Lincolnshire Community Health Services
NHS Trust

Safeguarding Children Policy and Procedures

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LINCOLNSHIRE COMMUNITY HEALTH SERVICES

Version Control Sheet
Safeguarding Children Policy and Procedures

Version	Section/Para / Appendix	Version/Description of Amendments	Date	Author/Amended By
1			November	Robert Wilson/ Jean Burbidge
2	Section 5	Identified names removed from text	February 2009	Robert Wilson/ Jean Burbidge
3			February	Joy Gilbert
4		Full review following restructure	September	Joy Gilbert
5	Section 1	Strengthen diversity	28.11.11	Joy Gilbert
6	Full document	Review post WT 2013	10.12 2013	Joy Gilbert
7	Full document	General update in line with national documents	020316	Jean Burbidge
7.1		Renumbered from P_CS_01 to P_SG_01	May 2016	Corporate Assurance Team
7.2	Full document	Contact details for Head of Safeguarding	August 2016	Jill Anderson
7.3	Full document	Updated contact details & education statement.	May 2017	Jill Anderson
8	Full Document	Due full review Changes due to transfer of 0-19 service to Local	March 2018	Jean Burbidge
9	Full document	Updated changes to LSCP.	July 2019	Eleanor Titley
10	Full document	Updates to flowchart, LADO included, and up to date multi agency details.	June 2020	Gemma Cross
10.1	Section 14	Update to legislation regarding data sharing	October 2020	Safeguarding Team
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Safeguarding Children Referral Flow Chart

If a concern is identified:

1. Obtain child's details; name and address (minimum), date of birth, school, GP, parents details

2. If the child is in immediate danger phone the Police on 101 or 999

3. Contact the Customer Services Centre 01522 782111 (during out of hours - EDT: 01522 782333)

Peterborough: 01733 864180 (during out of hours – EDT: 01733 234724)

4. Complete an online referral available here

4. Make a record of the referral - including a body map if the child has an injury

5. Flag the homepage of the child's SystmOne record with 'SAFEGUARDING ALERT'

6. Inform your line manager and complete a Datix (tick the 'safeguarding' box)

7. Follow up the outcome of the referral if you have not heard back within 24 hours

If you have a child safeguarding concern during normal working hours and would like some advice, you can call the LCHS Safeguarding Hub, details available on the Safeguarding page of the staff intranet.

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POLICY STATEMENT

Background	"All those working in the field of health have a commitment to protect children, and their participation in inter-agency support to social service departments is essential if the interests of children are to be safeguarded" (Children Act 1989). This policy is complementary to the Lincolnshire Safeguarding Children Partnership (LSCP) and Cambridgeshire and Peterborough Safeguarding Children's Partnership (CPSCPB) multiagency policy and procedures and is specific to health practitioners within Lincolnshire Community Health Services.
Statement	LCHS is committed to safeguarding and promoting the welfare of children and to protect them from harm, in accordance with its duty under Section 11 of the Children Act 2004. The Organisation has a commitment to deliver services to children in a non discriminatory way. Children should be safeguarded, protected and valued, regardless of their, Race, religion, first language or ethnicity Gender, Sexuality, Age, Health or disability Political or immigration status
Responsibilities	Working Together to Safeguard Children 2018 strengthens the responsibility for all workers in relation to safeguarding children. This is irrespective of the service they deliver. This policy applies equally to staff directly involved in providing care to children, and to those staff working with adults whose illness or condition may have an impact on the health or wellbeing of a child. Every staff member must have online access to the LSCP Inter-agency Procedures www.proceduresonline.com/lincolnshirescb for those working in Lincolnshire or for those working in Peterborough http://www.safeguardingcambspeterborough.org.uk/children-board/ Additional procedures can be found regarding Early Help at/http://www.lincolnshire.gov.uk/keeping-children-safe/team-around-child Peterborough https://www.peterborough.gov.uk/healthcare/early-help Staff members can access LCHS policies and procedures via the intranet at www.lincolnshirecommunityhealthservices.nhs.uk A host of safeguarding resources and how to access the LCHS safeguarding team can be found on the LCHS Staff intranet safeguarding page. Staff working with children and families MUST be familiar and regularly review these websites. LCHS is defined as an education provider by the Department for Education and Skills (DfES). The Named Nurse Safeguarding will undertake the role of Designated Learning Safeguarding Person (DLSP) and has responsibility for coordinating action regarding learners within LCHS and for liaising with other agencies.
Training	Newly appointed staff will attend the Trust mandatory induction training. All staff working with children and young people, and/or adults with children must access training in accordance with their role and responsibilities as outlined on the training matrix on LCHS website www.lincolnshirecommunityhealthservices.nhs.uk

Dissemination	The policy will be available on the LCHS website and in the Safeguarding newsletter. Managers and Safeguarding Champions are required to discuss the policy with all staff. If information is accessed on line and printed as a hard copy or saved in another location it must be checked that the version number and date on the hard copy matches that of the one on line.
Resource implications	Implications of this policy are primarily in relation to staff capacity to meet the service needs of the population.

1. Scope

This policy is appropriate for all staff employed by LCHS, all volunteers providing services and all commissioned/contracted services.

The Children Act (1989 & 2004) defines a child as anyone under the age of 18 years. Children therefore means children and young people' throughout this policy.

