SCHEDULE 6c

SAFEGUARDING VULNERABLE ADULTS GUIDELINES

SET Safeguarding Adults Guidelines

The Southend, Essex & Thurrock (SET) Safeguarding Adults Guidelines

Version 4.1 – August 15

Southend-on-Sea Adult Protection

Essex Safeguarding Adults Board

THURROCK SAFEGUARDING ADULTS

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PREFACE

The Safeguarding Adults Boards in Southend, Essex and Thurrock (SET) recognise the vital role that all agencies play in safeguarding adults. As part of their role to ensure that safe and effective systems are in place the Boards have worked together to develop these revised guidelines.

The guidelines set out clearly how concerns about adults at risk of abuse will be managed within the framework set out in the Care Act (DH 2014) and associated statutory guidance that are to be implemented by April 2015. This guidance represents a true multi-agency process which is comprehensive in its approach to procedures and compliant with legislation and best practice.

We are committed to protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is being promoted including, having regard to their views, wishes, feelings and beliefs in deciding on any action. We must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.

These guidelines will apply in all settings, including those managed by private, voluntary and statutory agencies. Anyone who suspects abuse in any setting should contact Adult Social Care (Southend), Social Care Direct (Essex), Community Solutions Team (Thurrock) or if known the relevant social services team to share their concern.

It is expected that all local agency safeguarding adults policies will comply with these SET guidelines, which supersede previous versions.

This document has been approved and endorsed by:

Christine Doorly Chair Safeguarding Adults Board Southend on Sea	Simon Hart Chair Essex Safeguarding Adults Board	Les Billingham Chair Thurrock Safeguarding Adults Board

Thanks are due to the SET Working Group who oversaw the development of these guidelines.

This steering group will continue to keep the document under review to take account of changes in legislation, government policy, research findings, and professional experience. For further details regarding this group or these guidelines, please contact: Michala Jury (michala.jury@essex.gov.uk).

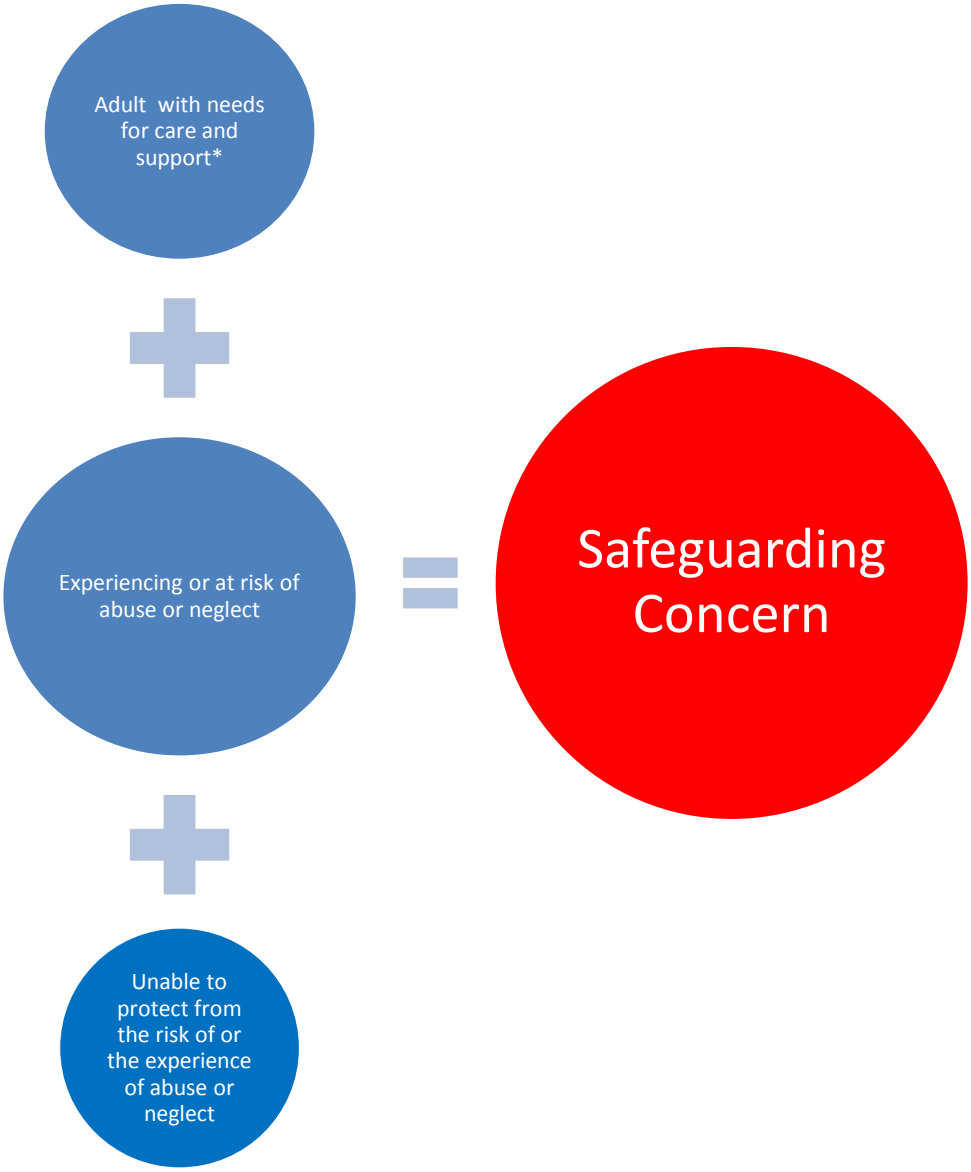
When should the SET Adult Safeguarding Guidelines be used?

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect.

Safeguarding is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is being promoted and has regard to their views, wishes, feelings and beliefs in deciding on any action.

The safeguarding process is inclusive, at all stages, of the adult(s) concerned.

This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.



*Whether or not the local authority is meeting those needs

Safeguarding is not a substitute for:

- Providers' responsibilities to provide safe and high quality care and support;
- Commissioners regularly assuring themselves of the safety and effectiveness of commissioned services;
- The Care Quality Commission (CQC) ensuring that regulated providers comply with the fundamental standards of care or by taking enforcement action; and
- The core duties of the Police to prevent and detect crime and protect life and property

It is important to recognise that there are occasions where customers and their families may be provided with support and help to manage risks around their safety that do not involve abuse. In these circumstances it may be more appropriate to follow alternative paths, for example, care management, complaints or serious incident processes.

If unsure whether a safeguarding concern should be raised you should contact your organisation's Safeguarding Lead who will be able to discuss with you further. Alternatively you can discuss with the adult social care department for your area.

1. SAFEGUARDING ADULTS

Introduction

1.1 Everyone has a duty to recognise abuse and take action to protect adults at risk of abuse or neglect. The whole community has a part to play in preventing, identifying and reporting neglect and abuse. The local authority's duty is to provide leadership across organisations throughout the county to keep people safe from harm. This is one of the local authority's highest priorities.

1.2 Since 2000, "No Secrets" (Department of Health) has provided the framework for safeguarding of adults. From April 2015, "No Secrets" is obsolete and the Care Act 2014 has established a new statutory framework for care and support, including adult safeguarding. This policy sets out how SET will fulfil its duties and commitment to protect people from harm.

Helping people to help themselves by making personalisation real

1.3 Councils across Southend, Essex and Thurrock (SET) are committed to delivering Adult Social Care. The three councils approach will always be based on helping people to help themselves and in so doing to promote progression and maximise independence

SET has signed up to 'Making it Real', demonstrating its commitment to personalisation and community-based support.
http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/TLAP/MakingItReal.pdf

Our goal is that people with eligible needs for care and support across Essex can say:

Information and advice	"I have the information and support I need in order to remain as independent as possible" "I have access to easy to understand information about care and support, which is consistent, accurate, accessible and up to date." "I can speak to people who know something about care and support and can make things happen." "I have help to make informed choices if I need and want it" "I know where to get information about what is going on in my community."
Active and supportive communities	"I have access to a range of support that helps me to live the life I want and remain a contributing member of my community."

	"I have a network of people who support me – carers, family, friends, community and if needed paid support staff." "I have opportunities to train, study, work or engage in activities that match my interests, skills, abilities." "I feel welcomed and included in my local community." "I feel valued for the contribution that I can make to my community"
Flexible integrated care and support	"I am in control of planning my care and support" "I have care and support that is directed by me and responsive to my needs." "My support is coordinated, co-operative and works well together and I know who to contact to get things changed." "I have a clear line of communication, action and follow up"
Workforce	"I have good information and advice on the range of options for choosing my support staff." "I have considerate support delivered by competent people" "I have access to a pool of people, advice on how to employ them and the opportunity to get advice from my peers." "I am supported by people who help me to make links in my local community."
Risk enablement	"I can plan ahead and keep control in a crisis" "I feel safe, I can live the life I want and I am supported to manage any risks" "I feel that my community is a safe place to live and local people look out for me and each other" "I have systems in place so that I can get help at an early stage to avoid a crisis."
Personal budgets and self-funding	"I can decide the kind of support I need and when, where and how to receive it." "I know the amount of money available to me for care and support needs, and I can determine how this is used (whether it's my own money, direct payment or a council managed personal budget)" "I can get access to the money quickly without having to go through over-complicated procedures"

	"I am able to get skilled advice to plan my care and support, and also be given help to understand costs and make best use of the money involved where I want and need this."

SET's Vision for Adult Safeguarding

People are able to live a life free from harm, where the community:

- **Has a culture that does not tolerate abuse**
- **Works together to prevent abuse**
- **Knows what to do when abuse happens**

Organisations and services are able to prevent abuse happening; act swiftly when it occurs and are competent in achieving good outcomes for people. There will be sufficient support for individuals, including specialist provision, within each area and all organisations are committed to work together.

Guiding principles

1.4 The government has established six principles that should underpin all adult safeguarding work and described the individual outcomes that should result:

	Individual Outcome	What we do to achieve that outcome
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."	We give individuals the right information about how to recognise abuse and what they can do to keep themselves safe. We give them clear and simple information about how to report abuse and crime and what support we can give. We consult them before we take any action. Where someone lacks capacity to make a decision, we always act in his or her best interests.
Prevention	**It is better to take action before harm occurs**	We help the community to identify and report signs of abuse and suspected criminal offences.

	"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."	We train staff how to recognise signs and take action to prevent abuse occurring. In all our work, we consider how to make communities safer.
Proportionality	**The least intrusive response appropriate to the risk presented.** "I am sure that the professionals will work for my interests as I see them and they will only get involved as much as needed."	We discuss with the individual and where appropriate, with partner agencies what to do where there is risk of significant harm **before** we take a decision. Risk is an element of many situations and should be part of any wider assessment.
Protection	**Support and representation to those in greatest need.** "I get help and support to report abuse. I get help to take part in the safeguarding process to the extent to which I want"	We have effective ways of assessing and managing risk. Our local complaints and reporting arrangements for abuse and suspected criminal offences work well. Local people understand how we work and how to contact us. We take responsibility for putting them in touch with the right person.
Partnership	**Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.** "I know that staffs 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 results for me."	We are good at sharing information locally. We have multi-agency partnership arrangements in place and staffs understand how to use these. We foster a "one team" approach that places the welfare of individuals before the needs of the system.

Guidelines

Accountability	**Accountability and transparency in delivering safeguarding.** "I understand the role of everyone involved in my life and so do they."	The roles of all agencies are clear, together with the lines of accountability. Staffs understand what is expected of them and others. Agencies recognise their responsibilities to each other, act upon them and accept collective responsibility for safeguarding arrangements.

Making Safeguarding Personal

1.5 Southend Borough Council, Thurrock Council and Essex County Council are committed to the principles of **Making Safeguarding Personal**, a project developed by the Local Government Association and the Association of Directors of Adults Social Services. The aim of Making Safeguarding Personal is to ensure that safeguarding is person-led and focused on the outcomes that they want to achieve. It engages the person 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.

1.6 We will:

- Work with adults (and their advocates or representatives if they lack capacity) at the beginning to identify the outcomes they want to achieve.
- Review with the adult at the end of safeguarding activity to what extent their desired outcomes have been achieved.
- Record and monitor the results in a way that can be used to inform practice and account to the three respective Safeguarding Adults Boards.
- Develop a range of robust and appropriate responses that focus on supporting adult to meet their desired outcomes and reduce the risk of or recurrence of abuse.

Definition of Adult Safeguarding

1.7 The purpose of adult safeguarding is to prevent harm and reduce the risk of abuse or neglect to adults with care and support needs. The statutory framework introduced under the Care Act applies to any person aged 18 or above who:

- Has needs for care and support (regardless of the level of need and whether or not the local authority is meeting any of those needs)
- Is experiencing, or is at risk of abuse or neglect, **and**
- As a result of those needs, is unable to protect themselves against the abuse or neglect or the risk of it.

1.8 Carers and safeguarding

Circumstances in which a carer (for example, a family member or friend) could be involved in a situation that may require a safeguarding response include:

- a carer may witness or speak up about abuse or neglect;
- a carer may experience intentional or unintentional harm from the adult they are trying to support or from professionals and organisations they are in contact with; or,
- a carer may unintentionally or intentionally harm or neglect the adult they support on their own or with others.

1.9 Where someone over 18 is still receiving children's services (e.g. in an education setting until the age of 25), and a safeguarding issue is raised the matter should be dealt with through adult safeguarding arrangements. Children's safeguarding and other relevant partners should be involved as appropriate. The level of needs is not relevant and the young adult does not need to have eligible needs for care and support under the Care Act.

1.10 Abuse and neglect can take many forms. It may be an isolated incident, a series of incidents or a long term pattern of behaviour and could affect one person or more, whether in someone's home, in public or in an institutional setting. It may be deliberate or the result of negligence or ignorance. The degree or lack of intent will inform the response. Also see appendix 1 for further guidance on this.

Physical abuse	Assault, hitting, slapping, pushing, misuse of medication, restraint, inappropriate physical sanctions.
Domestic violence	Psychological, physical, sexual, financial, emotional abuse; so-called "honour" based violence and forced marriage.
Sexual abuse	Rape, sexual assault, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, sexual act to which the adult has not consented or was pressured into consenting.
Psychological abuse	Emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber-bullying, isolation, unreasonable and unjustified withdrawal of services or supportive networks.
Financial or material abuse	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.
Modern slavery	Encompasses slavery, human trafficking, forced labour and domestic servitude.
Discriminatory abuse	Harassment, slurs or similar treatment because of race, gender and gender identity, disability, sexual orientation or religion.
Organisational abuse	Neglect and poor care practice within an institution or specific care setting, such as a hospital or care home, or in relation to care provided in someone's own home.
Neglect and acts of omission	Ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, withholding of the necessities of life, such as medication, adequate nutrition and heating.
Self-neglect	A wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

Proportionality

1.11 The types and forms of abuse or neglect are broad and it is important that where people have concerns about abuse that they raise these concerns. However growing awareness of adult abuse has led to an increase in reports of concerns and subsequent safeguarding work. Many concerns are directed towards the safeguarding system when they should be dealt with through contractual, managerial, complaints or disciplinary procedures. Some concerns require complex social work case management rather than a formal safeguarding response.

1.12 Examples of some of the distinctions include:

Non-safeguarding issues	Safeguarding issues
Isolated incidents of teasing or rudeness.	The alleged victim considers the actions against them abusive and there is a safeguarding issue.
One-off disagreements where neither person is harmed or is considered to be particularly vulnerable to the other.	There appears to be a deliberate attempt to cause harm, distress or exploitation.
One-off, minor incidents where no harm has been caused.	Incidents are repetitive and targeted at the person(s).

Incidents involving disputes or shouting between individuals where there is deemed to be an equal power relationship. Staff errors that cause no or little harm. Poor quality practice or services or non-compliance with care standards or contractual requirements, where no person is at risk of harm and incidents of disagreement between an adult and others, where the person is not at risk or harm. This requires a contractual management or quality improvement response.	Unexplained bruising, cuts or injuries especially if on repeated occasions. Bad practice, lack of care or negligence by a provider or care worker that places people at risk of harm or causes actual harm. Any incident that involves a potential criminal matter including assault, a sexual offence, coercion, fraud, theft, neglect or ill treatment leading to ill health or death, hate crime, inappropriate restraint.

1.12 All partners will ensure that concerns are addressed proportionately so that we do not make the situation worse for the person at the centre of our concerns. We will ensure that all alerts are logged promptly, people are given information and referred to the most appropriate organisation to help them. Guidance on referral thresholds will ensure that alerts receive the most appropriate response and enable Safeguarding and locality teams to focus on adult safeguarding issues.

Level 1: Universal Services	People's needs can be met through health, education or police services and they do not have additional needs.
Level 2: Complaints, case management, reviews	Low level concerns relating to people who need and receive additional services from a single practitioner or agency and whose wellbeing may be affected without those services. Issues that could be addressed through internal processes (disciplinary, complaints, care management).
Level 3: Risk assessment, risk management	Moderate concerns where the individual needs professional support to help them stay safe and manage risks effectively. Issues that could be addressed through risk management approaches, complex case management and / or an integrated multi-agency response.
Level 4: Adult safeguarding / protection	Serious concerns relating to an adult who has care and support needs, is unable to protect themselves because of those needs and who has been placed at risk of harm because of the actions (deliberate or unintentional) of others. Issues involving risk of significant harm to an adult who meets these

	criteria require a safeguarding response. Potential criminal matters **must** be referred to the Police.
Level 5: Safeguarding adults review	Under the Care Act, the Safeguarding Adult Board must undertake a review in any case where: • An adult with needs for care and support was (or it is suspected they were) experiencing abuse or neglect **and** • the adult dies or there is reasonable cause for concern about how the Safeguarding Adults Board, a member of it or some other person involved in the adult's case acted. See Appendix 16

1.13 Regular small concerns could amount to a far higher level of concern which then requires a safeguarding alert. Incidents should be logged and the context, background, history etc. should be taken into account when deciding whether an alert is required.

Empowering Individuals

1.14 If someone is – or feels – at risk of abuse, the primary duty is to protect them and support them to feel safer. The primary purpose of adult safeguarding is to stop abuse or neglect wherever possible and to prevent harm and reduce the risk of abuse or neglect to adults with care and support needs.

1.15 In line with the commitment to **Making Safeguarding Personal** and our Guiding Principles safeguarding work should ensure that individuals are supported to make choices and have control in how they choose to live their lives. Achieving a good outcome for the person is the key measure of success. The focus should be on improving their safety and wellbeing and supporting them to reach the resolution that is right for them.

Personalisation and achieving good outcomes

1.16 Personalisation in safeguarding requires engaging with people throughout the process to understand the outcome they want to achieve and support them to achieve it, recognising that their wishes may change along the way. Examples of the kind of outcomes that people might want are:

- to feel safer
- to maintain a key relationship
- to get new friends
- to have help to recover
- to have access to justice, or an apology, or to know that disciplinary or other action has been taken
- to know that this won't happen to anyone else
- to maintain control over the situation
- to be involved in making decisions

- to have exercised choice
- to be able to protect themselves in the future
- to know where to get help

1.17 Establishing whether or not harm or abuse has occurred or ensuring that the person receives increased monitoring or care are **not** outcomes – these are service responses.

1.18 In some cases, the discussion will involve helping people to reconcile competing outcomes – for example, to be safe and to maintain an unsafe relationship. It is also important to work with the family as a whole, particularly where a family carer may be the subject of the complaint. In these instances it will be important to explore why the situation arose and what would be helpful to the family rather than simply enquire who did what.

1.19 In safeguarding adults, all partners are committed to improve outcomes for people at risk of harm. The partners recognise that people have complex lives and that being safe is only one of the things they want for themselves. There are key elements to ensuring that the safeguarding service is effective in this:

	We will:
Engagement and informed choice	• engage with people to understand the outcome they want to achieve at the start and throughout the process and consult them before taking any decision on any intervention • provide timely information about choices in a non-threatening, clear and supportive way • actively involve the person and their family in planning to protect them from harm, minimise potential risks and take full account of their wishes and best interests
Workforce skills	Ensure practitioners • have the skills to work with families and wider networks • have the skills, knowledge and support to use the full range of legal and social work interventions
A range of person-centred responses	Ensure there is a range of responses to support people to achieve the outcomes they want. For example, the use of family group conferencing, network meetings or mediation to support people in resolving their circumstances.
Audit and monitoring	Establish and maintain systems to monitor how far the outcomes people want are realised in order to assess the effectiveness of our safeguarding services.

