

Safeguarding Policy

NHS England and NHS Improvement



Safeguarding Policy

Version number: 2

First published: 27th March 2014

Updated: 01st March 2019

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1 Introduction

- 1.1 This policy sets out the statutory requirements that apply to NHS England to ensure the safeguarding of children, young people and adults at risk of harm or abuse. It should be read alongside the NHS England Recruitment Guidance; Managing Safeguarding Allegations Against Staff: Policy and Procedure; Voicing Your Concerns (Whistleblowing) Policy; and Disciplinary Policy. If a particular issue relates to dealing with safeguarding allegations against staff, please refer to the Managing Safeguarding Allegations document.
- 1.2 NHS England and NHS Improvement have committed to delivering a new model of joint working. The purpose is to transform the organisations' ways of working to provide a single system view, single messaging and shared leadership to support and enable integrated care across England. Whilst neither Monitor or the NHS Trust Development Authority have specific statutory duties in relation to safeguarding, NHS Improvement fully supports NHS England in meeting its statutory duties. NHS Improvement considers that all its staff should be aware of the importance of protecting vulnerable children, young people and at-risk adults.
- 1.3 Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework (2015), to be superseded by any updated version of the Accountability and Assurance framework, sets out the safeguarding roles, duties and responsibilities of all organisations in the NHS. It has been developed by NHS England, now working jointly with NHS Improvement, 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 the new responsibilities set out in the Care Act 2014.
- 1.4 The Accountability and Assurance Framework aims to:
- define how health and other systems work together to safeguard children, young people and adults at risk of harm or abuse.
 - clearly set out the legal framework for safeguarding within the NHS, to help staff meet their statutory requirements to safeguard children and adults.
 - outline an ethos that recognises the crucial importance of safeguarding vulnerable individuals, and the fact that this is everybody's responsibility.
 - set out how the health system operates, and how it will be held to account, both locally and nationally.
 - 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.
 - 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.

- 1.5 This policy sets out the collective and individual expectation for NHS England and NHS Improvement staff to comply with legislation, codes of conduct and behaviours required as an employee of either NHS England or NHS Improvement. The policy describes the definitions of abuse for both children and adults; it sets out how employees should report such abuse and describes the inter-related Human Resources (HR) policies that should be read in conjunction with this policy.
- 1.6 This policy will also support NHS Improvement working arrangements as certain areas of its work are gradually merged with those of NHS England.

2 NHS England and NHS Improvement: commitments and values

- 2.1 The NHS Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled. It sets out the pledges the NHS is committed to achieving, together with the responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.
- 2.2 NHS England and NHS Improvement commit to provide line management support and opportunities for learning and development, to ensure that employees have the skills they need to perform their duties and to succeed in their role.
- 2.3 As publicly-funded NHS bodies, NHS England and NHS Improvement expect the highest standards of excellence and professionalism in the people it employs, the education, training and development they receive, and in the leadership and management of the organisation.
- 2.4 NHS England also has a statutory duty to safeguard and promote the welfare of children and young people, to protect adults at risk of abuse, and to support the Home Office Counter Terrorism strategy CONTEST, which includes a specific focus on PREVENT (see Appendix 3 for detailed information). Throughout this document, the phrase ‘children, young people, and adults at risk’ includes those vulnerable to violent extremism and radicalisation.
- 2.5 All staff carrying out the business of NHS England and NHS Improvement need to be aware of the integrated agenda to support and protect vulnerable children, young people and adults at risk.
- 2.6 The key legislative framework supporting this policy includes: the [Children Act 1989](#), the [Human Rights Act 1998](#), the [Children Act 2004](#), the [Crime and Disorder Act \(1998\)](#), the [Mental Capacity Act 2005](#), the [Health and Social Care Act \(2008\)](#), the [Care Act \(2014\)](#), the [Care and Support Statutory](#)

[Guidance](#) (Chapter 14) and the [Working together to safeguard children \(2018\)](#). (Appendix 3 sets out the legislative framework in detail).

- 2.7 Equality and diversity are important to both NHS England and NHS Improvement'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 in the Equality Act 2010). The following have also been referenced in the development of this document: European Convention on Human Rights, the UN Convention on Rights of the Child and the UN Convention on Rights of Persons with Disabilities. This policy will not discriminate, either directly or indirectly, on the grounds of the nine protected characteristics (age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion and belief; sex; and sexual orientation).

3 Purpose

- 3.1 This policy sets out the key principles that all staff and workers working in NHS England and NHS Improvement should be complying with in their safeguarding of children, young people and adults at risk of harm or abuse.

4 Application and scope

- 4.1 This policy applies to all employees and workers of NHS England and NHS Improvement, including secondees into and out of the organisation, volunteers and Patient and Public Voice (PPV) partners, students, honorary appointees, trainees, contractors, and temporary workers, including locum doctors and those working on a bank or agency contract. Performers registered on the National Performers List are also included in this policy.
- 4.2 For ease of reference, all employees and workers who fall under these groups will be uniformly referred to as 'staff' in this document.
- 4.3 Special safeguarding arrangements are in place in relation to patient and public participation within NHS England, including for PPV partners. [Safeguarding: Patient and Public Participation](#) has full guidance on safeguarding policy for these groups.
- 4.4 Appendix 1 gives detailed definitions of 'at risk', 'harm' and 'abuse'.

5 Objectives

- 5.1 In developing this policy, NHS England and NHS Improvement recognise that safeguarding children, young people and adults at risk is a shared responsibility, with the need for effective joint working between statutory and

non-statutory agencies, and professionals with different roles and expertise. In order to achieve effective joint working, there must be constructive relationships at all levels, with:

- strong executive lead at Board level for NHS England in respect of its statutory duties, and all Board members being accountable for safeguarding children, young people and adults at risk of harm or abuse
- clear lines of accountability for safeguarding within NHS England
- robust communication and escalation processes that complement LSCBs, Child Safeguarding Practice Review Panels (CSPRPs) - and their successors – (see 6.6 below) and Safeguarding Adults Boards (SABs) strategies
- staff training and continuing professional development for both organisations, so that staff are competent to undertake their roles and responsibilities, and understand those of other professionals and organisations in relation to safeguarding children and adults at risk
- safe working practices, including recruitment, vetting and barring procedures
- effective interagency working, including effective information sharing
- Designated Professionals, Adult Safeguarding Leads, Looked After Children and Named Professionals, who act variously, as clinical experts and strategic leaders, as a vital source of advice to NHS England and NHS Improvement
- provision of support, supervision and mentorship to safeguarding leads within NHS England and NHS Improvement.

