## Primary Care Commissioning Committee
### Part 1: Agenda

<table>
<thead>
<tr>
<th>Part 1: Topic</th>
<th>Purpose</th>
<th>Documentatio</th>
<th>Lead/s</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Welcome and apologies</td>
<td>N/A</td>
<td>N/A</td>
<td>AW</td>
<td></td>
</tr>
<tr>
<td>2. Declaration of Interest</td>
<td>N/A</td>
<td>Verbal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Approve minutes from PCCC Part 1</td>
<td>For information</td>
<td>Minutes from 4/10/17</td>
<td>AW</td>
<td>5 mins</td>
</tr>
<tr>
<td></td>
<td></td>
<td><img src="https://example.com" alt="Minutes from 4/10/17" /></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Safeguarding training strategy</td>
<td>For information</td>
<td>Paper</td>
<td>KC</td>
<td>15 mins</td>
</tr>
<tr>
<td>• Supervision strategy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Pharmacist in GP practice</td>
<td>For information</td>
<td>Paper</td>
<td>L Hardy</td>
<td>10 mins</td>
</tr>
<tr>
<td>6. PMS Review Update</td>
<td>For information</td>
<td>Paper</td>
<td>LF</td>
<td>10 mins</td>
</tr>
<tr>
<td>7. Actions/Issues raised by the PCAC</td>
<td>For information</td>
<td>Verbal</td>
<td>AS</td>
<td>5 ins</td>
</tr>
<tr>
<td>Questions from the public</td>
<td>N/A</td>
<td>Verbal</td>
<td>All</td>
<td>10 mins</td>
</tr>
</tbody>
</table>

- **Date and time:** Wednesday 1st November 2017, 4.15pm – 5.15pm (networking 4pm-4.15pm)
- **Venue:** Board Room B/C, Kirkdale House, 7 Kirkdale Road, London E11 1HP
- **Chair:** Alan Wells
- **Attendees:**
  - Caroline White (Deputy Lay Chair)
  - Terry Huff (CCG Accountable Officer)
  - Les Borrett (CCG Chief Finance Officer)
  - Dr Azeem Nizamuddin (Independent GP)
  - Lorna Hutchinson (NHSE)
  - Jane Mehta (WFCCG)
  - Aysha Patel (WFCCG)
  - Sharon Yepes-Mora (WFCCG)
  - Joe McDonnell (Public Health)
  - Alison Goodlad (NHSE)
  - Darren Newman (LA)
  - Dr D Kapoor (WFCCG GP Leyton/stone)
  - Dr A Sheikh (WF CCG GP Walthamstow)
  - Dr Tonia Myers (WFCCG GP Chingford)
  - Dr Gabby Ibijaro (LMC rep)
  - Vineeta Manchanda (Lay COI guardian)
  - Anne Walker (Quality lead CCG)
  - Communications (WFCCG)
AOB

Details of next meeting: 6th December (Joint meeting) 2017, 4.15pm – 5.15pm Kirkdale House
PRIMARY CARE COMMISSIONING COMMITTEE
Part 1
Minutes of Meeting held on 4th October 2017
Board Room B/C, Kirkdale House

VOTING MEMBERS | Initials | Role
--- | --- | ---
Alan Wells | AW | Chair, Lay Member, WFCCG
Azeem Nizamuddin | AN | Independent GP, WFCCG
Les Borrett | LB | Director of Strategic Finance, WFCCG
Caroline White | CW | Deputy Chair, Lay Member, WFCCG

MEMBERS

Aysha Patel | AP | Senior Commissioning Manager, WFCCG
Althea Bart | AB | Health Watch
Kasia Gaj | KG | NEL Primary Care Commissioning Team, NHS England
Alison Goodlad | AG | NEL Primary Care Commissioning Team, NHS England
Abdul Sheikh | AS | Clinical Director, WFCCG
Dinesh Kapoor | DK | Clinical Director, WFCCG
Anne Walker | AWa | Deputy Nurse Director, Quality & Clinical Governance - WFCCG
Sharon Yepes-Mora | SYM | Associate Director, Strategic Planning
Vineeta Manchanda | VM | Lay Member/Conflicts of Interest Guardian
Rebecca Waters | RW | Communications & Engagement Manager
Tonia Myers | TM | Clinical Director, WFCCG

IN ATTENDANCE

Scott Smith | SS | Primary Care Commissioning Manager
Tarlochan Boparai | TB | Primary Care Transformation Manager

APOLOGIES

Jane Mehta | JM | Director of Strategic Commissioning
Terry Huff | TH | Chief Officer
Jonathan Cox | JC | Consultant, PH
Gabriel Ivbijaro | GI | LMC Representative

ACTIONS LOG

<table>
<thead>
<tr>
<th>Who :</th>
<th>Actions from last meeting</th>
<th>When</th>
<th>Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>SYM</td>
<td>A CCG Improvement &amp; Assessment Framework report will be presented to the Committee post publication of the next quarter's performance</td>
<td>October/November</td>
<td></td>
</tr>
<tr>
<td>AG</td>
<td>NHSE to send out clarification and emails to GP's on the out of area registration DES.</td>
<td>November 1st</td>
<td></td>
</tr>
<tr>
<td>JP</td>
<td>PPG Standards to be sent to members</td>
<td>ASAP</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>Summary / Actions</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Welcome and Apologies</td>
<td>AW</td>
</tr>
</tbody>
</table>

The Chair welcomed members to the meeting. Apologies were noted as above.
### Declaration of Interest

None at this point.

Note: interests were declared later, see item 5.

### Approve Minutes of the previous PCCC Part 1

VM stated that on point 5 and 6 of the previous minutes it annotates that both topics were discussed ‘at length’ and queried if the committee are happy with that level of summary. AW stated that the minutes should be in more detail, not only on this committee but across other meetings in the CCG to allow for there to be evidence of challenge if they come into scrutiny.

### Finance report

LB presented the Finance Report to the Committee picking out the following key points. At the end of August the delegated primary care budget will be expected to be underspent by just over £300,000 caused by recovery of money from immunisation work done through PHE that the PMS GPs do. The rest of the budget remains on track with a small underspend on what the expected list size would be at the end of the first quarter. Overall the expectation is that the budget will balance or be slightly underspent.

### Estates Update

LB presented the Estates Working Group traffic light report focusing on the red points.

There is a significant piece of work happening on care and support hubs which is looking at what the pattern of services should be between health, social care, GPs and mental health. The estates strategy highlights which buildings could be used to provide these services over the next 5-10 years. The ‘One Public Estate’ piece of work looks into what is the right spread of services across those areas, for example, what can be done at hub level compared to what should be delivered within individual practices.

The work relating to the Sinnott Road relocation business case is ongoing.

There are space issues with the Community MSK Service. Barts Health are unable to identify sufficient numbers of sites to provide community MSK services from. A contract performance notice has been issued whilst we seek to support them to find appropriate estates for the service.

We have been successful in receiving 7 improvement grants, of which 3 have slipped as they were not able to provide the supporting documentation in time. AS declared interest as one of these surgeries was his. These practices are being supported to get the schemes up and running.

AS enquired if the Sinnott Road and Higham Hill merger was going ahead. LB confirmed this was no longer happening.

TM declared an interest before enquiring about GPs who are sitting in NHS a property service building without leases and the reliability on reimbursements. LB stated that the relationship is between the GP and NHSPS as a tenant so the CCG is not responsible. The rent is reimbursed according to what the district valuer signs off. However, there is a risk.

### PPG Local Standards

RW gave a presentation on the PPG Local Standards explaining to the Committee that these are a set of standards for PPG’s to potentially achieve. There is a gold, silver or bronze status given depending on the level achieved by each practice via a self-declaration process. The Committee noted the
presentation and discussed the Standards. The PPG Standards were seen as a good development and a beneficial tool for users. The Committee raised concern over the form perhaps being cumbersome for the users, RW took on the feedback and stated this is a pilot and can be revised at a later date. The Standards were not circulated before the meeting so they will be circulated. The Committee provided feedback on ensuring the effectiveness of PPGs and stating that face to face PPGs can be more effective, but having a virtual PPG also meets contractual obligations. RW stated work is being done on how to access PPGs and they are working through the process of how they will assess the PPG standards work via a panel.

<table>
<thead>
<tr>
<th>7</th>
<th>Enhanced Services report</th>
<th>KG</th>
</tr>
</thead>
<tbody>
<tr>
<td>KG presented the report on the enhanced services uptake. KG expanded on changes to Extended Hours Access. AG stated 32 practices that were closed for half a day were written to and 29 have now stated they will comply with the extended hours DES requirements and therefore will be open to patients. DK declared an interest in point 3, out of area registration. The Group discussed the out of areas registration stating there is a lack of awareness. TM enquired to the clarity to on how to apply the DES and NHSE agreed to send out confirmation. RW mentioned that this issue had come up as a question from the public at the AGM and AP had drafted a response.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8</th>
<th>Flu action plan update</th>
<th>SYM</th>
</tr>
</thead>
<tbody>
<tr>
<td>SYM presented the flu and immunisation action plans to the Committee explaining that a deep dive into the flu indicator had taken place, as it is a key target for the CCG and there is a risk of a flu pandemic this winter. The result of the deep dive has meant that the flu &amp; immunisations steering group now has a clinical lead – Dr Shui. The action plans focus on communications with the public and practices about the flu and the increase in reporting to GPs on performance. The local plan is still in draft form and will be a cyclical planner to help prepare for future flu years. SYM mentioned the ongoing issue of pork gelatine vaccinations causing children to possibly miss the vaccine on religious grounds which the Committee discussed at length with clarification from PHE guidance. The issues raised are being discussed in the flu and immunisation steering group.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9</th>
<th>Actions raised by PCAC</th>
<th>AS</th>
</tr>
</thead>
<tbody>
<tr>
<td>No actions from PCAC. AS noted the national cancer patient experience survey and primary care strategy implementation plan were discussed.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10</th>
<th>AOB</th>
<th>ALL</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Date of the next meeting:** 1 November 2017 4.15pm – 5.15pm
Title of report
Safeguarding Training Strategy 2017-2020

From
Dr Sabeena Pheerrungee and Korkor Ceasar

Purpose of report
To provide an update to the committee in relation to the new Safeguarding Training Strategy for the Health economy.

Recommendations
The Primary Care Committee is requested to:
- Note that the strategy promotes best practice within the Health economy
- Note that the strategy acts as a resource and guide in relation to competencies and the training matrix

Impact on patients & carers
Successful implementation of the strategies will ensure that children and adults in contact with commissioned services are safeguarded.

