

**SAFEGUARDING POLICY**

**July 2021**

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**Committee Approval Executive Committee**

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The on-line version is the only version that is maintained. Any printed copies should, therefore, be viewed as ‘uncontrolled’ and as such may not necessarily contain the latest updates and amendments.

**POLICY AMENDMENTS**

Amendments to the Policy will be issued from time to time. A new amendment history will be issued with each change.

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| --- | --- | --- | --- | --- |
| **New****Version Number** | **Issued by** | **Nature of Amendment** | **Approved by & Date** | **Date on Intranet** |
| 1.0 |  |  | Quality Group – 28/12/16 |  |
| 1.1 |  | Policy reviewed for compliance with safeguarding pathways.Updated contact details.Full review date extended to end of September 2019 |  | 30/11/18 |
| 2.0 |  | Policy reviewed to ensure compliance with Children’s and Social Work Act 2017, and statutory and advisory guidance issued in 2018 and2019. | Executive Committee - 2/7/19 |  |
| 2.1 |  | Due review and update of contact details. Minor changes only to reflect Working Together 2020 and the Domestic Abuse bill 2021 | Helen Davis – January 2022 |  21/01/2022  |

**CONTENTS**

[1. INTRODUCTION 4](#_Toc81475913)

[2. ENGAGEMENT 4](#_Toc81475914)

[3. SCOPE 5](#_Toc81475915)

[4. THE POLICY 5](#_Toc81475916)

[5. DEFINITIONS 7](#_Toc81475917)

[6. ROLES / RESPONSIBILITIES / DUTIES 8](#_Toc81475918)

[7. COMMISSIONING AND CONTRACTING ARRANGEMENTS 12](#_Toc81475919)

[8. RESPONDING TO CONCERNS ABOUT A CHILD OR ADULT’S WELFARE 13](#_Toc81475920)

[9. MANAGEMENT OF SAFEGUARDING SERIOUS INCIDENTS (SIS), COMPLAINTS AND CLAIMS. 15](#_Toc81475921)

[10. TRAINING. 16](#_Toc81475922)

[11. IMPLEMENTATION 17](#_Toc81475923)

[12. TRAINING & AWARENESS 17](#_Toc81475924)

[13. MONITORING & AUDIT 17](#_Toc81475925)

[14. POLICY REVIEW 17](#_Toc81475926)

[15. REFERENCES 18](#_Toc81475927)

appendixes

# INTRODUCTION

* 1. NHS North Lincolnshire Clinical Commissioning Group as with all other NHS bodies have a statutory duty to ensure that they make arrangements to safeguard and promote the welfare of children and young people that reflect the needs of the children they deal with; and to protect adults at risk of abuse.
	2. As commissioners of services, Clinical Commissioning Groups (CCGs) have a duty to take reasonable care to ensure the quality of the services they commission.
	3. In discharging these statutory duties/responsibilities account must be taken of:
		+ Children Act 1989
		+ Children Act 2004
		+ Adoption and children Act (2002)
		+ Female Genital Mutilation Act 2003
		+ Domestic abuse act 2021
		+ Children and Social Work Act 2017
		+ 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)
		+ Current data protection legislation and general data protection regulations (GDPR) (EU) 2016/679
		+ Working Together to Safeguard Children (DfE 2018 and update 2020
		+ Chapter 14 of Care and Support Statutory Guidance (DHSC)
		+ Making Safeguarding Personal Guide (ADASS, 2014)
		+ Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework (NHS England, 2015)
		+ Safeguarding children and young people: roles and competencies for health care staff – Intercollegiate Document (Royal College of Nursing, 2019)
		+ Adult Safeguarding: roles and competencies for health care staff – Intercollegiate Document (Royal College of Nursing, 2018)
		+ Promoting the Health and Wellbeing of Looked after Children (DoH ,DfE 2015)
	4. This policy should also be read in conjunction with North Lincolnshire Children’s Multi-Agency Resilience and Safeguarding Board (C-MARS) [Procedures and Guidance](http://www.northlincscmars.co.uk/policies-procedures-and-guidance/) and the North Lincolnshire Safeguarding Adult’s Board (NLSAB) [Policy and Procedures](http://www.northlincssab.co.uk/professionals/) which set out the North Lincolnshire multi-agency approach to safeguarding.

# ENGAGEMENT

* 1. This policy has built on previous safeguarding policies, and national policy and guidance. NLCCG commissions health services for patients registered with member GP practices. This means that for health services, the registered population includes 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 to the members of NLCCG Safeguarding Assurance Group, Lay Member and Heads of Service for comments.
	2. **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.

 **2.3 Sustainability**

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

 **2.4 Quality**

A quality assessment has been completed.

* 1. **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.

# SCOPE

* 1. 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.
	2. Organisations working on behalf of NLCCG must have policies and procedures in place consistent with this document and compliant with legislation and guidance including those listed in the Introduction to this policy.

# THE POLICY

* 1. **Policy Purpose**
		1. 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. Outline the mechanisms by which NLCCG, as a commissioning organisation, assures itself that the organisations from which they commission have effective safeguarding arrangements in place.
	2. **Policy Principles**

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.

With respect to adults, the Care Act 2014 sets out comparable requirements with regard to safeguarding adults from abuse or neglect and makes provision about care standards. The Making Safeguarding Personal agenda underpins the development of person-centred, outcome-focused responses to safeguarding adults.

* + 1. In developing this policy, the CCG recognises that safeguarding children and adults at risk of abuse is a shared responsibility with the need for joined up systems and processes between
			- agencies, organisations and services,
			- commissioners and providers,
			- professionals and staff

who have different roles and expertise.

* + 1. Effective collaborative working requires constructive relationships at all levels, promoted and supported by:
			- a commitment of senior managers and Governing Body members to seek continuous improvement with regards to safeguarding both within the work of the CCG and within those services commissioned
			- clear lines of accountability within the CCG for safeguarding.
			- service developments that take account of the need to safeguard all service users, and is informed, where appropriate, by the views of service users
			- staff training and continuing professional development so that staff have an understanding of their roles and responsibilities in regard to safeguarding children, adults at risk, children looked after and the Mental Capacity Act and Prevent
			- safe working practices including recruitment and vetting procedures
			- effective interagency working, including effective information sharing
		2. 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.
		3. Age, gender, cultural or religious beliefs, disabilities or social backgrounds all 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.
	1. **Policy statement**
		1. 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 will ensure a proportionate and timely response to safeguard adult(s) and/or child(ren) and young people within a multi-agency framework.
			* NLCCG will share 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 will work as statutory partners within North Lincolnshire C-MARS and SAB to maintain a local learning and improvement framework in order to learn from experience and improve services.

# DEFINITIONS

* 1. **NLCCG Staff**

All individuals employed by North Lincolnshire Clinical Commissioning Group or working on behalf on North Lincolnshire CCG. This includes

* + - those in posts shared with other CCGs
		- staff employed by other organisations, but who fulfil functions which are the responsibility of CCGs to provide
		- staff on fixed-term contracts, temporary staff, bank staff, locums, agency staff, volunteers, students and trainees.
	1. **Safeguarding Children**

(From Working Together to Safeguard Children 2018, updated 2020)

* + 1. 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 their status or entitlements to services or protection.

* + 1. 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
			- taking action to enable all children to have the best outcomes
			- consideration of risks outside of the home which may result in the need to protect children
		2. 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.

* 1. **Safeguarding Adults**

(From the Care act 2014)

* + 1. Adults requiring safeguarding

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 those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect
		1. Adult safeguarding
			- protecting an adult’s right to live in safety, free from abuse and neglect.
			- people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult’s wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action.
			- recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.

Further definitions used in this guidance are included at [Appendix 8](#_bookmark23) and [Appendix](#_bookmark24) [9](#_bookmark24).

# ROLES / RESPONSIBILITIES / DUTIES

The responsibilities of commissioning health organisations are set out in the NHS England/Improvement Safeguarding, Children, Young People and Adults at Risk in the NHS, Safeguarding Accountability and Assurance Framework (updated 2019).

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

* 1. **CCG Accountable Officer**
		1. The Accountable 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.
		2. The Accountable 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 Nursing & Quality.
		3. The Accountable Officer must provide strategic leadership, promote a culture of supporting good practice with regard to Safeguarding within the organisation and promote collaborative working with other agencies.
		4. Further details of the specific responsibilities of the Accountable Officer are included in the RCN led Intercollegiate Competency Framework documents for Safeguarding Children and Safeguarding Adults
	2. **Clinical Commissioning Group Governing Body**
		1. 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.
		2. 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.
		3. 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
		4. The Governing Body needs to review all safeguarding arrangements on an annual basis as a minimum.
	3. **Chair**
		1. 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.
		2. Further details of the specific responsibilities of the Chair are included in the RCN led Intercollegiate Competency Framework documents for Safeguarding Children and Safeguarding Adults
	4. **Executive Lead for Safeguarding**
		1. Whilst the Accountable Officer retains the overall responsibility for Safeguarding Children and Adults, 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 Nursing & Quality.

* + 1. Further details of the specific responsibilities of the Lay Member are included in the RCN led Intercollegiate Competency Framework documents for Safeguarding Children and Safeguarding Adults
	1. **Lay Member for Safeguarding**
		1. The CCG has a Lay Member of the Governing Body whose role is to:
			+ ensure the CCG discharges its safeguarding responsibilities appropriately and
			+ act as a champion for children and young people.
		2. Further details of the specific responsibilities of the Lay Member are included in the RCN led Intercollegiate Competency Framework documents for Safeguarding Children and Safeguarding Adults
	2. **All Clinical Commissioning Group staff**
		1. All officers and staff of NLCCG must
			+ adhere to this policy
			+ undertake safeguarding children and adults training and development commensurate with their roles
			+ know how to access C-MARS and SAB Procedures
			+ contact the Safeguarding Team if they have concerns in respect of the welfare of a child or adult with care and support needs
			+ ensure that all services
				- provided

by CCG staff, or

on behalf of NLCCG,

* + - * + commissioned by NLCCG

meet the standards outlined in this policy, and where applicable, ensure these standards are included within contracts.

