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NHS England

Safeguarding children, young people and adults at risk in the NHS

Safeguarding accountability and assurance framework

Version 3, 21 July 2022

Contents

1. Foreword

Dear Colleagues,

It gives me great pleasure to present the third NHS England[1] *Safeguarding accountability and assurance framework* (SAAF). This framework builds on its predecessor by strengthening the NHS commitment to promoting the safety, protection and welfare of children, young people and adults.

This framework has been developed in partnership with other arm's length and professional bodies. It has been updated to reflect changes in policy and legislation since its last iteration and seeks to clarify the roles and responsibilities in relation to system working. In addition, it provides the flexibility needed at local level to support the professional practice of individuals and the partnerships needed to promote healthy behaviours to keep individuals and communities safe from harm.

2020/21 has seen huge changes in our communities, our providers and our NHS with COVID-19 lockdowns and with the transition to integrated care systems (ICSs), new ways of working and new legislation which will impact how we all safeguard people and populations.

As we write this 2022 SAAF, one thing we know is that these changes are not concluded and so our 2022 SAAF may well be subject to further iterations as we recover and rebuild from COVID-19. Indeed, you will note there is only limited mention of domestic abuse; liberty protection safeguards or tackling serious violence – this is because there may be Acts or draft legislation but there is no statutory guidance yet published.

I would like to take this opportunity to thank all those who have contributed to the development of the revised SAAF, and all who work with passion and professionalism to safeguard the health and wellbeing of our most at risk people.

Ruth May
Chief Nursing Officer, England

[1] Until 1 July 2022, the regulatory body referred to as 'NHS England' in this document will still be known as 'NHS England and NHS Improvement'. References to 'NHS England' should therefore be understood to mean 'NHS England and NHS Improvement' during this interim period.

2. Introduction

This document replaces *Safeguarding vulnerable people in the reformed NHS – Accountability and assurance framework* issued by the NHS Commissioning Board in July 2015 and updated in 2019. This section gives an overview of the importance of this document, which we now refer to as the *Safeguarding accountability and assurance framework* (SAAF)

2.1 Purpose of the document

The purpose of this document is to set out clearly the safeguarding roles and responsibilities of all individuals working in providers of NHS-funded care settings and NHS commissioning organisations. This SAAF 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 under the care of the NHS at risk of abuse or neglect
- clearly set out the legal framework for safeguarding children and adults as it relates to the various NHS organisations, in order to support them in discharging their statutory requirements to safeguard children and adults
- outline principles, attitudes, expectations, and ways of working that recognise that safeguarding is everybody's responsibility and that the safety and wellbeing of those in vulnerable circumstances are at the forefront of our business
- identify how NHS England regional and national teams work with integrated care board (ICB) accountable leadership and ICB place-based leadership to support partnerships
- identify clear arrangements and processes to be used to support evidence based practice and provide assurance at all levels, including NHS England Board, that safeguarding arrangements are in place
- promote equality by ensuring that health inequalities are addressed and are at the heart of NHS England values.

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 statutory functions for each organisation and its

executive board must therefore ensure effective discharge within agreed baseline funding. 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
- given regard to the need to reduce inequalities between patients in access to and the experience of and outcomes from healthcare services, and in securing that services are provided in an integrated way where this might reduce health inequalities
- given regard to all Articles of the Human Rights Act.

2.2 Scope

Effective safeguarding arrangements seek to prevent and protect individuals from harm or abuse, regardless of their circumstances. In the UK, the foundations of safeguarding legislation are held within the United Nations Convention on the Rights of the Child for children, and for adults, the European Convention on Human Rights as well as the Convention on the Rights of Persons with Disabilities (applicable to both adults and children) and to that effect, must underpin core business. The arrangements set out within this SAAF will apply whenever a child, young person or adult under the care of the NHS, is at risk of abuse or neglect, regardless of the source of that risk.

This framework has been structured to identify where there are core duties across the lifespan of safeguarding and also to identify where there are unique functions specific to children, young people transitioning into adults, children in care[2] and adults. This framework will be updated biennially[3] to reflect pending legislative reforms currently in parliament.

[2] Children in care: NHS Safeguarding has listened to the voice of children who live or have lived in care. As such, throughout this document the legislative term of 'looked after children' has been replaced with 'children in care' as this is how these children have asked to be referred to.

[3] There are currently important legislative changes being laid before Parliament apropos of tackling serious violence, the Victim Strategy and the Care Review among other matters impacting on safeguarding across the NHS. NHS Safeguarding is awaiting the statutory guidance on these programmes before adding to any future version of the SAAF. In light of this, we plan to update the SAAF every two to three years moving forward.

3. Legislation and mandatory reporting

Responsibilities for safeguarding are enshrined in international and national legislation. Safeguarding for both children and adults has transformed in recent years with the introduction of new legislation, creating duties and responsibilities which need to be incorporated into the widening scope of NHS safeguarding practice. Regardless of the developing context, all health organisations are required to adhere to the following arrangements and legislation.

<table>
<tr><th colspan="3">Legislation for</th></tr>
<tr><td colspan="2">The Crime and Disorder Act 1998
Female Genital Mutilation Act 2003
Sexual Offences Act 2003
Mental Capacity Act 2005
Convention on the Rights of Persons with Disabilities 2006
Mental Health Act 2007
Children and Families Act 2014</td><td>Modern Slavery Act 2015
Serious Crime Act 2015
Mental Capacity (Amendment) Act 2019
NHS Constitution and Values (updated Jan 2021)
Domestic Abuse Act 2021
Serious Violence Duty: Draft guidance 2021
Prevent Duty 2015</td></tr>
<tr><th>Safeguarding children</th><th>Safeguarding young people transitioning into adults, including children in care</th><th>Safeguarding adults</th></tr>
<tr><td colspan="2">United Nations Convention on the Rights of the Child 1989</td><td>European Convention on Human Rights</td></tr>
<tr><td colspan="2">Children Act 1989 and 2004</td><td>The Care Act 2014</td></tr>
<tr><td colspan="2">Promoting the Health of Looked After Children Statutory Guidance 2015</td><td>Care & Support Statutory Guidance- Section 14 Safeguarding</td></tr>
<tr><td colspan="2">Children and Social Work Act 2017</td><td rowspan="2"></td></tr>
<tr><td colspan="2">Working Together to Safeguard Children Statutory Guidance 2018</td></tr>
<tr><td>Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019</td><td>Looked After Children: Roles and Competencies of healthcare staff 2020</td><td>Adult Safeguarding: Roles and Competencies for Health Care Staff 2018</td></tr>
</table>

3.1 Safeguarding – the context

Safeguarding is firmly embedded within the core duties and statutory responsibilities of all organisations across the health system. However, there is a distinction between providers' responsibilities to provide safe and high quality care, and commissioners' responsibilities to assure themselves of the safety and effectiveness of the services they have commissioned.

The context of safeguarding continues to change in line with listening to the lived experience narrative both locally and nationally, large scale inquiries and legislative reforms.

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 children and adults are holistically, consistently and conscientiously applied; the wellbeing of those children and adults is at the heart of what we do.

Every NHS funded organisation needs to ensure that sufficient safeguarding leadership capacity is in place for them to fulfil their statutory duties; they should regularly review their arrangements to assure themselves that they are working effectively to the safeguarding commissioning assurance toolkit (safeguarding-CAT). Organisations need to co-operate and work together within new demographic footprints to seek common solutions to the changing context of safeguarding and developing structural landscape needed to deliver the NHS Long Term Plan.

