

COMMISSIONER SAFEGUARDING POLICY INCLUDING STANDARDS FOR PROVIDERS

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Policy Title:	Commissioner Safeguarding Policy
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1 INTRODUCTION

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

All Clinical Commissioning Groups (CCGs) have a duty to take reasonable care to ensure the quality of the services they commission. There is an expectation that the provider organisations demonstrate robust safeguarding systems and safe practice within the agreed local multi-agency procedures. All providers will have appropriate and effective systems in place to ensure that any care provided, is done so with due regard to all contemporary legislation. This includes, but is not restricted to, the Human Rights Act (1998), Mental Capacity Act (2005), Mental Health Act (2007), Care Act 2014 and is consistent with Children Act 2004, section 11 duties

This policy is also informed by Working Together to Safeguard Children (DfE 2015), Children Act 1989, What to do if you're worried a child is being abused (2015) and Making Safeguarding Personal (2014).

Achieving good outcomes for adults and children requires all those who work with responsibility for assessment and the provision of services to work together according to an agreed plan of action. Effective collaborative working requires professionals and agencies to be clear about:

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

2 ENGAGEMENT

This policy has built on previous safeguarding policies. It has been circulated for comment to the safeguarding leads in the Hull and East Yorkshire NHS provider Trusts (Hull and East Yorkshire Hospital Trust, Humber NHS Foundation Trust,

Spire, Yorkshire Ambulance Service and City Health Care Partnership CIC. Comments have also been sought from the Hull and East Riding Safeguarding Boards (for children and vulnerable adults).

3 IMPACT ANALYSES

3.1 Equality

In developing this policy an equality impact assessment screening has been undertaken; details are available alongside this policy on the NHS Hull CCG website. As a result of performing the analysis, the policy, does not appear to have any adverse effects on people who share *Protected Characteristics* and no further actions are recommended at this stage. It is explicit that this policy will be made available in alternative formats, including Braille, audio tape and large print.

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

3.2 Sustainability

This policy has been assessed against NHS Hull CCGs sustainability themes; details are available alongside this policy on the CCG website. The impact of this policy appears to be neutral.

3.3 Bribery Act 2010

NHS Hull CCG follows good NHS business practice as outlined in the Business Conduct Policy and has robust controls in place to prevent bribery. Due consideration has been given to the Bribery Act 2010 in the development of this policy and no specific risks were identified.

4 SCOPE

This policy is focused on children under the age of 18. It also focuses on adults who have care and support needs and may be at particular risk of abuse (including neglect) due to, for example, old age, disability, mental or physical ill health or dependency on drugs and alcohol.

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

Organisations delivering commissioned services on behalf of NHS Hull CCG must have policies and procedures in place consistent with this document and compliant with any other safeguarding related statutory guidance and legislation, relevant to their organisation.

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

5 POLICY PURPOSE & AIMS

5.1 Policy statement

NHS Hull CCG shares a commitment to safeguard and promote the welfare of children and adults at risk from abuse or harm.

With respect to children this is underpinned by a statutory duty under Section 11 of the Children Act 2004. The Health and Social Care Act 2012 amended the Children Act 2004 to transfer the existing duties to Clinical Commissioning Groups. The duty is to ensure that health service functions are discharged with regard to the need to safeguard and promote the welfare of children.

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

This includes the requirement to have and follow safe recruitment policies and procedures; and have in place procedures for identifying and managing concerns and allegations that may arise in relation to staff with respect to safeguarding children/ adults.

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

All staff should be aware that age, gender, cultural or religious beliefs, disabilities or social backgrounds may also impact on an adult or child's ability to access help and support.

It is essential that whenever an individual has concerns about whether a child or adult is suffering from, or is at risk of suffering, significant harm, that they share their concerns following the Local Safeguarding Children Board (LSCB) procedures and guidance and the Local Safeguarding Adult Board (LSAB) policy and procedures as relevant. These procedures must be followed irrespective of the source of concern. NHS Hull CCG recognises that concerns may arise from many sources including carers, parents, professionals, volunteers and other staff, service users and visitors including celebrities and people with high profile/status working with or involved with organisations and service users.

NHS Hull CCG will adopt a zero tolerance approach to adult and child abuse and will work to ensure that its policies and practices are consistent with agreed local multi-agency procedures and meet the organisation's legal obligations.

Specifically:

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

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

Specifically:

- All organisations providing services commissioned by NHS Hull CCG are required to demonstrate commitment to safeguarding adults and children and to working within agreed local multi-agency procedures, national guidance and legislation.
- NHS Hull CCG will actively contribute to multiagency responses regarding concerns of abuse within commissioned services.
- All providers are expected to establish procedures and systems of working that ensure safeguarding concerns are referred to Hull Children's Social Care and/or Adult Social Care services as appropriate and as indicated in the HSCB and HSAB procedures.
- Provider services within Hull, commissioned by NHS Hull CCG, are expected to actively contribute to the work of the HSCB, HSAB and their sub groups.
- All providers who deliver services commissioned by NHS Hull CCG are required to meet the safeguarding standards as set out in this policy.

5.2 Policy aims

NHS Hull CCG has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare of children and young people and that these arrangements reflect the needs of the children they deal with; NHS Hull CCG will also ensure that arrangements are in place to protect adults at risk of abuse.

NHS Hull CCG has clear service standards against which healthcare providers (including independent providers, voluntary, and community sector) will be monitored.

In discharging these statutory duties/responsibilities account must be taken of the legislation and guidance listed in section 12.

As a commissioning organisation, NHS Hull CCG is also required to ensure that all health providers from whom it commissions services (both public and independent sector) have comprehensive single and multi-agency policies and procedures in place to safeguard and promote the welfare of children and to protect adults at risk from abuse; that health providers are linked into the HSCB/HSAB; and that health workers contribute to multi-agency working.

5.3 Safeguarding adult and children standards for providers

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

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. Those providers required to register with the CQC must ensure they meet the CQC essential standards of quality and safety, including Outcome 7 which is concerned with protecting people who use services from abuse. This includes making notifications to the CQC as required within their regulations.

5.3.1 Standards: Policy and Procedures

- 5.3.1.1 The provider will ensure that it has up to date organisational safeguarding policies and procedures, consistent with relevant legislation, which reflect and adhere to HSCB and HSAB policies and procedures. This must include the need to be mindful of adult issues that affect children's wellbeing such as; parental or carer mental ill health, domestic abuse, alcohol or substance misuse and adults who may pose a risk to children for any reason. There will be evidence of policy development, review dates, consultation and approval.
- 5.3.1.2 The provider will ensure that organisational safeguarding policies and procedures give clear guidance on how to recognise and refer safeguarding children and adults safeguarding concerns, including the importance of listening to the child or vulnerable adult and maintaining a clear focus on their needs, and ensure that all staff have access to the guidance and know how to use it.
- 5.3.1.3 The provider will ensure that all other corporate and clinical policies and procedures with relevance to safeguarding are consistent with, and referenced to, safeguarding legislation, national policy / guidance and local multi-agency safeguarding procedures. This includes having 'Prevent' embedded within safeguarding policies.
- 5.3.1.4 The provider will ensure that all policies and procedures are consistent with legislation/guidance in relation to Mental Capacity Act 2005 and consent, and that staff practice in accordance with these policies.
- 5.3.1.5 The provider will have an up to date 'whistle-blowing'/Raising Concerns procedure, which is referenced to local multi-agency procedures and covers arrangements for staff to express concerns both within the organisation and to external agencies. The

provider must have systems in place to demonstrate that all staff are aware of their duties, rights and legal protection, in relation to whistle-blowing/raising concerns and that they will be supported to do so.

- 5.3.1.6 Providers of care homes and hospitals will have an up to date policy and procedure covering the Deprivation of Liberty Safeguards 2009, and will have evidence to demonstrate that staff practice in accordance with the legislation.
- 5.3.1.7 The providers of care homes and hospitals will have an up to date policy(s) and procedure(s) covering the use of all forms of restraint. These policies and procedures must adhere to contemporary best practice and legal standards.
- 5.3.1.8 The provider will ensure that there is a clinical/professional supervision policy in place and that safeguarding practice is included appropriately as a standard item.
- 5.3.1.9 Providers will have evidence of an up-to-date policy which ensures that all staff working directly with children and families, young people and adults who are parents/carers, specialist / lead safeguarding practitioners and staff line managing these groups will have access to regular, planned safeguarding supervision.
- 5.3.1.10 The provider will ensure that they have relevant procedures in place to ensure appropriate access to advocacy within the care setting, including use of statutory advocacy roles. These must adhere to contemporary best practice and legislation.
- 5.3.1.11 The provider will ensure that their policies and procedures include clear guidance on the use of assessment processes in safeguarding children circumstances for the identification of early help and prevention needs.
- 5.3.1.12 In addition to the above, the provider policy, where appropriate, will include a process for
- the management of differences of opinion between agencies and between health professionals, including escalation of concerns
 - the management of discharge from in-patient units when there are child/adult protection concerns
 - checking for and encouraging registration with a GP
 - the management and follow up of no access and missed appointments.
 - managing cases or suspicions of fabricated induced illness in children
 - a process that outlines when A&E/unscheduled care staff should check whether a child is subject to a child protection plan, and how to access information about child protection plan status.

5.3.2 Standards: Governance

- 5.3.2.1 Provider organisations will identify a person(s) with lead responsibility for safeguarding. For NHS Bodies / Trusts, this will be a Board-Level Executive Director with lead responsibility for safeguarding.
- 5.3.2.1 All providers of NHS funded health services, including NHS Trusts, NHS Foundation Trusts and public, voluntary sector, independent sector and social enterprises should identify a Named Doctor and a Named Nurse (and a Named Midwife if the organisation provides maternity services) for safeguarding children (Working Together to Safeguarding Children 2013) with sufficient capacity to carry out these roles. For adult safeguarding, it is seen as best practice if NHS Trusts have in post,

a Named health or social care professional(s) for adult safeguarding with sufficient capacity to effectively carry out these roles.

