NHS
South Sefton
Clinical Commissioning Group

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Safeguarding Children & Adults at risk Policy 2015 (Incorporating Safeguarding and Mental Capacity Act Standards for Commissioned Services)

Title:	**Safeguarding Children & Adults at risk Policy**
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In the event of any changes to relevant legislation or statutory procedures this policy will be automatically updated to ensure compliancy without consultation. Such changes will be communicated.

Version Number	Type of Change	Date	Description of change
V3	Process	Sept 2015	Approved policy updated with Policy/version control sheet
V4 -8	Review	November 2015	Amended to reflect the Care Act 2014, Harmful Practices and the requirements of Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework
V9	Update	September 2016	Appendix 5 Audit tool updated and replaced with Cheshire & Merseyside Safeguarding Commissioning Standards

1.0 Introduction

1.1 South Sefton Clinical Commissioning Group (CCG) has a statutory duty to ensure it makes arrangements to safeguard and promote the welfare of children and young people and to protect adults at risk from abuse or the risk of abuse. The arrangements should reflect the needs of the vulnerable population they commission or provide services for. South Sefton CCG is also required to contribute to multi-agency arrangements to protect adults and children at risk from radicalisation. This strategy is known as Prevent.

1.2 As a commissioning organisation South Sefton CCG is required to ensure that all health providers from whom it commissions services have comprehensive single and multi-agency policies and procedures in place that are compliant with current legislation to safeguard and promote the welfare of children and to protect adults at risk of abuse (ie Care Act 2014 and Working Together 2015 compliant). South Sefton CCG should also ensure that health providers are linked into the local safeguarding children and safeguarding adult boards and that health workers contribute to multi-agency working.

1.3 This policy has two functions:

a) It details the roles and responsibilities of South Sefton CCG as a commissioning organisation, of its employees and GP practice members;
b) It provides clear service standards against which healthcare providers will be monitored to ensure that all service users are protected from abuse and the risk of abuse.

1.4 This policy should be used in conjunction with the Sefton Safeguarding Children Board (LSCB) and Sefton Safeguarding Adult Board (SAB) Framework for Action 2015.

2.0 Scope

2.1 This policy aims to ensure that no act or omission by South Sefton CCG as a commissioning organisation, or via the services it commissions, puts a service user at risk; and that robust systems are in place to safeguard and promote the welfare of children, and to protect adults at risk of harm.

2.2 Where South Sefton CCG is identified as the co-ordinating commissioner it will notify collaborating commissioners of a provider's non-compliance with the standards contained in this policy or of any serious untoward incident that is considered to be a safeguarding issue.

3.0 Principles

3.1 South Sefton CCG recognises that safeguarding children and vulnerable adults is a shared responsibility and there is a need for effective joint working between

agencies and professionals that have differing roles and expertise if vulnerable groups are to be protected from harm. To achieve effective joint working, there must be constructive relationships at all levels which need to be promoted and supported by:

a) A commitment of senior managers and board members to seek continuous improvement with regard to safeguarding both within the work of South Sefton CCG and within those services commissioned.
b) Clear lines of accountability within South Sefton CCG for safeguarding.
c) Service developments that take account of the need to safeguard all service users, and is informed where appropriate, by the views of service users or advocates.
d) Staff learning and development including a mandatory induction which includes familiarisation with responsibilities and procedures to be followed if there are concerns about a child or adult's welfare.
e) Staff training and continuing professional development so that staff have an understanding of their roles and responsibilities in regards to safeguarding children, adults at risk, looked after children and the Mental Capacity Act (2005).
f) Appropriate supervision and support for the workforce.
g) Safe working practices including recruitment and vetting procedures.
h) Effective interagency working, including effective information sharing.

The above principles reflect the expectations of the NHS safeguarding assurance and accountability framework (2015) and statutory guidance as referenced within this policy.

4.0 Equality and Diversity

4.1 The population of South Sefton is diverse and includes areas of high deprivation. Children and adults from all cultures are subject to abuse and neglect. All children and adults have a right to grow up and live safe from harm. In order to make sensitive and informed professional judgments about the needs of children (including their parents' capacity to respond to those needs) and the needs of adults at risk, it is important that professionals are sensitive to differing family patterns and lifestyles that vary across different racial, ethnic and cultural groups.

4.2 Professionals need to be aware of the broader social factors that serve to discriminate against black and minority ethnic populations. Working in a multi-cultural society requires professionals and organisations to be committed to equality in meeting the needs of all children and adults at risk and to understand the effects of harassment, discrimination or institutional racism, cultural misunderstandings or misinterpretation.

4.3 The assessment process should maintain a focus on the needs of the individual child or adult at risk. It should always include consideration of how the religious beliefs and cultural traditions influence values, attitudes and behaviours and the way in which family and community life is structured and organised. Cultural

factors neither explain nor condone acts of omission or commission that place a child or adult at risk of significant harm. Professionals should be aware of and work with the strengths and support systems available within families, ethnic groups and communities, which can be built upon to help safeguard and promote their welfare.

5.0 Definitions

5.1 Children

5.1.1 In accordance with the Children Act 1989 and 2004, within this policy, a **'child'** is anyone who has not yet reached their 18th birthday.
'Children' will mean children and young people throughout.

5.1.2 'Safeguarding and promoting the welfare of children is defined in *Working Together to Safeguard Children (2015)* as:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and
- Taking action to enable all children to have the best life chances.

5.1.3 Children in Need / Early Help
Under Section 17 (10) of the Children Act 1989, a child is a Child in Need if:

- He/she is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority;
- His/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services; or
- He/she is a Disabled Child.

Professionals should, in particular, be alert to the potential need for early help for a child who:

- has specific additional needs;
- has special educational needs;
- is a young carer;
- is showing signs of engaging in anti-social or criminal behaviour;
- is in a family circumstance presenting challenges for the child, such as substance abuse, adult mental health problems and domestic violence;

- Has Particular spiritual or religious beliefs
- Is a migrant/ unaccompanied asylum seeker
- Child victim of trafficking
- Victim of CSE
- has returned home to their family from care; and/or
- is showing early signs of abuse and/or neglect.

5.1.4 **Looked After Children** are those children and young people who are looked after by the state under one of the following sections of the Children Act 1989 including:

- Section 31 - Care Order
- Section 38 - Interim Care Order
- Section 20 -Voluntary accommodation at the request of or by agreement with their parents or carers
- Section 44 - Emergency Protection Order

Following the implementation of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 all children who are remanded into custody in England automatically also become looked after. A period of remand should only last for a short time and the automatic looked after status ends upon conviction, acquittal or grant of bail.

5.1.5 **Private Fostering** – this is a private arrangement made between a child's parents and someone who is not a close relative to care for a child for 28 days or more: where the child lives with the carer. Close relatives include aunt, uncle, brother, sister or grandparents but not a great aunt or uncle. South Sefton CCG staff have a responsibility to notify Children's Social Care of any private fostering arrangements that they become aware of.

5.2 Adults at risk

5.2.1 The Care Act 2014 identifies that safeguarding duties apply to an adult aged 18 or over and who:

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

5.2.2 Whilst there is no formal definition of vulnerability within health care, some people receiving health care may be at greater risk from harm than others, sometimes as a complication of their presenting condition and their individual circumstances. The risks that increase a person's vulnerability

should be appropriately assessed and identified by the health care professional/ care provider at the first contact and continue throughout the care pathway (DH 2010).

5.2.3 Making Safeguarding Personal (MSP)

Making Safeguarding Personal is a shift in culture and practice in response to what we now know about what makes safeguarding more or less effective from the perspective of the person being safeguarded. It is about having conversations with people about how a response in a safeguarding situation enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them.

5.2.4 The six principles for adult safeguarding ensure safeguarding is person centred and outcome focused, giving people choice and control over their lives.

a) **Empowerment** – Presumption of person led decisions and informed consent.
b) **Protection** – Support and representation for those in greatest need.
c) **Prevention** – It is better to take action before harm occurs.
d) **Proportionality** – Proportionate and least intrusive response appropriate to the risk presented.
e) **Partnership** – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
f) **Accountability** – Accountability and transparency in delivering safeguarding.

