Safeguarding Adults Policy

Safeguarding Children Policy

Looked after Children's Policy

Bath, Swindon and Wiltshire Clinical Commissioning Group BSW

APRIL 2020

BSW Clinical Commissioning Group (CCG)

Policy	Safeguarding Adults and Children at Risk Policy (Internal CCG)
Policy Reference	CliniG05
Policy Statement	This policy sets out the Statutory duties of NHS BSW Clinical Commissioning Group in relation to Safeguarding Adults and Children.
Version Number	1.0
Version Date	24.02.2020
Review Date	03.01.2022
Author	Rob Mills – Head of Safeguarding and Designated Nurse Swindon Jane Murray Designated Nurse Wiltshire Jackie Mathers Designated Nurse Adults and Children BaNES James Dunne Associate Director Safeguarding Wiltshire
Responsible Owner	Gill May – Executive Director of Nursing
Approving Body	Quality Performance and Assurance Committee (QPAC) BSW CCG Governing Body (GB) April 2020

Document Control
Reviewers & Approvals
This document requires the following reviews and approvals

Name	Position		Version Approved	Date Approved
	Chair	Chair, Commissioning for Quality Sub-Committee	1	
	Registered Nurse	Chair, Integrated Governance Committee	1	
	Clinical Chair	Chair, Governing Body	1	
	Chief Operating Officer	Chair, Quality, Performance and Assurance Committee	1	
	Clinical Chair	Chair, Governing Body	1	

Revision History

Version	Revision Date	Details of Changes	Author
0.2	01/03/20	Change of CCG Name , addition of links to locality safeguarding boards	James Dunne

Acknowledgement of External Sources
List any policies or procedures from external institutions that have been used to inform the writing of this policy.

Title/Author	Institution	Comment / Link
Rob Mills	Swindon CCG	03/01/19 Original document

Links or overlaps with other key documents & strategies

Document Title	Version and Issue Date	Link/Document

NHS England 2015 Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework	March 2013 updated August 2019	https://www.england.nhs.uk/publication/safeguarding-children-young-people-and-adults-at-risk-in-the-nhs-safeguarding-accountability-and-assurance-framework/
Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children	July 2018	https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

Distribution & Consultation

This document has been distributed to the following people

Name	Date of Issue	Version
Rob Mills ,Jackie Mathers ,Jane Murray , Sharren Pells	24/02/21	0.1

Document Version Numbering

Document versions numbered "0.1, 0.2, 2.4", are draft status and therefore can be changed without formal change control. Once a document has been formally approved and issued it is version numbered "Issue 1.0" and subsequent releases will be consecutively numbered 2.0, 3.0, etc., following formal change control.

Freedom of Information

If requested, this document may be made available to the public and persons outside the healthcare community as part of NHS BSW Clinical Commissioning Group's commitment to transparency and compliance with the Freedom of Information Act.

Accessibility

This document is available in other styles, formats, sizes, languages and media in order to enable anyone who is interested in its content to have the opportunity to read and understand it. Any such requests should be made to the CCG's Communications Team via

Table of Contents

Safeguarding Adults, Children and Looked after Policy

1. Introduction

1.1 Rights based Approach to safeguarding:

The CCG approach to safeguarding is based on the existing conventions and treaties addressing individual rights, the key ones in terms of this policy are:

- The Universal Declaration of Human Rights 1948
- United Nations Principles for Older People 1991
- UN Convention on the rights of the child (UK ratified 1992)
- Human Rights Act 1998:
- United Nations Convention on the Rights of Persons with Disabilities 2006

These are important in ensuring specific attention is paid to certain groups because of their vulnerabilities and to all individuals regardless of circumstance. They are rights we should hold firm when working directly with or on behalf of (e.g. as a commissioner) at all times. The key articles or principles against each of the above in relation to this policy are listed below, although none are more important than any other, they are all of equal value.

1.2 United Nations Universal Declaration of Human Rights 1948 and Human Rights Act 1998:

This declaration created a common standard of achievements for all peoples and all nations. It set out, for the first time, fundamental human rights to be universally protected. Of the 30 Articles within this declaration the following are relevant to this policy:

Article 2:

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 5:

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 6:

Everyone has the right to recognition everywhere as a person before the law.

Article 7:

All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 8:

Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

Article 12:

No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Article 21:

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Full list of articles within this convention found at: http://www.un.org/en/universal-declaration-human-rights/

1.3 Human Rights Act 1998

The Human Rights Act 1998 sets out the fundamental rights and freedoms that everyone in the UK is entitled to. It incorporates the rights set out in the European Convention on Human Rights (ECHR) into domestic British law. The Human Rights Act came into force in the UK in October 2000. Public bodies must respect individual rights within this Act. It requires all public bodies (like courts, police, local authorities, hospitals and publicly funded schools) and other bodies carrying out public functions to respect and protect human rights.

In respect of this policy the following articles are important:

Article 2: Right to life

Public authorities should also consider individual's right to life when making decisions that might put them in danger or that affect their life expectancy.

Article 3: Freedom from torture and inhuman or degrading treatment

torture (mental or physical) inhuman or degrading treatment or punishment, and deportation or extradition (being sent to another country to face criminal charges) if there is a real risk you will face torture or inhuman or degrading treatment or punishment in the country concerned. Public authorities must not inflict this sort of treatment on individuals. They must also protect individuals if someone else is treating them in this way. If they know this right is being breached, they must intervene to stop it.

Article 4: Freedom from slavery and forced labour (see also Modern Slavery Act)

Protects the right not to be held in slavery or servitude, or made to do forced labour

Article 8: Respect for your private and family life, home and correspondence

Protects the individual's right to respect for private life, family life, home and correspondence (letters, telephone calls and emails, for example).

Under this right others can be prevented from interfering in an individual's life. It also means that personal information about the individual (including official records, photographs, letters, diaries and medical records) should be kept securely and not shared without permission, except in certain circumstances.

Article 9: Freedom of thought, belief and religion

It includes the right to change your religion or beliefs at any time. Individuals have the right to put their thoughts and beliefs into action. This could include the right to wear religious clothing, the right to talk about your beliefs or take part in religious worship.

Public authorities cannot interfere with an individual's right to hold or change your beliefs, but there are some situations in which public authorities can interfere with this right to manifest or show, thoughts, belief and religion.

Importantly, this right protects a wide range of non-religious beliefs including atheism, agnosticism, veganism and pacifism.

Full list of articles within this Act found at: https://www.equalityhumanrights.com/en/human-rights/human-rights-act

1.4 United Nations Principles for Older People 1991

These principles are grouped under the headings of independence, participation, care, self-fulfilment and dignity, of the 18 principles the following are particularly relevant to this policy:

- Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.
- Older persons should have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help
- Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities
- Older persons should benefit from family and community care and protection in accordance with each society's system of cultural values.
- Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.
- Older persons should be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.
- Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.
- Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.

1.5 Council of Europe Report: Human Rights of Older Persons, and their Comprehensive Care 2017

This report made several recommendations concerning care, including that barriers to accessing health care should be removed, care should be provided in such a way as to enable people to maintain dignity, autonomy and quality of life, and health and social care should be integrated.

1.6 United Nations Convention on the Rights of Persons with Disabilities 2006

The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

The key articles under this convention in relation to this policy are:

Article 6 – Women with disabilities

1. States Parties recognize that women and girls with disabilities are subject to multiple discrimination, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms.

2. States Parties shall take all appropriate measures to ensure the full development, advancement and empowerment of women, for the purpose of guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in the present Convention.

Article 7 - Children with disabilities

1 States Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children.

2. In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration.

3 Ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right.

Article 8 - Awareness-raising

(b) To combat stereotypes, prejudices and harmful practices relating to persons with disabilities, including those based on sex and age, in all areas of life;
(a) ii To promote positive perceptions and greater social awareness towards persons with disabilities;

Article 9 – Accessibility

(e) To provide forms of live assistance and intermediaries, including guides, readers and professional sign language interpreters, to facilitate accessibility to buildings and other facilities open to the public;

Article 10 - Right to life

Every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others

Article 12 - Equal recognition before the law

Ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.

Article 14 – Liberty and security of person

Ensure that persons with disabilities, on an equal basis with others:

(a) Enjoy the right to liberty and security of person;

(b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

Article 15- Freedom from torture or cruel, inhuman or degrading treatment or punishment

1. No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.

2. States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.

Article 16- Freedom from exploitation, violence and abuse

1. take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects

Article 21 -Freedom of expression and opinion, and access to information

(a) Providing information intended for the general public to persons with disabilities in accessible formats and technologies appropriate to different kinds of disabilities in a timely manner and without additional cost;

Article 24- Education

1. *States Parties recognize the right of persons with disabilities to education. With a view to realizing this right without discrimination and on the basis of equal opportunity, States Parties shall ensure an inclusive education system at all levels and lifelong learning*

2. *In realizing this right, States Parties shall ensure that:*
(a) Persons with disabilities are not excluded from the general education system on the basis of disability, and that children with disabilities are not excluded from free and compulsory primary education, or from secondary education, on the basis of disability;

Article 25 - Health

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

(b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;

(c) Provide these health services as close as possible to people's own communities, including in rural areas;

(d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;

(f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

Full list of articles within this convention found at:
http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf

1.7 UN Convention on the rights of the child (UK ratified 1992)

Article 2

2. States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.

Article 3

1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

Article 6

1. States Parties recognize that every child has the inherent right to life.

2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

Article 8

1. States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference.

2. Where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection, with a view to re-establishing speedily his or her identity.

Article 9

1. States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child.

Article 11

1. States Parties shall take measures to combat the illicit transfer and non-return of children abroad.

Article 12

1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

Article 18

1. *States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern.*

Article 19

1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental

violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

Article 22

1. States Parties shall take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law and procedures shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments to which the said States are Parties.

Article 23

1. States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

Article 28

1. States Parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular:

(a) Make primary education compulsory and available free to all;

(b) Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child, and take appropriate measures such as the introduction of free education and offering financial assistance in case of need;

(c) Make higher education accessible to all on the basis of capacity by every appropriate means;

(d) Make educational and vocational information and guidance available and accessible to all children;

(e) Take measures to encourage regular attendance at schools and the reduction of drop-out rates.

Article 32

1. States Parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development.

Article 33

States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

Article 34

States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:

(a) The inducement or coercion of a child to engage in any unlawful sexual activity;

(b) The exploitative use of children in prostitution or other unlawful sexual practices;

(c) The exploitative use of children in pornographic performances and materials.

Article 35

States Parties shall take all appropriate national, bilateral and multilateral measures to prevent the abduction of, the sale of or traffic in children for any purpose or in any form.

Full list of articles within this convention found at:
https://www.unicef.org.uk/what-we-do/un-convention-child-rights/

1.8 BSW Clinical Commissioning Group (BSW CCG) safeguarding declaration

BSW Clinical Commissioning Group (BSW CCG) take its duty to safeguard the whole population it is responsible for very seriously and in particular, for those in our society who are the most vulnerable. The proceeding pages detailing the important 'rights' individuals have in relation to safeguarding, represent the value BSW CCG place on these rights and on ensuring they are met by all our endeavours.

It is important for us to ensure the link between these rights and this policy is explicit as this amplifies the fact that we are dealing with 'individuals', 'families' and 'communities' who make up the population of BSW.

We are committed to ensuring BSW CCG have the appropriate resources in place to fulfil all its statutory duties and obligations related to safeguarding children or adults under UK Legislation and guidance. BSW CCG are determined to fully engage with the range of partnerships that either directly or indirectly seek to improve the safeguarding outcomes for BSW; notably through the following arrangements:

- Local Safeguarding Children Board (LSCB) and its replacement structure under the Children and Social Work Act 2017 and subgroups
- Local Safeguarding Adult Board (LSAB) and subgroups
- Community Safety Partnership (CSP)
- Multi Agency Public Protection Senior Management Board
- PREVENT Board & Channel Panel
- Youth Offending Team (YOT) Board

Through our commissioning of health services, we will ensure all providers are compliant or on track to be compliant with local and national safeguarding requirements, enforced through contracts and quality assurance processes.
In addition to ensuring BSW CCG and its providers are meeting the essential requirements, BSW CCG will proactively seek to innovate and develop pathways to improve outcomes generally and safeguarding outcomes specifically.

As an organisation we stand by this declaration and are accountable to it. The CCG will be proactive and strive to maintain our declaration at all times. As a listening, open and transparent organisation we can evidence what is working well for children and adults, what is not working so well and learn from these areas.

2. Purpose

This policy sets out what the individual and collective responsibilities are for CCG staff and staff groups to ensure they understand what is expected of them and importantly how to respond to any safeguarding issue that arises in the course of the CCG carrying out its functions **(see roles and responsibilities table below)**.

3. Scope

This policy is aimed at all stay employed by BSW CCG and sets out how the CCG will safeguard children or adults from abuse or neglect. This policy draws on UK legislation and guidance and international conventions and treaties the UK is party to, to ensure the link between these important doctrines and legislation is made.

4. Definitions

4.1 Children

Under the Children Act (1989, 2004) **a child** is anyone who has not yet reached his or her 18th birthday. 'Children' therefore means children and young people throughout.

‘Safeguarding’ refers to a broad responsibility to promote and protect the wellbeing of all children, **‘child protection ‘refers** to a set of arrangements for any particular child or children who have been deemed to be at risk of **‘significant harm’** under the children Act 1989. ‘**Child abuse and neglect’** refers to what happens to the child or children in question at the hands of their parents, carers or others known or unknown to the child.

The Children Act (1989, 2004) states that “the welfare of the child is paramount”. All those in contact with children, young people or their families have therefore have an overriding “duty to protect from harm” and promote the welfare of all children through discharging their responsibilities.