Staff must be aware of indicators that make children and young people vulnerable and must take account of ethnicity, disability, asylum seeking children, children living with the impact of substance abuse, domestic violence and mental ill health, travelling families and children who may be subject to sexual exploitation and trafficking. Service delivery must take into account the cultural needs of children and families.

The organisation will work in partnership with all agencies to safeguard and protect the welfare of children.

2. Aim of the policy

The aim is:

- To raise the awareness that safeguarding children is **everyone's responsibility**.
- To assist those working with children, young people and their families to be aware of the signs and symptoms of child abuse and the procedures to follow when this is suspected.
- To raise awareness to **ALL** practitioners that the responsibility for making a referral to the local authority children's social care and/or signposting for appropriate support is there's to do.
- To promote multi-disciplinary and multi-agency working.

3. Introduction

In January 2003, Lord Laming published his report of the inquiry into the circumstances surrounding the death of Victoria Climbié (HMSO, 2003). The report drew attention to a number of serious failings in the provision of child health services for this extremely vulnerable girl. As a result of the inquiry, the government published revised guidance for all professionals directly involved in safeguarding children.

- What to do if you're worried a child is being abused (DfES, HM Government, 2015)
- Working Together to Safeguard Children (HM Government, last updated 2018)

Following the death of Peter Connelly in 2009 Lord Laming reviewed the recommendations of the Victoria Climbie Inquiry (The Protection of Children in

England: “A Progress Report" on 12 March 2009) and in 2010 The Department of Education commissioned a full review of child protection by Professor Munro.

Working with children and families where there are concerns about neglect or abuse is difficult and demanding. No two cases are identical, and the needs of children and families vary from case to case. Child protection is a difficult and highly emotive subject which invokes strong feeling. All those working in health have a professional responsibility to safeguard and protect children. This policy has been prepared to provide advice to Lincolnshire Community Health Services professionals and volunteers on safeguarding children issues.

4. Safeguarding Responsibilities

- The Chief Executive is responsible for ensuring that the health contribution to safeguarding and promoting the welfare of children is discharged effectively.

- The Director of Nursing and Operations is responsible for ensuring that Trust Board is fully aware of its safeguarding responsibilities.

- Section 11 of the Children Act 2004 places a duty on LCHS to make arrangements to ensure that, in discharging its functions, it has regard to the need to safeguard and promote the welfare of children: we are formally audited every three years by the LSCP and CPCSP to ensure that we have complied with this requirement.

- LCHS will ensure that all staff have ‘Disclosure and Barring Service’ (DBS) checks prior to employment if their work involves contact with children.

- LCHS has a Corporate Safeguarding team leading on all aspects of safeguarding including; safeguarding children, adults, mental capacity and deprivation of liberty safeguards.

- The team consists of, a Named Nurse for Safeguarding (adults and children), who provides strategic direction to the organisation in relation to safeguarding, and Deputy Named Nurses/Practitioners who support the operational teams in delivering safeguarding. They provide advice, support and supervision to the staff.

- The safeguarding team operates a single point of contact via our hub, which is looked after by our administrator. This is used for staff and multiagency colleagues to ensure a prompt response from the right person.

- The Looked after Children (LAC) team works alongside the Corporate Safeguarding team, their role is to manage and coordinate the initial and review health assessments (IHAs and RHAs).

- All staff working within LCHS who have contact with children and their parents/carer’s have a duty to safeguard and promote the welfare of children.

- Staff should be able to recognise and respond to concerns that a child’s health or development is, or may be, being impaired, or where there are concerns that they are suffering, or at risk of suffering significant harm.

All practitioners should be able to:-

- Assess the needs of children and the capacity of parents to meet the child/ren's needs.
- Identify concerns about the welfare of an unborn child.
- Identify concerns regarding "children in need" and parent's ability to meet those needs.
- Recognise children in need, and children in need of protection.
- Recognise the importance of how issues of age, gender, race, culture, sexuality and disability may impact on assessment of children and families and subsequent responses.
- Be aware of the local safeguarding procedures to be followed, to report concerns about a child/ren and family.
- Contribute to enquires about a child and family and provide information as appropriate.
- Provide reports and participate in strategy discussions and planning meetings when required.

A requirement of Working Together to Safeguard Children: A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children HM Government (2018) is for all Local Safeguarding Children Partnerships (LSCP) to produce a threshold document.

All practitioners must be familiar with the Lincolnshire LSCP threshold document "Meeting the Needs of Children in Lincolnshire - a shared responsibility".

The Cambridgeshire & Peterborough threshold document can be accessed here.

LCHS is committed to learning from complaints, incidents and compliments. All incident forms (Datix) relating to safeguarding children are reviewed by the Corporate Safeguarding team. Where appropriate an initial fact find (IFF) and/or root cause analysis (RCA) will be undertaken.

Serious incidents (SI) will be reported by LCHS to the CCG. A root cause analysis is always carried out where there has been an SI.

LCHS participates fully in each safeguarding practice review (formerly serious case review) commissioned by the Lincolnshire LSCP and Cambridgeshire and Peterborough SCB

The corporate safeguarding team provides representation on safeguarding practice review panels and contributes to serious case reviews in other areas where LCHS have been included in the delivery of care.