5.2.5 Definitions of abuse are contained within the glossary section of the policy.

5.3 Specific safeguarding categories

5.3.1 Domestic Abuse

The cross-government definition of domestic violence and abuse is:-

"Any incident or pattern of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial or emotional". (Home Office circular 003/2013)

This is regardless of race, culture, religion, gender, age and disability. It is also important to note that domestic abuse can also occur in lesbian, gay, bisexual and transgender relationships. Heterosexual females can also

abuse heterosexual males and children also abuse adults. Domestic abuse also features highly in cases of child abuse and in an analysis of serious case reviews, both past and present, it is present in over half (53%) of cases. (HM Government 2010) Approximately 200,000 children in England live in households where there is a known risk of domestic violence (Brandon et al, 2009

The term "domestic abuse" includes issues such as female genital mutilation (FGM), so called honour based crimes, forced marriage and other acts of gender based violence, as well as elder abuse and spiritual abuse (where someone uses a person's spiritual beliefs to manipulate, dominate or control the person) when committed within the family or by an intimate partner. Family members are defined as mother, father, son, daughter, brother, sister, and grandparents whether directly related or stepfamily.

Whilst an adult is defined as any person aged 18 or over, the new definition for domestic violence has been altered to include 16 and 17 year olds. Despite this change in definition, domestic abuse involving any young person under 18 years, even if they are parents, should be treated as child abuse and the Sefton Safeguarding Children Board procedures apply.

5.3.2 Forced Marriage

"marriage shall be entered into only with the free and full consent of the intending spouses" (Universal Declaration of human Rights, Article 16 (2)"

A forced marriage is where one or both people do not (or in the case of some people with learning or physical disabilities, cannot as they do not have mental capacity to make the decision) consent to the marriage and pressure or abuse is used. The pressure put on women and men to marry against their will can be physical, (including threats, actual physical violence and sexual violence), emotional or psychological (for example when a person is made to feel like they are bringing shame on their family) and financial abuse (taking money from a person or not providing money).

5.3.3 Female Genital Mutilation (FGM)

Female genital mutilation is a collective term used for procedures which include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. FGM is typically performed on girls between the ages of 4 and 13 years, although it may also be performed on infants, and prior to marriage or pregnancy. The Prohibition of Female Circumcision Act 1985 made this practice illegal in this country and the Female Genital Mutilation Act 2003 which replaced it has now made it illegal for girls to be taken abroad for the purpose of performing this procedure.

From 1st October 2015 there is a mandatory reporting duty, provided for in the FGM Act 2003 (as amended by the Serious Crime Act 2015) requiring health care professionals to report where, in the course of their professional duties, they either:

- Are informed by a girl under 18 that an act of FGM has been carried out on her; or
- Observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and have no reason to believe that the act was necessary for the girl's physical or mental health or for the purposes connected with labour or birth

5.3.4 Radicalisation/PREVENT

Prevent (Radicalisation of vulnerable people): Prevent is one of the 4 key principles of the CONTEST strategy, which aims to stop people becoming terrorists or supporting terrorism. The Prevent Strategy addresses all forms of terrorism including extreme right wing but continues to prioritise according to the threat posed to our national security. The aim of Prevent is to stop people from becoming terrorists or supporting terrorism and operates in the pre-criminal space before any criminal activity has taken place.

Terrorist groups often draw on extremist ideology, developed by extremist organisations. Some people who join terrorist groups have previously been members of extremist organisations and have been radicalised by them. The Government has defined extremism in the Prevent strategy as: "vocal or active opposition to fundamental British values (including calls for death of members of British armed forces), including democracy, the rule of law, individual liberty, mutual respect and tolerance of different faiths and beliefs.

Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) places a duty on"health" bodies, in the exercise of their functions, to have "due regard to the need to prevent people from being drawn into terrorism".

All relevant health staff should be able to recognise vulnerable individuals who appear to be being drawn into terrorism, including extremist ideas which can be used to legitimise terrorism and are shared by terrorist groups. Staff should be aware of what action to take in response, including local processes and policies that will enable them to make referrals to the Channel programme and how to receive additional advice and support.

The government counter terrorism strategy is called **CONTEST** and is divided into four priority objectives:-

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

The Prevent Strategy addresses all forms of terrorism including extreme right wing but continues to prioritise according to the threat posed to our national security. The aim of Prevent is to stop people from becoming terrorists or supporting terrorism and operates in the pre-criminal space before any criminal activity has taken place. Prevent aims to protect those who are vulnerable to exploitation from those who seek to encourage people to support or commit acts of violence.

In the event of a concern being raised staff are required to follow the Sefton SAB Framework for Action 2015 / LSCB Safeguarding Children Procedures.

5.3.5 Child Sexual Exploitation

Child sexual exploitation is a form of sexual abuse where children are sexually exploited for money, power or status. It can involve violent, humiliating and degrading sexual assaults. In some cases, young people are persuaded or forced into exchanging sexual activity for money, drugs, gifts, affection or status. Consent cannot be given, even where a child may believe they are voluntarily engaging in sexual activity with the person who is exploiting them. Child sexual exploitation does not always involve physical contact and can happen online. A significant number of children who are victims of sexual exploitation go missing from home, care and education at some point (HM Government, 2015)

6.0 Roles and Responsibilities

a) Ultimate accountability for safeguarding sits with the Chief Officer for South Sefton CCG. Any failure to have systems and processes in place to protect children and adults at risk in the commissioning process, or by providers of health care that South Sefton CCG commissions would result in failure to meet statutory and non-statutory constitutional and governance requirements.
b) South Sefton CCG must demonstrate robust arrangements are in place to demonstrate compliance with safeguarding responsibilities.
c) South Sefton CCG must establish and maintain good constitutional and governance arrangements with capacity and capability to deliver safeguarding duties and responsibilities, as well as effectively commission services ensuring that all service users are protected from abuse and neglect.

d) Establish clear lines of accountability for safeguarding, reflected in governance arrangements.
e) To co-operate with the local authority in the operation of the local safeguarding children and safeguarding adults board, be a member of the Boards.
f) To participate in serious case reviews, serious adult reviews and domestic homicide reviews.
g) Secure the expertise of a designated doctor and nurse for safeguarding children; a designated doctor and nurse for looked after children (LAC); a designated paediatrician for child deaths; a safeguarding adult lead and a mental capacity act lead.
h) Ensure that all providers with whom there are commissioning arrangements have in place comprehensive and effective policies and procedures to safeguard children and adults at risk in line with those of the Sefton LSCB / SAB.
i) Ensure that all staff in contact with children, adults who are parents/carers and adults at risk in the course of their normal duties are trained and competent to be alert to the potential indicators of abuse or neglect for children and adults at risk, know how to act on those concerns in line with local guidance.
j) Ensure that appropriate systems and processes are in place to fulfil specific duties of cooperation and partnership and the ability to demonstrate that South Sefton CCG meets the best practice in respect of safeguarding children and adults at risk and looked after children.
k) Ensure that safeguarding is at the forefront of service planning and a regular agenda item of South Sefton CCG governing body business.
l) Ensure that all decisions in respect of adult care placements are based on knowledge of standards of care and safeguarding concerns.
m) Commission services that are compliant with the Mental Capacity Act 2005
n) Ensure provision of independent Mental Capacity Act Advocates (IMCA) to represent people who lack capacity where there is no one independent of services, such as family member or friend, who is able to represent the person to support decisions around serious medical treatment or where to live.
o) Ensure that there are robust recruitment and vetting procedures in place to prevent unsuitable people from working with children and adults at risk. These procedures must be in line with national and Sefton LSCB/ SAB guidance and will be applied to all staff (including agency staff, students and volunteers) who work with or who handle information about children and adults at risk.

