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 2010	Joy Gilbert
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5	Section 1	Strengthen diversity	28.11.11	Joy Gilbert
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7.1		Renumbered from P_CS_01 to P_SG_01	May 2016	Corporate Assurance Team
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7.3	Full document	Updated contact details & education statement.	May 2017	Jill Anderson
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9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

Safeguarding Children Policy and Procedures
CONTENTS

LINCOLNSHIRE COMMUNITY HEALTH SERVICES

Safeguarding Children Policy and Procedures

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 Board (LSCB) and Peterborough Safeguarding Children's Board (PSCB) 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 2015 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 LSCB Inter-agency Procedures www.proceduresonline.com/lincolnshirescb for those working in Lincolnshire or for those working in Peterborough www.peterboroughlscb.org.uk/children-board/professionals/procedures Additional procedures can be found regarding Early Help at www.lincolnshirechildren.net or for Peterborough www.peterborough.gov.uk/healthcare/early-help/PCCEarlyHelpinPeterboroughGuidelines Staff members can access LCHS policies and procedures via the intranet at www.lincolnshirecommunityhealthservices.nhs.uk the safeguarding link will take you to range of useful documents. 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 Head of 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 is 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

This policy has been written using current legislation and guidance including:
Working Together to Safeguard Children (HM Government 1999, 2006, 2010, 2013. 2015)
The National Service Framework for Children, Young People and Maternity Services (DOH 2004)
The Framework for Assessment (DOH2000)
What to do if you're worried a child is being abused (HM Government, 2015)
NICE Guidance CG89 (2009)
Munro Review of Child Protection (2011)
Children and Social Work Act 2017

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.
- To raise the awareness of ALL practitioner's responsibility of making a referral to Local Authority children's social care and signposting for appropriate support.
- To promote multi-disciplinary and multi-agency working.

ALL staff and volunteers MUST adhere to this policy.

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, 2015)

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.

LCHS has a lead director for safeguarding who is responsible for ensuring that the Board is fully aware of its safeguarding responsibilities.

LCHS has a duty under Section 11 of the Children Act 2004 to make arrangements to ensure that, in discharging its functions, it has regard to the need to safeguard and promote the welfare of children: we will be regularly audited to ensure that we have complied with this requirement.

LCHS will work with Lincolnshire County Council (LCC) and other statutory bodies to provide coordinated, and where possible, integrated services.

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 Safeguarding Children and adults consisting of a Head of Safeguarding, a Named Nurse Safeguarding (Adults), Named Nurse Vulnerable Children and Young People (VCYP), Deputy Named Nurses for Safeguarding and a Specialist Nurse Domestic Abuse.

The Deputy Named Nurses provide support, advice; supervision and training for the workforce.

The Head of Safeguarding & the Named Nurses provide strategic direction to the organisation in relation to safeguarding.

The VCYP team (including looked after children) is also part of the Corporate Safeguarding team and consists of a Specialist Nurse, Community Nurses, health service coordinators and an administrator.

LCHS has access to a Designated Doctor for Safeguarding Children and a Designated Nurse for Safeguarding Children (SWCCG), for professional support and advice.

All staff working within LCHS who have contact with children, parents and other adults in contact with children, have a duty to safeguard and promote the welfare of children.

Staff should be able to recognise, and know how to act on, 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 (2015) is for all Local Safeguarding Children Boards (LSCB) to produce a threshold document.

All practitioners must be familiar with the Lincolnshire LSCB threshold document "Meeting the Needs of Children in Lincolnshire - A Shared responsibility". This document can be accessed via the following link www.lincolnshirechildren.net

The Peterborough LSCB Threshold document 2016 can be accessed here www.safeguardingpeterborough.org.uk/wp-content/uploads/2016/09/PSCB-Threshold-Document-2016.pdf

LCHS is committed to learning from complaints, incidents and compliments. All incident forms (IR1) 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 NWCCG. A root cause analysis is always carried out where there has been an SI.

LCHS participates fully in each serious case review (SCR) commissioned by the Lincolnshire LSCB and Peterborough LSCB

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

The Executive Summary for each serious case review is tabled in the Private Session of the Trust Board, and the Board is asked to formally ratify an action plan to implement the recommendations from the serious case review.