- 5.3.2.3 Where organisations provide maternity services, a Named Midwife is in place with sufficient capacity to effectively carry out this role.
- 5.3.2.4 The provider will identify a named health or social care professional with lead responsibility for ensuring the effective implementation of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009).
- 5.3.2.5 The provider will ensure that there is an effective system for identifying and recording safeguarding concerns, patterns and trends through its governance arrangements including; risk management systems, patient safety systems, complaints, PALS and human resources functions, and that these are shared appropriately according to multi-agency safeguarding procedures.
- 5.3.2.6 The provider must ensure that there are systems for capturing the experiences and views of service users in order to identify potential safeguarding issues and relevant service development needs.
- 5.3.2.7 Providers of hospitals and care homes will ensure that there are effective systems for recording and monitoring Deprivation of Liberty applications to the authorising body/Court of Protection.
- 5.3.2.8 The provider has a Board level review of the effectiveness of the organisation's safeguarding arrangements at least annually and will identify any risks, service improvement requirements and learning points as well as areas of good practice.
- 5.3.2.9 The provider must have in place evidence of robust annual audit programmes to assure itself that safeguarding systems and processes are working effectively and that practices are consistent with the Mental Capacity Act (2005) and section 11 of the Children Act 2004.
- 5.3.2.10 The provider will, where required by the HSAB/HSCB, consider the organisational implications of any multi-agency review(s), and will have evidence to show an action plan with recommendations submitted to the local responsible Safeguarding Board to evidence that any learning is implemented across the organisation.
- 5.3.2.11 The provider will have evidence to show recommendations and action from safeguarding inspections that have been implemented and embedded in practice.
- 5.3.2.12 The provider will conduct an annual audit of the quality of safeguarding referrals/alerts made to children and adult social care, with associated recommendations and action plans.
- 5.3.2.13 The mental health service provider will be able to evidence the number of assessments using the Mental Health Clustering Tool (MHCT) and referrals as a result with trend analysis.
- 5.3.2.14 The provider will submit an annual report to the CCG appending their completed assurance declaration (see Appendix 2) as relevant to their service, and will include information on training and supervision uptake, and evidence of its quality and effectiveness, and relevant audit information.
- 5.3.2.15 The provider will submit information on a quarterly basis demonstrating their current % compliance with safeguarding training at the levels described within their

approved training needs analysis/plan (see section 5.3.5); and of supervision uptake amongst relevant staff.

5.3.3 Standards: Multi-agency working and responding to concerns

- 5.3.3.1 The provider will cooperate with any request from the HSCB/HSAB to contribute to multi-agency audits, evaluations, investigations and reviews, including where required, the production of an individual management report.
- 5.3.3.2 The provider will, where required by the HSCB/HSAB, consider the organisational implications of any multiagency review(s) and will devise and submit an action plan to the responsible Local Safeguarding Board to ensure that any learning is implemented across the organisations.
- 5.3.3.3 The provider will ensure that any allegation, complaint or concern about abuse or neglect from any source is managed effectively and referred according to the local multi-agency safeguarding procedures.
- 5.3.3.4 The provider will ensure that all allegations in relation to harm to children against members of staff (including staff on fixed term contracts, temporary staff, locums, agency staff, bank staff, volunteers, students and trainees) are referred to the Local Authority Designated Officer (LADO) according to local multi-agency safeguarding procedures. Referral must also be made to the LADO in any situation where the provider is aware of allegations being made against professionals who work with children who are not employed by the provider. This may include, for example, service users who are child care professionals in other organisations.
- 5.3.3.5 The provider will be able to evidence that a root cause analysis is undertaken and serious incident declared for all acquired pressure ulcers of category 3 or 4 (including unstagable and deep tissue injury) and that a safeguarding alert is made where abuse or neglect are believed to be a contributory factor, according to local multiagency procedures.
- 5.3.3.6 The provider will be able to evidence the numbers and percentage of staff attendance at, and contribution to, safeguarding case conferences/strategy meetings where required as part of multiagency procedures.
- 5.3.3.7 The provider will, where required, ensure senior representation on the HSCB and HSAB and contribute to their sub-groups; and will have demonstrable evidence of the effectiveness on outcomes in relation to: HSCB, HSAB, sub-groups, training programmes, multi-agency case file audit processes and working with other agencies.
- 5.3.3.8 The provider will inform the relevant commissioner of any significant safeguarding issues, even if it is a specialist service taking patients from out of the area.
- 5.3.3.9 In delivering services, the Provider will work collaboratively with the HSCB and HSAB.

Additional standard for NHS Trusts / Foundation Trusts

- 5.3.3.10 The provider will ensure executive representation on the HSCB and HSAB and contribution to their sub groups by senior members of staff.

5.3.4 Standards: Recruitment and employment practice

- 5.3.4.1 The provider must ensure safe recruitment policies and practice which meet current NHS Employment Check Standards in relation to all staff, including those on fixed-term contracts, temporary staff, locums, bank staff, agency staff, volunteers, students and trainees.
- 5.3.4.2 The provider will ensure that post recruitment employment checks are repeated in line with all contemporary national guidance and legislation.
- 5.3.4.3 The provider must ensure that their employment practices meet the requirements of the Disclosure and Barring Service (DBS) and that referrals are made to the DBS and relevant professional bodies where indicated, for their consideration in relation to barring.
- 5.3.4.4 The provider should ensure that all contracts of employment (including staff on fixed-term contracts, temporary staff, locums, bank staff, agency staff, volunteers, students and trainees) include an explicit reference to staff responsibility for safeguarding children and adults.
- 5.3.4.5 The provider will ensure that all safeguarding concerns relating to a member of staff are effectively investigated, and that any disciplinary processes are concluded irrespective of a person's resignation, and that 'compromise agreements' are not be allowed in safeguarding cases. In cases where the allegation is in relation to children the advice in 5.3.3.4 will also be followed.
- 5.3.4.6 The provider will be able to demonstrate the uptake of staff appraisals, including volunteers.

5.3.5 Standards: Training

- 5.3.5.1 The provider will ensure that all staff, (including staff on fixed-term contracts, temporary staff, locums, bank staff, agency staff, volunteers, students and trainees) who provide care and treatment, undertake safeguarding training and have an understanding of the principles of the Mental Capacity Act 2005 and consent, including the Deprivation of Liberty Safeguards, at the point of induction appropriate to their role and level of responsibility; and that this will be identified in an organisational training needs analysis and training plan. For safeguarding children this needs to be in accordance with Working Together to Safeguard Children (2013) and the Intercollegiate Competency Framework: Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (Royal College of Paediatrics and Child Health et al 2014).
- 5.3.5.2 The provider will ensure that all staff, contractors and volunteers undertake safeguarding children and adult's basic awareness training (level 1 Intercollegiate Competency Framework 2014 - for children) on induction, including information about how to report concerns within the service or directly into the multi-agency procedures.
- 5.3.5.3 The provider will undertake a regular comprehensive training needs analysis to determine which groups of staff require more in depth safeguarding training (in accordance with the Intercollegiate Competency Framework (for children) and the 'National Framework for Standards for Good Practice and Outcomes in Adult Protection Work' (ADASS 2005).

5.3.5.4 The provider will ensure a proportionate contribution to the delivery of multiagency training/educational programmes where available, as required by Local Safeguarding Boards.

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

5.3.6 Standards: Prevent

5.3.6.1 NHS provider trusts will identify an Executive Lead with responsibility for the Prevent strategy.

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

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

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

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

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

5.3.6.7 The provider will ensure that implementation of the Prevent agenda is monitored through the Trust's audit cycle/governance reporting mechanisms. This will include complying with requests to complete and return status reports to the regional prevent co-ordinator. A copy of this report will also be sent to commissioners each month.

5.4 Performance and monitoring of providers

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

5.4.2 Information will be forwarded by providers to NHS Hull CCG on a quarterly or annual basis as indicated within the Self Declaration Template (Appendix 2), as applicable to each provider; and will include key findings from audits undertaken during the period of the review. The precise nature and frequency of reporting will be negotiated with the provider and the Director of Quality and Clinical Governance and Designated Safeguarding Nurses for Adults and Children. Adults at risk should expect the same high standard of safeguarding from all providers regardless of the size of the organisation, whether the organisation is in the statutory, voluntary or

independent sector or nature of the service received. The level of assurance that NHS Hull CCG require will be proportionate, taking into account a number of aspects including the potential risk to individuals and the larger the size of the contract, the more detailed and frequent the assurance requirements will be.