4.1.1 Principles under the children Act 1989

Section 1 of the Children Act (CA) sets out three general principles:

- The welfare of the child is paramount;
- Delay is likely to prejudice the welfare of the child;
- The court shall not make an order unless to do so would be better for the child than making no order (the ‘no order’ principle).

4.1.2 ‘’Paramountcy Principle"

A child's welfare is paramount when making any decisions about a child's upbringing, known as the "paramountcy principle" When making decisions about a child the court must ascertain the wishes and feelings of the child and shall not make an Order unless this is "better for the child than making no Order at all" every effort should be made to preserve the child's home and family links.
In practice this requires the safety and welfare of the child to be the primary consideration at any stage in the involvement of services to that child and family not only when the child is being considered by the court.

4.1.3 *Section* 2 Children Act 1989 – Parental Responsibility

Parental responsibility, defined as "the rights, duties, powers and responsibilities which by law a parent of a child has in relation to the child and his property"

(5) More than one person may have parental responsibility for the same child at the same time.
(6) A person who has parental responsibility for a child at any time shall not cease to have that responsibility solely because some other person subsequently acquires parental responsibility for the child.
(7) Where more than one person has parental responsibility for a child, each of them may act alone and without the other (or others) in meeting that responsibility; but nothing in this Part shall be taken to affect the operation of any enactment which requires the consent of more than one person in a matter affecting the child.
(8) The fact that a person has parental responsibility for a child shall not entitle him to act in any way which would be incompatible with any order made with respect to the child under this Act.
(9) A person who has parental responsibility for a child may not surrender or transfer any part of that responsibility to another but may arrange for some or all of it to be met by one or more persons acting on his behalf.

(S.2 subsections 5,6,7,8, and 9)

4.1.4 Section 17 Children Act 1989 – Provision of Services for Children in Need

A child is taken to be in need if—

he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority under this Part (of the Act);
his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or he is disabled (Children Act 1989 s.17 (subsection 10)

Under s17 of the Children Act the local authority have a duty to assess all children in need and they are also required to either provide such services or facilitate the provision of services by others.

Under s.17 all agencies have a duty to notify the LA of all children they deem to be a child in need and a duty to respond to requests by the local authority for the provision of services for children in need.

4.1.5 Section 47 Children Act 1989 – Duty to Investigate

Under this section there is a duty to investigate when a local authority —

are informed that a child who lives, or is found, in their area—

(i) is the subject of an emergency protection order; or
(ii) is in police protection;

(b) have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm,

The authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

4.1.6 (Children Act 1989 s.47 (subsection 1)

While the Act does not define 'significant harm' it defines harm;

"harm" means ill-treatment or the impairment of health or development including, for example, impairment suffered from seeing or hearing the ill-treatment of another;
"development" means physical, intellectual, emotional, social or behavioural development;
"health" means physical or mental health; and
"ill-treatment" includes sexual abuse and forms of ill-treatment which are not physical.

4.1.7 Section 11 Children Act 2004- duty to cooperate

The Children Act 2004 places duties on a range of organisations, agencies and individuals to ensure their functions, and any services they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children
This includes NHS organisations and agencies and the independent sector, including NHS England and clinical commissioning groups, NHS Trusts, NHS Foundation Trusts and General Practitioners;
Organisations and agencies identified by the Children Act 2004 should have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children, including:

- A clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children;
- A senior board level lead with the required knowledge, skills and expertise or sufficiently qualified and experienced to take leadership responsibility for the organisation's/agency's safeguarding arrangements;
- A culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services;
- Clear whistleblowing procedures, which reflect the principles in Sir Robert Francis' Freedom to Speak Up Review and are suitably referenced in staff training and codes of conduct, and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed
- Clear escalation policies for staff to follow when their child safeguarding concerns are not being addressed within their organisation or by other agencies;
- Arrangements which set out clearly the processes for sharing information, with other practitioners and with safeguarding partners;
- A designated practitioner (or, for health commissioning and health provider organisations/agencies, designated and named practitioners) for child safeguarding. Their role is to support other practitioners in their organisations and agencies to recognise the needs of

children, including protection from possible abuse or neglect. Designated practitioner roles should always be explicitly defined in job descriptions. Practitioners should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively;

- Safe recruitment practices and ongoing safe working practices for individuals whom the organisation or agency permit to work regularly with children, including policies on when to obtain a criminal record check;
- Appropriate supervision and support for staff, including undertaking safeguarding training;
- Creating a culture of safety, equality and protection within the services they provide.
- Employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role;
- Staff should be given a mandatory induction, which includes familiarisation with child protection responsibilities and the procedures to be followed if anyone has any concerns about a child's safety or welfare;
- All practitioners should have regular reviews of their own practice to ensure they have knowledge, skills and expertise that improve over time.

4.1.8 Categories of child abuse:

Under Working Together 2018 guidance there are four categories of abuse:

Physical abuse	A form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.
Emotional abuse	The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meets the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone
Sexual abuse	Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse Sexual abuse can take place online, and technology can be used to facilitate offline abuse. 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: a. provide adequate food, clothing and shelter (including exclusion from home or abandonment) b. protect a child from physical and emotional harm or danger c. ensure adequate supervision (including the use of inadequate care-givers) d. ensure access to appropriate medical care or treatment It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

4.2 Adults

The Care Act 2014 brings in the requirement for integrated care and support that is person centred, tailored to the needs and preferences of those needing care and support.

In discharging these duties, there are express reciprocal duties to co-operate on local authorities and their "relevant partners", and that category includes NHS England, and all CCGs and health trusts in the local authority's area in order to help and support adults in need along with their carers and to protect adults with care and support needs experiencing or at risk of abuse or neglect.

All NHS organisations need to ensure that there is sufficient capacity in place to fulfil their statutory duties and should regularly review their arrangements to assure themselves that they are working effectively. The Care Act 2014 places a duty on agencies to co-operate to safeguard adults

There are key sections to this Act regarding statutory duties for Local Authorities and **Other** agencies regarding safeguarding:

Section 1: The Local Authority has an overriding duty to promote individual wellbeing which also covers the protection from abuse or neglect;

Section 2: Outlines the duty to reduce dependency on state intervention through preventing, delaying and reducing needs for care and support which includes preventing needs that arise from experiencing, or being at risk of abuse and neglect;

Section 4: The promotion of independence is supported by the duty to provide information and advice which includes information around staying safe and who to contact if people are concerned about not being able to maintain their own safety;

Section 6: Outlines organisations general duties of cooperation, which includes the duty upon all organisations to work together to safeguard adults who are experiencing, or at risk of abuse and neglect;

Section 11: The refusal of a needs assessment allows the Local Authority to discharge its duty of assessment if an adult refuses their right to a S9 needs assessment. However, the Local Authority will be under a specific duty to undertake an assessment (when an adult is refusing) if there is reasonable belief that the adult is under coercion, or the adult is experiencing, or at risk of abuse or neglect;

Section 42: Duty of enquiry by Local Authority applies when there is a reasonable belief that an adult in its area (a) with care and support needs (b) is experiencing, or at risk of experiencing abuse and neglect (c) and is unable to safeguard themselves as a result of their care and support needs. When these conditions are satisfied the Local Authority must make or cause whatever enquiries it deems necessary to determine what actions (if any) are necessary to safeguard the adult. The Local Authority cannot delegate its duty under S42 and when it causes an enquiry to be made by an

external partner, it must satisfy itself that the enquiry has been concluded effectively and determine if it needs to undertake any further enquiries under S42 of the Care Act 2014. NB the eligibility for a safeguarding adult enquiry is determined by the conditions set out in S42 of the Care Act 2014 and it is UNLAWFUL to decline an enquiry on the grounds that someone is not receiving, or eligible for on-going paid support.

Section 43: Requires the Local Authority to establish a Safeguarding Adults Board (SAB) whose main objective is to protect adults from experiencing, or being at risk of abuse and neglect. The three main duties of the SAB are to produce an annual strategic plan, publish an annual report and undertake a safeguarding adults review under certain circumstances.

Section 44: The SAB must commission a safeguarding adults review when an adult with needs for care and support (a) dies and abuse or neglect is suspected (b) is alive but it is believed the adult experienced significant abuse or neglect. All partners must cooperate to ensure lessons can be identified to improve local multi agency safeguarding work.

Section 45: Enables the SAB to request specific information from an individual that is necessary to support the Board to meet its primary objectives of protecting adults from abuse or neglect.

Section 47: Outlines the circumstances under which a Local Authority is under a duty to safeguard an individual's property when they are being cared for (temporarily or permanently) away from their home.

Section 68: Places a duty on the Local Authority to provide an advocate to support an adult who would experience significant difficulties participating in a S42 enquiry, or a safeguarding adults review under S44. This Local Authority is not under a duty to provide an advocate if they believe there is an appropriate independent person to support the adult.

Section 81: Places a Duty of Candour on organisations to provide information when the person's safety is affected during the course of being provided a service by their organisation.

4.2.1 Safeguarding Principles under the Care Act 2014

The Care Act introduced six principles that underpin adult safeguarding:

- **Empowerment** – Personalisation and the presumption of person-led decisions and informed consent.
- **Prevention** – It is better to take action before harm occurs
- **Proportionality** – Proportionate and least intrusive response appropriate to the risk presented.
- **Protection** – Support and representation for those in greatest need.
- **Partnership** – Local solutions through services working with their communities.
- **Accountability** – Accountability and transparency in delivering safeguarding.

We have a duty to promote these principles through discharging the functions of the CCG and by ensuring providers have these principles imbedded within their organisational philosophies and practices as they work with adults and adults at risk of abuse or neglect.

4.2.2 Definition of an adult at risk under s.42 Care Act 2014

Safeguarding adults at risk of abuse or neglect

4.2.3 S. 42 Enquiry by local authority

(1) This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) —
(a)has needs for care and support (whether or not the authority is meeting any of those needs),
(b) is experiencing, or is at risk of, abuse or neglect, and
(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

(2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.
(3)"Abuse" includes financial abuse; and for that purpose "financial abuse" includes —
(a)having money or other property stolen,
(b)being defrauded,
(c)being put under pressure in relation to money or other property, and
(d)having money or other property misused.

4.2.4 Definition of Adult Abuse

"Any act or failure to act, which results in a significant breach of a vulnerable person's human rights, civil liberties, bodily integrity, dignity or general well-being, whether intended or inadvertent, including sexual relationships or financial transactions to which a person has not or cannot validly consent or which are deliberately exploitative"

4.2.5 Categories of Adult Abuse:

Physical abuse	including hitting, slapping, pushing, kicking, misuse of medication, inappropriate restraint, or inappropriate sanctions;
Sexual abuse	including rape and sexual assault, contact or non-contact sexual acts to which the adult at risk has not consented, or could not consent or was pressurised into consenting; indecent exposure sexual teasing or innuendo subjection to pornography or witnessing sexual acts
Psychological abuse	including emotional abuse, threats of harm or abandonment, deprivation of contact or communication, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks;
Financial or material abuse	including theft, fraud, exploitation, pressure in connection with Wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits, on-line fraud or theft;
Neglect or acts of omission	including ignoring medical or emotional/physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating; failure to report abuse or risk of abuse; Self-neglect
Discriminatory abuse	including that based on a person's ethnic origin, religion, language, age, sexuality, gender, disability, and other forms of harassment, slurs or similar treatment

	Organisational abuse	including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation
	Domestic Abuse	As defined by the home office. Any incident or pattern of incidents of controlling, coercive or 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. This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial and emotional
	Modern Slavery	encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment

4.3 Mental Capacity Act

Understanding the individual's mental capacity is key to effective safeguarding and key to ensuring all the rights owed to the individual are met in full within the context of safeguarding, there must be evidence of due diligence and attention to mental capacity and consent.

Mental Capacity and Consent

The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who may lack capacity to make decisions for themselves; and establishes a framework for making decisions on their behalf.
This applies whether the decisions are life-changing events or everyday matters. All decisions taken in the adult safeguarding process must comply with the Act.

The Mental Capacity Act outlines five statutory principles that underpin the work with adults who may lack mental capacity:

- A person must be assumed to have capacity unless it is established that he lacks capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

The majority of adults that require additional safeguards are people who are likely to lack mental capacity to make decisions about their care and support needs.

Mental Capacity refers to the ability to make a decision about a particular matter at the time the decision is needed. It is always important to establish the mental capacity of an adult who is at risk of abuse or neglect, should there be concerns over their ability to give informed consent to:

- Planned interventions and decisions about their safety
- Their safeguarding plan and how risks are to be managed to prevent future harm

4.4 Consent in relation to safeguarding

The Care Act 2014 statutory guidance advises that the first priority in safeguarding should always be to ensure the safety and well-being of the adult.

Making Safeguarding Personal (MSP) is a person-centred approach which means that adults are encouraged to make their own decisions and are provided with support and information to empower them to do so.

This approach recognises that adults have a general right to independence, choice and self-determination including control over information about themselves. Staff should strive to deliver effective safeguarding consistently with both of the above principles.

They should ensure that the adult has accessible information so that the adult can make informed choices about safeguarding: what it means, risks and benefits and possible consequences. Staff will need to clearly define the various options to help support them to make a decision about their safety.

