QUALITY SPECIFICATION	**Safeguarding Children and Young People (up to the age of 19 years)**

1. STATEMENT

1.1 Clinical Commissioning Groups (CCGs) have a responsibility (Section 11: Children Act 2004), to ensure that safeguarding and promoting the welfare of children is discharged effectively across the local health economy through its commissioning arrangements.

Health providers have a statutory duty of care towards children and young people.

Having safeguards in place within an organisation not only protects and promotes the welfare of children and young people but also enhances the confidence of staff, volunteers, parents/carers and the general public. Clear lines of accountability should exist and responsibilities for safeguarding and promoting the welfare of children should be encompassed within job descriptions.

Luton CCG fully recognises their responsibility, and takes all reasonable steps to promote safe practice and to protect children and young people from harm, abuse and exploitation whilst work closely with partners. The CCG will ensure robust monitoring arrangements are in place to support compliance and will be achieved through integral clinical governance arrangements.

Luton CCG need assurance that robust safeguarding arrangements are in place in the provider organisation, this includes working in partnership the Local Safeguarding Children's Board (LSCB) as outlined in the *Operating Framework 2014/15 and Working Together to Safeguard Children 2013, any revisions made (2015; expected 18).*

2. DEFINITION

2.1 For the purpose of this Schedule,

Safeguarding and promoting the welfare of children, is defined as;

- Protecting children from maltreatment;
- Preventing impairment of their health and development;
- Ensuring they are growing up in circumstances consistent with the provision of safe and effective care; and
- Taking action to enable all children to have the best outcomes (*Working Together to Safeguard Children 2018).*

All providers of health services are responsible for ensuring their organisations provide effective safeguarding processes and must co-operate with the Local Safeguarding Children's Board, Children's Social Care and Her Majesty Constabulary, as statutory partners, share responsibility for the effective discharge of functions in safeguarding and promoting the welfare of children.

3. SAFEGUARDING PRINCIPLES

3.1
Children may be vulnerable to neglect and abuse or exploitation from within their family and from individuals they come across in their day-to-day lives. These threats can take a variety of different forms, including: sexual, physical and emotional abuse; neglect; exploitation by criminal gangs and organised crime groups; trafficking; online abuse; sexual exploitation and the influences of extremism leading to radicalisation. Whatever the form of abuse or neglect, practitioners should put the needs of children first when determining what action to take.

3. SAFEGUARDING PRINCIPLES

3.2 A safeguarding children policy, which is child focused, is available to all staff. This should be informed by the Local Safeguarding Children's Board policy, and current legislation and guidance.

3.2.1 A safeguarding supervision policy that reflects a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, reflection, reflexivity and professional curiosity; assume responsibility for their own practice and enhance patient/client protection and safety of care in complex clinical situations. CQC 2013.
The key functions of supervision are:

- management (ensuring competent and accountable performance/practice);
- development (continuing professional development);
- support (supportive/restorative function); and
- engagement/mediation (engaging the individual with the organisation)

Working Together to Safeguard Children HM Government 2013

These policies should have CCG and Local safeguarding children board approval.

3.3 A process for following up referrals to Children's Services - Multi-Agency Safeguarding Hub MASH is in place. All staff MUST be aware of the local referral process and how to make safeguarding enquiries or escalate concerns

3.4 All concerns and allegations of abuse by staff and volunteers will be taken seriously, and responded to appropriately (as per LSCB guidance). This may require referral to appropriate children's services or the police and the Local Authority Designated Officer (LADO) as required.

3.5 A commitment to the safer recruitment process is in place.

3.6 An effective complaints procedure is in place.

3.7 The procedures and systems should include:

- A Board Executive Lead/Champion appointed to take accountability for governance systems and organisational focus on safeguarding. Has responsibility of ensuring there are robust and appropriate safeguarding policies/procedures/ in place and that regular reports are provided to the Board.
- Health providers should have an identified Named doctor, Named nurse and Named midwife (maternity services), Named LAC nurse or professional in post with explicit job descriptions and protected time to undertake these specialised roles. The Named professionals will receive safeguarding supervision from the CCG Designated professionals
- Health providers should ensure that all job descriptions and person specifications recognise responsibilities around safeguarding and improvements in outcomes for children.
- Arrangements should be in place for safeguarding advice which should be available to staff 24 hours a day.
- Safer recruitment processes are in place which is in line with legislation and national guidance.
- Health providers to ensure that there are adequate numbers of sufficiently trained, experienced people in the organisation to work safely and effectively to protect children and improve outcomes. All staff should understand their safeguarding responsibilities. This

3. SAFEGUARDING PRINCIPLES

includes being able to recognise when a child may require safeguarding, and knowing what to do in response to concerns about the welfare of a child.

