

**Safeguarding  
Vulnerable People in  
the NHS –  
Accountability and  
Assurance  
Framework**



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# **Safeguarding Vulnerable People in the NHS – Accountability and Assurance**

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# 1 Foreword

Dear Colleagues,

It gives me great pleasure to present the second NHS England Accountability and Assurance Safeguarding Framework. This updated framework builds on the previous one and reaffirms and strengthens our commitment to safeguarding vulnerable individuals.

The framework has been developed by leaders in the system in collaboration with those who will use it. The Department of Health, Department for Education, CQC, Monitor and the TDA have made significant contributions along with safeguarding and commissioning leaders across the whole commissioning system. The framework has also been subject to rigorous legal review to ensure changes in legislation are reflected appropriately.

As vulnerable children and adults face more challenges and the NHS commissioning system matures, it is important to have a document that sets out with greater clarity the responsibilities of each part of the system and the key individuals who work within it. It is also important to recognise that our communities have local characteristics and relationships that are needed to keep our most vulnerable citizens safe. We have therefore worked extensively with our local commissioning practitioners and partner agencies to ensure this framework is flexible to support appropriate decision making between partners at a local level.

NHS England together with CCGs has developed capability at individual and system level and delivered a significant programme of work over the last two years. Major achievements have been evidenced since the first Accountability and Assurance Framework was published in 2013 and I refer now to just a few of these.

The establishment of the National Safeguarding Steering Group has brought together safeguarding leaders for both adults and children from across the commissioning system. They have provided clinical leadership, developed common policies, shared good practice and have ensured that the growing areas within safeguarding such as CSE, Savile, FGM and Prevent have been integrated into the safeguarding agenda in a sensible and coherent way.

We commissioned the delivery of the executive safeguarding leaders programme across England, which received outstanding evaluations from our director colleagues, CCG Chief Operating Officers and Clinical Directors alike. We have invested and supported the development of a national Designated Professionals' network for children and commissioned an excellent leadership programme for our most senior clinical safeguarding experts that work across our commissioning system. NHS England also contributed significantly to the House of Lords inquiry into the Mental Capacity Act 2005, subsequently investing 14 million pounds into the system to support commissioners, providers and partners.

I would like to take this opportunity to thank all those who contributed to the development of the framework and all who work with passion and professionalism to safeguard the health and wellbeing of our most vulnerable people.

Safeguarding is challenging and I do not underestimate the daily issues that our practitioners, leaders and managers face in establishing and maintaining environments that keep people safe. I am proud of what these dedicated teams and individuals achieve.

Jane Cummings

Chief Nursing Officer

## 2 Introduction and background

This document updates and replaces Safeguarding Vulnerable People in the Reformed NHS – *Accountability and Assurance Framework* issued by the NHS Commissioning Board in March 2013. This section gives an overview of the importance of the procedural document.

### 2.1 Purpose of the document

The purpose of this document is to set out clearly the safeguarding roles, duties and responsibilities of all organisations commissioning NHS health and social care. It has been refreshed in partnership with colleagues from across the health and social care system, the Department of Health (DH) and the Department for Education (DfE), particularly recognising that the new responsibilities set out in the Care Act 2014 that came into force on 1<sup>st</sup> April 2015. The framework aims to:

- Identify and clarify how relationships between health and other systems work at both strategic and operational levels to safeguard children, young people and adults at risk of abuse or neglect.
- Clearly set out the legal framework for safeguarding as it relates to the various NHS organisations in order to support them in discharging their statutory requirements to safeguard children and adults.
- Promote empowerment and autonomy for adults, including those who lack capacity for a particular decision as embodied in the Mental Capacity Act 2005 (MCA), implementing an approach which appropriately balances this with safeguarding.
- Outline principles, attitudes, expectations and ways of working that recognise that safeguarding is everybody's business and that the safety and well-being of those in vulnerable circumstances is at the forefront of our business.
- Set out how the health system operates, how it will be held to account both locally and nationally and make clear the arrangements and processes to be undertaken to provide assurance to the NHS England Board with regard to the effectiveness of safeguarding arrangements across the system; and
- Outline how professional leadership and expertise will be developed and retained in the NHS, including the key role of Designated and Named Professionals for Safeguarding Children and Designated Adult Safeguarding Managers.

This accountability and assurance framework is not intended to generate new policy or priorities for either the NHS or its partners. It articulates how the performance of the wider NHS with respect to the duties and priorities defined elsewhere will be delivered and assured.



This framework aims to provide guidance and minimum standards but should not be seen as constraining the development of effective local safeguarding practice and arrangements in line with the underlying legal duties. The responsibilities for safeguarding form part of the core functions for each organisation and must therefore be discharged within agreed baseline funding.

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of this document we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities.

## 2.2 Scope

The definition of safeguarding is necessarily broad as there is a wide range of risks of abuse or neglect that can result in harm to children and adults. Effective safeguarding arrangements seek to protect individuals from harm caused by abuse or neglect occurring regardless of their circumstances. The arrangements set out within this framework will apply whenever a child or an adult is at risk of abuse or neglect, regardless of the source of that risk.

## 2.3 Context

Safeguarding is firmly embedded within the wider duties of all organisations across the health system but there is a distinction between providers' responsibilities to provide safe and high quality care and support, and commissioners' responsibilities to assure themselves of the safety and effectiveness of the services they have commissioned. The wider context continues to change in response to the findings of large scale inquiries, such as Francis<sup>1</sup> and Lampard<sup>2</sup>, and new legislation, such as the Care Act 2014. There has also been revised statutory and intercollegiate guidance, reflected in this framework. This document will support NHS England in maintaining the personalisation agenda as described in the Care Act 2014.

It is essential to continue to revisit and develop the safeguarding arrangements in place. NHS England, in its system leadership role, has revised and re-issued this framework to reflect these recent developments and to provide further clarity of roles and expectations where necessary.

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<sup>1</sup> The [Francis Inquiry](#) investigated the quality and safety failing in Mid Staffordshire Foundation NHS Trust.

<sup>2</sup> The Lampard Inquiry investigated the activities of Jimmy Savile in the NHS <https://www.gov.uk/government/publications/jimmy-savile-nhs-investigations-lessons-learned>

The framework seeks to set out clearly how these roles are discharged and statutory duties are fulfilled across the health system. It also describes how the health system works in partnership with the local authorities to discharge its statutory safeguarding duties.

Fundamentally, it remains the responsibility of every NHS funded organisation and each individual healthcare professional working in the NHS to ensure that the principles and duties of safeguarding adults and children are holistically, consistently and conscientiously applied, with the well-being of those adults and children at the heart of what we do. For adult safeguarding this also needs to respect the autonomy of adults and the need for empowerment of individual decision making, in keeping with the Mental Capacity Act and its Code of Practice.

This framework sets out the minimum standards expected across the system; however, it must be recognised that needs vary across England and therefore local arrangements must be tailored to meet these local needs.

All NHS organisations need to ensure that there is sufficient capacity in place to fulfil their statutory duties and should regularly review their arrangements to assure themselves that they are working effectively. Organisations need to come together to mitigate risks and develop workable local solutions based on local need. Some of the issues that must be considered include:

- The size and geography of the 'patch'.
- The deprivation of the population served and the numbers of children and adults in need, including looked after children.
- The evidence and advice from recent inspections, reviews, audits and case reviews of safeguarding.
- The number of providers and the complexity of the provider landscape.

The views of the LSCB, SAB and Health and Wellbeing Boards should be considered in the assessment of capacity.

Safeguarding adults at risk of abuse or neglect is a collective responsibility. Indeed the Care Act 2014 places a duty on agencies to co-operate to help and support adults in need and their carers<sup>3</sup>. Whilst individuals and organisations have distinct roles, the system cannot operate effectively unless the different individuals and organisations work together. The following section sets out a number of ways in which the system works together to do this.

In 2011 the Government published the third version of the United Kingdom's Counter-terrorism strategy, CONTEST. The strategy set out the threat the population face and the priorities for dealing with it through to 2015, as part of this strategy Health is involved in the fourth aspect of Prevent, which looks at identifying and supporting individuals who may be vulnerable and at risk of radicalisation before they

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<sup>3</sup> Care Act 2014 sections 6 & 7.

become radicalised. As this process is primarily looking at individuals who are at risk then it links to the safeguarding agenda highlighted in this framework.

Good partnership working is essential and individual practitioners should continue to develop relationships and work closely with colleagues across their local safeguarding system to develop ways of working that are collaborative, enable learning and effective information sharing. There are a number of systems that support this, for example the [Child Protection Information Sharing](#) (CP-IS) solution<sup>4</sup>, which provides key data from local authorities to unscheduled care providers in health on children and unborn children who are subject to child protection plans or have looked after child status. The use of such systems is crucial to ensure there are no gaps that allow children or adults to be overlooked.

## 3 Legal Framework

### 3.1 Legal Duties

Responsibilities for safeguarding are enshrined in legislation. Some duties apply only to children, some apply only to adults, and some apply to both. This section deals with each in turn.

There are fundamental differences between the legislative framework for safeguarding children and that for adults which stem from who can make decisions.