- 5.4.3 The Designated Nurse/ Professional for Safeguarding Children and Adults will review and scrutinise all safeguarding annual reports from providers and make comments to the Director of Quality and Clinical Governance/Contract Manager /Commissioning Lead/Performance Management Group through the Contract Monitoring Board (CMB) process.
- 5.4.4 Where a provider is unable to demonstrate compliance with any adult and children safeguarding standards, they will produce an action plan with timescales that details steps to be taken to achieve compliance. This action plan will be monitored by the Director of Quality and Clinical Governance/Contracts/Commissioning Manager and the Designated Nurse/ Professional for Safeguarding Children and Adults through the CMB process to the Quality and Performance sub-committee. Providers will also be subject to performance management as set out in their contract.
- 5.4.5 NHS Hull CCG may require providers to produce additional information regarding their safeguarding work, in order to monitor compliance with this policy.
- 5.4.6 In addition to the standards required by this policy, legislation, national guidance or other stakeholders, NHS Hull CCG may also use local quality and incentive schemes (eg. CQUINS) to identify additional safeguarding standards or related targets for providers.
- 5.4.7 NHS Hull CCG may receive and use information from other agencies and organisations where this is relevant to the performance management of the provider in relation to safeguarding. This may include information from:
- HSCB/HSAB and / or their sub groups
 - Police
 - Service user / advocacy groups
 - Local Authority Departments /Adult and Community Services
 - NHS Providers and Contractors
 - Care Quality Commission
 - Care Homes
 - Ofsted
 - ADASS
- 5.4.8 The Designated Nurse/ Professional for Safeguarding Children and Adults will provide safeguarding performance information to the NHS ERYCCG Quality Performance and Improvement Committee / NHS Hull CCG Quality and Performance Committee, and an annual report summarising trends, unresolved risks and safeguarding activity from commissioned services.
- 5.4.9 Provider Boards, executive teams and management committees must regularly receive and scrutinise assurance that their organisation is monitoring its safeguarding performance and provision, and meeting its safeguarding obligations.

5.5 Sharing of information

- 5.5.1 NHS Hull CCG is committed to sharing information with other agencies, in a safe and timely manner, where this is necessary for the purposes of safeguarding adults and children, in accordance with the law and multiagency procedures. This may include personal and sensitive information.
- 5.5.2 All providers of services commissioned by NHS Hull CCG are required to share information with other agencies, in a safe and timely manner, where this is necessary for the purposes of safeguarding, in accordance with the law and local multiagency safeguarding information sharing procedures. This may include personal and sensitive information about:
- the child or young person(s) at risk of or experiencing abuse
 - the adult(s) at risk of or experiencing abuse
 - family members of those experiencing or at risk of abuse
 - staff
 - members of the public
- 5.5.3 “The need to share confidential information becomes an absolute imperative in cases involving a threat to the safety of others” (HSIC 2013, p15); for example, to prevent the abuse of a vulnerable elderly person or child.
- 5.5.4 Where there is reasonable cause to believe a child is suffering, or is likely to suffer, significant harm practitioners must share their information with children’s social care following HSCB procedures and consistent with legislation and Caldicott principles. In these cases it may be necessary to dispense with consent if gaining consent would put the safety of the child or another person at significant risk.
- 5.5.5 Where a Hull resident is receiving care or treatment outside the Hull area, the care provider must inform the host authority (NHS Hull CCG/ Hull LA Social Care) immediately of individuals affected by safeguarding concerns.
- 5.5.6 All Providers are required to share anonymised and aggregated data where requested, for the purposes of fulfilling contractual obligations, assurance and the monitoring and developing of safeguarding practice.
- 5.5.7 Safeguarding referrals/alerts from providers, independent contractors and NHS Hull CCG may be monitored and information provided to the HSCB or HSAB as appropriate.

5.6 Management of safeguarding serious incidents (SIs)

- 5.6.1 All safeguarding serious incidents (SIs) involving children and/or adults must be reported in accordance with NHS Hull CCG Serious Incident Policy, as well as being managed and reported following the local multi-agency safeguarding adults and children policies.
- 5.6.2 All SIs in relation to adults at risk of abuse or neglect reported to NHS Hull CCG will be reviewed by the Quality Team and the Designated Professional for Safeguarding Adults to identify safeguarding concerns.

- 5.6.3 All safeguarding children and adult SIs reported to NHS Hull CCG will be reported to NHS England via the STEIS system.
- 5.6.4 NHS Hull CCG will lead the investigation and the providers will provide reports and attend meetings as required to a specific set timeline.
- 5.6.5 The SI team will produce a quarterly report outlining numbers of SIs that have a safeguarding adult's element to them, with themes, trends and lessons learnt. These reports will be shared with the HSAB.
- 5.6.6 In cases where there is to be a Serious Case Review (SCR), Safeguarding Adult Review (SAR) /Domestic Homicide Review (DHR) the SCR and SI systems will run together and will follow HSCB /HSAB/ Community Safety Partnership and statutory guidance, updating NHS England according to their guidance.
- 5.6.7 Any suspicions of fraud in safeguarding cases will be reported in accordance with the current Fraud and Corruption policy.
- 5.6.8 Any member of NHS Hull CCG staff dealing with any claims, complaints, disciplinary or performance issues will be responsible for seeking advice from the Designated Nurse/ Professional for Safeguarding Children and Adults regarding any safeguarding risks and making referrals, in accordance with the multi-agency procedures and this policy, where appropriate.

5.7 Allegations against staff

- 5.7.1 NHS Hull CCG will ensure that it adheres to legislation and statutory guidance in managing allegations against staff which indicate they may pose a risk to children. Such allegations may arise if it is felt that a person who works with children/vulnerable adults has:
 - Behaved in a way that has harmed a child/adult at risk of abuse or neglect, or may have harmed a child or adult at risk of abuse or neglect
 - Possibly committed a criminal offence against or related to a child or adult at risk of abuse or neglect
 - Behaved towards a child/ adult in a way that indicates they may pose a risk of harm to children/ adults at risk of harm or neglect.
- 5.7.2 For adults, a safeguarding concern would be raised to the local safeguarding team and reported through the appropriate HR and Risk Management CCG process.
- 5.7.3 NHS Hull CCG and commissioned services will ensure that all allegations of abuse against staff, including where there is clear evidence that the allegation is false, unfounded or malicious, will be recorded and monitored using the organisation's incident management /allegations against staff policy.
- 5.7.4 All allegations of abuse against staff must be managed according to HSCB or HSAB procedures as appropriate.
- 5.7.5 All allegations that a member of staff has, or may have, caused or been complicit in abuse or neglect of a child (i.e. where there is no immediate evidence that it is

false) must be reported to the Local Authority Designated Officer (LADO) and managed according to local multiagency safeguarding children procedures.

- 5.7.6 In line with HSCB/HSAB procedures, if there is clear and immediate evidence that an allegation is false/ malicious, the reasons for not undertaking any further investigation must be stated/recorded, along with any other measures taken to manage risks. A history of making allegations does not constitute evidence that an allegation is false.
- 5.7.7 NHS Hull CCG managers and commissioned services must also consider the need for temporary exclusion, suspension or redeployment under the disciplinary policy based on potential risk to the alleged victim whilst investigation takes place.
- 5.7.8 NHS Hull CCG and providers will ensure that all other concerns relating to the conduct or capability of staff are monitored and that any safeguarding related concerns are managed in accordance with this policy and local multi-agency procedures.
- 5.7.9 NHS Hull CCG and providers will ensure that any safeguarding concerns arising from disclosures made during the course of an investigation or other Human Resources process are managed in accordance with this policy and local multi-agency procedures.
- 5.7.10 Any instance where there is an allegation that a service user has suffered abuse from a member or staff, or volunteer, whilst in receipt of services must be notified to CQC in accordance with the Essential Standards of Quality and Safety (Outcome 20: Notification of other incidents).

5.8 Responding to concerns about harm

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

All practitioners should be familiar with both the LSCB's, LSAB's and their own organisation's policies and protocols for promoting and safeguarding the welfare of children and adults at risk of abuse or neglect, and for identifying and appropriately acting on safeguarding concerns.

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

5.8.1 Multi-agency working and responding to abuse

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

NHS Hull CCG is committed to multi-agency approaches to safeguarding children and vulnerable adults work and will ensure a proportionate contribution to the work of the HSCB, HSAB and their sub-groups.

5.8.2 Making a Referral to Children's Social Care

Anyone who believes that a child is at risk of significant harm should inform the parent/carer if safe to do so (gaining their consent if possible) and make a referral to Children's Social Care in accordance with HSCB procedures and guidance.

However, if the practitioner believes that informing the parent/carer of the intention to refer to Children's Social Care may jeopardise a potential police investigation, or increase the risk of harm to the child, then sharing the intent to refer with the parent or carer should be dispensed with. Additionally if a practitioner believes that informing the parent/carer of intent to refer would put themselves at risk, consent may be dispensed with. A record must be made of whether or not the parent/carer has been informed of the referral, and whether or not consent has been obtained together with reasons for over-riding or dispensing with consent.

N.B If a patient, or other person expresses delusional beliefs involving their own child or other children, or that they might harm their child as part of a suicide plan, a prompt referral must be made to Children's Social Care/ Police.

Anyone who has concerns about a child but is unclear whether they should make a referral should consult with the safeguarding lead for their organisation, or as advised within their organisational policy.

Professionals who telephone a referral to Children's Social Care must confirm referrals in writing within 24 hours.

A copy of the referral and any associated actions for example interventions, and details of telephone calls **must** be recorded within the child's records, and if relevant into the adult's record, taking care not to breach data protection principles.

5.8.3 Making a referral about an adult in need of care or support

The first priority is to ensure the safety and protection of the adult. In making the person (and others potentially at risk) safe, it may be necessary to inform the emergency services.

Where there are suspicions that a crime may have taken place, the police should be contacted immediately and physical, forensic and other evidence should be preserved where possible.

If a practitioner believes that an adult is at risk of abuse or neglect, and the adult meets the 3 stage criteria set out in the Care Act 2014 (Section 42.1) they should seek consent and make a referral into the local multi-agency safeguarding team, following HSAB procedures. However, if the referral is believed to be in the public interest, then consent does not have to be sought to make the referral. If the adult does not have the mental capacity to consent, in accordance with the Mental Capacity Act (2005), the process for making a decision in the person's best interests should be followed and documented.

Anyone who has concerns about an adult at risk of abuse or neglect but is unclear whether they should make a referral should consult with the safeguarding lead for their organisation, or as advised within their organisational policy. Alternatively, guidance can be sought from the Local Authority Safeguarding Adult Team.