- Health providers will have a clear accountability structure to ensure that all personnel understand their place in the organisation and how they receive support and guidance in their work with and for children (supervision).
- Health providers have an Equal Opportunities Policy and personnel understand the implications of the policy in contributing to improved outcomes for ALL children when working with diversity.
- Training programmes are in line with the *Intercollegiate Document (2019).*
- Health providers will keep confidential any information on a child or young person, and his or her family that is of a personal and sensitive nature, however, where there is concern about a child's safety and welfare, there will be a clear understanding of what information can be shared within the relevant legal frameworks and information sharing protocols.
- Health providers to ensure staff adhere to record keeping and sharing information principles according to registrant relevant professional body, and national guidance.
- The child's voice is evident in service design, reconfiguration of services/facilities and feedback about facilities/services and the voice of the child is crucial in safeguarding arrangements and evidence of how this is captured should also be demonstrated.
- Recognizing the needs of Looked After Children (LAC) and Care Leavers; ensuring that their needs are met by having a dedicated team of Looked After Children commensurate to the number of LAC and will include a Named Nurse and doctor for LAC.
- A "Think Family" approach is maintained in caring for adults who have caring responsibilities for children.

3.8 It is important that safeguarding policy and procedures are tailored to the type of contact that a service provider has with children and their families and, taking into account any particular vulnerabilities for the child or young person. Vulnerabilities include those within the families context which may have impact on the child with whom the provider has contact, for example disabled children who are potentially at increased risk of abuse, the unborn child, babies and toddlers who are vulnerable due to their age and dependence on adults. Language barriers also need to be addressed and be regularly audited to demonstrate the number of occasions a translator was used and the quality of translation services provided.

PERFORMANCE METRICS AGAINST ESSENTIAL STANDARD 7 SAFEGUARDING PEOPLE WHO USE SERVICES FROM ABUSE

Quality Requirement	Threshold	Method of Measurement	Frequency of Reporting
Review 20 staff files across Children's Services to evidence compliance with safer recruitment process		Procedure in place and evidence of compliance	Annually
Enhanced Disclosure and Barring Service(DBS) checks for all staff working with children	100%		Quarterly
Management of allegations of abuse against staff and volunteers process in place (LADO)		Policy in place with review date	Annually
Training / awareness of process included in SGC /Other training	90% of relevant staff trained		
Number of allegations of abuse against staff	Monitor Trend		Quarterly
Number that have progressed to further investigation	Monitor Trend		Quarterly
Number of staff who have been referred to their Professional Body	Monitor Trend		Quarterly
Section 11 Children Act 2004 Effective at each section, if any point below effective an action plan is required with timescales Action plan to be monitored and audited. Audit findings to be reported to evidence improvement and/or compliance with s11	Full compliance		As required by LSCB

Quality Requirement	Threshold	Method of Measurement	Frequency of Reporting
Safeguarding Children Training: Essential to job role Referring to Intercollegiate Document (2014) and Working Together to Safeguard Children (2013) Compliance with training at level 1-3, 90% of eligible staff are trained to appropriate level 100% staff trained /supported who are required to attend court.	Number of eligible staff at each level Number and % who have received training at their appropriate level Staff required to attend court are trained/supported	Percentage of staff who have received safeguarding training at the appropriate level as specified in the Intercollegiate document.	Quarterly
Safeguarding Children Supervision	Number of eligible staff who have received supervision Community : 100% Acute Hospital : 50% (first 6mths of the year) % of staff accessing supervision within Children's departments	Policy in place with review date Quarterly reporting on the DASH Board Quarterly reporting on the DASH Board Evidence of a robust safeguarding supervision/peer	Quarterly Quarterly

Quality Requirement	Threshold	Method of Measurement	Frequency of Reporting
	Outpatients Inpatients NICU PAU Children's A/E Adult A/E Maternity unit Midwives. CAMHS: 100%	review framework in place	
Involving service users and carers to ensure improved experience: • Listening to the child's voice • Hearing the child's voice • Document and action their responses Evidence outcomes that show children's views are heard. Services designed with input - children and young people.	20 records of service users within last year. Review surveys/audits undertaken within last year.	Review of records to evidence a child's input to services. Review of records to obtain evidence of child's input where relevant to decision making process about health/safeguarding concerns. Surveys/audits of young people's experience of services provided particularly in regards to safeguarding	Annually Quarterly
Children with Disability	Clear Health Plan on Education	Review of records and audits on documentation	Quarterly

Quality Requirement	Threshold	Method of Measurement	Frequency of Reporting
	Health Care Plan (EHCP)		
Rate of A/E attendances caused by unintentional & deliberate injuries to children.		Identification of abuse/neglect in A/E	Quarterly
Number of Children admitted due to self harm			Quarterly
Number of Children admitted due to substance misuse.	.		Quarterly
Percentage of children not chaperoned on examination by health professional			Quarterly
Chaperone policy in place			Annual Audit
Children under 16 are admitted to a children's ward or given choice			Quarterly
No. of children under 16 admitted to adult wards without choice.			Quarterly
Sharing information between midwifery and health visitor/GP			
Number of patients recorded as additional information sharing for safeguarding reasons.		Between midwifery and Children's Social Care	
Number of referral's of unborn babies to Children's Social Care			

