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Bolton Clinical Commissioning Group

NHS Bolton Clinical Commissioning Group

Safeguarding Children, Young People and Adults at Risk – Safeguarding Standards for commissioned services (2018-2019)

A Collaborative Greater Manchester (GM) Document

DOCUMENT CONTROL PAGE	
Title	NHS Bolton Clinical Commissioning Group: Safeguarding Children, Young People and Adults at Risk – Safeguarding Standards for Commissioned Services (2018-2019) A Collaborative Greater Manchester (GM) Document
Supersedes	Safeguarding Children, Young People and Adults at Risk – Contractual Standards 2017-2018 A Collaborative Greater Manchester (GM) Document
Minor Amendments	The content of the document has been refreshed and updated to better reflect the structural changes within the GM health economy. The content of the audit tools have been updated and reformatted into thematic areas to make the requirements of the standards clearer.
Author	Representatives from the GM Designated Professional Clinical Networks for: • Safeguarding Adults; • Safeguarding Children; • Looked After Children.
Ratification	Each CCG Designated Nurse will be responsible for ensuring this document is ratified via their CCG appropriate governance process.
Application	For incorporation into the contracts of all commissioned services.
Circulation	This Policy has been shared with the GM Directors of Commissioning and is to be added to **all** contracts.
Review	This Policy will be reviewed in November 2018

Contents

1. INTRODUCTION

1.1. NHS Bolton Clinical Commissioning Group regard our statutory responsibilities to safeguard children, young people and adults at risk of harm as a major priority for our organisation and for our work with local partners.

1.2. The NHS Constitution sets out safeguarding responsibilities, requiring the Governing Body of all the CCGs to oversee a clear strategy and regular reporting to ensure that the CCGs meets their duties, in line with:

- Children Act 1989;
- Children Act 2004;
- Care Act 2014;
- Criminal Justice and Courts Act 2015;
- Mental Health Act 1983 / 2007;
- Mental Capacity Act 2005 / Deprivation of Liberty Safeguards 2009;
- Equality Act 2010;
- Human Rights Act 1998;
- Looked after children: Knowledge, skills and competences of health care staff - Intercollegiate Role Framework (March 2015);
- Mental Capacity Act 2005: Code of Practice (Department for Constitutional Affairs 2007);
- Deprivation of Liberty Code of Practice 2009;
- Care Act guidance 2014
- Care and Support Statutory Guidance (DH, 2017);
- Safeguarding children and young people: roles and competences for health care staff - Intercollegiate Document Third edition (March 2014);
- Safeguarding Adults: The Role of Health Services (DH 2011);
- Safeguarding Vulnerable People in NHS Accountability and Assurance Framework NHS England 2015;
- Serious Incident Framework (March 2015);
- Statutory Guidance on Promoting the Health and Well-Being of Looked After Children (DH 2015);
- Working Together to Safeguard Children (HM Government 2015);
- The policies and procedures of the Local Safeguarding Children Board (LSCB) and the Local Safeguarding Adults Board (LSAB);
- The policies and procedures of the Greater Manchester Safeguarding Partnership - Safeguarding Children Procedures Manual;
- Channel Duty Guidance. Protecting vulnerable people from being drawn into terrorism (2015);
- Revised Prevent Duty Guidance: for England and Wales (HM Government 2015)
- Any other legislation, guidance and Code of Practice relevant to safeguarding children, Looked After Children and adults at risk.

1.3. All Clinical Commissioning Groups have a statutory duty to ensure that all health providers, from whom they commission services (both public and independent sector), have comprehensive single and multi-agency policies and procedures in place to safeguard and promote the welfare of children and to protect adults at risk from actual abuse or possible abuse; that healthcare providers are linked into their Local Safeguarding Children and Local Safeguarding Adults Boards; and that healthcare workers contribute to multi-agency working.

1.4. Safeguarding and the NHS

The Health and Social Care Act 2014 and the Safeguarding Vulnerable People in the NHS Accountability and Assurance Framework (July 2015) revised the responsibilities for commissioners and how they safeguard their populations. The responsibilities put patients and the quality of their care at the heart of the NHS. The Government's commitment to patient choice, control and accountability includes support and protection for those in the most vulnerable situations.

1.5. Commissioners have responsibilities for commissioning high quality healthcare for all patients in their area. However, they have particular safeguarding duties for those patients who are less able to protect themselves from harm, neglect or abuse, for example, due to impaired mental capacity. Safeguarding must encompass:

- The prevention of harm and abuse through provision of high quality care;
- Effective responses to allegations of harm and abuse, responses that are in line with local multi-agency procedures;
- Using learning to improve service to patients.
  (Role of NHS Commissioners: DH 2011)

2. PURPOSE AND SCOPE

2.1. The safety of children, young people and adults at risk is a vital element of the work in the NHS. We understand that people come to the NHS for healthcare, advice and support at the most vulnerable points in their life. As well as treating the illness, we recognise that the safety and health are intertwined aspects of their wellbeing. As such, we see the key role that NHS staff play in ensuring that children, young people, and adults at risk are protected from potential harm.

2.2. It is important that all practitioners working with children, young people and adults at risk understand fully their responsibilities and duties as set out in primary legislation and associated regulations and guidance. And it is important that commissioners understand their roles in creating a safe environment with the requisite checks and balances to ensure that local healthcare services meet their responsibilities.

2.3. This document provides clear service standards (Appendices 1-6) against which healthcare providers will be monitored to ensure that all service users are protected from abuse or the risk of abuse.

2.4. This document aims to ensure that no act of commission or omission on behalf of the CCG or by the services it commissions puts a service user at risk. It sets out the safeguarding standards required of commissioned services and includes the monitoring and escalation processes for ensuring the standards are complied with.

2.5. It also addresses training requirements, communication processes, and duties with associate commissioners, who will be notified of a Provider's non- compliance with the standards contained in this document. Associate commissioners will also be notified of reported serious incidents that have compromised the safety and welfare of a child, young person, or adult at risk, resident within their population.

3. DEFINITIONS

3.1. For the purpose of this document the following definitions provide clarity of terms:

3.2. Commissioning

A collaborative exercise in providing the highest quality healthcare services to meet the identified needs of a population within available resources.

3.3. Children

As defined in the Children Act 1989 and 2004, a child is anyone who has not yet reached their 18th birthday. 'Children' therefore means children and young people throughout.

3.4. Safeguarding Children

Safeguarding and promoting the welfare of children is defined for the purpose of this document as:

- Protecting children from maltreatment;
- Preventing impairment of children's health or development;
- Ensuring that children grow 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 2015)

3.5. Looked After Children

Children and young people under the age of 18 who live away from their parents or family are supervised by a social worker from the local council children's services department.

3.6. A looked after child may either be accommodated (which means that the council is looking after them with the agreement, at the request or in the absence of their parents) or subject to a Care Order made by the Family Courts.

3.7. Adult at Risk

The Care Act (2014) identifies an adult at risk as being: *"A person who has needs for care and support (whether or not the local authority is meeting any of those needs), and as a result of those needs the person is unable to protect him/herself against abuse, neglect or the risk of it."*

3.8. The term "adult at risk" is increasingly being used to replace that of "vulnerable adult" as it focuses on the situation causing the risk rather than the characteristics of the adult concerned.

3.9. Six key principles underpin all adult safeguarding work (DH 2017)

- **Empowerment** - People being supported and encouraged to make their own decisions and informed consent;
- **Prevention** - It is better to take action before harm occurs;
- **Proportionality** - The least intrusive response appropriate to the risk presented;
- **Protection** - Support and representation for those in greatest need;
- **Partnership** - Local solutions through services working with their communities.
- **Accountability** - Accountability and transparency in delivering safeguarding.

3.10. Mental Capacity Act

The Mental Capacity Act (MCA) (2005) sets out who can, and how to, make decisions relating to care and treatment for those who lack capacity to make such decisions. The MCA covers decisions relating to finance, social care, medical care and treatments,

research and everyday living decisions, as well as planning for the future. Within the MCA, the term capacity relates to the person's ability to consent to or refuse care or treatment.

3.11. The Act provides a two stage test for assessing a person's capacity and this must be used for each individual decision to be made. The MCA applies to all over the age of 16 years, with a presumption that all young people (16 and 17 years of age) and adults have the ability to give valid consent to or refuse treatment.

4. ROLES & RESPONSIBILITIES

4.1. The safeguarding of children, young people, and adults at risk is a **shared responsibility**, recognised by all GM CCGs, with the need for effective joint working between agencies and professionals that have different roles and expertise.

4.2. In order to achieve effective joint working there must be constructive relationships at all levels, promoted and supported by:

- The **commitment of senior managers** and board members to safeguarding children, young people, and adults at risk;
- **Clear lines of accountability** within the organisation for work on safeguarding;
- A commitment to **consider safeguarding in decision making;**
- The principle of **involving service users** in service developments;
- Clear commitment to **staff training** and continuing professional development so that staff have an understanding of their roles and responsibilities and those of other professionals and organisations;
- **Safe working practices** including recruitment and vetting procedures in line with NHS Employment Check Standards;
- **Effective interagency working**, including effective information sharing;
- Ensuring that **learning from reviews** is **embedded in practice**.

5. PREVENT

5.1. The Prevent Duty is set out in the Counter-Terrorism and Security Act 2015 which is part of the Government's Counter Terrorism Strategy (CONTEST). This places a duty on public bodies to work to prevent radicalisation in the healthcare sector and for the NHS to support initiatives to reduce the risk of terrorism.

5.2. The Counter-Terrorism and Security Act 2015 puts the Prevent programme on a statutory footing. Prevent is part of the Safeguarding agenda within the health sector. Healthcare professions must be trained to recognise the signs that someone at risk of radicalisation and they have a duty to find appropriate support through established arrangements.

5.3. Arrangements may include Channel – a multi-agency programme which provides tailored support to people who have been identified as at risk of being drawn into terrorism, for example by referring them to a health or social care provider.