6.1 Chief Officer for South Sefton CCG

a) Ensures that the health contribution to safeguarding and promoting the welfare of children and adults at risk is discharged effectively across the

whole local health economy through the organisation's commissioning arrangements.

b) Ensures that the organisation not only commissions specific clinical services but exercises a public health responsibility in ensuring that all service users are safeguarded from abuse or the risk of abuse.
c) Ensures that safeguarding is identified as a key priority area in all strategic planning processes.
d) Ensures that safeguarding is integral to clinical governance and audit arrangements.
e) Ensures that all health providers from whom services are commissioned have comprehensive single and multi-agency policies and procedures for safeguarding which are in line with the local safeguarding children and adult board procedures and are easily accessible for staff at all levels.
f) Ensures that all contracts for the delivery of health care include clear standards for safeguarding - these standards are monitored in order to provide assurance that service users are effectively safeguarded.
g) Ensures that South Sefton CCG staff, and those in services contracted by South Sefton CCG, are trained and competent to be alert to potential indicators of abuse or neglect in children and know how to act on their concerns and fulfil their responsibilities in line with the Sefton LSCB and LSAB policies and procedures.
h) Ensures South Sefton CCG cooperates with the local authority in the operation of LSCB and LSAB.
i) Ensures that all health organisations with whom South Sefton CCG has commissioning arrangements have links with Sefton LSCB and LSAB; that there is appropriate representation at an appropriate level of seniority; and that health workers contribute to multi-agency working.
j) Ensures that any system and processes that include decision-making about an individual patient (e.g. funding panels) takes account of the requirements of the Mental Capacity Act 2005 – this includes ensuring that actions and decisions are documented in a way that demonstrates compliance with the Act.
k) Is required to sign off the CCG's contributions to the Safeguarding Children and Adult annual report and annual plan, which are a statutory requirement.

6.2 South Sefton CCG Governing Body Lead with responsibility for safeguarding

a) Ensures that South Sefton CCG has management and accountability structures that deliver safe and effective services in accordance with statutory, national and local guidance for safeguarding children and looked after children (LAC)
b) Ensures that service plans / specifications / contracts / invitations to tender etc. include reference to the standards expected for safeguarding children and adults at risk.
c) Ensures that safe recruitment practices are adhered to in line with national and local guidance and that safeguarding responsibilities are reflected in all job descriptions.

d) Ensure that staff in contact with children and or adults in the course of their normal duties are trained and competent to be alert to the potential indicators of abuse or neglect and know how to act on those concerns in line with local guidance.

6.3 South Sefton CCG Individual staff members

a) To be alert to the potential indicators of abuse or neglect for children and adults and know how to act on those concerns in line with local guidance.
b) To undertake training in accordance with their roles and responsibilities as outlined by the training frameworks of Sefton LSCB and LSAB so that they maintain their skills and are familiar with procedures aimed at safeguarding children and adults at risk.
c) Understand the principles of confidentiality and information sharing in line with local and government guidance.
d) All staff contribute, when requested to do so, to the multi-agency meetings established to safeguard children and adults at risk.
e) All staff will cooperate with Local Authority solicitors and Merseyside Police as required in order to safeguard and protect children and adults at risk.

6.3.1 See appendices for guidance as to what action needs to be taken where there are concerns that a child or an adult at risk is being abused; and information sharing guidance:

a) Appendix 2 – What to do if you are worried a child is being abused
b) Appendix 3 – Possible signs and indicators of child abuse and neglect
c) Appendix 4 – Flowchart of key questions for information sharing
d) Appendix 5 - What to do if an adult is at risk of abuse

6.4 South Sefton CCG GP member practices

6.4.1 The CCG will ensure that safeguarding standards are included and monitored in all contracts issued by the CCG. Commissioners have a responsibility to assure themselves of the quality and safety of the organisations they place contracts with and ensure that those contracts have explicit clauses that hold the providers to account for preventing and dealing promptly and appropriately with any examples of abuse or neglect. South Sefton CCG GP member practices will take account of the safeguarding standards. Compliance with the standards will be subject to audit and scrutiny.

6.5 Designated professionals

6.5.1 South Sefton CCG is required to have in place arrangements to secure the advice of Designated Professionals for Safeguarding Children, Adults and Looked After Children (LAC). Access to and support from such

professionals will be through the shared Merseyside CCGs hosted team employed by Halton CCG. The Designated Professionals will:

a) Provide strategic guidance on all aspects of the health service contribution to protecting children and adults at risk within South Sefton CCG and Sefton LSCB and SAB area.
b) Work closely in the discharge of their responsibilities – this may include the convening of professional advisory and support groups.
c) Have enhanced Disclosure and Baring Scheme (DBS) clearance renewed every 3 years.
d) Provide professional advice on safeguarding issues to the multi-agency network.
e) Be a member of Sefton LSCB, Corporate Parenting Board, SAB and relevant sub-groups as required, delegating to other health professionals as appropriate.
f) Be involved in the appointment of Named Professionals, providing support as appropriate.
g) Provide professional safeguarding supervision and leadership to Named Professionals within the provider organisations.
h) Take the strategic overview of safeguarding and looked after children arrangements across South Sefton CCG and Local Authority area and assist in the development of systems, monitoring, evaluating and reviewing the health service contribution to the protection of children and adults at risk.
i) Collaborate with the Director of Public Health, LSCB, SAB, South Sefton CCG Chief Nurse and Named Professionals in Provider Trusts in reviewing the involvement of health services in serious incidents which meet the criteria for serious case reviews.
j) Advise on appropriate training for health personnel and participate where appropriate in its provision.
k) Advise on practice policy and guidance ensuring health components are updated.
l) Ensure expert advice is available in relation to safeguarding policies, procedures and the day to day management of safeguarding, looked after children and adults at risk issues.
m) Liaise with other designated and lead professionals for safeguarding children, looked after children and adults at risk across the Merseyside area and beyond as required to do so
n) Attend relevant local, regional and national forums.
o) Take part in an annual appraisal process via the Chief Nurse from the employing CCG.

7.0 Management of Allegations Against a South Sefton CCG Employee

7.1 *Working Together to Safeguard Children* (2015) details the responsibility of all organisations to have a process for managing allegations against professionals who work with children. This requires South Sefton CCG to inform the Designated

Officer (previously referred to as Local Authority Designated Officer) of any allegations it becomes aware of within one working day. A parallel process will be followed regarding adults at risk.
In the event of identification of a concern the Named Senior Manager / Officer should initially be directed to the Local Authority Safeguarding Co-ordinator will notify and access advice and guidance from the Designated Adult Safeguarding Manager (DASM) promptly as per Sefton SAB Framework for Action (2015). This role will be undertaken by the CCG by the Designated Safeguarding Adult Nurse.

8.0 Governance Arrangements

To ensure that safeguarding is integral to the governance arrangements of the CCG quarterly reporting into the CCG Quality Committee has been established.

The purpose is:
To provide assurance on the effectiveness of the safeguarding arrangements in place within commissioned services and the CCG; ensuring that safeguarding is integral to quality and audit arrangements within the CCG.

The CCG is kept informed of national and local initiatives for safeguarding and informed and updated on the learning from reviews and audits that are aimed at driving improvements to safeguard children and adults at risk.

In addition to the reporting arrangements above an annual safeguarding report will be submitted to the governing body with exception reporting on issues of significance e.g. serious case review reports, inspections' findings

9.0 Implementation

9.1 Method of monitoring compliance

9.1.1 Comprehensive service specifications for services for children and adults, of which child & adult protection / safeguarding is a key component, will be evident in all contracts with provider organisations. Service specifications will include clear service standards and KPI's (key performance indicators) for safeguarding Children & Adults and promoting their welfare, consistent with Sefton LSCB/ SAB procedures.

9.1.2 The standards expected of all healthcare providers are included in the Safeguarding Quality Schedule. Compliance will be measured by annual audit – an audit tool will be made available to all providers to facilitate the recording of information. The audit tool should be completed using the RAG definitions outlined in the procedures for monitoring safeguarding children and adults at risk via provider contracts. This procedure was developed in order to standardise the monitoring and escalation approach across the North West.