A safeguarding adult concern form is accessible from the HSAB website and should be completed and submitted within 24 hours. A copy of the safeguarding concern form and any conversations must be recorded within the person's records.

Records of incidents and concerns should be written as soon as possible, with the date, signature and designation made clear. If records are hand-written, the original should be kept for evidential purposes.

Staff should be aware that their records relating to any concern, referral or investigation could be used as evidence in a range of procedures: disciplinary, criminal or at a safeguarding case conference.

5.8.4 Escalating a Concern

Children

Good practice includes the expectation that constructive challenge amongst colleagues, within and between agencies, is in the best interests of children. Where members of staff from any agency believe concerns regarding a child are not being addressed it is expected that an escalation process will be used until a satisfactory conclusion is achieved.

Generally there are good working relationships between agencies but occasionally there will be a difference of professional views which is not resolved. The *HSCB Resolving Inter- Agency Disagreements Guidance* describes the actions required within Hull where there is an unresolved professional disagreement and the actions to be taken.

The child's safety and wellbeing must be the paramount consideration at all times.

Adults

Professional disagreements should be resolved at the earliest opportunity, ensuring that the safety and wellbeing of the adult at risk remains paramount. Challenges to decisions should be respectful and resolved through co-operation. Disagreements can arise in a number of areas and staff should always be prepared to review decisions and plans with an open mind. **Assurance that an adult at risk is safe takes priority.** Disagreements should be discussed and appropriate channels of communication established to avoid misinterpretation. In the event that staff are unable to resolve matters, more senior managers should be consulted and multi-agency network meetings may be used to reach a resolution.

5.9 Training for CCG Staff

- 5.9.1 NHS Hull CCG is responsible for ensuring that all its staff are competent and confident in carrying out their responsibilities for safeguarding and promoting adults at risk of abuse and neglect and children's welfare.

- 5.9.2 NHS Hull CCG will ensure it meets the requirements of associated guidance in respect of training requirements, e.g. Working Together to Safeguard Children (2015) which states that “all staff working in healthcare settings - including those who predominantly treat adults – should receive training to ensure they attain the competences appropriate to their role and follow the relevant professional guidance” (Chapter 2, para 16). Further detail in relation to the required competencies can be found in Safeguarding Children and Young People, Intercollegiate Document: roles and competencies for health care staff RCPCH (2014) and Looked After Children: Knowledge, skills and competencies of health care staff RCN RCPCH (2015). Until the re-publication of Safeguarding Adults: Roles and competencies for health care staff – Intercollegiate Document, the principles from the National Competence Framework for Safeguarding Adults (Bournemouth University 2010) continue to be applied.
- 5.9.3 NHS Hull CCG staff safeguarding children and adults mandatory training uptake requirements is outlined in the CCG Safeguarding Training Needs Analysis (Appendix 5) and should form part of the staff appraisal process.

6 ROLES / RESPONSIBILITIES / DUTIES

6.1 CCG Chief Officer

The Chief Officer is accountable and responsible for ensuring that NHS Hull CCG’s contribution to safeguarding and promoting the welfare of children and vulnerable adults is discharged effectively. The Chief Officer is also responsible for ensuring that NHS Hull CCG is compliant with the Care Act 2014 and Section 11 of the Children Act 2004; this is discharged through the Executive Lead for Safeguarding Children (The Director of Quality and Clinical Governance).

6.2 Clinical Commissioning Group Governing Body

The Clinical Commissioning Group Governing Body is responsible for the overall safeguarding of children and vulnerable adults in the organisation; and is responsible for reviewing and maintaining an effective system of internal control, including systems and resources for managing all types of risk associated with safeguarding children and vulnerable adults.

6.3 Executive Lead for Safeguarding/ Director of Quality and Clinical Governance

The Executive Lead for Safeguarding Children and Adults is the Director responsible, along with the Chief Officer, for ensuring that NHS Hull CCG discharges its duties in relation to safeguarding children and adults risk of abuse or neglect; and will access training and supervision commensurate with their role. This function is fulfilled by the Director of Quality and Clinical Governance for NHS Hull CCG. The Director of Quality and Clinical Governance oversees the risk management agenda of NHS Hull CCG and is the executive lead for ensuring that appropriate investigations are undertaken should serious incidents arise.

6.4 Designated roles

Designated doctor for Safeguarding Children

The Designated Doctor* (hosted within Hull and East Yorkshire Hospitals Trust) takes a strategic and professional lead on safeguarding children across the health economy of Hull.

Designated Nurse for Safeguarding Children

The Designated Nurse for Safeguarding Children takes a strategic and professional lead on safeguarding children across the health economy of Hull and works alongside designated colleagues within the Sustainable Transformation Plan (STP) footprint.

Designated Professional for Safeguarding Adults

The designated professional for safeguarding adults takes a strategic and professional lead across the health economy of Hull and works alongside counterparts within the STP footprint.

6.5 Named Doctors for Safeguarding Children and Adults (GPs)

The Named Doctors (GPs) for Safeguarding Children and Adults support NHS Hull CCG in their quality, governance and safeguarding role by providing advice and support for General Practice staff; and promoting good information sharing practice; and contributing to safeguarding processes within General Practice and supporting the investigation of safeguarding incidents. They work closely with the GP Practice Safeguarding Leads to support the implementation of the safeguarding agenda, ensuring safe processes, up to date internal procedures and a training needs analysis is in place to meet the learning needs of staff.

The designated and named safeguarding leads work closely with the named doctors* and nurses* within provider organisations to support the implementation of this agenda: ensuring safe processes, up to date internal procedures, and a training strategy to meet the learning needs of staff.

The designated and named safeguarding leads will access training and supervision commensurate with their roles.

The designated and named safeguarding leads report to the Director of Quality and Clinical Governance and will provide a safeguarding report, quarterly, to the NHS Hull CCG Quality Performance Committee.

6.8 Clinical Commissioning Group staff

All officers of NHS Hull CCG must:

- adhere to this policy and undertake safeguarding children and vulnerable adults training commensurate with their roles.
- ensure that all services meet these minimum standards where applicable, and that these standards are included within contracts and monitored.

Those with line management responsibility should ensure that their staff have access to, are aware of and adhere to this policy. They should also assure themselves that their staffs' safeguarding children and vulnerable adult competences are reviewed appropriately within their annual appraisal. If they have a safeguarding concern and are unsure of what action to take they must contact the appropriate Designated Nurse/ Designated Doctor for Safeguarding Children, Designated Professional for Safeguarding Adults or Named GP for safeguarding advice.

7 IMPLEMENTATION

Staff will be notified of the policy following the consultation and ratification process and it will be placed on the NHS Hull CCG staff intranet replacing the previous document.

8 TRAINING & AWARENESS

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

9 MONITORING & AUDIT

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

Information on monitoring of, and compliance with, this policy will be included in the quarterly governance, and annual, reports from the Designated Nurses which will be reported to the NHS Hull CCG Quality and Performance Committee. Once agreed, these reports will be submitted to HSCB and HSAB.

10 POLICY REVIEW

This policy will be reviewed in 3 years. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in national legislation/guidance, as instructed by the senior manager responsible for this policy.

11 REFERENCES

Care Quality Commission (2016) Fundamental Standards
www.cqc.org.uk/content/fundamental-standards.

Children Act 1989, HMSO

Children Act 2004, HMSO

Care Act 2014, HMSO

Mental Capacity Act 2005, HMSO

Hull Safeguarding Board Procedures and Guidance

Hull Safeguarding Adults Board Policy and Procedures

HM Government (2015) *Information Sharing: Guidance for practitioners and managers*

HM Government (2015) *Working Together To Safeguard Children*

HSCIC (2013) *A Guide to Confidentiality in Health and Social Care*
<http://www.hscic.gov.uk/3444>

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

National patient safety alert (2009) *Preventing Harm To Children From Parents With Mental Health Needs*

Royal College of Paediatrics and Child Health et al (2014) *The 'Intercollegiate Document', Safeguarding Children and Young People: roles and competences for health care staff*

RCN and RCPCH (2015) *Looked After Children: Knowledge, skills and competences of healthcare staff,*

Bournemouth University (2010) *National Competence Framework for Safeguarding Adults*
<http://www.scie.org/publications/guides/guide45/files/Bournemouth.pdf?res=true>

12 ASSOCIATED DOCUMENTATION

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

Statutory Guidance on promoting the Health and well-being of Looked After Children (DH 2015)

Safeguarding Adults: The Role of Health Services (DH 2011)

Making Safeguarding Personal: Guide (LGA and ADASS 2014)

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

HM Government (2015) Prevent Duty Guidance

NHS England (2015) Prevent Training and Competencies Framework

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

NHS England (2015) NHS Standard Contract 2015-2016 and 2016-2017

HM Government (2015) Channel Duty Guidance

General Protocol for Sharing Information between Agencies in Kingston upon Hull and the East Riding of Yorkshire

NHS Hull CCG: Clinical Quality Strategy

NHS Hull CCG: Serious Incidents Policy

NHS Hull CCG managing Complaints Policy

NHS HULL CCG: Fraud and Corruption Policy

APPENDIX 1

PREVENT STRATEGY

BUILDING PARTNERSHIPS, STAYING SAFE

The health sector contribution to HM Government's Prevent strategy: guidance for healthcare workers

Implications for the NHS

Background

As part of the Government's counter terrorism strategy (CONTEST) which was revised in June 2011, the NHS has committed to support initiatives to reduce the risk of terrorism.