5.4. Prevent is central to the Safeguarding agenda and therefore needs to be a priority within Safeguarding policies, procedures and training. The Health economy is a key partner in delivering the HM Governments Prevent strategy and promotes a non-enforcement approach to support the health sector in preventing people becoming radicalised.

- Radicalisation refers to the process by which people come to support and in some cases, to participate in terrorism;
- Violent extremism is defined by the Crown Prosecution Service as:
  "*The demonstration of unacceptable behaviour by using any means or medium to express views which:*
  - *Foment, justify or glorify terrorist violence in furtherance of particular beliefs*
  - *Seek to provoke others to terrorist acts;*
  - *Foment other serious criminal activity or seek to provoke others to serious criminal acts;*
  - *Foster hatred which might lead to inter-community violence in the UK".*

5.5. NHS Bolton CCG will need assurance from health provider organisations regarding the implementation of this government strategy. This is a statutory duty and will be included as part of the annual safeguarding toolkit self-assessment (Appendix 5).

5.6. NHS Bolton CCG is supported by the NHS England Regional Prevent Coordinator to ensure the local health economy is delivering on the statutory Prevent duty.

6. LAMPARD

6.1. In October 2012, the Secretary of State for Health commissioned an independent report on 'lessons learnt' drawing on findings from all published investigations and to draw out implications for healthcare organisations. The report 'Themes and Lessons from NHS investigations into matters relating to Jimmy Saville' report was published in February 2015 with 14 recommendations for all NHS provider organisations to consider.

6.2. Common themes and issues emerging from the findings relevant to the wider NHS currently are grouped under the following headings:

- Security and access arrangements, including celebrity and VIP access;
- The role and management of volunteers;
- Safeguarding;
- Raising complaints and concerns (by staff and patients);
- Fundraising and charity governance;
- Observance of due process and good governance.

6.3. Provider organisations should complete the Lampard Self-Assessment (Appendix 6) in order to demonstrate compliance. An action plan should be developed for any gaps identified which set out how the provider will achieve compliance.

7. DISSEMINATION & IMPLEMENTATION

7.1. The standards expected of all healthcare providers are detailed in the appendices. Compliance will be measured by annual audit; an audit tool will be made available to all providers to facilitate the recording of information. The audit tool should be completed using the BRAG/RAG definitions outlined in the Procedure for Monitoring Safeguarding Children and Adults at Risk via Provider Contracts and an action plan produced for any elements that are not fully compliant.

7.2. The action plan will be reviewed at agreed intervals throughout the year. This procedure was developed in order to standardise the monitoring and escalation approach across the North West.

7.3. The Designated Professionals are required to share the outcomes of the audit annually with the GM Health and Social Care Partnership and NHS England in the form of a dashboard linked to the standards.

7.4. Designated Professionals may also share the outcomes of the audit with the LSAB and LSCB as part of safeguarding assurance processes and in lieu of a Section 11 audit.

Breaches of the GM Standards and Recommendations

7.5. This document is intended to be mandatory. Where it is not possible to comply with the standards and recommendations or a decision is taken to depart from these, the Designated Safeguarding Professionals for NHS Bolton CCG must be notified within 5 working days so that the level of risk can be assessed and an action plan can be formulated.

7.6. All allegations of abuse made against a worker and any Serious Incident involving a child, young person, or an adult at risk should be reported in accordance with the organisations local reporting arrangements and as per LSCB and LSAB policies.

7.7. NHS Bolton CCG, as lead commissioner, will notify associate commissioners of a Provider's non-compliance with the standards and recommendations contained in this document, including action(s) taken where there has been a significant breach.

8. MONITORING AND ESCALATION PROCESS

8.1. NHS Bolton CCG and NHSE have a statutory responsibility to ensure that the organisations from which it commissions services from provide a safe system that safeguards children, young people, and adults at risk of abuse and neglect.

8.2. NHS Bolton CCG will monitor all commissioned services against the standards identified within this document (Appendices 1-6). To support the monitoring of the standards an audit tool, based on the standards, will be completed by all providers annually. For new contracts compliance with standards will be assessed prior to the contract commencing except in exceptional circumstances, emergency placements, when it will be requested as soon as possible.

8.3. The Guidance for NHS Contracts requires the provider to comply with the contractual standards document for children, young people, and adults at risk. From time to time, revisions may be required to the document part way through the contracting period to reflect changes to local, national and statutory guidance. Such revisions will be attached or referenced when they become available from the commissioner. A record of the new edition of the document will be recorded as part of the routine review process.

Monitoring Process

8.4. NHS Bolton CCG will gain assurance through the contract review process that the Provider is meeting the relevant safeguarding standards and will take appropriate action where they do not. Where NHS Bolton CCG is the lead commissioner they *will*:

- Establish a baseline for each provider against the relevant standards;
- Monitor against the set of standards on an annual basis;
- If an action plan is required this will be monitored quarterly until compliance is achieved;

- Associate commissioners will be informed of the outcome of the audit and of any gaps identified/actions being taken.

Audit Tool

8.5. To monitor the standards, Providers will be asked to complete a self-assessed BRAG rated audit tool based on the standards (Appendices 1 or 4). The criteria for rating are as follows:

- Green – fully compliant (even when fully compliant the provider should evidence continuous quality improvements);
- Amber – there is an action plan in place to ensure full compliance within the agreed time scales;
- Red – non-compliance against standards and/or failure to progress agreed action plan within agreed time scales;
- Blue – Not applicable.

8.6. The provider organisation will need to provide evidence to demonstrate compliance with the green rated standards.

8.7. The Designated Professionals for Safeguarding will review the evidence and assess if it is adequate. If an action plan is in place this will be reviewed to ensure it is robust and contains appropriate time scales.

Governance Arrangements

8.8. The Designated Professionals for Safeguarding will report Provider compliance to the CCG Safeguarding Assurance Group and to the Quality and Safety Committee and will highlight in an exception report those providers whose action plans are not progressing. The Quality and Safety Committee will then decide if this will be initially managed through the contractual process alone or whether the escalation process is triggered.

Escalation Process - Level 1

8.9. The CCGs and provider organisation will include **amber** and **red** standards on the appropriate organisational risk register and Associate Commissioners will be informed of the gaps identified. The relevant Safeguarding Board will also be informed of any red standards. These actions will ensure that the action plans are linked to organisational and, in the case of red standards, multi-agency governance arrangements.

Escalation Process - Level 2 (*applies to NHS Acute, Community, Mental Health and Ambulance Providers)*

8.10. When a standard rated amber moves to red, this will be considered a breach of contract. This line of action will be taken as the provider organisation will have had time to meet the standard during the amber period. This breach is serious, hence the level of response, due to the vulnerable population the provider is meant to be protecting and the fact that the standards are based in statute and key national policies as well as being in the CQC Essential Standards for registration.

8.11. A performance notice will be issued in this instance and appropriate contractual levers utilised, as well as a letter sent to the Care Quality Commission (CQC) and copied to GM Health and Social Care Partnership, Director of Nursing. This is to fulfill the CCG's

obligations to communicate with the CQC regarding quality of services and to GM Health and Social Care Partnership, in their role to assure systems are in place for commissioning safe quality services.

Escalation Process – Non-NHS Providers

8.12. These will be discussed with the relevant commissioner in conjunction with the Designated Professionals and CCG Executive for Safeguarding. If the non-compliance cannot be managed at a contract meeting and an organisational decision in respect to the way forward is required, then this will be escalated to the relevant internal Committee or Board.

9. TRAINING RECOMMENDATIONS

9.1. This Framework for Training is designed to provide the most appropriate approach for safeguarding training for Providers of health care. Its aim is to ensure that all staff working with children and/or adults are alert to the need to safeguard and promote the welfare of children, young people and adults at risk and are appropriately skilled and competent in carrying out their responsibilities for safeguarding appropriate to their role. Each Provider will be required to produce a training strategy that outlines how safeguarding training will be delivered.

9.2. This document has been informed by statutory and national guidance and the training strategies of GM Safeguarding Children and Adult Boards.

9.3. The recommendations for safeguarding training are relevant to all staff working in the health economy. It also provides recommendations for independent contractors in ensuring that their staff are trained in accordance with individual roles and responsibilities in relation to safeguarding children and adults at risk.

9.4. The training recommendations will be reviewed annually and in response to changes to national and local guidance or local policy initiatives.

9.5. All staff are trained and competent to be alert to potential indicators of abuse and neglect, know how to act on those concerns and to fulfil their roles and responsibilities for safeguarding children and adults at risk in line with Local Safeguarding Children Board (LSCB) and Safeguarding Adult Board (LSAB) procedures.

9.6. Interagency training should complement single agency training, all training should emphasise the importance of working together.

9.7. Single-agency training, and training provided in professional settings, should always equip staff for working collaboratively with others and communicating and sharing information.

9.8. All training provided should respect diversity (including culture, race, religion and disability), promote equality and encourage the participation of children, families and adults in the safeguarding process.

9.9. The purpose of training for interagency work at both strategic and operational levels is to achieve better outcomes for children, young people, and adults at risk by promoting:

- A shared understanding of the tasks, processes, principles and roles and responsibilities outlined in national guidance and local arrangements for safeguarding children, young people, and adults at risk and promoting their welfare;
- More effective and integrated services at both the strategic and individual case level;
- Improved communications between professionals including a common understanding of key terms, definitions, and thresholds for action;
- Effective working relationships, including an ability to work in multi-disciplinary groups or teams;
- Sound decision making based on information sharing, thorough assessment, critical analysis, and professional judgement;
- Learning lessons from statutory reviews, including Serious Case Reviews, Safeguarding Adult Reviews, Domestic Homicide Reviews and Mental Health Homicide Reviews and from local learning, including Serious Untoward Incidents, and implementing changes to practice based on recommendations from local and national cases.

Definitions in Relation to Training

9.10. Single agency training is training which is carried out by a particular agency for its own staff.

9.11. Multi-agency training is training for employees of different agencies who either work together formally or come together for training or development.