5. Safeguarding Children Partnership

The Lincolnshire Safeguarding Children Partnership (LSCP) and Cambridgeshire and Peterborough Safeguarding Children Partnership Board (CPSCP) are the key statutory mechanism for agreeing how the relevant organisations in Lincolnshire will co-operate to safeguard and promote the welfare of children in the county, and for ensuring the effectiveness of what we do.

The LSCP operates on two levels, the Strategic Management Board (SMB) at which LCHS representation is by the Director of Nursing and Operations, and the Operational Delivery Group (ODG) which LCHS is represented by the Named Nurse.

The Named Nurse for safeguarding sits on the Operational Delivery Group for Lincolnshire. The Peterborough Designated Nurse for Safeguarding Children attends the Peterborough Safeguarding Children's Board meetings and will liaise and share information as necessary. The Named Nurse for Safeguarding attends the Safeguarding People Health Sub group meeting in Cambridgeshire and Peterborough.

The strategic plans and details of subgroups are available here for Lincolnshire or here for Peterborough/Cambridgeshire.

6. Child Abuse and Neglect Categories of Concern

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting, by those known to them or, more rarely, by a stranger. They may be abused by an adult or adults, or another child or children.

6.1 Physical Abuse

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child (fabricated induced illness, known as FII)

6.2 Sexual Abuse and Child Sexual Exploitation

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males; women also commit acts of sexual abuse, as can other children.

In addition; sexual abuse includes abuse of children through sexual exploitation. Penetrative sex where one of the partners is under the age of 16 is illegal, although prosecution of similar age, consenting partners is not usual. However, where a child is under the age of 13 it is classified as rape under s5 Sexual Offences Act 2003.

The referral process for victims of sexual assault can be found here.

Child sexual exploitation (CSE) is a form of child sexual abuse. It occurs when an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity a) in exchange for something the victim needs or wants, and/or b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually

exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology. (Working Together 2018)
Where children are sexually exploited for money, power or status, it can involve violent, humiliating and degrading sexual assaults. In some cases, young people are persuaded or forced into exchanging sexual activity for money, drugs, gifts, affection or status. Consent cannot be given, even where a child may believe they are voluntarily engaging in sexual activity with the person who is exploiting them. Sexual exploitation can happen to boys and young men as well as girls and young women and that females can be involved as perpetrators as well as males;

CSE is never the victim's fault, even if there is some form of exchange: all children and young people under the age of 18 have a right to be safe and should be protected from harm.

Any concerns regarding a child where CSE is suspected, should have a CSE risk assessment completed in addition to either a safeguarding/early help referral made depending on the level of risk indicated.
Further information can be found here.

6.3 Exploitation

Children/young people may also be identified at risk of exploitation by trafficking/ modern day slavery exploitation. 'Exploitation' includes, at a minimum, sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.
This also includes risks of criminal exploitation, in activities known as county lines. Further information can be found here.

All referrals for young people deemed at risk of exploitation will be reviewed and those deemed meeting a threshold of high risk will be reviewed at the multi-agency child exploitation (MACE) meeting where required plans/disruption will be agreed.

Where LCHS practitioners receive information regarding concerns of exploitation, but there is not enough information to make a safeguarding/early help referral, information can be shared to the police on a partnership information report/operation insignia report form, available here.

A datix should be submitted for any referrals made for the above concerns/processes.

6.4 Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment).
- Protect a child from physical and emotional harm or danger.
- Ensure adequate supervision (including the use of inadequate care givers).
- Ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

6.5 Emotional Abuse

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development.
It may involve:

- Conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person;
- Imposing age or developmentally inappropriate expectations on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction;
- Seeing or hearing the ill-treatment of another e.g. where there is domestic violence and abuse;
- Serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger;
- Exploiting and corrupting children.

Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Research from serious case reviews has demonstrated a significant prevalence of domestic abuse in the history of families with children who are subject of child protection plans. Children can be affected by seeing, hearing and living with domestic violence and abuse as well as being caught up in any incidents directly, whether to protect someone or as a target. It should also be noted that the age group of 16 and 17 year olds have been found in recent studies to be increasingly affected by domestic violence in their peer relationships.

The Home Office define domestic violence and abuse (2019) is as follows:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence and abuse between those aged 16 or over, who are or have been intimate partners or family members regardless of gender and sexuality. The abuse can encompass, but is not limited to psychological, physical, sexual, financial, and emotional."

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

New police powers under the Stalking Protection Act 2019 allows police to issue stalking protection orders to be considered as part of local adult and/or child safeguarding and public protection procedures.

6.6 Potential Risk of Harm to an Unborn Child

In some circumstances, agencies or individuals are able to anticipate the likelihood of significant harm with regard to an expected baby (e.g. where there is information known about domestic violence, parental substance misuse or mental ill health).

These concerns should be addressed as early as possible before the birth, so that a full assessment can be undertaken and support offered to enable the parent/s (wherever possible) to provide safe care to the baby.

If your concern is in relation to an unborn child then you should follow the Lincolnshire LSCP pre-birth protocol, and if in Peterborough you can follow their pre-birth protocol.

6.7 Female Genital Mutilation (FGM)

Female genital mutilation (FGM) is a procedure where the female genitals are deliberately cut, injured or changed when there is no medical reason for this to be done: it is illegal in the UK.