3.2 Disclosure and barring service

The Disclosure and Barring Service (DBS) is responsible for administering the government's statutory scheme to help employers make safer recruitment decisions. There are different levels of checks that disclose a range of different information contained within the Police National Computer and Local Police Force Information. To help decide which level of check is needed for different roles, the DBS provide guidance specifically for NHS roles: Role eligibility for DBS Checks | NHS Employers.

The DBS Enhanced with Barred List check is required for those intending to work in regulated activity with children and vulnerable adults. It will show details of spent and unspent convictions (subject to filtering rules), non-conviction information

deemed relevant to disclose by police disclosure units, and barred list checks. These barred lists contain information about individuals who DBS have barred from undertaking regulated activity with children and/or adults. Barred individuals are committing a criminal offence if they seek to work in regulated activity from which they are barred as they present such a safeguarding risk. It is imperative therefore that such pre employment checks are carried out before any appointments are made.

The Safeguarding Vulnerable Groups Act also requires employers to refer individuals to DBS who have been removed from regulated activity or have resigned because of safeguarding concerns. The failure to make a barring referral in such circumstances not only breaches that legal duty but also prevents DBS from considering whether an individual should be included in a Barred List, potentially weakening the overall effectiveness of any check requested by future employers.

Every employer who has employees working within regulated activity with vulnerable groups needs to be aware of this responsibility and ensure any individuals who may pose a risk of harm are referred for DBS consideration in situations where they have resigned, been removed, or dismissed due to safeguarding concerns. Each NHS organisation should have a clear policy for who should make a referral to DBS. It is usually HR personnel who have the information required to make a referral and this should always be made in discussion with safeguarding leads.

A DBS check cannot guarantee that the employee does or does not pose a risk. It is a snapshot of intelligence that is known at the time of the check and things might change. This check should be part of a suite of measures to determine the overall suitability of any candidate both at recruitment and during employment.

Providers must refer to Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which stipulates what information is required for people employed or appointed for the purpose of regulated activity.

3.3 Fit and proper persons tests

There are two ‘fit and proper’ persons tests that are separated within the Health and Social Care Regulations:

- Regulation 19 - which outlines the requirements for the fit and proper persons test for persons employed
- Regulation 5 - which outlines the requirements for directors to be fit and proper persons.

3.4 Duty of candour

Safeguarding requires openness, advocacy, transparency and trust. The publication of the Francis Inquiry report recommended that a statutory duty should be introduced for healthcare providers to be open with people when things go wrong; this duty is regulated by the Care Quality Commission (CQC).

The duty of candour is triggered by a ‘notifiable safety incident’, for any ‘unintended or unexpected incident that has occurred in respect of all service users during the provision of a regulated activity’. A safeguarding incident might be because of a clinical procedure or practice that could have contributed to death, physical or psychological harm.

3.5 Information sharing

Robust information-sharing is at the heart of safe and effective safeguarding practice. Information sharing is covered by legislation, principally the General Data Protection Act 2018 (GDPR) and the Data Protection Act 2018. The GDPR and the Data Protection Act 2018 introduce new elements to the data protection regime, superseding the Data Protection Act 1998. Practitioners must have due regard to the relevant data protection principles which allow them to share personal information. The GDPR and Data Protection Act 2018 place greater significance on organisations being transparent and accountable in relation to their use of data.

All organisations handling personal data need to have comprehensive and proportionate arrangements for collecting, storing, and sharing information. The GDPR and Data Protection Act 2018 do not prevent, or limit, the sharing of information for the purposes of keeping children, young people and adults safe.

Professionals should refer to specific advice from their professional body regarding information sharing. There is a requirement for professionals to contribute, participate and share information for the purpose of statutory reviews; please see section 4.5 for more information.

Such guidelines are further supported by the Caldicott Principles, updated in 2020. Principle 7 states that the duty to share information can be as important as the duty to protect patient confidentially. It is crucial to understand that sharing information, when there is a need to share it, and a lawful basis for doing so, and maintaining its security and confidentiality, are compatible activities.

3.5.1 Information sharing specific to safeguarding children

Information must be shared to protect children, or to prevent or detect a crime. In addition, there are some specific statutory provisions that will require information sharing, for example relating to the operation of local safeguarding children's partnerships and relating to the statutory vetting and barring process for staff.

3.5.2 Information sharing specific to young people

A child may be safeguarded and protected under the Children Act 1989 until their 18th birthday. However, medical consent, mental capacity, and consent to sexual activity, are lawful from the age of 16. A Gillick Competency Assessment may be used to determine a child's capacity to consent to medical treatment or intervention before the age of 16.

The Assessment was designed to test whether a young person prior to their 16th birthday, had sufficient capacity, without parental intervention, to make decisions regarding their own medical treatment. The Fraser Guidelines were developed specifically in relation to consent for contraceptive or sexual health advice and treatment. Child protection procedures should always be instigated however when child exploitation and or child sexual exploitation is suspected, even if the child or young person is deemed competent.

3.5.3 Child protection – information sharing (CP-IS)

The Child Protection Information Sharing (CP-IS) programme links the IT systems used across health and social care to securely share basic information via a child's NHS number for children and unborn child (birth mothers NHS number is used) who are subject to child protection plans (CPPs) or children in care. CP-IS is endorsed by CQC and is included in the key lines of enquiry during CQC inspections. It is

also included in the 2022/23 NHS Standard Contract for providers of NHS unscheduled care.

The CP-IS system, shares information between health and children's social care when a vulnerable child attends an unscheduled NHS setting, such as A&E. This allows the clinician to consider whether the child has been maltreated and enables them to put in place actions to protect the child while their immediate health needs are addressed.

CP-IS has been delivered to 100% of unscheduled healthcare settings and local authorities – despite 152 local authorities and more than 1,200 unscheduled healthcare settings in England using more than 75 different computer systems.

Phase 1 was completed in 2019, hitting 93% implementation for both health and social care settings. In 2021, the target was 100% for social care settings. All children who have CPPs including children in care are now flagged in seven health settings including A&E, walk in centres, maternity services, ambulance trusts and out of hours services.

The NHS Long Term Plan mandates that by March 2023, CP-IS will be expanded to extend and cover all healthcare settings including general practice, dentistry, paediatric community, 0 to 19 services including health visiting and school nursing, mental health and sexual health services.

3.5.4 Information sharing specific to adults

Information should be shared to help protect an adult who may be subject to or potentially at risk of harm or abuse, or to prevent or detect a crime. The Mental Capacity Act (2005) and Mental Capacity (Amendment) Act (2019) provides the legal framework around consent in relation to care, treatment and support for those who may not have capacity to do so.

In addition, there are some specific statutory provisions for data sharing under the Care Act 2014 in relation to the operation of the local safeguarding adult board (SAB).

3.5.5 Female genital mutilation (FGM)

Female Genital Mutilation Act 2003 (as amended by the Serious Crime Act 2015) stipulates the mandatory reporting of FGM to NHS Digital for all cases. The

legislation requires regulated health and social care professionals and teachers in England and Wales to make a report to the Police where, in the course of their professional duties, they either:

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

3.5.6 Allegations against staff involving child abuse – local authority designated officer

Working Together to Safeguard Children stipulates that information must be shared with the local authority designated officer (LADO) where it is considered that a member of health staff poses a risk to children or might have committed a criminal offence against one or more children.