Risk implications
Non-compliance of the workforce with the requisite training competencies puts service users at risk.

Financial implications
Failure to comply with statutory requirements may result in sanctions from the regulator.

Equality analysis
NHS WF CCG is committed to fulfilling its obligations under the Equality Act (2010) and to ensure services commissioned by the CCG are non-discriminatory on the grounds of any protected characteristics. The CCG will work with providers, service users and communities of interest to ensure that any issues relating to equality of service within this report are identified and addressed.

Other committees/groups, including the CCG Reference Group and Rapid Feedback Group
WFCCG Multidisciplinary Team Meeting; WFCCG Safeguarding Meeting; Performance & Quality Committee; WFSCB Business Management Group and the Governing Body of WFCCG
TRAINING STRATEGY FOR
SAFEGUARDING CHILDREN AND
ADULTS 2017-2020

WALTHAM FOREST CLINICAL COMMISSIONING GROUP (WFCCG)
Employed Workforce, Temporary Staff, Locums and Consultants
This strategy will be reviewed a minimum of three yearly or in response to changes in national and local guidance.

EQUALITY IMPACT ASSESSMENT

This document has been assessed for equality impact. This Safeguarding Children Training Strategy is applicable to every member of staff within WFCCG irrespective of their race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation, age or disability.
Contents

1. Introduction and Scope ........................................................................................................3
2. Equality Statement.............................................................................................................4
3. The Purpose of Training...................................................................................................4
4. Roles & Responsibilities..................................................................................................5
5. Competencies expected of Staff working with children and young people .................6
6. Training required for Safeguarding Children and Young People...................................8
7. Competencies expected of Staff working with adults .....................................................9
8. Training required for Safeguarding Adults.....................................................................9
9. Monitoring and Assurance..............................................................................................10
10. Relevant Legislation and Guidance...............................................................................11
11. Appendix 1 –
    Healthcare Training Frequency and Competency Levels for Safeguarding Children and Adults ..........................................................................................12
12. Appendix 2 -
    Healthcare Staff Competencies for Safeguarding children ........................................13
13. Appendix 3 -
    Training Matrix ..............................................................................................................14
14. Appendix 4 –
    Prevent Training Matrix ................................................................................................15
1.0 Introduction

1.1 This Strategy should be read in conjunction with:

- Safeguarding Children and Young People: Roles and Competences for Health Care Staff (Intercollegiate Document 2014) linkSafeguarding Children and Young People, Roles and Competencies for Health Care (2014)

- Looked After Children knowledge, skills and competence of health care staff - Intercollegiate Role Framework (2015) Looked after children: knowledge, skills and competence of health care staff (March 2015)

- Adult Safeguarding Intercollegiate Document 2015

1.2 The purpose of this document is to provide a clear statement of the expectations WFCCG have in relation to the provision of safeguarding training for staff employed by the CCG.

1.3 There is an acknowledgement that safeguarding children is everybody’s business and the aim of safeguarding children training is to support each member of staff to know what this means for them.

1.4 WFCCG is a major commissioner of local health services and needs to assure itself that the CCG and organisations from which services are commissioned have effective safeguarding arrangements in place (Safeguarding Accountability and Assurance Framework, 2015). In order to have been authorised by NHS England, CCGs must have demonstrated plans to train their staff in recognising and reporting safeguarding issues and gain assurance from commissioned services that they meet this requirement.

1.5 All providers of health services are required to be registered with the Care Quality Commission (CQC). Registration requires providers to ensure that staff are suitably skilled and supported with effective training (Safeguarding Vulnerable people in the Reformed NHS: Accountability and Assurance Framework, 2015). All CQC registered providers of NHS commissioned services, including primary care, are responsible and accountable for the training of staff in both adult and children’s safeguarding.

1.6 All agencies are required to have in place arrangements to ensure that all staff undertake appropriate training to equip them to carry out their responsibilities effectively, and keep this up to date by refresher training at regular intervals in line with 5th Edition of the London Child Protection Procedures 2017 - www.londoncp.co.uk.

1.7 The safeguarding children training expectations, requirements and competences for health staff are detailed in ‘Safeguarding Children and Young People: Roles and Competences for Health Care Staff’ (Intercollegiate Document 2014).

1.8 Safeguarding children training is also underpinned by the ‘Common Core of Skills and Knowledge for the Children’s Workforce’ (2005) which sets out the six areas of
expertise that everyone working with children, young people and families should be able to demonstrate:

- Effective communication and engagement with children, young people and their families and carers;
- Child and young person development;
- Safeguarding and promoting the welfare of the child;
- Supporting transitions;
- Multi-agency working;
- Information sharing.

In conjunction with those responsibilities outlined in national and local guidance for safeguarding children it is also essential that staff working with Looked after Children (LAC) possess the knowledge, skills and competences to effectively safeguard, protect and promote the welfare of children and young people in care.

1.9 The need for professionals working with LAC to have the appropriate knowledge to enable them to deliver safe, effective and appropriate care is highlighted in statutory guidance pertaining to the Promotion of the health and wellbeing of LAC. The requirement for staff to undertake LAC training is further strengthened by the Intercollegiate Document 'Looked after Children: Knowledge, Skills and Competences of Health Care Staff' (2015). The interface between the training requirements for safeguarding and LAC are clearly demonstrated in both intercollegiate documents.

2.0 Purpose

2.1 The NHS England Area Teams (NHS England AT), Clinical Commissioning Groups (CCGs), and Local Safeguarding Boards have a duty to ensure that those organisations and other contractors from whom they commission services employ appropriate arrangements to ensure that the welfare of children is safeguarded and promoted.

2.2 This strategy provides a framework to ensure WFCCG meets its legislative responsibilities under Section 11 of the Children Act (2004) and the Care Act 2014 to equip staff to work effectively within their own service and collaboratively with those from other agencies to safeguard and promote the welfare of children, young people, including those looked after and adults.

2.3 Provider services must be able to assure commissioners that they have in place an appropriate training strategy to provide their staff with the appropriate level of skills and knowledge in relation to safeguarding children in order for them to fulfil their section 11 duties.

3.0 Scope

3.1 Safeguarding children training is a requirement for all health staff and this strategy is relevant to all staff working for or contacted to work across WFCCGs Health Economies. This includes acute hospitals, community providers, GP practices, other independent contractors such as dentists, pharmacists and opticians, voluntary services and any other services commissioned on behalf of the CCG across the Country.

3.2 This strategy provides guidance on the minimum level of safeguarding children training and competence required by each staff group as per the Intercollegiate Document
guidance. The requirements for those working with Adults and LAC are also specified as per national guidance and training competences for staff groups identified.

The strategy will be reviewed a minimum of three yearly or in response to changes in national and local guidance.

4.0 Duties

4.1 Commissioning bodies have a statutory duty under Section 11 of the Children Act (2004) to ensure their duties are discharged to providers to ensure staff are trained to an appropriate level in respect of safeguarding children and young people.

4.2 All staff employed / commissioned by WFCCG must attend relevant safeguarding children training and updates.

4.3 Individual managers must ensure their staff’s training needs are assessed and ensure staff are enabled to complete safeguarding children training relevant to their role.

4.4 Guidance can be sought from the CCG Safeguarding Teams regarding individual training requirements if staff / managers are unsure of frequency and/or level of training required.

4.5 The Designated Nurse for Safeguarding Children and LAC, and the Designated Adult Lead will –
- Develop, influence and promote relevant training on both a single and interagency basis;
- Provide advice on the training needs and support the delivery of safeguarding children/LAC and Adults training for health service staff;
- Develop a training needs analysis in collaboration with the safeguarding children/LAC/Adults Teams.
- Advise on the commissioning of relevant additional training at group/level 3 and above.

5.0 Procedure/Process

5.1 This strategy is based on the guidance and ‘levels’ listed within ‘Safeguarding Children and Young People: Roles and Competences for Health Care Staff’ (Intercollegiate document 2014).

5.2 A mandatory session of at least 30 minutes should be included in the general staff induction programme for all health staff (or within 6 weeks of taking up post within a new organisation). This should provide key safeguarding/child protection information, including vulnerable groups, the different forms of child maltreatment, and appropriate action to take if there are concerns. Organisations must be able to demonstrate that Safeguarding Children, LAC, and Adults Safeguarding components are covered.

5.3 Over a three-year period, staff should receive refresher training to meet the standards outlined within the intercollegiate document (2014). Refresher training should reflect the level of competency appropriate to the role of the practitioner and will negate the need to undertake refresher training at the lower levels.

5.4 For all staff, competences should be reviewed annually as part of staff appraisal in conjunction with individual learning and development plans.
5.5 Further information regarding the knowledge, skills, attitudes and values required at each level is available in the intercollegiate documents and these should be read alongside this policy:
Safeguarding Children and Young People; Roles and Competencies for Health Care (2014)
Looked after children: knowledge, skills and competence of health care staff (March 2015)

GP Safeguarding Tool Kit (2014)


These should be referred to for full details of competency for staff groups.

Level 1: All non-clinical staff working in health care settings

The knowledge, skills, attitudes and values for staff working with LAC at this level are encompassed in safeguarding children training.

| Staff Groups | All non-clinical staff working in health care settings as well as all non-clinical staff working for independent contractors within the NHS, such as receptionists, community advice centre staff, administrators, caterers, domestics, transport and maintenance staff, and volunteers. Administrators supporting safeguarding/LAC teams may need a greater understanding of issues relating to consent, confidentiality and the management of clinical records. |
| Mode of delivery | E-learning, face-to-face as part of induction course/day, single agency. |
| Responsibility for delivery | Employer |
| Updated | Over a three-year period, staff at Level 1 should receive refresher training equivalent to a minimum of 2 hours. This should provide key safeguarding/child protection information, including about vulnerable groups, the different forms of child maltreatment, and appropriate action to take if there are concerns. |

Level 2: All clinical staff who have any contact with children, young people and/or parents/carers

Level 1 training must have been completed prior to undertaking Level 2 training.

The knowledge, skills, attitudes and values for staff working with LAC at this level are encompassed in safeguarding children training.

| Staff Groups | This includes health care students, clinical laboratory staff, pharmacists, ambulance staff, dentists, dental care practitioners, audiologists, opticians, adult physicians, surgeons, anaesthetists, radiologists, nurses working in adult acute/community services (including practice nurses), allied health care practitioners and all other adult orientated secondary care health care professionals, including technicians. |
| Mode of delivery | E-learning, face-to-face training session, single agency. |
Responsibility for delivery | Employer
---|---
Updated | Over 3 year period professionals at Level 2 should receive refresher training equivalent to a minimum of 1 Programmed Activity (PA) i.e. 3-4 hours Training, education and learning opportunities should include multi-disciplinary and scenario-based discussion drawing on case studies and lessons learnt from research and audits.