FGM is usually carried out on young girls between infancy and the age of 15, most commonly before puberty starts.

It is the mandatory duty of all registered healthcare professionals, to report FGM in children to the Police; this duty cannot be delegated to anyone else. The duty applies where a health professional, in the course of their work either:

- Is informed directly by a girl that an act of FGM has been carried out on her, or
- Observes physical signs which appear to show an act of FGM has been carried out and has no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth

The duty applies to girls who are under 18 years at the time that FGM is observed or disclosed.

It does not apply if the health professional only suspects that FGM may have been carried out.

Best practice guidance, pathways and templates to 'safeguard against FGM' and the 'Mandatory Reporting Duty' are available. Advice for Regulated Professionals in Lincolnshire – FGM Mandatory Reporting.

6.8 Historical Abuse Allegations

Allegations of child abuse are sometimes made by adults and children many years after the abuse has occurred. There are many reasons for an allegation not being made at the time including fear of reprisals, the degree of control exercised by the abuser, shame or fear that the allegation may not be believed.

These cases may be complex as the alleged victims may no longer be living in the situation where the incidents occurred or where the alleged perpetrators are also no longer linked to the setting or employment role. Such cases should be responded to in the same way as any other concerns. It is important to ascertain as a matter of urgency if the alleged perpetrator is still working with, or caring for children. The Local

Authority (LA) and /or the Police in the area where the alleged incident took place, has responsibility for investigating in these circumstances.

7. Child Protection Process

There are key processes that underpin work for safeguarding and protecting the welfare of children. These are:-

- Assessment and analysis
- Planning
- Intervention
- Review and evaluation

Assessment Framework

Assessment requires information to be gathered to enable analysis about a child's needs and the ability of the family to meet those needs. It will also require consideration regarding the likely level of risk to a child where there are concerns about the child and family circumstances.

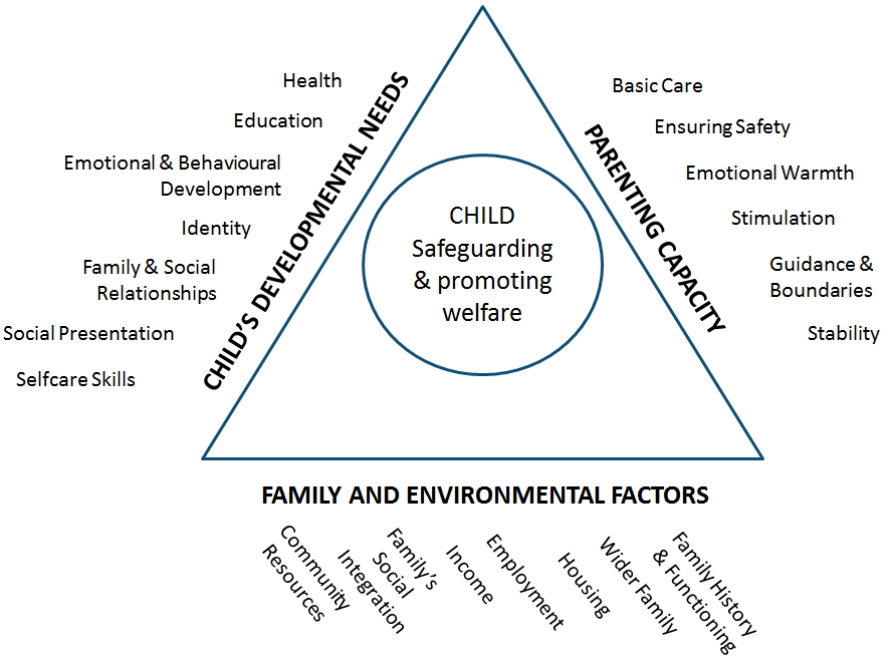
All staff members who have, or become aware of concerns about the welfare or safety of a child should know:

- What services are available locally?
- How to gain access to them?
- What sources of further advice and expertise are available?
- When and how to make a referral to LA children's Social Care?

"The Framework for the Assessment of Children in Need and their Families (DOH et al 2000) which is fully integrated with Working Together 2018 is used to assess the needs of children (see below)

Information should be gathered and analysed within the three domains of the Assessment framework.

1. The child's developmental needs
2. The parents or carers parenting capacity to respond appropriately to those needs
3. The wider family and environmental factors



A 'Signs of Safety' approach is in place for recording early help assessments/safeguarding referrals. (Turnell 2010)

Safeguarding referral forms can be found on the Lincolnshire Children Safeguarding Partnership website here, or, for Cambridgeshire and Peterborough, here.

8. Referrals to Children's Social Care where there are Safeguarding Concerns

National advice on these matters is contained in the booklet *'What to do if you're worried a child is being abused' (HM Government, 2015)* which can be downloaded from the LCHS Staff safeguarding website

Role of the Customer Service Centre (CSC)

The CSC will accept calls from professionals and the public and will offer:

- Information on parenting Issues through the provision of leaflets and website addresses
- Signposting to other services as appropriate including the Family Group Conference service
- Sign posting into the Early Help / Team Around the Child (TAC) process for children with additional need
- Referral onto children's Social Care

Where there are concerns that a child is suffering, or may be at risk of suffering significant harm they will pass the referral to children's Social Care.