3.5.7 Allegations against staff involving abuse or neglect – adults

The Care Act (2014) defines people in positions of trust (PiPoTs) as 'people who work in paid or unpaid capacity, including celebrities and people undertaking charitable duties with adults with care and support needs' (see Statutory Guidance 14.120 to 14.132).

It is a requirement of the Care Act 2014 Statutory Guidance that SABs should establish and agree a framework and process for any organisation to respond to allegations against "anyone who works, (in either a paid or an unpaid capacity) with adults with care and support needs". Where there is an allegation that a member of staff in an ICB or primary care services has abused or neglected an adult in their personal life, the designated professional for safeguarding adults in the ICB should be informed and HR due processes followed.

4. Roles and responsibilities

Safeguarding children and adults at risk of abuse or neglect is a collective responsibility. All employees who are registrants are reminded of their professional duty of care regardless of which NHS contract is used to deploy the functions they work to. This section provides greater clarity around the individual roles and responsibilities within the system. These are summarised and mapped to the health commissioning system in Appendix I.

4.1 NHS England

The chief nursing officer (CNO) for NHS England has executive lead and accountability to ensure the effective discharge of NHS England statutory responsibilities. The CNO is the lead board executive director for safeguarding and has a number of forums through which assurance and oversight is sought. The system-wide National Safeguarding Steering Group (NSSG) co-ordinates these forums and gains assurance on behalf of the CNO. See Appendix I for more information.

4.2 Health and care providers

4.2.1 Provider leadership

All health providers including provider collaboratives are required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of children and adults at risk of harm and abuse in every service that they deliver.

Providers must demonstrate safeguarding is embedded at every level in their organisation with effective governance processes evident. Providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working. These arrangements include:

- Identification of a named nurse, named doctor and named midwife (if the organisation provides maternity services) for safeguarding children. Identification of a named nurse and named doctor for children in care. Identification of a named lead for adult safeguarding and a Mental Capacity Act (MCA) lead – this role should include the management of adult

safeguarding allegations against staff. This could be a named professional from any relevant professional background.

- Safe recruitment practices and arrangements for dealing with allegations against staff.
- Provision of an executive lead for safeguarding children, adults at risk and prevent.
- An annual report for safeguarding children, adults and children in care to be submitted to the trust board.
- A suite of safeguarding policies and procedures that support local multi-agency safeguarding procedures.
- Effective training of all staff commensurate with their role and in accordance with the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019, Looked After Children: Roles and Competencies of Healthcare Staff 2020 and the Adult Safeguarding: Roles and Competencies for Health Care Staff 2018.
- Safeguarding must be included in induction programmes for all staff and volunteers.
- Providing effective safeguarding supervision arrangements for staff, commensurate to their role and function (including for named professionals).
- Developing an organisational culture where all staff are aware of their personal responsibilities for safeguarding and information sharing.
- Developing and promoting a learning culture to ensure continuous improvement.
- Policies, arrangements and records to ensure consent to care and treatment is obtained in line with legislation and guidance.

4.3 Named professionals

Named professionals have a key leadership 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 supervision and training is in place.

Named professionals should also attend regular supervision sessions. They should work closely with their organisation's safeguarding lead, designated professionals in

the ICBs and local safeguarding children partnerships, SABs as well as their regional safeguarding forums and networks.

Named professionals should have direct access to the head of safeguarding and/or executive lead for safeguarding in their organisation to ensure they have influence in the organisation's strategic plans.

This SAAF recognises the critical role that maternity services play with regards to safeguarding and the Think Family agenda. From work with the maternity transformation programme, NHS Safeguarding has a national maternity safeguarding network who will provide system leadership and oversight on maternity through a contextual safeguarding lens.

4.3.1 Mental Capacity Act (MCA) lead

All NHS providers are required to have an MCA lead. This role 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, as per the Deprivation of Liberty Safeguards (DoLS) legislation under the MCA.

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. GP practices are required to have a lead for safeguarding and MCA, who should work closely with named safeguarding GPs and designated professionals for safeguarding adults and 16 and 17 year olds with the advent of liberty protection safeguards (LPS).

There is a clear need for MCA (human rights and informed consent) awareness across all NHS services now. The SAAF position is that all training for NHS needs to be accredited, free, linked to ESR records and from HEE, Skills 4 Health or our NHS LPS clinical reference group.

There is also a repeated request for the LPS training partnership to collaborate for bespoke MCA and LPS key messaging by Decembers 2021 across some specialised NHS functions:

- Services for 16 and 17 years olds – noting we are expecting conversation in families to start when the child is 14 years old.
- NHS Continuing Healthcare – noting they will report to ICB responsible bodies (RBs).

- Community and domiciliary services – noting the link here with Skills 4 Health training plans.
- NHS outreach services.
- Healthcare in the secure estate.
- Independent providers with an NHS contract who are not RBs.

The NHS transformation plan from Code of Practice to implementation is likely to take 2 years.

- Clinical systems belonging to RBs (NHS Trusts and ICBs) **must collect all of the national minimum datasets (NMDS)** in order to discharge their statutory duties under LPS regulations – an Information Standard Notice (ISN) will also set this out.

- Clinical systems belonging to NHS providers (hospitals, GPs etc) **will not be compelled by LPS regulations/the ISN *directly* to collect any of the NMDS**, NHS England has requested to **embed the ISN in the NHS Standard Contract** to press provider systems suppliers to collect some of the NMDS data items to support smoother data flows between providers and RBs. We believe these data items will be those relating to the person/their care and treatment. Anything about the LPS process will be for the RB to input during the authorisation process.

4.4 Integrated care boards

As per the published Integrated Care Systems (ICSs): design framework (version 1, June 2021), all clinical commissioning group (CCG) functions and duties have transferred to an ICB along with all CCG assets and liabilities including their commissioning responsibilities and contracts. Relevant statutory safeguarding duties of the previous CCGs will transition to ICB executive leads in consultation with the regional chief nurses and regional safeguarding leads.

ICSs are partnerships of health and care organisations that have come together to plan and deliver joined up services and to improve the health of people who live and work in their area. They exist to achieve four aims:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access

- enhance productivity and value for money
- help the NHS support broader social and economic development.

Following several years of locally-led development, and based on the recommendations of NHS England, the government and the Department of Health and Social Care (DHSC) has put ICBs and integrated care partnerships (ICPs) on a statutory footing. DHSC will be publishing guidance regarding ICPs.

The SAAF governance processes will replicate ICB guidance and the ICB executive chief nurse will be accountable for the statutory commissioning assurance functions of NHS Safeguarding as per the agreed timelines with the regional chief nurse. These programmes will include:

- CP-IS
- FGM
- Prevent
- Working Together
- Modern Slavery and Human Trafficking
- Domestic Abuse
- Liberty Protection Safeguards.

The core principles of the executive accountability, including protecting the paramountcy of every child, will be sustained via the NHS SAAF. The ICB will also have accountabilities for prevention and strategic workforce planning.