Guidelines

1.20 One cause of dissatisfaction for people who have been victims of abuse or who feel the safeguarding service has not worked for them is feeling that they have not obtained justice or been treated fairly. All partners will work closely with local criminal and justice services to ensure victims get the same access to justice as everyone else.

Risk enablement

1.21 Managing risk is a key aspect of keeping people safe. However, it is recognised that risk is an inevitable consequence of people making decisions about their lives. If a person has the mental capacity to make a decision and understands the possible consequences of their choice, they are entitled to accept an element of risk.

Capacity, consent and decision-making

1.22 The Mental Capacity Act 2005 (MCA) applies to anyone over 16 who is unable to make all or some decisions for themselves. Adults (over 18) can appoint people to make decisions on their behalf in the event that they become unable to make their own decisions under a Lasting Power of Attorney. Alternatively, if the person does not have capacity to do this, the Court of Protection may appoint a Deputy to make decisions on their behalf. If an adult is believed to lack the capacity to engage in decisions about how their needs will be met, the **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.

1.23 There are some decisions which can never be made on behalf of someone who lacks capacity to make the decision themselves:

- Decisions concerning family relationships:
  - Consent to marriage / civil partnership;
  - Consent to sexual relations;
  - Consent to a child being placed for adoption or the making of an adoption order;
  - Discharging parental responsibility in a matter not relating to the child's property;
  - Treatment for mental disorder under the Mental Health Act.

Deprivation of Liberty

1.24 If arrangements proposed for the care or treatment of someone who lacks capacity would amount to a **deprivation of liberty**, this must be authorised in accordance with Mental Capacity Act or Mental Health Act requirements. A deprivation of liberty arises if the person will be under continuous supervision and control, is not free to leave and lacks capacity to consent to these arrangements. This includes domestic settings, such as a supported living placement, if the local authority has imposed the arrangement. The purpose of the placement or the person's compliance or lack of objection to it are not relevant to whether there is a deprivation of liberty requiring authorisation.

1.25 A potential safeguarding issue arises when a potential deprivation of liberty is identified and not acted upon through raising an appropriate authorisation. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/223403/dh_095873.pdf.

Appropriate person

1.26 Under the Care Act, the local authority is required to consider whether there is an appropriate person who can facilitate the adult's involvement in the safeguarding process. There are three requirements:

1. Someone who is already providing care and treatment in a professional capacity or on a paid basis **cannot** be the appropriate person. This includes a GP, nurse, key worker or care and support worker involved in the adult's care and support.

2. The adult subject to the safeguarding enquiry or Safeguarding Adults Review has to agree to the person supporting them, if they have capacity to make this decision. A relative cannot be an appropriate person if the adult with capacity does not wish to be supported by them. If the adult does not have capacity to consent to being supported by a particular person, the local authority must be satisfied that it is in the adult's best interests.

3. The role of the appropriate person is to actively support the adult's participation in the process. In some cases it is unlikely that they will be able to do this: for example:
   a. There is a conflict of interest;
   b. They live at a distance or only have occasional contact with the individual;
   c. They find it difficult to understand the Local Authorities processes themselves;
   d. They express their own opinions rather than those of the individual concerned.

1.27 If it becomes clear that the appropriate person has difficulty supporting the adult's involvement, the Local Authority must arrange for an independent advocate to do so.

1.28 If it is not immediately clear whether there is an appropriate person, the local authority may need to arrange for an advocate to support the adult in the initial stages of the process, who may hand over to the appropriate person once they are identified.

1.29 Where an advocate has been appointed, a family member or friend should still be appointed to offer support to the person.

Advocacy

1.30 Under the Care Act, the local authority or their agent **must** arrange for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review, where the adult has "substantial difficulty" in being involved in the process and where there is no other suitable person to assist. A person who is engaged to provide care or treatment for the adult in question in a professional capacity cannot be an advocate.

1.31 The adult must consent to being represented and supported by the advocate. If the adult lacks capacity, the local authority must follow the Mental Capacity Act Guidance in relation to determining that it is in the adult's best interests to be represented and supported by the advocate.

1.32 The local authority has a separate duty to provide an Independent Mental Capacity Advocate (IMCA) in safeguarding enquiries if someone lacks capacity to fully participate. An adult with dementia, significant learning disabilities, a brain injury or mental ill health is likely to need an IMCA. The IMCA can support and represent an adult at risk of abuse and neglect where necessary and appropriate. The local authority does not have to provide two separate advocates and it is not likely to be in the adult's best interests to do so. Please see Appendix 9 for more guidance.

Duty to make enquiries

1.33 Under the Care Act, the local authority **must** make enquiries, or ensure others do so, if it reasonably suspects that an adult who has care and support needs is being abused or neglected and they are unable to protect themselves against the abuse or neglect because of those needs.

1.34 The scope of that enquiry, who leads it and its nature, will depend on the circumstances. It could range from a conversation with the individual who is the subject of the concern, or their representative through to a more formal, multi-agency investigation.

1.35 Where a conflict of interest has been identified, the local authority will ensure that this is appropriately addressed when deciding who will lead the enquiry.

1.36 An enquiry will usually start with asking the adult their view and wishes which will often determine the next steps. Everyone involved in an enquiry must focus on improving the adult's wellbeing and work together to that shared aim.

1.37 The purpose of the enquiry is to decide whether or not the local authority, or another person or organisation, should do something to safeguard the person from actual or potential abuse or neglect. The objectives are to:

- Establish the facts
- Ascertain the individual's views and wishes and seek consent
- Assess the needs of the adult for protection, support and redress

- Safeguard from the abuse and neglect, in accordance with the wishes of the adult
- Make decisions as to what follow-up action should be taken with regard to the person or organisation responsible for the abuse or neglect.
- Enable the adult to achieve resolution and recovery

1.38 If the local authority decides that someone else should undertake the enquiry (a provider for example), the local authority must specify the timescales for this and be informed about the outcomes of the enquiry.

1.39 All staff must keep accurate records, clearly stating what the facts are, the views of the adult and the known opinions of professionals and others.

1.40 The adult should always be involved from the beginning of the enquiry unless there are exceptional circumstances that would increase the risk of abuse. If the adult has substantial difficulty in being involved and there is no one appropriate to support them, the local authority must arrange for an independent advocate to represent them.

1.41 As a matter of principle, the local authority must ensure that it does no further harm through its intervention. Any involvement must be proportionate and reasonable; however the first priority must always be to ensure the safety and wellbeing of the adult. Other less restrictive options should be explored as soon as it is safe and appropriate to do so.

1.42 If a crime is suspected the police should be informed and they will then be under a duty to investigate.

Fundamental Standards and the Duty of Candour

1.43 All health and social care providers are required to meet **fundamental standards** of care as a condition of their registration with the Care Quality Commission. There will be criminal penalties for failing to meet some of the standards.

1.44 The fundamental standards describe the basic requirements that providers should always meet and set the standard of care that adult should always expect to receive.

1.45 As part of the fundamental standard requirements, all health providers are subject to a statutory duty of candour. This means that the organisation must be open and transparent with adults about their care and treatment when it goes wrong. The duty requires to be triggered when there is identified harm, from their care or treatment, caused by the organisation.

Guidelines

Supporting Families

1.46 The safety of children is paramount – please visit the http://www.escb.co.uk/Portals/15/Documents/Local%20Practices/SET%20Procedures%202015.pdf to access the SET Safeguarding Children's Guidelines.

The SET Adults Guidelines are written in the spirit to holistically recognise and support the needs of families:

- Ensures a joined up approach to families' needs
- Improves the identification of children in need and in need of protection through increased understanding of the impact of an adult's problems on a child's life
- Recognises the needs of adults as customers and parents/carers
- Recognises the needs of children who may be acting as young carers
- Ensures good co-operation and collaborative working across organisations by agreeing and jointly owning procedures for all stages of the interaction between families and agencies from referrals to assessments and information sharing to planning
- Improves inter-agency communication and information sharing through the use of a common policy
- Takes account of the new young carers requirements
- Improves the identification of parents/relatives who may require services to live as independently as possible

Safeguarding Responsibilities for Prisoners

1.47 The Statutory Guidance for Implementation (DH 2015) makes clear that safeguarding responsibility for prisoners rests with the prison or approved premises, and that guidance on how this duty will be discharged will be the subject of separate guidance from the National Offender Management Service.

To promote good practice and to facilitate the sharing of intelligence SET will invite the Governors of local prisons and approved premises to be members of the relevant Safeguarding Adults Boards.

2. YOUR PART TO PLAY: AGENCY ROLES AND RESPONSIBILITIES

2.1 People, who use health and care services should be treated with dignity and respect, receive high quality, compassionate care and be safe from harm and abuse[1]**.**
Ensuring that this happens is the prime responsibility of those who provide and commission services and the main focus for those who regulate standards in care.

2.2 Clarity on roles and responsibilities is especially important at a time when:

- public and political concerns have been raised by a number of failures of care and cases of abuse that have shaken confidence in the care system
- major organisational changes in the NHS, and the transfer of safeguarding responsibilities to new organisations, have led to some uncertainty
- the Care Act, as it comes into effect, will place adult safeguarding arrangements on a statutory basis and bring in new duties.

What should be achieved through action to safeguard adults?

2.3 It's important to remain focused on outcomes rather than just the process of Safeguarding. The outcomes should be to:

- **Promote well-being** and **prevent** abuse and neglect from happening in the first place
- Ensure the **safety and wellbeing** of anyone who has been subject to abuse or neglect
- **Take action against those responsible** for abuse or neglect taking place
- **Learn lessons and make changes** that could prevent similar abuse or neglect happening to other people (e.g. through learning and development programmes for staff).

Putting the person at the centre

2.4 The vision for adult social care and health services is one where the person has real choice and control over what happens – "no decision is made about me without me" (People who lack capacity need someone to represent them in their best interests). Actions taken therefore need to be shaped by the best outcome for the person who has suffered abuse and neglect and fully involving that person, or their representative or advocate, in decisions. Work is currently underway to develop best practice[2] to achieve this aim and the following diagram shows how agencies should work together so that they are in the right relationship to the person they are trying to help to protect.

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[1] This includes having due regard to the need to eliminate discriminatory abuse, harassment and victimisation

[2] Making Safeguarding Personal

Summary of roles and responsibilities for adult safeguarding

- There is some concern nationally that the development of adult safeguarding working arrangements has resulted in too much focus on a specific process (of referral, strategy meeting, investigation, protection planning, case conference and review) and not enough on agreeing which actions will achieve the most positive outcomes for people. In some cases, other powers and actions could be used more quickly and beneficially rather than solely pursuing current formal safeguarding procedures. An appropriate balance needs to be struck between referring cases on for safeguarding investigation and an understanding of what other remedies there are available which could tackle and resolve the issue.

- **Safeguarding is everybody's business**. Therefore providers are required to meet essential/fundamental standards of care and people using services are safeguarded additionally through monitoring by providers and commissioners, regulation and inspection. People's welfare

should also be secured by good commissioning, contracts management and, for some people, by care management or other forms of review.

- It is for local safeguarding partnerships to make an agreement about how decisions are made, in different health and social care settings, as to what should be appropriately considered a safeguarding issue and addressed through a safeguarding investigation and what should be more appropriately dealt with through other routes including complaints, employment law, contract monitoring and compliance, regulation and quality improvement processes. All of these routes, used effectively, will safeguard people. The important thing is for all options to be considered, recorded and co-ordinated and for the best interests of the person who has been abused always to be at the forefront of people's minds. A common theme in the learning from Serious Case Reviews for children and adults has been that information about poor and dangerous services was not collated or linked with other information so that intervention might have taken place before serious harm or death occurred. Local partnerships therefore need to have effective procedures for sharing information and means of communication in place to intervene before a problem becomes a crisis.

- At a local level some partnerships have set up multi-agency groups which regularly review data and intelligence about care services and plan joint actions. Good practice would be to ensure that there is effective information sharing between staff responsible for monitoring the performance of care providers and those responsible for investigating safeguarding incidents. This is needed to ensure that co-ordinated and proportionate action is taken to tackle poor care and that the threshold into safeguarding investigation is kept under regular review.

- The simplified diagram below summarises the range of powers and responsibilities that agencies should be using to tackle abuse and neglect. Reference should be made to more detailed national guidance, the statutory responsibilities of organisations and professionals and local policies and procedures on adult safeguarding.

Safeguarding Adult Boards • Hold partners to account • Monitor outcomes and effectiveness • Use data and intelligence to identify risk and act on it • Coordinate activity	
Social Care and Health Providers • Show leadership and routinely monitor activity • Meet the required service quality standards • Train staff in safeguarding procedures and ensure they are effectively implemented • Investigate and respond effectively to incidents, complaints and whistleblowers	**Social Care and Health Commissioners** • Build safeguarding into commissioning strategies and service contracts • Review and monitor services regularly • Intervene (in partnership with the regulator) where standards fall below fundamental standards or abuse is taking place

• Take disciplinary action against staff who have abused or neglected people in their care		
Commissioners and Contract Monitors • Ensure that contract specifications guarantee services are bound contractually to follow local safeguarding procedures • Work with providers to ensure that services learn from safeguarding allegations • Monitor provider performance with regulators • Partake in safeguarding meetings or receive information and take actions from meeting to drive performance and quality		
Clinicians • Apply clinical governance standards for conduct, care & treatment & information sharing • Report incidents of abuse, neglect or undignified treatment • Follow up referrals • Consult patients and take responsibility for ongoing patient care • Lead and support enquiries into abuse or neglect where there is need for clinical input	**Social Workers/Care Managers (Mental Health Trusts or Local Authority)** • Identify and respond to concerns • Identify with people (or their representatives or IMCAs/Advocates if they lack capacity) the outcomes they want • Build managing safeguarding risks and benefits into care planning with people • Review care plans • Lead and support enquiries into abuse or neglect • Be champions in their organisations • Provide specialist advice and coordination • Respond to concerns • Make enquiries • Work with the person subject to abuse • Coordinate who will do what – e.g. criminal or disciplinary investigations	**Police** • Investigate possible crimes • Conduct joint investigations with partners • Gather best evidence to maximise the prospects for prosecuting offenders • Achieve, with partners, the best protection and support for the person suffering abuse or neglect – including victim support
Professional Regulators • Set the culture and professional standards • Apply the Fit to Practice test • Take action where professionals have abused or neglected people in their care	**Care Quality Commission** • Register, monitor, inspect and regulate services to make sure they provide people with safe, effective, compassionate, high-quality care • Intervene and take regulatory action on breaches • Publish findings including performance ratings	**Monitor** (within England) • Independent NHS foundation trusts are well-led so that they can provide quality care on a sustainable basis • Essential services are maintained if a provider gets into serious difficulties • The NHS payment system promotes quality and efficiency • Procurement, choice and competition operate in the best interests of patients

3. DEFINITIONS

The SET adult safeguarding guidelines use a number of specific words and terms that have specific definitions in the context of safeguarding many of which are set out in statute (for example the Care Act 2014) or other statutory guidance. Appendix 4 provides a reference for the key definitions that are used in these guidelines.

4. INFORMATION SHARING

1. Early sharing of information is key to providing effective help where there are emerging concerns. The wellbeing of adults at risk of abuse is likely to be more important than concerns about sharing information.

2. The Information Sharing Protocol for agencies working with adults and carers in Essex can be found here . It should be read in conjunction with the SET Safeguarding Adults Guidelines which set out the overall process for safeguarding enquiries.

3. No-one should assume that someone else will pass on information which they think may be critical to the safety and wellbeing of an adult at risk of abuse or neglect. If a professional has concerns about an adult's welfare and believes they are suffering abuse or neglect, they should share their concerns with the local authority.

Confidentiality and consent

4. Practitioners must always seek the consent of the person at the heart of the safeguarding enquiry before taking action or sharing information. However there may be circumstances when consent cannot be obtained because the adult lacks the capacity to give it but the best interests of the individual or others at risk of harm demand action. In these cases Mental Capacity Act guidance should be followed.

5. In some cases, where a person refuses consent, information can still lawfully be shared if it is in the public interest to do so. This may include protecting someone from serious harm or preventing crime and disorder. The key factors in deciding whether or not to share confidential information are:
   - **necessity –** sharing is likely to make an effective contribution to preventing the risk, and
   - **proportionality** – the public interest in sharing outweighs the interest in maintaining confidentiality.
6. If there is any doubt about whether to share information, advice should be obtained from the local authority's legal service.

   For guidance on Information Sharing see appendix 18

5. PROCEDURES FOR SECTION 42 ENQUIRIES

5.1 S42 – Summary

5.1.1 Local authorities in Southend, Essex and Thurrock have a statutory duty[3] to make enquiries or cause others to do so, if they reasonably suspect an adult[4] is, or is at risk of, being abused or neglected.

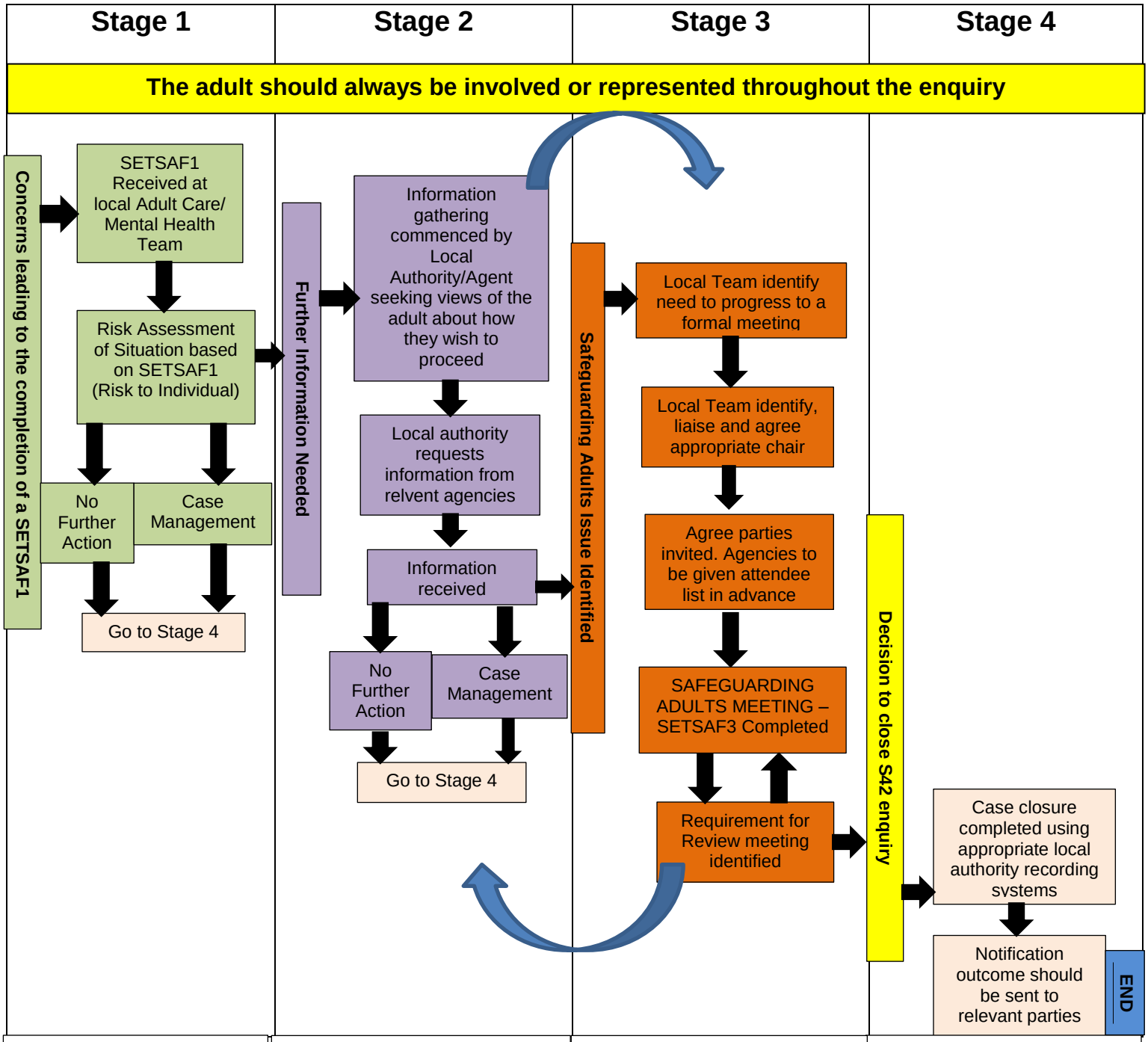
5.1.2 An enquiry is the action taken or instigated by the local authority in response to a concern being raised that abuse or neglect may be taking place. The professional concerned should record the concern, the adult's views and wishes, any immediate action taken and the reason for these actions on a SET SAF1.