5. LINCOLNSHIRE/ PETERBOROUGH SAFEGUARDING CHILDREN BOARD

The Lincolnshire Safeguarding Children Board (LSCB) and Peterborough Safeguarding Children's Board (PSCB) 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 LSCB operates on two levels, the Strategic Management Board (SMB) at which LCHS representation is by the Head of Safeguarding and the Operational Delivery Group (ODG).

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

LCHS are represented at LSCB subgroups and are invited to attend PSCB subgroup meetings.

The strategic plans and details of subgroups are available at www.lincolnshirelscb.org.uk or www.safeguardingpeterborough.org.uk

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, FII)

6.2 SEXUAL ABUSE AND 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**.

Child sexual exploitation 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. (Child Sexual Exploitation. DOH, Feb 2017)

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.

Child sexual exploitation 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.

6.3 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.

6.4 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 (2013) 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".

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."

6.5 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 LSCB Pre-birth protocol.

6.6 TRAFFICKED CHILDREN

'Trafficking of persons' means the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. 'Exploitation' includes, at a minimum, sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs. (Safeguarding Children who may have been Trafficked. HM Government 2011)

Trafficked victims are coerced or deceived by the person arranging their relocation. On arrival in the country/area of destination the trafficked child or person is denied their human rights and is forced into exploitation by the trafficker or person into whose control they are delivered. Although human trafficking often involves an international cross-border element, it is also possible to be a trafficked victim within a country or county and from one place to another.

For further information regarding trafficked children follow the Lincolnshire LSCB Trafficking protocol

6.7 FEMALE GENITAL MULTILATION (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. 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 via this link 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

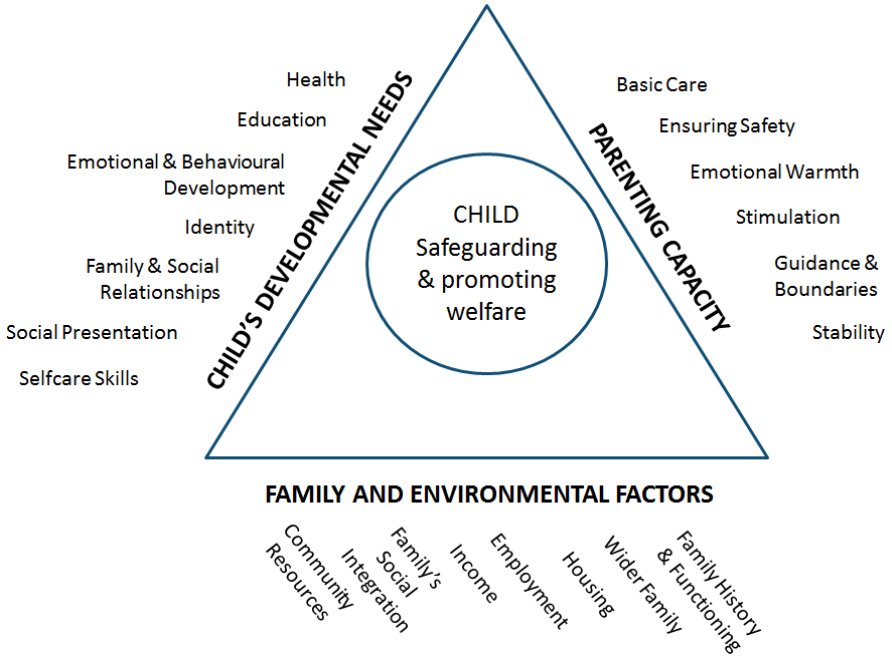
There are key processes that underpin work for safeguarding and protecting the welfare of children. These are:-

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

"The Framework for the Assessment of Children in Need and their Families (DOH et al 2000) which is fully integrated with Working Together 2015 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



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?

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

Referral Forms can be found on the Lincolnshire Children Safeguarding Board website **https://www.lincolnshire.gov.uk/LSCB**.

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 website

A LIST OF ALL USEFUL CONTACT NUMBERS CAN BE FOUND IN APPENDIX 2

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 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 TAC process, the lead professional or the key worker must always consider the need for a new S47 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 in writing or electronically within 24 working hours using the appropriate referral form, repeating all relevant information and agreed actions.

