|  |
| --- |
| **INSERT PRACTICE** |

|  |
| --- |
| **SAFEGUARDING ADULTS AT RISK – GENERAL PRACTICE POLICY** |

|  |  |
| --- | --- |
| **Version** | 1.0 |
| **Supersedes** | Not applicable |
| **Author** | Lynda Ellison-Rose |
| **Author Designation** | Quality Assurance Manager, *One*Norwich |
| **Date Ratified** |  |
| **Date for review** |  |
| **Policies, legislation and Care Quality Commission (CQC) Key Lines of Enquiry (KLOEs) relevant to this policy** | **Legislation –** Care Act 2014Care Standards Act 2000 Data Protection Act 2018Disability Discrimination Act 1998 Domestic Violence Crime and Victims Act 2004 Equality Act 2010 Human Rights Act 1998 Mental Capacity Act 2005 Modern Slavery Act 2015Public Interest Disclosure Act 1998The Protection of Freedom Act 2012 Sexual Offences Act 2003 The Safeguarding Vulnerable Groups Act 2006 Section 26 and 29 of the Counter Terrorism and Security Act 2015Serious Crime Act 2015 – Section 76 – Domestic Abuse**Policies –** Data Protection/Confidentiality, Equality and Diversity, Consent **Guidance** – Mental Capacity Act 2005 Code of Practice **CQC KLOEs** – S1.1, S1.2, S1.3, S1.4, S1.5, S1.6, S1.7, S2.3, S2.5, S3.1, S6.1, S6.2, S6.3, S6.4, S6.5, E6.1, E6.2, E6.3, E6.5, C1.4, R2.1 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Version** | **Date** | **Author** | **Status** | **Comment/details of amendment** | **Review date** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**CONTENTS**

| **Part** | **Description** | **Page** |
| --- | --- | --- |
| **1** | Introduction | **3** |
| **2** | Purpose | **3** |
| **3** | Scope | **3** |
| **4** | Principles of Adult Safeguarding | **3** |
| **5** | Responsibilities of staff | **4** |
| **6** | Making Safeguarding personal | **4** |
| **7** | Professional Curiosity | **4** |
| **8** | Categories of Abuse -PhysicalDomesticSexualPsychologicalFinancialModern SlaveryDiscriminatoryOrganisationalNeglectSelf-neglect and hoarding | **5****5****5****6****6****7****7****8****8****8****9** |
| **9** | Mental Capacity Act and Adult Safeguarding | **9** |
| **10** | Lasting Power of Attorney | **10** |
| **11** | Best Interests | **10** |
| **12** | Deprivation of Liberty Safeguards (DOLS) | **10** |
| **13** | Independent Mental Capacity Advocate | **11** |
| **14** | Safeguarding Individuals Vulnerable to Radicalisation (VTR) | **11** |
| **15** | Sharing Information and GDPR | **11** |
| **16** | Whistleblowing | **12** |
| **17** | Concerns in care homes | **12** |
| **18** | Reporting Safeguarding Concerns | **13** |
|  | Other Contacts | **14** |
|  | Policy – Document 1 – Safeguarding Individuals Vulnerable to Radicalisation (VTR) | **15** |
|  | Policy - Document 2 – Self neglect and hoarding | **17** |
|  | Policy – Document 3 – Domestic and (Dis)Honour Abuse, FGM and Forced Marriage | **19** |
|  | Policy - Document 4 – Modern Slavery and Trafficking | **21** |
|  | Appendix 1 – Data Protection Act 2018 | **22** |
|  | Appendix 2 - Flow Chart - IMCA | **23** |
|  | Practice information | **24** |
|  | Useful Contacts | **25** |

|  |
| --- |
| **All staff have a duty of care for the safety and wellbeing of patients and staff. Never assume that safeguarding is somebody else’s business.** |

**1.Introduction**

1.1 Safeguarding is everyone’s responsibility and aims to protect people's health, wellbeing and human rights, and enable them to live free from harm, abuse and neglect.

**2. Purpose**

2.1 The purpose of this policy is to highlight the responsibilities and roles of all staff to help protect adults at risk of abuse and/or neglect. It is designed to raise awareness and provide a framework to support staff who are in contact with patients, to recognise, report and to keep those adults at risk, safe.

**3. Scope**

3.1 All staff have a duty of care for the safety and wellbeing of patients and staff.

In any health organisation safeguarding is everybody’s business.

3.2 The Care Act 2014 sets out statutory responsibility for the integration of care and support between health and local authorities. The Care Act does not give a definition of ‘adults at risk’ but states that safeguarding duties apply to an adult who:

* Has needs for care and support
* Is experiencing, or at risk of, abuse or neglect
* As a result of those care and support needs is unable to protect themselves from either the risk of , or the experience of abuse of neglect

**Relevant section in The Care Act 2014:**

### <http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted>

### 4. Principles of Adult Safeguarding

### 4.1 Safeguarding adults means protecting a person’s right to live in safety, free from abuse and neglect.

### 4.2 The following six key principles underpin all adult safeguarding work:

**5. Responsibilities of staff**

5.1 All staff have a responsibility and duty of care for the safety and wellbeing of patients, carers and colleagues. If you are a doctor, nurse or allied health professional, your professional body (GMC, NMC etc.) will have guidance and expectations regarding duty of care and your responsibilities for safeguarding.

