Leicestershire Partnership
NHS Trust

Safeguarding & Public Protection Policy & Procedures

Including Safeguarding Children,
Adults, Domestic Abuse, Stalking & Harassment
People at Risk of Radicalisation (Prevent),
Visitors to trust Premises, Anti-Social Behaviour &
Multi-Agency Public Protection (MAPP) including
Potentially Dangerous Person (PDP) Protocol

This policy describes the principles and procedures within the Safeguarding Policy and staff roles and responsibilities in applying this within clinical practice

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Contents

Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
1	Feb-2022	New policy incorporating Child Protection Policy, Safeguarding Vulnerable Adult Policy, MARAC and MAPPA Protocol and MAPPA Policy.
1.1	May-2022	Minor typo errors
2	Feb-2023	Appendix 9 – Pressure Ulcer Pathway Updated. Appendix 12 – Fabricated and Induced Illness pathway added.
2.1	Jan-2024	Policy extended from Feb 24 -July 24 to allow new Government guidance to be reviewed and policy updated to reflect this.

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Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender),

gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 16) of this policy.

Definitions

This section outlines the key definitions used across the safeguarding and public protection agenda.

Professional Curiosity	**Professional curiosity** underpins all safeguarding practice. Building strong relationships with children, adults and their families, based on care and compassion is crucial in promoting disclosure of abuse and to reducing environments where abuse and neglect exist. For this to occur there needs to be interest and curiosity into people's narratives, which needs to be part of the organisations and individual practitioner's mind sets. To work with families with compassion, but retain an open and questioning mind set, requires regular, challenging supervision and time for analysis and reflection of cases. People are more likely to make disclosures of abuse when they feel safe and listened to; sometimes this may only be a partial disclosure which requires professional curiosity to enquire further.

Child Safeguarding

Child	Anyone under the age of 18
Local Area Designated Officer (LADO)	The Local Authority Designated Officer (LADO) refers to the specific role of the designated officer employed by the Local Authority to manage and have oversight of allegations across the children's workforce.
Child Safeguarding	**Child Safeguarding** is the action we take to promote the welfare of children, protect them from harm and is everyone's responsibility. Everyone who comes into contact with children and families has a role to play. Safeguarding and promoting the welfare of children is defined for the purposes of this guidance 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 HM Gov 2018). The identification and protection of children and young people who are 'living' with domestic abuse is a priority when safeguarding children, whether this be those currently living where there are incidents or the risk of incidents of domestic abuse taking place; children seeing or hearing domestic abuse outside of their home or witnessing the effects of domestic abuse on others.
Private fostering	Private fostering Private foster care occurs when a child under 16 (or under 18 if disabled) is cared for, and provided with accommodation, by an adult who is not a relative* for 28 days or more, by private arrangement between parent and carer. *The Children Act (1989) defines 'relative' in relation to a child as a grandparent, sibling, uncle, aunt or stepparent. They could be a full or half relation and could be related by marriage. A cohabite of the mother or father would not qualify as a relative; neither would extended family such as great aunt/uncle or parent's cousins.
Child Abuse	**Definitions of Child Abuse and Neglect** The following definitions are based on those identified in Working Together to Safeguard Children and Keeping Children Safe in Education: **Abuse-** A form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others. Abuse can take place wholly online, or technology may be used to facilitate offline abuse. Children may be abused by an adult or adults or another child or children. **Physical abuse** may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent fabricates the symptoms of, or deliberately induces illness in a child. **Neglect** is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance misuse, maternal mental ill health or learning difficulties or a cluster of such issues. Where there is domestic abuse towards a carer, the needs of the child may be neglected. Once a child is born, neglect may involve a parent failing to Provide adequate food, clothing and shelter (including exclusion from home or abandonment)

	• Protect a child from physical and emotional harm or danger. • Ensure adequate supervision (including the use of inadequate caregivers). • Ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional, social and educational needs. **Sexual abuse** involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. **Emotional abuse** is the persistent emotional maltreatment of a child such as to cause severe and persistent effects on the child's emotional development, and may involve: • Conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. • Not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. • Imposing age or developmentally inappropriate expectations on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. • Seeing or hearing the ill-treatment of another e.g., where there is domestic abuse. • Serious bullying (including cyberbullying). • Causing children frequently to feel frightened or in danger. • Exploiting and corrupting children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.
Fabricated and Induced Illness	Fabricated or Induced Illness by Carers (FII) can cause significant harm to children. FII involves a well child being presented by a carer as ill or disabled, or an ill or disabled child being presented with a more significant problem than he or she has in reality, and suffering harm as a consequence.
Strategy Meeting	Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, there should be a strategy discussion/meeting. The strategy discussion/meeting should be co-ordinated and chaired by a Children's Social Care Manager. The strategy discussion/meeting should involve Children's Social

	Care and the Police, health professionals involved with the child and/or named/designated nurse and/or named/designated doctor and other bodies as appropriate (for example, children's centre/school and, in particular, any referring agency). In the case of a pre-birth strategy discussion/meeting this should involve the midwifery services.
Child in Need	Under **Section 17 Children Act 1989**, a child will be considered in need if: • They are unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the Local Authority. • Their health or development is likely to be significantly impaired, or further impaired, without the provision of services from the Local Authority • They have a disability
Initial Child Protection Conference (ICPC)	Initial Child Protection Conference (ICPC) The initial child protection conference provides a key opportunity for agencies and families to share information, analyse current and future risk; make decisions about the need for a child protection plan and make recommendations to manage risk in the future. For this reason, timely planning and good participation in the meeting is crucial to support good quality decision making and planning.
Review Child Protection (RCPC)	The Review Child Protection Conference is the meeting used to consider progress of the plan and review the continued need for the Child protection plan. It should involve all relevant agencies and family members including, when appropriate, the child, so that decisions about the continued need or ending of the plan can be made robustly.
Child Protection Plan	The Child Protection plan captures the key actions, timescales and those responsible with focus on reducing risk and increasing the safety of the Child. It is a live document owned by the Core group members including the family and must be central to achieving outcomes in a timely way for the child. Any professional with actions in the plan will be accountable for delivering their actions in line with the timescales agreed and with support from the wider core group process.
Core Group	The Core group is the primary planning group for agencies and family to progress the child protection plan. The members should support and challenge each other to remain focused on achieving safety for the child in a timely way, removing barriers to the planning process and working together effectively throughout the period of the child protection plan.
LLR	Leicester, Leicestershire and Rutland

	Safeguarding Children: https://lrsb.org.uk/lrscp

Safeguarding Adults

Adult	Anyone over the age of eighteen years.
Adult at Risk	Safeguarding duties apply to an adult who: • has needs for care and support (whether or not the Local Authority are meeting any of those needs) and; • is experiencing, or at risk of, abuse or neglect and • as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse and neglect. Care Act (2014)
Abuse as defined by Care Act Guidance (2014)	**Physical abuse** – including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions. **Sexual abuse** – including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting. **Psychological abuse** – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks. **Financial or material abuse** – including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits. **Modern slavery** – encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment. **Discriminatory abuse** – including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion. **Organisational abuse** – including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

	Neglect and acts of omission – including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating • **Neglect (specific to a child)** The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to: • provide adequate food, clothing and shelter (including exclusion from home or abandonment); Protect a child from physical and emotional harm or danger. • Ensure adequate supervision (including the use of inadequate caregivers); or ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs. (Working Together 2018) • **Self-neglect** – this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoard Further definitions of abuse and neglect can be found in the multi-agency procedures relating to the specific safeguarding domain.
LLR	Leicester, Leicestershire and Rutland LLR Safeguarding Adults: https://www.llradultsafeguarding.co.uk/
Safeguarding	Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. Organisations have a duty to promote the adult's wellbeing in their safeguarding arrangements. In addition, there is a duty to make safeguarding personal: adult safeguarding arrangements are there to protect individuals and safeguarding action should be person-led and outcome-focussed.
Abuse	"…abuse is a violation of an individual's human and civil rights by any other person or persons…" Care and Support Statutory Guidance (2018)
Adult Safeguarding	Adult Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard in their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults

	sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances Care Act Statutory Guidance (2014, p230).
Six Principles of Safeguarding	The Six Principles of Safeguarding are defined in the Care and Support Statutory Guidance (DoHSC, 2018). These principles underpin all safeguarding adult practice: 1. Empowerment: People being supported and encouraged to make their own decisions and informed consent. “I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens.” 2. Prevention: It is better to take action before harm occurs. “I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.” 3. Proportionality: The least intrusive response appropriate to the risk presented. “I am sure that the professionals will work in my interest, as I see them, and they will only get involved as much as needed.” 4. Protection: Support and representation for those in greatest need. “I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want.” 5. Partnership: Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse. “I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me.” 6. Accountability: Accountability and transparency in delivering safeguarding. “I understand the role of everyone involved in my life and so do they.”
Safeguarding Enquiry	Section 42 of the Care Act states that each Local Authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. If a member of staff is requested to complete a safeguarding enquiry by the Local Authority, there is a statutory duty to comply with the request. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect and, if so, by whom.
Safeguarding Adults Board (SAB)	The overarching purpose of a SAB is to help safeguard adults with care and support needs. The SAB must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member or partner agencies. LPT is a member of the SAB.

	The SAB procedures set out the safeguarding principles and procedures agreed to by its partner agencies.
Safeguarding Adults Review (SAR)	Section 44 of the Care Act states that a Safeguarding Adults Review (SAR) must be conducted when an adult dies as a result of abuse or neglect and there is a concern that partner agencies could have worked more effectively to protect an adult.
Making Safeguarding Personal (MSP)	Making Safeguarding Personal is about professionals talking with adults and their carers about how they may all respond in safeguarding situations in a way that enhances the adult's involvement, choice and control as well as improving their quality of life, wellbeing, and safety. It means professionals seeing adults as experts in their own lives.
Persons in a Position of Trust (PiPOT)	These arrangements apply where a person works, or volunteers, with adults who have care and support needs and who, in connection with their personal life is are alleged to have committed a criminal offence against, or involving another person, or is alleged to have conducted themselves in a manner that might indicate that they are unsuitable to continue to work, or volunteer, with adults who have care and support needs.
Vulnerable Adult Risk Management (VARM)	The Vulnerable Adult Risk Management (VARM) process is a multi-agency approach to safeguarding adults who are making decisions which place them at imminent risk of significant harm or death.

Domestic Abuse

Domestic Abuse	**Domestic Abuse** is defined by The Domestic Abuse Act (2021) as behaviour ("A") towards another person ("B") is if A and B are each aged 16 or over and are personally connected to each other, and the behaviour is abusive of it consists of any of the following: a) physical or sexual abuse. b) violent or threatening behaviour. c) controlling or coercive behaviour. d) economic abuse e) psychological, emotional or other abuse. It does not matter whether the behaviour consists of a single incident or a course of conduct. "Personally connected" is defined as two people whom any of the following applies— a) they are, or have been, married to each other. b) they are, or have been, civil partners of each other. c) they have agreed to marry one another (whether or not the agreement has been terminated).

	d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated). e) they are, or have been, in an intimate personal relationship with each other. f) they each have, or there has been a time when they each have had, a parental relationship in relation to the same child. g) they are relatives. Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim." *This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.' (Home Office 2013).
DASH	The Domestic Abuse and Stalking and Harassment (DASH) Risk Indicator Checklist. This is a standardised risk assessment designed to assess the risks presented to an individual as a result of domestic abuse. A score of 14 or more is defined as high risk, however professional judgement is critical in identifying risk.
Multi-Agency Risk Assessment Conference (MARAC)	**Multi-Agency Risk Assessment Conference (MARAC)** In a single meeting, a domestic violence MARAC combines up to date risk information with a comprehensive assessment of a victim's needs and links those directly to the provision of appropriate services for all those involved in a domestic violence case: victim, children and perpetrator. Aims of the MARAC: • To share information to increase the safety, health and well-being of victim's adults and their children. • To determine whether the perpetrator poses a significant risk to any particular individual or to the general community. • To construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm. • To reduce repeat victimisation. • To improve agency accountability; and • Improve support for staff involved in high risk domestic abuse cases.
Honour	Honour Based Violence is a crime or incident, which has or may

Based Violence (HBV)	have been committed to protect or defend the honour of the family and/or community'. This definition is supported by further explanatory text: "Honour Based Violence" is a fundamental abuse of Human Rights. There is no honour in the commission of murder, rape, kidnap and the many other acts, behaviour and conduct which make up "violence in the name of so-called honour". It is a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour. Such violence can occur when perpetrators perceive that a relative has shamed the family and / or community by breaking their honour code. Women are predominantly (but not exclusively) the victims of 'so called honour-based violence', which is used to assert male power in order to control female autonomy and sexuality. Honour Based Violence can be distinguished from other forms of violence, as it is often committed with some degree of approval and/or collusion from family and/or community members (ACPO & CPS, 2013).
Forced Marriage	Forced Marriage is a marriage conducted without the valid consent of one or both parties where duress is a factor. Forced marriage is a violation of human rights and is contrary to UK law (HM Gov, 2000). A forced marriage is a marriage in which one or both spouses do not (or in the case of some adults with learning or physical disabilities, cannot) consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and emotional pressure. (HM Government 2008).
Female Genital Mutilation (FGM)	Female Genital Mutilation (FGM) comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. It has no health benefits and harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and hence interferes with the natural function of girls' and women's bodies. The practice causes severe pain and has several immediate and long-term health consequences, including difficulties in childbirth also causing dangers to the child (HMGov 2014).
Stalking & Harassment	Stalking is where an individual is fixated and/or obsessed with another. This can be exhibited by a pattern of persistent and repeated contact with, or attempts to contact, a particular victim. The term harassment is used to cover the 'causing alarm or distress' offences under section 2 of the Protection from Harassment Act (PHA) 1997 as amended by the Protection of Freedoms Act (2012), and 'putting people in fear of violence' offences under section 4 of the PHA. Stalking and harassment may

	be seen within the context of domestic abuse or as a separate offence where the victim has had no previous intimate relationship and is not related to the person committing the offence. It is important that both types of stalking and harassment are managed effectively by Trust staff wherever it is disclosed.
Adolescent to Parent Violence Abuse (APVA)	The Home Office (2015) defines adolescent to parent violence and abuse (APVA). There is currently no legal definition of adolescent to parent violence and abuse. However, it is increasingly recognised as a form of domestic violence and abuse1 and, depending on the age of the child, it may fall under the government's official definition of domestic violence and abuse. APVA requires a safeguarding response for the child or young person.