**Level 3:** All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/ child protection concerns

Levels 1 and 2 training must have been completed prior to undertaking Level 3 training. Although not included in the national list best practice would be for GP Practice Nurses to undertake Level 3 training. Due to the competences set out in national guidance level 3 LAC training is not incorporated within safeguarding children training and therefore staff requiring LAC training at this level cannot attain competences based on their attendance at safeguarding level 3 training. Therefore these staff must complete both training requirements.

**Staff Groups**
This includes Named GP’s, GPs, forensic physicians, forensic nurses, paramedics, urgent and unscheduled care staff, all mental health staff (adult and CAMHS), child psychologists, child psychotherapists, adult learning disability staff, learning disability nurses, specialist nurses for safeguarding, looked after children’s nurses, health professionals working in substance misuse services, youth offending team staff, paediatric allied health professionals, sexual health staff, school nurses, health visitors, all children’s nurses, midwives, obstetrician’s, child psychologists, obstetricians, all paediatricians, paediatric radiologists, paediatric surgeons, children’s/paediatric anaesthetists, paediatric intensivists and paediatric dentists.

**Mode of delivery**
Single agency core modules, plus multi-agency. Face-to-face or specialist e-learning modules with the agreement of the CCG and Safeguarding Board Training Leads. Core organisational modules should be used by health agencies that reflect the competencies/knowledge within the Intercollegiate document (RCPCH, 2014), (additional information may be added but content must not be removed). Core modules are available from the CCG Safeguarding Team.

**Responsibility for delivery**
Single agency – employer. Inter-agency – Waltham Forest Safeguarding Children Boards (WFSCB) / other relevant training provider. Individual staff must take responsibility for identifying their own learning and development needs with their line manager.

**Updated**
Within a year of appointment 2PAs (i.e. 8 hours) / those requiring specialist level competence should complete 4PAs (i.e. 16 hours). Then refresher training over a 3 year period equivalent to a minimum of 1.5 PAs (6 hours) for Level 3 Core and 3 - 4PAs (12- 16 hours) for Level 3 Specialist.
Training, education and learning opportunities should include multi-disciplinary and scenario-based discussion drawing on case studies and lessons learnt from research and audits.

**Level 4: specialist roles – named professionals**

Level 1, 2 and 3 training must have been completed prior to undertaking Level 4 training. Due to the competences set out in national guidance level 4 LAC training is not incorporated within safeguarding children training and therefore staff requiring LAC training at this level cannot attain competences based on their attendance at level 4 safeguarding training.

| Staff Groups | Safeguarding - Named doctors, named nurses, named midwives, named health visitors, named GPs, named health professionals in ambulance services LAC - specialist nurses, specialist child psychologists /psychiatrists, GPs with special interests and medical advisors to adoption/fostering agencies |
| Mode of delivery | Single agency (specific to role). Inter-agency – via WFSCB/ national study days and conference attendance. |
| Responsibility for Delivery | Employer. WFSCB Individual practitioners to source relevant courses / study days to attend. |
| Updated | • Named professionals should attend a **minimum** of six PAs/sessions (24 hours) of education, training and learning over a three-year period. This should include non-clinical knowledge acquisition such as management, appraisal, and supervision training
  • Named professionals should participate regularly in support groups or peer support networks for specialist professionals at a local and National level, according to professional guidelines (attendance should be recorded)
  • Named professionals should complete a management programme with a focus on leadership and change management within three years of taking up their post
  • Named Professionals responsible for training doctors are expected to have appropriate education for this role
  • Additional training programmes such as the newly developed RCPCH level 4/5 training for paediatricians should be undertaken within 1 year of taking up the post. |

**Level 5: Specialist roles – designated professionals**

Group’s 1-4/Levels 1-4 training/competence must have been completed prior to undertaking Group 5/6 / Level 5 training. Due to the competences set out in national guidance level 5 LAC training is not incorporated within safeguarding children training and therefore staff requiring LAC training at this level cannot attain competences based on their attendance at safeguarding group/level 5 training.
**Staff Groups**

| Designated doctors and nurses, lead paediatricians, consultant/lead nurses |

**Mode of delivery**

Inter-agency – via WFSCB / national study days and conference attendance.

Single agency – with colleagues.

**Responsibility for Delivery**

WFSCB

Individual practitioners to source relevant courses / study days to attend.

**Updated**

- Designated professionals including lead paediatricians, consultant/lead nurses should attend a *minimum* of six PAs/sessions (24 hours) of education, training and learning over a three-year period. This should include non-clinical knowledge acquisition such as management, appraisal, supervision training and the context of other professionals' work.
- Designated professionals should participate regularly in support groups or peer support networks for specialist professionals at a local, regional, and national level according to professional guidelines (and their attendance should be recorded).
- An executive level management programme with a focus on leadership and change management should be completed within three years of taking up the post.
- Additional training programmes such as the newly developed RCPCH level4/5 training for paediatricians should be undertaken within 3 years of taking up the post.

**Board Level**

It is envisaged that Chief Executives of healthcare organisations take overall responsibility for Safeguarding and Child protection strategy and policy with additional leadership being provided at board level by the executive director with the lead for safeguarding. All Governing Body members must have a level of knowledge equivalent to all staff working in a healthcare setting (level 1) as well as additional knowledge based competencies by virtue of their board membership, outlined below.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Board Level Chief Executive Officers, Trust and Health Board Executive and non-executive directors/ members, commissioning body Directors</th>
</tr>
</thead>
</table>
| **Responsibility for delivery** | WFSCB
Designated and Named safeguarding professionals
Individual member to source relevant courses/ study |

**Updated**

Competencies should be reviewed *annually* as part of appraisal.

**Adults Safeguarding**

<p>| Staff Groups for Level 1 | All staff including non-clinical and administrative staff: All staff including for example receptionists, administrative, transport and maintenance staff. |</p>
<table>
<thead>
<tr>
<th>Staff Groups for Level 2</th>
<th>All clinical staff, including GPs, GP practice managers, practice nurses, healthcare assistants, allied healthcare practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Groups for Level 3</td>
<td>Named adult safeguarding lead and identified specialist safeguarding leads across health organisations</td>
</tr>
<tr>
<td>Staff Groups for Level 4</td>
<td>Designated professionals for adult safeguarding</td>
</tr>
</tbody>
</table>

**Mode of delivery**

- Single agency (specific to role).
- Inter-agency – via LSCB / national study days and conference attendance.

**Responsibility for Delivery**

- Employer.
- LSCBs.
- Individual practitioners to source relevant courses / study days to attend.

**Updated**

- Named professionals should attend a minimum of six PAs/sessions (24 hours) of education, training and learning over a three-year period. This should include non-clinical knowledge acquisition such as management, appraisal, and supervision training.
- Named professionals should participate regularly in support groups or peer support networks for specialist professionals at a local and National level, according to professional guidelines (attendance should be recorded).
- Named professionals should complete a management programme with a focus on leadership and change management within three years of taking up their post.
- Named Professionals responsible for training doctors are expected to have appropriate education for this role.
- Additional training programmes such as the newly developed RCPCH level 4/5 training for paediatricians should be undertaken within 1 year of taking up the post.

**Training Delivery**

Safeguarding Children and Adults training is available at different competency levels to address the diverse learning needs of various staff groups. These levels should be considered in accordance with the levels stated within ‘Safeguarding Children and Young People: Roles and Competencies for Health Care Staff – Intercollegiate Document’ (RCPCH 2014). The document offers guidance on the variety of forms learning can take to support the knowledge and skills of practitioners.

LAC training levels are in accordance with the 5 levels as described by the intercollegiate document (2015). As per safeguarding children training staff must complete refresher training a minimum of three yearly.

Training typically takes place in two ways:

- single-agency training – which is carried out by a particular agency for its own staff;
- inter-(or multi-)agency training – which is for employees of different agencies who either work together formally or come together for training and development.
It is also expected the CCG is compliant with WFSCB training standard. Training modules should reflect Working Together to Safeguard Children (2015) Statutory Guidance and use evidenced based research to support the training contents. A variety of learning mediums should be sought and not an over reliance on e learning.

E learning Modules

It is the responsibility of organisations to take appropriate steps to ensure that e-learning modules reflect the core competency (RCPCH2014) for the level intended and are compliant with Working Together to Safeguard Children (2015)
Organisations should ensure that staff at all level also have access to local procedures and guidance to support them in their safeguarding work.

Best practice for those undertaking Level 3, is that a locally delivered training is undertaken as the assessing, planning, intervening and evaluation for children and young people and onward referrals require knowledge of local procedures as part of procedures.

At the time of ratification of the WFCCG Training Strategy the following e learning packages are known to have been through an external validation process prior to being made nationally available. However it remains the organisation or independent professional’s responsibility to gain assurance that the content of the e learning package is appropriate.

- www.rcpch.ac.uk
- www.E-lfh.org.uk
- www.virtualcollege.co.uk

6.0 Policy development

6.1 The following staff / groups were consulted and requested to contribute in the production of this strategy:
- Waltham Forest Safeguarding Children Board WFSCB Training and Development Managers
- WFCCG Safeguarding Team

WFCCG is the owner responsible for ensuring the Strategy is adhered to and reviewed appropriately.

6.2 Provider organisations are responsible for ensuring their internal safeguarding children training strategy is compliant with the CCG Training Strategy.

6.3 Provider organisations are responsible for ensuring eLearning training material is compliant with Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (Intercollegiate Document) and reflects national and Local Safeguarding Board guidance on safeguarding process and practice.

7.0 Dissemination and implementation process including training

7.1 This strategy is available to all staff via the CCG web sites or from the locality safeguarding children teams. The document is also widely circulated electronically to providers by the locality safeguarding teams.

7.2 Additional advice and support in its interpretation is available via the locality Safeguarding Children Teams.
8.0 Monitoring of compliance and effectiveness

8.1 Training attendance records are expected to be kept by the WFCCG and each Practice indicating the number within each training level cohort and the percentage trained against each cohort.

Records for WFCCG staff will be kept by the WFCCG Safeguarding Team and Governance Lead.

Training statistics will be reported according to current key performance indicators (currently into WFCCG Performance & Quality Committee and NHS England (upon request).

Training statistics will be reported into the WFSCB when requested / as part of the Section 11 Audits.