Training: Roles and Responsibilities

9.12. NHS Bolton CCG as a commissioner of health care services has a responsibility to ensure that the services commissioned have robust safeguarding training strategies that are fit for purpose and comply with national guidance.

9.13. Employers - Employers are responsible for ensuring that their staff are competent and confident in carrying out their responsibilities for safeguarding and promoting the welfare of children and adults at risk.

9.14. It is the responsibility of employers to recognise that in order for staff to carry out their roles and responsibilities for safeguarding they will have different training needs which are dependent on their degree of contact with and responsibilities for children and adults.

9.15. Employers also have a responsibility to identify adequate resources and support for inter-agency training by:

- Providing staff that have the relevant expertise to support the multi-agency training delivered under the auspices of the LSCB and or LSAB;
- Committing resources for inter-agency training, for example through funding, providing venues, providing staff who contribute to the planning, delivery and/ or evaluation of inter-agency training;
- Releasing staff to attend the appropriate inter-agency training courses and ensuring the time for them to complete inter-agency training tasks and apply their learning in practice;
- Ensuring that staff receive relevant single-agency training that enables them to maximise the learning derived from inter-agency training;

- Ensuring they keep accurate data of staff trained within the organisation including a breakdown of eligible staff trained at each level;
- Supporting staff to identify required learning opportunities through annual appraisal.

Level of training requirements

9.16. All organisations should develop a training strategy in accordance with the following:

- Safeguarding children and young people: roles and competences for health care staff: Intercollegiate document (2014);
- Looked After Children: Knowledge, skills and competences of health care staff: Intercollegiate Framework (2015);
- The anticipated intercollegiate document for Adults at Risk;
- Mental Capacity Act Competency Framework.

Training: Monitoring and Assurance

9.17. Training should be subject to audit, evaluation, quality assurance, scrutiny and reporting. All training identified within this document is compliant with the standards required within statutory and national guidance

9.18. Assurance will be required by NHS Bolton CCG, as a commissioner of services, that staff within Provider organisations have been trained to an appropriate level in safeguarding children and young people, and adults at risk.

9.19. This assurance should be obtained through relevant organisational quality and performance monitoring processes, internal and external audit, outcomes from inspections (e.g. CQC, Ofsted) as well as providers participating and cooperating with quality assurance processes such as Section 11 audit and Self-Assessment Framework for Adults. In order to provide assurance to the CCG, all commissioned services will record and provide information including:

- Numbers of staff requiring each level of training as set out in the recommendations;
- Attendance figures for all levels of training;
- Evidence that outcomes for at risk groups have improved as a result of training attended.

10. EQUALITY, DIVERSITY & HUMAN RIGHTS IMPACT ASSESSMENT

10.1. Equality, Diversity & Human Rights Impact Assessment has been completed. See reference number at front of document.

11. CONSULTATION & APPROVAL PROCESS

11.1. This document is a localised version of the GM Contractual Standards for Safeguarding Children, Young People and Adults at Risk 2017-2018 and has been written by members of the GM Designated Professional Clinical Networks for:

- Safeguarding Adults;
- Safeguarding Children;
- Looked After Children.

11.2. The content of the document has been refreshed and updated to better reflect the structural changes within the GM health economy.

11.3. The content of the audit tools have been updated and reformatted into thematic areas to make the requirements of the standards clearer.

11.4. This document will be included in **every** CCG contract.

11.5. This Policy has been shared with the GM Directors of Commissioning.

12. REFERENCES & BIBLIOGRAPHY (as detailed in section 1.2 plus the following)

- Carpenter et al (2009) The Organisation, Outcomes and Costs of Inter-agency Training to safeguard and promote the welfare of children. London: DCSF Child and Maternal Health Observatory (2012) Safeguarding Children Training Directory. London: CHIMAT
- Department of Health (2010) Clinical Governance and Adult Safeguarding: an integrated approach.
- HM Government (2015) Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children.
- Royal College of Paediatrics and Child Health (2014) Safeguarding Children and Young People: Roles and Competences for Health Care Staff Intercollegiate Document Third edition.

13. STANDARDS & KEY PERFORMANCE INDICATORS

Appendix 1: Audit Tool to monitor Safeguarding Arrangements for NHS Providers 2018/19

Date audit tool completed:	
Organisation Name:	
Organisation Code:	
Organisation Type:	
Name of person completing this toolkit:	
Designation:	
Email address:	
Contact Number:	

Instructions for completing this audit tool:

- Complete **ALL** yellow shaded sections of this toolkit by selecting a cell and adding text or by using in-cell drop down menus where there is an option to 'please select' (a menu icon appears once these cells are selected)
- RAG rating options are explained below to the left of these instructions
- If attaching evidence documents, **please pdf embedded files first** to ensure the filesize remains low
- Please use the provider comments section to explain any reasons behind non-compliant standards
- Useful links are provided below for further information on local adult and child safeguarding policies and procedures

Local Safeguarding Children Board policies/procedures	http://boltonchildcare.proceduresonline.com
Local Safeguarding Adult Board policies/ procedures	http://boltonsafeguardingadultsboard.org.uk

KEY TO RAG

GREEN - FULL COMPLIANCE - However remains subject to continuous quality improvement
AMBER - PARTIAL COMPLIANCE - Action plans in place to ensure full compliance and progress is being made within agreed timescales
RED - NON-COMPLIANT - Against standards and/or failure to progress agreed action plan within agreed time scales
BLUE - NOT APPLICABLE - Standard does not apply to the Provider

Complete all sections below shaded yellow (use the in-cell drop downs for 'please select' cells)

Embed documents using the following instructions:

Insert > Object > Create from file > (browse for file) > Insert > Display as icon (not link to file) > OK

	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
	1. ORGANISATIONAL GOVERNANCE AND ACCOUNTABILITY				
1.1	**There is a board lead for safeguarding children and adults at risk**	**Evidence to demonstrate compliance can include:** - Job Description which clearly identifies safeguarding roles and responsibilities - Evidence of relevant safeguarding training (i.e. certificates) within the last 3 years - Safeguarding Governance structure - Annual Report for Safeguarding and LAC	Please Select:		
1.2	**The organisation is linked into the Local Safeguarding Children Board (LSCB) and Local Safeguarding Adult Board (LSAB)**	**Evidence to demonstrate compliance can include:** - There is representation at a senior level - The organisation contributes to the work of the Safeguarding Boards, including that of its sub groups - Safeguarding Annual Report - Detail of Board and Subgroups representation - Evidence of attendance at meetings	Please Select:		
1.3	**The Provider Board regularly reviews safeguarding across the organisation**	**Evidence to demonstrate compliance can include:** - The board should receive regular reports on their arrangements for safeguarding. - At a minimum an annual report regarding safeguarding children and adults at risk should be presented at board level with the expectation that this will be made public. - The provider should be able to provide a document that clearly describes their safeguarding governance arrangements. - Annual Report which includes governance arrangements - Examples of papers for internal safeguarding meetings	Please Select:		
1.4	**Safeguarding responsibilities are reflected in all job descriptions relevant to role and responsibilities**	**Evidence to demonstrate compliance can include:** - Standardised job description template - Current jobs advertised on NHS jobs - Evidence of HR process to ensure standard is met	Please Select:		

KEY TO RAG

GREEN - FULL COMPLIANCE - However remains subject to continuous quality improvement	**Complete all sections below shaded yellow** (use the in-cell drop downs for 'please select' cells)
AMBER - PARTIAL COMPLIANCE - Action plans in place to ensure full compliance and progress is being made within agreed timescales	**Embed documents using the following instructions:**
RED - NON-COMPLIANT - Against standards and/or failure to progress agreed action plan within agreed time scales	Insert > Object > Create from file > (browse for file) > Insert > Display as icon (not link to file) > OK
BLUE - NOT APPLICABLE - Standard does not apply to the Provider	

	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
	2. CLINICAL LEADERSHIP				
2.1	**Identification of a named doctor and named nurse (and a named midwife if the organisation provides maternity services) for safeguarding children.**	**Evidence to demonstrate compliance can include:** - Named professionals have a key role in promoting good professional practice within their organisation, supporting the local safeguarding system and processes, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place. - The leads should be 'one step away' from the Board so as to ensure sufficient strategic influence in line with the Intercollegiate Document. - Be trained in line with the intercollegiate document - The named lead(s) will work closely with their organisation's safeguarding lead for adults, LSCB and CCG Designated Professionals - Job Description which includes safeguarding roles and responsibilities Job Description which includes safeguarding roles and responsibilities - Evidence of relevant safeguarding training (i.e. certificates) within the last 3 years	Please Select:		
2.2	**Identification of named lead for adults at risk and a named lead for MCA/DoLS – this must include the statutory role for managing adult safeguarding allegations against staff.**	**Evidence to demonstrate compliance can include:** - Named professionals have a key role in promoting good professional practice within their organisation, supporting the local safeguarding system and processes, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place. - The leads should be 'one step away' from the Board so as to ensure sufficient strategic influence. - The named lead(s) will work closely with their organisation's safeguarding lead for children, LSAB and CCG adult safeguarding lead - Job Description which includes safeguarding roles and responsibilities - Evidence of relevant safeguarding training (i.e. certificates) within the last 3 years	Please Select:		
	3. SAFEGUARDING PROCESSES				
3.1	**An adverse incident reporting system is in place which identifies circumstances/incidents which have compromised the safety and welfare of children and/or adults at risk**	**Evidence to demonstrate compliance can include:** - Commissioners provided with a quarterly report of key themes/learning from SUIs that involve safeguarding children and adults at risk. - All complaints that refer to the safety of children and adults at risk are referred and investigated thoroughly in accordance with the Duty of Candour (Care Act, 2014) - All incidents occurring within healthcare that reach LSAB thresholds are reported into multi-agency procedures - For adults the incident reporting policy must clarify when and how safety incidents must be reported to the police and to multi-agency procedures - Incident reporting policy - Anonymised incident reported which demonstrates appropriate actions taken. - Quarterly reports - Reports on any SARs undertaken	Please Select:		

