is known – if not known put N/K)			
Name of person who you are concerned about:			
Organisation:			
Gender:			
Home Address:			
Telephone Number:			
Age:	DOB:		
Ethnic Origin and or Nationality:			
Does the person have any Communication Needs:			
Are they aware of this referral	☐ Yes	☐ No	
Have they agreed to this referral:	☐ Yes	☐ No	If not, why not:
Is the adult in receipt of any social or health care services:	☐ Yes	☐ No	☐ Not Known
If yes, please give brief details:			

2a. – Current Situation and Details of the Incident/Concern(s) being raised		
Does the person continue to be at risk of harm?	☐ Yes	☐ No
Are there other people who may be at risk of harm?	☐ Yes	☐ No
If the answer to either of the above is yes, please describe the risk that remains and the names of any others potentially at risk: (please only refer to identified risk that relates directly to the concern)		

2b. Details of the concern(s) being raised
Time of incident:
Date:
Location of Incident:
Concern: What would the adult like as the outcome of the enquiry:
Brief factual details of the incident: This should include a clear factual outline of the concern being raised with details of times, dates, people and places where appropriate. (please continue on separate sheet if required).

If injuries are present please give a brief/accurate description:		
Has a body chart been completed? (If completed please attach to SET SAF 1 or forward as soon as possible.)	☐ Yes	☐ No
Details of any medical attention sought:		
Doctor Informed?	☐ Yes	☐ No
Name of Doctor informed: Date and time of information given:		
Actions taken to date to safeguard the individual:		
Are any other professionals aware in this alert? (in particular please specify if the police are involved)?		
Where Police are involved please state the crime incident number?		

3. Relative/Name of Main Carer		
Name: Relationship to Person:		
Is Relative/Carer aware of this referral?	☐ Yes	☐ No
Contact Address:		
County:		
Postcode:		
Telephone No:		
Mobile No:		
Email:		

4. Details of Person(s) of Concern involved if abuse is suspected or in the case of Self Neglect the name of the Adult concerned (please complete as much of this as is known)		
Name:		
Gender:		
D.O.B. :		
Address (if known):		
Do they live with the adult?	☐ Yes	☐ No
If yes, in what capacity e.g. spouse, fellow resident, carer:		
Occupation/Position/Title:		
What is the relationship between the person(s) of concern and the adult who is the subject of the concern?		
Does this person hold any position of trust (paid or voluntary) that we should be made aware of?		

5. Please provide details of the person raising the alert. (We cannot guarantee your anonymity but will do all we can to keep your details confidential if you prefer)		
Can your details be shared with third parties?		
Does the person raising the alert live with the vulnerable adult?	☐ Yes	☐ No
I would prefer to remain anonymous?	☐ Yes	☐ No
If yes, please give your reasons for remaining anonymous:		
Date:		
Name:		
Job Title and/or Relationship to person referred:		
Organisation (if applicable):		
Contact Address:		
County:		
Postcode:		
Telephone No:		
Mobile:		
Email:		

6. Details of person completing the form (add only if different to box 5)
Name:
Date completed:
Contact Address:
County:
Postcode:
Telephone No:
Mobile:

Email:

* FOR HEALTH STAFF ONLY – HAVE YOU COMPLETED YOUR LOCAL INCIDENT FORM PRIOR TO SENDING THIS FORM

Please tick which form of abuse you suspect:

☐ Physical

☐ Sexual

☐ Psychological

☐ Financial or Material

☐ Neglect

☐ Discriminatory

☐ Organisational

☐ Modern Slavery

☐ Self Neglect

☐ Domestic Abuse

☐ Not Determined

☐ Vulnerable to Radicalisation

Completed forms should be sent to your relevant Local Authority:

Southend

By Email:

Secure email only: accessteam@southend.gcsx.gov.uk

Please note you can only send emails to the secure address if you are sending from a secure email

Email: accessteam@southend.gov.uk

By Fax to: 01702 534794

Making a referral/enquiry by telephone:

Access Team: 01702 215008

Out of hours Referrals:

General Public - 0845 606 1212

Statutory Agencies – 0300 123 0778

Fax: 0300 123 0779

Essex

By Post to: Essex Social Care Direct, Essex House, 200 The Crescent, Colchester, Essex, CO4 9YQ

Secure email only: essexsocialcare@essex.GCSX.gov.uk Please note you can only send emails to the secure address if you are sending from a secure email address

Non Secure email: Socialcaredirect@essex.gov.uk

By fax to: 0845 601 6230

Making a referral/enquiry by telephone: 0845 603 7630

Out of hours Referrals:

General Public - 0845 606 1212

Statutory Agencies – 0300 123 0778

Fax: 0300 123 0779

Thurrock

By Email: SafeguardingAdultsTeam@thurrock.gcsx.gov.uk

By Fax to: 01375 652760

Making a referral/enquiry by telephone:

Community Solutions Team: 01375 652868

Out of hours: 01375 372468 (Fax 01375 397080)

Completion by Investigating/Receiving Team
☒ SET SAF1 Received (mandatory for all alerts) ☐ SET SAF RISK (*At all stages there must be an on-going and documented Risk Management Plan)* ☐ Proceed to information gathering SET SAF2 ☐ Proceed to Closure SET SAF4
Key team referred to**:**
Name:
Contact Address:
Telephone No:
Mobile No:
Email:

Referrer updated?	☐ Yes	☐ No	By Whom:
If not, reasons why:			
Signed:			
Date:			

* If this is a complaint refer to the Complaints Team

Appendix 7 **Quality/Safeguarding Information Sharing Sheet**

The purpose of this sheet is to share information, monitor information when a CHC Nurse assessor or a member of the CCG identifies concerns when they visit a resident/patient/any care setting.