* + 1. All staff must have access to the C-MARS/SAB Procedures - it is an individual, and manager’s responsibility to ensure they have access to this document at work.
		2. In responding to concerns, staff must refer to the flow charts for managing concerns of children or adults at risk at [Appendix 3](#_bookmark18) (child) or [Appendix 4](#_bookmark19) (adults).
	1. **Staff with line management responsibility**
		1. All managers must ensure that
			+ their staff
				- have access to, are aware of and adhere to this policy,
				- access appropriate learning and development
			+ they review safeguarding children and adult competences within annual PDRs.
	2. **Staff involved in commissioning services or monitoring contracts.**
		1. These staff must
			+ 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 Adults and Children at all stages of the commissioning cycle, from preparing service specifications, involvement in 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](#_bookmark16)

* + - * ensure the safeguarding clause and standards as outlined in Appendices [5](#_bookmark20) & [6](#_bookmark21) of this policy are included within contracts of all CCG and jointly commissioned services.
			* ensure Provider reporting of safeguarding arrangements on an Annual and Quarterly basis as outlined in section 7.2 of this policy, via the Annual Declaration ([Appendix 6](#_bookmark21)) and relevant quarterly reporting template ([Appendix 7](#_bookmark22)).
	1. **NLCCG Safeguarding Professional Team**
		1. NLCCG has a Safeguarding Team comprising:
			+ Designated Nurse for Children and Adults
			+ Designated Nurse for LAC
			+ Named GP for Safeguarding Adults
			+ Named GP for Safeguarding Children
			+ Specialist Safeguarding Nurses
			+ Safeguarding Nurse
		2. These professionals have a key role in promoting good professional practice within the CCG, supporting the local safeguarding systems and processes, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place. They will work closely with the Executive Lead for Safeguarding and the C-MARS and SAB.
		3. They will also support the CCG as commissioner of local health services to seek and gain assure that the organisations from which they commission have effective safeguarding arrangements in place.
	2. **Designated Professionals**
		1. 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
			+ Designated Nurse and Doctor for Looked After Children, and
			+ Designated Professional for Safeguarding Adults
		2. 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. 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 C-MARS/SAB and
			+ the Health and Wellbeing Board.
		3. 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.
		4. The Designated Doctors for Safeguarding Children, and Looked After Children for NLCCG are Consultant Paediatricians employed by Northern Lincolnshire and

Goole NHS Foundation Trust but provide the Designated Doctor function to NLCCG.

* + 1. The CCG Designated Safeguarding Nurse fulfils the role of
			- Designated Nurse for Safeguarding Children
			- Designated Professional for Safeguarding Adults
		2. The CCG Deputy Designated safeguarding nurse fulfils the role of
			- Designated Nurse for Looked After Children
			- Deputy role for the designated nurse

The Designated Nurse for NLCCG works closely with the Designated Nurse for North East Lincolnshire CCG, to ensure the availability of strategic professional leadership at times of leave.

* 1. **Named GP’s for Safeguarding – children and adults**
		1. The named GP for Safeguarding Children, and the named GP for Safeguarding Adults support the CCG in their quality, governance and safeguarding role by providing advice and support for General Practice staff; and promote 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.
		2. They will work closely with the GP Practice Safeguarding Leads to support the implementation of the safeguarding agenda: ensuring safe processes, up to date internal procedures, and a training strategy to meet the learning needs of staff.
		3. The named GP’s for safeguarding will access training and supervision commensurate with their role.
		4. Further details of the specific responsibilities of the named GP are included in the RCN led Intercollegiate Competency Framework documents for Safeguarding Children and Safeguarding Adults.
	2. **Staff in services working on behalf of NLCCG.**
		1. All staff working on behalf of NLCCG, (i.e. within services which are the responsibility of NLCCG to provide) must
			+ adhere to this policy
			+ undertake safeguarding children and adults training commensurate with their roles.
			+ contact the NLCCG Safeguarding Team for advice If they have a safeguarding concern in relation to a North Lincolnshire resident, or an individual registered with a North Lincolnshire GP practice,
		2. Those with line management responsibility must ensure that their staff
			+ have access to, are aware of and adhere to this policy,
			+ safeguarding children and adult competences are reviewed appropriately within their annual appraisal.
	3. **Member General Practices**
		1. The CCG will support all member practices to:
			+ Meet their duties and responsibilities to safeguard children and adults at risk
			+ Implement Practice level policies and procedures
	4. **Governance Framework**
		1. The CCG will have a quarterly Safeguarding Assurance Group to oversee assurance on the effectiveness of safeguarding arrangements within the CCG and all commissioned services
		2. The Quality, Performance and Finance Committee will receive bi-annual 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.

* + 1. The Governing Body will receives an Annual Report prepared by the Designated Nurse for Adults and Children which will set out the Strategy for the forthcoming year.

# COMMISSIONING AND CONTRACTING ARRANGEMENTS

* 1. **Expectations of providers.**
		1. All services commissioned by North Lincolnshire CCG must 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 undertake with due regard to
			+ all contemporary legislation,
			+ statutory guidance,
			+ local multi-agency procedures.
			+ Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework (NHS England, 2015), and successor documents
			+ Safeguarding children and young people: roles and competencies for health care staff – Intercollegiate Document (Royal College of Nursing, 2019) and successor guidance
			+ Adult Safeguarding: roles and competencies for health care staff – Intercollegiate Document (Royal College of Nursing, 2018), and successor guidance

All contracts for services for commissioned by NLCCG will include a standard clause outlining their responsibilities to comply with statutory and local requirements. This clause is included in [Appendix 5](#_bookmark20)

* + 1. All providers of services commissioned by NLCCG are required to meet the standards in relation to safeguarding adults and children as outlined in the Self Declaration Template ([Appendix 6](#_bookmark21)). 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 the self-declaration at least annually, submitting additional evidence as requested by the CCG.- embed?
		2. All Providers will be 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.
	1. **Performance and monitoring of providers**
		1. Providers’ performance in relation to safeguarding standards will be managed primarily through contract monitoring arrangements.
		2. The precise nature and frequency of reporting will be negotiated with the Provider, the Quality and Patient Safety Lead and Designated Nurse for Adults and Children. Both 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.
		3. The level of assurance that NLCCG require will be proportionate, taking into account a number of aspects including the potential risk to individuals. The larger the size of the contract, the more detailed and frequent the assurance requirements will be.
		4. CCG contract leads will ensure provider assurance and performance information in respect of compliance with safeguarding (including Prevent) is forwarded to the Designated Nurse for Adults and Children, via nlccg.safeguarding@nhs.net, within 3 working days of receipt.
		5. The CCG Safeguarding Team will review and scrutinise all safeguarding quarterly and annual reports from Providers and make comments to the Quality and Patient Safety Lead, and through contract management processes. Where a Provider is unable to demonstrate compliance with any adult and children safeguarding standards, they will be required to produce an action plan with timescales that details steps to be taken to achieve compliance. This action plan will be monitored by the Quality and Patient Safety Lead and the Designated Nurse for Adults and Children, through contract management process.
		6. 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 NL C-MARS or NLSAB
		7. 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:
			+ C-MARS/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
		8. The Designated Nurse for Adults and Children will provide safeguarding performance information to the NLCCG Quality, Performance & Finance Committee, and an annual report summarising trends, unresolved risks and safeguarding activity from commissioned services.

# RESPONDING TO CONCERNS ABOUT A CHILD OR ADULT’S WELFARE

* 1. **All** those who come into contact with
		+ children and their families and/ or
		+ adults with care and support needs

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.

* 1. All CCG staff, and those working on behalf of NLCCG, will take action to respond to concerns, or information which indicates that a child, or an adult has suffered, or is likely to suffer harm. Specific details in respect of action which must be taken can be found at [Appendix 2](#_bookmark17).
	2. In all cases where a member of staff identifies concerns, or receives information which indicates that a child, or an adult has suffered, or is likely to suffer harm, the staff member
		+ **MAY** highlight/discuss the concern with their line manager
		+ **MUST** contact a member of the CCG Safeguarding Team for safeguarding advice and/ or ensure they are sighted on all safeguarding issues. Contact details for these individuals can be found at [Appendix 1](#_bookmark16).
	3. CCG staff, or those working on behalf of NLCCG
		+ must not decide that concerns they have are not significant enough to discuss with their line manager/ or the CCG Safeguarding Team.
		+ MUST advice the Executive Lead for Safeguarding, or a member of the CCG Safeguarding Team, if they are advised of safeguarding concerns, including where there are allegations that a member of CCG staff, or staff within a provider may have harmed, or pose a risk of harm to a child or an adult (see section below on allegations against professionals.
	4. Line managers must:
		+ actively encourage/ support staff to discuss concerns and seek further advice.
		+ NOT prevent staff from discussing concerns with the CCG Safeguarding Team
	5. **Sharing of information**
		1. NLCCG staff will share relevant and proportionate information, with other agencies, in a safe and timely manner, in all circumstances where this is necessary for the purposes of safeguarding adults and children and 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 11](#_bookmark26).
		2. Staff will ensure that the CCG Safeguarding Team are aware of all requests for information for the purposes of safeguarding adults and children. Consideration must be given to discussing the request with the Caldicott Guardian. However, sharing of information in accordance with the “seven golden rules” MUST NOT be delayed if the Caldicott Guardian or Safeguarding Team are not available.
	6. **Allegations against staff – People in a Position of Trust (PiPoT)**
		1. NLCCG will ensure that all allegations of abuse against staff will be managed in accordance with C-MARS and/or SAB procedures as appropriate. Such allegations may arise if it is felt that a person who works with children/adults:
			+ has behaved in a way that has harmed or may have harmed an adult or child
			+ has possibly committed a criminal offence against, or related to, an adult or child.
			+ has behaved towards an adult or child in a way that indicates they may pose a risk of harm to adults with care and support needs.
			+ may be subject to an investigation by police as a perpetrator of domestic harm.
			+ has behaved (or is alleged to have behaved) towards children in a way that indicates that they may pose a risk of harm to adults with care and support needs.
			+ is subject of a formal safeguarding enquiry into allegations of abuse or neglect which have occurred in one setting. However, there are also concerns that the person is employed, volunteers or is a student in another setting where there are adults with care and support needs who may also be at risk of harm.
		2. NLCCG has identified the Designated Nurse for Adults and Children as the organisation’s Senior Officer for allegations/ PiPoT lead, whose role is to:
			+ Receive notifications on allegations
			+ Log and record details of allegations or concerns
			+ Lead management and oversight of individual cases
			+ Provide advice and guidance to personnel when needed.
			+ Liaise with the
				- Local Authority Designated Officer –for concerns in respect of safeguarding children
				- Safeguarding Adult Team – for concerns in respect of safeguarding adults.
			+ Liaise with police and other agencies where proportionate
			+ Monitor the process of the case and lead a speedy resolution through consistent and fair practice.
			+ Provide advice and guidance in relation to making referrals to the Disclosure and Barring Service (DBS) and regulatory bodies such as NMC, GMC, Ofsted, CQC
			+ Provide reports to the C-MARS and SAB Safeguarding Adults Board.
		3. 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 for Adults and Children, who will support further activity required. The Designated Nurse for Adults and Children will advise the Director of Nursing & Quality and, where appropriate, the Associate Medical Director of any allegation.
		4. In the absence of the Designated Nurse for Adults and Children, the Director