Never assume that safeguarding is somebody else’s business. Safeguarding is your responsibility.

5.2 All staff should undertake Adult Safeguarding training applicable to their role. Detailed guidance is referenced in the Intercollegiate document -

[file:///C:/Users/oneno/Downloads/PDF-007069%20(1).pdf](file:///C%3A/Users/oneno/Downloads/PDF-007069%20%281%29.pdf)

**6.0 Making Safeguarding Personal**

6.1 Making Safeguarding Personal (MSP) sits firmly within the Department of Health (DH) Care and Support Statutory Guidance, as revised in 2017 that supports implementation of the Care Act (2014). It means MSP is about making safeguarding person and outcome led, rather than process focussed. It also:

* engages the person and enhances involvement, choice and control
* improves quality of life, wellbeing and safety
* Is done “with” rather than “to” the adult at risk of abuse or neglect

**7.0 Professional Curiosity**

7.1 Professional curiosity requires the capacity and communication skills to explore and understand what is happening regarding an individual, their family, friends and other people who have a relationship with that individual rather than making assumptions or accepting things at face value.

7.2 Professional curiosity should always be exercised if an individual identifies themselves as a carer and it is clear that their own needs could impact on the ability to provide care.

**8.0 Categories of abuse**

8.1 Abuse can take many forms. The following 10 categories are among the most significant:

8.2 **Physical abuse**: including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions including female genital mutilation.

|  |  |
| --- | --- |
| **Physical abuse may include:** | **Possible indicators:** |
| HittingSlappingKickingPushing or rough handlingScratchingInappropriate restraint or sanctions including deprivation of food, clothing, warmth and healthcare needsMisuse or inappropriate withholding of medicationScalding and burningForcible feeding | Injuries that are on unusual sites e.g. cheeks, ears, neck, inside mouthFrequent injuriesBurns or scalds with clear outlines or have a uniform depth over a large area e.g. buttocksInjuries that are the shape of objects e.g. a hand, teethPresence of several injuries or scars of a variety of agesInjuries that have not received medical attentionA person being taken to many different places to receive medical attentionSkin infectionsDehydrationUnexplained weight changesMedication being ‘lost’Behaviour that indicates that the person is afraid of the alleged person causing harm |

8.3 **Domestic abuse**: including psychological, physical, sexual, financial, emotional abuse. So called ‘honour’ based violence and forced marriage.

|  |  |
| --- | --- |
| **Domestic abuse may include:** | **Possible indicators:** |
| The Home Office (March 2013) defines domestic abuse as: ‘Any incident or pattern of incidents of controlling, coercive or 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. This can encompass but is not limited to the following types of abuse:Psychological, sexual, financial, emotional abuse, ‘honour’ based violence | An intimate partner or family member:Tries to keep the person from seeing friends or familyIntergenerational abuse e.g. adult children on parentsPrevents them from continuing or starting a college course, or from going to workConstantly checks up or follows themAccuses them unjustly of flirting or having affairsConstantly belittles or humiliates them or regularly criticises or insults them in front of other peopleDeliberately destroys their possessionsHurts or threatens them or their childrenKeeps them short of money or items needed for their careForces them to do something that they didn’t want to doThe individual may have or feel:Low self-esteemFear of outside interventionThe abuse is their fault when it is not |

8.4 **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.

|  |  |
| --- | --- |
| **Sexual abuse may involve:** | **Possible indicators:** |
| Unwanted physical and sexual contactIntercourse with someone who lacks the capacity to consentRapeIndecent exposureSexual harassment (verbal or physical)Displaying pornographic literature or videosGross indecencyBeing forced or coerced to be photographed or videoed to allow others to look at their bodyInciting someone who cannot understand to engage in sexual activitySexual abuse or innuendo. Any sexual activity involving staff is regarded as contrary to professional standards and hence abusive | Sexually transmitted diseases or pregnancyTears or bruises in genital/anal areasSoreness when sittingSigns that someone is trying to take control of their body image e.g. anorexia or bulimia, self-harmSexualised behaviour or languageOral infectionsTorn, stained or bloody underclothingPregnancy in a woman who is unable to consent to sexual intercourseThe signs that a person may be experiencing sexual abuse and emotional abuse are often very similar. This is due to the emotional impact of sexual abuse on a person’s sense of identity and to the degree of manipulation that may be carried out in ‘grooming’ |

8.5 **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.

|  |  |
| --- | --- |
| **Psychological abuse may involve:** | **Possible indicators:** |
| HarassmentIntimidation by word or deedVerbal abuseBlamingControllingCoercionExcessive criticismHumiliationRidicule/mockeryThreats or harm to abandonment or exclusion from servicesEnforced isolation (including cultural discrimination) which may include withdrawal from services or supportive networksDenial of religious or cultural needsCyber bullying | Difficulty gaining access to the adult on their own or difficulty in the adult gaining opportunities to contactThe adult not getting access to medical care or to appointments with other agenciesLow self esteemLack of confidence and anxietyIncreased levels of confusionIncreased urinary or faecal incontinenceSleep disturbancePerson feeling/acting as if they are being watched all the timeDecreased ability to communicateCommunication that sounds like things that the alleged person causing harm would say, language being used that is not usual for the personSigns of distress |