Date of Visit:	**Time of Visit:**
Area Visited:	
Name of Nurse Assessor:	
Information Sheet Shared with: CCG safeguarding leads: **Sarah Jane Ward/Dawn Brown/Vicky Cline/other:**	
Safe - Environment	
First impressions: *sight, sound, smell, Is the area clean and tidy?*	
Visibility of staff, staff attitude.	
If a care home is the door entry/exit secure?	
Safe - Medication	
Is the MAR completed?	
Check for general storage of medication, e.g. if medication round in progress is the drug trolley secure, or locked, meds left on side	
Safe - Infection Control	
Do mattresses/pressure cushion appear clean?	

Are staff washing hands?	

Effective - Care Planning and Documentation	
Check for MCA/DOLS. Residents having 1 to 1?	
Have relevant risk assessments (Waterlow, MUST, falls, NEWS) been completed and reviewed regularly	
Are care plans reflecting needs of patient?	
Are care plans reviewed at least 6 monthly?	
Effective-Nutrition and Hydration	
Observation: *How does resident appear?* *Are other residents being assisted with eating and drinking.*	
Caring – Privacy, Dignity and Respect	
Observation: Are call bells ringing continually more than you would expect	
Responsive -	
Do staff respond to your concerns/look to resolve *Do they appear responsive to other residents?*	
Well Led - Staffing	
Does there appears to be enough staff on?	

Feedback	
Resident experience-what does resident/relative say	
Feedback	
Issues discussed?	
Expectation of when issues to be resolved?	
When will nurse assessor be returning?	

Completed By:

Name **Signature**	
Designation	
Date	

Copied and Shared with care home:

Name **Signature**	
Designation in care home	
Date	

CCG Outcome:

CHC team to review Y/N Quality Visit Y/N SETSAF Y/N

Appendix 8:

Guidance for caring for adults who allege serious sexual assault

Within Essex there is a sexual abuse referral centre (SARC) based in Brentwood called Oakwood place.

For any person who presents stating they have been sexually assaulted the SARC and police should be your first point of contact.

If the person is not vulnerable/at risk and does not want the police called it is imperative you gain expert advice and support for the person from the SARC

Tel: 01277 240620 (9am-5pm) *24 hour answer phone*

Out of Hours Help Line: 0330 223 0099

Email Address: Essex.SARC@mountainhealthcare.co.uk

The SARC provide a range of services including:-

- Forensic medical examination
- Support Worker
- Sexual Offences Liaison Officer (SOLO)
- Medical Care (Emergency contraception)
- Risk assessment

General advice for health practitioners for adults who say they have been sexually assaulted:

1. Call 999 – police (if incident has just occurred) and ambulance if the person requires urgent emergency care, discuss with the SARC
2. Call the SARC and 101 if incident has been reported to you retrospectively. (if the person does not want the police called – consider capacity & discuss with the SARC)
3. DO NOT interview the person (taking a medical history is acceptable). DO not "interview" the alleged perpetrator as this could cause legal problems later.
4. Medical attention should be sought where there is a possibility that an injury may have occurred even where there are no visible signs.
5. Notify manager or nominated senior person on duty as soon as practicable.
6. Preserve all essential and vital evidence.
7. Aim to minimise the risk of further harm to the adult.
8. Reassure the person.
9. Aim to minimise the risk of intimidation by any alleged perpetrator whether known or unknown.

10. Obtain **only** sufficient information to be able to tell the police and SARC what is believed to have happened, when and where. If a **serious physical or sexual assault** is known or suspected to have happened, in order to preserve evidence:

    10.1. DO NOT allow the person to wash.

    10.2. DO NOT change their clothes unless essential for person's wellbeing. If this is necessary put each item in a separate bag.

    10.3. Try not to touch anything which may be a source of evidence.

    10.4. Do not tidy or remove anything from the location.

    10.5. Minimise the number of people entering the location or having contact with the vulnerable adult.

11. If a sexual assault is suspected or known to have happened **DO NOT** allow the person to eat or drink anything until agreed by the police unless contrary to medical advice.

12. If the vulnerable adult and alleged perpetrator are in the same location keep them separate.

13. Try not to allow the same person to deal with both vulnerable adult and alleged perpetrator (to prevent cross contamination).

14. If the same person has had contact with both vulnerable adult and alleged perpetrator record this for the police.

15. If there are any witnesses record their details and give these to the police.

16. Secure any timekeeping sheets for duty staff to prevent them being tampered with.

17. Secure medical and care records for the vulnerable adult to prevent them being tampered with.