9.1.3 Additionally a number of specific quality KPI's will be set for all providers which compliment a number of the existing standards in the afore mentioned audit tool, these will require a detailed response with data and achievements clearly evidenced in the returns. The quality and effectiveness of which will be monitored on a quarterly/ annual basis (dependent on the indicator).

9.2 Breaches of policy

9.2.1 This policy is mandatory. Where it is not possible to comply with the policy, or a decision is taken to depart from it, this must be notified to South Sefton CCG so that the level of risk can be assessed and an action plan can be formulated (see section 9 for contact details).

9.2.2 South Sefton CCG, as a co-ordinating commissioner, will notify collaborating commissioners of a providers' non-compliance with the standards contained in this policy, including action taken where there has been a significant breach.

10.0 Contact details

Designation	**Contact Number**
Chief Officer	01704 387028/0151 247 7009
Chief Nurse	01704 387028/0151 247 7252
Designated Nurse Safeguarding Children	0151 495 5469 or 5295
Designated Doctor Safeguarding Children	0151 228 4811 Ext 2287
Designated Nurse Looked After Children	0151 495 5286
Designated Doctor Looked After Children	0151 228 4811 Ext 2287
Community Paediatrician - CDOP	0151 228 4811 Ext 2287
Designated Nurse Safeguarding Adults	0151 495 5469 or 5295
Lead for the Mental Capacity Act	0151 495 5469 or 5295
Prevent Lead	0151 495 5469 or 5295
Safeguarding Administrator	0151 495 5469 or 5295

NB: The Shared Merseyside Safeguarding Service and South Sefton CCG work in conjunction with Sefton Borough Council to safeguard and promote the welfare of children, young people and adults from abuse or risk of abuse, i.e. through adherence to multi-agency policy, collaboration, information sharing and learning and representation at Sefton Safeguarding Children Board and Sefton Executive Board (Safeguarding Adult Board.)

11.0 References

The following statutory, non-statutory, best practice guidance and the policies and procedures of the Sefton LSCB and SAB have been taken into account:

11.1 Statutory Guidance:

a) Department for Constitutional Affairs (2007) *Mental Capacity Act 2005: Code of Practice.* London: TSO
b) Department of Health (2000) *Framework for the Assessment of Children in Need and their Families.* London: HMSO
c) Department of Health (2014) Care Act. Care and Support Statutory Guidance

d) DfE/DH (2015) Promoting the health and welfare of looked-after children. Statutory guidance for local authorities, clinical commissioning groups and NHS England. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/378482/Promoting_the_health_of_looked-after_children_statutory_guidance_consult....pdf
e) HM Government (2007) *Statutory guidance on making arrangements to safeguard and promote the welfare of children under Section 11 of the Children Act 2004.* DCSF Publications
f) HM Government (2008) *Safeguarding children in whom illness is fabricated or induced.* DCSF Publications
g) HM Government (2009) *The Right to Choose: multi-agency statutory guidance for dealing with forced marriage.* Forced Marriage Unit: London
h) HM Government (2015) *Working Together to Safeguard Children.* Nottingham: DCSF Publications
i) HM Government (2015) *What to do if you're worried a child is being abused.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419604/What_to_do_if_you_re_worried_a_child_is_being_abused.pdf
j) Ministry of Justice (2008) *Deprivation of Liberty Safeguards Code of Practice to supplement Mental Capacity Act 2005.* London: TSO
k) Home Office (2015) Counter Terrorism and Security Act

l) HM Gov (2015) Revised Prevent Duty Guidance: for England and Wales https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445977/3799_Revised_Prevent_Duty_Guidance__England_Wales_V2-Interactive.pdf

m) Home Office (2015) Mandatory Reporting of female Genital Mutilation – procedural information

11.2 Non-Statutory Guidance:

a) Children's Workforce Development Council (March 2010) *Early identification, assessment of needs and intervention. The Common Assessment Framework for Children and Young People: A practitioner's guide.* CWDC
b) Department of Health (June 2012) *The Functions of Clinical Commissioning Groups* (updated to reflect the final Health and Social Care Act 2012)
c) Department of Health (March 2011) *Adult Safeguarding: The Role of Health Services*
d) Department of Health (May 2011) *Statement of Government Policy on Adult Safeguarding*
e) HM Government (2015) *What to do if you're worried a child is being abused.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419604/What_to_do_if_you_re_worried_a_child_is_being_abused.pdf
f) HM Government (2015) Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf
g) Law Commission (May 2011) *Adult Social Care Report*
h) www.justice.gov.uk/lawcommission/publications/1460.htm
i) Royal College of Paediatrics and Child Health et al (2014) *Safeguarding Children and Young People: Roles and Competences for Health Care Staff. Intercollegiate Document*
j) NICE (2013) The health and wellbeing of looked-after children and young people http://www.nice.org.uk/guidance/qs31
k) NICE (2015) Looked-after children and young people http://www.nice.org.uk/guidance/ph28
l) NICE (2014) Domestic violence and abuse: multi-agency working http://www.nice.org.uk/guidance/ph50
RCPCH (2015) Looked after children: knowledge, skills and competence of health care staff http://www.rcpch.ac.uk/improving-child-health/child-protection/looked-after-children-lac/looked-after-children-lac

11.3 Best Practice Guidance:

a) Department of Health (2004) *National Service Framework for Children, Young People and Maternity Services Standard 5* (plus including relevant elements that aren't contained in Core Standard 5)
b) Department of Health (2009) *Responding to domestic abuse: a handbook for health professionals*

c) Ending violence against women and girls. March 2014. www.gov.uk/government/policies/ending-violence-against-women-and-girls-in-the-uk
d) Department of Health (2010) *Clinical governance and adult safeguarding: an integrated approach.* Department of Health
e) HM Government (2009) *Multi-agency practice guidelines: Handling cases of Forced Marriage.* Forced Marriage Unit: London
f) National Institute for Health and Clinical Excellence (2009) *When to suspect child maltreatment.* NICE Clinical Guideline 89
g) Department of Health (2006) *Mental Capacity Act Best Practice Tool.* Gateway reference: 6703
h) HM Government (2011) *Multi-agency practice guidelines: Female Genital Mutilation*

11.4 Sefton Local Safeguarding Children Board:

Sefton safeguarding children board policies, procedures and practice guidance are accessible at:
Sefton Local Safeguarding Children Board

11.5 Sefton Local Safeguarding Adult Board:

Sefton safeguarding adult board, policies, procedures and practice guidance are accessible at:
Sefton Safeguarding Adults Board

11.6 Disclosure and barring

The DBS was formed in 2012 by merging the functions of the Criminal Records Bureau (CRB) and the Independent Safeguarding Authority (ISA) under the Protection of Freedoms Act 2012. DBS started operating on 1 December 2012.

Further guidance is available at: www.gov.uk/government/disclosure-and-barring-service

12. Glossary

CAF	Common Assessment Framework
CCGs	Clinical Commissioning Groups
DCSF	Department for Children, Schools and Families
DH	Department of Health

LAC	Looked After Children
LSAB	Local Safeguarding Adult Board
LSCB	Local Safeguarding Children Board
MCA	Mental Capacity Act
NCB	National Commissioning Board
SI	Serious Incident

12.1 Categories of child abuse as per *Working Together to Safeguard Children* (HM Government 2015).

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

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

Emotional abuse: The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children 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 the 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.

12.2 Abuse of adults at risk: For safeguarding adults, the definitions of abuse have been taken from The Care and Support Act 2014.

Abuse: Abuse is a violation of an individual's human and civil rights by another person or persons. Abuse may consist of single or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm, or exploitation of, the person subjected to it. Of particular relevance are the following descriptions of the forms that abuse may take:

Physical abuse: Including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions.

Sexual abuse: Including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, could not consent, 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, isolation or withdrawal from services or supportive networks.