8.6 **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.

|  |  |
| --- | --- |
| **Financial or material abuse may involve:** | **Possible indicators:** |
| Misuse and/or misappropriation of monies, benefits and/or propertyTheftFraudExploitationPressure or coercion in connection with wills, property, inheritance or financial transactionsInternet scamming | Change in material circumstancesSudden loss of assetsUnusual or inappropriate financial transactionsVisitors whose visits always coincide with the day person’s benefits are cashedInsufficient food in the houseBills not being paidPerson who is managing the finances overly concerned with moneySense that the person is being tolerated in the house due to the income they bring in, person not included in the activities the rest of the family enjoys |

8.7 **Modern slavery**: including forced labour, domestic servitude and human trafficking (including sex trafficking).

There is a national framework to assist in the formal identification and help to coordinate the referral of victims to appropriate services known as the National Referral Mechanism (NRM).

|  |  |
| --- | --- |
| **Modern slavery may involve:** | **Possible indicators:** |
| SlaveryHuman trafficking involves an act of recruiting, transporting, transferring harbouring or receiving a person through use of force, coercion or other means for the purpose of exploiting themCoercion deceit and forcing people into a life of abuse or inhumane treatment | Signs of physical or psychological abuse, look malnourished or unkempt, appear withdrawnRarely allowed to travel on their own, seem under the control or influence of others, rarely interact or appear unfamiliar with their neighbourhood or where they workBe living in dirty, cramped or overcrowded accommodation, and/or living and working at the same addressHave no identification documents, have few personal possessions and always wear the same clothes every day. What clothes they do wear may not be suitable for their workHave little opportunity to move freely and may have had their travel documents retained e.g. passportsAvoid eye contact, appear frightened or hesitant to talk to strangers and fear law enforcers for many reasons, such as not knowing who to trust or where to get help, fear of deportation, fear of violence to them or their family Be dropped off/collected for work on a regular basis either very early or late at night |

8.8 **Discriminatory abuse:** including forms of harassment, slurs or similar treatment because of race, gender and gender identity, age, disability, sexual orientation or religion.

|  |  |
| --- | --- |
| **Discriminatory abuse may involve:** | **Possible indicators:** |
| Treating a person or group less favourably than others on the basis of their race, gender, gender identity, age, disability, sexual orientation or religionSlurs, harassment, name callingBreaches in civil libertiesUnequal health or social careHate incidents and hate crime | Person overly concerned about race, sexual preference etc.Tries to be more like othersReacts angrily if any attention is paid to race, sex etc.Carer overly critical/anxious about these areasDisparaging remarks madePerson made to dress differentlyAn older person being acutely aware of age or ‘being a burden’ |

8.9 **Organisational abuse:** including neglect and poor care practice within an institution or specific care setting such as a hospital or care home or day centre.

|  |  |
| --- | --- |
| **Organisational abuse may involve:** | **Possible indicators:** |
| Repeated instances of poor care may be an indication of more serious problemsNeglect and poor professional practice leading to other forms of abuse as defined aboveMisuse of staff power to harm adults in their careStaff and volunteers not reporting or challenging bad practice | Over medicating peopleLack of social/leisure activities for the individualLack of personal clothing and possessionsDeprived environment and lack of stimulationPeople referred to or spoken to with disrespectInappropriate physical interventionsUnsafe environmentsAbsence of effective care plans and risk assessments |
| **Organisational factors that may contribute to institutional abuse** |
| Weak or oppressive managementInadequate staffingInadequate staff and volunteers supervision or supportInsufficient trainingRigid routinesClosed communication channels |

8.10 **Neglect and acts of omission:** including ignoring medical, emotional or physical care needs.

|  |  |
| --- | --- |
| **Neglect and acts of omission may include:** | **Possible indicators:** |
| Inadequate careNeglect of physical and emotional needsFailure to give prescribed medicationDeprivation of food, clothing, medical attention, necessities of life such as heating or aids for functional independenceDenial or basic right to make informed choicesFailure to provide access to health, social or educational servicesFailure to give privacy and dignityIgnoring medical, emotional or physical care needs | MalnutritionRapid or continuous weight lossNot having access to necessary physical aidsInadequate or inappropriate clothingUntreated medical problemsDirty clothing/beddingLack of personal careIf neglect is due to carer being overstretched or under-resourced the carer may seem very tired, anxious or apathetic |

8.11 **Self-neglect and hoarding:** this covers a wide range of behaviour neglecting to care for one’s personal hygiene, health or surroundings.

|  |  |
| --- | --- |
| **Self-neglect may involve:** | **Possible indicators:** |
| Self- neglect is an umbrella term that covers a wide range of types of behaviour:* neglect of self
* neglect of the domestic environment
* hoarding
* risky lifestyle behaviour

This may also pose a risk to others.Self-neglect may arise from inability or unwillingness to care for oneself, or both in complex interaction with each other. | May have pride in self-sufficiencyA sense of connectedness to place and possessionsA drive to preserve continuity of identity and controlTraumatic life histories and events that have had life changing effectsCauses of self-neglect may include physical problems, mental health problems, personality disorders, history of trauma, substance misuse, lack of social networks, isolation and old ageMultiple factors may exist with one person |

***For further information refer to:***

*Policy Document 2 – Self neglect and hoarding*

*Policy Document 3 – Domestic and (Dis) honour abuse, FGM and Forced marriage*

*Policy Document 4 – Modern slavery and trafficking*

**9.0 Mental Capacity**

9.1 The Mental Capacity Act 2005 (MCA) provides the legal definition of capacity; guidance on how to assess whether someone has the capacity to make a decision; and provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The decisions may be about everyday matters or may be about a life changing event. An adult (aged 16) or over has full legal capacity to make decisions for themselves, unless it can be shown at the time of the decision to be made that they lack capacity.