Cases that require urgent attention will be forwarded onto the daytime emergency duty team.

Non-urgent cases will be referred to planned assessment team.

If the case is an open case to children's Social Care, they will pass the information to the relevant key worker.

Where there are concerns that a child is considered to be a child in need (as defined under Section 17(10) of the Children Act 1989) CSC will advise referral to the Early Help Team as appropriate.

Hearing and Observing the Child

Whenever a child reports that they are suffering or have suffered significant harm through abuse or neglect, or have caused or are causing physical or sexual harm to others, the initial response from all professionals must be to listen carefully to what the child says and to observe the child's behaviour and circumstances to:

- Clarify the concerns;
- Offer re-assurance about how the child will be kept safe;
- Explain what action will be taken and within what timeframe.

The child must never be pressed for information, led or cross-examined or given false assurances of absolute confidentiality, as this could prejudice police investigations. If the child can understand the significance and consequences of making a referral to LA children's social care, they should be informed that this will happen. Their views must be documented.

It must be explained to the child that whilst their view will be taken into account, the professional has a responsibility to take whatever action is required to ensure their safety and the safety of other children.

With regard to cases that are already 'open' cases to children's Social Care or the Team Around the Child (TAC) process, the lead professional or the key worker must always consider the need for a new S47 (as defined under Section 47 of the Children Act 1989) enquiry to be commenced. A new incident or a significant change in circumstances will require a new Section 47 enquiry to be initiated.

It is good practice for professionals to discuss any concerns they have with the family and, where possible, to seek the family's agreement to making a referral to children's services.

There are exceptional circumstances where such discussion and agreement-seeking would place the child at increased risk of significant harm for example fabricated or induced illness, and sexual abuse. In these circumstances it can be appropriate to refer without discussion or agreement from the family although the source of referral will subsequently be disclosed to the family by children's social care.

In cases where a professional is acting in good faith in passing on third party information it may not be appropriate for children's Social Care to reveal the source of the referral.

Other factors relevant to the decision whether to refer without prior discussion with the family include:

- Issues of staff safety.
- The risk of destroying evidence.
- The likelihood of children or other family members being intimidated.
- The possibility of an increased risk of domestic abuse.
- The possibility of the family moving to avoid professional scrutiny.

When a parent, professional or other person contacts children's Social Care Customer Service Centre (CSC) with concerns about a child's welfare, it is the responsibility of CSC to clarify with the referrer:

- Contact details including names, addresses and dates of birth for all children (to include schools attended) in the family including names and other relevant information on other adults living in the household
- The nature of the concerns
- What appear to be the needs of the child and family, including any special needs arising from cultural, physical, psychological, medical or other factors?
- Information about which other agencies and professionals are involved with the child and family

This process should always identify clearly whether there are concerns about abuse or neglect, what their foundation is and whether the child/ren may need urgent action to make them safe from harm.

All discussions about a child will conclude with, both the referrer and CSC being clear about who will be taking what action, or that no further action will be taken. The decision must be clearly recorded.

All staff making a referral by telephone must confirm the referral electronically within 24 working hours using the appropriate referral form, repeating all relevant information and agreed actions. For Lincolnshire it this can be accessed here, and for Peterborough/Cambridgeshire, here.

Whenever CSC receives a referral which may constitute a criminal offence against a child, they must inform the police at the earliest possible opportunity. Confirmation that this will be done must be obtained by the referrer.

9. Response by Children's Social Care to a Referral

Children's Social Care must decide on the next course of action within 24 hours, following:

- Discussion with the referring professional or service.
- Review of existing records.
- Discussion with police where a criminal offence may have been committed against a child.
- Discussion with other services/involved professionals as far as practicable.

It is important to consider the needs of all the children in the household at this stage. This initial consideration of the case should address, on the basis of the available evidence:-

- whether there are concerns about either the child's health and development,
- or actual and/or potential harm which justify further enquiries, assessment and/or intervention and if so, when those enquiries (the initial assessment, and/or intervention) should take place.

Expected practice is to involve the family in the completion of the Early Help Assessment (EHA) Form and gain consent for referral unless unsafe or inappropriate to do so.
If the LCHS practitioner will not have further contact with the child/family (e.g. UCC / MIU staff) it has been agreed that an abbreviated Early Help referral form can be forwarded to the Early Help Team with the family consent. The full assessment will then be completed by the early help team.
If the LCHS practitioner is involved in continuing work with the young person or family they are responsible for the completion of the full early help referral.

Health professionals cannot remain anonymous when making a child protection referral.

Where members of the public inform you of a child protection concern, it is important you obtain their contact number, name of the child for whom they have concerns and the address if possible.

They must be advised to refer to children's Social Care themselves. However the health practitioner has a duty to check the referral has been made, and if not to make a third party referral giving the details obtained from the member of the public.

If your referral is not accepted by CSC please contact the locality Deputy Named Nurse/Practitioner for further support, advice and discussion.

Children's Social Care must acknowledge a referral within one working day of receiving it and must feedback their decision on next steps of action to the referrer within one working day.

If you do not receive a response following your referral within 3 working days the health professional must contact children's Social Care to determine what action has been taken.

Sometimes it may be necessary for emergency action to be taken to safeguard a child. Such action should be preceded by an immediate strategy discussion between the police, children's Social Care, health and other agencies as appropriate.