6 Accountability structure for safeguarding

- 6.1 NHS England and NHS Improvement have a single operating model defining their joint purpose with shared governance, systems and processes, organisation structures and capabilities, culture, values and behaviours.
- 6.2 There is senior clinical leadership at all levels of both organisations, including that with responsibility and expertise in safeguarding. The national leadership team includes the Chief Nursing Officer (CNO), who is the Lead Director for safeguarding and works to improve safeguarding practice.
- 6.3 The CNO is responsible to Ministers and NHS England's Board, for ensuring NHS England's statutory compliance with its specific duties under safeguarding legislation.
- 6.4 The Director of Nursing supports the CNO in discharging these functions under the legislation and works with the Head of Safeguarding to ensure both NHS England and NHS Improvement make arrangements to safeguard children, young people and adults at risk.

- 6.4 The Deputy CNO for professional and system leadership works with the CNO to ensure that safeguarding responsibilities are discharged; this post also works with the Head of Safeguarding to ensure that the statutory safeguarding functions of NHS England are properly executed, and that best practice is observed in both organisations.
- 6.5 The Head of Safeguarding supports the Director of Nursing and works with, and supports, Regional Safeguarding Leads to embed safeguarding leadership at every level of both organisations, working across and engaging with a range of stakeholders that influence safeguarding partnerships, such as:
- Health Education England
 - Local Safeguarding Children Boards / Child Safeguarding Practice Review Panels (see 6.6 below)
 - Safeguarding Adult Boards
 - Public Health England
 - Association of Directors of Adult Social Services (ADASS)
 - Society of Local Authority Chief Executives and Senior Managers (SOLACE)
 - Local Government Association (LGA)
 - National Network of Designated Healthcare Professionals for Safeguarding Children (NNDHP)
 - the voluntary sector.
- 6.6 The Children and Social Work Act 2017 replaces LSCBs with new local safeguarding arrangements, specifically the Child Safeguarding Practice Review Panels (CSPRPs), to be led by three partners (local authorities, chief officers of police, and CCGs). The Act places a duty on those partners to make arrangements for themselves, with relevant agencies as they deem appropriate, to work together to safeguard children in their area.

7 Roles and responsibilities

- 7.1 Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework (NHS England and NHS Improvement) sets out clearly the safeguarding roles, duties and responsibilities of all organisations in the NHS.
- 7.2 The CNO is responsible for providing overall assurance to the NHS England Board on the effectiveness and quality of the safeguarding arrangements to ensure that NHS England complies with its statutory duties and that best practice is observed throughout both organisations.
- 7.3 Each Regional Chief Nurse will produce an annual review that provides assurance that:

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- their health commissioning system is working effectively to safeguard children and adults at risk of harm or abuse
- NHS England is meeting its specific safeguarding duties in relation to both the services it commissions directly and the other activities it undertakes, such as public participation
- robust processes are in place for learning lessons from cases where children or adults die, or are seriously harmed, and abuse or neglect is suspected
- both NHS England and NHS Improvement are appropriately engaged in the Local Safeguarding Boards and any local arrangements for safeguarding, with effective mechanisms being in place for LSCBs/CSPRPs (and their successors – see 6.6 above), SABs and health and well-being boards to raise concerns about the engagement and leadership of the local NHS.

7.4 The annual review will draw upon and critically assess a range of intelligence and information from local sources including:

- providers' key performance indicators, identified in the markers of good practice, Section 11 audits, and the Adult Safeguarding: Roles and Competencies for Health Care Staff and the Children's Intercollegiate Document
 - inspection findings
 - statutory reviews that have taken place, their findings and action plans
 - Regulation 28 reports¹
 - CCG and direct commissioning assurance processes
 - Designated Professionals
 - LSCB/CSPRPs/SAB chairs (these roles are likely to change under the new Working Together arrangements – see 6.6 above)
 - contract monitoring processes
 - complaints.

7.5 The Head of Safeguarding, working closely with Regional Chief Nurses, will produce an annual safeguarding assurance report, which will be reviewed and signed off by the National Safeguarding Steering Group (NSSG). The NSSG is the joint committee that feeds into the NHS Board. It has ultimate accountability and responsibility for safeguarding in the NHS.

7.6 Any key findings will be reported to the NHS England Board Commissioning and Assurance Committee. The report will provide assurance, as well as enabling any themes, common issues, emerging trends, and system-wide learning from across the health system, to be identified.

7.7 Any issues identified through this process that require a coordinated and/or system-wide response will be captured and monitored through the NSSG work programme and the NSSG risk register and, where necessary, escalated to the nursing senior management team.

¹ 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'.

- 7.8 Each NHS England region has a Regional Chief Nurse and a number of Directors of Nursing who have the leadership and governance role for local safeguarding. Their role is to: set direction; ensure compliance with standards, policies and procedures; monitor progress and manage risks. They work collaboratively with other NHS England and NHS Improvement regional staff as required, including commissioners, Medical Directors and those with a role in assuring the local system. The following sections describe the roles and responsibilities for safeguarding at the regional level, though local circumstances will determine how these responsibilities are discharged.
- 7.9 The Regional Chief Nurse is responsible for developing and implementing a local model that:
- provides assurance to the NHS England Board, via the NSSG, on the effectiveness and quality of the safeguarding arrangements across the regional health system, to ensure they are meeting statutory requirements
 - disseminates national policy on behalf of both NHS England and NHS Improvement across the system
 - convenes a regular safeguarding network and escalates significant issues with potential system-wide relevance - such as significant issues from serious case reviews, safeguarding adult reviews, domestic homicide reviews, and other statutory processes that may require a national resolution - to the NSSG and quality surveillance groups
 - ensures effective arrangements are in place across the local NHS system to discharge safeguarding duties such as information sharing, sharing best practice and embedding learning from incidents, as well as leading and defining improvement in safeguarding practice at a local level
 - leads on delivering elements of the national safeguarding programme on behalf of the NSSG, as appropriate
 - ensures effective systems are in place for responding to incidents of abuse and neglect of children and adults, to ensure that timely and appropriate referrals are made
 - ensures appropriate representation at LSCBs/CSPRPs (and their successors – see 6.6 above) and SABs in the local area, based on a local determination based on local priorities
 - ensures both NHS England and NHS Improvement staff are appropriately trained, supervised and competent to carry out their safeguarding responsibilities
 - ensures safeguarding expertise is provided to support CCG assurance processes
 - ensures that provision is made for specialist safeguarding advice to NHS England commissioners, working with Designated Professionals as appropriate, to support them in commissioning services and monitoring contractors' performance, and ensuring compliance with safeguarding statutory duties and the Mental Capacity Act

