Essex County Council

Safeguarding Decision Support Framework

Provider Forums

Spring 2026

Purpose of Today

Talk through the current Safeguarding landscape.

Showcase the new Essex Safeguarding Adults Decision Support Framework.

Gather your feedback on using the tool.

A Person's Safeguarding Journey

Alert to web-based form

Making Safeguarding Personal:
Supporting people to express their wishes, preferences and concerns. Remaining centre of all we do, maximising choice and control over their lives and wellbeing outcomes.

Centralised Safeguarding Team

Initial screening in 24 hours

Is it a safeguarding concern?

Yes

Triage

Applying Care Act 3 Stage Criteria

Criteria met

No re-direct as needed

Does **not** meet S42 criteria

Locality or Countywide Team

S42 Enquiry Allocated and Managed

Focussing on the person's wellbeing. Advocacy considered and MDT working.

Organisational Safeguarding Team

Organisational Enquiry Allocated and Managed by specialist team

Targeted response and outcomes for all residents.

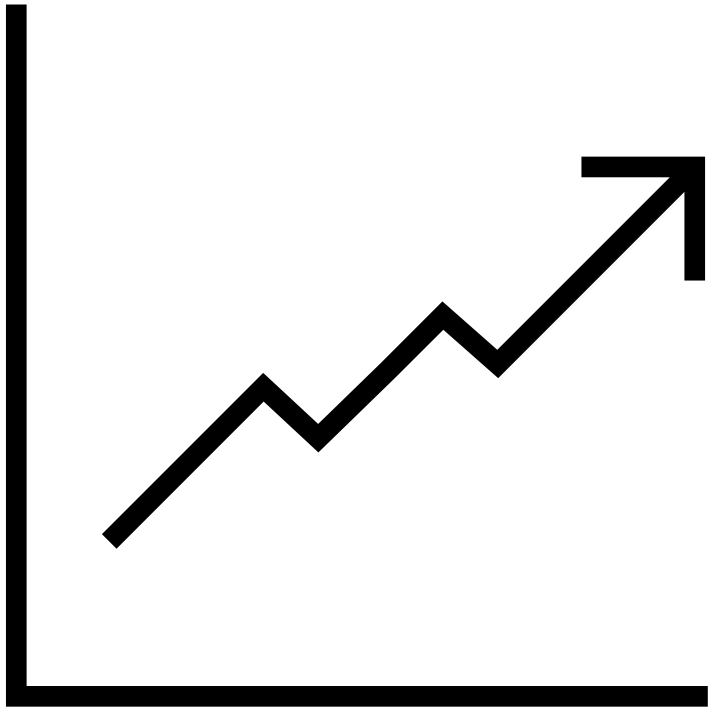
Outcomes achieved

Closure of Safeguarding

Consideration of SAR referral. Prevention, enablement and support

We prevent, enable and support by providing info and guidance: Including referrals to partners and the voluntary sector

Safeguarding Projections



Projections, based on current median numbers per month.

In 2023-24 Essex reported to NHS Digital 19,380 safeguards, and 4,745 section 42 enquiries, giving a conversion rate of 24%

In two years, numbers have significantly increased. Projections, based on current median monthly numbers, is our end of FY 2025-26 will be:

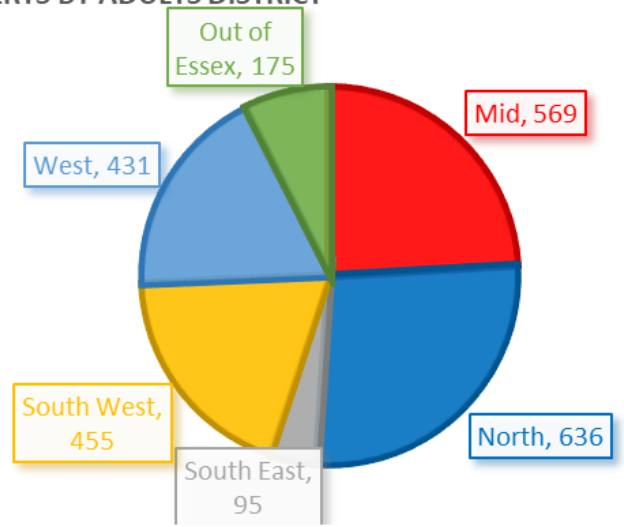
- Alerts: 28,200 (LY 24,000 +17%)
- Concerns: 23,500 (LY 21,000 +11%)
- Enquiries: 7,300 (LY 6,074 +21%)
- Conversion: 31%

This is a 56% increase in Section 42 Enquiries in just 2 years.