Where children's Social Care decides to take no further action at this stage, feedback should be provided to the referrer, who should be told of this decision and the reasons for making it. This must be clearly recorded in the child's records.

The referrer should be advised of alternative options for offering support to the family including information/advice/referral to other agencies such as the family group conference service or a coordinated package of interagency support through the Team Around the Child (TAC) process.

The referrer should discuss these options with the parent and young person and gain consent for the next steps. The referrer will have a key role in taking forward these options in partnership with the family.

10. Escalation and Challenge

It is the responsibility of the healthcare practitioner to appropriately and professionally challenge decision making by other professionals where necessary.

Challenge must be respectful and evidence based on the clinician's risk assessment. Challenge may be towards colleagues in other NHS settings or towards partners such as social care and police. It is essential that issues of status do not prevent appropriate challenge.

Support to do this is available via LCHS Safeguarding team who will take the appropriate action to escalate via the Named Nurse. The Named Nurse will have recourse to involving the Senior Lead Officer (SLO) and Lead director if necessary.

The LSCP Escalation policy is available here and the CPSCB Escalation policy is available here.

11. Use of Body Maps in Safeguarding

If a significant mark/ injury is seen that may be considered non accidental it must be recorded on a body map and a description must be recorded in the records.

When completing the body map ensure it is clear and correctly completed to include the date and time the injury was observed.
Body maps are available on SystmOne/or can be completed in paper format and scanned into child's record. Body maps are also be located on the LCC policies and procedures in the 'child protection' section.

12. Did Not Attend/Was Not Brought to Appointments

Failing to attend appointments is a known factor in abuse and neglect. Practitioners must ensure assessment is carried out to identify the significance of this and refer to agencies as appropriate.

To support practice and for further guidance refer to: Policy for Children, Young People and Adults who Was Not Brought (WNB) to health appointments (LCHS P_CS_45).

13. Transfer of Records

Practitioners must ensure that that all records for vulnerable children (including looked after children) are transferred following procedures to demonstrate that there has been effective handover to allow for continuity of care. Procedures for transfer of all records must be followed.

There **must** be telephone contact with the new practitioner to facilitate a thorough and safe handover.

The Child Health Department will be able to assist in accessing contact numbers for the new area. This procedure is for all children and families subject to child protection, child in need or Team Around the Child (TAC) processes.

14. Information Sharing

Sharing information is critical where you have reasonable cause to believe that a child or young person may be suffering or may be at risk of suffering significant harm, you must always refer your concerns to children's social care or the police, in line with your Local Safeguarding Children Partnership (LSCP) procedures.

14.1 Seven Golden Rules to Information Sharing

1. Remember that the Data Protection Bill is not a barrier to sharing information but provides a framework to ensure that personal information about "natural" persons is shared appropriately.
2. **Be open and honest** with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
3. **Seek advice** if you are in any doubt, without disclosing the identity of the person where possible.
4. **Share with consent where appropriate** and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest. You will need to base your judgement on the facts of the case.
5. **Consider safety and well-being:** Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.
6. **Necessary, proportionate, relevant, accurate, timely and secure:** Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.
7. **Keep a record** of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

(Information Sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers, HM Government, 2018).

14.2 Legal Considerations

The key principles governing the sharing of information are detailed in the UK Data Protection Legislation 2018 and the Caldicott Report 2016. The Human Rights Act 1998 and the common law "duty of confidentiality' are also relevant in this context.

The UK Data Protection Legislation 2018 has particular safeguards in respect of "sensitive data" which includes the (alleged) commission of any criminal offence, and any information about his or her "sexual life' or physical or mental health or condition.

Such information can be disclosed without the consent of the individual where it is necessary to safeguard the welfare of the child. This is because the act allows information to be processed if it is necessary for the exercise of Children Act 1989 and 2004 functions.

The Human Rights Act 1998, Article 8, requires all public authorities to have respect for an individual's (both children and adults) private and family life. Interference with that right can be justified provided it is "in accordance with the law and is necessary in a democratic society for the protection of health or morals, or for the protection of the rights and freedoms of others". However, any action that is taken must be proportional to the identified legitimate aim. Information necessary to safeguard the child(ren)'s welfare should be disclosed.

14.3 Child Protection Information System (CP-IS)

The Child Protection Information System (CP-IS) is a system dedicated to developing an information sharing process that will deliver a higher level of protection of children who visit NHS unscheduled care settings. It provides additional child protection information to staff, shares local authority information with the NHS and allows staff to deliver a higher level of safeguarding.

It is the responsibility of the Practitioner who is seeing the child to access CP-IS for ALL patients under the age of 18 years seen in an unscheduled care setting via the CPIS setting in the child's systm 1 record.

Sharing information effectively across health and care settings is vital in protecting vulnerable children and young people and preventing further harm. CP-IS focuses on three specific categories:-

- Those subject to a child protection plan or a plan with in the last 12 months
- Those with 'looked after child' status (children with full and interim care orders and voluntary care agreements)
- Any pregnant woman whose unborn child has a pre-birth child protection plan

More information on the CP-IS programme can be found at: http://digital.nhs

14.5 Information Sharing Process

Information may be shared in face to face meetings or by telephone using the ring back check system. Always check and document to whom you are speaking and their professional need to receive the information.

