NHS
North Lincolnshire
Clinical Commissioning Group

NORTH LINCOLNSHIRE

CLINICAL COMMISSIONING GROUP

Safeguarding Policy

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Name of responsible committee/individual:	Quality Group
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Version Control Sheet

Version	Date	Author/Director	Status	Comment
1.0	28/12/16	Sarah Glossop, Designated Nurse – Safeguarding	Ratified	
1.1	30/11/18	Sarah Glossop, Designated Nurse & Head of Safeguarding		Policy reviewed for compliance with safeguarding pathways. Updated contact details. Full review date extended to end of March 2019

CONTENTS

1. INTRODUCTION

1.1 This policy sets out clear standards and requirements for North Lincolnshire Clinical Commissioning Group (NLCCG), employed staff and services commissioned by NLCCG. This also includes locums, agency staff, contractors, volunteers, students, learners and celebrities. It details NLCCG governance arrangements for safeguarding and supports the advice and guidance laid out in the North Lincolnshire Safeguarding Children Board (NLSCB) Procedures and Guidance and the North Lincolnshire Safeguarding Adult's Board (NLSAB) Policy and Procedures and therefore should be read in conjunction with these.

1.2 This policy should also be read in conjunction with any other NLCCG policies which promote the welfare of staff and patients including:

- responses to Domestic Abuse
- implementation of and compliance with the Mental Capacity Act
- PREVENT
- identifying and responding to incidents of Female Genital Mutilation

1.3 All Clinical Commissioning Groups (CCGs) have a duty to take reasonable care to ensure the quality of the services they commission. There is an expectation that the provider organisations demonstrate robust safeguarding systems and safe practice within the agreed local multi-agency procedures. All providers will have appropriate and effective systems in place to ensure that any care provided, is done so with due regard to all contemporary legislation. This includes, but is not restricted to the:

- Children Act 1989
- Children Act 2004
- Care Act 2014
- Human Rights Act (1998)
- Mental Capacity Act (2005)
- Mental Health Act (2007)
- Serious Crime Act (2015)
- The Counter-Terrorism and Security Act (2015)

This policy is also informed by

- Working Together to Safeguard Children (DfE 2015),
- Chapter 14 of Care and Support Statutory Guidance (DH 2016)
- Safeguarding children and young people: roles and competencies for health care staff – Intercollegiate Document (Royal College of Paediatrics and Child Health 2014)
- Safeguarding Adults: roles and competencies for health care staff – Intercollegiate Document (published by NHS England in February 2016, withdrawn for amendments in April 2016)
- North Lincolnshire Safeguarding Children Board procedures[1].
- North Lincolnshire Safeguarding Adult Board procedures[2].

1.4 Achieving good outcomes for adults and children requires all those who work with responsibility for assessment and the provision of services to work together according

[1] http://www.northlincslscb.co.uk/professionals/policies/
[2] http://www.northlincs.gov.uk/EasySiteWeb/GatewayLink.aspx?alId=24928

to an agreed plan of action. Effective collaborative working requires professionals and agencies to be clear about:

- Their roles and responsibilities for safeguarding and promoting the welfare of children and adults at risk from abuse;
- The purpose of their activity, what decisions are required at each stage of the process and what are the intended outcomes for adults at risk, the child/children and their family members;
- The legislative, regulatory basis and guidance documents of their work;
- The protocols and procedures to be followed, including the way in which information will be shared across professional boundaries and within agencies, and what will be recorded;
- Which agency, team or professional has lead responsibility, and the precise roles of everyone else who is involved, including the way in which adults, children and other family members will be involved;
- Any timescales set down in regulations or guidance, which govern the completion of assessments, making of plans and timing of reviews.

2. ENGAGEMENT

This policy has built on previous safeguarding policies, and national policy and guidance. NLCCG commissions health services for patients registered with GP practices operating from North Lincolnshire. This means that for health services, the registered population include those who are ordinarily resident in other localities, so significant congruence is required with policies in place for neighbouring localities. This policy has been circulated for comment to the membership of the NLCCG Quality Group.

3. IMPACT ANALYSES

3.1 Equality

This policy aims to safeguard all children and young people, and adults with care and support needs, who may be at risk of abuse, irrespective of disability, race, religion/belief, colour, language, birth, marriage, nationality, ethnic or national origin, gender or sexual orientation. Approaches to:

- safeguarding children must be child centred, upholding the welfare of the child as paramount. (Children Acts, 1989 and 2004).
- adults with care and support needs must be person centred (Care Act 2014)

All CCG staff must respect the alleged victim's (and their family's/ carers) culture, religious beliefs, gender and sexuality. However this must not prevent action to safeguard those who are at risk of, or experiencing, abuse.

All reasonable endeavours must be used to establish the child/adult and family carer's preferred method of communication, and to communicate in a way they can understand. This will include ensuring access to an interpretation service where people use languages (including signing) other than English. Every effort must be made to respect the person's preferences regarding gender and background of the interpreter.

NLCCG promotes a culture of Equality and Diversity within its organisation and actively monitors themes arising from incidents for any potential discriminatory activity If, at any time, this policy is considered to be discriminatory in any way, the author should be contacted immediately to discuss these concerns.

3.2 Sustainability

A sustainability impact assessment has been completed. The impact of this policy is neutral.

3.3 Bribery Act 2010

Due consideration has been given to the Bribery Act 2010 in the development of this policy and no specific risks were identified.

4. SCOPE

In this document a child refers to a person who has not yet reached their 18th birthday. An adult is a person aged 18 years or over.

The policy is focused on:

- all children under the age of 18, and
- adults (aged 18 or over) at risk of abuse or neglect because of their needs for care and support.

This policy applies to all staff employed by NLCCG and its commissioned services. This includes; all employees (including those on fixed-term contracts), temporary staff, bank staff, locums, agency staff, contractors, volunteers (including celebrities), students, apprentices and any other learners undertaking any type of work experience or work related activity.

Organisations working on behalf of NLCCG must have policies and procedures in place consistent with this document and compliant with legislation and guidance including that listed in the Introduction to this policy.

5. LOCAL MULTI-AGENCY ARRANGEMENTS

5.1 North Lincolnshire Safeguarding Children Board (NLSCB)

Local authorities are required under Section 13 of the Children Act 2004 to establish a Local Safeguarding Children Board (LSCB) for their area, with specified organisations and individuals (other than the local authority that should be represented. LSCBs have a range of roles and statutory functions, including developing local safeguarding policy and procedures and scrutinising local arrangements.

The specified objectives outlined in Section 14 of the Children Act 2004 are:

a) To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
b) To ensure the effectiveness of what is done by each such person or body for those purposes.

Further details in respect to the functions of LSCBs, and how they meet their objectives are included in **North Lincolnshire Safeguarding Children Board Procedures** as available on the NLSCB website[3].

LSCBs do not commission or deliver direct frontline services.

[3] http://www.northlincslscb.co.uk/professionals/policies/

NLSCB has membership consisting of Senior Managers from North Lincolnshire Council, NLCCG, NHS England, (via the Designated Professionals), provider health organisations (NLaG, RDaSH), Humberside Police, National Probation Service and Lay representation. NLSCB is chaired by a person independent of all local organisations, and other public, private and voluntary organisations across North Lincolnshire who have responsibilities for children and their families

NLSCB has a number of subgroups. These are:

- Child Death Overview Panel
- Serious Case Review Subcommittee
- Safeguarding Operational Managers Group
- Neglect Strategic Group
- Child Sexual Exploitation Strategic Group

5.2 North Lincolnshire Safeguarding Adult Board (NLSAB)

NLSAB has membership consisting of Senior Managers from NLC, CCG, (representing NHS England), Humberside Police, National Probation Service, Voluntary Sector and Lay representation. The Leadership Board is supported by the Operational Group whose membership is drawn from the chairs of the sub-groups.

The sub-groups are:

- Safeguarding Adult Review Panel
- Quality Assurance and Performance Action Group
- Training
- Communications

Further details in respect to the functions of the SABs, and how they meet their objectives are included in **North Lincolnshire Safeguarding Adults Board Procedures** as available here[4]:

6. POLICY PURPOSE & AIMS

6.1 Policy aims

This policy has 2 key purposes.

1. Ensure staff working for, or on behalf of, NLCCG are clear around their responsibilities, and activity required, where there are concerns in respect to welfare of children, or adults with care and support needs.
2. As a commissioning organisation, NLCCG is required to assure themselves that the organisations from which they commission have effective safeguarding arrangements in place.

6.2 Policy statement

NLCCG has a statutory duty, under section 11 of the Children Act 2004 (amended by the Health and Social Care Act 2012), to ensure that it makes arrangements to safeguard and promote the welfare of children and young people and that these arrangements reflect the needs of the children they deal with.

[4] http://www.northlincs.gov.uk/EasySiteWeb/GatewayLink.aspx?alId=24928

The Care Act 2014 sets out comparable requirements with regard to safeguarding adults from abuse or neglect and makes provision about care standards, reforming previous legislation regarding care support for adults.

All adults and children have a right to protection. Some people are more vulnerable to abuse, exploitation, radicalisation and neglect due to a variety of factors impacting on their own, and/ or their families, parents' or carers' welfare.

All staff should be aware that age, gender, cultural or religious beliefs, disabilities or social backgrounds may also impact on an adult or child's ability to access help and support. **When dealing with vulnerable people and their families, staff must give due consideration to these issues at all times.** However this must not prevent action to safeguard those who are at risk of, or experiencing, abuse.

NLCCG has clear service standards against which commissioned providers (including independent providers, voluntary, and community sector) will be monitored.

In discharging these statutory duties/responsibilities account must be taken of the legislation and guidance listed in section 11.

NLCCG adopts a zero tolerance approach to adult and child abuse and works to ensure that its policies and practices are consistent with agreed local multi-agency procedures and meets the organisation's legal obligations.

Specifically:

- Where concerns are raised, NLCCG is committed to a proportionate and timely response to safeguard the particular adult(s) and/or child(ren) and young people within a multi-agency framework.
- NLCCG is committed to sharing information required by other agencies, within agreed protocols and legislation, in order to safeguard adults, children and young people who may be at risk of abuse.
- NLCCG and provider organisations will work collaboratively with the LSCB and SABs to maintain a local learning and improvement framework in order to learn from experience and improve services. This will include conducting reviews, not only on cases which meet the statutory criteria, but also on cases which can provide useful insights into the way organisations are working together to safeguard and protect the welfare of children and adults.

As a commissioning organisation, NLCCG will work with partner agencies in order to develop quality systems, promote safeguarding practice across the health economy and effectively monitor performance of providers in relation to safeguarding adults, children and young people.

Specifically:

- All organisations providing services commissioned by NLCCG are required to demonstrate commitment to safeguarding adults, children and young people and to working within agreed local multi-agency procedures, national guidance and legislation.
- NLCCG will actively contribute to multiagency responses regarding concerns of abuse within commissioned services.
- All providers are expected to establish procedures and systems of working that ensure safeguarding concerns are referred to North Lincolnshire Children's and/or Adult Social Care services as appropriate and as indicated in the NLSCB and SAB procedures.

- Provider services within North Lincolnshire, commissioned by NLCCG, are expected to actively contribute to the work of the LSCB, SAB and their sub groups.
- All providers who deliver services commissioned by NLCCG are required to meet the safeguarding standards as set out in this policy.

6.3 Responding to Concerns about a Child or Adult's Welfare

Harm may be caused to a child or adult with care and support needs as a result of:

For children	For adults
• Physical Abuse • Sexual Abuse – including through Sexual Exploitation • Emotional Abuse • Neglect	• Physical Abuse • Sexual Abuse • Psychological Abuse • Neglect • Self-Neglect • Organisational Abuse • Financial Abuse • Modern Slavery • Discriminatory Abuse • Domestic Abuse

Concerns that a child or adult may be a risk of suffering harm may arise from:

- Information given by:
  - A child/ vulnerable adult or his/her friends
  - A family member
  - A close associate
- Behaviour by the child/ vulnerable adult
- An injury that arouses suspicion
- Contact with someone known to pose a risk to children/ vulnerable adults

It is essential that whenever an individual has concerns about whether a child or adult is suffering from, or is at risk of suffering, significant harm, that they act on their concerns in accordance with statutory requirements, and in accordance with Local Safeguarding Children Board (LSCB) procedures and guidance and/or the Safeguarding Adult Board (SAB) policy and procedures as relevant.

These procedures must be followed irrespective of the source of concern. NLCCG recognises that concerns may arise from many sources including carers, parents, professionals, volunteers and other staff, service users and visitors including celebrities and people with high profile/status working with or involved with organisations and service users.

NB. Irrespective of whether there are concerns about the welfare of the children, NLCCG staff have a duty to act on information that a child may be subject to Private Fostering arrangements. Further details on Private Fostering can be found at Appendix 8.

Action required where staff working for, or on behalf of NLCCG, identify a safeguarding concern.

For staff working in a clinical role:

Where concerns are identified, the staff member MUST ensure they seek support/ supervision from appropriately experienced colleagues/ operational managers in deciding on the next course of action.

These staff can also contact the Safeguarding Specialists (listed below) as required.

For staff NOT working in a clinical role:

Where concerns are recognized the staff member

1. **MAY** highlight/discuss the concern with their line manager
2. **MUST** contact one of the CCG Safeguarding Specialists
    a. Designated Nurse for Safeguarding
    b. Specialist Nurse - Safeguarding
    c. Designated Doctor – Safeguarding Children
    d. Named GP – Safeguarding Children and Adults

    for safeguarding advice.

A link to the contacts for these individuals can be found at Appendix 1.

In all cases

If any member of staff believes a child or adult is at **immediate risk of harm**, or is in need of urgent medical attention, they should not delay/ wait for discussions and should **dial 999**, requesting police or ambulance assistance as appropriate..

No member of staff should feel or decide that concerns they have are not significant enough to discuss with their line manager/ or Safeguarding Specialist.

Line managers should actively encourage/ support staff to discuss concerns and seek further advice.

Where concerns are identified, staff should follow (or will be supported in following) the procedures produced by North Lincolnshire Safeguarding Children Board or Safeguarding Adult Board as relevant. The procedures can be accessed through the following links:

North Lincolnshire Safeguarding Children Board Procedures[5]

North Lincolnshire Safeguarding Adult Board procedures[6]:

All staff must have access to the LSCB/SAB Procedures - it is an individual, and manager's responsibility to ensure they have access to this document at work.