Financial or material abuse: Including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

Neglect and acts of omission: Including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services,

the withholding of the necessities of life, such as medication, adequate nutrition and heating. Neglect also results in bodily harm and/or mental distress. It can involve failure to intervene in behaviour which is likely to cause harm to a person or to others. Neglect can occur because of lack of knowledge by the carer.

NB: Self neglect by an adult will not usually result in the instigation of the adult protection procedures unless the situation involves a significant act of omission or commission by someone else with responsibility for the care of the adult. Possible indicators of neglect include:

a) Malnutrition
b) Untreated medical problems
c) Pressure ulcers (Bed Sores)
d) Confusion
e) Over-sedation

Discriminatory abuse: Including racist, sexist, that based on a person's disability; and other forms of harassment, slurs or similar treatment.

Neglect and **poor professional practice** also need to be taken into account. This may take the form of isolated incidents of poor or unsatisfactory professional practice, at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other. Repeated instances of poor care may be an indication of more serious problems and this is sometimes referred to as **institutional abuse**.

APPENDIX 1: What to do if you are worried a child is being abused.

For advice and support from the Designated Nurse for South Sefton CCG within the Shared Merseyside Safeguarding Service please ring the main contact numbers: 0151 495 5469 or 5295

Any member of staff who believes or suspects that a child may be suffering or is likely to suffer significant harm should always refer their concerns to Children's Social Care. Never delay emergency action to protect a child whilst waiting for an opportunity to discuss your concerns first.

Are you concerned a child is suffering or likely to suffer harm ? eg

- You may observe an injury or signs of neglect
- You may be given information or observe emotional abuse
- A child may disclose abuse
- You may be concerned for the safety of a child or unborn baby

Step 1

Inform parents/ carers that you will refer to Children's social care
UNLESS
The child may be put at increased risk of further harm (eg suspected sexual abuse, suspected fabricated or induced illness, female genital mutilation, increased risk to child, forced marriage or there is a risk to your own personal safety)

Step 2

Make a telephone referral to Sefton's Children's Services on 0845 140 0845 (8 a.m. – 6 p.m.) or for out of hours 0151 920 8234 (Mon – Thurs 5.30 p.m, Friday after 4 p.m and weekends)

- Follow up in writing within 48 hours
- Document all discussions held, actions taken, decisions made, including who was spoken to and who is responsible for undertaking actions agreed.
- For physical abuse document injuries observed

Step 3

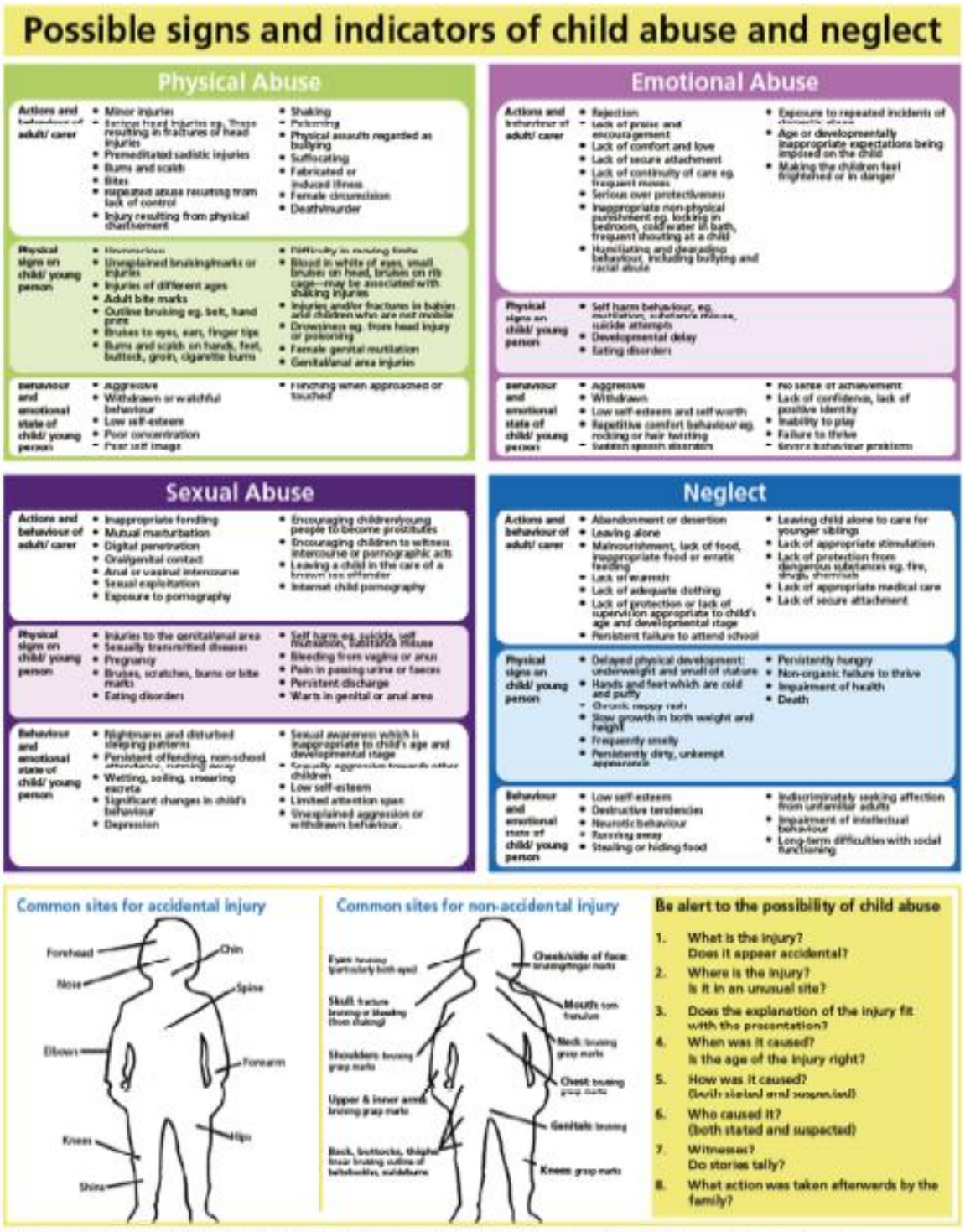
Children's Social Care acknowledges receipt of referral and decides on next course of action. If the referrer has not received an acknowledgement within 3 working days contact Children's Social Care again for an update.

Step 4

You may be requested to provide further reports / information or attend multi-agency meetings

