

South Norfolk & North Norfolk Clinical Commissioning Group

Adult Safeguarding Policy

Date of review	Reason for review	Reviewer & Role	Review due
October 2017	Review due	Gary Woodward Adult Safeguarding Lead Nurse, Norfolk Cluster CCGs	October 2018

Title	Safeguarding Adults Policy
Description of document	<p>CCG's have a responsibility to ensure there are effective safeguarding arrangements for services which they commission, including effective systems for reporting abuse and neglect. It must ensure that the safeguarding of vulnerable adults is central to the quality agenda, with that all staff employed by the CCG are aware of their individual responsibilities.</p> <p>The Care Act 2014 says workers across a wide range of organisations need to be vigilant about adult safeguarding concerns in all walks of life including, amongst others in health</p>

	<p>and social care, welfare, policing, banking, fire and rescue services and trading standards; leisure services, faith groups, and housing.</p> <p>Therefore for all staff, the first priority is to ensure the safety and protection of adults at risk and it is the responsibility of all staff to act on any suspicion or evidence of abuse and neglect and to pass their concerns onto a responsible person or agency.</p>
Scope	All staff employed by North Norfolk and South Norfolk Clinical Commissioning Group
Author and Designation	Gary Woodward – Senior Nurse Adult Safeguarding, Norfolk Cluster CCG's and Jackie Schneider – Governing Body Nurse NNCCG
Equality Impact Assessment	No negative impact
Associated Documents	<ul style="list-style-type: none"> • Norfolk Multi Agency Safeguarding Adults Policy • Norfolk Multi Agency Safeguarding Adults Procedures • North Norfolk and South Norfolk CCG Serious Incident Policy
Supporting References	<ul style="list-style-type: none"> • Care Act 2014 • Mental Capacity Act – (MCA) 2005 • Prevent Duty Guidance: for England and Wales 2015 • Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework, NHS England, 2015
Consultation or Development Process	North Norfolk and South Norfolk CCG Governing Body

Training Implications	<ul style="list-style-type: none"> • All staff must be made aware of this policy and their individual responsibilities under the policy. • All staff must receive safeguarding adults training at induction and via the mandatory training system. • Training for CCG staff groups requiring more detailed awareness will be provided by the Safeguarding Adults Team
Duties, Accountability and Responsibility	<ul style="list-style-type: none"> • Chief Quality Officer holds the accountability for ensuring that the Safeguarding Adult Agenda is discharged effectively across the whole of the organisation. • A member of the governing body has been identified with the lead for patient Quality and Safety • There is an adult safeguarding team who works on behalf of the CCG Norfolk and Waveney Cluster and is hosted by North Norfolk. • All Staff within the CCG have responsibility and accountability for reading this policy and following the procedures and processes identified, and completing their mandatory training.
Dissemination	North Norfolk and South Norfolk CCG Website
Approval Process	North Norfolk and South Norfolk CCG Governing Body
Review Arrangements	Review annually or sooner should changes to legislation or guidance require it

Adult Safeguarding Policy

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1. Introduction

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

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

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

1.4 The Norfolk Social Services Multi-agency policies and operational procedures are the main policy documents and should be read in conjunction with this policy.

1.5. North Norfolk and South Norfolk CCG promotes:

Safeguarding is everybody's business, and everybody's responsibility

Doing nothing is not an option.

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

- Norfolk Multi-Agency Safeguarding Adults Policy, Norfolk Safeguarding Adults Board, (updated March 2017)
- The Care Act Statutory Guidance, Department of Health, 2014
- Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework, NHS England, 2015
- Mental Capacity Act Code of Practice, Office of the Public Guardian, 2014
- Note on Deprivation of Liberty Safeguards (DoLS) judgments of the Supreme Court, Department of Health, 2014