of Nursing & Quality **MUST** be contacted directly.

* + 1. In accordance with multiagency safeguarding procedures, the Designated Nurse for Adults and Children or the Director of Nursing and Quality may hold discussions with:
			- for concerns regarding children, the Local Authority Designated Officer (LADO)
			- for concerns regarding adults, the Safeguarding Adult Team (SA Team for PIPOT)

A link to the contact details for the LADO and SA Team can be found in [Appendix 1](#_bookmark16).

* + 1. In line with C-MARS/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 by the Designated Nurse for Adults and Children, or Director of Nursing and Quality, along with any other measures taken to manage risks. A history of making allegations does not constitute evidence that an allegation is false.

# MANAGEMENT OF SAFEGUARDING SERIOUS INCIDENTS (SIS), COMPLAINTS AND CLAIMS.

* 1. **Complaints and Claims**
		1. Any member of NLCCG staff who is made aware of a claim or complaint, which
			+ include concerns in respect of an individual’s safety, or
			+ the member of CCG staff identifies safeguarding issues within the claim or complaint

must seek advice from the Safeguarding Team.

* + 1. All claims, complaints, letters from MPs must be forwarded to the Patient Experience Manager, in accordance with NLCCG Management of Complaints, Comments and Concerns Policy. However, it is the responsibility of the first member of staff who identifies safeguarding concerns to seek advice from the Safeguarding Team.
	1. **Serious Incidents**
		1. 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, as relevant.
		2. The Designated Nurse for Adults and Children will receive notification of all **Serious Incidents** logged on STEIS for North Lincolnshire Providers. The Designated Nurse for Adults and Children will review the notifications, and where safeguarding children or adult issues are identified, will work with the Head of Nursing and attend/ advise the SI meeting as appropriate.
		3. The Head of Nursing will monitor all **Incident** reports received by the CCG, and will request review by the Designated Nurse for Adults and Children as required.
		4. NLCCG will actively participate in any multiagency statutory reviews under the following frameworks:
			+ in line with *Working Together to Safeguard Children* (2018) safeguarding partners will commission Child Safeguarding Practice Reviews (CSPRs)
			+ in accordance with guidance for adult safeguarding concerns, the LSAB will commission Safeguarding Adult Reviews (SARs). The Local Authority will also initiate Safeguarding Adult Enquiries, or ask others to do so, if they suspect an adult is at risk of abuse or neglect
			+ subsequent to the Domestic Violence, Crime and Victims Act 2004, the Community Safety Partnership will commission Domestic Homicide Reviews.

In cases where there is to be a CSPR, DHR, SAR, the review and any SI will run together and will follow C-MARS, SAB or Community Safety Partnership statutory guidance.

* + 1. Further information on the interface between multiagency statutory reviews, and the NHS Serious Incident Framework can be found at [Appendix 13.](#_bookmark28)

# TRAINING.

* 1. **Training**
		1. NLCCG will ensure that all of its staff are competent and confident in carrying out their responsibilities for safeguarding and promoting the welfare of children and adults with care and support needs.
		2. NLCCG will ensure it meets the requirements of associated guidance in respect of training requirements, i.e.
			+ Working Together to Safeguard Children (2018)
			+ Safeguarding children and young people: roles and competencies for health care staff – Intercollegiate Document (Royal College of Nursing, 2019)
			+ Adult Safeguarding: Roles and competences for health care staff – Intercollegiate Document (Royal College of Nursing, 2018)

See [Appendix 10](#_bookmark25) for an outline of training required for CCG staff.

* + 1. It is the responsibility of the line manager to ensure that evidence of training completion is retained in the personnel file and the Electronic Staff Records is updated accordingly.
			- As a minimum staff training must be reviewed by the line manager at each appraisal point.
	1. **Safeguarding Supervision**

10.2.1 NLCCG will ensure that all staff working with children or adults with care and support needs, or who identify safeguarding concerns receive specialist safeguarding supervision in accordance with their role, or identified need.

See [Appendix 12](#_bookmark27) for details of NLCCG supervisions requirements and arrangements.

# 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.

# 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. The availability of the policy will be included in briefings and training delivered within the CCG

# MONITORING & AUDIT

Information on monitoring of, and compliance with, this policy will be included in report(s) from the Designated Nurse for Adults and Children. Once agreed, the Annual Report(s) will be submitted to C-MARS and SAB.

# POLICY REVIEW

This policy will be reviewed two years 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.

# REFERENCES

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

ADASS (2014) Making Safeguarding Personal Guide Care Act 2014, HMSO

Care and Support Statutory Guidance Issued under the Care Act 2014 Department of Health (updated 2018)

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 (2018) 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 Policy

NLC-MARS (2018) Safeguarding Arrangements for Escalation

Royal College of Nursing (2018) Safeguarding Adults: Roles and competencies for health care staff – Intercollegiate Document

[North Lincolnshire Safeguarding Adults Board Policy and Procedures](http://www.northlincssab.co.uk/professionals/) <http://www.northlincssab.co.uk/professionals/>

North Lincolnshire Children’s Multi-Agency Resilience and Safeguarding Procedures and Guidance

[http://www.northlincsC-MARS.co.uk/professionals/policies/](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,

Royal College of Nursing (2019) 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)

 **17.0 ,APPENDICES**

**APPENDIX 1: KEY CONTACTS – NORTH LINCOLNSHIRE**

North Lincolnshire CCG

|  |  |  |  |
| --- | --- | --- | --- |
| Helen Davis  | Executive Lead for Safeguarding  | Helen.davis6@nhs.net |  |
| Charlotte Morton | Designated nurse Safeguarding children and adults | Charlotte.morton11@nhs.net | 07912277251 |
| George Voulgaris  | Designated nurse LAC  | George.Voulgaris@nhs.net | 07900915837 |
| Liz Baxter  | Specialist Nurse – Safeguarding Children (Integrated Multi-Agency Partnership | liz.baxter@nhs.net | 07474275202 |
| Jakki Knight | Safeguarding Nurse- adults | Jakki.Knight@nhs.net | 07912269938 |
| Sarah Grimshaw | Specialist Nurse  | Sarah.grimshaw@nhs.net | 07912269935 |
| Julie Wilburn | Designated Nurse – Safeguarding (North East Lincolnshire CCG) | Julie.wilburn@nhs.net | 07702 975584 |
| Dr Sandeep Kapoor | Designated Doctor for Safeguarding Children | sandeepkapoor@nhs.net | 01724 282282 |
| Dr Lamia Ibrahim | Designated Doctor – Looked After Children | lamia.ibrahim@nhs.net | 01724 282282 |
| Dr Ahmed Mohammed  | Designated Paediatrician – Child Deaths | ahmed.mohammed4@nhs.net | 01724 282282 |
| Dr Elisabeth Alton | Named GP – Safeguarding Adults | Elisabeth.alton@nhs.net | 07738893011 |
| Dr Helen Thackery  | Named GP – Safeguarding Children  | Helen.thackery1@nhs.net  |  |

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 | **Stacey Darker**Local Authority Designated Officer: (LADO) | 01724 296101 |
| North Lincolnshire Safeguarding Children Board (NC-MARS) | **Nikki Alcock**C-MARS Service Manager | 01724 296101 |

**Adults**

|  |  |  |
| --- | --- | --- |
| For referrals where an ADULT is suffering or at risk of HarmORFor allegations that a member of staff has, or may have, caused or been complicit in abuse or neglect of an ADULT (PIPOT) | North Lincolnshire Adult Social Work Services**Single Access Point** | 01724 297000 |
| 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 usedFor concerns about harm to a child or adult, or for PREVENT referrals, or reporting FGM – use 101 |

**Prevent Contacts**

|  |  |  |
| --- | --- | --- |
| **Helen Davis** | Executive Lead for PREVENT | Helen.davis6@nhs.net01652 251058 |
| **Stuart Minto** | Local CHANNEL lead | Stuart.minto@northlincs.gov.uk |

**APPENDIX 2: RECOGNITION AND RESPONDING TO HARM TO CHILDREN OR ADULTS WITH CARE AND SUPPORT NEEDS**

**Harm**

1. 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
* Criminal exploitation
 | * Physical Abuse
* Sexual Abuse
* Psychological Abuse
* Neglect
* Self-Neglect
* Organisational Abuse
* Financial Abuse
* Modern Slavery
* Discriminatory Abuse
* Domestic Abuse
 |

1. Concerns that a child or adult may be a risk of suffering harm may arise from:
	* Information or observations provided by:
		+ A child/ vulnerable adult or his/her friends
		+ A family member
		+ A close associate
		+ Another professional/ practitioner
	* Behaviour by the child/ vulnerable adult
	* An injury that arouses suspicion
	* Contact with someone known to pose a risk to children/ vulnerable adults
2. 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 Children’s Multi-Agency Resilience and Safeguarding Board (C-MARS) procedures and guidance and/or the Safeguarding Adult Board (SAB) policy and procedures as relevant.
3. 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.
4. **Female Genital Mutilation**

Where concerns are identified in respect to Female Genital Mutilation in females under the age of 18, there is a **mandatory** duty for health professionals to report to the police via 101. Details on process for mandatory report can be found:- [https://www.gov.uk/government/uploads/system/uploads/attachment\_data/file/5254](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/525405/FGM_mandatory_reporting_map_A.pdf) [05/FGM\_mandatory\_reporting\_map\_A.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/525405/FGM_mandatory_reporting_map_A.pdf)



1. **Private Fostering.**

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.