CONTEST aims to reduce the risk we face from terrorism so that people can go about their lives freely and with confidence. It is made up of four work streams, or four Ps:

Protect – strengthening our borders, infrastructure, buildings and public spaces

Prepare – where an attack cannot be stopped, to reduce its impact

Pursue – to disrupt or stop terrorist attacks

The fourth P is **Prevent** which aims to stop people becoming terrorists or supporting terrorism. It has been described as “the only long term solution” to the genuine threat we currently face from terrorism. The *Prevent* strategy will specifically focus on three broad objectives:

- Respond to the **ideological** challenge of terrorism and the threat from those who promote it;
- Prevent **individuals** from being drawn into terrorism and ensure that they are given appropriate advice and support;
- Work with **institutions** where there are risks of radicalisation that we need to address.

Prevent is based on active engagement of the vulnerable individual and it is at the pre-criminal stage, therefore appropriate consent should be obtained. However, in exceptional circumstances, where seeking consent would cause immediate harm to the individual and/or where the person lacks capacity to give consent, a referral can be made without consent and in their best interests.

The Department of Health is supporting the delivery of initiatives which Prevent individuals being radicalised in terrorist activity. It is known that individuals who are most likely to engage in terrorist activities have vulnerabilities which often, as a result, put them into contact with health staff.

The *Prevent* strategy places an onus upon the health sector to support the work of counter-terrorist activity because of the volume of people who come into contact with healthcare workers on a daily basis and high profile cases associated with the NHS.

The roll out of the revised *Prevent* strategy intends to improve channels of communication across the public sector and other partners in order to counter terrorism in the UK mainland and its interests abroad.

NHS England is committed to tackling discrimination of any kind, promoting equality and diversity, protecting and promoting human rights. Encouragement of an open, honest and immediate incident reporting system that is used to improve practice and reduce risk. Reporting concerns to the Regional Prevent Co-ordinator and to other outside agencies for further risk assessment and support via the CHANNEL process are key. Staff have a responsibility to report incidents. Sharing limited and proportionate information is required in line with the information governance process.

The CHANNEL process is a partnership approach to safeguarding individuals who are vulnerable to being radicalised by terrorists. A supportive multi-agency process designed to safeguard those individuals who may be vulnerable to being drawn into terrorism. It is a key part of the Prevent strategy. CHANNEL works by identifying individuals who may be at risk of being exploited by radicalisers and subsequently drawn into terrorism-related activity. Assessing the nature and extent of the risk, and where necessary, providing an appropriate support package tailored to the individual's needs. Regular monitoring is undertaken. A multi-agency meeting decides on the most appropriate action to support the individual after considering their circumstances. If the referral is not deemed appropriate for CHANNEL, it will exit the process or be referred onto those services which are more appropriate to person's needs.

Work is currently underway to achieve this by including *Prevent* initiatives into the everyday practice of staff working within health services. Across NHS Hull and East Riding of Yorkshire *Prevent* will be integrated into Adult and Child Safeguarding.

Key Themes

Healthcare workers have the potential to:

- Prevent someone from becoming a terrorist or supporting terrorism as it is substantially comparable to safeguarding in other areas;
- To receive information that allows them to correctly identify signs that someone has been or is being drawn into terrorism;
- Identify people who could be considered "at risk";
- Need to be aware of the support which is available and be confident in referring people for support;
- Meet and treat people who are vulnerable to radicalisation; and
- Be working in the public sector have taken part in terrorist acts in the past.

The Department of Health will deliver on *Prevent* by:

- Ensuring organisations have identified *Prevent* leads;
- Developing knowledge and carrying out awareness raising events for healthcare workers;
- Developing guidance on governance policies and procedures to allow referrals and concerns to be raised with confidence;
- Developing awareness-raising initiatives and training products including the Health Workshop to Raise Awareness of Prevent(WRAP);

- Working with partner agencies to support the delivery of local Prevent initiatives

Implications for NHS Commissioner and Provider Services

Trusts should have structures and systems in place to implement the *Prevent* strategy. This will support compliance with Care Quality Commission Registration Regulations for Safeguarding (outcome 7). This can be achieved by conforming to national guidance, 'Building Partnerships, Staying Safe', published by the Department of Health which includes:

- Nominating a *Prevent* Lead;
- Provide Workshops to Raise Awareness of *Prevent* (Health WRAP) for staff and increase numbers of staff being trained to identify potential risks;
- Having systems in place to record how many referrals the organisation makes to multi-agency *Prevent* Groups/Channel groups;
- Joining local networks that exist with the Local Authorities and Police to support counter-terrorism and share information; and
- Being alert to the risk of attack on the organisation.

The following staff groups have been identified as priority groups for training

Staff who predominantly work with mental health and learning disability patients
Staff working in Emergency Departments (ED), minor injuries units and walk in centres, Ambulance staff
Staff working in chaplaincy services
School Nursing services
Drug and Alcohol NHS services
Safeguarding leads

The clinical commissioning groups are committed to ensuring vulnerable individuals are safeguarded from supporting terrorism or becoming terrorists themselves as part of the Home Office counter-terrorism strategy *Prevent*.

Staff have a responsibility to help the CCG fulfill its obligation to minimise risks by identifying and supporting adults and children who may be prone to exploitation or influence from violent extremism.

Roles and Responsibilities for Clinical Commissioning Groups

- ▶ Raise staff awareness so that they can recognise exploitation of vulnerable individuals being drawn towards terrorist-related activity
- ▶ Ensure staff have receive information about the organisational policies, procedures and process in place

- ▶ Ensure staff are aware of Prevent contacts within their organisation
- ▶ Work with partners to develop and strengthen safeguarding of vulnerable individuals
- ▶ Support the Regional Prevent Co-ordinator and send monthly information.

Further Information

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131929

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131911

If you have concerns about an individual patient or member of staff who may be susceptible to radicalisation and/or violent extremism or suspect of being engaged in terrorist activity, please contact the Designated Safeguarding Adults Nurse or in their absence, the Executive Prevent Lead who will take appropriate action based on regional and local guidance. Alternatively, referral directly to the regional Prevent Lead or local CHANNEL lead. You will be supported to share your concerns and CCG will work with partners to share information in order to reduce the risk of terrorism in East Riding of Yorkshire.

The Regional Prevent Co-ordinator is:

Chris Stoddart for NHS England North (Yorks & Humber Region) tel: 07909097769

e-mail: chris.stoddart@nhs.net

Local CHANNEL Co-ordinator e-mail at:

prevent@humberside.pnn.police.uk

APPENDIX 2 SELF DECLARATION : SAFEGUARDING ADULTS AND CHILDREN

Provider

Completed by.....

Date

RED: Not Compliant.

AMBER: Partially Compliant.

GREEN: Fully Compliant

1	Policy and procedures	RAG rating	Evidence of compliance	When
1.1	The provider will ensure that it has up to date organisational safeguarding policies and procedures which reflect and adhere to the Local Safeguarding Children Board (LSCB) and Local Safeguarding Adults Board (SAB) policies. Evidence of review dates and policy development.			Annual
1.2	The provider will ensure that organisational safeguarding policies and procedures give clear guidance on how to recognise and refer child / adult safeguarding concerns and ensure that all staff have access to the guidance and know how to use it.			Annual
1.3	The provider will ensure that all corporate and clinical policies where appropriate, includes reference to safeguarding children for staff who work primarily with adults. This must include the need to be mindful of adult issues that affect children's wellbeing such as; parental or carer mental ill health, domestic abuse, alcohol or substance misuse and adults who may pose a risk to children for any other reason.			Annual
1.4	The provider will ensure that all other corporate and clinical policies with relevance to safeguarding are consistent with and referenced to safeguarding legislation, national policy/guidance and local multiagency safeguarding procedures with candour and openness.			Annual
1.5	The provider will ensure that all policies and procedures are consistent with legislation / guidance in relation to Mental Capacity Act 2005 and consent, and that staff practice in accordance with these policies.			Annual

1.6	The provider will have an up to date 'whistle-blowing'/ Raising Concerns procedure, which is referenced to local multiagency procedures and covers arrangements for staff to express concerns both within the organisation and to external agencies. The provider must have systems in place to demonstrate that all staff are aware of their duties, rights and legal protection, in relation to whistle-blowing/Raising Concerns and that they will be supported to do so.			Annual
1.7	The providers of care homes and hospitals will have an up to date policy and procedure covering the Deprivation of Liberty Safeguards 2009. This will include evidence to demonstrate that staff practice in accordance with the legislation and will reflect the Winterbourne View concordat and CIPOLD objectives.			Annual
1.8	The providers of care homes and hospitals will have an up to date policy(s) and procedure(s) covering the use of all forms of restraint. These policies and procedures must adhere to contemporary best practice and legal standards.			Annual
1.9	The provider will ensure that there is a clinical/professional supervision policy in place that references safeguarding considerations where appropriate.			Annual
1.10	Providers will have evidence of an up-to-date safeguarding children/adult supervision policy. This must ensure that all staff as a minimum who work regularly with children and adults who are parents (Intercollegiate Level 3) have access to safeguarding supervision at least quarterly. This will be reported quarterly to the commissioners.			Quarterly
1.11	The provider will ensure that they have relevant policies and procedures in place to ensure appropriate access to advocacy within the care setting, including use of statutory advocacy roles. These policies and procedures must adhere to contemporary best practice and legislation. This should include guidance on legal support available where required.			Annual
1.12	The provider will ensure that their policies and procedures include clear guidance on the use of early help assessment processes (such as CAF).			Annual