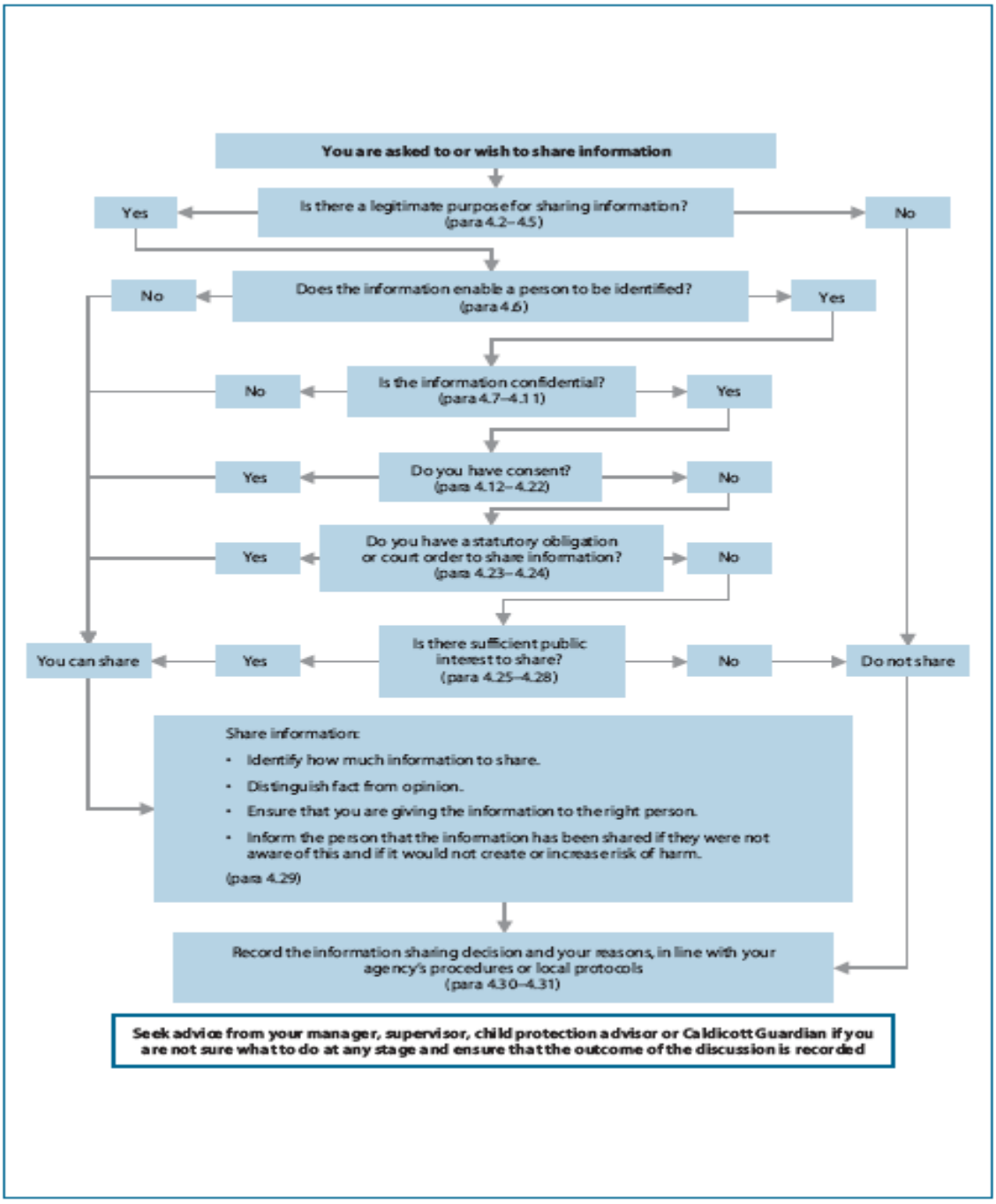
Other important numbers
Police - emergency 999 **Police - non-emergency 101**

APPENDIX 2: Possible signs and indicators of child abuse and neglect



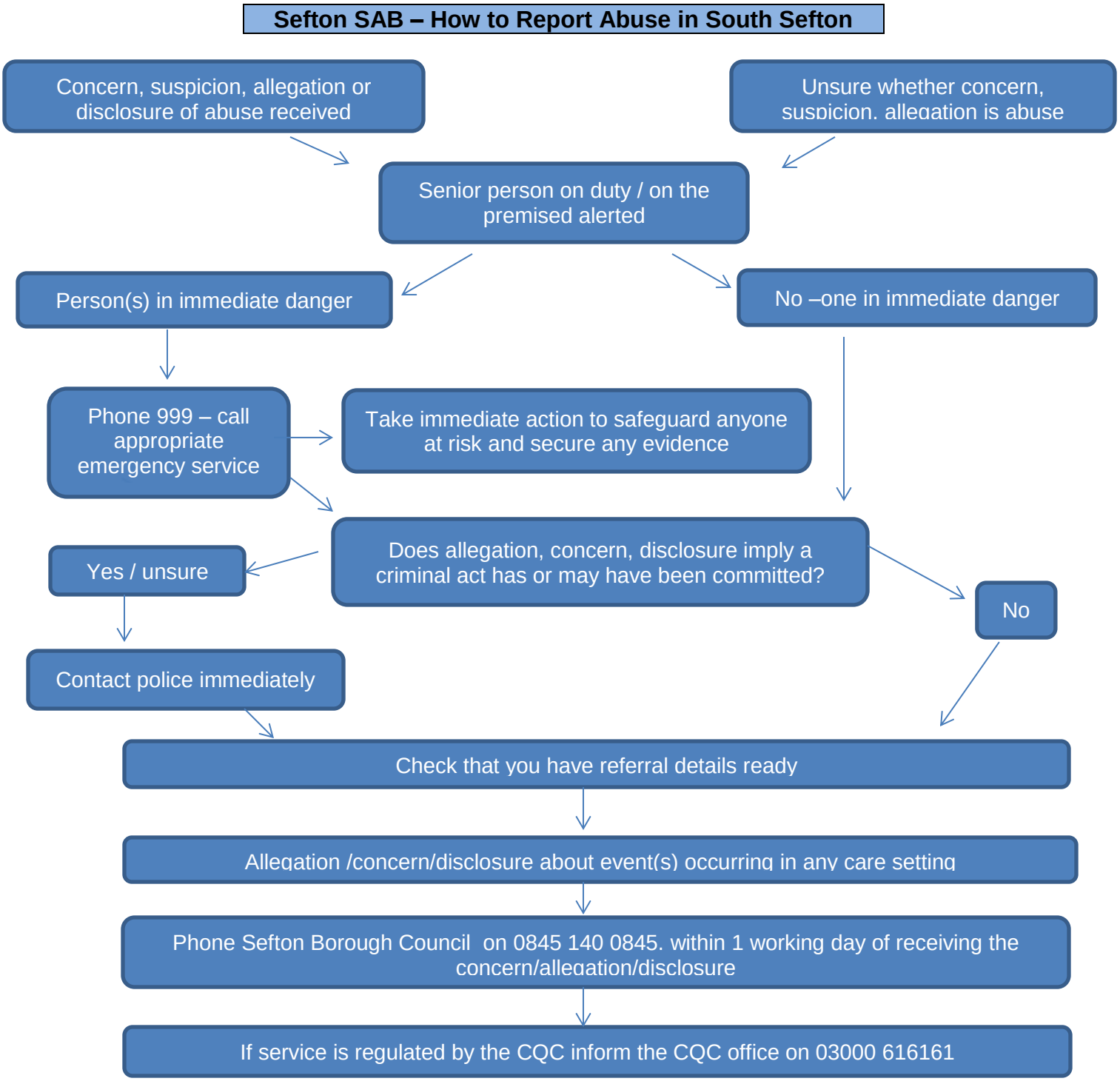
APPENDIX 3: Information Sharing Guidance

Sefton LSCB – Information Sharing Flowchart



For advice and support from the Designated Nurse for South Sefton CCG within the Shared Merseyside Safeguarding Service please ring the main contact numbers: 0151 495 5469 or 5295

APPENDIX 4: What to do if an adult is at risk of abuse



To discuss your concerns with the safeguarding adult lead for South Sefton CCG ring 0151 495 5469 or 5295

Appendix 5 Cheshire and Mersey Commissioning Standatrds 2016

Comm std tab.xlsx

Appendix 5b

Organisations will need to ensure that they have appropriate governance arrangements, policies and procedures in place to reflect the services they provide.

Section 1: details the policies that need to be in place for all providers of NHS care.

Section 2: details the governance arrangements, policies, procedures and guidance that should be in place within the larger providers of acute care & community health services.

Section 3: details the additional procedures that need to be in place within emergency care settings.

The list is not exhaustive and organisations need to always be mindful of changes to legislation and statutory/national/local guidance.