The ICB executive chief nurse is likely to stand up place based partnership structures of clinical leads to collaborate with local safeguarding partnerships and SABs. These partnerships need to be preventative: VRUs, Community Safety Partnerships; lived experience victim and survivor advocacy services, sustainable peer support community assets, police and crime commissioners and education leads.

4.5 Statutory and mandatory reviews

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. Broadly, this will involve evidence of contribution, meeting regularly with colleagues and attending panels or review

group meetings throughout the investigative phase. Statutory reviews are processes for learning and improvement and all health providers, including GPs, are required to provide and share information relevant to any statutory review process.

NHS England, via the designated professionals, may support panel chairs where learning and improvement have wider implications and need co-ordinated national action, and/or where there are obstacles to full NHS participation that require a range of relationship, contractual and professional influences.

4.5.1 Rapid reviews

As per chapter 5 in Working Together to Safeguard Children (2018) the purpose of rapid reviews for serious child safeguarding cases, at both local and national level is to identify improvements to be made to safeguard and promote the welfare of children. Serious child safeguarding cases are those in which abuse, or neglect of a child is known or suspected and the child has died or been seriously harmed.

The safeguarding partners should promptly undertake a rapid review of the case in line with any guidance published by the Child Safeguarding Practice Review Panel. The aim of this rapid review is to enable safeguarding partners to:

- gather the facts about the case, as far as they can be readily established at the time
- discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately
- consider the potential for identifying improvements to safeguard and promote the welfare of children
- decide what steps they should take next, including whether or not to undertake a child safeguarding practice review.

4.5.2 Child safeguarding practice review

The responsibility for how the system learns the lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel and at local level with the local safeguarding children's partnerships. A child safeguarding practice review should be considered for serious child safeguarding cases where:

- abuse or neglect of a child is known or suspected,

- and a child has died or been seriously harmed.

This may include cases where a child has caused serious harm to someone else.

4.5.3 Child death review (CDR)

Children Act 2004 requires ICBs and local authorities (child death review partners) to make local arrangements to undertake statutory CDR processes. The CDR process relies on inter-agency cooperation and information sharing.

These arrangements should result in the establishment of a child death overview panel (CDOP), or equivalent, to review the deaths of all children (under the age of 18 years) regardless of the cause of death normally resident in the relevant local authority area, and if they consider it appropriate the deaths in that area of non-resident children.

The review should then be carried out by a CDOP, on behalf of CDR partners, and should be conducted in accordance with Child Death Review: Statutory and Operational Guidance 2018 and Working Together to Safeguard Children Statutory Guidance 2018.

4.5.4 Learning disability mortality review (LeDeR) programme

LeDeR is a service improvement programme which aims to improve care, reduce health inequalities, and prevent premature mortality of people with a learning disability and autistic people by reviewing information about the health and social care support people received. Everyone with a learning disability aged four and above who dies and every adult (aged 18 and over) with a diagnosis of autism is eligible for a LeDeR review. It aims to make improvements in the quality of health and social care for people with learning disabilities and autism, and to reduce premature deaths in this population.

It does this by:

- delivering local service improvement, learning from LeDeR reviews about good quality care and areas requiring improvement
- driving local service improvements based on themes emerging from LeDeR reviews at a regional and national level
- influencing national service improvements via actions that respond to themes commonly arising from analysis of LeDeR reviews.

Local ICBs are responsible for ensuring that LeDeR reviews are completed for their local area and also, and very importantly, that actions are implemented to improve the quality of services for people with a learning disability and autistic people to reduce health inequalities and premature mortality.

The CDR process reviews the deaths of all children who are aged 4-17. This will be the primary review process for children with learning disabilities and autistic children; the results are then shared with the LeDeR Programme.

- Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) policy 2021
- LeDer Learning from Lives and Deaths

4.5.5 Domestic homicide reviews

A domestic homicide review (DHR) convened by the local community safety partnership, is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves.

4.5.6 Safeguarding adults reviews

Safeguarding adult reviews (SARs) are required under the Care Act and convened by an SAB when an adult has died from, or experienced, serious abuse or neglect, and there is reasonable cause for concern about how agencies and service providers worked together to safeguard the person, as per the Social Care Institute for Excellence Quality Markers .

4.5.7 Other reviews

Mental health homicide reviews, multi-agency public protection arrangements (MAPPAs) and learning disability mortality reviews are carried out under separate arrangements but may, depending upon the circumstances, need to link to a safeguarding statutory review. Such reviews may run parallel to local authority safeguarding inquiries and serious incident investigations.

4.6 Parallel investigations

At times, the safeguarding of children and/or adults in a health setting may feature in a wider multi-agency statutory review commissioned for other purposes, for example a DHR or a mental health investigation. In these circumstances a separate safeguarding practice review may be deemed appropriate. NHS organisations should be prepared therefore, to share information and cooperate with the parallel practice review panel. Duplication of effort should be avoided where possible with each review informing the parallel process.

System leaders need to be aware of the new patient safety incident response framework which may also be activated due to other incident management processes.

4.7 Designated professionals

Designated professionals are experts and strategic leaders for safeguarding. As such they are a vital source of safeguarding advice and expertise for all relevant agencies and other organisations, but particularly to health commissioners, ICBs, the local authority and NHS England, other health professionals in provider organisations, system quality groups (SQGs), regulators, the safeguarding children partnership arrangements, corporate parenting boards, SABs, community safety partnerships and the health and wellbeing board (HWB).

Where designated professionals (most commonly, designated doctors) continue to undertake clinical duties in addition to their designated safeguarding responsibilities, it is important that there is clarity about the two roles, particularly with regards to time and capacity to undertake designated duties. The ICB will require 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.

Clear accountability and performance management arrangements are essential for designated professionals to prevent professional isolation and promote continuous improvement. Designated professionals are required to:

- attend reflective/restorative supervision meetings regularly. These supervision meetings must be formally documented and should be professionally facilitated if possible

- have direct access to the ICB executive (board level) lead, to ensure that there is the right level of influence of safeguarding on the commissioning process. The ICB accountable officer (or other executive level nominee) should meet regularly with the designated professionals to review child, children in care and adult safeguarding in the local area
- co-ordinate practice reviews/learning reviews and management reviews on behalf of health commissioners. They are also responsible for actively contributing to quality assuring the health content and disseminating the lessons learnt
- provide expert advice to Health Education England (HEE) and local education and training boards (LETBs).

4.7.1 Designated professionals for safeguarding children

- Designated professionals will automatically become members of the National Network for Designated Healthcare Professionals for Safeguarding Children (NNDHP) – see Appendix II for further information. ICBs should support designated professionals to participate in NNDHP events, and particularly those designated professionals who have been elected as network regional leads and national officers.
- They must accompany or exceptionally fully brief their ICB members of the local safeguarding children partnerships to ensure up to date professional expertise is effectively linked into the local safeguarding arrangements.
- They must be consulted and able to influence at all points in the commissioning cycle from procurement to quality assurance. This will ensure that all services commissioned meet the statutory requirement to safeguard and promote the welfare of children.
- A designated doctor for child deaths must be a senior paediatrician, appointed by the CDR partners, who will take a lead in co-ordinating responses and health input to the CDR process, across a specified locality or region.

4.7.2 Designated professionals for children in care

- The designated professional will offer support and advice to the board member responsible for adult and children safeguarding and ensure the regular provision of training to staff and board of the ICB.