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.

1. **Ensuring Immediate Safety and Protection**
2. The first priority is to ensure the safety and protection of the child or adult. In making the person (and others potentially at risk) safe, it may be necessary to inform the emergency services. If the child/ adult is in immediate danger the police or ambulance service as appropriate should also be called (using 999).
3. 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.
4. **Seeking Consent & Referrals**
5. **Children**: 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 C-MARS procedures and guidance.

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
	+ increase the risk of harm to the child, or
	+ put themselves or another person at risk,

then sharing the intent to refer with the parent or carer may be dispensed with.

Any individual who believes that consent/ intent to refer may be dispensed with should discuss the issues with the Caldicott Guardian or a member of the Safeguarding Children Team. However, a referral MUST NOT be delayed if the Caldicott Guardian or Safeguarding Team are not available.

1. **Adults**: 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 adult 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.

1. **Making Referral**
2. Anyone who has concerns about a child/ adult with care and support needs but is unclear whether they should make a referral must consult with the CCG Safeguarding Team.
3. Alternatively, advice can be sought from the relevant social care team. Practitioners should not delay in making a referral to await advice.
4. **Children:** Referrals to Children’s Social Care must be telephoned through as soon as is safely possible and must be followed up, in writing, within 48 hours.
5. **Adults:** A safeguarding adult referral should be made via the Single Point of Access on 01724 296700, and followed up with completion of a Safeguarding Alert.
6. **Recording**
7. A copy of the referral and any associated actions for example interventions, and details of telephone calls **must** be recorded by the member of staff identifying the concerns, and any member of staff who takes action to respond to concerns, within the
	* child/ adults records, if available, and
	* if relevant into parent or carer’s records.
8. If records are not available, any member of staff who identifies, or responds to concerns must make a written or electronic record of the issues and action taken. Support on making such records, and storage of these recordings must be sought from the Safeguarding Team
9. Records of incidents and concerns must be completed as soon as possible. Where records are handwritten, the date, your signature and designation must be clear. If records are hand-written, the original must be kept for evidential purposes.
10. 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.
11. **Responding to concerns regarding potential radicalisation. (Prevent)**

If practitioners have concerns about an individual patient or member of staff who may be susceptible to radicalisation and/or violent extremism or suspected of being engaged in terrorist activity, please contact the Specialist Nurse for Safeguarding or in their absence that Designated Nurse for Adults and Children or the Director of Nursing & Quality in line with local guidance.

1. **Escalating concerns**

If any member of CCG staff is concerned that another professional, service or agency is not taking their concerns seriously, then the member of staff must discuss their concerns with a member of the CCG Safeguarding Team. Where there are differences of professional views on appropriate action to respond to concerns, the C-MARS and SAB’s escalation processes must be utilised to resolve these concerns.

1. **Sharing of information**
2. 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 12](#_bookmark26).
3. 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 NL C-MARS 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.

**APPENDIX 3 : RESPONDING TO CONCERNS OF ABUSE OR NEGLECT - CHILD**

**CONCERNS RAISED OVER CHILD UNDER 18. PHYSICAL PRESENTATION INCLUDING INJURY OR MEDICAL, BEHAVIOURAL INDICATIONS OF**

* **PHYSICAL HARM**
* **SEXUAL HARM**
* **EMOTIONAL HARM**
* **NEGLECT**

**LISTEN AND OBSERVE – CONSIDER ABOVE PRESENTATION AND PARENTAL-CHILD OBSERVATIONS. CONSIDER HISTORY**

**SEEK AN EXPLANATION WITH PARENT/YOUNG PERSON FOR PRESENTATION/INJURY**

**CHILD MAKES DISCLOSURE OF MALTREATMENT**

**MAKE RECORD OF PRESENTATION, CONCERNS AND EXPLANATIONS- WHAT IS OBSERVED, FROM WHOM AND WHEN – STATE WHY OF CONCERN**

**CONSIDER, SUSPECT AND EXCLUDE. DOES EXPLANATION FIT INJURY OR PRESENTATION? INCONSISTENT, IMPLAUSIBLE OR INADEQUATE EXPLANATION? CONSIDER DEVELOPMENTAL STAGE/AGE**

**NO CONCERNS CONCERNS REMAIN**

**SEEK ADVICE FROM SAFEGUARDING LEAD AND DISCUSS -**

**RECORD ACTIONS ALL ACTIONS TAKEN AND OUTCOME**

**REFERRAL TO DUTY SOCIAL CARE 01724 296500**

**OR ADVICE THROUGH SAFEGUARDING TEAM – 01652 251216**

26

**RECORD ACTIONS TAKEN AND OUTCOME**

**APPENDIX 4: RESPONDING TO CONCERNS OF ABUSE OR NEGLECT - ADULT**

**CONCERNS RAISED THAT ADULT HAS OR IS AT RISK OF ABUSE OR NEGLECTED BY**

**ENSURE SAFETY OF ADULT, IF THERE IS IMMEDIATE DANGER CALL 999 NON**

**EMERGENCY CALL 101**

**PHYSICAL HARM MODERN DAY SLAVERY**

**SEXUAL HARM DISCRIMINATORY REASONS PSYCHOLOGICAL HARM NEGLECT AND ACTS OF OMISSION SELF NEGLECT ORGANISATIONAL ABUSE**

**FINANCIAL ABUSE**

**DOMESTIC ABUSE – including coercive control**

**DO CONCERNS MEET THE NEED FOR SHARING UNDER PUBLIC NO INTEREST, HAS CRIME BEEN COMMITTED OR CHILD UNDER**

**DOES THE ADULT HAVE CARE AND SUPPORT NEEDS?**

**THE AGE OF 18 ALSO AT RISK**

**NO**

**UNABLE TO SHARE/REFER**

**DO THE CARE/SUPPORT NEEDS PREVENT THE ADULT FROM BEING ABLE TO PROTECT THEMSELVES?**

**YES**

**NO**

**YES**

**CONSENT GAINED TO SHARE CONCERNS?**

**DOES THE ADULT HAVE CAPACITY TO MAKE DECISIONS?**

**NO**

**YES**

**ADULT WITH CARE AND SUPPORT NEEDS GIVES CONSENT OR MEETS THRESHOLD CRITERIA WITH OUT CONSENT FOR POLICE/SOCIAL CARE REFERRAL**

**IF DOES NOT MEET SAFEGUARDING THRESHOLD & UNABLE TO SHARE/REFER**

**CONSIDER COMPLEX CARE NEEDS OR CONSENT FOR SUPPORT THROUGH MULTI AGENCY WORKING**

**DISCUSS WITH SAFEGUARDING LEAD.**

**FOR ADULT SAFEGUARDING CONTACT 01724 296700.**

**NON URGENT CRIME CALL POLICE 101**

**RECORD ACTIONS**

**APPENDIX 5: STANDARD CLAUSE FOR CONTRACTS.**

The Provider will have in place arrangements which ensure compliance with the following legislation/ statutory guidance, or successor documents:

* + Children Act 2004, sections 10 and 11
	+ Care Act 2014, sections 42-26
	+ Mental Capacity Act 2005
	+ Working Together to Safeguarding Children (2018)
	+ Care and support statutory guidance: Chapter 14
	+ CQC Fundamental Standards (2014); Regulation 13
	+ North Lincolnshire Children’s Multi-Agency Resilience and Safeguarding Board Policies and Procedures - [http://www.northlincscmars.co.uk/policies- procedures-and-guidance/](http://www.northlincscmars.co.uk/policies-procedures-and-guidance/)
	+ North Lincolnshire Safeguarding Adult Board Policy and Procedures -<http://www.northlincssab.co.uk/professionals/>

The Provider will also ensure compliance in accordance with new legislation/ statutory guidance on implementation.

In order to demonstrate compliance, the Provider will ensure they have arrangements as outlined within the **Expectation of Providers** (section 7.1) in NLCCG Safeguarding Policy, and provide evidence to the Commissioner as requested and as outlined in **Performance and monitoring of providers (**section 7.2) and **Appendices 6 and 7** of the same policy.