- contributes safeguarding expertise to those maintaining the Performers' List and advises on any performance management concerns related to safeguarding
 - works in partnership with the Local Education and Training Board (LETB) to highlight any safeguarding training needs, and to ensure these needs are met.
- 7.10 In agreeing local attendance arrangements, the Regional Chief Nurse (or their nominee) will work closely with the LSCB/ CSPRP/SAB chairs (these roles are likely to change under the new Working Together arrangements – see 6.6 above), CCGs and Designated Professionals to develop an escalation policy.
- 7.11 A representative of NHS England or NHS Improvement will only attend where there are specific concerns that require oversight or action, e.g. where an improvement board is in place. At other times the organisations will be represented by the Designated Professional or other agreed local representative with clear communication routes back to NHS England and NHS Improvement.
- 7.12 Where services are co-commissioned, arrangements must be agreed with the CCG as appropriate.
- 7.13 Employees of NHS England and NHS Improvement have a responsibility to achieve and maintain the standards set out in this policy. They must therefore report any safeguarding concerns to their line manager and must co-operate with their managers in identifying development needs and acting on them. Managing Safeguarding Allegations Against Staff: Policy and Procedure gives full guidance on the reporting of safeguarding concerns.
- 7.14 Line managers must understand the safeguarding policy and the commitment of NHS England and NHS Improvement, and help their staff maintain their training and awareness.
- 7.15 Line managers must conduct regular reviews of the standards required for each role. A full re-assessment will be required if changes are made to a role so that a new and different level of employment check is required (e.g. if the postholder takes on new duties involving children or adults at risk of harm or abuse).

8 Training

- 8.1 NHS England and NHS Improvement are committed to ensuring that all staff are effectively trained and expects them to be trained in child and adult safeguarding at a minimum of Level 1.
- 8.2 Higher levels of training will be determined by role functions and the responsibilities set out in job descriptions. Comprehensive guidance on the

different levels of safeguarding training required is given in the intercollegiate guidance documents ~

[Safeguarding Children & Young People - Roles and Competencies for Health Care Staff](#)

[Adult Safeguarding - Roles and Competencies for Health Care Staff](#)

- 8.3 Support, supervision and mentoring will be provided for safeguarding leads within NHS England and NHS Improvement as appropriate, in line with personal development needs and the NHS Accountability and Assurance Framework. Line managers will agree the level of safeguarding training required for each employee.
- 8.4 Staff are directed to the [National Skills Academy \(NSA\)](#), previously known as Skills for Health e-learning platform, for safeguarding training.
- 8.5 Health Education England (HEE), in conjunction with its Local Education and Training Boards (LETBs), is responsible for all professional education and training. HEE provides strategic leadership and workforce intelligence in support of NHS England and NHS Improvement and the delivery of the mandate.
- 8.6 Each region may review its training provision and decide on additional training for its staff as required.

9 Safe recruitment

- 9.1 Recruiting managers must seek guidance from Human Resources (HR), to determine the level of DBS (formerly CRB) check required for a role. The manager must ensure the check is completed before the applicant commences employment.
- 9.2 As an employer of staff in a 'regulated activity', NHS England has a legal duty to refer concerns to the DBS in accordance with the Safeguarding Vulnerable Groups Act 2006 (Some employees of NHS Improvement may fall within this category). Managers must report concerns to their local HR team, who should seek advice from the NHS England Safeguarding team, or directly through the Head of Safeguarding. See NHS England and NHS Improvement's Managing Safeguarding Allegations Against Staff: Policy and Procedure.
- 9.3 A staff member of NHS England (or NHS Improvement if appropriate) must be referred to the Disclosure and Barring Service if:

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- they have been permanently removed from 'regulated activity' through dismissal or permanent transfer, *or*
- they would have been removed or transferred if they had not left, resigned, retired or been made redundant, *and if*

- they are believed to have engaged in 'relevant conduct' (i.e. been involved in an action or inaction that has harmed a child, young person or vulnerable adult, or put them at risk of harm), *or*
- they have satisfied the 'harm test' (i.e. no action or inaction was found to have occurred, but there is still a significant risk that it could occur), *or*
- they have received a caution or conviction for a 'relevant offence' (i.e. involving automatic barring, either with or without the right to make representations).

See Appendix 1 for detailed information on 'relevant conduct'.

- 9.4 Anyone convicted or cautioned for certain serious offences will, subject to the consideration of representations where permitted, be barred from working in regulated activity with children and/or vulnerable adults.
- 9.5 The [Disclosure and Barring Service website](#) has comprehensive information and guidance on DBS checks and referrals. Human Resources departments can also offer advice.

10 Managing safeguarding concerns

- 10.1 If an employee of NHS England or NHS Improvement suspects that a child, young person or adult is at risk of harm or abuse, they should notify their line manager and/or local safeguarding lead, and the local Social Services department, in accordance with Working Together 2015 local policies and procedures. They should also consider informing the local police.
- 10.2 The Designated Professional will be available locally for advice and support. During working hours, the central safeguarding team will offer advice and additional support.
- 10.3 Out of hours, staff may contact the Social Services Emergency Duty team. In the case of an emergency, staff may also consider contacting the police.
- 10.4 Managing Safeguarding Allegations Against Staff: Policy and Procedure contains detailed information on the process for managing safeguarding allegations, and Appendix 2 gives a useful flowchart of the process.

11 Information sharing

- 11.1 It is important that patients remain confident that their personal information is kept safe and secure. Practitioners must be confident to share information appropriately when safeguarding vulnerable individuals. Failures of communication lie at the heart of many safeguarding failures. At the same time, care should be taken to maintain the right to privacy of individuals when it is appropriate to do so.
- 11.2 Professionals should refer to their own professional body's advice regarding information sharing. For example, the GMC offers this information on [Confidentiality and sharing information](#), the NMC has this [Code for nurses and midwives](#) and p.78 of the [Working together to safeguard children 2018](#) has guidance related to information requests.
- 11.3 Staff should ensure they are familiar with either the NHS England or NHS Improvement information governance policy (or joint policy when developed), and undertake mandatory information governance training. This will clarify the type of information it is appropriate to share. LSCBs/CSPRPs (and their successors – see 6.6 above) and SABs will have multi-agency information-sharing policies and protocols in place, and staff should ensure they understand and adhere to them.
- 11.4 The EU's General Data Protection Regulation (GDPR) came into force in May 2018 and strengthens personal data protection for all individuals within the European Union. New regulations will come into effect to amend the text of the GDPR when the UK leaves the EU². The [NHS GDPR Guidance](#) contains useful information on how the EU Regulations affect the collection, use, storage and sharing of personal information.
- 11.5 The following are regarded as the 'seven golden rules' of information sharing:
- 11.5.1 The Data Protection Act 2018 should not be regarded as a barrier to sharing information.
 - 11.5.2 A record should be kept of what has been shared, with whom and for what purpose, and of every decision made and the reasoning behind it.
 - 11.5.3 It is important to be open and honest with the individual concerned (and their family, where appropriate) from the outset, about why, what, how and with whom information will, or could, be shared, and to seek their agreement, unless it is unsafe or inappropriate to do so.
 - 11.5.4 If in doubt, and if possible, a staff member should seek advice, without disclosing the identity of the individual concerned.

² [Data Protection, Privacy and Electronic Communications \(Amendments etc.\) \(EU Exit\) Regulations 2019](#)

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- 11.5.5 Information sharing should be by consent where appropriate, and, wherever possible, respect the wishes of those who have not consented to share confidential information. Information may be shared without consent if it is believed, based on the facts of the case, that lack of consent can be overridden in the public interest.
 - 11.5.6 It is important to consider the safety and well-being of the individual concerned, as well as others who may be affected by their actions.
 - 11.5.7 Information sharing should always be necessary, proportionate, relevant, accurate, timely and secure.
- 11.6 Any safeguarding issue that may attract media interest should be shared with the regional communications team. They will share it with the national communications team, the Head of Safeguarding, and the Director of Nursing, so that they are able to brief the CNO/CEO/DHSC as required.

12 Monitoring

- 12.1 The NSSG will monitor compliance with this policy.
- 12.2 The Head of Safeguarding is responsible for the monitoring, revision and updating of this policy. The Head of Safeguarding will act on behalf of the Chief Nursing Officer (CNO) in this respect and will update the CNO on its implementation.
- 12.3 This policy will be monitored regularly with regard to its implications for equality and diversity.

13 Equality and health inequalities analysis

- 13.1 Promoting equality and addressing health inequalities are important to NHS England and NHS Improvement. Throughout the development of the policies and processes cited in this document, we have:
- considered 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;
 - considered 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.

Appendix 1:

Definitions of 'at risk', 'harm' and 'relevant conduct'

Definition of people at risk

Safeguarding means protecting a person's right to live in safety, free from abuse and neglect. All staff within NHS England and NHS Improvement have a responsibility to safeguard people in their care, but extra care must be taken to protect those who are least able to protect themselves. Children and young people, and vulnerable adults, can be at particular risk of abuse or neglect.

A child is a person aged under 18 years; young people aged 16 or 17 who are living independently are still defined as 'children'.

A vulnerable adult is someone who may be in need of care because of a physical, learning or other disability, or because of their age or an illness. This definition also applies to an adult who is unable to take care of him or herself properly, or who is unable to protect him or herself from significant harm or exploitation.

Some groups of people are particularly vulnerable to harm and exploitation, and it is important that their needs are carefully considered:

- those with disabilities
- those living away from home
- asylum seekers
- children and young people in hospital
- children in contact with the youth justice system
- victims of domestic abuse
- those who may be singled out due to their religion or ethnicity
- those who may be exposed to violent extremism.

Definitions of harm: Children

Physical harm

Physical harm is defined as physical contact that results in discomfort, pain or injury. It may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm.

Supplying drugs to children, or the use of inappropriate or unauthorised methods of restraint, also fall under this definition.

Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces or causes, illness in a child. This situation is commonly described as 'factitious illness by proxy' or 'Munchausen syndrome by proxy'.

Emotional and psychological harm

Emotional harm is defined as action or inaction by others that causes mental anguish. It involves the persistent emotional maltreatment of a child, which causes severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person.

Such harm may feature age or developmentally inappropriate expectations being imposed on a child. These can include interactions that are beyond the child's development capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction.

Emotional harm may also involve witnessing aggressive, violent or harmful behaviour towards another individual (e.g. domestic violence). It may also involve serious bullying, frequently causing a child to feel frightened or in danger, exploitation or corruption.

Some level of emotional harm is involved in all types of maltreatment of a child (e.g. grooming, harassment, or inappropriate emotional involvement), though it may occur alone.

Sexual harm and exploitation

Sexual harm is defined as any form of sexual activity involving a child under the age of consent. It involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening.

Such activities may involve physical contact, including penetrative (e.g. rape, buggery or oral sex) or non-penetrative acts. They may also include non-contact activities, such as involving children in the looking at, or production of, pornographic material, causing them to watch sexual activities, or encouraging them to behave in sexually inappropriate ways.

Downloading child pornography, taking indecent photographs of children, and sexualised texting, are all forms of sexual harm.

Neglect and acts of omission

Neglect is a persistent failure to meet a child's basic physical and/or psychological needs, which is likely to result in serious impairment of the child's health or development.

Neglect may occur during pregnancy as a result of maternal substance abuse.

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Once a child is born, neglect may involve a parent or carer failing to:

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

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

Female Genital Mutilation (FGM)

Female genital mutilation (FGM) is a procedure where the female genitals are deliberately cut, injured or changed, without medical justification. It is also known as 'female circumcision' or 'cutting', and by other terms such as initiation, infibulation, sunna, gudniin, halalays, tahur, megrez and khitan.

FGM is usually carried out on young girls between infancy and the age of 15, most commonly before puberty starts. It is very painful and can seriously harm the health of women and girls. It can also cause long-term problems with sex, childbirth and mental health.

UK communities most at risk of FGM include Kenyan, Somalian, Sudanese, Sierra Leonean, Egyptian, Nigerian and Eritrean. Non-African countries that practise FGM include Yemen, Afghanistan, Kurdistan, Indonesia, Malaysia, Turkey, Thailand (South) and Pakistan.

FGM is a form of child abuse and is illegal in the UK. It is a mandatory duty for a regulated healthcare professional to report any concerns they have about a female under 18 years old, and to record when FGM is disclosed or identified as part of NHS healthcare. This is a personal duty: the individual professional who becomes aware of the case must make a report, and the responsibility cannot be transferred.

The Home Office's [Multi-agency Statutory Guidance on Female Genital Mutilation](#) offers comprehensive information on FGM; [Mandatory Reporting of Female Genital Mutilation: procedural information](#) gives guidance on when and how to report a case of FGM.

Relevant conduct: Children

A child is a person under 18 years of age.

Any behaviour involving a child is classed as 'relevant conduct' if it:

- endangers a child, or is likely to endanger a child
- if repeated against, or in relation to, a child, would endanger the child or be likely to endanger the child

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- involves sexual material relating to children (including the possession of such material)
- involves sexually explicit images depicting violence against human beings (including the possession of such material)
- includes any behaviour of a sexual nature involving a child.