KEY TO RAG

GREEN - FULL COMPLIANCE - However remains subject to continuous quality improvement	**Complete all sections below shaded yellow** (use the in-cell drop downs for 'please select' cells) **Embed documents using the following instructions:** Insert > Object > Create from file > (browse for file) > Insert > Display as icon (not link to file) > OK
AMBER - PARTIAL COMPLIANCE - Action plans in place to ensure full compliance and progress is being made within agreed timescales	
RED - NON-COMPLIANT - Against standards and/or failure to progress agreed action plan within agreed time scales	
BLUE - NOT APPLICABLE - Standard does not apply to the Provider	

	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
3.2	**A programme of safeguarding audit and review is in place that enables the organisation to evidence the learning from review, incidents and inspections**	**Evidence to demonstrate compliance can include:** - Audits of safeguarding to include progress on action to implement recommendations from: • Serious Case Reviews / Local Case Reviews/Serious Adult Reviews • Internal Management reviews as consequence of SI's compromising the safety and welfare or service users • Reports from national bodies e.g. Ofsted/CQC Safeguarding audit schedule - Action plans implemented in the previous 12 months e.g. SCR - Audit reports - Recent CQC reports/Ofsted reports and action plans to meet any recommendations	Please Select:		
3.3	**There is a process for ensuring that patients are routinely asked about dependents such as children, or about any caring responsibilities**	**Evidence to demonstrate compliance can include:** - Assessment documentation, care plans, risk assessments - Evidence of the system/ process in place - Reports from audits undertaken to monitor effectiveness of the process	Please Select:		
3.4	**There are agreed systems, standards and protocols for sharing information within the service and between agencies in accordance with national and local guidance**	**Evidence to demonstrate compliance can include:** - The organisation participates in reviews as set out in statutory, national and local guidance - Systems in place to manage requests for information sharing relating to safeguarding e.g. case conferences, MARAC, serious case reviews, domestic homicide - Information sharing policies and protocols in place - Other safeguarding policies include relevant information sharing guidance - Evidence of a system in place to transfer data securely via a generic NHS.net account	Please Select:		
	4. SAFEGUARDING POLICIES				
4.1	**Staff at all levels, have easy access to safeguarding and policies and procedures. These policies and procedures must be consistent with statutory, national and local guidance**	**Evidence to demonstrate compliance can include:** - Policies and procedures are updated regularly to reflect any structural, departmental and legal changes - Policies take account of the Mental Capacity Act. - LSCB and LSAB policies can be accessed at (add own link) - Reviewed within the last 3 years	Please Select:		
4.2	**The Provider has a safer recruitment policy and ensures that any services commissioned provide assurance that staff are recruited according to safe recruitment practices and staff are appropriately trained in safeguarding in line with the intercollegiate document, e.g., interpreting services, security staff**	**Evidence to demonstrate compliance can include:** - In line with NHS Employers Guidance - Safer Recruitment Policy - Commissioning/sub-contracting Policy/Guideline - Evidence of contractual documentation - Training records	Please Select:		

KEY TO RAG

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	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
4.3	**There is clear guidance on managing allegations against staff and volunteers working with children and/or adults at risk in line with those of the LSCB and LSAB.**	**Evidence to demonstrate compliance can include:** - Policies or guidance needs to include the requirement to notify Disclosure and Baring Service (DBS) - Policy or guidance needs to include the requirement to notify the relevant professional body - Managing allegations policies - Evidence of notifications to DBS and relevant professional body	Please Select:		

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	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
4.4	**There is policy in relation to safeguarding adults at risk includes the key categories of adult abuse and in addition to core categories of abuse makes reference to:** • Human Trafficking • Domestic Abuse • Forced Marriage • Honour Based Violence • Female Genital Mutilation • Self-Neglect • Human Slavery • Chaperone	**Evidence to demonstrate compliance can include:** - Policies or guidance needs to include reference to the thematic areas listed above - Policies or guidance must be consistent with statutory, national and local guidance	Please Select:		
4.5	**There is policy in relation to safeguarding children which includes key categories of child abuse and in addition to core categories of abuse makes reference to:** • Domestic Abuse • Forced Marriage • Honour Based Violence • Female Genital Mutilation • Fabricated Illness • Sexually Abused or Sexually Exploited Children • Disabled Children • Working with sexually active young people under the age of 18 • Child Trafficking • Chaperone • Looked After Children with reference to the definition of a LAC, increased vulnerabilities and parental responsibility	**Evidence to demonstrate compliance can include:** - Policies or guidance needs to include reference to the thematic areas listed above - Policies or guidance must be consistent with statutory, national and local guidance	Please Select:		
4.6	**The organisation has a policy/guideline regarding appropriate behaviour by staff towards adults at risk and children.**		Please Select:		
4.7	**There are robust complaint and whistle blowing policies/procedures in place.**	**Evidence to demonstrate compliance can include:** - Policies, procedures and guidelines. - Assurance is provided to staff and service users that using the procedures appropriately will not prejudice their own position or prospects	Please Select:		

KEY TO RAG

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	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
4.8	**The organisation has a restraint policy that includes MCA in line with CQC guidance and MCA/Mental Health Code of Practice.** Where appropriate, staff who may be required to use restrictive physical interventions with children or adults have received specialist training.	**Evidence to demonstrate compliance can include:** The policy should include reference to: - The use of restraint within the best interest decision process - Where restraint is used, it is documented and followed by an assessment of the person restrained for signs of injury and any emotional or psychological impact - Restraint should only be used as a last resort where it is necessary and proportionate, and that restraint used should be the least restrictive and for the minimum amount of time to ensure that harm is prevented and that the person, and others around them are safe - The levels of training required - Restraint Policy - Capacity assessment - Risk assessments - Care plans - Advocacy - Clear evidence of consideration of MHA for informal patients when restraint/seclusion is used in psychiatric inpatient care - Training- training package and training data	Please Select:		
	5. SUPERVISION, TRAINING AND DEVELOPMENT				
5.1	**Staff working directly with children and adults at risk have access to advice support and supervision. This includes clinical and safeguarding supervision as per the organisation's safeguarding supervision policy** Named professionals seek advice and access regular formal supervision from designated professionals for complex issues or where concerns may have to be escalated.	**Evidence to demonstrate compliance can include:** - Supervision policies - Data to provide assurance that key staff receive supervision in accordance with policies - Audit reports	Please Select:		
5.2	**There is a training framework which identifies safeguarding training levels for the workforce (both paid and voluntary staff) in line with the Intercollegiate document for safeguarding children, Looked After Children and adults at risk.** The training framework should include training on safeguarding children; Looked After Children; safeguarding adults at risk; CSE, Prevent, trafficking, modern slavery, MCA, DoLS, FGM; and the interagency process that support safeguarding practices.	**Evidence to demonstrate compliance can include:** - The level of training an individual requires is dependent on their roles and responsibilities - Training must reflect statutory and local guidance. - Training should be audited to ensure its effectiveness and quality assurance - Training takes account of emerging messages from national and local reviews of safeguarding - All staff are trained to Level 1 safeguarding children, Looked After Children and adults at risk (Compliance rate of 95%) - Relevant staff are trained to Level 2 and Level 3 safeguarding children and Looked After Children (Compliance rate of 85%) - All staff receive Prevent training in line with the Prevent self-assessment tool (Compliance rate of 85%) - Training Framework - Training packages/links to eLearning - Audit reports - Evaluation reports - Training compliance data	Please Select:		

KEY TO RAG

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	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
	6. SAFEGUARDING CHILDREN				
6.1	**There is a process for following up children who 'Was Not Brought' to an appointment.**	**Evidence to demonstrate compliance can include:** - This will ensure the clinician and referrer are aware that the child was not brought and can take any follow up action considered appropriate to ensure the child's needs are being met. - The Safeguarding Team could consider completing an annual audit as part of their safeguarding audit programme to ensure that this process is working - Policies in place - Reports from audits undertaken to monitor effectiveness of the process	Please Select:		
6.2	**There is a system for flagging children for whom there are safeguarding concerns and Looked After Children.**	**Evidence to demonstrate compliance can include:** - Engaged with Child Protection Information Sharing (CP-IS) Project - The Safeguarding Team could consider completing an annual audit as part of their safeguarding audit programme to ensure that this process is working - The Looked After Children Team could consider completing an annual audit as part of their audit programme to ensure that this process is working - Evidence of system in place - Reports from audits undertaken to monitor effectiveness of the system - Evidence of engagement with CP-IS Project	Please Select:		
6.3	**When it is known that a child is not accessing education a referral will be made to the Local Authority in which the child lives.**	**Evidence to demonstrate compliance can include:** - Where it is discovered a child is not receiving any form of education the Children Missing Education Officer is to be notified. Information on missing education is available at: (add own link) - Evidence of referral process	Please Select:		
6.4	**There is clear guidance as to the discharge of children for whom there are child protection concerns or who are looked after.**	**Evidence to demonstrate compliance can include:** - Where there are child protection concerns there is evidence of discharge planning. This must include follow up arrangements and involve partner agencies as required. - The need to safeguard a child should always inform the timing of their discharge, so that the likelihood of harm can be assessed while he or she is in hospital. - Safeguarding Children Policy - Discharge Policy - Discharge Documentation - Guidance - Reports from related audit activity	Please Select:		
6.5	**The Child's GP and health visitor/school nurse (depending on the age of the child) are notified of admissions/discharges for children under 18 years to A&E, ambulatory care units, walk in centres and minor injury units and wards/units.**	**Evidence to demonstrate compliance can include:** - Where a child is not registered with a GP the parent/carer should be advised to register the child with a local GP practice. - Where the child has no parents in attendance and the child is not registered with a GP, it is the provider's responsibility to contact the CCG to inform them so that a GP can be allocated. - Evidence of information sharing processes in place - Information Sharing Agreements - Job description if the organisation has an A&E liaison post - Evidence of processes in place - Guidance on process to be followed where a child is not registered with a GP	Please Select:		