**APPENDIX 6: SELF DECLARATION : SAFEGUARDING ADULTS AND CHILDREN**

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

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

**ANNUAL Declaration to be submitted by mid-May, or within 6 weeks of request**

**ANNUAL Declaration**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Applicable to:** | **No** | **Standard** | **Evidence of Compliance** | **RAG****rating** |
| **Policy, Procedures, Organisational Systems** |
| **ALL** | **1** | The Provider has up to date organisational safeguarding policies and procedures, consistent with relevant legislation, which reflect and adhere to local multi-agency safeguarding boards & arrangements policies & procedures. i.e. North Lincolnshire Children’s Multi-Agency Resilience and Safeguarding Board (C-MARS) and Safeguarding Adults Board (SAB) .The Provider can provide evidence of review dates and policy development. |  |  |
| **ALL** | **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 STAFF1 have access to the guidance and know how to use it. |  |  |

1 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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Applicable to:** | **No** | **Standard** | **Evidence of Compliance** | **RAG****rating** |
| **NHS Trusts****Large Providers** | **3** | The Provider has policies which include as relevant, processes for::* 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 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
* 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
	+ appropriate recording of information where individuals are subject to MAPPA
 |  |  |
| **NHS Trusts****Large Providers** | **4** | The Provider has ensured that all corporate and clinical policies, where appropriate, include reference to 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. |  |  |
| **NHS Trusts****Large Providers** | **5** | The Provider has ensured that all corporate and clinical policies and procedures with relevance to safeguarding adults with care and support needs, are consistent with and referencesafeguarding legislation, national policy/guidance and local multiagency safeguarding procedures. |  |  |
| **All** | **6** | 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. |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Applicable to:** | **No** | **Standard** | **Evidence of Compliance** | **RAG****rating** |
| **All** | **7** | 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. |  |  |
| **All** | **8** | The Provider has ensured their policies reference that the management of allegations against a person in a position of trust (against an adult/s or child/ren) follows the C-MARS/ SAB procedures. |  |  |
| **All** | **9** | 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 referencing LADO/PIPOT  |  |  |
| **Care Homes Hospitals** | **10** | 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 CIPOLD objectives. |  |  |
| **Care Homes Hospitals** | **11** | 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, including Mental Capacity Act and Deprivation of Liberty Safeguards. |  |  |
| **All** | **12** | The Provider has an up-to-date clinical/professional supervision policy in place that references safeguarding considerations for all clinical staff. |  |  |

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| **Applicable to:** | **No** | **Standard** | **Evidence of Compliance** | **RAG****rating** |
| **NHS Trusts****Large Providers** | **13** | 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, specifically but nor exclusively parents with learning disabilities or mental health issues
* adults with care and support needs, and
* specialist / lead safeguarding practitioners and
* staff line managing these groups

have access to planned, protected and documented safeguarding supervision at least quarterly, or in accordance with the Intercollegiatedocument(s). |  |  |
| **All** | **14** | The provider has arrangements for Named or specialist/ lead safeguarding practitioners to access safeguarding supervision from the Designated Nurse or Doctor, or an alternative, suitably qualifiedprofessional who works outside the provider organisation. |  |  |
| **NHS Trusts****Large Providers** | **15** | The Provider has systems in place to evidence that staff are aware of how to contact Named Professionals, or Safeguarding Leads for their organisation, **and** all Designated Professionals. |  |  |
| **All** | **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. |  |  |
| **NHS Trusts****Large Providers** | **17** | The Provider includes in their policies and procedures clear guidance on the* use of assessment processes in safeguarding, and
* 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. |  |  |

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| **Applicable to:** | **No** | **Standard** | **Evidence of Compliance** | **RAG****rating** |
| **All** | **18** | The Provider has in place, or have adopted C-MARS and SAB policies/procedures for sharing information where there are concerns for the welfare of a child or adult with care and support needs. |  |  |
| **NHS Trusts****Large Providers** | **19** | The Provider has recording systems and processes in place, in all cases, which allow for appropriate information sharing* between health professionals within the organisation
* across health organisation boundaries, and
* across agency boundaries

to promote a holistic approach to assessing and addressing needs of service users of all ages, and evidence collaborative working. |  |  |
| **NHS Trust****Large Providers** | **20** | 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. |  |  |
| **NHS Trusts** | **21** | The provider has systems in place to ensure compliance with mandatory duty to report FGM. |  |  |
| **Governance - Leadership** |
| **NHS Trusts** | **22** | The Provider has a Board-Level executive Director with lead responsibility for safeguarding. |  |  |
| **Other organisations** | **23** | The Provider has (a) Senior manager(s) with lead responsibility for safeguarding child and adults. This individual is able to* speak for their organisation with authority;
* commit the organisation on policy and practice matters.
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| **All** | **24** | The Provider has have in post a named health or social care professional(s) for adult and children safeguarding with sufficient capacity to effectively carry out these roles |  |  |

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| **Applicable to:** | **No** | **Standard** | **Evidence of Compliance** | **RAG****rating** |
| **NHS Trusts,****Independent providers****Social Enterprises** | **25** | 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 (2019), and sufficient capacity to carry out these roles. |  |  |
| **Out of Hours services****Ambulance Trusts** | **26** | 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 (2019), and sufficient capacity to carry out these roles. |  |  |
| **Maternity Providers** | **27** | 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 (2019), and sufficient capacity to carry out these roles. |  |  |
| **All** | **28** | 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. |  |  |
| **Governance - Systems** |
| **All** | **29** | The Provider reviews the effectiveness of the organisations safeguarding arrangements at least annually and identifies any risks, service improvement requirements and learning points as well as areas of good practice. |  |  |
| **NHS Trusts****Large Providers** | **30** | The Provider has produced an Annual Report which reflects the effectiveness of their safeguarding arrangements.The Provider will have evidence that this report has been received and approved by their governing body |  |  |

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| **Applicable to:** | **No** | **Standard** | **Evidence of Compliance** | **RAG****rating** |
| **NHS Trusts****Large Providers** | **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. |  |  |
| **NHS Trusts****Large Providers** | **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. |  |  |
| **All** | **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. |  |  |
| **NHS Trusts****Large Providers** | **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. |  |  |
| **Care Homes Hospitals** | **35** | The Provider has effective systems for recording and monitoring Deprivation of Liberty applications to the authorising body/Court of protection. |  |  |
| **NHS Trusts****Large Providers** | **36** | The Provider has evidence of annual audit programmes to assure itself that safeguarding systems and processes, are working effectively**,** including* compliance with s11 Children Act 2004
* compliance with Care Act 2014
* quality and effectiveness of 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 has included this information within their Annual safeguarding report. |  |  |

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| **Applicable to:** | **No** | **Standard** | **Evidence of Compliance** | **RAG****rating** |
| **Mental Health organisations** | **37** | The Provider will is able to evidence the number of assessments using the Mental Health Clustering Tool (MHCT) and referrals as a result with trend analysis |  |  |
| **All** | **38** | The Provider has 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 Human Rights Act, Mental Capacity Act and Mental Health Act. |  |  |
| **Multi-agency Working & Responding to Concerns** |
| **All** | **39** | The Provider actively promotes their staff working together with other agencies in accordance with C-MARS or SAB policies and procedures, including use of assessments as the basis for early identification of needs, and ensures staff understand thresholds for referral to other agencies. |  |  |
| **All** | **40** | The Provider has mechanisms to ensure and monitor that organisational representatives / practitioners make an effective contribution to Child Protection Conferences, s47 and s42 strategy meetings where required as part of multiagency procedures. |  |  |
| **All** | **41** | The Provider ensures that a root cause analysis is undertaken for all pressure ulcers of grade 3 or 4, and that a multi-agency referral is made where abuse or neglect are believed to be a contributory factor. |  |  |
| **NHS Trusts****Large Providers** | **42** | The Provider has arrangements in place, to respond to the death of a child, and the statutory child death review process, including contributing relevant information in respect to significant adults |  |  |

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| **Applicable to:** | **No** | **Standard** | **Evidence of Compliance** | **RAG****rating** |
| **All** | **43** | The Provider has mechanisms in place to ensure that all allegations of a safeguarding nature involving staff members (including staff on fixed term contracts, temporary staff, bank staff, locums, agency staff, volunteers, students and trainees) are referred to the Local Authority Designated Officer (LADO)/ Adult Safeguarding Team according to multi-agency safeguarding procedures |  |  |
| **All** | **44** | The Provider ensures that any allegation, complaint or concern about abuse from any source is managed effectively and referred according to the local multi-agency safeguarding procedures. |  |  |
| **All** | **45** | The Provider ensures that there is a system for monitoring complaints, incidents and service user feedback, in order to identify and share any concerns of abuse (including potential neglect), using multiagency safeguarding procedures. |  |  |
| **NHS Trusts****Large Providers** | **46** | 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. |  |  |
| **NHS Trusts** | **47** | The Provider has systems in place to ensures the **NLCCG Designated Nurse and Designated Nurse for Adults and Children** is informed of any incident which meets (or may meet) the criteria for a Safeguarding Serious Incidentwithin 1 working day of identification. |  |  |
| **NHS Trusts****Large Providers** | **48** | The Provider has, or has access to, appropriately experienced staff to conduct, C-MARS/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 |  |  |
| **All** | **49** | The Provider, where required by the C-MARS or SAB, contributes to multi-agency audits, evaluations, investigations and reviews, including where required, the production of an individual management report |  |  |

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| **Applicable to:** | **No** | **Standard** | **Evidence of Compliance** | **RAG****rating** |
| **All** | **50** | The Provider, where required by the C-MARS or SAB, has arrangements to consider the organisational/ service implications of completed multiagency review(s) to ensure that any learning is implemented across all relevant services. |  |  |
| **All** | **51** | The Provider, where required by the C-MARS, SAB or CCG has developed an organisational/ service Action Plan in response to any multi- agency review, and had submitted, and provided updates this to the responsible Safeguarding Boards and the CCG |  |  |
| **All** | **52** | **Where the Provider has been/ is subject to regulatory inspection(s)**The Provider, where subject to a regulatory inspection, has evidence to show that* recommendations and action from safeguarding inspections, or
* safeguarding recommendations and actions from service/ organisational inspections

have been implemented and embedded in practice. |  |  |
| **NHS Trusts** | **53** | The Provider has evidence of its effectiveness in contributing to* C-MARS and SAB priorities,
* sub-group activity,
* training programmes,
* working with other agencies
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| **All** | **54** | The Provider, where required, ensures senior representation on the C- MARS and SAB and contribution to their sub-groups. |  |  |
| **NHS Trusts** | **55** | The Provider has evidence of its effectiveness in contributing to C-MARS and SAB priorities* sub-group activity,
* training programmes,
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| **Applicable to:** | **No** | **Standard** | **Evidence of Compliance** | **RAG****rating** |
| **Recruitment and employment** |
| **All** | **56** | 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. |  |  |
| **All** | **57** | The Provider ensures that post recruitment employment checks are repeated in line with all contemporary national guidance and legislation. |  |  |
| **All** | **58** | 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. |  |  |
| **All** | **59** | 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. |  |  |
| **All** | **60** | 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 |  |  |
| **All** | **61** | The Provider ensures that all allegations of neglect or abuse against members of staff (including staff on fixed-term contracts, temporary staff, locums, agency staff, volunteers, students and trainees) are referred according to the relevant local multi-agency safeguarding procedures. |  |  |