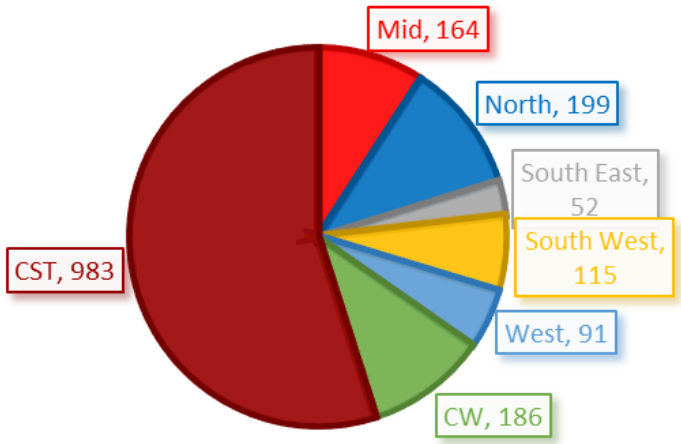
Essex is experiencing unprecedented and unsustainable demand

Geographical Spread – February 2026

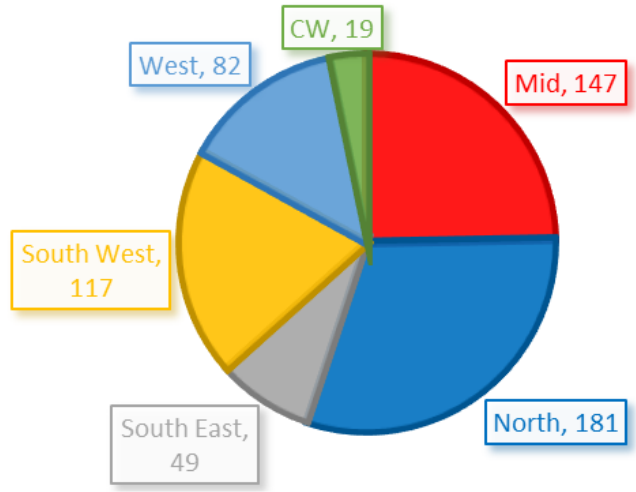
ALERTS BY ADULTS DISTRICT



INCOMING CONCERNS



INCOMING ENQUIRIES



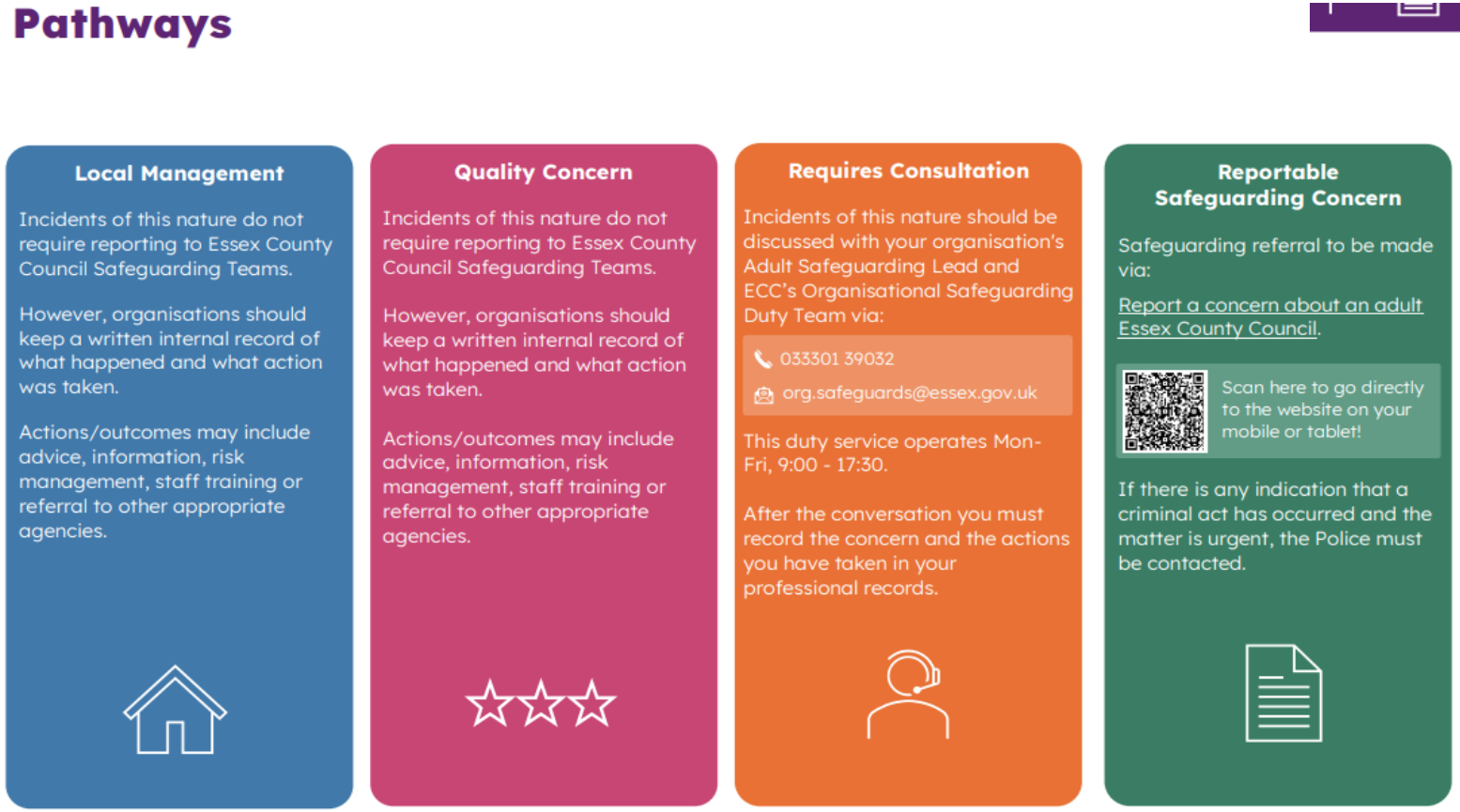
We are seeing a broad geographical spread of Safeguarding alerts, with North & Mid having the highest and the South-East the lowest

Essex Safeguarding Adults Decision Support Framework

The Framework is intended to support partners in **preventing low-level and quality concerns** becoming safeguarding issues.

This Framework has been **collaboratively developed** by multi-agency partners in Greater Essex, including Adult Social Care, Safeguarding and Quality Improvement colleagues, Essex Care Association, Social Care providers, our neighbouring LA's, East of England Ambulance Service, Provide Primary Care Service and the Care Quality Commission.

Pathways



Pathway Examples

Neglect and Acts of Omission: Missed Visits

INDICATORS OF NEGLECT AND ACTS OF OMISSION:

A person with care and support needs, whose medical or physical care needs are not recognised or met. This includes a failure to provide access to appropriate health, care and support or educational needs.

Local Management

- Isolated missed home care visit - no harm occurred, and no other person was missed that day.
- Person is not assisted with a meal/drink on one occasion, and no harm occurs.
- Person loses weight or is dehydrated, and the care plan is being followed with primary care support.
- One-off incident of discomfort that did not cause harm.

Quality Concern