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	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
6.6	COMMUNITY PROVIDERS: **There is good communication between GPs, community nursing services (i.e. health visiting, school nursing and community midwifery services) in respect of children for whom there are concerns and Looked After Children.**	**Evidence to demonstrate compliance can include:** - Each GP practice should be informed of who their 'named' health visitor / school nurse / community midwife is and how they can be contacted. - Evidence of the process in place to inform GPs - Evidence of established communication processes	Please Select:		
6.7	COMMUNITY PROVIDERS: **Organisations have:** • Have identified a strategic lead for Early Help to drive forward their local Early Help offer which will be explicit within policies, service action plans and governance structures. • Are clear which job roles will use Early Help and undertake the Lead Professional role; for these staff, recruitment, induction and supervision will reference Early Help.	**Evidence to demonstrate compliance can include:** - Governance structures - Service Action Plans - Policies, Guidance, Procedures - Training Framework - Induction Documentation - Job Descriptions	Please Select:		
	7. SAFEGUARDING ADULTS AT RISK				
7.1	**There is a system for flagging adults in inpatient care who have learning disabilities or dementia**	**Evidence to demonstrate compliance can include:** - Flagging will activate additional support for patients' decision-making including use of any relevant aids to communication (hearing aids/glasses/Makaton etc.) and access to advocacy services. - Evidence of implementation through routine audit	Please Select:		
7.2	**There is clear guidance as to the discharge of adults who lack capacity including best interests to keep themselves safe.**	**Evidence to demonstrate compliance can include:** - Where there are safeguarding concerns there is evidence of discharge planning following best interests processes. This must include follow up arrangements and involve partner agencies as required. - The need to safeguard an adult at risk should always inform the timing of their discharge, so that the likelihood of harm can be assessed while he or she is in hospital. - Safeguarding Adult policy - Discharge Policy - Discharge Documentation - Guidance - Reports from related audit activity	Please Select:		
7.3	COMMUNITY PROVIDERS: **There is good communication between GPs and community nursing services/allied health professionals in respect of adults for whom there are concerns.**	**Evidence to demonstrate compliance can include:** - Evidence of the process in place - Evidence of established communication processes	Please Select:		

KEY TO RAG

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	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
7.4	**Decision Makers under the MCA have a clear referral process to Independent Mental Capacity Advocacy (IMCA) including referrals for Serious Medical Treatment (SMT).**	**Evidence to demonstrate compliance can include:** - Evidence of referral process contained within organisational policy. - Organisational policy includes reference to who the local IMCAs are and how to contact them. - Sample of referrals made in relation to Serious Medical Treatment during previous 12 month period. - Referral process	Please Select:		

Appendix 2: Audit Tool for LAC 2018/19

Date audit tool completed:	
Organisation Name:	
Organisation Code:	
Organisation Type:	
Name of person completing this toolkit:	
Designation:	
Email address:	
Contact Number:	

Instructions for completing this audit tool:

- Complete **ALL** yellow shaded sections of this toolkit by selecting a cell and adding text or by using in-cell drop down menus where there is an option to 'please select' (a menu icon appears once these cells are selected)
- RAG rating options are explained below to the left of these instructions
- If attaching evidence documents, **please pdf embedded files first** to ensure the filesize remains low
- Please use the provider comments section to explain any reasons behind non-compliant standards
- Useful links are provided below for further information on local adult and child safeguarding policies and procedures

Local Safeguarding Children Board policies/procedures	http://boltonchildcare.proceduresonline.com
Local Safeguarding Adult Board policies/ procedures	http://boltonsafeguardingadultsboard.org.uk

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	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
	ORGANISATIONAL GOVERNANCE AND ACCOUNTABILITY				
1	**There is a board lead for Looked After Children (LAC)**	**Evidence to demonstrate compliance can include:** Their job description clearly identifies their LAC role and responsibilities - Evidence of relevant LAC training (i.e. certificates) within the last 3 years - LAC Governance structure - Annual Report for LAC	Please Select:		
2	**The organisation contributes to multi-agency working and is linked into the Local Corporate Parenting Board.**	**Evidence to demonstrate compliance can include:** - There is representation at a senior level - The organisation contributes to the work of the Corporate Parenting Board - Annual Report - Detail of Board and Subgroups representation - Evidence of attendance at meetings	Please Select:		
3	**Identification of a Named Doctor and Named Nurse for LAC.**	**Evidence to demonstrate compliance can include:** - Named professionals have a key role in promoting good professional practice within their organisation, supporting the local LAC system and processes, providing advice and expertise for fellow professionals, and ensuring LAC training is in place. - Named professionals should be suitably positioned within the Organisation to ensure sufficient strategic influence in line with the Intercollegiate Document. - Be trained in line with the intercollegiate document - Job Description which includes LAC role and responsibilities - Evidence of relevant LAC training (i.e. certificates) within the last 3 years - Resourced sufficiently to meet the needs of the LAC population - The named lead(s) will work closely with their organisation's named professionals for Safeguarding Children, Safeguarding Adults at Risk, Corporate Parenting Board and CCG Designated Professionals	Please Select:		

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	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
4	**The Provider Board regularly reviews safeguarding and arrangements for Looked After Children across the organisation.**	**Evidence to demonstrate compliance can include:** - The board should receive regular reports on their arrangements for Looked After Children. - At a minimum an annual report regarding Looked After Children should be presented at board level with the expectation that this will be made public. - The provider should be able to provide a document that clearly describes their LAC governance arrangements. - Annual Report which includes governance arrangements - Examples of papers for internal meetings	Please Select:		
5	**There are systems in place for completing Initial Health assessments (IHAs) and Review Health Assessments (RHAs) for Looked After Children; to enable the organisation to demonstrate levels of compliance for the completion of IHAs and RHAs within statutory timescales. Information from assessments which then informs health profiling - Statutory Guidance on Promoting the Health and Wellbeing of Looked After Children (DH 2015).**	**Evidence to demonstrate compliance can include:** - The organisation should be able to demonstrate how they are alerted to a new child in care (from within or from out of area) - What the process is for arranging the IHA - who does this and are they appropriately qualified? (i.e. medical practitioner) - What are the processes for arranging RHAs? - How does the organisation know the health assessments are of good quality? - What evidence can you provide that the health assessment has been informed by others i.e. GP and social worker? - The board should receive regular reports on their arrangements for children looked after; at a minimum an annual report on children looked after is presented at Board level - Detail of pathway to IHA and RHA - Numbers and % of IHAs and RHA completed in time - Evidence of audit of IHAs and RHAs - Quality assurance process for statutory health assessments - Annual Report - Evidence of how information from health outcome database informs commissioning/JSNA	Please Select:		
6	**There is a training framework which identifies training levels for the workforce in line with Looked after children: Knowledge, skills and competences of health care staff - Intercollegiate Role Framework (March 2015)**	**Evidence to demonstrate compliance can include:** - Training must reflect statutory and local guidance. - Training should be audited to ensure its effectiveness and quality assured - Training takes account of emerging messages from national and local reviews of LAC - Training Framework - Training packages/links to eLearning - Audit reports - Evaluation reports - Training compliance data	Please Select:		

KEY TO RAG

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	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
7	**Staff working directly with Looked After Children have access to advice support and supervision. This includes clinical supervision as per the organisation's supervision policy** Named Professionals seek advice and access regular formal supervision from Designated Professionals for complex issues or where concerns may have to be escalated.	**Evidence to demonstrate compliance can include:** - Supervision policies - Data to provide assurance that key staff receive supervision in accordance with policies - Audit reports	Please Select:		
8	**All children aged 16-17 should receive a summary of their health records 'Care Leaver Health Summary'**	**Evidence to demonstrate compliance can include:** - Evidence of system in place - Templates used - Arrangements are in place to ensure a smooth transition from LAC and care leavers moving from child to adult health services - Evidence in place to ensure the smooth transition of LAC out of care including SGO, adoption and home	Please Select:		
9	**A programme of Looked After Children related audit and review is in place that enables the organisation to evidence the learning from review, incidents and inspections**	**Evidence to demonstrate compliance can include:** - Looked After Children arrangements to include progress on action to implement recommendations from: • Serious Case Reviews / Local Case Reviews • Internal Management reviews as a consequence of SI's compromising the safety and welfare or service users • Reports from national bodies e.g. Ofsted / CQC - Action plans implemented in the previous 12 months e.g. SCR - Audit reports - Recent CQC reports/Ofsted reports and action plans to meet any recommendations - Service Users Feedback	Please Select:		
10	**The organisation can demonstrate they engage Looked After Children at each stage of their care planning in order to help them be involved in, and take ownership of, their own treatment and care.**	**Evidence to demonstrate compliance can include:** - Health records - Care plans - Statutory Review minutes - Resources, e.g., Talking Mats	Please Select:		
11	**The organisation can demonstrate that they have sought Looked After Children's views on what needs to be done to improve services that they use.**	**Evidence to demonstrate compliance can include:** - Service user feedback processes - Service User Consultations regarding the design, delivery and improvement of services - Attendance at Looked After Children groups - Evidence of involvement in recruitment processes	Please Select:		

Appendix 3: Audit Tool to monitor NHS Provider compliance with the Mental Capacity Act (MCA) 2018/19

Date audit tool completed:	
Organisation Name:	
Organisation Code:	
Organisation Type:	
Name of person completing this toolkit:	
Designation:	
Email address:	
Contact Number:	

Instructions for completing this audit tool:

- Complete **ALL** yellow shaded sections of this toolkit by selecting a cell and adding text or by using in-cell drop down menus where there is an option to 'please select' (a menu icon appears once these cells are selected)
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- Please use the provider comments section to explain any reasons behind non-compliant standards
- Useful links are provided below for further information on local adult and child safeguarding policies and procedures

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Local Safeguarding Adult Board policies/ procedures	http://boltonsafeguardingadultsboard.org.uk