Some teams within the CCG are required to have an in-depth knowledge of the MCA, to ensure they comply with the both the MCA 2005 and The MCA Code of Practice within the functions of their roles e.g. Continuing Health Care

Under the NHSE 'Safeguarding Vulnerable People in the NHS -Accountability and Assurance Framework. National Commissioning Board July 2015' the CCG are required to have a Mental Capacity Act lead (MCA lead) CCGs are required to have a Designated MCA lead who is responsible for providing support and advice to clinicians in individual cases and supervision for staff in areas where these issues may be particularly prevalent and/or complex.
They should also have a role in highlighting the extent to which their own organisation, and the services that they commission, are compliant with the MCA through undertaking audit, reporting to the governance structures and providing or securing the provision of training.

5. Process / Details of Policy or Procedure

This policy this policy is written with reference to the following local safeguarding policies and procedures produced by BSW Local Safeguarding Children Boards and Local Safeguarding Adult Boards.

5.1 Local Policies

- CCG Safer recruitment policy (as part of recruitment policy)
- CCG Domestic Abuse Policy

5.2 Legislation:

- The Children Act 1989
- The Children Act 2004
- Sexual Offences Act 2003
- The Adoption and Children Act 2002
- Safeguarding Vulnerable Groups Act 2006
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- The Care Act, 2014
- Children and Social Work Act 2017
- England and Wales: Modern Slavery Act 2015
- Counter Terrorism and Security Act (2015)
- Domestic Violence, Crime and Victims (Amendment) Act 2012
- Female Genital Mutilation Act 2003
- Data Protection Act 1998

- Data Protection Act 2018
- General Data Protection Regulation (GDPR) 2018
- Mental Health Act 1983
- Mental Capacity Act 2005
- The Serious Crime Act 2015
- Health and Social Care Act 2012
- Children and Families Act 2014

5.3 Guidance:

- Deprivation of Liberty Safeguards (amendment to MCA 2009) (to be replaced by Liberty Protection Safeguards (LPS)
- Safeguarding Vulnerable People in the NHS -Accountability and Assurance Framework. National Commissioning Board July 2015
- CQC Fundamental Standards; Outcome 13;
- Working Together to safeguarding children 2018: A guide to inter-agency working to safeguard and promote the welfare of children
- Care and Support Statutory Guidance Issued under the Care Act 2014
- Safeguarding Children & Young People: Roles and Competences for Health Care Staff (Intercollegiate Document 2019)
- Safeguarding Adults: Roles and Competencies for Health Care Staff First edition: August 2018
- Mental Capacity Act Code of Practice 2005
- NHSE Prevent: Training and Competencies Framework, October 2017
- Female genital mutilation: resource pack (Home Office 2014);
- FGM Multi-Agency Practice Guidelines (Home Office 2014);
- Female Genital Mutilation Risk and Safeguarding: Guidance for professionals
- (Department of Health 2015); Commissioning services to meet the needs of women and girls with FGM 2018
- Service standards for commissioning Female Genital Mutilation (FGM)
- Framework for the assessment of children in need and their families, Department of Health (2000).
- NICE guidance 'When to suspect child maltreatment' (2009)
- Tackling FGM in the UK, Intercollegiate recommendations for identifying, recording and reporting 2013
- Multi-agency statutory guidance on female genital mutilation 2016
- NICE guidelines for health and social care professional's Domestic violence and abuse: multi-agency working (2014)
- NICE Domestic violence and abuse Quality standard Published: 29 February 2016
- The NICE Quality Standards (2016)
- Controlling or Coercive Behaviour in an Intimate or Family Relationship Statutory Guidance Framework 2015
- Statutory Guidance on Promoting the Health and Well-being of Looked After children 2015 (DoH,DfE)
- Looked After Children – knowledge, skills and competence of health care staff Intercollegiate Role Framework (RCN, RCPCH) 2015
- NICE public health guidance 28 - Looked-after children and young people Issued: October 2010 last modified: April 2013

5.4 CCG Safeguarding activity

5.4.1 What the CCG will do in relation to the above duties, principles and definitions of either legislation and guidance related to safeguarding children or adults:

All services commissioned by BSW CCG will be expected provide safe systems that safeguard children and adults at risk, promoting their well-being at all times and ensuring these services keep them safe from harm, as set out in the above legislation and related guidance e.g. Working Together

to Safeguarding Children 2018 and the Care and Support Statutory Guidance issued under the Care Act 2014.

5.4.2 Listening and responding

The CCG will ensure there is a culture of listening to and engaging in dialogue with all the populations we serve but particularly with vulnerable groups, taking account of their wishes and feelings both in individual decisions and the establishment or development and improvement of services.

5.4.3 Authority to Act

The CCG will ensure that its Designated Professionals and Named GP as clinical experts in safeguarding and children looked after, are embedded in the decision-making processes of the organisation, with the authority to work within local health providers to influence local thinking and practice.

5.4.4 Safeguarding through Commissioning

This section applies to any service the CCG commissions, joint commissions or has a quality assurance role over.

Within the NHS Standard Contract Service Condition 32 (SC32) Safeguarding, Mental Capacity and Prevent the following are required by all providers:

The Provider must ensure that Service Users are protected from abuse, neglect and improper or degrading treatment, and must take appropriate action to respond to any allegation or disclosure of abuse in accordance with the Law.

The Provider must nominate:

- a Safeguarding Lead and/or a named professional for safeguarding children, young people and adults, in accordance with Safeguarding Guidance;
- a Child Sexual Abuse and Exploitation Lead;
- a Mental Capacity and Deprivation of Liberty Lead; and
- a Prevent Lead,
- and must ensure that the Co-ordinating Commissioner is kept informed at all times of the identity of the persons holding those positions.

The Provider must comply with the requirements and principles in relation to the safeguarding of children, young people and adults, including in relation to deprivation of liberty safeguards, child sexual abuse and exploitation, domestic abuse and female genital mutilation (as relevant to the Services) set out or referred to in:

- the Care Act 2014 and associated Guidance and Regulations;
- the Children Act 1989 and the Children Act 2004 and associated Guidance;
- the 2005 Act and associated Guidance;
- Safeguarding Guidance; and Child Sexual Abuse and Exploitation Guidance.

The Provider has adopted and must comply with the Safeguarding Policies and MCA Policies. The Provider has ensured and must at all times ensure that the Safeguarding Policies and MCA Policies reflect and comply with:

- the Law and Guidance referred to above; and
- the local multi-agency policies and any Commissioner safeguarding and MCA requirements.

The Provider must implement comprehensive programmes for safeguarding (including in relation to child sexual abuse and exploitation) and MCA training for all relevant Staff and must have regard to Safeguarding Training Guidance.

The Provider must undertake an annual audit of its conduct and completion of those training programmes and of its compliance with the requirements above.

At the reasonable written request of the Co-ordinating Commissioner, and by no later than 10 Operational Days following receipt of that request, the Provider must provide evidence to the Co-ordinating Commissioner that it is addressing any safeguarding concerns raised through the relevant multi-agency reporting systems.

If requested by the Co-ordinating Commissioner, the Provider must participate in the development of any local multi-agency safeguarding quality indicators and/or plan.
The Provider must co-operate fully and liaise appropriately with third party providers of social care services in relation to, and must itself take all reasonable steps towards, the implementation of the Child Protection Information Sharing Project.

The Provider must:

• include in its policies and procedures, and comply with, the principles contained in the Government Prevent Strategy and the Prevent Guidance and Toolkit; and
• include in relevant policies and procedures a programme to raise awareness of the Government Prevent Strategy among Staff and volunteers in line with the NHS England Prevent Training and Competencies Framework; and
• include in relevant policies and procedures a WRAP delivery plan that is sufficient resourced with WRAP facilitators.

NHS organisations are also subject to the section 11 duties of the Children Act 2004 and self-assessment requests by the Local Safeguarding adult Board under the Care Act 2014. They must comply with these duties and requests for information.

Health professionals are in a strong position to identify welfare needs or safeguarding concerns regarding individual children or adults at risk of abuse, and where appropriate, provide support.

This includes understanding risk factors, communicating effectively with children and families, liaising with other agencies, assessing needs and capacity, responding to those needs and contributing to multi-agency assessments and reviews.

Under current legislation (Children Act 2004 and the Care Act 2014) safeguarding is everyone's responsibility regardless of role and everyone who comes into contact with children and families or adults at risk has a role to play to ensure their welfare is promoted and they are kept safe at all times. Some roles will have a larger part to play than others but all staff should be equipped to fulfil their role in relation to safeguarding.

It is the responsibility of the provider and their services to ensure its staff are aware of, understand and are compliant with current UK legislation and National guidance with regard to discharging their safeguarding duties. This will not necessarily be a single Act but several that directly or indirectly set out duties to safeguard.
The key legislation and guidance are listed in section 5.2. and 5.3 of this policy.

5.4.5 Contractual Obligations

Through contractual agreements with local providers BSW CCG will provide a set of clear service standards including setting safeguarding schedules for all providers against which healthcare providers (including independent providers, voluntary, and community and faith sector and individual client placements e.g. CHC) will be monitored to ensure that all service users are protected from abuse or neglect and the risk of abuse. As par of this process a variety of services within providers will undergo a safeguarding specific quality assurance visit conducted by the CCG

5.4.6 Our duty of Candour

The NHS Constitution was updated in 2013 to include the requirements for NHS organisations under Duty of Candour. The NHS values include respect and dignity and the need to "foster a spirit of candour and a culture of humility, openness and honesty, where staff communicate clearly and openly with patients, relatives and carers". Providers and CCGs are therefore expected to be open

with individuals about any mistakes that are made during the course of their treatment or care and should:

- acknowledge, apologise and explain when things go wrong;
- conduct a thorough investigation into the incident and reassure patients, their families and carers that lessons learned will help prevent reoccurrence of the incident; and
- provide support for those involved to cope with the physical and psychological consequences of what happened.

BSW CCG are committed to being open about mistakes that happen within the health system and will promote this duty of candour with all the providers it commissions so that:

- Patients and their carers can be confident of the openness of the communication following a patient safety incident or complaint, including the provision of accurate information;

- Health care professionals can be assured that their employment or professional futures are not put in jeopardy by following the duty of candour guidance.

The CCG will ensure that it pays due regard to the NHS duty of candour throughout its functions and activities and will particularly ensure this duty is followed by all providers through the incident management processes.

Definitions and legal requirements

One of the key principles in the Serious Incident Framework is to be open and transparent. Both Providers and Commissioners have a statutory, contractual and professional responsibility in relation to duty of candour. The Care Act in regulation 20 clearly outlines when the duty of candour should apply and the NHS Standard Contract has been updated to align with this standard;

"(5A) Regulations under this section must make provision as to the provision of information in a case where an incident of a specified description affecting a person's safety occurs in the course of the person being provided with a service."

Individual members of staff who are professionally registered are also required to the uphold the duty of candour under the regulations of their professional body (e.g. Nursing and Midwifery Council, General Medical Council, Healthcare Professions Council) and providers should have systems in place to identify and respond when a breach of these regulations is identified.

A notifiable incident is defined as any unintended or unexpected incident involving a service user during the provision of care has appeared to result in death, severe or moderate harm, or prolonged psychological harm in the service user.
The Duty of Candour regulation refers to the open discussion of incidents with service users involved as soon as possible and must include an appropriate apology and information relating to the incident. The needs of those affected in the incident should be at the centre of the initial response and subsequent investigation process. Notification must also be followed up in writing and where it is not possible to contact the relevant individual a written record should be kept of the attempts made.

5.5 Multi-agency Safeguarding Partnerships and Arrangements

BSW CCG will work with all relevant stakeholders to ensure there are effective safeguarding arrangements across the BSW health economy. This will include ensuring organisations work together to take a coordinated approach to ensure effective safeguarding arrangements are evident in practice.

Under Working Together 2018 guidance and the Children and Social Work Act 2017

The local safeguarding arrangements have moved from LSCB/SAB to a safeguarding partnership covering a range of safeguarding arrangements (see below).The CCG with the police and the local authority are the three statutory agencies responsible for making arrangements for themselves and relevant agencies to work together in exercising their functions for the purpose of safeguarding and

promoting the welfare of children and adults within the BSW area. The CCG will be represented at all parts of these arrangements to ensure Health are an equal partner in the design of these arrangements and in discharging its responsibilities under them.

The CCG are also represented at the Multi-Agency Public Protection Arrangements (MAPPA) Senior Management Board, and the Corporate Parenting Advisory Board.

The CCG will take on the responsibility for coordinating the pre-existing health sub-group of the LCSB as the new partnership arrangements develop. This will ensure all the local health safeguarding leads have a fora to coordinate and improve health safeguarding arrangements across BSW. This health safeguarding fora will link with other professional fora operating within BSW to enable it to share and develop practice.

5.6 Safeguarding in Specific Circumstances

5.6.1 Counter-terrorism and PREVENT

Section 26 of the Counter-Terrorism and Security Act 2015 places a duty on certain bodies that in the exercise of their functions, to have "due regard to the need to prevent people from being drawn into terrorism". "Specified authorities" listed in Schedule 6 of the Act include:

- NHS Trusts;
- NHS Foundation Trusts; and
- NHS England

CCGs are not listed as a specified authority but listed as 'partners of local panels' under schedule 7 of the Act.