Staff should also maintain their own individual records of training attended / completed and link individual learning needs to annual appraisal.
References


Care and Support Statutory Guidance (Department of Health 2014)

Care Quality Commission: Essential Standards of Care. Care Quality Commission


Safeguarding Children and Young People: Roles and Competencies for Health Care (2014)

Royal College of Paediatrics and Child Health (2015) Looked after children: knowledge, skills and competence of health care staff (March 2015)

Section 11 Children Act 2004. Section 11 Children Act 2004

Skills for Health Skills for Health E –Learning. Skills for Health E-Learning

Social Care Institute for Excellence. Social Care Institute for Excellence
### Appendix 1- training frequency – safeguarding children and young people: roles and competencies for healthcare staff (2014)

<table>
<thead>
<tr>
<th>REQUIRED LEVEL OF TRAINING</th>
<th>Frequency of Training</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Level 1 (once only)</td>
</tr>
<tr>
<td></td>
<td>Level 2 (once only)</td>
</tr>
<tr>
<td></td>
<td>Level 3 (yearly)</td>
</tr>
<tr>
<td></td>
<td>Level 4</td>
</tr>
<tr>
<td>Level 1</td>
<td>✓</td>
</tr>
<tr>
<td>Level 2</td>
<td>✓ ✓</td>
</tr>
<tr>
<td>Level 3 Core</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td></td>
<td>✓ ✓</td>
</tr>
<tr>
<td></td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>Level 3 Specialist</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>Level 4</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td></td>
<td>✓ ✓</td>
</tr>
<tr>
<td></td>
<td>✓ ✓</td>
</tr>
</tbody>
</table>

- Level 1: Core
- Level 2: Core, Specialist
- Level 3: Core, Specialist
- Level 4: Core, Specialist
- Level 5: Governing Body

- Level 1: Once only
- Level 2: 3 yearly
- Level 3: 3 yearly
- Level 4: 3 yearly
- Level 5: Governing Body

**Minimum Requirements:**
- Level 1: Minimum of 8 hours over 3 years
- Level 2: Minimum of 12-16 hours over 3 years
- Level 4: Minimum of 24 hours over 3 years
## Appendix 2 - Table 2 – Level of competency for General Practice and WFCCG staff for safeguarding children

<table>
<thead>
<tr>
<th>Staff Groups</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3 (core/specialist)</th>
<th>Level 4</th>
<th>Level 5</th>
<th>Governing Body</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Practice/Primary care</strong></td>
<td>Practice Manager</td>
<td>Health Care Assistant</td>
<td>GPs/Locum GPs</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>Reception and Administrative staff</td>
<td>Pharmacist</td>
<td>Advanced Nurse Practitioners</td>
<td></td>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>Ancillary staff ie. Domestic and Maintenance staff</td>
<td>Counsellors</td>
<td>Practice Nurses</td>
<td></td>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Therapists</td>
<td>Safeguarding Leads (GP)</td>
<td></td>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phlebotomists</td>
<td></td>
<td></td>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td><strong>WFCCG</strong></td>
<td>All WFCCG staff</td>
<td>All WFCCG staff</td>
<td>Clinicians with face to face contact with children, young people and their families</td>
<td>Named/Clinical Lead GP</td>
<td>Designated Nurse for safeguarding children and Looked after children</td>
<td>Bespoke training for Governing Body members</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Designated Doctor for safeguarding children</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Designated Doctor for Looked after Children</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Designated Doctor for Child Deaths</td>
<td></td>
</tr>
</tbody>
</table>

Ref: Intercollegiate framework 2015 & 14
### Appendix 3 – WFCCG Training matrix

<table>
<thead>
<tr>
<th>Training level</th>
<th>Child safeguarding</th>
<th>Adult safeguarding</th>
<th>Domestic abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1</strong></td>
<td>Non-clinical and administrative staff: e.g. secretaries; reception staff, GP practice managers; administrative staff</td>
<td>All staff including non-clinical and administrative staff: All staff including for example receptionists, administrative, transport and maintenance staff.</td>
<td>Group 1: Staff who need awareness of domestic abuse but do not have client casework responsibilities. Group 2: Staff who have roles that also involve safeguarding responsibilities for clients they work with (e.g. GP practice safeguarding leads)</td>
</tr>
<tr>
<td><strong>Level 2</strong></td>
<td>All clinical staff who have any contact with children, young people and/or parents/carers</td>
<td>All clinical staff, including GPs, GP practice managers, practice nurses, healthcare assistants, allied healthcare practitioners</td>
<td>Specialist staff who have roles that involve assessing, supporting or providing interventions to clients that they work with; e.g. health visitors, practice nurses</td>
</tr>
<tr>
<td><strong>Level 3</strong></td>
<td>All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/ child protection concerns</td>
<td>Named adult safeguarding lead and identified specialist safeguarding leads across health organisations</td>
<td>For staff who have lead professional roles in domestic abuse, child protection or adult protection for their organisations: e.g. Domestic Abuse Health Visitors, Named Nurses, Policy Officers, Clinical Lead in GP surgeries,</td>
</tr>
<tr>
<td><strong>Level 4</strong></td>
<td>Specialist roles and named professionals</td>
<td>Designated adult safeguarding Leads</td>
<td></td>
</tr>
<tr>
<td><strong>Level 5</strong></td>
<td>Designated Nurses and Doctors for safeguarding Children /LAC/CDOP</td>
<td></td>
<td>Strategic /organisation lead roles</td>
</tr>
</tbody>
</table>
**Appendix – 4 Prevent Training Matrix**

<table>
<thead>
<tr>
<th>Basic Prevent Awareness Training – Level 1 &amp; 2</th>
<th>Prevent Awareness Training – Level 3, 4 &amp; 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency &amp; Target compliance</strong></td>
<td><strong>Frequency &amp; Target compliance</strong></td>
</tr>
<tr>
<td><strong>Staff Groups</strong></td>
<td><strong>Staff Groups</strong></td>
</tr>
<tr>
<td>Staff requiring Level 1 safeguarding training - All staff working in the health sector</td>
<td>Level 3 staff groups All clinical staff working with adults, children and young people and/or their parents/carers including: GPs, forensic physicians, urgent and unscheduled care staff, mental health staff (adult and CAMHS), child psychologists, learning disability staff, learning disability nurses, specialist nurses for safeguarding, looked after children’s nurses, health professionals working with substance misuse services, ambulance staff, nurses working in community services (including Practice nurses), court and prison based health staff, youth offender team staff, offender and forensic community health clinicians and practitioners, School college and university nurses and practitioners, paediatric allied health professionals, sexual health staff, safeguarding children’s nurses, health visitors, all children’s nurses, midwives, obstetricians, all paediatricians, paediatric radiologists, paediatric surgeons, lead paediatric anaesthetists for safeguarding, paediatric intensivists and paediatric dentist, People providing services to migrants or asylum seekers, Practitioners working in adult acute services, Practitioners working in children’s acute services, Practitioners working in adult community services with adults of a working age, Practitioners working in children’s community services with young people, People providing patient transport services, Health staff in secure children’s settings, chaplaincy staff</td>
</tr>
<tr>
<td>Staff requiring Level 2 safeguarding training - All non-clinical and clinical staff who have any contact with adults, children and young people and/or parents/carers including: administrators for looked after children and safeguarding teams, health care students, clinical laboratory staff, phlebotomists, pharmacists, dentists and dental care practitioners, audiologists, optometrists, contact lens and dispensing opticians, adult physicians, surgeons, anaesthetists, radiologists, allied health care professionals and all other adult orientated secondary care health care professionals</td>
<td>Level 4 staff groups Named professionals (named doctors, named nurses named health visitors, named midwives (in organisations delivering maternity services), named health professionals in ambulance organisations and named GPs for Organisations commissioning Primary Care)</td>
</tr>
<tr>
<td></td>
<td>Level 5 staff groups Designated Professionals (designated doctors and nurses, lead paediatricians, consultant/lead nurses)</td>
</tr>
</tbody>
</table>
Title of report
Safeguarding Supervision Strategy 2017-19

From
Dr Sabeena Pheerrungee and Korkor Ceasar

Purpose of report
To provide an update to the committee in relation to the new Safeguarding Supervision Strategy for the Health economy.

Recommendations
The Primary Care Committee is requested to:
- Note that the strategy promotes best practice within the Health economy
- Note that the strategy acts as a resource and guide in relation to the types of supervision and the model escalation pathway in the event of differences in professional opinion

Impact on patients & carers
Successful implementation of the strategies will ensure that children and adults in contact with commissioned services are safeguarded.

Risk implications
Non-compliance of the workforce with the requirement for safeguarding supervision for the relevant work groups puts service users at risk.

Financial implications
Failure to comply with statutory requirements may result in sanctions from the regulator.

Equality analysis
NHS WF CCG is committed to fulfilling its obligations under the Equality Act (2010) and to ensure services commissioned by the CCG are non-discriminatory on the grounds of any protected characteristics. The CCG will work with providers, service users and communities of interest to ensure that any issues relating to equality of service within this report are identified and addressed.

Other committees/groups, including the CCG Reference Group and Rapid Feedback Group
WFCCG Multidisciplinary Team Meeting; WFCCG Safeguarding Meeting; Performance & Quality Committee; WFSCB Business Management Group and the Governing Body of WFCCG
SAFEGUARDING CHILDREN and YOUNG PEOPLE SUPERVISION STRATEGY 2017-19
SAFEGUARDING CHILDREN AND YOUNG PEOPLE
SUPERVISION POLICY
2017 - 2019
### Document revision history

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Revision</th>
<th>Comment</th>
<th>Author/Editor</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.10.17</td>
<td>1.0</td>
<td></td>
<td>Strategy development</td>
<td>Korkor Ceasar</td>
</tr>
<tr>
<td>17.10.17</td>
<td>1.0</td>
<td></td>
<td></td>
<td>Dr Christine Slocynska</td>
</tr>
</tbody>
</table>

### Document approval

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Revision</th>
<th>Role of approver</th>
<th>Approver</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.10.17</td>
<td>1.0</td>
<td></td>
<td>Factual accuracy</td>
<td>Helen Davenport</td>
</tr>
<tr>
<td>25.10.17</td>
<td></td>
<td></td>
<td>Approval</td>
<td>Governing Body of WFCCG</td>
</tr>
</tbody>
</table>
# Contents

1 CONTENTS .................................................................................................................. Error! Bookmark not defined.

1.0 INTRODUCTION .............................................................................................................. 3

2.0 PURPOSE .......................................................................................................................... 4

3.0 DEFINITIONS .................................................................................................................... 4

4.0 ROLES AND RESPONSIBILITIES ...................................................................................... 5

5.0 ACCOUNTABILITY .............................................................................................................. 5

5.1 Individual Accountability .................................................................................................... 5

5.2 Organisational Accountability .......................................................................................... 5

6.0 Safeguarding Supervisory Responsibilities......................................................................... 6

7.0 Supervisee Responsibilities .............................................................................................. 7

8.0 POLICY PROCEDURAL REQUIREMENTS ........................................................................ 7

9.0 Sources of Advice to CCG Staff, Members and Health..................................................... 9

10.0 Escalation of Concerns ..................................................................................................... 10

11.0 DOCUMENTATION ......................................................................................................... 11

12.0 NON-ATTENDANCE AND PRACTICE ISSUES .............................................................. 11

13.0 RESOLUTION OF PROFESSIONAL DISAGREEMENT .................................................. 11

14.0 TRAINING AND FACILITATION ...................................................................................... 12

15.0 MONITORING COMPLIANCE .......................................................................................... 12

16.0 ASSOCIATED DOCUMENTATION ................................................................................... 12

17.0 REFERENCES ................................................................................................................... 13

18.0 EQUAL OPPORTUNITIES................................................................................................. 14

APPENDIX 1 - SAFEGUARDING CHILDREN SUPERVISION CONTRACT .................................. 15

Appendix 2 – SAFEGUARDING CHILDREN 1 TO 1 SUPERVISION RECORD .......................... 16

Appendix 3 – SAFEGUARDING CHILDREN GROUP SUPERVISION RECORD .......................... 17

APPENDIX 4 - RESOLUTION OF PROFESSIONAL DISAGREEMENT/ ESCALATION .............. 18

Resolution of professional disagreements relating to the safety of children .......................... 18

APPENDIX 5 - RESOLUTION OF PROFESSIONAL DISAGREEMENT/ ESCALATION .............. 19

APPENDIX 5A- SUPERVISION STANDARDS ........................................................................... 21
INTRODUCTION

1.1 Under section 11 of the Children Act 2004 and in accordance with Working Together to Safeguard Children, 2015 all members of staff in the employment of NHS Waltham Forest Clinical Commissioning Group (WFCCG) staff or in the employment of commissioned services are legally required to be compliant with their statutory duties. Therefore, safeguarding and promoting the welfare of children must be an integral part of the care offered to all children and their families by all health care professionals working within the Waltham Forest Health economy. The responsibility extends to members of staff providing care and offering services to children, young people, families or adults who are parents or carer’s.

1.2 Many of the inquiries into child deaths and serious incidents involving children have demonstrated serious failings in the effectiveness of professional responses. This has been partly attributed to a lack of appropriate supervised support. The National Service Framework for Children, Young People and Maternity Services (section 14.1, 2004) advocates that “consistent, high quality supervision is the cornerstone of effective safeguarding of children and young people”.

1.3 Working to ensure children are protected from harm requires sound professional judgments to be made. It is demanding work that can be distressing and stressful and those involved must have access to advice and support from professionals experienced in the field of safeguarding children.

2.0 PURPOSE

2.1 The purpose of this policy is to provide clear guidance on the implementation and utilisation of supervision and or telephone consultation within the context of safeguarding/child protection.

Good quality supervision can help to:

- Keep a focus on the child
- Avoid drift in cases
- Maintain a degree of objectivity and challenge fixed views
- Test and assess the evidence base for assessment and decisions; and
- Ameliorate the emotional impact of child protection/safeguarding work.

3.0 DEFINITIONS

3.1 Supervision is an accountable process which supports, assures and develops the knowledge, skills and values of an individual, group or team.

“Effective professional supervision can play a critical role in ensuring a clear focus on a child’s welfare. Supervision should support professionals to reflect critically on the impact on their decisions on the child and their family” (Working Together 2015; Chapter 1; para 5; p25)

3.2 Advice and Support Designated and Named safeguarding professionals provide expert safeguarding children advice, telephone consultation and support as required to commissioned and independent contractors, CCG staff, Clinical Support Unit (CSU) staff, who provide health services to the local population. This should not be confused with Safeguarding Children Supervision.

3.3 A child is anyone who has not yet reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate, does not change his/her status or entitlements to services or protection from harm.

3.4 Child In Need is defined under section 17 of the Children Act 1989 as a child who is unlikely to achieve or maintain a satisfactory level of health or development, or whose health and development will be significantly impaired, without the provision of services; or a child with disability.

3.5 Child protection is a part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.

3.6 Safeguarding and promoting the welfare of children is defined as:
- protecting children from maltreatment;
- preventing impairment of children’s health or development;
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and
- Taking action to enable all children to have the best outcomes

3.7 **Looked after children**
A child (under 18) is looked after by a local authority if he or she has been provided with accommodation for a continuous period of more than 24 hours either under a court order or through a voluntary arrangement made with the child’s parents.

3.8 **Safeguarding Children Supervisor** is a Designated/Named safeguarding professional or delegated person who has undertaken a professionally recognised safeguarding supervision skills course (e.g. NSPCC) and is experienced in the field of safeguarding children.

3.9 **WFCCG** is defined as the statutory body with responsibility for commissioning health services for the population of Waltham Forest.

4.0 **ROLES AND RESPONSIBILITIES**

4.1 The **Accountable Officer for WFCCG** is responsible for ensuring that the Clinical Commissioning Group, implements this policy.

4.2 **All staff** are responsible for adhering to and complying with the requirements of the policies, procedures, guidelines and protocols contained within and applicable to their area of operation. All staff have a duty to safeguard children by recognising abuse and neglect and referring onwards as required (Working Together 2015).

5.0 **ACCOUNTABILITY**

5.1 **Individual Accountability**
The process of supervision is underpinned by the principle that each practitioner remains accountable for their own practice and as such their own actions within supervision. Safeguarding children supervision does not replace nor should it delay the individual’s responsibility to make a referral to statutory agencies where there are concerns that a child or young person may be suffering or likely to suffer from significant harm. In such cases staff should refer to the WFCCG Safeguarding Children Policies and Procedures 2016 - 19.

5.2 **Organisational Accountability**
Under Section 11 of the Children Act 2004 all health care organisations have a duty to make arrangements to safeguard and promote the welfare of children and young people, and to cooperate with other agencies to protect individual children and young people from harm.
5.21 The Organisation must ensure that staff who work predominately with children, young people and adults who are parents/carers have access to safeguarding children supervision.

5.22 The Organisation will ensure that those practitioners providing supervision are adequately trained in supervision skills and have up to date knowledge of the legislation, policy and research relevant to safeguarding and promoting the welfare of children. This must reflect the requirements set out in Working Together (2015), the Intercollegiate Document (2014 and 2015), the Fifth Edition of the pan London Child Protection Procedures, WFCCG Safeguarding Children Policies and Procedures (2016-19) and WFCCG Safeguarding Through Commissioning Policy (2016-19).

5.23 A quarterly report through standard governance arrangements will be submitted to provide assurance that there is compliance with this policy.

6.0 Safeguarding Supervisory Responsibilities

6.1 Designated Safeguarding Professionals are responsible for providing prearranged safeguarding children supervision to Named Professionals in accordance with Intercollegiate Documents (2014 and 2015).

6.2 All safeguarding children supervisors will ensure that they:
- Have received professionally recognised supervision skills training (e.g. NSPCC) and ensure that their knowledge remains current through relevant course updates and accessing relevant literature
- Have up to date knowledge in legislation, policy and research relevant to safeguarding children
- Are accountable for the advice that they give
- Ensure those receiving mandatory safeguarding children supervision have agreed and signed a supervision contract with the supervisor (Appendix 1).
- Identify when they do not have the necessary skills/knowledge to safely address issues raised and redirect the supervisee accordingly
- Discuss management of individual safeguarding children cases to explore and clarify the management and thinking relating to the case.
- Share information knowledge and skills with the supervisee
- If required, constructively challenge any personal and professional areas of concern
- Document the agreed summary of the discussion with clear action plan indicating responsibility for each action. A copy should be held securely by the Supervisor and Supervisee.
- Where follow-up safeguarding children supervision sessions are arranged, documentation from the previous session will be made available for further discussion or closure by the supervisee (Appendix 2)
- The supervisor is responsible for ensuring that their own safeguarding children supervision needs are met.
7.0 **Supervisee Responsibilities**

7.1 The practitioner has certain responsibilities to ensure that they receive the most effective and timely support, which is:
- To access timely advice and support from the Designated/Named Professional for Safeguarding Children (or delegated person) as and when required
- For Named professionals for Safeguarding Children to take responsibility for ensuring they receive safeguarding children supervision within required time scales.
- For Named professionals for Safeguarding Children undertaking mandatory supervision, to agree, sign and adhere to a supervision contract (Appendix1)
- Maintain accurate, meaningful and contemporaneous records and documentation as per record keeping policy/professional guidance
- Identify and prioritise issues/cases to be discussed
- Develop and improve practice as a result of supervision, identifying any training needs
- Explore interventions that are useful
- Be prepared for constructive feedback/challenge
- Develop skills in reflective practice.

8.0 **POLICY PROCEDURAL REQUIREMENTS**

8.1 The arrangements for organising how safeguarding children supervision is delivered will vary across health organisations but there are some key essential elements. It should:
- Help ensure that practice is soundly based and consistent with Waltham Forest Safeguarding Children Board (WFSCB) and organisational procedures
- Ensure that practitioners fully understand their roles, responsibilities and the scope of their professional discretion and authority, and;
- Help identify the training needs of practitioners, so that each has the skills to provide an effective service.
- An understanding of when and how to escalate concerns

8.2 Effective professional safeguarding children supervision can play a critical role in ensuring a clear focus on a child’s welfare. Safeguarding Children Supervision should support professionals to reflect critically on the impact of their decisions on the child and their family (Working Together 2015).

8.3 It is not appropriate to be prescriptive regarding what type of cases should be brought to supervision, however below is a very general guide/checklist, and it is not an exhaustive list of risk factors that should be considered. These categories cannot indicate the nature, degree or severity of risk or act as a substitute for professional curiosity and judgment about the nature or degree of levels of risk within specific families.
Examples of cases to discuss at safeguarding supervision:
- Child protection plans where there is drift or professional disagreement
- High risk/escalating/concerning incidences of domestic abuse where children and young people are resident in the household.
- On-going concerns about neglect (including graded care profiles that are not progressing)
- Concerns in regard to Looked After Children
- Midwifery causes for concern
- Intimidating or aggressive adult behaviour/ Sexual offender in the household
- Potential sexual exploitation, gang involvement, honour based violence
- Risk factors associated with Female Genital Mutilation (FGM)
- Parental mental health issues that are impacting on parenting ability
- Young parents who do not meet/have refused Family Nurse Partnership (FNP).
- Families where the toxic trio (mental health, drug and alcohol misuse and domestic abuse) are present
- Non-compliant families,
- Risk factors associated with radicalisation
- Risk factors associated with Modern day Slavery
- Private fostering
- Families where professional intuition indicates there are issues or professional curiosity has not been satisfied.