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| **Applicable to:** | **No** | **Standard** | **Evidence of Compliance** | **RAG****rating** |
| **All** | **62** | The Provider ensures 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. |  |  |
| **Training -** N.B. STAFF include all permanent employees, those on fixed-term contracts, temporary staff, contractors, locums, bank staff, agency staff, volunteers, students, apprentices and trainees |
| **All** | **63** | The Provider has (a) training strategy(ies)/ programme which includes requirements for* Safeguarding Children,
* Safeguarding Adults,
* MCA & DOLS and
* PREVENT,

and is compliant with* C-MARS/ SAB strategy,
* Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (Royal College of Nursing, 2019)
* Safeguarding Adults: roles and competencies for health care staff (Royal College of Nursing, 2018)

or any successor editions of these documents. |  |  |
| **All** | **64** | The Provider has ensured that all STAFF, have a 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

within 6 weeks of commencing employment. (RCN, 2018 & 2019)) |  |  |
| **All** | **65** | The Provider holds comprehensive details of the uptake of all STAFF training, and uses this to inform a regular comprehensive training needs analysis and plan training required |  |  |

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| **Applicable to:** | **No** | **Standard** | **Evidence of Compliance** | **RAG****rating** |
| **All** | **66** | The Provider ensures a proportionate contribution to the delivery of multiagency training programmes through the C-MARS/SAB. |  |  |
| **All** | **67** | The Provider has evidence to support effectiveness of training |  |  |
| **PREVENT** |
| **NHS Bodies** | **68** | The Provider has an Executive lead with responsibility for the Prevent strategy |  |  |
| **All** | **69** | 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. This includes attendance, where required, at the local Prevent Silver Group. |  |  |
| **All** | **70** | The Provider has a policy/guidance which clearly sets out how to escalate Prevent concerns and make a referral. This policy/guidance is consistent with the Prevent guidance and the Prevent Toolkit and accessible to all staff |  |  |
| **All** | **71** | The Provider has a training plan that identifies the Prevent related training needs for all staff, including a programme to ensure access to appropriate training. |  |  |
| **NHS Bodies****Larger Independent Providers** |  | The Provider has ensured that implementation of the Prevent agenda is monitored through the Trust’s audit cycle/governance reporting mechanisms |  |  |

**Safeguarding Commissioners Standards: Remedial Action Plan**

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| --- | --- | --- | --- | --- |
| **Standard No.** | **Action(s) required to achieve standard** | **Person Responsible** | **Date Due** | **Comments / Progress** |
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**APPENDIX 7: QUARTERLY REPORTING**

Providers are required to provide a quarterly report where requested by the Commissioners on:

* Safeguarding Supervision Compliance
* Contribution to Multi-Agency Assessment and Planning
* Safe Recruitment Practice
* Training Compliance

in accordance with the relevant template as below:

* NHS Trusts – Acute Provider
* NHS Trusts – Community & Mental Health Provider
* Large Independent Provider
* Small Provider

**APPENDIX 8: 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, and coercive control.

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 9: DEFINITIONS – SAFEGUARDING CHILDREN**

(Taken from Working Together 2020, p 106-111

 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 mental and physical 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. Harm can include ill treatment that is not physical as well as the impact of witnessing ill treatment of others. This can be particularly relevant, for example, in relation to the impact on children of all forms of domestic abuse. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others. Abuse can take place wholly online, or technology may be used to facilitate offline abuse.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).

Parent carer

person aged 18 or over who provides or intends to provide care for a disabled child for whom the person has parental responsibility.

Child Sexual Exploitation

‘Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.

County Lines

 As set out in the Serious Violence Strategy, published by the Home Office, a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of ‘deal line’. They are likely to exploit children and vulnerable adults to move and store the drugs and money, and they will often use coercion, intimidation, violence (including sexual violence) and weapons.

 Child criminal exploitation

As set out in the Serious Violence Strategy, published by the Home Office, where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18 into any criminal activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial or other advantage of the perpetrator or facilitator and/or (c) through violence or the threat of violence. The victim may have been criminally exploited even if the activity appears consensual. Child criminal exploitation does not always involve physical contact; it can also occur through the use of technology

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.

Extremism.

Extremism goes beyond terrorism and includes people who target the vulnerable – including the young – by seeking to sow division between communities on the basis of race, faith or denomination; justify discrimination towards women and girls; persuade others that minorities are inferior; or argue against the primacy of democracy and the rule of law in our society. Extremism is defined in the Counter Extremism Strategy 2015 as the vocal or active opposition to our fundamental values, including the rule of law, individual liberty and the mutual respect and tolerance of different faiths and beliefs. We also regard calls for the death of members of our armed forces as extremist.

Domestic abuse

 is not limited to physical acts of violence or threatening behaviour, and can include emotional, psychological, controlling or coercive behaviour, sexual and/or economic abuse. Types of domestic abuse include intimate partner violence, abuse by family members, teenage relationship abuse and adolescent to parent violence. Anyone can be a victim of domestic abuse, regardless of gender, age, ethnicity, socio-economic status, sexuality or background and domestic abuse can take place inside or outside of the home. Domestic abuse continues to be a prevalent risk factor identified through children social care assessments for children in need. Domestic abuse has a significant impact on children and young people. Children may experience domestic abuse directly, as victims in their own right, or indirectly due to the impact the abuse has on others such as the non-abusive parent. 111 Item Definition More information can be found in the Draft Domestic Abuse Statutory Guidance Framework, including the new statutory definition of domestic abuse that will be introduced when the Domestic Abuse Bill is enacted.

Controlling or coercive behaviour

Also known as coercive control, the use of control and coercion in relationships is a form of domestic abuse and, since December 2015, a criminal offence. Controlling and coercive behaviour is outlined in Government guidance issued under section 77 of the Serious Crime Act 2015 as part of the Government’s non-statutory definition of domestic violence and abuse. It is described as: • Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour; and • Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim Coercive control is a form of abuse that involves multiple behaviours and tactics which reinforce each other and are used to isolate, manipulate and regulate the victim. This pattern of abuse creates high levels of anxiety and fear. This has a significant impact on children and young people, both directly, as victims in their own right, and indirectly due to the impact the abuse has on the non-abusive parent. Children may also be forced to participate in controlling or coercive behaviour towards the parent who is being abused. Controlling or coercive behaviour also form part of the definition of domestic abuse in section 1(3)(c) of the Domestic Abuse Bill. More information can be found in the Draft Domestic Abuse Statutory Guidance Framework.

Local authority designated officer

 County level and unitary local authorities should ensure that allegations against people who work with children are not dealt with in isolation. Any action necessary to address corresponding welfare concerns in relation to the child or children involved should be taken without delay and in a coordinated manner. Local authorities should, in addition, have designated a particular officer, or team of officers (either as part of multi-agency arrangements or otherwise), to be involved in the management and oversight of allegations against people who work with children. Any such officer, or team of officers, should be sufficiently qualified and experienced to be able to fulfil this role effectively, for example qualified social workers. Any new appointments to such a role, other than current or former designated officers moving between local authorities, should be qualified social workers. Arrangements should be put in place to ensure that any allegations about those who work with children are passed to the designated officer, or team of officers, without delay.

 Safeguarding partners

 A safeguarding partner in relation to a local authority area in England is defined under the Children Act 2004 as: (a) the local authority, (b) a clinical commissioning group for an area any part of which falls within the local authority area, and (c) the chief officer of police for an area any part of which falls within the local authority area. The three safeguarding partners should agree on ways to co-ordinate their safeguarding services; act as a strategic leadership group in supporting and engaging others; and implement local and national learning including from serious child safeguarding incidents. To fulfil this role, the three safeguarding partners must set out how they will work together and with any relevant agencies as well as arrangements for conducting local reviews.

 Child death review partners

 A child death review partner in relation to a local authority area in England is defined under the Children Act 2004 as (a) the local authority, and (b) any clinical commissioning group for an area any part of which falls within the local authority area. The two partners must make arrangements for the review of each death of a child normally resident in the area and may also, if they consider it appropriate, make arrangements for the review of a death in their area of a child not normally resident there. They must also make arrangements for the analysis of information about deaths reviewed under this section. The purposes of a review or analysis are (a) to identify any matters relating to the death or deaths that are relevant to the welfare of children in the area or to public health and safety, and (b) to consider 110 Item Definition whether it would be appropriate for anyone to take action in relation to any matters identified

**APPENDIX 10: 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, RCN (2019)
* For Safeguarding Adults: Safeguarding Adults: Roles and and competences for health care staff (RCN. 2018)

**Training Required**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Role***If a staff member features in more than one section below, they should access the higher level training.* | **Safeguarding Children** | **Safeguarding Adults** | **PREVENT** | **MCA** | **DoLS** |
| All Staff who do not feature in any other section below | 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 etc | Level 2 | Level 2 | Yes | Yes | Yes |
| Staff with a ‘live’ clinical professional qualification who* work with children and young people, including in transition to adult services, or
* have significant contact with adult service users who have care and support needs, mental health (including dementia) issues, substance misuse issues or learning disabilities
 | Level 3 | Level 3 | Yes | Yes | Yes |
| Other staff with a ‘live’ clinical professional qualification | Level 2 | Level 2 | Yes | Yes | Yes |
| 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 |
| Named & Specialist Safeguarding Professionals | Level 4 | Level 4 | Yes | Yes | Yes |
| Designated Nurse for Adults and Children | Level 5 | Level 5 | Yes | Yes | Yes |
| Designated Doctor(s)\*(Safeguarding Children, Looked After Children, Child Deaths) \* | Level 5 | Level 3 | Yes | Yes | Yes |