A person's conduct endangers a child if it:

- harms a child
- causes a child to be harmed
- puts a child at risk of harm
- makes an attempt to harm a child
- incites another person to harm a child.

A person's conduct satisfies the 'harm test' if they are thought likely to:

- harm a child
- cause a child to be harmed
- put a child at risk of harm
- make an attempt to harm a child
- incite another person to harm a child.

Definitions of harm: Vulnerable adults

Safeguarding means protecting the adult's right to live in safety and free from abuse and neglect and promoting the adult's wellbeing.

Safeguarding duties apply to an adult at risk as defined in [Section 42 of The Care Act 2014](#) which is:

- A. has needs for care and support (whether or not the authority is meeting any of those needs)
- B. is experiencing, or at risk of abuse and neglect
- C. as a result of their needs for care and support unable to protect themselves from the abuse or neglect or risk of it

Physical harm

Physical harm is any physical contact that results in discomfort, pain or injury.

Examples of physical harm include:

- assault, rough handling, hitting, slapping, punching, pushing, pinching, shaking, bruising or scalding
- exposure to excessive heat or cold
- a failure to treat sores or wounds
- inappropriate use of medication (e.g. under- or overuse of medication, or the use of un-prescribed medication)
- the use of inappropriate sanctions

- the unlawful or inappropriate use of restraint or physical interventions
- the deprivation of liberty.

Sexual harm and exploitation

Examples of sexual harm and exploitation can include the direct or indirect involvement of the vulnerable adult in sexual activity or relationships that:

- they do not want or have not consented to
- they cannot understand, and cannot consent to, since they lack the mental capacity
- they have been coerced into because the other person is in a position of trust, power or authority, e.g. a care worker.

Sexual harm can involve bruising or injury to the anal, genital or abdominal area, and the transmission of STD. It also includes inappropriate touching.

Being forced to watch sexual activity is also a form of sexual exploitation.

Psychological and emotional harm

This is behaviour that causes mental distress or has a harmful effect on an individual's emotional health and development. It can include:

- mocking, coercing, bullying, verbal attacks, intimidation or harassment
- demeaning, disrespectful, humiliating, racist, sexist or sarcastic comments, shouting, swearing or name-calling
- excessive or unwanted familiarity
- the denial of basic human and civil rights such as self-expression, privacy and dignity
- negating the right of the vulnerable adult to make choices
- undermining the individual's self-esteem
- isolation and over-dependence that has a harmful effect on the person's emotional health, development or well-being
- the use of inflexible regimes and lack of choice.

Neglect

Neglect occurs when a person's well-being is impaired because his or her care or social needs are not met.

Examples of neglect include:

- the failure to allow access to appropriate health, social care and educational services
- the failure to provide adequate nutrition, hydration or heating, or access to appropriate medication

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- ignoring medical or physical needs, e.g. untreated weight loss, or a lack of care that results in pressure sores or uncharacteristic problems with continence
- poor hygiene, e.g. lack of general cleanliness or soiled clothes not being changed
- the failure to address the vulnerable individual's requests.

Neglect can be intentional or unintentional. Intentional neglect can include:

- wilfully failing to provide care
- wilfully preventing the vulnerable adult from getting the care they need
- being reckless about the consequences of the person not getting the care they need.

Unintentional neglect can include:

- a carer failing to meet the needs of the vulnerable adult because they do not understand their needs
- a carer lacking knowledge about the services that are available
- a carer's own needs preventing them from being able to give the care the person needs
- an individual being unaware of, or lacking an understanding of, the possible effect on the vulnerable adult of a lack of action.

Discrimination

Discrimination exists when values, beliefs or culture result in a misuse of power, or the denial of rightful opportunities, so causing harm.

Any psychological abuse that is racist, sexist, or linked to a person's sexuality, disability, religion, ethnic origin, gender, culture, or age, is discriminatory.

Institutional harm

Examples of institutional harm can include:

- an observed lack of dignity and respect in the care setting
- the enforcement of rigid routines
- processes and tasks being organised to meet the needs of staff rather than those in their care
- disrespectful language and attitudes.

Financial harm

Financial harm is the use of a person's property, assets, income, funds or other resources without their informed consent or authorisation. It includes:

- theft
- fraud

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- exploitation
- unauthorised withdrawals of funds from an account
- undue pressure in connection with wills, property, inheritance or financial transactions
- the misuse or misappropriation of property, possessions or benefits
- the misuse of an enduring power of attorney, or a lasting power of attorney, or an appointeeship.

Domestic violence and self-harm should also be considered as possible indicators of, and/or contributory factors to, harm or abuse.

Relevant conduct: Vulnerable adults

A vulnerable adult is a person aged 18 years or over who is receiving a service or assistance which is classed as regulated activity for adults.

Any behaviour is classed as 'relevant conduct' if it:

- endangers a vulnerable adult or is likely to endanger a vulnerable adult
- if repeated against, or in relation to, a vulnerable adult, would endanger the vulnerable adult or be likely to endanger them
- involves sexual material relating to children
- involves sexually explicit images depicting violence against human beings (including possession of such images)
- is of a sexual nature involving a vulnerable adult.

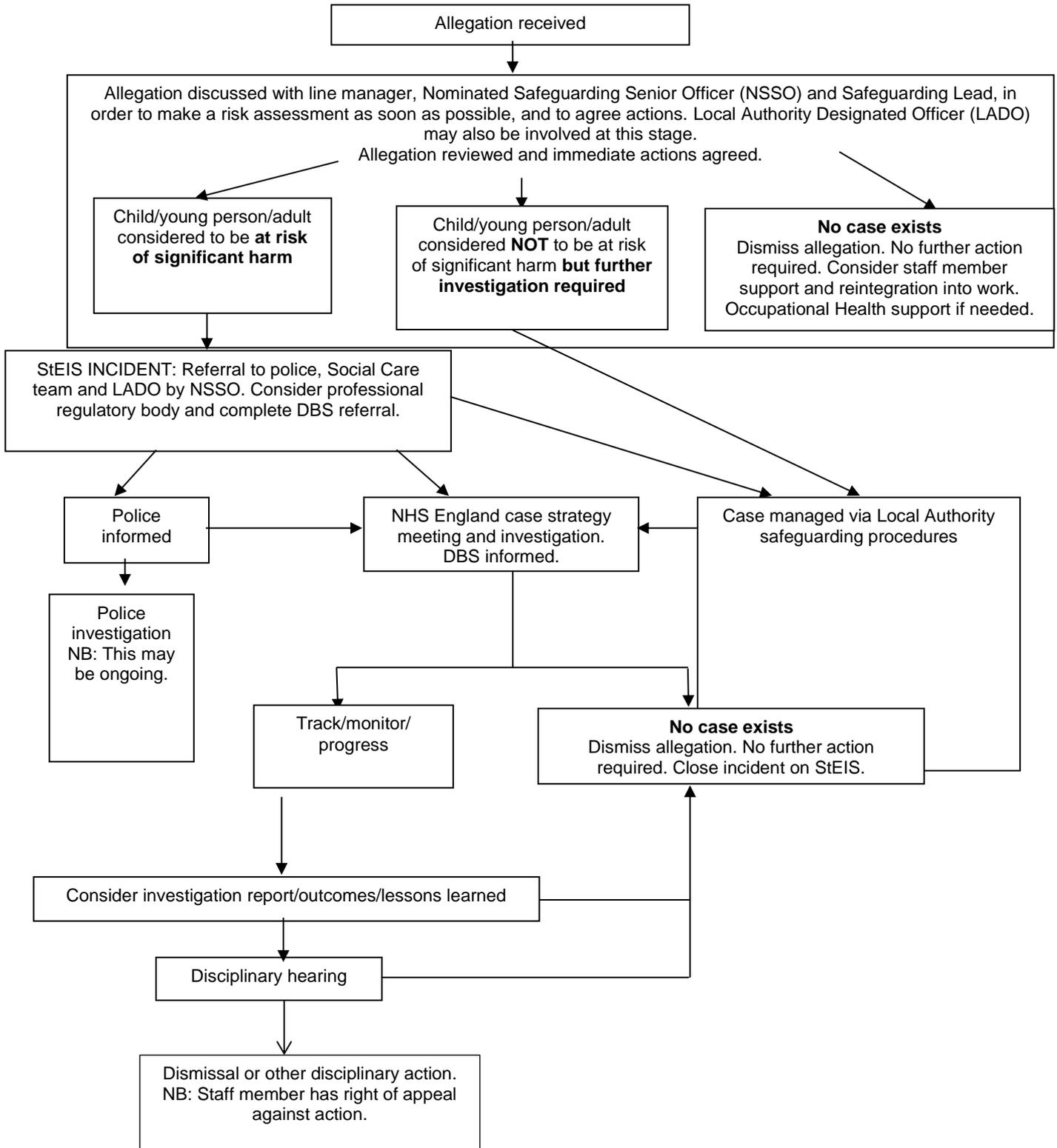
A person's conduct endangers a vulnerable adult if it:

- harms a vulnerable adult
- causes a vulnerable adult to be harmed
- puts a vulnerable adult at risk of harm
- makes an attempt to harm a vulnerable adult
- incites another person to harm a vulnerable adult.

A person's conduct satisfies the 'harm test' if they are thought likely to:

- harm a vulnerable adult
- cause a vulnerable adult to be harmed
- put a vulnerable adult at risk of harm
- make an attempt to harm a vulnerable adult
- incite another person to harm a vulnerable adult.

Appendix 2: Managing Allegations Process Flowchart



Appendix 3: Legislative Framework

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 the safeguarding of children and that of adults, based on who can make decisions.

The responsibility for decision-making relating to children lies with those who have parental responsibility. As a child grows in maturity and understanding, the law gives the child a greater say in decisions. Once a child understands fully the choice to be made and its consequences, the child's view prevails,³ at least as regards consent, though occasionally the courts have been prepared to override a capable child's refusal of life-saving treatment.

When issues about a child's care, or their money or property, are considered by a court, statute makes it clear that 'the child's welfare shall be the court's paramount consideration'.⁴ This 'paramountcy principle' has a far-reaching effect on children's healthcare practice, emphasising what a court would need to see in order to approve arrangements.

Adults have a legal right to make their own decisions, even if they are unwise, as long as they have capacity to make those decisions and are 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.⁵

While many key statutory provisions apply directly to a broad range of public bodies, including the NHS and the police, some key legislative provisions impose duties directly on Local Authorities. However, the NHS and other agencies are covered by these duties indirectly, because they must co-operate with Local Authorities over safeguarding.

Children and young people

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

- [The Children Act 1989](#)

³ Gillick v West Norfolk and Wisbech AHA [1986] AC 112

⁴ Section 1(1) Children Act 1989

⁵ Mental Capacity Act Code of Practice, HMG, 2005, 2.11.

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- [The Children Act 2004](#) as amended by Sections 12-31 of the Children and Social Work Act 2017
- [The Children and Social Work Act 2017](#)
- [Promoting the Health and Well-being of Looked After Children](#) – statutory guidance (2015)
- [Working Together to Safeguard Children – July 2018](#) (Statutory guidance)

Appendix B of the statutory guidance document [Working together to safeguard children](#) gives details of the statutory provisions relating to children’s safeguarding. This document focuses on the provisions relevant to the NHS.

The following broad and fundamental safeguarding duties apply to the care of children:

- There is a duty on Local Authorities to ‘safeguard and promote the welfare of children within their area who are in need’.⁶ 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.⁷
- Local authorities must also ‘take reasonable steps... to prevent children within their area suffering ill-treatment or neglect’.⁸
- All public-sector agencies providing services to children, including Local Authorities and 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’.⁹
- A child-centred approach is required. As far as reasonably possible, Local Authorities must ascertain the child’s wishes and feelings,¹⁰ and devise their support in consideration of those wishes and feelings. However, Local Authorities are not required to provide this 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.¹¹

All agencies must recognise that safeguarding is everyone’s responsibility. No individual agency can assume that safeguarding issues will be picked up by others. To confirm and illustrate this, there are the following duties on inter-agency co-operation:

- If, in discharging its safeguarding duties, a Local Authority requests assistance from a specified agency, such as NHS England, CCGs, or an NHS trust or foundation trust, that agency must provide assistance, as long

⁶ Section 17(1) Children Act 1989

⁷ Section 17(10) Children Act 1989

⁸ Paragraph 4, Schedule 2, Children Act 1989

⁹ Section 11 Children Act 2004

¹⁰ Section 53 Children Act 2004

¹¹ Section 47 Children Act 1989

as doing so is compatible with its own duties and will not hamper the discharge of its own function.¹²

- Local Authorities must promote co-operation with other agencies, including NHS England and all CCGs, to promote the well-being of children, and to protect them from harm and neglect. Those other agencies have an express duty to co-operate with the local authority.¹³

Local Safeguarding Partnerships are now responsible for monitoring inter-agency co-operation. CCGs and Designated Professionals and local providers should ensure they are appropriately represented on the Local Safeguarding Partnership, with the duty of co-operation to each other, specifically in relation to the establishment and operation of the Local Safeguarding Partnership objectives:

- to co-ordinate activities of board members to safeguard and promote the welfare of children
- to ensure the effectiveness of those activities
- commissioning serious case reviews where: abuse or neglect of a child is known or suspected; or the child has either died or been seriously harmed, and there is concern over how agencies and service providers have worked together.¹⁴

The Children and Social Work Act 2017 replaces LSCBs with new local safeguarding arrangements, specifically the Child Safeguarding Practice Review Panels (CSPRPs) to be led by three partners (local authorities, chief officers of police, and CCGs). The Act places a duty on those partners to make arrangements for themselves, with relevant agencies as they deem appropriate, to work together to safeguard children in their area. During 2019, eleven Early Adopter and six Partners in Practice 'Pathfinder' organisations are working to these new arrangements; their experiences will help inform the wider implementation of the new system.

