NHS
South Sefton
Clinical Commissioning Group

South Sefton Clinical Commissioning Group

Safeguarding Children & Adults at Risk Policy 2019 (Incorporating Safeguarding and Mental Capacity Act Standards for Commissioned Services)

Title:	**Safeguarding Children & Adults at Risk Policy**
Version:	V12
Ratified by:	South Sefton CCG Governing Body
Date ratified:	
Name of originator/author:	CCG Safeguarding Service
Name of Lead:	Chief Nurse
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Target audience:	CCG

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
V10	Update	June 2018	Updated to reflect changes in the provision of the CCGs Safeguarding Team and new contact details for the Team
V11	update	January 2019	Updated to reflect Working Together 2018 and revised following implementation of separate CCG LAC Policy
V12	update	March 2019	Appendix 3 updated with link to further support definition of 'legitimate' as per request from Governing Body (February 2019) and approved at Joint Quality Committee (March 2019)

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 2018 compliant). South Sefton CCG should also ensure that health providers are engaged in Multi Agency Partnership Arrangements and that health workers contribute to multi-agency working across both the Safeguarding Children and Adult agendas
The Children Act 2004, as amended by the Children and Social Work Act (2017), strengthens the relationship between key partners under a new duty to make arrangements to work together to safeguard and promote the welfare of all children in their area. Local Safeguarding Children Board (LSCB) arrangements will remain in place until the new safeguarding partnership arrangements are published before 29th June 2019.

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 has been developed with reference to the Sefton Safeguarding Children Board (LSCB) and Merseyside Safeguarding Adults Board multi agency policies.

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 adults at risk 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 Safeguarding Vulnerable People in the NHS - Accountability and Assurance 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 2018* 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 outcomes.

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:

- is disabled and has specific additional needs
- has special educational needs (whether or not they have a statutory Education, Health and Care Plan)
- is a young carer
- is showing signs of being drawn into anti-social or criminal behaviour, including gang involvement and association with organised crime groups
- is frequently missing/goes missing from care or from home
- is at risk of modern slavery, trafficking or exploitation
- is at risk of being radicalised or exploited
- is in a family circumstance presenting challenges for the child, such as drug and alcohol misuse, adult mental health issues and domestic abuse
- is misusing drugs or alcohol themselves
- has returned home to their family from care
- is a privately fostered child

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.

The CCG has a separate Children in Care Policy (2019) which highlights the CCGs roles and responsibilities to support Children in Care

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. Please refer to Sefton Multi Agency Domestic Abuse Protocol (2018).

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 PREVENT

Prevent forms part of the Counter Terrorism and Security Act 2015. The Prevent Strategy aims to stop people from becoming terrorists or supporting terrorism and operates in the pre-criminal space before any criminal activity has taken place. Recent history has demonstrated how children and adults at risk have been exploited and radicalised by terrorists.

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.

5.3.5 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.

5.3.6 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.

5.3.7 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.

5.3.8 Contextual Safeguarding

As well as threats to the welfare of children from within their families, children may be vulnerable to abuse or exploitation from outside their families. These extra-familial threats might arise at school and other educational establishments, from within peer groups, or more widely from within the wider community and/or online. These threats can take a variety of different forms and children can be vulnerable to multiple threats, including: exploitation by criminal gangs and organised crime groups such as county lines; trafficking, online abuse; sexual exploitation and the influences of extremism leading to radicalisation. Extremist groups make use of the internet to radicalise and recruit and to promote extremist materials. Any potential harmful effects to individuals identified as vulnerable to extremist ideologies or being drawn into terrorism should also be considered.

Assessments of children in such cases should consider whether wider environmental factors are present in a child's life and are a threat to their safety and/or welfare. Children who may be alleged perpetrators should also be assessed to understand the impact of contextual issues on their safety and welfare. Interventions should focus on addressing these wider environmental factors, which are likely to be a threat to the safety and welfare of a number of different children who may or may not be known to local authority children's social care. Assessments of children in such cases should consider the individual needs and vulnerabilities of each child. They should look at the parental capacity to support the child, including helping the parents and carers to understand any risks and support them to keep children safe and assess potential risk to child.