- Department for Constitutional Affairs. 2007. *Mental Capacity Act (2005) Code of Practice*. London. TSO.
- Ministry of Justice. 2008. *Deprivation of Liberty Safeguards (2007). Code of Practice*. London. TSO.
- The Stationary Office. 2005. *Mental Capacity Act. Code of Practice*. London. TSO.
- DH, 2010. *Clinical Governance and Adult Safeguarding; an integrated process*. London. TSO.
- NHS England, 2013. *Serious Incident Framework*.
- HM Government, (Updated 2016). *Prevent Duty Guidance: for England and Wales*. London. COI.
- Modern Slavery Act 2015

2. Aim of the Policy

2.1. The aim of this policy is to ensure that all members and employees of North Norfolk and South Norfolk CCG:

- Promote the wellbeing, security and safety of vulnerable people consistent with their rights, capacity and personal responsibility, and prevent abuse occurring wherever possible;
- Understand the process for reporting Adult safeguarding incidents and concerns;
- Use integrated governance systems for reporting to ensure that the process of reporting, investigation and subsequent action, is as effective as possible in achieving good outcomes for vulnerable patients and service users;
- Use the safeguarding principles to shape the strategic delivery and commissioning of services within North Norfolk and South Norfolk CCG
- Complies with The Care Act 2014 and the Mental Capacity Act 2005

3. Scope and Definitions.

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

3.2 The CCG must have clear lines of accountability which are reflected in its governance arrangements, and arrangements in place to co-operate with the Local Authority in the operation of the Safeguarding Adults Board

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

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

- a) Raise concerns, allegations and incidents in relation to safeguarding adults in a timely manner.
- b) Alert adult services in the local authority of the concerns as per the Norfolk multi-agency safeguarding policy.
- c) Contribute to the safeguarding process, including contributing to safeguarding adults investigations where requested to do so.
- d) All CCG managers and contractors are responsible for raising awareness of safeguarding adults with their staff, ensuring they attend the relevant training and follow this policy.

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

3.6 This policy uses the term "adult" to describe any person aged 18 years or over.

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

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

4. Categories of abuse

4.1 Care Act Definitions

The 'Care Act 2014' specifies ten categories of abuse, which are addressed in further detail in Appendix 1. These being:

- Physical

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

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

4.2 Other forms of abuse.

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

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

- Prevent
- Honour Based Violence
- Female Genital Mutilation
- Forced Marriage
- Hate Crime
- Modern Slavery

5. CCG Responsibilities.

5.1 Safeguarding Principles

5.1.1 North Norfolk and South Norfolk CCG will adhere to the statutory safeguarding principles that provide a foundation to achieve good outcomes for patients;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.1.5 In any intervention to reduce risk or respond to immediate danger, care should be taken to ensure the least possible disruption to people’s lives. Every effort will be made to ensure that the vulnerable adult(s) who have allegedly been abused, or witnessed such abuse, or their nominated representative will be involved as much as practically possible with the procedures in this document and be supported throughout the process

5.2 Responsibilities within the CCG

5.2.1 The Chief Quality Officer is the responsible officer for safeguarding adults in North Norfolk and South Norfolk CCG.

5.2.2 The five Norfolk CCGs are currently represented by North Norfolk CCG on the Norfolk Safeguarding Adults Board (NSAB).

5.2.3 Each of the Norfolk CCGs are members of the Norfolk SAB Health Sub Group (Health Executive Safeguarding Adults Alliance) which is core and central to the governance arrangements of the agenda for adults.

5.2.4 The Senior Nurse for Safeguarding Adults will represent the 5 Norfolk and Waveney CCGs at the NHSE regional safeguarding forum.

5.2.5 The Senior Nurse for Safeguarding Adults and the Safeguarding Adults' Team will provide leadership, consultancy and advice to the CCGs. The team will represent the CCGs at operational safeguarding meetings, overarching safeguarding meetings, and strategic working groups in partnership with other agencies.

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

5.2.7 The CCGs will report relevant Serious Incidents Requiring Investigation to the Local Safeguarding Adults Board and ensure that providers report in the same way.

5.2.8 The CCGs have a responsibility to ensure that commissioned services are meeting their safeguarding adults (including the provisions of the MCA/DoLs) responsibilities through regular reporting, the SIRI process, clinical visits, and hard and soft intelligence.