- Missed home care visits - several people are missed on a given day/consecutive days, but no harm occurs.
- A person is not assisted with a meal/drink on one or more occasions with no harm or impact.
- Inadequacies in care provision affecting more than one person leading to minor discomfort e.g. left wet for a short period of time. No harm experienced.

Requires Consultation

- Visits by carers are shortened or merged into other visits.

Reportable Safeguarding Concern

- Lack of care leading to deterioration in health and wellbeing.
- A missed home visit has an adverse effect on a person at risk.
- There are repeat missed visits to a person at risk.
- Unexplained weight loss or signs of dehydration where a care plan is not in place or has not been followed, and specialist advice has not been sought
- Failure to arrange access to medical care or lifesaving services.
- Where a risk assessment is not in place or is not being followed and insufficient prevention measures are in place.
- Where appropriate care interventions have not occurred.
- Failure by a person in a position of trust to report harm.

Supporting documents: People must refer to their own organisational policy in the first instance. ESAB also have a number of policies available on their **website**. Other legislation to consider include **Mental Capacity Act 2005**, **Human Rights Act 1998** and the **Equality Act 2010**.

Pathway Examples

Neglect and Acts of Omission: Falls

INDICATORS OF NEGLECT AND ACTS OF OMISSION:
A person with care and support needs, whose medical or physical care needs are not recognised or met. This includes a failure to provide access to appropriate health, care and support or educational needs.