CCGs are represented at both the PREVENT Board and Local Channel panel as commissioners have a responsibility to ensure providers are compliant with this legislation and supporting guidance

Healthcare professionals will meet and treat people who may be vulnerable to being drawn into terrorism. Being drawn into terrorism includes not just violent extremism but also non-violent extremism, which can create an atmosphere conducive to terrorism and can popularise views which terrorists exploit. It is important that all staff in Health are equipped to comply with this duty and should have in place the following:

- A Prevent lead who acts as a single point of contact for the health regional Prevent co-ordinators, and is responsible for implementing Prevent within their organisation and able to offer advice and guidance;
- Be part of local Safeguarding Forums, including local commissioners and providers of NHS Services. These forums have oversight of compliance with the duty, and ensure effective delivery;
- Have mechanisms in place for reporting issues to the National Prevent Board;
- Embed Prevent into their delivery of services, policies and training.
- Staff who are expected to be trained to recognise and refer those at risk of being drawn into terrorism to the Prevent lead / Channel programme.
- Have an understanding of information sharing to balance patient confidentiality with the duty in line with information sharing agreements with other sectors.
- Have policies in place that include the principles of the Prevent NHS guidance

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215251/dh_131934.pdf

- A programme to deliver Prevent training, resourced with accredited facilitators;
- Processes in place to ensure that using the intercollegiate guidance, staff receive Prevent awareness training appropriate to their role;
- Procedures to comply with NHSE Prevent Training and Competencies Framework.

The training should allow all relevant staff to recognise vulnerability to being drawn into terrorism, 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. Below are important documents that support compliance with prevent duties and also links to free e-learning packages

- Guidance for mental health services in exercising duties to safeguard people from the risk of radicalisation
- Prevent Statutory Duty
- Channel Guidance
- NHS Building Partnerships, Staying Safe
- Prevent Training and Competencies Framework
- Information Governance Guidance for Prevent

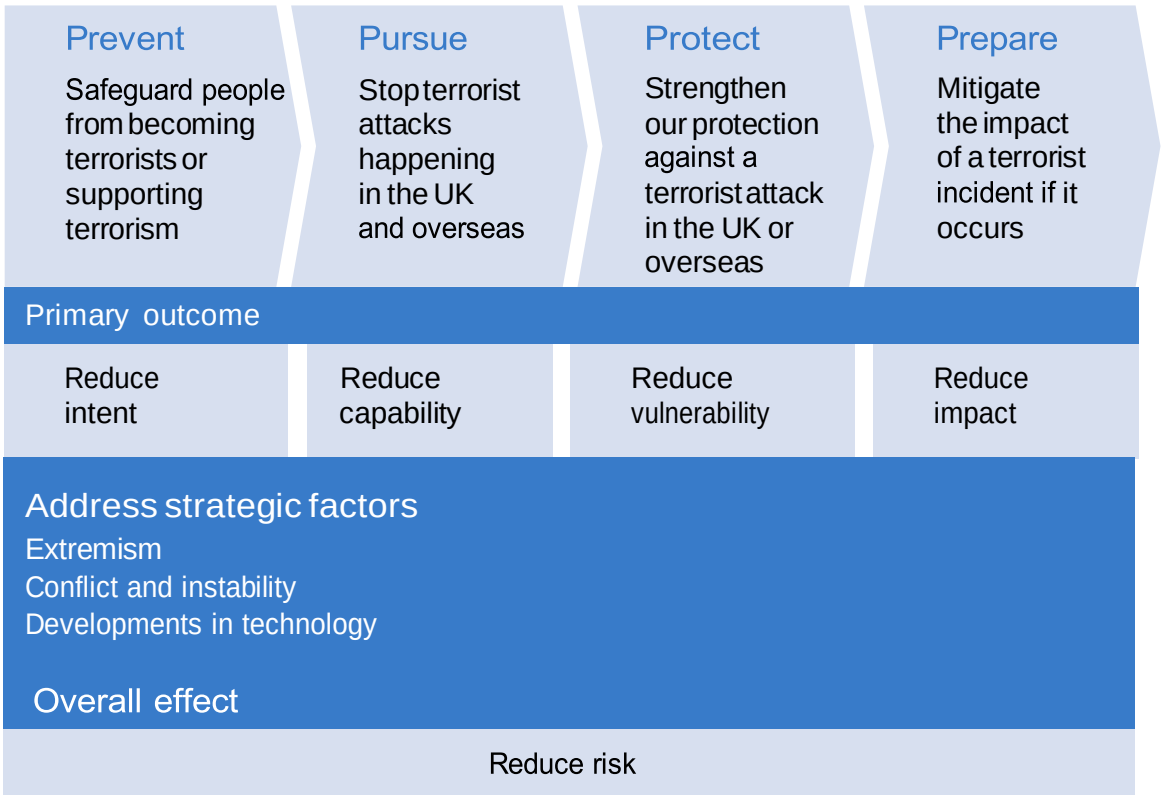
Free training resources

- The Prevent Mental Health e-Learning package
- Preventing Radicalisation Level 1 and 2
- E-Learning (e-learning for healthcare) Preventing Radicalisation Level 3
- Police Channel General Awareness Training
- Home Office Prevent E-learning

The Government's counter terrorism strategy is known as CONTEST. Prevent is part of CONTEST and its aim is to stop people becoming terrorists or supporting terrorism.

CONTEST has four key principles:

- Pursue – stop terrorist attacks
- Prevent – to stop people becoming terrorists or supporting terrorism
- Prepare – where we cannot stop an attack, mitigate its impact
- Protect – strengthen overall protection against terrorism attack.



The Health Service is a key partner in Prevent and encompasses all parts of the NHS, charitable organisations and private sector bodies which deliver health services to NHS patients.

Three national objectives have been identified for the Prevent strategy:

Objective 1: Tackle the causes of radicalisation and respond to the ideological challenge of terrorism.
Objective 2: Safeguard and support those most at risk of radicalisation through early intervention, identifying them and offering support
Objective 3: Enable those who have already engaged in terrorism to disengage and rehabilitate.

Prevent focusses on working with vulnerable individuals who may be at risk of being exploited by radicalisers and subsequently drawn into terrorism related activity. In BSW the strategy is managed by the PREVENT Board as part of the safeguarding adults' and children agenda.

Trusts are required to have Prevent implementation strategies in place to include leadership; policies and procedures and training across the workforce so that all staff are able to identify and make referral.

Further advice can be obtained via the revised counter terrorism strategy:
CONTEST: The United Kingdom's Strategy for Countering Terrorism June 2018

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/716907/140618_CCS207_CCS0218929798-1_CONTEST_3.0_WEB.pdf

(This section will be up-dated when the pending new counter-terrorism legislation is passed to reflect any changes within legislation)

5.6.2 Domestic abuse

The Governments definition of domestic abuse is:

"Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality."

This includes issues of concern to black and minority ethnic (BME) communities such as so-called 'honour killings'. Anyone can experience domestic abuse regardless of gender, race, ethnic or religious group, sexuality, disability or lifestyle.

One in four women and one in six men will experience domestic abuse in their lifetime

Domestic abuse includes a range of behaviours such as:

- Physical
- Emotional, psychological & mental
- Sexual
- Financial abuse
- Verbal
- Religious and Spiritual
- Honour Based Violence
- Forced marriage
- FGM
- Stalking & harassment

5.6.3 Staff affected by domestic abuse:

The CCG is committed to heightening awareness of, and providing guidance for, employees and management to address the occurrence of domestic violence & abuse and its effects on the workplace. The CCG is further committed to ensuring that every employee who is experiencing or has

experienced domestic violence & abuse has the right to raise the issue with us in the knowledge that we will treat the matter supportively and confidentially.

(See separate CCG Domestic Violence and Abuse Policy 2018)

5.6.4 Provider responsibilities / commissioning services to support Victims and perpetrators of domestic abuse

There is an inextricable link between domestic abuse and child abuse, the issue of children living with domestic abuse is now recognised as a matter for concern in its
own right by both government and key children's services agencies. The Adoption and Children Act 2002 s.120 amended The Children Act 1989 definition of significant harm in Sect. 31 of the 1989 Act (care and supervision orders), to include: "impairment suffered from seeing or hearing the ill-treatment of another".

The serious crime Act 2012 creates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76). The new offence closes a gap in the law around patterns of controlling or coercive behaviour in an ongoing relationship between intimate partners or family members.
It is important that all health professionals are aware of the potential impact of domestic abuse on:

- Any child known to be living within such circumstances.
- Intimate relationships where abuse or violence is occurring across the age spectrum e.g. an older person abused by a younger relative
- young people in intimate and abusive relationships
- Abuse or violence perpetrated against women and girls
- Any honour-based violence or forced marriage

Relevant staff within the provider organisations should be adequately trained and supported to enable them to make both routine and selective enquiries of women who they treat or come into contact with as part of their practice and men who they are aware of that are victims of domestic abuse or violence.

The CCG will ensure providers including primary care are compliant with the relevant guidance for health professionals:

- Improving safety, reducing harm Children, young people and domestic violence A practical toolkit for front-line practitioners (2009)
- NICE guidelines for health and social care professionals Domestic violence and abuse: multi-agency working (2014)
- NICE Domestic violence and abuse Quality standard Published: 29 February 2016

The CCG, through its representation at local domestic abuse focused partnerships e.g. Community Safety Partnership (CSP), The DA & VAWG Board (Domestic Abuse & Violence against Women and Girls), DA & QA Management Group will ensure health as an agency are included within local commissioning and service developments for either victims or perpetrators of domestic abuse.

5.6.5 Female Genital Mutilation (FGM)

FGM is everyone's concern including those responsible for the commissioning of services for supporting women affected by FGM. It is important to remember that girls and women who have had FGM are often reluctant to seek help and support and they may not associate their symptoms with the practice.

Commissioning services for women and girls with FGM provides recommendations for commissioners to help them understand what healthcare services are needed by women and children who have had Female Genital Mutilation. It provides advice on how to approach and commissioning these, to meet the needs of their local population.

Service Standards for commissioning Female Genital Mutilation care for patients under the age of 18 outlines the required standards for services offering examinations and care to under 18s. This includes services examining girls after a report has been made to the police under the Mandatory Reporting Duty.

5.6.6 Safeguarding against FGM

Safeguarding is everybody's business, and central to the NHS. Our work to protect girls from FGM is part of the wider safeguarding effort, and clinicians need always to remain alert that their patients may be need protection against other forms of abuse.

Professional responsibilities to act in relation to FGM were strengthened, when the FGM Mandatory Reporting Duty was in October 2015. Since this new legislation, if a girl under 18 tells or a professional sees that she has FGM, the professional has to report this to the police, using the 101 non-emergency police number.

Best practice guidance, pathways and templates are available from: safeguard against FGM

All health staff should be prepared for the possibility a young girl or women may present or disclose FGM to them. As such the service awareness of FGM are essential.

Maternity Services must routinely ask all pregnant women at booking whether they have been cut as a child. If FGM is disclosed:

- Document in the patient's medical record and red book;
- Offer an FGM appointment to identify type;
- Offer antenatal deinfibulation (if type 3);
- Share this information with the GP, Health Visitor and School Nurse; and
- A safeguarding risk assessment of the unborn child and other female children must be undertaken.

Services should be confident that they are equipped to identify and respond to all cases where FGM is suspected be it via patient disclosure or following a clinical assessment. This response will also include preparedness for mandatory reporting of FGM.

If FGM is identified in anyone under the age of 18, or they are suspected to be at risk of FGM a child protection referral must be made to BSW MASH, there is a professional duty to report these cases to the police by dialling '101'.

If FGM is identified in anyone over the age of 18, a case by case risk assessment must be undertaken and within this it must be considered if the woman is a vulnerable adult.

It is a mandatory requirement for the anonymous recording of cases of FGM that are identified and report this data to the Department of Health. Specific services will be required to support this data collection.

5.6.7 Resources and guidance

- FGM: mandatory reporting in healthcare
- FGM enhanced dataset: guidance on NHS staff responsibilities
- Safeguarding women and girls at risk of FGM
- Services for women and girls with FGM
- FGM: video resources for healthcare professionals

Further information can be found in:

- Female genital mutilation: resource pack (Home Office 2014);
- FGM Multi-Agency Practice Guidelines (Home Office 2014);
- Female Genital Mutilation Risk and Safeguarding: Guidance for professionals
- (Department of Health 2015)

5.6.8 Child and Adult Exploitation:

Child exploitation and the exploitation of vulnerable adults is a form of abuse. Exploitation is abuse characterised by a perpetrator's use of coercion, control, persuasion and duress, which often means that the individuals involved do not recognise themselves as victims.

The exploitation of includes:

- Criminal Exploitation
- Child/adult Sexual Exploitation
- Cyber Exploitation
- Human Trafficking and Modern Slavery
- Radicalisation (see PREVENT sect. of this policy)
- The individual is not free to come and go as they wish;
- The individual is unpaid, or paid less than minimum wage for carrying out forced labour or domestic servitude; working excessively long or unusual hours or unusual restrictions while at work

Because of the universal nature of most health provision, health professionals may often be the first to be aware that a child or adult may be involved, or be at risk of becoming involved, in sexual exploitation. Children involved in sexual exploitation are likely to need a range of services, including advice and counselling for harm minimisation, health promotion, advice on sexually transmitted diseases and HIV.

Clinical Commissioning Groups (CCGs) are responsible for commissioning children's healthcare treatment services for physical and mental health – child and adolescent mental health services (CAMHS) and other therapeutic recovery services and adult mental health services to treat historic or acute psychological trauma related to abuse.
CCGs are also responsible for identifying and sharing information about child or adult exploitation as part of their contribution to a strategic assessment of crime and disorder, anti-social behaviour, and drug and alcohol misuse, for the community safety partnership area/s in which they are a member.

Commissioning of health services should pay attention to the following requirements and ensure providers have sufficient resources and capacity to deliver on these:

- Health professionals should be alert and competent to identify and act upon concerns that a child or an adult is at risk of or experiencing abuse through exploitation. They have a crucial role in providing support for the physical and mental health on an individual basis.

- The role of the named professional for safeguarding children and equivalent for safeguarding adults in each health service trust should monitor information to identify when more than one child or adult within a particular setting or part of the community may be being targeted for sexual or other exploitation and act on this information;

- Where health professionals have immediate concerns, they should be supported to make a referral to MASH for children or the local authority safeguarding adult team for adults.