5.2.9 The CCGs will ensure that provider governance arrangements cover fundraising by celebrities and any access to premises by them, any privileges, and their use and value in relation to fundraising. The CCGs should also ensure that the culture within commissioned services encourages concerns to be raised and that these and any incidents of whistleblowing in relation to the sexual abuse of patients, staff and visitors are robustly investigated and managed.

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

5.3 Adult Safeguarding Lead Nurse

The Adult Safeguarding Lead Nurse (ASLN) provides the strategic overview of safeguarding adults across the local health economy on behalf of the Norfolk and Waveney CCGs.

The ASLN will support all activity required to ensure that the organisation meets its responsibilities in relation to safeguarding adults. The ASLN will offer support and advice to the CCG Board member responsible for adult safeguarding. The ASLN will ensure the regular provision of training to the staff and Board of the CCG. The ASLN will be a source of expertise and advice to those working in the CCG. He or she will

be able to advise the local authority, police and other organisations on health matters in relation to adult safeguarding.

Specific responsibilities of the ASLN will include:

- Responsibility for the management and oversight of individual complex cases.
- Coordination where allegations are made, or concerns raised, about a person, whether an employee, volunteer or student, paid or unpaid.
- Promoting partnership working and keeping in regular contact with their counterparts in partner organisations.
- Assessing and highlighting the extent to which their own organisation prevents abuse and neglect taking place.
- Ensuring that appropriate recording systems are in place that provide clear audit trails about decision making and recommendations in all processes relating to the management of adult safeguarding allegations against the person alleged to have caused the harm or risk of harm and ensure the control of information in respect of individual cases is in accordance with accepted data protection and confidentiality requirements.

The role of the safeguarding adult lead is to:

- Support and advise commissioners, including CCGs, NHS England and public health on adult safeguarding within contracts and commissioned services and in securing assurance from providers that they have effective safeguarding arrangements in place.
- Provide advice to commissioned services on how to improve systems for safeguarding adults
- Provide guidance on identifying adults at risk from different sources and in different situations.
- Understand and embed the routes of referral for adults at risk across the health system.
- Provide a health advisory role to the Safeguarding Adults Board (SAB), supporting the CCG SAB member.
- Take a lead for health in working with the SAB to undertake safeguarding adult reviews and take forward any learning for the health economy.

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

5.4 Role of the CCG in the prevention of abuse

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

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

5.5 Staff Responsibility in the CCG

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

- Direct observation during visits to providers of care
- Conversations with patients, families and staff from provider organisations
- Complaints and patient experience feedback
- Incident reports and serious incident reports
- Audits which identify lapses in care quality
- Concerns raised through whistleblowing
- CQC reports
- Soft intelligence about providers

- Concerns when patients are transferred from one setting to another about their previous care
- Commissioning and decommissioning services which will impact on vulnerable adults
- Quality data may highlight concerns about staffing, not meeting acceptable standards of care/service provision
- Staff should also be conscious of the fact that they may become aware of safeguarding issues who are known to/cared for by colleagues.

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

It is the responsibility of **everyone** to recognise suspected or actual abuse and to take appropriate action in line with the procedures in this document. **IGNORING ABUSE IS NOT AN OPTION!**

6. Capacity and Consent

6.1 Any intervention to protect an adult must be carried out with the consent of the adult concerned, **unless** they are unable to give consent or their consent is overridden by a duty to protect them or others.

6.2 All interventions must be:

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

6.3 Mental Capacity Act

6.3.1 In accordance with the Mental Capacity Act (2005) there is a presumption of mental capacity unless an assessment under the Act shows otherwise. The act defines someone who lacks capacity as 'a person, aged 16 or over, who lacks the capacity to make, or take, a particular decision for themselves at the time the decision needs to be taken'. Therefore assessments of capacity must be decision specific. The statutory principle aims to protect people who lack capacity and to help them take part, as much as possible, in decisions that affect them. The act provides statutory principles which are;

- A person must be assumed to have capacity unless it is established that s/he lacks capacity.
- A person is not treated as unable to make a decision unless all reasonable practicable steps to help her/him to do so have been taken without success.

- A person is not to be treated as unable to make a decision merely because s/he makes an unwise decision.
- An act done or decision made, under the act for or on behalf of somebody who lacks capacity must be done, or made, in their best interests.
- Before the act is done, or the decision made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

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

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

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

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

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

For supporting patients whom have; no capacity; no family; no identified carers; or if it is felt that the family and carers are not acting in the best interests of the patient an Independent Mental Capacity Advocate should be contacted through POhWER Tel: 0300 456 2370.

7. Deprivation of Liberty Safeguards (DoLS)

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

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

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

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

8. Confidentiality and information sharing.

8.1 The Care Act 2014 places duties to co-operate over the supply of information on relevant agencies.

8.2 Confidentiality must never be confused with secrecy.

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

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

8.5 The purpose of information sharing in the context of safeguarding an adult at risk is to provide an effective service or protect a person from harm, danger and abuse.

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

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

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

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

(Useful contact numbers Appendix 5)

9.1 The safeguarding adult alerting and referral process is set out in Appendix 3. This process must be followed by all staff. This process supports the Safeguarding Adults Multiagency Policy.

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

9.3 The Safeguarding Adults Team or CCG Quality and Safety Lead can be contacted at any point for advice and support.

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

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

Refer to the Safeguarding Adults Decision Making and Referral process Flowchart. (Appendix 2)

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

- the vulnerability of the individual
- the nature and extent of the abuse
- the length of time it has been occurring
- the impact on the individual
- the risk of repeated or increasingly serious acts involving this or other vulnerable adults.

9.7 For advice and guidance contact the **Safeguarding Adults Lead 01603 257030** or Chief Quality Officer 01602 257070.

9.8 To make an Adult protection referral, ring the Norfolk **Multiagency Safeguarding Adults Team on 0344 800 8020 (24hr line)**

9.9 Appendix 3 is a guidance checklist of what information will be required when making a referral.

9.10 Staff must enter in the patient records and/or maintain relevant file note details of the safeguarding referral and all future discussions/actions in relation to the safeguarding concern.

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

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

10. Strategy Meetings

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

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

11.1 Staff who work with adults, commission service for them or receive feedback about the care that they receive, have an individual responsibility to raise concerns with someone who has the responsibility to take action when they consider a patient/client has not been treated appropriately. North Norfolk and South Norfolk CCG will always act on such concerns when raised. In particular they have a specific duty to act when concerns are about:

- Inappropriate care given to a patient(s), client(s) or resident(s)
- Unlawful conduct
- Financial malpractice
- Dangers to the public or the environment
- Other behaviour inappropriate to the safety and wellbeing of patients

12. Domestic Violence

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

12.1 Where concerns are identified relating to a patient who is experiencing or perpetrating domestic violence, an assessment to the level of risk to the individual or those within the household should be undertaken and appropriate support sought. The safeguarding adult team should be consulted to assist and advise with this process. Where a high level of risk and imminent danger is suspected the police should be contacted in order to seek help.

12.2 For those who are assessed at the highest level of risk referral should be made to the locality MARAC which is a formal multi agency meeting to consider safety plans for the individual, their children and vulnerable adults living in the household. The purpose of MARAC is for partner agencies to meet 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 and in addition to:

- 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.

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

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

13. PREVENT

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

The objectives of the strategy are to:

1. Respond to the ideological challenge of terrorism and the threat we face from those who promote it.
2. Prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support.
3. Work with sectors and institutions where there are risks of radicalization which we need to address.

13.2 Any concerns related to staff or service users, who may be at risk of radicalization, need to be reported through the Adult Safeguarding Team or Head of Quality and Patient Safety

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

14. Honour Based Violence

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

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

14.3 Practitioners need to be aware of the 'one chance' rule. That is, they may only have one chance to speak to the potential victim and thus only one chance to save a life.

14.4 All front line staff should contact the Multi Agency Safeguarding Hub (MASH, see Appendix 2) safeguarding immediately to discuss their concerns and raise a referral;

Contact Norfolk Constabulary on 101 or 999 if an emergency.

15. Female Genital Mutilation (FGM)

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

15.2 FGM is prevalent in Africa, the Middle East and Asia. In the UK, FGM tends to occur in areas with larger populations of communities who practice FGM, such as first-generation immigrants, refugees and asylum seekers. These areas include London, Cardiff, Manchester, Sheffield, Northampton, Birmingham, Oxford, Crawley, Reading, Slough and Milton Keynes. Although nationally these areas have been highlighted, with ever changing local demographics and communities, awareness is needed across the country, including Norfolk.

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

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

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

16. Forced Marriage

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

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

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

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

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

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

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

17. Hate Crime

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

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

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

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

18. Modern Slavery

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

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

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

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

18.5 Adult victims may travel to the UK willingly, in the belief that they are destined for a better life, including paid work and may start their journey believing they are economic migrants, either legally or illegally. They may also believe that the people arranging their passage and papers are merely facilitators, helping with their journey, rather than people who aim to exploit them. In other cases, victims may start their journey independently and come to rely on facilitators along different stages of their journey to arrange papers and transportation.

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

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

- Albania
- Nigeria
- South East Asia, and China

- Eastern Europe (especially Romania and Slovakia, but large numbers from other countries in the region)

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

19. Sharing Information and Lessons Learnt

19.1 The Adult Safeguarding Team will report regularly to the CCG on activity that they have managed within our locality; this will be included within the reporting systems to the Governing Body, Council of Members and North Norfolk and South Norfolk CCG Quality and Patient Safety Committee.

19.2 In order to share information and lessons learnt the North Norfolk and South Norfolk CCG will be represented by the Head of Quality and Patient Safety from North Norfolk CCG at the Safeguarding Adults Board and the Senior Nurse from Adult Safeguarding Team will also be member of the Norfolk Safeguarding Adults Board and Locality and other relevant sub-groups.

19.3 North Norfolk and South Norfolk CCG will also regularly share information and lessons learnt from information on quality, safety and safeguarding performance via its internal bodies and systems and within the Cluster Clinical Quality and Patient safety Groups.

Appendix 1: Types of abuse

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

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

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

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

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

Examples of behaviour include:

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

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

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

Possible signs and symptoms of physical abuse include:

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

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

3. Sexual Abuse – including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual

photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

Refer to appendix 4 for advice on management of sexual abuse incidents.

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

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

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

Some possible signs and symptoms of sexual abuse include:

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

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

Some possible signs and symptoms of psychological abuse include:

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

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

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

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

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

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

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

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

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

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

Examples of behaviour include:

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

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

Some possible/indicators of neglect include:

- poor hygiene
- malnutrition
- inappropriate clothing
- broken skin

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

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

Appendix 2: Reporting Flow Chart

Reporting Adult Safeguarding Incidents within Norfolk

**This applies to all residents of Norfolk regardless of setting i.e.
Patients own home, Hospital, Community unit, Care Home**

Be Aware – suspicion of abuse, allegations, signs or disclosure of abuse



Contact 999 if risk is immediate

Seek advice if necessary

**Is there any evidence? Secure it.
Don't allow it to be removed or tampered with until advised.**

Make a referral to the Norfolk Multi-agency Adult Safeguarding Pathway on **0344 800 8020 (0808 800 4005 for Waveney)** use the refers checklist

Inform Line Manager and Adult Safeguarding Team **01603 257030**

Record and Document all information

Appendix 3: Referrers Checklist - Tel: 0344 800 8020

This Checklist is to assist you to have adequate information when you are making a referral as we know that it is often a very stressful conversation and you may forget vital information when you make the call. Referrals will still be considered when some of this information is not available.