Local Management

- One off incident of discomfort not causing harm.
- Accidental fall- may have minor injury requiring basic medical attention, isolated incident whereby the person is supported up from the floor in a timely manner.
- A risk assessment has been followed/reviewed and there is an associated care plan in place.
- A person has had a fall due to medical condition (including distressed behaviour); with medical assistance sought/care plan followed (as required).

In addition to Local Management – A post-falls assessment tool (e.g. ISTUMBLE) can be used to determine a person's level of injury.

Quality Concern

- Falls – minor injury where the risk assessment and associated care plan is in place, but is not being followed.
- Lack of robust auditing activity to identify themes, patterns and trends which impacts on early prevention.

Requires Consultation

- Fall where harm occurs, whilst in receipt of care and requires medical treatment, e.g head injury/undetermined fracture.
- Numerous falls affecting more than one person from the same care setting (3 or more people, with unwitnessed falls over 3mth period).
- 2 or more falls experienced by one person within a month period.
- Where a person has fallen and is receipt of 1:1 Care.

Reportable Safeguarding Concern

- Falls with serious injury, where the person has experienced avoidable harm.
- Where there is avoidable harm and risk assessment is not being followed or in place, insufficient prevention measures in place.
- Failure to arrange access to medical care or lifesaving services where a fall has resulted in a serious injury (in accordance with the organisations policy and NICE's Falls Guidance).
- Lack of care leading to deterioration in health and wellbeing.
- Where appropriate care interventions have not occurred.
- Where a person at risk has repeated unexplained injuries.
- Failure by a person in a position of trust to report harm.

Supporting documents: People must refer to their own organisational policy in the first instance. ESAB also have a number of policies available on their **website**. Other legislation to consider include **Mental Capacity Act 2005**, **Human Rights Act 1998** and the **Equality Act 2010**.

Pathway Examples

Neglect and Acts of Omission: Nutrition/Hydration

INDICATORS OF NEGLECT AND ACTS OF OMISSION:
A person with care and support needs, whose medical or physical care needs are not recognised or met. This includes a failure to provide access to appropriate health, care and support or educational needs.

Local Management

- Person is not assisted with a meal/drink on one occasion and no harm occurs.
- Person loses weight or is dehydrated, and the care plan is being followed with primary care support.
- One off incident of discomfort not causing harm.
- Person is experiencing or symptomatic of a Urinary Tract Infection which is being managed appropriately through treatment and care plan.

Quality Concern

- A person is not assisted with a meal/drink on one or more occasions with no harm or impact.
- Inadequacies in care provision affecting more than one person leading to small discomfort - no harm e.g. left wet for a period of time.
- Safe temperatures of hot items not maintained, increasing risk of injury.

Requires Consultation

- Where there is a suitable care plan in place, however, the person is refusing food/fluids.
- Weight loss – due to malnutrition or dehydration; complaints of hunger.

Reportable Safeguarding Concern

- Lack of care leading to deterioration in health and wellbeing.
- Burns/scalding from hot drinks/objects.
- Unexplained weight loss or signs of dehydration where a care plan is not in place or has not been followed and specialist advice has not been sought.
- Failure to arrange access to medical care or lifesaving services.
- Where a risk assessment is not in place or being followed, insufficient prevention measures in place-having adverse effect on the person.
- Where appropriate care interventions have not occurred.
- Where appropriate medical attention has not been sought in a reasonable time frame.
- Failure to provide hydration or nutrition with identified needs in this area.
- Failure by a person in a position of trust to report harm.

Supporting documents: People must refer to their own organisational policy in the first instance. ESAB also have a number of policies available on their **website**. Other legislation to consider include **Mental Capacity Act 2005**, **Human Rights Act 1998** and the **Equality Act 2010**.

Pathway Examples

Neglect and Acts of Omission: Medication errors

INDICATORS OF NEGLECT AND ACTS OF OMISSION:

A person with care and support needs, whose medical or physical care needs are not recognised or met. This includes a failure to provide access to appropriate health, care and support or educational needs.

Local Management

- Isolated incident where the person is accidentally given the wrong medicines, given too much or too little medicines or given it at the wrong time but no harm occurs.
- Delay in giving medication but with no ill effect to the person.
- Isolated incident/human error causing no harm.
- Isolated prescribing or dispensing human error by GP, pharmacist or other medical practitioner resulting in no harm. This may require a complaint to the prescribing clinician/pharmacy.