2	Governance			
2.1	The Provider will identify a person(s) with lead responsibility for safeguarding. For NHS Bodies / Trusts, this will be a Board-Level executive Director with lead responsibility for safeguarding.			Annual
2.2	The provider will have in post a named professional (s) for safeguarding adults with sufficient capacity to effectively carry out these roles			Annual
2.3	The provider will have a Named Doctor for safeguarding children in place as required in statutory guidance (Working together to safeguarding children 2013) with lead responsibility for promoting good professional practice and providing advice and expertise in safeguarding children.			Annual
2.4	The provider will have a Named Nurse/Professional for safeguarding children in place as required in statutory guidance (Working together to safeguarding children 2013) with lead responsibility for promoting good professional practice and providing advice and expertise in safeguarding children.			Annual
2.5	Where organisations provide maternity services, a Named Midwife is in place with sufficient capacity.			Annual
2.6	The provider will identify a named health or social care professional with lead responsibility for ensuring the effective implementation of the Mental Capacity Act and Deprivation of Liberty Safeguards.			Annual
2.7	The provider will ensure that there is an effective system for identifying and recording safeguarding concerns, patterns and trends through its governance arrangements including; risk management systems, patient safety systems, complaints, PALS and human resources functions, and that these are shared appropriately according to multiagency safeguarding procedures.			Annual
2.8	The provider will identify and analyse the number of safeguarding incidents identified by the above processes, that includes concerns of abuse or neglect			Annual

	and include this information in their annual safeguarding report.			
2.9	The Provider must ensure that there are systems for capturing the experiences and views of service users in order to identify potential safeguarding issues and relevant service development needs.			Annual
2.10	The provider will undertake an annual audit on adherence to record keeping and safeguarding policies, including Routine Enquiry (where appropriate) and demonstration of effective information sharing.			Annual
2.11	Providers of hospitals and care homes will ensure that there are effective systems for recording and monitoring Deprivation of Liberty applications to the authorising body/Court of protection.			Annual /exception reporting
2.12	The provider has a Board level review of the effectiveness of the organisations safeguarding arrangements at least annually and will identify any risks, service improvement requirements and learning points as well as areas of good practice.			Annual
2.13	The provider will have in place evidence of annual audit programmes to assure itself that safeguarding systems and processes, including supervision and training, are working effectively and that practices are consistent with the Mental Capacity Act (2005). These will include dip sampling and some element of case tracking where appropriate.			Annual
2.14	The provider will, where required by the Local Safeguarding Board, consider the organisational implications of any multiagency review and will have evidence to show an action plan with recommendations submitted to the local responsible Safeguarding Board to ensure that any learning is implemented across the organisation.			Exceptional
2.15	The provider will have evidence to show recommendations and action from safeguarding inspections have been implemented and embedded in practice.			Exceptional
2.16	The provider will have a process in place for following up children and vulnerable adults who do not attend outpatient appointments.			Exceptional
2.17	Providers have an alert system in place to flag up children and vulnerable adults where safeguarding is a concern.			Annual

2.18	The provider will conduct an annual audit of the quality of referrals made to children/adults social care and report on the outcomes and trend analysis.			Annual
2.20	The mental health service provider will be able to evidence the number of assessments using the Mental Health Clustering Tool (MHCT) and referrals as a result with trend analysis			Quarterly
3	Multiagency working			
3.1	The provider will cooperate with any request from the HSCB/HSAB to contribute to multi-agency audits, evaluations, investigations and reviews, including where required, the production of an individual management report.			Exceptional
3.2	The provider will ensure that any allegation, complaint or concern about abuse or neglect from any source is managed effectively and referred according to the local multi-agency safeguarding procedures.			Quarterly
3.3	The provider will ensure that all allegations in relation to harm to children against members of staff (including staff on fixed term contracts, temporary staff, bank staff, locums, agency staff, volunteers, students and trainees) are referred to the Local Authority Designated Officer (LADO) according to local multiagency safeguarding procedures.			Quarterly
3.4	The provider will be able to evidence that a root cause analysis is undertaken and serious incident declared for all acquired pressure ulcers of category 3 or 4 (included unstagable and deep tissue injury), that a safeguarding alert is made where abuse or neglect are believed to be a contributory factor, according to local multiagency procedures.			Quarterly
3.5	The provider will where required, ensure senior representation on the LSCB and SAB and contribution to their sub-groups.			Annually
3.6	The provider will inform the relevant commissioner of any significant safeguarding issues even if it is a specialist service taking patients out of area.			Exceptional

4	Recruitment and employment			
4.1	The provider must ensure safe recruitment policies and practice which meet the NHS Employment Check Standards in relation to all staff, including those on fixed-term contracts, temporary staff, bank staff, locums, agency staff, volunteers, students and trainees are in place.			Exceptional
4.2	The provider will ensure that post recruitment employment checks are repeated in line with all contemporary national guidance and legislation.			Exceptional
4.3	The provider will ensure that their employment practices meet the requirements of the Disclosure and Barring Service (DBS) and that referrals are made to the DBS and relevant professional bodies where indicated, for their consideration in relation to barring.			Exceptional
4.4	The provider will ensure that all contracts of employment (including staff on fixed-term contracts, temporary staff, bank staff, locums, agency staff, volunteers, students and trainees) include an explicit reference to staffs responsibility for safeguarding children and adults.			Exceptional
4.5	The provider will ensure that all safeguarding concerns relating to a member of staff are effectively investigated, and that any subsequently processes are concluded irrespective of a person's resignation. Compromise agreements will not be arranged in safeguarding cases.			Exceptional

5	Training			
5.1	The provider will ensure that all staff, bank staff, contractors and volunteers complete safeguarding training for both adults and children, including the appropriate level of MCA and DoLS training, appropriate to their role and level of responsibility. This will be identified in an organisational training needs analysis and training plan. For safeguarding children this will be in accordance with the Intercollegiate Competency Framework (Royal College of Paediatrics and Child Health et al 2014). Refresher training will be undertaken, and evidence of training uptake for the required training will be provided to the commissioner quarterly.			Quarterly
5.2	The provider will ensure that all staff, bank staff, contractors and volunteers complete safeguarding children and adults basic awareness training (level 1 intercollegiate competency framework 2014 - for children) on induction, including information about how to report concerns within the service or directly into the multi-agency procedures.			Quarterly
5.3	The provider will ensure that all staff (including staff on fixed-term contracts, temporary staff, bank staff, locums, agency staff, volunteers, students and trainees) who provide care or treatment, have an understanding of the principles of the Mental Capacity Act 2005 and consent training, including the Deprivation of Liberty Safeguards at the point of induction and appropriate to their role and level of responsibility and that this will be identified in an organisational training needs analysis and training plan.			Quarterly
5.4	The provider will ensure a proportionate contribution to the delivery of multiagency training programmes where available, as negotiated with the local safeguarding boards.			Annual

PREVENT STANDARDS REQUIRED OF PROVIDERS

6	Prevent			
6.1	NHS Provider trusts will identify an Executive lead with responsibility for Prevent.			Annual
6.2	The provider will identify an Operational Lead for Prevent and ensure that they are appropriately authorised and resourced to deliver the required national and local standards.			Annual
6.3	The provider will inform commissioners of any changes to the Prevent leads as soon as practicable and, in any event, no later than ten operational days after the change.			Exceptional
6.4	The provider must have a policy which clearly states how to escalate Prevent concerns and make a referral to Channel processes. This policy must be accessible to all staff.			Annual
6.5	The provider must have a procedure which is accessible to all staff, consistent with the Prevent guidance and the Prevent Toolkit.			Annual
6.6	The provider must have a training plan that identifies the Prevent related training needs for all staff, including a programme to deliver 'Health Wrap' and sufficiently resource that programme with accredited Health Wrap facilitators.			Quarterly
6.7	The provider will ensure that implementation of the Prevent agenda is monitored through the Trusts audit cycle and quarterly reports to the commissioners.			Quarterly
6.8	The provider will also forward the monthly Prevent compliance returns to the commissioners when returning the report to NHS England Regional Prevent Lead.			Monthly

Safeguarding Commissioners Standards: Remedial Action Plan				
Standard No.	Action(s) required to achieve standard	Person Responsible	Date Due	Comments / Progress

APPENDIX 3

DEFINITIONS – ADULT SAFEGUARDING

Abuse

Abuse is the violation of an individual's human or civil rights by any other person/s and involves the misuse of power by one person over another (Safeguarding Adults. ADASS, 2005)

Abuse can be unintentional or deliberate and can result from either actions or inactions.

Abuse can take many different forms and is often considered under the following headings:

- physical
- sexual
- emotional
- financial (or material)
- neglectful or
- discriminatory
- Institutional

Adult

For the purposes of this document, adult refers to anyone who is aged 18 years or older. Children and young people under the age of 18 are subject to safeguarding children policy and procedures.

Safeguarding Adult Teams

Safeguarding Adult Teams are based in the Local Authority and provide advice and support to agencies or individuals involved in adult protection work.

Safeguarding Adult Teams also co-ordinate strategy meetings where there is concern about an alleged victim within trust services or where the alleged perpetrator is a member of trust staff.

Safeguarding Adult Teams can also receive alerts directly from alleged victims, carers, staff and members of the public.

Concerns

This refers to any suspicion, allegation, or other concern relating to the safety or wellbeing of an adult who may be experiencing or at risk of abuse. Individuals do not need 'proof' in order to raise concerns under the safeguarding adults' procedures.

Mental Capacity

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

Mental Capacity Act

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

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

Multi-Agency Procedures

This refers to the locally agreed multi-agency adult protection procedures coordinated through the local Safeguarding Adults Board

In East Riding of Yorkshire district this is the East Riding of Yorkshire Safeguarding Adults Board: Adult Protection Procedures at:

www.ersab.org.uk/policy-documents

Neglect

Neglect is a form of abuse and may be defined as the persistent failure to meet a person's basic physical and/or psychological needs. Neglect can be either unintentional or deliberate.