- Where the concerns are not immediate or are unclear, have mechanisms in place to allow information sharing and discussion on health care professionals;

- Health staff should offer and/or continue to provide health education, counselling, sexual health and medical intervention to the child or adult as an appropriate part of early intervention and be equipped to make onward referrals;

- Health professionals should attend multi-agency planning meetings when invited; to share information e.g. strategy discussions for either the child or adult as part of a safeguarding investigation.

- Any previously involved health professionals (recent past) who would have a useful contribution to make to the meeting (i.e. most recent health reports and knowledge of child while at school);

5.7 Children Looked After and Care Leavers

Children Looked After are some of the most vulnerable children in society this is despite being in the care of the local authority. It can often be assumed by professionals and the public that once a child becomes looked after they are safe. Although the immediate risk of harm may have been removed Children Looked After remain at risk from a variety of sources particularly exploitation.

Most children become looked after as a result of abuse and neglect. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences. For example, almost half the children in care have diagnosable mental health disorder and two-thirds have special educational needs. Delays in identifying and meeting their emotional well-being and mental health needs can have far reaching effects on all aspects of their lives, including their chances of reaching their potential and leading happy and healthy lives as adults (DOH/DOE March 2015).

Children become looked after through a variety of routes

- Children accommodated through a voluntary agreement with the adult who holds parental responsibility
- Through a Court Order
- Children on remand through the Criminal Court
- Unaccompanied Asylum Seeker Children
- Children receiving more than 75 nights of respite care provided by the local authority

Children can come into the care of the local authority for a few days or be in care for years in long term fostering arrangements

There can be confusion regarding who is a looked after child as many children in society are not in the care of their parent's, but this doesn't mean they are looked after under the Children Act 1989

5.7.1 Children who are not looked after

- Children who are subject to a Special Guardianship or Residency Order
- Children who are Privately Fostered
- Children who have been adopted
- Children placed by a person with parental responsibility with a Grandparent, Aunt or Uncle or sibling over the age of 18 years.

As described in the statutory guidance "Promoting the health and well-being of looked after children" 2015 - the NHS has a major role in ensuring the timely and effective delivery of health services to children looked after. The Mandate to NHS England, Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies and The NHS Constitution for England outline the responsibilities of CCGs and NHS England to children looked after (and, by extension, to care leavers). In fulfilling those responsibilities, the NHS contributes to meeting the health needs of looked-after children in three ways:

- commissioning effective services,
- delivering through provider organisations
- through individual practitioners providing coordinated care for each child.

5.7.2 Care Leavers

Care Leavers are aged between 18 and 25-year olds who by virtue of being in care are entitled to continued support from the Local Authority. They each have a named personal advisor who can support with them with housing, employment, education and training and a variety of other issues. Care leavers may continue to have the same health issues as they did as Children Looked After particularly regarding emotional well-being and mental health. Transition to adult services can be difficult and many struggle to navigate the transition. The Designated Nurse, Doctor and Children Looked After Health Team are able to support with this transition.

5.7.3 Corporate Parent Responsibilities

BSW Clinical Commissioning Group is a relevant partner under the Children Act 2004 section 10.

Corporate Parenting is the term used to describe the responsibility that all Local Authorities, and their relevant partners, have to children and young people who are in their care. Strong corporate parenting arrangements are central to improving services for children and young people in care. It is the role of relevant partner to assist in the Corporate Parenting Role and this includes agreeing the priorities for children looked after and care leavers and to monitor and scrutinise service delivery and to improve their life chances.

The monitoring and scrutiny of service delivery to improve the life chances for children looked after and care leavers is done by the Corporate Parenting Advisory Board. BSW Clinical Commissioning Group will send a representative to each board meeting and the Designated Nurse for Children Looked After will provide a report for each board meeting.

5.7.4 BSW Clinical Commissioning Group Responsibilities

The roles and responsibilities of all organisations and staff groups regarding Children Looked After are laid out in statutory guidance listed above. All staff and managers should be aware of these responsibilities.

Under Section 10 of the Children Act 1989, CCGs and NHS England have a duty to comply with requests from a local authority to help them provide support and services to looked-after children which promote their health and well-being.

Chief Officer
The Chief Clinical Officer has a statutory responsibility for ensuring the health service contribution to promoting the health and well-being of children looked after is discharged effectively across the whole local health economy. This is operationally delivered through local commissioning arrangements.

Executive Lead for Safeguarding
The Executive Lead for Looked after Children is the Director of Nursing and Transformation. The Executive Lead has the responsibility for governance, systems and organisational focus on Looked After children. The Executive Lead represents BSW CCG on the Local Safeguarding Children Boards.

All Executive Directors & Lay Members of BSW CCG
BSW CCG Directors are responsible for embedding the statutory Children Looked After responsibilities by:

- Maintaining community focused leadership for Children Looked After and Care Leavers ensuring that their needs are at the forefront of local planning and service delivery
- Ensuring that all health providers from whom they commission services have a policy to promote the health and well-being of Children Looked After.
- Ensuring the health needs of Children Looked After are integral to contracts.
- Ensuring that clear criteria for Children Looked After is written into all procurement and contracting documentation when appropriate
- Ensuring that all health agencies with which they have commissioning arrangements are linked into the relevant Corporate Parenting Board and that there is an appropriate level of seniority in line with Promoting the health and well-being of Looked after Children. (2015)
- Ensuring that appropriate time, funding, supervision and support is in place to enable the Designated professionals for Children Looked After to meet their responsibilities effectively

Commissioning and contracting managers
Commissioning and contract managers will ensure that the service specifications of all health providers from whom services are commissioned include clear standards for promoting the health and wellbeing of Children Looked After consistent with statutory guidance.

Responsibilities of CCG employees
All CCG employees must be mindful of the health needs of Children Looked After and the depth of knowledge should be commensurate with their roles and responsibilities.
All staff must be up to date with the appropriate level of Children Looked After training as set out in the Intercollegiate Document
Staff should recognize that sharing information is vital to ensure that children are protected from abuse and neglect and that the safeguarding of children is paramount and can override any duty of confidentiality.

Designated Doctor and Nurse for Children Looked After
The term Designated Doctor or Nurse for Children Looked After denotes professionals with specific roles and responsibilities for Children Looked After including the provision of strategic advice and guidance to service planners and commissioning organisations. National guidance regarding these roles can be found in: Statutory guidance re promoting the health and Well-being of Looked After Children 2015 DoH, DfE and Looked after children: Knowledge, skills and competences of health care staff Intercollegiate Role Framework May 2015 Designated Professionals are a source of expertise for partner agencies including Children's Social Care, Police, Education and the Voluntary Sector.

Governing Body
The Governing Body has overall accountability for Children Looked After responsibilities laid out in legislation and statutory guidance.

5.7.5 Commissioning Arrangements

BSW CCG has commissioning arrangements in place.

These arrangements ensure:

- The provision of a Named Nurse for Children Looked After, nursing staff and administrative staff in the Children Looked After Health Team.
- Every Child Looked After has the required initial and review health assessments and health plan in place within the statutory time frames including children placed out of area.
- To ensure support and services for Children Looked After are provided without undue delay.
- If a Child Looked After moves out of the BSW CCG area, make arrangements through discussion with the new health providers to ensure continuity of healthcare.
- Ensure that any changes in healthcare providers do not disrupt the objective of providing high quality, timely care.
- The Designated Nurse will track Children Looked After placed out of area, and children placed in the area by another Local Authority when she has been notified they have been placed in BSW, ensuring that their health needs are met.

5.8 BSW Children Looked After Placed outside of BSW Clinical Commissioning Group

BSW CCG is the Responsible Commissioner for BSW Children Looked After when they are placed out of area. When a BSW Council informs BSW CCG the Designated Nurse will inform the CCG in which the child has been placed.
BSW CCG under Who Pays Guidance will fund Child and Adolescent Mental Health provision for children placed out of area. BSW CCG will through the Multi-agency Funding Panel process fund the therapeutic component of out of area residential placements for children with complex health needs.

5.9 Unaccompanied Asylum Seekers

Unaccompanied children and young people are outside their country of origin and are without the care and protection of their parents or legal guardian. Their status, age and circumstances may well be uncertain. Sometimes they may have witnessed or experienced traumatic events and they may be suffering the most extreme forms of loss. There are many reasons why children and young people may leave their home country.

Some of the reasons include;

- fear of persecution, due to their religion, nationality, ethnicity, political opinion or social group;
- parents having been killed, imprisoned or disappeared;
- in danger of being forced to fight or become a child soldier;
- war, conflict;
- poverty, deprivation;
- sent abroad by parents/family.

The literature suggests that unaccompanied children have significant physical and mental health needs. These are influenced by access to basic healthcare in their home country, their experience of hardship, including the witnessing and experiencing of traumatic events, and the duration of and conditions experienced on their journey to the UK.

Refugee and unaccompanied asylum-seeking children and young people are Children Looked After and have the same rights to care as UK nationals. The CCG will not arrange an Initial Health or Review Health Assessment without a suitable interpreter being available.

5.10 Quality Assurance and Monitoring

BSW CCG has a process for assuring Children Looked After Health Team performance through a monthly dashboard and monthly performance meetings with the Designated Nurse.

The Designated Nurse for Children Looked After will provide a report to each Corporate Parenting Board.

The Designated Nurse and Doctor will meet with the Director of Nursing and Transformation six to eight weekly.

5.11 Governance

BSW CCG, like all NHS organisations is expected to meet its statutory duties in respect of LAC. Annual Section 11 Self Audits are completed, with monitoring of the associated action plans through the LSCB and the Safeguarding Children Team.

The Designated Nurse and Doctor will provide an annual report on the health of Children Looked After and Care Leavers to the CCG Board

5.12 Children who go missing from home or care and children not in the education system

It is a legal requirement that all children of school age receive an education either within a registered school or under an Elected Home Educated arrangement. Any child of school age found not to be in the education system must be notified to the local authority. Some children will often run away from home or a care home or child looked after placement.

If a professional becomes aware that a parent/carer has not reported a child as missing, they should refer the child to Police immediately, particularly if there were concerns about the child's welfare prior to them going missing or if they have a history of going missing.

All missing children who are not already known to CSC should be referred by the police to BSW MASH as relevant who will make a decision within 24 hours on what action to take and what services are most suitable to support the child on their return.

Refer to the BSW LSCB procedures for specific protocols on Children Missing Education (SBC EWS) and Children Missing from Home and Care (BSW & Wiltshire)

5.13 Private Fostering

Health professionals play an essential role in identifying privately fostered children. Although most children in private fostering situations are likely to be safe, in some private fostering arrangements there are clear safeguarding issues and children and young people effectively have no one who is concerned for their safety or welfare.

5.13.1 What is a private fostering arrangement?

A private foster arrangement is when someone other than a parent or a close relative who cares for a child for a period of 28 days or more, in agreement with the child's parent. It applies only to children under 16 years, or under 18 if they are disabled. A close relative is defined as a grandparent, brother, sister (if over the 18 years old), uncle or aunt (whether full blood or half blood or by marriage or civil partnership) or step-parent.

A private fostering arrangement is not a when a child is Looked After by the Local Authority or placed in any residential home, hospital or school

5.13.2 Circumstances when a child might be privately fostered

- Children whose parents are unable to care for them, for example if they have chronic ill health or are in prison;
- Children sent to this country, for education or health care, by parents who live overseas;
- A child living with a friend's family because they don't get on with their own family;
- Children living with a friend's family because of their parents' study or work;
- Children staying with another family because their parents have separated or divorced;
- Teenagers living with the family of a boyfriend or girlfriend;
- Children from abroad who attend a language school or mainstream school in the county and are staying with host families;
- Children at boarding schools who do not return to their parents in the holidays but stay with 'host families' recruited by 'education guardians';
- Unaccompanied asylum-seeking minors who are living with friends, relatives or strangers.

Children who are trafficked into the UK are especially vulnerable and are often living in de facto private fostering arrangements. Child trafficking is the movement of children for exploitation, including domestic servitude, commercial sexual exploitation and to support benefit claims (see www.ecpat.org.uk for further information). Where trafficking is suspected, a safeguarding referral should be made to BSW Borough Council Children's Services.

5.13.3 What to do if you are aware of a private fostering arrangement:

As a professional it is important for you to notify Children's Services if you are in contact with a child or young person who is being privately fostered. This will help protect the child against abuse or neglect and provide some reassurance that the child is being looked after properly.

By law, a parent, private foster carer or other persons involved in making a private fostering arrangement must notify Children's Services as soon as possible. However, parents and carers often do not tell professionals or agencies about such arrangements; they may not be aware that they need to or they chose not to tell agencies about these arrangements. Children's Services are not involved in making private fostering arrangements but are responsible for checking that the arrangements are suitable for the child. Professionals should actively encourage the parents and/or carer to notify Children's Services of the arrangement.

5.13.4 What happens after the Local Authority is notified?

When the Local Authority receives notification about a private fostering arrangement they will for a social worker to visit the child within seven working days. They will contact the parent or person with parental responsibility, run checks on the carer and talk to the young person. This will be to ensure the young person is happy, safe and thriving in the arrangement and that they are able to access education, medical care and any other services they may need. The Local Authority will also check that the accommodation is safe and suitable and enable the carer to access suitable training if

required. Providing everything is in order, the family will continue the arrangement with the social worker providing checks at regular intervals to ensure the young person is safe, happy and has access to all the services to meet their needs.