- They will advise commissioning bodies on training needs and the delivery of training for all health staff across the health community including those GPs, paediatricians and nurses undertaking health assessments and developing plans for children in care.
- The designated professional will provide advice on monitoring of elements of contracts, service level agreements and commissioned services to ensure the quality of provision for children in care including systems and records to:
  - ensure the quality of health assessments carried out meet the required standard
  - ensure full registration of each children in care and all care leavers with a GP and dentist and optometric checks undertaken
  - ensure that sensitive health promotion is offered to all children in care and young people
  - ensure implementation of health plans for individual children
  - ensure an effective system of audit is in place.

- They will work with ICBs to ensure there are robust arrangements to meet the health needs of children in care placed outside the local area and ensure close working relationships with local authorities to achieve placement decisions which match the needs of children.

Transitional safeguarding

In the NHS Long Term Plan, NHS England has committed to moving to a 0-25 years' service model, where appropriate, to enhance children's and young people's (CYP) experience of health, continuity of care and outcomes.

Key to this will be transitional safeguarding. The term transitional safeguarding describes the need for "an approach to safeguarding adolescents and young adults fluidly across developmental stages which builds on the best available evidence, learns from both children's and adult safeguarding practice and which prepares young people for their adult lives".

It focuses on safeguarding young people, from adolescence into adulthood, recognising this period of transition will be experienced differently by young people at different times.

4.7.3 Designated lead professional for adult safeguarding

- They will automatically be members of the virtual Safeguarding Adults National Network (SANN) – see Appendix III for more information. ICBs should support designated professionals to participate in SANN deep dives, events, and task and finish groups.
- The designated professional will offer support and advice to the board member responsible for adult safeguarding and ensure the regular provision of training to staff and board of the ICB.
- Provide a health advisory role to the SAB and must attend, fully brief and support the ICB SAB member. To also take a lead for health in working with the SAB on safeguarding adult reviews, and to take forward any learning for the health economy.

4.7.4 Designated MCA lead

ICBs are required to have access to a designated MCA lead, 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 demonstrate how their own organisation, and the services that they commission, are compliant with the MCA through audits, effective reporting, and provision of appropriate training.

4.8 Named GPs/named professionals within primary care

Named GPs/named professionals for children and adults have a key role in promoting good professional practice, providing advice and expertise to professionals, and ensuring appropriate safeguarding training is in place. Training, experience, and qualification requirements for named GPs/named professionals are set out in the children's and adults intercollegiate documents and should be complied with.

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 local safeguarding boards/partnerships which will include the population capacity per named GP session.

4.8.1 Named GP for children's safeguarding

Functions of a named GP for children's safeguarding include:

- providing specific expertise on child health and development, and on children who have been abused or neglected, as well as in the care of families in difficulty
- liaising with provider organisations and other partners eg local councils, on local primary care arrangements for safeguarding children
- promoting, influencing and developing relevant training for GPs and their teams
- advising and supporting GPs in writing the general practice components of safeguarding children practice reviews and/or independent management reviews, Section 11 and other multi-agency audits.

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.

Ongoing training and personal development for practitioners with a special clinical interest is important and will require supervision from the designated doctor for child safeguarding, specialist education as well as access to relevant peer support. It is crucial that if named GPs for safeguarding children are to fulfil their role effectively, they have a clear line of management accountability and responsibility with the designated doctor and ICB safeguarding lead.

4.8.2 Named GP for adult safeguarding

The role of a named GP in adult safeguarding is evolving but the principle function is to promote within general practices the provision of effective primary care services to safeguard adults at risk and to improve their outcomes; to facilitate GPs and practice staff to understand their roles and fulfil their responsibilities towards the protection and safeguarding of adults.

Other functions of a named GP for safeguarding adults include:

- supporting and advising the ICB about safeguarding adults
- developing a role in quality monitoring and audit, in terms of primary care performance in relation to safeguarding adults

- undertaking the independent management review (IMR) for general practice when there is a SAR, as requested by the designated professional for safeguarding adults and SAB
- working with designated professionals when learning lessons reviews related to general practice and primary care are undertaken by the local SAB.

ICBs must have access to the services of a named GP for adult safeguarding to ensure that primary care services can meet their obligations to both adults and children and support contextualised safeguarding. The Adult Safeguarding: Roles and Competencies for Health Care Staff sets out the competencies for the named GP.

5. Commissioning and assurance

5.1 NHS England

The general function of NHS England is to improve the health outcomes for all children, young people and adults at risk in England by promoting a comprehensive health service. NHS England discharges its responsibilities by:

- allocating funds to, guiding and supporting ICBs, and holding them to account
- directly commissioning specialised health services, and health care services for those in secure and detained settings, and for serving personnel and their families, and some public health services.

5.1.1 NHS England system leadership

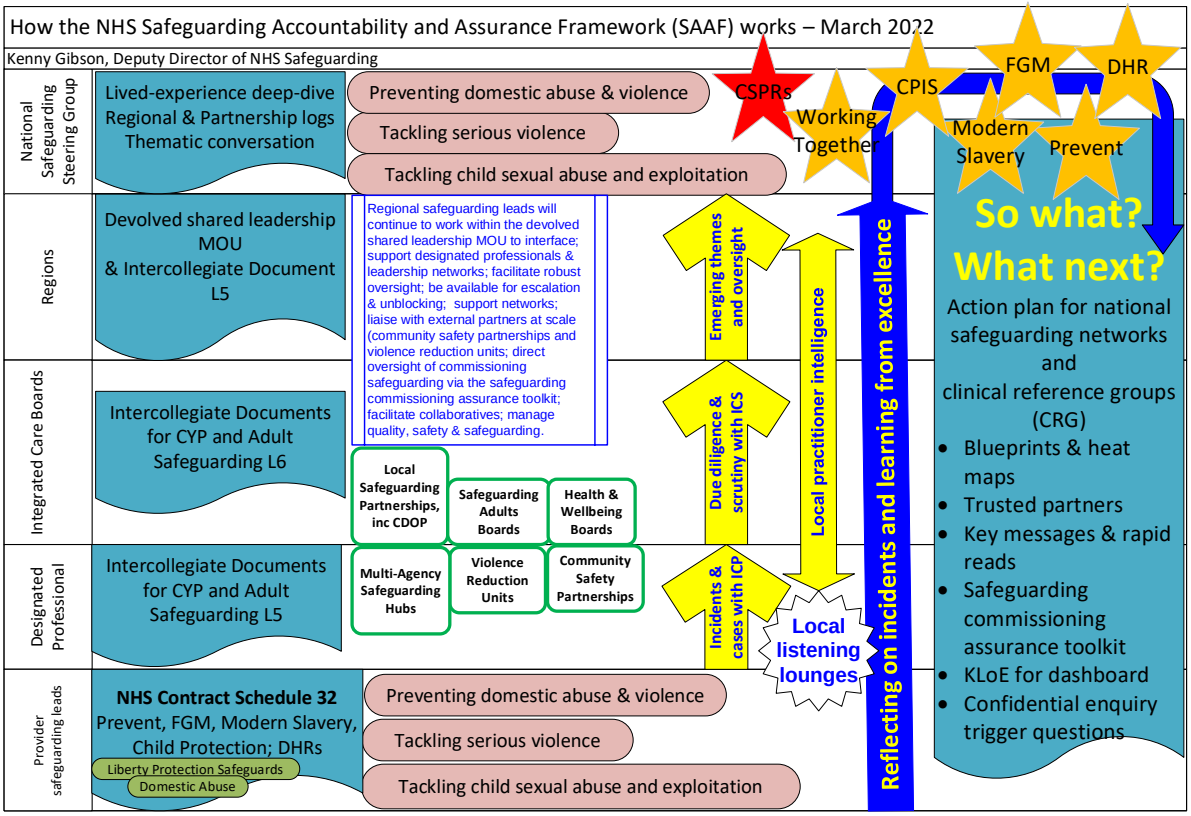
NHS England ensures that the health commissioning system as a whole is working effectively to safeguard and promote the welfare of children, young people and adults. NHS England is the policy lead for NHS Safeguarding, working across health and social care, including leading and defining improvement in safeguarding practice and outcomes. Its key duties are to:

- provide leadership support to safeguarding children, children in care and adult professionals, including working with 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 via the NSSG
- provide specialist safeguarding advice to the NHS
- encourage a culture that supports staff in raising concerns regarding safeguarding issues
- ensure that robust processes are in place to learn lessons from cases where someone has died or are seriously harmed, and abuse or neglect is suspected
- ensure that NHS England teams are appropriately engaged in the local place based multi-agency safeguarding partnerships, SABs, community safety partnerships and HWBs to raise concerns about the engagement and leadership of the local NHS.

5.1.2 NHS England support for safeguarding professionals

NHS England has also established safeguarding peer groups and forums, with access to an online community of practice to support system leaders to:

- underpin system accountability through peer review based assurance and other sources of intelligence, to identify local safeguarding improvements for children, children in care and adults
- support development of safeguarding arrangements, practice and values in ICBs
- identifying and share good practice initiatives across the local health system
- analysing the health implications of, and learning from, local incidents including practice reviews and individual management 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 LETBs
- maintaining an up-to-date risk register and an appropriate escalation mechanism.



5.2 NHS England – direct commissioning

NHS England ensures that safeguarding duties are met in relation to the services that it directly commissions. NHS England is responsible for commissioning primary care, specialised services, health care services in Health and Justice, health services for armed forces personnel and their families, and some public health services.

5.2.1 Direct commissioning for young people transitioning into adults

Joint commissioning procedures and partnership working standards will safeguard young people suffering from mental health disorders from sudden, unplanned withdrawal of child and adolescent mental health services (CAMHS) or refusals or delays by adult mental health provision to take up the mental health responsibility for young people, especially children in care and care leavers. Equity, accessibility and safeguarding are key transitional issues.

NHS England is responsible for the direct commissioning and assurance of health services and facilities for young people who are detained in secure accommodation or youth offender institutions (YOIs). Transitional planning is important for young people transferring to adult offender institutions, to ensure that their health and development, mental health and care outcomes are equivalent to young people in the wider community.

The NHS England commitment to quality and health improvement and reducing health inequalities is vitally important for young people who have experienced adverse childhood experiences leading to reduced life chances.

Under the NHS Long Term Plan, NHS Safeguarding have secured funding for a programme of work to research the challenges facing children in care, critique the unwarranted variation of transition services and establish best practice guidance notes for the NHS and care system leaders. The NHS, together with safeguarding partners at a national and local level, will commit to improve outcomes for our most at risk children and young people.

5.3 NHS England assurance of ICBs

NHS England has a statutory requirement to oversee assurance of ICBs in their commissioning role. This involves formal assurance reviews carried out quarterly, in

line with the published framework and technical guidance. Safeguarding system leaders have co-developed the safeguarding commissioning assurance toolkit to support all local commissioners to optimise the 2022/23 NHS Standard Contract.

This toolkit will provide an element of assurance supported by other local and regional mechanisms with qualitative measures i.e thematic learning from deaths and peer review. This quality assurance process will remain the accountability of the regional chief nurses.

5.4 Local authority commissioning

NHS England, via national membership networks and regional safeguarding leadership will support designated professionals and named professionals to have adaptive and collaborative conversations with local authority commissioners to ensure that effective local safeguarding arrangements are in place.

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 child safeguarding training. This applies to professionals delivering public health services commissioned by local authorities.

The commissioning of public health services for children is undertaken by local authorities. It includes sexual health services, school nursing services and 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. There is an opportunity at an ICP level to include the commissioning of care homes, hostels, services for adults with care and support needs – plus their LPS role in independent hospitals, hospices etc and receiving appropriate safeguarding training and supervision.

6. Regulators and safeguarding partners

Regulation is an important element of the assurance and accountability arrangements in place across the health system. Several 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. This is used alongside other internal information by NHS England in providing assurance (see Appendix I) on the effectiveness of safeguarding arrangements in local health systems.

All providers of health services are required to be registered with the CQC. 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.

6.1 Department of Health and Social Care (DHSC)

DHSC 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 holds it to account. DHSC assesses NHS England performance against the mandate, including the specific safeguarding elements. It also ensures that the health and care system work collaboratively through national groups.

DHSC 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 arms' length bodies. Both groups set out safeguarding policy, hold partners to account for implementing that policy, and address specific national concerns.

6.2 Office for Standards in Education, Children's Services and Skills (Ofsted)

Ofsted inspects and regulates local authority services which care for children and young people, and those providing education and skills for learners of all ages.

While many services inspected by Ofsted are not strictly within the health sector, there are many areas of overlap, for example where health professionals work within children's services provided by the local authority such as special needs schools. Ofsted regulation of multiagency safeguarding children partnerships has been influenced by the removal of local safeguarding children boards, the implementation of local multiagency arrangements, and the introduction of independent scrutiny.

6.2.1 Inspections of Local Authority Children's Services (ILACS) Framework

In January 2018, Ofsted launched the 'Inspection of Local Authority Children's Services' or ILACS, a flexible framework for inspecting children's services for local authorities. Under this system, intelligence and information is used to inform decisions about how best to inspect each local authority. Joint targeted area inspections (JTAIs) are included in this system inspection.

6.2.2 JTAIs

JTAIs are carried out by Ofsted, HMI Constabulary and Fire and Rescue Services, CQC, and HMI Probation. JTAIs assess how effectively agencies are working together in their local area to help and protect children.

6.3 The Office for Health Improvement and Disparities (OHID)

From the 1 October 2021, a new OHID was created in the DHSC, under the professional leadership of the chief medical officer and director general. OHID will be the home of the government's health promotion and prevention agenda. It will bring together evidence, data, and intelligence on what drives better and more equal health outcomes and what works in addressing health risks.

OHID will develop policies on priority areas for action. OHID will shape and drive health improvement priorities for government and will work with the whole of government, the NHS, local government, industry, and wider partners. OHID will place public health at the heart of the DHSC driving change across government and the health and care system, bringing together different skills and perspectives.

The OHID chief nurse department will lead international and national public health nursing, midwifery, and allied health professional advice. The department will also

lead clinical and quality improvement programmes and partnerships for promoting health. The early years children and families directorate will lead the policy, evidence and delivery of services that seek to improve the health of children and families including maternal health, tackling harms resulting from family violence and violence against women and girls.

6.4 Care Quality Commission (CQC)

The regulatory function of CQC is split between three directorates: adult social care; primary medical services; and hospitals. Each has a chief inspector providing leadership. Their role is to register, monitor, inspect, rate and regulate health and social care services to ensure they meet fundamental standards of quality and safety. It carries out this role through:

- the checks it carries out during the registration process for all new care services
- inspections
- monitoring a range of data sources that can indicate problems with services.