Adults have a legal right to make their own decisions, even if they are unwise, as long as they have capacity to make that decision<sup>5</sup> (which must be free from coercion or undue influence). However, if an 'adult repeatedly makes unwise decisions that put them at significant risk of harm or exploitation, or makes a particular unwise decision that is obviously irrational or out of character'. There might be need for further investigation<sup>6</sup>. Moreover, the wishes of victims of crime can be overridden in the public interest, which includes responding to suspected offences against them or the suspected abuse or neglect of others<sup>7</sup>.

When children, or those with parental responsibility for them, reject measures that could save them from significant harm, their wishes can be overridden. This is part of the statutory principle that makes the welfare of the child the paramount consideration<sup>8</sup> subject to that, decision-making power relating to children lies with those who have parental responsibility for the child.

However, when a child understands fully the choice to be made and its consequences, based on the Gillick competency, the child's decision prevails<sup>9</sup>;

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<sup>4</sup> <http://systems.hscic.gov.uk/cpis>

<sup>5</sup> Mental Capacity Act 2005, Section 1 Principle 3.

<sup>6</sup> Mental Capacity Act Code of Practice, HMG, 2005, 2.11.

<sup>7</sup> Care and Support Statutory Guidance, DH, 2014, 14.158.

<sup>8</sup> Children Act 1989 section 1(1).

<sup>9</sup> Gillick v West Norfolk and Wisbech AHA [1986] AC 112.

Parents and carers should still be fully involved<sup>10</sup> unless the criteria set out in the Fraser guidelines apply.<sup>11</sup>

The Mental Capacity Act covers and empowers children aged 16 and 17 ('young persons'). A young person has capacity unless it is established he or she lacks it.<sup>12</sup> If a young person lacks capacity because of an impairment of, or a disturbance in the functioning of, the mind or brain, the Mental Capacity Act will apply in the same way as it does to adults (people aged 18 or over). However if the young person is unable to make a decision for another reason, for example, because he or she is overwhelmed by its implications the common law principles set out in Gillick will apply<sup>13</sup>.

### 3.1.1 Children

The legislation and guidance relevant to safeguarding and promoting the welfare of children includes the following:

[Children Act 1989](#) and [2004](#).

[Working Together to Safeguard Children \(2015\)](#) – statutory guidance.

[Promoting the Health and Well-being of Looked After Children](#) – statutory guidance (2015).

[Safeguarding children and young people: roles and competences for health care staff](#), intercollegiate document (updated 2014).

A full exposition of statutory provisions relating to children's safeguarding can be found in appendix B of the statutory guidance document *Working Together to Safeguard Children*. This document focuses on those which are relevant to the NHS.

There are some broad, fundamental safeguarding duties, namely:

- All public sector agencies providing services to children, including local authorities and all NHS bodies, "must make arrangements for ensuring that their functions are discharged having regard to the need to safeguard and promote the welfare of children"<sup>14</sup>.
- There is a duty on local authorities to "safeguard and promote the welfare of children within their area who are in need"<sup>15</sup>. The concept of "need" is defined very broadly, covering any child whose health or development will be impaired without support, or who has a disability<sup>16</sup>.

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<sup>10</sup> Children Act 2004 section 10(3).

<sup>11</sup> Gillick v West Norfolk and Wisbech AHA [1986] AC 112, R (on the application of Sue Axon) v Secretary of State for Health EWCA 372006 (Admin) (and see <http://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/>)

<sup>12</sup> Mental Capacity Act 2005 section 1 Principle 1.

<sup>13</sup> Mental Capacity Act 2005 Code of Practice, HMG, 2005, 12.13.

<sup>14</sup> Section 11 Children Act 2004.

<sup>15</sup> Section 17(1) Children Act 1989.

<sup>16</sup> Section 17(10) Children Act 1989.

- Local authorities also have a further duty to “take reasonable steps...to prevent children within their area suffering ill-treatment or neglect”<sup>17</sup>.
- A child-centred approach is required. As far as reasonably possible, local authorities must ascertain the child’s wishes and feelings<sup>18</sup>, and devise their support in consideration of those wishes and feelings. Local authorities do not have to provide the support themselves.
- A local authority must enquire whether it needs to take safeguarding action if it has reasonable cause to suspect a child in its area is suffering, or is at risk of, significant harm. This duty also covers any child in police protection, or under an emergency protection order<sup>19</sup>.

It is essential practice that all agencies recognise that safeguarding is everyone’s business. ‘No professional should assume that someone else will pass on information which they think may be critical to keeping a child safe. If a professional has concerns about a child’s welfare and believes they are suffering or likely to suffer harm, then they should share the information with local authority children’s social care’<sup>20</sup>. Particular duties of inter-agency co-operation that support this general principle include:

- If, in discharging its safeguarding duties, a local authority asks certain specified agencies for help, those agencies must help as long as it is compatible with their own duties, and does not hamper the discharge of their own functions. These agencies include NHS England, CCGs, and all NHS trusts<sup>21</sup>.
- Local authorities are under a duty to make arrangements to promote co-operation with other agencies, including NHS England and all CCGs, in order to promote the well-being of children in general, and to protect them from harm and neglect in particular. Those other agencies are under an express reciprocal duty to co-operate with the local authority<sup>22</sup>.

The task of monitoring inter-agency co-operation falls to the Local Safeguarding Children Board (LSCB). Local authorities must establish an LSCB for their area. NHS England, CCGs, Designated Professionals and local providers should ensure appropriate representation on the LSCB. The local authority and the other board members owe to each other reciprocal duties of co-operation specifically in relation to the establishment and operation of the LSCB<sup>23</sup>.

The objectives of an LSCB are to co-ordinate activities of board members to safeguard and promote the welfare of children, and to ensure the effectiveness of those activities. LSCBs must commission serious case reviews where abuse or neglect of a child is known or suspected, the child has either died or been seriously

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<sup>17</sup> Paragraph 4, Schedule 2, Children Act 1989.

<sup>18</sup> Section 53 Children Act 2004.

<sup>19</sup> Section 47 Children Act 1989.

<sup>20</sup> Working together to safeguard children, HMG, 2015, paragraph 1.24.

<sup>21</sup> Section 27 Children Act 1989.

<sup>22</sup> Section 10 Children Act 2004.

<sup>23</sup> Section 13 Children Act 2004.

harmed, and there is concern over how agencies and service providers have worked together<sup>24</sup>.

### 3.1.2 Mental Capacity Act 2005

The [Mental Capacity Act 2005](#) (MCA) aims to empower people to make decisions for themselves as much as possible and to protect people who may not be able to take some decisions. The Act applies to anyone aged 16 or over in England and Wales and is relevant for both care and treatment decisions. The MCA is supported by a [Code of Practice](#) and health and social care staff are specifically highlighted as a category of professionals that are required to have regard to the code of practice. As a legal duty, NHS England expects all service providers that are funded by the NHS to meet the requirements of the Act. Equally, commissioners are required to ensure that the services that they commission are complying with the MCA.

### 3.1.3 MCA and safeguarding

The relationship between mental capacity and adult safeguarding has come under much scrutiny in recent months. The report of the House of Lords Select Committee on the Mental Capacity Act<sup>25</sup> reflected the views of many when they said: *“a consistent theme was the tension between the empowerment which the Act was designed to deliver, and the tendency of professionals to use the Act for safeguarding purposes. Prevailing professional cultures of risk aversion and paternalism have inhibited the aspiration of empowerment from being realised”*.

In its response, the Government noted<sup>26</sup> : “professionals need to be aware of their responsibilities in regard to safeguarding and the MCA in all that they do. Of course, the two do have interdependencies and professionals should ensure the empowering ethos of the MCA is built into the safeguarding discussion as is often already the case. Traditionally, there has been a tendency in health and care organisations to assign responsibility for the MCA to the named safeguarding lead. It is not for Government to determine other organisations’ management arrangements but we would urge that in such an arrangement care is taken to ensure that the “MCA voice” is heard in equal measure to the “safeguarding voice”. If this is not happening, then steps should be taken to ensure that the MCA does indeed have a strong advocate within the organisation.”

NHS England supports this view: care must be taken not to treat the MCA simply as a tool of safeguarding, and lose sight of the principles of empowerment and autonomy. Staff will need considerable support from their employers if they are to successfully safeguard adults and empower those adults to express their own wishes and preferences. Employers should ensure they have policies and procedures in place to achieve this.

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<sup>24</sup> Section 14 Children Act 2004 and paragraph 5 of the Local Safeguarding Children Boards. Regulations 2006.

<sup>25</sup> House of Lords post legislative scrutiny report March 2014.

<sup>26</sup> Government response “Valuing Every Voice” June 2014.

All practitioners should be aware that additional procedural and substantive obligations arise when care provided to a person, who lacks the capacity to consent to those arrangements, constitute a deprivation of that person's liberty<sup>27</sup>.

### 3.1.4 Adults at risk of abuse or neglect

The legislation and guidance relevant to safeguarding adults at risk of abuse or neglect includes the following:

[Care Act 2014](#)

[Care and Support Statutory Guidance \(Chapter 14 – Safeguarding\)](#)

Further practice materials to support implementation of the Care Act have been commissioned and will be found on the [LGA website](#) as they are published.

There are some broad and fundamental safeguarding duties covering adult services, namely:

- Local authorities must promote the adult's "well-being"<sup>28</sup>. Within this broad concept, the authority must "have regard to the need to protect people from abuse and neglect"<sup>29</sup>.
- If a local authority has reasonable cause to suspect an adult in its area is suffering or is at risk of abuse and neglect, and has needs which leave him or her unable to protect himself or herself, then it must ensure enquiries are made in order to decide what action (if any) should be taken, and by whom (the "duty to enquire"<sup>30</sup>). Enquiries should be made by the most appropriate professional, and in some circumstances that will be a health professional.

In discharging these duties, there are express reciprocal duties to co-operate on local authorities and their "relevant partners", and that category includes NHS England, and all CCGs and health trusts in the local authority's area<sup>31</sup>.

Where the safeguarding action requires assessing an adult's needs, or the preparation or revision of care plans, or care and support plans, the local authority is under a duty to consider if the adult needs an independent advocate. The trigger is when the adult would experience substantial difficulty in understanding or retaining relevant information, or weighing that information as part of the decision-making process, or communicating their views<sup>32</sup>.

Each local authority must establish a Safeguarding Adults Board (SAB) in its area<sup>33</sup>. Its main objective is to help and protect those adults in its area. CCGs, working with

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<sup>27</sup> MCA 2005 Schedule A1 (the "Deprivation of Liberty Safeguards" or "DOLS") and as regards deprivation of liberty outside the scope of DOLS, e.g. in a community setting – see Cheshire West and Surrey, Supreme Court, 19 March 2014.

<sup>28</sup> Section 1(1) Care Act 2014.

<sup>29</sup> Section 1 (2) (c) Care Act 2014.

<sup>30</sup> Section 42 Care Act 2014.

<sup>31</sup> Section 6 and 7 Care Act 2014.

<sup>32</sup> Section 68 Care Act 2014.

<sup>33</sup> Section 43 Care Act 2014.

the health system, should ensure appropriate representation on the SAB. The local authority may include any other body it considers appropriate following consultation with other members<sup>34</sup>.

A SAB can arrange a safeguarding adult review whenever it chooses. However it must arrange one where an adult has died from or experienced serious abuse or neglect, and there is reasonable cause for concern about how those agencies and service providers involved worked together to safeguard the adult<sup>35</sup>. Core partners are required to contribute to such reviews when requested.

The Government has issued a [policy statement on adult safeguarding](#) which sets out six principles for safeguarding adults. Whilst not legal duties, these do represent best practice and provide a foundation for achieving good outcomes:

- Empowerment - presumption of person led decisions and consent.
- Protection - support and representation for those in greatest need.
- Prevention of harm or abuse.
- Proportionality and least intrusive response appropriate to the risk presented.
- Partnerships - local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- Accountability and transparency in delivering safeguarding.

### 3.2 Information sharing

Good information sharing practice is at the heart of good safeguarding practice. The area is covered by legislation, principally the Data Protection Act 1998, and by court decisions on issues of confidentiality and privacy. Professionals will wish to refer to specific advice from their professional body regarding information sharing e.g. GMC guidance; [http://www.gmc-uk.org/guidance/ethical\\_guidance/13388.asp](http://www.gmc-uk.org/guidance/ethical_guidance/13388.asp) or NMC Code section 5; [NMC Code 2105](#). This is further supported by the newly updated Caldicot Guidelines, principle seven which individuals are informed that the duty to share information can be as important as the duty to protect patient confidentially, this is described in further detail at [Information to share or not to share - DH](#). It is very important to understand that sharing information when there is a need to share it and maintaining its security and confidentiality are compatible activities.

At its heart is the principle that information should be shared if that helps to protect children or adults, or to prevent a crime (abuse and many cases of neglect are crimes). In addition, there are some specific statutory provisions (for example relating to the operation of LSCBs, and SABs, and relating to the statutory scheme for vetting and barring) which require information sharing<sup>36</sup>.

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<sup>34</sup> Schedule 2 Care Act 2014.

<sup>35</sup> Section 44 Care Act 2014.

<sup>36</sup> Section 14B Children Act 2004; sections 37 and 40 Safeguarding Vulnerable Groups Act 2006; section 45 Care Act 2014.



### 3.2.1 Vetting and barring

There is a statutory scheme for vetting people working with children and adults at risk of abuse or neglect. It is administered by the Disclosure and Barring Service. The system provides for checks on people entering the workforce, and maintains lists of individuals who are barred from undertaking regulated activity with either children or adults at risk of abuse or neglect.

### 3.2.2 Domestic Violence, Crime and Victims Act 2004

Statutory guidance places a duty on Community Safety Partnerships to make arrangements for Domestic Homicide Reviews. Health bodies are required to participate in these as requested<sup>37</sup>.

### 3.2.3 Fit and proper persons test

There are new legal requirements that board level appointments of NHS trusts, foundation trusts and special health authorities are “fit and proper persons”. This excludes individuals who have been involved in “any serious misconduct or mismanagement”. Clearly, safeguarding falls within that definition<sup>38</sup>.

### 3.2.4 Duty of candour

Good safeguarding practice requires openness, transparency and trust. There is a legal “duty of candour” on health service bodies<sup>39</sup>. This is detailed in the DH paper [“Introducing the Statutory Duty of Candour”](#) following the Francis inquiry.

There is an overall duty that health service bodies “must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity”.

In addition, there is a specific duty triggered by a “notifiable safety incident”, where any “unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity” has caused, or could cause, death, severe, or moderate harm, or prolonged psychological harm, defined in detail in the Regulations. In this case, there is a duty to tell people (both in person and in writing), explain, apologise, and advise on any action taken as a result.

### 3.2.5 Statutory reviews

A number of statutory reviews are required to be undertaken by relevant health agencies when particular circumstances arise. The different types of review include:

- Domestic homicide review: convened by the local community safety partnership when the defined criteria has been met following the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect.

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<sup>37</sup> Section 9 Domestic Violence, Crime and Victims Act 2004.

<sup>38</sup> Regulation 5, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

<sup>39</sup> Regulation 20, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Safeguarding adult review: convened by a SAB for every case where an adult has died from, or experienced serious abuse or neglect, and there is reasonable cause for concern about how agencies and service providers involved worked together to safeguard the person.
- Serious case review: convened by a LSCB for every case where abuse or neglect is known or suspected and either: a child dies; or a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child;
- Child death review: a review of all child deaths up to the age of 18.

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

Health commissioners will provide a panel member, provide oversight of health involvement at panel meetings, ensure that recommendations and actions are achievable, and disseminate learning across the NHS locally. NHS England may support panel chairs where lessons learned have wider implications and need co-ordinated national action and/or where there are obstacles to full NHS participation which require a range of relationship, contractual and professional influences.

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

## **4 Roles and responsibilities**

Safeguarding children and adults at risk of abuse or neglect is a collective responsibility. This section provides greater clarity around the individual roles and responsibilities of the different elements of the system. These are summarised and mapped to the health commissioning system in figure 1 at Annex A.

### **4.1 Health Providers**

#### **4.1.1 Health and care professionals**

All staff, whether they work in a hospital, a care home, in general practice, or in providing community care, and whether they are employed by a public sector, private or not-for-profit organisation, have a responsibility to safeguard children and adults at risk of abuse or neglect in the NHS.

### 4.1.2 Provider leadership

Health providers are required to demonstrate that they have safeguarding leadership, expertise and commitment at all levels of their organisation and that they are fully engaged and in support of local accountability and assurance structures, in particular via the LSCBs, SABs and in regular monitoring meetings with their commissioners.

Health providers must ensure staff are appropriately trained in safeguarding adults, children, Prevent, domestic violence, the MCA and deprivation of liberty<sup>40</sup> at a level commensurate with their role and in line with the intercollegiate document 2014, and future guidance that may be produced to support training of staff. It is strongly recommended that safeguarding forms part of any mandatory training in order to develop and embed a culture within their organisation that ensures safeguarding is acknowledged to be everybody's business from "the board to the floor".

All health providers are required to have effective arrangements in place to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators and their commissioners that these are working. These arrangements include:

- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or vulnerable children as appropriate.
- A suite of safeguarding policies including a chaperoning policy.
- Effective training of all staff commensurate with their role and in accordance with the intercollegiate competences 2014.
- Effective supervision arrangements for staff working with children / families or adults at risk of abuse or neglect.
- Effective arrangements for engaging and working in partnership with other agencies.
- Identification of a named doctor and a named nurse (and a named midwife if the organisation provides maternity services) for safeguarding children. In the case of out of hours services, ambulance trusts and independent providers, this could be a named professional from any relevant health or social care background.
- Identification of a named lead for adult safeguarding and an MCA lead – this must include the statutory role for managing adult safeguarding allegations against staff.
- Developing an organisational culture such that all staff are aware of their personal responsibility to report concerns and to ensure that poor practice is identified and tackled.

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<sup>40</sup> MCA 2005 Schedule A1 (the "Deprivation of Liberty Safeguards" or "DOLS") and as regards deprivation of liberty outside the scope of DOLS, e.g. in a community setting – see Cheshire West, Supreme Court, 19 March 2014.

- Policies, arrangements and records to ensure consent to care and treatment is obtained in line with legislation and guidance including the MCA 2005 and the Children Act 1989/2004.

All providers of health services are required to be registered with the Care Quality Commission (CQC). In order to be registered, providers must ensure that those who use the services are safeguarded and that staff are suitably skilled and supported. This includes private healthcare providers. NHS trusts without foundation trust status are also accountable to the NHS Trust Development Authority.

### **4.1.3 Named professionals (health providers)**

Named professionals have a key role in promoting good professional practice within their organisation, supporting the local safeguarding system and processes, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place. They should work closely with their organisation's safeguarding lead, Designated Professionals and the LSCB/SAB.

All providers are required to have an MCA lead who is responsible for providing support and advice to clinicians in individual cases and supervision for staff in areas where these issues may be particularly prevalent and/or complex. They should also have a role in highlighting the extent to which their own organisation is compliant with the MCA through undertaking audit, reporting to the governance structures and providing training. The named lead(s) will work closely with the CCG adult safeguarding lead. GP practices are required to have a lead for safeguarding and MCA, who should work closely with named GPs and adult safeguarding lead. In some instances this role may be covered by the named professional.

## **4.2 Commissioners**

### **4.2.1 Clinical Commissioning Groups**

CCGs are statutory NHS bodies with a range of statutory duties, including safeguarding adults and children. They are membership organisations that bring together general practices to commission services for their registered populations and for unregistered patients who live in their area. CCGs are responsible for commissioning most hospital and community healthcare services. Initially in the reformed NHS CCGs were not directly responsible for commissioning primary medical care (or other primary care services), but they have a duty to support improvements in the quality of primary medical care. Further to this, co-commissioning arrangements between CCGs and NHS England are being put in place from 2015/16 and the implications for safeguarding duties are set out below.

CCGs as commissioners of local health services need to assure themselves that the organisations from which they commission have effective safeguarding arrangements in place. CCGs are responsible for securing the expertise of Designated Professionals on behalf of the local health system. It should be recognised that the Designated Professionals and Adult Safeguarding Leads undertake a whole health economy role. It is crucial that Designated Safeguarding Professionals play an integral role in all parts of the commissioning cycle, from procurement to quality

assurance if appropriate services are to be commissioned that support adults at risk of abuse or neglect, and children, as well as effectively safeguard their well-being.

Safeguarding forms part of the NHS standard contract (service condition 32) and commissioners will need to agree with their providers, through local negotiation, what contract monitoring processes are used to demonstrate compliance with safeguarding duties.

CCGs must gain assurance from all commissioned services, both NHS and independent healthcare providers, throughout the year to ensure continuous improvement. Assurance may consist of assurance visits, section 11 audits<sup>41</sup> and attendance at provider safeguarding committees.

CCGs are also required to demonstrate that they have appropriate systems in place for discharging their statutory duties in terms of safeguarding. These include:

- A clear line of accountability for safeguarding, properly reflected in the CCG governance arrangements, i.e. a named executive lead to take overall leadership responsibility for the organisation's safeguarding arrangements.
- Clear policies setting out their commitment, and approach, to safeguarding including safe recruitment practices and arrangements for dealing with allegations against people who work with children and adults as appropriate.
- Training their staff in recognising and reporting safeguarding issues, appropriate supervision and ensuring that their staff are competent to carry out their responsibilities for safeguarding.
- Effective inter-agency working with local authorities, the police and third sector organisations which includes appropriate arrangements to cooperate with local authorities in the operation of LSCBs, SABs and Health and Wellbeing Boards.
- Ensuring effective arrangements for information sharing.
- Employing, or securing, the expertise of Designated Doctors and Nurses for Safeguarding Children and for Looked After Children and a Designated Paediatrician for unexpected deaths in childhood.
- Having a Designated Adult Safeguarding Manager (DASM) which should include the Adult Safeguarding lead role and a lead for the MCA, supported by the relevant policies and training.
- Effective systems for responding to abuse and neglect of adults.
- Supporting the development of a positive learning culture across partnerships for safeguarding adults to ensure that organisations are not unduly risk averse.

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<sup>41</sup> Section 11 Children Act 2004.

- Working with the local authority (LA) to enable access to community resources that can reduce social and physical isolation for adults.

The role of CCGs is also fundamentally about working with others to ensure that critical services are in place to respond to children and adults who are at risk or who have been harmed, and it is about delivering improved outcomes and life chances for the most vulnerable. CCGs need to demonstrate that their Designated Clinical Experts (children and adults), are embedded in the clinical decision making of the organisation, with the authority to work within local health economies to influence local thinking and practice.

#### **4.2.2 Designated Professionals and Adult Safeguarding Leads**

CCGs are responsible for securing the expertise of Designated Professionals on behalf of the local health system. Therefore, it is expected that many Designated Professionals will be employed by CCGs. In some areas there will be more than one CCG per local authority and LSCB/SAB area, and CCGs may want to consider developing 'lead' or 'hosting' arrangements for their Designated Professional team, or a clinical network arrangement. Where a Designated Professional (most likely a Designated Doctor for Safeguarding or a Designated Professional for Looked After Children) is employed within a provider organisation, the CCG will need to have a Service Level Agreement (SLA), with the provider organisation that sets out the practitioner's responsibilities and the support they should expect in fulfilling their designated role.

The Designated Professional's role is to work across the local health system to support other professionals in their agencies on all aspects of safeguarding and child protection. Designated Professionals are clinical experts and strategic leaders for safeguarding and as such are a vital source of advice and support to health commissioners in CCGs, the local authority and NHS England, other health professionals in provider organisations, quality surveillance groups (QSG), regulators, the LSCB/SAB and the Health and Wellbeing Board.

Whatever arrangements are in place for securing the expertise of Designated Professionals it is vital that CCGs enable and support Designated Professionals to fulfil their system-wide role.

#### **4.2.3 Designated Professionals (children)**

Further details on the Designated Professional role for safeguarding children include:

- The role of Designated Professionals for safeguarding children should always be explicitly defined in job descriptions, and sufficient time, funding, supervision and support should be allowed to enable them to fulfil their child safeguarding responsibilities across the wider system effectively.
- Model job descriptions and person specifications which can be found in the intercollegiate document, [Safeguarding Children and Young People: roles and competences for healthcare staff](#)

- CCG representatives at the LSCB must be accompanied by their Designated Professional to ensure their professional expertise is effectively linked into the local safeguarding arrangements.
- Designated Professionals are responsible for undertaking serious case reviews/ case management reviews/significant case reviews on behalf of health commissioners and for quality assuring the health content.
- Designated Professionals must be consulted and able to influence at all points in the commissioning cycle to ensure all services commissioned meet the statutory requirement to safeguard and promote the welfare of children.
- Designated Professionals are responsible for providing expert advice to HEE and Local Education and Training Boards to ensure that the principles of safeguarding are integral to education and training curricula for health professionals.
- Designated Professionals are expected to give clinical advice, for example in complex cases or where there is dispute between practitioners.
- Clear accountability and performance management arrangements are essential. These need to account for the particular working arrangements but key elements of this are:
  - As single subject experts, peer-to-peer supervision is vital to ensuring Designated Professionals continue to develop their practice in line with agreed best practice. Designated Professionals are required to attend supervision meetings regularly with a lack of attendance raised as a professional concern in the annual appraisal and review process. These supervision meetings are to be formally minuted and preferably professionally facilitated.
  - The Designated Professional must have direct access to the Executive (Board level) Lead to ensure that there is the right level of influence of safeguarding on the commissioning process.
  - The CCG Accountable Officer (or other executive level nominee) should meet regularly with the Designated Professional to review child safeguarding.
  - Where Designated Doctors, in particular, are continuing to undertake clinical duties in addition to their clinical advice role in safeguarding, it is important that there is clarity about the two roles and the CCG will need to be able to input into the job planning, appraisal and revalidation processes. Designated Doctors may liaise with the Regional Medical Director on those occasions that need solely medical professional consideration.

#### **4.2.4 Designated Adult Safeguarding Manager (DASM)**

As a member of the Safeguarding Adults Board CCGs are specifically required by statutory guidance<sup>42</sup> to have a Designated Adult Safeguarding Manager (DASM).

The DASM will support all activity required to ensure that the organisation meets its responsibilities in relation to safeguarding adults. The DASM will offer support and advice to the Board member responsible for adult safeguarding. The DASM will ensure the regular provision of training to the staff and Board of the CCG. The DASM will be a source of expertise and advice to those working in the CCG. He or she will be able to advise the local authority, police and other organisations on health matters in relation to adult safeguarding.

Specific responsibilities of the DASM will include:

- Responsibility for the management and oversight of individual complex cases.
- Coordination where allegations are made, or concerns raised, about a person, whether an employee, volunteer or student, paid or unpaid.
- Promoting partnership working and keeping in regular contact with their counterparts in partner organisations.
- Assessing and highlighting the extent to which their own organisation prevents abuse and neglect taking place.
- Ensuring that appropriate recording systems are in place that provide clear audit trails about decision making and recommendations in all processes relating to the management of adult safeguarding allegations against the person alleged to have caused the harm or risk of harm and ensure the control of information in respect of individual cases is in accordance with accepted data protection and confidentiality requirements.

It is recommended that the DASM role also incorporates the safeguarding adult lead role as required through the CCG authorisation process and that this combined role has a strategic overview of safeguarding adults across the local health economy.

The role of the safeguarding adult lead is to:

- Support and advise commissioners, including CCGs, NHS England and public health on adult safeguarding within contracts and commissioned services and in securing assurance from providers that they have effective safeguarding arrangements in place.
- Provide advice to commissioned services on how to improve systems for safeguarding adults.

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<sup>42</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/315993/Care-Act-Guidance.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf)



- Provide guidance on identifying adults at risk from different sources and in different situations.
- Understand and embed the routes of referral for adults at risk across the health system.
- Provide a health advisory role to the Safeguarding Adults Board (SAB), supporting the CCG SAB member.
- Take a lead for health in working with the SAB to undertake safeguarding adult reviews and take forward any learning for the health economy.

The DASM needs to have a broad knowledge of healthcare for older people, those with dementia, learning disabilities, mental health issues and/or care leavers. Where further guidance is published on the role and competencies for the DASM then this should be followed.

#### **4.2.5 Designated MCA lead**

CCGs are required to have a Designated MCA lead who is responsible for providing support and advice to clinicians in individual cases and supervision for staff in areas where these issues may be particularly prevalent and/or complex. They should also have a role in highlighting the extent to which their own organisation, and the services that they commission, are compliant with the MCA through undertaking audit, reporting to the governance structures and providing or securing the provision of training.

#### **4.2.6 Co-commissioning arrangements**

Co-commissioning arrangements are being introduced from April 2015 and provide a number of different models for involving CCGs in the commissioning of primary care services – greater involvement of CCGs, joint commissioning or delegated arrangements.

Under delegated arrangements, CCGs will be responsible for ensuring that the GP services commissioned have effective safeguarding arrangements and are compliant with the MCA. NHS England will require assurance that such arrangements are in place before CCGs take on such responsibility. The overall effectiveness of CCGs in discharging their safeguarding and MCA duties will also be monitored as part of the CCG assurance process.

### 4.3 NHS England

The general function of NHS England is to promote a comprehensive health service so as to improve the health outcomes for people in England. NHS England discharges its responsibilities by:

- Allocating funds to, guiding and supporting CCGs, and holding them to account.
- Directly commissioning primary care<sup>43</sup>, specialised health services, health care services for those in secure and detained settings, and for serving personnel and their families, and some public health services<sup>44</sup>.

The mandate from Government sets out a number of objectives which NHS England is legally obliged to pursue. The objectives relevant to safeguarding are:

*Objective 13 - NHS England's objective is to ensure that Clinical Commissioning Groups (CCGs) work with local authorities to ensure that adults at risk of abuse or neglect, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care.*

*Objective 23 - NHS England's objective is to make partnership a success. This includes, in particular, demonstrating progress against the Government's priorities of:*

*Continuing to improve safeguarding practice in the NHS.*

*Contributing to multi-agency family support services for adults at risk of abuse or neglect and troubled families.*

*Contributing to reducing violence, in particular by improving the way the NHS shares information about violent assaults with partners, and supports victims of crime.*

There is further narrative within the mandate that provides detail on the expectations of the Government:

*"We expect to see the NHS, working together with schools and children's social services, supporting and safeguarding vulnerable, looked-after and adopted children, through a more joined-up approach to addressing their needs."*

NHS England's overall roles in terms of safeguarding are direct commissioning and assurance and system leadership.

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<sup>43</sup> The primary care commissioner may not be NHS England where some co-commissioning arrangements between CCGs and NHS England are in place.

<sup>44</sup> Commissioning of health visiting and family nurse partnerships transfers to local authorities in October 2015.

### **4.3.1 Direct commissioning**

NHS England ensures that safeguarding duties are met in relation to the services that it directly commissions, such as primary care and specialised services. The duties are set out in section 4.3.2.

### **4.3.2 Assurance and system leadership**

NHS England ensures that the health commissioning system as a whole is working effectively to safeguard adults at risk of abuse or neglect, and children. NHS England is the policy lead for NHS safeguarding, working across health and social care, including leading and defining improvement in safeguarding practice and outcomes. Key roles are:

- Provide leadership support to safeguarding professionals – including working with Health Education England (HEE) on education and training of both the general and the specialist workforce.
- Ensure the implementation of effective safeguarding assurance arrangements and peer review processes across the health system from which assurance is provided to the Board.
- Provide specialist safeguarding advice to the NHS.
- Lead a system where there is a culture that supports staff in raising concerns regarding safeguarding issues.
- Ensure that robust processes are in place to learn lessons from cases where children or adults die or are seriously harmed and abuse or neglect is suspected.
- Ensure that locally NHS England teams are appropriately engaged in the Local Safeguarding Boards and any local arrangements for safeguarding both adults and children, including effective mechanisms for LSCBs, SABs and Health and Wellbeing Boards to raise concerns about the engagement and leadership of the local NHS.

This role is discharged through the Chief Nursing Officer (CNO) who has a national safeguarding leadership role. The CNO is the Lead Board Director for Safeguarding and has a number of forums through which to gain assurance and oversight, particularly through the NHS England National Safeguarding Steering Group (NSSG).

The arrangements and processes through which NHS England provide oversight and assurance with regard to the effectiveness of safeguarding arrangements across the system are set out in Annex B.

### **4.3.3 Direct commissioning: safeguarding role**

NHS England is responsible for commissioning primary care, specialised services, health care services in justice, health services for armed forces and families and some public health services<sup>45</sup>. As a commissioner of health services, NHS England needs to assure itself that the organisations from which it commissions have effective safeguarding arrangements in place.

In addition, in relation to primary care<sup>46</sup> NHS England is responsible for ensuring, in conjunction with local CCG clinical leaders, that there are effective arrangements for the employment and development of Named GP/Named Professional capacity for supporting primary care within the local area. This capacity is funded through the primary care budget but it is for local determination exactly how this is done and what employment arrangements are adopted. Further detail on the Named GP/Named Professional role is set out below.

NHS England supports training for primary care by providing access to safeguarding training through available e-learning products, expertise from the Named GP/Named professional for primary care, access to Safeguarding Board training and support through the primary care safeguarding toolkit. (RCGP/NSPCC).

### **4.3.4 Named GP/Named Professional (primary care)**

Named GPs/Named Professionals have a key role in promoting good professional practice, providing advice and expertise for fellow professionals, and ensuring appropriate safeguarding training is in place. The Named GP/Named Professional capacity commissioned locally needs to reflect local needs as set out within the joint strategic needs assessment (JSNA) and in discussion with the Local Safeguarding Children Board. The criteria outlined below give further guidance to inform the precise nature of the local workforce; however, it is strongly recommended that two Named GP sessions per 220,000 population is secured as a minimum.

Broadly the role of the Named GP/Named Professional includes:

- Providing specific expertise on child health and development and in the care of families in difficulty as well as children who have been abused or neglected.
- Providing supervision, expert advice and support to GPs and other primary care staff in child protection issues.
- Offering advice on local arrangements with provider organisations for safeguarding children.
- Promoting, influencing and developing relevant training for GPs and their teams.

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<sup>45</sup> Commissioning of health visiting and family nurse partnerships transfers to local authorities in October 2015.

<sup>46</sup> The primary care commissioner may not be NHS England where some co-commissioning arrangements between CCGs and NHS England are in place.

- Providing input as a skilled professional to child safeguarding processes, in line with the procedures of Local Safeguarding Children Boards.
- Taking a lead in writing the general practice components of serious case reviews, independent management reviews, SAAF, section 11 and multi-agency audits.
- Supporting processes required by regulator unannounced and announced single and multi-agency inspections.
- Working with commissioners to develop and improve the quality of safeguarding arrangements locally.
- Supporting and encouraging collaborative working across the local safeguarding system with a particular role to work with the nominated safeguarding leads in GP practices.

Training, experience and qualification requirements for Named GPs/Named Professionals are set out in the intercollegiate document "[Safeguarding children and young people: roles and competences for health care staff](#)".

A role description specific to Named GPs is found within the [RCGP/NSPCC Safeguarding Children Toolkit 2014](#) and a competency framework is set out in "[Guidance and Competences for the Provision of Services Using Practitioners with Special Interests \(PwSIs\) Safeguarding Children and Young People](#)".

On-going training and personal development of practitioners with a special clinical interest is important and will require the specialist education as well as access to relevant peer support. It is crucial that if Named GPs/Named Professionals are to fulfil their role effectively that they are provided with a clear line of management accountability and responsibility, this must be agreed with the individual Named Professional in line with the precise employment arrangement adopted.

Whilst the Named GP role covers safeguarding of children and young people only it is recommended that NHS England/primary care commissioners and local CCG clinical leaders consider commissioning a cluster model of named safeguarding clinicians with a range of expertise. This could include child safeguarding, safeguarding people of all ages with mental health issues, physical disability, special educational needs, learning difficulties and learning disability, safeguarding looked after children and care leavers, adult safeguarding including domestic abuse, safeguarding in elderly care and dementia, and safeguarding in institutions including care homes.

### **4.3.5 Assurance of CCGs: safeguarding role**

NHS England has a statutory requirement to oversee assurance of CCGs in their commissioning role. This is done through the application of the CCG Assurance Framework.

This involves formal assurance reviews carried out quarterly in line with the published framework and technical guidance, which includes a number of domains of assurance and a delivery dashboard of indicators that reflect the planning guidance requirements<sup>47</sup>. Safeguarding is a fundamental element of commissioning plans as set out in the planning guidance<sup>48</sup> and, therefore, is an area that forms a core part of the commissioning assurance process.

NHS England in conjunction with CCGs also needs to consider where there are risks and gaps in services to develop an action plan to mitigate against the risk.

### **4.3.6 Local authority commissioners**

The commissioning of public health services for children is undertaken by local authorities and includes sexual health services, school nursing services, and, from October 2015, health visiting and family nurse partnership services. These health services have an integral role in safeguarding children and young people which should be clearly reflected within the relevant service specifications.

As commissioners of these health services, local authorities should liaise with the relevant Designated Professional as part of their assurance process to ensure that effective safeguarding arrangements are in place within these services to safeguard children and young people.

As with all organisations which are subject to the Children Act 2004 section 11 duty, local authorities are responsible for ensuring that their staff receive appropriate supervision and support, including undertaking safeguarding training. This applies to professionals delivering public health services commissioned by local authorities.

## **4.4 Other national organisations**

### **4.4.1 Department of Health (DH)**

The Department of Health (DH) provides strategic leadership for public health, the NHS and social care in England. It sets the strategic direction for the NHS, based on outcomes, and will hold it to account for achievements. DH assesses NHS England's performance against the mandate including the specific safeguarding elements. It also ensures that all parts of the health and care system work in partnership and collaboratively and convenes a number of national groups to support this.

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<sup>47</sup> <http://www.england.nhs.uk/ourwork/sop/>

<sup>48</sup> <http://www.england.nhs.uk/wp-content/uploads/2014/12/plan-guid-nhse-annx-231214.pdf>

DH convenes two specific safeguarding stakeholder groups, one for children and one for adults. Membership of these groups includes representatives from across government departments, regulators and Arm Length Bodies. Both of these groups set out safeguarding policy, hold partners to account for implementing that policy and address specific national concerns.

#### **4.4.2 Public Health England (PHE)**

Public Health England (PHE) has a range of public health responsibilities to protect and improve the health and wellbeing of the population and to reduce health inequalities in health and wellbeing outcomes. PHE specific safeguarding duties in relation to the front-line delivery of services to individuals and families relate to its delivery of health protection services. PHE has a named doctor and nurse for safeguarding. Front-line services for the health protection function are delivered through nine PHE centres. PHE work with local arrangements for safeguarding, liaising with NHS England to access local expertise and advice.

Local Authorities (LAs) are held to account for the public health duties that are transferred to them, through local management structures and LSCBs/SABs in the usual way. They are able to access specialist support and advice via the CCG safeguarding team or the Safeguarding Forum.

PHE is responsible for supporting the on-going development of the public health workforce in LAs to inform commissioning of early years services and the on-going support and development of the children's public health nursing workforce – including school nursing, health visiting and family nurse partnerships.

#### **4.4.3 Health Education England (HEE)**

HEE supports the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce has the right numbers, skills, values and behaviours, at the right time and in the right place. HEE has a mandate commitment to ensure that the principles of safeguarding are integral to education and training curricula for health professionals. This primarily focuses on influencing the pre-registration training provided for health professionals and ensuring safeguarding is embedded into these programmes. HEE provider-led Local Education and Training Boards (LETBs) are responsible for local health workforce development and education commissioning in their areas. These boards are responsible for developing their own training priorities to meet locally identified needs including safeguarding as appropriate. Commissioned training should be in accordance with the intercollegiate guidance and LSCB/SAB requirements.

HEE supports NHS England to deliver their mandate through strategic leadership of education and training and workforce intelligence. Similarly NHS England works collaboratively with HEE to fulfil their commitment by providing support and specialist safeguarding advice as required. HEE maintains an e-learning platform within which safeguarding is embedded as appropriate and HEE ensures that this is kept up to date and is easily accessible across health.

## 4.5 Regulators

Regulation is an important element of the assurance and accountability arrangements in place across the health system. A number of organisations are involved and their roles and remit are set out in brief below. Regulators are in place and work at an individual and organisational level as well as looking across local safeguarding systems and assessing their effectiveness. Reports from regulators, as the independent watchdogs, provide an important source of intelligence which is used alongside other internal information by NHS England in providing assurance (see Appendix II) on the effectiveness of safeguarding arrangements in local health systems.

### 4.5.1 Care Quality Commission (CQC)

The Care Quality Commission (CQC) regulates and inspects health and social care services in England to make sure they meet fundamental standards of quality and safety. The CQC publishes reports on what they find including performance ratings to help people choose care.

The CQC role is to make sure that hospitals, care homes, dental and general practices and other care services in England provide people with safe, effective and high quality care, and to encourage them to improve. It carries out this role through:

- Checks it carries out during the registration process that all new care services must complete.
- Inspections.
- Monitoring a range of data sources that can indicate problems with services.

The CQC has appointed Chief Inspectors for hospitals, adult social care and primary and integrated care. CQC inspection teams include inspectors that specialise in particular areas of care and lead teams that include clinical and other experts and experts by experience (people with experience of care). CQC uses information and evidence in a focused and open way, including listening to people's views and experiences of care in order to predict, identify and respond quickly to services that are failing, or likely to fail.

Part of the CQC remit is protecting the interests of people whose rights have been restricted under the MCA. The inspection of the proper use of Deprivation of Liberty Safeguards and the MCA are given a high prominence.

CQC has powers to review how health services keep children safe and contribute to promoting the health and wellbeing of looked after children and care leavers. This evaluates the quality and effectiveness of local health arrangements provided within local authority areas. CQC also carries out thematic reviews which focus on specific aspects of care, for example a thematic review of the experience of children with complex physical health needs in transition to adult services was published in 2014.



#### **4.5.2 Office for Standards in Education, Children’s Services and Skills (Ofsted)**

Ofsted inspects and regulates services which care for children and young people, and those providing education and skills for learners of all ages. Specialist inspectors carry out inspections across a range of services including children homes, nurseries, schools, colleges, and local authorities. Safeguarding forms a core part of the Ofsted inspection framework and they draw together a range of evidence and other information to make their professional judgements which they publish in inspection reports.

Whilst many services inspected by Ofsted are not strictly within the health sector there are many areas of overlap, for example where health professionals work locally with children services. In addition, as part of their inspections of local authority services for children in need of help and protection, children looked after and care leavers, Ofsted may also undertake a review of the effectiveness of the LSCB at the same time. This looks at whether the LSCB is complying with its statutory responsibilities including the co-ordination of the work of statutory partners which for health are CCGs, health trusts and NHS England.

#### **4.5.3 Monitor**

Monitor ensures that the boards of NHS foundation trusts are well-led and financially sustainable, in line with their duty to be effective, efficient and economic<sup>49</sup>. In addition, it assesses the remaining NHS Trusts applications for foundation trust status. As the sector regulator, Monitor manages key aspects of healthcare regulation, including regulating prices, enabling services to be provided in an integrated way, safeguarding, choice and competition and supporting commissioners so that they can ensure essential health services continue to run if a provider gets into financial difficulties.

In 2013, Monitor introduced the NHS provider licence for NHS foundation trusts, extending this to other eligible providers of NHS-funded care in 2014. The licence sets out a range of conditions that providers must meet.

The provider licence requires NHS foundation trusts to:

*“Establish and effectively implement systems and/or processes... to ensure compliance with healthcare standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board<sup>50</sup> and statutory regulators of healthcare professions.”*

This includes the essential standard on safeguarding monitored by CQC. Where foundation trusts are not compliant with this standard, Monitor may investigate, and could find the foundation trust in breach of its licence and take enforcement action.

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<sup>49</sup> Section 63 NHS Act 2006.

<sup>50</sup> NHS Commissioning Board is the legal name for NHS England.

#### **4.5.4 NHS Trust Development Authority (NHS TDA)**

The role of the NHS Trust Development Authority (NHS TDA) is to provide oversight and performance management of NHS Trusts in England, all of which have a duty to be effective, efficient and economic<sup>51</sup>. This involves a central focus on quality, including the expectation that trusts will have proper systems in place for child and adult safeguarding. The NHS TDA also has responsibility for the appointment of Board positions and the approval of foundation trust applications moving to Monitor.

In this context, the NHS TDA plays a significant role in the assurance and support system for all non-foundation trusts, working closely with commissioners and regulators via mechanisms such as QSGs and risk summits which involve safeguarding.

#### **4.5.5 Professional regulators<sup>52</sup>**

Health and social care professionals who work in the UK must be registered with one of 12 professional regulatory bodies. These organisations regulate individual professionals across the UK. In order to practice health and social care, professionals must be registered with the relevant regulator and demonstrate that they have the right skills and meet the standards given in the code of conduct or code of practice for their profession. Each regulator maintains a public register of those professionals who have demonstrated that they have met the standards set. These organisations investigate complaints and can take action to stop a professional working in all or part of the UK where there are serious concerns about a professional's ability to provide safe treatment or care.

#### **4.5.6 Quality Surveillance Groups**

The Quality Surveillance Groups (QSGs) support the discharge of local accountabilities for quality and for sharing non-personal information and intelligence in order to improve quality and safety. The key strength of the QSGs is that they draw together organisations with commissioning and regulatory roles to share their respective information and intelligence. Whilst they do not have any formal powers, members of the QSG can take action in line with their existing responsibilities. Published guidance<sup>53,54</sup> sets out in more detail how the groups operate including the QSG role for safeguarding and their links to other safeguarding bodies.

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<sup>51</sup> Section 26 NHS Act 2006.

<sup>52</sup> [http://www.gmc-uk.org/Who\\_regulates\\_health\\_and\\_social\\_care\\_professionals\\_English\\_1112.pdf\\_50487974.PDF](http://www.gmc-uk.org/Who_regulates_health_and_social_care_professionals_English_1112.pdf_50487974.PDF)

<sup>53</sup> How to establish a quality surveillance group <http://www.dh.gov.uk/health/2013/01/establish-qsg>

<sup>54</sup> How to make your quality surveillance group effective <http://www.england.nhs.uk/wp-content/uploads/2014/03/quality-surv-grp-effective.pdf>

Most notably:

- QSGs should routinely consider whether information and/or intelligence shared at the QSG may be relevant to the roles and functions of Safeguarding Boards, Health and Wellbeing Boards and Local Authority Overview and Scrutiny Committees. Where necessary, QSGs need to make sure that they have mechanisms in place to share any such information and intelligence.
- It is expected, however, that each QSG member would recognise their own responsibility for making referrals into either the safeguarding adults or safeguarding children process in their local area to ensure the protection of a child or adult at risk.

#### **4.5.7 Safeguarding networks**

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

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

#### **4.5.8 Multi-agency Boards – Local Authority led**

At a local level there are the multi-agency boards set out by statute including LSCBs and SABs whose roles are described in sections 3.1.1 and 3.1.4. There are also Health and Wellbeing Boards which have overall strategic responsibility for assessing local health and wellbeing needs in the joint strategic needs assessment (JSNA) and agreeing joint health and wellbeing strategies for each local authority area. They play

a vital role locally in identifying and ensuring that the needs of children and adults at risk of abuse or neglect are identified and addressed. The JSNA supports the commissioning of services so that effective coordinated help can be provided to those at risk and their families.

The exact relationship between LSCBs/SABs and Health and Wellbeing Boards is for local determination. However, it is important that the boards are complementary. The LSCB/SAB should not be subordinate to, or subsumed within, local structures that might compromise its separate identity and voice. NHS commissioners and providers are responsible for understanding these arrangements and ensuring that they are fully engaged and working effectively to support them.

## **5 Conclusion**

The safeguarding of all those who are vulnerable is an enormous obligation for all of us who work in the NHS and partner agencies. Safeguarding children and adults at risk of abuse or neglect is complex, frequently under review and we must all take responsibility to ensure that it works effectively.

Safeguarding is everyone's responsibility. Fundamentally it remains the responsibility of every NHS organisation and each individual healthcare professional working in the NHS to ensure that the principles and duties of safeguarding adults and children are holistically, consistently and conscientiously applied with the needs of adults at risk of abuse or neglect at the heart of all that we do.

Partnership working is also key and it is vital that local practitioners continue to develop relationships and work closely with colleagues across their local safeguarding system to develop ways of working that are collaborative, encourage constructive challenge and enable learning in a sustainable and joined-up way.

NHS England will continue to seek assurance that the safeguarding arrangements across the health system are effective.

## 6 APPENDIX 1

Healthcare commissioners must have:  
 Designated Professional (DP) for safeguarding children and a safeguarding adults lead and lead for MCA - or arrangements to access advice from DP to support commissioning activity  
 Executive lead for safeguarding, effective policies and procedures, safer recruitment, training, supervision and reporting arrangements for safeguarding adults and children that link to local procedures for the LSCB/SAB  
 Arrangements to ensure services they commission are safe for children and adults at risk of abuse or neglect  
 Arrangements to ensure the health commissioning system as a whole is working effectively - disseminating policy and escalating key issues and risks

Primary care commissioners are required to:  
 Ensure Named GP/ Named Professional capacity is secured to support primary care services in discharging their safeguarding duties  
 Ensure arrangements are in place for training primary care professionals

Healthcare service providers must have:  
 Named doctor, named nurse and named midwife\* or other named professional for safeguarding children  
 Named lead for safeguarding adults, MCA and Prevent  
 GP practices must have a named lead for safeguarding and MCA  
 Executive lead for safeguarding, effective policies and procedures, safer recruitment, training, supervision and reporting arrangements for safeguarding adults and children that link to local procedures for the LSCB/SAB  
 \* If maternity services are provided

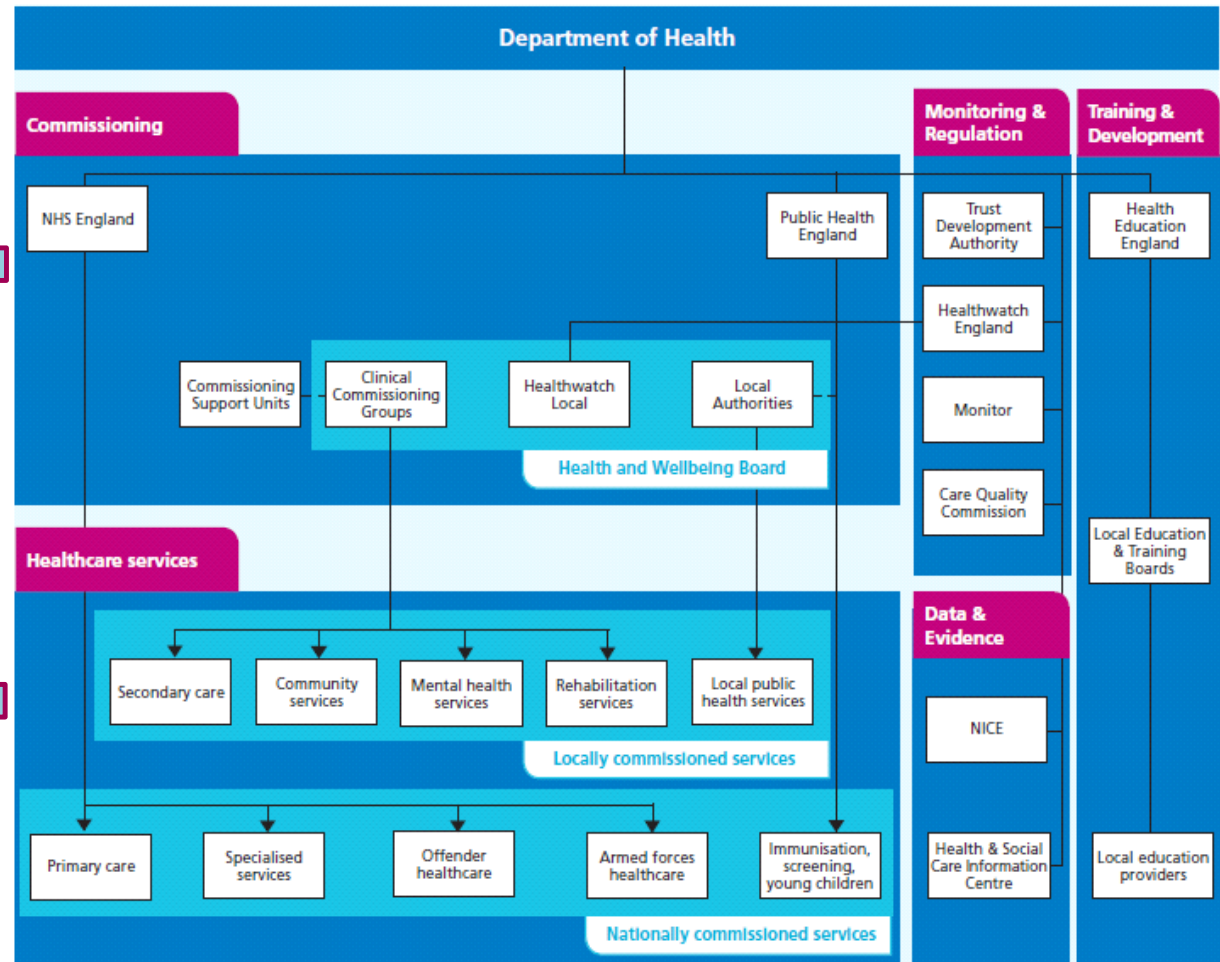


Figure 1: Summary of safeguarding duties

# 7 APPENDIX 2

## 7.1 How NHS England maintains oversight of safeguarding

NHS England’s role in terms of safeguarding is discharged through the Chief Nursing Officer (CNO) who has a national safeguarding leadership role. The CNO is the Lead Board Director for Safeguarding and has a number of forums through which to gain assurance and oversight, particularly through the NHS England National Safeguarding Steering Group (NSSG). These groups and the governance arrangements are set out in figure 2 below.

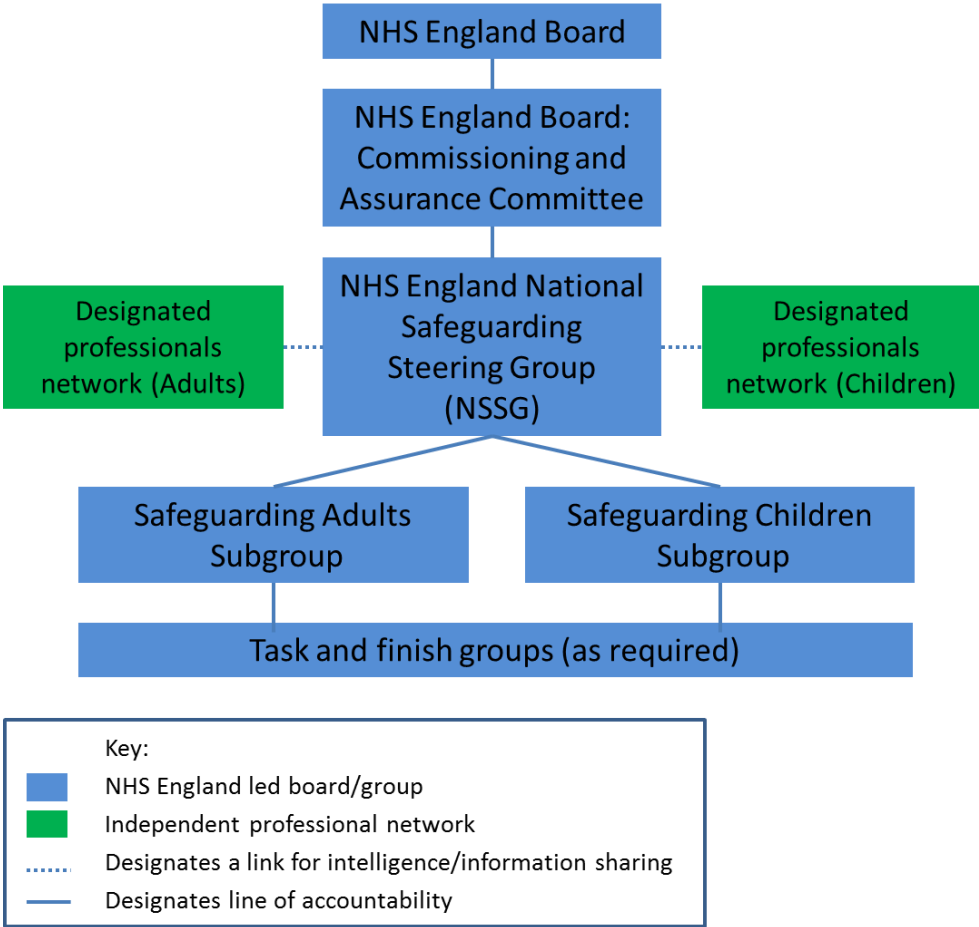


Figure 2: the Boards and Sub-groups for safeguarding

## 7.2 The NHS National Safeguarding Steering Group (NSSG)

The role of the NSSG is set out below. It discharges this through a range of temporary and permanent subgroups which focus on key issues using a risk-based approach. Membership of the NSSG includes representation from CCGs, provider trusts, and Designated/Named Professionals. The NSSG oversees and seeks assurance that agreed objectives and programmes of work are being met:

- Providing national leadership, support and advice in the delivery of the Accountability and Assurance Framework and continuing to revisit and challenge the safeguarding arrangements in place across the NHS system.
- Leading responsibility for policy on safeguarding and for overall assurance of the NHS safeguarding system including ensuring learning from, and taking action in response to, significant incidents.
- Adopting a shared learning approach, creating a repository for national best practice to be shared, and overseeing the delivery of the safeguarding leadership programmes.
- Providing national leadership, support and advice in the delivery of relevant recommendations from any national inquiries, investigations and reports.
- Ensuring that robust processes are in place to learn lessons from cases where children or adults die or are seriously harmed and abuse or neglect is suspected.
- Ensuring effective implementation across the NHS of national legislation and policies relating children and adults at risk of abuse or neglect.
- Identifying and taking forward action to respond to key priorities in relation to safeguarding adults and children, including but not limited to, preventing CSE (Child Sexual Exploitation), FGM (Female Genital Mutilation), Looked after Children, sexual violence domestic abuse and radicalisation (Prevent).

### 7.3 NHS England regions

Each NHS England region has a Regional Chief Nurse and a number of Directors of Nursing who have the leadership and governance role for safeguarding locally; setting direction, ensuring compliance with standards, policies and procedures, monitoring progress and managing risks. They involve, and work collaboratively with, other NHS England regional staff as required including commissioners, medical directors and those with a role in assuring the local system. The following section describes the roles and responsibilities for safeguarding at the regional level; however, it is for local discretion as to how these are actually discharged to suit local circumstances. Ultimately the Regional Chief Nurse is responsible for developing and implementing a local model that discharges all of the roles and responsibilities set out below:

- Providing assurance, via the National Safeguarding Steering Group (NSSG), to the NHS England Board on the effectiveness and quality of the safeguarding arrangements across the regional health system and determining whether these are meeting statutory duties.
- Disseminating national policy across the system.
- Escalating significant issues which may have system-wide relevance and/or require a national resolution to the National Safeguarding Steering Group

(NSSG). This includes any significant issues from serious case reviews, safeguarding adult reviews, domestic homicide reviews and other statutory processes.

- Convening a safeguarding network on a regular basis and ensuring significant issues which may have system-wide relevance are escalated, as appropriate, to quality surveillance groups and to the National Safeguarding Steering Group (NSSG).
- Ensuring effective arrangements are in place across the local NHS system in order to discharge safeguarding duties including information sharing, sharing best practice and embedding learning from incidents, as well as leading and defining improvement in safeguarding practice at a local level.
- Leading on delivering elements of the national safeguarding programme on behalf of the NSSG as appropriate.
- Ensuring effective systems are in place for responding to incidents of abuse and neglect of adults and children, making sure that when NHS England receives notification, a timely referral is made into either the local safeguarding adults or safeguarding children processes.
- Ensuring appropriate representation at LSCBs and SABs in the local area. This is for local determination using a risk-based approach. In agreeing local attendance arrangements the Regional Chief Nurse (or their nominee) will work closely with the LSCB/SAB chairs, CCGs and Designated Professionals to ensure any issues about the health system can be escalated. NHS England will only attend where there are specific concerns that require NHS England oversight or action, for example where an improvement board is in place. At other times NHS England will be represented by the Designated Professional or other agreed local representative with clear communication routes back to NHS England established.
- Ensuring NHS England staff are appropriately trained, supervised and competent to carry out their responsibilities for safeguarding.
- Ensuring safeguarding expertise is provided to support CCG assurance processes.
- Ensuring the provision of specialist safeguarding advice to NHS England commissioners, working with Designated Professionals as appropriate, to support them in commissioning services and monitoring contractors' performance, and to ensure compliance with safeguarding duties and the MCA. Where services are co-commissioned, arrangements must be agreed with the CCG as appropriate.
- Contributing safeguarding expertise to those maintaining the performers list and advising on any performance management concerns related to safeguarding.



- Working in partnership with the Local Education and Training Board (LETB) to highlight any safeguarding training needs and developing ways forward to meet these needs.

## 7.4 Safeguarding – Annual Assurance

The CNO is responsible for providing overall assurance to the NHS England Board on the effectiveness and quality of the safeguarding arrangements. Assurance is secured through an annual review process, the mechanism for achieving this is for local determination but the minimum requirements are set out below.

On an annual basis each Regional Chief Nurse will produce a report which provides assurance for their region across the following areas:

- The health commissioning system is working effectively to safeguard children and adults at risk of abuse or neglect.
- NHS England is meeting its specific safeguarding duties in relation to the services that it directly commissions.
- Robust processes are in place to learn lessons from cases where children or adults die or are seriously harmed and abuse or neglect is suspected.
- NHS England is appropriately engaged in the Local Safeguarding Boards and any local arrangements for safeguarding both adults and children, including effective mechanisms for LSCBs, SABs and Health and Wellbeing Boards to raise concerns about the engagement and leadership of the local NHS.

This report draws upon and critically assesses a range of intelligence and information from local sources including:

- Provider key performance indicators identified in the markers of good practice, section 11 audits and safeguarding adults assurance framework.
- Inspection findings.
- Statutory reviews that have taken place, including their findings and action plans.
- Regulation 28 reports<sup>55</sup>.
- Intelligence from CCG and direct commissioning assurance processes.
- Views of Designated Professionals.
- Feedback from LSCB/SAB chairs.

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<sup>55</sup> Paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and regulation 28 of the Coroners (Investigations) Regulations 2013, also known as reports to prevent future deaths or “PFD”.

- Contract monitoring processes.
- Complaints.

On an annual basis, the Head of Safeguarding, working closely with Regional Chief Nurses, will draw together an annual safeguarding assurance report which is reviewed and signed off by the National Safeguarding Steering Group. Any key findings are reported by exception to the NHS England Board Commissioning and Assurance Committee. The report has the dual purpose of providing assurance as well as enabling any themes, common issues, emerging trends and system-wide learning to be identified from across the health system.

Any issues identified through this process where a coordinated and/or system-wide response is needed, will be captured and monitored through the NSSG work programme and risk register. Where necessary, risks will be escalated via the governance route as set out in figure 2. Localised improvements are managed through local arrangements and infrastructure as appropriate.