Adults at risk of harm or abuse

The legislation and guidance relevant to safeguarding adults at risk of harm or abuse 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.

The following broad and fundamental safeguarding duties apply to adults at risk of harm or abuse:

¹² Section 27 Children Act 1989

¹³ Section 10 Children Act 2004

¹⁴ Section 14 Children Act 2004 and paragraph 5 of the Local Safeguarding Children Boards Regulations 2006

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- Local Authorities must promote the adult's 'well-being'.¹⁵ Within this broad concept, the authority must 'have regard to the need to protect people from abuse and neglect'.¹⁶
- If a local authority has reasonable cause to suspect that an adult in its area is suffering, or is at risk of, abuse or 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'¹⁷). Enquiries should be made by the most appropriate professional; in some circumstances that will be a health professional.

Local Authorities and their 'relevant partners', must co-operate in discharging these duties. 'Relevant partners' include NHS England and all CCGs and NHS Trusts and foundation trusts in the Local Authority's area.¹⁸

Where the safeguarding action requires that an adult's needs are assessed, or care plans (or care and support plans) are prepared or revised, the Local Authority must consider if the adult needs an independent advocate. This need is indicated when the adult would experience substantial difficulty in:

- understanding or retaining relevant information
- weighing up that information as part of the decision-making process
- communicating their views.¹⁹

Each Local Authority must establish a Safeguarding Adults Board (SAB) in its area.²⁰ The main objective of the SAB is to help and protect adults in its area. CCGs, working with the health system, should be properly represented on the SAB. The Local Authority may include any other body it considers appropriate, following consultation with other members.²¹

A SAB can arrange a safeguarding adult review whenever it chooses. However, it is obliged to arrange one where an adult has died from, or experienced, serious abuse or neglect, and there is reasonable cause for concern about how the agencies and service providers involved worked together to safeguard the adult.²² Core partners are required to contribute to such reviews when requested.

The Government's [policy statement on adult safeguarding](#) sets out six principles for safeguarding adults:

- Empowerment: the presumption of person-led decisions and consent
- Protection: support and representation for those in greatest need
- Prevention of harm or abuse: taking action before harm occurs

¹⁵ Section 1(1) Care Act 2014

¹⁶ Section 1 (2) (c) Care Act 2014

¹⁷ Section 42 Care Act 2014

¹⁸ Section 6 and 7 Care Act 2014

¹⁹ Section 68 Care Act 2014

²⁰ Section 43 Care Act 2014

²¹ Schedule 2 Care Act 2014

²² Section 44 Care Act 2014

- Proportionality: taking the least intrusive response appropriate to the risk presented
- Partnerships: local solutions through services working with their communities, which have an important part to play in identifying, preventing and reporting neglect and abuse
- Accountability and transparency in delivering safeguarding.

Whilst they are not legal duties, these principles do represent best practice. They also provide a foundation for achieving good outcomes.

The Mental Capacity Act

The Mental Capacity Act 2005 (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over.

People who may lack capacity include those with:

- dementia
- a severe learning disability
- a brain injury
- a mental health illness
- a stroke
- substance or alcohol misuse
- confusion, drowsiness or unconsciousness because of an illness or treatment for an illness.

Just because a person has one of these health conditions doesn't necessarily mean they lack the capacity to make a specific decision.

Five important principles underpin the Mental Capacity Act:

- It is important to assume that a person has the capacity to make a decision themselves, unless proven otherwise.
- Wherever possible, people should be supported to make their own decisions.
- A person should not be treated as lacking the capacity to make a decision just because they make what seems like an unwise decision.
- If a decision is made on behalf of someone who doesn't have capacity, it must be made in their best interests.
- Any treatment or care provided to someone who lacks capacity should be the least restrictive possible of their basic rights and freedoms.

The MCA also allows people to express their preferences for care and treatment, and to appoint a trusted person to make a decision on their behalf, should they lack capacity in the future.

Amendments to the Mental Capacity Act, to come into effect in 2019, will make changes to the ways in which a person may be deprived of liberty where he or she does not have the capacity to consent.

Information sharing

Good information-sharing practice is at the heart of good safeguarding practice. This area is covered by legislation, principally the Data Protection Act 2018 and the General Data Protection Regulation (as both will be amended after the UK leaves the EU), and by court decisions on issues of confidentiality and privacy.

At its heart is the principle that information should be shared if this helps to protect children or adults, or to prevent a crime. In addition, there are some statutory provisions, for example, relating to the operation of LSCBs/CSPRPs, and SABs, (and relating to the statutory scheme for vetting and barring) which specifically require information sharing.²³

Vetting and barring

There is a statutory scheme for vetting people working with children and adults vulnerable to abuse or neglect. The scheme is administered by the [Disclosure and Barring Service](#). This system provides 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 harm or abuse.

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.²⁴

During 2018, the Government will consult on its new Domestic Abuse Bill, aimed at seeking new laws and stronger powers of protection for those affected by domestic abuse.

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' and they must be of good character

Duty of candour

Good safeguarding practice requires openness, transparency and trust. There is a legal 'duty of candour' on health service bodies.²⁵ This means informing people (in person and in writing) about mistakes or other incidents that have not produced the

²³ Section 14B Children Act 2004; sections 37 and 40 Safeguarding Vulnerable Groups Act 2006; section 45 Care Act 2014

²⁴ Section 9 Domestic Violence, Crime and Victims Act 2004

²⁵ Regulation 20, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

desired outcome, apologising where appropriate, and advising on any action taken as a result.