Quality Requirement	Threshold	Method of Measurement	Frequency of Reporting
Domestic Abuse - Paternal name, DOB and lifestyle choice recorded within maternity records			
Number of referrals for DA to • Police • Social Care • Multi Agency Risk Assessment Conference (MARAC)			
Child Sexual Exploitation & Missing	Reporting of identified case and intelligence forms completed from A/E Sexual Health Mental health Services LAC Health	DASHBoard reporting Quality Schedules	Quarterly
Harmful Practices Identification of FGM		Documentation in records No of FGM cases identified	Quarterly
Identification of Honour Based Violence		and referred	
Forced marriage Gangs		No. of sharing information forms completed	

Quality Requirement	Threshold	Method of Measurement	Frequency of Reporting
Radicalisation/Prevent	WRAP Training to	Report on UNIQUE 2	Monthly
Slavery	achieve 85%		
Child Sexual Exploitation and Missing	Quarterly Audit	No of intelligence forms Completed and sent to police or MASH	
	Audit 20 maternity records		
Trafficking.	Record of cases 100% referred to relevant authority. Review referrals to Children's Social Care	Panel (CSEP)	Quarterly
Learning from the various reviews of practice to improve services • Serious Case Reviews (SCR) • Serious Incidents (SI)	Demonstrable evidence of improved	Number of incidents referred to LSCB for consideration by Serious Case Review Group	

Quality Requirement	Threshold	Method of Measurement	Frequency of Reporting
• Domestic Homicide Reviews (DHR) • Individual Management Reviews (IMR)	outcomes and impact for children from all of the measures identified. Demonstrate how learning has been cascaded throughout organisation. Review training provide to staff within last 6mths. Provide reports on all DHRs the organisation has been involved in and review action plans.	Root Cause Analysis Reports Audit report of implemented action plans Review of lower level concerns where learning can be gained Action plans with evidence of implementation of findings from lessons learned	Annual audit of SCR actions. Annual report Annually
Those children involved in gun and knife crimes	Evidence of data collection and any reports provided to the local Guns and Gang Partnership Coordination Group	Share information with standing groups as per local guidance for the protection of young people who are perpetrators or victims Number of referrals	Quarterly
Organisational Safeguarding Children Audit Programme,	Evidence of	Access to audit findings	6 monthly

Quality Requirement	Threshold	Method of Measurement	Frequency of Reporting
including • Missed Appointment	improved outcomes for children 100% of Was Not Brought;'s for children followed up. Database to monitor trends of referrals. Monitor trends via audit of records. No of CPM referred out of hours or transferred to L&D from CCS	Action plans with evidence of implementation of findings No of Was Not Brought;'s followed up. No. of referrals made due to impact of adult issues. Annual audit including dip sampling of records. No of child protection medicals (CPM) completed. Monitor trends of CPM reviewing category of abuse	Annual Report Quarterly Quarterly& Annual report Annual Quarterly Annual.
• No of Adult contacts that result in referral to children's Social Care Effective Interagency working to ensure children are safeguarded and medical intervention as required.			

Quality Requirement	Threshold	Method of Measurement	Frequency of Reporting
			Quarterly
LSCB and sub-groups	75% attendance at LSCB and subgroups Evidence of dissemination of information to staff	Attendance Participation Dissemination of information to staff	6 monthly
Personalised Care Planning	Evidence of improved outcomes for children	Case file review to evidence: • All children who have individual care plans have had these agreed with parents, carers and paediatricians where required • Care plans are shared across all providers to ensure seamless standards of care are maintained • A partnership with families, children and other professionals to ensure a timely approach to the Child in Need / Protection Plan is maintained, recommending updates of same, acknowledging positive progress and raising an alert	Annually Subject to CCG escalation process where appropriate

Quality Requirement	Threshold	Method of Measurement	Frequency of Reporting
		if the risk to the child increases	
Early Intervention Programme (Community only)	The number and % of initial assessments in relation to the Healthy Child Programme (HCP) (2009) that become: Core programme Targeted services Further assessed by Use of Common Assessment Framework (CAF) and/or Graded Care Profile (GCP) and Vulnerability Programme (Luton Community)	To ensure children and families are identified as early as possible for additional services and support	6 monthly
Adults who may pose a risk to children	Use of pathways and processes for adult mental health practitioner's assessment and analysis of risks	Identify parents/carers with • Substance misuse • Mental health • Learning disability • DA Victim / Perpetrator	

Quality Requirement	Threshold	Method of Measurement	Frequency of Reporting
	to children.	Appropriate referral/action	
Care Leavers will: • be given a copy of their health history • be supported by a health care leaving service • have a pathway plan agreed • have their mental health needs assessed and actioned	100% of care leavers	Report on numbers presented to the LAC Strategic Group 6 monthly	6 monthly