8.4 Safeguarding Children Supervision is the framework for safeguarding children and is different from clinical supervision and management supervision.

8.5 Safeguarding Children Supervision usually takes place on a one to one basis but may also be undertaken by a group when ‘members come together in an agreed format to reflect on their work by pooling their skills, experience and knowledge in order to improve both individual and group capacities’ (Morrison 2005). The recommended number of supervisees in a safeguarding group supervision session is 6. The group must not exceed a maximum of 8 members. This is to ensure that all participants can contribute and avail of supervision in a meaningful way.

8.6 For group supervision sessions staff members should have identified Children/families that they wish to discuss and these will be negotiated at the session. However for urgent cases advice should always be sought from the Safeguarding Children team at the time the concern is identified.

8.7 Safeguarding Children Supervision is mandatory for all Designated and Named professionals. Effective mandatory Safeguarding Children Supervision needs to be regular (not less than quarterly) and provide continuity, so the relationship between supervisor and supervisee develops.
8.8 Mandatory Safeguarding Children Supervision sessions must be pre-arranged to ensure adequate time for both the supervisor and supervisee to prepare for the session. At least 1½ hours should be allowed for the session.

8.9 Safeguarding Children Supervision sessions must be held in a suitable environment where confidential discussion can take place. Adequate protected time must be allowed for effective supervision to take place and interruptions only allowed for urgent situations. Practitioners accessing mandatory Safeguarding Children Supervision will agree a Safeguarding Children Supervision contract with their supervisor. The contract will:
- Promote the interests of children and young people
- Reflect the seriousness of the activity
- Represent a positive model of behaviour
- Ensure the supervisee is aware of his/her responsibilities and role within supervision
- Clarify accountability
- Provide a basis for reviewing and developing the supervisory relationship
- Act as a bench mark against which supervision can be audited
- Ensure the standard of Safeguarding Children Supervision provided is of appropriate quality
- Place a duty on staff to demonstrate continuing development.

9.0 Sources of Advice to CCG Staff, Members and Health Professionals

9.1 Designated/Named Safeguarding Children Professionals are available to WFCCG staff, members and Independent Contractors to provide advice and guidance with regards to the identification and management of safeguarding children concerns.

The Safeguarding Children Team Contact Details are as follows:

Dr Sabeena Pheerunggee, Clinical Lead for safeguarding on
sabeena.pheerunggee@nhs.net

Dr Shermina Sayani, Designated Doctor for Looked after children on
Shermina.Sayani@nhs.net
Telephone – 07984782058

Dr Christine Sloczynska, Designated Doctor for Safeguarding Children and Child Deaths
Christine.Sloczynska@nelft.nhs.uk and christine.sloczynska@nhs.net
Telephone – 02084307893/07795548987

Korkor Ceasar
Designated Nurse for Safeguarding Children and Looked After Children
Korkor.Ceasar@nhs.net

Tel: 020 3688 2670 Mobile: 07930195306
Generic inbox for the Safeguarding Team at  wfccg.safeguarding@nhs.net

Please click the web - links for further details:
Waltham Forest Safeguarding Children’s Board
http://www.walthamforestccg.nhs.uk/about/safeguarding-adults-children.htm

Waltham Forest Multi Agency Safeguarding (MASH) Hub team
To discuss your concerns on:
Tel: 020 8496 2310 (Monday to Thursday, 9am-5.15pm and Friday, 9am-5pm)
Tel: 020 8496 3000 (Out of Hours). An out of hour’s emergency duty social worker will be contacted who will call you back. You will get to speak to a social worker who is part of the Waltham Forest MASH team. The social worker will need to gain as much information as possible about the child and the family.

Unless otherwise agreed the person requesting advice is responsible for taking action as required and advised to safeguard and promote the welfare of the child.

10.0 Escalation of Concerns
10.1 Problem resolution is an integral part of professional co-operation and joint working to safeguard children. Concern or disagreement may arise over another professional’s decisions, actions or omissions in relation to a referral, an assessment or an enquiry. It is important to resolve difficulties quickly and openly by identifying areas in working together where there is a lack of clarity to promote resolution. Guidance should be sort from your line manager or safeguarding supervisor. WFSCB Escalation Procedures should be adhered to and there should be open dialogue with partner agencies when this process is being initiated.

10.2 The safety and focus of individual children are the paramount consideration in any professional disagreement and unresolved issues should be escalated to their line manager/safeguarding lead with due consideration to the risks that may exist for the child. Where children’s services practitioners are concerned or in disagreement with their colleague relating to the safeguarding of a child they should seek advice from the Designated/ Named Safeguarding Children Professionals to promote resolution.
11.0 DOCUMENTATION

11.1 A Copy of the signed Safeguarding Children Supervision Contract should be kept securely by the supervisor and supervisee.

11.2 Where possible the supervisee will ensure that children’s records are available to the supervisor when they seek supervision relating to individual children.

11.3 The supervisor and supervisee will agree how and where safeguarding children supervision records will be stored at the introductory session and what will be recorded within health records on an on-going basis. In cases where the supervisor does not make an entry into the health record s/he will make a summary of the Safeguarding Children Supervision with clear action plan indicating responsibility for each action. A copy should be held securely by the Supervisor and Supervisee. (Appendix 2). Where follow-up supervision sessions are arranged, documentation from the previous session will be made available for further discussion or closure.

12.0 NON-ATTENDANCE AND PRACTICE ISSUES

12.1 It is the responsibility of the supervisee to contact their supervisor to arrange Safeguarding Children Supervision and ensure that their attendance meets the mandatory requirements of this policy. The supervisor will maintain a record of supervision attendance and inform the practitioner’s line manager of any practitioner who does not access Safeguarding Children Supervision within the above prescribed time frames. It is the responsibility of the line manager to address this with the practitioner.

12.2 Safeguarding Children Supervision is a confidential process and the supervisor will allow time for the practitioner to reflect on and learn from mistakes, and rectify them. In cases where issues are resolved within the Safeguarding Children Supervision process the information will not be shared with the line manager.

12.3 Where there are on-going concerns about a supervisee's practice and/or their refusal to comply with the supervisor’s recommendations, the supervisee will be informed that their line manager will be contacted for resolution.

13.0 RESOLUTION OF PROFESSIONAL DISAGREEMENT

13.1 Concern or disagreement may arise over supervisors/supervisee’s opinions/advice. The safety of individual child/ren and focus on child/ren are the paramount considerations in any professional disagreement and any unresolved issues should be escalated via line managers with due consideration to the risks that might exist for the child. As the Designated Professionals (Supervisors) for children's safeguarding are directly employed by WF CCG, ongoing concerns / unresolved practice issues may be escalated to the Executive Lead for Safeguarding Children at WFCCG, who is the Director of Nursing, Quality and Governance.
14.0 TRAINING AND FACILITATION

14.1 All supervisors delivering Safeguarding Children Supervision must have completed training on the supervision process and should have undertaken the NSPCC Child Protection Supervision Course or its equivalent and ensure that their knowledge remains current through relevant course updates and accessing relevant literature. In addition further training should be undertaken to meet the competency levels set out in Working Together (2015) and the Intercollegiate Document (2014 and 2015).

15.0 MONITORING COMPLIANCE

15.1 Monitoring of adherence with this policy is required to ensure compliance with:
- Criteria 1.4 Section 11 Audit
- Outcome 7 Care Quality Commission Essential Standards
- Standard NHS Contract 2017/18 (as amended per year);

15.2 Designated and Named Professionals attendance to safeguarding supervision will be monitored continuously and compliance regularly reported to WFCCG Safeguarding Meeting, Waltham Forest Safeguarding Children Board (WFSCB) via subgroups and Performance and Quality Committee (P&Q). This is also reported in the WFCCG Annual Report with an annual overview.

15.3 Compliance with other requirements of this policy will be audited on an annual basis by Designated and Named Professionals and reported to the Governing Body of WFCCG.

16.0 ASSOCIATED DOCUMENTATION

16.1 Section 11 Children’s Act 2004

Care Quality Commission: Essential Standards of Care

WFCCG Training Strategy 2017-19
17.0 REFERENCES


Looked After Children knowledge, skills and competence of health care staff - Intercollegiate Role Framework (2015)

18.0 EQUAL OPPORTUNITIES

18.1 This policy reflects the organisation’s determination to ensure that all parts of our community have equality of access to services and that everyone receives a high standard of service as a service user, a carer or employee.

This policy anticipates and encompasses the WFCCG’s commitment to prevent discrimination on any illegal or inappropriate basis and recognise and respond to the needs of individuals based on good communication and best practice.

We recognise that some groups of the population are more at risk of discrimination or less able to access to services than others and that services can often unintentionally put barriers in place that can limit or prevent access. The organisation is continually working to prevent this from happening.
APPENDIX 1 - SAFEGUARDING CHILDREN SUPERVISION CONTRACT

Safeguarding Children Supervision Contract

<table>
<thead>
<tr>
<th>Supervisor Name &amp; Designation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisee Name &amp; Designation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Supervision</th>
<th>Frequency</th>
<th>Duration</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As supervisor and supervisee we agree to:
- work together in accordance with the Supervision Policy to facilitate in depth reflection on issues affecting practice to develop the practitioner both personally & professionally, to ensure high quality clinical practice is maintained
- ensure an appropriate venue is available for the supervision session
- allow 1 ½ hours for the supervision session, arrive on time and remain for the whole session
- have protected time by not allowing interruptions and switching off mobile phones
- not to cancel appointments with less than 5 working days’ notice unless an urgent situation arises
- maintain confidentiality within the boundaries specified within the Supervision Policy
- question differences constructively and actively work towards resolution

As a supervisee I agree to:
- prepare for the session and ensure any relevant records are available
- take responsibility for making effective use of time
- ensure all actions agreed are completed within timescales and report to the supervisor when actions are unable to be completed

As a supervisor I agree to:
- make time available for supervision to be booked in advance

- document the agreed summary of the discussion with clear action plan indicating responsibility for each action. A copy should be held securely by the Supervisor and Supervisee. Where follow-up supervision sessions are arranged, documentation from the previous session will be made available for further discussion or closure

Supervisor Signature & Date

Supervisee Signature & Date
## Appendix 2 – SAFEGUARDING CHILDREN 1 TO 1 SUPERVISION RECORD