All those who come into contact with children, families and adults with care and support needs in their everyday work, including practitioners who do not have a specific role in relation to child or adult protection have a duty to safeguard and promote the welfare of children and adults.

All practitioners should be familiar with both the LSCB's, LSAB's and the organisation's policies and protocols for promoting and safeguarding the welfare of children and vulnerable adults.

All staff should be aware of the National Institute for Clinical Excellence (NICE) clinical guideline 89 *When to suspect child maltreatment* (July 2009) and The Care Act (2014) which outlines a range of alerting features that may indicate child/vulnerable adult maltreatment and should use this to inform their decision making (Appendix 3).

If a member of staff is implicated in the concern about harm then the organisation's policy and multi-agency procedures for managing allegations against staff must be followed.

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[5] http://www.northlincslscb.co.uk/professionals/policies/
[6] http://www.northlincs.gov.uk/EasySiteWeb/GatewayLink.aspx?alId=24928

Multi-agency working and responding to abuse

Serious Case Reviews and Domestic Homicide Reviews (DHRs) both nationally and locally, have shown that effective multi-agency approaches and communication between agencies are at the heart of safeguarding.

NLCCG is committed to multi-agency approaches to safeguarding children and adults work and will ensure a proportionate contribution to the work of the LSCB, SAB and their sub-groups.

Making a Referral to Children's Social Care

a. If the practitioner believes that a child is at risk of significant harm they should inform the parent/carer if safe to do so (gaining their consent if possible) and make a referral to Children's Social Care in accordance with LSCB procedures and guidance.
b. If the child is in immediate danger the police or ambulance service as appropriate should also be called (using the 999 number).
c. However, if the practitioner believes that informing the parent/carer of the intention to refer to Children's Social Care may jeopardise a potential police investigation, or increase the risk of harm to the child, then sharing the intent to refer with the parent or carer should be dispensed with. Additionally if a practitioner believes that informing the parent/carer of intent to refer would put themselves at risk, this may be dispensed with. A record must be made of whether or not the parent/carer has been informed of the referral, and whether or not consent has been obtained together with reasons for over-riding or dispensing with consent.
d. N.B. If a patient, or other person expresses delusional beliefs involving their own child or other children, or if they might harm their child as part of a suicide plan, then a prompt referral must be made to Children's Social Care.
e. Anyone who has concerns about a child but is unclear whether they should make a referral should consult with the safeguarding lead for their organisation, or as advised within their organisational policy.
f. Referrals to Children's Social Care should be telephoned through as soon as is safely possible and must be followed up, in writing, within 48 hours.
g. A copy of the referral and any associated actions for example interventions, and details of telephone calls **must** be recorded within the child's records, and if relevant into the adult's record, taking care not to breach data protection principles.

NB. *Where concerns are identified in respect to Female Genital Mutilation in females under the age of 18, there is a* ***mandatory*** *duty to report to the police via 101.* Details on process for mandatory report can be found at Appendix 7.

Making a safeguarding adult referral

a. The first priority is to ensure the safety and protection of the adult. In making the person (and others potentially at risk) safe, it may be necessary to inform the emergency services.
b. Where there are suspicions that a crime may have taken place, the police should be contacted immediately and physical, forensic and other evidence should be preserved where possible.
c. If a practitioner believes that an adult is at risk of harm they should seek consent and make a referral into the local multi-agency safeguarding team, following SAB procedures. However, if the adult lacks capacity or it is believed to be in a public interest, than consent does not have to be sought to make the referral.
d. Anyone who has concerns about an adult, but is unclear whether they should make a referral, should consult with the safeguarding lead for their

organisation, or as advised within their organisational policy. Alternatively, guidance can be sought from the Local Authority safeguarding team.

e. A safeguarding adult referral should be made via the Single Point of Access at on 01724 296700
f. Records of incidents and concerns should be written as soon as possible, with the date, your signature and designation made clear. If records are hand-written, the original should be kept for evidential purposes.
g. Staff should be aware that their records relating to any alert, referral or investigation could be used as evidence in a range of procedures: disciplinary, criminal or at a safeguarding case conference.

6.4 Responding to concerns regarding potential radicalisation. (Prevent)

If you have concerns about an individual patient or member of staff who may be susceptible to radicalisation and/or violent extremism or suspect of being engaged in terrorist activity, please contact the Designated Nurse – Safeguarding or in their absence, the Executive Lead who will take appropriate action based on regional and local guidance. Alternatively, referral directly to the regional Prevent Lead or local CHANNEL lead. A link to the contacts for these individuals can be found at Appendix 1.

6.5 Safeguarding adult and children standards for providers

All providers of services commissioned by NLCCG are required to meet the standards in relation to safeguarding adults and children. These standards are not exhaustive and may be in addition to those required by legislation, national guidance or other stakeholders, including regulators and professional bodies. Providers are required to complete a self-declaration at least annually, submitting evidence as requested by the CCG and provide key performance data quarterly as indicated in the Self Declaration Template (Appendix 2).

All providers of NHS services are required to register with the Care Quality Commission. As part of their registration, each provider is required to meet the requirements of the Fundamental Standards (CQC, 2014). The CQC have powers under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to impose enforcement action, or deregister the provider from offering health services, if these standards are not met[7].

Regulation 13[8]: Safeguarding services users from abuse and improper treatment includes requirements for the safeguarding of children. The specific components of Regulation 13, which are relevant to the safeguarding of children, are:

1. Service users must be protected from abuse and improper treatment in accordance with this regulation.
2. Systems and processes must be established and operated effectively to prevent abuse of service users.
3. Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse
4. Care or treatment for service users must not be provided in a way that—

[7] www.legislation.gov.uk/uksi/2014/2936/contents/made
[8] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

a. includes discrimination against a service user on grounds of any protected characteristic (as defined in section 4 of the Equality Act 2010) of the service user,
b. includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint,
c. is degrading for the service user, or
d. significantly disregards the needs of the service user for care or treatment.

5. A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.
6. For the purposes of this regulation—
'abuse' means—
   a. any behaviour towards a service user that is an offence under the Sexual Offences Act 2003(a),
   b. ill-treatment (whether of a physical or psychological nature) of a service user,
   c. theft, misuse or misappropriation of money or property belonging to a service user, or
   d. neglect of a service user.
7. For the purposes of this regulation, a person controls or restrains a service user if that person—
   a. uses, or threatens to use, force to secure the doing of an act which the service user resists, or
   b. restricts the service user's liberty of movement, whether or not the service user resists, including by use of physical, mechanical or chemical means.

The guidance which the CQC has issued to support the implementation of the Fundamental standards[9] is replicated at Appendix 6:

Standard A: Policy and Procedures

A1. The Provider will ensure that it has up to date organisational safeguarding policies and procedures, consistent with relevant legislation, which reflect and adhere to LSCB and SAB policies and procedures. This must include the need to be mindful of adult issues that affect children's wellbeing such as; parental or carer mental ill health, domestic abuse, alcohol or substance misuse and adults who may pose a risk to children for any reason. There will be evidence of policy development, review dates, consultation and approval.

A2. The Provider will ensure that organisational safeguarding policies and procedures give clear guidance on how to recognise and refer safeguarding children and adults safeguarding concerns, including the importance of listening to the child or vulnerable adult and maintaining a clear focus on their needs, and ensure that all staff have access to the guidance and know how to use it.

A3. The Provider will ensure their safeguarding policies include, where appropriate, processes for:

- the management of differences of opinion between agencies and between health professionals, including escalation of concerns

[9] http://www.cqc.org.uk/content/regulation-13-safeguarding-service-users-abuse-and-improper-treatment#guidance

- the management of discharge from in-patient units when there are child/adult protection concerns
- checking for and encouraging registration with a GP
- the management and follow up where children, or adults with care and support needs, are not presented for appointments
- managing cases or suspicions of fabricated induced illness in children, or adults
- safe recruitment and operational practice
- outlining when, and how, A&E/unscheduled care staff should check whether a child or adult is subject to multi-agency activity to safeguard their welfare, including:
  - a child protection plan,
  - adult safeguarding plan
  - MARAC[10] arrangements
  - arrangements under PREVENT
- a process which allows for the appropriate recording of information where individuals are subject to MAPPA[11]

A4. The Provider will ensure that all other corporate and clinical policies and procedures with relevance to safeguarding are consistent with, and referenced to, safeguarding legislation, national policy / guidance and local multi-agency safeguarding procedures. This includes having 'Prevent' procedures embedded within safeguarding policies.

A5. The Provider will ensure that all policies and procedures are consistent with legislation/guidance in relation to Mental Capacity Act 2005 and consent, and that staff practice in accordance with these policies.

A6. The Provider will have an up to date 'whistle-blowing'/Raising Concerns procedure, which is referenced to local multi-agency procedures and covers arrangements for staff to express concerns both within the organisation and to external agencies. The Provider will have systems in place to demonstrate that all staff are aware of their duties, rights and legal protection, in relation to whistle-blowing/raising concerns and that they will be supported to do so.

A7. Providers of care homes and hospitals will have an up to date policy and procedure covering the Deprivation of Liberty Safeguards 2009, and will have evidence to demonstrate that staff practice in accordance with the legislation and will reflect the Winterbourne View concordat and CIPOLD objectives..

A8. The Providers of care homes and hospitals will have an up to date policy(s) and procedure(s) covering the use of all forms of restraint. These policies and procedures must adhere to contemporary best practice and legal standards.

A9. The Provider will ensure that there is a clinical/professional supervision policy in place and that safeguarding practice is included appropriately as a standard item.

A10. The Provider will have evidence of an up-to-date policy which ensures that all staff working directly with children and families, young people and adults who are parents/carers, specialist / lead safeguarding practitioners and staff line managing these groups have access to planned (and protected) safeguarding

[10] Multi-agency Risk Assessment Conference – in cases of high risk Domestic violence
[11] Multi-Agency Public Protection Arrangements

supervision at least quarterly, and includes access to, and awareness of how to contact Named Professionals for their organisation, **and** Designated Professionals.

A11. The Provider will ensure that they have relevant procedures in place to ensure appropriate access to advocacy within the care setting, including use of statutory advocacy roles. These must adhere to contemporary best practice and legislation.

A12. The Provider will ensure that their policies and procedures include clear guidance on the use of assessment processes in safeguarding children circumstances for the identification of early help and prevention needs.

A13. The Provider will ensure that their policies and procedures include clear guidance on the requirement to provide Early Help (i.e. resolving issues at the earliest point, to prevent escalation) for children, families, adults with care and support needs.

The Provider will ensure their arrangements for providing support to children and their families are compliant with NLC Helping Child and Families[12] (Threshold Document 2016/20) and they actively promote training and use of Early Help Assessment for children and their families. Providers may utilise their own assessments as Early Help Assessments if they ensure they cover all areas/ features of the North Lincolnshire Early Help Assessment as approved by NLSCB.

A14. The Provider will be cognisant of section 6.5 of this policy in respect to sharing of information. The Provider will:

- have in place or have adopted NLSCB/ SAB policies and procedures for sharing of information where there are concerns for the welfare of a child or adult with care and support needs.
- promote good practice in information sharing in accordance with *Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers*, HM Government March 2015
- ensure that recording systems and processes are in place which allow for
  - appropriate information sharing between health professionals within the organisation, across health organisation boundaries, and across agency boundaries, which promote a holistic approach to assessing and addressing needs of service users of all ages, and evidence collaborative working
  - ease of identification (through flagging/alerts) of Children in Need, children subject to Child Protection Plan, Looked After Children
  - exploration of systems to identify adults at risk due to their care and support needs

Standard B: Governance

B1. The Provider will identify a person(s) with lead responsibility for safeguarding. For NHS Bodies / Trusts, this will be a Board-Level executive Director with lead responsibility for safeguarding.

B2. The Provider will ensure they have a Named Doctor and Named Nurse for Safeguarding Children with

[12] http://www.northlincslscb.co.uk/professionals/policies/helping-children-and-families-threshold-document/

- job descriptions compliant with the intercollegiate document Safeguarding Children and Young People: roles and competences for health care staff (2014), and
- sufficient capacity to carry out these roles.

B3. Where organisations provide maternity services, The Provider will ensure they have a Named Midwife with sufficient capacity

B4. The Provider will identify a named lead professional for safeguarding adults with sufficient capacity to effectively carry out these roles.

B5. The Provider will identify a PREVENT lead

B6. The Provider will identify a named health or social care professional with lead responsibility for ensuring the effective implementation of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards 2009.

B7. The Provider will inform commissioners of any changes to the Executive or Professional leadership as soon as practicable and, in any event, no later than ten operational days after the change

B8. The Provider will ensure that there is an effective system for identifying and recording safeguarding concerns, patterns and trends through its governance arrangements including; risk management systems, patient safety systems, complaints, PALS and human resources functions, and that these are shared appropriately according to multi-agency safeguarding procedures.

B9. The Provider must ensure that there are systems for capturing the experiences and views of service users in order to identify potential safeguarding issues and relevant service development needs.

B10. Providers of hospitals and care homes will ensure that there are effective systems for recording and monitoring Deprivation of Liberty applications to the authorising body/Court of Protection.

B11. The Provider will undertake a Board level review of the effectiveness of the organisation's safeguarding arrangements at least annually and will identify any risks, service improvement requirements and learning points as well as areas of good practice.

B12. The Provider must have in place evidence of robust annual audit programmes to assure itself that safeguarding systems and processes are working effectively and that practices are consistent with the Care Act 2014, Mental Capacity Act (2005) and section 11 of the Children Act 2004.

B13. The Provider will, where required by the SAB/ LSCB, consider the organisational implications of any multi-agency review(s), and will have evidence to show an action plan with recommendations submitted to the local responsible Safeguarding Board to evidence that any learning is implemented across the organisation.

B14. The Provider will have evidence to show recommendations and action from safeguarding inspections that have been implemented and embedded in practice.

B15. The Provider conducts an annual audit of the quality of safeguarding referrals/alerts made to children and adult social care, with associated recommendations and action plans.

B16. The mental health service provider will be able to evidence the number of assessments using the Mental Health Clustering Tool (MHCT) and referrals as a result with trend analysis.

B17. The Provider will submit an annual report to the CCG appending their completed assurance declaration (see Appendix 2) as relevant to their service, and will include information on training and supervision uptake, and evidence of its quality and effectiveness, and relevant audit information.