Prevent

Prevent	Prevent the Government's countering terrorism strategy is known as CONTEST (2018). Prevent is part of CONTEST. The Government's response to counterterrorism is built on an approach that unites the public and private sectors, communities, citizens and overseas partners around the single purpose to leave no safe space for terrorists to recruit or act. The strategy, CONTEST, is the framework that enables agencies to organise this work to counter all forms of terrorism. CONTEST's overarching aim remains to reduce the risk to the UK and its citizens and interests overseas from terrorism, so that our people can go about their lives freely and with confidence. **Prevent objectives** • Tackle the causes of radicalisation and respond to the ideological challenge of terrorism. • Safeguard and support those most at risk of radicalisation through early intervention, identifying them and offering support. • Enable those who have already engaged in terrorism to disengage and rehabilitate.
CONTEST	CONTEST has four key principles: • **Prevent:** to stop people becoming terrorists or supporting terrorism • Pursue: to stop terrorist attacks • Protect: to strengthen our protection against a terrorist attack • Prepare: to mitigate the impact of a terrorist attack. The purpose of Prevent is at its heart to safeguard and support vulnerable people to stop them from becoming terrorists or supporting terrorism. Prevent work also extends to supporting the

	rehabilitation and disengagement of those already involved in terrorism. Prevent works in a similar way to programmes designed to safeguard people from gangs, drug abuse, and physical and sexual abuse. Success means an enhanced response to tackle the causes of radicalisation, in communities and online; continued effective support to those who are vulnerable to radicalisation; and disengagement from terrorist activities by those already engaged in or supporters of terrorism.
Channel	Multi-agency approach to protect people at risk from radicalisation.
Radicalisation	Radicalisation refers to the process by which a person comes to support terrorism and forms of extremism leading to terrorism (HM Gov, 2011).

Anti-Social Behaviour (ASB)

Anti-Social Behaviour (ASB)	Anti-Social Behaviour is defined by the Crime and Disorder Act 1998 as "acting in a manner that has caused, or is likely to cause harassment, alarm or distress to one or more persons not of the same household as (the defendant)". It is the broad term used to describe a range of nuisances, disorder and crime that affect people's daily lives. It covers many types of behaviour that vary in nature and severity, many of which are open to interpretation. Thus what is considered anti-social by one person can be acceptable to another.
The Anti-Social Behaviour Risk Assessment Conferencing (ASBRAC)	The Anti-Social Behaviour Risk Assessment Conferencing (ASBRAC) process brings local agencies together to address the needs of ASB victims, perpetrators and locations that have been identified most at risk of harm or causing harm. It provides a multi-agency meeting to consider and address the most complex and high risk cases and applies the most appropriate means of intervention. The aims of the ASBRAC are: • To identify and reduce the harm of high risk and vulnerable victims of ASB. • To share information in order to increase the safety, health and well-being of victims. • To identify and manage ASB hotspot locations. • To identify and take appropriate action against repeat or high-risk perpetrators of ASB. • To jointly construct and implement a risk management plan providing professional support to all those identified as at risk and reduce and/or manage the risk of harm. • To improve agency accountability. • To improve support for staff involved in high risk ASB cases by using a multi-agency approach.

Multi-Agency Public Protection Arrangements (MAPPA)

Multi-Agency Public Protection Arrangements (MAPPA)	The Criminal Justice Act 2003 ("CJA 2003") provides for the establishment of Multi-Agency Public Protection Arrangements ("MAPPA") in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders (MoJ, 2012, updated 2017).
MAPPA 1	**Level 1 cases ordinary agency management** Ordinary agency management level 1 is where the risks posed by the offender can be managed by the agency responsible for the supervision or case management of the offender. This does not mean that other agencies will not be involved, only that it is not considered necessary to refer the case to a level 2 or 3 MAPP meeting.
MAPPA 2	**Level 2 cases active multi-agency management** Cases should be managed at level 2 where the offender: • Is assessed as posing a high or very high risk of serious harm, or • The risk level is lower, but the case requires the active involvement and co-ordination of interventions from other agencies to manage the presenting risks of serious harm, or • The case has been previously managed at level 3 but no longer meets the criteria for level 3, or • Multi-agency management adds value to the lead agency's management of the risk of serious harm posed.
MAPPA 3	**Level 3** management should be used for cases that meet the criteria for level 2 but where it is determined that the management issues require senior representation from the Responsible Authority and Duty-to-Co-operate agencies. This may be when there is a perceived need to commit significant resources at short notice or where, although not assessed as high or very high risk of serious harm, there is a high likelihood of media scrutiny or public interest in the management of the case and there is a need to ensure that public confidence in the criminal justice system is maintained (MoJ, 2012).
Potentially Dangerous Person (PDP)	The term **Potentially Dangerous Person (PDP)** was introduced in the Association of Chief Police Officers (ACPO) Guidance, Protecting the Public: Managing Sexual Offenders and Violent Offenders (ACPO Guidance, 2007). For the purpose of this guidance, public protection was identified as 'the policing function of reducing harm in the context of Multi-Agency Public Protection Arrangements (MAPPA) and through the identification, assessment and management of PDP's who do not fall within MAPPA.'

	The revised ACPO guidance (2010) has amended the definition for a Potentially Dangerous Person which is now as follows: • A person who is not eligible for management under MAPPA but whose behaviour gives reasonable grounds for believing that there is a present likelihood of them committing an offence or offences that will cause serious harm. • A present likelihood reflects imminence and that the potential event is more likely than not to happen. Serious harm is defined in the Home Office (2002) Offender Assessment User Manual as '…a risk which is life-threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible.' There is no legislation that recognises the existence of PDPs and unlike offenders who fall within MAPPA there is no statutory multi-agency framework which governs the management of PDPs.

Other relevant definitions

Visitor	Visitor for the purposes of this policy is anyone attending Trust premises including outpatient and inpatient facilities and the process at Appendix F1 highlights how to manage such visitors including both adults and children whether patients, families, carers, contractors, volunteers and visiting workers at Trust sites. It also addresses security protocols to be considered in the event of a Very Important Person (VIP) visits.
eIRF	Certain safeguarding incidents require completion of an incident record on LPT's Incident Reporting systems (Ulysses) as per LPT Incident Reporting Policy. Examples of incidents reportable on LPT incident reporting system: • Allegations against staff • Safeguarding Adult referrals • Child Safeguarding • Patient on patient assault • Honour based violence and forced marriage • Female genital Mutilation • Pressure Ulcers

1. Purpose of the Policy

1.1 The Trust recognises its priority and duty to safeguard service users from abuse, neglect and the risk of radicalisation and work to protect the public from perpetrators of abuse and high-risk offenders.

1.2 The Trust has suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of a) taking reasonable steps to identify the possibility of abuse and prevent it before it occurs and b) responding appropriately to any allegation, suspicion or evidence of abuse.

1.3 The Trust has regard to national and local guidance issued under the legal duties and safeguarding boards as described in section 1 of this policy.

1.4 The Trust recognises its first priority should always be to ensure the safety, well-being and protection of unborn babies, children, and adults in its care and to the wider public. That it is the responsibility of all staff to act on any allegation, suspicion or evidence of abuse, neglect or radicalisation, and report their concerns to a responsible person, manager or agency as determined within this policy and related procedures.

1.5 The Trust recognises its duty to safeguard patients and visitors to its premises including outpatient and inpatient units. In line with the lessons taken from the independent report for the Secretary of State into the investigations relating to Jimmy Savile (Lampard 2015) the Trust has decided to include its process for visitors to Trust premises within this safeguarding policy. This includes all visits by adults, children, contractors and Very Important Persons (VIPs).

2. Summary

This policy describes the principles and procedures within the and staff roles and responsibilities in applying this within clinical practice.

3. Introduction

3.1 Leicestershire Partnership NHS Foundation Trust (the Trust) is committed to working in partnership with Leicester, Leicestershire and Rutland Safeguarding Boards namely; Local Safeguarding Children Partnership (LSCB), Safeguarding Adults Boards (SAB), Safeguarding Leicestershire Partnership (SLP), Strategic MAPPA Offender Management Board (SOMMB), Channel Panels, Public Protection (MAPP) partnerships to protect children (including unborn babies), adults, those experiencing domestic abuse and at risk of radicalisation from abuse and neglect; and by working to manage high risk offenders.

3.2 The Trust has in place systems and processes to support local multi-agency arrangements and implement local and national guidance and legislation and procedures to protect those who are vulnerable to abuse, neglect and exploitation.

3.3 As a member of these multi-agency partnerships the Trust is party to all the strategies, decisions, policies and procedures agreed by the safeguarding and protection boards and has agreed to support membership of the operational sub-groups responsible for implementing the safeguarding procedures, communication and training strategies.

3.4 Regulation 13 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014, states that the Trust has a legal duty to safeguard service users from abuse and improper treatment.

3.5 The Trust has a legal duty under Section 11 of the Children Act (2004) to make arrangements to ensure that, in discharging its functions, it has regard to the need to safeguard and promote the welfare of children as described in Working Together to Safeguard Children; a guide to inter-agency working to safeguard and promote the welfare of children (2018).

3.6 The Trust has a legal duty under Section 6 of the Care Act (2014) to co-operate with the Local Authority in relation to (a) their respective functions relating to adults with needs for care and support, (b) their respective functions relating to carers, and (c) functions of theirs the exercise of which is relevant to functions referred to in paragraph (a) or (b). This includes Section 42-47 of the Care Act – “safeguarding adults at risk of abuse and neglect”.

3.7 The Trust has a duty under subsection 4 of the Domestic Violence, Crime and Victims Act (2004) in the establishment and conduct of domestic homicide reviews.

3.8 The Trust recognises its responsibility recognise and respond to domestic abuse as defined in the Domestic Abuse Act (2021) s. 15-17 and the Serious Crime Act (205) relating to the offence of coercive and controlling behaviours (section 4.5).

3.9 Section 26 of the Counterterrorism and Security Act (2015) places a duty on the Trust (Schedule 6 to the Act), in the exercise of their functions, to have “due regard to the need to prevent people from being drawn into terrorism”. The Act states that the Trust must have regard for the Prevent Duty guidance (issued under section 29) when carrying out the duty.

3.10 The Modern Slavery Act (2015) Schedule 3; section 43, places the Trust under a duty to co-operate with the Independent Anti-slavery Commissioner.

3.11 The Trust has a legal reciprocal duty to cooperate with the Police, Probation Trust and Prison Services as the “Responsible Authority” under Section 325(3) of the Criminal Justice Act 2003; in its task of assessing and managing risk.

3.12 The Serious Crime Act (2015) requires Trust Health and Social Care professionals to report “known” cases of Female Genital Mutilation (FGM) in under 18s which they identify in the course of their professional work to the police. ‘Known’ cases are those where either a girl informs the person that an

act of FGM – however described – has been carried out on her, or where the person observes physical signs on a girl appearing to show that an act of FGM has been carried out and the person has no reason to believe that the act was, or was part of, a surgical operation within section 1(2)(a) or (b) of the FGM Act 2003. There are notifications and alerts in place to support and report this requirement.

4. Duties within the Organisation

4.1 The **Board of Directors** has a duty to ensure that it has policies and procedures in place to effectively safeguard; children and young people, adults; including domestic abuse and those at risk of radicalisation as well as the management of high-risk offenders. The Board will publish an annual safeguarding report and safeguarding assurance declaration on the public website.

4.2 The **Quality Assurance Committee** have a responsibility for approval, development, implementation, review and monitoring effectiveness of these policy and procedures on behalf of the Board, receiving assurance via the Legislative Committee bi-monthly update, exception and annual reports & annual safeguarding declaration.