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.

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 for Safeguarding 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 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 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 the Deputy Named Nurse who will take the appropriate action to escalate via the Named and Designated Professionals. The Named and Designated Professionals will have recourse to involving the Senior Lead Officer (SLO) and Lead director if necessary.

The LSCB Escalation policy is available at www.proceduresonline.com/lincolnshirescb and the PSCB Escalation policy is available at www.safeguardingpeterborough.org.uk/children-board/professionals/procedures/escalation-and-conflict-resolution-policy

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.

A copy of the body map must accompany any referral to children's social care and a copy retained within the Childs records.

Body maps are available on SystmOne.

12. DNA /NO ACCESS APPOINTMENTS/WAS NOT BROUGHT

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: The policy for Clients who Do Not Attend (DNA) and No Access Visits (LCHS P_CS_45.)
https://www.lincolnshirecommunityhealthservices.nhs.uk/policies/safeguarding-policie

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 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 Board (LSCB) 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, 2015).

14.2 LEGAL CONSIDERATIONS

The key principles governing the sharing of information are detailed in the UK Data Protection Legislation 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 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 STSTEM (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 Doctor or 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.

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
- 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 notes or 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.

The GMC States

If you believe a patient to be a victim of neglect, physical or sexual abuse and unable to give or withhold consent to disclosure, you should usually give this information to an appropriate responsible person / statutory agency in order to further prevent harm to the patient. In these and similar circumstances you may release information without the patients consent, but only if you consider that the patient is unable to give consent and the disclosure is in the patients best medical interests. Disclosure may be necessary in the

"public interest" where a failure to disclose information may expose the patient or others to risk of death or serious harm. In such circumstances you should disclose the information promptly to the authority requesting. The GMC confirms that disclosure of information which may assist in the prevention or detection of abuse applies to information regarding third parties

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
https://www.lincolnshirecommunityhealthservices.nhs.uk/policies/safeguarding-policie

15 WHY WE NEED RECORDS

Many serious case 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 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.
- Do not include abbreviations, subjective statements and avoid the use of exclamation marks.

- 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 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)
- Repeated "no access' to arranged contacts
- Repeated attendance for medical appointments e.g. hospital accident and emergency department or
- Repeated non-attendance 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.

15.3 FLAGGING

It is essential that records are flagged appropriately when children are subject to 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 parents/carers 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,2014)

Adults accessing care from adult services are frequently parents and carers of children, or may be in contact with children. Therefore staff who only work 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 LSCB e-learning and LSCB multi-agency face to face training to complement the LCHS training.

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 work with vulnerable children forms only 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 children supervision.

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

Please refer to the LCHS Safeguarding Children Supervision Policy P_CS_02 **for** further guidance. https://www.lincolnshirecommunityhealthservices.nhs.uk/policies/safeguarding-policie