CQC speaks with an independent voice, publishing views on major quality issues in health and social care. It reports on how care has been delivered in England in the annual State of Care report and protects the rights of vulnerable people, including those restricted under the Mental Health Act. It also carries out special investigations and reviews into aspects of health and social care on behalf of government.

CQC has a statutory duty to protect and promote the health, safety and welfare of people who use health and social care services. Their role in safeguarding people who use health and social care services includes:

- making sure that providers have the right systems and processes in place to ensure people are protected from abuse, improper treatment and neglect
- holding providers to account, securing improvements and taking enforcement action where required
- responding to information received from all sources, including the public, staff working in services, providers and stakeholders, assessing the risks to

people using services and taking regulatory action to mitigate risks to people using services

- working with other inspectorates such as Ofsted, HMI Probation, HMI Constabulary, HMI Prisons, and NHS England to review how health, education, police, probation and prison services work in partnership to help and protect people from harm
- working with local partners such as Local Healthwatch, local authorities, the police and ICBs to share information about safeguarding people using services.

6.5 Professional regulatory bodies

Health and social care professionals who work in the UK must be registered with one of twelve professional regulatory bodies. These organisations regulate individual professionals across the UK. To practice in health and social care, professionals must be registered with the relevant regulator, and demonstrate that they have the appropriate 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 when there are serious concerns about their ability to provide safe treatment or care.

6.6 System quality groups (SQGs)

SQGs replace existing local quality surveillance group structures to support ICSs to maintain and improve the quality of care. SQGs provide a strategic forum to facilitate engagement, intelligence-sharing, learning and improvement in the quality of care and services across the ICS. This includes safeguarding issues.

SQGs should consider:

- how they will ensure effective engagement with local authority representatives (directors of children's services and directors of adult social care) on the group

- how they will ensure that issues, risks, learning and trends from local authorities (e.g. emerging safeguarding concerns) are brought to the SQG, triangulated with wider intelligence and inform priorities and actions
- how they will inform local authority areas of priority and plans
- how they will partner with local authority partners on areas and concerns of mutual interest (e.g. safeguarding). SQGs may want to set up a sub-group focused on ICS safeguarding themes.

The National Quality Board's guidance recommended that SQGs are chaired by the ICB executive director of nursing. NHS England is a member of SQGs and supports their development, including helping to create a culture of shared ownership, sharing best practice and learning, and providing support to address serious concerns.

Regional quality groups, usually chaired by the regional nursing or medical director, will provide an equivalent forum at regional level, bringing together all ICSs within a geographical region, to share learning, best practice and risks/concerns, and identify mitigation/actions. There should be strong linkages with regional safeguarding assurance boards as appropriate, and consideration of safeguarding issues in all relevant discussions.

6.7 Health Education England (HEE)

HEE supports the delivery of excellent healthcare and health improvement to the patients and public of England. It ensures 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 works in partnership with Skills for Health for both health and social care training modules.

HEE provider led 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 safeguarding children partnership/SAB requirements.

6.8 Multi-agency safeguarding arrangements

6.8.1 Safeguarding children partnerships

The task of organising safeguarding arrangements is shared by three partner agencies (local authorities, police, and ICBs). The Children Act 2004 as amended in the Children and Social Work Act 2017, places a duty on those three agencies to establish multi-agency safeguarding arrangements (MASA) for their local child population, with other relevant agencies as they deem appropriate. The partners must work together to safeguard children and promote the welfare of all children in their area, and to monitor and ensure the effectiveness of those arrangements. They will be equally accountable for the system they create.

There is a shared and equal legal duty for partner organisations, working with relevant agencies, to safeguard and promote the welfare of all children in a local authority area. A safeguarding partner is defined as (i) the local authority, (ii) a ICB for an area, any part of which falls within the local authority area and (iii) the chief of police for an area, any part of which falls within the local authority area.

Local authorities, NHS England, ICBs, ICB designated professionals and local providers should ensure appropriate representation in the partnership arrangements. Partners must commission child safeguarding practice reviews (CSPRs) where abuse or neglect of a child is known or suspected and the child has either died or been seriously harmed, and there is concern over how agencies and service providers have worked together.

The three safeguarding partners should agree:

- local priorities
- ways to co-ordinate their safeguarding services with relevant agencies
- establishing a strategic leadership group in supporting and engaging others
- implementing local and national learning from serious child safeguarding incidents
- processes that facilitate and drive action beyond usual institutional and agency constraints and boundaries
- effective protection of children is founded on lasting and trusting relationships with children and their families
- a dispute resolution process
- an independent scrutiny arrangement

- the relationship and processes between HWBs.

6.8.2 Community safety partnerships

The Crime and Disorder Act 1998 introduced a statutory framework for community safety partnerships (CSPs). CSPs are made up of representatives from the police, local council, fire service, health service, probation as well as many others. Their purpose is to make the community safer, reduce crime and the fear of crime, reduce anti-social behaviour and work with business and residents on the issues of most concern. They also manage strategic plans for certain areas of safeguarding, for example Prevent and vulnerability to radicalisation, domestic abuse, serious violence and modern-day slavery.

Safeguarding system leaders are asked to note all possible partnerships which prevent violence: local safeguarding partnerships, SABs, local domestic abuse forums, community safety partnerships, violence reduction units, counter terrorism units, police and crime commissioner.

In 2019 the Home Secretary announced a £100 million Serious Violence Fund to help tackle serious violence, which has been invested to set up 18 violence reduction units. The Violence Reduction Network works collaboratively, building upon the community's existing strengths and to support communities to prevent serious violence in their geographical area, through understanding and tackling its root causes.

6.8.3 Safeguarding adult boards (SABs)

Under the terms of the Care Act 2014, each local authority must set up a safeguarding adult board (SAB), with statutory partners from the local authority, police and ICB. A SAB has a strategic role and has three core duties; it must:

- publish a strategic plan for each financial year, setting out how it will meet its main objectives. In developing the plan, it must involve the community and it must consult the local Healthwatch organisation(s)
- publish an annual report detailing the activities of the SAB which it must send to the following agencies for scrutiny:
  - LA chief executives and member leads
  - local HWBs
  - local police and crime commissioner

  - local Healthwatch organisation(s).

- decide when a SAR is necessary, arrange for its conduct and if it so decides, implement the findings. SARs are about learning lessons for the future so that practice improvements may be made.

There are also HWBs which have overall strategic responsibility for assessing local health and wellbeing needs in the JSNA, and for agreeing joint health and wellbeing strategies for each local authority area.

The nature of the relationship between and SABs and HWBs is decided locally. However, it is important that the boards are complementary. The SAB should not be subordinate to, nor subsumed within, local structures that might compromise their 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.

7. Conclusion

The safeguarding of children, young people and adults who are at risk is a fundamental obligation for everyone who works in the NHS and its partner agencies. Safeguarding children and adults at risk of abuse or neglect must be kept constantly under review. While there are some similarities, the safeguarding of children and adults are distinct and separate entities which need different approaches.