All professionals should be clear about:-

- Is the enquiry part of a safeguarding child investigation?
- Are there sufficient concerns to approach the agency and for that agency to agree to share information without the parent/carers knowledge?
- Why is information being shared?

- Is the information requested proportionate to achieve the aim?
- How the information will be used?
- Could the child be at risk of continuing significant harm if agencies do not share information?

If a request for information is received, clarify with the enquirer about their plans to discuss the information you have given them with those individuals concerned. Record all conversation in the child's health records, including what has been discussed and agreed actions. Be prepared to submit a written report if necessary.

NB: You will need to be aware of the LCHS policy before sending patient identifiable information by secure e-mail.

14.6 Caldicott Principles – A Code of Good Practice

Principle One: Justify the Purpose

Principle Two: Don't use personal information unless it is absolutely necessary

Principle Three: Use the minimum necessary personal identifiable information

Principle Four: Access to personal information should be on a strict need to know basis.

Principle Five: Everyone should be aware of their responsibilities

Principle Six: Understand and comply with the law

Principle Seven: Security. To have the appropriate security to prevent the personal data you hold being accidentally or deliberately compromised

14.7 Confidentiality of Adult Information

The safety and wellbeing of children is the paramount consideration as their age and vulnerability may render them powerless to protect their own interest. Wherever there is a conflict of interest between health service provision to an adult client and a child, the interests and welfare of the child are paramount (Children Act 1989) and must take precedence.

14.8 Allegations

Allegations of abuse of children relating to staff or volunteers of the organisation are addressed in LCHS Policy P_HR_01 "Allegations of Abuse' policy.

15. Why We Need Records

Previously many serious review reports of child deaths or serious injury have highlighted record keeping as poor.

The need for accurate, up to date, legible and complete records has never been more important. This is particularly true where safeguarding issues are raised.

All Health Professionals must keep meticulous contemporaneous records and with due regard for confidentiality. They should be prepared to share information contained within

them with others who need to know, including carers and children (see information sharing).

Records constitute:

- A contract between practitioner and family
- A rationale for care
- An accurate reflection of practice (practice should also reflect the records)
- A focus point for standard setting, quality assessment and audit
- A baseline against which to measure progress or deterioration
- An indication of the way forward

15.1 Record Keeping

Records must:

- Include demographics, groups and relationships (consider use of genogram). Record time and place.
- Must always state who child was accompanied by (name and relationship) and confirm they have parental responsibility.
- Be accurate and record purpose and professional activity with the child/family/carer. Think Family and be mindful of family dynamics and circumstances.
- Electronic records must include your name and job title.
- Unambiguous– distinguishing between factual information and professional opinion.
- Be contemporaneous – written as near to the actual event as possible (LCHS standard is within 24 hours).
- Use only approved LCHS abbreviations avoid subjective statements; ensure all information recorded is factual and non-biased.
- The same quality standards are required whether records are electronic or handwritten.

Where there are concerns about children's safety and wellbeing

If anyone has concerns about a child or young person's welfare or safety, it's vital all relevant details are recorded.

Keep an accurate record of:

- the date and time of the incident/disclosure;
- the date and time of the report;
- the name and role of the person to whom the concern was originally reported and their contact details;
- the name and role of the person making the report (if this is different to the above) and their contact details;
- the names of all parties who were involved in the incident, including any witnesses to an event;
- what was said or done and by whom;
- any action taken to look into the matter;
- any further action taken (such as a referral being made); and
- the reasons why the organisation decided not to refer those concerns to a statutory agency (if relevant).

All reports must be factual and any interpretation or inference drawn from what was observed, said or alleged should be clearly recorded as such. The record must always be signed by the person making the report.

15.2 Chronology of Significant Events

A chronology of significant events **MUST** be easily identified in all health records.

Examples of significance for a particular child/family may include:

- Incidents of abuse and neglect
- Incidents of domestic abuse
- Referrals to children's social care or other agencies
- Substance use
- Mental health issues
- Self-harm
- Significant moves / address changes or changes of carer/partner
- If child is subject to a child protection or child in need plan
- If child is subject to Team around the Child plan
- Repeated "no access' to arranged contacts
- Repeated attendance for medical appointments e.g. hospital accident and emergency department or
- Repeated non-attendance / not being brought to attend for medical/therapeutic appointments

A record forms the basis for a legal statement and for evidence in court. The records themselves may be subpoenaed by the court. All requests for release of LCHS records must be via the LCHS Information Governance department.

15.3 Flagging

It is essential that records are flagged appropriately when children are subject to Team Around the Child (TAC), Child in Need (CIN), Child Protection (CP), at risk of Child Sexual Exploitation (CSE) or Looked after Children (LAC). It is also essential that flags are updated and removed where appropriate.

Flags must also be used when victims are subject to MARAC. MARAC flags MUST always be removed after 12 months. It is the responsibility of the practitioner to ensure all flags are current and valid.

16. Safeguarding Children Training

To protect children and young people from harm all staff working within health services, including those in contracted services must have a level of child protection training appropriate to their role (RCPCH,2019)

Adults accessing care from adult services are frequently parents and carers of children, or may be in contact with children. Therefore staff who work only with an adult caseload also need to access appropriate levels of safeguarding children training.