17.1 AUDIT OF SUPERVISION

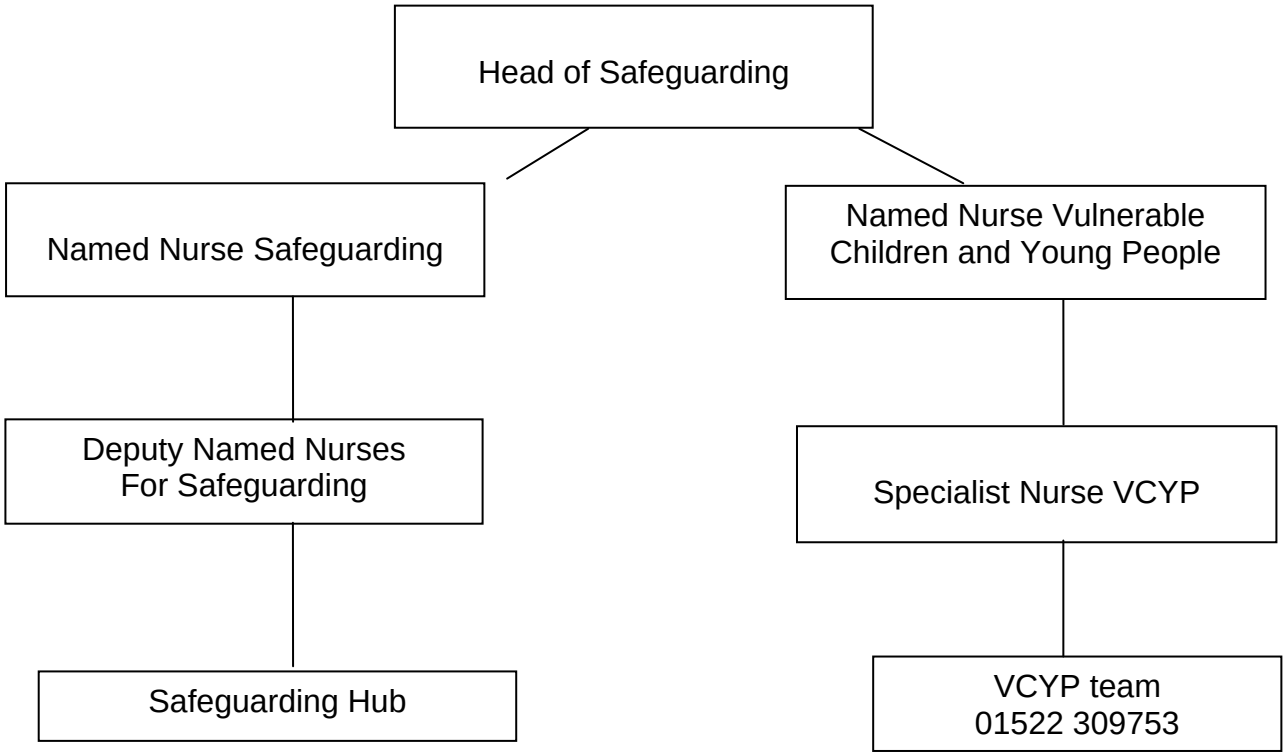
Performance indicators relating to child protection supervision are collated quarterly.

18 SAFEGUARDING AND PATIENT SAFETY Group (Governance group)

LCHS Safeguarding and Patient Safety Group (SPS) is chaired by the Deputy Director for Nursing and operations. 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

Corporate Safeguarding Team and Useful Contact Numbers



The Safeguarding team is available for advice and support Monday – Friday via the safeguarding hub on:

- **01522 308947 / 01522308949**

APPENDIX 2

USEFUL CONTACT NUMBERS

If you are concerned about a child, you can contact your local police or Local Authority Children's Social Care on these numbers:

Lincolnshire County Council Children's Social Care:

Customer Services Centre (CSC)	Tel: 01522 782111
Out of Hours Emergency Duty Team (EDT)	Tel: 01522 782111
Reviewing Unit Enquiries regarding whether child is/has been subject to a Child Protection Plan.	Tel: 01522 554061

Peterborough County Council Children's Social Care:

Peterborough Referrals 9am – 5pm - contact customer services	Tel: 01733 864170
Cambridgeshire Referrals (Mon – Thurs) 8am – 5:30pm; (Friday) 8am – 4:30pm	Tel:0345 045 1362
Emergency referrals – Peterborough / Cambridgeshire Out of Hours Emergency Duty Team	Tel: 01733 234724

Lincolnshire Police	Tel: 01522 532222
Police Central Referral Unit	Tel:01522 782159
In an emergency	999

Adult Social Care - Lincolnshire	Tel: 01522 782155
Adult Social Care - Peterborough	Tel: 01733 747474

APPENDIX 3

Links to relevant safeguarding policies and procedures

- Lincolnshire Child protection procedures i.e. referral, escalation: www.proceduresonline.com/lincolnshirescb

- Peterborough Child Protection procedures i.e. referral, escalation: www.safeguardingpeterborough.org.uk/children-board/professionals/procedures/escalation-and-conflict-resolution-policy

- Lincolnshire Early Help/TAC Manuals www.lincolnshirechildren.net

- Peterborough Early Help/TAC Manuals www.safeguardingpeterborough.org.uk/wp-content/uploads/2016/09/PSCB-Threshold-Document-2016.pdf