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	1. ORGANISATIONAL GOVERNANCE AND ACCOUNTABILITY				
1.1	**The organisation has a current Mental Capacity Act (2005) policy for adults including young people from the age of 16 which is accessible to staff and includes DoLS and local procedures.**	**Evidence to demonstrate compliance can include:** - Mental Capacity Act (2005) policy is accessible to support staff to implement the Act. - Documentation will be available to support staff to demonstrate capacity assessment and best interest decision making. - Policies, arrangements and records to ensure consent to care and treatment is obtained in line with legislation and guidance. - MCA/ Consent Policy - Evidence of personalised care plans with consent - Evidence of capacity assessments undertaken for young people aged 16+	Please Select:		
1.2	**The MCA Code of Practice is made available to all staff**	**Evidence to demonstrate compliance can include:** - Hard Copy - Internet/Intranet - Paper/Photo Copy - Office Folder - Computer Drive	Please Select:		
	2. TRAINING				
2.1	**Staff have completed MCA/DoLs training induction programmes.**	**Evidence to demonstrate compliance can include:** - Training matrix (including completion dates) - Report including training compliance - A training strategy is in place which incorporates MCA/ DoLs training for staff and includes MCA DoLs training within new starter induction programmes. - A minimum of 80% of staff have completed MCA/ DoLs training	Please Select:		
	3. WORKFORCE RESPONSIBILITIES				
3.1	**The Organisation has a MCA Lead**	**Evidence to demonstrate compliance can include:** - Name - Contact details	Please Select:		

KEY TO RAG

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AMBER - PARTIAL COMPLIANCE - Action plans in place to ensure full compliance and progress is being made within agreed timescales	**Embed documents using the following instructions:**
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	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
3.2	**Staff members understand their own roles and responsibilities when assessing mental capacity** The Organisation must support staff to understand their roles and responsibilities	**Evidence to demonstrate compliance can include:** - Training needs analysis - Anonymised completed document - Anonymised patient records - Internal audits - Anonymised Supervision records	Please Select:		
3.1	**The Organisation has utilised local MCA/ DoLs templates that have been approved by the local Children/Adult Safeguarding Board and these are accessible to staff** The Organisation must have access to local quality assured documentation for staff to apply in practice.	**Evidence to demonstrate compliance can include:** - Copy of Assessment tool - Who quality assured it? - When was this reviewed?	Please Select:		
3.2	**All staff members understand the implications of wilful neglect of people who lack mental capacity.** The Organisation must ensure staff understand their roles and responsibilities	**Evidence to demonstrate compliance can include:** - Evidence of training that includes criminal offence of ill treatment or wilful neglect - Copy of training materials - Supervision - Team meetings - Team briefings - Staff updates - Evidence of learning - Case studies and improved outcomes	Please Select:		
	4. MCA ASSESSMENT AUDIT				
4.1	**The organisation is able to demonstrate compliance with the 5 principles of the MCA (including DoLs)** Compliance with Principle's 1 to 5 of the Mental Capacity Act 2005 (Chapter 2, page 19) **https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf**	**Evidence to demonstrate compliance can include:** - Documented evidence why the organisation/ agency is undertaking a capacity assessment (anonymised capacity assessment) - Detail within patient records (anonymised) - The MCA is recorded in the Care plan - Relevant risk assessment - Evidence of Multi-agency referrals to share concerns - Mins of best interest meetings - Instruction regarding Covert medication has been recorded and a covert medication policy has been followed. - Best interest documentation forms - Referrals to IMCA, RPR or Advocacy - Evidence of LPA's recorded/ consulted - Evidence that an individual has a valid and relevant advance decision in place. - Evidence of urgent / standard Applications made to the Supervisory Body (Local Authority) (Hospitals / Care Homes only). - Evidence of Applications to the Court of Protection for people living in the community (Where relevant)	Please Select:		
	5. DEPRIVATION OF LIBERTY SAFEGUARDING (DoLS) COMPLIANCE				

KEY TO RAG

GREEN - FULL COMPLIANCE - However remains subject to continuous quality improvement	**Complete all sections below shaded yellow** (use the in-cell drop downs for 'please select' cells)
AMBER - PARTIAL COMPLIANCE - Action plans in place to ensure full compliance and progress is being made within agreed timescales	**Embed documents using the following instructions:**
RED - NON-COMPLIANT - Against standards and/or failure to progress agreed action plan within agreed time scales	Insert > Object > Create from file > (browse for file) > Insert > Display as icon (not link to file) > OK

	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
5.1	**The organisation understands that restraint should only be used as a last resort where it is necessary and proportionate, and that restraint used should be the least restrictive and for the minimum amount of time to ensure that the person being restrained is protected from harm.** Compliance with Principle 5 of the Mental Capacity Act 2005.	**Evidence to demonstrate compliance can include:** - Care plans - Risk assessments - Evidence of making safeguarding personal - Evidence people are being reviewed in a timely manner. Care plans and risk assessments monitoring of conditions.	Please Select:		

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	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
	6. INDEPENDENT MENTAL CAPACITY ACT (IMCA), RESPONSIBLE PERSON REPRESENTATIVE (RPR), ADVOCACY				
6.1	**The organisation can demonstrate the use of IMCA/ RPR Section 35 of the Mental Capacity Act 2005 gives duties to appoint an IMCA when a person lacks capacity and is un-befriended.**	**Evidence to demonstrate compliance can include:** - Evidence of local contact details with Independent Mental Capacity Act (IMCA) services. - Completed anonymised referrals to the IMCA service. - Patient records - Evidence that staff are aware of how to refer to an IMCA. Supervision / Training - Evidence of Information for responsible person representative (RPR)'s	Please Select:		

Appendix 4: Audit Tool to monitor Safeguarding Arrangements for Non-NHS Providers 2018/19

Date audit tool completed:	
Organisation Name:	
Organisation Code:	
Organisation Type:	
Name of person completing this toolkit:	
Designation:	
Email address:	
Contact Number:	

Instructions for completing this audit tool:

- Complete **ALL** yellow shaded sections of this toolkit by selecting a cell and adding text or by using in-cell drop down menus where there is an option to 'please select' (a menu icon appears once these cells are selected)
- RAG rating options are explained below to the left of these instructions
- If attaching evidence documents, **please pdf embedded files first** to ensure the filesize remains low
- Please use the provider comments section to explain any reasons behind non-compliant standards
- Useful links are provided below for further information on local adult and child safeguarding policies and procedures

Local Safeguarding Children Board policies/procedures	http://boltonchildcare.proceduresonline.com
Local Safeguarding Adult Board policies/ procedures	http://boltonsafeguardingadultsboard.org.uk

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Embed documents using the following instructions:

Insert > Object > Create from file > (browse for file) > Insert > Display as icon (not link to file) > OK

	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
	1. Clear Lines of Accountability for Safeguarding Children and Adults at Risk [CQC standards 7a, 7e, 7g, 7h, 7)				
1.1	**A safeguarding policy is in place which demonstrates commitment to safeguarding.**	**Evidence to demonstrate compliance can include:** - The policy makes it clear who has overall responsibility for the contribution to safeguarding including lines of accountability through to the person with ultimate accountability - The policy sets out key out clear priorities for safeguarding in line with those of the Local Safeguarding Adult & Children Boards. - The policy is consistent with the policies and procedures set out in Local Authority Multi-Agency Procedures. - The policy clearly states with whom staff should discuss and to whom staff should report any safeguarding concerns - The policy should include reference to the Prevent Duty - The policy should set out Mental Capacity Act and Deprivation of Liberty Safeguards - See section 3 - Copy of Safeguarding Policy for Adults/ Children - Reviewed within the last 2 years	Please Select:		
1.2	**There is a named lead for safeguarding. Arrangements for cover are in place when this person is not available.**	**Evidence to demonstrate compliance can include:** - Named lead must have had sufficient raining and time to undertake this task, role to be covered in job description, and a clear understanding of the Safeguarding Adult and Children's Board policy and procedures. - Job Description which includes safeguarding roles and responsibilities including MCA and DoLS where applicable. - Evidence of relevant safeguarding training (i.e. certificates) within the last 3 years. - Evidence of attendance at local provider forums (minutes of meetings).	Please Select:		

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	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
1.3	**All staff (paid and volunteers) should know how to act on concerns that an adult or child at risk of abuse may have been abused or neglected in line with local guidance.**	**Evidence to demonstrate compliance can include:** - All staff working under the auspices of the provider must have safeguarding adults training and have a training update not less than every three years. Minimum requirement: - Safeguarding Policy/ procedure - Training Matrix including percentages of staff up to date with level 1 adult safeguarding training (90% minimum requirement) Children's requirement: - Inclusion of children within local safeguarding procedures - -Evidence of completing level 1 Children's safeguarding training. (90% minimum requirement) - Anonymised Safeguarding referral (Additional supporting evidence)	Please Select:		
	2. Governance Arrangements/Quality Assurance [CQC standards 7a, 7j, 7k, 18, 20]				
2.1	**The provider is registered with the CQC**	**Evidence to demonstrate compliance can include:** - The provider is fully compliant with outcome 7 'Safeguarding people who use services from abuse'. Essential standards for Quality and Safety (CQC 2010). Where a provider is not compliant they will notify NHS Bolton CCG Safeguarding Team on 01204 463390 and inform them of agreed action plans in place. - CQC Website	Please Select:		
2.2	**An incident reporting system is in place which identifies circumstances/incidents which have compromised the safety and welfare of patients/residents.**	**Evidence to demonstrate compliance can include:** - All serious incidents (SI) compromising the safety and welfare of a patient funded by NHS Bolton CCG is to be notified to on 01204 463390 - All complaints that refer to the safety of patients are referred and investigated thoroughly. - Incident reporting policy - Anonymised incident reported which demonstrates appropriate actions taken. - Evidence of notification to the regulator.	Please Select:		
2.3	**A programme of internal audit and review is in place that enables the provider to continuously improve the protection of all service users from abuse or the risk of abuse.**	**Evidence to demonstrate compliance can include:** - Audits of safeguarding arrangements to include progress on action to implement recommendations from: Serious Case Reviews; Internal Management Reviews as a consequence of SI's compromising the safety/welfare of service users; reports from national bodies e.g. Care Quality Commission. - Recent CQC Inspection Report complete with completed action plans - Internally completed audits including, medication audits/ infection control. Record keeping - **Action plans submitted should demonstrate changes made**	Please Select:		

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	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
2.4	**Residents/service users are aware of the procedures for reporting abuse and neglect.**	**Evidence to demonstrate compliance can include:** - The procedure is publicised in appropriate ways e.g. in resident/service user induction, welcome packs, handbooks, notice boards etc. - Residents handbook/ welcome packs - Posters / notice boards - Minutes of residents meetings where safeguarding/ complaints discussed - Evidence of self surveys	Please Select:		

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	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
	3. Safeguarding Policies, Procedures and Systems [CQC standards 7a, 7b, 7c, 7d, 7e, 7f, 7h, 7i, 7k]				
3.1	**All staff (paid and volunteers) have access to safeguarding policies and procedures. Policies must be easily accessible by staff at all levels and be consistent with those of the Bolton Safeguarding Adults/Children's Boards which can be found in the links in the instruction section of this toolkit**	**Evidence to demonstrate compliance can include:** - Policies and procedures are updated regularly to reflect any structural and legal changes. - Policies and procedures undergo an equalities impact assessment. - Policies and procedures must be audited and reviewed at a minimum 2 yearly to evaluate their effectiveness and to ensure they are working in practice. - Policies and procedures specifically consider adults in special circumstances, e.g. those with a disability, those who do not speak English as their first language. - Safeguarding policies should take account of the Mental Capacity Act 2005. - Evidence may correlate with evidence provided for 1.1.	Please Select:		
3.2	**Safeguarding policy/procedures includes a process for recording and reporting concerns, suspicions and allegations of abuse or harm in line with Bolton Safeguarding Adult Board and Children Board.**	**Evidence to demonstrate compliance can include:** - Organisational policies and procedures, i.e, Whistleblowing Policy - Anonymised safeguarding referral - LSAB & LSCB procedures - Evidence may correlate with evidence provided for 1.1.	Please Select:		
3.3	**Safeguarding policy/procedures includes guidance on how to respond to a disclosure of abuse.**	**Evidence to demonstrate compliance can include:** - Evidence may correlate with evidence provided for 1.1.	Please Select:		
3.4	**Safeguarding policy/procedures incorporate clear guidance on managing allegations against staff and volunteers**	**Evidence to demonstrate compliance can include:** - All substantiated cases of abuse are to be reported to NHS Bolton CCG Safeguarding Team on 01204 463390 in addition to regulatory bodies, including professional bodies. - Evidence may correlate with evidence provided for 1.1 and 3.2 - Evidence of reporting to DBS/NMC - Managing allegation against staff policy	Please Select:		
3.5	**There are robust complaints and whistle blowing policies/procedures in place**	**Evidence to demonstrate compliance can include:** - Assurance is provided to staff and service users that using the procedures appropriately will not prejudice their own position or prospects. - Evidence may correlate with evidence provided for 1.1 and 3.2 - Minutes of staff meetings where whistleblowing policy is discussed.	Please Select:		
	4 Information Sharing [CQC standards 7d, 7e, 7k]				

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	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
4.1	**There are agreed systems, standards and protocols for sharing information within the service and between agencies in accordance with national and local guidance**	**Evidence to demonstrate compliance can include:** - Staff understand what to do and when to share information if they believe a child or adult is at risk of harm; - Agency specific guidance is produced to complement guidance issued by central government and training is made available to existing and new staff as part of their induction programme and on-going training; - Managers are fully conversant with the legal framework and good practice guidance issued for practitioners. - Information Sharing Policy or evidence within the safeguarding policy - Evidence of sharing information appropriately with other agencies	Please Select:		

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	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
	5. Inter-Agency Working [CQC standards 7b, 7e]				
5.1	**The provider works with partners to protect vulnerable adults and participates in reviews as set out in local guidance.**	**Evidence to demonstrate compliance can include:** - Staff to provide, when requested, information on their involvement with a vulnerable adult to inform the case discussion in relation to multi-agency meetings including Serious Case Reviews. - Professionals who are invited to attend a multi-agency meeting in relation to a vulnerable adult must make every effort to attend and will submit a written report where requested to do so. - Evidence of attendance at safeguarding meetings. - Evidence of additional quality initiative involvement i.e. attendance at record keeping training.	Please Select:		
	6. Safer Recruitment Practices [CQC standard 12]				
6.1	**Robust recruitment and vetting procedures are in place to help prevent unsuitable people from working with vulnerable adults and children.**	**Evidence to demonstrate compliance can include:** - Recruitment Policy - Training in safer recruitment - Evidence of DBS checks being completed - Evidence (where required) of overseas worker checks being completed as per Home Office requirements.	Please Select:		
6.2	**Safeguarding responsibilities are reflected in all job descriptions relevant to role and responsibilities**	**Evidence to demonstrate compliance can include:** - Registered Managers Job description - RN/ RMN job description - Carer's job description - Domestic staff/ activities coordinator job description	Please Select:		
6.3	**Staff involved in employing staff are trained in the processes of 'safer recruitment'**	**Evidence to demonstrate compliance can include:** - Evidence that recruited staff have received training in safer recruitment - Recruitment Training	Please Select:		
	7. Record Keeping [CQC standard 20]				
7.1	**Staff working, record their work in accordance with statutory and best practice guidance**	**Evidence to demonstrate compliance can include:** - All staff maintain an accurate, clear record of their involvement on a routine basis. The record is clear, accessible, comprehensive and contemporaneous with both judgments made and decisions taken carefully recorded. The record is dated, signed and the person's name legibly written at the end of the record entry; - Where there are concerns about an individual's welfare, all concerns, discussions held and decisions made and the reasons for those decisions must be recorded in the individuals records. - Evidence of record keeping audits and subsequent actions taken. - Evidence within recent CQC inspection report - Attendance at relevant record keeping training. - Evidence of record keeping discussions within staff meetings.	Please Select:		

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	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
	8. Supervision and Support [CQC standard 20]				
8.1	**Staff working directly with adults at risk and children have access to advice, support and supervision to enable them to manage the stresses inherent with this work.**	**Evidence to demonstrate compliance can include:** - Supervision policy - Supervision contracts - Supervision matrix	Please Select:		
	9. Staff Training and Continuing Professional Development [CQC standards 20, 7f, 7h]				
9.1	**Paid staff and volunteers in contact with vulnerable adults and children are trained and competent to be alert to the potential indicators of abuse and neglect, know how to act on those concerns in line with local guidance.**	**Evidence to demonstrate compliance can include:** - The level of training an individual requires is dependent on their roles and responsibilities. - Records are kept of those accessing training. - Refresher training is undertaken at regular intervals (at a minimum 3 yearly). - Training matrix – Level 1 Adult within the last 3 years for all staff - Level 1 children's safeguarding training - Evidence of additional safeguarding related training being completed i.e. NVQ/Six Steps	Please Select:		
	10. Providing Safer Activities and Trips [CQC standards 12, 7q]				
10.1	**All service users are protected when taking part in activities and trips.**	**Evidence to demonstrate compliance can include:** The organisation ensures that: - Paid staff and volunteers undertaking specialist roles (e.g. taking vulnerable adults off site on trips) are provided with appropriate training; - All activities are risk assessed to ensure that all reasonable steps are taken to prevent adults being harmed whilst participating in the organisations activities; - They take out employers' liability and public liability insurance to ensure that all activities and services and all people taking part are covered; - That all activities being provided are properly planned and organised; - They check that the driver holds the correct driving licence; the vehicle has the correct insurance, tax, MOT, seats, seatbelts and a first aid box. - Copies of insurance certificates - Recently completed risk assessments completed	Please Select:		
	11. Providing Safer Activities and Trips [CQC standard 2]				
11.1	**The provider has clear policy and documentation to support implementation of the Mental Capacity Act (2005).**	**Evidence to demonstrate compliance can include:** - Mental Capacity Act (2005) policy is accessible to support staff to implement the Act. - Documentation will be available to support staff to demonstrate capacity assessment and best interest decision making. - MCA/ Consent Policy - Evidence of personalised care plans with consent, or evidence for lack of capacity and best interests decision making	Please Select:		

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	Standard	Type of Evidence Required	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
11.2	**Paid staff and volunteers are trained to support implementation of the Mental Capacity Act (2005) and where applicable Deprivation of Liberty Safeguards (2009).**	**Evidence to demonstrate compliance can include:** - Providers must have in place a procedure that identifies whether a deprivation of liberty is or may be necessary; what steps are taken to assess whether to seek an authorisation; whether all practical and reasonable steps have been taken to avoid a deprivation of liberty; what action they should take if they do need to request an authorisation; how they review cases; and who should take the necessary action; - Providers must have in place a procedure that identifies what actions should be taken when an urgent authorisation needs to be made; who should take that action; and within what timescales; - Providers must have in place processes for reviewing deprivation of liberty and reducing the levels of restriction where reasonably possible at regular intervals (at a minimum 3 yearly); - The level of training an individual requires is dependent on their roles and responsibilities; - Records are kept of those accessing training. Refresher training is undertaken at regular intervals (at a minimum 3 yearly). - Evidence may correlate with evidence provided for 1.1 - DoLS procedures - Evidence of completed authorisations - Mental Capacity Act Policy (evidence of utilising a locally agreed policy where applicable) - Evidence of notification to local MCA/DoLS Team where applicable - Training Matrix	Please Select:		
11.3	**All staff understand that restraint should only be used as a last resort where it is necessary and proportionate, and that restraint used should be the least restrictive and for the minimum amount of time to ensure that the person being restrained is protected from harm.** Where appropriate, staff required to use restrictive physical interventions have received specialist training.	**Evidence to demonstrate compliance can include:** - The use of restraint should be evidenced within best interest decision making - Where restraint is used, it is documented and followed by an assessment of the person restrained for signs of injury and any emotional or psychological impact - Staff understand when different types of restraint are or are not appropriate, prioritizing de-escalation or positive behaviour support over restraint where possible - Know whether and what type of restraint should be used in a way that respects dignity and protects human rights where possible - Understand that restraint should only be used as a last resort where it is necessary and proportionate, and that restraint used should be the least restrictive and for the minimum amount of time to ensure that harm is prevented and that the person, and others around them are safe. This can include protection from harms they might suffer if others retaliate against them - Restraint to protect others has to be justified using other legal frameworks, e.g. Mental Health Act or criminal justice powers - EMI – Evidence of Restraint training and de-escalation procedures. - Evidence may correlate with evidence for 11.1/11.2	Please Select:		