NHS England as a commissioning organisation

As a commissioning organisation, NHS England is required to ensure that all health providers from which it commissions services (in the public and independent sectors) have comprehensive single and multi-agency policies and procedures in place to:

- safeguard and promote the welfare of children and young people
- protect vulnerable adults at risk of harm or abuse
- ensure that health providers are linked to the Local Safeguarding Children Boards and Safeguarding Adults Boards
- ensure that health workers contribute to multi-agency working.

This policy supports the commitment given in the NHS Mandate: '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 joined-up approach to addressing their needs.'

In April 2019, the NHS Standard Contract will explicitly contain NHS Safeguarding programmes, except Modern Slavery, for which the NHS is not yet a first responder. However, notwithstanding this, NHS staff must signpost those affected by modern slavery to accredited first responders.

PREVENT/ CONTEST

Healthcare professionals will meet and treat people who may be vulnerable to being drawn into terrorism. Being drawn into terrorism includes not just violent extremism but also non-violent extremism, which can create an atmosphere conducive to terrorism and can popularise views which terrorists exploit.

The key challenge for the healthcare sector is to ensure that, where there are signs that someone has been, or is being, drawn into terrorism, the healthcare worker is trained to recognise those signs correctly and is aware of, and can locate, available support, including the Channel programme where necessary.

Preventing someone from being drawn into terrorism is substantially comparable to safeguarding in other areas, including child abuse or domestic violence, and all providers and staff within NHS England have a statutory duty to prevent.

NHS England has incorporated Prevent into its safeguarding arrangements, so that Prevent awareness and other relevant training is delivered to all staff who provide services to NHS patients. These arrangements have been effective and should continue.

The Chief Nursing Officer in NHS England has responsibility for all safeguarding, and a safeguarding lead, working to the Director of Nursing, is responsible for the

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overview and management of embedding the Prevent programme into safeguarding procedures across the NHS.

Each regional team in the NHS has a Head of Patient Experience who leads on safeguarding in their region. They are responsible for delivery of the Prevent strategy within their region, and work with the health Regional Prevent Co-ordinators (RPCs). The RPCs are expected to have regular contact with Prevent leads in NHS organisations, to offer advice and guidance.

In fulfilling this duty, health bodies are expected to demonstrate effective action in these areas: Partnership, Risk Assessment, Staff Training, and Monitoring and Enforcement.

Partnership

All Sub Regions within the NHS should, under the NHS England Accountability and Assurance Framework, have in place local Safeguarding Forums, including local commissioners and providers of NHS Services. These forums have oversight of compliance with the duty and ensure effective delivery. Within each area, the RPCs are responsible for promoting Prevent to providers and commissioners of NHS services, supporting organisations to embed Prevent into their policies and procedures, and delivering training.

Mechanisms should be in place for reporting issues to the National Prevent sub board.

The Prevent lead should also have networks in place for their own advice and support to make referrals to the Channel programme.

Since April 2013, commissioners have used the NHS Standard Contract for all commissioned services excluding Primary Care, including private and voluntary organisations. Since that time, the Safeguarding section of the contract has required providers to embed Prevent into their delivery of services, policies and training. This is now reinforced by the statutory duty.

Risk Assessment

All NHS Trusts in England have a Prevent lead who acts as a single point of contact for the health regional Prevent co-ordinators and is responsible for implementing Prevent within their organisation.

To comply with the duty, and as a result of their training, staff are expected to be able to recognise those at risk of being drawn into terrorism, and to refer them to the Prevent lead, who may make a referral to the Channel programme. See below for details of BPA and WRAP training.

Regional health Prevent co-ordinators are able to provide advice and support to staff as required.

Staff Training

The intercollegiate guidance [Safeguarding Children and Young people: roles and competences for health care staff](#) includes Prevent information, and identifies competencies for all healthcare staff against six levels. See below for details of BPA and WRAP training.

The training should allow all relevant staff to recognise vulnerability to being drawn into terrorism, which includes someone with extremist ideas that are used to legitimise terrorism and shared by terrorist groups, and to be aware of what action to take in response. This can include local processes and policies that will enable them to make referrals to the Channel programme, and to receive additional advice and support.

It is important that staff understand how to balance patient confidentiality with the duty. They should also be made aware of the information sharing agreements in place for sharing information with other sectors, and get advice and support on confidentiality issues when responding to potential evidence that someone is being drawn into terrorism, either during informal contact or consultation and treatment.

It is expected that providers have in place:

- policies that include the principles of the Prevent NHS guidance and toolkit, which are set out in [Building Partnerships, Staying Safe: guidance for healthcare organisations](#)
- a programme to deliver Prevent training, resourced with accredited facilitators
- processes in place to ensure that using the intercollegiate guidance, staff receive Prevent awareness training appropriate to their role (see below)
- procedures to comply with the Prevent Training and Competencies Framework.

Monitoring and Enforcement

Within the NHS, it is expected that local safeguarding forums, including local commissioners and providers of NHS services, will have oversight of fulfilling the duty and ensuring effective delivery.

NHS Improvement ensures that NHS Foundation Trusts are well led and able to provide quality care on a sustainable basis and oversees the performance of NHS Trusts. The Care Quality Commission is the independent health and adult social care regulator that ensures these services provide people with safe, effective and high quality care.

Consideration is being given to whether these internal arrangements are robust enough to effectively monitor compliance with the duty, or whether the duty should be incorporated into the remit and inspection regimes of one of the existing health regulatory bodies, or another body.

Basic Prevent Awareness (BPA)

Staff who are required to have Level 1 or Level 2 training (as set out in the Intercollegiate Safeguarding documents for children and adults), are required to undergo Basic Prevent Awareness training.

BPA training is designed to build an awareness and understanding of:

- the indicators of risk relating to individuals becoming radicalised
- the impact that factors such as bullying, befriending and influencing, the media and the internet, might have on individuals, and how these factors might change their behaviour
- the importance of sharing information and concerns appropriately, and the possible consequences of not sharing them
- the mechanisms for raising concerns and accessing advice.

More information on Basic Prevent Awareness training is contained in the [Prevent Training and Competencies Framework](#).

Workshop Raising Awareness of Prevent (WRAP)

Staff who are required to have Level 3, Level 4 or Level 5 training, in line with the Intercollegiate Safeguarding documents, must undergo Workshop Raising Awareness of Prevent (WRAP). These are staff who could potentially contribute to assessing, planning, intervening in, and evaluating the needs of a child or vulnerable adult where there are safeguarding concerns.

WRAP is designed to provide the same basic skills as BPA training, but also equips practitioners to be able to:

- support and redirect vulnerable individuals at risk of being groomed into terrorist-related activities
- share concerns, get advice, and make referrals appropriately.

More information on Workshop Raising Awareness of Prevent is contained in the [Prevent Training and Competencies Framework](#).