Fundamentally, every NHS organisation, and every individual healthcare professional working in the NHS, must ensure that the principles and duties of safeguarding adults and children are holistically, consistently and conscientiously applied: **the needs of these at risk citizens and communities must be at the heart of everything the NHS does.**

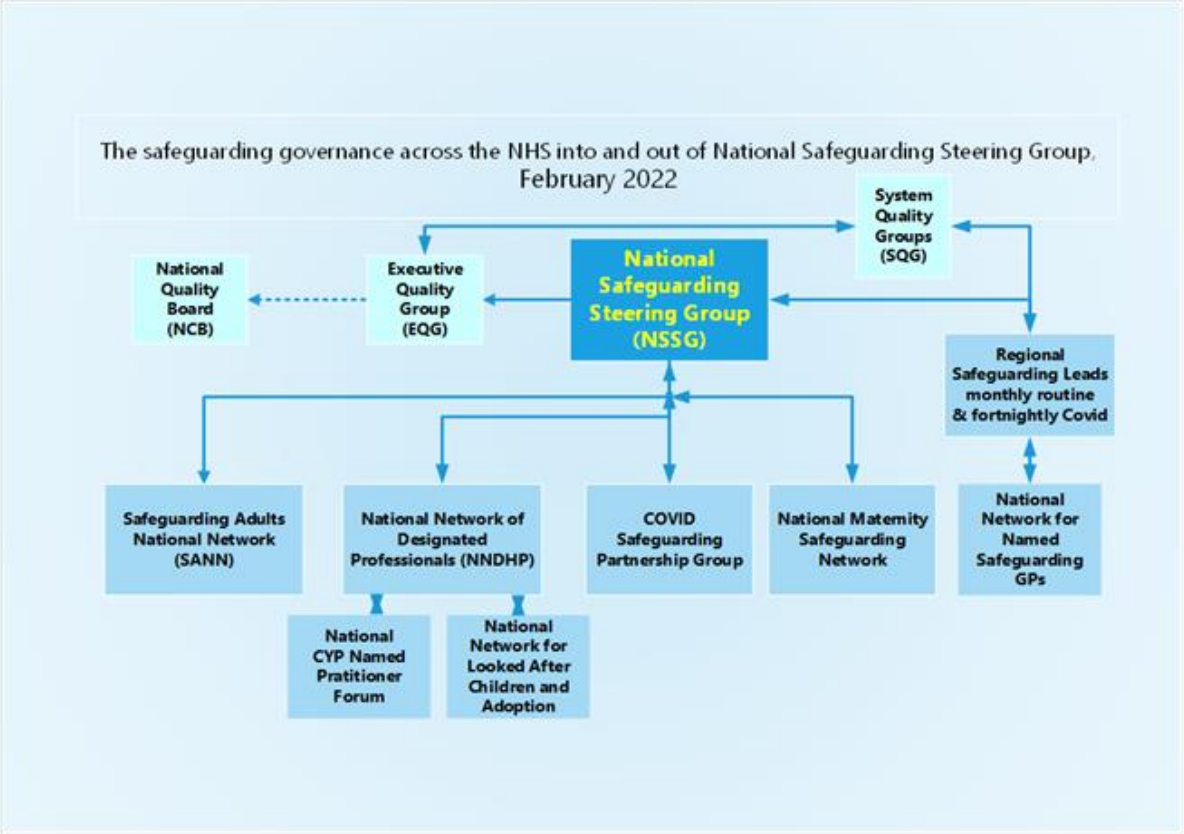
Partnership working is essential, and it is vital that local practitioners continue to develop relationships and work closely with colleagues across their local safeguarding system. This will help to develop ways of working that are collaborative, encourage constructive challenge, and enable learning in a sustainable and co-ordinated way.

NHS England will continue to seek mandated function of safeguarding arrangement assurance across the NHS and health system for pregnant women, children and young people, and at risk adults.

Appendix 1

How NHS England maintains oversight of safeguarding

NHS England's safeguarding role is discharged through the CNO for England, who has a national safeguarding leadership role. The CNO is the lead board executive director for safeguarding and has a number of forums through which assurance and oversight is sought. The system wide NSSG co-ordinates these forums and gains assurance on behalf of the CNO. These groups and the governance arrangements are set out below.



The NHS National Safeguarding Steering Group (NSSG)

The NSSG works with a range of temporary and permanent subgroups and clinical reference groups that focus on key issues using a risk based approach. Membership of the NSSG includes representation from the national safeguarding team, regional safeguarding system leadership, safeguarding clinical networks and safeguarding partners such as the royal colleges and OHID.

NHS England regions

Each NHS England regional chief nurse is accountable for discharging the NHS England safeguarding duties within their region.

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 the submission of regional annual reports using an agreed framework.

The regions provide an annual safeguarding assurance report to the NSSG. 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.

Appendix 2

National Network of Designated Healthcare Professionals for Children (NNDHP)

All members of the independent NNDHP are designated professionals for safeguarding children, children in care and child death overview panels. Information about the NNDHP can be found on the NHS England website. The network is supported financially by NHS England in recognition of the need to provide appropriate support to the practitioners undertaking this complex statutory role, and to enable the network to speak collectively at a regional and national level.

The purpose of the network is to improve the outcomes and life chances of children and young people by:

- bringing together all the child safeguarding, children in care and CDOP designated professionals into one NHS network
- giving a national voice to local safeguarding advice which collectively amounts to national concern
- enabling the ‘voice of health’ and the opinion of safeguarding children expert practitioners to contribute to and influence the national agenda with regards to safeguarding and promoting the welfare of children
- supporting NHS England and other external agencies, at regional and national level
- facilitating partnership working with the Royal College of Paediatrics and Child Health (RCPCH), Royal College of Nursing (RCN), The Faculty of Forensic and Legal Medicine, the NSPCC and CoramBAFF.
- speaking to the primacy of the needs of the child while supporting a ‘think family’ approach in connecting to the SANN via the chairs.

Appendix 3

Safeguarding Adults National Network (SANN)

The SANN is a community of practice providing the national voice of adult safeguarding leads working in commissioning and provider organisations from across England. Their role is to support NHS England in the strategic delivery of adult safeguarding services across England.

As SANN has evolved, its membership has widened to be more inclusive from across the spectrum of adult safeguarding including representation from other partner organisations such as CQC, the SAB Chairs Network, SAB Managers Network, the independent and voluntary sector.

SANN is designed to complement the work of the DHSC Adult Safeguarding Forum and is a clinical reference group to the NSSG.

The purpose of SANN is to:

- develop a strategic focus; encourage ICBs to quality improve and share learning, to proactively influence, shape and develop innovation and improve work streams for safeguarding adults
- contribute to the revisions of the SAAF Outcomes Framework to enable a joint approach to the reporting to CQGs and local SABs on key safeguarding issues
- promote effective communication to ensure that any learning from SARs or other reviews such as DHRs are shared as widely as possible to encourage practice development
- monitor risks within provider organisations for adult safeguarding, Mental Capacity Act, DoLs and prepare for the health implications of the LPSs that replace DoLs from April 2022
- provide a ‘think family’ strengths-based approach and strengthen relationship across related safeguarding networks such as, the National Designated Health Professional Network and National Maternity Safeguarding Network via the chairs

- provide an interface between NHS England and frontline staff by providing a flow of information between NHS Safeguarding Team, regional safeguarding leads and the SANN network.

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This publication can be made available in a number of alternative formats on request.