Section 1: ALL PROVIDER ORGANISATIONS	RAG
• Safeguarding children policy	
• Safeguarding adult policy	
• Complaints and whistle blowing policies promoting staff being able to raise concerns about organisational effectiveness in respect to safeguarding	
• Safe recruitment practices in line with LSCB/SAB and NHS Employers guidance and the recommendations of the Lampard report (post Savile) • Arrangements for dealing with allegations against people who work with children and vulnerable people as appropriate	
• Information sharing & confidentiality policy	
• MCA/DoLS implementation policy – this can be incorporated into the safeguarding policy for smaller providers. The MCA policy must be in line with the Mental Capacity Act Code of Practice 2007	
• Prevent – as applicable to the service being provided and as agreed by the coordinating commissioner in consultation with the Regional Prevent Co-ordinator ○ Include in its policies and procedures, and comply with, the principles contained in the Government Prevent Strategy and the Prevent Guidance and Toolkit ○ Include in its policies and procedures a programme to raise awareness of the Governments Prevent Strategy among staff and volunteers in line with the NHS England Prevent Training and Competencies Framework; a WRAP delivery plan that is sufficiently resourced with WRAP facilitators	
• To nominate a safeguarding lead, MCA lead and Prevent lead – to ensure the co-ordinating commissioner is kept informed at all times of the identity of the persons holding those positions	
• To be registered with the Care Quality Commission (CQC).	
• To implement comprehensive programme for safeguarding and MCA training for all relevant staff with due regard to the intercollegiate and LSCB/SAB guidance; and to undertake an annual audit in respect of the completion of those training programmes	

• To undertake an annual audit of its conduct in relation to compliance with required safeguarding standards	
Section 2: LARGE PROVIDERS OF ACUTE AND COMMUNITY HEALTH SERVICES	RAG
• The organisation is able to evidence how it is implementing the strategic aims of the LSCB/LSAB safeguarding strategies	
• At a minimum an annual report should be presented at board level with the expectation that this will be made public, there is an expectation that there will be also regular reporting on safeguarding to governance/quality committees	
• Named professionals have a key role in promoting good professional practice and in supporting the safeguarding system. They should work collaboratively with the organisations designated professionals and the LSCB/SAB.	
• All providers are required to have an MCA lead that is responsible for providing support and advice to clinicians in individual cases and in supervision of staff where there are complex cases. The MCA lead will highlight the extent of any areas to which their own organisation is compliant and will work closely with the CCG designated professional.	
• All NHS Trusts providing services for children must identify a named doctor and named nurse for safeguarding children; (where maternity services are provided, a named midwife for safeguarding children will be identified) Where organisations may have integrated specific services focused on children for example under Transforming Community Services children's community services may have integrated with Mental Health Trust – in this instance there must be named professionals for children's community services and also named professionals for the mental health trust. REF: Intercollegiate document	
• The Provider must comply with the Prevent requirements detailed in section 1	
• There is an operational framework/policy detailing the levels of supervision required for staff specific to their roles and responsibilities including a gap analysis. This framework meets LSCB/LSAB guidance for supervision	
• Named Safeguarding / MCA leads, seek advice and access regular formal supervision from designated professionals for complex issues or where concerns may have to be escalated	
• Procedures on recording and reporting concerns, suspicions and allegations of abuse to children and to vulnerable adults in line with national and local guidance	
GUIDELINES IN LINE WITH NATIONAL, LOCAL AND NICE GUIDANCE:	
• Sudden unexpected deaths in childhood	
• Child Sexual Exploitation	
• Private fostering	
• Fabricated Induced Illness (FII)	
• Children missing education	
• Missing from Home	
• Domestic violence and abuse	

• Forced Marriage and Honour Based Violence	
• Female Genital Mutilation (including national reporting)	
• Working with Children who self- harm or who have potential for suicide	
• Historical Sexual Abuse	
• Common Assessment Framework / Early Help Assessment Tool and local continuum of need	
• Practitioners working with sexually active children under 18 years	
• E safety – to incorporate the Lampard recommendations post Savile: • To have a robust trust wide policy setting out how access by patients and visitors to the internet, social media networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. • The policy to be widely publicised to staff, patients and visitors and to be regregularly reviewed and updated as necessary	
• Clear way of identifying those children who are subject to a child protection plan and are looked after	
• Conflict Resolution/Escalation Policies	
• Managing allegations against staff working with children and adults in line with LSCB/AB guidance	
• Policy for agreeing to and managing visits by celebrities, VIPs and other officials.	
2.1 This section is relevant to healthcare providers offering in-patient facilities to children under 18 years only	RAG
• Clear guidance as to the discharge of children for whom there are child protection concerns	
• The CCG and the Local Authority shall be notified of any child (normally resident in CCG area) likely to be accommodated for a consecutive period of at least 3 months; or with the intention of accommodating him/her for such a period (ref s.85 & s.86 CA1989)	
2.2 This section is relevant to providers of in-patient facilities and community services for adults	RAG
• Guidance on the use of restraint in line with Mental Capacity Act 2005 & DoLs	
• All inpatient mental health services have policies and procedures relating to children visiting inpatients as set out in the *Guidance on the Visiting of Psychiatric Patients by Children (*HS 1999/222:LAC (99)32), to NHS Trusts	
2.3 This section is relevant to community providers and acute trusts where they are commissioned to undertake statutory health assessments for children looked after	RAG
• Clear protocols and procedures in relation to completion of statutory health assessments	
• Provision of services appropriate for children looked after in accordance with statutory guidance	

Section 3: THIS SECTION IS RELEVANT TO EMERGENCY CARE SETTINGS	RAG
• Local procedures for making enquiries to find out whether a child is subject to a child protection plan /child looked after; this will be CP-IS once implemented	
• All attendances for children under 18 years to A&E, ambulatory care units, walk in centres and minor injury units should be notified to the child's GP	
• Guidance on parents/carers who may seek medical care from a number of sources in order to conceal the repeated nature of a child's injuries	
• Guidance on the use of restraint in line with Mental Capacity Act 2005 & DoLS	
Section 4: THIS SECTION IS RELEVANT TO AMBULANCE SERVICES, URGENT CARE/WALK IN CENTRES/MINOR INJURY UNITS, ACUTE SERVICES, A&E	RAG
• The provider must co-operate fully and liaise appropriately with 3rd party providers of social care services in relation to, and must take reasonable steps towards, the implementation of the Child Protection Information Sharing Project	

Appendix 6

Audit Tool to measure CCG compliance with the NHS Assurance and Accountability Framework for Safeguarding (Safeguarding Vulnerable People in the NHS 2015) and Section 11 Children Act 2004.	
CCG:	
Person completing the audit tool (include designation, contact details including email)	
Dated audit tool completed	
Useful links :	
Local Safeguarding Children Board policies/procedures	
Local Safeguarding Adult Board policies/ procedures	

Green: Fully compliant (remains subject to continuous quality improvement t)

Amber : Partially compliant - plans in place to ensure full compliance and progress is being made within agree timescales

Red: Non-compliant (standards not met / actions have not been completed within agreed timescales)

Standard	Components	Evidence	RAG
1. Accountability			
1.1 There is a clear line of accountability for safeguarding, reflected in CCG governance arrangements (SVP p.21)	A named executive to take overall leadership responsibility for the organisations safeguarding arrangements (SVP p.21)		
1.2 (s.11) It should be clear who has overall responsibility for the agency's contribution to safeguarding and what the lines of accountability are	• All staff know who to report concerns about a child/adult at risk to • Staff at all levels know and understand their responsibilities		

Standard	Components	Evidence	RAG
1.3 There are effective systems for responding to abuse and neglect (SVP p.21).			
1.4 NHS England in conjunction with CCGs to consider where there are risks and gaps in services to develop an action plan to mitigate against the risk (SVP p.30)			
2. **Leadership / Designated Professionals**			
2.1 S11) Senior managers will need to demonstrate leadership; be informed about and take responsibility for the actions of their staff who are providing services to the children and their families	Designated senior officers for safeguarding are in place and visible across the organisation Senior managers can evidence effective monitoring of service delivery		
2.2 To employ or secure the expertise of Designated Doctors and Nurses for Safeguarding Children and for Looked After Children; and a Designated Paediatrician for unexpected deaths in childhood. The role	Designated clinical experts embedded into the clinical decision making of the organisation, with the authority to work within local health economies to influence local thinking and practice (SVP p.22).		

Standard	Components	Evidence	RAG
of the designated professional to be explicitly defined in the job description for sufficient time, funding. (SVP p22)	Clear accountability and performance management arrangements are essential; key elements include: As single subject experts, peer-to- peer supervision is vital to ensuring designated professionals continue to develop in practice in line with agreed best practice. Designated leads must have direct access to the Executive Board lead for safeguarding to ensure that there is the right level of influence of safeguarding in commissioning process The CCG Accountable Officer (or other executive level nominee) should meet regularly with the designated professional to review safeguarding Where designated doctors are continuing to undertake clinical duties in addition to their clinical advice role in safeguarding, it is important		

Standard	Components	Evidence	RAG
	that there is clarity about the two roles – the CCG will need to input into the job planning, appraisal and revalidation process. (SVP p.23) Where a designated professional (most likely designated doctor for safeguarding children or a designated professional for Looked after Children) is employed within a provider organisation, the CCG will need to have a service level agreement, with the organisation that sets out the practitioner's responsibilities and the support they should expect in fulfilling their designated role. To employ, or have arrangements in place to secure the expertise of a consultant paediatrician whose designated responsibilities are to provide advice on the commissioning of: paediatric services from paediatricians with expertise in undertaking enquiries into unexpected		

Standard	Components	Evidence	RAG
	deaths in childhood; from medical investigative services; and the organisation of such services (WT p.90)		
2.3 To have a Designated Adult Safeguarding Manager (DASM) which should include an Adult Safeguarding lead role and to have a Designated Mental Capacity Act (MCA) Lead; supported by relevant policies and training. (SVP p. 21) N.B. The DASM can include both roles of Safeguarding Adult and MCA Leads	Designated clinical experts embedded into the clinical decision making of the organisation, with the authority to work within local health economies to influence local thinking and practice (SVP p.22). Clear accountability and performance management arrangements are essential; key elements include: As single subject experts, peer-to- peer supervision is vital to ensuring designated professionals continue to develop in practice in line with agreed best practice. Designated leads must have direct access to the Executive Board lead for safeguarding to ensure that there is the right level of influence of safeguarding in commissioning process		

Standard	Components	Evidence	RAG
	The CCG Accountable Officer (or other executive level nominee) should meet regularly with the designated professional to review safeguarding NB: An intercollegiate document for safeguarding adults incorporating MCA is currently being devised nationally. Until this is published there is no guidance as to the WTE required.		
2.4 Supporting the development of a positive learning culture across partners for safeguarding to ensure that organisations are not unduly risk adverse (SVP p.21)			
3.Commitment/Safeguarding Policies, Procedures and Guidance			
3.1 (S11) The agency's responsibilities towards children / adults at risk is clearly stated in policies and procedures that are available for all staff.	Statement of responsibilities (as per section 11) is visible in policies & guidance Policies and guidance refer to the LSCB/LSAB multi-agency procedures This is accessible and understood by all staff Policies and procedures are		

Standard	Components	Evidence	RAG
	updated regularly to reflect any structural, departmental and legal changes All policies and procedures must be audited and reviewed at a minimum 2 yearly to evaluate their effectiveness and to ensure they are working in practice (s.11)		
4 Service development review			
4.1 S11) In developing local services, those responsible should consider how the delivery of these services will take account of the need to safeguard and promote the welfare of children (at case management and strategic level).	The views of children, families are sought and acted upon when developing services and feedback provided The need to safeguard children has informed decision making about any developments		
5. Commissioning / Assurance.			
5.1CCGs as commissioners of local health services are assured that the organisations from which they commission have effective safeguarding arrangements in place (SVP p.20).	Gain assurance from all commissioned services, both NHS and independent healthcare providers, throughout the year to ensure continuous improvement. (SVP p.21) Safeguarding, including Prevent and MCA forms part of		

Standard	Components	Evidence	RAG
	the NHS standard contract (service condition 32) (SVP p. 21)		
6. Primary Care (co-commissioning and safeguarding)			
6.1 Primary care commissioners are required to ensure there is named GP/named professional capacity to support primary care services in discharging their safeguarding duties (SVP append 1) The capacity is funded through the primary care budget but it is for local determination exactly how this is done and what employment arrangements are adopted (SVP p.28)	Capacity commissioned locally needs to reflect local needs as set out in the JSNA - strongly recommended that two named GP sessions per 220,000 population is secured as a minimum. (SVP p.28) The named GP roles covers safeguarding of children – it is recommended that NHS England /primary care commissioner and local CCG clinical leaders consider commissioning a cluster model of named safeguarding clinicians with a range of experience. This could include child safeguarding, safeguarding people of all ages with mental health issues, safeguarding CLA and care leavers, adult safeguarding including domestic abuse safeguarding in elderly care and dementia and safeguarding in institutions		

Standard	Components	Evidence	RAG
	including care homes (SVP p.29) Arrangements are in place for training primary care professionals (SVP app 6		
7. effective information Sharing			
7.1 S11) Effective information sharing by professionals is central to safeguarding and promoting the welfare of children and adults at risk of harm (SVP p.21)	There are robust single / multi agency protocols and agreements for information sharing in line with national and local guidance (s.11)		
8. Interagency working			
8.1 (S11) Agencies and staff work together to safeguard and promote the welfare of children	Evidence of leadership to enable joint working Evidence of practitioner's working together effectively Early Help/Support is being used appropriately and effectively (s.11)		
8.2 Effective interagency working is in place with the local authority, police and 3rd sector organisations (svp p.21)	To co-operate with the local authority in the operation of the Local Safeguarding Children Board (LSCB), Local Safeguarding Adult Board (LSAB), and Health and Wellbeing Board (SVP p.21) CCG representatives at the LSCB/LSAB must be		

Standard	Components	Evidence	RAG
	accompanied by their designated professional to ensure their professional expertise is effectively linked into the local safeguarding arrangements (SVP p.23). When asked by the local authority for help in enabling the LA to discharge its safeguarding duties, the CCG must help, as long as it is compatible with the CCGs own duties and does not hamper the discharge of the CCGs own functions. (SVP p13) To co-operate with the local authority in order to promote the wellbeing of children in general and to protect them from harm and neglect in particular (SVP p13) Work with the local authority to enable access to community resources that can reduce social and physical isolation for adults (SVP p22		
8.3 To participate, when asked to do so, in a statutory			

Standard	Components	Evidence	RAG
review by providing a panel member. (SVP p.18)			
9. safer recruitment practices			
9.1 (S11) Robust recruitment and vetting procedures should be put in place to prevent unsuitable people from working with children and vulnerable adults	All recruitment staff are appropriately . trained in safe recruitment All appropriate staff receive a DBS check in line with national/local guidance Legal requirements are understood and in place Role of LADO understood and procedures in place All staff know who the Named Senior Officer for their agency is		
9.2 Clear policies setting out the commitment, and approach, to safeguarding including safe recruitment practices and arrangements for dealing with allegations against people who work with children and adults as appropriate (SVP p.21)			
10. Supervision and Support			

Standard	Components	Evidence	RAG
10.1 (S.11) Safeguarding supervision should be effective and available to all	All staff working with children and vulnerable adults receive appropriate regular supervision (including reviews of practice) Evidence that staff feel able to raise concerns about organisational effectiveness/concerns		
11. staff training and continuing professional development			
11.1 (S11) Staff should have an understanding of both their roles and responsibilities for safeguarding children, children looked after and those of other professionals and organisations.	All staff have received level 1 safeguarding training for children. For new starters, training to be undertaken within 6 weeks/during induction period, with refresher training every 3 years All staff who have contact with children and young people have undertaken CSE training All appropriate staff have received level 2 and above single agency training and or multi-agency training as appropriate		
11.2 Training of staff in recognising and reporting	• Training in line with the intercollegiate		

Standard	Components	Evidence	RAG
safeguarding issues, appropriate supervision and ensuring staff are competent to carry out their roles and responsibilities (SVP p.21).	documents and local and national guidance		

NB: The shaded sections highlight standards that are included in the **LSCB section 11 audit**

SVP: Safeguarding Vulnerable People in the NHS 2015