5.1.3 The purpose of the enquiry is to decide whether or not the local authority or another organisation or person, should do something to help and protect the adult. If the local authority decides that another organisation should make the enquiry, for example a care provider, then the local authority should be clear about timescales, the need to know the outcomes of the enquiry and what action will follow if this is not done.

5.1.4 What happens as a result of an enquiry should reflect the adult's wishes wherever possible, as stated by them or by their representative or advocate. If they lack capacity it should be in their best interests if they are not able to make the decision and be proportionate to the level of concern.

[3] Section 42, Care Act 2014 http://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted
[4] Definition set out at Appendix 4

5.2 S42 - SETSAF Stages



- SET SAF1 should be completed within 2 working days

- SET SAF Risk or the DASH Risk (if required) should be completed within four hours of receipt of Set SAF 1 into Social Care.

- If needed a meeting should be within 28 working days of completion of SET SAF 1
- Meeting actions to be distributed within: 5 working days of meeting
- SET SAF 3 distributed within: 10 working days Comments and accuracy to be returned within: 5 Working days

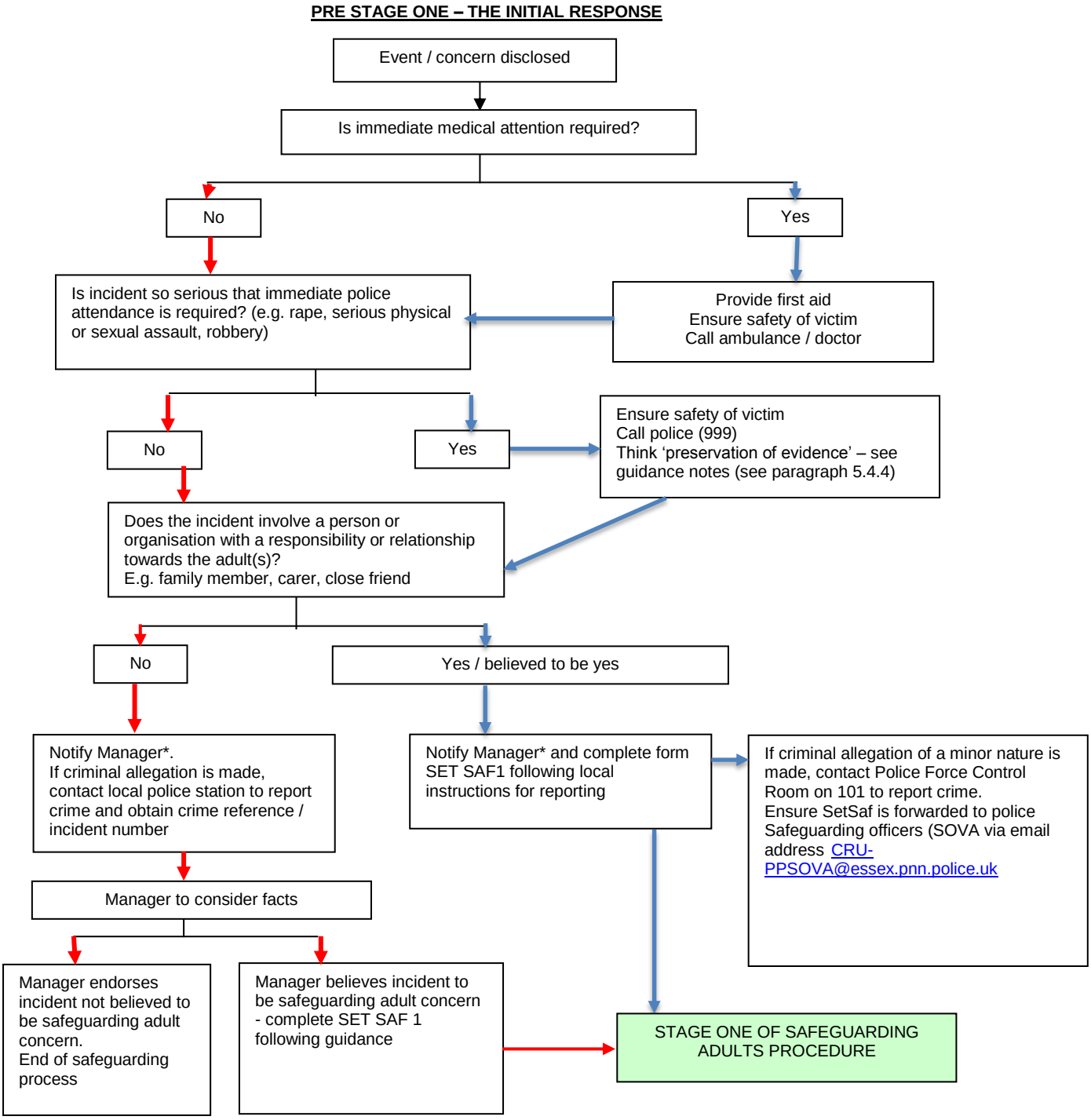
- Enquiry closure should be signed by the practitioners and manager within five working days of the case being closed. **Referrer must be advised of the outcome.**

5.3. SET PROCEDURES TIMESCALES FOR SECTION 42 ENQUIRIES

- SET SAF 1 should be completed as soon as possible but no later than within two working days of the concern being raised. Completion of SET SAF 1 must not delay immediate action being taken where necessary to ensure the safety of the adult and the preservation of evidence if it suspected that a crime has been committed.
- A decision regarding whether a concern will be managed as an ALERT or SECTION42 enquiry will be made within 4 hours.
- SET SAF Risk or the DASH Risk (if required) should be completed within 24 hours of receipt of SET SAF 1 into Social Care, where safeguard concerns have been identified.
- A visit to the adult or service should take place within a maximum of seven working days of receipt of a SET SAF 1, if after consultation it is agreed a face to face visit is not necessary, clear evidence of this decision must be recorded.
- If a safeguarding meeting is needed (SET SAF 3), this should be done within 28 working days of the completion of SET SAF 1 – if held outside of these timescales clearly documented reasons should be given.
- SET SAF 3 – Actions to be distributed within: five working days from when the safeguarding meeting took place
- SET SAF 3 distributed within: ten working days
- SET SAF 3 – Comments and accuracy to be returned within: five working days of receipt of the SET SAF3
- SET SAF 4 should be signed by the practitioners and manager within: five working days of the case being closed. **Referrer must be advised of the outcome.**

5.4 ACTIONS PRIOR TO S42 ENQUIRY

This flowchart is aimed at all staff



*Unless manager is alleged perpetrator or implicated in concern. In these circumstances identify alternative manager or discuss directly with social services

Health Care Organisations should follow local process for reporting which integrates Clinical Governance and Safeguarding
Ensuring the safety of the adult and any other people at risk is the primary responsibility of staff when they become aware of a serious incident

5.5 THE INITIAL RESPONSE – GUIDANCE

5.5.1 The first priority should always be to ensure the safety and wellbeing of the adult. The adult should experience the safeguarding process as empowering and supportive. The practitioners should wherever practicable seek the consent of the adult before taking action. However there may be circumstances when consent cannot be obtained because the adult lacks the capacity to give it, but it is in their best interests to undertake an enquiry.

5.5.2 Whether or not the adult has capacity to give consent, action may need to be taken if others are or will be put at risk if nothing is done or where it is in the public interest to take action because a criminal offence has occurred. It is the responsibility of all staff and members of the public to act on any suspicion or evidence of abuse or neglect and to pass on their concerns to a responsible person or agency.

5.5.3 The first actions taken on discovering an incident has occurred or concern is raised are critical to any subsequent enquiry. In some cases the course of action is very clear, for example where a person has been subjected to a physical assault and needs immediate medical treatment for injuries, or there is an allegation of a crime.

5.5.4 It is often the less obvious cases which create concerns for staff and family on how they should be reported. These guidelines seek to ensure positive action for all reports of injury, crime or concern raised on or behalf of an adult.

5.5.5 **IN ALL CASES**

- The views of the person about what they would like to happen should be sought, recorded and taken into account
- Any action should aim to minimise the risk of further harm to the adult (or others)
- Medical attention should be sought where there is a possibility that an injury may have occurred even where there are no visible signs
- Action should be taken to preserve all essential and vital evidence (see 5.5.6)
- Aim to minimise the risk of intimidation by any alleged perpetrator whether known or unknown should be minimised
- Obtain **only** sufficient information to be able to tell the police, medical personnel or management what is believed to have happened, when and where
- If a crime is being alleged contact the police
    - ‘999’ for an emergency (e.g. rape, serious physical or sexual assault, robbery),

- The non-emergency number 101 to report a crime where a safeguarding issue is not alleged/suspected (e.g. property has been stolen by another adult or the adult has been assaulted by a neighbour when out shopping)
- The non-emergency number 101 to report a crime if a safeguarding issue is suspected a setsaf should be completed and forwarded to the Safeguarding officers within Essex police on the email CRU-PPSOVA@essex.pnn.police.uk (e.g. property being stolen by a staff or family member, adult being seen with unexplained bruises following a family visit or complaints by family of excessive force being used on an adult)
- DO NOT interview any alleged perpetrator

- Notify manager or nominated senior person on duty as soon as practicable
- Relevant regulatory bodies must be notified when the concern relates to registered premises or services (e.g. Care Quality Commission (CQC), Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), environmental health, trading standards etc.).

SERIOUS EVENTS OR INCIDENTS

5.5.6 Additional considerations if it suspected that a crime has been committed

- If a **serious physical or sexual assault** is known or suspected to have happened, in order to preserve evidence:
  - The person should be advised not to wash
  - The person should be advised not to change their clothes unless essential for person's well-being. If this is necessary put each item in a separate bag.
  - Try not to touch anything which may be a source of evidence
  - Do not tidy or remove anything from the location
  - Minimise the number of people entering the location or having contact with the adult
- If a sexual assault is suspected or known to have happened, the person should be advised not to eat or drink anything until agreed by the police unless contrary to medical advice.
- Try not to allow the same person to deal with both adult and alleged perpetrator (to prevent cross contamination of evidence)
- If the same person has had contact with both adult and alleged perpetrator record this for the police

- If there are any witnesses record their details and give these to the police
- Secure any timekeeping sheets for duty staff to prevent them being tampered with
- Secure medical and care records for the adult to prevent them being tampered with

5.6 S42 ENQUIRY - STAGE ONE

SET SAF1 – Safeguarding Alert - Received

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

5.6.2 SET SAF1 will be received within the local authority by the agreed local route.

5.6.3 The team receiving the SET SAF1 will (where safeguarding concerns are identified) risk assess the situation within 24 hours, giving consideration to the views of the adult about how they wish to proceed, severity of the incident, risk to the adult and/or others and decide on an initial course of events. Ascertaining in this process any need for immediate police referral/or checking directly with police whether a referral has already been made by another agency has been received.

5.6.4 Where the SET SAF1 is received out of office hours, the Emergency Duty Service (EDS) will undertake a risk assessment on the information received and be responsible for the co-ordinator function until a named adult care or mental health team person takes on that role on the first working day following receipt.

5.6.5 When deciding if a Case should continue as an S42 enquiry the following should be taken into account:

- the adult's needs for care and support
- the individual's risk of abuse or neglect;
- the individual's ability to protect themselves;
- the impact on the individual, their wishes;
- the possible impact on important relationships;
- potential of action increasing risk to individual; and,
- the risk of repeated or increasingly serious acts involving children, or another adult at risk of abuse or neglect.

5.6.6 The adult should always be involved from the beginning of the enquiry unless there are exceptional circumstances that would increase the risk of abuse. If the adult has substantial difficulty in being involved, and where there is no one appropriate to support them, then the local authority must arrange for an independent advocate to represent them for the purpose of facilitating their involvement (see appendix 8)

5.6.7 Once the wishes of the adult have been ascertained and an initial enquiry undertaken, discussions should be undertaken with them as to further enquiry is needed and what further action could be taken.

5.6.8 That action could take a number of courses; it could include disciplinary, complaints or criminal investigations or work by contracts managers and CQC to improve care standards. Those discussions should enable the adult to understand what their options might be and how their wishes might best be realised.

5.6.9 In order to make sound decisions, the adult's emotional, physical, intellectual and mental capacity in relation to self-determination and consent and any intimidation, misuse of authority or undue influence will have to be assessed.

5.6.10 The adult's capacity or ability to make decisions is the key to what happens next, since if someone has the capacity to make decisions in this area of their life and declines assistance this can limit the intervention that organisations can make. The focus should therefore be, on harm reduction. It should not however limit the action that may be required to protect others who are at risk of harm. The potential for 'undue influence' will need to be considered if relevant. If the adult suspected of being abused or neglected is thought to be refusing intervention on the grounds of duress then action must be taken.

5.6.11 All S42 enquiries will be nominated a case co-ordinator whose role will be:

- To assess the risk to the adult (see 'Risk Assessment below)
- To assess the risk to others posed by an alleged perpetrator (see 'Risk Assessment below)
- To co-ordinate the process through to an agreed closure
- To link with the relevant manager to ratify any decisions made and if need be sign off SET SAF4
- To record the progress of the concern throughout the stages on the relevant SET SAF forms

5.6.12 The first priority should always be to ensure the safety and well-being of the adult and, when the adult has capacity to make their own decisions, to aim for any action to be in line with their wishes as far as appropriate. The safeguarding process should be experienced as empowering and supportive – not as controlling and disempowering. Where there are children involved please refer to the SET Safeguarding Children Guidelines. http://www.escb.co.uk/Portals/15/Documents/Local%20Practices/SET%20Procedures%202015.pdf

Practitioners **must** always seek the consent of the individual before taking action or sharing personal information. However, there may be circumstances when consent cannot be obtained because the adult lacks the capacity to give

it, but the best interests of the individual or others at risk demand action or others at risk in the public interest. It is the responsibility of all staff and members of the public to act on any suspicion or evidence of abuse or neglect and to pass on their concerns to a responsible person/agency.

Where there are concerns around the capacity of the adult the relevant MCA guidelines must be followed
www.essex.gov.uk/mentalcapacityact

Risk Assessment

5.6.13 Risks must be identified, in partnership with the adult involved in the safeguarding procedures where they have capacity, or with an appropriate person or advocate working in their "best interests".

5.6.14 The flowchart on page 38 identifies the process to follow in assessing and managing risk which should be initiated at the start of the safeguarding process by the most appropriate person and continuously reviewed and amended as appropriate throughout until case closure or transfer.

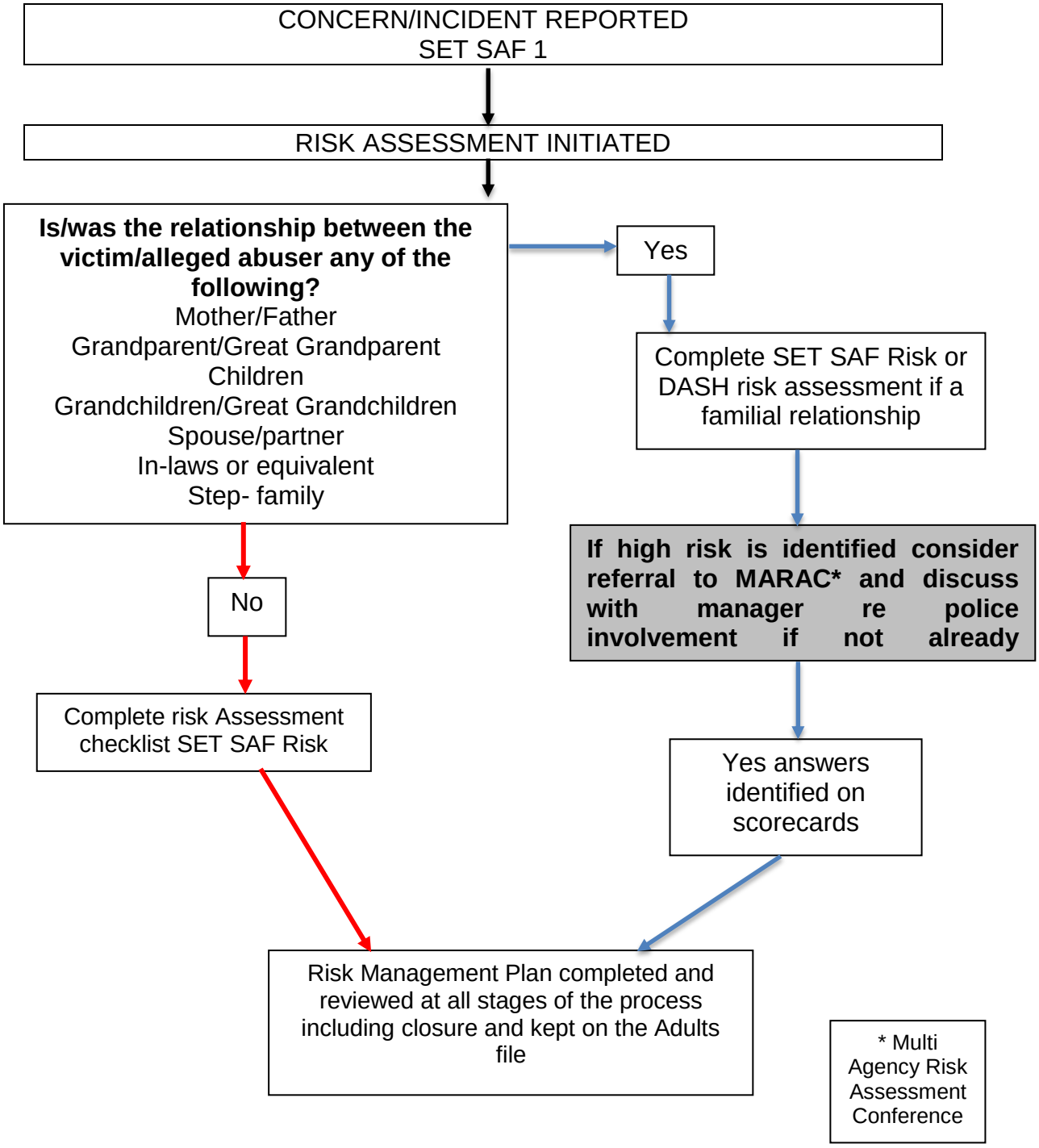
5.6.15 The risk assessment checklist is designed to prompt practitioners to identify immediate risks which need to be minimised/managed, these risks should be constantly monitored and the risk assessment amended as appropriate throughout the safeguarding process.

5.6.16 Where it is identified that the relationship between the victim and alleged abuser constitutes a domestic abuse situation (regardless of the type of abuse) as listed on the flowchart, the DASH (Domestic Abuse, Stalking and Harassment, Honour Based Violence) Risk Model must be completed (http://www.essexsab.org.uk/Documents/SETSAFForms.aspx).

In Southend, this is available on CareFirst.

If high risk is identified, consideration must be made of Police involvement if not already and a referral to MARAC (Multi Agency Risk Assessment Conference).

RISK ASSESSMENT FLOWCHART



Concern Pathways

5.6.17 In some circumstances a S42 enquiry may not be the most appropriate path to follow to manage concerns that are raised. The following should be used to consider other options that are available:

Level 1: Universal Services	People's needs can be met through health, education or police services and they do not have additional needs.
Level 2: Complaints, case management, reviews	Low level concerns relating to people who need and receive additional services from a single practitioner or agency and whose wellbeing may be affected without those services. Issues that could be addressed through internal processes (disciplinary, complaints, care management).
Level 3: Risk assessment, risk management	Moderate concerns where the individual needs professional support to help them stay safe and manage risks effectively. Issues that could be addressed through risk management approaches, complex case management and / or an integrated multi-agency response.
Level 4: Adult safeguarding / protection	Serious concerns relating to an adult who has care and support needs, is unable to protect themselves because of those needs and who has been placed at risk of harm because of the actions (deliberate or unintentional) of others. Issues involving risk of significant harm to an adult who meets these criteria require a safeguarding response. Potential criminal matters **must** be referred to the Police.
Level 5: Safeguarding adults review	Under the Care Act, the Safeguarding Adult Board must undertake a review in any case where: • An adult with needs for care and support was (or it is suspected they were) experiencing abuse or neglect **and** • The adult dies or there is reasonable cause for concern about how the Safeguarding Adults Board, a member of it or some other person involved in the adult's case acted. See Appendix 16

Incidents between adults

5.6.18 Incidents between adults are not always safeguarding issues. However, if there is a power imbalance between the two adults and that power imbalance is being used to one person's advantage then this is a safeguarding issue. If there is no power imbalance then the matter is one about risk and behaviour management and should not be taken through the safeguarding route. If the incident has occurred because of the lack of support and supervision by the provider then there may be a contractual issue and the provider may be seen as neglectful, which could be a safeguarding issue, but in such a case the safeguarding concern is about the provider.