B18. The Provider will submit information on a quarterly basis demonstrating their current % compliance with safeguarding training at the levels described within their approved training needs analysis/plan (see Standard E, paragraph E3); and of supervision uptake amongst relevant staff.

Standard C: Multi-agency working and responding to concerns

C1. The Provider will ensure that:

- their staff work together with other agencies in accordance with NLSCB or SAB policies and procedures. including use of agreed multi-agency assessments as the basis for early identification of needs.
- staff members who have, or become aware of, concerns about the safety or welfare of a child or adult know:
  - who to contact in what circumstances, and how; and
  - when and how to make a referral to local authority children or adult social care services or the police.
- if their staff have concerns that a child or adult is, or may be suffering harm, they will follow NLSCB/SAB procedures.

(For safeguarding children - NICE Clinical guideline 89 "When to suspect child maltreatment" (NICE, 2009) is an accessible resources which all staff should have available to use in everyday practice)

C2. The Provider will cooperate with any request from the LSCB/SAB to contribute to multi-agency audits, evaluations, investigations and reviews, including where required, the production of an individual management report.

C3. The Provider will ensure, they have, or have access to, appropriately experienced staff to conduct, any LSCB/SAB requested organisational review as part of multi-agency learning reviews; and those staff are adequately supported and provided with time to write reports, attend interviews and participate in the multi-agency review process

C4. The Provider will, where required by the LSCB/SAB, consider the organisational implications of any multiagency review(s) and will devise and submit an action plan to the responsible Safeguarding Board to ensure that any learning is implemented across the organisations.

C5. The Provider will ensure they are familiar with, and have arrangements in place, to respond to the death of a child, and the statutory child death review process.

C6. The Provider will ensure that any allegation, complaint or concern about abuse or neglect from any source is managed effectively and referred according to the local multi-agency safeguarding procedures.

C7. The Provider will have in processes in place to ensure their organisational safeguarding lead, **and** Named Professional(s) are informed, within 1 working day, of any incident (including SIs) or complaint relating to welfare or safeguarding of children or adults If the organisation is not an NHS Trust, the Provider ensures the **Designated Nurse for Safeguarding** is informed

C8. The Provider will be aware of CCGs responsibilities in respect to management of serious safeguarding incidents (as per section 6.6 of this policy) and as such should ensure the Designated Nurse is appropriately briefed in order for the CCG to fulfil its responsibilities.

C9. The Provider will be able to evidence that a root cause analysis is undertaken and serious incident declared for all acquired pressure ulcers of category 3 or 4 (including unstagable and deep tissue injury) and that a safeguarding alert is made where abuse or neglect are believed to be a contributory factor, according to local multiagency procedures.

C10. The Provider will be able to evidence the numbers and percentage of staff attendance at, and contribution to, safeguarding case conferences/strategy meetings where required as part of multiagency procedures.

C11. The Provider will, where required, ensure senior representation on the LSCB and SAB and contribute to their sub-groups; and will have demonstrable evidence of the effectiveness on outcomes in relation to: LSCB, SAB, sub-groups, training programmes, multi-agency case file audit processes and working with other agencies.

C12. The Provider will inform the relevant commissioner, **and** Designated Nurse for Safeguarding, of any significant safeguarding issues, including in circumstances where the child or adult is in a placement out of North Lincolnshire.

C13. In delivering services, the Provider will work collaboratively with the LSCB and SAB.

Additional standard for NHS Trusts / Foundation Trusts

C14. The Provider will ensure executive representation (Governing Body/ Trust Board lead) on the LSCB and SAB and contribution to their sub groups by senior members of staff.

Standard D: Recruitment and employment practice

D1. The Provider must ensure safe recruitment policies and practice which meet current NHS Employment Check Standards in relation to all staff, including those on fixed-term contracts, temporary staff, locums, bank staff, agency staff, volunteers, students and trainees.

D2. The Provider will ensure that post recruitment employment checks are repeated in line with all contemporary national guidance and legislation.

D3. The Provider must ensure that their employment practices meet the requirements of the Disclosure and Barring Service (DBS) and that referrals are made to the DBS and relevant professional bodies where indicated, for their consideration in relation to barring.

D4. The Provider should ensure that all job descriptions and contracts of employment (including staff on fixed-term contracts, temporary staff, locums, bank staff, agency staff, volunteers, students and trainees) include an explicit reference to staff responsibility for safeguarding children and adults.

D5. The Provider will have a named senior officer who has overall responsibility for ensuring the organisation operates procedures for dealing with allegations against members of staff, resolving any inter-agency issues & providing advice and liaison to staff/managers within the organisation

D6. The Provider will ensure they have information available to patients and their families in respect to expectations of staff behaviour.

D7. The Provider will ensure that all allegations in relation to harm to children against members of staff (including staff on fixed term contracts, temporary staff, locums, agency staff, bank staff, volunteers, students and trainees) are referred to the Local Authority Designated Officer (LADO) according to local multi-agency safeguarding procedures. Referral must also be made to the LADO in any situation where the provider is aware of allegations being made

against professionals who work with children who are not employed by the provider. This may include, for example, service users who are child care professionals in other organisations. When a referral is made to NLC LADO, by a health organisation, the Provider should also notify the Designated Nurse for Safeguarding

D8. The Provider will ensure that a referral is made to the Local Authority DASM (Designated Adult Safeguarding Manager) when a person in a 'position of trust' has or is alleged to have abused, neglected or harmed an adult with care and support needs; has behaved (or is alleged to have behaved) towards another adult in a way that indicates that they may pose a risk of harm to an adult with care and support needs or has behaved (or is alleged to have behaved) towards children in a way which means they may pose a risk of harm to adults with care and support needs. When a referral is made to NLC DASM, by a health organisation, the Provider should also notify the Designated Professional for Safeguarding.

D9. The Provider will ensure that all safeguarding concerns relating to a member of staff are effectively investigated, and that any disciplinary processes are concluded irrespective of a person's resignation, and that 'compromise agreements' are not be allowed in safeguarding cases. All allegations of abuse against staff, including where there is clear evidence that the allegation is false or malicious, will be recorded and monitored using the organisation's incident management /allegations against staff policy.

D10. The Provider will be able to demonstrate the uptake of staff appraisals, including volunteers.

Standard E: Training

For this section STAFF include all permanent employees, those on fixed-term contracts, temporary staff, contractors, locums, bank staff, agency staff, volunteers, students, apprentices and trainees

E1. The Provider will have a training strategy(ies)/ programme which includes requirements for Safeguarding Children, Safeguarding Adults, MCA & DOLS and PREVENT, and is compliant with

- NLSCB/ NLSAB strategy, and
- Safeguarding Children and Young People: Roles and Competencies for Health Care Staff Intercollegiate competency framework (Royal College of Paediatrics and Child Health et al 2014)
- on publication[13] Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document

E2. The Provider will ensure that all STAFF, have basic awareness of:

- safeguarding children and adult arrangements
- the principles of the Mental Capacity Act 2005 and consent, including the Deprivation of Liberty Safeguards,
- PREVENT

[13] This document was published in February 2016, but withdrawn for amendments in April 2016.

within 6 weeks of commencing employment. For those who provide direct care and treatment, training must be provided prior to any unsupervised work with service users.

E3. The Provider will hold comprehensive details of the uptake of all STAFF training, in order to inform a regular comprehensive training needs analysis to determine which groups of staff require more in depth safeguarding training (in accordance with their strategy/plan.

E4. The Provider will ensure a proportionate contribution to the delivery of multiagency training/educational programmes where available, as required by NLSCB/NLSAB.

E5. The Provider will enable and ensure/resource access for all STAFF (Level 3 (intercollegiate frameworks) and above) to multi-agency training provided by LSCB/SAB

E6. The Provider will have evidence to support effectiveness of training (e.g. post training evaluations, quarterly care record audits of incapacitated people where an MCA and best interest decision has been made).

Standard F: Prevent

F1. NHS Provider trusts will identify an Executive lead with responsibility for the Prevent strategy.

F2. The Provider will identify an Operational Lead for Prevent and ensure that they are appropriately authorised and resourced to deliver the required national and local standards.

F3. The Provider will inform commissioners of any changes to the Prevent leads as soon as practicable and, in any event, no later than ten operational days after the change.

F4. The Provider must have a policy/guidance which clearly sets out how to escalate Prevent concerns and make a referral. This policy/guidance must be accessible to all staff.

F5. The Provider must have a policy/guidance which is accessible to all staff, consistent with the Prevent guidance and the Prevent Toolkit.

F6. The Provider must have a training plan that identifies the Prevent related training needs for all staff, including a programme to deliver 'Health Workshop to Raise Awareness of Prevent (WRAP)' and sufficiently resource that programme with accredited Health WRAP facilitators.

F7. The Provider will ensure that implementation of the Prevent agenda is monitored through the Trust's audit cycle/governance reporting mechanisms.

F8. All providers delivering NHS services will submit a quarterly return to the NLCCG Prevent Lead to inform of their training figures and referrals.

6.6 Performance and monitoring of providers

Providers' performance in relation to safeguarding standards will be managed primarily through contract monitoring arrangements. Where in place, this will be through existing Contract Monitoring Meetings (CMM) and their sub groups.

Information will be forwarded by Providers to NLCCG on a quarterly or annual basis as indicated within the Self Declaration Template (Appendix 2), as applicable to each provider; and will include key findings from audits undertaken during the period of the review. The precise nature and frequency of reporting will be negotiated with the Provider, the Quality Lead and Designated Nurse for Safeguarding. Children, and

adults at risk should expect the same high standard of safeguarding from all providers regardless of

- the size of the organisation,
- whether the organisation is in the statutory, voluntary or independent sector or
- whether the service works primarily with children, adults or both.

The level of assurance that NLCCG require will be proportionate, taking into account a number of aspects including the potential risk to individuals and the larger the size of the contract, the more detailed and frequent the assurance requirements will be.

The contract leads are required to ensure the providers provide the information regarding safeguarding and Prevent to the Designated Nurse for Safeguarding in order for specialist consideration.

The Designated Nurse for Safeguarding will review and scrutinise all safeguarding quarterly and annual reports from Providers and make comments to the Quality Lead, and through contract management processes. Where a Provider is unable to demonstrate compliance with any adult and children safeguarding standards, they will produce an action plan with timescales that details steps to be taken to achieve compliance. This action plan will be monitored by the Quality Lead and the Designated Nurse for Safeguarding, through the contract management process. Providers will also be subject to performance management as set out in their contract.

NLCCG may require Providers to produce additional information regarding their safeguarding work, in order to monitor compliance with this policy, or emerging local or national priorities, including those identified by NLSCB or NLSAB

In addition to the standards required by this policy, legislation, national guidance or other stakeholders, NLCCG may also use local quality and incentive schemes (eg. CQUINS) to identify additional safeguarding standards or related targets for Providers.

NLCCG may receive and use information from other agencies and organisations where this is relevant to the performance management of the provider in relation to safeguarding. This may include information from:

- LSCB/SAB and / or their sub groups
- Police
- Service user / advocacy groups
- Local Authority Departments /Adult and Community Services
- NHS Providers and Contractors
- Care Quality Commission
- Care Homes
- OFSTED
- ADASS

The Designated Nurse for Safeguarding will provide safeguarding performance information to the NLCCG Quality Group, and an annual report summarising trends, unresolved risks and safeguarding activity from commissioned services.

Provider Boards, executive teams and management committees must regularly receive and scrutinise assurance that their organisation is monitoring its safeguarding performance and provision, and meeting its safeguarding obligations.

6.7 Sharing of information

NLCCG is committed to sharing information with other agencies, in a safe and timely manner, where this is necessary for the purposes of safeguarding adults and children, in accordance with the law and multiagency procedures. This may include personal and sensitive information. The "seven golden rules to sharing information" can be found at Appendix 9.

All providers of services commissioned by NLCCG are required to share information with other agencies, in a safe and timely manner, where this is necessary for the purposes of safeguarding, in accordance with the law and local multiagency safeguarding information sharing procedures. This may include personal and sensitive information about:

- the child or young person(s)at risk of or experiencing abuse
- the adult(s) at risk of or experiencing abuse
- family members of those experiencing or at risk of abuse
- staff
- members of the public

"The need to share confidential information becomes an absolute imperative in cases involving a threat to the safety of others" (HSIC 2013, p15); for example, to prevent the abuse of a vulnerable elderly person or child.

Where there is reasonable cause to believe a child is suffering, or is likely to suffer, significant harm, practitioners must share their information with children's social care following NLSCB procedures and consistent with legislation and Caldicott principles. In these cases it may be necessary to dispense with consent if gaining consent would put the safety of the child or another person at significant risk.

Where a North Lincolnshire registered resident is receiving care or treatment outside of the North Lincolnshire area, the care provider must inform the host authority (NLCCG/ North Lincolnshire Social Care) immediately of individuals affected by safeguarding concerns.

All Providers are required to share anonymised and aggregated data where requested, for the purposes of fulfilling contractual obligations, assurance and the monitoring and developing of safeguarding practice.

Safeguarding referrals/alerts from Providers, independent contractors and NLCCG may be monitored and information provided to the LSCB or SAB as appropriate.

6.8 Management of safeguarding serious incidents (SIs)

All safeguarding serious incidents (SIs) involving children and/or adults must be reported in accordance with NLCCG Serious Incidents, Incidents and Concerns Policy, as well as being managed and reported following the local multi-agency safeguarding adults and children processes.

All SI's in relation to vulnerable adults reported to NLCCG will be reviewed by the CCG SI Meeting and the Designated Nurse for Safeguarding to identify safeguarding concerns.

All safeguarding serious incidents in relation to children will be reported by the Designated Nurse for Safeguarding (or Patient Safety Lead in the Designated Nurse's absence) to NHS England via the STEIS system.

All safeguarding SI's will be performance managed by NHS England. NLCCG, through their Designated Professionals, will lead any investigations and the Providers will provide reports and attend meetings as required to a specific set timeline.

In cases where there is to be a Serious Case Review (SCR) /Domestic Homicide Review (DHR) the SCR/DHR and SI systems will run together and will follow LSCB /SAB and statutory guidance, updating NHS England according to their guidance.

Any member of NLCCG staff dealing with any claims, complaints, disciplinary or performance issues will be responsible for seeking advice regarding any safeguarding risks and making referrals, in accordance with the multi-agency procedures and this policy, where appropriate.

Professional oversight of all Serious Incidents and Incidents

The Designated Nurse for Safeguarding will receive notification of all **Serious Incidents** logged on STEIS for North Lincolnshire Providers. The Designated Nurse for Safeguarding will review the notifications, and where safeguarding children or adult issues are identified, will work with the Patient Safety Lead and attend/ advise the SI meeting as appropriate.

The Patient Safety Lead/ Quality Officer will monitor all **Incident** reports received by the CCG for potential safeguarding issues, and will request review by the Designated Nurse for Safeguarding as required.

6.9 Allegations against staff

NLCCG will ensure that it adheres to legislation and statutory guidance in managing allegations against staff which indicate they may pose a risk to children or vulnerable adults. Such allegations may arise if it is felt that a person who works with children/vulnerable adults has:

- Behaved in a way that has harmed a child/vulnerable adult, or may have harmed a child or vulnerable adult
- Possibly committed a criminal offence against or related to a child/vulnerable adult
- Behaved towards a child/vulnerable adult in a way that indicates they may pose a risk of harm to children/vulnerable adults

All allegations of abuse against staff must be managed according to LSCB or SAB procedures as appropriate.

All allegations that a member of staff has, or may have, caused or been complicit in abuse or neglect of a child, or an adult with care and support needs (i.e. where there is no immediate evidence that it is false) must be notified to the Designated Nurse – Safeguarding, who will support further activity required. If the absence of the Designated Nurse – Safeguarding, the Executive Lead for Safeguarding, the Director of Primary Care or the Head of Nursing must be contacted. In accordance with multiagency safeguarding procedures, discussions may be required with:

- for concerns regarding children, the Local Authority Designated Officer (LADO)
- for concerns regarding adults, the Adult Access and Protection Team (APT)

A link to the contact details for the LADO and APT can be found in Appendix 1.

In line with LSCB/SAB procedures, if there is clear and immediate evidence that an allegation is false/ malicious, the reasons for not undertaking any further investigation must be stated/recorded, along with any other measures taken to manage risks. A history of making allegations does not constitute evidence that an allegation is false.

CCG managers and commissioned services must also consider the need for temporary exclusion, suspension or redeployment under the disciplinary policy based on potential risk to the alleged victim whilst investigation takes place.

The CCG and Providers will ensure that all other concerns relating to the conduct or capability of staff are monitored and that any safeguarding related concerns are managed in accordance with this policy and local multi-agency procedures, and full records of investigations undertaken, and decisions made are recorded in relevant staff files and retained in accordance with LSCB/ SAB processes, and HR legal framework.

The CCG and Providers will ensure that any safeguarding concerns arising from disclosures made during the course of an investigation or other Human Resources process are managed in accordance with this policy and local multi-agency procedures.

Any instances where there is an allegation that a service user has suffered abuse from a member or staff, or volunteer, whilst in receipt of services must be notified to CQC in accordance with the Regulation 18[14].

6.10 Training for CCG Staff

NLCCG is responsible for ensuring that all of its staff are competent and confident in carrying out their responsibilities for safeguarding and promoting vulnerable adults and children's welfare.

NLCCG will ensure it meets the requirements of associated guidance in respect of training requirements, i.e.

- Working Together to Safeguard Children (2015)
- Safeguarding children and young people: roles and competencies for health care staff – Intercollegiate Document (Royal College of Paediatrics and Child Health 2014)
- on publication[15] Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document

See Appendix 5 for an outline of training required for CCG staff.

It is the responsibility of the line manager to ensure that evidence of training completion is retained in the personnel file and the training database updated accordingly.

As a minimum staff training must be reviewed by the line manager at each appraisal point.

The partnership board, as part of the annual report, will receive number of staff with in date training etc… This will allow for monitoring and assurance at board level.

7. ROLES / RESPONSIBILITIES / DUTIES

The responsibilities of commissioning health organisations are set out in the NHS England Safeguarding Vulnerable People in the NHS - Accountability and Assurance

[14] Care Quality Commission (Registration) Regulations 2009 (Part 4)
[15] This document was published in February 2016, but withdrawn for amendments in April 2016.

Framework (2015). Where arrangements in North Lincolnshire differ from those set out in the aforementioned document they are explicitly outlined in the sections below.

The responsibilities and duties of particular roles within CCGs are set out in the Accountability and Assurance Framework, and the Intercollegiate competency document(s) for Safeguarding Children and Adults.

7.1 All Clinical Commissioning Group staff

Safeguarding children and adults with care and support needs is everyone's responsibility under the Children Act 1989/2004, and the Care Act 2014.

All NLCCG staff (or those working on behalf of NLCCG) must adhere to this policy and undertake safeguarding children and safeguarding adults training commensurate with their roles.

Staff involved in the

- Commissioning of Services
- Monitoring of Contracts

must make themselves aware of section 7.3 below.

Those with line management responsibility should ensure that their staff have access to, are aware of and adhere to this policy. They should also assure themselves that their staffs' safeguarding children and safeguarding adult competences are reviewed appropriately within their annual appraisal.

7.2 Clinical Commissioning Groups (CCGs)

CCGs as commissioners of local health services need to assure themselves that the organisations from which they commission have effective safeguarding arrangements in place.

CCGs are responsible for securing the expertise of Designated Professionals on behalf of the local health system. It should be recognised that the Designated Professionals and Adult Safeguarding Leads undertake a whole health economy role. It is crucial that Designated Safeguarding Professionals play an integral role in all parts of the commissioning cycle, from procurement to quality assurance if appropriate services are to be commissioned that support adults at risk of abuse or neglect, and children, as well as effectively safeguard their well-being.

Safeguarding forms part of the NHS standard contract (service condition 32) and commissioners will need to agree with their providers, through local negotiation, what contract monitoring processes are used to demonstrate compliance with safeguarding duties.

CCGs must gain assurance from all commissioned services, both NHS and independent healthcare providers, throughout the year to ensure contractual requirements are met by the provider, to ensure a quality service is delivered and to facilitate continuous improvement. Assurance may consist of, but is not limited to; assurance visits; section 11 audits and attendance at provider safeguarding committees.

CCGs are also required to demonstrate that they have appropriate systems in place for discharging their statutory duties in terms of safeguarding. These include:

- A clear line of accountability for safeguarding, properly reflected in the CCG governance arrangements, i.e. a named executive lead to take overall leadership responsibility for the organisation's safeguarding arrangements.

- Clear policies setting out their commitment, and approach, to safeguarding including safe recruitment practices and arrangements for dealing with allegations against people who work with children and adults as appropriate.
- Training their staff in recognising and reporting safeguarding issues, appropriate supervision and ensuring that their staff are competent to carry out their responsibilities for safeguarding.
- Effective inter-agency working with local authorities, the police and third sector organisations which includes appropriate arrangements to cooperate with local authorities in the operation of LSCBs, SABs and Health and Wellbeing Boards.
- Ensuring effective arrangements for information sharing.
- Employing, or securing, the expertise of Designated Doctors and Nurses for Safeguarding Children and for Looked After Children and a Designated Paediatrician for unexpected deaths in childhood.
- Employing a lead role for Adult Safeguarding and a lead for the MCA, supported by the relevant policies and training.
- Effective systems for responding to abuse and neglect of adults.
- Supporting the development of a positive learning culture across partnerships for safeguarding adults to ensure that organisations are not unduly risk averse.
- Working with the local authority (LA) to enable access to community resources that can reduce social and physical isolation for adults.

The role of CCGs is also fundamentally about working with others to ensure that critical services are in place to respond to children and adults who are at risk or who have been harmed, and it is about delivering improved outcomes and life chances for the most vulnerable. CCGs need to demonstrate that their Designated Clinical Experts (children and adults), are embedded in the clinical decision making of the organisation, with the authority to work within local health economies to influence local thinking and practice.

<u>CCGs and Designated Professionals</u>

CCGs are responsible for securing the expertise of Designated Professionals on behalf of the local health system, irrespective of commissioner, or provider. Therefore, it is expected that many Designated Professionals will be employed by CCGs. In some areas there will be more than one CCG per local authority and LSCB/SAB area, and CCGs may want to consider developing 'lead' or 'hosting' arrangements for their Designated Professional team, or a clinical network arrangement. Where a Designated Professional (most likely a Designated Doctor for Safeguarding or a Designated Professional for Looked After Children) is employed within a provider organisation, the CCG will need to have a Service Level Agreement (SLA), with the provider organisation that sets out the practitioner's responsibilities and the support they should expect in fulfilling their designated role.

Whatever arrangements are in place for securing the expertise of Designated Professionals it is vital that CCGs enable and support Designated Professionals to fulfil their system-wide role.

7.3 Staff involved in commissioning services or monitoring contracts.

These staff need to

- ensure and provide evidence that the voice, wishes and feelings of children, and adults with care and support needs are reflected in the development of commissioned services.
- work with the Designated Nurse for Safeguarding at all stages of the commissioning cycle, from procurement to quality assurance in order to ensure appropriate services are commissioned that support adults at risk of abuse or

neglect, and children, as well as effectively safeguard their well-being. A link to the contacts for this individual can be found at Appendix 1

- ensure the standards outlined in section 6.5 of this policy are included within contracts of all commissioned services
- ensure Provider reporting of safeguarding arrangements on an Annual and Quarterly basis as outlined in section 6.6 of this policy.

7.4 CCG Chief Officer

The Chief Clinical Officer has overall responsibility for ensuring that the CCG discharges its responsibilities in accordance with the Care Act 2014 and Section 11 of the Children Act 2004.

The Chief Clinical Officer has overall (executive) responsibility for Safeguarding/ strategy and policy with additional leadership being provided at board level by the executive director with the lead for safeguarding – Director of Quality and Nursing.

The Chief Clinical Officer must provide strategic leadership, promote a culture of supporting good practice with regard Safeguarding within the organisations and promote collaborative working with other agencies.

Key Responsibilities of the Chief Officer

The RCPCH (2014) outline the role and responsibilities of Chief Executive Officers/ Accountable Officers, amended below to reflect safeguarding of both children and adults:

- To ensure that the role and responsibilities of the governing body in relation to Safeguarding are met
- To ensure that the organisation adheres to relevant national guidance and standards for Safeguarding
- To promote a positive culture for safeguarding to include: ensuring there are procedures for safer staff recruitment; whistle blowing; appropriate policies for safeguarding (including regular updating); and that staff and patients are aware that the organisation takes safeguarding seriously and will respond to concern about the welfare of children and adults.
- To appoint an Executive Director lead for safeguarding
- To ensure good Safeguarding practice throughout the organisation
- To ensure there is appropriate access to advice from Designated professionals
- To ensure that operational services are resourced to support/respond to the demands of Safeguarding effectively
- To ensure that an effective Safeguarding training and supervision strategy is resourced and delivered
- To ensure and promote appropriate, safe, multiagency//interagency partnership working practices and information sharing practices operate within the organisation

7.5 Clinical Commissioning Group Governing Body

NLCCG Governing Body is responsible for the oversight of safeguarding arrangements within the organisation; and is responsible for reviewing and maintaining an effective system of internal control, including systems and resources for managing all types of risk associated with safeguarding children and adults with care and support needs.

In order to ensure effective administration of this function, the Governing Body has delegated the task of ratifying and approval of policies and procedures to its formal sub-committees.

The Royal College of Paediatrics and Child Health document (2014) 'Safeguarding Children and Young people': roles and competencies for health care staff, published in April 2014, outlined the roles and responsibilities for governing bodies of health organisations, and for key individuals. A similar document is awaited for Safeguarding Adults. This policy will be updated to reflect this accordingly.

The Governing Body is under a duty to make arrangements to ensure that, in discharging their functions, they have regard to the need to safeguard and promote the welfare of children and adults with care and support needs. This includes ensuring appropriate arrangements are in place for the CCG to fulfil their critical role in quality assuring providers systems and processes, and thereby ensuring they are meeting their safeguarding responsibilities

The Governing Body needs to review all safeguarding arrangements on an annual basis as a minimum.

7.6 Chair

The Chair of the Governing Body is responsible for the effective operation of the Board with regard to Safeguarding Adults and children and young people.

Key Responsibilities for Chairs

The RCPCH (2014) outlines the role and responsibilities of Chairs, amended below to reflect safeguarding of both children and adults:

- To ensure that the role and responsibilities of the Governing Body in relation to Safeguarding are met
- To promote a positive culture of safeguarding across the Board through assurance that there are procedures for safer recruitment; whistle blowing; Prevent; appropriate policies for safeguarding and that these are being followed; and that staff and patients are aware that the organisation takes safeguarding seriously and will respond to concerns about the welfare of children and/or adults with care and support needs.
- To ensure that there are robust governance processes in place to provide assurance on safeguarding.
- To ensure good information from and between the organisation board or board of directors, committees, council of governors where applicable, the membership and senior management on safeguarding.

7.7 Executive Lead for Safeguarding

Whilst the Chief Officer retains the overall responsibility for Safeguarding Children and Adults, as with many other CCGs, and identified as good practice in the RCPCH (2014) document, much of the functional responsibility is delegated to an Executive Lead for Safeguarding Children. The Executive Lead provides leadership in the long term strategic planning for Safeguarding services supported by the Designated professionals. For NLCCG this is the Director of Risk and Quality Assurance (Chief Nurse).

Governing Bodies are also encouraged by the ICCFC to appoint a "Non Executive Director" board member to ensure the CCG discharges its safeguarding responsibilities appropriately and to act as a champion for children and young people. **Note:** NLCCG has Lay Members on their Governing Body who act as Non Executive Directors. One of the Lay Members provides independent challenge to CCG officers and quality/ governance arrangements in respect of safeguarding arrangements.

Key Responsibilities of the Executive Lead for Safeguarding

The Intercollegiate Competency Framework (RCPCH, 2014) outlines the role and responsibilities of the Executive Lead amended below to reflect safeguarding of both children and adults:

- To ensure that safeguarding is positioned as core business in strategic and operating plans and structures
- To oversee, implement and monitor the on-going assurance of safeguarding arrangements
- To ensure the adoption, implementation and auditing of policy and strategy in relation to safeguarding
- To ensure the appointment of Designated Professionals
- To ensure that provider organisations are quality assured for their safeguarding arrangements
- To ensure support of Named/Designated professionals across primary and secondary care and independent practitioners to implement safeguarding arrangements
- To ensure that there is a programme of training and mentoring to support those with responsibility for safeguarding
- Working in partnership with other health organisations and partner agencies to secure high quality, best practice in safeguarding
- To ensure that serious incidents relating to safeguarding are reported immediately and managed effectively

Key Responsibilities of the Lay Member Board lead

- To ensure appropriate scrutiny of the Organisation's safeguarding performance
- To provide assurance to the Governing Body of the Organisation's safeguarding performance

7.8 Designated Professionals for Safeguarding

Under the requirements outlined in the NHS England Accountability and Assurance Framework (2015), CCGs are required to secure the expertise of a Designated Nurse and Doctor for Safeguarding Children, and a Designated Professional for Safeguarding Adults.

The Designated Doctor for Safeguarding Children for NLCCG is a Consultant Paediatrician employed by Northern Lincolnshire and Goole NHS Foundation Trust, with a Service Level Agreement in place with NLCCG to provide the Designated Doctor function.

NLCCG directly employs a Designated Nurse for Safeguarding Children and Adults. The Designated Nurse works closely with the Designated Nurse for North East Lincolnshire CCG, to ensure the availability of specialist expertise at times of leave.

The Designated Nurse and Doctor job descriptions are in keeping with the RCPCH led intercollegiate competency framework, and NHS England Intercollegiate Document 2016[16]:

The Designated Professional's role is to work across the local health system to support other professionals in their agencies on all aspects of safeguarding.

[16] Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document This document was published in February 2016, but withdrawn for amendments in April 2016.

Designated Professionals are clinical experts and strategic leaders for safeguarding and as such are a vital source of advice and support to

- health commissioners in
  - CCGs,
  - the local authority and
  - NHS England,
- other health professionals in provider organisations,
- quality surveillance groups (QSG),
- regulators,
- the LSCB/SAB and
- the Health and Wellbeing Board.

Designated professionals are directly responsible to and accountable to the Executive Lead for Safeguarding in supporting all activities necessary to ensure that North Lincolnshire health economy meet their responsibilities in safeguarding including policy document development and performance scrutiny/management.

<u>Designated Professionals – Safeguarding Children</u>

- The CCG representative at the LSCB must be accompanied by their Designated Professional to ensure their professional expertise is effectively linked into the local safeguarding arrangements.
- Designated Professionals are responsible for undertaking serious case reviews/ case management reviews/significant case reviews on behalf of health commissioners and for quality assuring the health content.
- Designated Professionals must be consulted and able to influence at all points in the commissioning cycle to ensure all services commissioned meet the statutory requirement to safeguard and promote the welfare of children.
- Designated Professionals are responsible for providing expert advice to HEE and Local Education and Training Boards to ensure that the principles of safeguarding are integral to education and training curricula for health professionals.
- Designated Professionals are expected to give clinical advice, for example in complex cases or where there is dispute between practitioners.
- Clear accountability and performance management arrangements are essential. These need to account for the particular working arrangements but key elements of this are:
  - As single subject experts, peer-to-peer supervision is vital to ensuring Designated Professionals continue to develop their practice in line with agreed best practice. Designated Professionals are required to attend supervision meetings regularly with a lack of attendance raised as a professional concern in the annual appraisal and review process. These supervision meetings are to be formally minuted and preferably professionally facilitated.
  - The Designated Professional must have direct access to the Executive (Board level) Lead to ensure that there is the right level of influence of safeguarding on the commissioning process.
  - The CCG Accountable Officer (or other executive level nominee) should meet regularly with the Designated Professional to review child safeguarding.
  - Where Designated Doctors, in particular, are continuing to undertake clinical duties in addition to their clinical advice role in safeguarding, it is important that there is clarity about the two roles and the CCG will need to be able to input into the job planning, appraisal and revalidation processes. Designated Doctors may liaise with the Regional Medical Director on those occasions that need solely medical professional consideration.

Designated Professional – Safeguarding Adults

The role of the Designated Professional – Safeguarding Adults is to:

- support all activity required to ensure that the organisation meets its responsibilities in relation to safeguarding adults.
- offer support and advice to the Board member responsible for adult safeguarding.
- ensure the regular provision of training to the staff and Board of the CCG.
- be a source of expertise and advice to those working in the CCG.
- be able to advise the local authority, police and other organisations on health matters in relation to adult safeguarding.
- Responsibility for the management and oversight of individual complex cases.
- Contributing to the coordinated multi-agency response, and robust organisational recording, where allegations are made, or concerns raised, about a person in a position of trust, 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.
- Support and advise commissioners, including CCGs, NHS England and public health, at all points in the commissioning cycle to ensure all services commissioned meet the statutory requirement to safeguard and promote the welfare of adults with care and support needs. 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, representing NHS England, if required, and ensuring health service contribution to all subcommittees of the SAB
- Take a lead for health in working with the SAB to undertake safeguarding adult reviews on behalf of health commissioners, quality assuring the health content and taking forward any learning for the health economy.

Designated Professionals for Looked After Children and Sudden Unexpected Death in Childhood.

CCGs are required to secure the expertise of a Designated Nurse and Designated Doctor for Looked After Children and a Designated Paediatrician for Sudden Unexpected Death in Childhood.

The Designated Doctor and Nurse for Looked after Children assist commissioning health organisations in fulfilling their responsibilities as commissioner of services to improve the health of Looked After Children[17]. The Designated Doctor is a Consultant Paediatrician, and the Designated Nurse is a senior nurse employed by Northern Lincolnshire and Goole NHS Foundation Trust, with a Service Level Agreement in place with NLCCG to provide the Designated functions. The Designated Nurse and

[17] those in the care of North East Lincolnshire (or other) Councils

Doctor job descriptions are in keeping with Statutory Guidance on Promoting the Health and Well-being of Looked After Children[18]

Each commissioning health organisation needs to ensure that the LSCB, acting through the Child Death Overview Process, has access to a consultant paediatrician whose designated role is to provide advice on and coordinate the paediatric/ medical investigative response to the unexpected death of a child. This access is provided by Northern Lincolnshire and Goole NHS Foundation Trust. This is delivered by the Consultant Paediatrician on call at the time of a child's unexpected death, with the advice and coordination of the responses by the Designated Doctor for Safeguarding Children.

7.9 Named Doctor (GP) for Safeguarding

The Named Doctor (GP) for Safeguarding Children and Adults support the CCGs in their quality, governance and safeguarding role by providing advice and support for General Practice staff; and promoting good information sharing practice and contributing to safeguarding processes within General Practice and supporting the investigation of serious safeguarding incidents through undertaking individual management reviews when required.

7.10 Governance Framework

The Quality Group receives monthly briefing reports from the Designated Nurse for Safeguarding on compliance with safeguarding children and adults standards across the health economy. Exception reports on key risks or developments will be escalated to the Governing Body by the Executive Lead for Safeguarding.

The Governing Body receives an Annual Report prepared by the Designated Nurse for Safeguarding which also sets out the Action Plan/Strategy for the forthcoming year.

7.11 Implementation

Staff will be made aware of this policy through briefing(s) Any previous copy of either Safeguarding Children or Adult Policies will be removed from the website and replaced with this document.

8. TRAINING & AWARENESS

Staff will be made aware of this policy through briefing within the staff newsletter, and the document will be available on the website.

9. MONITORING & AUDIT

The approved policy will be submitted to the North Lincolnshire Safeguarding Children and Adult's Boards.

Information on monitoring of, and compliance with, this policy will be included in the bi-monthly governance, and annual report(s) from the Designated Nurse for Safeguarding which will be reported to the NLCCG Quality Group. Once agreed, the Annual Report(s) will be submitted to LSCB and SAB.

10. POLICY REVIEW

This policy will be reviewed one year after ratification. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation/guidance, as identified by the Designated Professionals, or Executive Lead for Safeguarding.

11. REFERENCES

ADASS (2005), Safeguarding Adults: A National Framework for Standards for Good Practice and Outcomes in Adult Protection Work.

Care Act 2014, HMSO

Care and Support Statutory Guidance Issued under the Care Act 2014 Department of Health (February 2016)

Care Quality Commission (2015) Regulation 13: Safeguarding service users from abuse and improper treatment

Children Act 1989, HMSO

Children Act 2004, HMSO

HM Government (2015) Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers

HM Government (2015) Working Together To Safeguard Children

HSIC 2013 *A Guide to Confidentiality in Health and Social Care'* http://www.hscic.gov.uk/3444

Mental Capacity Act (2005)

Mental Capacity Act 2005: Code of Practice (Department for Constitutional Affairs 2007)

Mental Health Act (2007)

National Institute for Clinical Excellence (NICE) (2009) Clinical Guideline 89: *When to suspect child maltreatment*

NLCCG Serious Incidents, Incidents and Concerns Policy

NLSCB (2016) Safeguarding Arrangements for Escalation
http://www.northlincslscb.co.uk/EasySiteWeb/GatewayLink.aspx?alId=31750

NHS England (2016) Safeguarding Adults: Roles and competencies for health care staff – Intercollegiate Document on publication *This document was published in February 2016, but withdrawn for amendments in April 2016*

North Lincolnshire Safeguarding Adults Board Policy and Procedures
http://www.northlincs.gov.uk/EasySiteWeb/GatewayLink.aspx?alId=24928

North Lincolnshire Safeguarding Children Board Procedures and Guidance
http://www.northlincslscb.co.uk/professionals/policies/

Prevent Duty Guidance (2015) The Home Office

Protecting Children and Young People: the responsibilities of all doctors, GMC (2012)

RCN and RCPCH (2012) Looked After Children: Knowledge, skills and competences of healthcare staff,

RCPCH (2014) Safeguarding Children and Young people: roles and competences for health care staff (Intercollegiate competency framework)

Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework (2015)

Serious Crimes Act (2015

Statutory Guidance on promoting the Health and well-being of Looked After Children (DH 2009)

The Counter-Terrorism and Security Act (2015)

APPENDICES

APPENDIX 1: Key Contacts – North Lincolnshire

North Lincolnshire CCG

Clare E. Linley	Executive Lead for Safeguarding	clare.linley@nhs.net 01652 251058
Sarah Glossop	Designated Nurse & Head of Safeguarding	Sarah.glossop@nhs.net 07789 615434
Sally Bainbridge	Specialist Nurse – Safeguarding	Sally.bainbridge3@nhs.net 07702 975637
Julie Wilburn	Designated Nurse – Safeguarding (North East Lincolnshire CCG)	Julie.wilburn@nhs.net 07702 975584
Dr Suresh Nelapatla	Designated Doctor for Safeguarding Children	suresh.nelapatla@nhs.net 01724 282282
Dr Jailosi Gondwe	Designated Doctor – Looked After Children	Jailosi.gondwe@nhs.net 01724 282282
Designated Paediatrician – SUDIC[19] – Rapid Response	Rapid Response On call consultant Paediatrician of the week Strategic Oversight Designated Doctor – Safeguarding Children	01724 282282
Dr Robert Jaggs-Fowler	Named GP – Safeguarding Children and Adults	Robert.jaggs-fowler@nhs.net

[19] Sudden Unexpected Death in Childhood

Other Services

Children

For referrals where a CHILD is suffering or at risk of Harm	North Lincolnshire Children's Social Work Services **Single Access Point**	01724 296500
For allegations that a member of staff has, or may have, caused or been complicit in abuse or neglect of a CHILD	**Jodie Turner** Local Authority Designated Officer: (LADO)	01724 296101
North Lincolnshire Safeguarding Children Board (NLSCB)	**Nikki Alcock** LSCB Business Manager	01724 296101

Adults

For referrals where an ADULT is suffering or at risk of Harm	North Lincolnshire Adult Social Work Services **Single Access Point**	01724 297000
For allegations that a member of staff has, or may have, caused or been complicit in abuse or neglect of an ADULT	**Marion Davison** Designated Adult Safeguarding Manager (DASM)	01724 297979
North Lincolnshire Safeguarding Adult Board (NLSAB)	**Helen Rose** SAB Manager	01724 298031

Children or Adults

Humberside Police	Except in an emergency when 999 should be used For concerns about harm to a child or adult, or for PREVENT referrals, or reporting FGM – use 101

Prevent Contacts

Clare E. Linley	Executive Lead for PREVENT	clare.linley@nhs.net 01652 251058
Stuart Minto	Local CHANNEL lead	Stuart.minto@northlincs.gov.uk
Chris Stoddart	Regional PREVENT lead	07909 097769 Chris.stoddart@nhs.net

APPENDIX 2: Self Declaration : Safeguarding Adults and Children

Provider ..... Completed by..... Date .....

RED: Not Compliant. AMBER: Partially Compliant. GREEN: Fully Compliant

ANNUAL Declaration

The requirements listed apply to ALL providers of health services unless otherwise indicated

No	Requirement	Evidence of Compliance	RAG rating
Policy, Procedures, Organisational Systems			
1	The Provider has up to date organisational safeguarding policies and procedures, consistent with relevant legislation, which reflect and adhere to the Local Safeguarding Children Board (LSCB) and Safeguarding Adults Board (SAB) policies. Evidence of review dates and policy development.		
2	The Provider has organisational safeguarding policies and procedures which give clear guidance on how to recognise and refer child / adult safeguarding concerns and ensure that all STAFF[20] have access to the guidance and know how to use it.		
3	The Provider's policies include as relevant: • the management of differences of opinion between agencies and between health professionals, including escalation of concerns • the management of discharge from in-patient units when there are child/adult protection concerns • checking for and encouraging registration with a GP • the management and follow up of no access and missed appointments. • managing cases or suspicions of fabricated induced illness in children, or adults		

[20] all employees (including those on fixed-term contracts), temporary staff, bank staff, locums, agency staff, contractors, volunteers (including celebrities), students, apprentices and any other learners undertaking any type of work experience or work related activity

	• a process that outlines when, and how, A&E/unscheduled care staff should check whether a child or adult is subject to multi-agency activity to safeguard their welfare, including: – a child protection plan, – adult safeguarding plan – MARAC arrangements – arrangements under PREVENT – a process which allows for the appropriate recording of information where individuals are subject to MAPPA		
4	The Provider has ensured that all other corporate and clinical policies, where appropriate, include reference and **duties to safeguard children** for staff who work primarily with adults. This will include the need to be mindful of adult issues that affect children's wellbeing such as; parental or carer mental ill health, domestic abuse, alcohol or substance misuse and adults who may pose a risk to children for any other reason.		
5	The Provider has ensured that all other corporate and clinical policies with relevance to safeguarding adults with care and support needs are consistent with and referenced to safeguarding legislation, national policy/guidance and local multiagency safeguarding procedures with candour and openness.		
6	The Provider has ensured that Prevent is embedded in all safeguarding policies		
7	The Provider has a policy/ procedure which is consistent with national Prevent guidance, and clearly states how to escalate Prevent concerns and make a referral to Channel processes. This policy is accessible to all staff.		
8	The Provider has ensured that all policies and procedures are consistent with legislation / guidance in relation to Mental Capacity Act 2005 and consent, and that staff practice in accordance with these policies.		
9	The Provider has an up to date 'whistle-blowing'/ Raising Concerns procedure, which is referenced to local multiagency procedures and covers arrangements for staff to express concerns both within the organisation and to external agencies. The Provider has systems in place and can evidence that all staff are aware of their duties, rights and legal protection, in relation to whistle-blowing/Raising Concerns and that they will be supported to do so.		

10	The Provider's policies include provisions for • investigating all safeguarding concerns relating to a member of staff, and concludes any disciplinary processes irrespective of a person's resignation, recognising that **'compromise agreements' are not be allowed in safeguarding cases**, and • ensuring all allegations of abuse against staff, including where there is clear evidence that the allegation is false or malicious, are recorded and monitored using the organisation's incident management /allegations against staff policy		
11	**For Care Homes and Hospitals** The Provider has an up to date policy and procedure covering the Deprivation of Liberty Safeguards 2009. This will include evidence to demonstrate that staff practice in accordance with the legislation and will reflect the Winterbourne View concordat and CIPOLD objectives.		
12	**For Care Homes and Hospitals** The Providers has an up to date policy(s) and procedure(s) covering the use of all forms of restraint. These policies and procedures must adhere to contemporary best practice and legal standards.		
13	The Provider has an up-to-date clinical/professional supervision policy in place that references safeguarding considerations where appropriate.		
14	The Provider has an up-to-date safeguarding children/ adult supervision policy which ensures that all staff working directly with • children and families, young people, • adults who are parents/carers, • adults with care and support needs, and • specialist / lead safeguarding practitioners and • staff line managing these groups have access to planned (and protected) safeguarding supervision at least quarterly.		
15	The Provider has systems in place to evidence that staff are aware of how to contact Named Professionals for their organisation, **and** Designated Professionals.		
16	The Provider has relevant policies and procedures in place to ensure appropriate access to advocacy within the care setting, including use of statutory advocacy roles. These policies and procedures must adhere to contemporary best practice and legislation. This		

	should include guidance on legal support available where required.		
17	The Provider includes in their policies and procedures clear guidance on the requirement to provide Early Help (i.e. resolving issues at the earliest point, to prevent escalation) for children, families, adults with care and support needs.		
18	The Provider has in place, or have adopted LSCB and SAB policies/procedures for sharing information where there are concerns for the welfare of a child or adult with care and support needs.		
19	The Provider has flagging/ alert systems in place to identify Children in Need, including in need of protection, Looked After Children, and adults at risk due to their care and support needs.		
Governance - Leadership			
20	**For NHS Bodies/ Trusts** The Provider has a Board-Level executive Director with lead responsibility for safeguarding.		
21	**For providers who are not NHS Bodies/Trusts** The Provider has a Senior manager with lead responsibility for safeguarding. This individual is able to • speak for their organisation with authority; • commit the organisation on policy and practice matters.		
22	**For all health providers** The Provider has (a) named professional (s) for safeguarding adults with sufficient capacity to effectively carry out these roles		
23	**For NHS Trusts, NHS Foundation Trusts public & voluntary sector, independent sector and social enterprises** The Provider has a Named Doctor and Nurse for Safeguarding Children in place with person specification, and job descriptions compliant with Safeguarding Children and young people: roles and competencies for health staff (2014), and sufficient capacity to carry out these roles.		

24	**For out of Hours services, independent providers and ambulance Trusts** The Provider has a Named Professionals for Safeguarding Children in place with person specification, and job descriptions compliant with Safeguarding Children and young people: roles and competencies for health staff (2014), and sufficient capacity to carry out these roles.		
25	**For providers of maternity services** The Provider has a Named Midwife for Safeguarding Children in place with person specification, and job descriptions compliant with Safeguarding Children and young people: roles and competencies for health staff (2014), and sufficient capacity to carry out these roles.		
26	The Provider has a Named health or social care professional with lead responsibility for ensuring the effective implementation of the Mental Capacity Act and Deprivation of Liberty Safeguards.		
27	The Provider has an Executive lead with responsibility for the Prevent strategy		
28	The Provider has an Operational Lead for Prevent and ensures that they are appropriately authorised and resourced to deliver the required national and local standards.		
Governance - Systems			
29	The Provider has a Board/ governing body level review of the effectiveness of the organisations safeguarding arrangements at least annually and will identify any risks, service improvement requirements and learning points as well as areas of good practice.		
30	The Provider produces an Annual Report of the effectiveness of their safeguarding arrangements which is received and approved by their Board/governing body		
31	The Provider has an effective system for identifying and recording safeguarding concerns, patterns and trends through its governance arrangements including; risk management systems, patient safety systems, complaints, PALS and human resources functions, and that these are shared appropriately according to multiagency safeguarding procedures.		

32	The Provider identifies and analyses the number of safeguarding incidents identified by the above processes, that includes concerns of abuse or neglect and include this information in their Annual safeguarding report.		
33	The Provider has systems for capturing the experiences and views of service users in order to identify potential safeguarding issues and relevant service development needs.		
34	The Provider undertakes an annual audit on adherence to record keeping and safeguarding policies, including Routine Enquiry (where appropriate) and demonstration of effective information sharing.		
35	**For Care Homes and Hospitals** The Provider has effective systems for recording and monitoring Deprivation of Liberty applications to the authorising body/Court of protection.		
36	The Provider has evidence of annual audit programmes to assure itself that safeguarding systems and processes, are working effectively**,** including • supervision and training, • ensuring practices are consistent with the Mental Capacity Act (2005). • quality of referrals made to children/ adults social care • dip sampling and some element of case tracking where appropriate. The Provider includes this information in their Annual safeguarding report.		
37	**For Mental Health organisations** The Provider will be able to evidence the number of assessments using the Mental Health Clustering Tool (MHCT) and referrals as a result with trend analysis		
Multi-agency Working & Responding to Concerns			
38	The Provider actively promotes their staff working together with other agencies in accordance with NLSCB or SAB policies and procedures, including use of agreed multi-agency assessments as the basis for early identification of needs, and ensure staff understand thresholds for referral to other agencies.		
39	The Provider has arrangements in place, to respond to the death of a child, and the statutory child death review process, including contibuting relevant information in respect to significant adults		

40	The Provider has appropriate systems in place to respond to any allegation, complaint or concern about abuse or neglect from any source and ensure it is managed effectively and referred according to the local multi-agency safeguarding procedures, including "Out of Hours"		
41	The Provider has systems in place to ensure their organisational safeguarding lead, **and** Named Professional(s) are informed, of any incident (including SIs) or complaint relating to welfare or safeguarding of children or adults with care and support needs within 1 working day.		
42	The Provider has systems in place to ensures the • **Designated Nurse for Safeguarding Children** or • **Designated Professional for Safeguarding Adults** is informed of any incident which meets (or may meet) the criteria for a Safeguarding Serious Incident within 1 working day of identification.		
43	The Provider has appropriate representation on the LSCB and SAB.		
44	The Provider has evidence of its effectiveness in contributing to • LSCB and SAB priorities, • sub-group activity, • training programmes, • multi-agency case file audit processes and • working with other agencies		
45	**For NHS Trusts/ Foundation Trusts***:* The Provider has Governing Body/Trust Board lead on the LSCB and SAB and contribution to their sub groups by senior members of staff		
Recruitment and employment			
46	The Provider has safe recruitment policies and practice which meet the NHS Employment Check Standards in relation to all staff, including those on fixed-term contracts, temporary staff, bank staff, locums, agency staff, volunteers, students and trainees are in place.		
47	The Provider ensures that post recruitment employment checks are repeated in line with all contemporary national guidance and legislation.		

48	The Provider has employment practices which meet the requirements of the Disclosure and Barring Service (DBS) and that referrals are made to the DBS and relevant professional bodies where indicated, for their consideration in relation to barring.		
49	All job descriptions and contracts of employment (including staff on fixed-term contracts, temporary staff, bank staff, locums, agency staff, volunteers, students and trainees) include an explicit reference to responsibility for safeguarding children and adults.		
50	The Provider has a named senior officer who has overall responsibility for ensuring the organisation operates procedures for dealing with allegations against staff who work with children, or adults with care and support needs, resolving any inter-agency issues & providing advice and liaison to staff/managers within the organisation		
Training			
51	The Provider has (a) training strategy(ies)/ programme which include requirements for • Safeguarding Children, • Safeguarding Adults, • MCA & DOLS and • PREVENT, and is compliant with • LSCB/ SAB strategy, • Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (Royal College of Paediatrics and Child Health et al 2014) and • Safeguarding Adults: roles and competencies for health care staff (NHS England, 2016)		
52	The Provider holds comprehensive details of the uptake of <u>all STAFF</u> training, and uses this to inform a regular comprehensive training needs analysis and plan training required		
53	The Provider ensures a proportionate contribution to the delivery of multiagency training programmes through the LSCB/SAB.		
54	The Provider has evidence that they ensure and resource access for all Level 3 (and above) staff to multi-agency training provided by LSCB/SAB		

55	The Provider has evidence to support effectiveness of training		

Safeguarding Commissioners Standards: Remedial Action Plan

Standard No.	Action(s) required to achieve standard	Person Responsible	Date Due	Comments / Progress

EXCEPTION REPORTING

The Provider will advise commissioners of exceptions as below – as soon as practicable – no later than 10 working days after changes/ issues are recognised

Requirement	Change & any further Action Required	RAG rating
Any changes to the Executive or Professional leadership, including • Board/ Governing Body/ Senior Manager • Named Professionals for Safeguarding • MCA/DoLS lead • PREVENT lead • management of allegations against staff who work with children, or adults with care and support needs		
Any challenges/ capacity issues in systems related to DoLS applications.		
Any challengs/ capacity issues which affect the Provider's abiltity to maintain compliance with Requirements as outlined in the Annual Declaration		

CASE OR ISSUE SPECIFIC REPORTING

The Provider will provide assurance on compliance as relevant

Requirement	Evidence of Compliance	RAG rating
The Provider has, or has access to, appropriately experienced staff to conduct, LSCB/SAB requested organisational review as part of multi-agency learning reviews; and those staff are • adequately supported and • provided with sufficient resource to write reports, attend interviews and participate in the multi-agency review process		
The Provider has arrangements to consider the organisational/ service implications of completed multiagency review(s) to ensure that any learning is implemented across all relevant services.		
The Provider has developed an organisational/ service Action Plan in response to any multi-agency review, and had submitted, and provided updates this to all responsible Safeguarding Boards		
The Provider has evidence to show that multi-agency and organisational learning, along with relevant Action plan(s) have been presented to the Provider governing body/ Board.		
The Provider has evidence to show recommendations and action from safeguarding inspections have been implemented and embedded in practice.		
The Provider has evidence of referrals to the Local Authority Designated Officer (LADO) according to local multi-agency safeguarding procedures. in all cases where allegations in relation to children • against members of staff (including staff on fixed term contracts, temporary staff, locums, agency staff, bank staff, volunteers, students and trainees) • (where the Provider is aware) against professionals who work with children who are not employed by the provider. This may include, for example, service users who are child care professionals in other organisations		

Requirement	Evidence of Compliance	RAG rating
The Provider has evidence of referrals to the Local Authority DASM (Designated Adult Safeguarding Manager), **via the Designated Professional for Safeguarding Adults**, when any person in a 'position of trust' has or is alleged to have • abused, neglected or harmed an adult with care and support needs; • behaved (or is alleged to have behaved) towards another adult in a way that indicates that they may pose a risk of harm to an adult with care and support needs or • behaved (or is alleged to have behaved) towards children in a way which means they may pose a risk of harm to adults with care and support needs.		
The Provider effectively investigates all safeguarding concerns relating to a member of staff, and concludes any disciplinary processes irrespective of a person's resignation, recognising that **'compromise agreements' are not be allowed in safeguarding cases**. All allegations of abuse against staff, including where there is clear evidence that the allegation is false or malicious, are recorded and monitored using the organisation's incident management /allegations against staff policy		

QUARTERLY

No	Requirement	Evidence of Compliance	RAG rating
Policies and procedures			
I	Percentage of Level 3[21] (and above) staff who received specialist safeguarding children supervision in quarter		
II	Percentage of Level 3[22] (and above) staff who received specialist safeguarding adults supervision in quarter		
Multi-agency Working & Responding to Concerns			
III	Numbers and percentages of staff actively involved in cases of children/ adults with care and support needs in attendance at, and contribution to, safeguarding case conferences/strategy meetings, where required as part of multiagency procedures		
IV	Number of Early Help (or similar) Assessments completed by staff group		
Recruitment and employment			
V	Percentage of staff in Regulated activity with DBS disclosure in line with all contemporary national guidance and legislation.		
VI	Percentage of staff, including volunteers, who have annual appraisals.		

[21] as specified by RCPCH 2014
[22] as specified by NHS England 2016

Training			
VII	Percentage uptake of training for <u>all staff</u>[23] – Levels 1 – 4 (as per RCPCH 2014, and NHS England 2016 (on reissue) • by locality, at service level and by staff group		
VIII	Percentage uptake of induction training for new staff which includes minimum of Level 1 safeguarding children & adults, MCA/ DoLs and PREVENT training • for staff providing direct care and treatment, prior to any **unsupervised** work with service users • for other staff, within 6 weeks of commencing employment.		
IX	Percentage of Level 3 (and above) staff who have accessed multi-agency LSCB/ SAB training within last 3 years.		
X	Percentage uptake of training to complete Early Help (or similar) Assessment		

[23] all employees (including those on fixed-term contracts), temporary staff, bank staff, locums, agency staff, contractors, volunteers (including celebrities), students, apprentices and any other learners undertaking any type of work experience or work related activity

APPENDIX 3: Definitions – Adult Safeguarding

(Taken from Chapter 14 - Care and Support Statutory Guidance Issued under the Care Act 2014 February 2016 pp1-9)

Adult

Any person over the age of 18 years.

Safeguarding Duties

The safeguarding duties apply to an adult who:

- Has needs for care and support (whether or not the local authority is meeting any of those needs)
- Is experiencing, or at risk of, abuse or neglect

As a result of the care and support needs the adult is unable to protect themselves from either the risk of, or the experience of abuse or neglect. Depending on the context, this could be an adult receiving a particular care and support service, or an adult who has such needs but are not receiving a service (for example, someone coming forward for an assessment).

Where someone is 18 or over but is still receiving children's services and a safeguarding issue is raised, the matter should be dealt with through adult safeguarding arrangements. Where appropriate, adult safeguarding services should involve the local authority's children's safeguarding colleagues as well as any relevant partners (e.g. the Police or NHS) or other persons relevant to the case.

Care and support

The mixture of practical, financial and emotional support for adults who need extra help to manage their lives and be independent – including older people, people with a disability or long-term illness, people with mental health problems, and carers. Care and support includes assessment of people's needs, provision of services and the allocation of funds to enable a person to purchase their own care and support. It could include care home, home care, personal assistants, day services, or the provision of aids and adaptations.

Adult Safeguarding Aims

- stop abuse or neglect wherever possible;
- prevent harm and reduce the risk of abuse or neglect to adults with care and support needs;
- safeguard adults in a way that supports them in making choices and having control about how they want to live;
- promote an approach that concentrates on improving life for the adults concerned;
- raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect;
- provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult; and
- address what has caused the abuse or neglect.

Abuse

Abuse is the violation of an individual's human or civil rights by any other person/'s and involves the misuse of power by one person over another.

Abuse or neglect may be deliberate, or the result of negligence or ignorance. Unintentional abuse or neglect arises, for example, because pressures have built up and/or because of difficult or challenging behaviour which is not being properly addressed.

Abuse and neglect can take many forms, including the following, although this is not an exhaustive list:

Physical abuse

including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.

Domestic violence

including psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence.

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.

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.

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 recorded abuse can occur in isolation, but as research has shown, where there are other forms of abuse, there is likely to be financial abuse occurring.

Potential indicators of financial abuse may include:

change in living conditions; lack of heating, clothing or food; inability to pay bills/unexplained shortage of money; unexplained withdrawals from an account; unexplained loss/misplacement of financial documents; the recent addition of authorised signers on a client or donor's signature card; sudden or unexpected changes in a will or other financial document.

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.

Discriminatory abuse

including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion

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.

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.

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.

Domestic Abuse

The cross-government definition of domestic violence and abuse 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; sexual; financial; and emotional. A new offence of coercive and controlling behaviour in intimate and familial relationships was introduced into the Serious Crime Act 2015.

Mental Capacity Act

The Mental Capacity Act (MCA) 2005 provides a statutory framework to empower and protect people who may require help to make decision or may not be able to make decisions for themselves.

The Mental Capacity Act is accompanied by a 'Code of Practice' which provides practical guidance and everyone who works with people who may lack capacity has a duty to work within and have 'due regard' to the Code. The CCG expects all staff who work with people who may have reduced capacity to work within the Code of Practice.

Mental Capacity

Mental capacity is the ability to understand, retain and weigh up information in order to make a decision and to communicate the choice they have made. When an adult's ability to make a particular decision is reduced, they can be at increased risk of abuse, including neglect.

People must be assumed to have capacity to make their own decisions and be given all practicable help before anyone treats them as not being able to make their own decisions. Where an adult is found to lack capacity to make a decision then any action taken, or any decision made for, or on their behalf, must be made in their best interests. Professionals and other staff need to understand and always work in line with the Mental Capacity Act 2005 (MCA).

APPENDIX 4: Definitions – Safeguarding Children

(Taken from Working Together 2015, p 92-93)

Child:

Anyone who has not yet reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate, does not change his/her status or entitlements to services or protection.

Safeguarding and promoting the welfare of children:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all children to have the best life chances

Child protection:

Part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm

Abuse:

A form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others (e.g. via the internet). They may be abused by an adult or adults, or another child or children

Physical abuse:

A form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

Emotional abuse:

The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Sexual abuse:

Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by

penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Neglect:

The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care-givers); or
- ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Young carers:

A young carer is a person under 18 who provides or intends to provide care for another person (of any age, except generally where that care is provided for payment, pursuant to a contract or as voluntary work).

Child Sexual Exploitation

The sexual exploitation of children is defined as:

'involving exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money, mobile phones) as a result of their performing, and/or another or others performing on them, sexual activities. It can occur through the use of technology without the child's immediate recognition; e.g. being persuaded to post sexual images on the internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child's limited availability of choice resulting from their social/economic and/or emotional vulnerability'.

Female Genital Mutilation

is a collective term for "procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons" (World Health Organisation, 2013).

The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life. The procedure is typically performed on girls aged between 4 and 13, but in some cases it is performed on new-born infants or on young women before marriage or pregnancy.

FGM has been a criminal offence in the U.K. since the Prohibition of Female Circumcision Act 1985 was passed. The Female Genital Mutilation Act 2003 replaced the 1985 Act and made it an offence for the first time for UK nationals permanent or

habitual UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is legal.

APPENDIX 5: Safeguarding Training for NLCCG Staff

The Levels indicated in this Appendix are as per:

- For Safeguarding Children: Safeguarding Children and Young People: roles and competences for health care staff, RCPCH (2014)
- For Safeguarding Adults: Safeguarding Adults: Roles and and competences for health care staff – Intercollegiate Document (NHS England – pending 2016) – This document was withdrawn in April 2016, and will be reissued later in 2016. Levels will be subject to review and change on reissue.

Training Required

	Safeguarding Children	**Safeguarding Adults**	**PREVENT**	**MCA**	**DoLS**
All Staff	Level 1	Level 1	Yes	Yes	Yes
Any staff who have contact with patients or the public	Level 2	Level 2	Yes	Yes	Yes
Staff who receive and manage incidents, complaints, PALS type issues	Level 2	Level 2	Yes	Yes	Yes
Continuing Healthcare staff - who work with young people, including in transition to adult services, or significant contact with adult service users who have mental health, substance misuse or learning disabilities	Level 3	Level 3	Yes	Yes	Yes
Other Continuing Healthcare staff	Level 2	Level 3			
Chief Officer, Board Level Staff and Governing Body members	Level 1	Level 1	Yes	Yes	Yes
	Board Level: Understanding CCG safeguarding duties and their implications				
Executive Lead for Safeguarding	Level 2	Level 2	Yes	Yes	Yes
	Board Level: Understanding CCG safeguarding duties and their implications				
Named GP Safeguarding children	Level 4	Level 4	Yes	Yes	Yes
Named GP Safeguarding adults	Level 4	Level 4	Yes	Yes	Yes
Designated Professional Safeguarding Adults	Level 5	Level 5	Yes	Yes	Yes
Designated Nurse Safeguarding Children	Level 5	Level 5	Yes	Yes	Yes

Designated Doctor Safeguarding Children* (incorporating Designated Paediatrician for Sudden Unexpected Deaths in Childhood)	Level 5	Level 5	Yes	Yes	Yes
Designated Doctor Looked After Children*	Level 5	Level 5	Yes	Yes	Yes
Designated Nurse Looked After Children*	Level 5	Level 5	Yes	Yes	Yes

*these posts are hosted within a provider's service therefore the CCG requires assurance that the appropriate training has been received.

Sources of Training

Staff and managers can seek advice on access to training by contacting the Designated Nurse – Safeguarding Children, Designated Professional – Safeguarding Adults, or Mental Capacity Act Strategic Lead.

Level 1

Available via e-learning

Level 2

e-learning for health (children & adults)

Bespoke sessions can be available for sufficient numbers by contacting the Designated Nurse – Safeguarding Children or Designated Professional – Safeguarding Adults

Level 3

Access via LSCB, SAB, negotiation/discussion with safeguarding leads in health providers

Level 4 and 5

Staff working at levels 4 and 5 will access training/ development opportunities through regional/ national events

APPENDIX 6: REGULATION 13: Safeguarding service users from abuse and improper treatment

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

The intention of this regulation is to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005.

To meet the requirements of this regulation, providers must have a zero tolerance approach to abuse, unlawful discrimination and restraint. This includes:

- neglect
- subjecting people to degrading treatment
- unnecessary or disproportionate restraint
- deprivation of liberty.

Providers must have robust procedures and processes to prevent people using the service from being abused by staff or other people they may have contact with when using the service, including visitors. Abuse and improper treatment includes care or treatment that is degrading for people and care or treatment that significantly disregards their needs or that involves inappropriate recourse to restraint. For these purposes, 'restraint' includes the use or threat of force, and physical, chemical or mechanical methods of restricting liberty to overcome a person's resistance to the treatment in question.

Where any form of abuse is suspected, occurs, is discovered, or reported by a third party, the provider must take appropriate action without delay. The action they must take includes investigation and/or referral to the appropriate body. This applies whether the third party reporting an occurrence is internal or external to the provider.

CQC can prosecute for a breach of some parts of this regulation (13(1) to 13(4)) if a failure to meet those parts results in avoidable harm to a person using the service or if a person using the service is exposed to significant risk of harm. We do not have to serve a Warning Notice before prosecution. Additionally, CQC may also take any other regulatory action. See the offences section for more detail.

CQC must refuse registration if providers cannot satisfy us that they can and will continue to comply with this regulation.

The regulation in full

13.—

1. Service users must be protected from abuse and improper treatment in accordance with this regulation.
2. Systems and processes must be established and operated effectively to prevent abuse of service users.
3. Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.
4. Care or treatment for service users must not be provided in a way that—
    a. includes discrimination against a service user on grounds of any protected characteristic (as defined in section 4 of the Equality Act 2010) of the service user,
    b. includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint,
    c. is degrading for the service user, or
    d. significantly disregards the needs of the service user for care or treatment.

5. A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

6. For the purposes of this regulation—
'abuse' means—
   a. any behaviour towards a service user that is an offence under the Sexual Offences Act 2003(a),
   b. ill-treatment (whether of a physical or psychological nature) of a service user,
   c. theft, misuse or misappropriation of money or property belonging to a service user, or
   d. neglect of a service user.

7. For the purposes of this regulation, a person controls or restrains a service user if that person—
   a. uses, or threatens to use, force to secure the doing of an act which the service user resists, or
   b. restricts the service user's liberty of movement, whether or not the service user resists, including by use of physical, mechanical or chemical means.

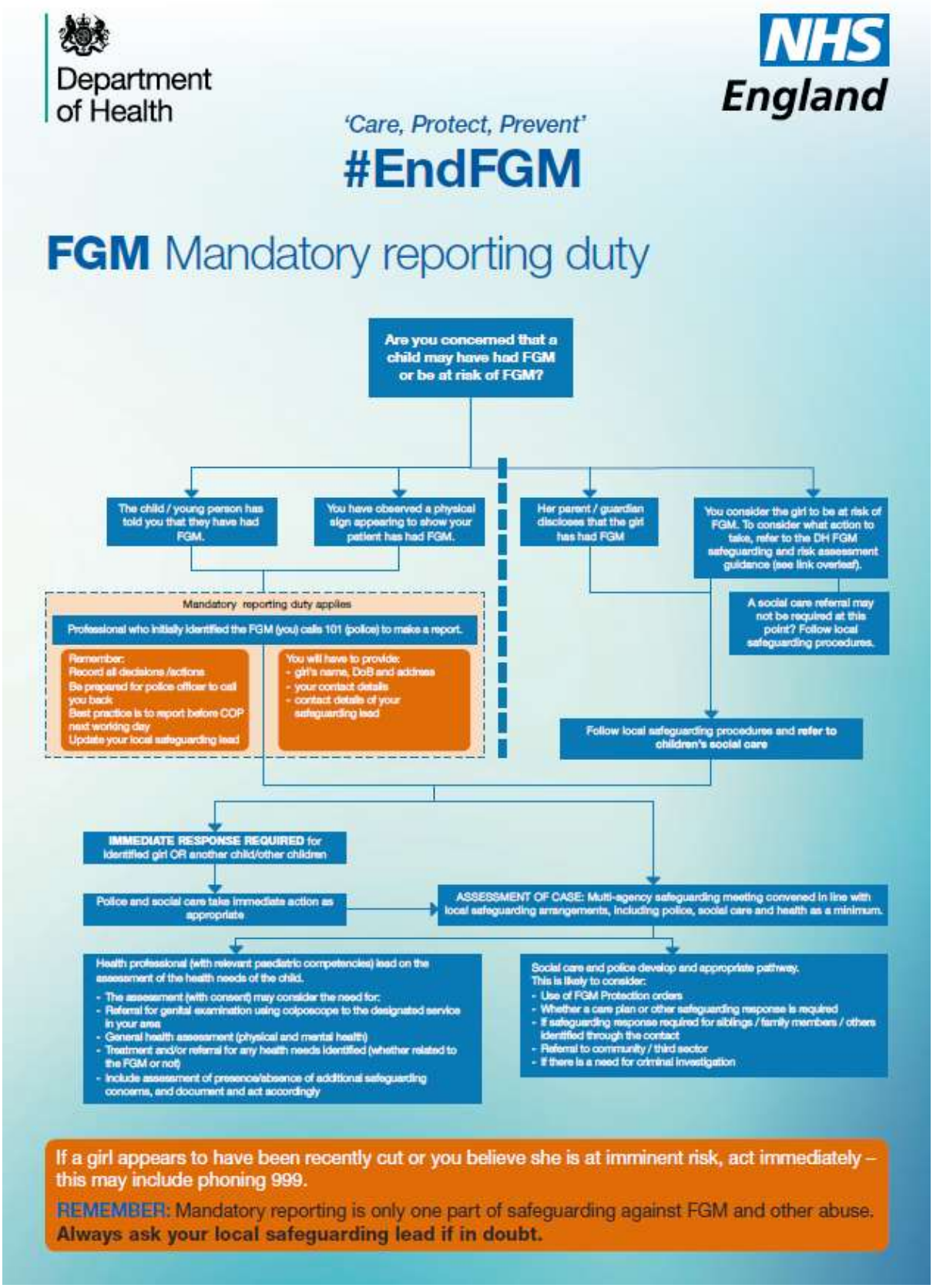
Guidance

Component of the regulation	**Providers must have regard to the following guidance**
13-(1) Service users must be protected from abuse and improper treatment in accordance with this regulation.	• All providers must make sure that they have, and implement, robust procedures and processes that make sure that people are protected. Safeguarding must have the right level of scrutiny and oversight, with overall responsibility held at board level or equivalent.
13-(2) Systems and processes must be established and operated effectively to prevent abuse of service users.	• As part of their induction, staff must receive safeguarding training that is relevant, and at a suitable level for their role. Training should be updated at appropriate intervals and should keep staff up to date and enable them to recognise different types of abuse and the ways they can report concerns. • Staff must be aware of their individual responsibilities to prevent, identify and report abuse when providing care and treatment. This includes referral to other providers. • Staff must understand their roles and associated responsibilities in relation to any of the provider's policies, procedures or guidance to prevent abuse. • Information about current procedures and guidance about raising concerns about abuse should be accessible to people who use the service, advocates, those lawfully acting on their behalf, those close to them and staff. • Providers should use incidents and complaints to identify potential abuse and should take preventative actions, including escalation, where appropriate. • Providers should work in partnership with other relevant bodies to contribute to individual risk assessments, developing plans for safeguarding children and safeguarding adults at risk, and when implementing these plans. This includes regularly reviewing outcomes for people using the service. • Providers and their staff must understand and work within the requirements of the Mental Capacity Act 2005 whenever they work with people who may lack the mental capacity to make some decisions.
13-(3) Systems and processes must be established and operated effectively to investigate,	• Providers must take action as soon as they are alerted to suspected, alleged or actual abuse, or the risk of abuse. Where appropriate, this action should be in line with the procedures agreed by local Safeguarding Adults or Children Boards.