Neglect can involve failing to provide adequate food, shelter and clothing, failing to protect from physical harm or danger, or the failure to facilitate access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness, to a person's basic emotional needs. Examples could include:

- Poor quality care
- Inadequate hygiene support

- Failure to ensure adequate hydration or nutrition
- Under or over use of medication
- Lack of privacy or dignity
- Serious pressure ulcer (category 3 or 4)
- Failure of care due to inadequate equipment, systems, procedures or practice

Provider

This refers to all organisations and individuals who provide services that are commissioned by the CCG, and extends to all their employees, locums and agency staff, sub-contractors, volunteers, students and learners undertaking any type of work experience placement or work related activity.

Safeguarding

Safeguarding means all work which enables an adult to retain independence, wellbeing and choice and to access their human right to live a life that is free from abuse and neglect.

ADSS (2005) Safeguarding Adults

Safeguarding work can include:

Prevention – actions which identify and reduce the risk of abuse, and

Adult protection – actions to protect someone who is experiencing abuse

APPENDIX 4:

Safeguarding Children: Definitions (Taken from Working Together 2015, p 85,86)

Children:

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

Safeguarding and promoting the welfare of children:

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

Child protection:

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

Abuse:

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

Physical abuse:

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

Emotional abuse:

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

Sexual abuse:

Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Neglect:

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

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

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

Young carers:

Are children and young persons under 18 who provide or intend to provide care assistance or support to another family member. They carry out on a regular basis, significant or substantial caring tasks and assume a level of responsibility, which would usually be associated with an adult. The person receiving care is often a parent but can be a sibling, grandparent or other relative who is disabled, has some chronic illness, mental health problem or other condition connected with a need for care support or supervision.

Safeguarding Training Requirements for Hull CCG Staff

	Safeguarding Children	Safeguarding Adults	PREVENT	MCA	DoLS
All Staff	level 1 Intercollegiate document	level 1 Intercollegiate document	Yes	Yes	Yes
Any staff who have contact with patients or the public	level 2	Level 2	Yes	Yes	Yes
Staff who receive and manage incidents, complaints, PALS type issues, comms and engagement	level 2	Level 2	Yes	Yes	Yes
Chief Officer, Executive Lead for Safeguarding, Board Level Staff and Governing Body members.	level 1 & understanding of the CCG's safeguarding duties & their implications (plus any additional level if in clinical role).	Level 1 and understanding of the CCG's safeguarding duties & their implications	Yes	Yes	Yes
Named Doctor Safeguarding children*	level 4	Level 2	Yes	Yes	Yes
Named Doctor Safeguarding adults	level 3	Level 4	Yes	Yes	Yes
Designated Professional Safeguarding Adults	level 3	Level 5	Yes	Yes	Yes
Designated Nurse safeguarding Children	level 5	Level 2	Yes	Yes	Yes
Designated Doctor safeguarding Children*	level 5	Level 2	Yes	Yes	Yes
Designated Paediatrician for the Child Death Review process*	level 5	Level 2	Yes	Yes	Yes
Designated Doctor Looked After Children*	level 5	Level 2	Yes	Yes	Yes

Designated Nurse Looked After Children*	level 5	Level 2	Yes	Yes	Yes
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*these posts are hosted within a provider's service therefore the CCG requires assurance that the appropriate training has been received.

Equality Impact Assessment (EIA) - Clinical and Patient-facing Policies

For more information about the equality impact assessment process in commissioning, please see: [EIA Overview and Navigation](#).

Clinical / Patient-facing Policy Equality Impact Assessment	
What is the name of the policy?	Commissioner Safeguarding Policy including standards for providers
Briefly describe the purpose of the policy (or cross reference to relevant section within policy)	To set out clear standards and requirements for NHS Hull CCG employed staff and services commissioned by NHS Hull CCG and to detail NHS Hull CCG governance arrangements for safeguarding.
Who is the policy lead?	Designated Nurse Safeguarding Children/ Designated Professional Safeguarding Adults
Who is likely to be affected by this policy?	This policy applies to all staff employed by NHS Hull CCG and its commissioned services. This includes; all employees (including those on fixed term contracts), temporary staff, bank staff, locums, agency staff, contractors, volunteers(including celebrities), students and any other learners undertaking any type of work experience or work related activity.
Needs and issues What do you currently know about the needs or issues affecting people from different protected characteristic groups, relevant to your policy?	<p>The Policy states:</p> <p><i>“All adults and children have a right to protection. Some people are more vulnerable to abuse and neglect due to a variety of factors impacting on their own, and/ or their families, parents’ or carers’ welfare. All staff should be aware that age, gender, cultural or religious beliefs, disabilities or social backgrounds may also impact on an adult or child’s ability to access help and support. “</i></p> <p>DH analysis of the equality impact of safeguarding¹ states”</p> <p><i>“...‘vulnerable adults’ are not a homogenous group. Any person can be in a vulnerable situation and a person’s age or disability does not of itself, make the person vulnerable. However, people who have a range of multiple and complex service requirements may be in positions that increases their dependency on others and makes them less able to protect themselves from harm or abuse e.g. a person with impaired mental capacity related to dementia. “</i></p>

¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215717/dh_125065.pdf

	<p>The information below highlights current relevant statistics and highlights potential issues or needs for people who may be vulnerable as a result of one or a combination of protected characteristic/s.</p>		
	<table border="1"> <tr> <td data-bbox="528 323 1077 564"> <p>Race</p> </td> <td data-bbox="1077 323 2195 564"> <p>The 2011 Census noted that 10.3% of the population of Hull are black or minority ethnic residents. 4.4% of Hull residents classify themselves as White Other and are largely Eastern Europeans. The largest non-White ethnicity is Asian or Asian British, making up 2.5% of Hull's population.</p> <p>Services commissioned by NHS Hull CCG under this policy will be available and accessible to all regardless of ethnicity. Where required, interpreting and translation services will be available to service users whose first language is not English.</p> </td> </tr> </table>	<p>Race</p>	<p>The 2011 Census noted that 10.3% of the population of Hull are black or minority ethnic residents. 4.4% of Hull residents classify themselves as White Other and are largely Eastern Europeans. The largest non-White ethnicity is Asian or Asian British, making up 2.5% of Hull's population.</p> <p>Services commissioned by NHS Hull CCG under this policy will be available and accessible to all regardless of ethnicity. Where required, interpreting and translation services will be available to service users whose first language is not English.</p>
<p>Race</p>	<p>The 2011 Census noted that 10.3% of the population of Hull are black or minority ethnic residents. 4.4% of Hull residents classify themselves as White Other and are largely Eastern Europeans. The largest non-White ethnicity is Asian or Asian British, making up 2.5% of Hull's population.</p> <p>Services commissioned by NHS Hull CCG under this policy will be available and accessible to all regardless of ethnicity. Where required, interpreting and translation services will be available to service users whose first language is not English.</p>		

Disability

The local Health & Lifestyle Survey 2014 suggests that 27.7% of the population of Hull identify that they have an illness or disability which limits daily activities.

Most patients will be referred to the ICC will have a long-term condition or disability.

Figures sourced from Projecting Older People Population Information System show the following estimates of people over 65:

- Learning Disability: 762
- Visual Impairment: 3,263
- Hearing Impairment – Moderate or Severe: 15,707
- Hearing Impairment – Profound: 402

Over 11,000 people living in Hull in 2008 had a blue parking badge (estimate 75% will be over 65²).

“The number of people diagnosed with dementia by Hull GPs is 1,362; and the numbers are expected to increase by around 500, however, the level of people diagnosed is expected to be lower than the number of people actually living with dementia. It is estimated that 3,194 people actually have disease. In the next 15 years it is projected that this figure will increase by 29%” - Hull Better Care Fund Plan

Depression affects around **22%** of men and **28%** of women aged 65 +³, yet the Mental Health Foundation estimate 85% of these do not receive any NHS support for their mental health.

Issues / Need:

Disabled people *may* be in vulnerable situations and less able to protect themselves from

- Physical disability
- Learning disability
- Disability arising from illness Mental health needs Impaired mental capacity

Research⁴ shows that disabled people are more vulnerable to harassment and abuse.

- *More than 20% of disabled people have experienced harassment in public because of their disability*
- *9 out of 10 people with a learning disability have been a victim of hate crime and abuse*

² Based on research quoted in a Department for Transport Blue Badge Reform Strategy (2008). <http://webarchive.nationalarchives.gov.uk/+http://www.dft.gov.uk/transportforyou/access/bluebadgesreformstrategyforreformstrategy.pdf>

³ Health and Social Care Information Centre, (2007). Health Survey for England, 2005: Health of Older People. [online] Available at: <http://www.hscic.gov.uk/pubs/hse05olderpeople>

⁴ <http://www.papworthtrust.org.uk/sites/default/files/Facts%20and%20Figures%202013%20web.pdf>

The Papworth report also raised concerns about the disabled children:

- About 60% of children and young people with both learning disabilities and mental health problems have a mental health problem
- Only 1 in 13 disabled children receive a regular support service of any sort
- Children in families with at least 1 disabled person are almost twice as likely to have a mental health problem