5.6.19 Issues that relate to contractual issues should be discussed with the relevant Commercial/Quality Improvement/Contracts Team rather than immediately raise a safeguarding concern. If there are general concerns about the quality of care within a care home then before raising a safeguarding concern there should be discussions to see if there is anything that they can do to assist the care home.

OPTIONS FOR DECISION FOLLOWING ALERT

Outcome	Examples
No further action Information and advice given	Not a safeguarding issue, based on risk thresholds guidance below.
Referred for case management	Issues are of a referral nature for increased or different care which would be resolved through assessment and possible care provision.
Signposted to another agency	Where there is not a safeguarding issue but other services would be most appropriate.
Process outcome for above	Front door service (Access Team, Social Care Direct) completes box on bottom of SET SAF 1 closed as inappropriate referral.

Where further information is required before a decision can be made the process will move on to **STAGE TWO – INFORMATION GATHERING and the alert becomes a referral.**

5.7 STAGE TWO – INFORMATION GATHERING

At all stages of a S42 enquiry, there must be an on-going and documented RISK MANAGEMENT PLAN or the DASH RISK PLAN (if required): http://www.essexsab.org.uk/Documents/SETSAFForms.aspx

Introduction

5.6.1 Stage 2 is the information collection stage. This stage allows for information to be sought from the adult and all involved partner agencies to ensure an informed decision is taken about how to proceed with an enquiry.

Safeguarding plans

5.7.2 In considering how to respond the following factors need to be considered:

- the adult's needs for care and support
- the adult's risk of abuse or neglect
- the adult's ability to protect themselves or the ability of their networks to increase the support they offer
- the impact on the adult and their wishes
- the possible impact on important relationships
- the potential of action increasing risk to the adult
- the risk of repeated or increasingly serious acts involving children or another adult at risk of abuse or neglect.
- the responsibility of the person or organisation that has caused the abuse or neglect and
- research evidence to support any intervention.

5.7.3 The local authority/agent **must** determine what further action is necessary. Where the local authority/agent determines that we ourselves should take further action (eg a protection plan) then the Local Authority/agent is under a duty to do so.

5.7.4 In accordance with the Mental Capacity Act, the local authority/agent **must** presume that an adult has the capacity to make a decision unless there is a reason to suspect that capacity is in some way compromised. Where the adult may lack capacity to make decisions about managing an abusive situation, their capacity must be assessed and any decision made in their best interests. If the adult has capacity to make decisions in this area of their life and they decline assistance, this limits the range of interventions the local authorities or its partners can make. In such cases the focus must be on harm reduction.

5.7.5 However this should not limit any action that may be required to protect others at risk of harm. Also if the adult suspected of being abused or neglected is thought to be refusing assistance on the grounds of duress then action must be taken.

5.7.6 Once enquiries are completed, the local authority/agent should decide with the adult who has been the subject of concern, what, if any, further action is necessary and acceptable. One outcome might be the development of an agreed plan of action for the adult which should be recorded on their care plan. This should set out:

- what steps are to be taken to assure their safety in future
- the provision of any support, treatment or therapy including advocacy
- any modifications needed in the way services are provided
- how best to support the adult through any action they take to seek justice or redress
- any on-going risk management strategy
- any action to be taken in relation to the person or organisation that has caused the concern.

Stage 2 Actions

5.7.7 Collate information received and, in consultation with their manager, decide whether the case is to be finalised at the end of STAGE TWO or if it should continue to **STAGE THREE – SAFEGUARDING ADULTS MEETING.**

5.7.8 Complete stage 4 actions if no further action or case management decision.

5.7.9 The referrer must be advised as a minimum of the general outcome e.g. “We have considered your call and appropriate action is being taken.” Where this is not possible the reason must be recorded.

5.7.10 Coordinate the move to STAGE 3 if evidence of safeguarding adult issue.

5.7.11 **Liaison with the adult or representative is essential** and their wishes should be considered at all stages of the process. For further information see Risk Assessment and Information sharing.

Police Involvement

5.7.12 The police will be responsible for investigating any criminal allegations and will be responsible for liaising with the case coordinator to keep them apprised of their investigation.

5.7.13 **In all cases** the SET SAF1 notification should be sent to police Safeguarding of Vulnerable Adults officers (SOVA’s) based within the CRU via email on the following address CRU-PPSOVA@essex.pnn.police.uk If the possibility of a

crime is suspected and either there is consent of the victim to share (if uncertain, check with the police if they are aware of the referral) or:

- the situation surrounding the allegation meets the threshold for information sharing as set down by the public interest test
- where an adult may be suffering or may be at risk of suffering serious harm, for more information please see the information sharing section. Examples could be:
  - Allegation of theft of money by a carer
  - Allegation of assault due to excessively rough handling within a care setting
  - Persistent unexplained bruising on a person who is being cared for by a relative (see also section on Risk Assessment)
  - Untreated pressure ulcers on a person within a care setting.

5.7.14 Where it is thought that a serious offence has been committed the police should be called as shown in the guidance notes for **Pre-Stage One – The Initial Response**. The adult will then be able to speak to the police and discuss what further action is to be taken. The more serious the potential offence the greater the requirement to notify the police as soon as it is discovered. For example if a staff member discovers a adult very distressed following a recent serious assault the police should be called immediately and the adult told that this has happened.

5.7.15 If there is evidence of a crime the police will decide whether it is an adult abuse case and will arrange for it to be dealt with by the appropriate staff. If there is no identified offence they will advise the lead agency accordingly. In all cases they will reply to the referrer by e-mail with the decision within seven days of being sent the notification.

Sharing Information

5.7.16 Consent to share information **should not be sought** from the individual or their family if doing so would:

- place a person (the individual, family member, yourself or a third party) at increased risk of significant harm (if a child), or serious harm (if an adult); or
- prejudice the prevention, detection or prosecution of a serious crime; or
- lead to an unjustified delay in making enquiries about allegations of significant harm to a child or serious harm to an adult.

Decisions not to share however should be clearly recorded.

Other enquiries and investigations

5.7.17 During this stage organisations for example care providers, may be carrying out their own internal enquiries. This should be co-ordinated with the S42 enquiry, but may be linked by information gathering and sharing.

5.7.18 Internal enquiries may be suspended where the police request such action, or where the organisation is unable to progress due to competing priorities between civil and criminal proceedings. For example a disciplinary hearing may not be possible until the conclusion of a police investigation in order not to prejudice any possible prosecution.

5.7.19 Any statements taken during the course of an internal enquiry remain the property of the person making it and their organisation. It can only be shared with the informed consent of the person making it, by a court order or under a relevant provision of the Data Protection Act 1998 (e.g. where an employee has been interviewed as an alleged perpetrator by their employer as part of an internal enquiry).

5.8 STAGE THREE – ADULT SAFEGUARDING MEETINGS

5.8.1 At all stages there must be an on-going and documented RISK MANAGEMENT PLAN or the DASH RISK PLAN (if required): http://www.essexsab.org.uk/Documents/SETSAFForms.aspx.

5.8.2 Adult Safeguarding meetings are held when more than two people are involved in a discussion about a safeguarding case. Typically meetings are held to plan the investigation of safeguarding cases, discuss and agree the on-going actions from cases or to review and close. This could be done virtually or by telephone. A SET SAF 3 will need to be completed for these meetings.

5.8.3 Adult Safeguarding meetings are considered when the information gathering identifies there is evidence that there is a safeguarding issue which requires a multi-agency meeting to be held to take issues forward. The individual at the centre of the enquiry should always be invited to the meeting. If they are unable to attend or do not wish to participate this should be recorded and other means should be used to ensure their views are communicated.

5.8.4 Agencies must be advised in advance who will be present at any stage of the meeting, Depending on the circumstances it may be appropriate to hold the meeting in separate parts, with the victim/victim representative(s) and the alleged perpetrator(s)/representative(s) are present (separately) and the second part where they are not.

5.8.5 This process runs parallel to any police or other investigation; however information from some agencies may be restricted dependent on the stage of their enquiry.

5.8.6 During a police investigation it is not permissible for the police to engage with an alleged perpetrator outside the criminal justice process. Therefore the police will not attend meetings or parts of meetings where the alleged perpetrator or representative is present.

Safeguarding meeting responsibilities

Who is responsible?	Task
Case Coordinator	Secure a chair.
	Secure a minute taker.
	Book a room and adapt it accordingly for needs and safety.
	Notify attendees of the meeting arrangements.
	Arrange for receipt of all reports before meeting, ensuring that the Chair sees them.
	Act as a central point of contact for updates on actions and additional information.
	Provide the updated SET SAF2 and SET SAF risk assessment to the chair prior to the meeting for their information.
	If action needs to be passed to an agency not present the case co-ordinator must ensure this takes place.
	Update the adult and/or their representative regarding the outcome of the meeting if they have not been in attendance.
Administrator	To record actions and minutes and prepare drafts for chair to proof within timescales. Minutes should be summaries of discussion points, not verbatim.
Joint (Chair/Case Coordinator)	Agree together: ○ Purpose of meeting ○ Attendees required ○ Agenda ○ Guidance on who should be invited and when ○ When the suspected perpetrator/provider/family should be invited or not It will be the responsibility of the case co-ordinator to carry out all agreed arrangements.
Chair	Review the updated SET SAF2 and SET SAF risk assessment provided by case

	coordinator.
	Set an agenda and ground rules.
	Consider meeting with the adult/family in advance of the meeting to set the context and expectations regarding the meeting.
	Agree the outcomes of the meetings with all parties and ensure that disagreements are recorded.
All meeting attendees	Pending circulation of the draft meeting notes, individuals should record and initiate their own actions.
	Agencies will be responsible for making notes of what is relevant to them during the meeting, their agreed actions and timescales.
	Proof the actions and the minutes.

Recording

5.8.7 The SET SAF 3 should be used as the standard format to record the meeting and will include:

- list of attendees
- summary of original concern
- notes of information shared and by which agencies
- agreed action points with timescales
- trigger to update SET SAF risk assessment
- names of people who have responsibility for these actions
- list of attendees and apologies received

5.8.8 A declaration of confidentiality should be included in the agenda.

5.8.9 Notes and actions of the meeting are to be circulated within the following time scales:

Actions distribution	Within 5 working days
SET SAF 3 distribution	Within 10 working days
Comments concerning accuracy or alternations to be returned	Within 5 working days of circulation of draft SET SAF 3

5.8.10 The adult safeguarding meeting is confidential. The SET SAF 3 can only be distributed to those agency members attending or invited to attend, other designated managers whose names shall appear on the distribution list on the

front of the SET SAF 3.

5.8.11 If there are to be no further Safeguarding Adult Meetings and the meeting agrees that the enquiry can be closed the outcome from outstanding actions should be recorded and action set out at stage 4 completed**.**

5.9 STAGE FOUR – S42 ENQUIRY CLOSURE

5.9.1 At all stages there must be an on-going and documented RISK MANAGEMENT PLAN or the DASH RISK PLAN (if required): http://www.essexsab.org.uk/Documents/SETSAFForms.aspx.

5.9.2 Stage 4 of the safeguarding process is used to close a S42 enquiry. An enquiry can be closed at any stage in the process where it is agreed that there are no longer safeguarding issues to be considered or that can be managed through case management.

5.9.3 Case closure can occur after each stage of the enquiry process and can be completed using the appropriate local authority recording system.

5.9.4 Where a S42 enquiry is to be closed there could be a number of additional actions required. These could be:

- Having considered all the information there is no evidence of a safeguarding issue and there is to be no further action
- All actions required to safeguard the individual have been carried out, or are in the process of being carried out and no further action is required
- The concern is being addressed or monitored through case management
- Civil or police proceedings are taking place which are no longer impacting on the safeguarding issues
- The concern is no longer a safeguarding issue and a single agency has taken responsibility for the on-going case management.

When decision to close the enquiry is made, the case co-ordinator will:

- If not already aware having been included in discussions regarding the closure of the case, notify the individual (and/or representative) of the outcome of the concern and any on-going issues relevant to their case management including risk management plans and review arrangements.
- The referrer **must be advised** as a minimum of the general outcome. Where this is not possible the reason must be recorded.
- Advise the alleged perpetrator of the closure of the enquiry (although this may be on-going with other agencies).
- Update or finalise the risk management plan.
- Ensure a review date is set where required/appropriate.
- Ensure the decision to close is authorised by the relevant manager.
- Consideration about whether a referral to the DBS is needed and which organisation will be responsible.

Abuse Types and Possible Indicators

ABUSE

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action.

Abuse can take place in any setting - these guidelines are applicable to all settings; an individual's private home, care home, hospital, day service, public transport, park, police station or college. This list is endless.

It is therefore, also important to recognise that abuse can consist of a single or repeated act(s); that it can be intentional or unintentional or result from a lack of knowledge. Abuse can be an act of neglect or an omission or a failure to act. Abuse can cause temporary harm or exist over a period of time and can occur in any relationship. Abuse can be perpetrated by anyone, individually or as part of a group or organisation. Importantly, abuse can often constitute a crime.

Abuse is NOT an accident and nor is an accident abuse. For example, if someone who is usually able to drink independently is handed a cup of tea, which they then spill resulting in red marks to the top of their legs, then this would be an accident. Whereas, if a person who is known not to be able to drink independently with an adapted cup is handed a cup of tea in a standard cup and is left to try to drink it independently but subsequently spills it and sustains a scald then this may constitute negligence.

Categories 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.

Physical abuse – The non-accidental infliction of physical force that results (or could result) in bodily injury, pain or impairment including; Assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions, accumulation of minor accidents without seeking medical assistance.

Possible indicators of abuse include unexplained bruising, cowering or flinching, bruising consistent with being hit, unexplained burns, unexplained fractures, scalds especially with well-defined edges e.g. from emersion in water.

Domestic violence –Incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse by someone who is or has been an intimate partner or family member regardless of gender or sexuality. Domestic abuse is not just about partners but all family relationships. This includes:

psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence; Female Genital Mutilation; forced marriage.

Possible indicators includes people being prevented from seeing family/friends, prevented from attending college/work/appointments, being followed or continuingly being asked where they are, accusations regarding other relationships unjustly, feeling scared of others, being threatened personally or threats against other family/friends, prevented from leaving the home, withholding finances, being forced to do something unwanted for their partner.

Sexual abuse – Direct or indirect involvement in sexual activity without consent. This could also be the inability to consent, pressured or induced to consent or take part. Could include: 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. Indicators of sexual abuse include unexplained changes in behaviours, incontinence/bed-wetting, difficulty/discomfort in walking, excessive washing, sexually transmitted diseases, pregnancy, bruising/bleeding in genital or rectal area, deliberate self-harm, unexplained love bites.

Psychological abuse – Acts or behaviour which impinge on the emotional health of, or which causes distress or anguish to, individuals. This may also be present in other forms of abuse. Some examples include: 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.

Possible indicators could be; disturbed sleep, anxiety, confusion, extreme submissiveness or dependency, sharp changes in behaviour in the presence of certain people, self-abusive behaviours, loss of confidence, loss of appetite.

Financial or material abuse – Unauthorised, fraudulent obtaining and improper use of funds, property or any resources of an adult at risk from abuse.

Examples 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. In practice possible signs include unexplained or sudden inability to pay bills, unexplained withdrawal of money from accounts, personal possessions going missing, contrast being known income and actual living conditions, unusual interest by friend/relative/neighbour in financial matters, pressure from next of kin for formal arrangements being set up.

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.

Possible indicators include poor physical appearance, isolation, poor living conditions, few or no personal effects, restricted freedom of movement, unusual travel habits, reluctance to seek help.

Discriminatory abuse – Discriminatory abuse exists when values, beliefs or culture result in a misuse of power that denies mainstream opportunities to some groups or individuals.

Examples including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion. In practice this may look like acts or comments motivated to harm and damage including inciting others to commit abusive acts, lack of effective communication provision e.g. interpretation, the adult being subjected to racist, sexist, ageist, gender based abuse, or abuse specifically about their disability.

Organisational abuse – Institutional abuse occurs where the culture of the organisation (such as a care home) places emphasis on the running of the establishment and the needs of the staff above the needs and care of the person 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 from domiciliary services. 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.

Possible indicators include lack of care plans, contact with outside world not encouraged, no flexibility or lack of choice e.g. time when to get up in a morning or go to bed or what to eat, routines are engineered for the benefit of staff, lack of personal effects, strong smell of urine, staff not visiting for allocated time due to pressure resulting in some tasks not being carried out fully, omission of visits, poor moving and handling practices.

Neglect and acts of omission – Ignoring or withholding physical or medical care needs which result in a situation or environment detrimental to individual(s). Ill-treatment and wilful neglect of a person who lacks capacity are now criminal offences under the Mental Capacity Act. Examples 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. This may be demonstrated by poor hygiene/cleanliness of the person who has been assessed as needing assistance, repeated infections, dehydration/weight loss/ malnutrition, repeated or unexplained falls or trips, withholding of assistance aids e.g. hearing aids or walking devices. Practitioners must respect the rights of the adult whilst seeking to ensure that their behaviour does not harm themselves or others. This means that there is an inherent right for the adult to take risks and a responsibility for the practitioner to help them identify and manage potential and actual risk to themselves and others. However, ignoring the risk or making the risk worse (intentionally or unintentionally) and placing an individual at harm is a safeguarding matter.

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 may or may not be a safeguarding issue, however agencies must assess concerns raised under their statutory duties; having consideration for an individual's right to choose their lifestyle, balanced with their mental health or capacity to understand the consequences of their actions.

Once identified as a situation that cannot be managed through regular case management, high risk or self-neglect situations will be managed through the safeguarding process.

Self-neglect is characterised as the behaviour of a person that threatens his/her own health or safety. Self-neglect generally manifests itself as a refusal or failure to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions.

The definition of self-neglect excludes a situation in which a mentally competent person, who understands the consequences of his/her decisions, makes a conscious and voluntary decision to engage in acts that threaten his/her health or safety as a matter of personal choice. Signs and symptoms of self-neglect include but are not limited to: dehydration, malnutrition, untreated or improperly attended medical conditions, and poor personal hygiene; hazardous or unsafe living conditions/arrangements (e.g. improper wiring, no indoor plumbing, no heat, no running water); unsanitary or unclean living quarters (e.g. animal/insect infestation, no functioning toilet, faecal/urine smell); inappropriate and/or inadequate clothing, lack of the necessary medical aids (e.g. glasses, hearing aids, dentures, walking aids); grossly inadequate housing or homelessness. Appendix 17 gives more guidance on this.

Care Act 2014

The Care Act 2014[5] for the first time establishes legislation setting out specific safeguarding duties for local authorities and their partner agencies. The 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 is 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.

The Care Act requires that each local authority must:

- Make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so by whom
- Set up a Safeguarding Adults Board (SAB) See appendix 15
- Arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has `substantial difficulty` in being involved in the process and where there is no other suitable person to represent and support them
- Co-operate with each of its statutory partners in order to protect the adult. In their turn each relevant partner must also co-operate with their local authority

Further details about each of these statutory requirements are set out in the Care Acts associated statutory guidance issued by the Department of Health in November 2014[6]

[5] Care Act 2014 http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted

[6] Care and Support Statutory Guidance https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf

Care Home and Community Medication Guidance

This is guidance to try to help care home and agency managers decide what route of investigation to follow and whether a medication error could be a safeguarding issue.

It should be used in conjunction with local and national policy, CQC requirements and professional responsibilities.

For those adults that need to take medication to maintain their health and wellbeing it is essential to ensure that the person has the right level of medication and has access to medication when necessary.

It is also important that medication is not given without consent. If a person is unable to consent then the evidence of this and a clear best interest decision should be in place. These should be reflected in the care plan and the care plan should be followed.

The 'Essential Standards of Quality and Safety' should be followed and from 1 October 2010, the Care Quality Commission (CQC) under the Health and Social Care Act 2008 must be notified about specific incidents. The law requires these notifications to be submitted within certain timescales – further guidance is available on what should be reported, how and in what timescales via the CQC guidance on Statutory Notifications.