Quality Concern

- Reoccurring incident where one person is accidentally given the wrong medicines, given too much or too little medicines or given it at the wrong time but no harm occurs.
- Prescribing or dispensing error by GP, pharmacist or other medical practitioner resulting in no harm.
- Medication has been given but not signed for. This is poor practice and needs to be addressed through internal processes (e.g. refresher training, observation of practice, competency assessments). However, multiple omissions may indicate a culture of poor practice and therefore consideration should be given to raising an organisational safeguarding concern.

Requires Consultation

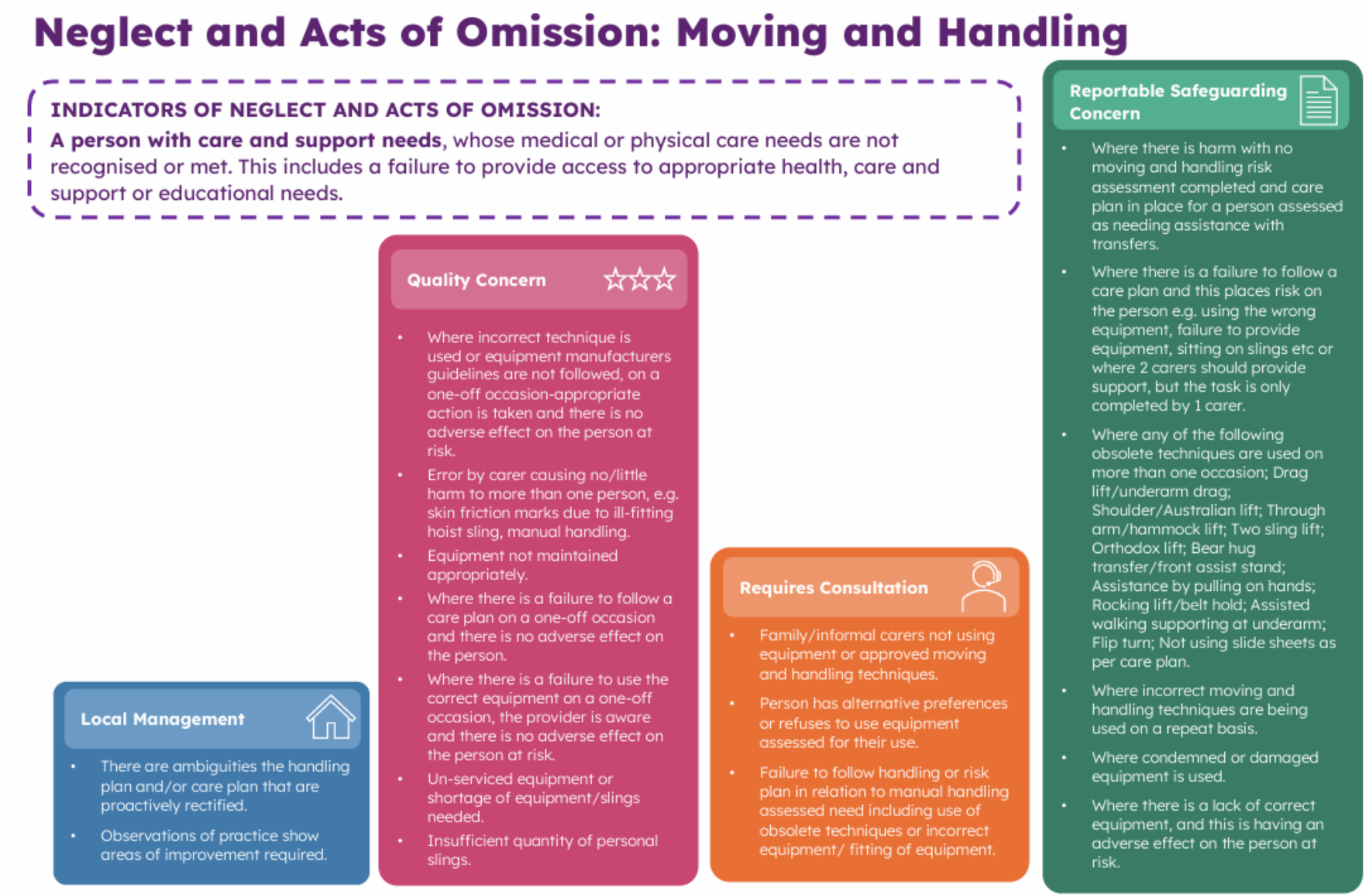
- A number of incidents causing no harm that are not reported by carer/s.
- Recurring prescribing or dispensing errors by GP, pharmacist or other medical practitioner that affect more than one person and/or result in harm to one or more persons.
- Covert administration without following Mental Capacity Act and/or NICE guidance.
- Repeated medication errors and repeated medication errors not reported.

Reportable Safeguarding Concern

- Deliberate withholding of medicines or failure to follow proper procedures, e.g. controlled medicines.
- Deliberate falsification of records or coercive/ intimidating behaviour to prevent reporting.
- Misuse of/over-reliance on sedatives to control challenging behaviour.
- Incident where a person is given wrong medication or failure to administer medication causing significant harm.
- Delay in receiving medication that leads to an adverse effect on the person.
- Recurring missed medicines or errors that affect more than one person and results in actual , deliberate or potential harm to one or more persons.

Supporting documents: People must refer to their own organisational policy in the first instance. ESAB also have a number of policies available on their **website**. Other legislation to consider include **Mental Capacity Act 2005**, **Human Rights Act 1998** and the **Equality Act 2010**.

Pathway Examples



Pathway Examples

Neglect and Acts of Omission: Pressure Care

INDICATORS OF NEGLECT AND ACTS OF OMISSION:

Ongoing failure to meet a person **with care and support needs'** basic physical or psychological needs.

Ensure that the following guidance is followed prior to raising a safeguarding concern: **www.gov.uk/pressure-ulcers-how-to-safeguard-adults**

Local Management

- Pressure damage with no evidence of neglect or failure to provide or access adequate care or pressure relieving equipment.
- Pressure damage, person has capacity and makes an informed decision to decline treatment and pressure ulcer develops.
- Single or isolated incident of pressure ulcer.

Quality Concern

Isolated pressure ulcers where:

- A care plan is in place and being followed; and
- Action is being taken; and
- Other relevant practitioners have been notified; and
- There has been full discussion with the person, their family or representative; and
- There are no other indicators of abuse or Neglect.

Requires Consultation

- Pressure ulcers that have been investigated through the serious incident process and have found to be preventable.
- Where the pressure sore has occurred outside the specified care setting i.e. new hospital acquired pressure sore.
- Primary health colleagues are involved and supporting the person.

Reportable Safeguarding Concern

- Pressure damage - Person not risk assessed with regards to pressure ulcers risk and management and harm occurs.
- Pressure damage - Person risk assessed with regards to pressure ulcers, but actions not implemented.
- Failure to assess risk and lack of care plan.
- Failure to provide suitable pressure relieving equipment and harm occurs.
- Failure to seek or follow the advice of clinical specialists regarding pressure ulcer care.

NB Category 3 or above pressure ulcers must be reported to the CQC and follow Department of Health guidance.

Recording of Safeguards

This Framework will help you identify the possible abuse type and determine necessary actions.

However, professionals should **always use their knowledge, skills and professional judgement** when deciding on applicable actions. Professionals should use the Framework to assist decision-making with their organisation's safeguarding leads with reference to the guidelines provided, and documenting their rationale.

The decision-making process **must always be recorded** in the person's notes or records and those of the organisation, even if the outcome is that no safeguarding intervention is required.

The Care Quality Commission supports the use of our Essex tool and **that only reportable safeguarding concerns** require notification to the local authority through the safeguarding adult portal.

Professionals can also contact the local authority's **advice line** which offers consultation to enable decisions as to whether to raise a safeguarding alert through the Adult Social Care Safeguarding Portal.

We’d like to hear from you

1. To what extent are you aware of the new Safeguarding Decision Support Framework and its purpose?

2. Are you currently using the Safeguarding Decision Support Framework within your organisation to support decision-making?

3. If not; how will you utilise this tool after today?

4. How confident do you feel using the Safeguarding Decision Support Framework to support safeguarding decisions?

5. What do you find most valuable about the Safeguarding Decision Support Framework?

Thank you

and

Don’t forget to take away your Safeguarding Desk Tent!

Spring 2026 - Safeguarding Decision Support Framework – Fill in form

Video link

[Safeguarding Adults Decision Support Framework | Essex SAB]