9.2 **The five principles of the Mental Capacity Act**

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is 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.

9.3 Health professionals should presume that adults have the capacity to consent to or refuse a proposed treatment unless it can be established that they lack that capacity. Each assessment of an individual’s capacity should relate to a specific decision at a particular time. The person who assesses an individual’s capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made, i.e. the ‘decision maker’. This means that different people will be involved in assessing someone’s capacity to make different decisions at different times.

9.4 Evidence and justification regarding a mental capacity assessment, decision and rationale for decision must be recorded in the patient medical record.

It is important to record your rationale which supports your decision as you might need to justify in the future.

Your GP system may include a MCA template for recording assessment and rationale for decision made. For example ARDENS templates have. a notes section on the template which enables further evidence to be recorded.

**If unsure contact the Adult Safeguarding Team for guidance (not for referrals)**

**Contact: Tel: 01603 257030**

**10.0 Lasting Powers of Attorney (LPA)**

10.1 The MCA allows individuals aged 18 or over and who have capacity to appoint an attorney under an LPA, to make financial and health and welfare decisions on their behalf once they lose capacity. Whilst a patient can pass their financial power of attorney to their nominee(s) whilst they still have capacity, the health and welfare LPA, is only relevant once the patient has lost capacity. Even still, the LPA for health and welfare will then be called upon to assist in making a “best interests decision. Attorneys are under a duty to act in the incapacitated adult’s best interests. As a practitioner you must be satisfied that the LPA is valid and registered with The Office of the Public Guardian. https://www.gov.uk/government/organisations/office-of-the-public-guardian

**11.0 Best Interests**

11.1 Under the MCA, all decisions taken on behalf of someone who lacks capacity must be taken in his or her best interests. A best interests judgement is not an attempt to determine what the person would have wanted, although this must be taken into account. It is as objective a test as possible of what would be in the person’s actual best interests taking into account all relevant factors including:

* the likelihood that the person will regain capacity, and whether the decision can be delayed until that time
* the person’s past and present wishes and feelings, including any relevant written statement
* his or her beliefs or values where these would have an impact on the decision through consultations with relevant persons
* other factors the person would have considered if able to do so, such as the effect of the decision on other people

11.2 A best interests meeting may be needed where an adult lacks mental capacity to make significant decisions for themselves and need others to make those decisions on their behalf. For example a best interests meeting may be held when there are a number of agencies working with an individual.

**12.0 Deprivation of Liberty Safeguards (DOLS)**

12.1 The Deprivation of Liberty Safeguards (DOLS) protect people who lack capacity to consent to being deprived of their liberty. This means that because an illness, an injury or a disability has affected the way their mind works they are not able to agree that they will not be allowed to do certain things.

12.2 DOLS is a safeguard so that vulnerable people cannot have their freedom taken away unless it is in their best interests and there is no ‘less restrictive alternative’ (an option which will affect the person’s freedom or rights less).

**13.0 Independent Mental Capacity Advocate (IMCA)**

13.1 An IMCA is an advocate specifically in relation to the Mental Capacity Act 2005 who can support and represent an individual who are unable to make decisions for themselves and they may not have family or friends who are able to speak for them. An IMCA has been specially trained. They do not make decisions for the individual and they must be independent of the people who do make the decisions.

13.2 Contact details: POhWER 0300 456 2370 or email pohwer@pohwer.net

**For further information see** - *Appendix 3 - Flow chart - Referral to IMCA - Page 23*

**14.0 Safeguarding Individuals Vulnerable to Radicalisation (VTR)**

14.1 Radicalisation is defined as the process by which people (children or adults) begin to support terrorism and violent extremism and potential participation in terrorist groups. The vulnerabilities of individuals may be exploited towards crime or terrorism. The exploitation may be by a third party who has their own agenda. The exploitation of vulnerable individuals can be face to face, via social media or the internet.

14.2 PREVENT is part of the Government’s CONTEST strategy which focuses on stopping people becoming terrorists or supporting terrorism. Healthcare organisations could encounter an adult at risk who may be in the process of being radicalised towards terrorism. It is important that staff are confident and knowledgeable in addressing such concerns. Prevent is a safeguarding process, staff should be curious about the characteristics individuals may portray. All staff must ensure vulnerable people are safeguarded.

**For further information refer to:**

*Page 15 - Document 1 – Safeguarding Individuals Vulnerable to Radicalisation (VTR)*

**15.0 Sharing Information and GDPR and Data Protection**

15.1 Information should be shared with consent wherever possible. General Data Protection Regulation (GDPR), Data Protection Act 2018 and human rights law are not barriers to justified information sharing, but provide a framework to ensure that personal information about living individuals is shared appropriately.

15.2 Under the GDPR and Data Protection Act 2018 you may share information without consent if, in your judgement, there is a lawful basis to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case. When you are sharing or requesting personal information from someone, be clear of the basis upon which you are doing so:

(i)   protecting an individual from any of the abuses outlined in the Care Act 2014

15.3 Where you do not have consent, be mindful that an individual might not expect information to be shared.

15.4 Consider safety and well-being: base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions.

15.5 Consider if the sharing is necessary, proportionate, relevant, adequate, accurate, timely and secure. Ensure that the information you share is necessary for the purpose for which you are sharing it. That it is shared only with those individuals who need to have it. That it is accurate and up to-date, is shared in a timely fashion, and that it is shared securely. 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.

15.6 It is important to remember that in most Serious Case Reviews, lack of information sharing can be a significant contributor when things go wrong. It can be easier to defend why you shared rather than why you did not share if your decision is challenged at a later date.

***For details regarding the relevant section of the Act see Appendix 1 - page 22***

**16.0 Whistleblowing**

16.1 Whistleblowing is the term used when someone who works for an employer raises a concern about malpractice, risk (for example about patient safety), wrongdoing or possible illegality, which harms, or creates a risk of harm, to people who use the service, colleagues or the wider public. If you suspect a safeguarding issue this should be dealt with using safeguarding reporting procedures. If you wish to discuss or seek further guidance please contact Norfolk CCG Adult Safeguarding Team:

**If unsure contact the Norfolk CCG Adult Safeguarding Team for guidance (not for referrals)**.

**Contact: Tel: 01603 257030**

16.2 GMC Guidance – Further guidance for GPs regarding reporting concerns can be accessed on GMC website: [www.gmc-uk.org](http://www.gmc-uk.org)

GMC Confidential Helpline - 0161 923 6399. Lines are open 9 am–5 pm, from Monday to Friday.

GMC Publication - Raising and acting on concerns about patient safety, GMC 2012

16.3 Freedom to speak up in Primary Care - Guidance to primary care providers on supporting whistleblowing in the NHS, NHS England 2017

**17.0 Concerns regarding Care Homes**

17.1 If you have concerns regarding standards of care in care homes this should be raised with the Manager (or other appropriate person) at the time.

17.2 The following can be contacted for advice or referral regarding standards of care:

**Norfolk County Council** (concerns regarding quality about care homes and domiciliary care providers, including but not limited to environmental, food hygiene, heating, care etc.) - 0344 800 8020

**Care Quality Commission (CQC)** – Telephone: 03000 616161
Fax: 03000 616171

[www.cqc.org.uk](http://www.cqc.org.uk)

**Remember** - You have a duty of care to report any safeguarding concern. Do not think somebody else will be reporting the concern or already knows about the concern.

**18.0 Reporting Safeguarding Concerns**

You have a duty of care to report any safeguarding concern.

When making a Safeguarding Adult referral please phone 0344 800 8020.

If you are unsure thether the concern should be treated as an Adult Safeguarding you can discuss with the CCGs Adult Safeguarding Team - phone: **01603 257030**

Please record any discussion with a Safeguarding professional or Health lead to ensure that your actions can be accessed if required in the future.

**Guidance, documents and forms can be found on the regarding any safeguarding issue can be found on the Norfolk Safeguarding Adults Board website:**

[www.norfolksafeguardingadultsboard.info](http://www.norfolksafeguardingadultsboard.info)

**Referrer checklist –**

[www.norfolksafeguardingadultsboard.info/assets/Uploads/SGA-Referrer-CHECKLIST-2-sidedSEPT2016.pdf](http://www.norfolksafeguardingadultsboard.info/assets/Uploads/SGA-Referrer-CHECKLIST-2-sidedSEPT2016.pdf)

**Reporting Safeguarding Concerns**

**Phone: Norfolk County Council (Adult Social Services) on 0344 800 8020 (available 24 hours a day)**

**In an emergency call the police on 999**

**OTHER CONTACTS**

|  |  |
| --- | --- |
| **AGENCY** | **CONTACT INFORMATION** |
| Norfolk CCGs Safeguarding Team | Gary Woodward – Adult Safeguarding Lead NurseTel: 01603 257030Mobile 07827 835057gary.woodward@nhs.netDr Pippa Harrold, Phone: 01603 257030.pippa.harrold@nhs.net |
| Norfolk DOLS | Please contact Norfolk CCGs Safeguarding Team for advice – 01603 257030 |
| Police | For specialist Police Advice you can call the Police on 101 and ask to speak to the MASH Duty Sergeant or in an emergency always dial 999. |
| For a list of useful contacts please see page 25 |

**Document 1**

**Safeguarding Individuals Vulnerable to Radicalisation (VTR)**

Radicalisation is defined as the process by which people (children or adults) begin to support terrorism and violent extremism and potential participation in terrorist groups. The vulnerabilities of individuals may be exploited towards crime or terrorism. The exploitation may be by a third party who has their own agenda. The exploitation of vulnerable individuals can be face to face, via social media or the internet.

PREVENT is part of the Government’s CONTEST strategy which focuses on stopping people becoming terrorists or supporting terrorism. Healthcare organisations could encounter a vulnerable person who may be in the process of being radicalised towards terrorism.

The four priority objectives are:

* Pursue – stop terrorist attacks
* Prepare – where we cannot stop an attack, mitigate its impact
* Protect – strengthen overall protection against terrorist attacks
* Prevent – stop people becoming terrorists and supporting violent extremism

General Practitioners and their staff are often the first point of contact for people and are in a prime position to safeguard those people they feel may be at risk of radicalisation. It is important that staff are confident and knowledgeable in addressing such concerns. Prevent is a safeguarding and staff should be curious about the characteristics that people may portray. All staff must ensure vulnerable people are safeguarded.

**For further information see link below:**

[www.norfolksafeguardingadultsboard.info/assets/PREVENT/PREVENT-Vulnerable-to-Radicalisation-Referral-Process.pdf](http://www.norfolksafeguardingadultsboard.info/assets/PREVENT/PREVENT-Vulnerable-to-Radicalisation-Referral-Process.pdf)

Channel is a Multi-Agency Process, which provides support to those who may be vulnerable to being drawn into terrorism. Channel uses existing collaboration between partners to support individuals and protect them from being drawn into terrorism.

**For further information regarding Channel Norfolk see link below:**

[www.norfolksafeguardingadultsboard.info/assets/CHANNEL-NORFOLK/Channel-Norfolk-SOP-JUNE-2015-update1.pdf](http://www.norfolksafeguardingadultsboard.info/assets/CHANNEL-NORFOLK/Channel-Norfolk-SOP-JUNE-2015-update1.pdf)

Healthcare professionals have a key role in prevent. Prevent focuses on working with vulnerable individuals who may be at risk of being exploited by radicalisers and subsequently drawn into terrorist related activity. All staff must escalate a concern and have confidence that each issue will be taken seriously, handled appropriately and where necessary specialist advice will be available. What is important is that if you are concerned that a vulnerable individual is being exploited in this way, you can raise these concerns in accordance with your organisation’s policies and procedures, as you would do with any Safeguarding issue. If you are uncertain about what to do, speak with your manager as the first step, or another person with authority.

**For further information see link below from Norfolk Safeguarding Adults Board (NSAB)**

**Practitioner’s Quick Guide**: [www.norfolksafeguardingadultsboard.info/assets/PREVENT/PREVENT-Vulnerable-to-Radicalisation-Referral-Process.pdf](http://www.norfolksafeguardingadultsboard.info/assets/PREVENT/PREVENT-Vulnerable-to-Radicalisation-Referral-Process.pdf)

**Document 2**

**Self Neglect and Hoarding**

Within the accompanying statutory guidance for the Care Act (2014), new categories of abuse were added including self-neglect. Self-neglect is now incorporated as a form of abuse and neglect covered by multi-agency safeguarding adult’s policy and procedures.

The statutory guidance’s definition of self-neglect is ‘Self-neglect covers a wide range of behaviour neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding’.

The statutory guidance identifies that it can be difficult to assess self-neglect. Specifically, that it may be difficult to distinguish between whether a person is making a capacitated choice to live in a particular way (which may be described as unwise) or whether the person lacks mental capacity to make the decision.

Research has suggested that there are three recognised forms of self-neglect which include:

* Lack of self-care – this may involve neglecting personal hygiene, nutrition and hydration or health. This type of neglect would involve a judgement to be made about what is an acceptable level of risk and what constitutes wellbeing.
* Lack of care of one’s environment – this may result in unpleasant or dirty home conditions and an increased level of risk in the domestic environment such as health and safety and fire risks associated with hoarding. This may again be subjective and require a judgement call to determine whether the conditions within an individual’s home environment are acceptable.
* Refusal of services that could alleviate these issues – this may include the refusal of care services, treatment, assessments or intervention, which could potentially improve self-care or care of one’s environment.

**Hoarding**

Hoarding Disorder used to be considered a form of obsessive compulsive disorder (OCD). It is now considered a standalone mental disorder and is included in the 5th edition of the Diagnostic and Statistical Manual of Mental Health Disorders 2013. Hoarding can also be a symptom of other mental disorders. Hoarding Disorder is distinct from the act of collecting, and is also different from people whose property is generally cluttered or messy. It is not simply a lifestyle choice. The main difference between a hoarder and a collector is that hoarders have strong emotional attachments to their objects which are well in excess of their real value. Hoarding does not favour a particular gender, age, ethnicity, socio-economic status, educational/occupational history or tenure type. Anything can be hoarded, in various areas including the resident’s property, garden or communal areas.

Commonly hoarder items include but are not limited to:

* Clothes
* Newspapers, magazines or books
* Food and food containers
* Animals
* Medical equipment
* Collectibles such as toys, video, DVD, or CD’s

**For further information see Norfolk Adults Safeguarding Board – Self-Neglect and Hoarding Strategy and Practitioner Guide:**

**Strategy** - www.norfolksafeguardingadultsboard.info/assets/SELF-NEGLECT-and-HOARDING/NSAB-SNandH-Strategy2.0-JUN2018FINAL03.pdf

**Practitioner Guide** - [www.norfolksafeguardingadultsboard.info/assets/PRIMARY-CARE/NSAB-SN-H-Practitioners-Guide-JUNE2018FINAL02.pdf](http://www.norfolksafeguardingadultsboard.info/assets/PRIMARY-CARE/NSAB-SN-H-Practitioners-Guide-JUNE2018FINAL02.pdf)

**Document 3**

**Domestic And (Dis)Honour Abuse, FGM And Forced Marriage**

An estimated 1.9 million adults aged 16 to 59 years experienced domestic abuse, according to the year ending March 2017 Crime Survey for England and Wales (1.2 million women, 713,000 men). - *Office of* *National Statistics*

The Home Office (March 2013) defines domestic abuse as: ‘Any incident or pattern of incidents of controlling, coercive or 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. This can encompass but is not limited to the following types of abuse: This can encompass but is not limited to the following types of abuse:

* psychological
* physical
* sexual
* financial
* emotional

This definition includes so-called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage. It is made clear that victims are not confined to one gender or ethnic group. The Care Act specifies that freedom from abuse and neglect is a key aspect of a person’s wellbeing.

A Forced marriage is where one or both people do not consent to the marriage and pressure or abuse is used. A marriage must be entered into with the free and full consent of both parties. The pressure put on people to marry against their will can be:

* Physical – including threats, actual physical violence, sexual violence
* Emotional
* Psychological

Female Genital Mutilation FGM (may be referred to as female circumcision or cutting) refers to procedures which intentionally alter or cause injury to the female genital organs for non-medical reasons.

FGM is illegal in the UK as is taking anyone out of the UK for the procedure. Approximately 137,000 women living in England and Wales are living with consequences of FGM.

Over 60,000 girls under the age of 15 are at risk of FGM in the UK each year.

For further information regarding Adult Safeguarding and Domestic and (Dis)Honour Abuse, FGM, Forced Marriage and domestic abuse see links below:

**Leeway –** Leeway is an independent charity providing support to adults, young people and children who are experiencing domestic abuse in Norfolk and Suffolk. Leeway works independently from the police. Domestic Abuse Helpline: 0300 561 0077

Email – referrals@leewaynwa.org.uk

**Forced Marriage Unit** – 020 7008 0151

Monday to Friday, 9am to 5pm

Out of hours: 020 7008 1500 (ask for the Global Response Centre)

**FGM Helpline** – 0800 028 3550

NSPCC website has further information on FGM

[www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/female-genital-mutilation-fgm](http://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/female-genital-mutilation-fgm)

Publication - Multi-Agency Statutory guidance on female genital mutilation [www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation](http://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation)

**Responding to Domestic Abuse, A resource for Health Professionals (Department of Health)**

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/597435/DometicAbuseGuidance.pdf

**Adult Safeguarding and Domestic Abuse – A guide to support practitioners and managers (Local Government Association, ADASS) -**

<https://coercivecontrol.ripfa.org.uk/wp-content/uploads/Adult_safeguarding_and_domestic_abuse_Feb_2015.pdf>

The MARAC is an integral part of the Coordinated Community Response model to Domestic Abuse in Norfolk. It is linked to the Independent Domestic Violence Advocacy (IDVA) service and the Specialist Domestic Violence Court (SDVC). The main aim of the MARAC is to reduce the risk of serious harm or homicide for a victim and their families and to increase the safety, health and wellbeing of victims. In a MARAC local agencies will discuss the highest risk victims of domestic abuse in their area. Information about the risks faced by those victims and the actions needed to ensure safety. The resources available locally are shared and used to create a risk management plan involving all agencies.

**For further information:**

[www.norfolk.gov.uk/safety/domestic-abuse/information-for-professionals/multi-agency-risk-assessment-conference-marac](http://www.norfolk.gov.uk/safety/domestic-abuse/information-for-professionals/multi-agency-risk-assessment-conference-marac)

**Supporting Practice Staff**

As part of the health and wellbeing of its workforce, it is important that the practice support staff who may also be victims of domestic violence and abuse, to enable them to disclose information and receive support. Although domestic abuse is more likely to occur outside of the workplace, staff should feel able to disclose information about abuse. The practice will offer support to staff.

**Document 4**

**Modern Slavery and Trafficking**

The Modern Slavery Act 2015 gives law enforcement the tools to fight modern slavery, ensure perpetrators receive suitably severe punishments for their crimes, and enhance support and protection for victims. Section 1 outlines the criminal offence of slavery, servitude and forced or compulsory labour and Section 2 covers the separate criminal offence of human trafficking. The act also defines the meaning of exploitation and two civil orders (slavery & trafficking risk orders and slavery & trafficking prevention orders) have been created to prevent modern slavery. The Anti-Slavery Commissioner role was created under the act and provision for the protection of victims also forms part of the act.

Modern slavery is a serious crime and is an abuse of human rights. Modern slavery can be defined as the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. Individuals may be trafficked into, out of or within the UK, and they may be trafficked for a number of reasons including:

* Sexual Exploitation - An adult or a child who is trafficked for the purpose of sexual exploitation may be controlled by violence, threats, substance abuse, deception or grooming.
* Domestic Servitude - This involves a victim being forced to work in private households, usually performing domestic chores and childcare duties. Their freedom may be restricted and they may work long hours frequently for little or no pay, often sleeping where they work. Nearly a quarter of reported victims of domestic servitude in the UK are children.
* Forced labour - Victims may be forced to work long hours for little or no pay in poor conditions under verbal or physical threats of violence to them or their families. Forced labour can occur in various industries, including construction; manufacturing, home improvement, gardening, hospitality; food packaging, agriculture, maritime and beauty (e.g. nail bars).
* Criminal exploitation - This is the exploitation of a person to commit a crime, such as robbery, shop-lifting, cannabis cultivation, drug trafficking, etc.
* Other forms of exploitation - This can include organ removal, forced begging, forced benefit fraud, forced marriage and illegal adoption.

Modern slavery exists in many sectors. Victims of modern slavery may be reluctant to engage with services, report and feel humiliated. Threats may have been made against them or their families. They may be fearful of the police.

If you suspect that a person is a victim of modern slavery, this is a safeguarding issue. Trust and act on your professional instinct that something is not quite right. There may be a combination of an inconsistent story and a pattern of symptoms that may cause you to suspect trafficking. If you have any concerns about a child, young person or adult take immediate action to ask further questions and get additional information and support. It is sometimes difficult for the victim to speak about their situation.

**Appendix 1**

**Data Protection Act 2018 (c. 12)**

Schedule 1 — Special categories of personal data and criminal convictions etc. data

Part 2 — Substantial public interest conditions

**Safeguarding of children and of individuals at risk**

18 (1) This condition is met if—

(a) the processing is necessary for the purposes of—

(i) protecting an individual from neglect or physical, mental or emotional harm, or

(ii) protecting the physical, mental or emotional well-being of an individual,

(b) the individual is—

(i) aged under 18, or

(ii) aged 18 or over and at risk,

(c) the processing is carried out without the consent of the data subject for one of the reasons listed in sub-paragraph (2), and

(d) the processing is necessary for reasons of substantial public interest.

(2) The reasons mentioned in sub-paragraph (1)(c) are—

(a) in the circumstances, consent to the processing cannot be given by the data subject;

(b) in the circumstances, the controller cannot reasonably be expected to obtain the consent of the data subject to the processing;

(c) the processing must be carried out without the consent of the data subject because obtaining the consent of the data subject would prejudice the provision of the protection mentioned in subparagraph (1)(a).

(3) For the purposes of this paragraph, an individual aged 18 or over is “at risk” if the controller has reasonable cause to suspect that the individual—

(a) has needs for care and support,

(b) is experiencing, or at risk of, neglect or physical, mental or emotional harm, and

(c) as a result of those needs is unable to protect himself or herself against the neglect or harm or the risk of it.

(4) In sub-paragraph (1)(a), the reference to the protection of an individual or of the well-being of an individual includes both protection relating to a particular individual and protection relating to a type of individual.

**Appendix 2**

**Flowchart – Referral to an Independent Mental Capacity Advocate**

Is there an issue of:

Proposed change to accommodation or

Serious medical treatment?

No

You are not required to refer to an IMCA

Yes

Does the person lack capacity to make a decision on the issue in question at this time?

You are not required to refer to an IMCA

Yes

No

Yes

Yes

No

You are not required to refer to an IMCA

Is the person unfriended? No one else who is appropriate to consult with?

Refer to an IMCA

Contact: POhWER

Phone: 0300 456 2370

Email: pohwer@pohwer.net

**Practice Information**

**The Practice Adult Safeguarding Lead is:**

INSERT CONTACT

Insert information relevant to your practice – for example if a member of staff ignores policy what is procedure? What information is contained in staff handbook etc.?

**Useful Contacts**

|  |  |
| --- | --- |
| **Organisation** | **Contact** |
| **Adult Social Services - Norfolk County Council**  | 0344 800 8020 (available 24 hours a day)  |
| **Care Quality Commission (CQC)** | Telephone: 03000 616161Fax: 03000 616171Website - [www.cqc.org.uk](http://www.cqc.org.uk) |
| **DOLs (Norfolk)** | Please contact Norfolk CCGs Safeguarding Team for advice – 01603 257030 |
| **FGM Helpline**  | 0800 028 3550 |
| **Forced Marriage Unit** | 020 7008 0151Monday to Friday, 9am to 5pm Out of hours: 020 7008 1500 (ask for the Global Response Centre)  |
| **GMC Confidential Helpline -**  | 0161 923 6399Lines are open 9 am–5 pm, from Monday to Friday |
| **IMCA - POhWER**  | 0300 456 2370 email pohwer@pohwer.net |
| **Leeway (Domestic Abuse support – independent from police)** | Domestic Abuse Helpline: 0300 561 0077Email – referrals@leewaynwa.org.uk |
| **Norfolk CCGs Safeguarding Team** | Gary Woodward – Adult Safeguarding Lead NurseTel: 01603 257030Mobile 07827 835057gary.woodward@nhs.netDr Pippa Harrold, Phone: 01603 257030.pippa.harrold@nhs.net |
| **Norfolk DOLS** | Please contact Norfolk CCGs Safeguarding Team for advice – 01603 257030 |
| **Police** | For specialist Police Advice you can call the Police on 101 and ask to speak to the MASH Duty Sergeant or in an emergency always dial 999. |
| **Silverline** (free confidential helpline for older people across the UK – open 24 hours a day, seven days a week) | 0800 470 80 90 |
|  |  |