It is the practitioner's responsibility to keep themselves professionally updated in respect of safeguarding.

Staff groups however will have different training needs according to their degree of contact with children, parents and carers, and their level of responsibility.

Staff must achieve the required level of training identified on the Mandatory Training Matrix available on LCHS website

All staff should access LSCP e-learning and LSCP multi-agency face to face training to complement the LCHS training appropriate to their role, more information is available in the intercollegiate document, here.

For further information regarding education in Safeguarding contact LCHS Education & Workforce Development Team. The corporate safeguarding team is also available for help and advice.

16.1 Audit of Training

Staff member attendance at identified levels of training is audited by the Education & Workforce Development Team. The compliance is reported to and monitored by the Safeguarding and Patient Safety Group

17. Support and Supervision

It is recognised that safeguarding forms only a small part of a staff member's workload. This work can be both stressful, demanding and anxiety provoking. When the staff member encounters children who are suffering or are at risk of abuse they will need to make difficult decisions about what action to take. It is because of this stress and anxiety that practitioners require support in their work, both formal and informal.

All staff can receive support in a number of ways, including informal peer support, managerial guidance and through safeguarding supervision.

Effective safeguarding supervision is important to promote good standards of practice and to support individual staff members.

Please refer to the LCHS Safeguarding Supervision Policy P_CS_02 for further guidance.

17.1 Audit of Supervision

Performance indicators relating to Safeguarding supervision are collated quarterly.

18. Safeguarding and Patient Safety Group

The LCHS Safeguarding and Patient Safety Group (SPSG) is chaired by the Deputy Director for Nursing and Quality. The terms of reference for this group ensure it reviews all incidents relating to safeguarding and monitors any action plans in relation to lessons learned for safeguarding practice. This group also monitors organisational compliance regarding safeguarding supervision and training.

APPENDIX 1

- The Children Act 1989 / 2004
- Working Together to Safeguard Children: A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children. HM Government (2018)
- What to Do If You're Worried a Child is Being Abused. HM Government (2015)
- The Victoria Climbie Inquiry. Lord Laming (2003)
- A Progress Report. Lord Laming (2009)
- Munro Review of Child Protection: Final Report – A Child Centered System (2011)
- Information Sharing: Advice for Practitioner's providing Safeguarding Services to Children, Young People, Parents and Carers. HM Government, 2015
- Brandon et al Building on Learning from Serious Case Reviews (2010)
- Safeguarding Children and Young People: Roles and Competences for Health Care Staff. Intercollegiate Document. Royal College of Paediatrics and Child Health (2019)
- The Signs of Safety Child Protection Practice Framework (Turnell 2010)
- The Home Office Define Domestic Violence and Abuse (2019)
- Stalking Protection Act 2019

NHSLA Monitoring

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individuals/ group/ committee	Frequency of monitoring/audit	Responsible individuals/ group/ committee (multidisciplinary) for review of results	Responsible individuals/ group/ committee for development of action plan	Responsible individuals/ group/ committee for monitoring of action plan
Number of cases reported	spreadsheet	Safeguarding and Patient Safety Group	Monthly assurance	Safeguarding and Patient Safety Group	Service Leads Named Nurse Safeguarding	Safeguarding and Patient Safety Group

Appendix 2 Equality Analysis

NB - It is the responsibility of the author / reviewer of this document to complete / update the Equality Analysis each time it has a full review and to contact the Equality Diversity and Inclusion Lead if a full equality impact analysis is required

Equality Impact Analysis Screening Form

Title of activity	Safeguarding Children		
Date form completed	May 2020	Name of lead for this activity	Gemma Cross

Analysis undertaken by:		
Name(s)	Job role	Department
Gemma Cross	Named Nurse for Safeguarding	Safeguarding

What is the aim or objective of this activity?	That all those working in the field of health comply with their commitment to protect children and vulnerable adults through their participation in inter-agency support to social service to ensure the safety, wellbeing and protection of vulnerable adults in their care
Who will this activity impact on? *E.g. staff, patients, carers, visitors etc.*	All trust staff either directly employed or by contract agreement and service users

Potential impacts on different equality groups:

Equality Group	Potential for **positive** impact	**Neutral** Impact	Potential for **negative** impact	Please provide details of how you believe there is a potential positive, negative or neutral impact (and what evidence you have gathered)
Age	☐	☐x	☐	
Disability	☐	☐x	☐	

Gender reassignment	☐	☐x	☐	
Marriage & civil partnerships	☐	☐x	☐	
Pregnancy & maternity	☐	☐x	☐	
Race	☐	☐x	☐	
Religion or belief	☐	☐x	☐	
Sex	☐	☐x	☐	
Sexual Orientation	☐	☐x	☐	
Additional Impacts ***(what other groups might this activity impact on? Carers, homeless, travelling communities etc.)***	☐	☐x	☐	

If you have ticked one of the above equality groups please complete the following:

Level of impact

	Yes	No
Could this impact be considered direct or indirect discrimination?	☐	☐
If yes, how will you address this?		

	High	Medium	Low
What level do you consider the potential negative impact would be?	☐	☐	☐

If the negative impact is high, a full equality impact analysis will be required.

Action Plan

How could you minimise or remove any negative impacts identified, even if this is rated low?
How will you monitor this impact or planned actions?
Future review date: