NHS Public Protection Accountability and Assurance Framework

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Purpose

This Framework sets out exemplar evidence of high-quality, safe, and effective services that promote the protection of children and adults. Evidence reflects key recent policy and practice developments, findings from Scotland's Independent Care Review and subsequent publication of The Promise, and a range of sources including inspection findings and reviews of cases where children and adults have died or been significantly harmed.

The Framework is intended to guide Health Boards in assessing the adequacy and effectiveness of their public protection arrangements at both strategic and operational levels and to inform existing Health Board and shared multi-agency governance and assurance arrangements, covering all levels of staff including independent contractors. The aim is to ensure greater consistency in what children, adults at risk of harm, and families can expect in terms of support and protection from health services in all parts of Scotland.

Introduction

Public protection is the prevention of harm to children (including unborn babies), and adults. In Scotland, the rights and responsibilities in the United Nations Convention on the Rights of the Child ('UNCRC') should underpin the provision of all services. In addition, public authorities have a legal duty under the Human Rights Act 1998 to act compatibly with the rights enshrined in the European Convention on Human Rights ('ECHR').

Public protection requires effective joint working between statutory and non-statutory agencies, as well as with staff with different roles and expertise. To achieve effective joint working, there must be constructive relationships at all levels, with a strong executive lead at Health Board level in respect of its statutory duties, and shared Health Board member accountability. These arrangements should also facilitate clear oversight of the Board's corporate parenting duties and responsibilities as set out in the Children and Young People (Scotland) Act 2014. Moreover, where requested by a local authority, the Board must provide mutual assistance with the exercise of that authority's functions under the Children's Hearings (Scotland) Act 2011. As an employer and contractor of services, Health Boards are required to support staff to uphold professional standards and guidance outlined by their governing bodies.

Under Section 5 of the Adult Support and Protection (Scotland) Act 2007, Health Boards, along with other named public bodies, must, so far as consistent with the proper exercise of their functions, co-operate with the relevant council and each other where they know or believe a person is an adult at risk (in the meaning of that Act).

Health Boards are also Responsible Authorities for the purposes of Multi-Agency Public Protection Arrangements (MAPPA) in Scotland. The Management of Offenders etc. (Scotland) Act 2005 places a statutory duty on Responsible Authorities to jointly establish arrangements for assessing and managing the risks posed by registered sex offenders, restricted patients and other "risk of serious harm" individuals. Health Boards are Responsible Authorities in relation to the management and care of restricted patients.

In addition, Health Boards have a duty to cooperate with other agencies about all individuals who are subject to MAPPA. This statutory duty to cooperate includes the provision and sharing of information relevant to the assessment and management of the risks posed by these individuals. All Health Boards should have robust reporting and escalation mechanisms in place to identify and report on MAPPA activity.

While inspections, Significant Case Reviews, and Learning Reviews have highlighted strong and effective health partnership working in some areas, they have also identified unwarranted variation and inconsistencies in public protection roles and accountability arrangements across the country. Issues identified include:

- A lack of clarity of role in multi-agency planning processes resulting in insufficient join-up and health involvement in risk assessment processes, including lack of representation at key meetings arising from child or adult protection activity.
- Lack of resources and capacity to meet the demands of attending a number of critical protection meetings.
- Communication and information sharing within and between services, including at points of transition between healthcare services and settings, and in transition between other services.
- Cultural issues which impact on shared ownership of case responsibility and in establishing the lead agency.
- The importance of a coordinated approach to the work of the National Child Death Review Hub and local Child Protection Committee requirements to conduct reviews whilst avoiding duplicity of effort in parallel processes.
- A lack of co-ordination and oversight across the range of staff working in different clinical settings, including inconsistent multi-disciplinary approach to protection of adults and children that promotes all individuals feeling their contributions are valued.
- In a few but important number of cases, a lack of health involvement in assessments, including a lack of medical examinations in a small, but again, important number of child protection cases.
- A lack of clarity about the role of capacity in adult protection activity, and inconsistent understanding of the interface between child and adult protection, Adults with Incapacity legislation, the Mental Health (Care and Treatment) (Scotland) Act, and the revised child protection guidance (up to the age of 18).
- A need to consider whether there are any indicators of abuse or assault, including trafficking, as part of pre-birth assessment and planning.
- Inconsistency in the level of Health Board engagement with MAPPA in relation to individuals who are not restricted patients.

- Variation in the level of seniority of the Health Board liaison role and the contribution they make to MAPPA meetings about specific individuals. This can be limited to factual information about the individual's access to health services rather than information supporting multi-agency management of risk and the sharing of expertise in risk management.
- Variation in appropriate and consistent Health Board representation on MAPPA Strategic Oversight Groups (which is the overarching governance forum in each of the 10 MAPPA regions in Scotland). As a result, representatives do not always have the authority to take decisions.

In addition, variations have been highlighted in Health Board designated roles, functions, resourcing, and governance arrangements for public protection. This has led to inconsistencies in lines of accountability, shared understanding of governance, and support for public protection services. Key designated health roles for child protection (including unborn babies) in Scotland are non-statutory, unlike comparative roles in other parts of the UK. This places an even greater responsibility on all agencies to have in place robust and rigorous processes to support staff in carrying out their professional roles.

Furthermore, the establishment of Integration Joint Boards (IJBs) and delegation of functions and budgets has led to more integrated arrangements in adult services (and children's services for those IJBs with strategic planning, commissioning, and oversight of children's services responsibilities), which has impacted on a number of aspects of accountability and assurance arrangements across Scotland. This is apparent at a strategic level, in terms of the role of Chief Officers and members of the Health Board and the Integration Joint Board. It is also the case in relation to operational responsibility, with variation in the responsibilities and reporting lines for Child Health Commissioners, Child Protection Advisors, public protection leads, and lead officers in paediatric and community teams.

While the responsibilities of Chief Officers are set out in national guidance, given the range of factors that impact on public protection responsibilities and the breadth of legislative, policy and practice changes in recent years, there is a strong case for a restatement of critical accountabilities within Health Boards and Integration Joint Boards.

Background

Roles and responsibilities of NHS Boards, employees, and GP contractors in protecting children and adults at risk of harm

Health Boards have structural and organisational responsibilities in respect of child and adult protection. These include use of appropriate policies to keep children and vulnerable adults safe, safe recruitment practices, staff induction and provision of adequate training, procedures for whistleblowing and complaints, robust information sharing agreements, and the promotion of a workplace culture that listens to children, young people, and adults and considers their views and wishes.

Health boards, NHS employees, and contractors have an important role in upholding the wide range of rights which underpin public protection, reinforcing and protecting many of the guarantees set out in the UNCRC (such as Articles 3, 12 and 24) and in the ECHR.

All NHS employees, GP and dental practices, and other independent contractors have a role in protecting the public and **all** regulated staff in Health Boards and services have professional duties to protect children (including unborn babies) and adults. Staff in supporting roles (including administrative, catering, cleaning, and other support roles) across primary, secondary, specialist, and community health services also have public protection responsibilities. These contacts provide opportunities for early and effective interventions and, in many cases, avoiding escalating need.

This role includes:

- Being aware of their responsibilities to identify and promptly share concerns, including making referrals where appropriate, about actual or potential risk of harm from abuse or neglect.
- Undertaking training and learning to ensure they attain and maintain their competencies, skills, and knowledge appropriate to their role.
- Knowing where and when to seek specialist advice and supervision.
- Being aware of their own regulated responsibilities and duties as well as understanding relevant legal frameworks within which they operate and their duty to refer.
- Being aware of the early signs of neglect; recognising the signs of self-harm and self-neglect and the need for co-ordinated assessment.
- In working with or treating adults who are parents/carers, being alert to the possibility that their patient may pose a risk to an unborn baby or child and have a duty to act.
- Working collaboratively with social work and police on multi-agency child and adult protection activity.
- Contributing to GIRFEC and, in relation to Health Visitors holding the named person function for pre-school children, coordinating the assessment and planning for children for whom a GIRFEC response is appropriate.
- Contributing to Looked After Children and other multi-agency child and adult protection processes, including pre-birth assessment and planning, child protection Inter-agency Referral Discussions, Children's Hearings, child protection investigations, Child Protection Planning Meetings, and interim safety planning.
- Working collaboratively with the lead professional when there is a multi-agency child's plan.
- Working collaboratively with the Council Officer undertaking adult protection procedures and contributing to Case Conferences as well as the development and implementation of Protection Plans.
- Maintaining factual, accurate, concise, and up to date records.
- Contributing to ensuring that there are planned and co-ordinated transitions between age and services, particularly where there are multiple and/or complex health needs.

- Having a Protecting Vulnerable Groups (PVG) Scheme in place via Disclosure Scotland.
- Contributing to multi-agency analyses of child and adult protection data (for example the Minimum Dataset for Child Protection Committees) to identify and understand key trends in numbers of vulnerable children and adults, types of concerns, and service responses.
- Using the available qualitative and quantitative data for robust analyses of the protection landscape.

NHS staff must also comply with their regulatory body's codes of practice:

Nursing and Midwifery Council The Code: Professional standards of practice and behaviour for nurses, midwives, and nursing associates

General Medical Council Protecting children and young people – The responsibilities of all doctors

Health and Care Professions Council Standards of conduct, performance and ethics

General Dental Council Standards for the Dental Team

NHS Education for Scotland Core Competency Framework for the Protection of Children

General Pharmaceutical Council Standards for pharmacy professionals

General Optical Council Standards of practice for optometrists and dispensing opticians

The Royal College of Nursing Intercollegiate Framework Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff provides further details of required skills and competencies and applies to all healthcare staff.

Role of Health Boards in Multi-Agency Public Protection Arrangements (MAPPA)

As MAPPA Responsible Authorities, Health Boards are the lead agencies for restricted patients within the meaning of Section 10 of the Management of Offenders etc. (Scotland) Act 2005. They are responsible for both the clinical care and risk management of these patients.

As MAPPA Duty to Co-operate Agencies, Health Boards have a duty to share information which is relevant to risk for all individuals subject to MAPPA. Each Health Board should have a MAPPA health liaison officer who has responsibility for this. The MAPPA health liaison officer also represents the Board at MAPPA meetings about specific individuals and manages information which is relevant to their risk which is provided to them by other MAPPA partners. This information is used to ensure that risk is considered and, when appropriate, managed within a healthcare setting.

Health Boards also have a responsibility to contribute to MAPPA strategic planning. Each Health Board should have a nominated senior manager who attends meetings of the MAPPA Strategic Oversight Groups (the overarching governance forum in each of the 10 MAPPA regions). Senior managers also attend MAPPA meetings about specific individuals who are managed at MAPPA Level 3 (the highest level of MAPPA meeting convened involving the most multi-agency involvement).

The role of the NHS in MAPPA can be summarised as follows:

- Restricted Patients: Health Boards are the lead Responsible Authorities in terms of assessment and management of risk.
- All individuals subject to MAPPA: Health Boards share information with other agencies – receiving and giving information to help protect the public (including NHS employees, contractors, and patients) from serious harm.
- Representation and points of contact – involvement of senior staff who can cover both management and clinical issues.
- Involvement in the strategic management of MAPPA.
- Providing clinical knowledge and resources, where appropriate, to help other agencies in the assessment and management of risk of serious harm posed by sexual and violent offenders.

Health Boards have a critical role in MAPPA, and NHS employees, GP practices, and other independent contractors should be supported to be clear on their role in relation to these arrangements and be appropriately supported. For example, those who attend MAPPA meetings about specific individuals need to know what is expected of them to be able to contribute meaningfully to risk management considerations.

Local leadership, governance, and accountability

Chief Officers in the context of child and adult protection are the Chief Executives of Local Authorities, the Chief Executives of Health Boards, and Police Scotland Divisional Commanders. Chief Officers, both individually and collectively, are responsible for the leadership, direction and scrutiny of child and adult protection services and public protection more broadly. Clear ownership and accountability by Chief Officers is required to ensure that protecting children and adults at risk of harm remains a priority within and across agencies.

Chief Executives of Health Boards are responsible for ensuring that governance, accountability, and assurance reporting frameworks are in place to ensure all health staff, including those contracted, are competent in discharging their child and adult protection responsibilities.

Health Boards also have corporate responsibility for ensuring that NHS staff have access to expert professional leadership and advice from their Health Board designated public protection leads, and it is desirable for this to extend to GP practices and other independent contractors. Whilst Health Board Executive Nurse Directors often have delegated responsibility for child protection, a designated Chief/Lead Nurse or Nurse Consultant (or equivalent) should be in

place in each Health Board with responsibility for child protection. This strategic role carries full-time responsibilities and should have protected time allocation. The lead doctor for child protection is usually a paediatrician who, together with the lead nurse, provides clinical leadership, advice, and strategic planning.

The Chief Officers of Health and Social Care Partnerships are accountable to the Chief Executives of the local authority and the Health Board that make up their partnership, for their role in relation to child and adult protection. These Chief Officers should be appropriately linked to local governance arrangements for the protection of children and adults at risk of harm in their area. This applies regardless of whether children's services are in the scheme of integration and whatever scheme of integration is applied. Health Board Chief Executives should be assured that clinical and care governance has a high profile, ensuring that the quality of care – including attention to child and adult protection - is given the highest priority at every level within integrated services.

Child Protection and Adult Protection Committees are the multi-agency partnerships responsible for monitoring and advising on procedures and practice, ensuring appropriate cooperation between agencies, and improving the skills and knowledge of those with a responsibility for the protection of children and adults at risk. It is crucial that health representation on Committees has sufficient seniority to represent the Health Board in discussions and decisions about policy, resources, and strategy. It is also important that the Health Board is a key contributor to local, multi-agency analyses of child and adult protection data (for example the Minimum Dataset for Child Protection Committees) to ensure that data and intelligence held by health is shared with multi-agency partners and helps build a shared understanding of local needs and service responses.

An overview of national guidance and leadership is provided at Annex A.

Exemplar evidence for Health Boards

The following section sets out exemplar evidence of high-quality, safe, and effective services that promote the protection of children and adults for territorial Health Boards. Some aspects of this evidence will also apply to Special Health Boards. We recognise that some examples provided do not apply equally to all employees and contractors due to varying contractual and management arrangements, in particular with regard to independent general practices.

Chief Executives should consider whether this evidence is reflective of the public protection arrangements in their Health Board, and where further focus is required as part of ongoing development and quality assurance processes.

1. An executive Health Board lead has overall responsibility for child protection, adult protection, and MAPPA and champions public protection across the Health Board and contracted services.

Evidence

- This lead is up to date with their public protection training, has public protection responsibilities reflected in their job description, and participates in relevant Chief Officer and Committee meetings.
- It can be shown that the executive lead promotes a positive culture of safeguarding children (including unborn babies) and adults at risk of harm.
- This lead ensures that local governance arrangements for the protection of children and adults at risk of harm in their area support Chief Officers of Health and Social Care Partnerships.

2. Lead clinicians are resourced and supported to provide advice, expertise, and professional leadership across the Health Board and contracted services.

Evidence

- There is a Chief/Lead Nurse or Nurse Consultant (or equivalent) for child protection. There is a Chief/Lead Nurse or Nurse Consultant (or equivalent) for adult support and protection. If this role is combined it must be shown that the nurse is able to undertake duties within their Health Board area. It can be shown that the Chief/Lead Nurse(s) or Nurse Consultant(s) take the professional lead on all aspects of the health contribution to safeguarding and are central to the Health Board's clinical and care governance processes for public protection.
- In Health Boards providing care to children, there is a Lead Paediatrician for child protection directly employed or contracted through a Service Level Agreement to provide expertise to the Board.

- The Lead Paediatrician and Chief/Lead Nurse or Nurse Consultant (or equivalent) have job descriptions which clearly define their roles, responsibilities, and expectations. They have sufficient protected time and support to carry out their duties and responsibilities.

- There is a designated Health Board Trauma Champion who supports the ongoing development of trauma-informed practice across all services. This role may be undertaken by the Chief/Lead Nurse or Nurse Consultant (or equivalent) in Special Health Boards and smaller territorial Health Boards.

- There is a process in place to monitor the workload of Health Board lead clinicians with a clear reporting mechanism to the executive Health Board lead.

- The Chief/Lead Nurse(s) or Nurse Consultant(s) and Lead Paediatrician have a high degree of visibility across Health Board and contracted services. They are responsible for preparing a child and adult protection annual report for the Health Board to provide assurance that the Board is meeting its obligations in respect of child and adult protection in line with national guidance which highlights areas for improvement.

- Lead clinicians have access to regular supervision appropriate to their role.

- The Chief/Lead Nurse or Nurse Consultant (or equivalent) for adult support and protection has access to relevant resources and support, including links with the NHS Adult Support and Protection Leads Network.

3. All NHS employees, GP practices, and independent contracted practitioners are supported and directed to the actions they need to take when a child or adult is at risk of harm.

Evidence

- The role of Health Board lead clinicians is communicated and understood throughout the Board and contracted services. All employees, GP practices, and independent contracted practitioners know where and when to seek advice, support, and supervision at an appropriate level for their role.

- Public protection protocols and guidance are up to date, aligned with national guidance, and accessible to all employees, GP practices, and independent contractors; information regarding where these protocols and guidance documents can be found is communicated to all.

- Health Board information sharing guidance and advice, including on sharing information during the pre-birth period, is accessible to all employees and contractors. Records are maintained in line with this advice. There are Caldicott Guardians who can advise on sharing information about children and adults at risk of harm.

- There is a mechanism to monitor awareness and understanding of public protection responsibilities and duties including the duty to refer.

- There are arrangements in place to monitor timescales for actions required as part of public protection processes, including the health contribution to Inter-agency Referral Discussions (IRDs), Child Protection Planning Meetings, Adult Protection Case Conferences, MAPPA case review meetings, and reports requested by the Scottish Children's Reporter Administration (SCRA), in line with national guidance. There is a clear reporting mechanism on performance to the executive Health Board lead.

- There is evidence that transitions between age and services, including the Scottish Ambulance Service and NHS 24, particularly where there are multiple and/or complex health needs, are planned and co-ordinated.

4. The Health Board promotes a children's rights-based approach and a culture of listening to children and young people and taking account of their wishes and feelings, both in individual decisions and in the development of services.

- The Health Board can evidence how it meets its statutory duties (including safeguarding and promoting the welfare of children) under the Children (Scotland) Act 1995, which provides a major part of the legal framework for child welfare and protection in Scotland. The Health Board can also evidence how it satisfies its duties under Part 1 of the Children and Young People (Scotland) Act 2014, which embeds duties on public authorities, and can demonstrate how they have secured the better or further effect within its areas of responsibility of the UNCRC requirements.

- Service planning and delivery is developed with an understanding of the evolving capacities of children and young people in relation to decisions which affect them.

- Feedback from children and young people is sought on matters affecting them and used to inform service planning and delivery (Service User feedback), in line with Article 12 of the UNCRC (children and young people have a right to express their views on matters affecting them and for those views to be given due weight).

- The outcomes of individual decisions are evaluated from the perspective of Article 3 of the UNCRC which states that the best interests of the child shall be a primary consideration.

- Complaint procedures are child friendly and adapted according to age, level of maturity, and understanding.

- Support and advocacy are available for children and young people who do not feel their full range of rights, under the UNCRC and otherwise, are being fulfilled.

5. Robust governance, accountability, assurance, and reporting arrangements for public protection are in place across Health Board services.

Evidence

- The Health Board has clear written governance, accountability, and assurance frameworks for public protection that apply to all services, both provided and commissioned. These frameworks link to Scottish Ambulance Service and NHS 24 public protection arrangements. Public protection governance processes and systems apply to IJBs and are embedded in wider Health Board governance arrangements.

- Reporting arrangements enable organisational assurance that all NHS employees and contractors are supported in accessing relevant learning and education appropriate for their role and scope of professional practice.

- There are arrangements to monitor compliance with safer recruitment procedures and selection procedures in relation to children and adults, including Protecting Vulnerable Groups (PVG) scheme membership.

- Guidance and support are in place for employees, GP practices, and independent contractors raising child and adult protection concerns. Audit shows that policy and procedures are adhered to.

- There are clear governance arrangements and processes in place to determine the appropriate review process when the Board is notified about the death of a child or adult who was subject to Adult Support and Protection measures.

6. Education, learning, and development arrangements support all NHS employees, GP practices, and independent contracted practitioners in their public protection roles and responsibilities.

Evidence

- There is an organisational training plan or strategy that ensures all employees and contractors are competent to carry out their public protection responsibilities in line with national guidance.

- All employees and contractors have undertaken training at an appropriate level for their role and area of practice, including the NES eLearning modules to support health professionals in their child and adult protection roles (available on Turas Learn). There is a mechanism in place to ensure that training is up to date.

- An education and learning framework supports all employees and contractors to build confidence and competence in discharging their duty to safeguard and protect children and adults. This framework also

supports all employees and contractors to build confidence and competence in taking a children's rights-based approach.

- Safeguarding training is available on a single and multi-agency basis, accessible to all noted above.

- Senior managers monitor attendance and non-attendance at training.

- Public protection is a mandatory aspect of induction for all employees, GP practices, and contractors, with access to child and adult protection supervision at an appropriate level for their role to support continuous professional development.

- All NHS employees and contractors are trained to the appropriate level, dependant on their role, in line with the Transforming Psychological Trauma Knowledge and Skills Framework, using guidance in the Scottish Psychological Trauma Training Plan.

- NHS employees and contractors are aware of, and suitably skilled, to fulfil their duties in relation to the rights of children and adults.

- All NHS employees and contractors working with children or parents have a clear understanding that young children can be especially vulnerable as they are (often) not able or in a position to verbalise or explain concerns or distress personally.

- All NHS employees and contractors are clear about the interaction of the National Hub for Reviewing and Learning from the Deaths of Children and Young People with other review processes.

7. Strategic and operational arrangements between the Health Board and its multi-agency partners support effective joint working and communication.

Evidence

- There is appropriate and consistent Health Board representation on Chief Officer Groups and Child Protection/Adult Protection/Public Protection Committees with specified reporting mechanisms to the Health Board.

- There is appropriate health representation in Inter-agency Referral Discussions (IRDs), Child Protection Planning Meetings, Adult Protection Case Conferences, Learning Review meetings, and MAPPA Strategic Oversight Group and case review meetings, in line with national guidance. There are systems in place to allow clinicians including, for example, midwives, paediatricians, health visitors, family nurses, and GPs to attend when appropriate. Support and guidance are provided to Board representatives attending these meetings.

- Protocols and guidance are in place to support effective multi-agency working, including Special Health Boards where relevant. This includes that the Health Board can demonstrate its contribution to training and multi-agency audit.

- There are clear arrangements and processes in place to determine the appropriate review process when the Health Board is notified about the death of a child or adult who was subject to Child Protection or Adult Support and Protection measures. There is a process in place for staff to contribute to work across organisations and agencies to undertake one single review wherever this is possible. There is a process in place to notify relevant agencies or bodies if a Health Board-led review is undertaken that may have relevance for wider needs and risk assessment, as well as learning.

- There is a process in place for learning from child and adult protection reviews, including Significant Case Reviews, Learning Reviews, Significant Clinical Incident Reviews, and Significant Adverse Event Reviews, and from inspection findings. Learning is shared across the Health Board and contracted services.

- Health engagement in all risk assessment processes is monitored and reviewed with a clear reporting mechanism to the executive Health Board lead.

- There are clear whistleblowing procedures and a policy for dealing with complaints against employees and contractors.

- The Health Board has clear information sharing guidance which sets out the process and principles for sharing information, relevant to safeguarding and promoting the wellbeing of children and vulnerable adults. This includes guidance on handling and storage of information and records, including responding to requests made under Section 10 of the Adult Support and Protection Act 2007 (Councils may, in certain circumstances, request health records relating to an individual's physical or mental health). Information sharing guidance is accessible to practitioners.

- The Health Board ICT systems allow sharing of information about children and adults for whom there are concerns, and ICT systems allow flagging where there is a concern. Audit work demonstrates public protection learning is disseminated and acted upon.

- The Health Board is a key contributor to local, multi-agency analyses of child and adult protection data (for example the Minimum Dataset for Child Protection Committees) to ensure that data and intelligence held by health is shared with multi-agency partners and helps build a shared understanding of local needs and service responses.

- When the Board is notified about the death of a child or adult who was subject to Adult Support and Protection measures, there is a process in

place to notify relevant agencies or bodies, including those leading on Adult Support and Protection activity, if a Board-led review is undertaken which may have relevance for wider needs and risk assessment, as well as learning.

8. The Health Board provides an effective medical response for children and adults in need of assessment and care.

Evidence

- Arrangements are in place to provide assessment for child abuse and neglect, including joint paediatric/forensic medical assessment examinations (JPFE) when required.

- Medical assessments are conducted in line with sections 9 and/or 11 of the Adult Support and Protection (Scotland) Act 2007 where a Council Officer knows or believes a person is an adult at risk of harm. The assessment may be conducted under an assessment order, if the court has granted an order for a health professional nominated by the council to conduct a private medical examination of the specified person.

- Assessment and care arrangements draw on best practice contained in the Child Protection Scottish National Clinical Guidelines.

- There are clear assessment pathways for accessing assessments of capacity to contribute to protection decisions, including decisions relating to the use of Adult Support and Protection, Adults with Incapacity, and/or Mental Health (Care and Treatment) (Scotland) Act 2003 legislation.

- There is access to appropriately trained medical staff during out of hours periods when there is a requirement for paediatric examination, medical assessment, or a JPFE.

- Processes are in place within Emergency Departments and acute receiving units to respond to suspected abuse and neglect of children and vulnerable adults, with appropriate information sharing mechanisms to support clinical staff and named persons to work in line with Getting it right for every child/everyone.

- Medical assessment and care responses are monitored and reviewed with a clear reporting mechanism to the executive Health Board lead.

Annex A: National Guidance and Leadership

Child protection

Chief Officer guidance

The Protecting Children and Young People: Child Protection Committee and Chief Officer Responsibilities Guidance (2019) sets out Ministers' expectations that Chief Officers work collaboratively with regard to local arrangements for child protection, including to oversee local Child Protection Committees. It also sets out the role of the Chief Social Work Officer in providing professional leadership and supporting performance improvement and management of corporate risk. Additionally, the Chief Social Work Officer has a pivotal role to play in building strong collaborative relationships with Health Board named professional leads for child protection and other professional leads in Health and Social Care Partnerships.

National Guidance for Child Protection in Scotland 2021

The National Child Protection Guidance in Scotland 2021 was published on 2 September 2021, replacing the 2014 version and the 2012 National Guidance for Child Protection in Scotland: Guidance for Health Professionals in Scotland. Revision of the guidance has involved consultation and collaboration with a wide range of partners including a formal Scottish Government consultation. It incorporates understanding of best practice from various sources, including practitioner and stakeholder experience, inspections, research, and learning from Significant Case Reviews.

This guidance sets out the overarching responsibilities for all NHS staff and particular roles and responsibilities for staff within a range of services. The previously separate guidance for health professionals – the 'Pink Book' – has been integrated to underline the multi-agency nature of child protection and the guidance more clearly defines the role, function, and contribution of health professionals and designated services to child protection processes.

The guidance makes clear that NHS employees and contractors working with or treating adults who are parents/carers and/or significant adults must also be alert to the possibility that their patient may pose a risk to an unborn baby or child. Healthcare staff have a duty to act and must raise their concerns in line with local child protection procedures.

The guidance also notes that those experiencing trauma and adversity in childhood, in the absence of compensating protections, are at greater risk of a multiplicity of disadvantage. It states that trauma can leave those most in need of support and protection least able to develop the necessary trusting relationships to engage with health care and wider support and protection services. The need for trauma informed child protection practices is highlighted throughout, specifically in child protection assessment, planning, and interventions that avoid re-traumatising with links to the National Trauma Training Programme.

Further details of the intended outcomes of the new national guidance and key changes from the 2014 version is provided in Annex B.

Linked to the guidance, but published separately is the National Guidance for Child Protection Committees Undertaking Learning Reviews. This guidance supports Child Protection Committees to reflect, learn and improve child protection systems and practice when a child dies, is significantly harmed, or was at risk of death or significant harm, or where effective practice has prevented harm or risk of harm.

Implementation of the National Guidance for Child Protection in Scotland

Implementation of the national guidance will support greater consistency in what children and families can expect in terms of support and protection in all parts of Scotland. However, it is recognised that local structures and protocols must be attuned to local conditions and demands. This may necessitate some flexibility in local implementation, to take account of this context and need.

While a degree of local variability may be seen across the country, the Scottish Government has set out its expectation in the supporting narrative that there should be a clear alignment between local and national guidance, with an expectation that all public bodies in local areas will be able to describe the rationale for any divergent arrangements or practice within the context of their Children's Services and Corporate Parenting Plans. Public bodies will be expected to set out how their practices remain consistent with the national guidance to avoid unwarranted variation and ensure compatibility with their human rights obligations.

A National Child Protection Guidance Implementation Group has been established to provide strategic oversight and offer support to local areas. This group has strong health representation including a Health Board Chief Executive, Executive Nursing Director, clinical and nursing leads, Health Improvement Scotland, and Public Health Scotland. Resources that are currently or soon to be available to support implementation and likely areas of focus include:

- The Minimum Dataset for Child Protection Committees which supports Child Protection Committees to collect, present, and analyse data on key indicators to inform local planning and practice and discussions with Chief Officer Groups. Version 2 of the Minimum Dataset for Child Protection Committees in Scotland was published in June. This includes new key indicators, which align with the guidance and support local areas with implementation. Webinars and bespoke support for CPCs is planned.
- The Chief Officers Public Protection Induction Resource which supports effective leadership and highlights key policy, legislation, and Chief Officers' role within public protection. This resource, which has been developed in response to a request of Chief Officers for induction support, emphasises linkages in the public protection arena, supporting senior leaders to work together and offering opportunities to reflect on their local context and data.
- The development of an NHS Education for Scotland public protection national e-learning education resource to support health professionals in their child and adult protection roles. This "Once for Scotland" approach is

intended to help alleviate some of the current pressures on the resources of individual Health Boards and improve consistency and access to high quality educational resources across Scotland. The aim is to enhance the patient safety culture which the NHS seeks to embed within safe, effective, and person-centred care. The specific focus on public protection is intended to build on each employee's knowledge, competence, and confidence in this area of practice and therefore support, enhance, and maximise their contribution within both a multi-disciplinary and multi-agency context.

Regular updates on the development of implementation supports will be provided to the Chief Executives Group, Scottish Executive Nursing Directors, Scottish Nursing Leadership for Child Protection, Scottish Association of Medical Directors, and Child Protection Managed Clinical Networks.

The National Child Protection Guidance Implementation Group reports to the National Child Protection Leadership Group. Membership of the National Child Protection Leadership Group, which is chaired by the Minister for Children and Young People, includes the Chief Medical Officer and Chief Nursing Officer. It also has Health Board Chief Executive and Executive Nurse Director representation.

Adult support and protection

The Adult Support and Protection (Scotland) Act 2007 provides measures to identify, support and protect certain adults who may be at risk of any type of harm, including neglect; self-harm or self-neglect; physical, psychological, sexual, financial, or institutional harm. Health Boards have duties under the Act to refer adults they know or believe to be at risk of harm and to co-operate with other agencies to aid inquiries and investigations. Additionally, the Adult Support and Protection Code of Practice sets out the roles and responsibilities of named public bodies, including health, and others in relation to supporting and protecting adults at risk of harm.

The Code of Practice has been refreshed to ensure it takes account of policy and practice developments since the Act came into operation in 2008, and brings the guidance up to date with current legislation and relevant changes in policy. The revised Code was published in July 2022.
The substantive amendments are:

- More detail about the three-point criteria in section 3 of the Act, which determines if a person is an "adult at risk" for the purposes of the Act
- Clarification on capacity and consent
- Emphasis on the duty to refer and co-operate in inquiries
- Clarification regarding information sharing expectations
- Clarification of relationship between inquiries and investigations
- New sections on referrals and related matters
- Further detail and clarification on visits and interviews
- New chapter on assessing and managing risk, including case reviews and large scale investigations
- New section on chronologies

In tandem with the refresh of the ASP Code of Practice, revisions have also been made to the Guidance for General Practice. The updated guidance provides greater clarity so that GP practices can be confident that their actions will meet safeguarding expectations and improve outcomes, whilst adhering to their professional guidelines and ethos.
Revisions to note include:

- expanded sections on information sharing
- emphasis on collaboration and co-operation
- trauma and its impacts
- types of harm, locations, and undue pressure
- the role of general practice in ASP
- the referral process – why and when

Both the revised ASP Code of Practice and updated ASP GP Practice Guidance place considerable emphasis on the need for trauma informed approaches to Adult Support and Protection practices.

The Adult Support and Protection (Scotland) Act 2007 recognises that a person may be capable of some decisions and actions and not capable of others. A person lacks capacity to take a particular decision or action when there is evidence that he/she is unable to do so. Adult support and protection applies to those with and without mental capacity. ASP legislation is relevant to those who are "unable to safeguard their own well-being, property, rights or other interests."

Health professionals may be the first professionals to see signs of potential harm, and thus a collaborative approach is vital. Participation of health staff and managers is invaluable when developing or refining local adult protection policy, procedure, and strategy. This includes contributions from GP practices.

Like Child Protection Learning Reviews, the purpose of Adult Protection Significant Case Reviews (SCR) is to learn lessons from circumstances where an adult at risk has died or been significantly harmed.

Scottish Government has revised the ASP Significant Case Review (SCR) Guidance and published National Guidance for Adult Protection Committees Undertaking Learning Reviews, aligning this with the recently published Child Protection Learning Review Guidance. The purpose of the learning review guidance is to promote consistency and to make it easier for learning to be shared. It provides a common set of objectives and criteria for establishing if a learning review is required. The guidance is designed to complement local processes. The Adult Protection Committee is responsible for deciding whether a learning review is warranted using the criteria in this framework, and for agreeing the way in which the review is conducted on behalf of the Chief Officers Group or equivalent. Some Adult Protection Committees may have an established group whose role is to oversee, on behalf of the Adult Protection Committee, matters relating to learning reviews.

Scottish Government is also working with the Care Inspectorate to identify and share learning arising from learning reviews, as well as from Initial Case Reviews and SCRs undertaken since November 2019.

MAPPA

Updated MAPPA National Guidance, which was published on 31 March 2022, provides guidance to support the Responsible Authorities in carrying out their statutory obligations under Section 10 of the Management of Offenders etc. (Scotland) Act 2005.

Annex B: National Guidance for Child Protection in Scotland 2021 – Intended Outcomes and Key Changes

The intended outcomes of the National Child Protection Guidance in Scotland 2021 are to:

- Support a reduction in the incidence of significant harm and child death in Scotland

- Improve professional inter-agency practice, supervision, management, training, and development

- Promote a shared, rights-based inter-agency ethos and philosophy of care and protection, as experienced by children, families, and communities

This guidance integrates child protection within the GIRFEC continuum. It uses GIRFEC language and core components to frame identification and proportionate responses to child protection concerns within the national practice model.

There are tonal changes including a focus on engagement and collaboration with families, on building resilience, strengthening relationships, and ensuring a learning culture in workforce supervision, training, and development, as well as a focus throughout on children's rights.

Standards and principles are augmented with, for example, new guidance on assessment, interviewing, and planning; trauma informed practice; chronologies; timescales; and complex investigations. General principles also underpin the consideration and conduct of investigative activities in relation to children who may be harmed and those who may cause harm to others.

Other key changes in the 2021 National Child Protection Guidance include revisions to core requirements including, for example, new guidance on information sharing and focus on children's rights throughout.

There is additional detail on essential processes such as Inter-agency Referral Discussions (IRDs). Whereas the 2014 National Child Protection Guidance referred only to social work and the police, the 2021 guidance sets out that:

> "Where information is received by Police, Health or Social Work that a child may have been abused or neglected and/or is suffering or is likely to suffer significant harm, an IRD must be convened as soon as reasonably practicable."

In relation to core professionals the guidance states that:

> "Practitioners in police, social work and health must participate in the IRD; and Education/ELC may have an essential contribution. Information gathering should involve Education/ELC; and other services working together to ensure child safety, as appropriate. IRD participants must be sufficiently senior to assess and discuss available information and make

decisions on behalf of their agencies. They must have access to agency guidance, training and supervision in relation to this role."

Within the guidance the term 'child' is taken to mean a child up to 18 years of age (it also considers the protection of unborn babies). Where a child is aged between 16 and 18 and requires support and protection, the guidance sets out the need for multi-agency professional judgement and assessment to consider which legal framework best fits the child's needs and circumstances.

The guidance strengthens the role of adult services and underlines their responsibility to consider the needs of children and their parents where vulnerability and protection needs are identified.

The guidance notes the crucial roles that ambulance crews and NHS 24 staff have in the recognition and timely response to public protection concerns in relation to unborn babies and children.

The guidance also emphasises the requirement for services to work together to ensure the best protection of children at key transition points. This includes transitions between placements; schools; child and adult services (including transition between child and adult protection processes); stages of recovery; and phases of relationships when vulnerabilities may present. There is additional information on child protection in transitions to adult life and services for disabled children.

Child Protection Case Conferences (CPCCs) have been renamed as Child Protection Planning Meetings (CPPMs), allowing families to clearly understand the purpose of the meeting. This change is to terminology alone; these meetings still operate as multi-disciplinary meetings and have the same importance and purpose as a CPCC. The CPPM continues to require paediatricians' input, particularly in the cases where medical evidence is crucial to decision making for the child and family.

Other changes have been made to sections relating to child protection assessment and planning including pre-birth Child Protection Planning Meetings, Joint Investigative Interviews, and health assessment and medical examination. There is also a new section added on multi-agency child protection assessment.

Part 4 of the guidance covering specific support needs and concerns has been re-written and includes many new sections/text on areas including sexual abuse; disabled children; parents with learning disabilities; domestic abuse; Fabricated or Induced Illness (FII); Sudden Unexpected Death in Infants and children (SUDI); transitional phases; when obesity is a cause for escalating concerns about risk of harm; mental ill health in adults and children; and children and families affected by alcohol and drug use.

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