Appendix 3 – Care Home and Community Medication Guidance

NOT SAFEGUARDING – NORMAL CARE MANAGEMENT
An adults needs can be met through statutory services such as Local Authority, police, health, and education

- The Adult does not receive prescribed medication (missed/wrong dose) on one occasion and no harm occurs.
- Minimal harm to the adult but robust prevention measures in place such as training, supervision & auditing.

NOT SAFEGUARDING - SERVICE IMPROVEMENT / QUALITY ISSUES
A low level concerns that can be dealt with through complaints processes, case reviews, quality process etc.

- Recurring missed medication or administration errors in relation to the adult that cause no harm
- No ongoing concerns
- Prevention measures in place such as training, supervision and auditing

SAFEGUARDING REFERRAL MAY BE REQUIRED - CONTACT YOUR SAFEGUARDING LEAD FOR DISCUSSION
This would include an adult who may be in need of a multi-agency response to manage their risk. Concerns at this point may meet the threshold for Adult Safeguarding and must be considered on a case-by-case basis. Advice should be sought from your organisation's Adult Safeguarding Lead.

If this affects more than one patient, organisational abuse should be considered

- One off medication error to more than the adult - 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 the adult, leading to the need for medical intervention
- Previous concerns identified/ongoing ineffectiveness
- Insufficient prevention measures in place such as training, supervision & auditing

SAFEGUARDING REFERRAL - REFERRAL TO POLICE SHOULD BE CONSIDERED
The adult has been harmed or placed at harm because of actions, deliberate or unintentional, of others. High level concerns. If there is any suspicion that a criminal act has occurred then the Police MUST be contacted using your organisation's internal escalation processes.

- Deliberate maladministration of medication
- Covert administration without proper medical supervision

SAFEGUARDING REFERRAL - REFERRAL TO POLICE REQUIRED
This includes incidents where adult(s) at risk of abuse have died as a consequence of harm or neglect. High Level concerns. This would include cases referred on for a Serious Adult Review, Multi Agency Serious Incident Review or Domestic Homicide Review. This must be reported using your organisation's internal escalation processes.

- Pattern of recurring errors or an incident of deliberate maladministration that results in ill-health or death
- Catastrophic harm to more than one adult leading to hospitalisation/long term effects/death
- Staff misusing their position of power over the adult
- Over-medication and/or inappropriate restraint used to manage behaviour within an institutional setting

Definitions

Abuse

The Care Act 2014 does not set out a specific definition of abuse other than to state that it includes financial abuse which includes:

(a). having money or other property stolen,
(b). being defrauded,
(c). being put under pressure in relation to money or other property, and
(d). having money or other property misused.

The Act's statutory guidance lists ten types of abuse but states that local authorities should not limit their view of what constitutes abuse or neglect to those types or the different circumstances in which they can take place. Further information can be found in Appendix 1 of the guidelines.

Adult

The SET safeguarding guidelines 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.

Allegation

An allegation is an assertion by the adult with care and support needs, or other person(s) that the adult with care and support needs is or has been a victim of abuse, and can include a statement regarding the alleged perpetrator.

Anti-Social Behaviour

Anti-social behaviour is any aggressive, intimidating or destructive activity that damages or destroys another person's quality of life.

Case Coordinator

'Someone who coordinates communication between two or more people or groups'.

It is important to state that the coordinator is not to be seen as having assumed case management responsibility, as this will remain the responsibility of the officially allocated worker.

Within the safeguarding adult process, the role of coordinator is primarily a central point of contact and liaison for all parties and for the collating of information and reports which will form part of any safeguarding process.

Each safeguarding adults situation will vary and the professionals will retain their own responsibilities within the process, (i.e. health, social care) and may have related tasks identified during the safeguarding process. The success of any safeguarding plan will be dependent on all parties effectively working together.

It is recommended that the case coordinator should be someone who has access to administrative skills or support.

Case Management

The resolution of the risks identified by use of a personal support plan implemented and monitored by a care manager or social worker.

Disclosure

A disclosure occurs when the adult who has care and support needs says or implies that they are being, have been, or are at risk of being abused. Disclosure may be direct, or may take the form of odd hints or veiled comments.

Exploitation

Exploitation can be seen as taking advantage of a person who has care and support needs in an unjust or unethical way for one's own gain, to the detriment of that person. In other words, using someone's own care and support needs as a fulcrum to obtain a personal benefit at the expense of the adult(s) with care and support needs. Exploitation is commonly financial, material or sexual.

Hate Crime

Hate crime is a term used to describe an offence committed against a person because of hate or prejudice. It affects such a range of people it is difficult to define but we describe it as, any incident, which may be a criminal offence, motivated by prejudice or hatred towards an individual from a particular social group or associated with same due to their:

- Race, Colour, Ethnic origin and/or Nationality
- Religion and Faith
- Gender or Gender Identity
- Sexual Orientation
- Sensory, Physical or Learning Disability
- Mental Health

Hate crimes can take many forms which can include:

- Physical attacks – physical assault, damage to property, offensive graffiti, neighbour disputes and arson
- Threat of attack or bullying – offensive letters, abusive telephone calls, malicious complaints

- Verbal insults or abusive gestures
- Inciting others to commit hate crimes

Incident

An occurrence or event that gives rise to a concern or allegation.

Indicators

An indicator is a sign, symptom or behaviour that should alert the person noting / observing it, that the adult with care and support needs may have been, is or might be a victim of abuse. (*See* Appendix 1).

Safeguarding Adults

Safeguarding Adults activity are the steps taken to prevent, protect and investigate where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

(a) has needs for care and support (whether or not the authority is meeting any of those needs),
(b) is experiencing, or is at risk of, abuse or neglect, and
(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it (DH The Care Act 2014 S42).

Self-neglect

Self-neglect may or may not be a safeguarding issue, however agencies must assess concerns raised under their statutory duties; having consideration for an individual's right to choose their lifestyle, balanced with their mental health and/or capacity to understand the consequences of their actions or inactions. Utilisation of the Mental Capacity Act 2005 to guide interventions is crucial where the material mental capacity is in anyway in doubt.

Once identified as a situation that cannot be managed through regular case management, high risk or self-neglect situations will be managed through the safeguarding process following receipt of SET SAF 1 outlining the risks involved. The flow charts (Appendix 17) outline the process to be followed.

Serious Incident (SI)

NHS organisations investigate all incidents in line with the organisation's Policy and Guidance. Any incidents meeting the criteria to be raised as a Serious Incident will be investigated in line with National Guidance. Where the incident is deemed to meet the criteria for a Serious Incident and Adult Safeguarding, one investigation can be completed to inform both processes within the shortest and most appropriate time frame to meet the wishes of the person, keep them as safe as possible and ensure the learning from the circumstances.

Locally in the NHS, incident reporting is undertaken via an electronic system. This feeds into the framework for the management of those incidences deemed an SI (Serious Incident). This is in accordance with best practice and in line with the expectations of Clinical Commissioning Groups (CCG) and in adherence to the National Patient Safety Agency (NPSA), the NHS Litigation Authority (NHSLA), the Care Quality Commission (CQC) and Monitor. This process will occur for all incidences; some of which will also be deemed a Safeguarding Adults Incident reportable under these guidelines to the Local Authority for investigation.

Risk

Risk is not, in itself, a safeguarding issue. Risks are hazards that could have a negative impact on an individual. Adult Social Care has a strong focus on enabling adults to live independently by giving them a choice of services, such as individual budgets which enables them to take control of their life. This will inevitably involve a degree of risk, and whilst not all risk can be eliminated, it can be managed. Further information about risk assessment and management can be found here.

Undue Influence

Undue influence occurs when:

- The unduly influenced person has the mental capacity to make the decision in question but their will has been overborne not just by influence but by the undue influence of somebody else.
- The person is influenced to enter into a transaction concerning a gift, or a will, in such a way that it is not of their own free will or that the person lacked capacity at the relevant time.

There are two types of undue influence:

(i) “express”, when there is evidence of coercion or undue pressure
(ii) “presumed” when there is no such evidence but it has occurred when the relationship is of an unequal nature and one person is taking unfair advantage of another.

What is the role of the practitioner and the safeguarding interventions that can be offered in incidents of undue influence?

- If it is before the transaction occurs and it is appropriate, the practitioner can suggest that independent advice is required e.g. via a solicitor or an accountant.
- If a criminal offence seems to have been committed then police involvement should be considered and sought.
- The basis for undue influence is the establishment of dishonesty and this can relate to a living or dead person.

Disclosure and Barring Service

https://www.gov.uk/government/organisations/disclosure-and-barring-service/about

1. The Disclosure and Barring Service exists to help employers make safer recruitment decisions and prevent unsuitable people from working with adults or children. The service is responsible for:

    - processing requests for criminal records checks
    - deciding whether a person should be barred from working with vulnerable groups, including children
    - maintaining lists of people who have been barred from working with vulnerable groups.

2. Employers are under a duty to make a referral to the Disclosure and Barring Service if they have dismissed or removed an employee from working in regulated activity, following harm to a child or adult or where there is a risk of harm.

3. Regulated activity includes healthcare, personal care, social work, assistance with general household matters, assistance in the conduct of a person's affairs (eg under a power of attorney or deputyship) or transporting or escorting a person. The term includes day to day management of regulated activity and covers any frequency of activity including one-off occurrences.

4. The local authority is considered to be a provider of regulated activity, and thus under a duty to make a referral to the Disclosure and Barring Service, if:

    - we are responsible for management or control of the activity
    - it is carried out for the purposes of the local authority; and
    - we make or authorise arrangements for another person to engage in the activity

5. The local authority also has a power to make a referral to the Disclosure and Barring Service if we think a person has harmed a child or adult (or there is a risk of harm) and we think the person may engage in regulated activity in future.

Domestic Violence and Abuse

The definition of domestic abuse used by the Home Office and most agencies 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

Intimate partners or family relationships extends to include partners but also including mother, father, son, daughter, brother, sister, and grandparents whether directly related or in-laws or step family.

Controlling behaviour

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Domestic abuse is about the power and control of one person over another. The abuse can take many forms, but is sometimes classified under headings including:

- Making threats
- Intimidation
- Economic / financial abuse
- Using isolation
- Emotional abuse
- Taking domineering role in the partnership
- Using the children
- Minimising / denying own behaviour
- Physical / sexual violence

The links between adult safeguarding and domestic abuse are clear in the similarities between the types of abuse experienced. Incidents can be considered as both domestic and adult safeguarding abuse when the perpetrator is, for example, both daughter and carer to the person.

It is the familial relationship between the people involved which makes an incident or series of events 'domestic abuse'.

Domestic abuse is a complex issue, adults who are victims, may remain with an abusive partner for many years suffering emotional, physical or other abuse without considering leaving or recognising that they are living within an abusive relationship. They cannot be forced to leave an abusive situation, but consideration must always be given to offering appropriate support and sign posting, where possible, ensuring the safety and protection of the person being abused. Domestic abuse can happen where an adult is being cared for by a child, grandchild, sibling or parent. It is not confined to intimate relationships or partnerships.

People working with adults may regularly encounter situations of domestic abuse. They must be careful not to judge the people involved and must take action appropriate to their organisation. Where an adult has disclosed domestic abuse to a worker/volunteer then that person has a responsibility to consider the risk to the adult/victim and balance that against how the adult wants the matter dealt with. However all allegations of domestic abuse must be recorded within the adults records in case of further reports or serious incident. Each agency should have a process by which allegations of domestic abuse are recorded along with actions taken. Where there is a child/children involved, guidelines/protocols should also be followed
http://www.escb.co.uk/Professionals/InformationResources/SETChildProtectionProcedures.aspx

Where the indication of risk to the adult is very high, there is an absolute requirement to take positive action to protect them and this will almost certainly require information to be shared with other agencies. For more information about risk assessment and for Information Sharing.

Where the risk identified to the victim is high then consideration may be given to referring the victim to a Multi-Agency Risk Assessment Conference (MARAC) in addition to any other processes. MARAC is a victim focused process in which the needs of the victims in domestic abuse cases and the risks posed by the alleged perpetrator are considered in a multi-agency forum and a joint safety plan is constructed around the individual. The MARAC works in conjunction with, and supports, the normal safeguarding processes outlined in this guidance.

Common examples of abusive relationships and how risk can be considered are:

- A husband and wife have been together for many years and she is now suffering from dementia. The care worker sees bruising on her arms and reports this to the Adult Social Care Team.

  A care plan assessment shows that he is having severe troubles coping with his wife's increasing needs and does not know how to safely lift or restrain her. The wife has said that she does not want the police involved as she wants him

to care for her. Additional support and instruction is provided to the husband and the situation is resolved.

The risk indication for this case would show that although this fits the definition of domestic abuse, the risks can be significantly reduced by effective case management. It can be dealt with on a single agency basis without the need to share information against the wife's wishes.

- An 80 year old widow's son returns home after his marriage breaks down, she has mobility issues and has adaptations provided through social care in her home. He demands money from his mother over a period of time, threatening her when she protests and when she finally refuses he violently assaults her leading her to be hospitalised for two days due to serious bruising across her face and body. She refuses to report it to the police because he is her son and she does not want to criminalise him.

  The risk indication for this case would show that there is a high risk to the adult, the injuries suffered are severe, the assault has followed escalation of abuse over a short time, he is controlling, has money issues and there may well be other background issues. There is a need in this case to consider positive action to support and protect this lady. She may need advice on removing him from the home without going to the police. Due to the risk to the adult, notifying other agencies without consent is a possibility in order to obtain information about the risks and options available to provide her with support and protection.

Disability

- Disabled adults are at increased risk of experiencing domestic abuse compared to non-disabled adults and from a wider range of other adults, including carers.
- Disability of victims often increases their dependency on the perpetrator for care and for meeting their basic needs. This can be exploited by the perpetrator, making it harder for the victim to leave. It is also hard for a survivor to leave a home or care package that has been specially designed or adapted to meet their needs.
- Survivors of domestic abuse who have a disabled child or dependent adult may also find it difficult to leave a perpetrator who is also a carer for a child or dependent adult or to leave a home or system of care which meets their needs.
- Survivors of domestic abuse who are being abused by a perpetrator who is disabled, or disabled people who are being abused by a carer, may find it hard to be believed as this contradicts many stereotypical views of disabled people and of carers.
- A disabled child or dependent adult may have a Joint Education, Health and Care (EHC) Plan. This may take time to transfer if the victim and children leave the area or home. It may also be the cause of the perpetrator discovering where they live, if they are informed of the transfer. This is possible if the perpetrator is the other parent.

Consent

Where it has been identified that an individual is a victim of domestic abuse, unless the risk is assessed as being high i.e. indicates an immediate risk to the victim of significant harm or death, this information MUST NOT be shared with the police unless the victim's consent has been obtained. It is only in cases where the risk is assessed as high that cases can be referred into the police without the victims consent. Any incidents referred into the police without the appropriate consent of the victim, which are deemed not to be High risk, will be returned to the original referring agent who will remain responsible of the ongoing safeguarding of the victim.

Safety Planning

Safety planning for survivors, children and other people at risk is crucial to all interventions to safeguard adults affected by domestic abuse.

Safety planning will need to take place whether or not the survivor is still living with or in a relationship with the perpetrator. Because of the risks involved in separation, safety planning will usually need to increase in strength and intensity around and after separation. It is crucial that separation is **NOT** seen as the only or essential element in safety planning.

Survivors of domestic abuse, children and other people at risk, will almost always have developed their own safety strategies, and all immediate and subsequent assessments of the risk to these individuals should include assessing the strategies they currently use or have thought of.

Practitioners should always refer to the guidance and templates in the full procedures, and consult with specialist agencies, when developing safety plans with victims.

‘Honour’ Based Abuse, Female Gentile Mutilation & Forced Marriage (HBA, FGM & FM)

Honour Based Abuse

The Police definition of so-called ‘honour’ based abuse is: 'a crime or incident, which has or may have been committed to protect or defend the honour of the family and/or community'. The ‘honour code’ means that women generally, but sometimes males, must follow rules that are set at the discretion of the male relations and which are interpreted according to what each male family or community member considers acceptable.

This term can be used to describe murders in the name of so-called honour, sometimes called 'honour killings'. These are murders in which predominantly women are killed for perceived immoral behaviour. So-called ‘honour killings' are often the culmination of a series of events over a period of time and are planned. There tends to be a degree of premeditation, family conspiracy and a belief that the victim deserved to die.

‘Honour’ based abuse cuts across all cultures and communities, and cases encountered in the UK have involved families from Turkish, Kurdish, Afghani, South Asian, African, Middle Eastern, South and Eastern European communities as well as the Travelling Community. This is not an exhaustive list. In reality it cuts across all cultures, nationalities, faith groups and communities and transcends national and international boundaries.

Professionals should respond in a similar way to cases of ‘honour’ violence as with domestic abuse and forced marriage (i.e. in facilitating disclosure, developing individual safety plans, completing individual risk assessments etc.). Professionals should not approach the family or community leaders, share any information with them or attempt any form of mediation. In particular, members of the local community should not be used as interpreters.

All 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 they may only have one chance to save a life. This means that all practitioners working within statutory agencies needs to be aware of their responsibilities and obligations when they come across these cases. If the victim is allowed to walk out of the door without support being offered, that one chance might be wasted.

It must be noted that in most cases, the Police will take the lead for all HBA incidents. In those cases, much of the following guidelines in terms of procedures would be the responsibility of the lead organisation and not Social Services. However, a victim may be known to Social Services as an adult or child at risk and joint working with police and other organisations is required.

Also, a victim may approach Social Care or another local authority service in the first instance, yet they may not be under 18 and/or may not have a disability or condition that would ordinarily meet eligibility criteria as an adult. In such cases, it is important

that you do not 'turn the individual away'. You need to ensure their immediate safety and support them to make urgent and safe contact with Police.

HBA can manifest in many different ways and often presents with accompanying criminal offences, domestic abuse or the civil offence of forced marriage. If incidents include domestic abuse, missing persons, child abuse or other serious crime then it should be read in conjunction with the relevant policies and procedures on these subjects.

This section should be considered in conjunction with the Southend, Essex and Thurrock Child Protection Procedures.

For details on honour based abuse please follow your local guidelines or https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/35532/fmu-right-to-choose.pdf

Forced Marriage

The Home Office definition of forced marriage is 'a marriage without the consent of one or both parties and where duress is a factor'. The Court of Appeal clarified that duress is: '[when] the mind of the applicant has been overborne, howsoever that was caused'.

An arranged marriage is very different from a forced marriage. An arranged marriage is entered into freely by both people, although their families take a leading role in the choice of partner.

A forced marriage is where one or both people do not (or in some cases of people with learning or physical disabilities, cannot) consent to the marriage and pressure, coercion or abuse is used. The pressure put on people to marry against their will can be physical (including threats, actual physical violence and sexual violence) or emotional and psychological (for example, when someone is made to feel like they're bringing shame on their family). Financial abuse (taking wages or not giving someone any money) can also be a factor.

Marriages within communities that believe in protecting the 'honour' of their family are a significant event. Marriage contracts will often be drawn up when children are young and are seen as a binding arrangement between the two families. If one or both parties then seek to disengage from the contract it is seen as bringing great shame on the family and very contentious.

The majority of forced marriages reported to date in the UK have involved families from South Asia; other communities in which there have been cases include Europe, East Asia, the Middle East and Africa. Some forced marriages take place in the UK with no overseas element, while others involve a partner coming from overseas or a British national being taken abroad.

Professionals should respond in a similar way to forced marriage as with honour based abuse (i.e. in facilitating disclosure, developing individual safety plans, ensuring the child's safety by according them confidentiality in relation to the rest of

the family, completing individual risk assessments etc.). There may be only one opportunity to effectively intervene.

In 2004, the Government's definition of domestic violence was extended to include acts perpetrated by extended family members as well as intimate partners. Consequently, acts such as forced marriage and so-called 'honour crimes' (which can include abduction and homicide) now come under the definition of domestic violence and abuse.

Forced marriage is illegal in England and Wales. This includes:

- taking someone overseas to force them to marry (whether or not the forced marriage takes place)
- marrying someone who lacks the mental capacity to consent to the marriage (whether they're pressured to or not)

Forcing someone to marry can result in a sentence of up to 7 years in prison.

Anyone threatened with forced marriage or forced to marry against their will can apply for a Forced Marriage Protection Order. Third parties, such as relatives, friends, voluntary workers and police officers, can also apply for a protection order with the leave of the court. Fifteen county courts deal with applications and make orders to prevent forced marriages. Local authorities can now seek a protection order for adults and children without leave of the court. Guidance published by the Ministry of Justice explains how local authorities can apply for protection orders and provides information for other agencies. This is available at the Justice website.