5.14 Fabricated or Induced illness

The term 'Fabricated or Induced Illness' encompasses many different situations in which children are presented as 'sick' but where illness has arisen as a result of a parent/carers actions in inducing an illness or by fabricating an illness by telling a story of symptoms which lead Health Professionals to believe the child has an illness.
These include five key forms of parent/carer behaviour:

- Pretence of illness (e.g. feigning symptoms)
- Fabrication of illness or medical history
- Inducement of illness
- Exaggeration of genuine illness
- Enforced invalidism

Further guidance is available within supplementary guidance "Safeguarding Children in Whom Illness is Fabricated or Induced" (2008) and the Royal College of Paediatrics and Child Health (RCPCH) report "Fabricated or Induced Illness by Carers: A Practical Guide for Paediatricians (2009).

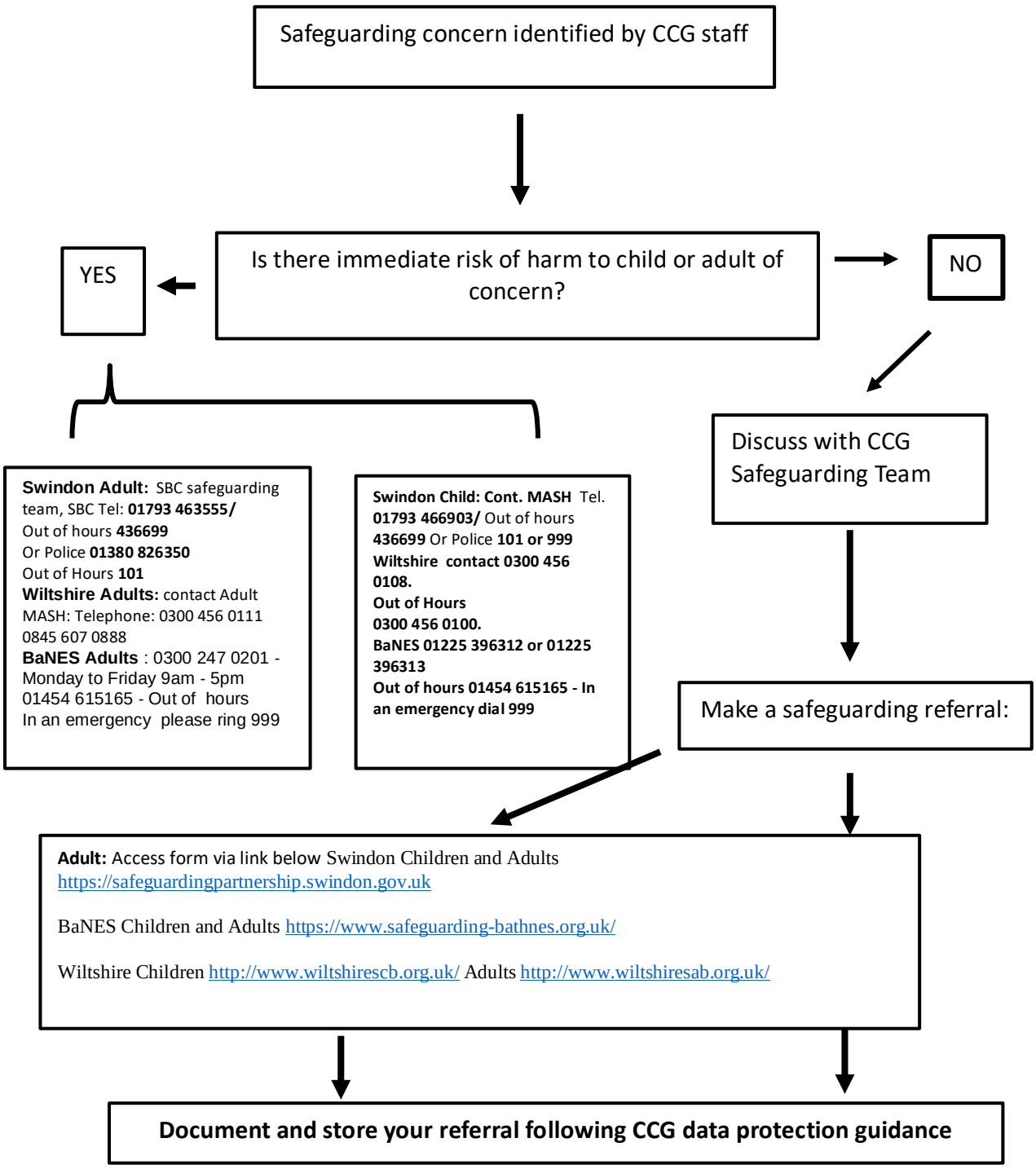
Safeguarding Children in whom illness is fabricated or induced Supplementary guidance to Working Together to Safeguard Children 2008

5.15 Response to concerns being expressed by a member of the public about a child or adult

If a member of the public contacts a member of staff with information regarding the possible abuse of a child, they should be encouraged to contact the local authority MASH (for Children) and Local Authority Safeguarding Adults Team (for Adults) to report their concern, they should be informed that they can do this anonymously.

Details of the incident should be recorded, and the member of staff should also telephone MASH or the safeguarding Adult Team to check that the information has been received. They must make clear that they are relaying information from a third-party source.

5.16 How to respond to a safeguarding concern Flow Chart:



5.17 CCG Internal Assurances:

The CCG Governing Body receives safeguarding assurances annually via the Annual Safeguarding report and bi-annually via the Integrated Governance Committee and quarterly as part of the quality report via the Quality and Performance Assurance Committee.

At a directorate level the CCG joint Safeguarding (children & Adults) Group meets bi-monthly chaired by the CCG Executive Nurse.

Safeguarding incidents, performance and delivery of statutory duties are monitored through BSW CCG Quality and Performance Assurance Committee. This committee will formally consider incidents, actions and learning from BSW local safeguarding partnerships and arrangements, action and learning from any Ofsted/CQC inspections or Joint Area Targeted Inspections JATI and all statutory reviews conducted by BSW safeguarding partnerships or other are reviews BSW has been requested to be involved with.

5.18 Statutory reviews:

The CCG and the wider health system must comply with any request made to be involved within a statutory review. The CCG will support and ensure attendance at such reviews by the relevant health professionals and health providers. The CCG Designated Professionals take the lead role for health in respect of these reviews and will coordinate health's engagement in these reviews and ensure the dissemination of the lessons once completed. The different types of review include:

5.19 Adults:

5.20 Domestic homicide review:

Commissioned by the Community Safety Partnership (CSP) under S.9 Domestic Violence, Crime and Victims Act (2004). The act states:
(1) In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—
(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

5.21 Safeguarding adult review (SAR):

Commissioned by the LSAB under S.44 of the Care Act 2014, LSABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

LSABs must also arrange a SAR if the same circumstances apply where an adult is still alive but has experienced serious neglect or abuse. SABs are free to arrange for a SAR in other situations where it believes that there will be value in doing so. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults and can include exploring examples of good practice.

5.22 Serious Case Review Under MAPPA arrangements

It is a Strategic Management Board ("SMB") responsibility to commission a MAPPA SCR when the mandatory criteria have been met. The SMB must commission a MAPPA SCR if both of the following conditions apply:

- The MAPPA offender (in any category) was being managed at level 2 or 3 when the offence was committed or at any time in the 28 days before the offence was committed.
- The offence is murder, attempted murder, manslaughter, rape, or attempted rape.

It is also an SMB responsibility to decide whether to commission a discretionary MAPPA SCR. It is difficult to prescribe discretionary criteria, as much will depend on the circumstances of the particular case, and whether there has been a significant breach of the MAPPA Guidance, but MAPPA discretionary SCRs might be commissioned when:

- A level 1 offender is charged with murder, manslaughter, rape or an attempt to commit murder or rape.
- An offender being managed at any level is charged with a serious offence listed in PI 10/2011 - see the list at Appendix 6, or

It would otherwise be in the public interest to undertake a review, e.g. following an offence which results in serious physical or psychological harm to a child or vulnerable adult but which is not an offence listed in PI 10/2011.

5.23 Children:

Under the Children and Social Work Act 2017 and the revised Working Together statutory guidance 2018, the local safeguarding partnerships must consider either a National Child Safeguarding Practice Review (overseen by the national Child Safeguarding Practice review panel) or a Local child safeguarding practice review in response to serious child safeguarding incidents.

5.24 Criteria - National Child Safeguarding Practice Review:

5.24.1The criteria which the local safeguarding partners must take into account include whether the case:
• highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified • highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children • highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children • is one which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate (Working Together statutory guidance 2018)

And further consider:

5.24.2Safeguarding partners should also have regard to the following circumstances:
• where the safeguarding partners have cause for concern about the actions of a single agency • where there has been no agency involvement and this gives the safeguarding partners cause for concern • where more than one local authority, police area or clinical commissioning group is involved, including in cases where families have moved around • where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings (Working Together statutory guidance 2018)

5.25 Criteria - Local child safeguarding practice review

The criteria which the local safeguarding partners must take into account include whether the case:

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children
- highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children
- is one which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate

(Working Together statutory guidance 2018)

And further consider:

Safeguarding partners should also have regard to the following circumstances:

- where the safeguarding partners have cause for concern about the actions of a single agency
- where there has been no agency involvement, and this gives the safeguarding partners cause for concern
- where more than one local authority, police area or clinical commissioning group is involved, including in cases where families have moved around
- where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings

(Working Together statutory guidance 2018)

5.26 Child Death Review

Child death reviews are conducted under the Children Act 2004 (the Act), as amended by the Children and Social Work Act 2017.Safeguarding partners (Local Authority, CCG and the Police are responsible for ensuring Child Death Reviews are conducted.

5.26.1 Statutory Requirements – Child Death

When a child dies, in any circumstances, it is important for parents and families to understand what has happened and whether there are any lessons to be learned.

The responsibility for ensuring child death reviews are carried out is held by 'child death review partners,' who, in relation to a local authority area in England, are defined as the local authority for that area and any clinical commissioning groups operating in the local authority area. Child death review partners must make arrangements to review all deaths of children normally resident in the local area97 and, if they consider it appropriate, for any non-resident child who has died in their area.

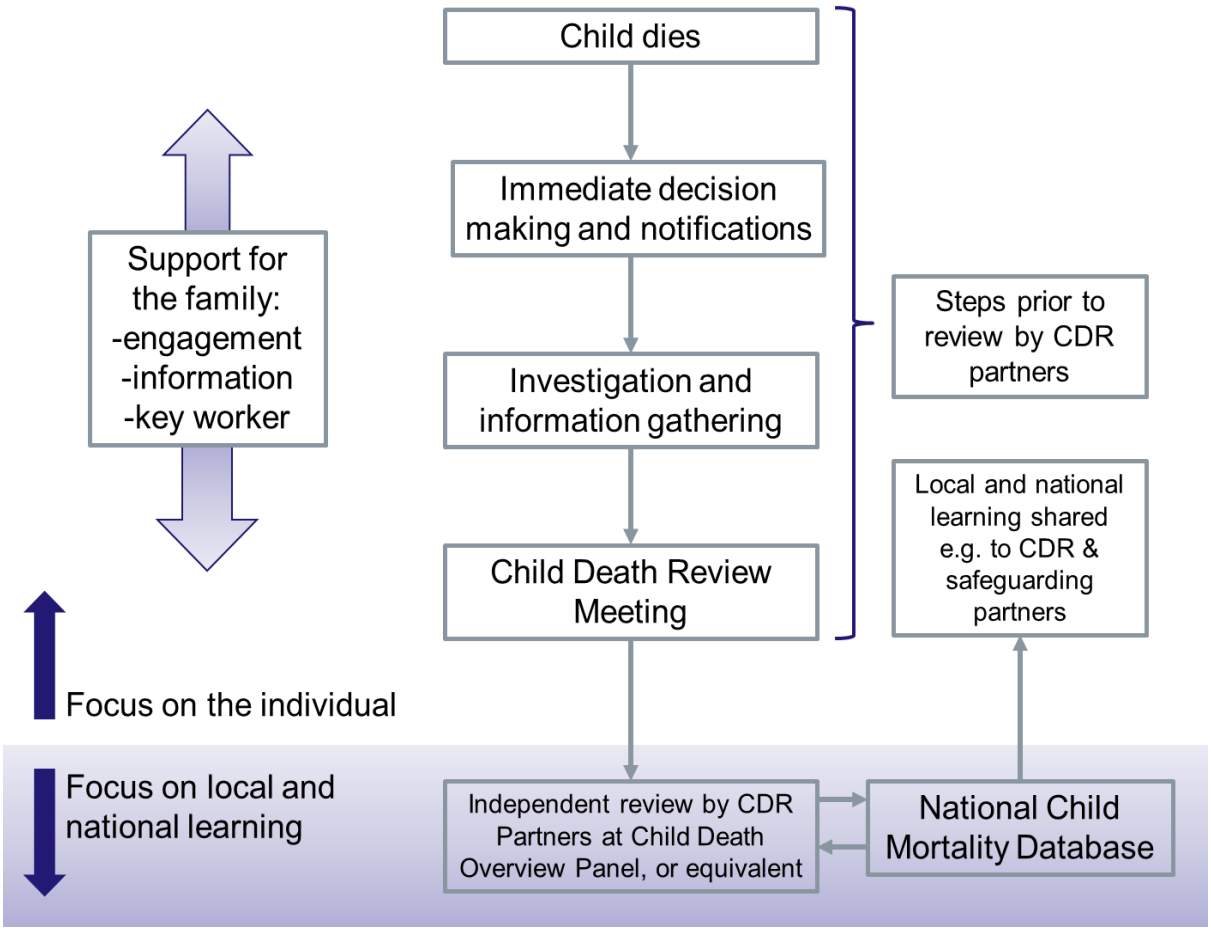
Child death review partners for two or more local authority areas may combine and agree that their areas be treated as a single area for the purpose of undertaking child death reviews. Child death review partners must make arrangements for the analysis of information from all deaths reviewed.