- Mandatory Reporting of Female Genital Mutilation – procedural information (Home Office, October 2015 – last updated 200117) https://www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information

- FGM. Mandatory reporting in health care (Home Office, October 2015 – last updated 200117) https://www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare

- Safeguarding Children and Young People from Child Sexual Exploitation (DoE, 2017) https://www.gov.uk/government/publications/safeguarding-children-and-young-people-from-sexual-exploitation-supplementary-guidance

- Safeguarding Children in whom illness is Fabricated or induced (DOH, DoE, Home Office 2008) https://www.gov.uk/government/publications/safeguarding-children-in-whom-illness-is-fabricated-or-induced

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The Code-Standards and conduct, performance and ethics for nurses and midwives. London:NMC Nursing & Midwifery Council (2008)

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NSF for Children, Young People and Maternity Services (2004)

The Victoria Climbie Inquiry. Lord Laming (2003)

A Progress Report. Lord Laming (2009)

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Staying Safe: Action Plan. HMG 2008

A Child-centred System, The Governments Response to the Munro Review of Child Protection, 2011

Department of Health (2004a) Core Standards-National Service Framework for Children, Young People and Maternity Services Department of Health (2004b) Choosing Health: Making healthy choices easier. London: Department of Health

Department of Health (2007) National Standards, Local Action-Health and Social Care Standards and Planning Framework 2005/6-2007/8

Brandon et al Building on Learning from Serious Case Reviews (2010)

Statutory guidance on making arrangements to safeguard and promote the welfare of children under Section 11 of the children Act 2004. HM Government (2007)

Brighter futures-the strategy for children and young people's health. HM Government (2009)

Supervision in Social Work. 4th ed. New York: Kadushin, A. and Harkness, D. (2002)

Columbia University Press
Safeguarding Children and Young People: roles and competences for health care staff. Intercollegiate document. Royal College of Paediatrics and Child Health (2014)

Safeguarding Children who may have been Trafficked. (HM Government 2011)

NICE Guidance CG89 (2009)

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 Practitioner Performance Assurance Committee	Annual	Safeguarding and Patient Safety Committee Practitioner Performance Assurance Committee	Service Leads Named Nurse Safeguarding	Safeguarding and Patient Safety Group

Section 1 – to be completed for all policies

A.	Briefly give an outline of the key objectives of the policy; what it's intended outcome is and who the intended beneficiaries are expected to be	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		
B.	Does the policy have an impact on patients, carers or staff, or the wider community that we have links with? **Please give details**	All trust staff either directly employed or by contract agreement and service users		
C.	Is there is any evidence that the policy\service relates to an area with known inequalities? **Please give details**	No		
D	Will/Does the implementation of the policy\service result in different impacts for protected?	No		
		Yes	**No**	
	Disability		X	
	Sexual Orientation		X	
	Sex		X	
	Gender Reassignment		X	
	Race		X	
	Marriage/Civil Partnership		X	
	Maternity/Pregnancy		X	
	Age		X	
	Religion or Belief		X	
	Carers		X	
	If you have answered 'Yes' to any of the questions then you are required to carry out a full Equality Analysis – please go to section 2			

The above named policy has been considered and does not require a full equality analysis	
Equality Analysis Carried out by:	Jean Burbidge
Date:	March 2018
Agreed by: Equality & Human Rights Lead	
Date:	

Human Rights Assessment Tool

The Human Rights Act, which came into force in October 2000, incorporates into domestic law the European Convention on Human Rights to which the UK has been committed since 1951. Section 6 of the Human Rights Act makes it unlawful for a public authority to act in a way that is compatible with a Convention right. The underlying intention of the Act is to create a Human rights culture in public services.

		Yes/No	Comments
1	Will it affect a person's right to life?	No	
2	Will someone be deprived of their liberty or have their security threatened?	No	
3	Could this result in a person being treated in a degrading or inhuman manner?	No	
4	Is there a possibility that a person will be prevented from exercising their beliefs?	No	
5	Will anyone's private and family life be interfered with?	No	.

If the answer is ''yes'' to any of the above questions on the proforma can the policy be amended to avoid impacting on Human Rights? If not, please refer it to the Equality & Human Rights Lead for advice and guidance.