This section should be considered in conjunction with the Southend, Essex and Thurrock Child Protection Procedures.

For further information on Forced Marriage follow the link: https://www.gov.uk/forced-marriage.

Female Genital Mutilation

The World Health Organisation (WHO) defines female genital mutilation (FGM) as: "all procedures (not operations) which involve partial or total removal of the external female genitalia or injury to the female genital organs whether for cultural or other non-therapeutic reasons" (WHO, 1996).

FGM has been a criminal offence in the UK since the Prohibition of Female Circumcision Act 1985 was passed. The Female Genital Mutilation Act 2003 extended the prohibition making it also illegal to take a British national abroad to undergo FGM. In Scotland FGM is illegal under the Prohibition of FGM (Scotland) Act 2005.

Female genital mutilation is much more common than people realise. It is a complex issue because despite the harm it causes, many women from FGM practising communities consider FGM normal to protect their cultural identity.

Appendix 7 – Honour Based Abuse, Female Genital Mutilation & Forced Marriage (HBA, FM & FGM)

The age at which girls are subjected to female genital mutilation varies greatly, from shortly after birth to any time up to adulthood. The average age is 4 to 13 years, in some cases it is performed on new born infants or on young women before marriage or pregnancy.

Female genital mutilation has been classified by the WHO into four types:

- Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
- Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).
- Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.
- Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area."

http://www.who.int/mediacentre/factsheets/fs241/en/

All girls/women who have undergone FGM (and their boyfriends / partners or husbands) must be told that re-infibulation is against the law and will not be done under any circumstances. Each woman should be offered counselling to address how things will be different for her afterwards.

The practice is most common in the western, eastern, and north-eastern regions of Africa, in some countries in Asia and the Middle East, and among migrants from these areas.

This section should be considered in conjunction with the Southend, Essex and Thurrock Child Protection Procedures.

For Multi-Agency Practice Guidelines: Female Genital Mutilation follow the link https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380125/MultiAgencyPracticeGuidelinesNov14.pdf

Independent Advocates

1. The local authority **MUST** arrange when there is no appropriate individual, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review where the adult has 'substantial difficulty' in being involved in contributing to the process and where there is no other appropriate adult to assist. A person who is engaged professionally to provide care or treatment for the adult in question cannot be an advocate.

2. The adult must also consent to being represented and supported by the advocate (or where the adult lacks capacity, the local authority must consider it in that adult's best interests to be represented and supported by the advocate).

3. This duty to provide an independent advocate is separate from the power of the local authority to provide an Independent Mental Capacity Advocate in safeguarding enquiries where someone lacks capacity to fully participate. Both these provisions are in recognition of the importance of providing support and representation for people who have experienced abuse and neglect. The IMCA can support and represent an adult at risk of abuse and neglect, where necessary and appropriate. The local authority is not required to provide two different advocates. It is not likely to be in the adult's interest to do this.

4. Advocates have two roles. They need to provide support to the adult to assist them in understanding the safeguarding process. The second role is representation, particularly in ensuring that the individual's voice is heard and the safeguarding process takes account of their views wherever appropriate.

5. Effective safeguarding is about seeking to promote an adult's rights, rather than merely their physical safety and taking action to prevent similar situations occurring again.

6. However, if an enquiry needs to start urgently, then it can begin before an advocate is appointed but one must be appointed as soon as possible. In such cases, all agencies should set out how the services of advocates can be accessed, and the role they should take.

7. The Care Act sets out four areas where a substantial difficulty might be found such that an independent advocate should be made available.

8. The first area to consider is whether or not the individual understands relevant information. Many people can be supported to understand information, if it is presented appropriately and if time is taken to explain it. Some people however may not be able to understand it, for example if they have advanced dementia, or substantial learning difficulties but nevertheless should be involved in all decisions that they do have capacity to make.

9. The second area to consider whether or not the individual can retain information. If the adult is unable to retain information long enough to be able to

weigh up options within the decision making, then they are likely to have substantial difficulty in understanding the options open to them.

10. The third area is if the adult has substantial difficulty using or weighing information. An adult must be able to weigh up information, in order to participate fully and choose between options. For example they need to be able to weigh up the advantages and disadvantages of changing where they live or who they live with. If they are unable to do this, they will have substantial difficulty in coming to a decision.
11. And the fourth area involves communicating their views, wishes and feelings whether by talking, writing, signing or any other means. It is critical in this particularly sensitive area that people are supported in what may feel a daunting process which may lead to some very hard and difficult decisions.

Independent Mental Capacity Advocates (IMCA)

"The purpose of the IMCA service is to help particularly people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation and who have family or friends that it would be appropriate to consult about those decisions. The IMCAs will work with and support people who lack capacity, and represent their views to those who are working out their best interests." (Chapter 10, MCA Guidance).

An Independent Mental Capacity Advocate (IMCA) should be appointed in order to support people who lack capacity through the safeguarding process.

Please also refer to SET MCA procedures which can be found at: http://www.essexsab.org.uk/Documents/SETdocuments.aspx

The MCA Regulations extend the powers of local authorities and National Health Service (NHS) to instruct IMCA's in certain cases of adult safeguarding. There is a duty on local authorities and the NHS to decide which clients would most benefit from IMCA support. It is unlawful not to consider the use of an IMCA in these circumstances.

The Regulations specify that local authorities and NHS have powers to instruct an IMCA before a decision is made if the following two requirements are met:

Where protective measures are being put in place in relation to;

- the protection of adults at risk from abuse; and
- where the person lacks capacity.

In these circumstances the local authority or NHS body may instruct an IMCA to represent the person concerned if it is satisfied that it would be of benefit to the person to do so.

An IMCA can be appointed if the person has no friends or relatives. An IMCA can also be appointed if friends or family are unwilling or unable to support the decision making process or are involved in the alleged abuse.

The power to instruct an IMCA must be looked at in each individual case if they satisfy the requirements. The IMCA may be required to interview the person in private, examine records, consult professionals, friends and family, which should be supported and facilitated by the agencies concerned. If an IMCA is instructed then the local authority and/or NHS body must take into account any information or submission made by the IMCA in their report, including possible alternative courses of action when reaching any decision about protective measures for the adult.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224660/Mental_Capacity_Act_code_of_practice.pdf

MARAC
(Multi-Agency Risk Assessment Conference)

MARAC is a formal multi-agency meeting to consider and safety plan for the highest risk victims of domestic abuse, their children and adults living in the household. The purpose of MARAC is for partners 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.

Such meetings will be held on a regular basis as required. Each MARAC covers a specific area of Essex, this means that currently there are 11 MARAC's covering the Essex Police area each meeting on a regular basis.

Each partner agency will nominate individuals who will have access to the information provided at MARAC and attend MARAC on behalf of their organisation. Information shared at MARAC must 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.

The full information sharing agreement and working practices for MARAC can be found on local intranet sites where appropriate or caada - co-ordinated action against domestic abuse.

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 in high risk domestic abuse cases.

OUT OF AREA ADULT SAFEGUARDING ARRANGEMENTS

Prior to the introduction of the Care Act, the Association of Directors of Adult Social Services produced protocol in December 2012 for Inter-Authority Safeguarding Adults Investigation and Protection Arrangements. The protocol is based on 6 principles:

1. The host authority (the local authority or NHS body in the area where the abuse occurred) will have overall responsibility for co-ordinating the safeguarding adult's investigation and for ensuring clear communication with all placing authorities and other stakeholders, especially with regards to the scheduling of meetings and the planning of the investigation.

2. The placing authority (the local authority or NHS body that has commissioned the service for an individual involved in a safeguarding adult's allegation) will have a continuing duty of care to the adult they have placed.

3. The placing authority will contribute to the investigation as required, and maintain overall responsibility for the individual they have placed.

4. The placing authority should ensure, through contracting arrangements and in service specifications, that the provider has arrangements in place for protecting adults and for managing concerns, which in turn link with local (host authority) multi-agency safeguarding adults policy and procedures. This includes the requirement to inform the host authority of both individuals and placing authorities affected by the safeguarding concerns.

5. Authorities may negotiate flexible arrangements, for example relating to another authority undertaking assessments, reviews, investigative activities or other supportive activities on behalf of a placing authority. In such cases, the placing authority would maintain overall responsibility for the person they have placed, and reimbursement would be required and agreed as part of such negotiations.

6. Providers of care and support services have rights and responsibilities, and may be required to undertake their own investigations. The host authority must ensure effective and timely communication with the provider of care throughout the investigation.

A full copy of the guidance can be found at http://adass.org.uk/images/stories/Policy%20Networks/Safeguarding_Adults/Key_Documents/ADASS_GuidanceInterAuthoritySafeguardingArrangementsDec12.pdf

PREVENT

Exploitation by radicalisers who promote violence – Individuals 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 individuals of the legitimacy of their cause.

There are a number of factors that should not be considered in isolation but in conjunction with the particular circumstances of the individual: identity or personal crisis, particular personal circumstances, unemployment or underemployment, mental health issues and criminality. All of these may contribute to alienation from UK values and a decision to cause harm to symbols of the community or the state.

CONTEST is the national counter terrorism strategy. The aim of **CONTEST** is to reduce the risk to the United Kingdom and its interests overseas from international terrorism, so that people can go about their lives freely and with confidence. The Office for Security and Counter Terrorism (OSCT) is responsible for providing strategic direction and governance on CONTEST.

The strategy has four work streams:

1. **Prevent:** to stop people becoming terrorists or supporting terrorism
2. **Pursue:** to stop terrorist attacks
3. **Protect:** to strengthen our protection against terrorist attack
4. **Prepare:** where an attack cannot be stopped, to mitigate its impact

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 radicalisation which we need to address.

The **Channel** programme was developed as a key part of the Prevent strategy. **Channel** is a Home Office funded programme to utilise the existing partnership working and expertise between the police, local authority, other partner agencies and the local community in the form of a professionals panel to identify those at risk of being drawn into terrorism or violent extremism and to provide them with community-based safeguarding strategies and interventions. There is guidance for local implementation. Prevent will address all forms of terrorism but continue to prioritise according to the threat posed to our national security.

Preventing abuse or neglect

1. It is better to take action before harm occurs.

2. However, most abuse and neglect takes place in secret. This makes it hard to know that an abusive event has taken place. It is vital that people – both professionals and those in the wider community – are alert to signs of abuse or neglect and know how to respond. Anyone could be in a position to notice signs of abuse and neglect. They must all understand what to do and where to go to get help and advice.

3. People are most vulnerable to abuse and neglect when they are isolated or cut off from families and friends. Supporting people to maintain or develop positive relationships and support networks will help to reduce their vulnerability and the risk that abuse could occur. As well as supporting individuals to maintain and develop positive relationships and support networks, the local authority will work to minimise circumstances in which people may become vulnerable to abuse.

Empowering individuals	"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help." Prevention is not about being over-protective or risk averse towards individuals. Section 4 sets out our approach towards supporting individuals to make informed choices and supporting them to identify and manage risks. Services should prioritise both safety and independence. People should be informed of their rights to be free from abuse and supported to exercise those rights. Options to support individuals to be free from abuse should be tailored to people's individual needs and target the outcome or resolution they want to achieve.
Workforce development	A common finding in serious adult reviews is that if professionals or other staff had acted upon concerns or sought more information, death or serious harm might have been prevented. Southend Borough Council, Essex County Council & Thurrock Council's policy is that all staff should have a basic awareness of safeguarding and know how to report concerns. Specialists are expected to have and develop the knowledge and skills to work with people in complex situations. This includes understanding and using powers under social care legislation, the Mental Capacity Act, Mental Health Act and other legislation to safeguard people's rights.
Multi-agency approach	Southend, Essex and Thurrock work in partnership to provide a common approach to safeguarding across the county. The SET Safeguarding Adults Guidelines set out the system and process all organisations should use to raise safeguarding concerns.

	This includes a framework for confidentiality and information sharing across agencies. Early sharing of information is key to providing effective help where there are emerging concerns. The wellbeing of adults at risk of abuse or neglect is more important than concerns about sharing information.
Commissioning and contract management	Southend Borough Council, Essex County Council & Thurrock Council is committed to ensure that services provided are up to standard and that people receiving services are treated with dignity and respect. All staff and contractors should have a basic awareness of safeguarding issues, capacity and dignity and know what to do if they have concerns. While more specialist services and staff should have the knowledge, skills and support to work with people in complex situations. In commissioning services, safeguarding should be the overarching standard, underpinned by all other care standards, such as privacy, dignity, clinical governance, practice standards and service quality.
Community safety	Southend Borough Council, Essex County Council & Thurrock Council must work with health partners and the police to raise awareness within the community to encourage people to recognise harm when they see it and know how to report concerns or get help. Awareness raising will include specific issues such as domestic violence, hate crime, elder abuse, fraud and financial abuse. Southend Borough Council, Essex County Council & Thurrock Council will also promote the development of good universal services, including community safety services.
Strategic leadership	Under the Care Act, the Safeguarding Adults Board will have a duty to publish a strategic plan each year that is developed with the community as a whole. This will take account of referral trends, findings from investigations and Safeguarding Adults Reviews, emerging issues and local circumstances to identify priorities and propose action to reduce risks across the community as a whole. The Board will also monitor the effectiveness of safeguarding activity and ensure the right systems and support is in place across the county for safeguarding to be effective.

Resolution of Professional Disagreements

Problem resolution is an integral part of professional co-operation and joint working to safeguard adults. Concern or disagreement may arise over another professional's decisions, actions or lack of actions, in relation to a referral, an assessment or an enquiry.

It is important to:

- Avoid professional disputes that put the adult(s) at risk or obscure the focus of the adult
- Resolve difficulties (within and) between agencies quickly and openly
- Identify problem areas in working together where there is a lack of clarity and to promote resolution via amendment to protocols and procedures.

The safety of adult(s) are the paramount considerations in any professional disagreement and any unresolved issues should be escalated with due consideration to the risks that might exist.

For disputes within agencies, in house procedures should be followed. This process relates to the resolution of differences between agencies.

PROFESSIONAL DISAGREEMENTS – STAGE 1

The aim should be to resolve difficulties at practitioner/fieldworker level between agencies.

Initial attempts should be taken to resolve the problem within a maximum of five working days for stages 1 and 2 or earlier if the adult is at risk. This should normally be between the people who disagree, unless the adult is at immediate risk.

It should be recognised that differences in status and/or experience may affect the confidence of some workers to pursue this unsupported.

PROFESSIONAL DISAGREEMENTS – ESCALATION - STAGE 2

If unresolved, the problem should be referred to the worker's own line manager who will discuss with their opposite number in the other agency.

Most day to day inter-agency differences of opinion will require a local authority Adult Social Care team manager to liaise with their (first line manager) equivalent in the relevant agencies, e.g.:

- A police Detective Sergeant
- A named health professional
- Care provider manager

PROFESSIONAL DISAGREEMENTS – ESCALATION - STAGE 3

If agreement cannot be reached following discussions between the above first line managers within a maximum of a further working week or a timescale that protects the adult(s) from harm (whichever is less), the issue must be referred without delay through the line management to the equivalent of service manager, Detective Inspector or other designated senior professional.

The professionals involved in this conflict resolution process must contemporaneously record each intra and inter-agency discussion they have, approve and date the record and place a copy on the adults file together with any other written communications and information.

If the problem remains unresolved, the line manager will refer 'up the line'. Any verbal report should be followed up in writing, showing the nature of the dispute and what attempts have been made to resolve this.

PROFESSIONAL DISAGREEMENTS – ESCALATION – STAGE 4

If professional differences remain unresolved, the matter must be referred to the relevant senior manager for each agency involved, with a copy being sent to the Chair of the appropriate area safeguarding board. This should include forwarding a written account of the dispute and what attempts have been made to resolve this.

In the unlikely event that the issue is not resolved by the steps described, consideration will be given to referring the matter to the Chair of the appropriate area Safeguarding Board who will offer mediation/or refer to the appropriate area Safeguarding Board sub-committee as soon as possible bearing in mind the impact on the adult(s). A clear record should be kept at all stages, by all parties. In particular this must include written confirmation between the parties about an agreed outcome of the disagreement and how any outstanding issues will be pursued.

When the issue is resolved, any general issues should be identified and referred to the agency's representative on the appropriate area's safeguarding board for consideration by the relevant area's safeguarding boards sub-group to inform future learning.

At any stage in the process, it may be appropriate to seek expert advice to ensure resolution is informed by evidence based practice.

It may also be useful for individuals to debrief following some disputes in order to promote continuing good working relationships.

DISSENT ABOUT IMPLEMENTATION OF THE ADULT SAFEGUARDING PLAN

Concern or disagreement may arise over another professional's decisions, actions or lack of actions in the implementation of the adult safeguarding plan.

The line managers of the professionals involved should first address these concerns.

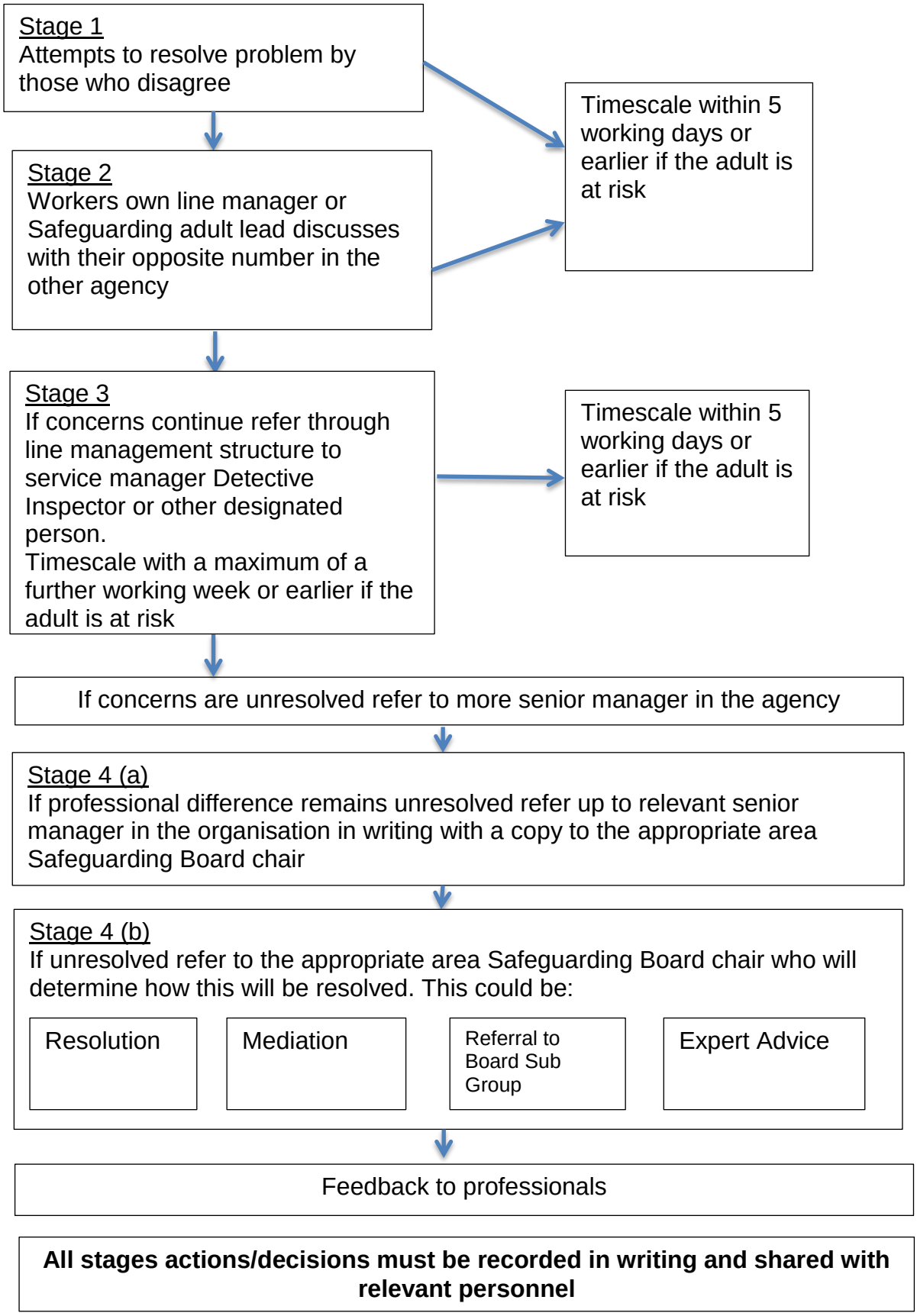
If agreement cannot be reached following discussions between the above 'first line' managers, the issue must be referred without delay through the line management to the equivalent of service manager/ detective inspector or other designated professional.

WHERE PROFESSIONAL DIFFERENCES REMAIN

If professional disagreements remain unresolved, the matter must be referred to the heads of service for each agency involved.

In the event that the issue is not resolved by the steps described above and/or the discussions raise significant policy issues, it may be helpful to convene a relevant area safeguarding board sub-committee which has the brief to consider policy and practice or serious cases.

RESOLUTION OF PROFESSIONAL DISAGREEMENT - Flowchart



All stages actions/decisions must be recorded in writing and shared with relevant personnel

THE ROLE OF ADULT SAFEGUARDING BOARDS

Safeguarding Adult Boards (SABs)

The Care Act 2014 has for the first time established legislation to put Safeguarding Adult Boards on a statutory footing. Safeguarding Adults Board (formerly Adult Protection Committee's) have existed in Southend, Essex and Thurrock for more than 10 years but the Care Act 2014 now gives the Boards three core duties:

- Publication of a strategic plan for each financial year which sets out how it will meet its main objective and what the members will do to achieve this. The plan must be developed with local community involvement and in consultation with the local Healthwatch organisation.
- At the end of each year the SAB must publish an annual report detailing what it has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing findings of any safeguarding adult reviews and any subsequent actions
- Conduct Safeguarding Adult Reviews (SARs) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult[7], or if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect, or any other situations that they feel require a review.

Objective and Role

The main objective of a Safeguarding Adults Board (SAB) is to assure itself that local safeguarding arrangements and partners act to help and protect adults[7] in its area.

A SAB has a strategic role that is greater than the sum of the operational duties of the core partners. It overseas and leads adult safeguarding across the locality and will be interested in a range of matters that contribute to the prevention of abuse and neglect. These will include the safety of patients in its local health services, the quality of local care and support services, effectiveness of prisons and approved

[7] Adult is defined in Care Act as someone who:

- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing or is 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.

premises in safeguarding offenders and awareness and responsiveness of further education services.

Additionally the Care Act's statutory guidance sets out that safeguarding boards must understand the many and potentially different concerns of the various groups that make up its local community. This might include such things as scams targeted at older householders, bullying and harassment of disabled people, hate crime directed at those with mental health problems, cyber bullying and the sexual exploitation or forced marriage of people who may lack the capacity to understand that they have the right to say no.
The board should be able to hold agencies to account but the agencies should not be accountable to the board.

Membership

Statutory members of SABs are:

- The local authority which set it up
- The Clinical Commissioning Groups in the local authority area
- The chief officer of police in the local authority area

A board will also include such other organisations and individuals as it considers appropriate to carry out its functions, for example ambulance and fire services.

Safeguarding Adults Reviews

1. The Safeguarding Adults Board **must** arrange a Safeguarding Adults Review when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

2. The Board **must** also arrange a Safeguarding Adults Review where an adult is still alive but has experienced serious neglect or abuse, and there is concern that partner agencies could have worked more effectively to protect them. Safeguarding Adults Boards are free to arrange for a Safeguarding Adults Review in other situations where it feels there is a value in doing so, for example to prevent or reduce abuse or neglect or explore practice.

3. The purpose of the Review is to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learnt and applied to future cases to prevent similar harm occurring in future. It is not to hold any individual or organisation to account.

4. The Safeguarding Adults Board should include the findings from any Safeguarding Adults Reviews in its Annual Report and report what actions it has taken / intends to take in relation to those findings. Where the Board decides not to implement an action from the findings it must state the reason for that decision in the Annual Report.

Self-Neglect Guidance

Prior to the Care Act 2014 guidance around safeguarding reflected the principle that those falling within the remit of adult safeguarding guidelines adults were those at risk of abuse and neglect *from others*. Thus many Local Safeguarding Adults Boards excluded self-neglect from their remit.

With the Care Act 2014, the definition of adults in need of care and support is broadened and gives Local Safeguarding Adults Boards (LSABs) a statutory objective to help and protect adults with care and support needs who are experiencing or at risk of abuse and neglect and are unable (as a result of those needs) to protect themselves. The statutory guidance to the Act (DH 2014) includes self-neglect within the list of circumstances that constitute abuse and neglect, thus locating it firmly within LSABs' remit.

What is self-neglect?

People self-neglect through:

- lack of self-care (for example, neglect of personal hygiene, nutrition, hydration and/or health),
- lack of care of the domestic environment (for example squalor or hoarding), and/or
- refusal of services that would mitigate risk to safety and wellbeing.
- they are unable to make reasonable or informed decisions because of their state of mental health or because they have a learning disability or an acquired brain injury; and/or
- they are unable to obtain necessary care to meet their needs

It is important to recognise the early signs of self-neglect through such indicators as age related changes that result in functional decline, cognitive impairment, frailty or psychiatric illness because these can increase the individual's vulnerability to abuse, neglect and exploitation as well as increase the potential for developing a number of underlying health conditions.

Why is self-neglect important in the context of safeguarding of persons at risk?

Failing to engage with people who are not looking after themselves, whether they have mental capacity or not, has serious implications for the health and well-being of the person concerned, and for the people engaged in the provision of their care and support. An adult will be considered to be at risk from abuse where they are unable or unwilling to provide adequate care for themselves.

Intervention in cases of self-neglect

APPENDIX 17: SELF-NEGLECT GUIDANCE

The nature of any intervention centres on whether the adult concerned has the mental capacity to make decisions that have legal force. A person may have mental capacity and yet disagree with the views of the local authority or another agency. This right is a right that cannot be taken away from a person who has mental capacity. However, it does not preclude the local authority or other agency entering into a dialogue with the person in order to explore the area of concern.

It is important that the rights of people to make apparently unwise lifestyle choices and to refuse services are respected.

An assessment of the person's mental capacity to make decisions in this respect must be taken into account with specific consideration of the risks and safety implications of the decisions being made.

Self-neglect is challenging for practitioners, due to:

- its complex and varied presentation, typically an interplay between personal, mental, physical, social and environmental factors unique to each person;
- the high risks it poses both to the individual and sometimes to others;
- the possibility that adult social care intervention is not welcomed by the individual, thus engagement can be difficult to establish and maintain;
- the challenges of assessing mental capacity;
- ethical dilemmas arising from the tension between respecting autonomy and fulfilling a duty of care;
- care management systems that prioritise short-term, task focused involvement rather than long-term relationships with adults;
- the need for multifaceted interventions from a range of agencies, all of which must be optimally coordinated.

Practice in self-neglect practice is more effective where practitioners:

- build rapport and trust, showing respect, empathy, persistence, and continuity of involvement;
- seek to understand the meaning and significance of the self-neglect, taking account of the individual's life experience;
- work patiently at the pace of the individual, but know when to make the most of moments of motivation to secure changes, even though these may be small;
- keep the question of the individual's mental capacity to make self-care decisions constantly in view;
- communicate about risks and options with honesty and openness, particularly where coercive action is a possibility;
- ensure that options for intervention are rooted in sound understanding of legal powers and duties;
- think flexibly about how family members and community resources can contribute to interventions, building on relationships and networks;
- work proactively to engage agencies who have specialist expertise to contribute and ensure that involvement is coordinated towards shared goals.

Effective practice is best supported when:

- strategic responsibility for self-neglect is clearly located within a shared interagency governance arrangement such as the LSAB;
- agencies share definitions and understandings of self-neglect presentation;
- self-neglect referrals and outcomes are monitored and quantified;
- interagency coordination and shared risk-management is facilitated by clear referral routes, communication and decision-making systems;
- longer-term supportive, relationship-based involvement is accepted as a pattern of work;
- training and supervision both challenge and support practitioners to engage with the ethical challenges, legal options and skills involved in self-neglect practice.

High Risk & Self-Neglect Situations

The Care Act 2014 has introduced self-neglect as a type of abuse to be managed through safeguarding procedures. The SET guidance also acknowledges that this process can also be used in other high risk situations where it is necessary to engage with a range of disciplines and professionals.

This process contained within the flow chart identifies the process to follow to ensure that the adult is centre to any discussions or decisions made and that there is multi-agency input to support what are usually complex situations.

Central to this involvement is the capacity of that adult to understand the issues involved. The principles of the Mental Capacity Act 2005 must be followed at all times and good assessments recorded to establish capacity or otherwise. It may be that the adult understands the situation they are in and can voice what outcomes they might want to achieve, they may however lack the executive capacity to undertake those changes, even with assistance and support. Where it is deemed that a person has the capacity to understand their situation, it must also be recorded why the practitioner has reached that conclusion.

The multi-disciplinary meeting is crucial to enable all parties to discuss the options and solutions, including any potential legal action or enforcement which informs the risk management plan.

Where the adult is deemed to have the capacity to understand the implications of their actions or inactions every effort should be made to encourage them to engage with support.

It is recognised that managing cases of severe self-neglect is a long term piece of work and the most relevant team should take the lead for this, still drawing on other sources of support where appropriate.

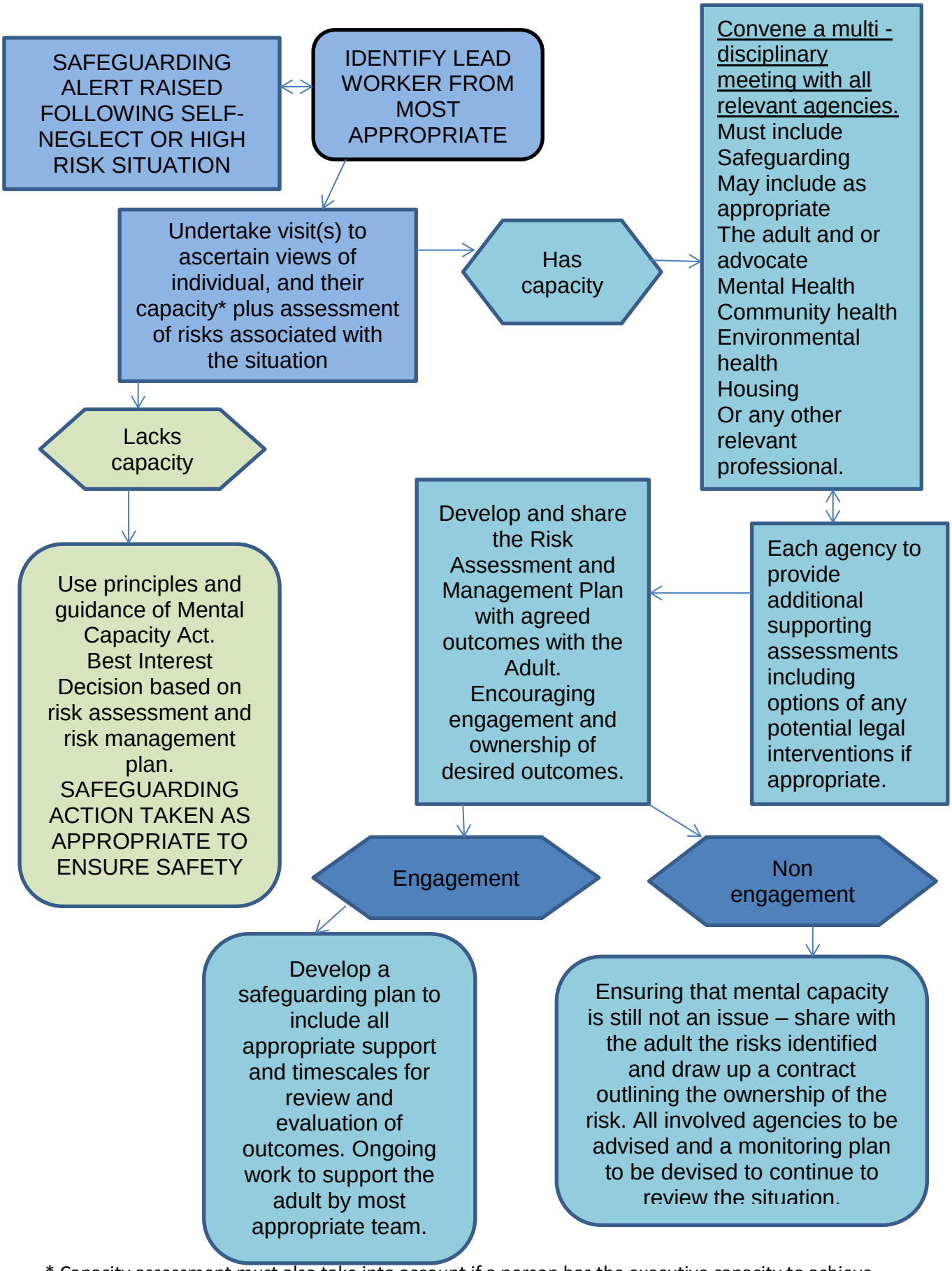
In some cases, where the adult does have capacity, and refuses to engage with support to minimise risks, these should be shared with the adult, and a formal contract drawn up to identify the ownership of those risks. This must always be supported with comprehensive assessments and reports. This will evidence that the

Local Authority has taken all possible steps to resolve the situation, but it is acknowledged that some people chose to live and continue to live in risky situations.

In all cases however a monitoring plan must be drawn up to ensure that the situation is reviewed regularly and the process repeated as appropriate.

Please see flowchart below

APPENDIX 17: SELF-NEGLECT GUIDANCE



* Capacity assessment must also take into account if a person has the executive capacity to achieve their desired outcomes.

SET Information Sharing

1. Introduction

Care Act 2014 states that there is a new duty on relevant organisations to supply information to Safeguarding Adult Boards (SABs) on request. This mirrors a duty in children's legislation relating to local safeguarding children boards.

Creating a duty to provide the information is intended to alleviate fears leading to persistent resistance in this regard (for example, due to misconceptions around data protection laws). In this day and age, however, there is really no excuse for having misconceptions about data protection laws, and safeguarding boards, and the people who operate enquiries and make plans, must of course be legally literate.

If certain conditions are met, a person or body must supply information to a SAB at its request, or to any other person mentioned in the request. The information must be requested for the purpose of enabling or assisting the SAB to perform its functions. But its functions relate to doing anything it believes necessary to co-ordinate and ensure the effectiveness of all those who exercise 'enquiries' functions.

The use to which this information-sharing power of request can be made will extend into the day-to-day work of those doing the safeguarding assessments. SAB members can therefore expect to be 'leant upon' to issue requests for the information on a regular basis.

The government expects organisations to share information about individuals who may be at risk from abuse. This is also stressed by Safeguarding Adults [ADSS 2005] the framework for good practice.

This protocol should be read in conjunction with the SET (Southend. Essex and Thurrock) Policy and Procedures. In particular, see pages 19 -21 and 49 -79 of the Policy and Procedures for further information and the legal context for information sharing.

1.1 This protocol sets out the details of sharing information in accordance with the principles defined in the Essex Trust Charter. Each organisation that has signed the Charter is known as a charter member.

1.2 This protocol and associated documents, sets out the underpinning values and legal framework for information sharing between agencies working with Adults in Essex. It provides for information sharing to support Safeguarding Adults and provide early intervention. Each organisation should have supporting procedures in place which set out how the process is carried out within their agency.

1.3 This document provides an agreed basis for sharing information. It demonstrates commitment to these underpinning values and is a reference document to clarify the legality of sharing information.

1.4 Associated documents give guidance to staff who wish to give information to, or obtain information from, other agencies locally or elsewhere.

Important note: when dealing with Adult Safeguarding issues agencies must always refer to the Southend Essex and Thurrock (SET) procedures. (www.essexsab.org)

2. Purpose

2.1 The purpose of information sharing under this protocol is to:

2.1.1 Provide early and effective multi-agency intervention to safeguard vulnerable adults, which will promote social inclusion, health and well-being.

2.1.2 To encourage and help develop effective information sharing between different services and professional groups, based upon trust and mutual understanding

2.1.3 Facilitate and provide clear guidance on the exchange of personal and sensitive information for the investigation and response to suspected abuse and neglect of adults within Essex.

2.1.4 Support the prevention and reduction of crime and identification and apprehension of offenders and suspected offenders.

2.2 The underpinning values for sharing information under this protocol are:

1.2.1 Safeguarding and promoting the welfare of vulnerable adults is the prime consideration in all decisions about whether to share information.

1.2.2 Professionals can work together effectively to safeguard and promote the welfare and well-being of adults only if there is an exchange of relevant information between them.

1.2.3 Where a vulnerable adult has a need for services from a number of agencies, ongoing appropriate information sharing between those agencies is likely to be necessary.

1.2.4 Workers should share only as much information as they need to – but should share enough to achieve the purpose for which information is being shared.

2.3 The consent of those involved to share information should be obtained unless it would place someone at risk or be likely to prejudice the prevention or detection of crime or the apprehension or prosecution of offenders (See Appendix A). The competence of an adult to understand the issues must be considered when seeking consent (see appendix A).

2.4 Personal information relating to an adult is private to them and should generally be kept confidential. People should normally be kept aware of what is happening to information relating to them and have the right of access to it unless it would be likely to prejudice the prevention or detection of crime or the apprehension or prosecution of offenders.

2.5 Article 8 of the European Convention on Human Rights gives everyone the right to respect for their private family life, home and correspondence. Authorities may only interfere with this if they are not doing anything which is against the law, have a legitimate purpose (including protection of health and the rights of others), and the action is no more than is needed. Sometimes this may mean a worker has to judge one person's rights against another's or the different rights of one person (for example, a vulnerable adult's right to privacy against their right to protection).

3. Who is involved

3.1 The charter members involved in this information sharing protocol may change from time to time.

3.2 This protocol is owned equally by all participating charter members and is co-ordinated and administered on their behalf by Essex Safeguarding Adult Board – esab@essex.gov.uk

3.3 Where relevant, WEISF members should seek the agreement of their Caldicott Guardian, nominated deputy or information governance officer or Data protection officer before signing this protocol.

4. Information to be shared

4.1 The information which may be shared between signatory charter members is:

- Name, including any additional names by which the vulnerable adult is known
- Date of birth
- Gender
- Address
- Name, contact details of GP
- The charter member providing the information
- Name, contact details of person/people working with vulnerable adult
- Relationship to, involvement with, and information about the reason for current concern about, the vulnerable adult including, where relevant, details of offending and risk of harm to others

5. Legal Basis for sharing information

5.1 Three main areas of law apply to the disclosure and sharing of people's personal information. The first is the ***common law of confidentiality*****.** The second is the ***Human Rights Act 1998*****.** The third is the ***Data Protection Act 1998.***

HM Government has published two guidance documents which should be read in conjunction with this agreement and both are an invaluable resource for all safeguarding professionals;

1. Information sharing: Guidance for practitioners and managers

2. Information Sharing: Further guidance on legal issues

Both documents, although described as *'guidance'*, should be considered as a summary of the legal principles and requirements for lawful decision making concerning the sharing of information.

The Caldicott Review recommendations where released and accepted by Government in 2013, these recommendations focussed on data sharing in the health and care system, introduced was a 7th Caldicott principle:-

'The duty to share information can be as important as the duty to protect patient confidentiality' Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles.

This should be taken into consideration as well as the remainder of the Caldicott Principles when deciding to share personal information.

1. Caldicott Principles

Listed in Appendix B of this document is the underpinning legislation likely to apply to sharing under this protocol.

5.2 In order to comply with the Data Protection Act 1998 (DPA), one requirement is that personal information is shared fairly and lawfully (principle 1). In order to achieve this, organisations must comply with a least one condition from schedule 2 and, where sensitive information is included, at least one condition from schedule 3 of the DPA. The schedule 2 and 3 conditions can be founding in Appendix C of this document.

6. Consent

6.1 It is good practice to seek the consent of data subjects. However, charter members agree that disclosure without consent is lawful if certain conditions are met. For example, personal information may be shared when anonymised or to ensure the performance of public functions or legal obligations (also see 4.2.5).

6.2 Occasionally, an individual may refuse to give consent to share their information. Where it is lawful to share such information in spite of the refusal, the data controller must record the refusal of consent and the reasons for overriding that refusal.

6.3 The data controller is responsible for ensuring that data subjects are advised when appropriate that their information is being or may be shared.

7. Access and individuals' rights

7.1 Access to Records requests will be dealt with by each organisation in line with their internal process and procedures. If an organisation receives an Access to Records request relating to the information held by the partner

organisation, then the requester will be referred as appropriate to the correct data controller.