Appendix 5: Prevent Self-Assessment Audit Tool for NHS Providers 2018/19

Date audit tool completed:	
Organisation Name:	
Organisation Code:	
Organisation Type:	
Name of person completing this toolkit:	
Designation:	
Email address:	
Contact Number:	

Instructions for completing this audit tool:

- Complete **ALL** yellow shaded sections of this toolkit by selecting a cell and adding text or by using in-cell drop down menus where there is an option to 'please select' (a menu icon appears once these cells are selected)
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- Please use the provider comments section to explain any reasons behind non-compliant standards
- Useful links are provided below for further information on local adult and child safeguarding policies and procedures

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	Standard	Care Quality Commission Registration Regulations (amended 2010)	RAG Rating Self-Assessment	Provider Comments	Action Required and Department Lead/ Nominated Lead	Date for Completion	Embed evidence N.B. Embedded files in PDF format ONLY
	Organisational						
1	**Policies and procedures are in place within the respective departments that address Prevent concerns that is embedded into the existing safeguarding policy.** (A separate policy on prevent is not required)	**Regulations** 12, 24	Please Select:				
2	**The Organisation has a Prevent lead**		Please Select:				
3	**Statutory and mandatory induction and updating programmes contain Prevent awareness training and policy updates – This is e-learning package and WRAP 3**	**Regulations** 12, 13, 14	Please Select:				
4	**There are organisational and joint agency agreed protocols and procedures for Prevent referrals and when to make a referral to Channel Panel:** **Regulations** 12, 21, 22, 23, 24	Obtaining advice	Please Select:				
		Raising concerns	Please Select:				
		Reporting concerns	Please Select:				
		Consent	Please Select:				
		Information sharing	Please Select:				
		Escalation sharing	Please Select:				
		Escalation process and procedures	Please Select:				
		List of local and regional Prevent contacts	Please Select:				
5	**Organisational risk assessments include risk issues in Prevent Objectives 2 and 3**	**Regulations** 12, 21, 22, 23, 24	Please Select:				
6	**Governance and risk reporting requirements including Prevent incident(s) reporting for both organisational and inter-agency issues**	**Regulations** 12, 21, 22, 23, 24	Please Select:				
7	**Action plans are put in place to address issues following a 'near miss' incident or event and are fed back to staff through appropriate communication channels**	**Regulations** 21, 22, 23, 24	Please Select:				

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	Standard	Care Quality Commission Registration Regulations (amended 2010)	RAG Rating Self-Assessment	Provider Comments	Action Required and Department Lead/ Nominated Lead	Date for Completion	Embed evidence N.B. Embedded files in PDF format ONLY
8	**All staff and volunteers are aware where they can obtain information about Prevent and how and where they can raise any concerns**	**Regulations** 21, 22, 23, 24	Please Select:				

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	Standard	Care Quality Commission Registration Regulations (amended 2010)	RAG Rating Self-Assessment	Provider Comments	Action Required and Department Lead/ Nominated Lead	Date for Completion	Embed evidence N.B. Embedded files in PDF format ONLY
9	**All protocols, policies and procedures address issues of patient involvement, participation and engagement; management of grievances/complaints/patient feedback; equity of access; cultural diversity; inclusion; and dignity and respect, and are approved through the organisation's governance framework**	**Regulations** 21, 22, 23, 24	Please Select:				
10	**Protocols, policies and procedures address issues of internet access**	**Regulations** 21, 22, 23, 24	Please Select:				
11	**Protocols, policies and procedures address the management of booking meeting rooms/public areas/seminar rooms, etc., and the safety of their use**	**Regulations** 16, 17	Please Select:				
12	**Protocols, policies and procedures address issues of inappropriate canvassing/leafleting**		Please Select:				
	Staff and Volunteers						
13	**Staff apprise themselves with and know where to access organisational protocols, policies and procedures**	**Regulations** 21, 22, 23, 24	Please Select:				
14	**Staff and volunteers attend Health WRAP awareness raising and associated updates in accordance with organisational requirements. Organisation has approved Health WRAP trainers**	**Regulations** 21, 22, 23, 24	Please Select:				
15	**Staff and are aware of issues that can lead to the exploitation of at risk individuals, resulting in them being drawn into terrorist-related activity, and know how to support patients at risk**	**Regulations** 21, 22, 23, 24	Please Select:				
16	**Staff and volunteers are aware of their responsibility to raise concerns and know how and where to do this**	**Regulations** 21, 22, 23, 24	Please Select:				
	Partnership Working						
17	**Locally agreed protocols, policies and procedures are in place for addressing Prevent Referrals / concerns that appropriately utilise the expertise of partner agencies when dealing with concerns linked to the local Channel Panel.**	**Regulations** 12, 24	Please Select:				
18	**There are locally agreed protocols and procedures for sharing information, including joint information sharing**	**Regulations** 12, 24	Please Select:				
19	**There is a nominated Prevent representative who regularly attend local or regional inter-agency Prevent meetings**	**Regulations** 12, 24	Please Select:				

KEY TO RAG

GREEN - FULL COMPLIANCE - However remains subject to continuous quality improvement	**Complete all sections below shaded yellow** (use the in-cell drop downs for 'please select' cells)
AMBER - PARTIAL COMPLIANCE - Action plans in place to ensure full compliance and progress is being made within agreed timescales	**Embed documents using the following instructions:**
RED - NON-COMPLIANT - Against standards and/or failure to progress agreed action plan within agreed time scales	Insert > Object > Create from file > (browse for file) > Insert > Display as icon (not link to file) > OK

	Standard	Care Quality Commission Registration Regulations (amended 2010)	RAG Rating Self-Assessment	Provider Comments	Action Required and Department Lead/ Nominated Lead	Date for Completion	Embed evidence N.B. Embedded files in PDF format ONLY
20	**There are appropriate processes for co-operation and joint care planning with other providers/agencies where care is transferred or shared. The above should take account of appropriate information procedures**	**Regulations** 12, 24	Please Select:				

Appendix 6: Lampard Self-Assessment Audit Tool for NHS Providers 2018/19

Date audit tool completed:	
Organisation Name:	
Organisation Code:	
Organisation Type:	
Name of person completing this toolkit:	
Designation:	
Email address:	
Contact Number:	

Instructions for completing this audit tool:

- Complete **ALL** yellow shaded sections of this toolkit by selecting a cell and adding text or by using in-cell drop down menus where there is an option to 'please select' (a menu icon appears once these cells are selected)
- RAG rating options are explained below to the left of these instructions
- If attaching evidence documents, **please pdf embedded files first** to ensure the filesize remains low
- Please use the provider comments section to explain any reasons behind non-compliant standards
- Useful links are provided below for further information on local adult and child safeguarding policies and procedures

Local Safeguarding Children Board policies/procedures	http://boltonchildcare.proceduresonline.com
Local Safeguarding Adult Board policies/ procedures	http://boltonsafeguardingadultsboard.org.uk

KEY TO RAG

GREEN - FULL COMPLIANCE - However remains subject to continuous quality improvement
AMBER - PARTIAL COMPLIANCE - Action plans in place to ensure full compliance and progress is being made within agreed timescales
RED - NON-COMPLIANT - Against standards and/or failure to progress agreed action plan within agreed time scales

Complete all sections below shaded yellow (use the in-cell drop downs for 'please select' cells)

Embed documents using the following instructions:

Insert > Object > Create from file > (browse for file) > Insert > Display as icon (not link to file) > OK

	Lampard Recommendations	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
1	**All NHS hospital providers should a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all such visits without exception.**	Please Select:		
2	**All NHS providers should review their voluntary services arrangements and ensure that:** • They are fit for purpose; • Volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; • All voluntary services managers have development opportunities and are properly supported.	Please Select:		
3	**All NHS provider staff and volunteers should be required to undergo formal refresher training in safeguarding at the appropriate level at least every three years.**	Please Select:		
4	**All NHS provider staff should undertake regular reviews of:** • Their safeguarding resources, structures and processes (including their training programmes) • The behaviour and responsiveness of management and staff in relation to safeguarding issues to ensure that their arrangements are robust and operate as effectively as possible.	Please Select:		
5	**The NHS provider has conducted a risk assessment to determine what 'checking at periodic intervals' means within their organisation in relation to DBS checks on their staff and volunteers (NHS Employment Check Standards).**	Please Select:		
6	**All NHS providers should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, social networks and other social media activities such as blogs and Twitter is managed and where necessary, restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.**	Please Select:		
7	**All NHS providers should ensure that arrangements and processes for the recruitment, checking and general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.**	Please Select:		

KEY TO RAG

GREEN - FULL COMPLIANCE - However remains subject to continuous quality improvement	**Complete all sections below shaded yellow** (use the in-cell drop downs for 'please select' cells)
AMBER - PARTIAL COMPLIANCE - Action plans in place to ensure full compliance and progress is being made within agreed timescales	**Embed documents using the following instructions:**
RED - NON-COMPLIANT - Against standards and/or failure to progress agreed action plan within agreed time scales	Insert > Object > Create from file > (browse for file) > Insert > Display as icon (not link to file) > OK

	Lampard Recommendations	RAG Rating Self-Assessment	Provider Comments	Embed evidence files here N.B. Embedded files in PDF format ONLY
8	**NHS Providers should review their recruitment, check training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.**	Please Select:		
9	**NHS providers and their associated charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a results of their associations with celebrities and major donors, and whether their risk registers adequately reflect this.**	Please Select:		