The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified. If child death review partners find action should be taken by a person or organisation, they must inform them.

In addition, child death review partners:

- must, at such times as they consider appropriate, prepare and publish reports on:
    - what they have done as a result of the child death review arrangements in their area, and
    - how effective the arrangements have been in practice;
- may request information from a person or organisation for the purposes of enabling or assisting the review and/or analysis process - the person or organisation must comply with the request, and if they do not, the child death review partners may take legal action to seek enforcement: and
- may make payments directly towards expenditure incurred in connection with arrangements made for child death reviews or analysis of information about deaths reviewed, or by contributing to a fund out of which payments may be made; and may provide staff, goods, services, accommodation or other resources to any person for purposes connected with the child death review or analysis process.

5.26.2 Responding to the death of a child: the child death review process



Flow chart illustrating the full process of a child death review. This includes both the statutory responsibilities of Child Death Review partners to review the deaths of children (described here as review at CDOP or equivalent), and the processes that precede or follow this independent review.

5.26.3 Parallel Reviews

Sometimes the case under review will give rise to the need for parallel review, this means the case under review meets the criteria for another or several other statutory reviews, which have to be conducted under separate statutory guidance; common parallel review processes are:

- child safeguarding practice review and a DHR, or
- child safeguarding practice review and a Child Death Review
- or child safeguarding practice review and SAR, or
- child safeguarding practice review, DHR and SAR

These often remain separate reviews but where it is practicable in these situations the review process is combined.

5.26.4 Mental health homicide and drug related reviews

These are carried out under separate arrangements but may, depending upon the circumstances, need to link to a safeguarding statutory review.

All NHS agencies and organisations must comply with a request to participate in a statutory. The input and involvement required will be discussed and agreed in the terms of reference for the review but broadly this will involve meeting regularly with colleagues and attending panels or review group meetings throughout the investigative phase.

The CCG's Designated Professionals are responsible for ensuring the total engagement of health partners within any statutory review processes, they are also responsible for ensuring any recommendations and findings from such reviews are acted upon across the health system.

The Designated Professionals and the CCG Named GP for safeguarding will together conduct a review into the practice of primary care within the review being undertaken. The CCG designated Professionals will attend all review panels to represent the CCG and other health providers when necessary.

6. Roles and Responsibilities

Party	Responsibilities
CCG Accountable Officer *	Responsible for ensuring that the health contribution to safeguarding and promoting the welfare of children is discharged effectively across the whole local health economy through BSW CCG commissioning arrangements.
CCG Governing Body*	• Responsible for ensuring safeguarding children and adults systems are in place and monitored • Ensures safeguarding and promoting the welfare of children and adults at risk is implemented effectively across the local health economy, both through commissioning arrangements and through the responsibilities of provider boards and committees • Receives an annual report on safeguarding children and adults in the CCG, and a separate annual report for looked after children • Receive other reports and considers the indirect safeguarding aspects of these other reports.
CCG Subgroups	• Each Board subgroup ensures safeguarding children and Adults are reflected within their work plans and discussions
CCG Governing Body Lead for	• Acts a Governing Body lead with responsibility for safeguarding children and adults

Safeguarding *	• Ensures strategic ownership of safeguarding children and adults at Governing Body level • Chairs the CCG Safeguarding Group/mtg/Committee • Provides regular feedback to the Governing Body on all safeguarding children and adults activity in the organisation, including Serious Incidents and any Statutory Reviews conducted where there has been involvement by BSW commissioned health services e.g. Serious Case Review, Safeguarding Adult Review or Domestic Homicide Review.
CCG Designated Professional for Adult Safeguarding*	• Delegated day to day responsibility for safeguarding adults • Attends the Local Safeguarding Adults Board (LSAB) Coordinates the CCG's involvement in LSAB workstreams, sits on the panels conducting Safeguarding Adult Reviews and Domestic Homicide Reviews as they rise. • Takes a lead role in conducting the health component of all statutory Reviews across health. • Prepares the CCG annual reports for the Governing Body and contributes the CCG section of the LSAB Annual report • Ensure appropriate training is available for all CCG staff including the Board, and that compliance is monitored • Provides support and advice to the CCG on safeguarding adult matters • Takes a strategic and professional lead across the health community on all aspects of adult safeguarding. • Provides, supports and ensures contribution to safeguarding appraisal and appropriate supervision for colleagues across the health community
CCG Designated MCA lead	• MCA lead is responsible for providing support and advice to clinicians in individual cases and supervision for staff in areas where these issues may be particularly prevalent and/or complex. • Have a role in highlighting the extent to which their own organisation, and the services that they commission, are compliant with the MCA through undertaking audit, reporting to the governance structures and providing or securing the provision of training.
Designated Professionals safeguarding children *	• The designated safeguarding professionals take a strategic, professional lead on all aspects of the health service contribution to safeguarding children in BSW CCG. Their responsibilities include: • Sitting on the BSW CCG Safeguarding Children and Adult Group supporting the CCG to hold to account all healthcare providers for safeguarding and protecting the welfare of children across BSW • Ensuring staff and commissioners are aware of best practice related to safeguarding • Delivering training to commissioners including the Governing Body to ensure they understand their safeguarding responsibilities • Providing advice on and interpreting the monitoring of the safeguarding elements of contracts and service level agreements with commissioned services • Monitoring and reporting on the implementation of this policy • Advising commissioners on commissioning, investment and service redesign decisions in relation to safeguarding • Leading on quality assurance and improvement issues

Designated Professionals Looked After Children*	• Provide advice to the service planning and commissioning organisation and to the local authority • Work closely with the Named Nurse LAC and the wider LAC health team. • Ensure expert health advice on looked after children is available to BSW Borough Council, health care organisations, residential children's homes, foster carers, school nurses, clinicians undertaking health assessments and other health staff; • Work with health service planners and commissioners to ensure there are robust arrangements to meet the health needs of looked after children placed outside the local area and ensure close working relationships with Other Local Authorities and Designated Nurses LAC in other CCGs receiving BSW Children • Work with local service planners and commissioners to advocate on behalf of and ensure looked after children benefit as appropriate from the implementation of wider health policies • Work with commissioners and providers to gain the best outcome for the child/young person within available resources. • Work with other professionals taking a strategic overview of the service to ensure robust clinical governance of local NHS services for looked after children • Contribute to local children and young people's strategies to ensure there is a system in place to check the implementation and monitoring of individual health plans • Advise and input into the development of practice guidance and policies for all health staff and ensure that performance against these is appropriately audited • Work with provider health organisations across the health community to ensure that appropriate training is in place to enable health staff to fulfil their roles and responsibilities for looked after children
Named GP Safeguarding children and Adults *	• Be able to align national guidance to local practice. • Contributes as a member of the safeguarding team to the development of internal safeguarding policy, guidelines and protocols. • Able to effectively communicate local safeguarding knowledge, research and findings from audits and challenge poor practice. • Support and develop improvements in care/practice/ local responses/services/act in response to identified locality knowledge needs. • Undertakes and contributes the primary Care aspects of Statutory reviews including preparing the Individual Management Review (IMR) for such reviews. • In conjunction with designated safeguarding lead, co-ordinates and contributes to implementation of action plans and the learning following reviews. • Works effectively with all Designated Professionals within the CCG and colleagues from other organisations, providing advice as appropriate. • Provides safeguarding supervision and leads or ensures appropriate reflective practice is embedded in primary care, to include peer review. • Leads/oversees safeguarding quality assurance and improvement processes within primary care.

	• Undertakes risk assessments of the organisation's ability to • safeguard/protect Children or adults at risk of abuse or neglect. • Understands the role and procedures of coroner's courts, court of protection and regulators professional bodies.
Individual commissioners	• Ensure safeguarding children and Adult arrangements are integral to their contracts and service level agreements by amending the NHS Standard Contract to ensure consistency in the standard for safeguarding schedules as written into the contract and monitoring processes. Which provides detail on the key areas to be considered to establish, maintain and improve the safeguarding of children when commissioning • services, as well as identifying key responsibilities in relation to this policy. • Ensures quality indicators are developed for all commissioned services • Ensures relevant information is provided to assure the CCG that these services are safe, accessible and effective.
Safeguarding Children and Adults Committee/group/mtg	• Safeguarding Children and Adults Committee ensures the CCG's safeguarding responsibilities are discharged effectively and comprehensively through commissioning arrangements • Sets a strategic direction for safeguarding Children and adults within the CCG • Ensure commissioning intentions, integrated delivery and other strategic health plans are considered from a safeguarding perspective whereby decisions to commission or de-commission are informed by an assessment of the safeguarding impact of these decisions. • Takes strategic responsibility for supporting commissioners to effectively monitor and challenge healthcare providers to safeguard children and adults • Advises commissioners about the appropriate content of contracts, service specifications and service level agreements • Ensures strong multi-agency relationships are developed and maintained with all the borough Safeguarding Children and safeguarding Adults Boards • Learns and disseminates lessons from Serious Case Reviews, Serious Incidents and other audit or performance information • Responsible for updating the Safeguarding children and adults departmental risk register.
Patient Advice and Liaison Services (PALS) and complaints departments in provider Trusts	• Act as an early warning system about concerns including quality of care in providers identified through the patient journey and experience. • Assess all informal and formal complaints for potential that the person could be at risk of abuse or neglect, reporting any issues to their managers • Where necessary, agree with their managers who will make referrals to the local authorities' Safeguarding Adults leads in accordance with this procedure • Share with the CCG the nature of these concerns so the CCG can take remedial action with the relevant provider
Directors and line managers	• Ensure that staff are aware of the CCG and multi-agency policies and procedures • Support staff in responding to and reporting concerns of abuse against children or adults

	• Ensure staff access the safeguarding children and adult training commensurate to their role and record and report on safeguarding children and adult training attendance levels in respect of staff they manage.
CCG Staff	• Ensure all safeguarding children and adults and children Looked After principles are imbedded within their daily functions and service areas • Understand the indicators of child and adult abuse and neglect • Know how to raise a safeguarding concern within the CCG and when and how to share this information with the local authority as a safeguarding referral. • Attend relevant training and to maintain appropriate knowledge and skills in identification and responding to concerns of abuse against children or adults • Apply service safeguarding standards to contracts and service level agreements, and monitor providers' adherence to them • Act in a timely manner on any concern or suspicion that a child or an adult is being or is at risk of being abused, neglected or exploited and ensure that the situation is reported to the relevant authorities
CCG and Local Safeguarding Boards (children and Adults) BSW	• Ensure CCG representation at Local Safeguarding Boards • Provide Boards with assurance that he CCG is compliant with its respective safeguarding arrangements as per Children Act 2004 and Care Act 2014 and Children and Social Work Act 2018

*Denotes specific key role in respect of the following Intercollegiate documents for safeguarding where there are additional responsibilities than those listed above:

1. Adult Safeguarding: Roles and Competencies for Health Care Staff First edition: August 2018
2. Safeguarding children and young people: roles and competences for health care staff INTERCOLLEGIATE DOCUMENT Third edition: March 2014
3. Looked after children: Knowledge, skills and competences of health care staff INTERCOLLEGIATE ROLE FRAMEWORK March 2015

7.Training

All employees will complete Safeguarding training commensurate to their role under statutory or mandatory training requirements as detailed within the following intercollegiate guidance documents for health staff.

- Adult Safeguarding: Roles and Competencies for Health Care Staff, First edition: August 2018
- Safeguarding children and young people: roles and competences for health care staff INTERCOLLEGIATE DOCUMENT Third edition: March 2019
- Looked after children: Knowledge, skills and competences of health care staff INTERCOLLEGIATE ROLE FRAMEWORK March 2015

Monitoring of training will be undertaken as part of the CCG workforce management and individual staff PDP processes.

The CCG will undertake needs analysis to determine which groups of staff require further safeguarding children training in accordance with the Safeguarding Children and Young people: roles and competences for health care staff Intercollegiate Document March 2014.

The CCG will undertake regular training needs analysis to determine which groups of staff require further safeguarding adults training. This will be agreed with the commissioners' Safeguarding Adults Lead and as a minimum will include all professionally registered staff with team leadership roles undertaking multiagency training in how to recognise and respond to abuse.

The CCG will ensure that its contribution to the provision of multiagency training is proportionate to its multiagency training requirement

Within the CCG some roles are required to receive either external or internal safeguarding supervision alongside management one-to-ones these are;

- The Designated Doctor Safeguarding Children
- The Designated Nurse Safeguarding
- The Designated Nurse Children Looked After
- The Named GP safeguarding

All other staff can access ad hoc advise from any member of the safeguarding team as required

The designated professionals are experts in their filed and available system wide to advise and support all health providers and other agencies in relation to the health aspects of safeguarding or children looked after.

7.1 Safer Recruitment

The CCG has a separate safer recruitment policy detailing how it will undertake safer recruitment all CCG employees will be vetted with regard to the suitability of their employment and have a DBS check as per the safer recruitment policy.

Disclosure and Barring Service: Recruitment Processes:
Further guidance is available at: http://www.homeoffice.gov.uk/crime/vetting- barring-scheme/

7.2 Allegations made against CCG staff:

Concern may also be raised if the staff member is behaving in a way which demonstrates unsuitability for working with children, young people or adults at risk, in their present position, or in any capacity. The allegation or issue may arise either in the employee's/professionals work or private life. Examples include:

- Commitment of a criminal offence against or related to children, young people or adults at risk.
- Failing to work collaboratively with social care agencies when issues about care of children, young people or adults at risk for whom they have caring responsibilities are being investigated.
- Behaving towards children, young people or adults at risk, in a manner that indicates they are unsuitable to work with children, young people or adults at risk of harm or abuse.
- Where an allegation or concern arises about a member of staff, arising from their private life such as perpetration of domestic violence or where inadequate steps have been taken to protect vulnerable individuals from the impact of violence or abuse.
- Where an allegation of abuse is made against someone closely associated with a member of staff such as a partner, member of the family or other household member.

The scope of allegations covers allegations made against staff in the course of discharging their CCG roles and responsibilities and outside of this, including their private life and family home or working as a volunteer.

Managing Allegations about CCG staff – immediate actions
There are three strands in consideration of an allegation:

- Enquiries and assessment by children/adult Social Care, about whether a child/young person/ adult at risk of harm or abuse, is in need of protection or in need of services.
- A police investigation of a possible criminal offence.
- Consideration of disciplinary action (including suspension).

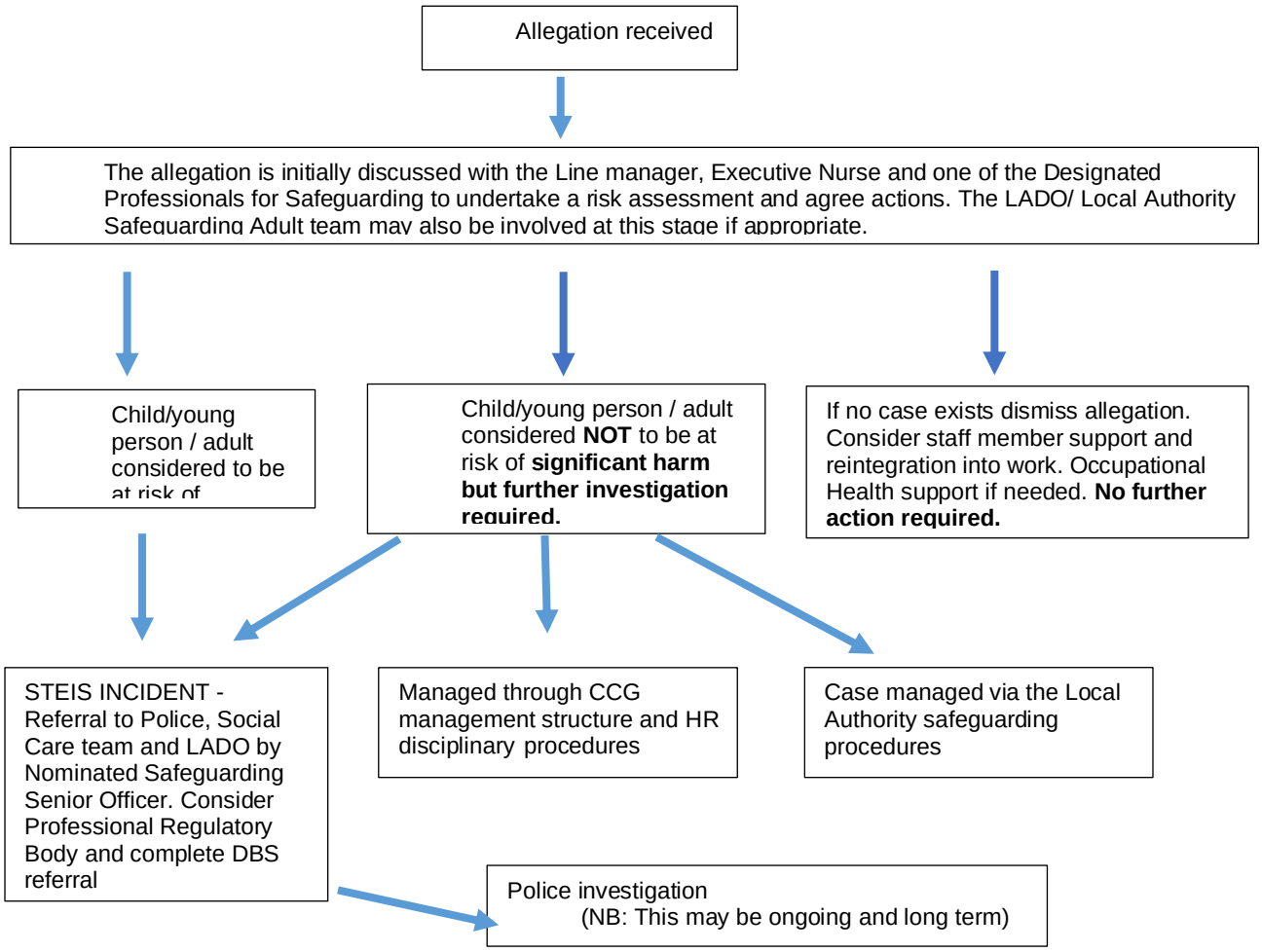
The safety of the child, young person or an adult at risk is of paramount importance. Immediate action may be required to safeguard investigations and any other children, young people or adults at risk. Any concern that children, young people or adults may be at risk of harm or abuse, must immediately be reported.

All staff must be familiar with referral procedures to protect an adult/child at risk (see section 'How to respond to a safeguarding concern' above) and the process to follow regarding each allegation below.
7.2.1 LSCB/LSAB processes can be found at following links

Swindon Children and Adults
https://safeguardingpartnership.swindon.gov.uk/
BaNES Children and Adults
https://www.safeguarding-bathnes.org.uk/
Wiltshire Children http://www.wiltshirescb.org.uk/
Adults http://www.wiltshiresab.org.uk/

7.2.2 Adults
For allegations made by or on behalf of an adult at risk; a safeguarding alert should be made to the local authority safeguarding adult team
The allegations manager for BSW CCG must be included in any decisions made and actions taken. Any allegations made against a member of staff must be reported to the Local Authority Designated Officer (LADO) and the BSW CCG will cooperate fully with any subsequent investigation or recommendations made.

7.2.3 CCG Response to an allegation against CCG staff Flow Chart:



7.2.4 Safeguarding networks

CCGs and NHS England need to provide appropriate support and advice to the Designated and Specialist Professionals and to be able to access the widest possible expertise to support improving safeguarding practice across the NHS system. In order to support this, NHS England has established local safeguarding networks and forums. The role of these safeguarding networks includes:

- Underpinning system accountability through peer review-based assurance and other sources of intelligence to identify local improvement priorities.
- Identifying and sharing best practice across the local health system.
- Leading and driving improvement in safeguarding practice across the local NHS system, working closely with the LSCB/SAB as appropriate.
- Considering in detail the health implications and learning from inspection and local incidents including serious case reviews, safeguarding adult reviews, individual management reviews, domestic homicide reviews and developing local action plans as appropriate.
- Ensuring the commissioning of appropriate education and development for Designated and Specialist Professionals, through engagement with the Local Education and Training Boards.
- Maintaining an up-to-date business / operations risk register and an appropriate escalation mechanism.
- Contributing to and overseeing Section 11 and SAAT audits on behalf of the local system.

7.2.5 Professional Bodies

Royal College of General Practitioners and BMA guidance-
RCGP Safeguarding Toolkit http://www.rcgp.org.uk/clinical-and-research/clinical-resources/child-and- adolescenthealth/safeguarding-children-toolkit.aspx

Royal College of Nursing

Children: http://www.rcn.org.uk/development/practice/safeguarding/children_and_young_people

Adults: http://www.rcn.org.uk/development/practice/safeguarding/adult

NHS England

NHS England is responsible for ensuring that the health commissioning system as a whole is working effectively to safeguard and promote the welfare of children. It is also accountable for the services it directly commissions, including primary care, and healthcare services in the under-18 secure estate.

NHS England also leads and defines improvement in safeguarding practice and outcomes and should also ensure that there are effective mechanisms for safeguarding partners and Health and wellbeing boards to raise concerns about the engagement and leadership of the local NHS. Each NHSE region should have a safeguarding lead to ensure regional collaboration and assurance through convening safeguarding forums (Working Together 2018)

NHS England's *Safeguarding Vulnerable People in the Reformed NHS – Accountability and Assurance Framework (2015)* sets out the clear responsibilities of each of the key players in safeguarding within the NHS. NHS England regional and local area teams each have a Director of Nursing who is responsible for supporting and providing assurance on the safeguarding of children and adults at risk of abuse or neglect at a regional level.

BSW CCG will work closely with NHS England to ensure there are effective NHS Safeguarding arrangements across each local authority health community.

All NHS and NHS funded organisations are expected to participate fully with the local safeguarding partnerships and arrangements including providing practical support and resources or resources in kind where appropriate. NHS commissioners should use contractual mechanisms to reinforce and monitor these requirements.

The NHS National Safeguarding Steering Group (NSSG)

The National Safeguarding Steering Group chaired by the Director of Nursing for NHS England, Deputy Chief Nursing Officer, England, to provide leadership to all staff working in the health environment so that vulnerable children and adults who are at risk of physical or emotional harm, are identified and protected by all NHS health staff.
The NHS England National Safeguarding Steering Group is made up of five sub-groups, two networks (one for adults one for children) and a task and finish group on Child Protection Information Sharing (CP-IS) and Modern Slavery the five Sub groups are:

- Female genital mutilation (FGM)
- Mental Capacity Act (MCA)
- Child sexual exploitation (CSE)
- Looked after children (LAC)
- Prevent

7.3 Regulatory bodies and Processes

The CCG takes a lead role with regard to all health system safeguarding inspections be they a single agency inspection by CQC or as part of a multi-agency inspection under Joint Area Targeted

Inspections. For either the CCG will ensure the health system is prepared as it can be for such inspections via the LSCB Health subgroup and JATI inspection planning meetings with BSW Borough Council.

7.4 Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care. The CQC registers all providers of health and adult social care and requires them to meet essential standards of quality and safety. This includes a standard on safeguarding (Care Quality Commission (2009) guidance about compliance: Essential Standards of Quality and Safety).

In addition to monitoring the compliance of registered providers against the essential standards, CQC also has powers to inspect children's services under the Children Act and participates in joint inspection work looking at services for children.

The Executive Nurse and Associate Director for Patient Safety and Quality will (according to the level of any identified risks) communicate safeguarding concerns either directly to the CQC or indirectly through the South West Intelligence Network meetings

7.5 Review of Health Services for Children Looked After and Safeguarding

The CQC conducts a single agency Review of Health Services for Children Looked After and Safeguarding under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

These reviews explore the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children. They focus on the experiences of looked after children and children and their families who receive safeguarding services.

And look at:

- the role of healthcare providers and commissioners.
- the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
- the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.

They also check whether healthcare organisations are working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2018.

7.6 Joint Area Targeted Inspections (JATI)

JTAIs commenced in 2016 and are carried out under section 20 of the Children Act 2004. They are an inspection of multi-agency arrangements for:

- the response to all forms of child abuse, neglect and exploitation at the point of identification
- the quality and impact of assessment, planning and decision making in response to notifications and referrals
- protecting children and young people at risk of a specific type (or types) of harm, or the support and care of children looked after and/or care leavers (evaluated through a deep dive investigation into the experiences of these children)
- the leadership and management of this work
- the effectiveness of local safeguarding arrangements in relation to this work.

7.7 Evaluation criteria for JATI Inspections

Inspectors will evaluate children's experiences against the full range of the criteria, looking for strengths, areas for development and examples of innovative and effective practice. The evaluation criteria are subject to periodic review.
The inspection reviews the effectiveness of the multi-agency 'front door' along with a 'deep dive' into a themed area.

The 'front door' aspect of the inspection is about the effectiveness of practice and arrangements for identifying and managing risks of harm to children and young people. Some JTAIs will inspect responses to all forms of child abuse, neglect and exploitation but others will mainly focus on a specific type (or types) of harm in line with the theme identified for the deep dive aspect of the inspection.
The criteria for each deep dive are different. For a list of the deep dive themes and their criteria see www.gov.uk/government/collections/joint-inspections-of-local-area-services.

8. Equality and Diversity

The CCG has standard processes for assessing and monitoring Equality, Diversity and Inclusion.

Equality Impact Assessment (EIA) Summary for:

CCG Safeguarding Policy

Date of Assessment:

16/01/2019

Document/Policy/Strategy/Project Aims:

Policy

EIA: Summary Table:

9 Protected Characteristics	Impact Considered (√/x)	Equality risk identified: Yes/No/Expand
Race	√	No
Gender	√	No
Disability	√	No
Age	√	No
Maternity & Pregnancy	√	No
Religion or Belief	√	No
Gender Identity	√	No
Marriage & Civil Partnerships	√	No
Sexual Orientation	√	No

Groups/Individuals considered and engaged with during the EIA Process:

No legal obligation for consultation required. The policy applies eqaly to all protected characteristics as defined in law.

Actions Summary (timescales and action overview and review):

EIA Completed by: **Rob Mills** **Executive approval: Gill May**

A Full copy of the EIA must be sent to the Quality team and also published on the CCG website.

9. Monitoring

The Designated Nurses are responsible for ensuring the policy is monitored and will liaise with commissioning and contracts teams to ensure service specifications, performance monitoring encompass the elements in the Appendices. Any non-compliance will be managed.

10. Review

January 2022 or when new evidence, policy or guidelines come to light. The Policy review will be delegated by the Executive Nurse.

11. Dissemination

Dissemination Communication and circulation

The Distribution across and within the CCG shall take place through Staff meetings and key groups which will include delegated Boards

12. Implementation

The Designated Nurse is responsible for making sure that the policy is enacted and monitored.

The policy will be made available on BSW CCG Intranet and Website and it will also be highlighted in the staff newsletter.