### SAFEGUARDING CHILDREN 1 to 1 SUPERVISION RECORD

<table>
<thead>
<tr>
<th>Name of supervisor and designation</th>
<th>Name of supervisee and designation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of session</th>
<th>Time commenced</th>
<th>Time ended</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Reflection on last session

<table>
<thead>
<tr>
<th>Issues brought to supervision and Why</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### Actions already taken

<table>
<thead>
<tr>
<th>Expectations from Supervisee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### Advice Given

<table>
<thead>
<tr>
<th>Action to be taken:</th>
<th>By whom:</th>
<th>Date to be completed by:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Signature of supervisor**

**Signature of supervisee**
### Appendix 3 – SAFEGUARDING CHILDREN GROUP SUPERVISION RECORD

#### SAFEGUARDING CHILDREN GROUP SUPERVISION RECORD

<table>
<thead>
<tr>
<th>Group:</th>
<th>Facilitator:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Time:</td>
</tr>
<tr>
<td>Venue:</td>
<td></td>
</tr>
<tr>
<td>Date &amp; time of next meeting:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group Members</th>
<th>Present (√)</th>
<th>Manager</th>
<th>Reason for non-attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Themes Discussed</th>
<th>Possible Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason for non-attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
</tr>
<tr>
<td>B</td>
</tr>
<tr>
<td>SL</td>
</tr>
<tr>
<td>L</td>
</tr>
<tr>
<td>DNA</td>
</tr>
</tbody>
</table>

---

Page 17 of 25
Resolution of professional disagreements relating to the safety of children

Introduction

Learning from reviews has highlighted the need for staff across all agencies to have a clear understanding about their responsibility for professional challenge and to know how to escalate concerns about decisions made where there are concerns about the welfare of a child.

Whilst there is generally a good working relationship between agencies and professional difference can be a driving force in developing practice, occasionally disagreements may arise which requires timely resolution so as not to delay decision making.

The Strategy aims to support positive resolution of professional difference between agencies working with children and families in Waltham Forest. The Strategy offers pathways (Appendices 1 & 2) to support health practitioners which are based within the Waltham Forest Health and Social care economy.

Local organisational guidance should be available to staff to support staff with communication issues between agencies that impacting on case knowledge or management.

Areas of possible dissent

Disagreements can arise in a number of areas, but are most likely to arise around thresholds, roles and responsibilities, the need for action and communication. Some examples may include:

- The referral does not meet the eligibility criteria for assessment by children’s social care
- Where one professional disagrees with another around a particular course of action, such as closing involvement with a child or family.
- Where one worker or agency considers that another worker or agency has not completed an agreed action for no acceptable or understood reason.
- Where one agency considers that the plan is inappropriate and that a child's needs are not being best met by the current plan. This could include a disagreement that a particular agency does not feel it needs to be involved, but another does.
- Where a member of staff or an agency considers that the child’s safeguarding needs are better met by a Child Protection Plan and have requested that a Child Protection Conference be called and feel that this has been denied.
- The best way of resolving difference is through discussion and where possible a face to face meeting between those concerned which will enable clear identification of the specific areas of difference and the desired outcomes for the child. Email communication, whilst important, can be open to misinterpretation or make for a stilted exchange of views
- Disagreement should be resolved at the lowest possible stage between the people who disagree but any worker who feels that a decision is unsafe should consult their manager, named or designated safeguarding lead. It should be acknowledged that differences in status and/or experience may affect the confidence of some workers to pursue this unsupported.
APPENDIX 5 - RESOLUTION OF PROFESSIONAL DISAGREEMENT/ ESCALATION

Problem resolution is an integral part of professional co-operation and joint working to safeguard children however it is important to:

- Avoid professional disputes that lose sight of the child
- Resolve agency difficulties quickly and openly
- Identify problem areas where there is lack of clarity and amend protocols and procedures to promote resolution

Stage 1

- Resolve difficulties at Practitioner level between agencies
- Maximum of 5 working days to resolve but earlier if child is at risk
- Difference in status/experience of professionals may affect communication

Stage 2 - Escalation

Problem should be referred to line manager or child protection advisor who will discuss with their counterpart in other agency usually at Children’s Social Care manager, Named Health Professional, Detective sergeant or designated teacher level.

Stage 3 - Escalation

- If no agreement at line manager level must be escalated to senior manager level i.e. service manager, detective inspector, head teacher or Designated Senior professional alternatively in health Designated Doctor or nurse.
- Timescale 1 working week or in a timescale that protects the child.
- Contemporaneous records of each intra agency and inter-agency discussion needed
- If unresolved- matter should be referred up. Verbal reports should be followed up in writing.

Stage 4 - Escalation

- If Professional differences remain unresolved the matter must be referred to senior management in each agency involved with a copy being sent to the chair of the WFSCB- this should be a written account of the dispute and the attempts to resolve it.
- If the issue is not resolved referral to the chair of the WFSCB should be considered for mediation or referral to WFSCB sub group. Again there should be clear documentation.
- When issue resolved general issue should be highlighted to the agency’s LSCB rep for consideration and future learning.
- At any stage it may be appropriate to seek expert advice-informed by best practice.
- Debriefing may be useful following disputes to promote good working relationships.
ESCALATING A SAFEGUARDING CONCERN RAISED BY NAMED NURSE / NAMED DOCTOR*(Stage 3 & 4)

Named Doctor/Nurse clarifies provider has followed internal escalation process, (Appendix 1)

Discussion with Designated Nurse/Doctor
Escalation agreed, Action plan drawn up including issues and concern

Issues & risk presented to Divisional Director of Children’s Services, LBWF & Assistant Director of Quality Assurance, LBWF and WFCCG Director of Nursing, Quality & Governance

At meeting
Action Plan with outcomes including case review date within 28 days to be agreed

NON-RESOLUTION

RESOLUTION

Consider multi-agency locality learning outcomes to be shared with the Learning Improvement Forum (LIF) and MA Audit themes

Designated raises to Director Children Services & LSCB
Independent Chair made aware
Action Plan agreed, including meeting with health professional/provider.

Inform WFCCG Chief Accountable Officer and Executive Lead for Safeguarding

Feedback to Provider (if not in attendance) & WFCCG
And WFSCB Chair

Decide with Named professional who will attend the meeting

Prepare summary of background chronology & own interpretation of risk

5 working days

10 working days
APPENDIX 5A- SUPERVISION STANDARDS

1.0 Introduction

1.1 Standards will apply to safeguarding children to ensure the CCG has promoted the view that effective supervision promotes good standards of practice. There is an expectation that all relevant health organisations will have a supervision policy which outlines the model used and requirements and responsibilities of the organisation, and that of the supervisor and the supervisee and is compliant with Standards 1-10.

1.2 It is recognised that where there are newly qualified practitioner/professionals these standards may not be fully applicable and this should be taken into account.

Standard 1

Practitioners and their supervisors are provided with formal and regular (not less than quarterly) supervision which relates to their needs and those of the children and young people /Adults at risk with whom they are working

The organisation will have a supervision policy in place which outlines the minimum standards for supervision.

Standard 2

All supervisory relationships are subject to a written agreement to be signed up by both parties/groups at the first supervision session (Appendix 1)

The agreement should address:

- Respective roles and responsibilities
- The frequency of supervision
- How agendas are to be drawn up
- How the supervision sessions are to be recorded
- How confidentiality is to be maintained – and what the limits are to this
- How performance and development review requirements are to be met
- How differences in the working relationship are to be managed
- How the principles of diversity (within the supervisor/supervisee relationship and in service delivery) are to be handled
- How and when the agreement is to be reviewed

Standard 3

Supervision is a planned and purposeful activity

The health organisation must have a policy in place which clearly outlines the supervisor and supervisee’s responsibility around preparation for the agenda before a supervision session.

Standard 4

All supervision sessions should be recorded promptly, competently and records stored appropriately and securely

Each health organisation should have a policy that clearly identifies the documentation to be completed and the record keeping policies in respect of supervision records.
Standard 5

_Supervisors and supervisees are trained and sufficiently skilled to carry out their role_

- Health organisations must offer training opportunities to both supervisor and supervisee to enable them to undertake their safeguarding responsibilities in supervision
- The health organisation must support individuals to undertake the necessary training.

Standard 6

_The supervisor should ensure through supervision that the supervisee is able to carry out their role competently, with the child/ young person and/or adult at risk being central to all decision making/activity carried out._

Supervision meets this function by ensuring that:

- Practice is child focused
- Agency policies and procedures are understood and adhered to
- The supervisees workload is reviewed
- Statutory responsibilities are met
- Practitioner is competent to practice
- There is evidence of a purpose relating to the plan or work
- Professional judgment is used appropriately
- The worker is supported/challenged to reflect on their practice and sufficient time is given to do this.
- Learning from Serious case Reviews

Standard 7

_The supervisor must ensure that the support function for the member of staff is met through supervision._

The safeguarding supervision policy will outline the responsibilities of the supervisor to ensure the support needs of the supervisee are met:

- Enable staff to cope with the stresses that the work entails
- Offer advice on help available to cope with stress and personal issues
- Create a safe climate for workers to examine their practice
- Help workers explore the effect of the work on them, both personally and professionally.
- Help workers explore emotional blocks to the work
- Monitor the overall functioning of workers, especially with regard to the effects of stress, team dynamics and relationships

Standard 8

_Supervision promotes a commitment to diversity in all aspects of work (i.e. that all children and young people and Adults at risk with children are entitled to the same quality of service irrespective of ethnicity, religion, language, gender, age, disability, or sexual orientation)
Supervision addresses this function by ensuring that:

- All assessments, plans and interventions address the diverse needs of children and young people and/or Adults at risk as applicable.
- The potential vulnerabilities of specific children, young people and their families and/or Adults at risk are identified and countered.
- Discrimination that a child/young person and/or adult at risk or their family may experience is acknowledged and, in so far as is possible, countered by service provision.
- There is effective communication with all children and young people, Adults at risk and their families (this to include, e.g. for whom English is a second language or who are disabled).
- All children and young people and/or adult at risk receive an appropriate level of protection.

**Standard 9**

*Managers assure the quality of supervision*

Supervision policy will outline how the quality of supervision is to be audited within the organisation.

**Standard 10**

*Joint supervision, which is also subject to the standards set out in this document, is provided in addition to individual supervision when more than one practitioner is involved in direct work with children, young people and families.*

Agreements for this supervision arrangement should be based on requirements arising from the work involved.
Purpose of report  To inform and update the group on the community pharmacists in primary care project awarded to FedNet

Recommendations FedNet is asking practices to express an interest in using the clinical pharmacist in their practice for a number of sessions between 3 months and 1 year.

Impact on patients & carers: Patients will be seen by a clinical pharmacist who will complement the GP by running specific clinics on eg minor ailments, LTCs, med reviews etc

Risk implications: Main risk to federation. Pharmacists employed by FedNet. Practice will mentor and work with the pharmacist. Pharmacists will receive a total of 49 days training over 18 months. GP Practice are required to add pharmacist to practice indemnity in the same way as nurses. An honorary contract between practice and pharmacist. SLA between practice and FedNet.

Financial implications: There is a cost to practices – year 1 £15ph junior pharmacist, £20ph senior pharmacist. Year 2 £22.50ph junior pharmacist, £25,00ph senior pharmacist. Year 3 £30 junior and senior pharmacist when all training is complete and prescribers.

Equality analysis

Other committees/groups, including the CCG Reference Group and Rapid Feedback Group
Clinical Pharmacist in Primary Care Project

Liz Hardy, General Manager, WF FedNet
Clinical Pharmacist in Primary Care Scheme

Background

A new scheme to support placing clinical pharmacists in primary care was announced by the Department of Health in July 2015 inviting practices and Federations to submit bids enabling them to participate in the pilot
Local Information

• Waltham Forest has a registered population of just over 306,000 patients
• GPs are clinical experts focussed on the needs of their patients, and they are facing increased pressure with their additional workloads as well as larger list sizes.
• A large number of GPs in WF are facing retirement and Fewer GPs are coming forward to work in general practice, not only locally but nationally.
• This means to enable patients to be continued to be seen and treated within a timely manner AND to ensure good clinical care is offer, new initiatives need to be found. The logical solution is by integrating other disciplines into primary care
• One of these solutions is by placing clinical pharmacists within GP practices.
Project Plan

• Waltham Forest FedNet has been successful in securing funding for 3 years for up to 8 junior pharmacists and 2 senior pharmacists to work on a rotational basis across the whole borough.

• The clinical pharmacists will work on a rotational basis to ensure ALL practices are able to access the benefit of the clinical pharmacist within their practice.

• Clinical pharmacists will be based in a GP practice either short term or longer term, working with the practice for the best possible outcome for the GPs and the patients

• Senior pharmacists will be based within academic practices around the borough and will support and mentor the junior pharmacists
Examples of Identified Benefits to Patients

• Clinical Pharmacist will be able to review patients with LTC, with the view to improving access to the surgery
• Deliver medicines optimisation and offer high-quality, safe, cost effective prescribing expertise
• Work within a multidisciplinary general practice team, offering medication review for people with multi-morbidities taking multiple medications
• Help educate patients to manage their own health, medicines and long term conditions
• Helping surgery staff to deal with prescription queries. This is normally done by the GP
• Improve care by seeing appropriate clinician according to symptoms through real-time access to results and treatments
• Patients will experience a more streamlined service – improving overall patient experience
• Patients will receive care according to individual needs, resulting in potential reduction of medicines being prescribed
• In depth patient review of repeat prescribing, e.g. care home patients
Examples of Identified Benefits to Practices

• Help with medicine management/practice audits which are requested by CQC inspectors.
• Meeting quality standards for practice by adherence to national and international guidelines for patients displaying LTC, Hypertension, COPD.
• To increase the proportion of patients receiving appropriate care through clear guidelines on initiation and discontinuation of medicines as clinically appropriate.
• Patients will experience a more streamlined patient experience. Treatment promptly by clinical pharmacist without the need to see GP if appropriate.
• Improve the discharge process of patients through improvement of the interface between hospital and other secondary care departments.
• Reducing GP patient appointments allowing GP’s to focus on more complex cases.
• To perform practice audits, useful for revalidation to reflect change in clinical practice.
• Reduce A&E patient visits.
QUESTIONS?
**Title of report**  
Personal Medical Services (PMS) contract Review – Update on progress and next steps

**From**  
Jane Mehta

**Purpose of report**
The aim of this paper is to update the primary care commissioning committee on the progress with the implementation of the PMS review in Waltham Forest and to provide information on the intended short term actions including the plans for performance management and contracting.

**Recommendations**
The primary care commissioning committee is asked to:

1. Note the progress with implementing the PMS review in Waltham Forest
2. Note and support the planned contracting and performance management arrangements
3. Note the project plan for January 1 Implementation
4. Note the need to develop and agree 2018/19 locally commissioned services

**Impact on patients & carers**
A key aim of the PMS indicators for 2017/18 is to improve primary care access for residents of Waltham Forest.

**Risk implications**
A range of risks associated with the programme have been identified and are monitored through the established risk management process.

**Financial implications**
Detailed financial modelling has taken place to establish the affordability of the programme.

**Equality analysis**
The local primary care access indicators aim to ensure there is equity of offer to all Waltham Forest residents
Other committees/groups, including the CCG Reference Group and Rapid Feedback Group

None
Report to Primary Care Commissioning Committee

Personal Medical Services (PMS) contract Review – Update on progress and next steps

Purpose

The aim of this paper is to update the primary care commissioning committee on the progress with the implementation of the PMS review in Waltham Forest and to provide information on the intended short term actions including the plans for performance management and contracting.

Introduction

Following the agreement of the CCG commissioning intentions for primary care by this committee in April 2017, and the successful completion of the NHS England /Londonwide LMC assurance process first offer letters were issued to PMS practices on 22 August 2017. These set out the basis of the new contractual offer alongside an indicative finance schedule based upon April 2017 list sizes. Practices have 3 months to consider the offer and sign the new contract. The new contract and locally commissioned indicators will be effective from 1 January 2018.

The GMS primary care access Local Improvement Scheme (LIS) was issued on 23 August 2017, with a deadline for return of registration forms by 25 September 2017. If registration forms were returned by this date GMS practices would be eligible to receive a preparatory payment for the period July – September 2017 as well as an aspiration payment for the following quarter (October – December 2017). The delivery of the indicator standards was effective from 1 October 2017.

Current position

6/22 PMS practices have returned the signed registration forms for the locally commissioned indicators. Given the three months ‘consideration’ period, this is not of concern at this stage.

15/19 GMS practices have signed up to the LIS within the agreed deadline. At the time of writing this report, 1 practice has indicated that it does not wish to participate in the LIS and there has been no response from three practices. All four are being followed up by the CCG to discuss further.

Following a meeting between practices, a concern was raised with the CCG regarding indicators for 2018/19 and 19/20. Practices were advocating that the CCGs approach to the review and development of local indicators should be reconsidered and future investment provided to practices without the need for associated requirements. The CCG has formally responded to the LMC setting out that the current commissioning intentions were subject to a robust process, agreed after lengthy negotiation with a group nominated by practices, formally endorsed by the PCCC at a part 1 meeting then assured by NHS England and Londonwide LMC. On this basis negotiations are concluded and cannot be reopened. The CCG did however provide assurance to the LMC that future locally commissioned schemes would support general practice sustainability and would again be subject to local negotiation.
Contracting

As part of the first offer, each PMS practice has received the link to the current national PMS contract template. The next step is to populate the contract schedules for each practice. This will be led by the primary care contracting team and supported by PMO support funded by NHS England (London). CCG officers will provide the schedules for the locally commissioned services and service requirements. It is intended that final offers are issued early in November based on October 2017 list sizes with the expectation that practices sign their contracts during November and early December.

GMS practices have been issued with a memorandum of understanding that sets out the contractual agreement between practices and the CCG for the LIS.

Performance monitoring requirements

Performance monitoring of the core contract is led by the primary care contracting team and will be carried out in line with established processes (eg annual e-declaration).

The locally commissioned indicators will be monitored by CCG officers and practices will be remunerated based upon actual achievement. The following table sets out the mechanism for undertaking this:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Monitoring mechanism</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice opening hours as defined within PMS service requirements – schedule 13</td>
<td>Contractor declaration, through ‘mystery shopping’ exercises, practice website and other practice publicity.</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Number of available patient consultations provided by a GP or other suitably qualified clinician per 1000 Carr-Hill weighted patients per week. This can include, surgery face to face, home visits, telephone or video consultations.</td>
<td>Contractor – through extraction from clinical system appointment book.</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Overall Experience Percentage of patients responding within the 'good' range to the question &quot;Overall, how would you recommend your experience of your GP Surgery?&quot;</td>
<td>National GP Patient Survey</td>
<td>Annually</td>
</tr>
<tr>
<td>Experience of making an appointment? Percentage of patients who responded very or fairly good</td>
<td>National GP Patient Survey</td>
<td>Annually</td>
</tr>
</tbody>
</table>

The CCGs preference is to use the Edenbridge APEX software to directly extract the information for indicators 1 and 2 but this is subject to the voluntary agreement of practices to share data. A memorandum of understanding has been developed to support this. In addition the CCG is working with Edenbridge to develop automated payment processes which will have the potential to significantly reduce administrative burden for practices but they will need to agree to data sharing in order to benefit from this.
For the first quarter (October – December for GMS practices only), it is proposed that a lighter touch process is implemented for indicator 2 as an interim arrangement whilst the APEX software is installed, tested and training completed. It is proposed that this is in the form of a declaration with random verification. The CCG are in the process of commissioning Health Watch to support this process in relation to researching indicator 1.

Once detailed performance management commences with effect from January 2018 for both GMS and PMS practices, not agreeing to the sharing of data with the CCG will require practices to provide the same detailed level of information on an Excel template.

CCG officers and the primary care contracting team will need to work closely and effectively in order to realise the benefits of implementing and monitoring the new PMS contract and locally commissioned services.

Next steps

A project plan has been developed mapping out the process to 1 January implementation is being developed and will be shared at the meeting.

Practices are continuing to raise queries with commissioners related to the changes in the PMS contract and these are being managed on an individual basis.

It is hoped, that given the extensive negotiation with the nominated group locally, PMS practices will sign up to the locally commissioned indicators and the revised PMS contract. If a formal dispute is raised this will be managed using the established dispute resolution process for primary medical services contracts. Practices who do not agree to the new contract have the right to return to GMS.

The next tranche of performance indicators will need to be ready for implementation in April 2018, so the process for developing and agreeing these needs to be considered without delay in order to ensure there is appropriate time for engagement and negotiation.

Recommendations:

The primary care commissioning committee is asked to:

1. Note the progress with implementing the PMS review in Waltham Forest
2. Note and support the planned contracting and performance management arrangements
3. Note the project plan for January 1 Implementation
4. Note the need to develop and agree 2018/19 locally commissioned services

Linda Finch
24 October 2017