If practitioners have concerns that a child may be a potential victim of modern slavery or human trafficking then a referral should be made to the National Referral Mechanism, as soon as possible.
The National Referral Mechanism is a process set up by the Government to identify and support victims of trafficking in the UK. It was born out of the Government's obligation to identify victims under the Council of Europe Convention on Action against Human Trafficking, which came into force on 1 February 2008. The National Referral Mechanism (NRM) is a framework for identifying victims of human trafficking and ensuring they receive the appropriate protection and support.

The NRM is also the mechanism through which the Modern Slavery and Human Trafficking Unit (MSHTU) collects data about victims. This information aims to help build a clearer picture about the scope of human trafficking in the UK.

From 31st July 2015, the NRM was extended to all victims of modern slavery in England and Wales following the implementation of the Modern Slavery Act 2015.

Modern slavery is comprised of:

1) Human trafficking
2) Slavery, servitude and forced or compulsory labour

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 arrangements 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 Safeguarding Adult Board SAB / Sefton LSCB (or subsequent partnership arrangements).
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 SAB / Sefton LSCB (or subsequent partnership arrangements) 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 Board (or subsequent partnership arrangements) 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 (or subsequent partnership arrangements) and SAB policies and procedures.

h) Ensures South Sefton CCG cooperates with the local authority in the operation of LSCB (or subsequent partnership arrangements) and LSAB.

i) Ensures that all health organisations with whom South Sefton CCG has commissioning arrangements have links with Sefton LSCB (or subsequent partnership arrangements) and SAB; 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 CCG Safeguarding Training Strategy and Training Needs Analysis (informed by Sefton LSCB (or subsequent partnership arrangements) and SAB Policy) 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 1 – What to do if you are worried a child is being abused
b) Appendix 2 – Possible signs and indicators of child abuse and neglect
c) Appendix 3 – Information sharing guidance
d) Appendix 4 - 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 Children in Care (CiC). 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 (or subsequent partnership arrangements) 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 (or subsequent partnership arrangements), 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 (or subsequent partnership arrangements), 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, adults at risk and mental capacity 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 (or delegated representative) within the CCG.

7.0 Management of Allegations Against a South Sefton CCG Employee

7.1 *Working Together to Safeguard Children* (2018) 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. Further detail is included in the CCG Management of Allegations Policy and Procedures (2018).

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.

- to ensure that 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 / safeguarding adult review reports and 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 and & adults and promoting their welfare, consistent with SAB / Sefton LSCB (or subsequent partnership arrangements).

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 (Appendix 5) 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 aforementioned 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 Chief Nurse so that the level of risk can be assessed and an action plan can be formulated (see section 10 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	0151 317 8366
Chief Nurse	0151 317 8360
Designated Nurse Safeguarding Children	0151 247 6449
Designated Doctor Safeguarding Children	0151 228 4811 Ext 2287
Designated Nurse Looked After Children	0151 317 8356
Designated Doctor Looked After Children	0151 228 4811 Ext 2287
Community Paediatrician - CDOP	0151 228 4811 Ext 2287
Designated Adult Safeguarding Manager	0151 317 8357
Mental Capacity Act Lead	0151 317 8357
Prevent Lead	0151 317 8357
Safeguarding Administrator	0151 317 8358

11.0 References

The following statutory, non-statutory, best practice guidance and the policies and procedures of the Sefton LSCB (or subsequent partnership arrangements) 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 NHSEngland.
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) Department of Health (June 2012) *The Functions of Clinical Commissioning Groups* (updated to reflect the final Health and Social Care Act 2012)
b) Department of Health (March 2011) *Adult Safeguarding: The Role of Health Services*
c) Department of Health (May 2011) *Statement of Government Policy on Adult Safeguarding*
d) 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
e) HM Government (2018) Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice
f) Law Commission (May 2011) *Adult Social Care Report* www.justice.gov.uk/lawcommission/publications/1460.htm
g) Royal College of Paediatrics and Child Health et al (2014) *Safeguarding Children and Young People: Roles and Competences for Health Care Staff. Intercollegiate Document*
h) NICE (2013) The health and wellbeing of looked-after children and young people http://www.nice.org.uk/guidance/qs31

i) NICE (2015) Looked-after children and young people http://www.nice.org.uk/guidance/ph28

j) 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 (2017) *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) National Institute for Health and Care Excellence (2017) *Child Abuse and Neglect*

h) Department of Health (2006) *Mental Capacity Act Best Practice Tool.* Gateway reference: 6703

i) HM Government (2011) *Multi-agency practice guidelines: Female Genital Mutilation*

11.4 Sefton Local Safeguarding Children Board (or subsequent partnership arrangements):

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

11.5 Merseyside Safeguarding Adult Board:

Merseyside Safeguarding Adult Board, policies, procedures and practice guidance are accessible at:
Merseyside 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

CCGs	Clinical Commissioning Groups
DCSF	Department for Children, Schools and Families
DH	Department of Health
LAC	Looked After Children
(L)SAB	(Local) Safeguarding Adult Board
LSCB	Local Safeguarding Children Board (or subsequent partnership arrangements)
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 2018).

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: Typically, there are signs of physical abuse both within and outside the relationship in which it occurs. However, spotting the signs of physical abuse may not always be easy and sometimes people choose to overlook them as

they don’t wish to believe that physical abuse is taking place. There are physical, behavioural and emotional signs of physical abuse. Behaviours are seen both in the abuser and in the victim.

Obvious signs of physical abuse include:

- Black eyes
- Bruises
- Burns
- Cuts
- Restraint or grip markings
- Unusual pattern of injury; repeated trips to Accident and Emergency.

While these signs of physical abuse may seem obvious, most victims may try to cover them up so as to hide the abuse due to fear of further abuse or shame about the abuse. While physical violence is never okay, and physical abuse is never the fault of the victim, many victims feel the abuse is their fault.

While the above signs of physical abuse are visible, other signs of physical abuse may be more subtle. These may include:

- Abuse of alcohol or other drugs
- Anxiety, including panic attacks and post-traumatic stress disorder (PTSD)
- Depression
- Fearfulness
- Pelvic pain; vaginal or urinary tract infections
- Sexual problems
- Social isolation or withdrawal
- Unwanted pregnancy; lack of prenatal care
- Vague medical complaints such as chronic headaches, fatigue or stomach pain.

Types of physical abuse

- Assault, hitting, slapping, punching, kicking, hair-pulling, biting, pushing
- Rough handling
- Scalding and burning
- Physical punishments
- Inappropriate or unlawful use of restraint
- Making someone purposefully uncomfortable (e.g. opening a window and removing blankets)
- Involuntary isolation or confinement
- Misuse of medication (e.g. over-sedation)
- Forcible feeding or withholding food
- Unauthorised restraint, restricting movement (e.g. tying someone to a chair)

Possible indicators of physical abuse

- No explanation for injuries or inconsistency with the account of what happened
- Injuries are inconsistent with the person's lifestyle
- Bruising, cuts, welts, burns and/or marks on the body or loss of hair in clumps
- Frequent injuries
- Unexplained falls
- Subdued or changed behaviour in the presence of a particular person
- Signs of malnutrition
- Failure to seek medical treatment or frequent changes of GP

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.

Emotional or Psychological abuse: Types of psychological or emotional abuse

- Enforced social isolation – preventing someone accessing services, educational and social opportunities and seeing friends
- Removing mobility or communication aids or intentionally leaving someone unattended when they need assistance
- Preventing someone from meeting their religious and cultural needs
- Preventing the expression of choice and opinion
- Failure to respect privacy
- Preventing stimulation, meaningful occupation or activities
- Intimidation, coercion, harassment, use of threats, humiliation, bullying, swearing or verbal abuse
- Addressing a person in a patronising or infantilising way
- Threats of harm or abandonment
- Cyber bullying
- Possible indicators of psychological or emotional abuse
- An air of silence when a particular person is present
- Withdrawal or change in the psychological state of the person
- Insomnia
- Low self-esteem
- Uncooperative and aggressive behaviour
- A change of appetite, weight loss/gain
- Signs of distress: tearfulness, anger
- Apparent false claims, by someone involved with the person, to attract unnecessary treatment

Financial or material abuse: Financial or material abuse can occur in isolation, but research has shown where there are other forms of abuse, there is likely to be

financial abuse occurring. Although this is not always the case, everyone should be aware of this possibility.

Potential indicators of financial abuse 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's or donors signature card
- Sudden or unexpected changes in a Will or other financial documents.

Neglect and acts of omission: Definition of neglect: The failure of any person, who has responsibility for the charge, care or custody of an adult at risk, to provide the amount and type of care that a reasonable person would be expected to provide. Neglect can be intentional or unintentional.

Neglect and Acts of Omission includes:

- 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.
- The following are also potential indicators of Neglect and Acts of Omission:
- Poor environmental conditions
- Inadequate heating and lighting
- Poor physical condition of the vulnerable adult
- Clothing is ill-fitting, unclean and in poor condition
- Malnutrition
- Failure to give prescribed medication properly
- Failure to provide appropriate privacy and dignity
- Inconsistent or reluctant contact with health and social care agencies
- Isolation – denying access to callers or visitors.

Self neglect and Hoarding: can be defined as:

- Neglecting to care for one's personal hygiene
- Neglecting to care for one's health
- Neglecting to care for one's surroundings
- Hoarding* which can include:
- Inanimate objects (commonly clothes, newspapers, books, DVDs, letters & food/packaging)

- Animals
- Data

*Excessive collection & retention of any material to the point that it impedes day to day functioning

This could also involve refusal of services, treatment, assessments or intervention, which could potentially improve self-care or care of one's environment. There are other less overt forms of self – neglect such as: eating disorders; misuse of substance; and alcohol abuse. Self-neglect differs from other safeguarding concerns as there is no perpetrator of abuse, however, abuse cannot be ruled out as a purpose for becoming self-neglectful.

Discriminatory abuse including hate crime: It is against the law to discriminate (treat less favourably) against anyone because of:

- Age
- Being or becoming a transsexual person
- Being married or in a civil partnership
- Being pregnant or having a child
- Disability
- Race including colour, nationality, ethnic or national origin
- Religion, belief or lack of religion/belief
- Sex
- Sexual orientation.

These are called 'protected characteristics'.

What is hate crime?

A hate crime is any behaviour that someone thinks was caused by hostility, prejudice or hatred of their:

- Disability (including physical impairments, mental health problems, learning disabilities, hearing and visual impairments
- Gender Identity (people who are transgender, transsexual or transvestite)
- Race, skin colour, nationality, ethnicity or heritage
- Religion, faith or belief (including people without a religious belief)
- Sexual orientation (people who are lesbian, gay, bisexual or heterosexual etc.)

It can include:

- Name calling or verbal abuse
- Graffiti or abusive writing
- Damage to property
- Threats or intimidation
- Bullying or harassment
- Physical attacks or violence, including sexual violence, arson and murder.

Anyone can be a victim of hate crime if they are targeted because of who they are, their friends or family or even who the perpetrator thinks they are.

Modern slavery: Encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to force individuals into a life of abuse and inhumane treatment.

Poverty, limited opportunities, lack of education, unstable social and political conditions, economic imbalances and war are the key driving forces that contribute to the trafficking of victims into, through and across the UK.

Radicalisation and Extremism:

Radicalisation or extremism is where someone holds views that are intolerant of people who are of a different ethnicity, culture, religion, gender or sexual identity. Extremists may try to force their views on others and, in some cases, may believe that these views can justify the use of violence in order to achieve certain aims.

Examples of violent extremist causes that have used violence to achieve their ends include white extremists from the far-right or Islamist fundamentalists and animal rights activists, all of which usually attract people to their cause through a persuasive, sometimes violent narrative. These kinds of narratives often provide people with answers democracy doesn't give to the various grievances they may have either towards their school, family, missed opportunities in life or other. They then justify violence or criminal actions with the need to impose radical changes or avenge any suffering they themselves or others may have been subjected to.

Organisational Abuse: The following list includes some indicators of 'possible' organisational abuse:

- Batch care – lack of individual care programmes
- Deprived environmental conditions and lack of stimulation
- Illegal confinement or restrictions

Honour Based Violence, Forced Marriage and Female Genital Mutilation:
'Honour' based violence (HBV) is a form of domestic abuse which is perpetrated in the name of so called 'honour'. The honour code which it refers to is set at the discretion of male relatives and women who do not abide by the 'rules' are then punished for bringing shame on the family. Infringements may include a woman having a boyfriend; rejecting a forced marriage; pregnancy outside of marriage; interfaith relationships; seeking divorce, inappropriate dress or make-up and even kissing in a public place.

HBV can exist in any culture or community where males are in a position to establish and enforce women's conduct, examples include: Turkish; Kurdish;

Afghani; South Asian; African; Middle Eastern; South and Eastern European; Gypsy and the travelling community (this is not an exhaustive list).

Males can also be victims, sometimes as a consequence of a relationship which is deemed to be inappropriate, if they are gay, have a disability or if they have assisted a victim. In addition, the Forced Marriage Unit have issued guidance on Forced Marriage and vulnerable adults due to an emerging trend of cases where such marriages involving people with learning difficulties.

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 please ring: 0151 247 6449

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 referral to Sefton's Children's Services following the link below:

- https://www.sefton.gov.uk/social-care/children-and-young-people/report-a-child-or-young-person-at-risk/information-for-professionals.aspx. Prior to making a referral through to Children's Social Care, if you would like to have a consultation with a Social Worker please call Sefton's MASH Team on either 0151 934 4013/ 4481. Please note a Child Referral Form should be completed in all cases unless you deem the child to be at risk of immediate significant harm to which MASH Contact Officers will receive information via the telephone in the first instance but following this a Child Referral Form must be completed.
- 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

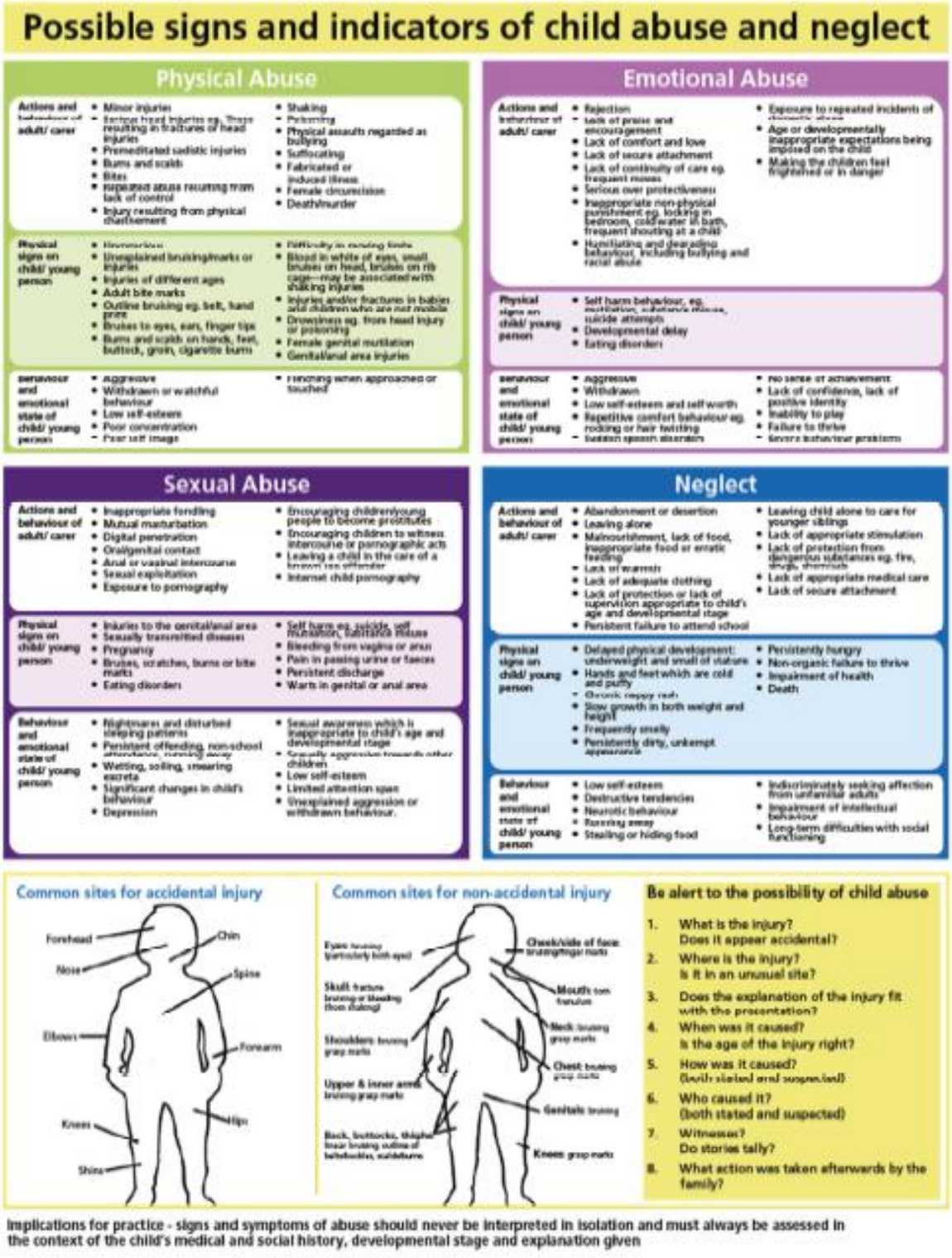
Children's Social Care acknowledges receipt of referral and decides on next course of action. If the referrer has not received an acknowledgement within 3 working days contact Children's Social Care (0151 934 4013 or 4481) again for an update.

Step 4

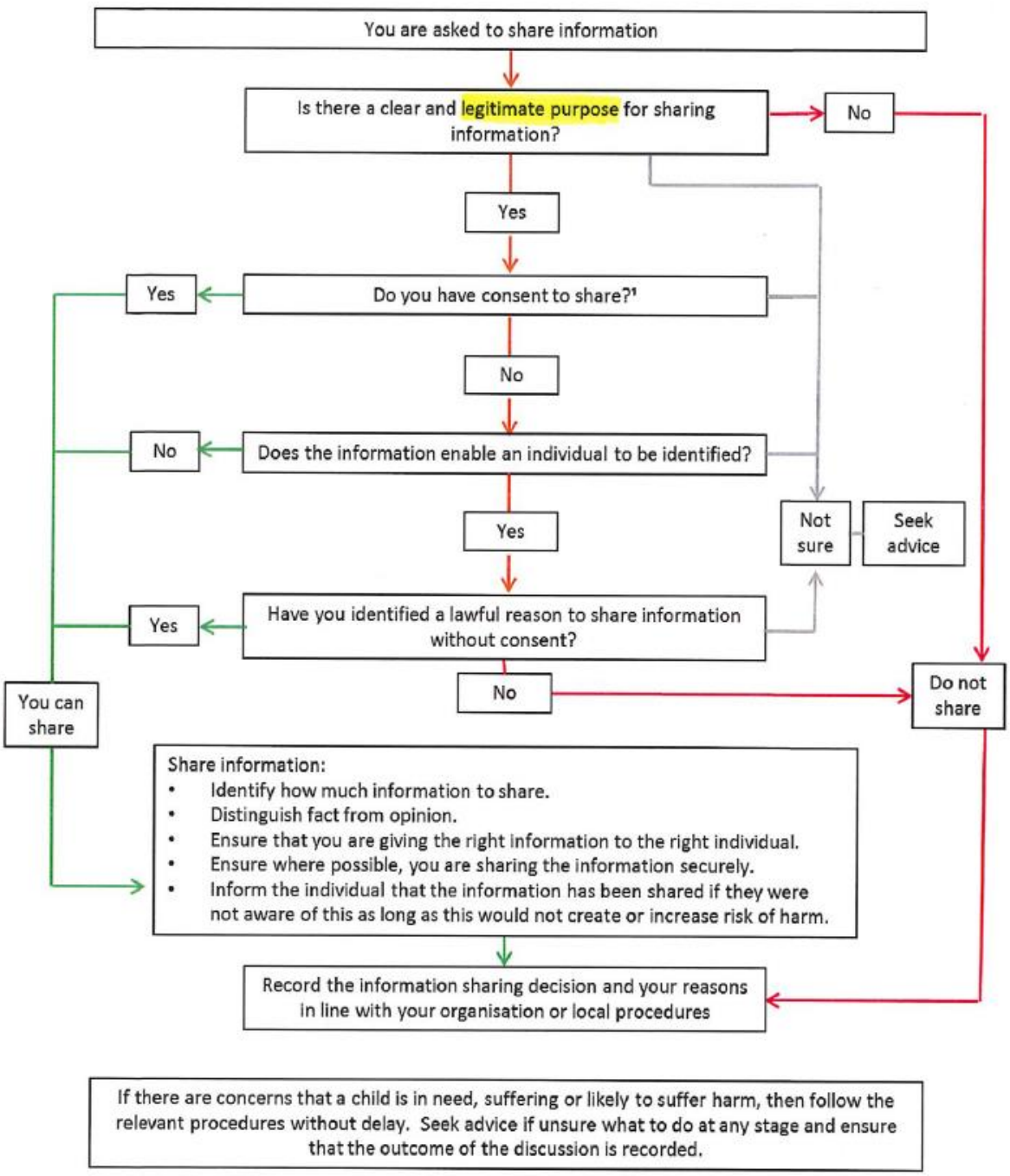
You may be requested to provide further reports / information or attend multi-agency meetings

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



Please click on link for further information in respect of 'a clear and legitimate purpose for sharing information'.

For advice and support from the Designated Nurse Safeguarding Children for South Sefton CCG please ring: 0151 247 6449

APPENDIX 4: What to do if you are worried an adult is being abused.

For advice and support from the Designated Safeguarding Adult Manager for South Sefton CCG please ring: 0151 317 8357

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

Are you concerned an adult at risk is being abused ? eg

- You may observe an injury or signs of neglect
- You may be given information that outlines abuse or neglect
- An adult may disclose abuse

Step 1

Inform the adult that you will refer to adult social care and obtain consent and discuss their wishes and feelings
UNLESS
The adult may be put at increased risk of further harm (eg suspected sexual abuse, female genital mutilation, increased risk to adult, forced marriage or there is a risk to your own personal safety)

Step 2

Make a referral to Sefton's Adult Services:

- Call Sefton Adult Social Care on 0151 934 3737.
- 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 on a body map.

Step 3

Adult Social Care acknowledges receipt of referral and decides on next course of action. If the referrer has not received an acknowledgement contact Adult Social Care 0151 934 3737 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 5

Audit Tool to monitor Safeguarding Arrangements for CCG Commissioned Services (held within quality schedule)	
Organisation:	
Person completing the audit tool (include designation, contact details including email)	
Dated audit tool completed	
Useful links :	
Local Safeguarding Children Board	
Local Safeguarding Adult Board policies/ procedures	

Rag rating key:

Green		Fully compliant (remains subject to continuous quality improvement)
Amber		Partially Compliant – plans in place to ensure full compliance and progress is being made within timescales
Red		Non-compliant (standards not met / actions have not been completed within agreed timescales)

Standard	Components of standard	Evidence (embed or attach evidence including audits)	RAG
1. Governance / Accountability			
1.1(S11 It should be clear who has overall responsibility for the agency's contribution to safeguarding and what the lines of accountability are from each staff member up through the organisation through to the person with ultimate responsibility	• Board lead demonstrating specific safeguarding competence in line with National & Local Guidance • Job descriptions clearly identify safeguarding responsibilities • All staff know both how and who to report concerns about a child/adult at risk of harm		

1.2 The organisation is linked into the Local Safeguarding Children Board (LSCB) and Local Safeguarding Adult Board (LSAB)	• The organisation is able to evidence how it is implementing the strategic aims of the LSCB/LSAB safeguarding strategy.		
1.3 The organisation regularly reviews the arrangements in place for safeguarding and MCA	• The governing body should receive regular report on their arrangements for safeguarding and MCA implementation		
1.4 An adverse incident reporting system is in place which identifies circumstances and . or incidents which have compromised the safety and welfare of patients	• All STEIS reporting in relation to patient safety and welfare are to be reported to the CCG Lead • Commissioners provided with a regular report (interval to be agreed between the provider and the commissioner but must be at least annually) of key themes/learning from STEIS that involve safeguarding • Complaints are considered in the context of safeguarding		
1.5 A programme of internal audit and review is in place that enables the organisation to continuously improve the protection of all service users from abuse or the risk of abuse	Audits to include: • Progress on action to implement recommendations from Serious Case Reviews (SCRs); Internal management reviews; recommendations from inspections; • Referral, Contribution to multi-agency safeguarding/protection meetings; early help and LAC		

1.6 There is an annual safeguarding plan for safeguarding children and adults which includes quality indicators to evidence best practice in safeguarding	•		
2. Leadership			
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 There is a named lead for safeguarding children and a named lead for vulnerable adults. The focus for the named professionals is safeguarding within their own organisation	• Safeguarding leads will have sufficient time, support and flexibility to carry out their responsibilities – this should be detailed in their job plans • The Commissioner is kept informed at all times of the identity of the Safeguarding Lead		
2.3 There is a named lead for MCA – the focus for named professionals is MCA implementation within their own organisation (ref MCA Best Practice Tool (DH2006)).	• MCA Leads must have in-depth, applied knowledge of MCA/DoLs, including awareness of relevant case law, and must have protected study time to ensure they keep their knowledge up to date		
3. Service Development Review			
3.1 (S11) In developing local services those responsible should consider how these services will take account of the	• The view of children, families and vulnerable adults are sought and acted upon when developing services and		

need to safeguard and promote the welfare of children, children looked after and vulnerable adults (at case management and strategic level)	feedback provided		
4. Safeguarding policies, procedures and guidance (see supporting sheet to identify those that are relevant to your organisation)			
4.1 (S11) The agencies responsibilities toward children and adults at risk is clearly stated in policies and procedures that are available for all staff	• A statement of responsibilities is visible in policies and procedures • Policies and guidance refer to the LSCB / LSAB multi-agency procedures • These procedures are accessible and understood by all staff • Policies and procedures are updated regularly to reflect any structural, departmental and legal changes • All policies and procedure must be audited and reviewed at a minimum 2 yearly to evaluate their effectiveness and to ensure they are working practice.		
5. Domestic violence including Forced Marriage and Honour Based Violence, Female Genital Mutilation			
5.1 The organisation takes account of national and local guidance to safeguard those Children and adults subjected to harmful practices.	•		
6. Information sharing			
6.1 (S11) Effective information sharing by professionals is central to safeguarding and promoting the welfare of children	• There are robust single/multi agency protocols and agreements for information sharing in line with national		

and adults at risk of harm	and local guidance • Evidence that practitioners understand their responsibilities and know when to share information		
7. Prevent			
7.1 The Provider includes in its policies and procedure, and complies with, the principles contained in Prevent and the Prevent Guidance and Toolkit. There is a proportionate response in relation to the delivery of WRAP for staff and volunteers	• The Provider must nominate a Prevent Lead and must ensure that the Commissioner is kept informed at all times of the identity of the Prevent Lead.		
8. Inter-agency working			
8.1 (S11) Agencies and staff work together to safeguard and promote the welfare of children and vulnerable adults	• Evidence of leadership to enable joint working • Evidence of practitioner's working together effectively • Evidence that Early Help/Support is being used appropriately and effectively • Evidence of engagement in, and contribution to, safeguarding processes/enquiries e.g. attendance at child protection/adult safeguarding meetings, audit schedule to demonstrate commitment to multi-agency work and staff that contribute to agreed assessment processes (CAF and single assessments)		

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 • Staff has access to policy detailing who the named senior officer is in relation to managing allegations.		
10. Supervision and support			
10.1 (S11) Safeguarding supervision should be effective and available to all	• All staff working with children and vulnerable adults receive appropriate regular supervision (including review of practice)		
11. Staff training and continuing professional development			
11.1 (S11) Staff should have an understanding of both their roles and responsibilities for safeguarding children, looked after children and adults and those of other professionals and organisations.	• There is a learning and development framework for safeguarding and MCA implementation which is informed by national and local guidance and includes a training needs analysis • All staff have received level 1 safeguarding children at induction or within 6 weeks of taking up the post (include %) • All staff have received level 1 safeguarding adults at		

	induction or within 6 weeks of taking up the post (include %) • All staff who have contact with children and young people have undertaken CSE e-learning • Evidence of compliance with national guidance including percentage of workforce trained relevant to roles and responsibilities: all appropriate staff have received safeguarding children level 2 and above (include %) • MCA awareness should be included in staff induction programme and mandatory training • All appropriate staff have received MCA training (include %) • Training to be audited to ensure its quality and effectiveness		
NB: The shaded sections highlight standards that are included in the LSCB section 11 audit			

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 of the designated	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		

Standard	Components	Evidence	RAG
professional to be explicitly defined in the job description for sufficient time, funding. (SVP p22)	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 that there is clarity about the		

Standard	Components	Evidence	RAG
	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 deaths in childhood; from		

Standard	Components	Evidence	RAG
	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 The CCG Accountable Officer		

Standard	Components	Evidence	RAG
	(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 updated regularly to reflect any		

Standard	Components	Evidence	RAG
	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 the NHS standard contract		

Standard	Components	Evidence	RAG
	(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 including care homes (SVP		

Standard	Components	Evidence	RAG
	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 accompanied by their		

Standard	Components	Evidence	RAG
	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		

Standard	Components	Evidence	RAG
8.3 To participate, when asked to do so, in a statutory 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			

Standard	Components	Evidence	RAG
appropriate (SVP p.21)			
10. Supervision and Support			
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		

Standard	Components	Evidence	RAG
11.2 Training of staff in recognising and reporting safeguarding issues, appropriate supervision and ensuring staff are competent to carry out their roles and responsibilities (SVP p.21).	• Training in line with the intercollegiate 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