	<p>Age/Gender / Sex</p>	<p>The 2016 estimates for Hull identify that the male population is 148,103 individuals and for the female population is 144,934 individuals. There are approximately 60,000 children under the age of 18 years. This equates to 20.6% of the local population. In the over 65 year age group the 2016 estimates suggest there are 20,585 male and 24,244 females in this cohort.</p> <p>Issues / Need:</p> <ul style="list-style-type: none"> • Disability through age related conditions - age related frailty and health conditions that disproportionately affect older people such as dementia, all increase a person's dependency and susceptibility to harm or abuse⁵ • Hidden Voices: Older Peoples Experience of Abuse 2006 – report by Action on Elder Abuse found 23% of calls to their help line were from older adults in care homes. This was disproportionately high given that only 4.9% of the survey group were in a care home setting • Gender: Although domestic violence is not a gender specific crime, <i>“Domestic violence can affect one in four women in their lifetimes, regardless of age, social class, race, disability or lifestyle. Domestic violence accounts for between 16% and one quarter of all recorded violent crime”</i>⁵.
	<p>Gender identity (gender reassignment)</p>	<p>There are no official statistics nationally or regionally regarding transgender populations, however, GRIES (Gender Identity Research and Education Society – www.gries.org.uk) estimated that, in 2007 the prevalence of people who had sought medical care for gender variance was 20 per 1000,000 i.e. 10,000 people, of whom 6.000 had undergone transition. 80 5 were assigned as boys at birth (now transwomen) and 20% as girls (now trans men).</p> <p>Issues / Need:</p> <p>The Women and Equalities Committee report on transgender equality, reports a significant concern about some social workers' lack of knowledge on gender variance” and recommended this should be addressed through formal training.</p> <p><i>Evidence in the report, submitted by Mermaids UK (who support young people with gender identity issues “There have been many cases where, if the families support their child's gender variance, social services have attempted to remove children from the family home by treating this as a safeguarding concern and investigating the parents accordingly. Social workers have no formal knowledge or training around gender variance and appear to act on their own prejudices rather than researching gender issues.”</i></p> <p><i>“...many trans looked-after children felt “very unsafe”.</i></p>

⁵ DH Guidance: Assessing Equality Impact in Safeguarding, 2011: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215717/dh_125065.pdf

		<p><i>The report identified a “lack of sufficient understanding on trans issues by professionals in the public sector, probably reflecting society’s lack of knowledge – and sometimes prejudice”</i></p>
	<p>Sexual orientation</p>	<p>There are no statistics for how many LGBT people live within Hull. However, the Government estimates that 5% of the national population is lesbian, gay or bisexual.</p> <p>Significant issues affecting LGBT people:</p> <ul style="list-style-type: none"> • A significant proportion of older gay people are likely to live alone, have limited family support and rely on formal services for help in the future • Many older gay people have experienced, or fear, discrimination because of their sexual orientation and they say this creates a barrier to receiving appropriate care and treatment. • Research from Stonewall, Being the Gay One (2007) drew attention to widespread discrimination and negative attitudes towards gay, lesbian and bisexual employees within health services • Incidence of violence related to homophobia is recognised by the Home Office. Police are obliged to record hate crime⁵ where the incident is motivated by prejudice or hate based upon sexual orientation⁵

Religion or belief

According to the 2011 Census, 54.9% of the population has identified themselves as Christian and 3.1% of the population is made up of other religions. The remainder of the population did not state anything (7.2%) or stated 'no religion' (34.8%).

Christian	54.90%
Buddhist	0.30%
Hindu	0.20%
Jewish	0.10%
Muslim	2.10%
Sikh	0.10%
Other Religion	0.30%
No Religion	34.80%
Religion Not Stated	7.20%

Issues / Need:

With respect to the Prevent element of this policy: HM Government conducted an EIA of their Prevent Strategy and found that the strategy did have a potential negative impact on Religion and Belief, with consultation showing that people thought the strategy unfairly targeted Muslim people. (*"The main theme dominating the online comments in terms of perceived negative impact of the Prevent strategy on race/religion/ belief, was that the previous Prevent strategy was too Islam focused and only aimed at Muslims. Respondents felt strongly that the focus on Al Qa'ida-influenced terrorism had led to the stigmatising and stereotyping of Muslims, especially those of South Asian (e.g Pakistani), Middle Eastern and African descent.*

	<p>Pregnancy and maternity</p>	<p>Just over a decade ago, national statistics singled out Hull as having one of the highest teenage pregnancy rates in the country including repeat pregnancies. Hull City Council and Hull PCT (prior to the CCG) launched a joint initiative to reduce numbers and as a result, figures from the ONS show that teenage pregnancies have reduced by 35% over the course of the life of the 12 year strategy. This compares to a national reduction of 24%.</p> <p>Issues / Need:</p> <ul style="list-style-type: none"> • The Lewis, Gwynneth, Drife, James, et al. (2001) Why mothers die: Report from the confidential enquiries into maternal deaths in the UK 1997-9; commissioned by Department of Health from RCOG and NICE (London: RCOG Press found 30% of domestic violence started in pregnancy • The months surrounding the birth of a baby carry the greatest risk for women of developing mental illness and this can have a significant impact on the child as well as the mother. The most common is postnatal depression (between 10 and 15% of mothers) and the most serious, puerperal psychosis. Women’s Mental Health: Into the Mainstream DH 2002
	<p>Marriage or civil partnership</p>	<p>Data from the ONS covering the period 2008-2010 indicates that there were 18,049 Civil Partnerships in England and Wales during the 3 year period – 52% men and 48% women. No relevant need or issues identified.</p>
	<p>Socio-economic disadvantage</p>	<p>Using the Index of Multiple Deprivation (IMD) 2015 score Hull has moved from the 10th to the 3rd most deprived local authority area out of 36. Child poverty (children living in households where income is less than 60% median household income before housing costs) is high in Hull. Three in ten (29%) of dependent children aged 0 – 19 years live in relative poverty compared to 18.05 across England (public Health Outcomes Framework Data for child poverty for the year 2013).</p>
<p>Do you have gaps in understanding about the needs of different groups, and how will you fill these?</p>		<p>There is a lack of local and national data regarding transgender numbers.</p>
<p>How does your policy promote equality and / or help</p>		<p>This policy enables NHS Hull CCG to meet its statutory duties in relation to safeguarding children and adults with care and support needs including those with or without protected characteristics. This equality impact assessment supports the CCG’s objective to “ensure and provide evidence that equality is consciously considered in all commissioning activities and ownership of this is part of everyone’s day-to-day job”. The policy also recognises the need to provide the</p>

the CCG meet its equality objectives?	policy in different formats based on need. This support the equality objective “Ensure patients and public have improved access to information and minimise communications barriers”.		
Communication and Engagement How are you going to engage with different groups and communities and show that their feedback informs your service review?	<p>Consultation has taken place with the following local safeguarding communities:</p> <ul style="list-style-type: none"> • Named Safeguarding leads for City Health Care Partnership, Humber NHS Foundation Trust, Hull and East Yorkshire Hospital Trust, Named Safeguarding GPs for children and adults. • Yorkshire Ambulance Service. • The Hull Safeguarding Children Board. • The Hull Safeguarding Adults Board. • The NHS England Safeguarding Children and Adults leads. <p>Amendments have been made to the policy following the NHS England safeguarding assurance visit in July 2016 and to the self-declaration following comments received from providers.</p>		
Is information provided appropriate and accessible?	This policy will be available to all to whom it applies via the staff intranet. Information regarding its content will be provided on induction and paper copies will be provided where appropriate. Information regarding the policy update will be provided via email.		
Impact	Will your policy have a disproportionate or negative impact on a particular protected characteristic group?	Race	No - this policy applies to all irrespective of grounds of race.
		Disability	No - this policy applies to all irrespective of disability. The policy will be made available in alternative formats including Braille, audio and large print when requested.
		Gender / Sex	No - this policy applies to all irrespective of gender.
		Gender identity (gender reassignment)	No - this policy applies to all irrespective of gender reassignment.
		Sexual orientation	No - this policy applies to all irrespective of sexual orientation.
		Religion or belief	No - this policy applies equally to all irrespective of religion or beliefs.
		Age	No - this policy covers services provided to children and adults who are resident in the City of Hull and/ or registered with a hull GP.
		Pregnancy and maternity	No - this policy applies to all irrespective of pregnancy, maternal or paternal status.
		Marriage or civil partnership	No - this policy applies to all irrespective of marital or civil partnership status.
	Socio-economically disadvantage	No - this policy applies to all irrespective of socio-economic status.	
	If Yes, is		

	how is this impact justifiable?	It provides inclusive access to the policy by all to whom the policy is applicable.
		<p>Whilst this policy does not disproportionately or negatively impact on any particular protected characteristic group, this equality impact assessment has highlighted particular needs potentially associated with people who share one or more protected characteristic. The main recommendation is for training to include awareness of equality issues identified in this EIA. In particular:</p> <p>Staff should be able to demonstrate awareness of:</p> <ul style="list-style-type: none"> • Issues and inequalities affecting people with learning disabilities • How disability may impact on children and young people, in a family and socio economic context • How disability and age may impact on safeguarding • Particular issues relating to Lesbian, Gay and Bisexual young and older people • Greater understanding of issues affecting transgender people, particularly relating to young people with gender identity • How to apply Prevent in a proportionate and fair way with an understanding of the impact on people from different religions and / ethnicities • Links between pregnancy and domestic violence
	What measures have been put in place to mitigate any potential impact?	<p>NHS Hull CCG can provide this policy in alternative formats if requested via the CCG Communications and Engagement Team.</p> <p>In partnership with NHS England, NHS Hull CCG hosted/facilitated a workshop in 2016 entitled Differentiating Islamic Culture and Extremism (DICE) to explore misbeliefs regarding this particular religion. Partner agencies were invited and attended the workshop from health and wider public sector who are involved in local safeguarding functions.</p> <p>Review of Prevent WRAP training resources.</p>

Follow up actions

Action required	By whom?	By when?
Safeguarding training for CCG to incorporate equality issues	LM/DB	July 2017
Providers to be required to ensure safeguarding training includes awareness of equality issues	LM/DB	July 2017
Prevent WRAP training resources have been reviewed to ensure all types of extremism are included not just Islamic extremism.	DB	Completed January 2017.

Signoff

Signed off by: Name & Role		Date: 22.11.7	
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