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

**APPENDIX 11: 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.

**APPENDIX 12: SAFEGUARDING SUPERVISION-**

1. **Definition - what is supervision?**

Supervision is a term used to describe a formal and agreed process of professional support and learning which enables practitioners to develop knowledge and competencies. The process allows the practitioner to assume responsibility for their own practice and to provide an enhanced service for the service user. It is defined as:

*“An accountable process which supports assures and develops the knowledge, skills and values of an individual, group or team. The purpose is to improve the quality of their work to achieve good outcomes” Promoting effective supervision (Skills for Care and CWDC 2007)*

*‘A formal process of professional support and learning, which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice, and enhance consumer protection and safety of care in complex clinical situations. It is central to the process of learning and to the scope of the expansion of practice and should be seen as a means of encouraging self- assessment and analytical and reflective skills’ (DH 2004).*

Supervision for staff working with children, young people their families and/or adults with care and support needs therefore provides a framework for examining a case from different perspectives, and facilitates the analysis of the risk and protective factors involved. It provides staff with the opportunity to reflect upon their work and decision making in relation to child/Adult protection. It enables the practitioner not only to deal with the stresses inherent in working with vulnerable children and their families and/or adults with care and support needs, but also to explore their own role and responsibilities in relation to the families/carers that they are working with. It facilitates good quality, innovative and reflective practice in a safe environment and in turn enables the provision of restorative practice.

1. **Types of supervision**

Supervision may be provided in a variety of arrangements.

**B1 Individual Supervision**

This process will be based around the NHS reflective practice process for revalidation (Appendix c), now being used for nurses. It is a clear and precise process allowing for description, analysis and evaluation of the experience helping the reflective practitioner to make sense of experiences and examine their practice. Reflection alone is not sufficient.

The practitioner must then put any learning into practice and to enable the reflective process to inform practice. Taking action is the key; and the process encourages development of an action plan enabling the reflective practitioner to explore and review their practice and to determine what changes are required in order to develop their practice in order to improve outcomes for vulnerable people. For Designated, Named and specialist safeguarding staff, supervision may be more strategic and be based around an overview of roles and responsibilities as well as individual case discussion. A general supervision recording template has been created to be used when CCG staff are required to report on safeguarding matters, review practice and then plan further action (Appendix b).

**B2 Group Supervision**

The Specialist Nurse and Safeguarding Nurse will offer group supervision to all staff who are case load holders but who do not necessarily have on-going responsibility for child protection.

The Designated Nurse will conduct such supervision at the request of the Specialist or Safeguarding Nurse if there are particularly complex issues or during the absence of other safeguarding leads. Group supervision recording can also be completed on the general supervision template.

**B3 Ad**‐**hoc supervision**

It is recognised that staff will often require advice or support in relation to safeguarding adult/children outside of formal supervision sessions. For example “following on call” or a complex case around capacity of care for the CHC staff.

Staff will access this supervision where required from any member of the Safeguarding Team. The member of the CCG Safeguarding Team will record the information discussed and the actions agreed (see Appendix b).

All staff should have access to daily ad hoc supervision for urgent and routine work, which should be recorded for quality assurance purposes and by the supervisee in the relevant child or adults record. This type of supervision will not involve a contract of supervision. Ad hoc supervision may take place either face to face or in some circumstances via telephone contact.

**B4 Named GP/Dr/Nurse supervision/Adult lead in provider organisations**

In addition to any internal supervision the Designated Nurse will offer supervision sessions for the Named Professionals, or safeguarding leads within provider trusts. Named or Lead safeguarding professionals in provider trusts are required to access supervision from a professional outside their host organisation.

1. **Supervision matrix**

|  |  |  |  |
| --- | --- | --- | --- |
| **Staff Group** | **Supervisor** | **Type of****supervision** | **Frequency** |
| Designated Professionals | Out of area peer | Individual | 3 monthly |
| Named GP for safeguarding | Designated Doctor for Safeguarding ChildrenOut of area peer for Adultsupervision | Individual | 3 monthly |
| Specialist Nurse for safeguardingSafeguarding Nurse | Designated and Lead for Children/ Adult Safeguarding CCGOut of area peer | Individual | 3 monthly |
| GP safeguarding leads | Named GP for SafeguardingPeer safeguarding lead | Group/Individual | 3 monthly |
| GPs and Practice Nurses | GP practice safeguarding leadCCG | Group/ Individual | 3 monthly |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Safeguarding Team |  |  |
| CHC staff | Specialist Nurse or Safeguarding Nurse | Group/Individual | 3 monthly |
| All CCG staff | CCGSafeguarding Team | Ad hoc |  |

1. **Roles and Responsibilities D1 Line Managers**

It is the responsibility of the line managers to address any managerial issues arising from supervision. These may include the need for additional resources, caseload issues, any potential disciplinary matters, or health and safety issues. Line managers will ensure that staff are made aware of the policy/ procedure and ensure its implementation.

**D2 Designated Nurse for Safeguarding**

This member of staff will deliver safeguarding supervision to safeguarding specialists within NLCCG. The Designated Nurse will also provide supervision to Named Nurses/ Midwives and safeguarding professional leads within provider organisations, and peer supervision to other Designated Nurses from other localities.

**D3 Named GP**

The Named Children’s GP for the CCG will receive safeguarding supervision from the Designated Children’s Doctor. The named GP will also provide supervision, expert advice and support to GPs and other primary care staff in child protection issues (Safeguarding Vulnerable people in the NHS; Accountability and assurance Framework; 2015)

**D4 Supervisors**

* + Within North Lincolnshire CCG safeguarding supervisors include the Designated Nurse, Specialist Nurse and Named GP for Children and Adults
	+ The supervisor has the primary responsibility for managing the process of safeguarding supervision.
	+ Supervisors will take the lead on drawing up, in discussion with the supervisee and the supervision contract.
	+ Professionals carry the final accountability for decision making.
	+ Supervisors are responsible for ensuring, in conjunction with their managers, that they are appropriately qualified to provide supervision, are in receipt of appropriate continual professional development and are provided with their own regular supervision
	+ Where there are safeguarding concerns or where there is a suspicion or allegation of abuse against a member of staff, the processes laid out in this Policy must be followed.
	+ Both supervisors and supervisees are responsible for ensuring that they access mandatory and relevant safeguarding education and training.
	+ They are also responsible for ensuring that the Local Safeguarding Board interagency procedures and the Trusts Safeguarding Policies are being consulted and used.
	+ Supervisors and supervisees are responsible for ensuring that practitioners are working in partnership with both adult and children’s health care professionals as appropriate and that they work together using a multi-agency and as well as multi-disciplinary approach
	+ A safeguarding supervision summary sheet must be completed for each case discussed and revisited at the following supervision session, which is to be retained by the supervisor (Appendix b).
	+ Where the supervisee is providing frontline practice, both supervisors and supervisees are responsible for ensuring that all supervision sessions are recorded in the client/patient records. For individual cases discussed, all actions and decisions agreed are to be documented and the records are countersigned by both.
	+ All supervision sessions that take place and any actions agreed should be documented within the safeguarding summary sheet (appendix b). These records need to be clear and accurate, As required by the Data Protection Act, 1998, any records should be kept in a locked cabinet; protected by a password if stored on computer, and recorded by codes if used for statistical purposes, to maintain anonymity.

**D5 Supervisees**

* + The supervisee is responsible for negotiating the supervision ground rules with the supervisor, preparing information for the supervision session in advance and ensuring that the relevant documentation is completed.
	+ The supervisee is responsible for ensuring that the records are available for any individual/family to be discussed at the supervision session
	+ The supervisee is responsible for ensuring that the plans formulated during supervision are adhered to and that targets set are achievable and realistic.
	+ Both supervisors and supervisees are responsible for ensuring that they access mandatory and relevant safeguarding education and training.
	+ They are also responsible for ensuring that the Local Safeguarding Board interagency procedures and the Trusts Safeguarding Policies are being consulted and used.
	+ Supervisors and supervisees are responsible for ensuring that practitioners are working in partnership with both adult and children’s health care professionals as appropriate and that they work together using a multi-agency and as well as multi-disciplinary approach
	+ A safeguarding supervision summary sheet must be completed for each case discussed and revisited at the following supervision session, which is to be retained by the supervisor (Appendix 2).
	+ Where the supervisee is providing frontline practice, both supervisors and supervisees are responsible for ensuring that all supervision sessions are recorded in the client/patient records. For individual cases discussed, all actions and decisions agreed are to be documented and the records are countersigned by both.
	+ All supervision sessions that take place and any actions agreed should be documented within the safeguarding summary sheet (appendix b). These records need to be clear and accurate, As required by the Data Protection Act, 1998, any records should be kept in a locked cabinet; protected by a password if stored on computer, and recorded by codes if used for statistical purposes, to maintain anonymity.

**Appendix a**

**Supervision Agreement**

**Aim:** To ensure robust, supportive supervision is available for staff working with children and adults at risk of harm.

This contract is established as part of that requirement and sets the foundation for a proactive partnership. The content of this contract is to be agreed by both individuals involved and shall be reviewed on an annual basis following the initial agreement.

**The agreement:**

* + Each to identify protected time for supervision of no more than 1 1/2 hours
	+ Brief notes to be kept of the session and shared
	+ Each to agree to robustly challenge assumptions and opinions based on experience, knowledge and where available research based evidence
	+ The sessions will have an identified structure of:
1. Plan agenda
2. Agree time frame to allow each person to speak
3. Opportunity to ‘off load’
4. Cases and staff issues to be considered, as appropriate
5. Actions following supervision to be agreed
6. Note taker agreed.
	* To allow ad hoc supervision over and above the scheduled sessions if required. Ad hoc supervision may require additional face to face sessions or telephone contact
	* If either professional identifies issues of concern with standards of practice this will be discussed at the supervision session. Further actions will be agreed and may require discussion with the individual’s line manager.
	* All information discussed or provided will remain confidential, unless there is concern re: above or it is agreed to share a particular issue.
	* Agreed record will be kept by both parties and may be used in audit evidence if required.