7.2 Freedom of Information requests will be dealt with by each organisation in line with their internal process and procedures. If an organisation receives a Freedom of Information request relating to the information held by the partner organisation, then the requester will be referred as appropriate to the correct data controller.

8. Keeping information secure

8.1 Security for the exchange of information will be achieved through:

- Encryption of electronic records;
- Appropriately marking paper records (for example, "confidential");
- Using agreed processes for checking the identity of the recipient;
- Applying other appropriate secure technologies.

8.2 Charter members receiving shared information will:

- Ensure that their workers are able to access only the shared information necessary for their role;
- Ensure that their workers are appropriately trained so that they understand their responsibilities for confidentiality and privacy;
- Protect the physical and electronic security of the shared information

9. Frequency of sharing

9.1 The format and frequency will depend upon the circumstances in which the information is being shared.

9.2 The frequency with which the information will be shared is at regular pre-agreed intervals or as the circumstances of the vulnerable adult or their family/carer changes.

10. How information may be exchanged

10.1 Information will be exchanged using secure methods approved by partners, e.g. *Govconnect* and these may include: verbal exchanges by telephone or face-to-face, fax, letters and other written material; secure websites and electronic records. The following general standards should be considered when exchanging information:

- Where information is exchanged via email, only secure email in an encrypted attachment will be used, e.g. via GCSX, nhs.net, .pnn, cjsm, .gsi or a secure system such as Egress;

- When exchanging information via email, telephone, post etc. members are to ensure that their local procedures surrounding secure methods of data transfer are followed these should include the following:

- When disclosing information by telephone consideration must be given to authenticating the caller and ensuring sensitive conversations are not overheard;
- Do not send personal or confidential information to personal email addresses;
- Information in hard copy format sent via Royal Mail must be double wrapped;
- If the data is particularly sensitive Partners may wish to consider using Special Delivery or a contracted courier under tracked conditions;
- If information is to be sent via fax, then safe haven procedures must be used;
- Information sent in hard copy must be addressed to a specific person and marked *'for addressee only'*.

- Where datasets (defined as a collection of records, which may be personal data) are exchanged between charter members, the format, frequency, intervals and security will be documented, and agreed between the parties involved.

11. Data Retention

11.1 After their involvement with the vulnerable adult ends, charter members retaining shared information must review the need to continue to hold it, and must destroy it after the period specified in their organisation's retention and destruction schedule, or a period agreed with the data controller. Where practical, the outcome of review or destruction should be notified to the relevant data controller.

12. Responsibility for exchanging these data and ensuring data are accurate

12.1 Charter members are expected to ensure as far as possible that the information they share and receive is accurate; and to differentiate between observations, allegations, facts and opinions.

12.2 Charter members receiving shared information are responsible for applying relevant quality assurance before using the information.

12.3 If information is found to be inaccurate, it is the responsibility of the charter member discovering the inaccuracy to notify the appropriate data controller. The data controller will ensure that the source data is corrected and will notify all recipients, who will be responsible for updating the information they hold.

12.4 Charter members will not be liable for any financial or other costs incurred by other parties to this protocol as a result of any information being wrongly disclosed by another party to this protocol or as a result of any negligent act or omission by another party to this protocol.

12.5 The Partner Organisation originally supplying the information should be notified of any breach of confidentiality or incident involving a risk or breach of the security of information.

12.6 Everyone sharing data under this agreement is responsible for the quality of the data they are sharing.

12.7 Before sharing data, officers will check that the information being shared is accurate and up to date to the best of their knowledge. If sensitive data is being shared which could harm the data subject if it was inaccurate, then particular care must be taken.

12.8 If a complaint is received about the accuracy of personal data which affects datasets Shared with partners in this agreement, an updated replacement dataset will be communicated to the partners. The partners will replace the out of date data with the revised data.

13. Breach of Confidentiality

13.1 In the event of a breach of confidentiality, staff should contact their organisation's Data Protection Officer/Information Governance team/Legal advisers for advice and guidance.

13.2 Where a breach is identified as serious, it may have to be reported to the Information Commissioners Office.

14. Review of Data Exchange Agreement

14.1 The Protocol will be reviewed one year after signature and at an agreed period thereafter.

15. Agreement

15.1 We undertake to implement and adhere to this protocol.

Signed by Governance Lead

Print:……

Signed:……

On behalf of
(Organisation):……

Appendix A:

CONFIDENTIALITY AND INFORMATION SHARING

1. THE VULNERABLE PERSON

1.1 Expectations

A vulnerable person is entitled to expect that all information held on them in whatever form is treated with confidentiality.

Personal information should only be shared with the person's agreement if they have capacity (see 2.2 below) to give this agreement.

The person should be aware that information is shared within agencies on a need to know basis.

The person can expect that information is shared in a confidential manner. This applies to sharing within agencies as well as between agencies.

1.2 Consent

If a vulnerable person has disclosed a potential abuse or a third party has reported a potential abuse, it must be explained that the information cannot be kept a secret between them and the member of staff / volunteer, but must be shared with their agency's management.

The vulnerable person should also be aware that their circumstances may be to referred to Adults Social Services even though they may not wish this.

The vulnerable adult can ask that the information is only shared as part of the decision in respect of the Strategy Meeting and the potential abuse is not pursued to investigation.

In this case they must be made aware that this can be overridden in certain circumstances

If this is the case the reasons for this and the procedure must be fully explained to the vulnerable person and their family / carer. They should be given a chance to reconsider their withdrawal of consent. All this must be fully recorded both as part of the Strategy Meeting.

2. Vulnerable Adult does not want a referral

Issues of capacity and consent must be considered
The wishes of the individual must be respected but the Strategy Meeting needs to consider the wider picture when considering how to proceed. They need to consider some of the following:

- Is it in the public interest to proceed?
- Is there a question of proportionality i.e. does the public duty to protect

vulnerable people override the human rights of the individual?
- Is it lawful to proceed even though the individual does not wish this?
- If an investigation is pursued or abandoned can that decision be justified in terms of the statutory authorities' duty to be accountable?
- Is there a necessity to proceed and override the rights of the individual?

2.1 When consent can be overridden

- A serious crime has been committed
- Where the alleged perpetrator may go on to abuse other adults
- Other vulnerable adults are at risk in some way
- The vulnerable adult is deemed to be in serious risk
- There is a statutory requirement e.g. Children's Act 1989, Mental Health Act 1983, Care Standards Act 2000
- The public interest overrides the interest of the individual
- When a member of staff of a statutory service, a private or voluntary service or a volunteer is the person accused of abuse, malpractice or poor professional standards.

2.2 Capacity to consent

If a practitioner considers that an adult may not have the capacity to give 'informed consent' for information sharing, they must follow the *Mental Capacity Act 2005 Code of Practice* If you judge that an individual does not have the capacity to make decisions, their views should still be sought as far as possible.

3. INTERAGENCY SHARING OF INFORMATION

3.1 Responsibilities of individual employees

To record and maintain records in a confidential manner and to share information on a need to know basis.

To realise information belongs to their agency and not them as an individual. They should never make promises to a vulnerable person, which they cannot keep, in respect of information sharing.

To refer to their agencies' own policy on confidentiality and information sharing.

To ensure confidentiality standards should apply even if the person does not have capacity to give consent to information sharing.

3.2 Responsibilities of agencies

All agencies have a duty to inform Adult Social Services as the lead agency that a potential abuse that has taken place.

If the vulnerable person has not given consent and the circumstances do not require the overriding of this, Adult Social Services should keep the required information sharing within the Strategy Meeting and for overall monitoring purposes as required in *No Secrets*.

If the Strategy Meeting agrees that another agency is the key investigator then only Adult Social Services should retain the information shared at the Strategy Meeting, until such time as the outcome of the investigation is reported back for the protection plan to be put in place, if required.

3.3 Sharing Information with the Police

Early discussions with the Police Domestic Abuse and Hate Crime Units are required if a possible crime has been committed.

This can be on an anonymous basis in the first instance to enable the Police to give advice.

The Police can only proceed if the vulnerable person has given consent or the circumstances are such that this must be overridden.

Protocols in relation to the Crime and Disorder Act 1998 are also relevant.

3.4 Sharing information from other investigations

There are situations when other investigations will be undertaken as part of the strategy for the Inquiry into a potential abuse. The details of those investigations cannot always be fully shared or can only be shared after the investigation is completed.

Discussions can take place between the Police undertaking a criminal investigation and the lead person for the disciplinary proceedings to agree what information / interviews can be shared to assist both processes.

4. PRINCIPLES OF INFORMATION SHARING

4.1 Caldicott

These outline the principles for the sharing of information.

This guidance accepts that information may need to be shared in the best interests of the person concerned, and explains the possible circumstances and the safeguards required.

- All information will only be shared on a ‘need to know basis’ when it is in the best interests of the vulnerable person
- Confidentiality must not be confused with secrecy
- Informed consent should be obtained, but if this is not possible and other vulnerable adults are at risk, it may be necessary to override the requirement

Appendix 18 – SET Information Sharing

- It is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other vulnerable people may be at risk.

4.2 Guiding Principles

Information shared must be only that which is specific to the situation being discussed or information that has a bearing on the situation.

Information should only be shared with those who have a direct interest in the decision making, planning, and service provision or protecting of that vulnerable adult.
The requirements of the Data Protection Act must be observed in relation to information held on the individual.

Good communication between agencies is essential when dealing with situations of potential abuse.

Appendix B: Relevant legal statutes

Care Act 2014
Crime and Disorder Act 1998
Criminal Justice Act 1967
Domestic Violence Crime and Victims Act 2004
Family Law Act 1996
Fraud Act 2006
Medicines Act 1969
Offences Against the Person Act 1861
Police and Criminal Evidence Act 1970
Protection from Harassment Act 1997
Public Order Act 1986
Sexual Offences Act 1956
Sexual Offences Act 1967
Sexual Offences Act 2003
Theft Acts 1968 and 1978
Carers (Recognition and Services) Act 1995
Carers and Disabled Children Act (2000)
Care Standards Act 2000
Chronically Sick and Disabled Persons Act 1970
Community Care (Direct Payments) Act 1996
Disabled Persons (Service Consultation and Representation) Act 1986
Employments Rights Act 1996
Health and Social Care Act 2001
Health Service and Public Health Act 1968
Health Act 1999
Housing Act 1985
Housing Act 1996
Housing Act 2004
Local Authority Social Services Act 1970

Mental Capacity Act 2005
Mental Health Act 1983
National Assistance Act 1948
National Assistance (Amendment) Act 1951
National Health Service Act 1977
National Health Service and Community Care Act 1990
Public Health Act 1936 and Public Health Act 1961
Registered Homes (Amendment) Act 1991
Court of Protection Rules 1994
Data Protection Act 1998
Disability Discrimination Acts 1995 & 2005
Enduring Power of Attorney Act 1985
Health & Safety at Work Act, 1974
Human Rights Act 1998
Power of Attorney Act 1971
Public Interest Disclosure Act 1998
Race Relations (Amendment) Act 2000
Safeguarding Vulnerable Groups Act 2006
Social Security (Claims and Payments) Regulations 1987

Appendix C: Data Protection Act Conditions for Processing

Sharing non-sensitive[8] personal information in accordance with this protocol is likely to be lawful if at least one of the following circumstances exists (Data Protection Act 1998 **schedule 2 conditions):**

- *The data subject has given their consent to the processing.*

- *The processing is **necessary** to comply with any legal obligation to which the data controller is subject, other than an obligation imposed by contract.*

- *The processing is **necessary** in order to protect the vital interests of the data subject.* In this condition, 'vital interests' refers to matters of life or death.

- *The processing is **necessary** –*
  for the administration of justice;
  for the exercise of any functions conferred by or under any enactment;
  for the exercise of any other functions of a public nature exercised in the public interest.

- *The processing is **necessary** for the purposes of legitimate interests pursued by the data controller or by the third party or parties to whom the data are disclosed, **except** where the processing is unwarranted in any particular case because of prejudice to the rights and freedoms or legitimate interests of the data subject*.

[8] For the purposes of this protocol, sensitive personal information is as defined in the Data Protection Act 1998. All other personal information is deemed to be non-sensitive. Information about physical or mental health is classed as sensitive.

Sharing sensitive[9] personal information in accordance with this protocol is likely to be lawful if at least one of the following circumstances exists in addition to one of the above:

- *The data subject has given his **explicit** consent to the processing of the personal data (See Appendix A).*

*The processing is **necessary** –*

(a) in order to protect the vital interests of the data subject or another person, in a case where –

(i) consent cannot be given by or on behalf of the data subject, or

(ii) the data controller cannot reasonably be expected to obtain the consent of the data subject, or

(b) in order to protect the vital interests of another person, in a case where consent by or on behalf of the data subject has been unreasonably withheld.

- *The information contained in the personal data has been made public as a result of steps deliberately taken by the data subject.*

  The processing –

  *(a) is **necessary** for the purpose of, or in connection with, any legal proceedings (including prospective legal proceedings),*

  *(b) is **necessary** for the purpose of obtaining legal advice, or*

  *(c) is otherwise **necessary** for the purposes of establishing, exercising or defending legal rights.*

- *The processing is **necessary** –*

  (a) for the administration of justice;

  *(b) for the exercise of any functions conferred by or under any enactment; or the processing is **necessary** for medical purposes (including the purposes of preventative medicine, medical diagnosis, medical research, the provision of care and treatment and the management of healthcare services) and is undertaken by –*

  (a) a health professional (as defined in section 69 of the Act); or

  (b) a person who owes a duty of confidentiality which is equivalent to that which would arise if that person were a health professional.

- *The processing –*

  (a) is of sensitive personal data consisting of information as to racial or ethnic origin;

  *(b) is **necessary** for the purpose of identifying or keeping under review the existence or absence of equality of opportunity or treatment between persons of different racial or ethnic origins, with a view to enabling such equality to be promoted or maintained; and*

  (c) is carried out with appropriate safeguards for the rights and freedoms of data subjects.

[9] For the purposes of this protocol, sensitive personal information is as defined in the Data Protection Act 1998. All other personal information is deemed to be non-sensitive. Information about physical or mental health is classed as sensitive.

- *The processing –*

  (a) is in the substantial public interest;

  (b) is necessary for the purposes of the prevention or detection of any unlawful act; and

  (c) must necessarily be carried out without the explicit consent of the data subject being sought so as not to prejudice those purposes.

- *The processing is necessary for the exercise of any functions conferred on a constable by any rule of law.*

Whistleblowing

1. A whistle blower is an employee, a former employee or member of an organisation especially a business or government agency who reports misconduct to people or entities that have the power and presumed willingness to take corrective action.

2. Each organisation should have its own policy/guidance with regard to whistleblowing. Staff must be made aware of these policies which should be in an easily accessible location for staff reference.

3. It is good practice, and staffs have a duty of care, to draw attention to bad/poor practice in the workplace. This includes practice that may be abusive and/or neglectful. **Failure to report amounts to collusion with the perpetrator and abuse.**

4. Staff have an individual responsibility to raise concerns with someone who has the responsibility to take action. Sometimes it may be necessary to go outside the immediate work environment or the immediate organisation.

5. It is the responsibility of all organisations to promote a culture which values good practice and encourages whistle blowing.

6. People have in the past often been deterred from `whistle blowing` about abuse or neglect by duties of confidentiality and/or fear of the consequences of speaking out. The Public Interest Disclosure Act 1998 seeks to protect disclosure of the following:
    - Criminal offence (past, ongoing or prospective)
    - failure to meet a legal obligation miscarriage of justice
    - health and safety being endangered
    - Risk of environmental damage, or
    - Deliberate concealment of any of the above.

7. The Act envisages that disclosure about such malpractice will generally be made in the first instance to the person's employer, or another person or body who appears responsible for the malpractice (e.g. a relative of a resident reporting matters to managers of a home).

8. The Act envisages employers establishing procedures, so that staffs who have justified concerns about breaches of practice or the law can pass on these concerns to be investigated.

9. They are only protected by the Act if they are acting in good faith, and reasonably believe that their allegations are true. Allegations made for financial gain are not protected, even if they are true.

10. Staff making disclosures to people other than their employer are likely to be protected if:

- They reasonably believe that they will be treated detrimentally for disclosing to the employer; or
- They reasonably believe that the evidence will be destroyed or hidden if the employer is `tipped off`; or
- The employer has been told, but has not taken appropriate action.

11. Disclosure to a third party has to be a `reasonable` step in all the circumstances including:
    - Who is told (e.g. disclosure to a statutory inspectorate in preference to the press);
    - How serious the concern is, and whether it is a continuing problem;
    - Whether the employer has a whistle blowing procedure and if so, whether the employer has followed it.

12. It may be justified for the whistle blower to disclose to a third party in the first instance rather than the employer.

13. A disclosure made in accordance with the Act's expectations will mean that:
    - A confidentiality clause in an employment contract cannot be used to prevent a person from disclosing relevant breaches of the law or practice. This means that confidentiality terms in employment contracts cannot be used by employers who are responsible for breaking a law or for abuse or neglect or other malpractice
    - Dismissal on grounds of disclosure within the terms of the act is automatically unfair, and can be challenged before the employment tribunal.

14. The person providing the information may be reluctant to give their name or they may ask that they remain anonymous. Their wishes will be recorded however while respecting their right to confidentiality, they cannot however be given an absolute undertaking that they will not be identified at a later date, especially, if any legal action is indicated.

15. There are a myriad of different helplines available nationally (CQC, NHS, GMC, etc.) to assist staff if required.

Supporting Material

National guidance and best practice:

Association of Directors of Adult Social Services	Safeguarding Adults: Advice and guidance to Directors of Adult Social Services (March 2013) offers practical advice to Directors to ensure services are effective. It includes the focus on people and the outcomes they want. Safeguarding Adults - Joint Statement (2014) in partnership with ACPO, the LGA, the NHS Confederation and NHS Clinical Commissioners.
Local Government Association	**Making Safeguarding Personal** is a joint programme with ADASS to facilitate person-centred, outcomes-focused responses to adult safeguarding. Standards for Adult Safeguarding (December 2012) – the national framework of standards was updated to focus on outcomes and quality Councillors' Briefing (2013) More resources
Social Care Institute for Excellence	SCIE has developed a range of resources to support best practice in adult safeguarding. These include: • Report 41: Prevention in Adult Safeguarding (May 2011) • Report 45 Governance of Adult Safeguarding (Safeguarding Adults Boards) (September 2011) • Report 46: Self neglect and adult safeguarding (September 2011) • Report 47 User involvement in Adult Safeguarding • Report 50: A legal guide for practitioners (December 2011) • Two guides on Commissioning Care Homes with the aim of ensuring safeguarding is integral to the process. • Guidance on Mediation and family group conferencing
NHS England	For a list of NHS resources please see the NHS England website on http://www.england.nhs.uk/resources/

Glossary

ADASS	Association of Directors of Adult Social Services
Agent	SEPT or NEPFT
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CRU	Central Referral Unit incorporating Domestic Abuse and Hate Crime (Essex Police)
DASH	Domestic Abuse Stalking, Harassment and Honour Based Abuse
DH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DBS	Disclosure and Barring Service
EDS	Emergency Duty Service
EHC	Education, Health and Care Plan
FGM	Female Genital Mutilation
GMC	General Medical Council
GP	General Practitioner
HBA	Honour Based Abuse
IMCA	Independent Mental Capacity Advocate
LA	Local Authority
MARAC	Multi-Agency Risk Assessment Conference
MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983
NHS	National Health Service
RIDDOR	Reporting of Injuries, Diseases & Dangerous Occurrences Regulations

Appendix 21 – Glossary

SAF	Safeguarding Adults Form
SET	Southend Essex & Thurrock
Social Services	Department of People (Southend) Adult Operations (Essex) Adult Social Care (Thurrock)
WHO	World Health Organisation

Local Authority Contact Details

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
Non Secure email: accessteam@southend.gov.uk

By safe haven 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

By email:
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

Making a referral/enquiry by telephone: 0845 603 7630
By safe haven fax to: 0845 601 6230

Out of hours Referrals:
General Public - 0845 606 1212
Statutory Agencies – 0300 123 0778
Fax - 0300 123 0779

Thurrock

By Email:
Secure email only: SafeGuardingAdultsTeam@thurrock.gcsx.gov.uk
Please note you can only send emails to the secure address if you are sending from a secure email
Non Secure Email: SafeguardingAdults@thurrock.gov.uk

By safe haven Fax to: 01375 652760

Making a referral/enquiry by telephone:

Community Solutions Team: 01375 652868
Out of hours: 01375 372468 (Fax 01375 397080)