immediately upon becoming aware of, any allegation or evidence of such abuse.	• Providers and staff must know and understand the local safeguarding policy and procedures, and the actions they need to take in response to suspicions and allegations of abuse, no matter who raises the concern or who the alleged abuser may be. These include timescales for action and the local arrangements for investigation. • Staff must be aware of, and have access to, current procedures and guidance for raising and responding to concerns of abuse. Staff should have access to support from line management when considering how to respond to concerns of abuse. • Managers and staff must understand their individual responsibilities to respond to concerns about abuse when providing care and treatment, including investigating concerns. • Staff must understand their roles and associated responsibilities in supporting the actions the provider takes in responding to allegations and concerns about abuse. • Providers should make sure that staff are kept up to date about changes to national and local safeguarding arrangements. • Where appropriate, staff must follow local safeguarding arrangements to make sure that allegations are investigated internally or externally. Providers must make sure that they respond without delay to the findings of any investigations. • When people who use services make allegations of abuse, or actually experience abuse, they must receive the support they need. • Where allegations of abuse are substantiated, providers must take action to redress the abuse and take the necessary steps to ensure the abuse is not repeated. This may involve seeking specialist advice or support. • When required to, providers must participate in serious case reviews. Any changes to practice and/or recommendations relating to the provider must be implemented.
13-(4) Care or treatment for service users must not be provided in a way that–	
13-(4)(a) includes discrimination against a service user on grounds of any protected characteristics (as defined in Section 4 of the Equality Act 2010) of the service user,	• Staff must understand their individual responsibilities in preventing discrimination in relation to the protected characteristics set out in s.4 of the Equality Act 2010. These are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; and sexual orientation. • Providers should have systems for dealing with allegations and acts of discrimination regardless of who raises the concern or who the allegation is against. This includes policies and procedures that describe the required actions and the timescales in which to take action. • Providers must support people who use services when they make allegations of discrimination or actually experience discrimination. They must not unlawfully victimise people who use services for making a complaint about discrimination. • When allegations of discrimination are substantiated, providers must take corrective action and make changes to prevent it happening again. This may involve seeking specialist advice or support.
13-(4)(b) includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a	• See Regulation 13(7) for the meaning of restraint in relation to this regulation. • As part of their induction, staff must receive training that is relevant to their role and at a suitable level to make sure any control, restraint or restrictive practices are only used when

risk of harm posed to the service user or another individual if the service user was not subject to control or restraint,	absolutely necessary, in line with current national guidance and good practice, and as a last resort. The provider should make arrangements to keep staff up to date at appropriate intervals. • If using restraint, providers must make sure that restraint: o Is only used when absolutely necessary. o Is proportionate in relation to the risk of harm and the seriousness of that harm to the person using the service or another person. o Takes account of the assessment of the person's needs and their capacity to consent to such treatment. o Follows current legislation and guidance. • Providers and staff should regularly monitor and review the approach to, and use of, restraint and restrictive practices. • Where a person lacks mental capacity to consent to the arrangements for their care or treatment, including depriving them of their liberty, providers must follow a best interest process in accordance with the Mental Capacity Act 2005, including the use of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards, where appropriate.
13-(4)(c) is degrading for the service user, or	• Providers and staff must take all reasonable steps to make sure that people who use services are not subjected to any form of degradation or treated in a manner that may reasonably be viewed as degrading, such as: o not providing help and aids so that people can be supported to attend to their continence needs, and o making sure people are not: ▪ left in soiled sheets for long periods ▪ left on the toilet for long periods and without the means to call for help ▪ left naked or partially or inappropriately covered ▪ made to carry out demeaning tasks or social activities ▪ ridiculed in any way by staff. **This list is not exhaustive.** • Providers should consult and consider the views of people using their service when defining the meaning of 'degrading'.
13-(4)(d) significantly disregards the needs of the service user for care or treatment.	• Care and treatment must be planned and delivered in a way that enables all a person's needs to be met. This includes making sure that enough time is allocated to allow staff to provide care and treatment in accordance with the person's assessed needs and preferences. There should be policies and procedures that support staff to deliver care and treatment in accordance with the requirements detailed in the plan(s) of care. • When a person lacks the mental capacity to consent to care and treatment, a best interests process must be followed in accordance with the Mental Capacity Act 2005. Other forms of authority such as advance decisions must also be taken into account. • Staff should raise any concerns with the provider about their ability to provide planned care. When concerns are raised, the provider should respond appropriately and without delay.
13-(5) A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.	• Providers must act at all times in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Code of Practice and the Mental Capacity Act 2005 Code of Practice. • Hospitals and care homes must follow the Deprivation of Liberty Safeguards. • Other types of services must ensure that any deprivation of the liberty of a person who lacks mental capacity is authorised by the Court of Protection.

APPENDIX 7: Mandatory Reporting of Female Genital Mutilation



APPENDIX 8: What Is Private Fostering?

Private fostering is where someone other than a parent or a close relative cares for a child for a period of 28 days or more, in agreement with the child's parent. It applies only to children under 16 years, or under 18 if they are disabled.

Close relatives are not private foster carers. Close relatives are defined as:

- step-parents,
- grandparents,
- brothers, sisters,
- uncles or aunts (whether of full blood, half blood or by marriage).

The 28 days do not need to be consecutive, e.g. a child who is cared for by someone who is not a close relative during the week, but stays with parents at weekends is still subject to private fostering.

People become private foster carers for all sorts of reasons. Private foster carers can be

- wider family
- friend of the child's family, or
- someone who is willing to care for a child of a family they do not know.

It is **not** a private fostering arrangement if the placement was made by a social worker who has intervened on behalf of the local authority.

Some of the common situations where children are privately fostered are:

- Where parent(s) are unable to care for their children, for example if they have chronic ill health or are in prison
- Where parent(s) are unable to care for, or need support in caring for their children, as a result of caring for another dependent relative
- Where children from abroad are sent to stay with relatives, often to improve their education, or to access health care
- Teenagers living with a friend's family because of a breakdown in relationship with their own family
- Teenagers living with the family of a boyfriend or girlfriend
- Those living with host families whilst taking courses of study

Private Fostering Legislation

Children's Social Care are not involved in making private fostering arrangements. But there is a legal duty on parents and private foster carers to notify local authority children's social care of a private fostering arrangements. Anyone who believes that a child may be privately fostered must make sure they notify children's social care.

The majority of private fostering arrangements are safe, but children's social care have a responsibility to ensure that the child's needs are being met, including education, health and cultural needs, so will complete an assessment. Children's social care will also be able to provide support the carers if needed.

APPENDIX 9: Sharing Information

The seven golden rules to sharing information

1. Remember that the Data Protection Act 1998 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.

2. Be open and honest with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

3. Seek advice from other practitioners if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.

4. Share with informed consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, there is good reason 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 certain of the basis upon which you are doing so. Where you have consent, be mindful that an individual might not expect information to be shared.

5. 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.

6. 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, is shared only with those individuals who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely (see principles).

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

INTEGRATED IMPACT ASSESSMENT

Policy/project/function/service	Safeguarding Policy	
Date of analysis:		19/12/16
Type of analysis completed	Quality	19/12/16
	Equality	19/12/16
	Sustainability	19/12/16
What are the aims and intended effects of this policy/project or function?	1. Ensure staff working for, or on behalf of, NLCCG are clear around their responsibilities, and activity required, where there are concerns in respect to welfare of children, or adults with care and support needs. 2. to outline standards for commissioned providers so NLCCG can receive assurance that the organisations from which they commission have effective safeguarding arrangements in place.	
Please list any other policies that are related to or referred to as part of this analysis		
Who does the policy, project, function or service affect?	Service users	
	Members of the public	
	Other (please list)	Statutory Compliance

QUALITY IMPACT

	Please 'X' ONE for each Chance of Impact on Indicator			Brief description of potential impact	Mitigation strategy and monitoring arrangements	Risk 5 x 5 risk matrix)	
	Positive Impact	No Impact	Negative Impact			Likelihood	Consequence
	X	X	X				
PATIENT SAFTEY							
Patient safety /adverse events	X						
Mortality position		X					
Infection control MRSA/CDIFF		X					
CQC status	X						
NHSLA / CNST		X					
Mandatory/statutory training	X						
Workforce (vacancy turnover absence)		X					
Safe environment		X					
Standard & suitability of equipment		X					
CLINICAL EFFECTIVENESS							
NICE Guidance and National Quality		X					

Standards, eg VTE, Stroke, Dementia							
Patient related outcome measures		**X**					
External accreditation e.g. professional bodies ie RCN		**X**					
CQUIN achievement		**X**					
PATIENT EXPERIENCE							
Will there be an impact on patient experience if so how		**X**					
Will it impact on carers if so how		**X**					
INEQUALITIES OF CARE							
Will it create / reduce variation in care provision?		**X**					
STAFF EXPERIENCE							
What is the impact on workforce capability care and skills?		**X**					
Will there be a change in working practice, if so, how?		**X**					
Will there be an impact on training	**X**			**All staff will have to undertake mandatory safeguarding training**			
TARGETS / PERFORMANCE							
Will it have an impact on performance, if so, how?	**X**			**Should support compliance with legislation and statutory guidance.**			
Could it impact on the achievement of local, regional, national targets, if so, how?		**X**					

EQUALITY IMPACT

Analysis Rating (see completion notes)	Red		Red/ Amber		Amber		Green	X

Approved by:	Commissioner Lead:	tbc	GP lead for E&D:	tbc
	Date		Date	

Local Profile Data	
General	N/A
Gender (Men and Women)	
Race (All Racial Groups)	
Disability (Mental and Physical, Sensory Impairment, Autism, Mental Health Issues)	
Religion or Belief	
Sexual Orientation (Heterosexual, Homosexual and Bisexual)	
Pregnancy and Maternity	
Transgender	
Marital Status	
Age	

Equality Data	
Is any equality data available relating to the use or implementation of this policy, project or function?	No Impact
List any consultation e.g. with employees, service users, Unions or members of the public that has taken place in the development or implementation of this policy, project or function.	None – legal duty and statutory guidance
Promoting inclusivity; How does the project, service or function contribute to our aims of eliminating discrimination and promoting equality and diversity?	None – legal duty and statutory guidance

Equality Impact Risk Assessment test				
What impact will the implementation of this policy, project or function have on employees, service users or other people who share characteristics protected by *The Equality Act 2010*?				
Protected Characteristic:	No Impact	Positive Impact	Negative Impact	Evidence of impact and if applicable justification where a *Genuine Determining Reason* exists
Gender (Men and Women)	**X**			
Race (All Racial Groups)	**X**			

Disability (Mental and Physical, Sensory Impairment, Autism, Mental Health Issues)	**X**			
Religion or Belief	**X**			
Sexual Orientation (Heterosexual, Homosexual and Bisexual)	**X**			
Pregnancy and Maternity	**X**			
Transgender	**X**			
Marital Status	**X**			
Age	**X**			

Action Planning

As a result of performing this Equality Impact Analysis, what actions are proposed to remove or reduce any risks of adverse outcomes identified on employees, service users or other people who share characteristics protected by The Equality Act 2010?

Identified Risk:	Recommended Action:	Responsible Lead	Completion Date	Review Date
None				

SUSTAINABILITY IMPACT

Staff preparing a Policy / Board Report / Committee Report / Service Plan / Project are required to complete a Sustainability Impact Assessment. Sustainability is one of the Trust's key Strategies and the Trust has made a corporate commitment to address the environmental effects of activities across Trust services. The purpose of this Sustainability Impact Assessment is to record any positive or negative impacts that this activity is likely to have on each of the Trust's Sustainability Themes.

	Positive Impact	**Negative Impact**	**No Specific Impact**	**What will the impact be? If the impact is negative, how can it be mitigated? (action)**
Reduce Carbon Emission from buildings by 12.5% by 2010-11 then 30% by 2020			**X**	
New builds and refurbishments over £2million (capital costs) comply with BREEAM Healthcare requirements.			**X**	
Reduce the risk of pollution and avoid any breaches in legislation.			**X**	
Goods and services are procured more sustainability.			**X**	

Reduce carbon emissions from road vehicles.			**X**	
Reduce water consumption by 25% by 2020.			**X**	
Ensure legal compliance with waste legislation.			**X**	
Reduce the amount of waste produced by 5% by 2010 and by 25% by 2020			**X**	
Increase the amount of waste being recycled to 40%.			**X**	
Sustainability training and communications for employees.			**X**	
Partnership working with local groups and organisations to support sustainable development.			**X**	
Financial aspects of sustainable development are considered in line with policy requirements and commitments.			**X**	