I agree to abide by the above and see this approach as in the best interests of my practice**.**

|  |  |
| --- | --- |
| **Name:** |  |
| **Signature:** |  |
| **Name:** |  |
| **Signature:** |  |
| **Date:** |  |

**Appendix b Supervision template**

|  |  |  |  |
| --- | --- | --- | --- |
| Supervisee Name |  | Supervisor Name |  |
| Role |  | Role |  |

|  |  |  |
| --- | --- | --- |
| Ad hoc - Telephone/ face to face | Group | Individual |
|  |  |  |

|  |
| --- |
| Issues Raised |
|  |
| Options Discussed |
|  |
| Actions | By Whom | When |
|  |  |  |
|  |  |  |
|  |  |  |

Signed Supervisee Date Signed Supervisor Date





You must use this form to record your reflective discussion with another NMC-registered nurse or midwife about your five written reflective accounts. During your discussion you should not discuss patients, service users or colleagues in a way that could identify them unless they expressly agree, and in the discussion summary section below make sure you do not include any information that might identify a specific patient or service user. Please refer to the section on non-identifiable information in [**How to revalidate with**](http://revalidation.nmc.org.uk/download-resources/guidance-and-information/)[**the NMC**](http://revalidation.nmc.org.uk/download-resources/guidance-and-information/) for further information.

**To be completed by the nurse or midwife:**

|  |  |
| --- | --- |
| **Name:** |  |
| **NMC Pin:** |  |

**To be completed by the nurse or midwife with whom you had the discussion:**

|  |  |
| --- | --- |
| **Name:** |  |
| **NMC Pin:** |  |
| **Email address:** |  |
| **Professional address including postcode:** |  |
| **Contact number:** |  |
| **Date of discussion:** |  |
| **Short summary of discussion:** |  |
| **I have discussed five written reflective accounts with the named nurse or midwife as part of a reflective discussion.****I agree to be contacted by the NMC to provide further information if necessary for verification purposes.** | **Signature:** |
| **Date:** |





You must use this form to record five written reflective accounts on your CPD and/or practice-related feedback and/or an event or experience in your practice and how this relates to the Code. Please fill in a page for each of your reflective accounts, making sure you do not include any information that might identify a specific patient, service user or colleague. Please refer to our guidance on preserving anonymity in the section on non-identifiable information in [**How**](http://revalidation.nmc.org.uk/download-resources/guidance-and-information/)[**to revalidate with the NMC**.](http://revalidation.nmc.org.uk/download-resources/guidance-and-information/)

|  |
| --- |
| **Reflective account:** |
| **What was the nature of the CPD activity and/or practice-related feedback and/or event or experience in your practice?** |
| **What did you learn from the CPD activity and/or feedback and/or event or experience in your practice?** |
| **How did you change or improve your practice as a result?** |
| **How is this relevant to the Code?**Select one or more themes: Prioritise people – Practise effectively – Preserve safety – Promote professionalism and trust |

**APPENDIX 13: SERIOUS INCIDENT FRAMEWORK: SUPPORTING LEARNING TO PREVENT RECURRENCE**

**NB. Sections in bold have been updated by NLCCG policy author to reflect changed statutory children’s multi-agency safeguarding arrangements from Working Together 2018**

1.3. How are serious incidents identified?

…, serious incidents are often triggered by events leading to serious outcomes for patients, staff and/or the organisation involved. They may be identified through various routes including, but not limited to, the following:

* + …
	+ Initiation of other investigations for example: **Child Safeguarding Practice Reviews (CSPRs)**, Safeguarding Adult Reviews (SARs), Safeguarding Adults Enquires (Section

42 Care Act) Domestic Homicide Reviews (DHRs) and …. NB: whilst such circumstances may identify serious incidents in the provision of healthcare this is not always the case and SIs should only be declared where the definition of an SI is fulfilled

* + …
		1. Serious Case Reviews and Safeguarding Adult Reviews

**Safeguarding Partners via the Children’s Multi-Agency Resilience and Safeguarding Arrangements** (**C-MARS**) or the Local Authority via Local Safeguarding Adult Board (LSAB), has a statutory duty to investigate certain types of safeguarding incidents/ concerns. In circumstances set out in ***Working Together to Safeguard Children* (2018)** the **C-MARS** will commission **Child Safeguarding Practice** Reviews and in circumstances set out in guidance for adult safeguarding concerns the LSAB will commission Safeguarding Adult Reviews. The Local Authority will also initiate Safeguarding Adult Enquiries, or ask others to do so, if they suspect an adult is at risk of abuse or neglect.

Healthcare providers must contribute towards safeguarding reviews (and enquiries) as required to do so by the **C-MARS** or LSAB. Where it is indicated that a serious incident within healthcare has occurred …, the necessary declaration must be made.

Whilst the **Safeguarding Partners or** Local Authority will lead **CSPRs**, SARs and initiate Safeguarding Enquiries, healthcare must be able to gain assurance that, if a problem is identified, appropriate measures will be undertaken to protect individuals that remain at risk and ultimately to identify the contributory factors and the fundamental issues (in a timely and proportionate way) to minimise the risk of further harm and/or recurrence. The interface between the serious incident process and local safeguarding procedures must therefore be articulated in the local multi-agency safeguarding policies and protocols. Providers and commissioners must liaise regularly with the **safeguarding partner or** local authority safeguarding lead to ensure that there is a coherent multi-agency approach to investigating and responding to safeguarding concerns, which is agreed by relevant partners. Partners should develop a memorandum of understanding to support partnership working wherever possible.

* + 1. Domestic Homicide Reviews

A Domestic Homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, sets out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews.

* + 1. Homicide by patients in receipt of mental health care

Where patients in receipt of mental health services commit a homicide, NHS England will consider and, if appropriate, commission an investigation. This process is overseen by NHS England’s Regional investigation teams. The Regional investigation teams have each established an Independent Investigation Review Group (IIRG) which reviews and considers cases requiring investigation. Clearly there will be interfaces with other organisations including the police and potentially the Local Authority (as there may be interfaces with other types of investigation such as DHRs and/or **CSPRs**/SARs, depending on the nature of the case). To manage the complexities associated with such investigations (and to facilitate joint investigations where possible), a clearly defined investigation process has been agreed. Central to this process is the involvement of all relevant parties, which includes the patient, victim(s), perpetrator and their families and carers, and mechanisms to support openness and transparency throughout.

|  |
| --- |
| **INTEGRATED IMPACT ASSESSMENT** |
| Policy/project/function/service | Safeguarding Policy |
| Date of analysis: | 1/08/21 |
| Type of analysis completed | Quality | 1/08/21 |
| Equality | 1/08/21 |
| Sustainability | 1/08/21 |
| 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** | **Brief description of potential impact** | **Mitigation strategy and monitoring arrangements** | **Risk 5 x 5 risk****matrix)** |
| **Chance of Impact on Indicator** |
| **Positive Impact** | **No Impact** | **Negative Impact** |  | **Likelihood** | **Consequence** |
| **X** | **X** | **X** |
| **PATIENT SAFTEY** |
| Patient safety/adverse events | **X** |  |  |  |  |  |  |
| Mortality position | **X** |  |  |  |  |  |  |
| Infection controlMRSA/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, e.g. VTE, Stroke, Dementia |  |  |  |  |  |  |  |
| Patient relatedoutcome measures | **X** |  |  |  |  |  |  |
| External accreditation e.g. professional bodiesi.e. RCN | **X** |  |  |  |  |  |  |
| CQUIN achievement |  | **X** |  |  |  |  |  |
| **PATIENT EXPERIENCE** |
| Will there be an impact on patientexperience if so how | **X** |  |  |  |  |  |  |
| Will it impact oncarers if so how | **X** |  |  |  |  |  |  |
| **INEQUALITIES OF CARE** |
| Will it create / reduce variation incare provision? |  | **X** |  |  |  |  |  |
| **STAFF EXPERIENCE** |
| What is the impact on workforce capability care andskills? | **X** |  |  |  |  |  |  |
| Will there be achange 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, ifso, how? |  | **X** |  |  |  |  |  |
|  |
| **EQUALITY IMPACT** |  |
| Analysis Rating (see completionnotes) | Red |  | Red/ Amber |  | Amber |  | Green | X |  |
| Approved by: | Commissioner Lead: | tbc | GP lead for E&D: | tbc |  |
| Date |  | Date |  |  |

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| **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 |  |

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| **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 |

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| **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 andWomen) | **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 andBisexual) | **X** |  |  |  |
| Pregnancy andMaternity | **X** |  |  |  |
| Transgender | **X** |  |  |  |
| Marital Status | **X** |  |  |  |
| Age | **X** |  |  |  |

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| **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** |  |  |  |  |
|  |  |  |  |  |
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| **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 2010-11then 30% by 2020 |  |  | **X** |  |
| New builds and refurbishments over £2million (capital costs) comply with BREEAMHealthcare requirements. |  |  | **X** |  |
| Reduce the risk of pollution and avoid any breaches inlegislation. |  |  | **X** |  |
| Goods and services areprocured more sustainability. |  |  | **X** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Reduce carbon emissions fromroad vehicles. |  |  | **X** |  |
| Reduce water consumption by25% by 2020. |  |  | **X** |  |
| Ensure legal compliance withwaste legislation. |  |  | **X** |  |
| Reduce the amount of waste produced by 5% by 2010 and by25% 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 sustainabledevelopment. |  |  | **X** |  |
| Financial aspects of sustainable development are considered in line with policy requirementsand commitments. |  |  | **X** |  |