	Essential	Desirable
Name of Alerter (You can remain anonymous)		✓
Contact details of Alerter		✓
Relationship to Victim		✓
Organisation of Alerter		✓
Name (of Vulnerable Adult)	✓	
Address of Vulnerable Adult	✓	
Address, if different, of place of alleged abuse	✓	
Contact details of Vulnerable Adult	✓	
Details of Category of Vulnerability (Older, frail, Mental Health, Learning Difficulties etc.)	✓	
Date of Birth or Age		✓
Gender		✓
Ethnicity		✓
Religion		✓
Capacity and understanding		✓
Communication needs (sensory loss, Language, other)		✓
Name of Alleged Perpetrator		✓
Address of Alleged Perpetrator		✓
Date of Birth of Alleged Perpetrator		✓
Details of Referral - You need to consider the following so that the person taking the referral can gain adequate information		
Nature of abuse/incident	✓	
When did it happen?	✓	
Where did it happen?	✓	
Was anyone else involved?		✓
Was the incident witnessed?		✓
Have you had previous concerns regarding this person? If so what?		✓
Does the vulnerable adult know you are making this referral?	✓	
Have you done anything to assist the Vulnerable Adult at this time? (What actions have been taken?)	✓	
How do you want to be contacted in the future?	✓	

Appendix 4: Procedure guidance for serious sexual assault

1. Call 999 - police and ambulance if incident has just occurred.
2. Call 101 if incident has been reported to you retrospectively.
3. DO NOT interview any alleged perpetrator.
4. Medical attention should be sought where there is a possibility that an injury may have occurred even where there are no visible signs.
5. Notify manager or nominated senior person on duty as soon as practicable, out of hours contact On call manager.
6. Preserve all essential and vital evidence.
7. Aim to minimise the risk of further harm to the vulnerable adult.
8. Reassure the person.
9. Aim to minimise the risk of intimidation by any alleged perpetrator whether known or unknown.
10. Obtain **only** sufficient information to be able to tell the police, medical personnel or management what is believed to have happened, when and where. If a **serious physical or sexual assault** is known or suspected to have happened, in order to preserve evidence:
 - 10.1. DO NOT allow the person to wash.
 - 10.2. DO NOT change their clothes unless essential for person's wellbeing. If this is necessary put each item in a separate bag.
 - 10.3. Try not to touch anything which may be a source of evidence.
 - 10.4. Do not tidy or remove anything from the location.
 - 10.5. Minimise the number of people entering the location or having contact with the vulnerable adult.
11. If a sexual assault is suspected or known to have happened **DO NOT** allow the person to eat or drink anything until agreed by the police unless contrary to medical advice.
12. If the vulnerable adult and alleged perpetrator are in the same location keep them separate.
13. Try not to allow the same person to deal with both vulnerable adult and alleged perpetrator (to prevent cross contamination).
14. If the same person has had contact with both vulnerable adult and alleged perpetrator record this for the police.
15. If there are any witnesses record their details and give these to the police.
16. Secure any timekeeping sheets for duty staff to prevent them being tampered with.
17. Secure medical and care records for the vulnerable adult to prevent them being tampered with.

Appendix 5 Contacts and telephone numbers

Cluster CCG Safeguarding Adults Team: Senior Nurse/Lead Safeguarding Practitioner	Gary Woodward gary.woodward@nhs.net Vacant post	01603 257030
North Norfolk and South Norfolk CCG Chief Quality Officer	Alison Leather alison.leather3@nhs.net	North Norfolk and South Norfolk 01603 257070
Norfolk Multi-Agency Safeguarding Referrals	Social Services 24hr referral line	0344 800 8020
Suffolk Multi-Agency Safeguarding Referrals	Social Services 24hr referral line	0808 800 4005
Independent Mental Capacity Advocacy	POhWER	0300 456 2370
Norfolk Constabulary	Honour based crimes/Safeguarding	Emergency: 101 or 999 Non-emergency: 0845 4564567
CCG Lead Clinician for Adult Safeguarding and Mental Capacity	Julie Glenn	01603 257000