4.3 The **Executive Director of Nursing / AHP's & Quality** is the Executive Safeguarding Lead and will champion safeguarding within the Trust.

4.4 The **Deputy Director of Nursing and Quality will attend** strategic safeguarding children & adult boards and identify a policy lead and ensure safeguarding practice and procedures are reviewed in line with policy. The Deputy Director will also Chair and manage the Safeguarding Committee.

4.5 A **Non-Executive Director** will be appointed to provide scrutiny and additional Board assurance, whilst championing safeguarding across the wider organisation.

4.6 The **LPT Safeguarding Committee** meets every 2 months and has the responsibility to recommend the safeguarding policy and procedures for approval, monitoring the compliance against these and training, safeguarding reporting, multi-agency reviews and audits. The committee will report after every meeting and on an exception basis to the Quality Committee and review safeguarding training annually.

4.7 It is the responsibility of the **Head of Safeguarding** to ensure that comprehensive arrangements are in place regarding adherence to this policy and that policies and procedures are reviewed in line with local and national guidance and good practice in relation to safeguarding adults, children, Prevent, MAPPA and Domestic Violence and Abuse. This role will also ensure that there are robust advice and training procedures in place in relation to safeguarding adults, children, Prevent, MAPPA and Domestic Violence and Abuse and that safeguarding and public protection are championed across the Trust. The Head of Safeguarding will attend strategic boards and panels to

and ensuring that the Trust complies with all safeguarding and public protection legislative requirements.

4. 8 It is the responsibility of the **Lead Practitioner for Safeguarding Adults, MCA, Prevent and MAPPA** and the **Named Professionals** (Named Doctor & Nurse for Safeguarding Children) to:

- Act in accordance with the roles and competencies laid out within Working Together to Safeguard Children (HMGov, 2018), Care Act (2014), Prevent & Channel Duties (2015) the Local Safeguarding & Prevent Boards, Adult Safeguarding Roles and Competencies and the Intercollegiate Competencies (RCN, 2019).
- Be responsible for monitoring and auditing the safeguarding, Prevent and MAPP arrangements and activity within the Trust and will report to the Safeguarding Committee where appropriate.
- To provide specialist advice, training, support, guidance, escalation of individual cases and where necessary training and supervision to Safeguarding Link Practitioners and Trust staff. This does not absolve individual practitioners of their professional accountability and duties.

4.9 The Trust's Community Forensic Service will attend the MAPPA Level 2 meetings on behalf of the Trust and liaise with staff involved in the MAPPA cases.

4.10 It is the responsibility of **Heads of Directorates, Deputy Heads of Nursing, Operational Managers and Heads of Service** to ensure that:

- Safeguarding policies and procedures are managed within their own Directorates or Services in line with the guidelines in this policy.
- Team managers and other management staff are given clear instructions about policy arrangements so that they in turn can instruct staff under their direction. These arrangements will include:
- Keeping informed of any changes to policies.
- Ensuring that all staff have access to up-to-date policies, either through the internet or if policy manuals are maintained that the resources are in place to ensure these are updated as required.
- Maintaining a system for recording those changes to policies and procedures have been noted by staff and that necessary arrangements have been made in line with the implementation plan in each policy.
- Ensuring effective safeguarding assurance and governance processes within Directorates and areas of responsibility.

4.11 **Managers and Team Leaders** will be responsible for**:**

- Ensuring allegations against staff / volunteers / students & contractors, reports of abuse, neglect, risk of radicalisation and high risk to others are reported as per the Trust and multi-agency policy and procedures.
- Ensuring that policies and procedures are followed and understood as appropriate to each staff member's role and function. This information

must be given to all new staff on induction.

- Provide safeguarding support and guidance as per the Trust's Supervision Policy.
- Promote the use and concept of professional curiosity from staff within team meetings and supervision.
- To ensure that staff seek advice from the LPT Safeguarding Team when indicated and ensure that the advice is followed in a timely way.
- Assess risk to and impact on alerter / referrer / reporter and plan supportive measures where indicated.
- Ensuring that their staff know how and where to access current policies and procedures.
- Ensuring that a system is in place for their area of responsibility that keeps staff up to date with new policies and policy changes
- To ensure staff complete appropriate reporting and recording of safeguarding and risk issues as per Trust procedures
- To follow up on safeguarding actions via liaison with staff member and escalate matters according to the Trust's escalation procedure where concerns are not being appropriately acted upon by another Trust employee or external agency.
- To ensure staff training compliance is monitored and any non-compliance is addressed in a timely manner.

4.12 Safeguarding Link Practitioners

- Raise awareness of safeguarding and public protection within the organisation and wider community
- To act as a forum for discussion of relevant issues – providing consistency in approach across the organisation and promoting the concept of professional curiosity
- To robustly disseminate changes to legislation/guidance and practice throughout the organisation.
- Opportunity to share information/examples of best practice with colleagues
- Provide a support network for colleagues in clinical practice
- Involvement of frontline staff in decision making regarding safeguarding practice
- Develop a framework of expertise within localities
- To provide opportunities for learning, increase knowledge and confidence regarding safeguarding issues.
- To provide a framework for identifying areas in need of strengthening regarding safeguarding practice.
- To attend the Link Practitioner learning and development sessions.

4.13 Trust Secretary

On behalf of the approving committees, the Trust Secretary's Office is the central control point for administering the distribution of all policies and maintains a database of all Trust policies and procedures. The Trust Secretary will therefore be responsible for:

- Co-ordinating and managing the creation, consultation, approval,

ratification, review and archiving processes for all Trust-wide policies.

- Ensuring that a master copy is kept of all Trust-wide policies and procedures for a minimum period of 10 years in line with the guidance set out in 'The Records Management: NHS Code of Practice' (2016)
- Maintaining a single register of all Trust-wide policies.
- Ensuring that policies follow the prescribed format.
- Ensuring that policies follow the prescribed format.
- Ensuring that policies are kept under review.
- Being the main authority in all but rare circumstances for the inclusion of new policies or procedures on the Internet (in the interests of continuity, version control and security).
- Ensuring that the dedicated Corporate Governance Documents, Policies & Procedures pages of the Internet are regularly kept up to date.
- Ensuring that staff are informed regarding any policy updates or new policies.

4.14 **All Staff** (including seconded staff, volunteers and those who have a roving role in the Trust) should be aware that despite the above responsibilities of senior staff, every staff member has an individual duty of responsibility to ensure that they:

- Know where to locate the safeguarding policy and procedures
- Adhere to safeguarding processes and carry out their responsibility and duty to report actual or suspected abuse, neglect and risk of radicalisation or from high-risk offenders to their Line Manager.
- Report safeguarding information to the appropriate agency and record actions and outcomes on the Trust's safeguarding child and adult screening tool and/or incident recording system (as per procedure 1D)
- Attend the appropriate level of safeguarding training as per mandatory Training Matrix Section 1E.
- Practice with a mind-set that promotes professional curiosity and enquiry to promote and enable disclosures of abuse.

4.15 The responsibility for **investigating safeguarding incidents** of alleged or actual abuse and neglect lies with the Local Authorities and / or the Police, unless agreed on a case-by-case basis relating to allegations against Trust employees or Enquiries as per the Care Act (2014).

5. Development of Policies and Procedures

5.1 This policy was originally reviewed and merged to incorporate existing Child Protection policy (COR 10), Safeguarding Vulnerable Adults policy (OPR 02 & Appendix 1, 2 & 3), MARAC & MAPPA protocol (OPR 25) and MAPPA policy (OPR 34). The policy also included domestic abuse and prevent policy and procedures with the addition of generic safeguarding process and information relating to allegations, escalation, information sharing and record keeping.

5.2 In addition this latest version includes a clearer focus on stalking and harassment and includes the Trust's visitor procedures and anti-social behaviour processes.

5.3 The procedures section of this document incorporates all of the Trust's safeguarding related procedures in to one document.

5.4 The policy and procedures are applicable to all of the Trust's geographical coverage and indicate whether they are generic to all counties or specific to a particular area.

5.5 All of the policy and procedures have been refreshed and reviewed to incorporate changes in other Trust policies and national and local policy review and guidance.

6. Consultation, Approval and Ratification Process

6.1 The policy has been consulted upon, approved and ratified in accordance with corporate documents & Policies Procedure (2018).

7. Review and Revision Arrangements including Version Control

7.1 This policy will be reviewed annually by the policy author/lead in accordance with Corporate Documents & Policies Procedure (2018) and the safeguarding assurance processes. Revision may occur earlier if relevant new legislation or guidance is issued.

7.2 The Legislative and/or Quality Committees monitoring the effectiveness of the policy may also call for an early review on the basis of the reports it receives.

7.3 The Trust Secretary will maintain a version control sheet, as per Corporate Documents & Policies Procedure (2018).

8. Dissemination, Implementation and Training of the Policy

8.1 The Safeguarding Committee will oversee developments, review processes and the policy implementation.

8.2 Training for Safeguarding Adults and Children, Domestic Abuse, Prevent and MAPPA training is mandatory to *all* LPT staff and is identified within the Trust's Safeguarding Training Matrix (1E) which is reviewed annually. The Training Matrix will be shared at induction with the requirement that all staff are trained within the first 2 months of their employment or when commencing as a volunteer.

8.3 Safeguarding information, amendments and updates are disseminated throughout the Trust by the Safeguarding Committee, Trust intranet, weekly Trust Communications, the monthly LPT Safeguarding Briefing, lessons learned bulletin, Safeguarding Link Practitioners and operational services meetings and forums.

9. Policy Control including Archiving Arrangements

9.1 The Trust Secretary's Office will retain a copy of each policy for a minimum of 10 years in line with the recommendations contained within 'Records Management NHS Code of Practice' (2006). Individuals wishing to obtain previous versions of this policy should contact The Trust Secretary's Office.

10.0 Monitoring Compliance with and Effectiveness of Policies and Procedures

Systems	**Monitoring and/or Audit**				
Standard	Measurables	Lead Officer	Frequency	Reporting to	Action & Monitoring
Implementation of policy	As per section 8	Head of Safeguarding	From 1st November 2021	Safeguarding Committee	Executive Team
Internal safeguarding audit of dissemination, knowledge and effectiveness of policy & procedures	Knowledge of Safeguarding Policy & Processes	Head of Safeguarding	Annual safeguarding operational audit	Safeguarding Committee	Divisional Management Teams Quality Assurance Committee
Recording and assessment of safeguarding via incident reporting system or safeguarding screening tools including monitoring dashboards on Prevent to NHSE and Safeguarding Dashboard to health & Social Care Commissioners	Number and quality of recorded data	Head of Safeguarding	Quarterly	Safeguarding Committee	Quality Committee

Systems in place to monitor safeguarding training and recording as identified in training matrix	Percentage of training compliance against competency for role	Learning & Development Manager	Monthly Training Reports to Divisions Bi-monthly training reports	Safeguarding Committee	Divisional Management Teams Quality Committee
Audit & inspection Framework	Compliance with Section 11 audit (LSCB), Prevent Plan & NHS England reporting & quality reporting for CCG Safeguarding Assurance Template (SAT)	Head of Safeguarding	Outcomes of inspections and audits Quality Review Meetings, S75 & SWCCG	Safeguarding Committee Head of Quality & Safety	Quality Committee Divisional Management Teams

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13. Associated Trust Documentation

Trust Policies

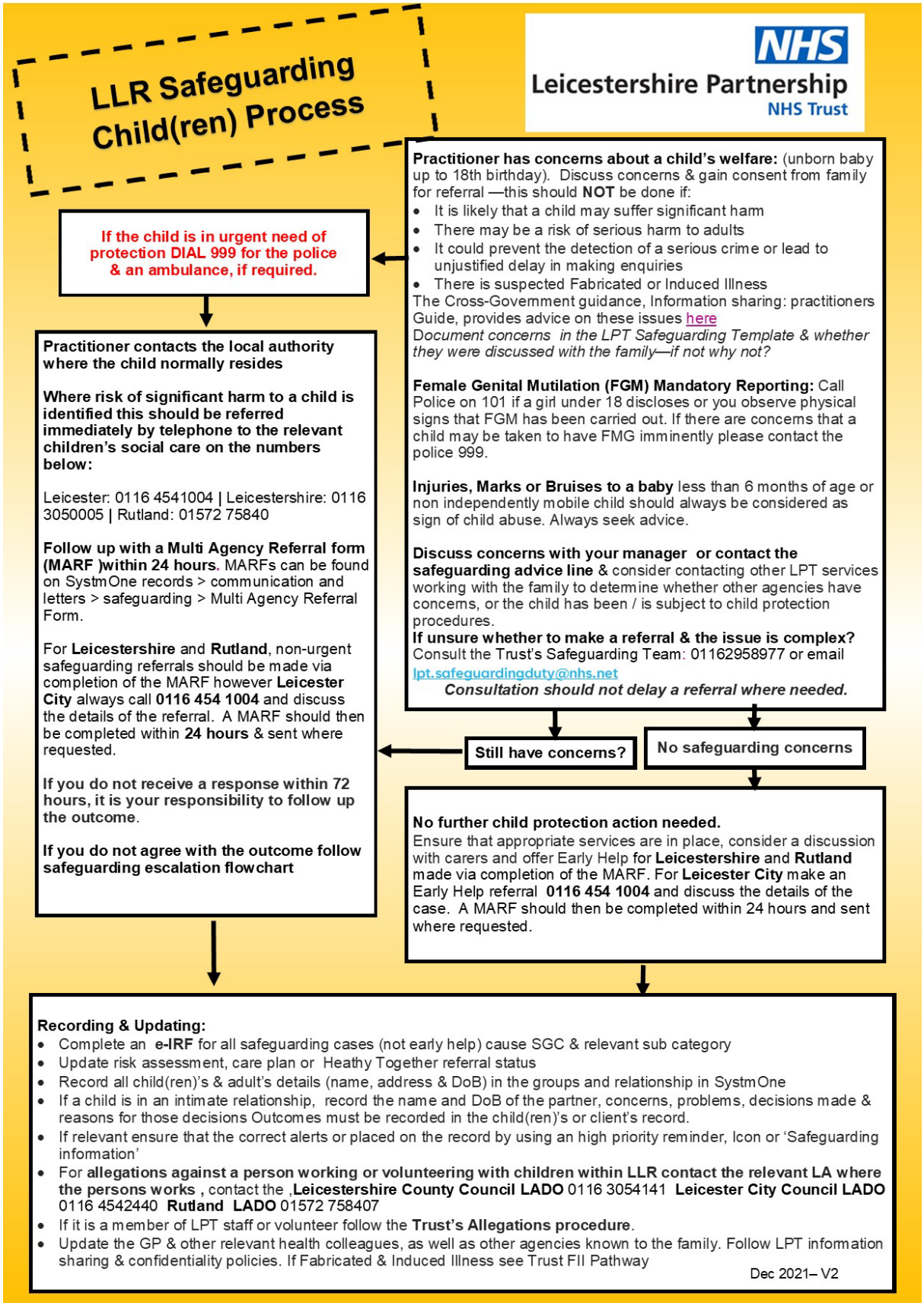
Incident/Serious Incident Reporting Policy https://www.leicspart.nhs.uk/wp-content/uploads/2020/04/Incident-Serious-Incident-Reporting-Policy-exp-Dec-20.pdf

Data Protection and Information Sharing Policy https://www.leicspart.nhs.uk/wp-content/uploads/2020/11/Data-Protection-and-Information-Sharing-Policy-exp-Dec-21.pdf

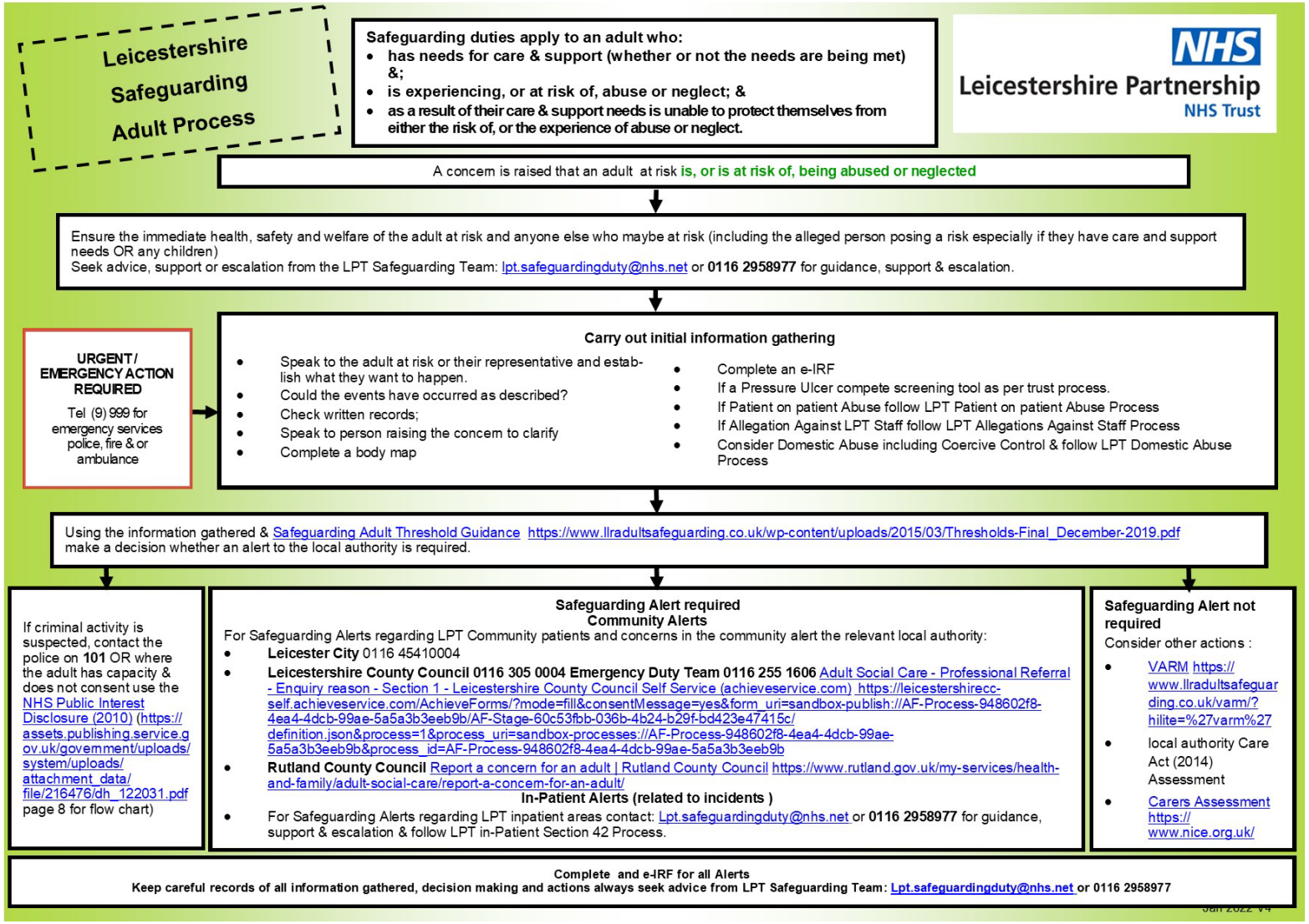
Mental Capacity Act (2005) Policy https://www.leicspart.nhs.uk/wp-content/uploads/2021/09/Mental-Capacity-Act-Policy-exp-Jul-24-updated-Sep-21.pdf

Supervision Policy https://www.leicspart.nhs.uk/wp-content/uploads/2020/04/Supervision-Policy-exp-Feb-23.pdf

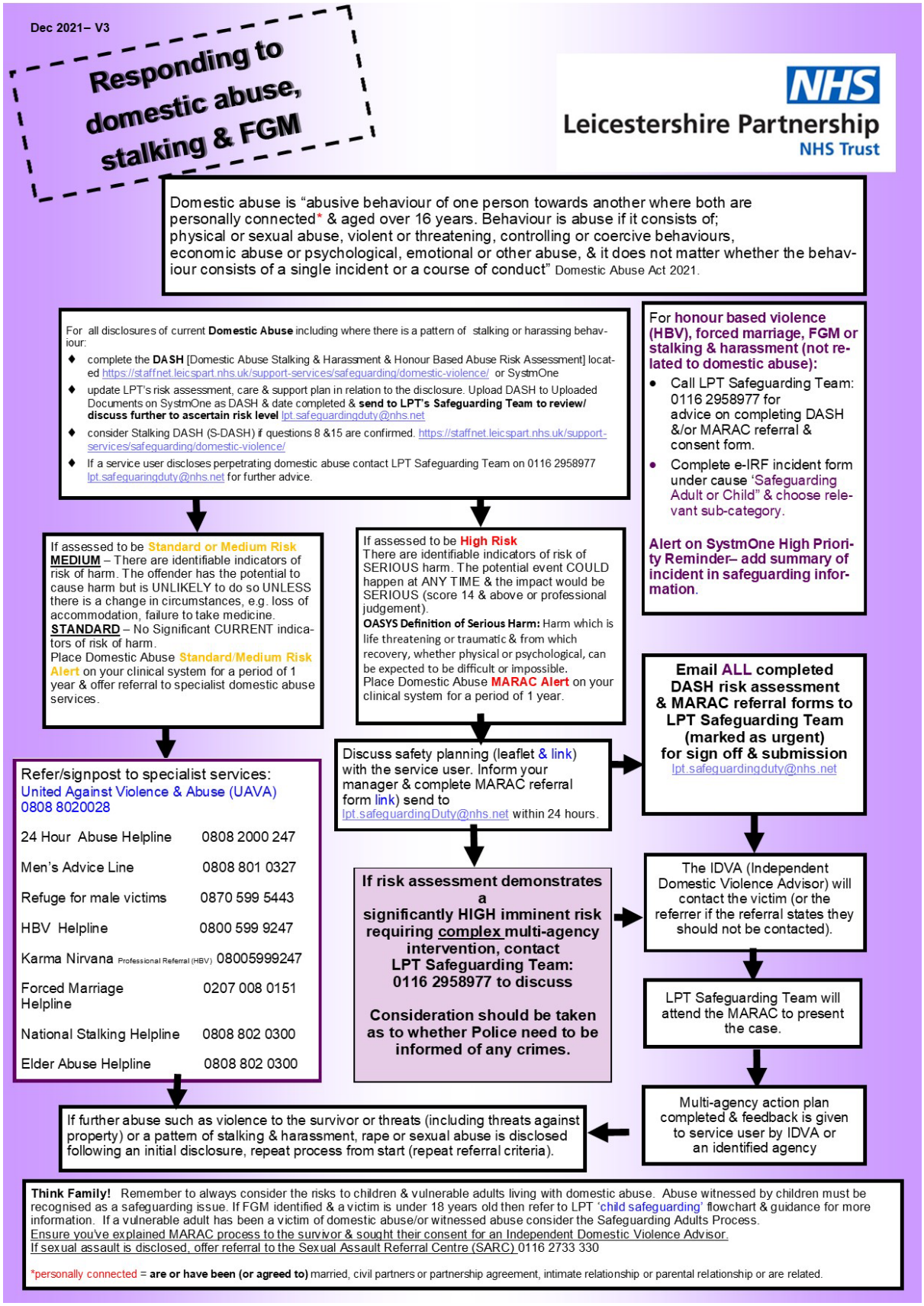
Appendix 1 – Safeguarding Children Pathway



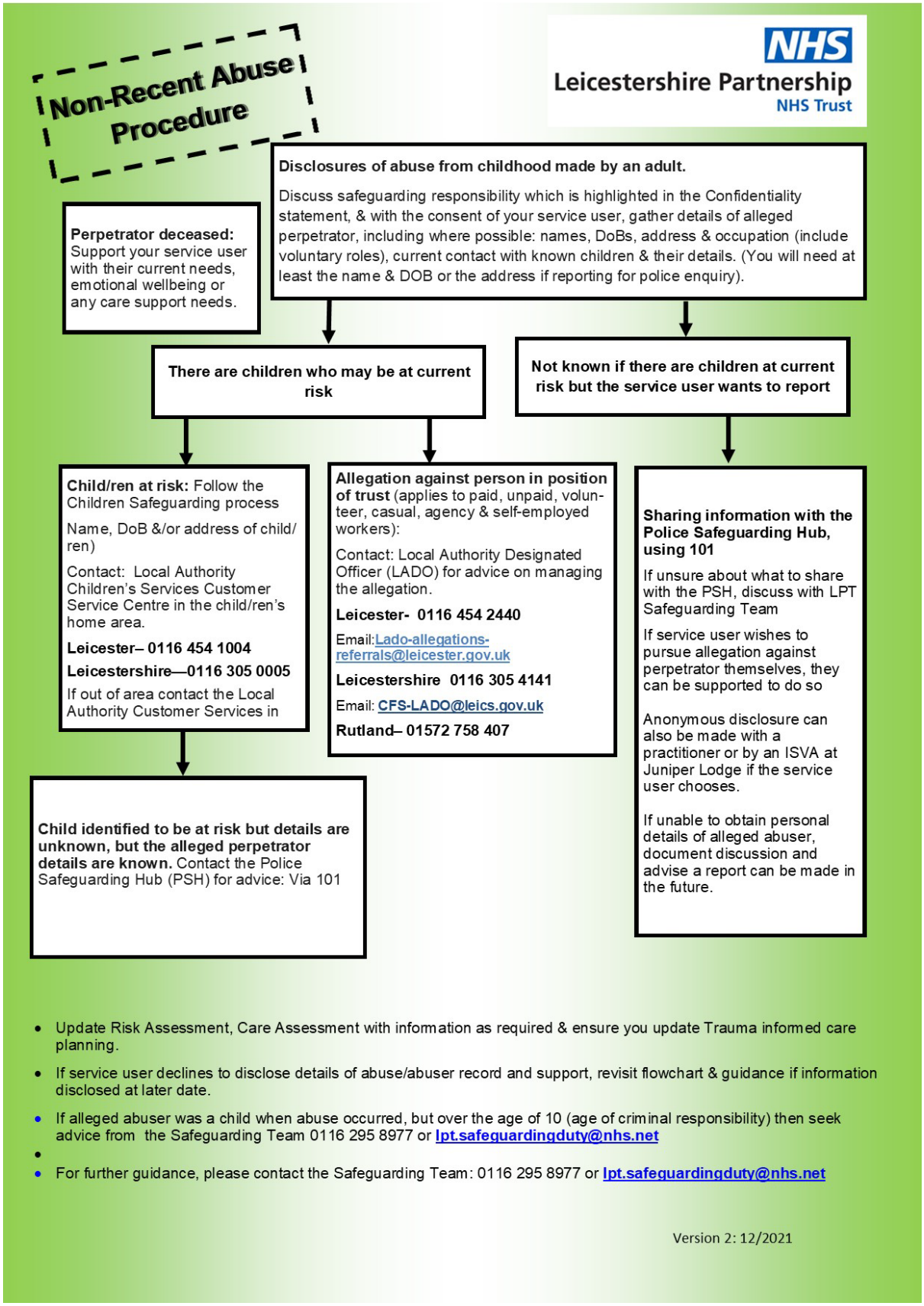
Appendix 2 – Safeguarding Adult Pathway



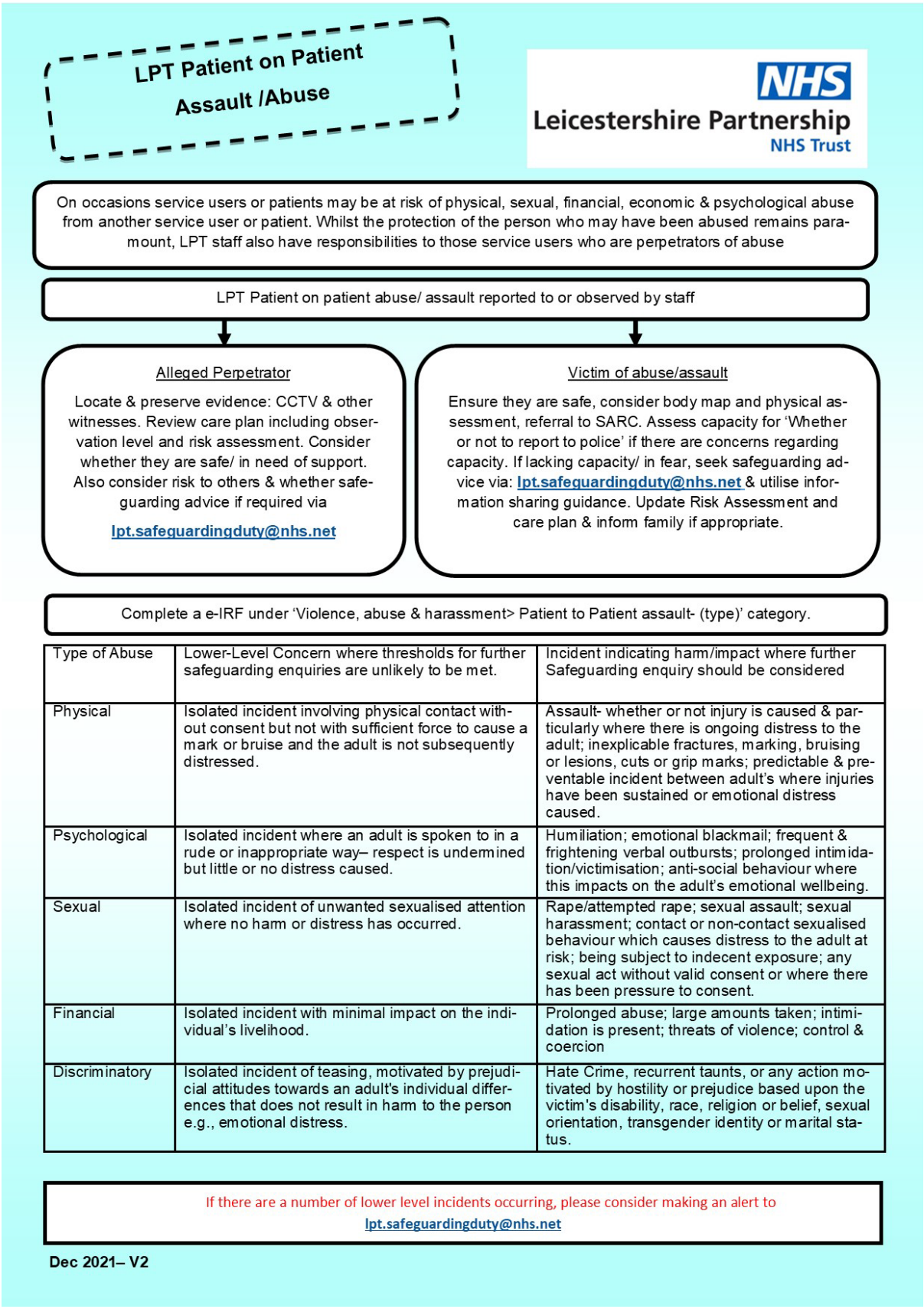
Appendix 3 - Domestic Violence and Abuse



Appendix 4 - Non-Recent Abuse



Appendix 5 - Patient on Patient Assault



Type of Abuse	Lower-Level Concern where thresholds for further safeguarding enquiries are unlikely to be met.	Incident indicating harm/impact where further Safeguarding enquiry should be considered
Physical	Isolated incident involving physical contact without consent but not with sufficient force to cause a mark or bruise and the adult is not subsequently distressed.	Assault- whether or not injury is caused & particularly where there is ongoing distress to the adult; inexplicable fractures, marking, bruising or lesions, cuts or grip marks; predictable & preventable incident between adult's where injuries have been sustained or emotional distress caused.
Psychological	Isolated incident where an adult is spoken to in a rude or inappropriate way– respect is undermined but little or no distress caused.	Humiliation; emotional blackmail; frequent & frightening verbal outbursts; prolonged intimidation/victimisation; anti-social behaviour where this impacts on the adult's emotional wellbeing.
Sexual	Isolated incident of unwanted sexualised attention where no harm or distress has occurred.	Rape/attempted rape; sexual assault; sexual harassment; contact or non-contact sexualised behaviour which causes distress to the adult at risk; being subject to indecent exposure; any sexual act without valid consent or where there has been pressure to consent.
Financial	Isolated incident with minimal impact on the individual's livelihood.	Prolonged abuse; large amounts taken; intimidation is present; threats of violence; control & coercion
Discriminatory	Isolated incident of teasing, motivated by prejudicial attitudes towards an adult's individual differences that does not result in harm to the person e.g., emotional distress.	Hate Crime, recurrent taunts, or any action motivated by hostility or prejudice based upon the victim's disability, race, religion or belief, sexual orientation, transgender identity or marital status.

If there are a number of lower level incidents occurring, please consider making an alert to lpt.safeguardingduty@nhs.net

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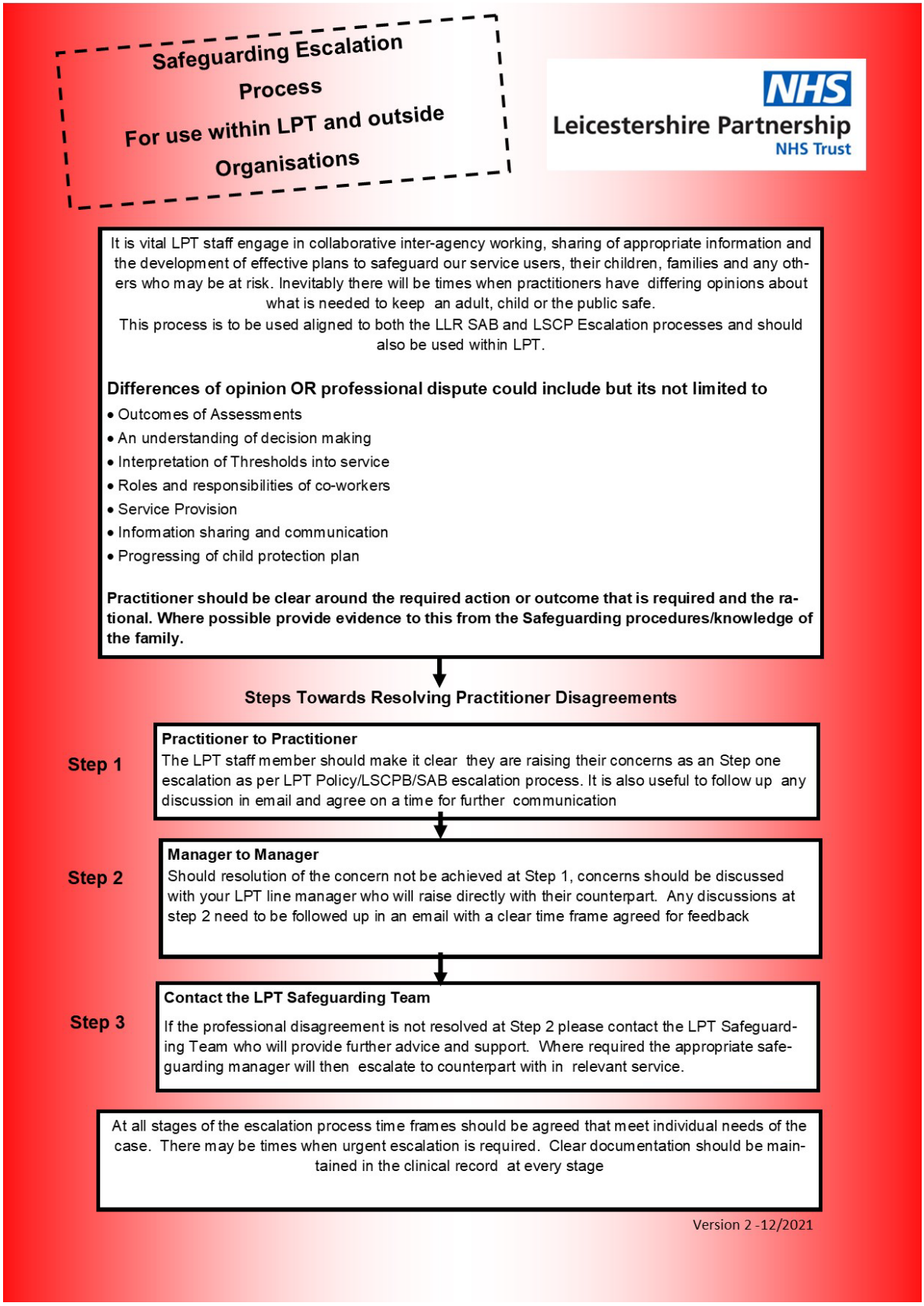
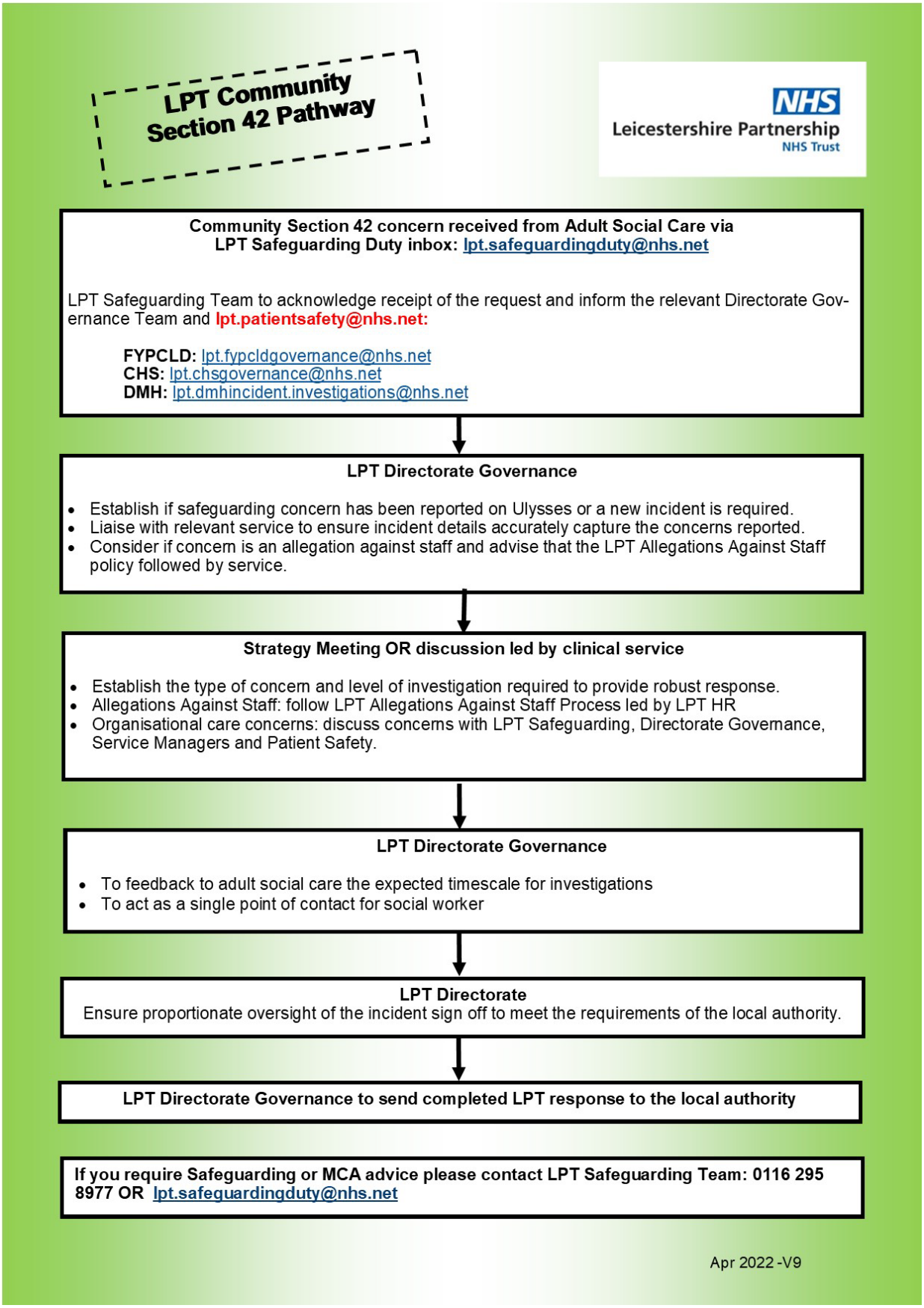
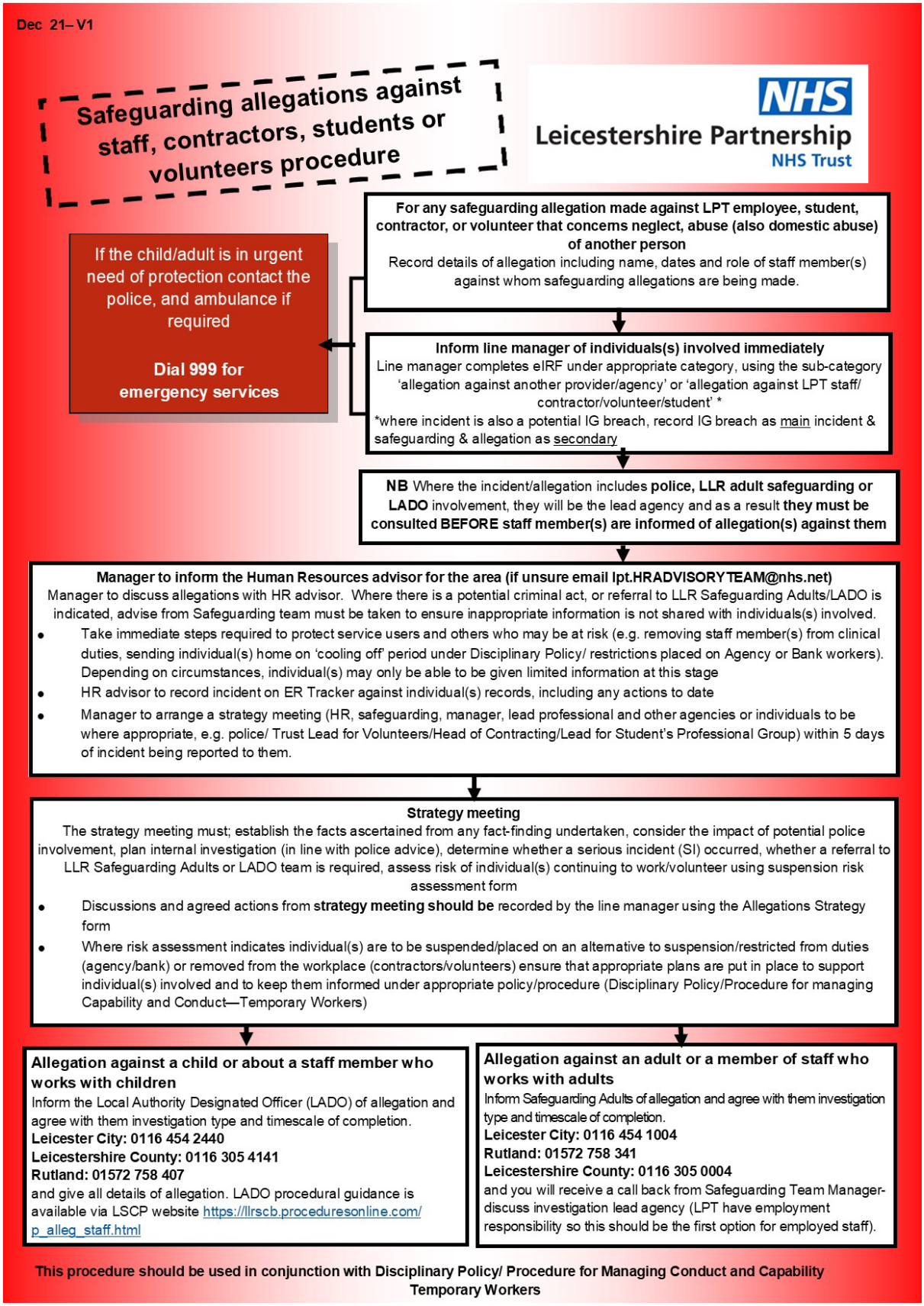
Appendix 6 - Safeguarding Escalation Process



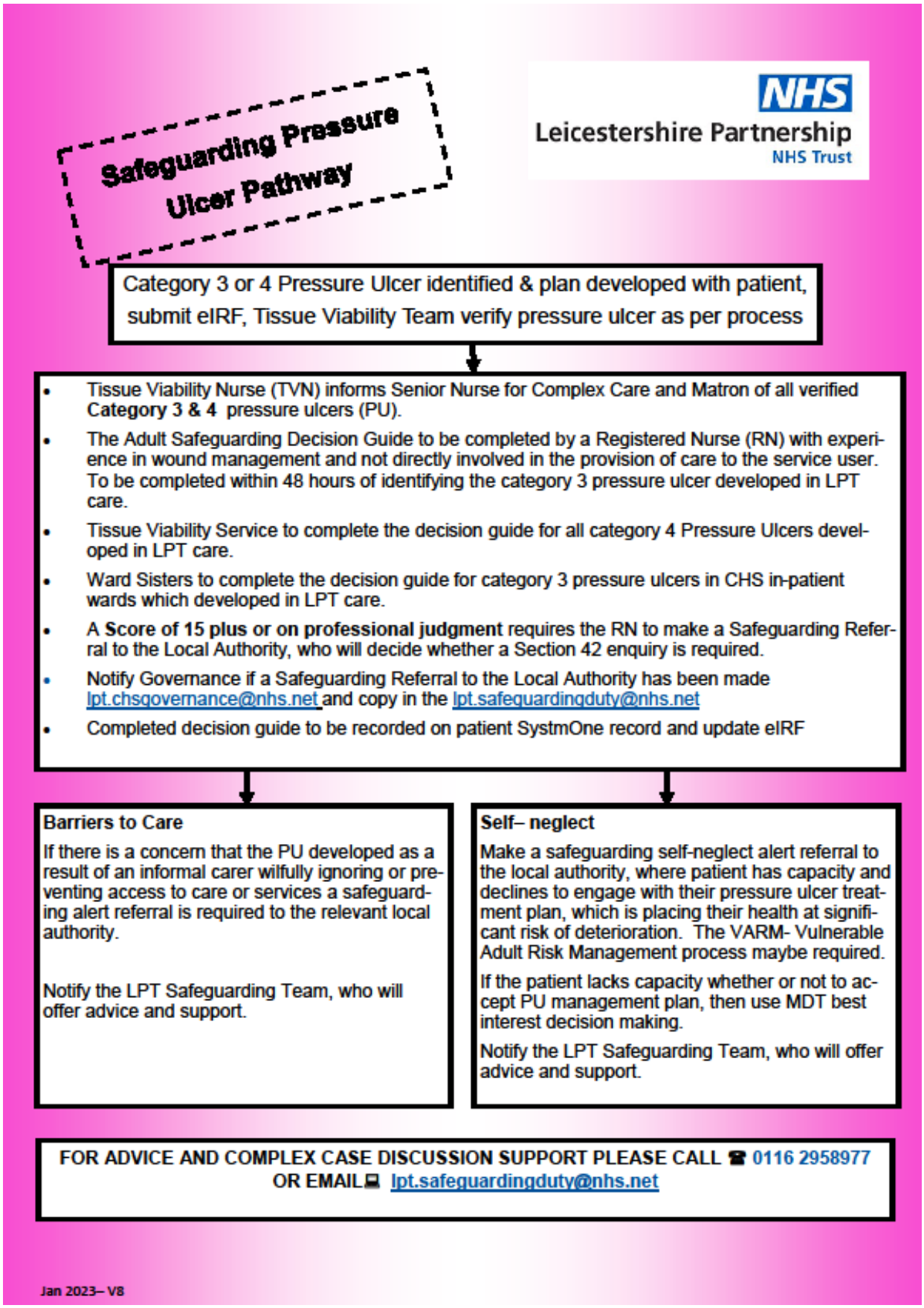
Appendix 7 - Community Section 42



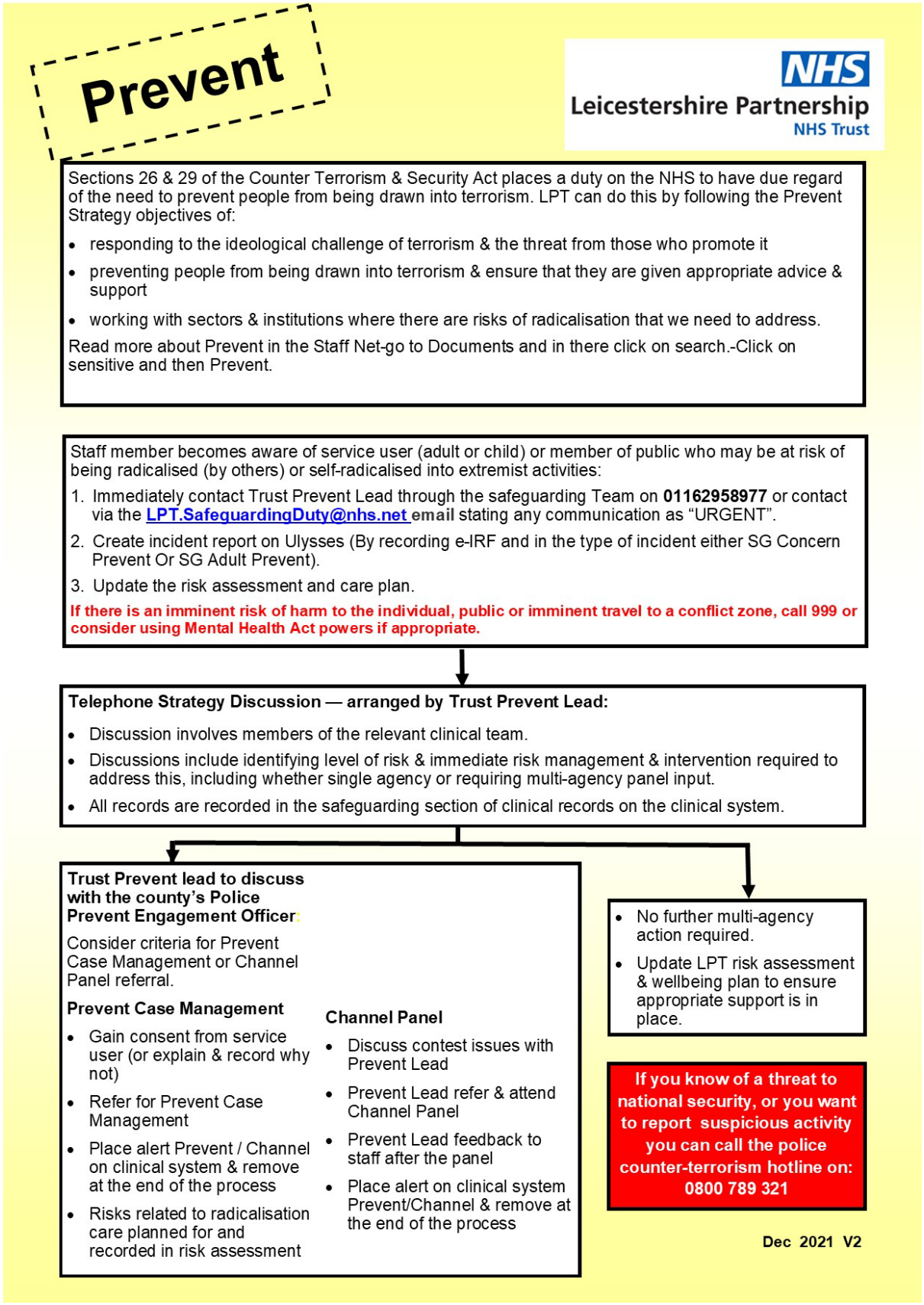
Appendix 8 - Allegations Against Staff



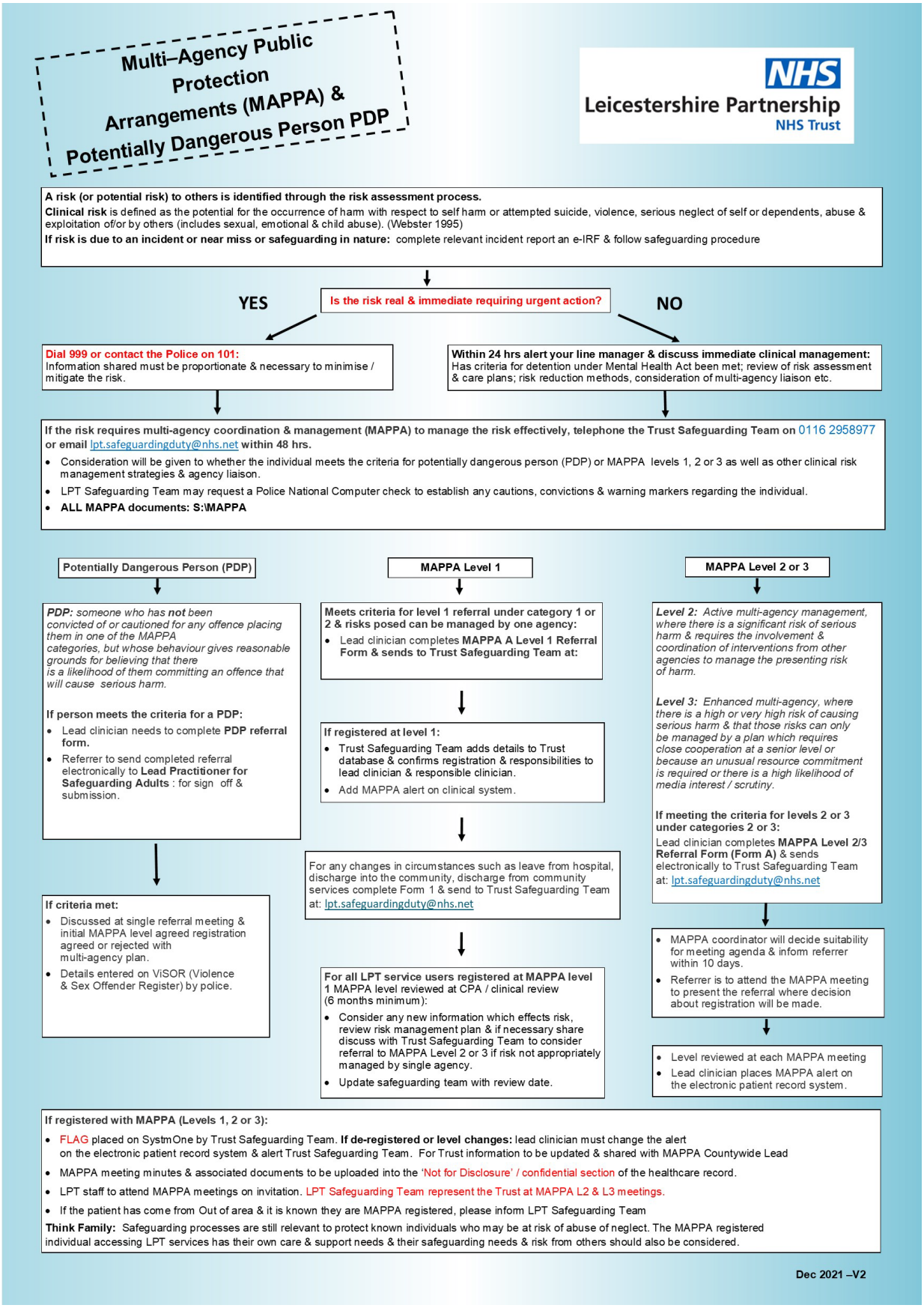
Appendix 9 - Pressure Ulcers and Safeguarding



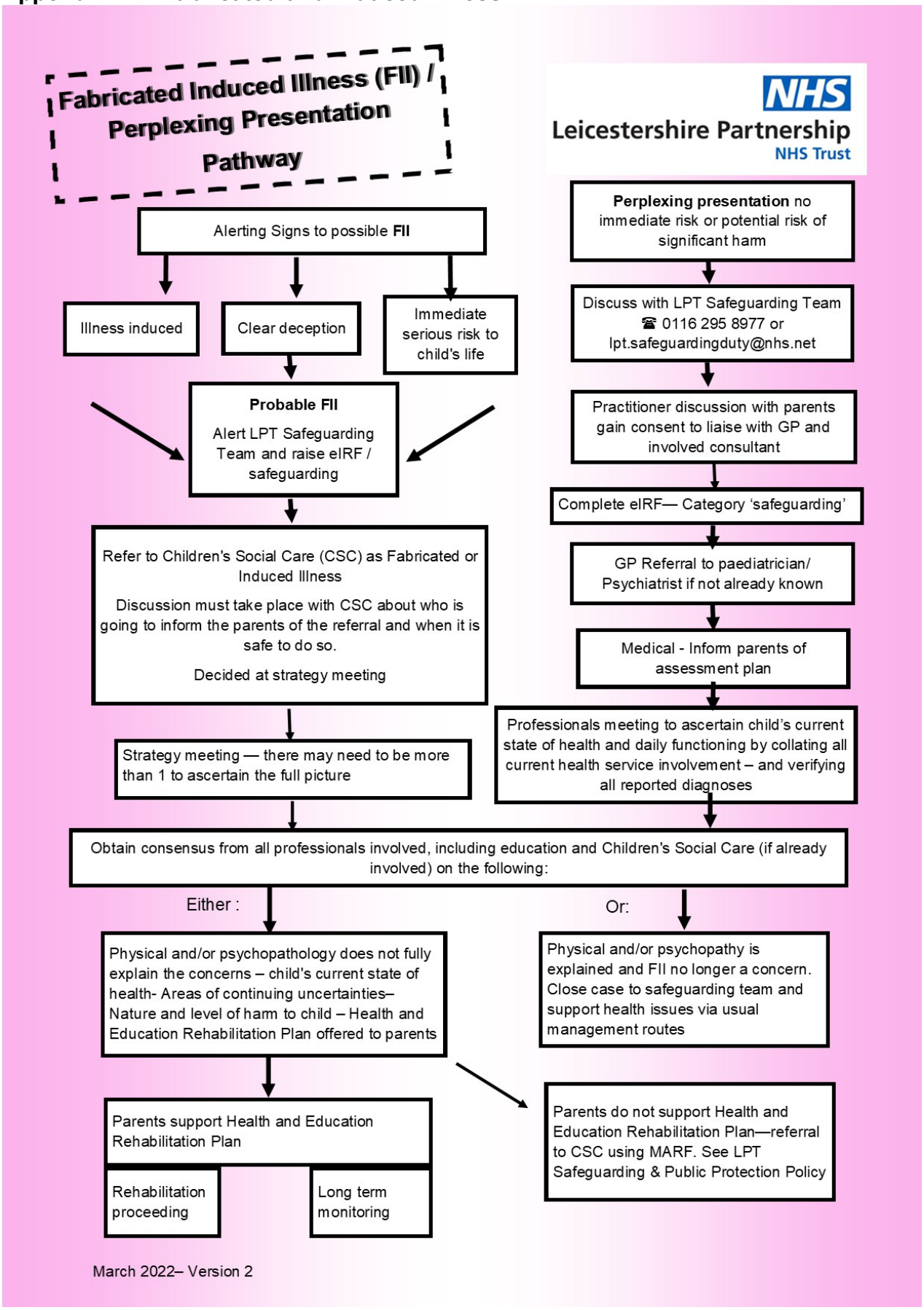
Appendix 10 - Prevent



Appendix 11 - Multi Agency Public Protection Arrangements (MAPPA)



Appendix 12 - Fabricated and Induced Illness



Appendix 13 - Information Sharing and Record Keeping

Safeguarding Information Sharing Guidance (to be read alongside Data Protection and Information Sharing Policy https://www.leicspart.nhs.uk/wp-content/uploads/2020/11/Data-Protection-and-Information-Sharing-Policy-exp-Dec-21.pdf)

Information sharing with children

Effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision.
Early sharing of information is the key to providing effective early help where there are emerging problems. At the other end of the continuum, sharing information can be essential to put in place effective child protection services. Serious Case Reviews (SCRs) have shown how poor information sharing has contributed to the deaths or serious injuries of children.
Fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children. To ensure effective safeguarding arrangements.

Information sharing with adults

Information sharing between organisations is essential to safeguard adults at risk of abuse, neglect and exploitation. Decisions about what information is shared and with whom will be taken on a case-by-case basis.

Whether or not information is shared with or without the adult at risk's consent, the information should be:

- necessary for the purpose for which it is being shared.
- shared only with those who have a need for it.
- be accurate and up to date.
- be shared in a timely fashion.
- be shared accurately.
- be shared securely.

Seven golden rules for information sharing

1. Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared
appropriately.

2. Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

3. Seek advice if you are in any doubt, without disclosing the identity of the person where possible.

4. Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be

overridden in the public interest. You will need to base your judgement on the facts of the case.

5. **Consider safety and well-being:** Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.

6. Necessary, proportionate, relevant, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.

7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

The Caldicott Principles - Revised September 2013

Principle 1. Justify the purpose(s) for using confidential information.
Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.

Principle 2. Don't use personal confidential data unless it is absolutely necessary.
Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

Principle 3. Use the minimum necessary personal confidential data.
Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data is transferred or accessible as is necessary for a given function to be carried out.

Principle 4. Access to personal confidential data should be on a strict need-to-know basis.
Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.

Principle 5. Everyone with access to personal confidential data should be aware of their responsibilities.
Action should be taken to ensure that those handling personal confidential data - both clinical and
non-clinical staff - are made fully aware of their responsibilities and obligations to respect patient confidentiality.

Principle 6. Comply with the law.
Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.

Principle 7. The duty to share information can be as important as the duty to protect patient confidentiality.
Health and Social Care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies

Recording Safeguarding Information

Basic Record Keeping Principles

- Use Trust Headed Paper / Patient records/ Appropriate Referral forms
- Dated and timed
- Who was present?
- What concerns were identified?
- Record – what was observed, what was said and who by? For injuries use body map / drawing to clarify details
- Remain factual and objective
- Record what you did
- Sign using full name and designation
- Don't ask leading questions
- Ensure your manager oversees your record and actions

Please also see: https://www.leicspart.nhs.uk/wp-content/uploads/2021/09/Record-Keeping-and-Care-Planning-Policy-exp-Jan-22.pdf

It is always good practice to discuss concerns and any planned referrals with the family members involved. However, this should not be done if:

- Alerting them will endanger the adult or child further
- It could place another adult at risk of serious harm
- It could prevent the detection of a serious crime or lead to unjustified delay in making enquiries.
- suspected fabricated or induced illness

Document concerns and whether they were discussed with the family. If not, why not?

Flagging & Alerts
It is important that cases are appropriately flagged / alerted relating to safeguarding matters. These flags/ alerts require regular review and removal once the safeguarding matter is resolved. Seek advice from LPT Safeguarding Team if you require advice on when and how to add an alert.

Recording information in relation to perpetrators of abuse
Information that is recorded in relation to a third party or a perpetrator of abuse should be clearly marked as confidential and stored in the relevant clinical systems section identified. Consideration for the victim and their families should always be a priority when working with perpetrators and guidance and relevant consent should be sought before sharing information disclosed by the victim with a perpetrator. This may include:

- MARAC minutes
- MAPPA minutes
- 'Adults at Risk' Conference minutes/Protection plans etc.
- Information in relation to Fabricated and Induced Illness

Useful Guidance for safeguarding record-keeping and information sharing

HM Government (2018) **Information sharing advice for practitioners providing safeguarding services to children, young people, parents and carers.**
Information sharing: advice for practitioners (publishing.service.gov.uk)

HM Government (2008 archived 2013) **Information Sharing: Guidance for practitioners and managers.**
https://webarchive.nationalarchives.gov.uk/ukgwa/20130401151715/https:/www.education.gov.uk/publications/eOrderingDownload/00807-2008BKT-EN-March09.pdf accessed 1.10.21

Department of Health (2010) **Confidentiality: NHS Code of Practice Supplementary Guidance: Public Interest Disclosures**
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216476/dh_122031.pdf accessed 1.10.21

Information Governance Alliance (2016)
https://www.nhsx.nhs.uk/media/documents/NHSX_Records_Management_CoP_V7.pdf accessed 2.10.21

Appendix 14 - LPT Safeguarding Training Matrix 2022-2023

Mandatory & Essential to Role Training Matrix 2022-2023
Safeguarding Training for Adults, Children, Domestic Abuse, Prevent, Public Protection& the Mental Capacity Act / Competency

Due to the diverse nature of LPT Services, where there is a need for specialised training for groups that work with both adults & children or a specific patient group this can be delivered by local arrangement. Please contact add LPT safeguarding email to arrange this.

New Starter WITHIN 12 WEEKS OF STARTING ROLE FREQUENCY – Once Method - eLearning Volunteers have a face-to-face induction with L1 adult, child, domestic abuse and Prevent awareness training.					
	Peer Support Workers & Pharmacist	**Administrators, contractors, corporate & support staff with no direct clinical role but will have public & patient contact**	**All Clinical Staff working with adults. Including nurses, AHP's, Social Workers, Doctors & Health Care Support Workers**	**All clinical staff working with children including health visitors, nurses, AHP's, nursery nurses, Doctors, Practitioners & Health Care Support Workers**	**Staff who mainly work with adults but direct contact with children. Dieticians, Perinatal, Liaison & Diversion**
Safeguarding Children Level 1	X	X	X	X	X
Safeguarding Children from abuse by Sexual Exploitation	X		X	X	X
An introduction to FGM, Forced Marriage, spirit Possession & Honour Based Violence	X		X	X	X
Safeguarding Adults Level 1	X	X	X	X	X
Awareness of domestic violence & abuse	X		X	X	X
Domestic abuse awareness short course		X			
Preventing Radicalisation Basic Prevent Awareness Training Level 2	X	X			
Preventing Radicalisation (mental health) Level 3			X	X	X
Mental Capacity Level 1	X		X	X	X

Mandatory & Essential Training WITHIN 4 MONTHS OF STARTING ROLE FREQUENCY - Once Method - Face to Face or e-learning					
	Peer Support Workers & Pharmacist	**Administrators, contractors, corporate & support staff with no direct clinical role but will have public & patient contact**	**All Clinical Staff working with adults. Including nurses, AHP's, Social Workers, Doctors & Health Care Support Workers**	**All clinical staff working with children including health visitors, nurses, AHP's, nursery nurses, Doctors, Practitioners & Health Care Support Workers**	**Staff who mainly work with adults but direct contact with children. Dieticians, Perinatal, Liaison & Diversion**
Safeguarding Children Level 3 (1-day) (LPT will provide role relevant training: 3a for staff working directly with children & level 3b for staff working with adults who have children).			X 3b	X 3a	X 3a
Safeguarding Children level 2	X				
Safeguarding Adults Level 3 (1-day)			X		X
Safeguarding Adults Level 2	X			X	
Mental Capacity Act & Competency Level 2Child includes domestic abuse				X	
Mental Capacity Act Level 2 e-learning or face to face	Pharmacists only				
Mental Capacity Act & DoLS / Liberty Protection Safeguards Level 3 (4 hours)			X		X
E-learning public protection module (90 mins e-learning) MAPPA, PDP & ASBRAC			X	X	X

Refresher Training FREQUENCY - 3 years Method - Face to Face (e-learning for administrators, contractors, corporate & support staff with no direct clinical role)					
	Peer Support Workers & Pharmacist	**Administrators, contractors, corporate & support staff with no direct clinical role but will have public & patient contact**	**All Clinical Staff working with adults. Including nurses, AHP's, Social Workers, Doctors & Health Care Support Workers**	**All clinical staff working with children including health visitors, nurses, AHP's, nursery nurses, Doctors, Practitioners & Health Care Support Workers**	**Staff who mainly work with adults but direct contact with children. Dieticians, Perinatal, Liaison & Diversion**
Safeguarding Refresher Adult staff (1-day) includes: Safeguarding Children 3b, Safeguarding Adults Level 3, Domestic Abuse, Prevent Level 3 Public Protection			X 3b refresher		X 3b refresher
Safeguarding Refresher Child Staff 3a (1-day) includes: Safeguarding Children (CSE) 3a, Safeguarding Adults Level 2, Domestic Abuse, Prevent Level 3 & Public Protection				X 3a refresher	
Safeguarding Refresher Peer Support or Pharmacy (1 day) includes: Safeguarding Children Level 2, Safeguarding Adults Level 2, Domestic Abuse, Preventing Radicalisation & Public Protection	X				
Safeguarding Refresher Admin Staff (repeat all level 1 e-learning) including "safeguarding children", "safeguarding adults", "domestic abuse awareness - short course", Preventing Radicalisation"		X			
Mental Capacity Act & DoLS / Liberty Protection Safeguards Level 3 (4 hours)			X		X
Mental Capacity Act & Competency Level 2Child (4 hours)				X	
Mental Capacity Act Level 2 e-learning or face to face	Pharmacists only				

Due to the diverse nature of LPT Services, where there is a need for specialised training for groups that work with both adults & children and/or a specific patient group this can be delivered by local arrangement. Please contact LPT Safeguarding Team to arrange this.

The matrix is the minimum standard for roles however as part of development additional courses can be attended as identified in appraisal. This will not alter the Trust's requirement but can be added to OLM.

Appendix 15 - Visitors to LPT Premises

Visitors to LPT Premises

Includes:

1. Visits to Adults by Adults
2. Visits to Adults by Children
3. Visits to Children (Inpatients Units)
4. Visits by VIP's

1. Visits to Adults by Adults

1.1 The wishes of the service user should be respected with regards to who they would like to visit them. This should be clarified and documented, including any individuals they do not wish to visit. If they refuse a visitor this requires documenting, ensure detailing reasons for refusal. Providing there is justification, the nurse in charge can prevent, supervise or terminate a visit. On such an occasion an incident report should be generated detailing all aspects of the refusal.

1.2 Visitors and those being visited should be advised of visiting hours, mealtimes and any therapy sessions/appointments.

1.3 Any visits outside of agreed times will be judged on a case by case basis and will be agreed through discussion with staff.

1.4 A 'prohibited items list' should be displayed in full view of all visitors and service users. If staff have reasonable grounds to suspect that a visitor is bringing prohibited items onto site, they should be asked to hand them over (in?) for the duration of the visit. If they refuse, staff can ask the visitor for permission to look in (search?) their bag and pockets if they remain non-compliant, staff can ask the visitor to leave or can inform them that their visit will be continually supervised. If necessary, the Local security Management Specialist (LSMS) or Police should be contacted. An incident report should be submitted detailing reasons for refusal of admittance or supervision.

1.5 Visits can be prevented where a relationship is anti-therapeutic, where there are concerns for the safety of visitor from the service user, or where there are concerns for the safety of the service user. This includes relationships which meet the definition of domestic abuse and where abuse or neglect is suspected (safeguarding policy 11). Consideration must be given to the service user's capacity to determine anti-therapeutic relationships (mental capacity act policy 6B). In addition, if the behaviour of the visitor may be disruptive e.g. incitement to abscond, smuggling substances that could impair care path ways and /or breaching confidentiality of the service user.

2. **Visits to Adults by Children**

2.1 The last decade has seen a gradual recognition that many adult mental health service users are also parents and a steady growth in concern over the implications of this for their children (Working Together 2015). Contact between parents and children when a parent is in hospital needs to be actively encouraged by staff (Barnardo's 2007).

2.2 The welfare of the child is paramount, and the Trust has a statutory responsibility for safeguarding children and promoting their welfare in accordance with Section 11 of the Children Act 2004. All visiting children aged 18 years and under should be accompanied by a responsible adult, who remains with them throughout their visit and accepts responsibility for them. Discretion/risk assessment is required when older teenagers are visiting. Any concerns that a particular visiting environment is unsafe for a child must be the subject of a risk assessment and the identification of an alternative venue.

2.3 The Ward / Unit where the visit will take place should be sufficiently flexible to enable regular visits if in the child's best interest. The facilities provided should be comfortable, welcoming, child friendly, well equipped and provide a safe environment. Where possible this should be in an area away from others such as a family room. Such visits should be supported by a qualified member of staff who has received training in safeguarding children and is familiar with this Visitors Policy. Staff should discuss any potential risks with the accompanying adult and the importance of a prompt response, should the visit need to be terminated imminently.

2.4 Mental Health professionals must consider the family context of service users and consider the wellbeing of any dependent children. It would be helpful if, after visiting a parent with a mental illness, a member of staff talks to the child and accompanying adult about the child's experience during the visit (Parents as Patients 2011).

3. Their children (Working Together 2018). Contact between parents and children when a parent is in hospital needs to be actively encouraged by staff (Barnardo's 2007).

4. The welfare of the child is paramount, and the Trust has a statutory responsibility for safeguarding children and promoting their welfare in accordance with Section 11 of the Children Act 2004. All visiting children aged 18 years and under should be accompanied by a responsible adult, who remains with them throughout their visit and accepts responsibility for them. Discretion/risk assessment is required when older teenagers are visiting. Any concerns that a particular visiting environment is unsafe for a child must be the subject of a risk assessment and the identification of an alternative venue.

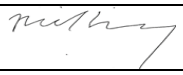
5. The Ward / Unit where the visit will take place should be sufficiently flexible to enable regular visits if in the child's best interest. The facilities provided should be comfortable, welcoming, child friendly, well equipped and provide a

safe environment. Where possible this should be in an area away from others such as a family room. Such visits should be supported by a qualified member of staff who has received training in safeguarding children and is familiar with this Visitors Policy. Staff should discuss any potential risks with the accompanying adult and the importance of a prompt response, should the visit need to be terminated imminently.

Appendix 16 - Due Regard Screening Template

Section 1	
Name of activity/proposal	Mental Capacity Act Policy.
Date Screening commenced	May 2021
Directorate / Service carrying out the assessment	LPT Safeguarding Team.
Name and role of person undertaking this Due Regard (Equality Analysis)	Alison Taylor-Prow
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: This policy describes the principles and procedures within the Mental Capacity Act and staff roles & responsibilities in applying this within clinical practice.	
OBJECTIVES: The policy objective is for Leicestershire Partnership NHS Trust to meet its legal responsibilities as defined in the Mental Capacity Act (2005). Adherence to the legislation will ensure that no differential treatment will occur as a result of a person's protected characteristic.	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	This policy applies to people over the age of 16. The application of these policies and procedures will ensure that patients are supported to make their own decisions regardless of their age.
Disability	The application of this policy will ensure that people are supported to make their own decisions regardless of any disability.
Gender reassignment	This policy applies to all groups with no exceptions in line with the human rights approach as set out in LPT's Equality & Diversity policy.
Marriage & Civil Partnership	This policy applies to all groups with no exceptions in line with the human rights approach as set out in LPT's Equality & Diversity policy.
Pregnancy & Maternity	This policy applies to all groups with no exceptions in line with the human rights approach as set out in LPT's Equality & Diversity policy.
Race	This policy applies to all groups with no exceptions in line with the human rights approach as set out in LPT's Equality & Diversity policy.
Religion and Belief	This policy applies to all groups with no exceptions in line with the human rights approach as set out in LPT's Equality & Diversity policy.
Sex	This policy applies to all groups with no exceptions in line with the human rights approach as set out in LPT's Equality & Diversity policy.
Sexual Orientation	This policy applies to all groups with no exceptions in line with the human rights approach as set out in LPT's Equality & Diversity policy.
Other equality groups?	This policy applies to all groups with no exceptions in line with the human rights approach as set out in LPT's Equality & Diversity policy.

Section 3				
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.				
Yes			No	
High risk: Complete a full EIA starting click here to proceed to Part B			Low risk: Go to Section 4.	**X**
Section 4				
If this proposal is low risk please give evidence or justification for how you reached this decision:				
Having reviewed the policy it meets the Trust's Equality, Diversity and Human Rights Policy. It does not discriminate on the grounds of any Protected Characteristic and follows clear Human Rights Approach.				
Signed by reviewer/assessor		**Date**	19th May 2021	
Sign off that this proposal is low risk and does not require a full Equality Analysis				
Head of Service Signed		**Date**	19th May 2021	

Appendix 17

PRIVACY IMPACT ASSESSMENT SCREENING

Privacy impact assessment (PIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet individual's expectations of privacy. The first step in the PIA process is identifying the need for an assessment.

The following screening questions will help decide whether a PIA is necessary. Answering 'yes' to any of these questions is an indication that a PIA would be a useful exercise and requires senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	Mental Capacity Act Policy		
Completed by:	Alison Taylor-Prow		
Job title:	Lead Practitioner for Safeguarding	**Date**	May 2021

	Yes / No
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	No
2. Will the process described in the document compel individuals to provide information about themselves? This is information in excess of what is required to carry out the process described within the document.	No
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	No
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	No
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	No
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	No
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	No
8. Will the process require you to contact individuals in ways which they may find intrusive?	No

If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via lpt-dataprivacy@nhs.net
In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.

Data Privacy approval name:	
Date of approval:	

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

Appendix 18

The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	☑
Respond to different needs of different sectors of the population	☑
Work continuously to improve quality services and to minimise errors	☑
Support and value its staff	☑
Work together with others to ensure a seamless service for patients	☑
Help keep people healthy and work to reduce health inequalities	☑
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	☑